



House of Commons
Committee of Public Accounts

**The Care Quality
Commission:
Regulating the quality
and safety of health
and adult social care**

**Seventy-eighth Report of Session
2010–12**

*Report, together with formal minutes, oral and
written evidence*

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Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine "the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit" (Standing Order No 148).

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The following Members were also Members of the committee during the parliament:

Dr Stella Creasy (*Labour/Cooperative, Walthamstow*)
Justine Greening (*Conservative, Putney*)
Joseph Johnson (*Conservative, Orpington*)
Eric Joyce (*Labour, Falkirk*)
Rt Hon Mrs Anne McGuire (*Labour, Stirling*)

Powers

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.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/pac. A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

Committee staff

The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

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Contents

Report	<i>Page</i>
Summary	3
Conclusions and recommendations	5
1 The management and governance of the Care Quality Commission	7
2 The operations of the Care Quality Commission	10
Formal Minutes	14
Witnesses	15
List of printed written evidence	15
List of Reports from the Committee during the current Parliament	16

Summary

The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. It was formed in 2009 from the merger of three previous regulators. It currently regulates over 21,000 care providers against 16 essential standards of quality and safety. The Commission plays an absolutely vital role in providing assurance to the public, both by ensuring appropriate quality standards and by deterring poor quality and unsafe care. The Commission takes action where it finds standards are not being met. To date, however, it has failed to fulfil this role effectively.

The Commission has more responsibilities but less money than its predecessors. Despite this it has consistently failed to spend its budget because of delays in filling staff vacancies. It is overseen by the Department of Health (the Department), which underestimated the scale of the task it had set in requiring the Commission to merge three bodies at the same time as taking on an expanded role. The Commission did not act quickly on vital issues such as information from whistleblowers. Neither did it deal with problems effectively, and the Department is only now taking action. We have serious concerns about the Commission's governance, leadership and culture. A Board member, Commission staff, and representatives of the health and adult social care sectors have all been critical of how the Commission is run.

Neither the Commission nor the Department have defined what success would look like in regulating health and adult social care. This makes it hard for us to know whether the Commission has the resources it needs to operate effectively. In addition, while the Commission reports what it does, it does not measure the quality or impact of its work. Where information is available, it is not presented in a way that allows the public to make meaningful comparisons between care providers. As a result, the public are unclear what the Commission's role is and lack confidence that it is an effective regulator.

The Commission faces a major challenge later in 2012 with the registration of 10,000 GP practices. In the past, the Commission's inspection work has suffered when it has had to register large groups of providers. It shifted its focus to registration and carried out far fewer inspections than planned. In the light of these problems, the Commission has changed the registration process. Registration will now be decided primarily on the information provided by the GPs themselves. GP practices will be required to declare whether or not they are meeting the essential standards. This process carries risks and the Commission must make sure the registration process is robust and provides meaningful assurance about the quality of GP practices.

The Commission's inspectors are responsible for large and varied portfolios of providers. Individual inspectors do not have sufficient support to develop the range of expertise and experience needed, and there is a lack of consistency in their judgements and in the Commission's approach to taking enforcement action. Whistleblowers have to be a key source of intelligence in helping the Commission to monitor the quality of care, but the Commission has closed the dedicated whistleblowing line that the Healthcare Commission had used.

The Commission has a long way to go to become an effective regulator. It is not ready to take on the functions of other organisations, such as the Human Fertilisation and Embryology Authority, as the Department has proposed.

On the basis of a report from the Comptroller and Auditor General¹ we took evidence from the Commission and the Department on the Commission's management and governance, and on the Commission's operations to regulate the health and adult social care sectors.

¹ C&AG's Report *The Care Quality Commission: Regulating the quality and safety of health and adult social care*, Session 2010-12, HC 1665

Conclusions and recommendations

- 1. The Department is ultimately responsible for the effective regulation of health and adult social care but has not had a grip on what the Commission has been doing.** It is clear that the Commission has been struggling for some time, but only now has the Department started to take action. During the hearing the Department's Accounting Officer set out five areas where she wants to see improvements. The Department should turn these areas into an action plan which sets out in detail exactly what needs to be done to secure the changes required. The Department should report back to us by the end of April 2012 on when we can expect to see progress against each of the five areas.
- 2. The Commission has been poorly governed and led.** The Commission has failed to strike the right balance between registration and inspection. A Board member, Commission staff and representatives of the health and adult social care sectors have raised serious concerns about the Commission's leadership, governance and culture. The Commission is regarded as overly focused on reputation management and has included gagging clauses in its severance deals with staff. Such clauses discourage people from speaking out and making public information that would help drive improvement and hold the Commission to account. The errors in the Commission's annual report to Parliament also raise questions about the effectiveness of governance and internal control. The Department should carry out a fundamental review of the adequacy of the Commission's current governance and leadership, take action to strengthen these areas and hold the Commission and its senior management to account.
- 3. The Commission's role is unclear and it does not measure the quality or impact of its own work.** The Commission's objective, as set out in legislation, is to 'protect and promote the health, safety and welfare of people who use health and social care services' but it has not defined what success in delivering this objective would look like. It is unclear to what extent the Commission's role involves improvement beyond the essential basic standards of quality and safety. Although the Commission is a Quality Commission it only measures itself against quantitative, activity-based performance measures, with no measures of quality or impact. The Commission, working with the Department, should set out clearly what it is seeking to achieve and develop measures of quality and impact which can be used to assess its effectiveness.
- 4. The information provided to the public on the quality of care is inadequate and does not engender confidence in the care system.** The Commission does not collate data on enforcement action, and does not present its assessments in a way that gives the public a clear picture of the state of care available. Residential care homes are no longer awarded star ratings, which previously helped the public to differentiate between providers. The Commission should collect and publish data on enforcement, together with information on the extent to which providers in particular areas are meeting the essential basic standards to allow the public to get a national, regional or local picture of the state of care. In addition, the Department should address the gap left by the removal of star ratings.
- 5. The registration of GP practices must involve a meaningful assessment of compliance with the essential standards of quality and safety.** The proposed process will involve GP practices declaring areas where they are not compliant, and the Commission

told us that it will seek to draw on other sources of information to indicate which practices give rise for concern. We are not convinced that this approach will work in practice, particularly given the number of GP practices to be registered, and the Commission risks becoming simply a postbox. The Commission should review and set out how it will make sure that the assessment of GP practices is meaningful. It should develop clear criteria to use to judge when it needs to undertake further investigations before a practice can be registered.

6. There are inconsistencies in the judgements of individual inspectors and in the Commission's approach to enforcement. The Commission's own internal auditors found variations in how inspectors assess risk and we received evidence that there is insufficient focus on both the quality and consistency of inspectors' work. In addition, the approach to enforcement is variable, with action more likely to be taken against care homes than hospitals. The Commission should provide training and guidance to inspectors that specifically addresses the risk of inconsistent judgements in inspections and enforcement, and should use performance data to monitor trends and identify areas of concern.

7. The Commission must strengthen its whistleblowing arrangements. Whistleblowing information from staff and the public should be a key source of intelligence about the quality of care, and the number of whistleblowers has increased dramatically since the Winterbourne View case came to light in May 2011. However, the Commission expects callers to use its general enquiry line, which may discourage whistleblowers and not give them the specialist support they require. The Commission should re-establish a dedicated whistleblowing line, operated by specialist staff, and publicise it widely.

8. The Commission should not take on the functions of the Human Fertilisation and Embryology Authority at this time. The Department is proposing to transfer to the Commission the functions of other organisations, including the Human Fertilisation and Embryology Authority, which regulates IVF services. In our view, the Commission does not have the capacity to take on oversight of such a complex area, and the change would undermine its ability to focus on the improvements it needs to make in relation to its existing regulatory functions.

1 The management and governance of the Care Quality Commission

1. The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. It is a non-departmental public body, overseen by the Department of Health (the Department). Its objective is to ‘protect and promote the health, safety and welfare of people who use health and social care services’.² Formed in 2009 by merging the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission, it currently regulates over 21,000 care providers against 16 ‘essential standards’ of quality and safety, through registration, inspection and, where necessary, enforcement action. Tougher enforcement powers were a key element of the Commission’s design and the new system brought more providers, including dentists and GPs, within the scope of the regulator.³

2. Although the Commission has more responsibilities, its budget for 2010-11 was 6% less than the combined budget of its predecessors for 2008-09.⁴ Despite this, the Commission has consistently underspent against its budget. For 2011-12, it is projecting an underspend of £14 million (10%), mainly because of the continuing delays in filling staff vacancies.⁵

3. The Commission focused the staff it did have on registration rather than inspection, and as a result carried out far fewer inspections than planned. The Department clearly underestimated the scale of the task it had set the Commission.⁶ The Department told us that it is ultimately responsible for ensuring there is improvement in the Commission’s systems and processes, and that where there are problems it is accountable for ensuring these are addressed. The Department’s Accounting Officer set out five areas where she would like to see improvements. These were: clarifying the Commission’s strategic direction; setting clear priorities, matching resources to them, and understanding what things cost; improving accountability between the Department and the Commission; improving engagement and communication with the public; and developing the regulatory regime to get the right balance between inspection, the ‘user voice’ and the use of information.⁷

4. We have serious concerns about the leadership, governance and culture of the Commission.⁸ In its most recent annual report to Parliament, the Commission reported incorrect information, claiming to have completed twice as many inspections and reviews than was in fact the case. One member of the Commission’s Board has been so troubled that she has made public her concerns about how the Commission is being run. She told us that she had still not had adequate opportunity to discuss her concerns with the

2 Health and Social Care Act 2008, part one, chapter one, para 3 (1)

3 Q 48, C&AG’s report para 1.3 & 1.5

4 Q 111

5 Qq 113, 196, Ev 46

6 Q 49

7 Qq 53- 58

8 Qq 52, 118, 165

Department, and that she had been ostracised and vilified since she challenged the Commission's leadership.⁹

5. The Commission has been criticised for being overly concerned with reputation management at the expense of transparency and accountability.¹⁰ Staff leaving the Commission have been made to sign compromise agreements containing confidentiality clauses, tantamount to gagging clauses. This Committee has expressed concern on previous occasions about the use of such clauses. The Department confirmed that confidentiality clauses are not in themselves prohibited, but its guidance makes clear that clauses that seek to prevent the disclosure of information in the public interest should not be allowed. We are concerned, however, that the use of confidentiality clauses makes people reluctant to speak out, even though their whistleblowing rights may be legally protected.¹¹

6. The Commission's strategy and focus remain unclear. In particular there is confusion about the extent to which its role goes beyond regulating against the essential minimum standards into wider quality improvement.¹² This was illustrated by the evidence we heard. One witness felt that the Commission should be doing more to drive improvement, while others considered that the Commission's primary role should be to ensure minimum quality and safety standards.¹³

7. The Commission has not defined what successful regulation would look like, even though it has been operating for nearly three years.¹⁴ Currently its performance metrics are quantity-based measures of activity, such as the number of reports produced, with no measures of quality, a position we find astonishing given the Commission's purpose is to regulate quality.¹⁵

8. The Commission is the third regulator for health and adult social care in the last decade. None of the witnesses we heard from was in favour of further reorganisation, stressing that the existing arrangements need to be made to work better. The Department thought that visible and sustained improvement should be apparent in two years time.¹⁶

9. The Department has proposed to transfer the functions of the Human Fertilisation and Embryology Authority and the Human Tissue Authority to the Commission in 2015.¹⁷ The Chair of the Human Fertilisation and Embryology Authority (the Authority) argued passionately against this change. The Authority already shares premises and back-office functions with the Commission and has achieved the savings set out in the public spending review. The Chair felt there would be little benefit in merging the Authority's specialist role

9 Q 104

10 Qq 22, 35, 40, 56

11 Qq 102-107, Ev 45

12 Q 12

13 Qq 13, 18, 20

14 Qq 143- 149

15 Qq 35, 52 144

16 Qq 32,165, C&AG Report para 1.2

17 Q 5

of regulating IVF services with the wider role of the Commission. Furthermore, a merger would put the standard of regulation at risk and would not provide value for money.¹⁸

10. The Department congratulated the Authority on the way it had worked with the Commission. In the light of the discussion it had heard at the Committee, the Department said it would have a full consultation before further decisions were made about transferring the functions of the Human Fertilisation and Embryology Authority and the Human Tissue Authority to the Commission. This is a welcome pause.¹⁹

18 Qq 2-6

19 Q 117

2 The operations of the Care Quality Commission

11. The Commission plays a vital role in protecting the users of health and adult social care services by deterring poor quality or unsafe care, detecting where it does exist, and taking action to ensure providers comply with the essential standards. The way the Commission operates has a significant impact on the quality and safety of care, and on public confidence in the health and social care system.²⁰

12. The National Audit Office reported that, in November 2011, the Commission had major concerns about 407 providers, 94% of whom were adult social care providers. This paints a worrying picture for the users of the services in question.²¹ The Commission confirmed that each of the 407 cases would be reviewed on a regular basis and progress monitored. If necessary, additional inspections or enforcement action would be taken.²²

13. In December 2009 the Commission reorganised its staff into regional teams and disbanded its national investigations team.²³ Since then it has begun to undertake thematic reviews of particular aspects of care covering a sample of providers. For example, the dignity and nutrition inspections carried out between March and June 2011 identified concerns in 55 of the 100 NHS hospitals inspected. The Commission has since re-visited the hospitals concerned.²⁴

14. The remaining large scale registration exercise is the registration of GP practices. The Commission will have to register some 10,000 GP practices between September 2012 and April 2013.²⁵ Previous registrations did not run smoothly and the Commission has streamlined its approach for GP practices. The new process will involve each GP practice completing a simplified online application form, which will require them to declare if they are fully compliant with the essential standards or to highlight areas of non-compliance.²⁶

15. The Commission has piloted the streamlined approach and 25% of GP practices declared that they were not compliant with the essential standards.²⁷ The Commission does not expect it will need to follow up all such cases, especially where there is an action plan in place to mitigate the risks. However, a proportion will need to be looked at in greater detail, together with GP practices where the Commission has concerns based on information from other sources. The Commission will draw on information from primary

20 Qq 31, 82, 165, C&AG's para 1.5

21 Q 38

22 Ev.43

23 Q 86

24 Qq 26, 27

25 C&AG's Report, Figures 3 & 12

26 Q 68

27 Ev.40

care trusts and the General Medical Council to inform its judgement as to whether a particular GP practice should be registered, and will, if necessary, carry out an inspection.²⁸

16. Registration is important as it indicates that the Commission is satisfied that a GP practice is complying with the essential standards and, without it, practices will not be subject to the Commission's enforcement powers.²⁹ We are concerned, however, that the Commission will simply be a 'postbox' for self-certified applications and that the process will not be sufficiently robust to give the public meaningful assurance that registered GP practices are meeting the essential standards.³⁰

17. When the Commission has had to register large numbers of providers in the past, the number of inspections undertaken dropped dramatically. Inspections are now increasing, however, and the Department assured us that inspectors will not be diverted to help with the registration of GP practices.³¹

18. There is evidence of inconsistency in how inspectors carry out their work. The Commission's own internal auditors reported in March 2011 that differences in approach were leading to inconsistencies within and between regions.³² We received evidence that there is no robust assurance system to ensure that inspectors' judgments are consistent, and that the Commission's focus is on activity levels rather than the quality of inspectors' work.³³ The Commission referred to the quality assurance systems it has in place and the role of compliance managers in overseeing inspectors and securing consistency.³⁴

19. Each inspector has a large and varied portfolio, covering, for example, hospitals, care homes and dentists. We received evidence that inspectors have not been given enough training and support to understand fully what constitutes good quality care in sectors where they have no experience.³⁵ The Commission told us that inspectors are expected to be experts in regulatory, not clinical, standards, and are supported by practitioners with up-to-date clinical expertise. For example, when the Commission starts to inspect GP practices, inspectors will be accompanied by GPs to help establish the things they should be looking for.³⁶

20. The Commission has a range of enforcement powers to deploy when it judges that a provider is failing to meet the essential standards. For example, it can restrict the number of beds in a care home or hospital or the type of activity that can be undertaken at a particular location. Ultimately, it can prosecute a provider, although this power has never been used.³⁷

28 Qq 70-74

29 Qq 61-62, Ev. 39

30 Qq 157, 161

31 Qq 80-81, C&AG's Report, para 4.20

32 Qq 139, 212, C&AG's Report, para 4.13

33 Q 208, Ev.37, C&AG's Report, para 4.13

34 Ev.44

35 Qq 166, 193, Ev.38

36 Qq 194-195

37 Q 35, C&AG's Report, para 4.25 – 4.27, Figure 16

21. We heard evidence about inconsistencies in the Commission's approach to enforcement. Specifically that enforcement action is not taken as quickly in hospitals as it is in care homes, and that the sanctions applied in the case of NHS providers are more lenient.³⁸ The Commission told us that it may use its powers differently because of local circumstances. In making judgments about enforcement action it has a legal obligation to be proportionate and to consider the impact of its decisions on the provider and the services available to the wider community. It had begun to take action against NHS providers, and agreed that it had the option of closing individual wards rather than whole hospitals.³⁹

22. The Commission collects only limited data on enforcement.⁴⁰ It is therefore not possible for the public, or the Commission's own Board, to build a national picture of enforcement activity or to see where the Commission is having an impact. This information is fundamental to maintaining public confidence.⁴¹ More generally, data on compliance with the essential standards is not presented in a way that allows comparisons between providers and there is no comprehensive view of the overall state of care.⁴² The Commission said that, starting with adult social care from April 2012, it would have a specialist team which would produce a 'market overview' of trends in non-compliance.⁴³

23. In the past, residential care homes were awarded star ratings, which helped the public to differentiate between providers and make informed choices. Ministers decided in June 2010 to stop the star ratings system. The Commission assesses providers simply as compliant or non-compliant with the essential standards, and no organisation provides information on the quality of care beyond this.⁴⁴ The Department agreed that the public wanted to be able to differentiate between care providers and that there was currently an information gap. It does not consider it is the Commission's role to fill the gap, and plans to address the issue in the Social Care White Paper.⁴⁵

24. Whistleblowers should be a key source of intelligence about the quality of care. The Winterbourne View case highlighted major problems in the way the Commission handled whistleblowing information.⁴⁶ The Commission was contacted on more than one occasion by a whistleblower with information about what was happening at the home and, although it passed the information on to the local authority concerned, it did not follow up to check what action had been taken. It took a *BBC Panorama* programme to expose the abuse of patients.⁴⁷

38 Qq 25, 29

39 Qq 30, 127-128

40 C&AG's Report, para 1.17

41 Q 35

42 Q 228

43 Ev.43

44 C&AG's Report, para 1.13

45 Q 202

46 C&AG's Report, para 4.8

47 C&AG's Report, Appendix three

25. Since the *Panorama* programme in May 2011, the Commission has received approximately 2,500 whistleblowing calls, a dramatic increase on the 200 calls received in the course of a year prior to the programme.⁴⁸ However, the Commission scrapped the dedicated whistleblowing helpline that the Healthcare Commission had used and whistleblowers are expected to use the general helpline number.⁴⁹ The Commission stressed, however, that its arrangements had improved since Winterbourne View. It now has a team of six people to make sure that every whistleblowing call is followed up by an inspector.

48 Q 100

49 Qq 95-96

Formal Minutes

Monday 12 March 2012

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon
Jackie Doyle-Price
Matthew Hancock
Meg Hiller
Fiona Mactaggart

Austin Mitchell
Nick Smith
Ian Swales
James Wharton

Draft Report (*The Care Quality Commission: Regulating the quality and safety of health and adult social care*) proposed by the Chair, brought up and read.

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

Paragraphs 1 to 25 read and agreed to.

Conclusions and recommendations 1 to 8 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Seventy-eighth 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 reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Wednesday 14 March at 3.00pm]

Witnesses

Wednesday 25 January 2012

	<i>Page</i>
Professor Lisa Jardine CBE , Chair, Human Fertilisation and Embryology Authority	Ev 1
Mike Farrar , Chief Executive, NHS Confederation, Dr Anna Dixon , Director of Policy, King's Fund, Gary Fitzgerald , Chief Executive, Action on Elder Abuse, and Peter Walsh , Chief Executive, Action against Medical Accidents	Ev 3
Una O'Brien , Permanent Secretary, Department of Health, Cynthia Bower , Chief Executive, and Amanda Sherlock , Director of Operations, Care Quality Commission	Ev 9

List of printed written evidence

1	Action against Medical Accidents	Ev 32: Ev 36
2	Care Quality Commission	Ev 35: Ev 39: Ev 47
3	Kay Sheldon	Ev 37
4	Amanda Pollard	Ev 37
5	Department of Health	Ev 44: Ev 45

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 2010–12

First Report	Support to incapacity benefits claimants through Pathways to Work	HC 404
Second Report	Delivering Multi-Role Tanker Aircraft Capability	HC 425
Third Report	Tackling inequalities in life expectancy in areas with the worst health and deprivation	HC 470
Fourth Report	Progress with VFM savings and lessons for cost reduction programmes	HC 440
Fifth Report	Increasing Passenger Rail Capacity	HC 471
Sixth Report	Cafcass's response to increased demand for its services	HC 439
Seventh Report	Funding the development of renewable energy technologies	HC 538
Eighth Report	Customer First Programme: Delivery of Student Finance	HC 424
Ninth Report	Financing PFI projects in the credit crisis and the Treasury's response	HC 553
Tenth Report	Managing the defence budget and estate	HC 503
Eleventh Report	Community Care Grant	HC 573
Twelfth Report	Central government's use of consultants and interims	HC 610
Thirteenth Report	Department for International Development's bilateral support to primary education	HC 594
Fourteenth Report	PFI in Housing and Hospitals	HC 631
Fifteenth Report	Educating the next generation of scientists	HC 632
Sixteenth Report	Ministry of Justice Financial Management	HC 574
Seventeenth Report	The Academies Programme	HC 552
Eighteenth Report	HM Revenue and Customs' 2009-10 Accounts	HC 502
Nineteenth Report	M25 Private Finance Contract	HC 651
Twentieth Report	Ofcom: the effectiveness of converged regulation	HC 688
Twenty-First Report	The youth justice system in England and Wales: reducing offending by young people	HC 721
Twenty-second Report	Excess Votes 2009-10	HC 801
Twenty-third Report	The Major Projects Report 2010	HC 687

Twenty-fourth Report	Delivering the Cancer Reform Strategy	HC 667
Twenty-fifth Report	Reducing errors in the benefit system	HC 668
Twenty-sixth Report	Management of NHS hospital productivity	HC 741
Twenty-seventh Report	HM Revenue and Customs: Managing civil tax investigations	HC 765
Twenty-eighth Report	Accountability for Public Money	HC 740
Twenty-ninth Report	The BBC's management of its Digital Media Initiative	HC 808
Thirtieth Report	Management of the Typhoon project	HC 860
Thirty-first Report	HM Treasury: The Asset Protection Scheme	HC 785
Thirty-second Report	Maintaining financial stability of UK banks: update on the support schemes	HC 973
Thirty-third Report	National Health Service Landscape Review	HC 764
Thirty-fourth Report	Immigration: the Points Based System – Work Routes	HC 913
Thirty-fifth Report	The procurement of consumables by National Health Service acute and Foundation Trusts	HC 875
Thirty-seventh Report	Departmental Business Planning	HC 650
Thirty-eighth Report	The impact of the 2007-08 changes to public service pensions	HC 833
Thirty-ninth Report	Department for Transport: The InterCity East Coast Passenger Rail Franchise	HC 1035
Fortieth Report	Information and Communications Technology in government	HC 1050
Forty-first Report	Office of Rail Regulation: Regulating Network Rail's efficiency	HC 1036
Forty-second Report	Getting value for money from the education of 16- to 18-year olds	HC 1116
Forty –third Report	The use of information to manage the defence logistics supply chain	HC 1202
Forty-fourth Report	Lessons from PFI and other projects	HC 1201
Forty-fifth Report	The National Programme for IT in the NHS: an update on the delivery of detailed care records	HC 1070
Forty-sixth report	Transforming NHS ambulance services	HC 1353
Forty-seventh Report	Reducing costs in the Department for Work and pensions	HC 1351
Forty-eighth Report	Spending reduction in the Foreign and Commonwealth Office	HC 1284
Forty-ninth Report	The Efficiency and Reform Group's role in improving public sector value for money	HC 1352
Fiftieth Report	The failure of the FiReControl project	HC 1397

Fifty-first Report	Independent Parliamentary Standards Authority	HC 1426
Fifty-second Report	DfID Financial Management	HC 1398
Fifty-third Report	Managing high value capital equipment	HC 1469
Fifty-fourth Report	Protecting Consumers – The system for enforcing consumer law	HC 1468
Fifty-fifth Report	Formula funding of local public services	HC 1502
Fifty-sixth Report	Providing the UK's Carrier Strike Capability	HC 1427
Fifty-seventh Report	Oversight of user choice and provider competition in care markets	HC 1530
Fifty-eighth Report	HM Revenue and Customs: PAYE, tax credit debt and cost reduction	HC 1565
Fifty-ninth Report	The cost-effective delivery of an armoured vehicle capability	HC 1444
Sixtieth Report	Achievement of foundation trust status by NHS hospital trusts	HC 1566
Sixty-first Report	HM Revenue and Customs 2010-11 Accounts: tax disputes	HC 1531
Sixty-second Report	Means Testing	HC 1627
Sixty-third Report	Preparations for the roll-out of smart meters	HC 1617
Sixty-fourth Report	Flood Risk Management	HC 1659
Sixty-fifth Report	DfID: Transferring cash and assets to the poor	HC 1695
Sixty-sixth Report	Excess Votes 2010-11	HC 1796
Sixty-seventh Report	Whole of Government Accounts 2009-10	HC 1696
Sixty-eighth Report	Ministry of Defence: The Major Projects Report 2011	HC 1678
Sixty-ninth Report	Rural payments Agency – follow up of previous PAC recommendations	HC 1616
Seventieth Report	Oversight of special education for young people aged 16-25	HC 1636
Seventy-first Report	Reducing costs in the Department for Transport	HC 1760
Seventy-second Report	Services for people with neurological conditions	HC 1759
Seventy-third Report	The BBC's efficiency programme	HC 1658
Seventy-fourth Report	Preparations for the London 2012 Olympic and Paralympic Games	HC 1716
Seventy-fifth Report	Ministry of Justice Financial Management	HC 1778
Seventy-sixth Report	Department for Business, Innovation and Skills: reducing bureaucracy in further education in England	HC 1803
Seventy-eighth Report	The Care Quality Commission: Regulating the quality and safety of health and adult social care	HC 1779

Oral evidence

Taken before the Committee of Public Accounts on Wednesday 25 January 2012

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon
Stephen Barclay
Jackie Doyle-Price
Matthew Hancock
Chris Heaton-Harris

Meg Hillier
Fiona Mactaggart
Austin Mitchell
Nick Smith

Amyas Morse, Comptroller and Auditor General, **Marius Gallaher**, Alternate Treasury Officer of Accounts, **Gabrielle Cohen**, Assistant Auditor General, NAO, and **Laura Brackwell**, Director, NAO, were in attendance.

Examination of Witness

Witness: **Professor Lisa Jardine CBE**, Chair, Human Fertilisation and Embryology Authority, gave evidence.

Q1 Chair: Welcome, Lisa. Let me explain a little about the proceedings. Our prime aim is to take evidence from the responsible accounting officers for the CQC and the Department of Health, to hold them to account for value for money for what they are doing. We use this early session, which we keep very tight, to get some feel from people in the field, who are working with them or are likely to, about the issues that you think are key to our assessment of value for money. That is the context.

Lisa approached me rather late but I thought it was worth having her evidence. I am going to keep you very tight to five or 10 minutes.

Professor Jardine: I promise.

Q2 Chair: Okay. It is over to you. Tell us what you, as Chair of the Human Fertilisation and Embryology Authority, think about the proposals regarding the CQC and whether it can provide value for money for your organisation.

Professor Jardine: That is how I approached you. We are an extremely good example of a small case study in why rolling regulation into one bigger operation may not be cost-effective, and may not provide good value for money, when what is involved is a specialist regulator, as in our case. I hope the Committee knows that the HFEA regulates assisted reproduction—IVF—the sharp, pointy end of risk in our society. It requires enormous trust from the public; it requires trust, not about what happens after an incident, but if should there be an incident. By the time there has been an incident in IVF there is a baby in the wrong mother or a baby with the wrong donor, and it is too late by a long chalk. The public believe that we regulate in such a way that that is unlikely to happen.

If you are looking at cost, the costs that would be incurred by such a catastrophe, or even by much smaller catastrophes such as multiple births, which we look at closely—twins being produced and having to be looked after in the health service—would be all further costs. We are to be rolled in with CQC. We have rolled in pretty effectively in terms of operational

costs already. On our own initiative, we have moved into the CQC premises and are sharing back-office functions. We have reduced our costs already by several million. We are going to come down to—I don't have the figures in front of me, but if you wanted them—

Chair: I have £1.5 million.

Professor Jardine: We will be below what the public spending review wanted of us by 2013, without going any further than we have gone now. The issue is whether there is anything to be gained in your terms from dismantling our functions and rolling them in with CQC. We sit within CQC, and I have to tell you it is quite a good operation. It is huge. It does something very different from us. We watch it happening; we marvel at the amount of ground they cover. We are quite clear that we will not be a help to them and we might be a hindrance to their operation. That is probably the first thing I would say to you. If we go fully into CQC, I partly say—I think the chief executive is behind me—"Heaven help you."

Our funding is a couple of million. Most of our costs are met by the delivery. Every IVF cycle pays a small fee. There are 60,000 cycles anticipated this year; the money we get in goes up and up, so we cost very little. If we go into CQC, they have to take on all our dismantled functions, which will cost them quite a lot.

Q3 Chair: Something we look at as a Committee is effectiveness of service. In terms of the service you currently deliver, what are your fears of amalgamation into the bigger regulatory body?

Professor Jardine: I find it impossible to see how, within the existing legislation, CQC can regulate IVF. That is the short answer. We have an authority of 15 members. They are sitting today; I have come away from a meeting. They are experts, users, members of the clergy; they are extremely high powered. They are the people who oversee by law regulation of IVF. CQC has a panel of five commissioners. We worked out this week that our members contribute 600 hours each a year to regulation. If you just start totting up

25 January 2012 Professor Lisa Jardine CBE

dismantling this tiny organisation's functions and putting them like grit in the wheels of the CQC—as if CQC did not have enough grit already—I cannot see how a Committee such as yours could consider that it was a financially sensible thing to do.

Q4 Chair: What are the dangers?

Professor Jardine: The danger is not being able to regulate to the standard that we do. I have said on the record—I know it is in the hands of Ministers, but I am very lippy; I am not a traditional chair of one of these organisations—that I am going to regulate this sector to this standard until I am sure that somebody else can regulate it to the same standard. I do not see any evidence that the path it has been going down is financially advisable or that it will improve regulation, and I think that the risk level is going to go up so steeply that I would not want to think about it.

Q5 Austin Mitchell: How many people will lose their jobs, and how much money will be saved by this merger? Do you stay in your job? How many people actually lose jobs? How much money is saved? Don't you already share back-office functions anyway?

Professor Jardine: You mean going forward from now? Now we are sharing most back-office functions and we are going to share more. We have reduced our staff already from over 80 to I think around 60. We are going to reduce the number of our authority members; we can do with a few less. If this dismantling happens in 2015, which seems to be around when we are being told it is, the chair of the HFEA—that would not be me, because my term would be over and I would have moved on from the job—would then become a chair under the chair of CQC. The authority members, were there any, would be under—to be brutally frank, I would never have put in for such a job.

Can I just correct something, Margaret? Members spend 650 days per year on HFEA business.

Q6 Austin Mitchell: The real loser will be the sector. It will not get the same tender loving care as it gets now. Is that what you are saying?

Professor Jardine: It will not get anticipatory regulation. This afternoon, we have been discussing how to get the sector to reduce multiple births to 10%. At the moment we are trying to press them to 15%. We do that by going in before the babies are born, not waiting until after they are born, adding up the numbers and deciding it did not work. I do not think that CQC should be doing that. That is not their job; they do not do that kind of regulation.

Q7 Fiona Mactaggart: What is the biggest risk you have failed to avoid, as the HFEA? What is the worst thing that has happened, regulatory-wise?

Professor Jardine: There will always be adverse incidents, as there always are, for regulators. We have them. I think we have quite a lot of them, actually. We had an issue with embryos being under the hood at the same time, and there being a mix-up between one person's embryos and another's. Generally, fortunately, that is detected before you are dealing with a baby in the wrong person, but at the end of the

day that is what you are talking about. You are talking about life going forward in perpetuity, to be frank.

On the research side, which we also regulate at the moment, you are talking about our overseeing future interventions in the human body with manipulated genes and manipulated embryos. We are doing a study for the Government at the moment on mitochondrial manipulation. What happens if in 50 years' time it turns out that two generations down the line, there is a problem? It is the GM crops issue all over again. We try to anticipate. We use a much richer version of monitoring and dialoguing, but we are quite coercive when we have to be, and we can be mean when we have to regulate a clinic that is causing problems or a researcher who is causing problems.

Mary Warnock, right at the beginning of all this, was quite clear that the creation of life was an absolutely special area of science and life, and it had to be regulated in a very particular way. I think assisted dying and IVF—the beginning and end of life—are the two areas where we have to do that. At our peril do we think it can be done cheaply—it never will be cheap—or that you can cut any corners or roll it in with much simpler things. I am not going to name any, because you can all think of them. There are things that are easier to check in a much more routine way. You cannot do box-checking with IVF.

Q8 Meg Hillier: So far you have told us that you moved in and saved money on back-office functions. You are going to be reducing your members and your staff. Will there be extra savings? From what you have described, there seems to be an administrative change where you lose your high profile position as an independent body and you come under the CQC. Is there any greater financial saving that the move in 2015 will bring?

Professor Jardine: There is none, and we believe there will be associated costs.

Q9 Chair: Because?

Professor Jardine: Because if you fragment our functions, you will need a lot of back-office help putting together the data to feed each strand of that operation. At the moment, we obviously work across the board.

Q10 Mr Bacon: You were very polite about the CQC. You said you marvelled at how much ground they covered, but the evidence before us in the National Audit Office Report and elsewhere suggests that the CQC at the moment is not fit for purpose. You are a small expert organisation and I do not think anyone has said that you are not fit for purpose—quite the contrary. You have established a high reputation. Is there not a serious reason to be concerned about an organisation that is small and expert like yours being merged with an organisation that has enormous problems administratively and managerially, and that has been criticised for very poor leadership?

Professor Jardine: I am in absolutely no position to have a view on the CQC. How could I? I am a professional academic who chairs a small, perfectly formed regulator. I know how well we operate. I have absolutely no knowledge about them, but the people

25 January 2012 Professor Lisa Jardine CBE

going up and down in the lift look like they are working really hard to me. I do think it would damage us, but if we are merged, George Osborne will have one less quango.

Q11 Mr Bacon: But he will be spending more money.

Professor Jardine: He will be spending more money, but we have already heard that over the last couple of

weeks. We know that none of these things was factored in. I have no views at all on CQC's capabilities. I do not think we should be rolled in with any larger regulator.

Austin Mitchell: Stay around, then.

Professor Jardine: Is that an invitation?

Chair: Thank you very much indeed.

Examination of Witnesses

Witnesses: **Mike Farrar**, Chief Executive, NHS Confederation, **Dr Anna Dixon**, Director of Policy, King's Fund, **Gary Fitzgerald**, Chief Executive, Action on Elder Abuse, and **Peter Walsh**, Chief Executive, Action against Medical Accidents, gave evidence.

Q12 Chair: Welcome. We are under time constraints, so I would be grateful if you could be completely clear about the key points that you want us to think about as we look at the effectiveness and value for money of this organisation. I will start with you, if I may, Dr Dixon. I have read quite a lot of the stuff that you have written on all this. If you were us, what would be the chief issues that you would raise? What are the pluses and minuses? Where are the successes and challenges?

Dr Dixon: One of CQC's early challenges was a bit of confusion about its focus and its role overall in the wider system of quality and quality regulation. That was as much about the Department of Health and indeed the establishing legislation as about the leadership of the CQC, particularly in two respects. Whether it was about improvement—

Q13 Chair: As opposed to what?

Dr Dixon: As opposed to ensuring basic, essential, minimum quality and safety standards. There was confusion, because in the early policy documents it was quite clear that it was about minimum safety and quality standards, but there was an expectation that those should rise over time. That was the reference to improvement. By the time of the legislation, it seemed that it was a primary objective of the organisation to improve health and social care. I think it is from those origins that there was some confusion about focus. That is now resolved. The major task of registering and licensing providers and ensuring that they meet those essential standards is the organisation's first and primary focus. Early questions about its effectiveness came, in part, from that confusion.

The approach—the methodology that regulators use—is the second area that has come under question. It relates more, perhaps, to the value-for-money aspect of your inquiry. Of course, inspection is resource-intensive. Even the organisation's predecessor, the Healthcare Commission, made limited use of inspections; it was always very clear that it had not been resourced to do them very frequently.

CQC was established in a wider policy environment. Light-touch and proportionate regulation seemed to get a grip on government, with the Better Regulation Executive and the Better Regulation Task Force. The idea was that we could do regulation without going near organisations—by looking at data and having a

targeted approach. CQC built on the methodologies developed by its predecessor to try to make use of the vast amounts of data that were swishing around in the health service to see if it could apply that approach. One or two pieces of research have been published that have tried to look at how that targeted and data-informed approach to inspection performed against random. It seems that the targeted approach identified more areas of non-compliance.

Q14 Chair: You think it worked as an approach? I have to ask you to tighten your answer. Is your view that it worked, or that it did not work?

Dr Dixon: I do not think it could be relied on alone. The data quality and methodologies were being developed, but they were certainly not sufficient. Again, that was an early discrepancy in views, and there was a lack of evidence about the right balance between inspection, reliance on data and the very important issue of listening to voices, whether of patients or professionals. In the beginning, it did not necessarily get that balance right, but I reflect that there was a lack of evidence. It has developed its methodologies in light of its own learning. My view is that there is a lack of evidence, and it would be great if there were a lot more. CQC could play a part in publishing more about its own approach.

The last thing is: did it have enough resources? Registering providers is a huge task. It comes down to a question of how much risk we are willing to tolerate. An external regulator can never assure us all of the quality of every patient-and-doctor interaction and every patient-and-clinical interaction. Sometimes we have expected too much of external regulation.

Q15 Fiona Mactaggart: Are the tools to measure risk sufficient?

Dr Dixon: In terms of making decisions about resources versus risk, it is difficult to know what performance measures you might use to see whether CQC is making good use of its resources to look at risk appropriately. I wonder how many false positives there are. How many times does an organisation pass the standards and subsequently be found not to have met them? To put it the other way round, how many times has it put in enforcement notices that have been successfully appealed and upheld? Do we know that? I do not know, but it would be the sort of performance

measure to start to get to the heart of whether an organisation is appropriately using its resources to tackle risk.

Q16 Chair: What is the difference between regulation and inspection?

Dr Dixon: Inspection is a tool of regulation, in my understanding. There are many other tools to support regulation.

Q17 Chair: What else does it do?

Dr Dixon: The key tasks of a regulator are usually: defining standards, although in this case some of the standards have been defined by the Department and some draw on NICE standards; monitoring—as to how they monitor, they might use data or they might use inspection—and enforcement. There is a real issue about how capable and willing the environment is to allow CQC to use its enforcement powers. There is a view, particularly in health care, that organisations may be too big to fail.

Q18 Chair: Thank you. We might come back to that if we have time. Mr Fitzgerald, I heard you on the radio and I thought that you were being pretty vociferous in your views on CQC, so I thought that you should have a chance to express them to the Committee.

Gary Fitzgerald: Thank you very much. I would come at this from the point of view of the public and the experiences of people on the receiving end of regulation. I have to start by saying that I am not convinced that the debate about the role of CQC is fully concluded or understood by people. It was only six months ago that CQC told us that we did not understand its role. We are specialists in safeguarding; if we do not understand its role, it is difficult for the public to do so. That boils down to a debate about whether CQC is an improvement agency—an agency to make improvements. Clearly, certainly up to six months ago it was publicly saying that it was not an improvement agency. We find that unacceptable, given what the Act said was its primary function, and what people understood.

Q19 Chair: What does the Act say?

Gary Fitzgerald: The Act says that it has a responsibility to improve social and health care. That is one of the primary objectives stated within the Act. For us, there is a disconnect between what the CQC was saying publicly and what the Act says.

Q20 Stephen Barclay: Are you are drawing that distinction because, in your view, CQC was focusing on minimum standards, rather than bringing standards up across the board?

Gary Fitzgerald: It is about comparisons with its predecessors and the expectations of the public. Clearly, for us, it is not enough to go in, look at what has taken place in some place, pass comment on it, and then stand back, if there are other means by which you can drive up standards and improve performance. To give an example, the predecessor, the CSCI, brought out what we considered to be an excellent document discussing domiciliary care and looking at,

in its totality, ways in which that service could improve. There is a role for a regulator as not simply an observer, but someone who can point to ways that good practice can be disseminated and improved. For us, it is therefore important that CQC not only acknowledges that it has an improvement role, but that we see that built into its strategy and its thinking.

Q21 Stephen Barclay: Taking that line of argument, you would therefore expect it to disseminate that nationally, not just regionally.

Gary Fitzgerald: Yes, indeed. One of my worries is that much of what CQC does is disseminated, in media terms, at a local level, not at a national level. I am also concerned that there are times when that organisation uses its resources to manage its image, and not manage what is taking place. An example that I would give you is that the Equality and Human Rights Commission published an excellent report late last year on domiciliary care. The day before the report, CQC came out with a public statement about its inspection process for domiciliary care. I must be honest: I find it difficult to see the value for CQC in doing that, other than to have an impact on the following day's report. That is wrong.

Q22 Stephen Barclay: It is a very serious charge that you are putting before the Committee. Can I clarify this for my own understanding? What you are saying is that in your view, to manage its own reputational risk, potentially negative news that would benefit patients nationally was not shared nationally, but was kept to regional media to limit the PR effect on the organisation or the NHS as a whole.

Gary Fitzgerald: I cannot comment on the motivation; I can only observe what has taken place. What I observe is that much of the work is done at a regional level, and it would be beneficial at a national level.

Q23 Stephen Barclay: If a precursor organisation, such as the Healthcare Commission, was doing a report through its national investigations team, which was behind a number of high-profile lessons that the NHS learned, such as on C. difficile, that would have been reported on a national basis.

Gary Fitzgerald: It would indeed.

Q24 Stephen Barclay: So there was a change of direction.

Gary Fitzgerald: Yes, most definitely. We observed that change of direction.

Austin Mitchell *rose—*

Q25 Chair: Hang on a minute. Let Mr Fitzgerald finish his initial remarks. I shall then bring in Meg. I promise that I will bring you in, Austin, but be very quick. I shall keep things tight, only because of time.

Gary Fitzgerald: CQC makes a very clear statement that it acts quickly to protect. I have to disagree with that and say that, in my assessment, it does not act quickly to protect. If we look at the DANI inspections last year of the hospitals, we did not see the sort of instant action that we would see if it were social care in care homes.

We have questioned CQC quite considerably. For example, why it did not bring some of the issues in the hospitals to the attention of adult safeguarding locally? One safeguarding co-ordinator, for instance, e-mailed me the other day to say, "Why is it that I get referrals from CQC about care homes, yet I did not get a single referral about what took place in the hospitals?" For us, there is a concern that CQC appears to be a medium to long-term responder, not an immediate responder.

I worry, on the DANI inspections, that inspectors walked out of those wards, having brought some issues to the attention of ward staff—the very ward staff who were neglecting and abusing—but actually took no further immediate action. What happened the next day, the day after, or the day after that? For me, and for a lot of patients and clients, the issue is how to make sure that the regulator actually has the instantaneous impact that it needs to have when it spots abuse and neglect.

There is a real issue for us in terms of the inconsistency of what is shown in inspection reports, and the messages that are given out. I shall give you a couple of examples. When the DANI inspections took place, CQC said publicly that there was not a single major concern identified on dignity. The definition of "major concern" used made it impossible to reach the conclusion that there was a major concern. It was not possible to use that definition. We brought that to the attention of CQC, yet in its report it still told the public that there was no major concern. An inspection report of a learning disability home was published in January that very clearly said that there were real safeguarding issues, and that the home was not dealing with them appropriately and was not referring on. It still called that a moderate concern.

Q26 Chair: They called it a what?

Gary Fitzgerald: A moderate concern. For me, it was a major concern. The messages that the public are getting from the regulator do not necessarily reflect what is contained in the body of the inspections. We saw time and again comments made by inspectors in the body that did not translate into recommendations or outcomes for people, and that worried us.

When I look at what the predecessor organisation did, even if it carried out a themed inspection and if, during that themed inspection, other issues emerged, it was possible that it would take those issues and move them on to be themed inspections. Within the DANI process, there were some major issues in some hospitals about "Do not attempt resuscitation", and the fact that the national guidance was not being implemented. That is one of the most serious things imaginable. We have had already a public case of somebody dying because this was misunderstood. CQC, despite our bringing it to its attention, has not taken it on as an issue, has not pursued it and could not tell me when I asked it the other day how many other cases of DNAR were identified within the process. As a regulator, it is letting down the public. I do not think that people actually understand what its role is, and I think that people are disappointed with the outcomes from this.

Q27 Meg Hillier: The remit of the CQC is very broad. Do you think that it is too broad? The Independent Safeguarding Authority deals with individuals, to be brutal about it, in a way that will transform, over time, adult care. Would you say that the CQC deals more with institutions? Can you pick up on that point as well as the wide remit point?

Gary Fitzgerald: The Independent Safeguarding Authority has a far more limited role, so it can only be responsive for what comes to its attention. It cannot fulfil a wider remit of being proactive. I think that CQC's role is far wider than it has the capacity to deal with. I mean "capacity" on two levels. There is an issue of funding, although I do not believe that some of the issues we have raised are associated with funding. They are to do with strategic management.

I also think that there is an issue for CQC in terms of understanding its role and how it delivers that role. All of us remain unclear, when CQC carries out an inspection, whether there is an ongoing process after that inspection. If we take DANI, 100 hospitals were inspected. We identified about 51 of them as hospitals where there were issues of concern.

As of yesterday, from information I got yesterday from the CQC, half of those hospitals did not get a second follow-up inspection, despite those concerns. Also, I have to say that when you look at what was concluded in those inspections, hospitals were deemed compliant with recommendations to remain compliant. You can only have recommendations to improve compliance; you are either compliant or you are not. The public are told that these hospitals were compliant when it is very obvious that what the CQC was actually saying was, "Well, they were not compliant, but—". That is not a clear enough message for the public, or for us.

Chair: Austin, please keep it brief.

Q28 Austin Mitchell: Thanks, Chair. I was just going to complain that the interruption of my question was elder abuse, but I will do that later.

You run a hotline. You must get a lot of complaints about elder abuse in homes, which you then presumably take up with the Commission. About how many do you get, and how responsive are they?

Gary Fitzgerald: We take between 6,000 and 10,000 calls a year, depending on the year and what is going on. Two thirds of those are about care in the home. I have to say that when we raise issues with the CQC I am, in general, satisfied with the response that I get from them. I do not think the issue is whether they respond to organisations like ours, because I think they are very cute and they do respond to organisations. It is about the day-to-day operation, and how they are performing on that. I get the feeling that they have been firefighting since inception and have never quite got a grip on it, and they deal with issues as they come up in order to manage what is a constantly changing environment for them. That is me being charitable.

Q29 Nick Smith: Mr Fitzgerald, thank you for that. Implied in your evidence during the last 10 minutes or so is that hospitals get an easier ride than the care home sector. Is that really what you are saying?

Gary Fitzgerald: Yes. I would say that in my estimate, some of those hospitals, had they been care homes, would have had bans on admissions, been referred to adult safeguarding, and would have had a far more serious approach taken with them. I have had discussions with the CQC about their approach, and they clearly feel challenged by what to do if, for example, an A and E department is underperforming. Can they close that department, and what is the impact for the community?

I must be honest; I take a slightly different view. If an A and E department or an older people's ward is underperforming, and is neglecting and abusing people, perhaps it should not be open until it can deliver the quality of care. When you look at some of what was being dealt with in those hospitals, it is hard to imagine that from the patient's point of view, that was actually a good place to be.

Dr Dixon: I want to back up the difference between health and social care in that respect. In the health care system, many of them are operating at very high occupancy rates. There is actually nowhere else for those people to go, which makes closing, and the CQC using its powers, particularly in relation to the acute NHS sector, somewhat different from its ability to act on a small care home, with a smaller number of residents, where there is lower occupancy in alternative providers.

Gary Fitzgerald: That is a statement that the NHS makes a lot. We have large, complex nursing homes within our communities, where the dependency levels and needs of those people are as great as we see in some of the old people's wards.

Q30 Chair: You can close wards without closing hospitals as well.

Gary Fitzgerald: You can, and I think one of the challenges for the CQC is they registered at the level of the trust. That made it difficult, if they saw a ward that was performing well and one that was performing badly, as regards how they took action.

Q31 Chair: Peter Walsh, you deal with people taking action.

Peter Walsh: We support people who have been on the wrong end of the system when it was not being safe and of high enough quality, and therefore with people suffering from medical accidents, and we promote better patient safety. Like Gary, the charity and I come at this from the point of view of the public and the patients. We are critical of the CQC, and we think that it is not fully fit for purpose at the moment. We judge that by whether it does what it says on the tin, which is uphold essential standards of quality and safety. We were core participants at the Mid Staffordshire public inquiry, and all through that, we were asking ourselves, "Could the same thing have happened under the CQC's watch, as it is currently constituted?" We have not heard enough evidence so far to give us confidence that the same thing could not happen.

I summarise my criticisms and concerns in two main areas. One of them—this is similar to Gary's point—is an unwillingness to act proactively to protect patients or service users. I would also say that there

are some in-built problems for the CQC with the regulations set for it by the Department of Health, which somewhat limit what it can do and what it can enforce.

Q32 Chair: Explain that a little bit.

Peter Walsh: For example, there is a big debate on at the moment about whether there should be a duty of candour—a duty to be open with patients or their families when things go wrong in health care and cause harm or death—and whether there should be a statutory duty on any health care provider who is registered in this country to be open or not. That could be regulated effectively by the CQC if it was included in their registration regulations, which would then give it clear, legal enforcement powers. That is an example of where it could be given more leeway or more of an armoury to actually fulfil its purpose. Another debate is around what we would expect it to do around protecting whistleblowers, and something that the NAO picked up on was that they need to review whether they are doing enough and acting proactively enough.

We recently wrote to the Secretary of State in connection with the breast implant scandal, which has been in the news, to say that there is nothing in the requirements for registering a health care provider with the CQC to require it to have proper insurance and indemnity arrangements. If there was, Mr Lansley would not have had to appeal to the moral responsibility of the private cosmetic surgery organisations. They would have been required by those regulations to act to put things right. The Department could do more to help.

While we are critical, we really value the concept of the CQC. We think that it put some very important building blocks in place. It has some super people working with it, and we would be very wary of throwing out the baby with the bathwater.

Q33 Chair: We are tight on time, but give me two or three things that would improve it.

Peter Walsh: It needs to be more proactive. In the evidence that we submitted, we gave the example of patient safety alerts. There is a culture within the CQC that they simply register and then enforce. There are simple common-sense, but vitally important, things that it could be doing short of that in order to be more reactive and proactive to information at its disposal. Another point is about hospitals that are not implementing life-saving patient safety alerts. NHS Choices is publishing a list tomorrow of the third of NHS hospitals that are not implementing or complying with these vitally important alerts. The CQC has been very slow and laissez-faire about following those up. That does not mean striking a hospital off the list and taking away its registration, but you can write to it and give it a warning about a warning. To simply sit back and do nothing, as it did initially around those, simply is not good enough. We do not think that the quality and risk profile, which is a sophisticated tool that it developed, is robust enough. It needs to be able not to wait for all the dials to tip into the red, but to see a problem that is on its way, and to act on it to prevent it becoming another

Stafford, rather than waiting for a Stafford and then taking the registration away from that hospital.

Q34 Chair: Thank you very much indeed. Finally, Mike Farrar, from the NHS Confederation perspective, what would you like us to think about this afternoon?

Mike Farrar: The first thing that we want to say is that it is not the responsibility of the regulator to ensure that you have proper provision of care. We absolutely believe that it is the responsibility of our members to deliver the highest quality of care that they possibly can. However, we believe that regulation is really important in the health service, because it is a way in which the public can be assured that those people providing their care are subject to assurance that they are passing acceptable standards. The use of “minimum” is unfortunate. These have to be acceptable standards for patients to understand what they get when they go into our facilities.

We recognise the complexity of the way in which the CQC currently exists, and the journey it has come on, but we think it can do more to improve, and we are certainly not in favour of another big reorganisation of regulation. In part, that has given us some difficulties. I think we would list a number of things that can be done very practically. First, we would want much more clarity on the scope and the purpose of what the CQC does. We would want that to be understood in the context of what other regulators do. This is a very important point because, particularly when the CQC starts to look at general practice, the lines between the professional conduct standards, regulated by people like the GMC and the Nursing and Midwifery Council as well, need to be understood in the context of an organisation’s responsibilities.

Our commission on age and dignity, which has been conducted with Age UK and the Local Government Association, has found that one ward in an organisation can be tremendous, while the next-door ward is not. At some point, you have to ask what the professional responsibilities are, and if the organisation is consistently applying the right monitoring and signals about quality. We want to be clear about the alignment of the regulatory function the CQC has with other regulators.

There are some obvious practical things. The standards need to be understood by the public, and there should be greater alignment with what the public believe acceptable care is. We should not have a situation in which CQC has one view of an organisation and local people take a very different one. That is unacceptable. We want proportionality, so when there are failings we need to recognise the distinction between very serious failings and failings in one bit of an organisation, and we want response to be proportionate. We are clear in our mind that we want it to be value for money, because the money that the regulatory system applies to the health service effectively takes away from its ability to respond to regulation and improve patient care. The balance of the costs of regulation, and indeed inspection, versus the benefits need to be clear and understood as well.

Q35 Jackie Doyle-Price: I was very interested in what you were saying, Mr Fitzgerald, about the fact that the CQC is very slow to act quickly, and about the idea that perhaps there is too much of an ethos about protecting reputation and PR. Taking that a little bit further, in my dealings with it, I have found very much that its informing value has been to keep people confident, but that is going to undermine the accountability for people delivering good quality health care. To underline that, one of the findings of the NAO Report is that the CQC does not collect data on enforcement actions, so we cannot really build up a picture of where things are going wrong and whether any particular provider is worse than another. What are your feelings about that? Do you think the CQC should be more transparent about the enforcement action it is taking?

Gary Fitzgerald: First, I found it very easy to agree with the Report and its conclusions. I asked the CQC about 18 months ago for what I thought were fairly basic performance monitoring data: can you demonstrate that if you issue a requirement, a recommendation or an enforcement, that follows through, or are you issuing the same one 12 months later? The message I got back was that the data are held regionally and there is no central knowledge or control of it. I asked for information recently on the DANI process, bearing in mind that the report was published in October; again, the CQC does not have the information centrally. It would have to go and look in each of the records to find the data that I was asking for. It seems to me that there is not a follow-through to conclusion.

Although I do not think that it is the case, because work has happened afterwards with DANI, sometimes it feels as though the production of the report becomes the end in itself, not the improvement. I want to be careful in saying that, because clearly there have been improvements in those hospitals, but when you look at, for example, an inspector recording that staff on a ward were falsifying records in relation to nutrition intake, fluid intake or turning a patient to avoid pressure ulcers, and you can see no action triggering a response to that individual member of staff—the CQC would not recognise that it has a role in it, and cannot tell me that any action was taken—it feels that that becomes almost an observation tool or process, rather than a means of finding out whether we have effected change. That worries me greatly.

Chair: Nick, and then I think we are going to have to move on, guys. If any of you has a final thing you want to ask, think about it during the next question.

Q36 Nick Smith: Mr Farrar, I was interested in your point about the role of the regulator and of professional organisations around misconduct and investigations into professionals’ clinical practice. Can you talk a little bit more about that? How much data sharing is there between the professional organisations and the CQC in terms of identifying problems?

Mike Farrar: The issue comes down to how the regulators, collectively, because there are a number of them, distinguish between organisational failure—dipping below minimum standards in terms of how it

has supported people to deliver the best quality—and the competence of individual practitioners to be conducting their duties in line with their professional codes of conduct. That is really important, because we find that many organisations, in response to improvements in the regulatory system, are starting to take what they are doing more seriously at organisational and board level, and finding that elements of their organisation are not responding as positively as others. They could have wonderful paediatric services but their elderly care services might not be as strong.

The answer in that case is not necessarily to look at whether the organisation is taking it seriously, but to drill into what is happening in a particular ward or service. It may well be that it is professional competence, particularly of leadership in wards, that is at fault. The risk is that when the regulator describes its process at the moment and says to the public that it has concerns about the organisation, the public understand that to be the whole of the organisation rather than one area of that organisation. Indeed, the actions of the organisation could be severely distracted, if they what they should really be doing is taking this as a professional conduct issue and changing the leadership or the individuals by reporting them to their regulator, rather than getting the organisation itself to implement a huge and potentially costly quality improvement plan or whatever.

That is where it is key that the regulators work together. In the new environment, it is important that the Department of Health is clear about the way it sees the regulatory systems operating, and indeed that Parliament is clear about whom it is holding to account.

Q37 Nick Smith: Is there much information or data sharing about professional standards in the professions and the CQC?

Mike Farrar: There was at one time a real drive to get the data across, which involved Monitor, the CQC and what was known by local commissioners about organisations and pinpoints. I suspect there has been a demise in that with other thoughts on registration. It is important that there is that data sharing between regulators about the state of individual organisations.

Q38 Chris Heaton-Harris: Going back to the point you made about how the public view something when the CQC strikes up a concern, the Report states:

“In November 2011, the Commission had major concerns about 407 providers, 94% of whom were adult social care providers.” If I had a relative in a home that had that marker put down on it, I would be freaking out. How can you improve that? The public want information; they want to know that the homes that their relatives are in are safe. Equally, you don’t want an over-aggressive marker put down on homes that might just have minor problems. How do you balance that?

Mike Farrar: I think that is my point on proportionality and alignment with the public understanding of what the CQC’s warnings or concerns mean. We were very pleased because there was one category of compliance but with issues. That has now been taken care of and resolved. I also have

a relative—my mother—in a care home, so I know exactly what you are thinking. The answer is more transparency, more explanation about what those standards mean, and more explanation about what actions could and should be taken, with follow-up to demonstrate that that was done. I think that is one of the important elements that I, as a member of the public, would expect of the regulatory regime.

Q39 Chris Heaton-Harris: Will you all briefly say how transparent you think the CQC is?

Mike Farrar: I think it has tried hard. It think it could be more transparent. There may well be an opportunity post the Mid Staffs discussion to align on the basis of more transparency a discussion with the public about it.

Q40 Chair: Could do better, is how I take that.

Peter Walsh: It is nowhere near transparent enough. If you were one of the patients or a relative of the people at Stafford and it was happening now, how could you ring the alarm bells with the CQC? It tells you to make a complaint; it pushes you back to all the other places where you were getting shrugged off, as opposed to showing that it really wants to hear about families’ and patients’ concerns and will act on the information. There should be information much more readily available about every enforcement improvement action that has been made. For even the NAO not to be able to get its hands on it speaks volumes.

Gary Fitzgerald: The CQC is transparent in some ways, but not in the ways that we would all like it to be. It is very difficult to ask a question of the CQC and guarantee that the response actually means what you think it means.

Q41 Chair: Go on, give me an example. It is a bit gobbledegook to me.

Gary Fitzgerald: For example, last year there was media reporting about Southern Cross care, and some of it was about data that were released by the CQC—I suspect as the result of an FOI—which publicised really quite damning information about that care provider. The context was that other provider groups were worse but, because only that data were provided in only that context, it gave an impression to the public that actually was not true. What is sometimes lacking in what the CQC does is context. I do not know whether that is because it does not understand the implications of some of what it does or whether it is deliberate—I have no way of knowing that—but that would be an example of where you ask a question.

To give another example, I asked a question about the frequency of inspections, because the inspections had dropped. I was told that they would pick them up again. What I did not realise was that that did not necessarily mean they would be inspecting against all 16 essential standards, as they had been 12 months previously.

Q42 Chair: What are they doing then?

Gary Fitzgerald: They have had some consultation about reducing the number of standards that have been

 25 January 2012 NHS Confederation, Kings Fund, Action on Elder Abuse and Action against Medical Accidents

part of the inspection process in any one particular inspection activity, which means that you are not necessarily comparing like with like.

Q43 Chair: Did you know that?

Laura Brackwell: I think they are reducing the number of standards and trying to focus on those where they see the greatest risk.

Q44 Chair: We did not see that in the Report, did we?

Laura Brackwell: We were certainly aware that they were focusing.

Q45 Chair: I was not aware of that.

Dr Dixon: The aspect of transparency I feel qualified to answer on is the information made available to the public and patients via the website. There is a requirement that the quality and risk profiles be published. The CQC has worked very hard to present those in a way that are meaningful and useful. Since they have been published and improvements have been made to the website, that aspect of transparency has got a lot better. It is much clearer where there are concerns, where inspectors have been in and, indeed, where enforcement actions are in place.

On the other aspect, however, there could be greater transparency between the Department of Health and the CQC in relation to accountability, how the performance of CQC is measured, whether it has sufficient resources to do its job and how it demonstrates that, so I think there is more to be done.

Q46 Chair: Any final word? I am conscious that we are very tight on time. Go on, Mike Farrar.

Mike Farrar: One sentence: let's work to improve what we have; let's work very hard to do that; and let's not think that the answer is to load more and more inspections on a service and then believe that that will get us a better answer.

Q47 Chair: So do not give them the new stuff.

Peter Walsh: Avoid the temptation to throw the baby out with the bathwater. Regulation should not be treated as a dirty word. There is a train of thought, which one hears discussed at the moment, that perhaps the commissioning process could in some respects replace what regulation is there to do. We do not think that works. Let's improve what we have.

Gary Fitzgerald: I do not think any of us could stomach another regulator, so whatever happens we do not need another regulator. We need to live with what we have.

Dr Dixon: Let's be realistic about what an external regulator can ever do to assure quality and safety. I agree with Mike that, at the end of the day, we have to put the focus on professionals who are there, interacting with patients and users in care homes, and the providers and the boards of those organisations first and foremost. So let's be realistic about what a regulator can do. But at least give it the resources to do what we ask of it, and do not keep adding to its work load. Let it learn, improve and get on with the job, and certainly do not reorganise it yet again.

Chair: Thank you, all of you, for being very succinct and clear in what you have said. You will help us in what becomes the main evidence session. Many thanks for appearing.

Examination of Witnesses

Witnesses: **Una O'Brien**, Permanent Secretary, Department of Health, **Cynthia Bower**, Chief Executive, Care Quality Commission, and **Amanda Sherlock**, Director of Operations, Care Quality Commission, gave evidence.

Q48 Chair: Welcome to Una again. We saw you last week.

Una O'Brien: Yes.

Chair: Welcome also to Cynthia Bower and Amanda Sherlock. You can see that we are tight on time, and people have to go to another meeting from here. I think you were here last Wednesday, Una, when people started disappearing. If I interrupt you, it is because I think that you are not answering the question as directly as I would like. In that context, we will try to keep the questions as tight as we can. I know Committee members have done a lot of work around this issue and that they have a lot to say. I will start with you, Una, because you devised this scheme of regulation, as I understand it, in your previous job. The broad question to you is what did you want the CQC to achieve and to what extent do you feel that it has gone to your plan?

Una O'Brien: I will not use up the Committee's time by telling you about the whole journey, but it started with a decision made by the then Chancellor of the Exchequer to combine three regulators in order to

save money and improve efficiency in the run-up to the 2005 election. Following that, with Alan Johnson as the then Secretary of State—first of all Patricia Hewitt and then Alan Johnson—a great deal of research and work was done. Rather than just binding the three together—the MHAC, the CSCI and the HCC—we said that if we are going to do this merger, what should be the bigger, wider purpose?

That journey of policy research, but also responding to events, particularly Maidstone and Tunbridge Wells, led the Ministers of the day to the conclusion that they wanted tougher enforcement powers, and this was the essential element in the design. They discovered that they did not have powers to close things down when Maidstone and Tunbridge Wells occurred, and so the big switch in the policy at that point was to say, "We need enforcement powers." Everything started with that fundamental decision in 2007. There were then four consultations on how to do this—whether it was the initial policy or, later on, the draft regulations.

The second thing that was very important was that there was unhappiness, through various feedback, that on the social care side the standards at that time were very input-focused. They were not focused on outcomes, and there was a genuine interest from politicians right the way through to users in whether we could come up with a regulatory structure for quality and safety that was focused on outcomes for people and users, rather than counting inputs.

The third objective was to say—in a world where we were looking at that time quite a long way ahead, and it was a big ambition of the Government of the day—we need to see greater integration between health and social care. How can we think about a method of regulation that would allow for a design going forward that was common and consistent across health and social care? Those were the three main objectives. Obviously, things got changed as we went through Parliament and various things got developed around that, but, fundamentally, what we have today is very much a regulatory system in development. It has only been active for 20 months. Nobody in the world has tried to do what we tried to do, which is to have nationally consistent outcome-based standards. We have got the enforcement powers and they have—we need to understand the evidence more systematically—a deterrent effect. We are learning about the conditions in which those powers can and cannot be used. We have also got a set of outcomes-based standards, and we now need to see how we can get value out of that. I think that the intentions of the Government of the day and of Parliament were met in that respect.

I have one final point, if I may.

Q49 Chair: You did not answer the second bit of my question. You have told us what you wanted to do. There is quite a lot that, if people are let loose on it, will attract a load of criticism. I asked about what went to plan. Perhaps I should have said what went wrong and what are the challenges that you have now.

Una O'Brien: I think that the NAO Report is fair. It has drawn out some of the operational problems in delivering what we set out to do. We certainly take our share of responsibility for that, and I know that the CQC has done the same. We have learned some very big lessons from what looked like a sensible sequence. From 2007, the sequence that was intended was to implement the new regime over three years. From the work that was done at the time, it seemed as though that would be enough time to do it. The powers were not all switched on on day one—that was April 2009—but were stretched out over three years. It turns out that we all underestimated the scale of the task, and we must learn from that, particularly in my role looking forward to the implementation of other bodies. There have been many discussions about this; indeed, we had a major lessons-learned seminar only this month about how optimism bias gets in the way. There is an ambition to do things quickly, which people want, so you set tight timetables. We have to get a hell of a lot better at scoping and understanding what needs doing.

Q50 Chair: What is worrying you most? Things ain't good, right? I accept it is new. I accept that it was an ambitious thing. I accept that everybody is trying to save money. What is worrying you and what do you feel accountable for?

Una O'Brien: Three things strike me: first, we need to continue to see improvements in the organisation itself—

Q51 Chair: On what?

Una O'Brien: Specifically on, first, setting the strategy; secondly, performance metrics, where we definitely have more to do to be able to measure and understand the impact; and, thirdly, continuing to engage with stakeholders—I know that a huge amount goes on, and in the capability review that I have been conducting, I have met many stakeholders myself—like the witnesses you have had today, to really understand how we can improve the model in a way that genuinely addresses the concerns of people and those who are in care and in hospitals.

Q52 Chair: Who is responsible if there is another Staffordshire or Winterbourne View? Wherever we get to, if you use those as examples, are you responsible? Is Cynthia Bower responsible? Where does accountability lie? You are talking very generally, but if we move to specifics, the CQC has not done its registration on time, it has done many fewer inspections and there are concerns about whether the public understand what on earth it is supposed to be delivering. I was shocked to see that the metrics by which you judge the CQC are totally quantitative and not based on quality, yet this is a quality-based organisation. There is a lot wrong there. I think that you are being a bit general in your answers. It would be really helpful if you were more specific about your priorities, what you think the major things are and where the accountability lies.

Una O'Brien: Okay. If I may, I will take that in two parts. Please come back to me if I have not answered everything. If the question is, what needs to improve about the Care Quality Commission, as one part of the wider landscape on quality, I think that there are five things: first, as I said earlier, there needs to be more work on clarifying the strategic direction—

Q53 Matthew Hancock: Hold on. That was not quite the question, and you had three things and now you have five. There were two parts: first, who is accountable? Crucially, of the three things that you said needed to change, who is responsible for the fact that they are not already improved? You have just set out three things that need to change. Why are they not already put right? Take strategy, you said that there needs to be a strategy, but why is there not already a strategy and who is responsible for the fact that there is no strategy?

Una O'Brien: Improvement is taking place in all three of those areas. I think that what we are learning from the capability review is that we now need to take things a step—

Matthew Hancock: Can you answer the question?

25 January 2012 Department of Health and Care Quality Commission

Mr Bacon: With respect, I am listening to the questions too. I heard the question and it was not, “Is improvement taking place?”

Matthew Hancock: My question is very simple. You have set out three areas that are not performing well. Who is accountable for those three failures?

Una O'Brien: I have set out three areas where there needs to be further improvement—

Matthew Hancock: Yes. Who is accountable for those three areas?

Una O'Brien: Accountability rests first and foremost with the organisation itself, and my—

Matthew Hancock: So who?

Una O'Brien: The chair and chief executive of the organisation bear the accountability. I hope that you have had an opportunity to see my accounting officer’s statement. My accountability is to assure myself that the systems and processes in the organisation are continuously improving, and where there are problems with performance, as have been highlighted by the NAO and ourselves, to assure myself that they are being addressed and attended to. That is the journey of improvement that we are seeing. To say that we are there would be wrong; there is more to do, and I am very clear about that.

Q54 Chair: Right. You said that you had five areas. I think that there is a lot wrong with the organisation. I accept all the difficulties of establishing it, but we all think there are real problems. What are the five things? There is not a strategy—go on.

Una O'Brien: Forgive me, there is a strategy, but it needs to be pushed to a better level with a clearer time horizon, with much more information about how the regulatory model will improve. I want to be clear on that. I said that there were five. First, there is the point of the strategy—I won’t repeat that. Secondly, we must be much clearer about setting priorities, matching resources to them and understanding what things cost. Improvements are taking place on that front—for example, much greater clarity about the cost of an inspection. Thirdly, we must improve the accountability relationship between the Department and the CQC.

Q55 Chris Heaton-Harris: What does that mean?

Una O'Brien: It means that we must have a more open and transparent information flow between us and a better—how shall I put it? One of the things that are clear from the NAO Report is that we did not hear about the build-up of risk until it was too late to do anything about it. We must work together on properly assessing risk and making sure that those risks are flagged up in our quarterly accountability meetings. I have mentioned engagement. Self-evidently, there must be improvement in communications, and that has been reinforced today in the evidence that we have heard. I absolutely do not accept—I have never seen evidence in the way it was put—the point about managing reputation. Information about CQC’s reports is put out on all national channels. Whether the press choose to take it up is a matter for them.

Q56 Chair: I have to say that in her statement to the Mid Staffordshire inquiry, one of the board members,

Kay Sheldon, said that in her view, the organisation’s approach—I have heard it before—to strategy was reactive and led by reputation management. She said that she also believed that the personal survival of those leading the organisation was a main driver, so it is out there—people are saying it.

Una O'Brien: I recognise the concerns that have been raised by Ms Sheldon, and they are very well known to us. She has contributed those to the capability review. It is also the case that other board members take a different view. It is important to state that on the record.

Q57 Chair: Was that your five?

Una O'Brien: The fifth one was the development of the regulatory model. There are many aspects to this, but how we make the inspection regime fit—work better—

Q58 Mr Bacon: You nearly said fit for purpose, didn’t you? You did. I heard you say, “F—”, and then you stopped. And you were not going to use the F-word. You were going to say, “How we make it fit for purpose,” and you just stopped yourself. Do you think that the CQC is fit for purpose?

Una O'Brien: If I might finish my sentence—how we make the inspection regime fit with the other two dimensions of regulation, one of which is user voice. A third one is using information. It was brought up in the earlier evidence that getting the balance right between the three is a really difficult thing to do; it is not an easy thing. This is the challenge for the next phase. As we learn about the impact of inspection, we need to know how it can be better informed by flow of information and by user voice.

Q59 Chair: When you have looked at the history so far, you have focused on registration—or the organisation has focused on registration—at the expense of regulation and inspection. Was that right?

Una O'Brien: Sorry—

Chair: If you look at the NAO report, one of the things that appears to have gone a little bit wrong is that the focus was entirely on registration and not on regulation and inspection. Do you, as the accounting officer, think that was right? That is a systemic issue.

Una O'Brien: Overall, it was right to do registration.

Q60 Chair: At the expense of regulation and inspection. That is what happened.

Una O'Brien: I certainly think that it could have been done better. I still hold to the fact that registration was necessary because through registration providers then are subject to the new enforcement powers. Without registration, they are not subject to those powers. That is a simple fact of the way the legislation and the regulations are developed. It is not possible to take enforcement action against an organisation—

Q61 Mr Bacon: If I am a cowboy and I avoid being registered, you can’t get me. That is what it sounds like. Is that right?

Una O'Brien: That is correct.

Q62 Mr Bacon: Who on earth drafted that legislation?

Una O'Brien: That is why it was necessary to make sure that everybody did become registered; otherwise, they were not subject to enforcement powers. That is a complex, legal process that I could talk about, but I realise that you want to go on to other questions.

Q63 Chair: I want to ask one more question, if you think that registration is more important than inspection. We now have I do not know how many GPs who need registering. In terms of your oversight as accounting officer, are you going to say that it is more important to get the practices registered than it is to have them regulated and inspected? That will continue, and if they are given the additional powers, more stuff will have to be registered. How long do us punters—the public—have to wait?

Una O'Brien: The last big piece of registration in introducing the new regulatory regime will be general practice. We have allowed more time to prepare. We have allowed an additional year, in light of what we learnt about the fact that this takes more time to do. Once that is through, there is no other large group of providers on that scale to go into registration.

Q64 Chair: Over this period, we are going to see an emphasis on registration, and not on regulation and inspection, as we have seen in the past. I accept that there might be a slight rebalancing, but there will still be an over-emphasis and that is of concern around quality, care, safety and all those issues.

Una O'Brien: I absolutely understand your concern. That is why—I know that Cynthia Bower can talk about this in more detail—the approach to the registration of GPs will be different. We will be not be in a position where inspectors of other areas have to be involved in that process.

Q65 Chair: I was told in a briefing by the NAO that the registration of GPs will actually involve the GP simply signing a little bit of paper saying, “These are my qualifications. This is where I live. This is my address.” Is that right?

Laura Brackwell: Well, I said that CQC had streamlined the process for GPs and was going to ask for less information. I wasn't sure of exactly the extent of it, but I thought it was asking who the providers were, what they do, where they do it and whether they were compliant. I am not sure how much more you were asking for in that first instance.

Amyas Morse: I do not recollect a little bit of paper being mentioned.

Q66 Mr Bacon: Will it be self-certified for GPs?

Cynthia Bower: No, we have, as the report, or the auditors, described, made it a more simple process—an online process for GPs. We will have to identify who is legally responsible—what the partnership is.

Q67 Chair: A small form. What will be on the form?

Cynthia Bower: It is an online application form.

Q68 Mr Bacon: I am not with you. If it is online, it must by definition be self-certified. The GP sits in

front of the computer, fills in some information, and gives it to you. That is what you are saying, yes?

Cynthia Bower: They apply. It is not self-certification. It is an application. That is what is being referred to. The application form has been made much more simple. We are asking them for the partnership because we have to identify who is legally accountable for the services, the location and whether it is a partnership of many practices or a single practice .

Q69 Mr Bacon: You can find any GP in the country now by going on to the GMC website. They are all there. It is all public, now.

Cynthia Bower: The partnerships are not. The GMC registers individual practitioners. It does not register the partnerships. It is the legal partnerships that we need to see. Then they have to declare what locations they will be operating at, and the services they will run out of those locations. These are all required under the legislation. They then declare whether or not there is any non-compliance.

Q70 Chair: They declare?

Cynthia Bower: They declare non-compliance, then it is up to us to make a judgment based on any other information that we have. We have piloted this activity. Actually, GPs are very open about declaring non-compliance if they think that it is there. We then have further debates with them, including, if necessary, going out and carrying out an inspection to determine whether or not we believe that they are compliant with the legislation.

Q71 Chair: So I say to you, “I'm M. Hodge; I practise from the House of Commons; I'm doing X, Y and Z, and I'm compliant.” What are you then going to do?

Cynthia Bower: We will see whether or not we have got any information from any other sources, particularly the local primary care organisations, or from the GMC—for example, if we had information from the GMC that there were practice issues about a particular general practitioner. We will look at the information that we have got; we will look at whether or not they are declaring non-compliance.

Q72 Chair: Have you, for example, planned on doing a percentage of checks—actual physical checks?

Amanda Sherlock: Yes.

Q73 Chair: What percentage?

Amanda Sherlock: We are anticipating that there will be 10% that will be a significant risk of non-compliance.

Q74 Chair: Will you go and physically check?

Amanda Sherlock: We will physically go.

Q75 Chair: All 10%?

Amanda Sherlock: Yes.

25 January 2012 Department of Health and Care Quality Commission

Q76 Meg Hillier: Can I just clarify; you think 10% of GPs currently will be at considerable risk—a considerable risk to patients?

Amanda Sherlock: Yes.

Q77 Matthew Hancock: How have you come to that figure?

Cynthia Bower: On the basis of the pilot.

Q78 Jackie Doyle-Price: Are you relying on GPs to self-refer themselves as non-compliant, for that 10%?

Amanda Sherlock: The law requires the person applying for registration to make a legal declaration.

Q79 Jackie Doyle-Price: That does not fill me with much confidence, I have to say.

Una O'Brien: If I could explain, the fundamental responsibility for complying with the standards rests with the provider, not with the regulator.

Q80 Jackie Doyle-Price: Yes, but we are relying on the regulator to deliver that and make sure that they are accountable for that and meet their obligations. It is not good enough to have a regulatory system in place and say, "Ultimately, it rests with the provider." We are relying on you to hold those providers to account.

Cynthia Bower: If I may, the application process—and it is something that we have referred to a lot in registration—is the beginning of being engaged in regulation, so registration is part of the regulatory activity of the organisation. The pilot work we have done, as I have said, has demonstrated that GPs are quite open where they believe that there is non-compliance. A proportion of those we will absolutely go and visit, because we think that the concerns that they are raising are ones that might pose a risk to patients or mean that the essential standards are not complied with. So we have a process in place that, on the basis of the numbers that we have worked through our pilot, ensures that the registration activity won't affect inspections, so in answer to your earlier challenge, Chair, we will not tie up inspection staff in registration. We have a registration team who will focus on the registration of general practice and it will—

Q81 Chair: A registration team going out and doing the inspections in your 10%?

Cynthia Bower: We have a registration team, exactly, who do that, who will go out and visit providers if we believe that they are not going to be compliant with the law.

Q82 Chair: You will see what our report says in the end, but I shall mention two concerns and then I'll turn to Steve, who is being very patient. One concern is the balance between registration and inspection, and the second is that the nature of the registration for GPs may not be qualitatively of a sufficient standard to give the public and, maybe, us as their representatives, assurance that you are actually registering good quality GPs. I think that is what I take from that little exchange.

Q83 Stephen Barclay: One of your precursor organisations, the Healthcare Commission, carried out 16 major investigations over a five-year period. You were set up in April 2009. Between May 2009 and June 2011 you did not start a single investigation. Did the risk within the NHS change so dramatically during that period?

Cynthia Bower: The risk did not change but the nature of regulation changed.

Q84 Stephen Barclay: Clearly. We can see that from the fact that you did not do any investigations. Why was it justified to have such a change?

Cynthia Bower: Because the Healthcare Commission that was the previous regulator of the NHS did not have the powers that CQC has. As Una O'Brien was saying in her opening remarks, the Healthcare Commission produced an annual statement about the performance of the NHS, but organisations were not registered by the Healthcare Commission; it did not have powers of enforcement in the way Una was describing. So the range of powers that we have are very different to the range that the Healthcare Commission had. We are operating under very different legislation, so our view in the first instance was that we would begin to inspect the NHS. As you have heard already the NHS was not inspected particularly under the Healthcare Commission regime. We therefore began a process of inspection. We have started a process of enforcement. We have begun to undertake some investigations into NHS organisations, but the powers we have, in the way in which we can require improvement by hospitals, are very different from the ones that the Healthcare Commission had.

Q85 Stephen Barclay: Would you accept that very important lessons were learned in the NHS from those major investigations?

Cynthia Bower: Absolutely, yes indeed.

Q86 Stephen Barclay: And it was your decision, supported by the board, to get rid of the national investigations team?

Cynthia Bower: In December 2009, the board took a view of how it wanted to deploy its fieldwork staff, to take on this bigger role which we had been given. It was the decision of the board—I am not a member of it—that it would abolish a number of central teams and move its resource into front-line inspection.

Q87 Chair: Was it your recommendation to the board?

Cynthia Bower: Yes, absolutely.

Chair: Well, don't distance yourself from it. The way boards work is that they work from papers prepared by the executive.

Q88 Stephen Barclay: As the Chair says, it was a recommendation from yourself as chief executive. We have already seen evidence from one of your board members who felt it necessary to act as a whistleblower, who said that the board is predominantly passive and is often asked to simply endorse decisions. That was a team that had criticised

the strategic health authority that you led prior to taking on your role as chief exec, was it not?

Cynthia Bower: Yes, it was. The investigation into Mid Staffordshire hospital, which was the main focus of that investigation, had indeed criticised the SHA and a number of other organisations.

Q89 Stephen Barclay: You were criticised. You then take over the organisation, including staff that had criticised you and you screw up the team that had been responsible for that criticism. I put in a named day parliamentary question for the board minutes pertaining to that discussion, which have not been provided, even though the deadline has passed. Can you explain why that is the case?

Cynthia Bower: Well, I understood that the board minutes had been provided to you¹.

Q90 Stephen Barclay: No, they haven't.

Cynthia Bower: I apologise for that. As far as I am aware, we have released the board minutes.

The decision to abolish a number of central teams, including the investigations team, was absolutely to do with the change in the nature of regulation that was going to happen in the NHS and was not to do with a personal agenda of mine. I would absolutely not engage in anything like that.

Q91 Stephen Barclay: We have already heard about the problems around mis-registration. No investigations were done over the first couple of years. Can we come to inspections? It was reported that Parliament was misled, with a claim that twice as many inspections and reviews had been carried out than reported in the annual report. Was that the case?

Cynthia Bower: That was a typographical error in the report, which was immediately corrected.

Q92 Stephen Barclay: So stating that you had done twice as many inspections as was the case was just a typo?

Cynthia Bower: As far as I am aware, yes.

Q93 Stephen Barclay: But you are responsible for that report. We are not just talking about a little memo here. This is the annual report. These documents are usually checked extensively. Any that I have been involved in usually go through numerous editions. When was the mistake discovered and when was Parliament informed?

Cynthia Bower: I cannot give you that information now, I apologise. I am sure that we can let you have it.

Q94 Stephen Barclay: I understand that you have previously said that it was discovered in August and that it was revealed during the Mid Staffs inquiry at the end of September, during questioning to Sir David Nicholson. I was wondering, given that Parliament was the body that was misinformed, when Parliament was told, or, indeed, whether it has yet been formally told.

Cynthia Bower: I am sorry. I am not aware of the sequencing of events and I would not like to mislead you. We can, no doubt, let you have a note of that.

Q95 Stephen Barclay: Okay, you can let us have a note.

You also took the decision to scrap the dedicated whistleblower line that the Healthcare Commission had had. Given what happened with Winterbourne View, where, as I understand it, the CQC was contacted more than once by the whistleblower before he went to "Panorama", do you think that it was the right decision to get rid of the dedicated whistleblower line?

Cynthia Bower: We established a single telephone contact point for CQC, which is in our national customer services centre in Newcastle. That is a line that is published for everybody.

Q96 Stephen Barclay: That is a general helpline, isn't it?

Cynthia Bower: Indeed it is.

Q97 Stephen Barclay: So you don't have the experts. If you have a specialist whistleblower line, manned by the national investigations team, they are going to be far more skilled at picking up the nuances and importance, and the crank calls that we are all familiar with as constituency MPs—the genuine case from the maverick. Having a dedicated whistleblower line staffed by people who are used to investigating such issues is surely better—I put it to you—than having a general helpline of people who usually deal with very high volumes of calls. As we saw with Winterbourne View, there was a failure not once, but more than once, to pick up on important whistleblower allegations. Do you accept now, with the benefit of hindsight, that that was a mistake?

Cynthia Bower: No, I do not. Obviously, we have apologised for our failures in terms of how that whistleblowing information was dealt with, but it was not that the information did not get to the right place in the organisation. It did indeed, but the inspector made the wrong judgment about how she dealt with that information. I would argue that we do have a dedicated whistleblower team now within the organisation.

Q98 Stephen Barclay: Which was set up when?

Cynthia Bower: There is track and chase—Amanda can tell me.

Amanda Sherlock: Produced in 2011.

Q99 Stephen Barclay: Okay. As we have seen with the number of whistleblowers who have come forward, is there not a conflict in a regulator that, as part of its remit, has to encourage openness and a culture for whistleblowers within the NHS, but has been signing gagging clauses with its own staff?

Cynthia Bower: Can I just return to your previous question? I believe very firmly that the systems that we now have in place for dealing with whistleblowing—indeed, the number of whistleblowers who have contacted the organisation since the Winterbourne View events has risen very

¹ The Department of Health replied to the Parliamentary Question referred to on Tuesday 24 January.

25 January 2012 Department of Health and Care Quality Commission

dramatically, so at least it has raised people's awareness that they can come to us. We now have a team that deals with that.

Q100 Fiona Mactaggart: Can I ask how many whistleblowing events have happened, and how many of those have been followed up?

Cynthia Bower: Winterbourne View was in June last year. Since that was published, we have had about 2,500 contacts from whistleblowers into the organisation, but before that we had had about 200 over the course of a year, so they did go up very dramatically. The team we have in place makes sure that every single one of them is now followed up by the compliance inspector.

Q101 Chair: How big is your team?

Amanda Sherlock: Approximately six.

Chair: So, 2,500 and six.

Mr Bacon: Six people.

Amanda Sherlock: Yes.

Chair: Blimey.

Q102 Stephen Barclay: The point I was driving at is why you feel it is value for money—that is the Committee's remit—to be signing gagging clauses with your own members of staff.

Cynthia Bower: What we have signed with a number of members of staff are compromise agreements. We do not make any attempt to gag members of staff. Indeed, it would be against the law—the public disclosure legislation—if we attempted to do that, so we do not. What we have done is, in a small number of cases, sign compromise agreements with staff. Those are to the benefit of the staff as well as to the organisation, and we are obliged to ensure that individuals get proper legal advice before they sign such an agreement.

Q103 Stephen Barclay: But if they are not enforceable in law, why do you need them?

Cynthia Bower: They are about the protection of the individual and the protection of the organisation in employment issues.

Q104 Stephen Barclay: No, they are not. They are about transferring legal risk. Several whistleblowers felt they needed to be subpoenaed by the Mid Staffordshire inquiry because they were concerned. Even your own board members said—to quote directly from a member of your board: “My endeavours to provide robust scrutiny and challenge led to my professionalism being questioned. Doubt was cast on my mental health and my performance”. That is someone who, for 11 years, was a mental health commissioner and was trying to raise concerns. What does that say about the culture of the organisation you have been leading?

Cynthia Bower: Obviously, it is deeply distressing to the organisation that a member of our board chose to go to the Mid Staffordshire inquiry and has spoken out in that way.

Q105 Stephen Barclay: It was more than one. It wasn't just her. Amanda—

Cynthia Bower: Pollard.

Q106 Stephen Barclay: Amanda Pollard, who discovered an internal document that you were not sharing with the Committee, as I understand it. There was Roger Davidson, who was subpoenaed, and Heather Wood. A whole host of whistleblowers gave evidence to Mid Staffordshire.

Cynthia Bower: It was absolutely clear, particularly for Heather Wood for example, where we did sign an agreement but made it clear to her that that did not override any requirement for her to give evidence about any work she had undertaken during her time at the Healthcare Commission. So there was no attempt by the organisation to prevent any dialogue with the Mid Staffordshire inquiry or anywhere else, in terms of the use of those very common employment agreements.

Q107 Stephen Barclay: Given that I am out of time, may I ask one final question to Ms O'Brien? The Committee has repeatedly expressed its concern over the use of gagging clauses. In 1999, the Department of Health prohibited them in a circular, and then it changed that in its 2004 circular. The effect of that has been referred to. PIDA does not allow them to be enforced, but it transfers the legal risk to the whistleblower, so they are then reluctant to give evidence. Why does the Department continue to maintain that 2004 circular?

Una O'Brien: That is the question that I want to answer for you, but I do not have the background to be able to answer it today.

Q108 Mr Bacon: I suggest you go and look at the NAO Report on *The Management of Suspensions of Clinical Staff*.

Una O'Brien: I have not come prepared to talk about gagging orders. Forgive me.

Q109 Mr Bacon: It was when Sir Nigel Crisp, Lord Crisp as he became, was permanent secretary and chief executive—I think he was both at the same time—and the NAO did a Report on the management of suspensions of clinical staff. Lots of clinicians, whose clinical competence was not being questioned, were being suspended for very long periods of time, at public expense. In the end, Sir Nigel put out an amended circular, shortly after our hearing and our Report was published, which basically said, “There really shouldn't be gagging clauses anymore”—comma—“unless you really feel you absolutely have to.” That is the circular that Mr Barclay is referring to. There is no justification for it, in my view, especially when you are dealing with public money.

Una O'Brien: Forgive me. I have not come prepared to speak about gagging orders. I completely take the concern that you have raised. I will look into it and I will write to the Chair of the Committee with a full account of that.

Q110 Chair: We would like to include that in our Report, so asap is the answer.

Una O'Brien: Yes, of course.

Q111 Austin Mitchell: We have heard all the criticisms of the Commission—some of them today and some of them in the Report. The Department of Health has never given it a fair deal. The budget is cut by 6% compared with the budget of the three preceding bodies, and it is given more responsibilities. Is it not being set up to fail, in fact?

Una O'Brien: On the question of the budgets, first, we clearly need to get this right. Each of the years that the CQC has been in place, we have had a dialogue with it about the budget that is needed for the following year—whether it is sufficient. All those conversations in any setting, as you know, are testing and challenging, because organisations always want more than a Department is able to afford, but on each occasion we have agreed a budget. What is now clear, as we have understood more about this regime and how it needs to work, is that we have to adjust our expectations in terms of the budget.

Q112 Austin Mitchell: You mean you adjust the expectations down to the budget level?

Una O'Brien: No, up. At a time when pretty much, on average, every one of my organisations is taking a year-on-year 8% cut, we will not be applying that to the CQC. Indeed, we are moving some resources in its direction, both in the current year and next year, to enable it to employ more inspectors. But we did not have that clarity of understanding about resource utilisation at the beginning, and that is why I have listed it as one of my five areas where we need to see more improvement. What is clear now is that we have a better understanding of what the costs are, and therefore we can refine the budget in a more precise way.

If I may say, Mr Mitchell, on your first point, nobody wants the CQC to succeed more than the Department of Health. It has been set up in order to protect patients and the public and, indeed, to inspect a great big piece of delivery for which we are responsible. We want it to succeed: we need greater transparency about quality and safety for the public. We want it to succeed, and that is why we will continue, in a very focused way, to work with the organisation to continue on its progress of improvements.

Q113 Austin Mitchell: If you want it to succeed, why do you have such a tight hand on making it more difficult for them to recruit staff and such a tight timetable on registration. It says in the Report that, at September last year, “14 per cent of positions were vacant...including 108 registration assessors and compliance inspectors”, which you have just talked about. The Commission was subject to Government-wide recruitment constraints and was not able to fill vacancies promptly. The staff were not classed as front-line and it needed the Department’s approval to recruit new staff. Why are you keeping these tight strings on them and expecting them to do better?

Una O'Brien: I appreciate your point. The strings that you have described were pulled extremely tight in the first months after the general election, when there was a freeze on recruitment across the whole of government on absolutely everything.

Q114 Austin Mitchell: Have they been relaxed now?

Una O'Brien: To say that they have been relaxed would not be the right word.

Q115 Austin Mitchell: What would be the right word?

Una O'Brien: The right word is to say that, in the areas where we are clear about front-line staff, there is a proper delegation of authority to individual organisations to proceed and recruit the staff. Indeed, the CQC have now filled pretty much all their inspection vacancies. So the strings remain tight in the areas where there are non-essential, back-office staff—policy-type people like me. On front-line staff, there is a much clearer regime where organisations across the whole of government now have permission.

Q116 Austin Mitchell: And increased numbers. You say that there is a clearer regime. Are there larger numbers?

Una O'Brien: In some cases, there have to be, such as in the case of CQC, where they now have the permission to increase the number of inspectors.

On a day when so much is being said about the economy, I would add that, overall, it is still the case that the Department of Health has to bring down the running costs of its total system by one third during the spending review, so moving resource towards the CQC means that we will have to find the running cost saving from other efficiencies elsewhere in our system.

Q117 Chair: You said that you want it to succeed. Is it therefore sensible to give it additional, new, different functions, particularly—you probably heard their evidence—those of the Human Fertilisation and Embryology Authority? Is that sensible?

Una O'Brien: We are listening very carefully to the representations that are being made.

Chair: You are reviewing.

Una O'Brien: I heard the recommendations today and I take them very seriously. After all, the HFEA is one of the Department of Health’s great successes. In the light of the recommendations, we are going to have a full consultation on both the HFEA and the Human Tissue Authority before any further decisions are made.

However, I must congratulate the HFEA on the way in which they have worked with the CQC to find the savings that they have. They have been completely professional about it and, indeed, have exceeded our expectations from when the work was done in the summer of 2010. It is right that we take a full and comprehensive look at all the arguments that are being put to us.

Chair: I think that is a welcome pause, and we hope that you come out with the right decision at the end of the pause.

Q118 Chris Heaton-Harris: I have some questions for Cynthia Bower. As I hope you know, because I have been in correspondence with you in the past, I have some concerns about the systems that the CQC has in place to control the huge amount of power that it has—from victimising homes and home owners to

how it self-regulates its powers. I have particular issues with the culture management and transparency of the organisation.

As a starter, could you tell me whether there are any circumstances in which you would propose to cancel the registration of a care home that did not, when inspected, warrant a single recommendation or, indeed, requirement?

Cynthia Bower: Do you mean would we close a home on the basis of a single failure?

Q119 Chris Heaton-Harris: If you did not find any failures. There is a home in my constituency, and I would have loved to have a face-to-face meeting with you about it, but you would not meet me, so I am afraid that I am doing it here, which seems like a perfectly nice place to do it.

You proposed to cancel the registration of the owner of a home in my constituency even though they had been inspected and had had no recommendations, let alone any requirements. Why would that be? How could that happen?

Cynthia Bower: First, I apologise for not meeting you. I cannot imagine the circumstances. Legally, we would not be able to close a home without there being some breach of the regulations. We would be subject to very rigorous legal challenge if we tried to do that, so I cannot understand why that should be the case, and if it would be helpful, I will be more than happy to take that up outside

Q120 Chair: You will be meeting him outside.

Cynthia Bower: I will indeed.

Q121 Chris Heaton-Harris: The home owners are actually in the audience.

Cynthia Bower: We can have an instant meeting.

Q122 Chris Heaton-Harris: It would be helpful if you could meet them as well.

Cynthia Bower: Absolutely.

Q123 Chris Heaton-Harris: Is it common practice for the CQC, when proposing cancelling registrations, to rely—it is essentially whistleblowing practice, and we have come across this before. When you have already dismissed the actions of someone who is blowing the whistle because they are unreliable, surely you would then close any further investigations based on unreliable evidence.

Cynthia Bower: If you are asking what cognisance we would take of whistleblowing, Amanda is more of an expert on the detail of our operations than I am. When we get whistleblowing information—I can think of an instance that I followed up in the last few days. Depending on the nature of that—we have done some research on how we have responded to the whistleblowing events that we have had since Winterbourne View—that could easily prompt an inspection. If we feel that there are safeguarding concerns or urgent concerns about the quality of care, we can easily follow that up with an inspection. I can think of an instance over the past few days, as I said, where we followed that up very rapidly.

We would use the whistleblowing information to test with the patients or the relatives who were there, the service users and the front-line staff. We may speak to the whistleblower if they want us to do that. Sometimes people want to remain anonymous. We would use that to make a judgment. We would neither ignore—I hope, notwithstanding the problems with Winterbourne View—what a whistleblower says to us, but nor would we act solely on whistleblowing information.

Q124 Chris Heaton-Harris: Before Amanda Sherlock comes in, can I just ask about what happens when you get information? This is about a home called Rosedale in Herefordshire. You got to the point where you knew the information was bad, but it seems as though your team there just desperately wanted to get a result in closing down that home. They went to the following extent: I have a letter from a local police officer basically saying that it is your job to look after and regulate these sorts of homes, and that the police are not going to seize documents or enter care homes where they know there has been no criminal activity. Why would the CQC try to put pressure on the local police to do something where there was not a problem?

Cynthia Bower: I cannot imagine. I am sure Amanda can talk a bit more about when we do engage with the police.

Amanda Sherlock: In terms of that specific circumstance, we clearly need to take that away. I would agree with Cynthia Bower that I cannot envisage any circumstance in which we have no evidence of non-compliance against the essential standards where we would progress to cancel registration.

Q125 Chris Heaton-Harris: Well, I can present you with plenty of it. My overall concern is that I feel—and I want some clarification from you—that with all the scandals that were around at the time I want to be assured that there was no message from the top in the management team that some results were needed somewhere in the country. These are very sensitive actions. In this case, Rosedale, you closed it down; you removed residents, even though evidence was, let us say, shaky, rather than anything else. That has a dramatic effect on the residents, the families and everyone else. Was there nothing from the centre that maintained the pressure on your staff to do that sort of thing?

Cynthia Bower: Absolutely not. As I indicated earlier, the threshold for closure and the legal challenge around closure are extremely high for the organisation. That is something that we do quite rarely. More often we work towards voluntary closure, for example, if we think there are concerns about the quality of care. I am sure we are more than happy to take this issue up outside. I can assure you we have set no targets, for example, for closure of homes.

Q126 Chris Heaton-Harris: I have one final question. Is there a guide? Do you have a guide for your staff on what steps should be taken along this process, with timelines and that sort of stuff? If

possible, would it be okay to share it with me or other interested Members of the Committee?

Amanda Sherlock: Absolutely. We have both an enforcement policy that we are obliged to publish and consult on, if we wish to make any changes, and a scheme of delegation that sets decision-making levels in the organisation, depending on the seriousness and impact of the regulatory decisions that we are taking.

Chris Heaton-Harris: I will leave my questions there. I am quite happy with the meeting outside.

Chair: We do not have to vote in the current Division, so nobody worry.

Q127 Matthew Hancock: We are all so evenly matched.

Can I first ask you to address some of the concerns that were raised in the previous evidence session that the approach of CQC to hospitals and to care homes is different and you are much more lenient to one rather than the other? Did you hear the concerns?

Cynthia Bower: I absolutely heard that.

Q128 Matthew Hancock: Can you address those?

Cynthia Bower: I would address it in this way: we are very clear with our staff and in the guidance that we put out that the judgment about compliance at the most simple level and about whether a provider is compliant with the law or not, is the same, no matter what the provider. Either you are compliant with the law or you are not. There are not different rules for the NHS, for example, as was being implied, and for adult social care homes.

When we are making judgments about the enforcement action that we take, we are obliged by the law to be proportionate—to think about the impact of our actions on the provider—and also to think about the impact of our actions on the wider community. We constantly think through, beyond compliance, what will be the impact of the enforcement action that we will take. That is a requirement of the law.

Q129 Matthew Hancock: Does that mean that you therefore do not take enforcement action against hospitals as much as you do against care homes?

Cynthia Bower: There is evidence of our having begun to take enforcement action against the NHS. We have issued warning notices to the NHS. We have required the NHS to improve services in the way that we do with adult social care. Clearly, the issues about closing a hospital are very different from those about closing a home.

Q130 Matthew Hancock: You do not have to close a whole hospital. You can close a ward. Can I just pick you up on one point? First, you can close just a ward, not a hospital, right?

Cynthia Bower: We can put restrictions on the registration, yes.

Q131 Matthew Hancock: Secondly, you said, “We have begun to take enforcement actions against the NHS.” But, as my colleague, Mr Barclay, pointed out, there was a long period after you came into existence

when you did not take any enforcement actions against the NHS, unlike your predecessor.

Cynthia Bower: The predecessor did not take enforcement action against the NHS because it did not have the legal powers to do it. No one has ever taken enforcement action against the NHS, until we came along and started to do it. We have been regulating the NHS under this legislation since—

Q132 Stephen Barclay: The point was the investigations. On enforcement, how many prosecutions have you undertaken?

Cynthia Bower: We have not undertaken any prosecutions under the legislation.

Q133 Stephen Barclay: Not one. When you were giving the answers earlier, one of the points you were stressing was that one of the differences between the previous regulatory bodies and yourself was that you had far greater powers. What you are saying is, “Yes, we have far greater powers, but we haven’t undertaken a single prosecution.” Yet, the other powers that your predecessor organisation had was to use deep-dive, thematic investigations that usually took around a year. The whole board was interviewed. The whole organisation was scrutinised, and major lessons within the NHS were learnt. You are not doing that either. That is the nub of it, is it?

Cynthia Bower: I do not agree with that position. Amanda Sherlock can come back to you.

Stephen Barclay: Well, it is factual.

Q134 Matthew Hancock: Hold on. You don’t agree with that decision? That position? You don’t think that that was the fact?

Cynthia Bower: No, it is not a fact.

Q135 Stephen Barclay: There were not any investigations. You have just said that you haven’t done any prosecutions.

Una O’Brien: The powers are tiered so there are about five stages before you would come to a prosecution. If you just go back to 2009 when the registration was simply on health care acquired infections, a number of organisations were registered with conditions and then they addressed the issue. Instead of getting worse, worse, worse, which would have led to a prosecution, having had the warning, they addressed the issue and brought it back into compliance, which is a success. It is not a success necessarily to count up the number of prosecutions.

Q136 Stephen Barclay: How many legal challenges have there been to CQC over the past two years?

Amanda Sherlock: To my knowledge, and we will confirm this after the hearing, we have had no applications for judicial review.

Q137 Stephen Barclay: You say, “judicial review”. Are you saying that the only legal challenge to CQC is judicial review? You have not had any push-back on warning notices or any of the other notices that you issue. The only legal response is judicial review. That is the position, is it?

25 January 2012 Department of Health and Care Quality Commission

Amanda Sherlock: No. There is a representations process. There are two lines of power that CQC can take. It can use its criminal powers or it can use its civil. If it uses its civil, anything that is an enforcement has representation built into it.

Q138 Chair: I think that Stephen is asking about action against the CQC.

Q139 Stephen Barclay: No, the push-back. One of the points I hope we will come on to is that the regionalised approach does not have a very good audit in terms of the consistency of standards of inspectors. There are real issues around the training of inspectors. You have pretty much doubled the amount of training. You have a regional approach with very different standards around the country.

I do not think you have even harmonised the pay, which is a staff morale issue within the organisation. You have people doing the same job on very different pay, which obviously is corrosive to morale. Because you have different standards across the country in the way that inspections are being carried out, mainly by generic people rather than clinicians for routine inspections, it was put to me that there is more push-back now to CQC because people are starting to challenge and say, "Well, just a second here. The standard of the inspection in this region is different from the standard that is being applied elsewhere." That is a pretty bizarre situation to be in for what is a national body regulating the national health service.

Cynthia Bower: Can I pick out two or three points that I would like to try and address? To go back to your earlier point, under the legislation we are allowed to put compliance actions on organisations. That is a sub-enforcement activity. We have put compliance actions on to NHS organisations so that we can require them to improve, and we will go back and check to make sure that they have undertaken the actions that they have said. We can issue warning notices on NHS organisations, which is a more formal requirement to improve activity and, again, we have done that. We have also conducted a number of investigations. We have completed two investigations: one into Barking hospital and one into Pilgrim hospital in Lincolnshire. We are in the process of conducting an investigation into more hospitals.

Stephen Barclay: June 2011.

Cynthia Bower: We are beginning to pick up the investigation role. We have been regulating the NHS for not quite two years yet under this legislation, so we are taking action and using the powers that the law has given us. We have had a large exercise to deal with the pay and grading of our staff. We have completed that work. We have reached agreement with the trade unions about how we would take that piece of work forward, but our ability to implement it has been limited by the pay constraints that the Government have put on us in common with every other organisation, so we are not able to move people to new higher grades although we are going to start to move people downwards, if they are overpaid in a particular role, from April this year. The constraints around sorting out our pay and grading system have

been because some of the Government's constraints about raising people's pay.

The third issue you raised was about quality and how we try to assure quality across the organisation. Again, Amanda is more of an expert on this than I am, but we do have quality assurance systems in place at a regional and at a local level. We do expect our managers to shadow inspections. We do expect them to read reports. We do expect them to follow up things like whistle-blowing and safeguarding things, so we are putting into place a quality assurance system to give greater consistency to the judgments that our inspectors are making.

Q140 Matthew Hancock: I lost the line of questioning slightly, but I want to come back to the big picture. You were explaining why you don't think that there is a different approach between care homes and hospitals, despite the fact that there is a difference in outcomes in terms of the various levels of action. Will you address the concerns that the permanent secretary raised at the start—the five concerns that she has with the CQC, where she thinks that the CQC needs to improve? Will you tell me why, in the time that you have been in post, that has not been achieved?

Cynthia Bower: So I can go through the five points that she raised?

Q141 Matthew Hancock: Yes.

Cynthia Bower: The permanent secretary made a point about development and strategy. In the very early days of the organisation, we did indeed produce a strategy. We consulted on a strategy.

Q142 Matthew Hancock: Why is that inadequate?

Cynthia Bower: The issues that now need to be addressed with it, and the issue is raised in the report is not about whether we had a strategy, but whether or not we used it to determine whether the organisation was being successful. We said in our strategy that it is our job to protect the rights of patients and to make sure that care is centred on their needs. We have particular responsibilities under the Mental Health Act, for example, because of that. We said that it is our job to try to do our best to contribute to eliminating poor care. One of the challenges around the strategy, which is contained in the report, is that we have not sufficiently started to measure success against that. One of the challenges now coming from the Department is, "Say what success look like and start to evaluate it." We have already begun a piece of work to tackle that.

Q143 Matthew Hancock: You have begun a piece of work. How long did it take to do that?

Cynthia Bower: As I said, we did have a strategy. In the two years that we have been working under this legislation and the three years as a regulator, a number of our functions have changed and responsibilities have been taken away from us, for example. So we have been trying, as Una mentioned in her opening remarks, to consolidate and develop our regulatory model. It was too early to start saying what success represented in implementing—

Q144 Chair: When I read this Report, I found it a bit shocking that you are an organisation that is set up—you have just said it yourself—to ensure quality and ensure improvement, and yet the metrics that you have for assessing your own performance contain nothing on quality. It is all quantitative stuff. It is gob-smacking that you would even set yourselves up in that way.

Cynthia Bower: To answer that challenge, it all comes back to the point that is made in the NAO Report, which is that—I know that you acknowledged it at the beginning—this is a new organisation that has taken on an enormous task. We are bringing the entirety of health and social care, including the NHS, into an entirely new regulatory system, which is much better than the previous system in my opinion.

Q145 Chair: Was it a mistake—this would almost be good to hear—that, when you set yourself up, you did not establish some indicators of your own performance that would assess the quality of the CQC?

Cynthia Bower: The only thing that I would say is that if we had done, many of the functions that we were undertaking in the early days have changed or have been taken away from us—

Matthew Hancock: But not all of them.

Cynthia Bower: Also, I would argue that we have been in the process of deciding how we are going to regulate this incredibly complex system, much of which has never been regulated before. No one has regulated general practice. No one has regulated dentists.

Q146 Chair: You have not got to general practice yet.

Cynthia Bower: But no one has regulated the NHS.

Q147 Matthew Hancock: The process of deciding how to regulate is within the legislative structure that was set out. You are two years into it, and you are saying that you are starting a piece of work to work out how you can ensure quality within the care home system, which you regulate.

Cynthia Bower: What we have done is that we established a model, as we have already mentioned, at the end of 2009. We established the way in which we were going to deploy our fieldwork staff. We said that we were going to undertake reviews in certain ways. We said that we would use inspections in certain ways, and we have been in the process of consulting our staff and stakeholders and deciding whether that is the right way forward. Should we, for example, be putting more emphasis on inspection, which is one of the debates that has gone on?

Q148 Matthew Hancock: I am absolutely astonished by this evidence. You started in 2009 to come out with a number of measures, and you are now going through the process of consulting people on whether, for instance, you are doing the right number of investigations. We are three years down the track.

Cynthia Bower: No, I apologise. The point that I am trying to address is the issue of evaluation and whether we have established whether we have been

successful. What I am trying to say, but clearly not as well as I should, is that some of the functions have been taken from us, which we did not predict, so we would have been evaluating things that are no longer within our remit. We have been trying to establish a successful model of how we regulate the sector.

Q149 Matthew Hancock: I completely understand that some things have been taken away that you did not expect at the start. Obviously, if you had a strategy for dealing with those, that would have to change. However, there are large swathes of what you do that have not changed over the past three years, and now you are starting to come out with a strategy and starting a consultation on doing the job that you started doing three years ago.

Cynthia Bower: What I am trying to establish is that what we are looking at now is that, having thought through how the model is going to work—how much emphasis will be placed on inspections, user voice, whistleblowing, and data and analysis—we are looking at how we evaluate the success. That is the bit of the strategy that we think has been missing—not having a view of how we regulate the sector, but how we then evaluate our impact.

Una O'Brien: Can I add that there is a wider dimension to this? The context in which CQC does its work—the set-up in one context—has now shifted the centrality of quality as a responsibility that has to be held for the NHS, for example, in all different parts of the system: the role of the commissioners; the role of NICE; and the work that is being done by the National Quality Board to clarify who does what. I think Mike Farrar and Anna Dixon referred to this. Many different bodies have a responsibility for quality in addition to what goes on inside a given organisation. We have the regulators of the professions and we also have the role of commissioners.

One of the things that are shifting in the external environment is the creation of the Commissioning Board. The challenge—it is a broader one than CQC, although the CQC needs to reflect it in its strategy—is this: what is the essential part that CQC and its regulatory activity plays within that wider quality landscape? In the Department, we absolutely recognise that this is a responsibility that we have to steward among all the organisations in order to get that clarity, particularly with the Commissioning Board coming into being in the coming weeks and months, so that the respective responsibilities for quality of different parts of the system are properly and clearly articulated.

To finish answering Mr Hancock's point, I would then expect that the strategy—this is why I have prioritised it—of each of the organisations needs to reflect that, so that we can demonstrate the alignment to the public. Each part has a unique and specific role to play, but no one organisation can or should claim that it is entirely responsible for quality. Part of the difficulty for CQC has been that people project the entirety of quality on to it, whereas, in fact, it is responsible for essential safety and quality standards.

25 January 2012 Department of Health and Care Quality Commission

Q150 Chair: We do understand that. Things always change, and you respond to that by changing your quality criteria. What is quite astonishing is that an organisation that you conceived of in 2007, I think, is now, in 2012, waiting for another strategy to establish the quality criteria against which its effectiveness will be judged. It is a quality body—that is not a good place to be.

Q151 Meg Hillier: I want to pick up on that issue of quality. Thank you, Ms O'Brien, for explaining what you are regulating for—I think it was a bit of an answer. Cynthia Bower, what is your view of improvement across your areas of responsibility? How would you define success and improvement for the suppliers on the ground?

Cynthia Bower: We are very clear that the law makes us responsible for monitoring essential standards of quality and safety. That is what we look at, what providers are registered against and what we regulate—inspect—against. I would argue that improvement for many organisations is to ensure that they are compliant with those essential standards—not beyond that.

Q152 Meg Hillier: You are not looking at improvement. We have heard about elder abuse. I have some direct experience of care for older and disabled people. I and many of my constituents would argue that there needs to be a lot of improvement in many of those areas. You think that the minimum standards, as set by Parliament, are enough.

Cynthia Bower: No. We would argue that the essential standards of quality and safety are themselves aspirational. They represent a high quality standard; they are not some sort of bare minimum. They talk to engagement, to safeguarding, to high quality care. These are the essential standards that have been established in the Act. We, as an organisation, have said that that is our focus. It is not improvement beyond those essential standards; it is making sure that, at all times, we are monitoring organisations to see if they are compliant with those essential standards. That would include safeguarding, engagement and people being involved in their care planning. We do not do improvement beyond that; we focus on those essential standards.

Q153 Meg Hillier: That answer rather worries me in relation to GPs. We have seen a lot of political pressure from all parties about improving the service that GPs offer. I am not that worried when GPs self-register, because I do not think that most GPs are out to get their patients, but we have all come across interesting issues, I am sure. Take, for example, the GP working with a relative, who is the practice manager, and no external professional coming into that surgery. Would that throw up a warning sign for you? You talk about the 10% that you are worried about, but I am not clear what a good GP would be, in your book, compared with a bad one. As patients, how would my constituents know from your work?

Cynthia Bower: Again, Amanda will help me out. One of the things that we have been doing in this period of preparation for the registration of general

practice is some model compliance reviews, so starting to look at those essential standards as they will apply to general practice and see where the risk areas are and what the problems in compliance are likely to be.

Amanda Sherlock: It would absolutely raise concerns if it was a single-handed GP who had a close relative as their practice manager.

Q154 Meg Hillier: How would you know that?

Amanda Sherlock: They would have to apply for a registered manager as part of the application.

Q155 Meg Hillier: But how would you know that they were related, or married or whatever?

Amanda Sherlock: We would not necessarily know.

Meg Hillier: So you would be worried about it, but you wouldn't necessarily know. If I were, even just innocently, in that situation—

Q156 Chair: You would know or you wouldn't know?

Amanda Sherlock: We would not necessarily know. You could make assumptions if it was the same surname, for example, but we would not ask the question, "Are you related?"

Q157 Meg Hillier: I do not have the same surname as my children, so that is me off the hook if I wanted to try. If I were out to get patients, I could very happily do so in this situation. There is nothing to stop me registering online, and if I was a bad GP—there probably are some out there, although they have mostly been found out, hopefully—there is nothing to stop them under your system. There is nothing that would flag it up to you as a risk area.

Amanda Sherlock: There are a number of ways that we will be identifying risk for general practice, including where GPs as professionals are being investigated or have been subject to referral to the GMC.

Q158 Meg Hillier: So that is from the professional body?

Amanda Sherlock: Yes, it is very important. We will be talking to primary care groups, and we are currently talking to PCTs while they are going through structural change, to ensure that we get all that knowledge and information into our organisation before they disappear.

Q159 Meg Hillier: Not all of it is recorded. The chief executive of my PCT, when we had one for my borough, and I would sit down and go through the risk list of GPs, but it would not all be written down. There are all sorts of issues about writing down those concerns without 100% evidence, and people had to be careful. How are you going to capture that knowledge, which is not necessarily at this point evidential—that suspicion and worry, which is the sort of thing that you get from a local environment where people will tell each other about things and other doctors will worry about patients who have been transferred?

Amanda Sherlock: We will be talking to overview and scrutiny committees.

Q160 Meg Hillier: Councillors—the local authority?

Amanda Sherlock: Yes, councillors, and we will be talking to LINKs.

Meg Hillier: So, clearly, I need to go and talk to Hackney LINK.

Q161 Chair: To be honest, you are a posting box. That is what it sounds like. It sounds to me as though, on the GP registration, you have got a form that people fill in, and your checks are with another organisation. You are a post box. You are not doing any quality—I do not get a feel for a quality assessment, and in a constituency where I, like Meg, have huge concerns about my GPs, as I think Amanda knows—

Meg Hillier: I should just say, Chair, that I have great confidence in the vast majority of excellent GPs in Hackney. There have been concerns over the years, but I am mostly impressed.

Chair: I do not share that, not least because there are a lot of referrals to A and E, which should not happen, because GPs do not answer their phones or have their phones blocked at 8.30 in the morning and refuse to take phone calls at 6.30 at night. It sounds to me as though you are a post box; that is the main point.

Amanda Sherlock: I absolutely refute that, because I think it undermines the professional work that our registration assessors and inspectors are doing every single day.

Amyas Morse: Let me try to untangle this. This is meant to be helpful and elucidate a bit. Is it that as you cycle up, most people are registered, and that is really the start of it? To say that registration will flush everything out is misleading. Once it is registered, as the system cycles up, you will make more and more links and it will become apparent where there are difficulties. Is that the reality? I want to ensure that we understand.

Amanda Sherlock: That is the reality. A point was made earlier by Mr Bacon, I think, that if you do not register, you are therefore immune. That is not the case. The law requires that if you are providing regulated activities, defined in the Health and Social Care Act, you must register. If we are made aware, and we are—we have significant levels of referrals for services where people whistleblow and say that they believe that services are being delivered without registration—there is a clear process of working with those individuals to investigate whether they should be registered. If they are not registered, we require them to apply for registration and we make a decision as to their fitness, on the basis that they have not registered previously. Alternatively, we can prosecute. The burden of evidence for prosecution for delivering unregistered services is high. It has to pass the criminal test and the evidence test. It has to be in the public interest and it has to demonstrate value for money by having more than a 50% chance of successful prosecution. You are not immune by not applying.

Amyas Morse: Just to be clear, if we are talking about cycling up, and many of your replies have said that,

when would be a fair time—it cannot be too long from now—for this system to be cycled up? When will we see it functioning as it is intended to function? When would be a fair time for this Committee to look at that, would you say?

Una O'Brien: The first thing to say is that we would want to look at it, because each piece has come into the registration regime at a different point in time, in 2010–11. To be realistic, it will take time for it to mature. It is in the course of the first and second years, just as is now happening with the NHS, that the capability and intelligence about what is going on inside a particular organisation comes to light, as the thematic inspections reveal more information and as the inspectors on the ground become more au fait with what is happening in their locality. It is a new and different regime from the one that existed before.

Amyas Morse: When are you recommending that we look at it, then?

Una O'Brien: The first thing to say is that, in the Department of Health, we are looking at it all the time.

Q162 Chair: Date, Una. We are after a date.

Una O'Brien: I am looking at it now. I am not waiting for a big review at some point in the future. We are constantly pushing for and evaluating the effectiveness. That is why we have taken action to have the capability review. There will be a series of changes that follow on from that. This is not something that I have planned to take out of the drawer in a couple of years' time; this is absolutely something that we are doing now.

Amyas Morse: When should we expect to look at a model that has evolved more fully? I was not trying to ask a difficult question.

Una O'Brien: You mean the NAO coming back again?

Amyas Morse: Well, the NAO is waiting and expects—

Cynthia Bower: About 12 months. We began the process of regulating dentists against the new system on 1 April last year. We already have evidence about compliance action that we have taken against dentists. We have evidence about inspections and how they have progressed in terms of looking at dentists' services. I would say that after a year we would be able to demonstrate the action that we are taking in relation to dental practices.

Chair: That is not the question that was being asked, is it?

Amyas Morse: It is not meant to be a difficult question. I am just trying to understand. I appreciate that the system is complex. It is multi-factorial. You start with people registering and you get to know more, so you will cycle up and we will see how it is operating at a point in time. When is the point where we should look at it and see it in a more evolved state than it is in now? When do you suggest that we look at it and sit down and evaluate it and see it as it is meant to be operating? When is that to be? If we are planning to bring you back, when should it be?

Cynthia Bower: Specifically on general practice?

Q163 Amyas Morse: We want to see this organisation functioning, as intended, by design.

25 January 2012 Department of Health and Care Quality Commission

When is that to be? What are you recommending? Is it two years? I am asking when we should plan for that. When would be fair?

Una O'Brien: I think that there is an intention in five years—so that is 2014—to look at whether we have got the regulations right. We in the Department are committed to having a review of that. Are the 16 in the secondary legislation correct? Do we need to change or improve them? That work will be going on in—

Q164 Chair: That is the standards. I think that we were after a feel of when would be a good time for the NAO and us to say, “A lot of problems identified in the Report will be sorted out and the organisation will be functioning as you intended when you designed it.”

Una O'Brien: I would say, to come back from this Report, in two years, we would demonstrate visible and sustained improvement.

Q165 Chair: I hope that I am not putting words in your mouth, but I think that you said at the beginning that there are challenges here and that you are not happy with the existing performance. I think that we have concerns, and it is a really important regulator. You heard from that brief evidence session that nobody wants us to throw the whole thing up in the air and put it down again, so we want this to work, but it is not working well at the moment. When will you as the accounting officer with the strategic responsibility be able to assure us that the concerns we have raised will be tackled?

Una O'Brien: I think that it would be good to take stock again two years from when the Report was done. I think it will take at least five years from when it was set up to get the whole thing working, because it is a major undertaking to do this. It is the first time that it has ever been done and no country in the world has as organised an approach to the external regulation, quality and safety as we are endeavouring to have here. We need to understand the scale of ambition behind it.

Q166 Chair: There are a lot of people waiting so I am being a bit naughty here, but can I ask you something? One thing that strikes me, and I say this a little from my ministerial experience in the DFES, is that you have set up an organisation that is inspecting a massive range of bodies, from mental health institutions to GPs, to hospital trusts, to care homes—a massive range. We did a similar thing when we established the children's services and gave Ofsted those wider powers, and, on reflection, I think that that was an over-ambitious endeavour. One would have hoped that you, with your experience, had learned from some of the mistakes that we made. I just think that you are trying to establish something—the same inspectors going into a care home who go into a hospital who go into a mental health institution—

Mr Bacon: And a dentist's.

Chair: Or a dentist's. It is not common sense.

Q167 Mr Bacon: Does the fact that, in your opinion, it will take five years, having established the organisation, to get it up and running properly, not give you pause for thought about how you are doing it and whether it can actually be made to be effective? It is true that it is slightly less time in this case than it took to fight the second world war, but not much less.

Una O'Brien: I would not characterise it like that, although I do appreciate the—

Q168 Mr Bacon: It is a matter of history that the war started in 1939, unless you are an American, in which case it was 1941.

Una O'Brien: Exactly, and I should say that I was taking the American perspective.

Q169 Mr Bacon: Is that a message about where the health service is going?

Una O'Brien: No, seriously, Mr Bacon, I think that you know by now that this is a very important enterprise both to me personally and for the Department of Health, and we have to make it work, because it is what matters to patients and the public. They want a tough regulator, and that is what I want to see happening. To answer your specific question, I think that institutions take time to mature, and too often in the public sector we are in denial about that. We expect new bodies to arrive ready made, and time and again we keep being surprised that they are not. The truth is that we knew at the start that this would take time. We sequenced the introduction, and obviously under-estimated the scale of the task—we absolutely recognise that. I am very keen to learn those lessons for the other organisations that we will be talking about on another occasion, but let's get real about what it actually takes to build a new organisation. We are taking staff in, and you go to the private sector—I know you know it well—and talk to them about a merger: it takes three to five years.

Q170 Mr Bacon: Terry Smith will tell you that 75% of mergers in the private sector fail. He has made a lot of money on the basis of that proposition. May I ask one simple question? I know that others are waiting. Do you think that the CQC now is fit for purpose?

Una O'Brien: What matters to me when I look at an organisation that has had a rough time and has got some things wrong—part of that was to do with the sequence we set, so I have to accept that—is whether it learns quickly and puts things right, and that is what I am seeing. I am seeing sustainable improvement, which I absolutely expect to carry on, going forward.

Q171 Mr Bacon: That is all very encouraging, but what is the answer to my question?

Una O'Brien: I think the answer is that it is, and it will be even fitter for purpose when it carries on—

Q172 Mr Bacon: You think that it is fit for purpose now, do you?

Una O'Brien: I know that you like me to give yes-or-no answers.

Q173 Mr Bacon: Well, it is a fairly standard piece of terminology; it is a term of art that accounting officers use.

Una O'Brien: It is a pejorative piece of terminology, to be fair.

Mr Bacon: It has become pejorative, but you are obliged to be able to say, "Yes, this is fit for purpose", or "No, that isn't fit for purpose."

Fiona Mactaggart: That is what you have to do with the bodies you inspect.

Q174 Mr Bacon: At the end of the day, it is a binary choice. As Ms Mactaggart says, that is what you have to do with the bodies you inspect. Is it fit for purpose?

Una O'Brien: It is fit for the job that it is there to do, and it needs to improve. I have been clear about that.

Q175 Mr Bacon: That is not the evidence we have; the evidence we have is that it is not delivering value for money and has not done enough inspections. One of its own board members has gone on record about the repeated failures of delivery, governance and effective leadership. The poor supervision that it has undertaken, with a crash in the number of inspections, has led to an increased risk of poor-quality care. I have to say that the annual report's misprint of the number of inspections—it left it at around 15,000 when it had actually fallen to 7,300—appeared to be an attempt to disguise just how much the number of inspections had fallen. That does not sound like an organisation that is doing its job or is fit for purpose, but you are saying it is.

Una O'Brien: All I can do is repeat my previous answer. Had the situation that you describe remained static and continued to go backwards, of course it would not be fit for purpose, but that is not what I am seeing. For example, I spent a day at the operations centre in Newcastle last week. I have met tens of stakeholders over the last five weeks. I have asked them this question and I have listened to all the feedback about what people want and how they think it is improving and can improve further, so I am not going to sit here today and give you the categorical answer no. I am going to say that it is doing its job, and I expect it to improve.

I will be extremely focused on making sure those improvements are made. A lot of good things have been done over the last year. It is all very well to pile up the evidence on the things that have been tough and hard. That is your job, and it is my responsibility to make sure those issues are addressed. At the same time, it is important to be fair and to recognise the major work that the organisation is doing in deterring bad practice and in bringing into place a system that I believe will have much stronger protection for patients and the public than anything we have had before.

Chair: I am asking for tight questions and answers.

Q176 Meg Hillier: Just so that my constituents, patients and I are clear about what you inspect in GPs, you are clearly looking at safeguarding; we get that. What about those expensive 084 telephone numbers? Is that something that you will consider in your inspection?

Amanda Sherlock: It is not an element of the essential standards, no.

Q177 Meg Hillier: What about consultations that are held with two people in the same room? Would you consider that?

Amanda Sherlock: Yes, we would.

Q178 Meg Hillier: Under what criteria would that be?

Amanda Sherlock: That would be part of the appropriateness of treatment, and it would be dignity. A number of the essential standards would address that practice.

Q179 Meg Hillier: How would you find that out?

Amanda Sherlock: We would have a number of techniques. First and most obvious is people telling us. We will be going and doing inspections as part of our compliance.

Q180 Meg Hillier: Most of my constituents would not know who you were.

Cynthia Bower: All our inspections are focused on talking to service users: patients and their carers and families. We can gather local intelligence from things such as LINKs; HealthWatch when it comes along; and local authorities and social services departments. We would seek intelligence from people who are using the service to make our judgments.

Q181 Meg Hillier: This is inspection. My LINK has very committed people, but a few of them are active, and they do not have a finger in every GP's surgery. People tend not to complain to their MPs about—we do not have time to go into all that, but it is something to look at. It seems to me that you get more rigorous inspection as a licensee of a pub than as a GP. That is a real concern. I do not think that most GPs are out to do bad things to their patients, but it is those softer-end things that do make a difference to patients. On insurance, are you going to check in your inspections that the registered bodies have proper indemnity insurance? You will be looking not just at GPs, but at other regulated providers under the new Health and Social Care Act.

Cynthia Bower: It is not a legal requirement under the legislation.

Q182 Chair: Are you thinking of putting it as a legal requirement, given all the stuff about this in the House of Lords?

Una O'Brien: That has been a lesson that we have learned over recent weeks, and we will definitely look at that. Ms Hillier, may I comment on some of the issues that you are raising about the quality of general practice? It is important to remember in all this that the commissioner, whoever that is in the health and care system, has a role in terms of quality.

Q183 Meg Hillier: The question was about GPs; that is why I am asking these questions in particular.

Una O'Brien: At the moment, PCTs are responsible for that relationship. In the new arrangement it will be the commissioning board.

25 January 2012 Department of Health and Care Quality Commission

Q184 Meg Hillier: For GPs?

Una O'Brien: Yes, absolutely. The commissioning board has a responsibility; it will take over the current role that PCTs have in relation to general practice.

Q185 Chair: I think the point that Meg is making is that GPs will be inspecting themselves, because the commissioning boards are GPs.

Una O'Brien: No, I am talking about the commissioning board of which David Nicholson is the chief executive.

Chair: But he won't look at that.

Q186 Meg Hillier: He is not coming to Hackney, is he? Well, he is very welcome to come to Hackney; I will take up the offer.

Una O'Brien: Hang on a minute. The work that a PCT currently does—

Q187 Chair: But he will have to work through these commissioning bodies.

Una O'Brien: No, not in relation to the provision of primary care. That is not the responsibility of a clinical commissioning group. They cannot commission from themselves. The contract for the provision of primary care will be the responsibility of the commissioning board. The commissioning board will hold the contract with the GP, will set the QOF standards, and will be responsible for the sort of work that the PCT currently does.

Q188 Chair: I hear that. Does that mean that the commissioning board—I can't remember how many GP practices there are; how many are there?

Cynthia Bower: Around 10,000.

Q189 Chair: So the commissioning board will have to establish its own regulatory capability to assess the capability of GP practices.

Una O'Brien: Performance capability.

Q190 Chair: So we are going to have this lot doing it, and the commissioning board.

Una O'Brien: No, they deal with essential standards. The purpose of the commissioning board—

Q191 Chair: Oh, dear.

Una O'Brien: We can come and talk about the role of the commissioning boards on a further occasion, but—

Chair: I am not saying "Oh, dear" because of that; I am saying "Oh, dear" because I had not appreciated that you have already got two separate bodies, both of whom will be responsible for the quality offered by GPs.

Q192 Stephen Barclay: How many of your inspectors are qualified as doctors at the moment?

Cynthia Bower: There is no requirement for our inspectors to have clinical qualifications, so we do not keep a national register.

Q193 Stephen Barclay: Can you provide the Committee with a note of the breakdown of the clinical qualifications of the inspectors you have?

What I am driving at is this: in 2009–10, I think you did about 10 days' training, partly through workshops and partly through e-learning. If you are going to inspect doctors or into hospitals to inspect and potentially challenge clinically trained staff, how are you going to ensure that someone with a generic background will have the skills, training and competence to be able to spot clinical issues?

Cynthia Bower: Our inspectors are regulators. They are inspecting against a series of regulatory standards. They are not clinicians. It is not about clinical standards in a straightforward way.

Q194 Stephen Barclay: Sure, but you have got to understand the industry you are inspecting.

Cynthia Bower: We do have a range of ways in which, when inspectors are going into different types of organisations, they can get professional advice, up to and including joint inspections. I can think of instances where we have taken surgeons with us to inspect surgery; we have taken midwives to inspect midwifery services. We can bring in up-to-date, current clinical expertise—not someone who qualified 10 years ago, but someone currently working in the service. That is the way we did it with the dignity and nutrition reviews, and the way we are doing it now with the learning disability review. We take people who are current practitioners in an area, and if we need to take them with us on inspections in order to get a clearer understanding of what is happening, we will.

In adult social care, for example, we have people with social care backgrounds, people with clinical backgrounds, people with managerial backgrounds in health and social care, and people with no background in the sector. We are expecting them to be, and training them to be, experts in regulation who can draw on additional expertise. For example, when we begin to inspect GP surgeries, we will, I am sure, in the first instance take GPs with us to help us establish the things that we need to start looking at.

Q195 Chair: On every inspection?

Cynthia Bower: We will take GP advisers with some. Our process is being led by a GP at the moment. We have taken our dental adviser, who is a dentist, with us into our early inspections of dental surgeries.

Chair: I think this is chaotic.

Q196 Meg Hillier: Why are you projecting a 14% underspend, given the pressures on you to have more inspectors?

Cynthia Bower: The issues this year have been about the delays in getting people into post because of the hangover from recruitment delays, which we have already talked about. We have recruited to the additional inspector posts, but it has taken a while to get people into post, having recruited them.

Q197 Meg Hillier: Is that because of slow CRB checks, or what? What is the problem?

Cynthia Bower: There is an entire process between making somebody an offer of a job and their getting into post. There have been delays in filling the original 100 vacancies that we had in inspector posts. There

has been some expenditure that we did not incur because the registration of general practice was put back, so the money we had for systems development and for temporary staff to support some of our administrative processes, for example, we have not needed to use. We have made additional efficiencies on offices and on IT systems, which were greater than we expected. Of course, there are still restrictions on our consultancy spend. Those things have contributed to our underspend this year.

Q198 Meg Hillier: Would you give us a note with a breakdown of that? Just one final question, Ms O'Brien: will you be clawing back that underspend into the Department of Health budget?

Una O'Brien: I am afraid somebody might get their hands on it before I do, called the Treasury. I would love it, actually.

Q199 Fiona Mactaggart: I am concerned. You have implied throughout this evidence session that your role is a binary one, to check whether people pass basic standards or not—although I have to say that we have not had very binary answers from you. Am I right in that? That is a yes/no question.

Cynthia Bower: Yes, that is our job: to check against essential standards.

Q200 Fiona Mactaggart: Am I not right in also saying that the legislation requires you to publish information about the services that you regulate in order to drive choice and improvement?

Cynthia Bower: Yes.

Q201 Fiona Mactaggart: In that context, why did you decide to abolish the star rating system for care homes in June 2010?

Una O'Brien: That was a ministerial decision.

Q202 Fiona Mactaggart: Do you think that the star ratings helped to drive choice and quality?

Una O'Brien: The Department is definitely listening to the feedback we have had on that, and we are addressing that in the social care White Paper. It is clear that the social care sector is looking for, and members of the public and families—I am in exactly that position myself—want to have an understanding about, differential quality. That is true, but the one thing that we have absolutely learned through all the evidence in setting up this new regulator is that you cannot be the policeman at the level of the essential standards of safety and quality, and be an advisory body at the same time.

Q203 Fiona Mactaggart: May I interrupt you, Ms O'Brien, because I think you can. Sitting behind you is an example of a regulator that does precisely that, namely the HFEA. It is the policeman on IVF cases, but it also publishes information about the results of individual clinicians, which patients use in order to choose which service to have. You can do both.

Una O'Brien: I take your point absolutely, but the judgment that has been arrived at is that you would end up with inspectors inspecting the output of their own work over time. That is the reason for it. That is

why, in the thinking about this in policy terms, the distinction between this enforcement-related regulation on essential standards of safety and quality, and the role of commissioners—in local government or individuals purchasing, in the case of social care, or commissioners in the NHS—is the place that drives up the aspirational improvement. We have had powerful feedback from users, families and the social care sector that they want some mechanism whereby people can differentiate on the different levels of quality, way above essential. We also know that homes offer different types of facilities and regimes, and we need to have a verifiable source of information about them. That is exactly what we are now engaged in with the sector and users when discussing what might go into the social care White Paper. We accept the gap. What we do not agree with is that it is the role of this regulatory regime to address the gap.

Q204 Chair: But you are giving it HealthWatch.

Una O'Brien: That is a different thing.

Q205 Chair: HealthWatch is the consumer voice.

Una O'Brien: Because we want the consumer voice to really be at the door of the regulator, saying—

Q206 Chair: I know that it is difficult for you to justify it, but you cannot have the consumer voice that will be presumably commenting on the standard. I am sorry, Fiona, I will not interrupt you, but there is a contradiction there.

Una O'Brien: It is a different thing.

Q207 Fiona Mactaggart: If it is your job to collect information and, if you share it with people who are going to use the services, it seems a jolly good way to empower the consumer.

Una O'Brien: We do publish—

Q208 Fiona Mactaggart: Look at the issue of whistleblowing. You will have heard the concern of the Committee about past failures to act on issues that have been raised by whistleblowers. I heard from what you said to the Committee that there were something like 2,000 reports from whistleblowers, which are passed on to six members of staff whose job is to make them acted on. In paragraph 4.8 of the NAO Report, it tells us what that action is. That action is passing the report to the relevant inspector. If I combine reading that with paragraph 4.13, which highlights the fact that, partly because they tend to work from home, inspectors are very separated from each other, and there is not a robust system—if I can say that; I am not going to allege that there is no system—to ensure equality of standards across each inspector and equivalent action. What action do you take to make sure that each one of your inspectors acts in the same way in relation to whistleblowing?

Cynthia Bower: I will clarify a bit, and then let Amanda pick it up. It is the job of the central team of six to make sure that the information gets to the right inspector. It is the inspector who has to make the judgment.

25 January 2012 Department of Health and Care Quality Commission

Q209 Chair: So they are completely admin. Let us get that clear. They do not assess the seriousness of it, or anything.

Amanda Sherlock: Yes.

Q210 Chair: What level are they? Are they admin people or not?

Amanda Sherlock: They are admin staff. We have experts who are advising them. We have guidance. We have frequently asked questions, and they have their own experience of triaging this huge level of information coming into the organisation.

Chair: I do not understand the system.

Una O'Brien: Can I just explain? I sat with this team when I was up in Newcastle. I have to say that I was most impressed. I did not know what to expect because, like you, I had heard, "Well, it's a team. They are admin people", but a huge amount of training has gone into this. Now, if you do not deal with the contact right the first time you get it, everything after that is wrong. Let us not diminish please the importance of handling the initial call, really listening very carefully and understanding where the right place is to direct that call. They are hugely diverse.

Q211 Chair: We agree with that. Everybody agrees with you, which is why there was concern that the whistleblowing line was gone. I do not decry at all the hugely important role that every member of staff plays, but you need people at the right level, with the right skills, to be able to deal sensitively with the calls. It sounded to me from the description we were getting that it was again more of another post box effort where they come in, and you make sure that they go to the right inspector.

Cynthia Bower: If you wish us now to address the issues about the quality assurance systems we have in place, we specifically follow up whistleblowing and indeed safeguarding calls that come through to our contact centre, and there are other quality assurance systems and improved training for inspectors.

Q212 Fiona Mactaggart: How do you make sure? What are your standards and how do you make sure for each of these inspectors? One of the critical points in this Report is that it does not believe that your mechanisms are sufficiently robust to get an absolutely equal standard of quality across inspectors, and learning between them, as I read paragraph 4.13. How do you make sure, in relation to whistleblowing—I am just taking that as an example—that you get absolutely equal standards, whether you are in Slough or in Southampton? That is what I do not understand, although they are probably the same inspector actually.

Amanda Sherlock: If I can try to provide some additional information here, I have now worked for three regulators and consistency has been a common theme. How do you achieve consistency? There is a differential notion of consistency, depending on whom you are speaking to—when you are speaking to a provider, they have a different view of consistency from a service user, who wants the regulator to go in and be tough. We have a duty of proportionality. What we have done in the CQC is provide significant

amounts of guidance about compliance, which providers can use and that is available to the public. We have management assurance quality standards that compliance managers and registration managers oversee for their inspection teams.

The National Audit Office makes reference to our having a systematic approach to the management of regulatory risk. Whistleblowing and information all contribute to the effective management of regulatory risk. We have enhanced training, we have introduced a centralised team for safeguarding and for whistleblowing, and we have introduced audit, tracking and chasing of any information that comes into the organisation. Has it taken us too long from April 2009? Probably yes, but I believe we have introduced robust systems for the performance management—in its widest sense—of our front-line staff and the quality assurance of the decisions that they are making.

Amyas Morse: Before we pass on—if you do not mind, Ms MacTaggart—I am sorry to take you up on this point, but I want to take you to paragraph 4.13, which Ms MacTaggart referred to. Your own internal audit function reported in 2011 concerns that the arrangements were not in place to allow inspectors to provide a consistent standard. That is the auditors' findings, not ours. I really must urge you—I am not trying to knock you down with it—to please not go so far in defending the position as to think that you do not need to address this.

Amanda Sherlock: No, absolutely not. If we gave that impression—

Amyas Morse: I am sorry. This really is a serious issue in our view.

Cynthia Bower: The story on the consistency of quality assurance is the story of the organisation. We have had challenges in bringing people into this new system. We recognise that we have been slow on some issues and made mistakes, but we have learned an enormous amount and we have learned very quickly. I think our quality assurance systems are now much more robust. Our internal auditors will doubtless look at this again, as they are going to look at our whistleblowing processes again some time during the next financial year. We have already put that into their plan.

My view is that, like many other issues, this is a snapshot of a time when the organisation is facing enormous challenges in implementing this legislation, but we have learned and we are making improvements. Those improvements are now demonstrable in terms of the amount of activity we are undertaking and the speed with which we are dealing with significant processes such as registration. We are genuinely addressing the concerns of the public, as through the dignity and nutrition reviews.

Chair: Very short answers now—it is five past six and I want to bring everybody in.

Q213 Fiona Mactaggart: I actually wanted to say one good thing about what you are doing. You have been having a hard time, but the thematic inspections of learning disability centres have shown the kind of job that I think a Care Quality Commission should be doing. From those thematic inspections, other

inspectors can learn. I am very concerned that that is not your normal way of doing things; I am very glad you have instituted them.

This is an area where whistleblowing is very important. I am concerned, from looking at paragraph 1.17 of the report, that at your board level, the performance measures that you are using are not quality-based but quantity-based. Unless you have a quality way of working that is exemplified by sharing reports like the nutrition one, you will not get a board that understands quality standards but one that deals with a set of numbers.

Cynthia Bower: I absolutely agree. One of the things that we have tried to do with the dignity and nutrition inspections—again, Amanda knows more of the detail—is spend a lot of time looking at the impact on organisations that we inspected. Indeed, we have looked at the impact on some of the organisations that we did not go to. We have tried to learn the lessons from that and promote it into the organisation.

Q214 Fiona Mactaggart: What type of lessons?

Cynthia Bower: About how, for example, we conducted the inspections. We did them in a particular way: we engaged 100 nurses who were currently working in hospitals in our inspection process, we trained users to come along on our inspections, and we talked about whether people speak more openly to an expert service user or a carer than to an inspector who is coming on to a ward. We have gone back and surveyed the hospitals and talked to them about what the impact of our going in and doing those inspections has been on their organisations. We have tried hard to learn from that.

I was not answering the earlier question well. We absolutely accept that we have to start to define what success looks like, and we are developing for our balanced scorecard that we agree with the Department of Health some more qualitative measures. A lot of the emphasis that we have put on developing management information has been about getting the processes right as we kicked off the organisation. We accept that we need to start looking at return to compliance following enforcement activity and a range of other markers that can start to demonstrate the impact of what we do as a regulator.

Q215 Nick Smith: Ms Bower, earlier on, Dr Dixon said that the CQC did not put enough emphasis on seeking improvements. You will know that about 400,000 older people are resident in UK care homes. Experts say that the standard of primary and GP health care for that large number of people is very mixed. I am told that in 2010, CQC was going to publish a report on health care support in care homes, so that local decision makers and GPs could make decisions about the matter. When will that report be published in terms of best practice?

Amanda Sherlock: End of February.

Q216 Nick Smith: It was going to be in 2010; now it will be at the end of February.

Amanda Sherlock: It was a special review that was undertaken that involved inspections and gathering information from the sector, from primary care

clinicians and from people's experience of using services. That has been analysed. It will be a national report with national learning rather than a commentary on individual providers. That is done under our special review powers, and we anticipate publication at the end of February 2012.

Q217 Nick Smith: That sounds really good. It was supposed to be produced in 2010. Why has it been delayed so long?

Cynthia Bower: I suspect because of the complexity of the data collection and, to be honest, the fact that we have been focusing on trying to get the basic inspection processes up and running and right. We have not had the impetus behind some of that work, but we have looked at it very recently and we will publish it. It will still be pertinent, I am sure, to the issues that you referred to.

Q218 Jackie Doyle-Price: I want to talk about the enforcement powers. The degree to which you are delivering value for money depends on whether you are able to weed out really poor performance, which is obviously a function of enforcement. I was struck by what you said, Cynthia, about being able to deploy those powers only when it is proportionate and with reference to the impact on the community. One of our previous witnesses said that that led to some institutions being too big to fail. It seems that there is a major fault line here. If you have these enforcement powers, we really need you to deploy them to tackle institutions that are not meeting essential standards, but it seems to me that there is a bigger concern about what that will do for the community, in terms of confidence and provision. Perhaps you can address how you deal with that.

Cynthia Bower: I do think that is a genuine issue. In the enforcement action we have taken so far, which has been mainly through compliance actions—which is a sub-enforcement action, but it is where we ask a provider to conduct certain improvements and for action plans, and we follow that up—and through the issue of warning notices, we think that we have been able to demonstrate that care has then improved. We do go back and follow up where we have issued notices. We review to make sure that appropriate improvements have followed the activity that we have undertaken.

Where we think there may be broader concerns that relate to issues that may be across a hospital, for example—that might be the way in which the hospital manages its governance, or there might be broader issues about recruitment—we have used our investigative powers. At Barking hospital, in Lincoln hospital, and now in Morecambe Bay, we are starting to stand back and ask, “Okay, are there broader issues here?” For example, we issue a warning notice, “You have to do something about your staffing”, or we issue a warning notice about dignity for older people. But is this symptomatic of a broader concern? Well, that is when we have started to use our investigatory powers to think more widely about whether other issues are preventing care from being improved. For example, the report that we issued on Barking hospital contained a number of recommendations for

25 January 2012 Department of Health and Care Quality Commission

improvement for the hospital, which we are following up, and as we do that, we will continue to take enforcement action if we believe it is necessary.

So I think there are genuine challenges to taking enforcement action when people are very heavily dependent on their local hospital services. The reason that we talk about being proportionate is, to take a very dramatic example, if we close the local A and E service in a hospital, and people then have to travel 30 miles to the next hospital, one would argue that we might be putting patients more at risk than if we had worked to improve the services in that locality. There will always be challenges. We are just beginning to use those enforcement powers in relation to the NHS. It is still relatively new and that will be something that we debate with the Department, as we think about the regulations and how they work.

Q219 Jackie Doyle-Price: But ultimately, we are dealing with hospitals, so as a given aside, you are always going to be putting patients more at risk by closing a facility than leaving it open, which means that it will be very difficult for you to drive up standards.

I will give you an example. My local hospital is Basildon and Thurrock university trust, which has had—as Amanda well knows, because I have discussed it with her before—consistently poor reports. It routinely fails to meet the essential standards of care and welfare of people who use the service, but there is never any enforcement action. I have spent a great deal of time reading these inspection reports, which I think are a brilliant source of intelligence about what is going wrong there, but the board fails to react to it and no enforcement action is taken. You look at what happens in other hospitals, then look at these figures here, which show that only five NHS trusts were enforced against in 2009–10, and 13 in 2010–11, and look at the list of institutions that are at risk on Monitor’s website, and you wonder how bad you have to be to face enforcement action.

Amanda Sherlock: It has to be, in the case of Basildon, which is a foundation trust, a joint approach between ourselves and Monitor. We both have different but complementary powers to lever change in organisations where it is systemic. We have taken enforcement action against that particular organisation, have issued warning notices, and are working with the Health and Safety Executive on some particular issues around Legionella.

There is an enormous amount of work influencing the strategic health authorities to action change. In the Chair’s constituency, we are working very closely with NHS London to ensure that very specific and important front-line services in accident and emergency and maternity, in that part of north-east London, can maintain and sustain safe, quality services.

Q220 Chair: Can I interrupt you? The interesting thing about being subject to it is that we had to ring you. Let us be clear: you did a very good report. We had, I think, two babies dying, which were not reported to you, although you had issued a report of whatever-you-call-it on the hospital. Nevertheless,

two babies died in circumstances that required a review, and you were not told. It was only when my office rang you that the CQC heard about it, which makes you think, “Bloody hell. What is going on here?” when the trust feels that it does not need to tell you, even though it has had this report.

Amanda Sherlock: That is a very clear governance failing in the provider organisation in that NHS trust.

Chair: What happens then? Perhaps that is a question for Una.

Q221 Jackie Doyle-Price: It is going to get worse, because of the role of Monitor. I am not sure, as we move forward, whether we have a regulatory gap or overlap. What you set up is something that is an overlap, but it actually means that the buck stops with no one and that issues of governance never get dealt with.

Una O'Brien: Self-evidently, this is an extremely important issue as we get the commissioning board up and running and get a system—

Q222 Chair: But you have it now, Una. Now. For the mums in Barking, it is now.

Una O'Brien: I know that NHS London is doing everything possible to work to resolve the situation.

Q223 Chair: But it is shocking. Do you agree?

Una O'Brien: Of course it is.

Q224 Chair: I am actually grateful to the CQC in Barking and Dagenham, because they came in and finally exposed what we all knew was a terrible situation.

Una O'Brien: That is what it is there for.

Q225 Chair: They put actions in place, and then the trust thinks that it does not have to tell the CQC after two babies die, and the local MP’s office tells them.

Una O'Brien: You are describing exactly the agenda that we now need to address. This is the whole point of having a regulator. Let’s face it, we have never had this. This is the first time in the history of the NHS that this form of regulation has been operating. Between 1948 and 2010, it was not there. This is a new thing. The other parts of the system have to learn how to work with that and to address it. So we have both the improvement process, which in this particular case is led by NHS London, and then there is an issue perhaps for another day that Mr Bacon has touched on—

Q226 Chair: Who gets disciplined? Let me take that instance, because it is interesting. Who gets disciplined in this example where the trust fail to inform the CQC after an inspection that there were two further instances—actually, there were many more—of babies dying? Who gets disciplined for that failure in your regime?

Una O'Brien: The responsibility for the proper running of an NHS trust lies with the chief executive of the trust.

Q227 Chair: Who disciplines her?

Una O'Brien: In this case, because it is not a foundation trust, it would be NHS London, which is the responsible oversight body.

Q228 Jackie Doyle-Price: When I was challenging the management of Basildon about what was going wrong and their failure to address the failings, one of the things that they threw back at me was, "They are just finding all this because they keep looking at us." I am pleased that you kept looking at them, and that actually shows some evidence of a risk-based approach, which is very welcome.

However, I would have been much more able to rebut that if I had had a bigger picture of what else you have found elsewhere, so that we could have some comparative data. In that sense, the fact that you do not really have a comprehensive picture of your enforcement actions is not very helpful. Are you actually going to deal with that in some way?

Amanda Sherlock: That is a really interesting challenge and proposition for us. The enforcement actions are against the individual providers, so the challenge is comparing apples with pears, and the enforcement action that you take with provider A is not necessarily appropriate to the context of provider B. What we are doing, starting with the adult social care field, is that we will have a specialist team, starting in April, which will be doing the market corporate overview. What are the trends? What is the horizon scanning? What is the picture of non-compliance against particular outcome areas? If you see that a large proportion of the market is failing on safeguarding, for example, that information is useful for the regulator, and it is certainly useful for commissioners and the public to understand why that might be the case.

Q229 Jackie Doyle-Price: The public will always be their best guardians, and I say that as somebody who used to be a regulator on behalf of consumers. I would say that transparency is the best form of sunlight. Naming and shaming is probably one of the most powerful enforcement tools, particularly since, when we look at your possible actions, ultimately you are not going to cancel the registration of a major facility. I think that being public, however, about what is going wrong there will be the most effective way of driving up performance.

Cynthia Bower: That is one of the reasons, for example, that we focused on publishing warning notices. We now have a process in place that allow us to do that. Although I reflect that in the early evidence session someone was commenting—I think it was Mr Fitzgerald—on our being focused on local publicity, we believe strongly that part of our responsibility is to inform local people about what is happening in their local hospital. He is right; we have put an emphasis on local information about what is happening in your local hospital and local care home and publishing, much more widely, information about enforcement activity.

Q230 Jackie Doyle-Price: Una, are you satisfied that we have got clear boundaries of responsibility

between Monitor and CQC and that things are not falling between two stools?

Una O'Brien: I think there was a real risk, and some of that has been exposed in the evidence to the Mid Staffs inquiry, which was in relation to the Healthcare Commission and Monitor. We had to learn rapidly from that when CQC was created. By the way, CQC came into effect in 2009. I just wanted not to connect CQC to Mid Staffs, because that was mentioned earlier. We have all worked to get a much tighter working relationship between Monitor and CQC. I am confident that it has improved. It is always the case of the unknown unknown. You just don't know whether you have covered everything, but I know that the working relationship is, by a whole measure, much better. Also, we have stronger systems in localities to bring together, where there are concerns, all the different players in these risk summits, which happen regularly to address where information is coming in. Maybe it is a PCT, maybe it is Monitor or maybe it is CQC. Any one of them can trigger a risk summit and all the parties then get together and consider what the issues are. You have asked me a very important question, and I am confident that huge improvement has been made. I will never be satisfied, if I can put it like that, because that would suggest a degree of complacency and we will always have to retain vigilance around this area.

Q231 Chris Heaton-Harris: I just want to rescue one good thing out of what has been a bit of a crash of a session. Please stay behind to meet my constituents; I am aware that they have sat here patiently. I want to ask for a note on a couple of things, because there are a couple of important things that we have not talked about at all in the recommendations. Recommendation A says: "The Commission has not made clear what success in delivering its priorities would look like." I would like a note on an idea of what that would be in future. Recommendation B says: "There are shortcomings in the Commission's performance management arrangements." It lists a few things. It would be really useful to see what you think improvements in the near future would look like.

Cynthia Bower: We are addressing both of those currently, so, yes, we will do that.

Q232 Mr Bacon: Ms Bower, I just want to ask a couple of questions about your remuneration. You are paid in the £195,000-£200,000 bracket. Can you confirm your exact salary?

Cynthia Bower: It is £198,000.

Q233 Mr Bacon: That is your basic salary.

Cynthia Bower: Yes.

Q234 Mr Bacon: On top of that, there are various other items, including a bonus that was paid in November 2009, which related to the previous financial year. In that period there was also a second-home transitional allowance. The total, it says, was £210,000 to £215,000. You understand and recognise those figures.

25 January 2012 Department of Health and Care Quality Commission

I have a question about your pension. In the 2009–10 annual report for the CQC, it stated that there was a real increase in the value of your pension. On 31 March 2009, it was stated to be £871,000. It then went up to £1,081,000 the following year, which was an increase of £210,000. The real increase it states, which I presume strips out inflation, is £181,000. In the following annual report—the more recent one, for 2010–11—there is a further increase from £1,081,000 up to £1.35 million, which is £269,000 more. It states that that is a real increase in CETV of £240,000, making a total cash increase of £479,000 in two years, and a real increase, if you add the two real increases in CETV together, of £421,000, just in two years. Amanda Sherlock's increase in the last financial year was £8,000; yours was £240,000, and the total increase was £421,000. Where did that money come from?

Cynthia Bower: I am a normal member of the NHS pension scheme. I pay in to the scheme, as I am required to do as an employee of the NHS, but I have never made any additional payments, nor has anybody made any on my behalf. This has been raised with us in the past, and my understanding is that in one year—perhaps we should write you a note on this, to make sure I am giving you the right detail—there was a mistake in the calculations by the NHS Pensions Agency, so the information that was put into the annual report was incorrect, because we were given incorrect information from the NHS Pensions Agency.

Q235 Mr Bacon: Was it stated in the annual report subsequently that there had been a mistake?

Cynthia Bower: No, I do not think so.

Q236 Mr Bacon: Well it should have been, shouldn't it? For example, when you printed on page 50 of the current annual report that there had been 15,220 inspections when there had only been 7,368, you subsequently published, at least on the website, a correction. I have got it here, because I first looked up this report on the web before I got the hard copy. There is a correction there saying that the correct figure should be 7,368. I have found nothing on the website or anywhere else to say that the calculation of your pension was incorrect. Surely that should have been picked up and reported.

Cynthia Bower: Possibly.

Q237 Mr Bacon: We have seen in the Report that the internal auditors of the CQC have sometimes failed to identify things, or that they have sometimes identified things that have not had anything done about them. I don't know whether that was the case here, but it seems very odd that in two consecutive years you have an enormous increase in your pension, so it has gone from £871,000 total value just two years ago in the annual report to £1.35 million now.

Cynthia Bower: Again, all I can do is to assure you that that is not because of any action I took or any action that CQC took.

Q238 Chair: Can you check that, just out of interest, as the permanent secretary?

Una O'Brien: Clearly we will check it. These are factual points that you have put to us, and we will take them away and check it with the NHS pension scheme.

Q239 Stephen Barclay: So it was not drawn to your attention at the time as the accounting officer, responsible as you are for the allocation of funds to arm's-length bodies?

Una O'Brien: It was not drawn out to me as a specific point. As I say, these are technical details to do with the NHS pension scheme. I am responsible for the civil service pension scheme within the Department of Health.

Chair: It just seems one heck of a lot, doesn't it?

Q240 Mr Bacon: If we could have a detailed note explaining how this happened, and what action was taken and why, I would be very grateful.

Una O'Brien: Absolutely, yes.

Q241 Chair: Finally, I would like to test whether improvement has been made. In November 2011, you said you had concern over 407 providers, according to the Report. How many of those have you been back to?

Amanda Sherlock: We will get back to the Committee with that information.

Q242 Chair: You don't know? You have concerns?

Cynthia Bower: If we took enforcement action or compliance action in any way, that will have been followed up.

Q243 Chair: The Report actually says—in terms of your raising your game, it will be interesting. There is an instance. It is fairly recent: you had major concerns about 407 providers, 94% in adult social care. I am interested in how many you went back to, you inspected, you took enforcement action, whatever.

Amanda Sherlock: We will give you a detailed breakdown. All I can say is that, if we have major concerns, they will be subject to either compliance actions and—

Q244 Chair: I understand that. I just want to know whether it happened.

Amanda Sherlock: Yes.

Q245 Chair: Can I ask a similar question? When you did the hospital nutrition standards—page 36, paragraph 4.24—in June 2011, you found concerns in 55 hospitals. If you have raised your game, how many of those have you gone back to?

Amanda Sherlock: All.

Q246 Chair: How many do you now have concerns about?

Amanda Sherlock: Again, we will give you a detailed breakdown. Some of it is subject to ongoing enforcement action, so we have to be careful.

Q247 Chair: Well, you can give us the figures.

Amanda Sherlock: Yes.

Cynthia Bower: We can give you the figures, yes.

Q248 Chair: Good. It has been a very long session, but I hope what it reflects—I expect you experienced it—is actually the concern across the piece, which often comes from constituency concerns about the importance of the organisation and the journey that it still has to undertake to become what we would consider an effective regulator.

Una O'Brien: Chair, if I might say that what I take from that concern is a genuine desire on the part of the Committee to see the organisation improve. We have some very good recommendations from the National Audit Office. I would like to ensure that we

take the feedback from the points that Members have raised today, that we make sure that they are fully addressed in the capability review, which is something on which CQC is working with us very, very closely. We all want to achieve the same thing, which is an effective regime that protects patients and the public from unsafe care and from poor care. We have a common purpose in addressing that. I appreciate the questions that Members have put. I know the direction you are coming from, and we will take those points on board.

Chair: Okay. Thank you very much. Thanks to Members as well. It was a long session.

Written evidence from the Chief Executive, Action against Medical Accidents

1. INTRODUCTION

Action against Medical Accidents (AvMA) is the patients' charity which works for better patient safety and justice for patients when things go wrong. The charity celebrates its 30th anniversary in 2012. Amongst its many achievements, AvMA has been credited with helping bring about the creation of a national health regulator in the first place, and getting patient safety moved higher up the agenda. AvMA provides help and advice to approximately 4,000 people a year who have been affected by medical accidents and works with the NHS, Department of Health, the Care Quality Commission (CQC) and others with a view to improving regulation and safety. AvMA is a core participant at the Mid Staffordshire NHS Foundation Trust public inquiry.

2. SUMMARY OF MAIN POINTS

This submission does not attempt to be exhaustive. We have chosen to comment on aspects of the CQC with which we are familiar due to our own activities, and where we think there is significant room for improvement. In particular, we discuss:

- whether the CQC should be more proactive in following up indicators of potential patient safety lapses, drawing on our research on implementation of Patient Safety Alerts issued by the National Patient Safety Agency (NPSA);
- whether the CQC does enough to regulate openness and transparency, both with respect to promoting the protection and support of whistleblowers, and openness with patients/their relatives when things go wrong;
- whether the CQC engages appropriately with the public; and
- whether the CQC's remit is too wide.

3. *Is the CQC proactive enough? The example of Patient Safety Alerts*

3.1 AvMA published its first report on the implementation of Patient Safety Alerts in February 2010, and followed this up with further reports in August 2010, February 2011 and August 2011. Copies of these reports are provided in the appendices.

3.2 Patient Safety Alerts are issued to NHS bodies by the NPSA. They cover issues which have been shown to repeatedly go wrong in the NHS causing harm or death to patients. They contain specific actions designed to avert these problems and a deadline by which these should be completed. It is meant to be a requirement for NHS bodies to complete the required actions *by the given deadline*.

3.3 AvMA found that the CQC were not initially taking implementation of patient safety alerts into consideration at all, in their monitoring and regulation of NHS bodies. Even after our report of February 2010 which exposed shocking rates of non-compliance, the CQC failed to do anything at all to chase NHS bodies up or ensure compliance. They admitted not to have written a single letter or made a single telephone call to trusts even where they had more than 10 alerts outstanding, and/or alerts which were outstanding years past the deadline. We found this a shocking oversight for a regulator who is supposed to have a key role in patient safety.

3.4 More recently, the CQC has acknowledged that it should have been taking implementation of patient safety alerts more seriously. It now says that it takes this into consideration in building the "Quality and Risk Profile" for each NHS body. However, it remains very unclear what this means in practice. We have been provided with no evidence of NHS bodies being taken to task by the CQC for being behind with implementing patient safety alerts.

3.5 In its evidence to the Mid Staffordshire NHS Foundation Trust public inquiry, the CQC remained vague about this. It appears to be entirely a matter for the discretion of regional managers. The CQC appears to have a blind spot as regards what it could and should be doing short of a full blown “responsive review” or taking action using its statutory powers.

3.6 AvMA believe that the CQC needs to be more proactive in encouraging compliance by taking simple common sense steps such as writing to NHS bodies who are known to be behind, warning them that they should ensure compliance within a given timeframe or face formal investigation or regulatory action. This would not be labour intensive and could have the same or more effect than AvMA publishing its six monthly exposés of the situation.

3.7 The CQC should also develop better links with commissioners to establish who is monitoring what and share information. We were amazed that this did not happen with regard to patient safety alerts.

3.8 Whilst we have concentrated on patient safety alerts and whilst timely implementation of these alerts is vitally important (literally a “life and death” issue), we believe that this is an indicator of how the CQC overall could be more effective.

4. *Does the CQC do enough to provide openness and transparency with patients?*

4.1 AvMA has been in discussion with the CQC for two years about how the CQC could help ensure that patients or their families are dealt with openly and honestly when things go wrong and cause harm. This is considered a fundamental essential part of patient safety as well as an ethical requirement. The CQC has consistently said how seriously they take this issue, but AvMA believe that their actions with regard to this, seriously call into question its commitment to do all it can to promote and regulate it, and the judgement of its leadership.

4.2 As part of its campaign for a statutory “duty of candour” with patients, AvMA has advocated that such a duty be made explicit and given statutory force by it being a specific regulation in the CQC’s registration regulations.

4.3 CQC staff have consistently told AvMA that they had to remain neutral on what should or should not be in their registration regulations, as this was a matter for the Department of Health. However, they reassured AvMA that should the Department be minded to introduce this, that they (the CQC) would be happy and able to regulate it. Indeed, in April 2010 the CQC’s regulations were amended to include a statutory requirement for registered providers to report to the CQC patient safety incidents which have caused moderate or serious harm to patients. It clearly feels able to cope with regulating this, and there is an obvious irony that has been created with it being a statutory requirement to report anonymised details of these incidents to the CQC, whilst it is not a requirement to be open with the patient/their family.

4.4 The new coalition government has a policy of introducing a “requirement” to be open with patients when things go wrong. It recently announced its intention to introduce such a “Duty of Candour” as a contractual duty as part of the commissioning process (with NHS hospitals only). Ministers have rejected the option preferred by AvMA, other patients’ groups and many other commentators to give the duty statutory force in the CQC’s regulations. In justifying this decision, Ministers have relied heavily on comments from the CQC themselves that they could not cope with regulating this.

4.5 AvMA believes that not only has the CQC been duplicitous about this, but their actions seriously call into question the judgement of its leaders. Furthermore we believe that if it were to be correct that the CQC could not cope with including a duty of candour in its regulations, then this calls into question its ability to cope with regulating many of the other essential standards already in its regulations.

4.6 Ironically, the chief organisation with responsibility for upholding standards, the CQC, may go down in history as being the main reason why perhaps the biggest advance in patient safety and patient rights since the NHS began—a statutory duty of candour—was not achieved. The CQC should be ashamed of itself for not showing more insight and leadership, and failing to be honest.

5. *Does the CQC do enough to promote the protecting and support of whistleblowers?*

5.1 As has been widely reported, the CQC failed dismally to protect residents at Winterborne View, partly because it failed to listen and react appropriately to warnings from whistleblowers.

5.2 AvMA is working with a number of whistleblowers at present, all of whom confirm that their experience of seeking help or support from the CQC was unhelpful.

5.3 The CQC says it has revamped its internal procedures for dealing with concerns by whistleblowers, and AvMA is due to meet the CQC on 7 December to discuss these arrangements and other ideas.

5.4 As well as having concerns about how the CQC deals with concerns raised by whistleblowers which have consequences for the safety of patients, AvMA is concerned that not enough is being done by the CQC to ensure that registered organisations protect, support and act on the concerns of whistleblowers appropriately.

5.5 AvMA recommend that support and protection of whistleblowers is made a more explicit requirement in the CQC registration regulations and that the CQC is more proactive in assessing NHS bodies' compliance with this requirement. This should include assessing NHS bodies' systems and procedures and reacting to reports of failure to protect and support whistleblowers by whistleblowers themselves.

5.6 Evidence presented to the Mid Staffordshire NHS Foundation Trust public inquiry suggests that the CQC itself may not listen to, support and protect its own staff appropriately. There was even a report of use of gagging clauses—something we think the CQC should have a role in stamping out the use of amongst registered organisations. If the CQC is to enjoy the confidence of NHS staff and patients, it needs to rebuild trust by demonstrating that it preaches the right things, and practices what it preaches.

6. *Engaging with the Public*

6.1 Although the CQC has put various mechanisms in place to engage with service users and the public, it still does not have its basic managing right or even provide some essential information on its website.

6.2 For example, the CQC website for members of the public gives information about how to complain about health or social care providers, but it offers no information about how members of the public can inform the CQC itself about concerns about registered organisations. This is in spite of the CQC telling us and other organisations repeatedly that it wants to hear from members of the public and everything received will be considered.

6.3 Unless members of the public and patients' organisations can have easy access to ways of reporting serious concerns about a registered organisation directly to the CQC, opportunities for the CQC to spot a failing or dangerous organisation will be lost. Whilst the CQC does not investigate complaints as such, it must show itself to be more receptive to reports of concerns. Information about this should be provided on the website, together with how the CQC will use such information.

7. *Is the CQC's remit too wide?*

7.1 The CQC has been given a very challenging set of roles. We have always had doubts about whether its remit should have been as wide as it is, at least until it had fully got to grips with its core responsibility towards health.

7.2 However, we believe that a decent start has been made in addressing their responsibilities. We think it would be counter-productive to reverse the direction of travel right now.

7.3 We think it is particularly important to bring General Practitioners within the same regulatory framework under the CQC. This should not be abandoned or delayed further.

7.4 One area where we do not believe it is acceptable to extend the CQC's responsibilities still further is the hosting of Healthwatch England. As well as this being an unnecessary extra burden to the CQC, we think it is quite inappropriate for the CQC to host an organisation which is supposed to be an independent monitor of it.

8. CONCLUSIONS

8.1 Whilst we have been highly critical of some aspects of the CQC's operation and decision making in this submission, we remain convinced of the need for a national regulator. We agree with the concept of Essential Standards of Quality and Safety around which the CQC registers and regulates. We should avoid any temptation to throw the baby out with the bathwater.

8.2 There needs to be a clearer understanding about the respective roles of the CQC as a national regulator and commissioners in ensuring standards. We believe that the CQC should hold the key over essential standards of safety and quality, whilst commissioners monitor compliance at the local level and are more operationally focussed.

8.3 We think that in terms of value for money and effectiveness, it is more of a question of focussing on how the CQC can be more productive. Increasing the number of inspections is a good start. However, we need to see the CQC being much more responsive to other data which may provide early warning signals, such as implementation of patient safety alerts and reports of concerns from the public.

8.4 It would be inappropriate to give the CQC the added responsibility of Healthwatch.

8.5 The CQC's registration regulations/Essential Standards of Quality and Safety should be amended to make more explicit the requirements as registered organisations to:

- abide by a "Duty of Candour" with patients/their families when things go wrong;
- and cause harm;
- listen to, support and protect whistleblowers; and
- implement patient safety alerts by the required deadline.

8.6 The CQC should reflect, with the benefit of independent input, about the approach it has taken to external stakeholders, its own staff, gagging clauses, and the culture of the organisation/its leadership.

5 December 2011

Written evidence from the Care Quality Commission

I would like to provide the Committee with some context ahead of the hearing on 12 December (hearing postponed until 25 January 2012).

The Care Quality Commission (CQC) was created under the Health and Social Care Act 2008, and became a legal body on 1 April 2009 through a merger of three predecessor organisations: the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. CQC is unique as the first health and adult social care regulator and the first regulator to be set up built on the principles of outcome focused, risk-based regulation which centres on what is important to people who use services. This means that we put particular importance on listening and acting on the concerns of people who use services. It could be argued that not enough time was spent on the planning of how to make these changes operational. We have made mistakes but we have been frank about these and have sought to learn from them.

The NAO report states that the merger meant a decrease in the recurring budget of 6% between 2008–09 and 2010–11, which excludes any transitional costs. The Act also introduced a new regulatory framework, bringing the NHS into registration for the first time, and introducing a common set of standards applicable across NHS, independent healthcare and adult social care provider organisations. The year 2009–10 was a transition year when CQC ran the three previous regulatory systems whilst developing its new regulatory system. CQC only began operating under its new powers from April 2010, when NHS organisations came into the scope of registration.

CQC operates within a complex system. Our role is to assess compliance with and regulate against essential standards of quality and safety. There is a ladder of responsibility in ensuring that care meets these essential standards, starting with those who deliver it, through the people who manage and lead them, to those who commission care. When care fails to meet our essential standards, there have already been failures somewhere else in the ladder. Our role is to hold the provider to account for these failures. Other regulators (professional and system), commissioners, oversight bodies, and those involved in the complaints process must also play their part as well, and take responsibility for failure where appropriate.

Much of the criticism we have faced has focused on transitional registration; the process by which we brought people into CQC's remit against demanding legislative standards and deadlines. This was a one-off exercise for providers, which will not have to be repeated again for them. CQC has published figures that make clear that compliance activity was significantly affected by transitional registration, particularly that of adult social care providers. This was by far the largest piece of registration, involving around 12,000 providers, the Commission faced and it was this that has had the most significant impact on CQC's work—and not dental registration as has been suggested. We have asked the Department of Health to defer registration of Primary Medical Services, including GPs, so that we can improve our methodology to avoid some of the problems we experienced through transitional registration for adult social care providers.

We have pulled together an advisory group to ensure that our approach is relevant to and understood by the sector. Changes include the intention to develop an entirely on-line process; putting in place a dedicated central team to assess and make judgements about registration applications to minimise the impact on inspections, and only those applications judged to be very high risk will be dealt with by front-line inspection staff. In the past year we have turned a corner. The number of inspections we are carrying out is increasing, and we will have inspected every NHS provider and 62% of adult social care and independent healthcare providers by the end of this financial year. We are making a real impact through our thematic inspections. The first of these was the Dignity and Nutrition inspection programme which saw our inspection staff visit 100 NHS hospitals to assess the standards of care. There is evidence that this had a wider effect on the NHS more generally—the NHS Operating Framework for 2011–12 highlights this as an area in which providers should be concentrating. This is also reflected in feedback from our stakeholder survey earlier this year:

“... CQC was seen to have progressed over the past 12 months ...”

“... enforcement powers are seen as effective ...”

As the NAO have noted, there is as yet no way of measuring the true impact of the individual regulators in these sectors; and that therefore our performance so far has been judged on basic metrics on activity that do not reflect the full impact of our work. We believe that regulation builds confidence amongst the public, and has the power to both correct and deter poor performance. To this end we are working to measure the impact of our regulatory activity in terms of quality and not just quantity. We are improving our management information, developing sustainable measures for quality and effectiveness, and are rolling out systems to assess performance and use of resources in more detail in 2012. CQC faces a challenge to explain what it alone can achieve through regulation. While the NAO notes this, they have not assessed the impact we make through the quality and safety data on our website, or through the extensive local media coverage we generate alerting people to the performance of local services (in itself, a powerful deterrent to other providers). We believe this public

information is a clear benefit of regulation and CQC will continue to tell people about failures in care and the action it takes.

We have learnt valuable lessons from events at Winterbourne View and our Internal Management Review has made recommendations to improve our working practices. We have submitted the report from this review to the Serious Case Review, to which we are contributing fully. Because of this, and because of criminal charges being brought against former members of staff at the hospital, we cannot talk in detail about these events, at risk of prejudicing both processes. We will be publishing our report early next year once these have been completed.

We are still a young organisation, only assuming our new powers just over 18 months ago. Whilst we recognise the urgency for a regulator to be fully functional across the board, there is good evidence that it takes time to mature and establish a new organisation as a strong, wise and cost-effective regulator that adds value to the overall system. We are looking forward to the next phase of our work which will concentrate on developing effective methods of ensuring providers comply with essential standards.

We have examples of our recent work which reveal instances where the intervention of CQC has contributed to improvements in care. A few which could be particularly relevant to the discussion are as follows:

- The re-registration of the care homes formerly owned by Southern Cross (which is mentioned at para 3.17 in the NAO report).
- The Dignity and Nutrition Inspections (mentioned at point 6 in the Summary of the NAO report) of 100 NHS hospitals which are now to be extended to the adult social care sector.
- The investigation of maternity services at Barking, Havering and Redbridge Hospitals.

We recognise that CQC faces a strong set of challenges in developing its approach so that it centres on people who use services. However we believe that we are taking action to improve our approach and further develop our methods of regulation. This is whilst CQC learns more about the sectors it regulates in terms of the risks and levels of compliance to the new outcome-based approach to standards.

We hope this note helps to inform the PAC hearing and look forward to the discussion on the development of CQC's approach to regulation. Also attached are links to related reports.

Implementation of patient safety alerts (August 2011)
http://www.avma.org.uk/data/files/patient_safety_alerts_aug_11_full_report.pdf

Implementation of Patient Safety alerts "too little too late?" (February 2011)
http://www.avma.org.uk/data/files/patient_safety_alerts_report_feb_11.pdf

Implementation of patient safety alerts (August 2010)
http://www.avma.org.uk/data/files/patient_safety_alerts_august_2010.pdf

NHS Failure to implement patient safety alerts (February 2010)
http://www.avma.org.uk/data/files/patient_safety_alerts_full_report.pdf

30 November 2011

Further written evidence from Action against Medical Accidents

CARE QUALITY COMMISSION REGISTRATION REGULATIONS

I am writing to ask for your urgent attention and action with regard to what we consider to be important gaps in the provisions of the CQC Registration Regulations 2009.

1. INSURANCE/INDEMNITY COVER

It has come to our attention as a result of our work around the PiP Breast implant scandal, that healthcare providers in England are not required to demonstrate that they have adequate insurance/indemnity cover in place in order to be registered with the CQC. This needs to be rectified. No organisation should be allowed to provide healthcare if they cannot demonstrate they have arrangements in place to compensate or provide remedial treatment to their patients in the event things go wrong. The regulations should also be framed in such a way that the healthcare provider is required to carry out or pay for remedial treatment in circumstances such as those involving the sub-standard PiP implants. Such an arrangement would have prevented the unsatisfactory situation where you have had to appeal to the conscience of private healthcare providers to honour their "moral obligations".

A different but related issue is the need for similar requirements to be introduced for suppliers of healthcare products or medicines to have adequate insurance/indemnity cover in order to be licensed for use in the UK. As you know, hundreds of women affected by PiP's faulty products in the UK may be unable to obtain compensation because no such arrangements were in place and the company went out of business.

2. REPORTING OF INCIDENTS

Regulation 18 in the regulations sets out requirements for registered organisations to notify the CQC of incidents which cause harm. Unfortunately, in spite of our advice at the time, the way that these regulations are worded excludes incidents of diagnostic testing procedures.

This means, for example, that if there is a system failure in assessing breast screening results affecting hundreds of patients, there is no requirement to notify the CQC. Although at this point no actual harm may have resulted and may not result, this is an extremely serious incident which would require the re-calling of the patients concerned. It should surely be something which registered organisations are required to report to the CQC in order for the CQC to be able to fulfil its role properly? I look forward to hearing your comments.

For further information on patient safety alerts
http://www.avma.org.uk/pages/patient_safety_alerts.html

19 January 2012

Written evidence from Kay Sheldon

I watched yesterday's PAC meeting on CQC with interest. I am the CQC board member that ultimately felt obliged to "blow the whistle" to the Mid Staffs Public Inquiry. I was impressed that the PAC members got to the heart of many of the issues.

I was disturbed to hear Una O'Brien say that my concerns were "well known" to the Department and that I had contributed them to the Capability Review. This is not the case. I have stated several times to Una over the last two months (I have emails as evidence) that I have not had adequate opportunity to describe, discuss and evidence the serious concerns I have about the leadership, management and culture of CQC. Interestingly, yesterday morning Una's PA emailed me saying that the Capability Review was coming to a close but if I had any other concerns a member of the review team could meet with me today (Thursday) or tomorrow. I am not able to make these dates but in any case I no longer have any confidence in the review.

Furthermore there is another review taking place (conducted by Gill Rider) that is supposed to be looking into the responses I received from CQC when I raised my concerns internally (which I did appropriately and reasonably over a sustained period—which I can also demonstrate) "taking into account all perspectives". The review was supposed to report "in 10 working days" but well over a month has gone by. I had an hour's interview with Gill Rider on 19 December but have heard nothing since then. I have stated to Una O'Brien and Gill Rider that I have not had adequate opportunity to present my perspective (and supporting evidence) to this review either. I have also raised concerns about the transparency, clarity and fairness of the review. I was told I would be kept informed of the progress and development of the review but this hasn't happened.

I have been having a very torrid time on the board having steeled myself to attend the two board meetings since giving evidence at the Public Inquiry. Indeed I have been ostracised and vilified—as often experienced by whistle blowers—by the rest of the board and the executive team (I can also demonstrate this). A letter from Jo Williams on 24 January states "*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*". This is simply not the case and I think my evidence shows this clearly. I have nothing to gain personally from the Disclosure and have sought throughout to be guided by the principles of public appointments such as accountability, transparency, selflessness, honesty, objectivity and integrity.

I hope this is not an inappropriate email (I am not particularly cognisant with parliamentary etiquette!). If you have any advice this would be much appreciated. In turn, if I can be of assistance to the Committee, please let me know.

27 January 2012

Written evidence from Amanda Pollard

This week I watched the Public Accounts Committee session regarding the CQC. I am a compliance inspector who gave "whistleblower" evidence last November at the Mid Staffs Public Inquiry.

On one hand I feel reluctant to carry on raising my concerns about the CQC given the treatment I've received from the organization regarding my appearance at the Inquiry (documented in my transcript), but not challenging the Board members' assurances that all is well would be more frustrating.

There is no robust assurance system to ensure inspectors' judgments are consistent. Judgments differ from manager to manager; as inspectors we know those managers who support "tougher" decisions than others. No manager has shadowed me during any inspection, or even part of one. Our reports are generally not peer reviewed unless we organize these ourselves. The consistency of judgments is not assessed or audited and as inspectors we do not receive any useful or constructive audited feedback or information to help us improve the decisions we reach.

The entire focus is on activity levels. Amanda Sherlock promised the Health Select Committee that we would inspect all providers once a year (an undertaking not ratified or known at the time by the full Board). Fulfilling this promise seems to have become our only risk, and the only information we get from management is about how many *new* providers we've inspected.

I have at least three homes that I have serious concerns about. All three require a reasonable amount of time to fully inspect and potentially move to enforcement. The management has made it totally clear that I am expected to inspect at least one new provider each week, and any follow up inspections have to be fitted around this. On challenging this, my manager has told me lots of other inspectors are managing this and has queried what I do with my time. It is not possible to carry out in depth inspections and gather evidence for enforcement, and carry out new inspections in the same week, and keep the quality in one's work.

Your comments about the registration of GPs being a "postbox process" are spot on. There is no "quality added", no analysis or primary intelligence gathering by the CQC, again, the emphasis is purely on speed and getting as many as possible registered in time.

The issue of inspectors' experience and skills was also raised by the Committee. I know of one inspector who was a doctor, but generally inspectors come from social work or nursing backgrounds. There are many of us who are not clinicians. I myself used to work as an NHS manager and have a Masters degree in health service management, but that does not necessarily qualify me to assess health or social care settings. In my previous role with the Healthcare Commission I inspected hospitals against the outcome for healthcare associated infections. We were given regular effective training, had easy access to experts and were encouraged to contact them with any issues, and our managers came out to shadow us during inspections. We also inspected in pairs so learned from each other and this helped us not to miss anything. We had a forum for ensuring consistency of decision making, and this forum kept a log of decisions online so we could refer to it. I felt competent in the role and could challenge clinicians. None of this happens now. I appreciate there are far more providers to inspect, but there's not even any attempt to create consistency.

I recall inspecting a home for people with learning disabilities. I have not been given any training on what constitutes good care for people with learning disabilities. I muddled through, and found some concerns. The home had not attempted to make care plans accessible to people through pictorial diagrams or the suchlike. The provider owns another home, so I looked up the report for them, and found they were compliant in every outcome. I found the home I inspected non-compliant in most areas. Yet they're managed by the same provider, and I saw no reference made in the other report to pictorial care plans or any structured teaching to develop skills. Why such different judgments? I'm not throwing any doubt on the other inspector's findings—I'm making the point that we all view things differently and we need a robust (and blame-free) quality assurance process.

I haven't been involved in thematic reviews so can't comment on them—but I haven't received any information or learning points from that exercise that could help me in my job.

The organization has done more regarding whistleblowers. We now get one of the whistleblowing team (discussed at length by your Committee) email us on the same day they receive the alert. They then look at the computer records to check that some sort of action has been taken by the inspector; if no action has been taken within 24 hours they alert the manager. However, no-one (including managers) asks about consistency of approach to whistleblowers. I can't imagine I deal with them in the same way as other team members—but equally I have no information to the contrary. Again, the CQC only wants to know that they've "dealt" with it. The quality of action is not reviewed or audited in any robust way.

Someone somewhere needs to do something about the CQC. We've had Winterbourne, the Health Select Committee report, the NAO, the Mid Staffs Public Inquiry etc, etc. There are enough signs now that all is not well. Those in power need to stop gathering evidence and start taking action, because the assurances that Cynthia Bower, Dame Jo Williams and Amanda Sherlock are making to the public and parliament are not based in fact. Last week we received our latest copy of the CQC newsletter. In there a Board member wrote "*We need to be confident about standing up to people in positions of power who may not want to hear what we have to say*". They just don't get it.

I didn't tell many inspectors that I was submitting evidence to the Mid Staffs Public Inquiry, but felt that my views weren't out of step with their feelings (conversations in meetings etc). But since my appearance I've received numerous emails and calls from inspectors within the CQC and those that have left. If there's a common theme it's this—they tell me "It could have been my name at the bottom of your statement; it's been the same for me too". One inspector's reply was particularly resonant. They emailed me about the "generic Inspector" role and how inspectors with social care backgrounds are now responsible for NHS trusts, and people with health backgrounds are doing social care (I have no trusts on my caseload), and with no training. They struggled with this, but were told they would be "performance managed" if they didn't get on with it.

We all have skills and experience built up over decades, and each of us could state where our interests and knowledge lie. But we've been given portfolios of providers that in no way complement our skills. The first time I went into a nursing home was to inspect it, and without any training whatsoever. I shadowed a team member for two inspections, and then had to get on with doing it myself. My background is in ambulance services, women's services and latterly with the Healthcare Commission infection control. I've never been

asked to join an inspection where infection control was deemed to be an issue. I have helped on ambulance inspections, but that happened through chance. People are losing their skills and it's de-motivating.

If the Public Accounts Committee can't recommend action regarding the Board, I would be grateful to know who can, although I do appreciate that we've yet to hear from Robert Francis QC, and the Mid Staffs Public Inquiry did want to hear my and Kay Sheldon's views.

I know that an awful lot of inspectors will be grateful for the robust challenge the PAC gave the Board members this week.

28 January 2012

Further written evidence from the Care Quality Commission

Thank you for the opportunity to provide clarification on our responses at the Public Accounts Committee hearing on 25 January. You will already have received our correction to the transcript but I have also included it with this letter for convenience.

The hearing followed a report by the NAG on the Care Quality Commission, published on the 2 December 2012, following a five month review. The main findings of that report (at paragraph 21) were that CQC had not made clear what success in delivering its priorities would look like; there were perceived shortcomings in CQC's performance management arrangements; registering GP practices would be a key test for CQC; CQC compliance inspectors needed better support and information to make sound, consistent judgements; whistleblowing should be a key source of information for CQC to detect poor quality or unsafe care; the perceived risk that extending CQC's role might distract it from its core work; and that there is uncertainty over how much money CQC would need in the longer term to regulate health and adult social care effectively.

The hearing provided a useful opportunity to examine the role and performance of CQC to date. This was undertaken with due consideration of the complexity of the health and adult social care sectors within which it operates; the ambition of its remit to regulate a wide range of health and adult social care providers against a single set of outcome-based standards, and the fact that the responsibility for delivering care that meets essential standards of safety and quality lies primarily with those delivering care—rather than with the regulator.

CQC has a particular role in providing information to the public about whether these standards are being met—and where they are not, we also have an important responsibility in pushing providers to take action where standards of care have fallen short.

I have set out below clarifications and additional contextual information by topic, in response to points raised in the hearing, which I hope will assist your committee.

Where possible, I have addressed specific questions, and where we agreed to supply information, this is also provided.

UNREGISTERED PROVIDERS

Mr Bacon asked whether CQC has any powers to deal with providers not registered with CQC. I am able to clarify the position with respect to providers who are carrying on regulated activities as defined within the Health and Social Care Act 2008, but remain unregistered with the Care Quality Commission (CQC).

It is a criminal offence to provide listed services without being registered with CQC.

CQC is unable to take enforcement action (as opposed to prosecution) against such providers, but we do have a process for dealing with unregistered providers, starting with explaining the legal situation to them and encouraging them to apply for registration, through to prosecution and, where appropriate, reporting to the relevant professional regulator, such as the General Medical Council General Dental Council. We are currently undertaking this process with several dentists and social care providers who have refused to register with us at the appropriate time, and continue to refuse to register.

GP REGISTRATION, INCLUDING INSPECTIONS OF GP PRACTICES AS PART OF THE TRANSITIONAL REGISTRATION PROCESS

There were questions from several members about our processes for the registration of GPs which is due to be completed by April 2013.

Providers of NHS general practice will be required to fill out an online registration application form, which will be accessible from July 2012. They must submit their application within a 28 day window that they choose themselves, between September and December 2012.

In the form we ask providers to tell us their address, who their partners are, which services (regulated activities) they provide and where they provide them. We also ask them to declare whether they are compliant or non-compliant with the essential standards of quality and safety for all of the services they provide, at all

of the locations they provide them. If they declare they are non-compliant, they must tell us how they are mitigating any associated risk and what their plans are to meet compliance within a suitable timeframe.

We will review each application we receive, taking into consideration information from other sources including the GMC, Criminal Records Bureau checks (where appropriate), and whistleblowers. We are also exploring additional sources to provide more contextual information about GP practices. The information we received from PCTs to support registration of dentists was limited and difficult for us to use; we are working to determine the best way to do this for GPs given the changes in the NHS landscape, as a result of the Health and Social Care Bill.

During our assessment of a provider application if we have concerns, we may require more information from the provider, or we may call or visit them to discuss these concerns further. We will carry out this level of assessment activity with as many providers as required, and what approach we take will be determined by the level of concern.

During our pilot, 25% of the providers involved declared non-compliance with essential standards. We estimate that not all of these will need to be followed up, especially where *there is an action plan to mitigate non-compliance. There will, however, be a subset* which will need to be looked at in greater detail. We will also look at other providers where we have concerns based on information given to us by others, such as whistleblowers or other regulators and commissioners. Our current planning assumption is that these together will come to around 10% of the total number of GP practices, and could warrant an inspection as part of the registration process.

I would like to stress that non-compliance with essential standards can translate into poor care, but does not necessarily automatically do so.

INVESTIGATIONS

Mr Barclay asked why CQC had not carried out as many investigations as the Healthcare Commission.

CQC uses its powers under section 48 of the Health and Social Care Act 2008 to carry out investigations of providers where there is concern that there is systemic risk at provider level rather than specific concerns at location or service level. So far, these powers have only been used a small number of times, and generally as part of broader regulatory action. These powers are only relevant for NHS and adult social care providers—they do not apply to independent healthcare providers. The Healthcare Commission had no enforcement powers for NHS providers, and did not carry out regular reviews of NHS trusts other than the Annual Health Check, which involved very little inspection activity. With the introduction of regulation of the NHS under the 2008 Act, including the introduction of registration and enforcement powers, the context in which CQC operates has changed radically from that of the Healthcare Commission.

Our on-going monitoring of compliance means that we are generally more aware of issues in provision at an early stage, and can take appropriate action. There are occasions when the problems at the provider level mean that there is concern across all services, or there are on-going deeper problems which can't be addressed easily. In these circumstances we would launch an investigation to look at how the provider can best address these issues. This is what happened at Barking, Havering and Redbridge NHS Trust, United Lincolnshire Hospitals NHS Trust and University Hospitals of Morecambe Bay NHS Foundation Trust, where we have carried out a more detailed look at providers. An investigation reports relatively quickly so that appropriate action can be taken to prevent further harm to patients. Where we do take action as a result of an investigation, using our enforcement powers under the 2008 Act, this is undertaken in partnership with Commissioners and other regulators such as Monitor to ensure that the greatest levers for change are used. Where we have identified problems with maternity services for example, we have undertaken joint investigations with the Nursing and Midwifery Council.

The Healthcare Commission did not carry out regular inspections. The Investigations Team became involved with trusts much later on. The Healthcare Commission concluded investigations by making recommendations to the Secretary of State at the end of the process, often a year to eighteen months later. CQC's approach means action can be taken more quickly to improve the care that patients receive.

INVESTIGATIONS TEAM

I would like to confirm that the Board Minutes requested by Mr Bacon as part of a Parliamentary Question were released to the Department of Health on Thursday 19 January. The response was printed in the Official Report, Tuesday 24 January 2012, Column 194W, which stated that the minutes had been placed in the Parliamentary Library.

Mr Bacon queried why CQC had abolished its whistleblowing hotline. I am able to provide some background to the decision to rationalise all the help lines run by the predecessor organisations. I would also like to make it clear that at no point did we abolish a whistleblowing hotline. The creation of the dedicated whistleblowing team by CQC was covered in some detail during the course of questions.

In the Healthcare Commission, a general helpline sat with the investigations team. The types of calls coming into the helpline varied widely and included NHS trusts looking for assistance and guidance on their

declarations for the Annual Health Check, as well as patients and professionals calling to give information about services. CSCI also ran helplines on a regional basis, which again would take calls about inspection and assessment processes, as well as from people using services and whistleblowers.

At its inception, CQC created a national call centre based in Newcastle to replace these numerous helplines, and to continue to take calls from all sources. The intention was to ensure better consistency in response to calls coming into CQC and to minimise costs as part of the office rationalisation programme. The centre also deals with a range of queries by email. All calls are triaged, and calls from whistleblowers are directed to our dedicated whistleblowing team immediately.

ANNUAL REPORT—ACCURACY OF FIGURES

Mr Barclay queried the process by which we reported and amended figures in our Annual Report. The CQC Annual Report and accounts were printed by The Stationery Office (TSO) on 13 July 2011. CQC alerted the Department of Health to an error in our Annual Report and Accounts on 19 August 2011.

CQC placed a correction note in the copy of the Annual Report and Accounts on our website.

Following discussions with the Department of Health's CQC Sponsor Branch, Parliamentary Branch and TSO, CQC approved a correction slip to be printed to amend hard copies on 11 October 2011. TSO undertook to distribute the printed correction note to all recipients of the Annual Report and Accounts from TSO, including the Parliamentary Libraries. TSO also placed notice of the correction note on their website.

The Annual Report and Accounts undergo a factual accuracy checking process both within CQC and by the Department of Health. CQC has improved the process for this year to reduce the chance of errors occurring in future.

ENFORCEMENT ACTIVITY—QUOTAS OR TARGETS

Chris Heaton-Harris queried whether CQC operates with quotas or targets for enforcement activity. CQC is a risk based regulator—it follows up where there is a degree of risk of noncompliance with regulations and, as a result, a risk of harm to people who use services. We take an absolute approach rather than a relative one—this means that we follow up all risks that give us cause for concern. We do not have any quota for or target for any of our enforcement activity, be this issuing warning notices or using our powers to close care homes or hospitals.

Where action is taken to close a care home, it would be taken in a considered manner, and on the basis of robust evidence. We would not take action of this type on the basis of a single source of information—where a whistleblower, for example, alerts us to their concerns, we will follow up with partner organisations locally to check their intelligence, and would often include an (unannounced) visit to the provider. Where there is sufficient concern about a service as a result of information received, the Compliance Inspector would carry out an inspection to look for further evidence of non-compliance, and would always listen to the views of people using services there. If, after this follow-up activity there was sufficient evidence to support a judgement of non-compliance with standards, we would then proceed to take appropriate action against that provider, which might include the closure of a care home.

We would need to weigh that course of action against the potential harm that closure might do to the displaced residents.

UNDERSPEND

Meg Hillier asked for a breakdown of CQC's underspend for 2011–12. CQC's total recurring expenditure budget is £142.7 million; our projected underspend against this budget is £14 million.

The breaks down into the following areas:

Staff costs	£9.8 million	Delay in recruitment to establishment and implementation of Pay & Grading and Job Evaluation
Staff related costs	£2.0 million	Budget assumed full establishment for full year
New functions	£1.6 million	Delay in establishment of HealthWatch and delay in GP Registration
Premises/ICT	£0.6 million	Efficiency Savings
Total	£14.0 million	

CLOSURE OF WARDS, SERVICES OR CARE HOMES

Mr Hancock asked about enforcement action taken against hospitals being different to enforcement action taken against care homes.

CQC has the power to place restrictions on the registration of providers. This may be a restriction on the numbers of beds in a care home or hospital, or may be a restriction on the type of activity which can be undertaken at a particular location, including closing hospital wards, where there is sufficient concern. We also

have the power to remove a location from a provider's registration by placing conditions on the registration to prevent regulated activities (services) being provided there. We have used these powers in both care homes and hospitals where we have had concerns.

When we use these powers, we take into account the context in which the provider is operating. This will include looking to see what other provision of the same or very similar services is available locally. Within adult social care there is generally more capacity locally than in provision of acute hospital services, which tend to run at high occupancy rates and there can be fewer acute services nearby. Therefore, we will work with commissioners of services locally to ensure alternative arrangements can be made for care before deciding on a course of action.

We have used these powers differently in distinct settings because of local circumstances. We were concerned, for example, about high mortality rates in maternity services in both Barking, Havering and Redbridge NHS Trust and University Hospitals Morecambe Bay NHS Foundation Trust. Our concerns led to the Trust taking action to restrict the number of births, with alternative maternity services being provided at nearby hospitals to cover the additional births. This was not feasible for University Hospitals Morecambe Bay NHS Foundation Trust, and neither was the closure of the maternity unit there, as it would mean that the next nearest maternity unit, a 40 mile drive away, would adversely affect the standard of the maternity care offered there. Similarly, because of geographical considerations, it is easier to *find* alternative accommodation for people living in care homes in towns and cities than it is in more rural areas where there are fewer care homes and often fewer places.

APPEALS AGAINST ENFORCEMENT ACTION UNDER THE HEALTH AND SOCIAL CARE ACT

Stephen Barclay asked how many legal challenges we have received against the enforcement actions that we have taken.

If a provider does not agree with CQC's judgement, they can make representations to CQC against its enforcement decisions. If they are not content after the representation process they can take their case to a First-Tier tribunal.

We do not currently collate information centrally about representations, although it is something we plan to be able to do in the near future. We do, however, have figures on appeals to the tribunal service. Since January 2011, there have been 18 appeals to the tribunal against CQC enforcement decisions. Five were appeals against the cancellation of a registration, ten were against our refusal to register the provider, two were against our imposing conditions on the provider and one was against an urgent cancellation of registration.

As far as we are aware, 15 of these appeals are still open and continuing, two were withdrawn by the appellant (one related to the urgent cancellation and the other was an imposition of a condition) and one is recorded as being in favour of CQC (which was an appeal against our refusal to register the provider).

CQC has not been subject to judicial review.

DEFINING SUCCESS AND USING PERFORMANCE MANAGEMENT INFORMATION

Chris Heaton-Harris asked for information about improvements in our performance management arrangements, and work to define what success for CQC looks like. I would like to give some context about what we are trying to achieve, the performance information we collect, and how we plan to extend our current performance measures from activity and process measures towards being able to make some assessment of CQC's impact on how people experience care.

The role of CQC is to provide assurance to people using services and the public that registered services meet essential standards of safety and quality. Our main effect is through monitoring and increasing the level of compliance amongst providers. This is achieved in two ways. The first is our *corrective effect* on those we directly inspect and intervene—by identifying potential non-compliance, how we then use our range of compliance and enforcement actions to *act* to ensure that the provider returns quickly to compliance or leaves the sector. The second is our *deterrent effect*, where other providers take action to meet the regulations and outcomes because of the ever present prospect of unannounced inspection or other regulatory action. This second effect was shown in a sample survey of NHS trusts in response to the recent Dignity and Nutrition inspection programme which showed that three quarters of all Trusts surveyed had taken action in anticipation of an inspection after the announcement of the inspection programme; even though not all Trusts were expected to be inspected.

Our key performance indicators and supporting management information systems have been developed since 2009 against a background of a changing remit, roles, and transfer between data systems.

We have developed our measures within a performance framework in our corporate scorecard, which contains a wide range of measures. We are developing more of a "customer focus" on how we carry out our activities. In the processing of new registration applications and applications for variations to existing registrations we have halved the time taken by the legacy organisations to carry out similar processes by setting a target of eight weeks for processing applications for new registrations. From April 2012, a new target of four weeks will come in for variations to services that are already registered. The National Customer Service

Centre in Newcastle handles all incoming correspondence including the helpline, whistleblowing concerns, and statutory notifications such as deaths in care homes.

We can now report reliably on these measures—and regularly do so in public reports. An internal audit carried out this year was positive about the approach, progress and our plans to take forward developments in the Corporate Scorecard. We have established a programme of work, which will include working with an independent partner, that will include both more qualitative and quantitative measures of the impact of CQC. Qualitative measures will include views from providers on the experience and impact of compliance reviews, views from stakeholders and the public on a range of effectiveness factors. From April, we are including more outcome related measures in our scorecard that focus on levels compliance with essential standards of care. Examples of this should include reporting on the numbers of compliant against non-compliant providers; the numbers of inspections resulting in compliance or enforcement actions, the time taken to move non-compliant providers into compliance; and de-registrations. This is likely to involve some further work to our management information systems, so we are planning for these to be in place for regular reporting in 2012–13, or earlier if possible. We are developing qualitative outcome measures to support a complete view of our effectiveness, quality and impact. Of particular importance is our impact on the organisations we regulate and their compliance with the essential standards of quality and safety. This will include an assessment of the impact on the experiences of people who use services, as well as how we are perceived by the public and other key stakeholders.

407 PROVIDERS ON CQC'S RISK LOG IN NOVEMBER 2011

You asked for clarification on action taken against the providers on CQC's risk log in November 2011.

The providers identified on CQC's risk log will have been judged as having major concerns due to a level of non-compliance with our Essential Standards. Each provider will be reviewed; the timescales for this review will be determined by the regulatory and enforcement action that has been taken. These timescales will vary depending on local circumstances and enforcement action taken. In the case of compliance actions, timescales will be linked to the action plans submitted by the provider; for warning notices the CQC will have prescribed a compliance deadline and for Notices of Proposal, timescales will be defined through legislation.

Throughout the period in which a provider is judged as a major concern, the case will be reviewed on a regular basis and progress monitored via the regional risk panel. This regional oversight ensures that the region is best placed to judge the effectiveness of the regulatory action in addressing the risk and if necessary escalate the action through formal enforcement or the bringing forward of additional site visits. The central Risk & Escalation Committee provides additional oversight to this process and seeks assurance from the regional summaries. This can be, and often is, supplemented in complex cases such as Barking, Havering and Redbridge NHS Trust with the receipt of the regulatory plan setting out options for actions to manage the risk as well as consideration and rationale to preferred options.

In summary, the major concerns will be revisited. However timescales will be dependent on the action and hence reviewed on a case-by-case basis.

DIGNITY AND NUTRITION INSPECTIONS

You also asked about follow-up activity on the 55 Trusts found to be non-compliant with standards in the course of the Dignity and Nutrition inspections.

I have appended a spreadsheet to this letter which gives the latest position for all of these trusts.¹

CONSISTENCY IN INSPECTION ACTIVITY AND JUDGEMENTS

Stephen Barclay asked about consistency in our inspection activity and judgements. I am able to provide some further information as background as to the action that we are taking to improve consistency between our regions.

We have recently consulted on a revised and simplified judgement framework and enforcement policy that CQC staff use to guide their decisions about taking regulatory action. These improvements will make it easier for our inspectors to make a clear and transparent judgement about compliance and also easier for the public to understand the information we publish about providers.

Our eight-week training and induction programme for new inspectors is designed to equip them with a thorough understanding of how to make judgements about compliance and appropriate enforcement action. This includes spending time shadowing experienced compliance inspectors. All inspectors have access to formal and informal support to aid them in making robust decisions.

Whilst consistency across regions, and within compliance teams, is important, this does not equate to benchmarking. Judgements need to be based on all available information. While the QRP of a service is one source of intelligence for our inspectors, they will use their local knowledge and networks to add a qualitative perspective to inspections and assessments of compliance.

¹ Note from witness: www.cqc.org.uk/danifollowup

REPORT WRITING AND QUALITY ASSURANCE

The Committee may find it helpful to receive an insight into our internal assurance processes for report writing. Checkpoints are in place throughout the inspection process to ensure inspectors consider the integrity of the process. Furthermore, peer review at local level is a central part of quality assurance around regulatory judgements and the production of reports.

During the planning phase of a review of compliance (the overall process that usually includes an inspection), inspectors consider all the information CQC has about a service and then decide what specific issues to explore. For example, if the inspection will need to cover detailed aspects of medicines management, the inspector will talk to our pharmacy specialists to request advice and, if necessary, ask them to attend the inspection.

The inspector may also call on a range of clinical specialists for advice. This can include taking specialists along during an inspection (eg the use of practising nurses in our “dignity and nutrition” inspections, or working with midwifery experts as part of our investigation into Barking, Havering and Redbridge NHS Trust).

The planning stage is followed by the inspection, which will be unannounced in all but exceptional cases. During the inspection, the inspector will look for evidence to see whether or not the care service is compliant with CQC’s essential standards. The planning stage will usually involve making decisions about which standards are most relevant to the provider. The subsequent inspection will seek to gather evidence most relevant to these.

During our inspections we ask people about their experiences of receiving care, talk to carers and family, observe care being delivered, talk to staff, check that the right systems and processes are in place, and look for evidence that suggests care might not be meeting the essential standards. We can follow up an inspection by asking for further evidence and inspectors can seek expert advice at this stage if needs be.

Following the inspection and collection of evidence there are several stages to ensure that the judgement made by the inspector is fair and evidence-based. The inspector who led the inspection produces a draft report, including in this their judgements. This report is reviewed by another inspector who comments on the judgements, the flow and readability of the report. The amended report is then sent to the inspector’s line manager (the compliance manager) for approval. Once approved, the report is sent to the provider for them to comment (only on its factual accuracy). The inspector will consider all comments and make changes where appropriate.

If an inspection uncovers a “major concern” with the care provided, an internal CQC management review meeting will be convened. The meeting is chaired by the compliance manager and attended by the inspector and, where necessary, a legal advisor. The purpose of the meeting is to decide what regulatory or enforcement action will be taken, based on ensuring fairness, consistency and making an evidence-based judgement.

The final draft of any report is sent to the compliance manager for approval prior to publication. For themed inspections, such as the recent “dignity and nutrition” and learning disability inspections, a national quality assurance panel is used.

I have written to Chris Heaton-Harris separately about his constituents’ particular concerns.

CONCLUSION

I do hope that you find this information useful in explaining further how CQC carries out its regulatory role through inspection and other activities. I hope that it is clear from this note that CQC operates within a broader regulatory framework and statutes. CQC has sought to develop an integrated set of processes and activities in the 18 months in which we have operated under our new powers.

We are continually looking to improve how we operate and regard the comments from the PAC hearing, taken alongside comments from other reviews (including those of the Department of Health and the Health Select Committee), as providing us with material that we can use to challenge and improve our systems further.

Should you have any further points for clarification, then do please come back to me.

February 2012

Written evidence from the Department of Health

In the hearing on 25 January, I promised to write to the Committee with answers to two questions regarding the Public Interest Disclosure Act (PIDA) and the NHS (Q107); and the pension of Cynthia Bower (Q246). This letter sets out the facts regarding Cynthia Bower’s pension.

I have asked the NHS Business Services Authority (NHSBA) to investigate the circumstances of increase in Cash Equivalent Transfer Value (CETV) of Ms Bower’s pension. The NHSBA administer the NHS Pension Scheme on behalf of the Secretary of State for Health.

Ms Bower is a member of the NHS Pension Scheme and elected to transfer in the pension rights that she had built up as a member of the Local Government Pension Scheme.

The substantial increase in the CETV of Ms Bower's pension appears to be the result of two factors. Firstly, calculation errors were made in relation to the treatment of her transferred-in service which consequently led to an increase in the CETV once the error was corrected. These errors only emerged in response to CQC's own requests for information in September 2011 and January 2012. Secondly, an uplift in Ms Bower's pensionable pay from £132,000 in the year ending 31 March 2009 to £198,000 for the year ending 31 March 2010 led to a corresponding increase in the CETV.

On the first factor, the NHSBA has confirmed that an error was made in the 2009 and 2010 CETV calculations which led to the incorrect treatment of her transferred-in service. It appears that Ms. Bower's transferred-in service from the Local Government Pension Scheme was erroneously subjected to an earnings cap when it should have been uncapped. The 2011 CETV was however calculated correctly. Correction of the error resulted in a significant increase in the transfer values between the 2010 and 2011 reported figures.

The Committee asked at the hearing why these errors were not flagged to Parliament. The NHSBA has checked Ms Bower's file for any evidence that the NHSBA informed the CQC about the incorrect calculations prior to the submission of their accounts to Parliament. The NHSBA has no record of confirming to the CQC that the significant increase was due to incorrect calculations in earlier year(s), although the NHSBA did make a minor revision to the 2011 figures on 4 May 2011 and this is the CETV value that the CQC reported in their accounts (£1.35 million).

The NHS Business Services Authority, and I on their behalf, apologise for the errors made in the calculation of Ms Bower's pension arrangements. I hope this explanation clarifies the position.

February 2012

Further written evidence from the Department of Health

In the hearing on 25 January, I promised to write to the Committee with answers to two questions regarding the Public Interest Disclosure Act (PIDA) and the NHS (Q107) and the pension of Cynthia Bower (Q246). However, as the issues regarding pensions are complex I will be responding on that matter in detail in a separate piece of correspondence.

PUBLIC INTEREST DISCLOSURE ACT AND THE NHS

The hearing touched on the issue of public interest disclosures and confidentiality clauses. I felt it may be helpful to outline the Department of Health's general approach to these matters before turning to specific issues which the Committee raised. DH has issued unequivocal guidance to NHS organisations that all contracts of employment should cover staff whistleblowing rights. Changes were made to the NHS staff terms and conditions of service handbook to include a contractual right to raise concerns. Supporting guidance was published on the NHS Employers website and in the NHS Employers Workforce Bulletin Issue 232 (in September 2010). The Social Partnership Forum (SPF) also published guidance in June 2010, "Speak up for a Healthy NHS", with advice to the NHS on achieving best practice for their whistleblowing arrangements.

The NHS Constitution will be amended shortly to highlight and make clear the rights and responsibilities of NHS staff and their employers in respect of whistleblowing. DH is working with the national regulators around how concerns are currently handled and, where appropriate, implementing improvements to systems for ensuring concerns are not overlooked.

In addition the General Medical Council (GMC) is currently updating its guidance, "Raising and acting on concerns about patient safety" which makes clear that doctors have a duty to act when they believe patient safety is at risk, or when a patient's care or dignity is being compromised. The revised guidance is due to come into force on 12 March 2012.

Finally, Sir David Nicholson wrote on 11 January 2012 to NHS Chief Executives and HR managers reminding them of their obligations under HSC 1999/198.

Turning to the specific points raised at the hearing, Stephen Barclay MP referred to two Health Service Circulars, HSC 1999/198 "The Public Interest Disclosure Act" and HSC 2004/001 "Use of confidentiality and clawback clauses in connection with the termination of a contract of employment". I have attached some background to these, which you may find useful, at Annex A. In summary, HSC 1999/198 (issued by the Department of Health in August 1999) states that local policies should prohibit confidentiality clauses that seek to prevent the disclosure of information in the public interest in contracts of employment and compromise agreements. HSC 2004/001 (issued by the Department of Health in February 2004) relates specifically to senior NHS managers. It states that NHS employers must consider with their legal advisers whether confidentiality or clawback clauses are necessary in the circumstances of each case, and that if such a clause is included within a particular agreement that it complies with statutory obligations regarding the treatment of confidential information, including the Public Interest Disclosure Act 1998.

Mr Barclay asked why the Department of Health had issued HSC 2004/001, contravening HSC 1999/198. I would like to clarify that the former does not replace or contravene the latter, but expressly states that HSC 1999/198 "must continue to be followed". It also strengthens the position set out in two previous circulars,

HSC 1999/138 and HSC 1999/140 issued in 1999 These direct that where a severance agreement contains a confidentiality clause it must be disclosed by the employer to any subsequent NHS employer; and that the NHS manager concerned should consent to such a disclosure to the Appointed Auditor, the Public Accounts Committee and Parliament, if requested by either the Department of Health or the National Audit Office or both.

CQC RESOURCES FOR 2011–12 TO 2012–13

I would like to clarify my response to Austin Mitchell's questions about the Commission's budget at Q112. In my response I stated that the Commission would be receiving additional resource in 2011–12 and 2012–13 for the recruitment of extra inspectors. In fact, the additional resource for CQC to recruit inspectors was agreed in 2011–12 but will only be included in its budget allocation for the financial year 2012–13.

In response to Meg Hiller's question at Q204, I indicated that I felt the Treasury would want to recover any underspend by CQC. I would just like to expand briefly on the process for handling finances under those circumstances.

CQC are funded from the DH administration budgets as opposed to the programme budgets which are used to fund front line services (mainly the NHS). Any underspend in administration is returned to the DH in the first instance and consideration is given to alternative priorities. Ultimately any underspend not re allocated will be returned to the Treasury.

In returning any underspend to the Treasury the DH has the opportunity to negotiate budget exchange ie carrying forward into the following financial year a proportion of that underspend. We have taken advantage of Treasury's Budget Exchange Scheme in 2011–12 and transferred monies into 2012–13 to fund pressures.

Finally, at Q201 Meg Hiller stated that CQC was projecting a 14% underspend for 2011–12. In fact, CQC's projected underspend for 2011–12 is £14million, which works out as 10% of its total expenditure budget.

NAMED DAY PQ PQ91440

At Q89 Stephen Barclay stated that he had not yet received a response to a named day PQ requesting sight of the board minutes relating to the decision by the Care Quality Commission to abolish (a) its national investigation team, (b) its healthcare associated infection team and (c) a whistleblower telephone line. I can confirm that the Department of Health replied to the Parliamentary Question referred to on Tuesday 24 January.

Annex A

HSC 1999/198

The Health Service Circular (HSC 1999/198) "The Public Interest Disclosure Act 1998 (PIDA)—*Whistleblowing in the NHS*" was issued by the Department on 2 August 1999. The guidance is clear that local policies should prohibit confidentiality clauses (also known as "gagging" clauses) in contracts of employment and compromise agreements *that seek to prevent the disclosure of information in the public interest*. This means that the use of confidentiality clauses in either contracts of employment or severance agreements are not prohibited *per se*.

Employees are subject to various legal obligations dictating how they use, treat and disclose confidential or personal information. Express confidentiality terms are often included in contracts of employment or compromise agreements in termination agreements in order to emphasise a legal obligation relating to the protection of confidential or personal information both during the employment and after the termination of that employment.

For example, an express confidentiality clause might be included in a contract or other agreement where an employee has access to confidential patient information, or information considered to be of commercial sensitivity.

The Department recognises that there are circumstances when it is appropriate to include a confidentiality clause in either a contract of employment or a severance agreement, provided that it does not seek to prevent legitimate public interest concerns from being raised.

The Public Interest Disclosure Act 1998 provides that any clause or term in a contract or other agreement, including a compromise agreement, between an employee and their employer, is void insofar as it purports to preclude the employee from making a protected disclosure under the Act. This means that an employer could not enforce a clause in a court if it sought to prevent an employee from making a disclosure within the scope of the Act.

HSC 2004/001

Health Service Circular (HSC 2004/001) "Use of confidentiality and clawback clauses in connection with the termination of a contract of employment" was issued by the Department on 5 February 2004. It relates specifically to senior NHS managers.

The guidance was developed in response to a National Audit Office recommendation to strengthen the existing guidance; HSC1999/138 “Conditions of service for general and senior managers—Early termination of fixed term rolling contracts” and HSC 1999/140 “Conditions of service for general and senior managers employed by health Authorities”. HSC 2004/001 replaces HSC 1999/138 and HSC 1999/140 with respect to the use of confidentiality clauses in severance agreements between senior NHS managers and their employer. HSC 2004/001 does not however replace HSC 1999/198 on the Public Interest Disclosure Act 1998. HSC 2004/001 expressly states that HSC 1999/198 “must continue to be followed”.

HSC 2004/001 states specifically that NHS employers must consider with their legal advisers whether such a clause is necessary in the circumstances of each case and that if such a clause is included within a particular agreement that it complies with their various statutory obligations regarding the treatment of confidential information, including the Public Interest Disclosure Act 1998. If it is decided that such a clause is appropriate, then its terms should go no further than is necessary to protect the NHS employer’s legitimate interests.

6 February 2012

Further written evidence from the Care Quality Commission

Thank you again for the opportunity to appear before your committee last month. We wrote in following the session to address some of your points in more detail, which I hope you have had the opportunity to consider.

As we stated in our oral evidence, CQC has weathered a difficult period and faces a strong set of challenges over the coming year. However we believe that we are taking action to improve our approach and further develop our methods of regulation. We acknowledge the five areas that Una O’Brien flagged during the session and have already commenced work on addressing these areas in particular.

Our Board met on 14 February to further develop our strategic approach, and we have set up an evaluation programme to define success measures for cac. This may include working with an external partner. Work so far has included an early analysis of the impact of the Dignity and Nutrition inspections and we have also continued to engage with the National Quality Board including discussions on cac’s role in the broader quality framework.

CQC is setting clearer priorities, and improving management information beyond measures of activity and resource. We are actively working to improve the accountability relationship between ourselves and the Department of Health—particularly around performance frameworks. To this end we are sharing more information with DH on regulatory risk to ensure more transparency.

CQC continues to build up the information published at a national level as well as local level, improving our website to make information more accessible to people using services. We acknowledge that any development of the regulatory model must ensure it listens to user voice and to this end we have programmes of work that seek to address these issues. As discussed in January part of this work includes information from whistleblowers, who are a key source of information for CQC.

At the session in January we advised the Committee that we would be publishing our review of Healthcare needs of people in care homes in February. We are on track to publish this imminently in the week commencing 5 March. We will ensure that you receive a copy.

There has been much learning from previous transitional registrations and we are continually looking to improve how we operate, particularly in supporting our inspectors and developing our quality assurance systems. We regard your comments from this hearing, as well as the other recent external reviews as very useful sources we can use to challenge and improve our systems further.

We have met with yourself and some members of your committee in the past in relation to constituency issues and we would be most grateful to meet any members and particularly yourself to discuss our work or any areas from the session on 25 January that you would like to discuss further. We would be happy to come to you or we would also be delighted to host you if you would like to see how we work. My office will be in contact with yours to arrange a mutually convenient time to meet.

23 February 2012

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