House of Commons

Health Committee

2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13

First Special Report of Session 2013–14

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The Health Committee

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

Membership

Rt Hon Stephen Dorrell MP (*Conservative, Charnwood*) (Chair)[1]
Rosie Cooper MP (*Labour, West Lancashire*)
Andrew George MP (*Liberal Democrat, St Ives*)
Barbara Keeley MP (*Labour, Worsley and Eccles South*)
Grahame M. Morris MP (*Labour, Easington*)
Andrew Percy MP (*Conservative, Brigg and Goole*)
Mr Virendra Sharma MP (*Labour, Ealing Southall*)
Chris Skidmore MP (*Conservative, Kingswood*)
David Tredinnick MP (*Conservative, Bosworth*)
Valerie Vaz MP (*Labour, Walsall South*)
Dr Sarah Wollaston MP (*Conservative, Totnes*)

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Additional written evidence may be published on the internet only.

Committee staff

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

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5466. The Committee's email address is healthcom@parliament.uk.

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

First Special Report

On 9 January 2013 the Health Committee published its Seventh Report of Session 2012–13, *2012 accountability hearing with the Care Quality Commission*. The Government Response to the Report was received by this Committee on 18 April 2013 and is published as Appendix 1 to this Report. The Care Quality Commission's response was received on 19 April 2013 and is published as Appendix 2 to this Report.

The Committee will be taking evidence from the CQC again in the autumn of 2013 as part of its function of holding medical regulators accountable on behalf of Parliament.

Appendix 1 – Government Response

Introduction

On 9 January 2013, the House of Commons Health Committee (the Committee) published the report: *2012 Annual Accountability Hearing with the Care Quality Commission.*

This is the second accountability hearing with the Care Quality Commission (CQC). The Department believes that these hearings are of great value in strengthening the accountability of the Department's independent Arm's Length Bodies to Parliament and the wider public.

Departmental response

We welcome this report and have carefully considered the Committee's recommendations and the issues it raises. The regulatory landscape has changed significantly in the last twelve months. The Health and Social Care Act 2012 has made a number of changes to the role of the CQC, which were described in the evidence submitted to the Committee in July 2012. In February 2013, Robert Francis QC published the Report on Mid Staffordshire NHS Foundation Trust Inquiry, which has wide ranging implications for the provision and regulation of the NHS in England. On 1 April, significant changes to the way NHS services are commissioned and regulated took effect.

The Francis report contains 290 recommendations, many of which have implications for the CQC. The Government has considered all of these recommendations and on 26 March 2013, published *Patients First and Foremost*, its initial response to the Report. The document sets out an initial overarching response, on behalf of the health and care system as a whole. It details key actions to ensure that patients are 'the first and foremost consideration of the system and everyone who works in it'. The Report still needs further consideration and the Government intends to publish a fuller response later in the year. The Department will work with the CQC, Monitor, NHS Trust Development Authority and NHS England and other organisations to ensure that the lessons from Mid Staffordshire are fully learned and acted upon.

The Government's response to each of the Committee's recommendations made in relation to CQC is shown below. In many cases we have drawn from *Patients First and Foremost*, which sets out the forthcoming changes we wish to see CQC take forward. Some of these will be developed in more detail over the coming months, in the light of the Government's response to the Francis Report. Though many of the Committee's recommendations are clearly for CQC to take forward, the Department has commented on all recommendations. In many areas, the CQC has already taken action to improve the efficacy of its compliance activity and is taking steps to address the issues raised by the Committee. The CQC's response is published in parallel with this memorandum to the recommendations.

We are grateful to the Committee for raising many issues with respect to CQC in advance of the Inquiry report itself, and for its scrutiny of CQC in recent years, which has helpfully contributed to the policy we now set out.

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

The Government accepts the Committee's recommendation.

Following the Department of Health's performance and capability review of the Care Quality Commission (CQC) in 2012, the Department stated that it would work with the CQC to develop new unitary board arrangements to strengthen the Board. The Government expects to legislate for a Unitary Board – to put CQC in line with other arm's length bodies – as soon as Parliamentary time allows.

The CQC Chief Executive is now a member of the Board, and the Department is recruiting new non-executive directors (NEDs) to strengthen it further – the advertisement for new NEDs closed on 27 March, with appointments expected in May 2013. The Department aims to appoint senior figures with skills and experience in business, clinical practice, academia, and an external-facing public figure.

On the Executive side, a Director of Strategy and Intelligence was appointed in March. The new Chief Inspector of Hospitals – advertised on 7 April – will have a place on the Board. CQC is also in the process of recruiting an executive Director of Corporate Services.

The Department has confidence in the new leadership of CQC and its ability to define its core purpose. The new Chair and Board will review governance structures throughout the organisation to ensure that decisions are taken by the right people at the right time. The Department looks to the Chair to ensure that suitable governance arrangements and NED appraisals are in place to run the Board effectively and to provide leadership for the whole of the organisation. The Department welcomes the CQC Board's approval at its meeting on 8 February 2013 of revised Board Standing Orders and Code of Conduct for Board

Members which incorporate processes by which Board members can raise concerns about the performance of another Board member or the Chair.

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

The Government notes the Committee's concerns about responsibility for patient safety. We recognise the Committee's concerns with respect to the prime responsibility for patient safety residing with CQC. However we believe there are good reasons not to make further structural changes now, but we will keep the position under review.

On the specific issue of patient safety and essential standards, the Government has announced that a set of new fundamental standards will be developed by CQC to represent the basic requirements that should be the core of a quality service. The new fundamental standards will sit within five main areas including 'safe[ty]: such as avoiding pressure ulcers, MRSA, wrong site surgery, medication errors' [*Patients First and Foremost* paragraph 3.4].

With respect to the roles and duties of CQC, with particular reference to patient safety, we said in *Patients First and Foremost* paragraph 1.40 and 1.41 that we would 'ask Don Berwick to lead a National Patient Safety Advisory Group to advise on a whole system approach to make zero harm a reality in the NHS, reporting by the end of July. The Group will reflect on the findings of the Francis report in relation to the quality and safety of patients and propose a new improvement programme that will build capacity and capability for safety in the NHS. The Group will also advise on how to bring about a genuine culture of change in the NHS so that staff at every level and across the entire healthcare system can take serious and profound action to make patient care and treatment as safe as it can possibly be.'

Following the Berwick Review, the Department of Health, the NHS Commissioning Board and the CQC will jointly consider the recommendations and work with other stakeholders to agree the key roles and responsibilities for patient safety across the healthcare system.

With respect to concentrating patient safety functions in the CQC, we said in *Patients First and Foremost* that:

> 'From 2012 the mechanism by which patient safety incidents are reported nationally transferred to the NHS Commissioning Board. This data is used to derive learning from patterns and trends in incidents to prevent future harm. The NHS Commissioning Board will develop and deliver a revised, easy to-use and responsive National Reporting and Learning System (NRLS) that will provide a "one-stop shop"

for the NHS, clinicians, patients and the public to report patient safety incidents and receive advice. It was Robert Francis' recommendation that the functions of the National Patient Safety Agency should be transferred from the NHS Commissioning Board to the Care Quality Commission. However, given that the NRLS was only transferred to the NHS Commissioning Board in 2012, the Department believes that reallocating this work at this stage would be unnecessarily disruptive. There are already good information flows from the NRLS to the CQC, which are analysed and brought to inspectors' attention through the Quality Risk Profile (QRP) to support their planning of inspections. In addition, the functions transferred to the NHS Commissioning Board go further than the remit of the CQC at this time. The Department will, however, keep this under review.'

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

The Government accepts the Committee's recommendation. Two changes should ensure a closer connection between standards measured by CQC and the experience of residents.

Firstly, the new fundamental standards should reflect the experiences of service users and carers. 'A key recommendation from Robert Francis' report related to setting new fundamental standards. These standards will help to set the context for delivering compassionate, safe care. Already the system rightly has a focus on 'never events' – the errors that should never happen. These new fundamental standards represent the basic requirements that should be the core of a quality service and they need to have a similar status to 'never' events.' [*Patients First and Foremost* paragraph 3.1].

Secondly, there will be a new Chief Inspector of Social Care, who will be charged with inspecting and rating care homes, home care agencies and other registered care providers, promoting excellence and identifying problems, as outlined in *Patients First and Foremost* paragraph 15. The post-holder should ensure there is no disconnect between standards and patient experience: one way of achieving this is that physical inspection will be a key part of the approach taken by the new Chief Inspector.

These changes will also take account of the responses received as part of the Red Tape Challenge and Focus on Enforcement reviews looking at the regulation of care homes, currently being conducted by the Cabinet Office and the Department for Business, Innovation and Skills.

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

The Government agrees and looks to the CQC to demonstrate that it has an effective process to ensure inspections and reports are consistent in approach and outcome.

In response to the Francis Report, the Government made clear that generalist inspection had run its course. The Secretary of State said in his Written Ministerial Statement to the House of Commons on 26 March that CQC 'has committed to bring an end to the days of generalist inspectors briefly visiting organisations who often have little specialist insight into the organisations they visit. From this year, new and thorough expert-led inspections will get to the heart of how hospitals are serving their patients, exposing the poor, spurring on the complacent and celebrating the achievements of the good and the excellent.'

The CQC is developing its inspection regime and its strategy, published on 18 April 2013, outlines the steps to change its inspection approach. A higher-skilled inspection resource will be able to inspect hospitals that have significant or long standing care quality issues. A national hospital team will undertake more specialised and longer reviews of hospital care standards and quality governance.

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

The stated purpose of the CQC is to work as part of the health and adult social care system with a common purpose of driving improvements to the quality and safety of care services. The CQC's "one size fits all" inspection model is ending and it is developing a differential inspection regime (see response to recommendation 4) to target its inspections more effectively and make best use of its resources. In *Patients First and Foremost* (paragraphs 2.3 to 2.5) the Government said:

> 'When assessing individual providers, the CQC will look at quality in the round, not just registration standards. While in the past a plethora of signals and imperatives left providers pulled in conflicting directions about what was really expected of them, in future there will be a clear, single nationally agreed definition of success, a single assessment of achievement against that and no room for manoeuvre locally of playing one national supervisory body off against another.
>
> 'The CQC, the NHS Commissioning Board, Monitor and the NHS Trust Development Authority will be required to agree together the data and methodology for assessing hospitals. This will ensure a single set of expectations on hospitals of what is required of them that is aligned with the way in which commissioners, led by clinicians and guided by the views of local patients, ensure high quality care in the hospitals for which they are responsible. Providers will demonstrate, through annual Quality Accounts, how well they are meeting that single set of expectations.
>
> 'The Chief Inspector will become the leader in the system that coordinates national bodies for a single set of quality expectations, a single assessment of performance against them and ensuring that nationally and locally everyone works together to detect poor care and ensure appropriate action is taken.'

This should lead to a better quality of evidence for commissioners about the state of services.

The recruitment advertisement for the Chief inspector of Hospitals said:

> 'Accountable to the Chief Executive and to the CQC board, the Chief Inspector will be a senior figure who will inspire the trust and confidence of the public, and who will have immediate credibility across the clinical professions. This is a public-facing role and the Chief Inspector must have the professional standing to be persuasive to the Secretary of State, clinical professions, and the public. In addition to possessing first class leadership skills, the successful candidate will need to be an exemplary communicator, with a record of delivering change. Most of all, the Chief Inspector must have a reputation for putting the interests of patients first, and provide an honest and independent assessment of how well or badly hospitals serve their patients.'

Following the introduction of these changes, we expect the CQC to demonstrate how its use of resources has led to improved regulatory practice.

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

The Government agrees with the Committee's recommendation. The CQC is independent of the Department of Health and is responsible for developing and consulting on its methodology for assessing whether providers are meeting the registration requirements. *Patients First and Foremost* paragraphs 3.2 and 3.3, described how:

> '[The Francis report] recommended these standards must be developed with public involvement and consultation with staff. The Department will start work immediately with the CQC, Monitor, NHS Trust Development Agency, the NHS Commissioning Board and NICE and then consult with the public to develop a small number of new fundamental standards focusing on key areas of patient care. The Chief Inspector will use these standards, and the evidence from inspections, to make judgements about the quality of a hospital's services.'

The CQC's consultation on new fundamental standards is expected to be carried out alongside work on its new inspection model and a system of aggregate ratings for providers.

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

The Government agrees with the Committee's recommendation.

Reflecting the importance of organisational culture to high quality patient care, one of the five areas on which CQC inspection will focus is 'well led: such as visible leadership, organisational culture, helpful staff, openness and transparency' [*Patients First and Foremost* paragraph 3.4].

In *Patients First and Foremost* paragraphs 1.1 and 1.2, we said:

> 'Much of the response to the Francis Report is focussed on new and radical approaches to identifying problems quickly, ensuring swift action to address them, holding organisations to account and ensuring that staff have the skills, motivation and support they need to give the best to patients. But our first focus must be to prevent poor care occurring in the first place, in which the issue of culture is absolutely central to this task. To prevent a reoccurrence of the events at Mid Staffordshire NHS Foundation Trust and to ensure that all care is consistently to the standard that patients, the public and staff themselves wish to see, we need to ensure a culture that is consistently supportive of this aim.'
>
> 'Robert Francis' report sets a profound challenge to change the culture of the health and care system so that it never loses sight of its core values of compassion and care. This demands "*the engagement of every single person serving patients*", from the hospital porter to the Secretary of State for Health.

The job description for the Chief Inspector of Hospitals explains that 'The Chief Inspector will be responsible for assessing and judging how well hospitals put the quality of care at the heart of everything that they do, protecting the interests of people that use services. He or she will be charged with leading the CQC's hospital inspectorate to accomplish this goal. As part of the CQC's unitary board, the Chief Inspector will assess the performance of all hospitals in England and publish a rating in order to enable more informed patient choices and commissioning decisions. The Chief Inspector is expected to deliver a crucial role in the assurance that new fundamental standards are being met by all Trusts. Where Trusts are in breach of these standards, the Chief Inspector will determine what action should be taken, including whether a Trust is entered into a failure regime.'

The Department will also look to the CQC to consider how the Chief Inspector of Hospitals will develop indicators of healthy cultures and openness in organisations.

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

The Government agrees that registration should be robust but not overly bureaucratic. The Government notes the success of the recent registration process for NHS GP providers, who from 1 April 2013 fall within the scope of registration for the first time. Over 7,600 providers applied and were registered before the deadline, with eight practices being refused registration.

CQC is committed to making registration more robust and will move towards a system of initial registration that involves a robust assessment of whether a provider is meeting the registration requirements.

The Department of Health will look to the CQC to provide information about its registration process and the numbers of new registrants that are found to be non-compliant within 12 months of initial registration.

The Government will also learn from the CQC's own internal investigation into the events at Morecambe Bay, when published, and ensure CQC reflects its findings in its re-design of regulatory method.

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

The Government absolutely agrees that the regulatory landscape must be joined up. The Mid Staffs Inquiry demonstrated that this was not the case between 2005–2009. In *Patients First and Foremost* paragraphs 3.7 to 3.9, the Government has said:

> 'Since 2009, Monitor and the CQC have worked to develop a better working relationship and improve the coordination of their regulatory activities. This was strengthened by the Health and Social Care Act 2012, which makes Monitor and the CQC subject to stronger duties of cooperation and requires them to operate a joint application process for the CQC registration and a Monitor licence.
>
> 'The Government agrees that regulators and commissioners should ensure they have a shared picture of provider performance, and that there should be greater transparency in identifying those that are failing to meet new fundamental standards.'

However, 'the Government also believes there continues to be a strong case for maintaining the CQC and Monitor as separate organisations fulfilling distinctly different functions. Assessing quality and highlighting failures of care should not be conflated with the responsibility for overseeing the turnaround of failing NHS providers. So, rather than

merging the responsibilities of the regulators, we will deliver Robert Francis' vision through a single failure regime that will place the same emphasis on addressing failures in quality of care as there is on financial failure.'

Within this co-ordinated approach, the Government believes there is still an autonomous role for the CQC, particularly the judgments of the Chief Inspector of Hospitals 'who will be the focal point for honest and independent assessment about how well or badly hospitals are serving patients and the public' [*Patients First and Foremost* paragraph 2.2]. CQC will be accountable to Ministers and Parliament for its actions, and decisions.

The CQC has set out in its future strategy document, *Raising Standards, putting people first – our strategy 2013–16*, published on 18 April, how it will work better with partners in health and social care, build relationships with the public and those it regulates, and build a high performing organisation.

Recommendation 10: The Committee welcomes the greater use and availability of clinical expertise to support the work of inspectors. We note, however, that 87% of inspections carried out since this resource became available did not use it. We recommend that the CQC should develop a consistent methodology for their inspectors to follow which would help to regulate when and how clinical experts are allocated to inspection. We also recommend that the CQC should monitor the effect of the deployment of this resource on the quality and consistency of its inspections in order to ensure that its practice evolves in the light of experience. We will examine these issues again at the next accountability hearing and seek a progress report on the balance between generic and specialist inspection. (Paragraph 44)

The Government is pleased that the Committee recognises the progress CQC has made in areas of patient safety, whistleblowing and developing its regulatory model. The report also observes the CQC has made a 'positive start' to GP registration, which is welcome. Over 7,600 providers applied and were registered with eight providers refused registration by the deadline. The CQC has boosted its inspection capacity and capability to address concerns made after the first accountability hearing in 2011, and is now beginning the process to overhaul its regulatory method from a generalist to a specialist approach.

The Government has said in *Patients First and Foremost* paragraphs 12 and 2.11:

> 'From this year, new and thorough expert-led inspections will get to the heart of how hospitals are serving their patients, exposing the poor, spurring on the complacent and celebrating the achievements of the good and the excellent.
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> 'To have authority and credibility, inspection must be led by individuals with deep insight and specialist experience in the areas for which they are responsible, with the close involvement of patients, staff and others. The new CQC leadership is developing a model of inspection that will secure thorough and insightful inspections which combine first-hand expert experience with data and feedback from patients and staff. The CQC set out its proposals in more detail in its new strategy.'

As we commented in response to recommendation 5 with respect to the effectiveness of advice to commissioners, that we expect CQC to compare the deployment of its resource with the effectiveness of its inspections. This should provide a useful baseline when discussing budgets for future years.

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

The Government agrees with the Committee that it is important to ensure resources are deployed appropriately and that the CQC has sufficient flexibility to manage fluctuations in workload. Overall expenditure and workforce numbers are agreed as part of the annual business planning process and are kept under review during the year. For 2013/14, the Department will continue to work with CQC to ensure its workload is suitably resourced**.**

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

The Government notes the Committee's recommendation. In November 2012 the CQC introduced improvements to its website with a widget application that enables organisations regulated by CQC to embed a summary of its inspections on their website. The CQC has also set up an email alert system to allow people to be notified of the publication of the most up to date reports about care providers.

The CQC is committed to publish better information for the public including the introduction of an aggregated system of ratings. The new system of ratings for hospitals and other care providers 'will be of value to the public in helping to choose the right services' [*Patients First and Foremost* paragraph 2.14].

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

The Government agrees that employees should be able to raise legitimate concerns with their employer without fear of recrimination or discrimination. The CQC has previously set out its whistleblowing policy in response to the Committee's 2011 report. The

Department looks to the CQC to consider the Committee's recommendation and evaluate how and if this could practically be integrated into its inspection regime.

The Francis Report set out a range of recommendations for promoting greater openness, transparency and candour, including the introduction of a statutory duty of candour and related sanctions. *Patients First and Foremost* describes how 'a spirit of candour will be critical to ensuring that problems are identified quickly and dealt with promptly. Openness is a key element of healthy organisational cultures in health' [*Patients First and Foremost* paragraph 2.29]. One of the areas which inspection will focus on is whether organisations are well led, including 'visible leadership, organisational culture, helpful staff, openness and transparency' [*Patients First and Foremost* paragraph 3.4].

The Government will also 'introduce a statutory duty of candour on health and care providers to inform people if they believe treatment or care has caused death or serious injury, and to provide an explanation. The Government will need to carefully consider the scope of this duty on all providers, and will also work closely with professional regulators to examine what more can be done to encourage professionals to be candid with their patients at all times' [*Patients First and Foremost* paragraph 2.32].

'The NHS Standard Contract for 2013/14 will include a contractual duty of candour on all providers to be open and honest with patients when things go wrong with penalties for breaching the duty. The rationale for a contractual duty is that individual clinical commissioning groups (as opposed to a single national body) are best placed to examine their own local providers and take action where required. A contractual duty placed upon organisations is also the best approach for encouraging staff to be open and report incidents, and thereby promote a positive safety culture. This is because the onus is on the organisation to create a supportive culture in which people can admit mistakes – a challenging, but nonetheless essential task when it involves a needlessly injured patient or relatives who have been bereaved' [*Patients First and Foremost* paragraph 2.31].

In addition, the CQC and the Department will consider the findings of the Don Berwick review.

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

It is for the CQC to assess the content and seriousness of information received from members of the public and decide how it might or might not be used. In *Patients First and Foremost* paragraph 2.46, we said that 'all key organisations within the health and care system need to ensure that they are listening to and understand the views of people who have experience of using the NHS and care services so that the work they do is properly informed by the voice of patients and citizens.' The Department looks to the CQC to consider how it might integrate into its structure the views of patients through their user group representatives.

As the national consumer champion for health and care services, Healthwatch will provide feedback to the CQC through a number of routes: directly from Anna Bradley, Chair of Healthwatch England and a CQC Board member; via Healthwatch England as a committee of the CQC; and directly from local Healthwatch organisations.

In February, the Government announced the start of a major review of the way the NHS in England deals with complaints from patients and their relatives. The review will be carried out by Ann Clwyd MP and report to the Prime Minister. The lessons from this review should be absorbed by CQC when it is published.

From April 2013, the Government has introduced a family and friends test. This will provide a constant, up-to-date picture of how every hospital, department and ward is performing as judged by the most important people of all, patients. This information should be used by CQC to contribute to its inspection processes and its regulatory decisions.

Appendix 2 – Care Quality Commission Response

This memorandum sets out the Care Quality Commission's (CQC) response to the Health Select Committee's annual accountability report published on 7 January 2013.

1. Background and context

1.1 We welcome the Committee's report. It comes at a time of considerable change for CQC. Since May 2012 we have been extensively engaging with a wide range of people and organisations including patients, people who use or provide services, key stakeholders, MPs, policy formers and trade bodies on our strategic review and the development of a new strategy for CQC. Our recently appointed Chair and Chief Executive have been greatly involved in the development of the new strategy, which is being published on 18 April 2013.

1.2 Our core purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage these services to improve. Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

1.3 The strategy will see fundamental changes to the way in which we work. To support its implementation, we are planning to appoint a Chief Inspector of Hospitals and a Chief inspector of Social Care, and will give consideration to a Chief Inspector of Primary Care and Integrated Care. The Chief Inspectors will be responsible for leading specialist teams in inspecting hospitals, social care and community, primary medical and dental services respectively. These dedicated teams will be able to take in-depth reviews into those services where we have the most concerns. We will develop proportionate, risk-based methodologies for regulating each sector, moving away from a one-size-fits-all approach to regulation, and will develop ratings systems for each sector.

1.4 The strategy will also address concerns identified through various studies we have commissioned of our current regulatory approach including the review of the regulatory model led by the respected academic Kieran Walshe, and the review of our investigatory powers carried out by Deloitte. In addition, it will look to, and address, many of the recommendations made in the recently published Serious Case Review of the events at Winterbourne View, the Francis report of the Public Inquiry of Mid Staffordshire NHS Foundation Trust, the Government's response to the Francis report, Patients First and Foremost, and the Nuffield report on ratings in health and social care.

1.5 We will be changing the way we inspect services, and have six strategic objectives for the next three years to develop this new way of working:

- Better use of information and inspection
- Working better with our partners in the health and social care system
- Building better relationships with the public
- Building relationships with those we regulate
- Strengthening the delivery of our responsibilities in terms of mental health and mental capacity
- Building a high performing organisation.

1.6 We will publish our Business Plan for 2013–14 on 18 April 2013. The plan outlines eight priorities for change to implement the strategy. These are:

- Improve assessment and judgement of all services we regulate by appointing a Chief Inspector of Hospitals, and a Chief Inspector of Social Care, and giving consideration to a Chief Inspector of Primary and Integrated Care.
- Improve the safety and quality of care in NHS acute hospitals and mental health trusts by changing the way we inspect them.
- Identify, predict and respond more quickly to services that are failing or likely to fail by using data, intelligence and evidence in a more sophisticated and transparent way.
- Improve our understanding of how well different care services work together by introducing specific reviews of people's experiences of care when they move between services.
- Work better with other regulators and partners to improve the quality and safety of care.
- Publish better information for the public – including organisation ratings – to improve transparency.
- Introduce a more rigorous test for organisations applying to provide care services, which includes ensuring named directors and managers commit to meeting the standards and tests their ability to do so.
- Build a high-performing organisation that is well run, has an open culture that supports and enables its staff, and is focused on its customers.

The implementation of these changes will ensure CQC is delivering its statement of purpose. It will improve the health and social care market by supporting the removal of services that are failing or preventing services that are not fit to deliver care from entering the market. People who use services will be better informed about the services they need to use to choose from and about the care they should expect to receive, as they will know how to access this information via CQC, and CQC and its workforce will be regarded as credible, authentic and a reputable source of information about the health and social care market.

1.7 Operationally, in 2012/13 we have completed the process to bring primary medical services, including 7,600 GPs, into registration from 1 April 2013 whilst carrying out more than 35,000 inspections. There are currently no vacant inspector posts; all of the 229 recently recruited additional inspectors have completed their eight week induction and are inspecting providers of health and adult social care services.

1.8 In the past year we have actively sought to increase the amount of feedback we get from people using services to feed into the information and data we hold about individual services. This has been done in a number of ways – working with the Patients Association and the Relatives and Residents Association to gather information which they receive through their help-lines, and raising awareness of CQC at a local level through advertising in local newspapers and GP waiting rooms, encouraging people to report their experience of care to us. This information has been used by inspectors to gain a better overall picture of the services provided, particularly in social care, and has in some cases prompted responsive inspections to be carried out. In total, four inspections and two safeguarding investigations were triggered as a result of this information.

1.9 We have, and continue to develop our website to give clearer information to the public about health and social care services, and mechanisms to allow providers to publish information about our inspections on their websites. We have also launched an email alert service, which allows people to sign up for alerts telling them when a care home or hospital in their area has been inspected and when the report has been published.

Response to individual recommendations

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

2.1 We accept this recommendation.

2.2 We will make our governance more robust by strengthening the membership of our Board to include a number of new non-executive Directors and Executive Directors. The Department of Health is currently recruiting additional non-executive Directors who should be in place by May 2013. The Executive Director of Strategy and Intelligence has recently been recruited and will take up his post in May this year, and we are currently recruiting a Chief Inspector of Hospitals

and an Executive Director of Corporate Services and appointments will be made this spring. We expect to advertise the post of Chief Inspector of Social Care later this year and will give consideration to a Chief Inspector of Primary and Integrated Care.

2.3 As the new members of the Board come into place, the Board itself will hold a series of development days led by the Chair to ensure it becomes a functional body.

2.4 We are creating an environment in which an open culture which actively encourages staff to voice their views and concerns without fear can flourish. We have introduced two anti-bullying initiatives. The Chief Executive has commissioned an external consultant to undertake a review of CQC to look at how to build a stronger anti-bullying and harassment culture. This work is being led by Sarah Hunter who has spent the first three months of 2013 talking to members of staff about their experiences of bullying and harassment within CQC, and will make recommendations at the end of April 2013.

2.5 We are implementing a dignity at work scheme which was launched at the beginning of April 2013. This scheme will see 24 specially trained members of staff who have volunteered to act as dignity at work advisors. Their role will be to provide confidential support and advice to members of staff experiencing bullying and harassment, whether that member of staff is making a complaint, being accused of bullying or harassment, or who may be a witness to bullying or harassment.

2.6 The most recent staff survey, carried out in February 2013, shows that improvement has been made in bullying and harassment compared to the July 2012 staff survey. Morale has also improved in this period.

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

3.1 We accept this recommendation.

3.2 Our purpose is to make sure health and social care services provide people with safe, effective, compassionate high-quality care and we encourage these services to improve.

3.3 Safe, effective, compassionate high-quality care cannot be achieved by inspection and regulation alone. The primary responsibility for delivering quality lies with care professionals, clinical staff, providers and commissioners.

3.4 It is for the Secretary of State to decide which responsibilities sit with which body. We look forward to Don Berwick's report on patient safety and will work with our partners to implement the recommendations made. We are actively working with the other bodies in the system including NHS England, the Trust Development Authority, Monitor and the National Institute for Health and Care Excellence (NICE) to share information about safety incidents, and we are beginning to work with Lord Ara Darzi and his team at Imperial College as they develop the National Reporting and Learning System to ensure it remains useful and that the information contained in the database is shared effectively.

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

4.1 We accept this recommendation.

4.2 We are planning to appoint a Chief Inspector of Hospitals and a Chief Inspector for Social Care, and to give consideration to a Chief Inspector of Primary and Integrated Care. The Chief Inspectors will improve the way all the services we regulate are assessed and judged and make sure that we, and our partners in the health and social care system, focus on the things that matter to people.

4.3 We will develop new fundamental standards which focus on these five areas, working with the public, people who use services, carers, providers and professionals, and our partners to do so. We will make sure they are driven by the interests of people who use services.

4.4 Increasingly, the frequency of our inspections will depend on the 'risk' involved. By this we mean the quality and safety of a service, and the type of care being provided. We will inspect services more often where there is a high risk of harm to people who use them, and where people are vulnerable because of their

circumstances, such as services caring for people with learning disabilities, those caring for people in their own homes, and those caring for people with mental health issues.

4.5 Our inspection and regulation of care services will ask the following questions about services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they well led?
- Are they responsive to people's needs?

4.6 During our inspections we will continue to observe care directly and we will always talk to people using the service, family carers and care staff about their views and experiences of care. We will also continue to check whether the right systems and processes are in place to deliver good care.

4.7 We will work closely with our partners and NICE so we are clear about the measures we use in our assessments. We will monitor and assess performance using our standards and measures, but we will always use our professional judgement so that we never tick the box but miss the point.

4.8 From 1 April 2013, our inspectors will specialise in particular areas of care and will lead teams that include clinical and other experts, and people with experience of care who we call experts by experience. We will also introduce national teams with specialist expertise to carry out in-depth reviews of hospitals, particularly those with significant or long-standing problems and trusts applying to become foundation trusts.

4.9 We will consider working with other agencies to carry out inspections and make greater use of reviews carried out by others, including Monitor, local Healthwatch and overview and scrutiny committees.

4.10 We will continue our programme of unannounced inspections across the sectors we regulate and inspections based on particular aspects of care. We will also continue to inspect at any time when we have a concern, or when we do not have enough information about a service.

4.11 We will take into account the findings of the Red Tape Challenge and Focus on Enforcement reviews of regulations and their implementation as we develop our new regulatory models.

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

5.1 We welcome this recommendation.

5.2 We recognise that quality care cannot be achieved by inspection and regulation alone. The main responsibility for delivering quality care lies with care professionals, clinical staff, providers and those who arrange and fund local services. However, we will set a clear bar below which no provider must fall and publish clear ratings of services which will encourage and drive improvement.

5.3 We will develop new fundamental standards working with the public, people who use services, carers, providers and professionals, and our partners to do so. We will make sure they are driven by the interests of people who use services. The standards and the measures will depend on the types of services we regulate. We will work closely with our partners and National Institute for Health and Care Excellence (NICE) so we are clear about the measures we use in our assessments.

5.4 We are currently carrying out a survey with a representative sample of the public to look at how aware the public are of CQC, and how confident they are in CQC's ability to carry out its functions effectively. This is a repeat of a survey carried out last year, and will be run on an annual basis. The results of this year's survey will be available in the spring. Through this, we will be able to track people's confidence in CQC over time.

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

6.1 We accept this recommendation.

6.2 We will play a central role in making sure that concerns about quality and safety are acted on and brought to the attention of all of our partners in the health and social care system. Nationally and locally we will work with other regulators and organisations that manage and oversee the health and social care system to identify and act on the public's concerns.

6.3 We will develop aggregated ratings for health and social care providers, as proposed by the Nuffield Trust in their recent review for the Department of

Health. These ratings will take into account key measures and indicators for each sector, and will be developed in the course of the next year. We will give an overall rating to a service, with individual ratings for hospital services or departments to allow commissioners, patients and their families to compare how well services are being provided.

6.4 We will play a central role in making sure that concerns about quality and safety are acted on and brought to the attention of all of our partners in the health and social care system. Nationally and locally we will work with other regulators and organisations that manage and oversee the health and social care system to identify and act on the public's concerns.

6.5 Locally we will focus on developing relationships with local authorities, clinical commissioning groups, local Healthwatch organisations, overview and scrutiny committees, foundation trust councils of governors, quality surveillance groups, and health and wellbeing boards.

6.6 Together with our partners we will improve how care is overseen, make the most efficient use of our joint resources, and reduce duplication. We will build effective systems for improving how we share information and evidence, strengthening our ability to listen better to people's views and experiences, identify new problems more quickly, and co-ordinate our inspections and other activities better.

6.7 We will work closely with Healthwatch England to make sure that we are acting appropriately on information we receive and that we do not miss opportunities to identify poor care or shed light on failings affecting people using health and social care services. Over time we will identify topics where we can work jointly at national level to influence improvement in standards of care.

6.8 We will also continue to develop our working relationships with other organisations to make sure we co-ordinate our roles and methods effectively. For example, we will improve the way we work and share information with the professional regulators, the Local Government Ombudsman and Parliamentary and Health Services Ombudsmen, employers organisations and professional associations.

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

7.1 We accept this recommendation.

7.2 Since May 2012 we have been engaging extensively with a range of bodies and individuals including providers, patients, people who use services, members of the public, policy formers, elected representatives and others, on the development of our revised strategy. This consultation and engagement will continue as we develop our differentiated methods of regulation and sector specific fundamental standards.

7.3 The Chief Inspector of Hospitals will initially focus on changes we need to make in how we regulate and inspect hospitals, particularly in the NHS. This will include developing fundamental standards for hospitals which will be the basis for the new model of regulation which will be implemented by the end of the 2013/14 financial year. We will develop this in other sectors with the introduction of a Chief Inspector of Social Care and will give consideration to a Chief Inspector of Primary and Integrated Care. As we develop and refine methodology for each sector we will engage with relevant partners, particularly people who use services, and will continue to have discussions about regulatory methods which have been initiated in the engagement and consultation on the development of our strategy.

7.4 To support this development programme, we will run a programme of formal evaluation, consultation and engagement alongside the informal discussions. We will also continue to survey providers of services and front-line staff to ensure there is a full understanding of our methods, to identify that they think works well and what they think could improve. We will use this feedback to refine our methodology over time.

7.5 We will also be developing a Citizen's Panel, where members of the public will review various aspects of our work, and to provide input into the development of our methodologies and standards, as well as feeding back on the overall quality of our work.

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

8.1 We agree with this recommendation.

8.2 We will expect providers to encourage people who use their service, and the people who work in it, to speak out without fear about what they see, hear and experience. We will expect managers and boards to promote an open culture that encourages this. We will expect all services, particularly those for people with mental health issues, learning disabilities and dementia, to have effective ways of making sure they listen to, and act on people's views and experiences.

8.3 'Is this service well led?' will be a domain of the new approach to approach to inspection. When we look at whether services are well-led, we will want to be sure that they have an open and transparent culture, backed up by effective leadership, governance and clinical involvement. We will want to be sure that the service puts people first, protects their rights, and encourages them to speak out without fear. We are working with Monitor, the Trust Development Authority and NHS England to agree how we will assess culture, and we will be developing fundamental standards around culture, leadership and quality governance as one of the five domains in the new model of regulation.

8.4 As part of this we will develop measures and methods to assure ourselves that there is an open and transparent culture, underpinned by effective leadership and clinical engagement, that puts people first, protects their rights and encourages them to speak without fear. This will include, for example, assessing morale, staff turnover, sickness levels, how the views of people who use the service are acted upon and how providers welcome, respond to and learn from the complaints people make.

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

9.1 We accept this recommendation.

9.2 A key priority for 2013/14 will be to make sure that those applying to offer new care services face a more rigorous test of whether they are fit to do so. We will tailor our approach to the type of service being proposed. Only organisations that pass the test will be allowed to provide care to the public.

9.3 We will also expect directors and managers of care services to explain how they plan to deliver and maintain safe, quality care and to make a declaration that they will answer for it in their statement of purpose. We will introduce this approach first to services for people with learning disabilities, other high-risk services where there is less public scrutiny and openness, and then all organisations proposing to offer new care services. This will be an effective way of holding people to account for the quality of care provided by their organisation.

9.4 This more rigorous test of a provider's ability to meet standards and fulfil their commitments will ensure that registration is the start of a regulatory contract with CQC. We will continue to check whether or not a provider is delivering against its commitments and takes action where it fails to do so.

9.5 We will expect providers to encourage people who use their service, and the people who work in it, to speak out without fear about what they see, hear and experience. We will expect managers and boards to promote an open culture that encourages this. We will expect all services, particularly those for people with mental health issues, learning disabilities and dementia, to have effective ways of making sure they listen to, and act on people's views and experiences.

9.6 We will make it explicit, as part of the terms of registration, an expectation for providers to display relevant CQC materials, including the latest inspection reports, in their premises, and through their on-line presence.

9.7 By doing this, the public can be reassured that only organisations that pass a rigorous test will be allowed to provide services. The public will also know which individuals are accountable for the quality of care and they can be assured that we will hold those individuals to account if we find that they are failing to meet that commitment.

9.8 Additionally, through 2013-14 we will be introducing the joint licensing and registration scheme with Monitor. This process ensures that all organisations providing NHS funded care are registered by CQC on quality grounds and licensed by Monitor on financial grounds. This will initially apply to all currently approved Foundation Trusts, and will subsequently apply to all trusts wishing to attain Foundation status, with other types of provider being brought into this scheme in due course.

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

10.1 We accept this recommendation.

10.2 Nationally and locally we will work with other regulators and organisations that manage and oversee the health and social care system to identify and act on the public's concerns. We will, through our Chief Inspectors, play a central role in making sure that concerns about quality and safety are acted on and brought to the attention of all of our partners in the health and social care system.

10.3 Together with our partners we will improve how care is overseen, make the most efficient use of our joint resources, and reduce duplication. We will build effective systems for improving how we share information and evidence, strengthening our ability to listen better to people's views and experiences, identify new problems more quickly, and co-ordinate our inspections and other activities better. We will begin by working better with those national partners which are new in the health and social care system or have significant changes to their responsibilities. Our priority will be to work with Monitor, NHS England and the NHS Trust Development Authority to develop a clear programme to tackle the failure of an NHS trust to meet fundamental standards.

10.4 We will also work with our national partners to give the public and others a single, clearer picture of how NHS hospitals are performing on things that matter to people. This will include an overall rating for a hospital and ratings for individual services provided at that hospital.

10.5 We will work closely with Healthwatch England to make sure that we are acting appropriately on information we receive and that we do not miss opportunities to identify poor care or shed light on failings affecting people using health and social care services. We will identify topics where we can work jointly at national level to influence improvement in standards of care.

10.6 We will continue to work closely with Ofsted on our joint inspections of children's services and with HMI Probation on our joint inspections of Youth offending services. We will also continue to develop our working relationships with other organisations to make sure we co-ordinate our roles and methods effectively. For example, we will improve the way we work and share information with the professional regulators, the Local Government Ombudsman and Parliamentary and Health Services Ombudsmen, employers organisations and professional associations.

10.7 Locally we will focus on developing relationships with local authorities, clinical commissioning groups, local Healthwatch organisations, overview and scrutiny committees, foundation trust councils of governors, quality surveillance groups, and health and wellbeing boards.

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

11.1 We accept this recommendation.

11.2 The new inspection teams, led by Chief Inspectors, will see an increase in the use of both professionals and experts by experience in our inspections as we develop new ways of assessing and regulating services. It is intended that all inspections will include the input of professional experts.

11.3 We launched our pool of advisors on 1 July 2012. Prior to this, advisors were used on an ad-hoc basis. Between July and October 2012, 54 specialist advisors were used. Between November 2012 and January 2013, 119 specialist advisors were used. In addition to this, specialist advisors were used in our all of our themed inspections on dignity and nutrition in hospitals and more than half of the inspections in care homes. We currently have more than 200 advisors in the bank.

11.4 As well as participating in inspection activity, 19 specialists have been used to help to develop guidance and methodology in this time.

11.5 We have 10 National Professional Advisors, senior health and social care professionals covering a range of professions and specialties who work for CQC on a part-time basis, who are available to input into policy and strategy development, and to take part in inspections where their expertise is needed.

11.6 Clear guidance has been developed for inspectors on how to access the pool, and on the circumstances under which they should seek specialist input, and the degree to which that input can be used.

11.7 We continue to recruit health and social care specialists to the pool to ensure there is a broad range of expertise available to support our work. We are currently recruiting specific clinical specialists to support our inspection activity. This includes GPs, dentists, practice nurses, practice managers and other clinical and social care professionals who work in or directly with primary medical care providers to support inspections of GP practices from April this year.

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

12.1 We accept this recommendation.

12.2 As we implement our new strategy the Chief Inspectors will lead the inspection activity for their particular areas. We are in the process of concluding discussions with the Department of Health about resourcing for the new organisational structure and any additional responsibilities which may be given to CQC in response to the Francis Inquiry. We continue to discuss resourcing issues with the Department of Health as any other new functions or activities are proposed for CQC.

12.3 We have begun to schedule our inspection activity for 2013/14 as we transition to the new model of regulation. In 2012/13 we introduced an activity recording tool to assist operational managers to plan inspections and manage the workload of their inspectors effectively. We have used the results of this to inform our planning for this year to ensure there is capacity to allow for unexpected demands on time, as well as ensuring there is sufficient time for enforcement and other statutory activities, and training and development.

12.4 We will continue to develop our approach to scheduling and capacity building on this work. We will commission a piece of work later this year to identify how regulators in other sectors schedule their inspection activities to inform the development of our inspection scheduling and capacity planning.

12.5 We will continue to develop our risk-based approach to regulation, ensuring that providers of the lowest risk services are not overly burdened by unnecessary regulation. We are exploring how we can use accreditation more effectively in these areas, allowing us to be more responsive to those providers where problems are identified and to reduce the pressure on inspectors to allow additional capacity to respond to either problems which have been identified at short notice, or to undertake additional inspection work as appropriate.

13 Recommendation 12: We recommend that the CQC should develop clearer guidelines for communicating the results of its inspections to interested parties. When inspections are complete, patients, operators, residents and relatives are all entitles to effective access of the results, both positive and negative which is prompt, accurate and complete.

13.1 We accept this recommendation.

13.2 We will publish better information for the public that will help them choose care. We will provide a balanced, clear, timely, accurate picture of the quality of a service, highlighting both what the service does well and where its performance is poor. We will take forward the recommendations of the Nuffield Review to publish ratings of services working with people who use services, professionals and providers to develop how we do this.

13.3 We will tailor our information to meet people's needs, making sure that it is easier to find when people most need it, in a format that is understandable to them. We will share our information with other websites and other organisations to help make it more widely available. We will publish regular insights on issues, trends and specific aspects of care at a national and local level with improved information on what works well.

13.4 We will make clear, as part of the terms of their registration, an expectation for providers to display relevant materials we provide, including the latest inspection reports and information about our responsibilities under the Mental Health Act. We will also expect care services to publish their own up-to-date accurate information on how they are performing.

13.5 NHS hospitals will have a duty to tell people when things go wrong. We will work with the Department of Health and others to clarify our role in monitoring this duty which will need to be set out in law.

13.6 In line with Government expectations around the Digital First agenda, we will continue to publish all of our reports on our website, together with individual provider profiles which outline how well services are being provided. This information is updated every time a judgement made about a service and a report is published. We have developed several mechanisms for individuals to keep up to date with reports and judgements about compliance, including a digital alert service for people to be kept up to date either about a particular hospital or care home, or about how well services are doing across a geographical area, either by local authority or constituency. In January this year we launched a service for MPs which allows them to sign up for alerts about inspections in their constituencies; more than 60 MPs have signed up to this service since it was launched.

13.7 We have recently started to publish more historical information about care homes so that people making choices about care have more background information about how care homes have performed in the past to give them more information on which to base decisions.

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

14.1 We accept this recommendation.

14.2 We agree that a culture of openness is important to ensure there is minimal risk to patients and people using services. As described above, we are developing our approach to assessing how the organisational culture supports openness and welcomes feedback from both its staff and the people using its services. We believe that the way in which organisations respond to whistleblowers should form a part of our assessment of organisational culture.

14.3 Since setting up our whistleblowing line in 2011 the number of calls has continued to increase, with 826 calls in January 2013 and 850 calls in February 2013, taking the total number of calls between April 2012 and February 2013 to 7,604. This compares with 4155 contacts received between the launch of the whistleblowing line in June 2011 and March 2012. We use the information coming through this route to guide our activity, and, through our audits we have found that it has prompted activity such as responsive inspections and safeguarding investigations.

14.4 The whistleblowing team in our National Customer Service Centre ensures that all cases are followed up by the relevant inspector and the person contacting us with their concerns is contacted by the inspector wherever possible. We carry out regular audits of whistleblowing calls to ensure the information we receive is used effectively and that appropriate decisions are made about the course of action.

14.5 We are developing links between CQC's whistleblowing helpline and the Department of Health's National Whistleblowing Helpline, which is currently run by Mencap. We are beginning to take information from this helpline to inform our regulatory activity. Wherever we can we will feed back to the people sharing their concerns on the action we have taken as a result. Where we do take action we try to do so in a way which keeps their identity confidential.

14.6 We welcome the recent announcements about supporting whistleblowers more effectively. We continue to work with the signatories of the Charter on whistleblowing to promote and encourage individuals to share their concerns.

15 Recommendation 14: If the CQC is to genuinely treat feedback from the public as free intelligence then it must show that it can act swiftly when serious complaints are made.

15.1 We accept this recommendation.

15.2 When information of a concerning nature is shared with us we will take action as soon as is possible. Any information which comes to us is passed to the relevant compliance inspector for their assessment, alongside any other information we hold about that provider. We also undertake our own analysis of intelligence and data more effectively to predict or anticipate where there may be problems.

15.3 Between April 2012 and March 2013 we received more than 9,000 forms from our website which were completed by members of the public. This equates to around 25 forms per day. Unfortunately, as many people choose to remain anonymous when completing these forms, it is not always possible to contact them to either get further information or to report back to them on action we have taken.

15.4 Whilst we have been carrying out the pilot work with the Patients' Association and the Relatives' and Residents' Association we have been tracking the action taken as a result, and have published case studies outlining the action taken as a result. From the information passed to us during these pilots, we have undertaken two responsive reviews, initiated two safeguarding investigations and brought forward two scheduled reviews.

15.5 Following one of these inspections, action was taken jointly with a local authority to improve staffing levels at a care home, and the home was prevented from admitting any new residents to the home until the problems had been resolved.

15.6 We continue to use this information, and have created a Safety Escalation Team in our National Customer Services Centre to ensure there is a swift response to all high risk information coming into CQC. This includes information coming

from people using services, whistleblowers, safeguarding alerts and calls about mental health services as part of our duties under the Mental Health Act 1983. All of these referrals are subject to the track and trace process used by the Whistleblowing team to ensure they are followed up by compliance inspectors as appropriate.