



House of Commons
Committee of Public Accounts

Care Quality Commission: regulating health and social care

Twenty-Fourth Report of Session 2017–19

*Report, together with formal minutes relating
to the report*

*Ordered by the House of Commons
to be printed 28 February 2018*

The 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).

Current membership

[Meg Hillier MP](#) (Labour (Co-op), Hackney South and Shoreditch) (Chair)

[Bim Afolami MP](#) (Conservative, Hitchin and Harpenden)

[Sir Geoffrey Clifton-Brown MP](#) (Conservative, The Cotswolds)

[Martyn Day MP](#) (Scottish National Party, Linlithgow and East Falkirk)

[Chris Evans MP](#) (Labour (Co-op), Islwyn)

[Caroline Flint MP](#) (Labour, Don Valley)

[Luke Graham MP](#) (Conservative, Ochil and South Perthshire)

[Robert Jenrick MP](#) (Conservative, Newark)

[Gillian Keegan MP](#) (Conservative, Chichester)

[Shabana Mahmood MP](#) (Labour, Birmingham, Ladywood)

[Layla Moran MP](#) (Liberal Democrat, Oxford West and Abingdon)

[Stephen Morgan MP](#) (Labour, Portsmouth South)

[Anne Marie Morris MP](#) (Conservative, Newton Abbot)

[Bridget Phillipson MP](#) (Labour, Houghton and Sunderland South)

[Lee Rowley MP](#) (Conservative, North East Derbyshire)

[Gareth Snell MP](#) (Labour (Co-op), Stoke-on-Trent Central)

Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No. 148. These are available on the Internet via www.parliament.uk.

Publication

Committee reports are published on the [Committee’s website](#) and in print by Order of the House.

Evidence relating to this report is published on the [inquiry publications page](#) of the Committee’s website.

Committee staff

The current staff of the Committee are Richard Cooke (Clerk), Dominic Stockbridge (Second Clerk), Hannah Wentworth (Chair Support), Ruby Radley (Senior Committee Assistant), Carolyn Bowes and Kutumya Kibedi (Committee Assistants), and Tim Bowden (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Committee of Public Accounts, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6593; the Committee’s email address is pubaccom@parliament.uk.

Contents

Summary	3
Introduction	4
Conclusions and recommendations	5
1 Current performance	8
Publication of inspection reports	8
Regulating GP practices	9
2 Future Challenges	11
Inspection staffing levels	11
Information systems	12
Sources of information	13
Local system reviews	14
Formal Minutes	16
Witnesses	17
Published written evidence	17
List of Reports from the Committee during the current session	18

Summary

The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. It plays a vital role in ensuring people receive safe, effective, compassionate, high-quality care. This is the third time this Committee has reported on the Commission since 2012 and it has improved significantly over this period. There remain areas where the Commission needs to improve its current performance. It does not make inspection reports available to the public quickly enough following an inspection and it needs to improve how it interacts with and regulates GP practices. It also has a number of challenges ahead. With health and care providers under severe financial pressure, the Commission's workload is likely to increase if services deteriorate. The Commission needs to monitor this closely and understand the impact on its staff requirements. The Commission wants to move to a more intelligence-driven regulatory approach, but to do so it must improve its information systems. It also has more work to do to ensure it has the wide range of intelligence it needs to identify early warning signs of poor care. Since our evidence session, Sir David Behan has announced his retirement. The new Chief Executive will have a big task to ensure the Commission is able to tackle the big challenges that are on the horizon.

Introduction

The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England and has two main purposes: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care; and to encourage providers to improve the quality of care. It is accountable to Parliament and sponsored by the Department of Health and Social Care (the Department). The Commission regulates providers across three sectors: hospitals, adult social care, and primary medical services. It registers, monitors and inspects providers, and publishes its assessments and provider ratings. The Commission can also take enforcement action when care falls below fundamental standards.

The Committee of Public Accounts has reported twice before on the Commission, in 2012 and 2015. In 2012, the Committee raised serious concerns about the Commission's governance, leadership and culture. In 2015, it reported that the Commission had made substantial progress since 2012, but there remained issues with: staffing levels; the accuracy and timeliness of inspection reports; its capacity to take on new responsibilities; and how it measured its own performance. The Commission has since introduced a new five-year strategy, which includes a move to a more intelligence-driven regulatory approach. The Commission's funding is set to reduce by 13% between 2015–16 and 2019–20.

Conclusions and recommendations

1. **Given the current stresses in the system, the Commission's review of 20 local health and care systems will provide important information on how local systems are working, but these fall outside the core remit of the Commission.** Under its current legal and regulatory framework, the Commission regulates individual organisations rather than health and care systems. When inspecting individual organisations, the Commission tests the extent to which they are working with other local stakeholders. Its view is that there needs to be oversight of how local systems are working, in addition to individual inspections. The Secretary of State for Health and Social Care specifically requested the Commission to undertake 20 local health and care system reviews, and it has now produced an interim report on the first six reviews. However, for the Commission to inspect and rate local systems and take enforcement action would require a change in legislation.

Recommendation: *The Department should set out in its Treasury Minute response its plans for providing oversight of local health and care systems, making sure it draws on lessons from the Commission's local system reviews.*

2. **The Commission's hospital inspection reports are not published quickly enough after an inspection to allow the public to make informed and timely choices about their care.** The Commission has made progress in improving the timeliness of publishing inspection reports since 2015. However, it still does not meet the targets it sets itself across any of the sectors it regulates. The biggest gap in performance is in hospitals. For example, in quarter one 2017–18, for hospitals where fewer than three services were inspected, only 25% of reports were published within 50 days compared to the target of 90%. Delays in publication mean the public do not have timely information to make informed decisions about their care. Reasons for delays include inefficient processes within the Commission and the time taken to resolve comments from providers on the factual accuracy of reports. The Commission has introduced an improvement programme and expects to publish at least 50% of hospital reports within its timeliness target by 2018–19. Immediately after an inspection the Commission writes to inform hospitals of any safety issues, and the actions it expects the hospital to take, but not all trusts make this letter public.

Recommendations:

The Commission should make sure findings from hospital inspections are available to the public as soon as possible. It should write to us in April 2019 with an update on its performance. This should include whether it has achieved the commitment it made on publishing at least 50% of hospital reports within its timeliness target by 2018–19 and how it has balanced this with maintaining the quality of reports.

The Commission should also work with NHS England and NHS Improvement to ensure that trusts routinely publish the post-inspection letter from the Commission, thus ensuring the public has access to this information.

3. **The Commission's regulation of GP practices is vital in highlighting poor care, although GPs continue to have concerns about the value provided by the Commission's regulation.** The Commission has rated nine out of ten GP practices as either good or outstanding, but its inspections have also identified some poor and unacceptable services. The Commission's own provider surveys show that GPs view its regulation less favourably than other sectors. The Commission thinks this is partly due to GPs being regulated by an external independent regulator for the first time. However, the Commission recognises that it also needs to make changes to how it regulates GP practices including reducing the burden on practices. The Commission is working with the Royal College of GPs and British Medical Association to improve relationships and how it regulates the sector.

Recommendation: *Without compromising the robustness of its regulation, the Commission should set out in its Treasury Minute response how it will ensure the regulatory burden on GPs is proportionate and that patients can be well informed about GP performance.*

4. **We are concerned that the Commission will not have enough inspection staff if its key planning assumptions do not hold, including that the quality of care services does not deteriorate.** The Commission has completed its comprehensive inspection and rating programme, which took all providers through the new inspection regime introduced in 2014. The frequency of re-inspecting providers is now based on the current inspection rating, along with reactive inspections if it is aware of particular concerns. Vacancy rates for inspectors and analysts have fallen significantly since 2015 and the Commission now thinks it is adequately resourced. As part of its cost reduction strategy, the Commission plans to reduce staffing levels through to 2019–20. Its ability to do so, while also being able to carry out enough inspections, will depend on the accuracy of certain assumptions it has made; one of which is that the current profile of provider ratings remains unchanged. However, providers in all sectors are under stress, which is causing some services to deteriorate, and has already resulted in a greater number of inspections than planned at the start of the 2017–18 financial year.

Recommendation: *When the Commission writes to the Committee in April 2019, it should include an update on whether changes in the external environment are affecting its staffing assumptions and how it is managing these changes. The update should include the impact of any changes on its planned cost reductions and on its ability to meet its inspection programme.*

5. **The Commission's ambition for a more intelligence-driven regulatory approach, including reducing the frequency and depth of its inspections, is heavily dependent on improving its information systems.** The Committee has highlighted in other areas of government the importance of ensuring the right infrastructure is in place before introducing wider changes. The Commission's current information systems require significant work including: improving its registration systems; fully implementing its software for analysing text-based information; updating its systems for collecting information from providers; and continuing to develop its ability to draw together information on a provider from different sources. The Commission

is testing its new systems as it progresses and has developed a wider digital strategy which sets out the priorities for moving towards an intelligence-driven regulatory approach.

Recommendation: *The Commission should ensure that its digital and information collection infrastructure is in place and working as expected before fully extending the inspection periods in its frequency-based inspection regime planned for 2019–20.*

6. **The Commission has more work to do to ensure it has the wide range of intelligence it needs to identify early warning signs of poor care.** Around 20% of the Commission's re-inspections are in response to receiving information of concern. The Commission collects information from a wide range of sources including: the public; whistleblowers; other health bodies and local Healthwatch organisations; the health and local government Ombudsmen; and professional regulators (e.g. the General Medical Council). However, the Commission's relationships with local Healthwatch organisations are variable; there has been a recent decline in the number of whistleblowers providing information to the Commission; and while the Commission is increasingly seeing clinical commissioning groups as a source of information, there is variation in the extent to which individual groups share information with local inspection teams.

Recommendation: *The Commission should set out in its Treasury Minute response how it intends to strengthen local relationships and the information it collects including how it will: work with NHS England to ensure clinical commissioning groups are sharing intelligence on local services; reduce the variation in relationships with local Healthwatch organisations; and ensure that whistleblowers feel confident to contact the Commission with any concerns they have.*

1 Current performance

1. On the basis of a Report by the Comptroller and Auditor General, we took evidence from the Care Quality Commission (the Commission) and the Department of Health and Social Care (the Department) on the Commission's regulation of health and social care.¹

2. The Commission is the independent regulator of health and adult social care in England. It is a non-departmental public body accountable to Parliament, sponsored by the Department. The Commission has two main purposes: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care; and to encourage providers to improve the quality of care.²

3. The Commission registers, monitors and inspects providers, and publishes its assessments and provider ratings. It can also take enforcement action when care falls below fundamental standards. The Commission regulates providers across three sectors:

- Hospitals—including NHS acute, community and mental health hospitals; ambulance services; and independent sector hospitals;
- primary medical services—including GP practices; GP out-of-hours services; dental practices; prison healthcare services; urgent care centres; and independent consulting doctors; and
- adult social care services—including nursing homes; residential care homes; domiciliary care services; hospices; and supported living services.³

4. This Committee reported on the Commission in 2012 and again in 2015. In 2012, the Committee raised serious concerns about the Commission's governance, leadership and culture. In 2015, it found the Commission had made substantial progress since 2012, but there remained issues with: staffing levels; the accuracy and timeliness of inspection reports; its capacity to take on new responsibilities; and how it measures its own performance.⁴ We recognise that the Commission has continued to improve as an organisation since the previous Committee reported in 2015.⁵

Publication of inspection reports

5. In December 2015 the Committee recommended that the Commission should ensure it published its reports more quickly after completing its inspections.⁶ The Commission's performance has generally improved in both the adult social care and primary medical services sectors since 2015. Compared with a target to publish 90% of reports within 50 days, in quarter one 2017–18 it achieved 83% for adult social care reports and 64% for primary medical services reports. This compares with 67% and 50% respectively during

1 Report by the Comptroller and Auditor General, [Care Quality Commission – regulating health and social care](#), Session 2017–2019, HC 409, 13 October 2017

2 [C&AG's Report](#), paras 1.1–1.2

3 [C&AG's Report](#), paras 1.3–1.4

4 The 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, HC 1779, 30 March 2012; The Committee of Public Accounts, *Care Quality Commission*, Twelfth Report of Session 2015–16, HC 501, 11 December 2015

5 Q 32; [C&AG's Report](#), para 25

6 See Footnote 4

2015–16.⁷ The Commission acknowledged that performance in the hospital sector is markedly worse. The Commission aims to publish 90% of hospital reports within 50 days, where the inspection covers fewer than three core services, and 90% within 65 days, where the inspection covers three or more core services. In quarter one 2017–18, it achieved 25% and 38% respectively against these targets.⁸ The Commission explained that hospitals are complex organisations and this adds to the size and complexity of inspection reports.⁹

6. Delays in publishing reports means that information is not provided to the public in a timely way. Delays can occur due to: inefficient processes within the Commission; time taken to resolve comments from providers on the factual accuracy of reports; delays because of enforcement actions (for example, because of the need to seek legal advice); and issues with the technology to support report writing.¹⁰

7. The Commission set out its plans to improve its performance on hospital reports. It told us that it is: looking to produce shorter reports; learning from areas of good practice within the Commission; and setting out more clearly the role of inspectors and how other staff can support them in writing reports. The Commission stated that it has also streamlined some of its quality assurance processes, although it is conscious that it needs to strike the right balance between improving the timeliness of reports and maintaining quality and consistency.¹¹ The Commission also highlighted that its revised approach to inspecting hospitals will mean smaller inspections, with fewer individual services inspected, and this will also improve the speed with which reports are published.¹² The Commission committed to publishing at least 50% of hospital inspection reports within its timeliness targets by 2018–19.¹³

8. The Commission explained that where there are concerns around safety following an inspection, it writes to the hospital immediately after the inspection setting out the issues and the actions it expects the hospital to take.¹⁴ The Commission confirmed that it does not publish these letters as the current regulations do not allow it to make public any enforcement actions it intends to take before taking the action. It said that many hospitals make the letter public by presenting it at the public session of the hospital's board meeting.¹⁵

Regulating GP practices

9. In its comprehensive inspection and rating programme, the Commission has rated nine out of ten GP practices as either good or outstanding. The Commission stated that, while this is a good news story, its inspections had still found poor and unacceptable services which had not been highlighted before.¹⁶

7 [C&AG's Report](#), para 2.17, figure 3

8 Qq 37–38; [C&AG's Report](#), para 2.17, figure 3

9 Qq 38, 45

10 [C&AG's Report](#), para 2.17

11 Q 37

12 Qq 39–40

13 Qq 41–42

14 Q 44

15 Qq 110–111

16 Q 105

10. The Commission's own provider survey shows that GPs view the Commission's regulation less favourably than other sectors. For example, in the Commission's 2017 survey, 42% of primary medical services providers (mostly made up of GP practices) agreed that enforcement action is effective in encouraging compliance, compared to 74% of adult social care providers and 72% of hospitals. In addition, while most adult social care and hospital providers thought that the Commission's inspections or inspection reports helped them to identify or make improvements, this was only the case for a minority of primary medical services providers.¹⁷

11. While the Commission thought these poor survey results were partly due to GPs being regulated by an external independent regulator for the first time, it acknowledged that it needed to improve how it regulates GP practices.¹⁸ It is meeting regularly with the Royal College of GPs and the British Medical Association to discuss how to work together to make improvements. The Commission highlighted areas for improvement including: reducing the regulatory burden on GP practices, for example, when registering simple changes to a GP practice partnership; and ensuring that the data it collects and publishes on GP practices is relevant to practices.¹⁹

12. The Royal College of GPs submitted written evidence which described the good working relationship between the Royal College and the Commission and was positive about the Commission's plans to move to a more proportionate regulatory approach. However, it did also state that there remains work to do. For example, the Royal College commissioned a survey of 316 GP practices in 2015 which showed that, whilst 88% of respondents agreed with regulation in principle, 74% felt that changes were needed to the Commission's current approach.²⁰

17 Q 104; [C&AG's Report](#), para 2.22, 2.24

18 Qq 104, 106

19 Qq 50, 104, 107

20 Q 105; Royal College of General Practitioners ([CQC0001](#))

2 Future Challenges

13. In May 2016, the Care Quality Commission (the Commission) introduced its five-year strategy for 2016–2021. It aims to deliver “a more targeted, responsive and collaborative approach to regulation”, including more targeted use of inspections and a more intelligence-driven regulatory approach. The strategy does not fundamentally change the Commission’s purpose, role or regulatory model. As part of its five year strategy the Commission intends to change the frequency and depth of its inspections including: extending the period between inspections for ‘good’ and ‘outstanding’ providers; and undertaking shorter, more focused inspections where appropriate. The Commission’s budget is set to reduce by 13% from £249 million in 2015–16 to £217 million in 2019–20. It expects around half of its cost savings to come from reducing staff.²¹

Inspection staffing levels

14. In January 2017, the Commission completed its comprehensive inspection and rating programme, comprising inspections at more than 28,000 provider locations between October 2014 and January 2017. All providers registered with the Commission had therefore been through the new inspection regime introduced by the Commission in 2014.²²

15. The Commission explained that the frequency with which it re-inspects services is now based on the current inspection rating, along with reactive inspections if it is aware of particular concerns. For example, for adult social care services, it will re-inspect services rated ‘inadequate’ within six months and in certain cases more quickly. It will re-inspect services rated ‘requires improvement’ within 12 months and services rated either ‘good’ or ‘outstanding’ within two years.²³ By 2019–20, the Commission plans to extend the re-inspection time period for ‘good’ and ‘outstanding’ adult social care services to two and a half years and three years respectively as it improves its information systems and the information it collects from providers. Hospitals will receive an approximately annual inspection covering how well-led the hospital is and a minimum of one individual service; re-inspection of individual hospital services will also be based on their previous rating or can be reactive. The Commission set out that approximately one in five of its inspections is reactive, that is in response to it becoming aware of information of concern rather than carried out at a pre-defined interval.²⁴

16. The Commission’s vacancy rates for inspectors and inspection managers have fallen significantly since 2015. In June 2017 vacancy rates were 6% for inspectors and 0% for inspection managers compared with 34% and 35% respectively in April 2015.²⁵ The Commission stated that the number of inspectors has increased from 846 full-time equivalent inspectors in 2012 to 1,370 as at 1 April 2017. It has plans to recruit a further 280 inspectors by March 2019 and does not have any current restrictions on recruitment. The Commission said that it is confident it currently has broadly the right level of staffing.²⁶

21 Q 35; [C&AG’s Report](#), paras 4.2–4.3, 4.7, figure 14

22 Q 32, [C&AG’s Report](#), para 2.14, figure 7

23 Q 57

24 Qq 80, 92–93; [C&AG’s Report](#), para 4.7, figure 14

25 [C&AG’s Report](#), para 3.6

26 Qq 33–34

17. The Commission stated that in the longer-term, to live within its reduced budget, it does have plans to reduce staffing levels. It explained that this will be achieved through moving to the risk-based approach to regulation outlined in its strategy.²⁷ The Commission set out how it plans future staffing levels. This is based on calculating the number of frequency-based inspections it will undertake according to the current rating profile of providers and then factoring in the number of reactive inspections it estimates it will undertake. From this total number of inspections, it calculates the number of inspectors it needs and the resulting budget.²⁸

18. The Commission thought that its current planning assumptions were reasonable, including that the profile of provider ratings would remain the same in the future.²⁹ However, it also highlighted that it is beginning to see a deterioration in some providers with ratings reducing from 'good' to 'requires improvement', as noted in its annual State of Care report. As a result, it was having to re-inspect a greater number of services than it had planned for at the beginning of the financial year. The Commission confirmed that if the profile of ratings did change it would need to revisit its planning assumptions and that it was monitoring this.³⁰ The Commission expressed the view that the health and social care system does need more funding, but this funding needs to go into a reformed system.³¹

19. The Department of Health and Social Care (the Department) stated that the Commission had historically underspent against its budget, so funding had not been a constraint on activity. It confirmed that if funding was becoming a constraint this would prompt a discussion between the Department and the Commission to ensure that what was being asked of the Commission and its level of funding remained aligned.³²

Information systems

20. The changes that the Commission is planning to make to the frequency and depth of its inspections depend on making improvements to its information systems. The Commission recognised the importance of getting the timing right between changing its inspection regime and having the information systems in place to support this.³³

21. The Committee has highlighted before the impact of not getting the timing right when introducing changes, for example in its report Quality of service to personal taxpayers and replacing the Aspire contract. The report found that HM Revenue & Customs released too many staff too soon because it was over-optimistic about how quickly the demand on its call centres would fall following the digitisation of its services.³⁴

22. The Commission set out that much of its registration system remains paper based. At present around 50% of its registration applications are completed on-line. Where applications are undertaken on-line around 70% do not need any further action before

27 Qq 35, 64

28 Qq 61–62

29 Qq 87, 89

30 Q 63

31 Q 103

32 Qq 64, 114

33 Q 76, [C&AG's Report](#), para 4.7, figure 14

34 Committee of Public Accounts, Quality of service to personal taxpayers and replacing the Aspire contract, Thirteenth Report of Session 2016–17, HC 78, 20 July 2016.

being processed compared with only around 40% of application forms sent by email.³⁵ The Commission explained that it has put in place a registration improvement programme to digitise its processes and is also making changes to its underlying process, for example, extending the time period to undertake Disclosure and Barring Service (DBS) checks when a GP practice partnership changes.³⁶

23. The Commission confirmed it has purchased an off-the-shelf software package in February 2016 to enable it to analyse and quantify the text based information it receives from the public through its website. The Commission explained that the software is not intuitive and it needed to train staff to use it.³⁷ The Commission also stated that its processes for collecting information from adult social care providers will become digital in January 2018 with an ambition for GP collections to be digital by April 2018. This will allow providers to submit information in real-time rather than through an annual collection.³⁸

24. The Commission explained it has been developing its ‘Insight’ model which supports inspectors by drawing information together on individual providers from different sources. It also highlighted that, for GP practices, this information is available on its website to allow practices to benchmark themselves against others.³⁹

25. The Department and Commission confirmed that the Commission is testing its systems as it develops them with support from the Department’s digital assurance teams and the Cabinet Office.⁴⁰ The Commission confirmed that it has established a digital strategy to support its ambition for a more intelligence-driven regulatory approach and that it had agreed this strategy with its board.⁴¹ The Commission explained that its strategy has two key elements: first, to strengthen its digital infrastructure; and second, to ensure it is collecting the right information and using it effectively. To support the implementation of the strategy, the Commission has made two key appointments: a chief digital officer (jointly with NHS Improvement) and a director of intelligence.⁴²

Sources of information

26. The Department highlighted that regulators across all sectors need a wide range of information sources to effectively assess the risk of providers. The Commission confirmed that over the last six months it had brought forward 230 inspections as a result of information from the public raising concerns about a provider, and that approximately 20% of its inspection activity is reactive inspections when it receives information of concern.⁴³

27. The Commission confirmed that it receives information from a wide range of sources including: the public through its ‘tell us about your care’ webpage; whistleblowers; local Healthwatch organisations; the Parliamentary and Health Service Ombudsman, and

35 Q 48

36 Qq 47, 50

37 Qq 68, 75; [C&AG’s Report](#), para 2.13

38 Qq 72, 76

39 Q 71

40 Qq 54, 77–79

41 Qq 65–66

42 Qq 65–69, 72; [C&AG’s Report](#), para 4.7

43 Qq 80–82, 92–93

the Local Government and Social Care Ombudsman; other professional regulators such as the General Medical Council and Nursing and Midwifery Council; and clinical commissioning groups.⁴⁴

28. The Commission stated that, while it has looked to formalise its relationships with local Healthwatch organisations, relationships remain variable.⁴⁵ In Healthwatch England's 2016 survey, 65% of local Healthwatch organisations said that they had a very or fairly good relationship with their local inspection team, while 55% felt that the Commission used their information to inform its work.⁴⁶

29. From 2015–16 to 2016–17, the number of whistleblowers contacting the Commission had declined by 16%. The Commission claimed that the number of referrals of concern from whistleblowers was higher in 2016–17 when compared to 2012–13.⁴⁷ It confirmed whistleblower information had resulted in it bringing forward inspections. However, the Commission also acknowledged that this is an area where it needs to do more work. It is reviewing its whistleblowing policy and will be carrying out quality reviews of how it deals with individual whistleblowing cases. Its ambition is to ensure whistleblowers feel confident in approaching the Commission and that the Commission uses the information they provide.⁴⁸

30. The Commission confirmed that it works with clinical commissioning groups and is increasingly seeing them as a source of information, particularly with regard to GP practices.⁴⁹ However, there is still variation in information-sharing between the Commission's local inspection teams and other bodies such as Clinical Commissioning Groups.⁵⁰

Local system reviews

31. The Commission explained that under its current legal framework it regulates individual organisations rather than health and social care systems and that it has no plans to change this approach. It stated that it is monitoring how new models of care develop and is preparing for potential new legal entities to be established, such as Accountable Care Organisations.⁵¹

32. The Commission confirmed that when it inspects individual organisations, particularly hospitals, it expects them to be able to demonstrate how they are collaborating with other areas of the health and social care system. It had been specifically requested by the Secretary of State for Health to undertake 20 local system reviews using powers under section 48 of the Health and Social Care Act 2008. The Department provided additional funding for these reviews.⁵² The Commission has now produced an interim report setting out the key findings from the first six reviews.⁵³

44 Qq 80–83,

45 Q 82

46 [C&AG's Report](#), para 2.11

47 Q 83; [C&AG's Report](#), para 2.19

48 Qq 83–86

49 Q 82

50 [C&AG's Report](#), para 2.11

51 Q 96

52 Qq 97, 99

53 Care Quality Commission, [Local system reviews: Interim Report](#), published December 2017

33. The Commission felt that it was important that there was oversight of how local health and social care systems are working, in addition to inspecting individual organisations. However, it stated that there would need to be a change in the legislation if the Commission was to inspect and rate local health and social care systems, and use its enforcement powers. This would require agreement by the Secretaries of State for both the Ministry for Housing, Communities and Local Government and the Department of Health and Social Care.⁵⁴

Formal Minutes

Wednesday 28 February 2018

Members present:

Meg Hillier, in the Chair

Bim Afolami

Anne Marie Morris

Sir Geoffrey Clifton-Brown

Lee Rowley

Gillian Keegan

Draft Report (*Care Quality Commission: regulating health and 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 33 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twenty-fourth 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.

[Adjourned till Monday 5 March 2018 at 3.30pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 13 December 2017

Question number

Sir David Behan, Chief Executive, Care Quality Commission, **Lee McDonough**, Director General for Acute Care and Workforce, Department of Health, and **Sir Chris Wormald**, Permanent Secretary, Department of Health

[Q1-117](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

CQC numbers are generated by the evidence processing system and so may not be complete.

- 1 Dr Minh Alexander ([CQC0003](#))
- 2 NHS Providers ([CQC0002](#))
- 3 Royal College of General Practitioners ([CQC0001](#))

List of Reports from the Committee during the current session

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Tackling online VAT fraud and error	HC 312 (Cm 9549)
Second Report	Brexit and the future of Customs	HC 401 (Cm 9565)
Third Report	Hinkley Point C	HC 393 (Cm 9565)
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396 (Cm 9575)
Fifth Report	Managing the costs of clinical negligence in hospital trusts	HC 397 (Cm 9575)
Sixth Report	The growing threat of online fraud	HC 399 (Cm 9575)
Seventh Report	Brexit and the UK border	HC 558 (Cm 9575)
Eighth Report	Mental health in prisons	HC 400 (Cm 9575)
Ninth Report	Sheffield to Rotherham tram-trains	HC 453 (Cm 9575)
Tenth Report	High Speed 2 Annual Report and Accounts	HC 454 (Cm 9575)
Eleventh Report	Homeless households	HC 462 (Cm 9575)
Twelfth Report	HMRC's Performance in 2016–17	HC 456
Thirteenth Report	NHS continuing healthcare funding	HC 455
Fourteenth Report	Delivering Carrier Strike	HC 394
Fifteenth Report	Offender-monitoring tags	HC 458
Sixteenth Report	Government borrowing and the Whole of Government Accounts	HC 463
Seventeenth Report	Retaining and developing the teaching workforce	HC 460
Eighteenth Report	Exiting the European Union	HC 467

Nineteenth Report	Excess Votes 2016–17	HC 806
Twentieth Report	Update on the Thameslink Programme	HC 466
Twenty-First Report	The Nuclear Decommissioning Authority's Magnox	HC 461
Twenty-Second Report	The monitoring, inspection and funding of Learndirect Ltd.	HC 875
Twenty-Third Report	Alternative Higher Education Providers	HC 736
First Special Report	Chair of the Public Accounts Committee's Second Annual Report	HC 347



HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Care Quality Commission, HC 465

Wednesday 13 December 2017

Ordered by the House of Commons to be published on 13 December 2017.

Watch the meeting

Members present: Meg Hillier (Chair); Geoffrey Clifton-Brown; Chris Evans; Gillian Keegan; Shabana Mahmood; Nigel Mills; Gareth Snell.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Robert White, Director, NAO, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-117

Witnesses

[I](#): Sir David Behan, Chief Executive, Care Quality Commission, Lee McDonough, Director General for Acute Care and Workforce, Department of Health, and Sir Chris Wormald, Permanent Secretary, Department of Health.



HOUSE OF COMMONS

Reports by the Comptroller and Auditor General

Capacity and capability to regulate the quality and safety of health and adult social care (HC 271)

The Care Quality Commission: Regulating the quality and safety of health and adult social care (HC 1665)

Examination of witnesses

Witnesses: Sir David Behan, Lee McDonough and Sir Chris Wormald.

Chair: Welcome to the Public Accounts Committee on Wednesday 13 December 2017. We are here today to consider the National Audit Office's Report into the Care Quality Commission. This is the third time that this Committee has looked at the Commission since it was established in 2009; I am a veteran of those two previous appearances. We were pleased to see that there has been some progress.

Let's face it, the Care Quality Commission had a rocky start—it took six years to get going. It is good that there has now been a completion of the new inspection and rating regime. We know that there are challenges meeting the performance indicators. In particular, there have been delays to the publication of inspection reports relating to the 50-day limit. There are some big challenges ahead as the Commission moves to a more intelligence-led regulation approach, at the same time as having a funding cut by 2020 of 13%.

There is a lot to get our teeth into this afternoon. Before I do that and introduce our witnesses, I will just alert the Permanent Secretary that I have got a couple of questions, as you might expect, about some of the other issues relating to health that have been around in the last few weeks. That gives the others a moment to pause.

From my left to right, Lee McDonough is the Director General for the Acute Care Workforce at the Department of Health. Is it your first time in front of us, Ms McDonough?

Lee McDonough: Yes.

Q1 **Chair:** Welcome. We are a very friendly team here. Chris Wormald is the Permanent Secretary at the Department of Health. Sir David Behan—you have been knighted since we last saw you—is the Chief Executive of the Care Quality Commission. For anyone following on Twitter, our hashtag today is #CQC.

Let me ask first about the shared business services, Sir Chris. The last time you were in front of us, Simon Stevens said that they had found 164,000 extra pieces of correspondence. Have you got any update on what progress has been made on delving into those pieces of correspondence? Have any further problems arisen?



HOUSE OF COMMONS

Sir Chris Wormald: I am not aware of any further problems.

Chair: That is good news—bank that one.

Sir Chris Wormald: NHSE plans to come back to the Committee with a further update. I don't have an update today. They are carrying out the planned work that they described at the previous hearing, and are doing so with urgency.

Q2 **Chair:** So at the moment you are content with how it is going.

Sir Chris Wormald: As I hope we made clear at the hearing, no one is content with the situation we found ourselves in. The hearing was very fair in terms of how that situation came about, and we are putting all our efforts into the remedial action, which is led by NHSE. As I said, they promise to keep you updated.

Q3 **Chair:** Okay. For those who do not always know the jargon, NHSE is NHS England, which Simon Stevens heads up. As you know, we are watching this closely, and we expect to look again at around Easter time when the National Audit Office has looked into this. We asked, and they are very happy to do that. We remain concerned, and we will hopefully pick up recommendations we can make to the Department about how to ensure this doesn't happen in the future.

I want to come on to some serious issues that have arisen this week. Sir Bob Kerslake—a former colleague of yours in Whitehall, Sir Chris—has just resigned as chair of King's NHS trust in south London. He said: "Ministers are in denial about the reality of how much extra money the NHS requires". He said that we "need a fundamental rethink. Until then, we are simply kicking the can down the road."

Look at the people over recent months who have raised concerns about the amount of money available for the NHS. Let me just list a few: Simon Stevens, chief exec of NHS England, Malcolm Grant, Sir Bruce Keogh, Sir Bob Kerslake—I have mentioned him, obviously—Jim Mackey, the outgoing chief exec of NHS Improvement, the King's Fund, the Nuffield Trust and NHS Providers. That is just some of them. Mr Wormald, do you think Ministers are in denial about the amount of money available for the NHS and current demand?

Sir Chris Wormald: No. It will not surprise you that I don't. We don't agree with a number of the comments that Bob Kerslake made. The circumstances around his departure have been widely discussed in the press, and indeed were debated in the House yesterday. I won't add to that, other than to say that there was a series of very specific problems at King's relating to its financing.

In terms of the wider debate, it is not a secret that a number of people in the NHS have argued for more resources. The Government responded in the last Budget—

Chair: We know—with £1.6 billion.



HOUSE OF COMMONS

Sir Chris Wormald: With a really rather significant, in the circumstances, set of additional investments in the NHS.

Q4 **Chair:** We know about that money, Sir Chris. Are you, as Permanent Secretary, convinced that for the current demands on the NHS, the money available is enough to deliver all that is currently required to be delivered?

Sir Chris Wormald: We believe that the NHS mandate can be delivered for the resources—that is how we set the mandate.

Q5 **Chair:** What about rationing of services? Simon Stevens has been open about saying that there needs to be a discussion about what the NHS continues to do. Is that in your mind as well?

Sir Chris Wormald: Yes. We discuss with the NHS the entire time—specifically, when we discuss the annual mandate—what is a reasonable ask for the NHS for the resources that we make available. That discussion goes on all the time, and what Simon Stevens, the Chief Executive of NHS England, and his colleagues were pointing to is that, as we have discussed with this Committee on a number of occasions, you have to make prioritisation decisions. That is not the same as rationing in the clinical sense, but of course we have to work within limited resources, which are clearly not as much as some in the NHS were asking for.

Q6 **Chair:** So where have the discussions about what prioritisation should take place in any of the areas reached so far?

Sir Chris Wormald: They happen annually as part of the mandate setting process. We are in discussion with all relevant bodies in the NHS about next year's mandate and what can be achieved for the money that is made available.

Q7 **Chair:** Do you think that you and Ministers have a role in engaging the public in this discussion? Should the discussion be wide and all-encompassing or will you go away into a room with Simon Stevens and come out with a solution at the end?

Sir Chris Wormald: The formals, as set out in the 2012 Act about how the mandate is decided, are that it is a discussion and consultation between the Department and NHS England. If there are big changes to the mandate, there is a public consultation process. One thing there is not a lack of in the health debate is public debate, parliamentary scrutiny and a wide debate about what should happen.

Chair: We are part of that parliamentary scrutiny.

Q8 **Geoffrey Clifton-Brown:** Sir Chris, shortages of about 100 important key drugs seem to have arisen in the last six months and are causing huge pricing increases. They have probably cost the NHS £180 million so far; some drugs are up 4,000% in price. When did you become aware of that emerging problem and what are you doing about it?

Sir Chris Wormald: I will not give you a date when we became aware, but I will write to you with exactly when we identified the problem.



Q9 **Chair:** Just to give an idea of dates, is it months or weeks?

Sir Chris Wormald: Months. This is an issue we have been looking into for a while. The issue arises in the generic part of the market where it is the market that sets the price. It is not like the newly branded drugs where we have a role in the price setting; prices are controlled by the action of the free market.

Clearly, there are some problems in the market and there is a shortage of some drugs. As in any market, that causes price rises. We have been in discussion with the industry about what we can do about that, but all our levers are quite informal as you would expect in a market situation. It is something the Department is aware of and in discussions about, but there is not an obvious solution because it is a question of supply and demand in a generic market.

Q10 **Geoffrey Clifton-Brown:** In the case of the specific drug, quetiapine, which is an anti-psychotic drug and really important for mental health, the price has risen from £1.62 to a staggering £65. That cost the NHS an extra £32.1 million in April and £53 million in June. These are really significant increases and, given that the whole winter provision for the NHS is only an additional £200 million, there is a real concern that these price rises will mop that up in no time.

Sir Chris Wormald: We share your concern. I will not comment on individual drugs because I do not have the information in detail straight in front of me. Of course in a market, prices go up and down: in some cases we pay less than we would expect for drugs and in some cases more. Your question is pertinent, however, because quite clearly there have been individual drugs where the rises have been quite spectacular.

There are cases of drugs where—I go well beyond my competence here—it is very difficult for an individual patient to switch drugs, for a variety of reasons, and therefore it is very difficult not to pay the market price. That is why this becomes such a difficult issue. As I say, it is an issue that the Department is fully engaged on but, given that the prices are, as it were, set by the market and in the end you have to buy a needed drug or not, obviously we have to balance the commercial and financial effect of purchasing a drug against the clinical effect of not purchasing it. Those are not easy decisions.

Q11 **Geoffrey Clifton-Brown:** Presumably, the NHS is a very big purchaser of these drugs. I bet most of these manufacturers are selling more than one drug to the NHS. Can you not use your bulk-buying might to negotiate with these suppliers?

Sir Chris Wormald: Those are the types of discussions that we do have, but do remember that this is a world market—these are generic drugs sold all over the world, which have a market price and of which, although we are a big buyer, we are not a colossal buyer.

There have been some genuine issues in the market, particularly around supply—basically, failure of a series of regulatory tests, so there was actually a decline in supply of various of the drugs in question. So can we



HOUSE OF COMMONS

have the kinds of conversation you are suggesting? Do we have those with the market? Yes. What there isn't is a sort of silver bullet where Government can act—

- Q12 **Geoffrey Clifton-Brown:** The other even more worrying aspect of all this is shortages for patients. There have been anecdotal stories of them going to the pharmacy and the pharmacy saying, "Well, can you make do until Friday?", but if you are on a vital anti-psychotic drug or an anti-tumour drug for a particular form of cancer, it is really serious news if you have to wait a day or two. What can be done in those cases to make sure that they never actually run short of drugs?

Sir Chris Wormald: Again, your question is spot on. We have seen the same reports of those issues as you. I don't think we have had reports of them being widespread. Of course, that is related to the price you are prepared to pay to get said drugs when they are at shortage—

- Q13 **Geoffrey Clifton-Brown:** May I interrupt you there? It is nothing to do with the price you are prepared to pay. If the individual goes along to the pharmacy and the pharmacy says, "Sorry, you're going to have to wait till Friday for this drug", that is nothing to do with the price; that's to do with the supply to the pharmacy.

Sir Chris Wormald: Oh yes, but sorry, the price is going up because the supply is short. That is the underlying problem—not enough of the drug is being made and therefore, as in any other market, the price rises. As I say, this is a straight free market in which we buy, which normally works in our favour. Compared with our international competitors, we buy more of our supply from generic sources and that is normally cheaper. In this case, the market is against us.

But I am not disagreeing with any of the issues that you raised. These are very serious issues. The Department is engaged on them. What there isn't is a sort of simple solution, given that we are a buyer in a market, just like everyone else.

- Q14 **Geoffrey Clifton-Brown:** The final question on this: we have all agreed that it is a serious issue, so when do you expect to resolve it? When will you be able to report back to this Committee that you have made progress?

Sir Chris Wormald: As you have shown a keen interest, I will write following this hearing on the exact position. But it is not the kind of issue where there is a date on which you solve it; we are continuously buying in a market, and we are taking decisions about what price we will buy at monthly. It is a big, complicated process by which we do it. So we would want to see those prices coming down again, clearly, for all the reasons that you say. We also want to see the supply secured, also for the reason that said. It is not an issue where you would name a date and it would end. We want to see the market working properly and prices therefore returning to that level.

- Q15 **Geoffrey Clifton-Brown:** Understood. If you undertake to write to the Committee about the problem, and then keep us updated, that would be



HOUSE OF COMMONS

helpful.

Sir Chris Wormald: Yes, that's fine. I just want to be clear that it is not the kind of thing where the Government announces an answer one day.

Q16 **Chair:** We appreciate that there are complexities, but obviously this is a vital and sensitive part of the NHS. As Mr Clifton-Brown highlighted, we have been one of the bigger purchasers. I am sure that we will be liaising with our sister Committee, the Health Committee, to keep an eye on this issue, because it is pretty critical.

Before we get on to the main hearing, let me finish with another key point. You talked about earlier about the £1.6 billion for the NHS and how it would enable the NHS to meet its mandate this year, but we have seen clear evidence of the stress on A&E recently, with over 3 million patients visiting UK A&Es waiting for more than four hours in the past 12 months. That is a 120% increase since 2012-13, but the number of visits has risen by just over 7%, so there is not just a direct correlation with more people attending A&E. Will A&E be able to cope with winter?

Sir Chris Wormald: As we discussed with this Committee before, we believe that the NHS is better prepared for winter than it ever has been before. The strains you described are real and we have never denied that.

Q17 **Chair:** Taj Hassan, the president of the Royal College of Emergency Medicine, was quoted as saying that the A&E system had been "stretched to its very limits". Anyone who has been to A&E recently would confirm that.

Sir Chris Wormald: As I said, we have never denied that the NHS is under pressure, and it is particularly under pressure over winter. In the Budget, the Chancellor put more money in this year, including specifically for resources for winter.

Q18 **Chair:** May I just pick you up on that? It is all very well announcing money for this winter in the Budget, but you would need to spend that at an enormously fast pace to get the right specialists in place to make sure that A&Es can turn patients round fast enough. The BBC's analysis suggested that you would need another 20 A&Es staffed by at least 170 consultants to hit the target again, if you are not moving people through at the pace that the four-hour target demands.

Sir Chris Wormald: Just to be clear, the way this has worked is that winter money was always built into the budget. It was given out every winter. A couple of years ago, the system was changed so that that money was put in at the beginning of the year as part of a baseline budget, so that it could be spent at a reasonable speed.

Q19 **Chair:** But winter money doesn't create more beds. When you are in a hospital such as my local, the Homerton, which is chock-full and does not have spare beds, where do you put people? You have to have the beds and money in place as a back-up to get people out of A&E.

Sir Chris Wormald: That's why the "usual" winter money was put in the baseline at the beginning of the year, so that capacity could be created in



HOUSE OF COMMONS

advance. This money is in addition to that. You can do some short-term things to create extra capacity. As you know, we have been working with local authorities and others to try to reduce the number of delayed transfers of care. We have had some success with that. The NHS will be putting in extra emergency beds. We have also just begun our advertising campaign—

Q20 Chair: The delayed transfers of care deals with older people, but a lot of other people in hospital need to be transferred. When you talk about other options for the extension of emergency beds, can you clarify precisely what you mean? What practical things are being done? Where are they going to be placed?

Sir Chris Wormald: Yes. Where hospitals have, for example, mothballed beds previously, they can be reopened—

Chair: Sorry, “mothballed” beds?

Sir Chris Wormald: Where you have wards that have previously closed, you can reopen them. Individual hospitals can do various things. We set out in our winter plan a whole range of those things. As I said, we and the NHS believe that it is better prepared than it has been ever before, but there are clearly strains on the system and it will be difficult.

Q21 Chair: If you talk to people on the ground, as some of the BBC’s recent analysis has, the hard-working staff feel stretched to breaking point. Wards are full. There are no beds to refer people on to. It is easy for you to sit there and say all that, but when you are actually at the sharp end, it is very challenging. Talking about opening mothballed beds does not provide the staff that are necessary to make sure that people get the treatment they need when they need it.

Sir Chris Wormald: No, and those are some of the reasons why we are putting in new resources. Sorry, but I am not trying to deny that there are strains and difficulties in the system. The people at NHS Improvement who are in charge of this are people from the sharp end. They are people who have run hospitals and A&E departments; they are taken from the service. They are not people who are in any way disconnected from the frontline; they understand all these strains and challenges. I couldn’t disagree with you about the pressures on frontline staff; there quite clearly are pressures. I think NHS Improvement and their colleagues do understand those pressures and have the right plans to mitigate them, but that does not stop it being very difficult.

Q22 Gareth Snell: Let me give you an example. My local hospital in Stoke-on-Trent reported 100% capacity at the weekend because we had snow. The four-hour waiting time target was breached in numerous cases. The staff are working flat out. How quickly will the money announced by the Secretary of State to go into the system this year have reached Stoke-on-Trent to provide extra capacity? The reality is that there aren’t any mothballed beds and there are more people needing care, so how is that money going to help and how quickly will it have arrived? If I go to meet my local chief exec tomorrow, will she be able to tell me that she has had extra cash as a result of that announcement?



HOUSE OF COMMONS

Sir Chris Wormald: Probably not tomorrow, but probably in the next few days.

Q23 **Gareth Snell:** But the crisis hit last weekend, so the fact that the money is there in the next few days does not help what happened this weekend. And winter has been here for a while—they come round quite frequently.

Sir Chris Wormald: Yes, and the winter plan that I was describing has been worked up with the health service since last winter. The extra resources, which were very welcome, that the Chancellor put in the Budget are additional to the plan we had in place already, and we will get that out to individual hospitals as quickly as we can. That should be in the next few days.

Q24 **Chair:** I want to pick up on what Mr Snell said about where you get the resources and the people in short order to fill places where there aren't mothballed beds. When we talk about planning, we always talk about older people, but let's just take paediatrics. If you talk to any paediatric nurse, they will say that bronchial issues mean that the ward fills up very quickly. Does the Department have any planning to make sure that some of those children don't ever need to go to A&E and on to a ward, because there are ways of treating them in the community? There may be other solutions. We always talk about older people, but what about the other, different specialisms?

Sir Chris Wormald: Yes, and that sort of issue is what the winter plan that the NHS has developed is all about. The Chancellor chose to enhance that plan with some additional resources, on top of the planning that had already been put in place, which is seeking to address exactly the types of issue that the Committee is raising. As I said, it is not easy, for all the capacity reasons that you are quoting, but there is a plan. The NHS and we have confidence in it, and that is what we will roll out over the winter.

Q25 **Gareth Snell:** A final point. How much of the extra money announced by the Chancellor has actually reached the frontline already?

Sir Chris Wormald: I don't think any of it will have reached the frontline already, because we are allocating it in the next few days via NHSI. Lee, is that correct?

Q26 **Chair:** Lee McDonough, can you shed some light on this?

Lee McDonough: That is correct. Pauline Philip, the national director appointed by NHS Improvement and NHS England to oversee the winter plans, has been engaging with each trust to discuss with them their specific, individual plans and requirements to access the money. There is a panel process to oversee that, which has happened, and I think it will be releasing the money in the next couple of days.

Q27 **Gareth Snell:** Given that it is now 13 December, how long is that process going to take and when will all that money have been allocated? This was an in-year allocation, so that takes us through until the end of March. If this is for winter, presumably by the end of January or by Christmas—when would you expect all that money to be out and actually being used



HOUSE OF COMMONS

to help to deliver care?

Lee McDonough: The money will be out in the next couple of days.

Q28 **Gareth Snell:** All the money will be allocated?

Lee McDonough: The money will be allocated.

Q29 **Gareth Snell:** And delivered to the frontline—not just allocated, but actually in the accounts of the places that are delivering care?

Sir Chris Wormald: Well, once trusts know that they have the money, they spend it. It does not have to have physically reached a bank account for them to spend the money.

Q30 **Chair:** Well, we promised some of our local hospitals that we were going to do some work to find out about how they are getting that money and how quickly they can spend it. As you will have picked up, the concern is that it's all very well announcing it in the Budget, but an in-year allocation is harder to spend.

Sir Chris Wormald: Well, yes. Obviously—

Chair: I think we can leave it there for now. We could go into this a lot more, but we have other important issues to discuss. Sir David Behan is sitting there very patiently, thinking he is off the hook, but I'm afraid not.

Sir Chris Wormald: I am sure he is enjoying this exchange. I will just finish with one point. The Government and the NHS have been planning for this for quite some time, and the money the Chancellor put in is additional. Yes, of course it is an in-year allocation, and that of course raises questions about how quickly it can be spent, because it doesn't go through normal systems. However, it is still much better to have that than to not have it, and it is widely welcomed in the NHS that we are putting in that extra resource.

Could they have spent it in a different way had they had it earlier? Possibly, but it is still better to have it. I do not think the generosity of the Chancellor in this case should be pushed aside.

Q31 **Chair:** Anyone will welcome more money for the NHS, but we are talking about the efficiency and effectiveness of spending that money, and the value for money. Shoving money in late, in any organisation, is not the best way of planning.

Sir Chris Wormald: We are putting it into an existing plan.

Chair: We will leave it there, but we will be coming back to this. Whether winter is over or not the next time you are here is another matter, but we will be able to assess the effectiveness of this money. Anyone out there who is a chief executive of an NHS trust is very welcome to send us any evidence about how they are getting this money and how quickly they can spend it. We would be very interested in hearing that.

I will now move us on to the main part of our hearing. I ask Mr Gareth Snell to kick off. Sir David, you need to step up now.



Q32 **Gareth Snell:** Sir David, the NAO Report that we received shows there has been some improvement since the last time your organisation was properly looked at. Can you give us an understanding of what the main driver for those improvements has been, and what specifically you think are the key achievements since the last time the Committee looked at the Care Quality Commission?

Sir David Behan: Thank you and good afternoon. I think what is behind it is just sheer hard work by the 3,000 people who work in the CQC. May I first thank Sir Amyas and his team—they are somewhere on the back row—who carried out the review? We think it is a very fair Report. It captures what we have achieved and also sets out the areas for development. The CQC board meets next week, and next Tuesday, I will take the action plan that responds to the recommendations from Sir Amyas's Report to that board in public session.

To your point on the things that were particularly significant, we achieved the first comprehensive rating programme of all health and social care services in England. It is my belief that there is not another country in the world that has that kind of baseline assessment across all health and care services. We published reports at the end of the programme that identify some of the key issues and that touch on some of the things you have just been exploring with Chris, around winter and so on.

We are also taking more enforcement action than we have done previously. In 2012, about 2.6% of all our inspections resulted in enforcement action; we are currently at about 9% of all inspections. To part of the point you have just been discussing, we published our "State of Care" report, I think both the year before and this October, which is to you in Parliament. We laid our report in Parliament on our assessment of the state of care. I am particularly pleased with our independence. There was an editorial in *The Observer* on Sunday that mainly commented on Ofsted, but one of its—

Chair: We read the papers; we do not need to have that replayed in the Committee.

Sir David Behan: The point I would just like to make in response is about our independence in relation to the assessment we made about some of the issues you have just discussed. We also published our five-year strategy last year, which we are busy delivering.

Lastly, I think we have become more efficient, as well as effective, in the way that we are delivering. We are managing our cost reductions, as the audit team referred to.

In summary, there are some achievements there that are based on hard work. We have responded to the previous challenge from the Committee and I think we have made year-on-year progress on the work that we have needed to do.

Q33 **Gareth Snell:** The 2015 NAO Report talked about staffing levels and the



HOUSE OF COMMONS

slow time it took to recruit staff. Are you now confident that you have the right level of staffing to take forward the organisation in the way that you want?

Sir David Behan: Yes. On our current staffing this year, on 1 April we had 1,370 full-time equivalent inspectors. That was up from 846 in 2012. We have a recruitment plan to recruit an additional 280 inspectors by March 2019.

We have an “always on” approach to recruitment. In addition, it is not just about inspectors; we have 106 analysts who work with us and are critical to delivering our strategy. In 2012, we had 31, so we have been quite successful. Our turnover is about 9% and our sickness rate is about 4.9%.

Q34 **Gareth Snell:** Anecdotally, it has been suggested to me that in Staffordshire, where a vacancy for an inspector has arisen—they had eight and they are down to seven—they should not be looking to fill that vacancy because part of your longer-term savings strategy is to make half the savings to your budget through staff reductions. Is that something you recognise?

Sir David Behan: I do not recognise making half our savings through staff reductions. This year, we saved £14.3 million through non-staffing costs. We will make a further investment in inspectors next year. We will do that by managing the money that we have. To the best of my knowledge, we have no restrictions on staffing levels. Currently, I am projecting an underspend on our budget.

Q35 **Gareth Snell:** The NAO suggests that you intend to make your required budget reductions from staffing, but that is not something you recognise as part of your longer-term plan for savings reductions?

Sir David Behan: Sorry, I thought you asked me whether there were restrictions on appointing staff—moving from eight to seven. That is slightly different from what we are planning to do. It is no secret that over a five year period, we are moving to a budget of £217 million in 2019-20. That will be predominantly made up of fees—£119 million—and the balance made up of a Government grant for those tasks that we carry out but for which we cannot recover a fee, such as the National Guardian service and Healthwatch England—a number of our activities. We are looking at our staffing levels and we have a trajectory around decreasing the number of staff that we have, but I have no hold on vacancies at the present.

Q36 **Gareth Snell:** Sir Chris, are you comfortable—happy, for want of a better word—with the progress that the CQC is making?

Sir Chris Wormald: We basically agreed with the findings of the National Audit Office. We believe that the CQC has made considerable progress over the last few years under Sir David’s leadership; that it knows where it needs to improve further, which is basically in the areas set out in the National Audit Office Report; and that it has a plan to do so. Although it is not perfect, we think it has moved significantly in the right direction and knows what it has to do next. We think we have a good accountability



HOUSE OF COMMONS

system in place between the Department and the CQC, which Lee might elaborate on, and we are very happy that that relationship is working. This is an organisation heavily moving in the right direction. I agree with everything Sir David said at the beginning, but there is further work to do and a plan to do so in the areas that the NAO identified.

Q37 Gareth Snell: I am heartened, Sir David, to hear you say that there are areas where there need to be improvements. Moving on to them, the starkest of the statistics provided by the NAO is the inspection report publication timescale in figure 3 on page 16 of the Report. The 2016-17 targets for publication within 50 days for hospitals with less than three core services or 65 days for hospitals with more than three core services were 70% by quarter 2 and 90% by quarter 3, but your figures are much lower than that. Can you explain why that is or give an indication of the work you are likely to undertake to improve them?

Sir David Behan: Yes. Again, I acknowledge our level of performance. We have had an improvement project in place and we take this issue very seriously. As a result of some of the work we have been doing on the improvement project, we are seeing month-on-month improvements. You identified hospitals, so let me begin there. We have looked at producing shorter reports with a clear separation between the evidence and our findings. We have got parts of the organisation that perform better than others, so we have got some good practice, which is clearly demonstrating improvements. We are being very clear about what inspectors need to do and what other staff can do to help in that process. We have streamlined some of our quality assurance processes.

I guess one of the things you want to speak to me about is consistency. There is a balance to be struck between quality assurance, which ensures consistency, and that adding time delays in. We have looked quite hard at that and we are seeing improvements take place in our reports on hospitals. In relation to adult social care—

Gareth Snell: No. If I could stay with hospitals for a minute.

Chair: Let Mr Snell continue on this point and then we can come back.

Q38 Gareth Snell: I want to stay with hospitals for a moment because the adult social care figures are not as bad as the hospital figures. You say that there have been month-on-month improvements. With the figures on page 16, particularly for the hospital reports published within 50 days, there is no marked significant improvement as a trend. You have the odd increase over 30% but that has been hovering around the mid-20% since quarter 1 of 2016-17.

When did the improvement process begin? Could you give me a figure of what you would consider to be a quantifiable achievement that shows that the programme is working and a date by when you would like to see that?

Sir David Behan: We have set our ambition for what want these reports to do. These are big, complex reports on big, complicated organisations and it is important that we get this right.



HOUSE OF COMMONS

Q39 **Gareth Snell:** Yes, but you are a big, complicated organisation that should have the resources to do that.

Sir David Behan: Yes, we are and we are working very hard to ensure that we can deliver this. We are seeing month-on-month improvements and I want to continue to see that. I am not going to set an arbitrary figure by which we will complete these reports within a given date.

I will try to address what we have done in hospitals. We have changed the way we are inspecting hospitals. We began our new inspection process from October. We will inspect how well led a hospital is and one or two or more core services. That inspection will be annual and I will see improvements in the speed at which those reports are being produced as a consequence of the change in our inspection. We will see that improvement take place over—

Q40 **Chair:** The speed will improve because they will be annual inspections?

Sir David Behan: And they will be smaller inspections, Chair. Instead of looking at comprehensive, all core services, there will be shorter inspections that will look at the leadership of the trust and the core service. For instance, if the last hospital inspection flagged a “requires improvement” around, say, children’s and maternity services but other services were good, in all likelihood we will go back and look at leadership and children’s and maternity services, not the other good services.

Q41 **Gareth Snell:** I appreciate that you do not want to put an arbitrary figure on it but there is an arbitrary figure—it is a target—and you have it in your own documents. It was suggested that you wanted to have 70% by quarter 2 and 90% by quarter 3. You are woefully far from that in both the hospital reporting programmes.

If you cannot give me an actual figure, can you at least give a range of figures? Say you were to come back in front of this Committee in 12 to 18 months, what would you consider to be a failure, had you not reached a particular target?

Sir David Behan: Clearly, as a senior team and a board, we have set a target in our business plan for this year. Let’s be unambiguous: we are missing it. We don’t like missing it and we are working very hard to try to hit it. That is what we will continue to try to do.

Q42 **Gareth Snell:** Okay. What I am trying to get from you, Sir David, is the pace of change at which you are going to achieve that target. It is all well and good saying you wish to change the reporting mechanism to have shorter reports, but if you are unable to get those reports out in good time, the length of the report is almost an irrelevance. So I’m afraid I am going to push you on this.

By what point would you expect to see, say, 50% of all the reports that you commission put out in good time? When would you expect, under your leadership, that to happen? At what point in the future would you want to say, “Right. I want to see at least half of the reports that we commission put out within the timescale that we set.”?



HOUSE OF COMMONS

Sir David Behan: I would expect that to happen during the financial year 2018-19. That is what we are working towards and I would expect you to hold me—and the organisation—to account for that at the next meeting.

Q43 **Geoffrey Clifton-Brown:** We have had an example from an individual colleague where the first inspection was carried out in July and the report was not published until December. That does seem an awful long time between inspection and publication.

Chair: Can you name the colleague?

Geoffrey Clifton-Brown: I am happy to. It is Louise Haigh, and it is the Cygnet mental health hospital in Sheffield that she is talking about. I appreciate that you may not have the details for every hospital, Sir David, but as a generality, that seems an awful long time.

Sir David Behan: It is a long time. Again, I acknowledge the issue that is flagged. We are not satisfied or happy with that, and we are working towards it. I am sorry, Chair; I cannot comment on the individual case.

Q44 **Chair:** We are not expecting you to comment, but in this case, it was not the first inspection. There has been a series, and the delay has just got longer between when the inspections happen and the reports come out. Even though the inspection team has been in, the delays have got longer.

Sir David Behan: I do not know whether there has been a difficulty with the inspection or a particular concern. I can write to the Committee about the circumstances in relation to this, but the figures that we provide are on average. Therefore, by definition, there will be reports that are delivered—in response to the previous question—well within the timescale we set. That has happened, and it was a mental health trust. I think the mental health team here published a report on the trust within 35 days. Others will take longer. That is my point about the quality assurance processes, which may take that time.

The important thing I want to stress is that where there are concerns around safety, the chief inspector writes to the trust immediately. In terms of action that we expect people to take, we are not waiting until the publication of the report before we contact the trust. That is a hugely important point from our perspective in relation to patient safety or an immediate quality issue.

Q45 **Geoffrey Clifton-Brown:** The problem is that until you publish a report, the public, who are the consumers of that particular hospital, are not aware of what action you have taken. A particular Member of Parliament, Louise Haigh, said to us that this particular hospital was “inadequate on safety grounds for 16 months, and the NHS kept commissioning beds.” This is most telling of all: “I found the CQC to be really alarmingly defensive throughout the process.” You are there to inspect, not to be defensive of the individual institution. You may not want to comment on the individual case, but as a case study, do you not find that surprising—in fact, more than surprising, frankly alarming?



HOUSE OF COMMONS

Sir David Behan: I am disappointed to hear that. As I say, from this meeting I will now speak to the team that delivers those mental health inspections. I have also had contact from MPs who are happy and pleased with the inspection work we have done. They have appreciated the transparency. I think they have appreciated our independence in calling out where there is good and outstanding care, as well as challenging care. Anecdotes are important, and I will certainly respond to that in the faith that you have offered it, but I would argue that there has also been a huge amount of satisfaction with some of the work we are doing.

Chair: To force some balance, Victoria Prentis, who is the hon. Member for Banbury, said in relation to some of the issues she has had locally, which I will not replay, "The CQC have been willing to listen. I really have been impressed by those I have met." We recognise that it is not all a bad picture, but we were very concerned by the points raised by Louise Haigh, from Sheffield, Heeley.

Q46 **Gareth Snell:** Chris, you hold the CQC accountable for its actions at the Department of Health. What are your thoughts on the delays of those publications? Are you happy with meeting a 50% target in the financial year 2018-19, as Sir David said?

Sir Chris Wormald: I will ask Lee to comment in a moment, but in general I endorse every single word that Sir David said. Clearly the targets are there to be hit. CQC should work to hit them, but what we see overall is an organisation that is in no way complacent about its performance and recognises the problems when they exist and acts to deal with them. Shall we say a little about how we hold them to account?

Lee McDonough: Absolutely. We have a formal framework agreement with CQC that sets out the accountability framework we operate under. The highest level of that is formal quarterly meetings, which until recently have been chaired alternately by me and the Minister of State for Health, Philip Dunne. The Minister has actively asked to chair all those meetings going forward, because he is so interested in the oversight of the organisation. We have a very full, open and frank discussion about performance, finance, strategy and any other policy issues that come up. I can assure you that issues around timeliness of reporting have been actively discussed in those meetings, in the sense of expectations of progression going forward and the specific actions that the organisation is taking to address those timeliness issues. We hold Sir David and the chair, Peter Wyman, to account through those processes.

Q47 **Gareth Snell:** Can we turn our attention to adult social care and, in particular, look at paragraph 2.4 on page 17 of the NAO Report? This looks like another performance indicator that the CQC has failed to meet. The paragraph talks about the performance indicator for "newly registered locations to be inspected within specified time periods based on the date of registration" and says: "In quarter one 2017-18, 100% of primary medical services providers and 94% of adult social care providers receiving a first inspection were...within target." But in "this quarter" that dropped to 49% and 42% respectively. Are you able, Sir David, to give any commentary or context as to why there has been such a sharp



HOUSE OF COMMONS

decline in meeting that target?

Sir David Behan: We have been dealing with increased volumes coming through, and as a consequence of the feedback we have had from those people we register, through the NAO Report and from our own performance monitoring, we have had in place a registration improvement project. I think you are beginning to see—I am beginning to see—improvements in performance in relation to the timeliness with which we undertake this registration activity. We are currently dealing with about 3,000 applications a month. Again, this is up, and some of the—

Q48 **Gareth Snell:** Sorry, but you have said that there has been a large increase in volume and that 3,000 applications is “up”. What is that up from? How large is the increase in volume?

Sir David Behan: The increase is in the order of 20% from about 2012. We have a large number of organisations applying for registration, but we also have changes to the organisations that are currently registered with us, so that is driving some of the activity. But your challenge is about our level of performance, and we have been doing two things here. One is that we have been improving the way we operate. An example of this would be developing an online portal, a digital portal, for people to make an application to us. At the minute, a lot of our registration systems are paper based, not digitally based. Currently, as of this month, we have got something like 51% of applications to us online, which is a significant change. That means that more of the applications are got right at the first stage; 71% of online applications need no remedial action and can come through, whereas something like 41% of email applications are right when they come through and do not need any remedial action, and paper—

Q49 **Chair:** When you say they are right, who is making the mistake: the organisation registering or someone inputting at the CQC end?

Sir David Behan: There is often confusion in the application form. That is the applicant filling it in. I am not saying this is all with the applicant; it could be—

Chair: The forms that the CQC provides have not been—

Sir David Behan: It would be a mixture, in all honesty. It will be a mixture of, “Have we been clear enough?”, and—

Q50 **Chair:** So online registration is not just digitising what you are doing; it is actually changing the questions you are asking.

Sir David Behan: That is absolutely right. Simple examples of this would be as follows. GPs have made representations to us about changing their registration. A simple partnership change needs to be notified to us. One of the things that we have asked for is a DBS check within six months; we have now changed that to a DBS check within 12. That means the DBS check is current; you will understand why we need to do that. But we have extended the period, so it is not as burdensome. These are small examples of small changes that will make a difference, leading to improvements in our process.



HOUSE OF COMMONS

In addition to improving our current systems, we consulted in the summer about a significant shift in the way we register. We were effectively asking, "Should we register the guiding mind of organisations?", so instead of the individual care homes or general practices, the company that owns these organisations.

- Q51 **Gareth Snell:** The footnote in the NAO Report says that you apply a 10% threshold; you consider something to be on time if it is less than 10% late. So realistically that is not a 12-month target but a 13-month target, because 10% of 52 weeks is five, which is roughly an additional month. Given that you have talked about improving the registration process and the way in which you operate, do you intend to reduce that threshold, that leeway that you give yourself over the time, so that your 12-month target is actually 12 months, as opposed to 12 months plus 10%?

Sir David Behan: As we change the system, we will actually change the targets. We will take those to the board as part of our business plan and get the board signed up. I think this is here in the interests of transparency; it is not a dodge to increase our figures.

Chair: I don't think Mr Snell was suggesting that.

- Q52 **Gareth Snell:** But a 12-month target with a 10% threshold is not a 12-month target; it is a 13-month target.

Sir David Behan: I completely accept the point. You have got no fight with me in relation to that. We need to improve our performance on registration and we are working hard to do that.

- Q53 **Geoffrey Clifton-Brown:** But given that the whole thrust of your efficiency programme must be to get more people to do this via the portal online, the inputting system needs to be as simple as possible. When you make these changes, do you road test them with a representative group, whether it be adult social care, hospitals or GPs?

Sir David Behan: Increasingly—and I think—

- Q54 **Chair:** First of all, do you do any road testing: yes or no?

Sir David Behan: Yes we do. The paradox here is that we will then get questions about milestones and hitting milestones. The thing about testing is that sometimes when you test it, you think, "That's not the way to do it; let's do it a different way," and then that ends up taking longer. That is why we then get challenges back to us—quite properly—in relation to milestones. What we are trying to do here is keep pace about our reform programme and the changes we are taking, but actually do this properly and road test it as well. I offer the DBS check going from six to 12 months as a very small example of road testing something.

We had a meeting on Monday evening with the leadership of the Royal College of General Practitioners. We have regular meetings with them to demonstrate that we are listening, working with them—the jargon is co-production—because, to your point, Chair, we need to get this right with them.



HOUSE OF COMMONS

Q55 **Gareth Snell:** Looking at rates for inspection, the CQC has struggled to meet reinspection rates in adult social care, hasn't it? Is that a workforce issue? Is that a resource issue? What would you need, Sir David, to ensure that you are meeting all your targets for both initial inspections after registration and reinspections of adult social care providers?

Sir David Behan: When the NAO team came to us, we were coming to the end of the inspection programme—I think this is the point you were picking up, Chair, about our last meeting and where we were in terms of progress against that programme. We are not running a programme in the same way in the changes that we have made. What we have laid out is a change to the frequency of our inspections across adult social care, general practice and hospitals. For adult social care—your question—we will inspect all newly registered adult social care services within 12 months of registration.

Q56 **Gareth Snell:** You aim to inspect?

Chair: Or you will?

Sir David Behan: Well, we have not done it yet, but that is what we are setting out.

Q57 **Chair:** We love it when people make firm commitments, because we can have them back in a year's time. But you will inspect?

Sir David Behan: We will inspect. We want to be completely transparent about what our ambition is. Going back to the money question, I will come to this in a second, but we have worked out the numbers based on these frequencies. For a service that we have rated "inadequate", we will visit that to reinspect within six months. In some of them, we go back more frequently than six months, and we might go two or three times within six months on certain occasions. For those we have rated "requires improvement" in adult social care, we will go back within 12 months of the last inspection. For those we rated "good" and "outstanding" we will go back within two years—24 months.

In addition, we do reactive inspections where, as a result of, say, a complaint that comes in, a referral from Healthwatch or somebody blowing the whistle in relation to concerns they have, we will revisit more frequently. Between April and October of this year, something like one in five of our inspections were reactive, following somebody raising a concern, so that is outside of those frequencies. It is where we bring forward an inspection or introduce an inspection as a result of a concern. That is what we are setting up to do. It is that reactive inspection we are taking that is difficult to plan for in the future.

Q58 **Gareth Snell:** You said you will inspect everybody within six months, and I applaud your candour and being so bold in your commitment, but when exactly will you hit that target?

Sir David Behan: We have begun our new inspection programme. There is not an end date to this. We have said that that is the frequency we will go to—



HOUSE OF COMMONS

Q59 **Chair:** From now on?

Sir David Behan: From now on. That is how we are going to operate. That is our operating model. There is not something saying, "It will all be done by this date." That is how we will go on. I hope I have been clear in what I have said. Because we will bring forward inspections, because we are reacting, there is not an end date to this. Our strategy talked about an approach to inspection based on risk and proportionality. If a risk is introduced into a service because of a complaint or because a key member of staff moves, we will bring forward the inspection that sits outside that inspection frequency, which is a different approach to when we were applying a comprehensive rating inspection.

Q60 **Gillian Keegan:** You have a new system. You are going to reinspect in six months. How many have you got to do right now? How many are on the books?

Sir David Behan: Something like 80% are rated good or outstanding at the minute in adult social care. There are about 16,000—I'm sorry, I can't do the arithmetic off the top of my head, but I can send you a letter.

Chair: It is all right if you can't say now. You can clarify in a moment, but it is 20% of those that you inspect.

Sir David Behan: Yes. In our "State of Care" report this year, we—

Gillian Keegan: So that is about 3,000.

Chair: Are we talking hundreds, thousands or tens of thousands? We should be able to calculate from the Report, but you might be able to do it quicker.

Sir David Behan: About 3,000—about 20% of 16,000.

Q61 **Gillian Keegan:** How many resources do you need to do all of those within six months?

Sir David Behan: This year—this goes back to the questions you are asking—we looked at the frequencies of inspection that we will be undertaking. We then translated that into—

Gillian Keegan: We know the frequency for these reinspections; they are in six months.

Sir David Behan: Yes. That is the programme we are now on. That is our operating model. That is our programme. In terms of how many adult social care inspectors we require, we took the model of what the ratings are. We then applied the frequencies—what the rate of revisiting will be. We then calculated how many inspectors we would require to do that, and that is how we have built the budget.

Q62 **Gillian Keegan:** Maybe you could tell us later, if you do not know right now, but the questions are: how many are scheduled to be reinspected within six months—I think we said about 3,000—and how many resources are in place to make sure that you meet that target?



HOUSE OF COMMONS

Sir David Behan: I am very happy to. Generally, we have about 1,300 inspectors, and we are looking to recruit a further 200. Our calculation is that we should be able to carry out our responsibilities. The challenge—

Q63 **Gillian Keegan:** We often have targets here, but do you have a plan in advance to actually meet them? That is why I am trying to get the figures.

Sir David Behan: The challenge here is how you balance a risk-based approach to inspection, where the frequency of inspection is related to the risk, and the target. One of the issues we are grappling with—this plays to your question—is that when we go back to some of the services we rated good, we are now rating them “requires improvement”. On the whole, in the previous two years we have noted that 80% of the services we rated “inadequate” improved to at least “requires improvement” when we reinspected. We are now seeing—we flagged some of this in the “State of Care” report—that some services we rated “good” are not holding on to that rating; they are deteriorating. That means, over and above our planning that we set at the beginning of the financial year, we are having to go back to some services, which we did not anticipate at the beginning of the financial year.

I am not evading the question about targets, but if you follow it through, a risk-based approach to this means you do not set a number. We have set some assumptions, but if there is a deterioration in performance or an improvement in performance that is different from the assumption, we need to vary that, hence our monitoring in the report.

Q64 **Gareth Snell:** I know Ms Keegan is going to talk about risk. On page 38 of the NAO Report, the third bullet point of paragraph 4.7 states: “The Commission expects around half of its cost savings to come from reducing staff.” You have said today that you are moving towards a risk-based process, with more inspectors. First, how do you reconcile those two statements? Secondly, if you end up in a system whereby the quality of adult social care providers in the country starts to decrease and therefore you are required to undertake more inspections, what is the flexibility and robustness of your organisation to have sufficient staffing levels to undertake all that work, given that you have just said yourself it is no longer a target but a six-month rolling process based on risk?

Sir David Behan: I am sorry if I am not being clear. Given that, at its high water mark, our budget was £249 million and where we are going it will be £217 million, we have taken non-staff costs out this year to the value of about £14.3 million. It is inevitable that, to balance a £217 million budget, we will have fewer staff than we did at the beginning. You challenged us last time, Chair—both you and your predecessor—about the number of vacancies we had. Then, we were talking about the difference between posts and people. Now, we have 1,360 people carrying out this work. I told you we were underspending during this financial year, so we are using some of our underspend to bring forward some appointments. We can keep some of our underspend, thanks to the work we have done with the Department, so we are able to balance some of our resources as we go through and use the flexibility that we have.



HOUSE OF COMMONS

We are going to take out cost. How do we do this? We do this by having a risk-based, proportionate approach to this. Will this balance in 2019-20? Once we have the results from our monitoring of our performance, we can have discussions with the Department, as you have said, through our quarterly accountability meetings, and we will have debate at the board. We are planning to discharge our responsibilities to inspect within the resources that we have available. If we are not able to do that, I will tell you.

To be clear, the issue here is that we are fee funded, so our income comes from the fees that we charge the people we regulate. This is not now grant that we get from the Department. By 2019-20, the grant we get from the Department of Health will be for the market oversight function, Healthwatch England and the National Guardian's Office, plus one or two other things that the fees regulations do not allow us to raise a charge for.

Sir Chris Wormald: Just to be clear on what would happen, the situation described has never arisen, because the CQC has traditionally underspent its budget, so resource has not been a constraint on activity. Other things have been a constraint on activity—capacity and so on. If there were a position in which there was not enough resource for the level of activity that the CQC needed to carry out, that would prompt a discussion between the Department and the CQC. The CQC is funded in two ways: a diminishing amount of grant and an increasing amount of fee. We would have a grown-up discussion about how we ensured that what is asked of the CQC and its resources remained in alignment. There are obviously two things you can do in that circumstance—you can increase the resource or you can reduce the ask—and that is the conversation it would trigger. As I say, this is currently a hypothetical question, because it has traditionally underspent.

Chair: But it is a potential risk in the future scenario. I am going to bring in Gillian Keegan on this point.

Q65 **Gillian Keegan:** Perhaps we can move to your future model. What is required to ensure that you are ready to move to an intelligence-led approach—the so-called insight model? What do you need to do?

Sir David Behan: We have been doing a lot, and some of that is flagged in the NAO Report. From the strategy we have laid out, we want to move towards being intelligence-driven. We have developed a digital strategy. That digital strategy has now set priorities, which have been to our public board and been agreed. We take to our board meeting next Tuesday the programme to deliver that and the resourcing plan to deliver those programmes.

Q66 **Gillian Keegan:** What does that programme to deliver it look like?

Sir David Behan: It says, "These are the seven or so priorities that we have set as part of our strategy," and it lays out how we are going—

Q67 **Gillian Keegan:** What are the key things you need to deliver?



HOUSE OF COMMONS

Sir David Behan: We have set out two things, in essence. The first is how we strengthen the infrastructure that we have in place. What is the platform that some of these systems run on? Are these platforms robust, resilient and modern enough to allow us to do the analysis?

Q68 **Gillian Keegan:** What is the answer to that? I think there is some implication that at the moment it probably isn't robust and modern enough.

Sir David Behan: No, it isn't. A small example of this is that we have just bought software called Endeca, which allows us to analyse text and then begin to quantify that text, so it can provide information. We get thousands of contributions on our website from people feeding back. It is unstructured, and the software allows us to begin to analyse some of that.

Q69 **Gillian Keegan:** Okay, so that will structure your free-flow text. What new information sources have you identified that you need to inform this new approach? Obviously your system is one thing, which is the wrapper. What else needs to go into this?

Sir David Behan: There are two bits. First, is our infrastructure strong enough to operate the new systems that we need? Secondly, are we collecting the right information and intelligence, and are we then curating it, keeping it and making it available well enough?

Q70 **Gillian Keegan:** I know the questions; it is the answers I want to know really.

Sir David Behan: There are two bits to what we are we doing in relation to this. The challenge is that two issues were raised in the report that we have. First, do inspectors have the right information drawn together to support them to do the job that we are asking them to do?

Q71 **Gillian Keegan:** The inference is no. Certainly for an intelligence-led approach, which you are moving to, the inference is that that would be insufficient.

Sir David Behan: That was indeed right, and we have accepted that. I have here a copy of the document that is now available on our website for all inspectors, which draws together the relevant information about service X, Y or Z in relation to the key data. We have also published something that we call an insight tool. I have one here for a particular GP practice that draws together our information. That is available on our website, and each individual general practice can go and look at that data. It allows them to not only get back the information that we hold, but to benchmark against other organisations. Those are two products that we have available that we have developed as a result of our ongoing work—something that helps our staff to do their job, and also something that helps organisations to do their job as well.

Q72 **Gillian Keegan:** The key thing about an insight model is that you have to very carefully design all the leading indicators and you have to be right on top of them in a very timely fashion. The capability is there today—not in your organisation, but in general, in the wider organisations—in terms



HOUSE OF COMMONS

of IT. The key thing is to have that system working. When will it all be available?

Sir David Behan: The adult social care provider information collection, which is the information that we ask adult social care providers to provide to us—we call it a collection—will become digital from January next year. For general practice primary medical services—I am being careful about my words here, Chair—our ambition is that that information will be available from April. That means it is always on; it is not about an annual collection that we do on 31 March. It will be web-enabled, allowing people to provide information to us in real time. That will be an example of how we are using the platform and the digital technology to provide some real-time information that we can begin to use in relation to assessing risk in a way that is intelligence-driven.

We have made two key appointments within the organisation: Peter Sinden, our chief digital officer, has a background in working in technology; and Helen Louwrens, our director of intelligence, who joins us from a retail analyst company, Dunnhumby, bringing experience of the application of modern data science techniques to the analysis of data and helping us to stretch the way we work. We have developed a relationship with the Alan Turing Institute, where we are drawing on some of their expertise. We have just completed a piece of work where a number of their analysts have worked with ours over a week to look at developing predictive analytics. We are now taking that material and using it to inform our next steps. I hope that that is a practical example of some things that we are putting in place.

Q73 **Gillian Keegan:** Given the record that Health has on IT systems that sounds almost in the too-good-to-be-true category.

Sir David Behan: We are humble about it.

Q74 **Chair:** You sound confident, Sir David, and we will hold you to account on that.

Sir David Behan: There is an awful lot of accountability here. We are being humble about this, but we are having a really good go to try to get this right.

Q75 **Chair:** May I just check that what you have described is off-the-shelf software that you have bought? You are not designing it yourself.

Sir David Behan: Endeca was off the shelf, but we need to make it bespoke it to our organisation. Our staff need to know how to use it, which I think goes to the point that Gillian Keegan is making as well. It is not intuitive software; people need to be trained.

Q76 **Gillian Keegan:** If this platform arrives and works, you will have the quality of the data being put in and the consistency of the data across the country, and you will have time, in terms of analysing the data so you can pick up trends from the data and it can be useful. Are you sure that the timing, in terms of the new system readiness, is going to work in conjunction with the reduction in inspections, linked to the cost



HOUSE OF COMMONS

management targets, that you plan for the new regime? It seems like you might be introducing the new regime, in terms of the number of inspections, before you have this super-duper system in place.

Sir David Behan: It is a good question. That is what we're trying to balance: the imperative on us to move quickly and modernise and use some of these techniques against the position we find ourselves in. I think that is my job, and it is the board's job to hold me and the senior team to account for how we strike that balance. I have been trying to explain this afternoon how we have taken the frequencies and the work we do, modelled that, tried to assess the number of inspectors we need to deliver that programme and actually do this.

You pressed me on what we are doing now, and I said that, from April next year, adult social care provider collection will be digitised. We are collecting some of that information now, but that is a manual system. Taking that on to a digital platform will help us to do that more effectively and more efficiently. That is how we will attempt to strike that balance.

Q77 **Gillian Keegan:** I understand. The reason I am pushing you on this is that when we talk about data or digital or IT systems, we are actually talking about a way to recognise service and system failures that increase risk to patients in care homes or people who are not getting the service that they need, so it is crucial that we get this right. To test if that system is actually capable of spotting warning signs when things are going wrong, particularly in adult social care, is quite a big ask of the system. It probably needs a long time before you are confident that you can rely on it.

Sir Chris Wormald: Can I add a couple of things here? What Sir David is describing—the Chair's point earlier about IT systems in Health is well made—is a much more agile system than those we have previously implemented, where you try something, you test it and you try it again and so on, for exactly the reasons you say. That makes it more unpredictable in the way that Sir David was describing, because you are continually testing before you go on to the next bit.

This is also an area where the Department and, indeed, the Cabinet Office looks across what CQC does and gives extra assurance, for exactly the reasons that you say. Lee, do you want to add anything?

Lee McDonough: The DH digital assurance teams work really closely with CQC to test the online services. The two that are at the forefront are the one that Sir David referred to—the provider information from adult social care—and the other one is the feedback on care service. Those two have already passed the Cabinet Office standard for digital online services.

The three others that are currently in the pipeline, which Sir David referred to, are about inspection reporting, provider information collection and provider registration. They will go through the same close process, so there is monitoring from the central side as well.

Q78 **Chair:** It is an assurance regime?



HOUSE OF COMMONS

Sir Chris Wormald: Yes. Well, it is both assurance and—

Q79 **Chair:** So if it goes wrong, you are equally in the frame?

Sir Chris Wormald: We are always in the frame, as you know.

Chair: I am glad you understand that, Permanent Secretary.

Sir Chris Wormald: I have always understood that. More positively, the point of it being a Cabinet Office system, as I think the questions implied, is that a lot of these issues have been dealt with in other sectors and, indeed, have been done in other parts of Government, so it gives us the ability to bring in an assurance that draws on the examples that have already been done. The technology you are describing is not that complicated. It is always the interaction between that technology and the humans that is the challenging bit.

Lee McDonough: We do that from two perspectives. It is clearly about the deliverability and the operation, but it is also about the spending controls, in relation to the value for money element, that we look at through that process.

Q80 **Gareth Snell:** Briefly, looking at figure 5 on page 19 of the NAO Report, it talks about local intelligence sources. Obviously, as you move towards a system of risk whereby you are more dependent on local intelligence sources to inform your inspection regime, you are dependent on those organisations to provide you with good-quality and timely information.

May I ask two questions? First, potentially how long could an institution go without being inspected if it does not flag up on your system as being at risk? Secondly, if I can give you an example—it's an anecdote, I'm afraid—the CQC came to Stadium Court in Stoke-on-Trent to do one of its all-singing, all-dancing local leadership investigations recently under the guise of the Department of Health. The CQC shut down that home, immediately saying that no more people could be moved in. The CCG had continually missed all the problems that the CQC subsequently found. What weight of evidence—how confident are you that the people you rely on to inform your intelligence are going to be able to meet the demands that you have?

Sir David Behan: I am sorry—

Chair: Basically, the CCG got it wrong, but you got it right—Mr Snell alleges—so I would take the pat on the back while you can.

Gareth Snell: Yes, so you got it right—

Sir David Behan: Thank you for clarifying that. I wasn't quite sure.

Gareth Snell: The CQC stopped admissions the moment it did its inspection because of the home's quality of care; the CCG had missed that. You are now moving to a system whereby you are far more dependent upon external inputs of data. How confident are you that those people you now rely on will give you the good-quality data in good time to properly inform your inspection regime under a risk register?



HOUSE OF COMMONS

Sir David Behan: I think you also asked how long we would go before we inspect, and I am back to the frequency: six months for inadequate, 12 months for requires improvement and two years for good and outstanding. I did say that we were bringing forward something in the order of about one in five inspections at the minute—17%—where we get a concern raised and we bring forward an inspection. That is an example of us being more responsive. That plays to your point.

What do we do in relation to this? We have a “tell us about your care” website where people will come in. over the past six months we have done 230—

- Q81 **Gareth Snell:** I don’t need you to describe those things. What I want to know is, how confident are you that the input you get from external data providers are good-quality data to help you be confident that your risk rating of institutions is accurate, because that is what will be forming the inspection regime?

Sir David Behan: I am confident that as we become better known and as public recognition and awareness of us increase, more people will come to us, so we will get more referrals, more safeguarding alerts, up from—

- Q82 **Chair:** When you say “people”—here we are talking about the CCG, in this case, an organisation—are you talking about individuals, users—

Sir David Behan: I am being loose in my language, Chair. To be precise, members of the public who come to our website to tell us about their care. We have brought forward, in the past six months, over 230 inspections because of the concerns they have raised. We are also developing increasingly mature relationships with local healthwatches, which will raise issues with us as a result of their local visits to care homes and hospitals. They will raise concerns if they pick up intelligence in the local community. We have increasingly formalised our relationships at local level with local healthwatches. That is still variable, if I’m being honest. Therefore, to answer to your question about whether I am confident that we have those arrangements in place all over, no I am not, but I am confident that that is our ambition.

I think we also get referrals from the Parliamentary and Health Service Ombudsman, the local government ombudsman and the professional regulators, the GMC and the NMC. We do get referrals, particularly in relation to general practice, about the performance of general practitioners—the performance of a GP—which we will pick up as part of our inspections. We may refer someone to the GMC as a consequence of our inspections, but we do not have performance oversight of CCGs. But we do work with CCGs, we regard them as a source of intelligence and, increasingly—particularly in primary medical services—work with them.

If I have understood properly the issue you are referring to, the Department—the Secretary of State—asked us to do 20 local system reviews. We did the local system review in Stoke in October and we published that report on 10 November.



HOUSE OF COMMONS

Chair: We will come back to the issue of system reviews in a moment, but we do not want to lose our thread.

Sir Chris Wormald: Figure 5 is extremely useful in this regard—this is classic inspection theory that you would find in any sector—and not relying on any one thing is the crucial bit—

Chair: Which brings me to Mr Geoffrey Clifton-Brown, who has another bit.

Q83 **Geoffrey Clifton-Brown:** On page 25, paragraph 2.19, we see contacts relating to safeguarding issues—very important contacts. The overall contacts had gone up in 2016-17 by 1% compared with the year before, but although there were 7,452 contacts from whistleblowers—importantly, often people at the front line—that is actually a decrease of 16%. I am interested in the treatment you give to whistleblowers and why that figure has gone down.

Chair: Do you want to read it out, Mr Clifton-Brown?

Geoffrey Clifton-Brown: “During 2016-17, the Commission received 153,000 contacts that it classified as relating to safeguarding issues”—that is, important issues—“and 7,452 contacts from whistleblowers. Safeguarding contacts have increased slightly (1%) since 2015-16, with whistleblower contacts falling by 16%.” The heart of my question is what treatment do you give to whistleblowers and why have the contacts—these are safeguarding issues—from whistleblowers gone down so much?

Sir David Behan: Interestingly, in 2012-13 we had 6,100 referrals of concerns that would be classed as whistleblowers and in 2016-17 we had 7,689, so if you put it in a wider context, they have actually gone up since 2012, rather than down. I am not arguing on the figures. I think your question is what we do with whistleblowers.

Our responsibility is clear. Under the legislation, we are an appropriate body to be notified, very often by whistleblowers and people raising concerns—they may not have secured, nor want to secure, the status of a whistleblower, but they do want to raise a concern about quality and safety. We will consider those. Again, we may bring forward a review, trigger a responsive review or use the information in our next inspection. This is an area where we are challenged the most, I am sure it will not have escaped your attention: we have been working to improve how we report action following people raising a concern and making a disclosure. We will do everything we reasonably can to ensure people’s anonymity is preserved. Recently, we have been looking at reviewing whistleblowing policies; we will be completing that process over the final quarter of this year, and we will be completing some quality sampling of how we are dealing with individual cases over this period of time.

There are a couple of examples, and I will give one if I may. We often do not do this, but we recently, from 2016, inspected Marie Stopes International clinics for the termination of pregnancy. We had begun our programme of inspection with them, but the concerns that we escalated



HOUSE OF COMMONS

and the look at the headquarters of Marie Stopes International were brought about as a result of a whistleblower exercising concerns about clinical supervision. I think we have some strong examples where whistleblowing has caused us to bring forward an inspection and then take subsequent action. That is an example of where it worked.

Chair: Before I bring Mr Clifton-Brown back in, I need to stress that we need shorter answers, because we have read the Report and we know the background. It is lovely to have examples, but I think we have plenty now.

Sir David Behan: I am trying to make it—

Chair: We can bank those, Sir David, and get to short and sharp exchanges.

Q84 **Geoffrey Clifton-Brown:** Given that whistleblowers in the NHS are generally not treated very well, it is particularly important that you should welcome whistleblowers, because they are more likely to report things to you than they are to report directly to their employers, so it is a very important aspect, is it not?

Sir David Behan: I completely agree with that, which is one of the reasons why we are very sensitive to it. We want to make this work. I was just trying to give an example of where it has worked.

Q85 **Chair:** Do you think we should be giving more protection to whistleblowers?

Sir David Behan: This is one of the key issues and you know the controversy around this—you have invited me to be brief. The issue is what we as a regulator can do to protect whistleblowers, as distinct from what is it that the employers need to do to protect whistleblowers.

Q86 **Chair:** But you, as a regulator that relies on whistleblowers, could be a strong voice. I notice that you have been more vocal in the media in recent months on a number of issues, which we will come on to. Do you think there is something that you could be doing to intervene, to support whistleblowers, and support a culture of openness and transparency in health and social care?

Sir David Behan: I think the issue is we support the openness and transparency. A key part of that is whistleblowers feeling that they can come to us, they are being listened to and we use that information. That is our ambition and that is what we are trying to do.

Q87 **Gillian Keegan:** It is clear that you will have more sources, more information and more ability to read that information in a structured format. When that happens, you would expect to have more issues unearthed—to find more problems—yet your resource planning is built on the assumption that your ratings picture remains in a steady state and unchanged overall. There is a reference to that in the last bullet point under paragraph 4.7 on page 38: “the profile of ratings across providers will remain broadly unchanged.” Is that a reasonable assumption?



HOUSE OF COMMONS

Sir David Behan: I have a draft Report with different numbers on, apologies.

Chair: Ms Keegan, perhaps could you read it out slowly?

Sir David Behan: Chris is helping me—just to show we are working together.

Gillian Keegan: You are going to get a donated copy.

Sir David Behan: Thank you.

Chair: Page 38.

Gillian Keegan: Did you get the question? It was effectively that there will be more sources and more information so probably more issues and problems will be unearthed, but your resource planning assumes that, “the profile of ratings across providers will remain broadly unchanged.” Is that a reasonable assumption?

Sir David Behan: We think it is at the minute, but clearly it can change.

Q88 **Gillian Keegan:** It does not sound as though it might be, logically, does it? In fact, I would say that it is not a reasonable assumption. You are introducing a new system that will ask a lot of people a lot more things. You will get a lot more problems. I would assume that.

Sir David Behan: I have told you about the number of people who make approaches to us, which is up 6,000 to 8,000. That is 2,000 a quarter coming in.

Q89 **Gillian Keegan:** They are not coming to say how wonderful it is, are they?

Sir David Behan: No, they are not. We are trying to process that and use intelligence. Some of your earlier questions were about there being technology to help us sort and sift this information. We have tried to be very open and honest—very transparent—about trying to match that demand and anticipate future demand against the workforce and the budget that we have. You asked what we would do if that got out of kilter; Chris and I gave you an answer. We would have a conversation and try to work that out.

I think your question was, is that a reasonable assumption? At the minute, I think it is a reasonable assumption. We have built some assumptions in. My teams are looking at our business plan for next year and how we carry forward our plans. That will go to the private board in January and the public board in February, where we will lay out again what our assumptions are and how many people we will need to take that work forward. If I look at my staff survey and what staff tell me as a result of it, people are working very hard and they feel their work-life balance is out of kilter. So this is something that, realistically, we are attempting to juggle and judge—we are very open about that. We are working hard to do it. The only thing I can say to you is that we are giving it our best



HOUSE OF COMMONS

endeavours by having a rational planning model where we have looked at what we anticipate doing next year, how many people we will need and how much money we have.

Q90 Gareth Snell: Sir David, when I asked you earlier about data sources and the public, you said, "When people know about us". That implies that you anticipate an increase in contact from the public as your profile as a regulator increases. What assumptions have you made in your planning as to the number of contacts you will have from the public? You say it is 2,000 a quarter at the moment; what do you expect that figure to be when your all-singing, all-dancing intelligence system is up and running?

Sir David Behan: Unprompted public recognition of the CQC runs at about 62%. It was down at about 20-odd per cent. in 2012.

Q91 Gareth Snell: What do you think it will be?

Sir David Behan: Forgive me, I have not calculated how many of the people who go on our website translate into a referral that means we bring forward an inspection. This afternoon, I have tried to be very straight and honest with you and say that in the past six months of people telling us about their care on our website, we have brought forward 231 increased inspections. You asked me whether we would have enough people to do that, and my team have offered me a note that says we do. I could give you the numbers for that, and I will write it out for you, but we have taken it into account.

Chair: They're now going to get a Christmas bonus for that answer, aren't they?

Q92 Gareth Snell: On that point, if you are anticipating an increase in public recognition and you are expecting that to form a huge part of your new intelligence-driven inspection regime, do you not think you should have done the calculation to work out how many people have triggered quicker inspections? Then you would at least be able to do your workforce planning on how many inspectors you might need if the assumption you have made in paragraph 4.7 is not correct.

Sir David Behan: I have shared a figure with you today. This is the short answer that said 17%, or one in five, of our inspections are reactive; they are brought forward as a consequence of people giving us information. That is factored into our work and it will be factored into our business plan for next year, which will drive the number of inspectors we need.

Q93 Gareth Snell: But you are still saying that that figure will be one in five—sorry, what was the figure you said was brought forward?

Sir David Behan: I said that as a result of people raising concerns to us, some 17%, or one in five, of our inspections between April and October this year, have been reactive.

Q94 Gareth Snell: So you are not anticipating a larger percentage of reactionary inspections based on an increase in public involvement and engagement with the CQC once your public profile increases, as part of



HOUSE OF COMMONS

your intelligence-driven system?

Sir David Behan: No, what I am saying is that we will use that figure of the number of reactive inspections to inform our workforce planning for next year. I think that is a responsible and proper way to respond.

Q95 **Gillian Keegan:** I think you said last year that social care was approaching a tipping point. We all have concerns about social care and how we need to regulate that sector. There are also new models being discussed, such as accountable care organisations, with lots of different-shaped organisations that you will be regulating in the future. What plans have you made, and how have you anticipated the future in your plans?

Sir David Behan: In relation to new care models, STPs, we have been heavily involved in the discussions at a national level. We have staff linked to the local arrangements. For instance, one of our deputy chief inspectors, Alison Holbourn, is linked to the changes taking place in Manchester. The reason we are doing that is to pick up the learning from those developments in real time. I am involved in discussions at a senior level.

We have been looking at our inspection model. The key initial challenge of new care models is not how we would inspect them but, if we got truly new models and new legal entities, how we would register those services. We have been developing our different approaches and different models of inspection for how to do that. The local system reviews, which I referred to earlier, are an example of how we can look at a system and not just at individual institutions and organisations. I hope that gives you some idea of what we are attempting to do here.

Q96 **Gareth Snell:** My area, Stoke-on-Trent, is one of the places that have had a local system review.

Sir David Behan: Indeed it is.

Gareth Snell: I have been informed that it is likely to be the worst outcome of all the 20 you are about to do, but that is a problem for me, not you. What I want to understand, if you are going to move away from doing institutional inspections towards system leadership inspections, is the resource implications for your organisation. How does that fit in with your new intelligence-led system? You may have systems that are all okay, but a system that is failing in terms of the interactions between the institutions.

Sir David Behan: At the minute, our forward plan is not to move to systems but to look at institutions. That is the legal and regulatory framework that you set for us and that we will work within. The question Gillian Keegan asked was about new models of care; at the minute, those new care models do not change the legal accountabilities for statutory organisations, nor do they change the arrangements for accounting officers. We will follow those legal implications and accounting officer responsibilities. If there were an accountable care organisation, it would be a new legal entity and we would have to address that when we came to it. We are preparing for that eventuality.



HOUSE OF COMMONS

Q97 **Chair:** Can I chip in there? When we ask other inspectorates, we often ask about the other interventions around the edge. You could look at the hospital but find that there are issues with social care, for instance—something you have spoken quite vocally about. To pick up on what Mr Snell is driving at, even if you are looking at those individual organisations and not inspecting the system as a whole, how much will you take into account the other pressures in the system?

Sir David Behan: One of the questions we ask is how well led is an organisation? It is our view—we said this in this year's "State of Care" report—that successful organisational leadership collaborates with other bits of the system. When we are doing an individual organisational inspection, particularly of a trust, we expect the trust to be able to demonstrate how it is collaborating with the CCG, primary care, community care, mental health and adult social care.

In relation to the question that is being asked about local system reviews, we were asked very specifically to carry out a review using our powers under section 48 of the legislation. To use those powers, I need to make a request to the Secretary of State, or the Secretary of State will ask me to use them. In this case, local system reviews are over and above the fees we are paid by regulators. The Department has given me the money to carry out these reviews, and we are looking at how the system, not the individual services, operates.

If we are to look at the system, rate them and use some of our enforcement powers, there would need to be a change in regulations. In the current system, we will continue to look at the institutions and the leadership that they demonstrate, unless we are asked by the Secretary of State—in this case, by the Department for Communities and Local Government as well as the Department of Health—to carry out those reviews.

Q98 **Chair:** Do you want to do that? Take resources out of it for a minute. Is that something you think you could do and add value to the system?

Sir David Behan: I think it is a really important function. Whether it is us who carries it out or somebody else, somebody needs to look at the system and the direction of travel. That is not instead of looking at institutions. There needs to be some oversight of how the system operates. That is a matter of policy and legislation.

Q99 **Chair:** So if you are not doing it, you think somebody should be.

Sir David Behan: Well, we have been asked to do it. We bring our particular expertise to it, by virtue of our background. The feedback on the local system reviews from the people being reviewed is that the reviews are effective. We have only published, by the 19th, eight out of the 20 we have been asked to do.

Chair: We know you are doing 20. It is a start. We will no doubt come back and look at this, because we are very interested in the system-wide study.



HOUSE OF COMMONS

Q100 **Gareth Snell:** The benefit of that, certainly in Stoke-on-Trent, has been brilliant, because it has allowed us for the first time to see who is accountable. Sir David, you said that social care is at tipping point. In terms of the way you are now going to regulate, what does that actually mean?

Sir David Behan: Again, the Act that sets up the CQC requires us—it is a statutory responsibility—to report to Parliament. That is the context in which I made those comments last year and again this year. It is my view based on the evidence. It is nothing to do with my background; that is the evidence from the report. We will not change the way we inspect.

Chair: I think you have just answered the question. That's fine.

Q101 **Gareth Snell:** Sir Chris, do you recognise that social care is at tipping point in this country?

Sir Chris Wormald: I accept the CQC's view.

Q102 **Gareth Snell:** Is it your view?

Sir Chris Wormald: That is of course why the Government are doing all the things that I have described to this Committee on several occasions in the social care space. We have an inspectorate to report the truth to us.

Q103 **Gareth Snell:** Sir David, very quickly, what do you think is the cause of that? Bluntly, do you think it is a finance-related issue? In other words, would more money in the health and social care system change your view that it is at tipping point?

Sir David Behan: My view—this picks up on Chris's point—is that the system needs more money, but that money needs to go into a reformed system.

Chair: Okay. Thank you. That is very clear.

Q104 **Geoffrey Clifton-Brown:** Sir David, you are to be congratulated on getting the baseline for all three areas—hospitals, social care and GPs—to meet your target by this year. That is a fantastic achievement. Anybody can see where their local NHS hospital or GP practice is. Your supervision of one of those areas—GP practices—doesn't seem to be working quite as smoothly as it is for the other two. If I can take you to page 25 of the report, the very last sentence reads: "In the Commission's 2017 provider survey," 70%, basically, of hospitals and social care providers thought you were doing a good job, "compared with 42% of primary medical services providers." Can you tell us why you think that is?

Sir David Behan: There are a number of different reasons. Again, I will be brief. When regulation through CQC into general practice was introduced, that was the first time general practice had been regulated by any external independent body, so I think there is some reaction about being regulated. I let that sentence stand all by itself.

I think there are improvements that we need to make in the way that we have regulated that sector, so it becomes relevant. I referred earlier to



HOUSE OF COMMONS

how—only on Monday night; this is absolute coincidence—some of the senior team at CQC met with the senior leadership team at the Royal College of General Practitioners. We meet regularly with the BMA. What we are trying to do here is establish a professional working relationship. We have talked about the new developments that we are taking forward—doing that in co-production; doing it with the general practice.

The conversation earlier about data and the analytics: we want to work with them about data which is relevant to them. They were the conversations we were having on Monday evening about how we do that, and then, critically, how we evaluate whether we are being successful in the way we do this. I think it is to CQC's credit that we do these stakeholder surveys. You are able to play them back to us; the NAO are able to pick them up in the Report, and we have been actively working on developing and improving our relationship with the Royal College. I understand they are one of the organisations that have submitted evidence to you, and they shared that with me. I think they are positive in the developing relationship we have got with them, but equally challenging about the areas that we need to continue to develop. I think that is the work we are going to take forward with them.

Q105 Geoffrey Clifton-Brown: Just to take you to that evidence, which we may not have time to examine in detail, it says of the survey 74% of the GPs surveyed reckoned that you needed to make changes. In particular they were worried about the “unacceptable variation”, “elements of quality that do not reflect the role or the priorities of general practice”, “a lack of alignment between CQC strategy and what happens on the ground” and, probably most important, “the workload and distraction caused by regulatory activity”.

Now, I suppose a newly-regulated body of people would be bound to come up with some of those concerns, but it does seem to me that you have got quite a bit of work to do to convince them that you are actually adding value.

Sir David Behan: That is absolutely right. That is indeed the stretch that we have, and that was the very basis of the conversation that we have been having with the BMA and the Royal College. I believe we have made progress in relation to those issues. The meeting we had on Monday evening was part of four meetings a year that I will have with the president of the college. The president is coming to our pre-board dinner in January and we have very regular meetings at an operational level to improve these working relationships and develop these tools; so I think we are set on a good course.

Of course the GP story is a very good one. Nine out of 10 are rated good and outstanding. I think the thing that we have managed to do through the regime that CQC has introduced—and I think, again, this is to our credit, and I commend Professor Steve Field for leading this—is challenge the poor and unacceptable practice that has existed in general practice. Many people have said that we have always known there has been unacceptable practice in general practice, but it has never before been called out. I think that is what we have done. We don't need to go round



HOUSE OF COMMONS

and do another comprehensive rating inspection of GPs, which is why we are moving to a much more risk-based and proportionate approach. We are trying to work with the grain of their comments but stand fast by what you in Parliament have asked us to do in relation to providing assurance about the quality of general practice.

Q106 Geoffrey Clifton-Brown: I am slightly mystified by your answer. If 90% are being rated satisfactory, you would have thought the profession would actually welcome your inspection regime because it would be calling out those that do not come up to standard, so I cannot quite see why there is this antipathy towards your inspection regime.

Sir David Behan: I cannot give you a more sophisticated answer than that general practice is new to regulation. If you look at the teaching profession they have been regulated for—there has been a chief inspector of schools since about 1850. So, in a sense—the last time I checked, the NUT wanted to abolish Ofsted. This issue between how you regulate a sector to assure you in Parliament and members of the public that this is safe sometimes will collide with professional ambitions. We want to get this triangle between professionals, members of the public and Parliament. I think that's the job you asked me to do—to give you as the politicians, the public and the professionals satisfaction about the assurance of the quality and safety of services. In adult social care and in the health sector more generally we have got that triangle roughly in balance. I think it is slightly out of kilter here. My job, to be challenged by you, with the board and the teams that we have got in CQC, is to continue to provide you with assurance about the quality of general practice.

Chair: Mr Clifton-Brown.

Sir Chris Wormald: If I can add—

Chair: I want to bring Mr Clifton-Brown back.

Q107 Geoffrey Clifton-Brown: The problem with all of this is that the Department of Health requires you to increase charges at a time when they are not happy with what you are doing. Isn't that going to make the whole thing even more difficult?

Sir David Behan: Let me defend Chris. It is not the Department of Health but the Treasury that has asked regulators to move to full-cost recovery.

Chair: The Government.

Sir David Behan: Governments of all colours have done this. That is a policy decision, so that is what we will do. My understanding is that the fees for general practice are being picked up by NHS England.

Sir Chris Wormald: If I could just add to that. As I think your question implied, it is not the job of an inspector necessarily to be popular. It is their job to be respected. We should not chase the numbers. For balance—I think we are looking at the same written evidence—after the paragraph you read out, the Royal College of General Practitioners made a series of positive comments about the direction in which the CQC was moving.



HOUSE OF COMMONS

Chair: It is in the written evidence.

Sir Chris Wormald: What there is, however—we used to see this in schools, even with hundreds of years of history—is clearly a greater burden on small organisations from inspections than on big ones. That is an issue that CQC is struggling with: what is proportional for things that are really quite little organisations, which GP practices frequently are, as opposed to a big sophisticated hospital that turns it into a process. That is some of what we are seeing here as well.

Q108 **Chair:** Two quick points from me, one going back to the issue around the timeliness of reports and their accuracy. Darren Jones, who is the Member of Parliament in Bristol North West, raised a concern with us that CQC reports often flag up one issue and then they come back and maybe there is another issue that is flagged next time round, but it is not clear—I wonder how your organisation makes it clear, Sir David—when issues have been flagged but they have been addressed. Clearly, you can close them down if they are very bad, but there may be issues that come up in the report that are not addressed. How do you deal with that? How do you communicate that to the public?

Sir David Behan: Our approach, and what I would expect if we flagged an issue with an NHS trust in an inspection—

Chair: I should say for the record that he was talking about Avon and Wiltshire Mental Health Partnership, so it is quite a big organisation.

Sir David Behan: It is a very big organisation. Having flagged a range of issues in the report that we publish, when we go back to re-inspect we would expect to be updated on progress against the recommendations in much the same way that you have asked me to account for progress since the last time I was in front of you.

Q109 **Chair:** How do you make sure that, as you go back to re-inspect that some issues have been resolved, you are not just passing the bubble down the line and that the eye has not been taken off the ball elsewhere? We talked about system-wide. What about system-wide within an organisation of that size?

Sir David Behan: This is a massive organisation, as you know. One of the things that we want to avoid is their fixing a problem that is raised, but they take their eye off the other ball and something else happens. That is perhaps why we had raised an issue with them. That is indeed the reason why we think whether they are well-led is the one thing we need to look at in all organisations to check whether they have got the leadership—not the personalities—and systems and processes in place so that there is a team approach to improvement in a particular trust, particularly in somewhere like that trust where they have got literally hundreds of sites and it is not possible for any individual chief exec to walk round every single site.

Q110 **Chair:** For the record, that inspection was in June this year and the report was released on 3 October, so that is another delay. I know there are probably good examples, but there are too many still—



HOUSE OF COMMONS

Sir David Behan: There are, Chair. We are working on this. I stress the point that if we had concerns—I don't know that service—around, say, ligature points that were not removed and we went back, we would write to the chief executive immediately with that concern and would expect action to be taken.

Q111 **Chair:** But that is not a public letter, is it?

Sir David Behan: We do not make those public because, if we intend to take action, the regulations at the minute do not allow us to flag that action until we have taken it.

Chair: That is an interesting point for us to bear in mind.

Sir David Behan: Just to add to that point, many trusts will publish that letter by taking it to the board in a public session, and that letter then becomes public. There is a way that this can come out, but it requires the trust—

Chair: With the reduction in good local journalists, perhaps that is not always as public as it should be, but that is another debate. I recognise that is not something you can resolve right now.

Q112 **Geoffrey Clifton-Brown:** Sir David, I just want to ask you a question about resources. Earlier in this session, when you were talking about an increased number of inspections, particularly for the adult social care sector, you said that if you did not have enough resources to do it, you would have a conversation with the Department. I presume you meant the Treasury, not the Department of Health, given that in your last answer you said that your overall financial framework is set by the Treasury.

Sir David Behan: To clarify, the policy of regulators going to full-cost recovery is one that I believe has been set centrally by the Treasury.

Sir Chris Wormald: Let's not get into who in Government does what. The conversation would be between the CQC and the Department. We would involve other bits of Government as appropriate, but the fees decision is an all-of-HMG decision.

Q113 **Chair:** The Government decide it.

Sir Chris Wormald: Yes, but I want to be very clear that the accountability and therefore the discussions are between the CQC and the Department. We are responsible for that. If we needed to involve other bits of Government, that would be at our discretion.

Q114 **Geoffrey Clifton-Brown:** The purpose of that question was not to catch you out; its purpose was to ensure that you have enough resources to do your regulatory role in a way that you, the CQC, feel fit. Do you believe that that is the case?

Sir David Behan: If it helps the Committee, we will underspend our budget this year, but I would not hesitate in going to Chris and saying, "I have a problem here." In a full-cost recovery, one of the issues is that we



HOUSE OF COMMONS

could increase fees. You will have had correspondence about our fee levels. What we are trying to do is balance the fee structure, the work we need to do and the resources we have. At the minute, I am saying that we can strike that balance, and that is the work that is going on for 2018-19 for our business plan. If I felt we were not able to make that, I would have conversations with the Department. I am absolutely confident in our relationship with the Department and my personal relationship with Chris. I am confident that I would be able to have a discussion with Ministers if necessary in relation to that. We are not at that stage at the minute, but if we needed to do that, we would. I would not go on thinking, "I can fix this," when we could not. What I have tried to demonstrate here is complete transparency in the approach we have. I have been very open with you on that. That is what we have done.

Sir Chris Wormald: And we would have a grown-up conversation about that. Obviously the Department and the Government would have to take a judgment about what you would stop doing—

Chair: Absolutely. We have got the answer from Sir David. A last tight point from Gareth Snell. Quick questions, quick answers.

Q115 **Gareth Snell:** Sir Chris, if Sir David comes to you and says he needs more resource urgently, how quickly could that resource be put in place to allow him to do the things he needed to do, given the time-sensitive nature of the—

Sir Chris Wormald: If it was something urgent, we can do that very quickly, but it does have to be a proper process.

Q116 **Chair:** Finally, Permanent Secretary, what does success look like for you? If the CQC is delivering everything that it should, what would that look like from your point of view in the Department?

Sir Chris Wormald: The absolute key—this is not just for the CQC; I think it is true of every inspectorate—is what I said before. It is not necessarily about popularity; it is about respect. The best thing that we have seen with the CQC, which we have seen all over the country, is the respect in which its judgments are held by the system. That has gone up and up. That is the basis of a huge quantity of our sector improvement work. For me, that is the key achievement that they have managed over the past few years.

Q117 **Chair:** So it is quality and respect.

Sir Chris Wormald: Yes. It is quality and respect, but not necessarily popularity. As I said, we do not pay inspectors to be popular.

Chair: There you go, Sir David. You are not here to be popular.

Sir Chris Wormald: That is also true of my friends over here, the NAO officials. It is not a popularity contest; it is about the respect in which they are held.

Chair: Thank you very much indeed. I thank you for your time. The



HOUSE OF COMMONS

transcript will be up on the website in the next couple of days, uncorrected as ever, so get your corrections in if you need to. Our report will not now be out until after Christmas.