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Health Committee

2013 accountability hearing with the Care Quality Commission

Sixth Report of Session 2013–14

Report, together with formal minutes relating to the report

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The Health Committee

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

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Membership at the time of the report

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

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Oral evidence taken and some or all written evidence is published on the internet only.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), Laura Daniels (Committee Specialist), Stephen Aldhouse (Committee Specialist), Emma Sawyer (Senior Committee Assistant), and Su Panchanathan (Committee Assistant).

Contacts

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

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

Contents

Summary

Purpose of the CQC

The CQC's new approach to registration and inspection was established in their revised strategy published in April 2013 and consulted on by the CQC in July 2013. The CQC said that it now had a clear purpose – "to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve." Allied to this is the CQC's role which they said is to:

> monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what we find, including performance ratings to help people choose care.

Lack of clarity and direction has previously undermined the CQC's attempts to establish itself as an authoritative regulator. In our report following the 2012 accountability hearing, the Committee found that CQC had failed to establish its core purpose or describe what it intended to achieve through its regulatory activity.

The committee welcomes the fact that the CQC has now set out its objectives in clear terms. This in turn has helped to provide clarity to a regulatory landscape the committee described in 2012 as "cluttered and opaque" . The Committee believes that the CQC is now ready to undertake a programme of substantial reform to develop and improve its regulatory functions.

Chief Inspectors

The CQC has appointed three Chief Inspectors to oversee the inspection of Hospitals, Primary and Integrated Care, and Adult Social Care. The Chief Inspectors are tasked with leading specialist inspection teams, applying the CQC's revised model of inspection and developing a rating system for providers.

It has been proposed by the Department of Health that the Chief Inspectors be established as permanent statutory positions rather than simply appointments within the CQC. The CQC's Chief Executive, David Behan, explained, however, that this would not invest them with additional powers and that the Chief Inspectors will remain accountable to the CQC's Chief Executive and Board.

The committee will continue to follow the evolving relationship between the Chief Inspectors and the Chief Executive of the CQC regarding policy and operational decisions. We believe that as the methodology for registration, inspection and rating of health, social care and primary care advances over time the Chief Executive, acting on the authority of the Board, will play an important role in coordinating the approaches of the Chief Inspectors.

Definition of Standards

The CQC has announced that it will now assess the quality of hospitals against a range of standards which are divided in to three groups: Fundamentals of Care, Expected Standards and High-quality Care. The CQC, in conjunction with the Department of Health, plans to alter its regulations so that it can immediately initiate a prosecution following breaches of fundamental standards without first being required to issue a warning notice. The Committee believes that in most cases the ability to close a unit or a department by cancelling a provider's registration and withdrawing their licence is of more immediate significance to patient care than prosecution. The Government and the CQC should therefore keep these powers under review to ensure the CQC enjoys a sufficient range of sanctions to levy against failing providers.

Expected Standards

The standards expected of providers are to be directly linked to five key questions which have been established by the CQC. The questions ask of providers:

    i.   Are they safe?

    ii.   Are they effective?

    iii.   Are they caring?

    iv.   Are they responsive to people's needs?

    v.   Are they well led?

The Committee believes that translating standards into regulations is the key challenge for the Department of Health and the CQC as the registration requirements for providers underpin the rest of the surveillance, inspection and rating system. We believe the new system could simplify the regulatory process but the new standards must be meaningful in relation to the everyday experiences of patients. Taking immediate and firm action against those who breach these standards will enhance the credibility of the system.

Implementation of reform

The evidence provided to the committee shows that the CQC has an ambitious timetable for reform of registration and inspection. We note, however, that some witnesses have expressed concern that the new model for registration and inspection will focus too closely on hospitals, primary care and social care at the expense of community, ambulance and mental health services. In addition the CQC has published substantially more information on its programme for hospitals than it has for general practice and adult social care.

The committee believes that the CQC is right to establish clear priorities but at our next accountability hearing we expect the CQC to present clear details of how effective registration, surveillance and inspection will be extended beyond hospitals.

Surveillance

The CQC plans that future inspections will be informed, and on occasion prompted, by an ongoing surveillance process. The CQC has said that they will not draw definitive conclusions from the indicators they use to asses risk, but they will be used as "smoke detectors which will start to sound if a hospital is outside the expected range of performance or is showing declining performance over time for one or more indicators." If it is to build public confidence in a risk-based regulatory system, the CQC will require early identification of developing problems. The surveillance system must identify problems and trigger inspections before they become widely publicised by the media, patient groups or local representatives.

Staffing

The CQC plans to apply its methodology so that it can provide an accurate assessment not only of the theoretical establishment of a provider but of the actual number of staff working. The Committee welcomes the significance the CQC attached to staffing in their evidence. We believe that information gathered from the CQC's surveillance model which suggests that staffing levels are inadequate should be a trigger for inspection. The Committee is satisfied by the CQC's statement that staffing levels will be attached to the fundamental standards of care which providers must meet or face immediate sanction.

Patient safety incidents

In the report of the Committee's last accountability hearing with the CQC we questioned the rationale for transferring the functions of the National Patient Safety Agency to NHS England. The committee recommended that "the Secretary of State should reconsider whether prime responsibility for patient safety should reside with the CQC." The committee is pleased that the CQC is, in principle, willing to take on the responsibilities that once resided with the NPSA. It is illogical to split different aspects of patient safety between NHS England and the CQC and this reform would simplify the regulatory environment.

Financial monitoring of social care

The Care Bill currently before Parliament proposes to give the CQC specific powers to monitor the financial strength of approximately 50 to 60 care providers whose financial collapse could trigger a local crisis in the delivery of care. The CQC said that in order to fulfil their obligations the CQC does not currently have the financial skills that are required to achieve this and will need to buy in skills from external organisations.

The Committee recommends that the Government should reconsider its decision to allocate this responsibility to CQC and that it should ask Monitor to undertake this role. This would facilitate the reduction of boundaries between healthcare and social care and would maintain the existing distinction of principle between the CQC, which focuses on care quality, and Monitor, which focuses on financial performance.

Fit and Proper Persons test

Part of the revised registration process arises from the Government's desire for the CQC to operate a fit and proper persons test so that named directors or leaders of organisations can be held to account. However, it was revealed in evidence that the CQC will not apply the test to Chairs of NHS Trusts and NHS Foundation Trusts. The Committee does not believe that patients and the public will understand or accept this exclusion.

Inspections

The process of inspection is changing significantly as the CQC adopts a model of differentiated, in-depth inspection. The new model abandons generalist, generic inspections and from 2013-14 the CQC intends only to operate "teams of inspectors who specialise in particular types of care". The CQC told the Committee that problems identified by surveillance will be a trigger for inspection but it will not be possible to pick up every single error or failure.

The Committee accepts this and reiterates that primary responsibility for the quality of care delivered to patients rests unambiguously on the staff and management of care providers. The proposed inspection system represents a comprehensive improvement but the CQC must ensure that inspection is accurately targeted at risk. David Prior, Chair of the CQC, recognised that surveillance will not identify specific risks in outstanding hospitals and that some high risk services will require frequent inspection even if they are regularly classified as 'outstanding'.

Assessing the culture of providers

In the report of the Committee's last accountability hearing, we recommended that CQC should consult on how to assess the culture of a care provider. The CQC's fifth question for inspection – is a provider well led? – addresses this as does the presence of the Chief Inspectors who have been tasked with making such an assessment. The Committee welcomes this development and urges the assessment to be developed so that it does not simply measure Board level governance practices, but properly assesses whether a culture of openness and challenge exists amongst front-line staff.

CQC internal restructuring

In oral evidence David Behan provided an overview of how the CQC workforce will be restructured, telling the Committee that the role of every member of staff is likely to change. This will include creating specialist inspection teams and recruiting additional inspectors, a process which could take up to 18 months.

The CQC is planning to recruit an additional 150 inspectors to increase their establishment from 950 to 1,100. This process is vital to improving the effectiveness of the organisation; we therefore recommend that the CQC set an early target date for the achievement of this increase and provide regular reports to Parliament on progress towards delivery of the objective.

Beyond the inspection teams the CQC has said that they will need a total complement of 2,700 staff to fulfil their obligations. £20 million has already been allocated to support recruitment and retraining and a further £29 million will be used to support the new inspection process. The CQC has, however, yet to establish how this allocation will be used. The Committee recommends that the CQC Board reach early decisions about the allocation of this additional resource and that it should make its decision public.

Ratings

The CQC proposes a rating system for NHS hospitals comprising four separate classifications: Inadequate, Requires improvement, Good, and Outstanding. The same system will be applied to general practice and social care and all providers will be awarded a rating. The Committee welcomes this proposal; the CQC must quickly establish public understanding of, and confidence in, the new system.

Providing information to the public

Behind the headline rating attached to a hospital, care home or GP surgery, there will be a detailed inspection report. In our last report the Committee recommended that the CQC explore how they "can more effectively communicate with residents of care homes and their relatives about the outcomes of inspections." The CQC said that they are considering whether they should write to residents of care homes informing them of the outcome of inspections. The Committee is disappointed that the CQC is still "going to consider" this issue. It regards early action as fundamental to delivery of the core purpose of the CQC. It recommends that this recommendation of last year's report is adopted and implemented by the CQC no later than 30 June 2014.

Internal culture at the CQC

At previous accountability hearings we have taken evidence on the workplace culture within the CQC. In the committee's last report we outlined worrying practices related to the excessive workloads of inspectors. The CQC has accepted that there was a chronic problem with the CQC's workplace culture and they have developed new mechanisms for staff to raise concerns about bullying and other workplace problems. The Committee welcomes the CQC management's commitment to this process of culture change within the organisation.

Concern has been expressed to the Committee about the impact of individual workload on the culture of the organisation. Management of workload is an important part of business planning. At our next accountability hearing the Committee will seek assurances that workforce planning associated with the new regulatory model has not repeated the mistakes of the past.

Funding

The CQC's budget has risen rapidly in the last year and is likely to rise further. The CQC confirmed that it is no longer their objective to phase out grant–in–aid funding. This is because only a substantial increase in fees would allow for the elimination of grant–in–aid.

The Committee welcomes the commitment that has been given to ensure adequate funding for the CQC. In the longer term, however, the independence of the CQC will be substantially reinforced when arrangements are in place to ensure that the cost of regulation is met by the registrant community.

The case of Anna Jefferson

On 3 October 2013 it was announced that the CQC's Head of Media, Anna Jefferson had been cleared of any wrongdoing by an internal inquiry examining allegations that a critical internal report related to University Hospitals of Morecambe Bay NHS Foundation Trust had been suppressed by senior CQC staff. The Grant Thornton report alleged that Ms Jefferson had been involved with the decision to cover up the report.

The Committee regards it as regrettable that the Grant Thornton report appeared to lend weight to the allegations made against Ms Jefferson. The Committee does not, however, believe that this case undermines the broad conclusions made by the Grant Thornton report in relation to serious historic failures made by the CQC.

1 Introduction

1. We report on the Committee's 2013 accountability hearing with the Care Quality Commission (CQC). We took evidence from David Prior, Chair of the CQC and David Behan CBE, Chief Executive of the CQC.

2. The CQC is a non-departmental public body which is the first regulator to cover both health and social care in England. It is responsible for the registration, review and inspection of health and adult social care services and it also monitors the operation of the Mental Health Act in England. As of 31 March 2013 the CQC had registered 49,528 health and social care locations among 30,261 registered providers.[2]

3. In 2012–13 the CQC carried out 35,371 inspections.[3] This included at least one inspection of every NHS trust and adult social care location in England, which met the CQC's main performance targets for 2012–13.[4]

4. From 2013–14 the CQC will begin to move to a differentiated model of regulation whereby inspection will be undertaken on the basis of risk. Annual appraisals of hospitals and care homes will, however, continue until the new model is fully deployed. The CQC's written evidence summarises their progress in 2013–14 to date:

> As at the first week of October, we have already inspected over 17,000 locations this year against our business plan commitment; this is compared to just under 10,000 undertaken against the business plan programme of scheduled inspection activity this time last year.[5]

5. On 1 October 2013, the Secretary of State for Health, Jeremy Hunt MP, announced that the Care Bill [*Lords*] was to be amended to give the CQC statutory independence. Under the Health and Social Care Act 2008 the Secretary of State has the formal power to direct CQC inspections and dictate how inspections are conducted and reported. In their evidence, the Department of Health say:

> Under the proposals, the Health Secretary will relinquish a range of powers to intervene in the operational decisions of the CQC. This means that the CQC will no longer need to ask for Secretary of State approval to carry out an investigation into a hospital or care home. It will also remove the Secretary of State's power to direct CQC on the content of its annual report.[6]

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[2] Care Quality Commission, *Annual report and accounts 2012/13*, HC 374, (July 2013), p 3

[3] CQC (ACQ 02), para 10

[4] CQC, July 2013, HC 374, p 84

[5] CQC (ACQ 02), para 10

[6] Department of Health (ACQ 01), para 7

2 Purpose of the CQC

6. The CQC's new approach to registration and inspection was established in their strategy document 'Raising standards, putting people first' published in April 2013. A subsequent consultation document, 'A new start' was published by the CQC in July 2013. The CQC's strategy contains six strategic priorities:

   i.   Better use of information and inspection

   ii.   Working better with our partners in the health and social care system

   iii. Building better relationships with the public

   iv.   Building relationships with those we regulate

   v.   Strengthening how we deliver our responsibilities in terms of mental health and mental capacity

   vi.   Building a high performing organisation

7. The CQC said that it now has a clear purpose – "to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve".[7] Allied to this is the CQC's role which they said is to:

> monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish what we find, including performance ratings to help people choose care.[8]

8. The Department of Health said in its written evidence that it believes "the CQC has made good progress and now has a coherent plan to build its capability and consolidate its role as an effective regulator."[9] The Department concludes that the work the CQC has undertaken to revise its registration and inspection process means "the foundations are in place on which a reformed and more effective regulator of health and adult social care can be built."[10]

9. Lack of clarity and direction has previously undermined the CQC's attempts to establish itself as an authoritative regulator. David Behan, CQC, Chief Executive, said in evidence that "public and professional confidence has been shaky in the CQC"[11] and this can be attributed to a failure of the CQC to establish its purpose and role. In our report following the 2012 accountability hearing, the Committee found that CQC had failed to establish its core purpose or to describe what it intended to achieve through its regulatory activity. The Committee reported that:

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[7] CQC, _A New Start_, June 2013, p 2

[8] CQC, July 2013, HC 374, p 2

[9] Department of Health (ACQ 01), para 2

[10] _Ibid._

[11] Q2

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

In failing to understand its essential purpose, the CQC risks undermining its own attempts to realign its strategic priorities following a period of sustained criticism and review.[12]

10. The Department of Health said in its memorandum to the Committee that the "Department believes the CQC has made good progress and now has a coherent plan to build its capability and consolidate its role as an effective regulator."[13] The Kings Fund noted in their evidence that the CQC's work to establish its strategic direction has created a "strong foundation for its future work"[14]

11. **The Committee welcomes the fact that the CQC has now set out its objectives in clear terms. This in turn has helped to provide clarity to a regulatory landscape the committee described in 2012 as "cluttered and opaque".[15] The Committee believes that the CQC is now ready to undertake a programme of substantial reform to develop and improve its regulatory functions.**

Strategic reform

12. Having defined its purpose and role, the CQC is now in the process of developing a reformed regulatory methodology. A new set of standards examined through a system of differentiated inspection are at the heart of the reformed regulatory system. The CQC's strategy outlining the reforms said:

How often we inspect, how long we spend on an inspection, and the size and membership of the inspection team will be based on the 'risk' of the service – the type of care being offered, the vulnerability of the circumstances of people who use it, the information we have about a service, and its current rating. We will inspect services less often if we are confident that they are offering safe, high-quality care and can continue to do so. We will focus less on the number of inspections we carry out and more on the number of days we spend inspecting services.[16]

13. Once inspections are completed providers will be awarded a rating. The CQC's evidence stated that:

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[12] Health Committee, Seventh Report of Session 2012–13, 2012 accountability hearing with the Care Quality Commission, HC 592, paras 16–17

[13] Department of Health (ACQ 01), para 2

[14] The King's Fund (ACQ 16), para 4

[15] HC 592, para 37

[16] CQC, *A New Start*, June 2013, p 17

Initially, ratings will be given to hospital trusts and we will explore how quickly we can also rate individual services such as critical care or A&E. We will begin to award ratings for adult social care and primary care in line with the roll out of our new regulatory approach in these sectors.[17]

14. By January 2016 all NHS and independent hospitals will have received a rating and by April 2016 this will be extended to all NHS and social care services.[18] In advance of this the CQC believe that by April 2014 thirty-five hospitals will have been inspected using the new 'in-depth model' "with the majority of these receiving an overall rating, as well as ratings of specific services, and against each of our five key questions".[19] The CQC's proposals for regulatory reform are explored in sections three and four.

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17 CQC (ACQ 02), para 24

18 *Ibid.*

19 *Ibid.*

3 Regulatory reforms

Chief Inspectors

15. The CQC has appointed three Chief Inspectors to oversee the inspection of Hospitals (Professor Sir Mike Richards), Primary and Integrated Care (Professor Steve Field) and Adult Social Care (Andrea Sutcliffe). Professor Sir Mike Richards took up his role in July 2013 and therefore the CQC's work to develop their renewed approach to the inspection of hospitals is at a more advanced stage than their proposals in primary care or adult social care. Professor Field and Ms Sutcliffe both joined the CQC in October 2013.

16. The Chief Inspectors are tasked with leading specialist inspection teams and developing the revised model of inspection which the CQC has launched. The Chief Inspectors of Hospitals and General Practice will also be responsible for developing the ratings system for these parts of the health system. Another key function of the Chief Inspectors will be to:

> use the expert findings, ratings and judgements of their teams of inspectors, together with information and evidence held by CQC and our partners in the system, to enable CQC to provide a single, authoritative assessment of the quality and safety of care of the services we regulate.[20]

17. The CQC's written evidence said that Chief Inspectors will be responsible for ensuring that "appropriate action is taken against providers where necessary, and will be working with our partners in the regulatory and oversight system"[21]. In relation to Sir Mike Richards's role as Chief Inspector of Hospitals, the CQC say that he will be "working with Monitor, the NHS Trust Development Authority and NHS England to implement the Single Failure Regime for NHS and Foundation Trusts."[22]

18. It has been proposed by the Department of Health that the Chief Inspectors of Hospitals, General Practice and Adult Social Care be established as permanent statutory positions rather than simply appointments within the CQC. The Department of Health's written evidence said:

> The Department intends that Chief Inspector positions will be enshrined in law, through the Care Bill currently in the House of Lords. This will place the positions on a permanent footing and ensure that individuals who are appointed to the roles are able to speak up for patients and provide clear judgements about quality of care. As a Unitary Board, the Chair and non-executive directors will appoint executive members to the Board without Secretary of State intervention. The requirement to appoint Chief Inspectors to three of these executive member posts will not alter the governance arrangements of CQC. The Chief Inspectors will be accountable to the

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[20] CQC, *A New Start*, June 2013, p 20

[21] CQC (ACQ 02), para 28

[22] *Ibid.*

Chief Executive and the Board, will act under the powers of CQC and will remain employees of the CQC.[23]

19. David Behan explained in more detail how he expects the relationship to develop between the Chief Inspectors and the Chief Executive, he said:

> I see my job as to support the chief inspectors to do their job. I am the accounting officer and the chief executive of the organisation. That is how I see the difference. I do not see myself making operational decisions, but, if an internal appeal is required on a decision made by a chief inspector, it may well be that I would consider an appeal, in the way that that operates internally.[24]

He added that putting the Chief Inspectors on a statutory footing "preserves their role in statute so that it cannot be done away with, in a sense. It does not invest in them special powers."[25]

20. David Behan provided greater clarity about the organisational arrangements and the mechanisms for accountability that will apply to the Chief Inspectors. The Committee will, however, continue to follow the evolving relationship between the Chief Inspectors and the Chief Executive of the CQC, who will retain responsibility for strategic policy and operational decisions.

21. **The Committee welcomes the fact that the Chief Inspectors are accountable to the CQC Board. As the methodology for registration, inspection and rating of health, social care and primary care advances over time the Chief Executive, acting on the authority of the Board, will play an important role in coordinating the approaches of the Chief Inspectors in order to maintain a consistent approach on these key issues across the activities of the CQC.**

Definition of Standards

22. The CQC has announced that it will now assess the quality of hospitals against a range of standards which are divided into three groups:

   i.   The Fundamentals of Care

   ii. Expected Standards

   iii. High-quality Care

23. The CQC launched a consultation on these standards in July 2013 and the Department of Health plans to "consult on the new regulations this Autumn setting out these standards, reflecting the findings of the consultation [...] the new regulations should come into force from April 2014."[26]

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[23] CQC (ACQ 01), para 11

[24] Q15

[25] Q16

[26] CQC (ACQ 01), para 15

The Fundamentals of Care

24. The Department of Health is yet to consult and the new standards have not been formally established, but it is expected that the fundamentals of care will be based on the easily identifiable basics of care which can be "understood by all".[27] The CQC's strategy document announcing the reforms said that:

> There will be immediate, serious consequences for services where care falls below these levels, including possible prosecution. Anyone should be able to recognise a breach of the fundamentals of care, even in the absence of specific guidance.[28]

25. The CQC, in conjunction with the Department of Health, plans to alter its regulations so that it can immediately initiate a prosecution following breaches of fundamental standards without first being required to issue a warning notice. Under the existing regulations these steps are rarely taken, even in cases of serious and blatant breaches, as warning notices must be issued in the first instance. A consequent improvement in performance achieved within the time stated in the warning notice means a provider has returned to compliance and a prosecution is no longer possible.[29]

26. **The Committee notes the intention to revise the CQC's powers to enhance its ability to quickly prosecute directors and corporate bodies in the most serious cases. We believe, however, that in most cases, the ability to close a unit or a department by cancelling a provider's registration and withdrawing their licence is of more immediate significance to patient care. The Government and the CQC should keep these powers under review to ensure the CQC enjoys a sufficient range of sanctions to levy against failing providers.**

Expected standards

27. The expected standards are to be directly linked to five key questions which have been established by the CQC. These standards will form the principal focus of the inspection process and will be assessed by asking the following key questions about providers and their services:

    i.   Are they safe?

    ii.   Are they effective?

    iii. Are they caring?

    iv. Are they responsive to people's needs?

    v.   Are they well led?[30]

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[27] CQC, *A New Start*, June 2013, p 13

[28] *Ibid.*

[29] Department of Health, *Strengthening corporate accountability in health and social care*, July 2013, p 12

[30] CQC, *A New Start*, June 2013, p 2

Shortfalls in meeting these standards will be reflected in inspection reports, and ratings decisions, but will not necessarily result in immediate action to suspend the operator's licence or individual prosecution.

High-quality Care

28. The definitions which will be applied to high-quality care have yet to be established but the CQC has said that they are likely to be related and of a similar style to NICE quality standards.[31] The CQC said:

> Our inspectors will use good practice guidance developed by these other organisations to identify and describe whether a service is providing high-quality care. We will also look for where providers are using new ways of providing good, innovative care.[32]

Application of Standards

29. In evidence to the Committee the English Community Care Association questioned whether differentiated standard levels were practical:

> We question the need for "fundamentals of care" to be detached from "expected standards" in the manner proposed. We are not confident that members of the public will be able to understand the qualitative difference that is intended to separate fundamentals from expected standards.[33]

30. David Behan said in oral evidence that the CQC is still working on developing the fundamental standards and added that they will eventually be set out in regulations.[34] Mr Behan added that the CQC will:

> inspect all services against the five key questions that will drive a rating on that four point scale of outstanding, good, requires improvement or inadequate. The fundamental standards will be set in law so that they are enforceable.[35]

31. In their written evidence the Royal College of Nursing say that the CQC will have to develop "tangible, transparent standards that can be inspected against".[36] The Committee believes that translating standards into regulations is the key challenge for the Department of Health and the CQC as the registration requirements for providers underpin the rest of the surveillance, inspection and rating system.

32. In our last report the Committee found that:

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[31] *Ibid*, p 16

[32] *Ibid*

[33] CQC (ACQ 04), para 2.3

[34] Q38, Q41

[35] Q38

[36] CQC (ACQ 07), para 3.5

There have been too many reports of CQC inspections which focus on easily measurable inputs, rather than the essential quality of care provided. The organisation has sometimes seemed to be an illustration of the dangers of the principle that 'what gets measured gets managed'.[37]

The committee believes that the CQC's broad approach of linking five key questions to the inspection of expected standards and linking immediate regulatory action to breaches of fundamental standards has the potential to simplify the regulatory process. Provided the CQC focuses on evidence of outcomes achieved, there is now an opportunity to move away from a system that focused on inputs and failed to illustrate a realistic picture of the standards of care offered by providers.

33. **The ultimate test of the new standards will be whether they are meaningful in relation to the everyday experiences of patients, care home residents and the public. The committee welcomes the commitment on the part of CQC to take immediate action against providers who fail to meet fundamental standards and therefore breach their registration requirements. If applied firmly, we believe this measure has the potential to considerably enhance the credibility of the new system.**

Implementation of reform

34. The evidence provided to the committee shows that the CQC has an ambitious timetable for reform of registration and inspection. In October 2013 the CQC launched its new risk-based system of inspection. The new model is being rolled out through 2013-14 and the CQC has said that the risk-based regulation of all sectors is expected to be "fully operational in 2014–15".[38] The CQC proposes to have undertaken their first wave of inspections and published ratings across the majority services by July 2015[39], but the Foundation Trust Network (FTN) has warned that this process could be "disruptive to providers".[40]

35. The FTN's evidence to the Committee sounded a note of caution about the emphasis placed on the sectors covered by the three Chief Inspectors and their respective teams. In the past FTN members have criticised the CQC for "being too acute or social care focused, causing particular problems for community, ambulance and mental health services"[41] and the FTN argued that:

The CQC is in danger of falling into the same trap with the appointment of Chief Inspectors of Hospitals, Social Care and Primary Care, and delaying the development of the new regulatory approaches for community, ambulance and mental health services.[...]

There is a danger of over-focusing on the regulation of hospital-based care, which ignores the trends to provide more care in community-based settings and for trusts

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[37] HC 592, para 29

[38] Care Quality Commission, *Business Plan 2013–14*, p 20

[39] CQC (ACQ 020), Annexe 1

[40] CQC (ACQ 09), para 3.2

[41] CQC (ACQ 09), para 9.1

providing a mix of types of services or care that is more integrated. Many acute trusts now also provide community services, while some mental health providers provide more community health services than mental health services. Members from integrated and specialist trusts participating in recent FTN/ CQC engagement events highlighted how many aspects of the new regulatory and surveillance model did not apply to them.[42]

36. It should be noted that the details of standards, inspection methodology and ratings have not yet been confirmed by the CQC. The system in social care in particular is still under consultation and David Behan conceded that: "To be brutally honest, we need to do more work on developing that methodology and model."[43]

37. In response to the suggestion from the FTN that the CQC's strategy may be too focussed on three core areas David Behan said "If everything is a priority, nothing is."[44] The initial focus has been "to sort out what we are doing around acute hospitals".[45] Mr Behan explained that once the hospital programme is in place the CQC "will begin to tackle what we are doing around independent healthcare, mental health, community trusts, and ambulance services."[46]

38. It was also clear from the evidence presented that the CQC does not yet have a firm plan for the surveillance and inspection of home care services which, by their nature, are more difficult to observe. David Behan told the Committee that:

> A lot of our methodologies are built on being able to observe care [...] but of course a lot of care is not delivered in an observable set of circumstances and situations. Personal care takes place in somebody's own home, and how we assess the quality of that is something that we need to work through. Remember, there are 8,000 domiciliary care agencies delivering care to individuals in their own homes. By definition, it is not in an organisation like a hospital, a care home or a school, so it requires different approaches. [47]

39. The FTN said that some of their members "have expressed disappointment at the language of 'hospitals' in recent CQC documentation"[48] which underlines David Behan's statement that hospital regulation has been prioritised. **If the CQC seeks to prioritise everything then they will prioritise nothing, but they must now begin to provide detailed information to the full breadth of health and social care providers to build support for reform across the system. At our next accountability hearing we expect the CQC to present clear details of how the effective registration, surveillance and inspection procedures will be extended beyond hospitals to cover adult social care and general practice. In particular the CQC should by then have developed clear and**

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42 *Ibid*, para 9.2

43 Q11

44 Q29

45 Q29

46 Q29

47 Q107

48 CQC (ACQ 09), para 6.7

creative proposals for scrutinising the quality of care delivered by providers in a person's own home.

4 Regulatory model

Surveillance

40. The CQC plans that future inspections will be informed, and on occasion prompted, by an ongoing surveillance process. The CQC said in their consultation on the proposed reforms that they would not draw definitive conclusions from the indicators they use to assess risk, but such indicators would be used as "smoke detectors which will start to sound if a hospital is outside the expected range of performance or is showing declining performance over time for one or more indicators."[49] Offering more detail, David Prior said that the surveillance model would use over 150 indicators and therefore they were "not capable of being gamed in the way that five or six may be."[50]

41. The CQC intends to use three tiers of indicators to analyse risk. They describe the system as follows:

Tier 1 Indicators

> The first set of indicators will be the centrepiece of our new model. It will include data and evidence such as mortality rates, never events, specific results from the national NHS staff and patient surveys, information from whistleblowers, information from individual members of the public who make complaints, raise concerns and provide feedback, and information from Quality Surveillance Groups.

> They have been selected because they are things that have a high impact on people and because they can alert us to changes in those areas. An example of a trigger would be higher than expected deaths for people who have had operations that would not normally carry that level of risk. [...]

> Any indicator in this set which points to a potential concern or a decline in quality over a period of time will trigger questions from us. Our response will vary depending on the concern. For example we may ask the trust responsible for the hospital for more information and explanation; we may carry out an inspection; or in extreme cases we may suspend a service.

Tier 2 Indicators

> The second set of indicators will include a much wider range of intelligence which on their own may not trigger action by us. We will check them if the first set of indicators signal a concern, to help understand the issues raised and decide what an inspection should focus on. This second set of indicators will include nationally comparable data such as results from National Clinical Audits, admission profiles for each NHS trust, wider sets of patient and survey results, and information from accreditation schemes.

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[49] CQC, _A New Start_, June 2013, p 22

[50] Q106

Tier 3 Indicators

> The third set will include indicators that are not yet nationally comparable, are not routinely available or which are the result of 'one-off' data collections. We will use this set to horizon scan for those indicators which may be useful in the future as part of the first or second set of indicators.[51]

42. In their written evidence the CQC summarised how the new system of tiered indicators was intended to inform the inspection process. Their evidence stated that:

> The indicators will be used to raise questions about the quality of care but will not be used on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, national surveillance data and local information from the trust and other organisations. This insight will help us to decide what we need to inspect, where and when. This means that we can anticipate, identify and respond more quickly to services that are failing, or at risk of failing.[52]

43. **If it is to build public confidence in a risk based regulatory system the CQC will require early identification of developing problems. The surveillance system must identify problems and trigger inspections before they become widely publicised by the media, patient groups or local representatives. If the CQC's surveillance model cannot pre-empt high profile failings it will be viewed as purely reactive and will not be regarded as a credible basis for regulatory activity.**

Staffing levels

44. In oral evidence the CQC outlined how their new model would assess the adequacy of staffing levels in hospitals, care homes and other providers. David Behan told the committee that the CQC was working with NICE and NHS England on "a tool that can assess the adequacy of staffing"[53] The Government has since asked NICE to set out:

> authoritative, evidence-based guidance on safe staffing. By summer 2014, NICE will have produced guidance on safe staffing in acute settings, including a review and endorsement of existing staffing tools. This initial phase will be followed by further work to develop similar tools and endorsement in non-acute settings, including mental health, community services and learning disability.[54]

45. Mr Behan said that the CQC wanted to be able to assess how many people were actually working on a ward on in a care home as opposed to the theoretical establishment. He added that the CQC was "actively building an assessment of the adequacy of staffing into our new inspection model."[55]

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[51] CQC, _A New Start_, June 2013, p 24–25

[52] CQC (ACQ 02), para 16

[53] Q19

[54] Government Response to the House of Commons Health Committee Third Report of Session 2013-14: _After Francis: making a difference_, Cm 8755, November 2013, p 30

[55] Q23

46. **The Committee welcomes the importance attached to staffing levels by the CQC. We believe that analysis of staffing figures should not only be part of inspection but should also form a fundamental part of the surveillance model. Staffing data should extend beyond the ratio of registered nurses to patients working on a hospital ward and should examine other measures, such as consultant coverage in emergency departments, which is a crucial factor in improving patient outcomes.[56] Information gathered from surveillance which suggests that staffing levels are inadequate should be a trigger for inspection as "the quality of care that people receive is related to the number of staff on duty."[57]**

47. Significantly, David Behan pre-empted the Government's full response to the Mid Staffordshire NHS Trust Public Inquiry by saying that "the fundamental standards will also address this issue, so the regulations will need to address the appropriateness of staffing"[58]. The Government's full response to the Public Inquiry said:

> The Care Quality Commission through its Chief Inspector of Hospitals will monitor this performance and take action where non-compliance puts patient at risk of harm and appropriate staffing levels will be a core element of the Care Quality Commission's registration regime.[59]

48. **The Committee welcomes the commitment made by the CQC that the fundamental standards by which providers are registered will incorporate appropriate staffing levels. It is essential that those providers that fail to achieve adequate staffing levels are aware that they are in breach of fundamental standards and therefore liable not only to inspection but also to regulatory action including prosecution. The regulations have yet to be published and it is vital that the public have the opportunity to scrutinise how they define an 'appropriate staffing level'.**

Patient safety incidents

49. In the report of the Committee's last accountability hearing with the CQC we questioned the rationale for transferring the functions of the National Patient Safety Agency (NPSA) to NHS England. The committee recommended that "the Secretary of State should reconsider whether prime responsibility for patient safety should reside with the CQC."[60]

50. In oral evidence David Prior told us that patient safety is something which the CQC Board "feels ought to be with us, not with NHS England."[61] David Behan rightly cautioned that these responsibilities would extend beyond "critical incidents where patients have been

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[56] Health Committee Second Report of Session 2013–14, *Urgent and emergency services*, HC 171, para 74–75

[57] Q19

[58] Q19

[59] Department of Health, *Hard Truths, The Journey to Putting Patients First*, Cm 8754-I, January 2014, para 28

[60] HC 592, para, 19

[61] Q46

badly cared for"[62] and include alerts about "machinery and equipment"[63] which would raise questions about the breadth of the CQC's responsibilities.

51. **The committee is pleased that the CQC is, in principle, willing to take on the responsibilities that once resided with the NPSA. It is illogical to split different aspects of patient safety between NHS England and the CQC and this reform would simplify the regulatory environment. The Committee believes that would allow more information to be quickly factored into the CQC's surveillance model which already includes 'never events' in its first tier of indicators.**

Financial monitoring of social care

52. The Care Bill [*Lords*], currently in Public Bill Committee, proposes to give the CQC specific powers to monitor the financial strength of approximately 50 to 60 care providers whose financial collapse could trigger a local crisis in the delivery of care.[64] Subject to the Bill receiving Royal Assent, from April 2015 CQC will:

> "i. Require regular financial and relevant performance information from some providers.

> "ii. Provide early warning of a provider's failure.

> "iii. Seek to ensure a managed and orderly closure of a provider's business if it cannot continue to provide services.[65]

53. The CQC said that this "will strengthen our ability to help make sure that concerns about people's care are identified and acted upon as early as possible."[66] They add that they will:

> "i. Carry out financial checks on a small number of providers (based on their size, local or regional concentration and specialisation of services which makes them difficult to replace).

> "ii. Monitor risks to financial sustainability and, depending on the level of risk, ensure these providers have effective 'sustainability plans' in place to satisfy us that it can manage the risk. We will need to be sure that the provider is taking sufficient steps to address a threat to their business sustainability. We will be able to commission an independent business review to help the provider become financially sustainable.

> "iii. Require information from providers in order to facilitate an orderly closure of a provider's business, should that become necessary, and ensure the continuity of care for people who use the service.

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[62] Q47

[63] Q47

[64] Care Quality Commission, *A fresh start for the regulation and inspection of adult social care*, October 2013, p 20

[65] *Ibid*, p 20

[66] *Ibid*, p 21

"iv. Oversee and coordinate the process when a provider fails across all involved local authorities, and communicating nationally on progress to provide reassurance and information."[67]

54. The CQC has been asked to take on this additional responsibility because it relates specifically to adult social care, a sector which Monitor, the economic regulator for NHS Foundation Trusts, does not cover.[68] The Government's response to their consultation on Market Oversight of Adult Social Care explained the reasoning behind the CQC being tasked with these functions:

> the Government believes there are greater benefits for service users to having a single regulator which oversees care and support services and can build a picture of overall performance combining quality and financial data. Consequently the Government will legislate to enable the CQC to undertake this function.[69]

55. David Behan told us that in order to fulfil their obligations the CQC will need to "buy in skills from organisations that do insolvency work".[70] David Prior explained that the CQC did not have the financial skills that were required and it is highly unlikely that they would want to have them in house.[71] Mr Prior also observed that many of the backers of adult social care businesses were "private equity companies with very complex capital structures".[72]

56. **Undertaking the financial monitoring of adult social care is a significant challenge for the CQC and it is essential that they procure the right skills to fulfil this role. David Behan noted in his evidence that there was a close correlation between poor quality and poor financial performance, saying that "[m]aking a distinction between finance and quality is a false distinction."[73] We do not dispute this point, but the Committee believes that, ultimately, it is easier to identify and address poor quality at an early opportunity than it is to demonstrate that a provider is financially distressed.**

57. **We recommend that the Government should reconsider its decision to allocate this responsibility to CQC and that it should ask Monitor to undertake this role. Although this development would divide oversight of adult social care between Monitor and the CQC, it would facilitate the reduction of boundaries between healthcare and social care and would maintain the existing distinction of principle between the CQC, which focuses on care quality, and Monitor, which focuses on financial performance.**

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[67] *Ibid*.

[68] Q50

[69] Department of Health, *Oversight in Adult Social Care, The consultation response*, May 2013, p 15

[70] Q50

[71] Q51

[72] Q51

[73] Q58

A Fit and Proper Persons test

58. Part of the revised registration process arises from the Government's desire for the CQC to operate a fit and proper persons test (FPPT) so that "named directors or leaders of organisations are personally held to account"[74] for the commitment made at registration "to deliver safe, effective, compassionate, high-quality care."[75]

59. It is expected that the powers to implement penalties as part of the FPPT will come into force in April 2014. The ultimate sanction in this regard will be the power to remove board members from their post by placing a condition on a provider's registration. Allied to this, the CQC could bring a prosecution resulting in a fine.[76]

60. The Government proposes that regulations should define a fit and proper person, and the Government's consultation on the proposals stated that:

> This could include identifying if there are any concerns from general or financial background checks about the individual's honesty and integrity, competence and capability and previous history as a Director.[77]

The CQC said in written evidence that over time they would develop intelligence to guard against individuals who would fail the test being appointed elsewhere:

> Names of all directors will be collected as part of the application process. Information about Directors/Board Members will build over time and CQC will be able to check their intelligence when a new organisation applies to register, to determine if any of the listed Directors have been associated with a provider whose registration had been previously cancelled or refused by CQC.[78]

61. In order minimise the administrative and bureaucratic burden of the FPPT the Government proposes a model whereby:

> organisations retain full responsibility for appointing trustees and/or senior managers and Board members. However, the regulator has a power to intervene where it considers an individual is not a fit and proper person.[79]

62. The Government proposes that the requirement for a FPPT should apply to "the senior governance positions"[80] of NHS Trusts and Foundation Trusts, independent healthcare organisations and social care providers, but the CQC stated in written evidence that it would not be asked to apply the test to Chairs of NHS Trusts or Foundation Trusts.[81] The FPPT also provides an additional dimension to the regulation of private providers of care by providing a link between those who determine the quality of care and the financial

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74 CQC, _A New Start_, June 2013, p 11

75 _Ibid_.

76 CQC, _A New Start_, June 2013, p 18

77 _Ibid_, p 9

78 CQC (ACQ 020), para 8

79 Department of Health, _Strengthening corporate accountability in health and social care_, July 2013, p 8

80 _Ibid_.

81 CQC (ACQ 020), para 10

performance of a provider, and David Behan noted in oral evidence that the purpose of strengthening registration was to allow the CQC "to hold people who sit behind service provision to account"[82].

63. **The Committee welcomes the introduction of the fit and proper person test for senior governance positions, but does not understand why it is proposed to exclude Chairs of NHS Trusts and NHS Foundation Trusts from the scope of this test. It does not believe that this exclusion will be understood or accepted by public or patients.[83]**

Inspections

64. The process of inspection is changing significantly as the CQC adopts a model of differentiated, in-depth inspection. In relation to hospitals, the CQC has said that inspections will typically last for a total of 15 days with 6 to 7 days on site.[84] The Department of Health summarised the new approach in its evidence and said that CQC inspectors would:

> spend longer inspecting hospitals and cover every site that delivers acute services and eight key services areas: A&E, maternity, paediatrics, acute mental health and surgical pathways, care for the frail elderly, end of life care and outpatients. Each inspection will start with a listening event to canvas and collate views and experiences of patients, carers and staff. Inspections will be a mixture of announced and unannounced visits and will include inspections in the evenings and weekends.[85]

65. In the report of the last accountability hearing with the CQC, the Committee was critical of the CQC for using specialist inspectors in only 13 per cent of inspections.[86] The new model abandons generalist, generic inspections and from 2013-14 the CQC intends only to operate "teams of inspectors who specialise in particular types of care."[87] The CQC said that in-depth inspection teams should be in place by Q3 of 2013-14.

66. Commenting on the old model of inspection, David Behan told the committee that "I was absolutely clear on coming into this job that the generic model did not work and we needed to move away from it and to specialist inspections."[88] Explaining the new system, the CQC's consultation document said that differentiated inspection means that some hospitals regarded as outstanding might only be inspected every 3 to 5 years. Good hospitals might only be inspected on a 2 to 3 yearly basis, adequate hospitals annually and inadequate hospitals as and when required. Mr Behan confirmed, however, that in the new system no provider would go as long as five years without inspection. He said that the CQC

82 Q119

83 Q120–Q121

84 CQC, *A New Start*, June 2013, p 27

85 Department of Health (ACQ 01), para 14

86 HC 592, p 14

87 CQC, *A New Start*, June 2013, p 17

88 Q89

"got a very clear message from our consultation that five years is out. Nobody is interested in anything being on a five-year frequency."[89]

67. The CQC told the committee that although indicators within the surveillance model would be the trigger for inspection[90], at ward level specific problems in otherwise good or outstanding hospitals might not be picked up.[91] This builds on the observation made by David Prior that it was not possible for the CQC to "pick up everything in a hospital"[92] and that providers were ultimately responsible for the standard of care provided. Mr Prior said:

> If you think that we are the guarantor and deliverer of high quality standards, that just is not the case. We have to rely upon clinicians, boards and commissioners as well as on ourselves. If you are looking to us solely to deliver high-quality care in Britain, you will be disappointed.[93]

Echoing this view, the FTN warned in their written evidence that "primary responsibility for the standards of care provided to patients lies with the provider boards. [...] Unrealistic expectations of what CQC can do risk it being set up to fail."[94]

68. **The CQC has an important role in providing quality assurance for a vital public service, but it cannot guarantee care quality. Primary responsibility for the quality of care delivered to patients rests unambiguously on the staff and management of care providers.**

69. **The Committee believes that generic inspection was a failure and the new model is a necessary step towards making the CQC an effective regulator. The proposed system represents a comprehensive improvement but the CQC must ensure that inspection is accurately targeted at risk. Surveillance will not always identify specific risks in outstanding hospitals and some high risk services will require frequent inspection even if they are regularly classified as 'outstanding'.**

Assessing the culture of providers

70. In the report of the Committee's last accountability hearing, we recommended that:

> as part of a general consultation about regulatory method, CQC should consult in particular on how to assess the culture of a care provider – in order to satisfy itself that a healthy open culture prevails amongst professional staff.[95]

In response to this the CQC said they would work with Monitor, the NHS Trust Development Authority and NHS England to agree how culture can be assessed and how the fundamental standards should be developed.[96]

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89 Q95

90 Q35

91 Q37

92 Q1

93 Q106

94 Foundation Trust Network (ACQ 09), para 4.3

95 HC 592, para 31

71. The CQC's fifth key question to be examined during inspection asks whether a provider is well led. The CQC said that:

> By well-led, we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation, and an open, fair and transparent culture that listens and learns from people's views and experiences to make improvements. The focus of this is on quality. For example, does a hospital board make decisions about quality care based on sound evidence and information about their services, and are concerns discussed in an open and frank way? Is there a good complaints procedure that drives improvement?[97]

72. The Department of Health emphasised that in relation to NHS hospitals "the Chief Inspector of Hospitals will consider the culture of a Trust during inspections visits, in particular whether it is well-led, when deciding an overall assessment."[98]

73. **The Committee welcomes the CQC adopting our recommendation to assess the culture of providers as a core part of the inspection process. This assessment must be developed so that it does not simply measure Board level governance practices, but properly assesses whether a culture of openness and challenge exists amongst frontline staff.**

74. **In the report on the Committee's 2012 accountability hearing with the CQC we concluded that:**

> **A key element of this assessment [of culture] should be a judgement about the ability of professional staff within the organisation to raise concerns about patient care and safety issues without concern about the personal implications for the staff member concerned.**

The Committee believes that the CQC should undertake an assessment of both the number of concerns raised by staff members and the way in which those concerns have been addressed. This would serves as a useful proxy by which the CQC can begin to measure the culture of an organisation.

Staffing and workforce planning

Restructuring

75. In oral evidence David Behan provided an overview of how the CQC workforce would be restructured to meet the demands of the new inspection model. He said:

> We are committed to introducing our restructured organisation where people will be organised on a specialist basis by 1 April next year, so we will begin that process of restructuring and moving from the current model we have of people being organised

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[96] 2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13, First Special Report of Session 2013–14, HC 154, para 8.3

[97] CQC, *A New Start*, June 2013, p 10

[98] Department of Health (ACQ 01), para 17

geographically and generically into our specialist model. That is a huge change. All 2,000 people in this organisation will change their role.

We are also committed in our hospital, adult social care and primary medical services inspections that inspections will not be carried out by single inspectors. Inspection has ceased to become an individual pursuit and has become a team pursuit.[99]

76. In written evidence the Royal College of Nursing's (RCN) written evidence expressed concern about the process that the CQC is undertaking to change its workforce. Their evidence said:

We remain concerned about the lack of a robust approach to workforce planning within the CQC; how the CQC will transition away from a generic inspector model; and the pressing need to improve learning and development opportunities and support for staff.[100]

77. The FTN has welcomed the concept of specialist inspection teams, but they too expressed concern that "there are shortages of skilled inspectors in some areas, such as governance, which CQC must address urgently".[101] The CQC explained in oral evidence that whilst they would eventually employ approximately 1,110[102] full time inspectors there would also be a bank of clinical experts who could be added to inspection teams as and when required.[103]

Workforce Planning

78. In order to establish new teams the CQC's business plan recognised the requirement for extensive staff training in new methodologies over the course of 2013-14.[104] In addition, an element of the costs associated with the strategic review (£20 million in total) has been allocated to the recruitment of "more experienced specialists into senior inspector roles".[105] The CQC's additional written evidence noted that the recruitment programme for inspectors in each speciality would largely be determined by the Chief Inspectors and that the overall programme was expected to last approximately 18 months.[106]

79. In their written evidence the CQC provided an overview of the training programme that would be necessary to develop the inspection workforce to service the new model. The evidence stated that:

To support our staff through the changes to the new model of regulation we have recently launched an Academy. Through the Academy will ensure that all members

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[99] Q69

[100] Royal College of Nursing (ACQ 07), para 3.8

[101] Foundation Trust Network (ACQ 09), para 6.3

[102] Q78

[103] Q85

[104] Care Quality Commission, *Business Plan 2013–14*, p 20

[105] *Ibid.*

[106] CQC (ACQ 020), para 4

of staff, starting with inspectors, are appropriately trained to carry out their work. [...] We have recently carried out a skills audit amongst our inspectors to assess the degree of training required, and to assist with the redeployment of inspectors into the new ways of inspecting.[107]

80. **The CQC is planning to recruit an additional 150 inspectors to increase their establishment from 950 to 1,100.[108] This process is vital to improving the effectiveness of the organisation; we therefore recommend that the CQC set an early target date for the achievement of this increase and provides regular reports to Parliament on progress towards delivery of this objective.**

Funding for workforce changes

81. David Behan told us in oral evidence that in total the CQC would "need about 2,700 staff in the future to discharge our responsibilities".[109] The CQC's additional written evidence outlined the support services which lie behind the core inspection teams:

> there will be 2 enabling directorates; strategy and intelligence and corporate services. Strategy and intelligence includes intelligence, engagement, strategy and planning and performance functions. The intelligence function will increase with the enhanced surveillance required to provide greater analytical support to the inspection directorates. Corporate services provide back office functions, IT, HR, finance and estates, governance, legal services and the national customer service centre, which makes up a significant proportion of the staff in that directorate.[110]

82. Beyond the £20 million allocated by the Department of Health to support the recruitment, training and workforce development programmes, David Behan told the Committee that £29 million would be available in the next year to support the new inspection process.[111] The CQC's written evidence conceded, however, that exact proposals for how this funding would be deployed had yet to be put in place: "some of this additional funding would be spent on recruitment; we have not yet calculated the exact costs."[112]

83. **Substantial additional resource is being directed towards the CQC; the Committee recommends that the CQC Board reach early decisions about the allocation of this additional resource and that it make its decision public.**

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107 CQC (ACQ 02) para 39

108 Q78

109 Q91

110 CQC (ACQ 020), para 6

111 Q80

112 CQC (ACQ 020), para 4

Ratings

84. In its consultation document 'A New Start' the CQC proposes a rating system for NHS hospitals comprising four separate classifications:

Proposed hospital ratings

    i.   Inadequate

    ii.   Requires improvement

    iii. Good

    iv. Outstanding

The Department of Health said in its written evidence that the new regime was needed to:

> give patients and the public a fair, balanced and easy to understand assessment of how well a provider is doing relative to its peers. In addition, clear ratings on performance will help incentivise providers to improve their services, as they will be able to see how well they are doing in comparison to their peers.[113]

85. The CQC has confirmed that following inspection all providers across health, adult social care and primary care will be afforded an overall rating. In oral evidence David Prior explained that large hospitals would be given an overall rating but:

> there will also be a rating of the eight core services, which are identified as A and E, maternity, paediatrics and the like.[114] There will also be a rating for whether it is well led and whether there is compassionate, safe, effective care and responsiveness.[115]

Mr Prior added that the eventual aim was to rate every service within a hospital, but did not attach a timeframe to this. David Behan explained in oral evidence that the process for establishing rating methodologies in adult social care and primary care remained at an early stage.[116]

86. **The Committee welcomes the decision to publish ratings for all health and care providers. It is essential that the CQC act quickly to establish public understanding of, and confidence in, the ratings system.**

Providing information to the public

87. Behind the headline rating attached to a hospital, care home or GP surgery, there will be a detailed inspection report. In our last report the Committee recommended that CQC explore how they "can more effectively communicate with residents of care homes and

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[113] Department of Health (ACQ 01) para 18

[114] A&E, maternity, paediatrics, acute mental health and surgical pathways, care for the frail elderly, end of life care and outpatients

[115] Q6

[116] Q104

their relatives about the outcomes of inspections".[117]   We made this recommendation because "providers are not simply offering an episode of care with a finite end date but offering residents a permanent home combined with life-long care".[118]

88. **David Prior informed the committee that the CQC was "going to consider writing to residents of a care home, for example, telling them in words of plain English, 'This is what we have found'."[119] The Committee is disappointed that the CQC is still "going to consider" this issue. It regards early action as fundamental to delivery of the core purpose of the CQC. It recommends that this recommendation of last year's report is adopted and implemented by the CQC no later than 30 June 2014.**

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[117] [HC 592](#), para 50

[118] *Ibid*.

[119] Q105

5 Governance

Internal culture

89. At previous accountability hearings we have taken evidence on the workplace culture within the CQC. In the committee's last report we outlined worrying practices related to the excessive workloads of inspectors. The committee's report of the 2012 accountability hearing reported that:

> the average inspector's caseload has increased from approximately 50 locations per compliance inspector as at 1 April 2010 to 62 locations per inspector on 1 April 2011.[120]

The Committee also reported evidence from the RCN that inspectors were being forced to manage excessive caseloads partly as a result of having to provide cover for absent colleagues.[121]

90. The CQC's written evidence demonstrated that CQC management accepts that there has been a chronic problem with the CQC's workplace culture. The CQC provided evidence regarding the outcomes of their staff surveys which stated that:

> Bullying, harassment and discrimination were areas identified in the 2012 survey as giving cause for concern. As a result, Sarah Hunter, an independent consultant, was appointed to lead an independent review of bullying and harassment within CQC. Her report, published in June 2013, found that there was a worrying level of perceived bullying and harassment and made recommendations to address the issues identified.[122]

The independent report confirmed the concerns expressed by the RCN and concluded that:

> manifestations of bullying are systemic and largely the result of the number of reorganisations that the CQC has gone through whilst being expected to deliver an increasing workload.[123]

The report found that:

> Many people we spoke to talked about workload in the context of institutional bullying. "This is a long hours culture – they wring the blood out of you." [...]

> A number of those who had experienced bullying by their line manager connected it to their desire to make more thorough inspections than their line manager felt was necessary.[124]

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[120] HC 592, para 45

[121] *Ibid.*

[122] CQC (ACQ 02), para 37

[123] People Opportunities Limited, *Exploring Bullying and Harassment in the CQC*, June 2013, p 3

[124] *Ibid*, p 16

91. The CQC's written evidence outlined the new mechanism for members of staff to report concerns about workplace practices to a senior board member:

> Michael Mire, one of the newly appointed non-executive directors, has been appointed as the Senior Independent Member to whom members of the Commission and members of staff can raise their concerns where they feel that they cannot do so through their line management or through HR.[125]

In oral evidence David Behan added that staff surveys would be conducted twice yearly by an independent organisation. He reported the outcome of their most recent survey, which had found that:

> 82% said that they were positive about the CQC changing for the better. Staff satisfaction went up to 61% and they calculated an engagement index at 63. The public sector average is 56.[126]

Mr Behan, however, qualified the positive outcomes of the staff survey and said:

> I am not happy to be average and I am certainly not happy just to beat the best of the public sector. [...] Our lowest scores in the survey—it is not appropriate just to look at the high scores—were about whether people feel valued in the CQC, whether their morale is high, and whether they have confidence that the senior leadership will effectively make the changes that we have to make.[127]

92. **The Committee welcomes the CQC management's commitment to this process of culture change within the organisation and, in particular, their commitment to monitor progress in delivering this objective.**

93. **Creating a mechanism for staff to report bullying and harassment to a director at a very senior level will help the executive team and the Board maintain a realistic understanding of the experiences of the CQC's frontline workforce. Whilst this is an important step that delivers necessary senior oversight, this system, in itself, is not enough to eliminate the culture that has produced bullying and harassment.**

94. **Concern has been expressed to the Committee about the impact of individual workload on the culture of the organisation. Management of workload is an important part of business planning. At our next accountability hearing the Committee will seek assurances that workforce planning associated with the new regulatory model has not repeated the mistakes of the past and that inspectors are be able to complete their work thoroughly (including weekend and out-of-hours inspections) without being required to manage unreasonable workloads.**

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[125] CQC (ACQ 02), para 37

[126] Q130

[127] *Ibid.*

Funding

95. In 2012–13 the CQC's expenditure was £166 million, £17 million more than the £149 million spent in 2011–12.[128] The CQC's net expenditure is funded by grant–in–aid from the Department of Health. This amounted to £60 million in 2012-13, up £15 million from the previous year.[129]

96. The CQC attributes the greater expenditure and funding requirement to the recruitment of additional staff. Of the £17 million increase in expenditure, £16 million was attributable to staff costs. In 2013-14 the CQC's revenue budget is expected to reach £180 million of which £80 million will be grant-in-aid.[130] The inclusion of £17 million in capital expenditure costs takes the CQC's total proposed expenditure for 2013–14 to £197 million.[131]

97. In 2012, the CQC said in its evidence to the Committee that in 2013/2014 it proposed generating £100 million from fees and reducing the grant-in-aid contribution from 24 per cent to 19 per cent of its overall costs. This was as part of a proposal to phase out grant–in–aid funding by 2015–16.[132]

98. The CQC's budget has risen rapidly in the last year and is likely to rise further. Mr Prior told the Committee that "Her Majesty's Government have wished us to become an effective strong regulator, and there is a cost attached to that."[133] He confirmed that it was no longer the CQC's objective phase out grant–in–aid funding. He explained the rationale behind this change in policy:

> At the moment we spend about £153 million[134], of which £100 million comes from fees. In three years' time we will be spending between £200 million and £210 million. I do not think our fees are going to go up by very much, but we will see.[135]

Mr Prior added that that CQC's funding for the next three years had been "substantially agreed with the Department of Health"[136] but he was less sure "how far they have agreed it with the Treasury."[137]

99. David Behan explained that the three-year registration and inspection strategy required a financial plan to support it.[138] David Prior told the Committee that uncertainty still exists

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[128] HC 374, p 81

[129] *Ibid*, p 83

[130] CQC (ACQ 02), para 27

[131] Care Quality Commission, *Business Plan 2013–14*, p 19

[132] HC 592, Ev 50

[133] Q126

[134] The CQC's recurring budget in 2012–13

[135] Q125

[136] Q127

[137] Q127 (Mr Prior)

[138] Q127 (Mr Behan)

regarding funding after 2013–14, he said "for the next two years, the details are still being nailed down, but in principle we have full support from the Department."[139]

100. **The Committee welcomes the commitment that has been given to ensure adequate funding for the CQC. In the longer term, however, the independence of the CQC will be substantially reinforced when arrangements are in place to ensure that the cost of regulation is met by the registrant community.**

The case of Anna Jefferson

101. On 3 October 2013 it was announced that the CQC's Head of Media, Anna Jefferson, had been cleared of any wrongdoing by an internal inquiry examining allegations that a critical internal report related to University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT) had been suppressed by senior CQC staff. The Grant Thornton report alleged that Ms Jefferson had been involved with the decision to cover up the report, claiming that she said "this can never be in the public domain nor subject to FoI."[140]

102. Ms Jefferson, who was a media manager at that time, contested ever having made the remarks, arguing that her concern was that the internal report was not of a good enough standard and that an external party should review the registration of UHMBFT. In written evidence submitted to the Committee in June 2013 she said that Grant Thornton had never put the quote to her in interview despite saying otherwise.[141]

103. The CQC statement which followed the review conducted in line with the CQC's disciplinary procedures concluded that:

> Anna Jefferson had not supported any instruction to delete an internal report prepared by a colleague – Louise Dineley – or otherwise acted inappropriately in that regard.[142]

It added:

> The CQC regrets any distress Anna Jefferson has suffered as a consequence of this matter and is pleased to welcome Anna back to the organisation following a period of maternity leave. She is currently undertaking a course of postgraduate study with CQC's support.[143]

104. Commenting on the implications of this sequence of events, David Prior told the committee that the CQC's internal findings had not challenged the overall conclusions of the Grant Thornton report. Mr Prior said:

> They (Grant Thornton) raised issues about the behaviour of certain individuals, which we looked at very carefully. They raised issues but did not come to a

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[139] Q128

[140] Grant Thornton, *The Care Quality Commission re: Project Ambrose*, June 2013, p 265

[141] HC 526-i, 3 July 2013, Ev 27

[142] http://www.cqc.org.uk/public/news/statement-regarding-anna-jefferson

[143] *Ibid*.

conclusion that anyone was guilty of this, that or the other. They raised issues. We checked those issues out very thoroughly through a disciplinary process and found that, in the case of Anna Jefferson, the allegations raised were not valid.[144]

105. The Committee does not find this argument convincing. The Grant Thornton report concluded that any attempt to withhold the internal report, even on the grounds that it was not of sufficient quality, could not be justified.[145] As a result Grant Thornton concluded that there may have been an attempt to 'cover up' the internal report and that the evidence was persuasive.[146] The Grant Thornton report, therefore, did more than simply raise issues: it sought to form conclusions based on the behaviour and actions of CQC staff.

106. Mr Prior said that the case of Anna Jefferson and the outcome of the disciplinary investigation:

> does not in any way undermine the major thrust of the Grant Thornton report, which was that the whole organisation, and the regulatory system that we were implementing, was completely unfit for purpose.[147]

107. The Committee agrees with this statement. Mr Behan noted that there was no "contemporaneous evidence in relation to the allegation against her" [Anna Jefferson]. In the light of this observation the Committee regards it as regrettable that the Grant Thornton report appeared to lend weight to the allegation.

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[144] Q32

[145] Grant Thornton, June 2013, para 6.248 – 6.249.

[146] *Ibid*, paras 6.252

[147] Q32

Conclusions and recommendations

Purpose of the CQC

1. The Committee welcomes the fact that the CQC has now set out its objectives in clear terms. This in turn has helped to provide clarity to a regulatory landscape the committee described in 2012 as "cluttered and opaque". The Committee believes that the CQC is now ready to undertake a programme of substantial reform to develop and improve its regulatory functions. (Paragraph 11)

Chief Inspectors

2. The Committee welcomes the fact that the Chief Inspectors are accountable to the CQC Board. As the methodology for registration, inspection and rating of health, social care and primary care advances over time the Chief Executive, acting on the authority of the Board, will play an important role in coordinating the approaches of the Chief Inspectors in order to maintain a consistent approach on these key issues across the activities of the CQC. (Paragraph 21)

Definition of Standards

3. The Committee notes the intention to revise the CQC's powers to enhance its ability to quickly prosecute directors and corporate bodies in the most serious cases. We believe, however, that in most cases, the ability to close a unit or a department by cancelling a provider's registration and withdrawing their licence is of more immediate significance to patient care. The Government and the CQC should keep these powers under review to ensure the CQC enjoys a sufficient range of sanctions to levy against failing providers. (Paragraph 26)

Expected standards

4. The committee believes that the CQC's broad approach of linking five key questions to the inspection of expected standards and linking immediate regulatory action to breaches of fundamental standards has the potential to simplify the regulatory process. Provided the CQC focuses on evidence of outcomes achieved, there is now an opportunity to move away from a system that focused on inputs and failed to illustrate a realistic picture of the standards of care offered by providers. (Paragraph 32)

5. The ultimate test of the new standards will be whether they are meaningful in relation to the everyday experiences of patients, care home residents and the public. The committee welcomes the commitment on the part of CQC to take immediate action against providers who fail to meet fundamental standards and therefore breach their registration requirements. If applied firmly, we believe this measure has the potential to considerably enhance the credibility of the new system. (Paragraph 33)

Implementation of reform

6.   If the CQC seeks to prioritise everything then they will prioritise nothing, but they must now begin to provide detailed information to the full breadth of health and social care providers to build support for reform across the system. At our next accountability hearing we expect the CQC to present clear details of how the effective registration, surveillance and inspection procedures will be extended beyond hospitals to cover adult social care and general practice. In particular the CQC should by then have developed clear and creative proposals for scrutinising the quality of care delivered by providers in a person's own home. (Paragraph 39)

Surveillance

7.   If it is to build public confidence in a risk based regulatory system the CQC will require early identification of developing problems. The surveillance system must identify problems and trigger inspections before they become widely publicised by the media, patient groups or local representatives. If the CQC's surveillance model cannot pre-empt high profile failings it will be viewed as purely reactive and will not be regarded as a credible basis for regulatory activity. (Paragraph 43)

8.   The Committee welcomes the importance attached to staffing levels by the CQC. We believe that analysis of staffing figures should not only be part of inspection but should also form a fundamental part of the surveillance model. Staffing data should extend beyond the ratio of registered nurses to patients working on a hospital ward and should examine other measures, such as consultant coverage in emergency departments, which is a crucial factor in improving patient outcomes. Information gathered from surveillance which suggests that staffing levels are inadequate should be a trigger for inspection as "the quality of care that people receive is related to the number of staff on duty." (Paragraph 46)

9.   The Committee welcomes the commitment made by the CQC that the fundamental standards by which providers are registered will incorporate appropriate staffing levels. It is essential that those providers that fail to achieve adequate staffing levels are aware that they are in breach of fundamental standards and therefore liable not only to inspection but also to regulatory action including prosecution. The regulations have yet to be published and it is vital that the public have the opportunity to scrutinise how they define an 'appropriate staffing level'. (Paragraph 48)

10.   The committee is pleased that the CQC is, in principle, willing to take on the responsibilities that once resided with the NPSA. It is illogical to split different aspects of patient safety between NHS England and the CQC and this reform would simplify the regulatory environment. The Committee believes that would allow more information to be quickly factored into the CQC's surveillance model which already includes 'never events' in its first tier of indicators. (Paragraph 51)

Financial monitoring of social care

11.   Undertaking the financial monitoring of adult social care is a significant challenge for the CQC and it is essential that they procure the right skills to fulfil this role. David Behan noted in his evidence that there was a close correlation between poor quality and poor financial performance, saying that "[m]aking a distinction between finance and quality is a false distinction." We do not dispute this point, but the Committee believes that, ultimately, it is easier to identify and address poor quality at an early opportunity than it is to demonstrate that a provider is financially distressed. (Paragraph 56)

12.   We recommend that the Government should reconsider its decision to allocate this responsibility to CQC and that it should ask Monitor to undertake this role. Although this development would divide oversight of adult social care between Monitor and the CQC, it would facilitate the reduction of boundaries between healthcare and social care and would maintain the existing distinction of principle between the CQC, which focuses on care quality, and Monitor, which focuses on financial performance. (Paragraph 57)

13.   The Committee welcomes the introduction of the fit and proper person test for senior governance positions, but does not understand why it is proposed to exclude Chairs of NHS Trusts and NHS Foundation Trusts from the scope of this test. It does not believe that this exclusion will be understood or accepted by public or patients. (Paragraph 63)

Inspections

14.   The CQC has an important role in providing quality assurance for a vital public service, but it cannot guarantee care quality. Primary responsibility for the quality of care delivered to patients rests unambiguously on the staff and management of care providers. (Paragraph 68)

15.   The Committee believes that generic inspection was a failure and the new model is a necessary step towards making the CQC an effective regulator. The proposed system represents a comprehensive improvement but the CQC must ensure that inspection is accurately targeted at risk. Surveillance will not always identify specific risks in outstanding hospitals and some high risk services will require frequent inspection even if they are regularly classified as 'outstanding'. (Paragraph 69)

16.   The Committee welcomes the CQC adopting our recommendation to assess the culture of providers as a core part of the inspection process. This assessment must be developed so that it does not simply measure Board level governance practices, but properly assesses whether a culture of openness and challenge exists amongst frontline staff. (Paragraph 73)

17.   In the report on the Committee's 2012 accountability hearing with the CQC we concluded that:

> A key element of this assessment [of culture] should be a judgement about the ability of professional staff within the organisation to raise concerns

about patient care and safety issues without concern about the personal implications for the staff member concerned.

The Committee believes that the CQC should undertake an assessment of both the number of concerns raised by staff members and the way in which those concerns have been addressed. This would serves as a useful proxy by which the CQC can begin to measure the culture of an organisation. (Paragraph 74)

Staffing and workforce planning

18. The CQC is planning to recruit an additional 150 inspectors to increase their establishment from 950 to 1,100. This process is vital to improving the effectiveness of the organisation; we therefore recommend that the CQC set an early target date for the achievement of this increase and provides regular reports to Parliament on progress towards delivery of this objective. (Paragraph 80)

19. Substantial additional resource is being directed towards the CQC; the Committee recommends that the CQC Board reach early decisions about the allocation of this additional resource and that it make its decision public. (Paragraph 83)

Ratings

20. The Committee welcomes the decision to publish ratings for all health and care providers. It is essential that the CQC act quickly to establish public understanding of, and confidence in, the ratings system. (Paragraph 86)

21. David Prior informed the committee that the CQC was "going to consider writing to residents of a care home, for example, telling them in words of plain English, 'This is what we have found'." The Committee is disappointed that the CQC is still "going to consider" this issue. It regards early action as fundamental to delivery of the core purpose of the CQC. It recommends that this recommendation of last year's report is adopted and implemented by the CQC no later than 30 June 2014. (Paragraph 88)

Internal culture

22. The Committee welcomes the CQC management's commitment to this process of culture change within the organisation and, in particular, their commitment to monitor progress in delivering this objective. (Paragraph 92)

23. Creating a mechanism for staff to report bullying and harassment to a director at a very senior level will help the executive team and the Board maintain a realistic understanding of the experiences of the CQC's frontline workforce. Whilst this is an important step that delivers necessary senior oversight, this system, in itself, is not enough to eliminate the culture that has produced bullying and harassment. (Paragraph 93)

24. Concern has been expressed to the Committee about the impact of individual workload on the culture of the organisation. Management of workload is an important part of business planning. At our next accountability hearing the Committee will seek assurances that workforce planning associated with the new

regulatory model has not repeated the mistakes of the past and that inspectors are be able to complete their work thoroughly (including weekend and out-of-hours inspections) without being required to manage unreasonable workloads. (Paragraph 94)

Funding

25. The Committee welcomes the commitment that has been given to ensure adequate funding for the CQC. In the longer term, however, the independence of the CQC will be substantially reinforced when arrangements are in place to ensure that the cost of regulation is met by the registrant community. (Paragraph 100)

Formal Minutes

Tuesday 14 January 2014

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper	Andrew Percy
Andrew George	Mr Virendra Sharma
Barbara Keeley	David Tredinnick
Charlotte Leslie	Valerie Vaz

Draft Report (*2013 accountability hearing with the Care Quality Commission*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 107 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

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

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

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

[Adjourned till Tuesday 21 January at 2.00 pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's web page at http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cqc-2013/?type=Oral#pnlPublicationFilter

Tuesday 22 October 2013   *Question number*

David Prior, Chair, and **David Behan CBE,** Chief Executive, Care Quality
Commission.   Qq 1–130

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/cqc-2013/?type=Written#pnlPublicationFilter. INQ numbers are generated by the evidence processing system and so may not be complete.

1   Department of Health (ACQ 01)
2   Care Quality Commission (ACQ 02)
3   The Royal College of Radiologists (ACQ 03)
4   English Community Care Association (ACQ 04)
5   Lifeways (ACQ 05)
6   Dr Richard Fairburn (ACQ 06)
7   Royal College of Nursing (ACQ 07)
8   General Medical Council (ACQ 08)
9   Foundation Trust Network (ACQ 09)
10   The Royal College of Pathologists (ACQ 10)
11   Relatives and Residents Association (ACQ 11)
12   David Hogarth (ACQ 12)
13   Dr Mark Tattersall (ACQ 13)
14   South West Whistleblowers Health Action Group (ACQ 14)
15   Margaret and Janet Brooks (ACQ 15)
16   The King's Fund (ACQ 16)
17   Care Quality Commission (ACQ 20)