HOUSE OF COMMONS

Health Committee

Oral evidence: 2013 accountability hearing with the Care Quality Commission, HC 761

Tuesday 22 October 2013

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Written evidence from witnesses:

- Care Quality Commission

Watch the meeting

Members present: Mr Stephen Dorrell (Chair); Andrew George; Barbara Keeley; Charlotte Leslie; Andrew Percy; David Tredinnick; Valerie Vaz;

Questions 1-130

Witnesses: **David Prior, Chair, and David Behan, Chief Executive**, Care Quality Commission, gave evidence.

Q1 Chair: You are welcome. On these occasions I normally ask witnesses to introduce themselves. You might feel you have been here sufficiently often for that to be unnecessary. You come on an occasion where we are at least in calmer water. We would like to examine not just the specifics of the cases that we have discussed on previous occasions but where the CQC is on the path of improvement that was acknowledged to be necessary following both of you taking up your roles over the last 12 months.

I would like to open by asking you this. It is an acknowledged fact—and you have both acknowledged it in public many times—that the CQC, until recently, has not been delivering the service that the public looked to it to deliver. You have both committed the organisation to a process of renewal and raising of standards. The core question I am interested in is, what do you think we should be looking for to assess how successful you are being in delivering that objective? What does good look like and how do we recognise it when we see it?

David Prior: It is very much work in progress at the moment. As to the new hospital inspections we have started, we will have done 18 by Christmas and we will have published a shadow rating for three of them. An assessment of those 18 inspections will be very important. The question is, have we got underneath the skin of these hospitals? Can we actually do an inspection that can determine whether or not that hospital is safe, well led, of high quality and providing compassionate care? I guess the jury is still out on that.

I should say that, as to the ones we have done so far, we have had between 25 and 30 people on the inspection team, a large preponderance of clinicians and experts by experience as well as inspectors, and Mike Richards' view is that we are getting underneath the skin of those hospitals, finding out what is happening and getting a real understanding of what is going on in them. If we can do that and hold it up as an accurate mirror to the public, commissioners and to other hospitals, that will be one marker in the ground in the hospital sector of what is good. It will not pick up everything. We are not going to pick up everything in a hospital.

To give you an idea of the size of it, Barts has revenues of £1 billion, employs 15,000 people and is on five different big hospital sites. We are not going to pick up everything in every ward, department and specialty, but we do feel that we will pick up systemic problems in those hospitals. So, in the hospital sector, the honest answer to the question is that it is too early to say, but that is critical to me. Are we getting under the skin of those hospitals?

Q2 Chair: Mr Behan, do you wish to enlarge on that?

David Behan: No, but I think it is an important question, Chair, and, just to build on what David has said, public, political and professional confidence has been shaky in the CQC, so one of my measures will be a restoration of public, political and professional confidence. The way we will do that is by doing what we have been set up to do. You personally have challenged us about clarity of purpose on numerous occasions and we have tried to settle that issue about our purpose and clarity of purpose. Now what we are doing is building an organisation that will deliver that purpose. We have reorganised at a senior level. Andrea is here behind me; Mike Richards is off to a flying start, if I may say so. We are six inspections into the 18 by Christmas. I did the Barking, Havering and Redbridge inspection for a couple of days last week and will join the Bournemouth inspection on Friday this week. We are using that wave 1 group to think our way into and challenge ourselves in the way that we are taking that forward, learning from every one and tweaking the way we approach the learning we extract from each of those inspections. I am confident that, by the time we get to the end of these 18 and into the second wave beginning in January, we will have extracted the learning and will be building on that.

Q3 Chair: When will these reports start to reach the public domain?

David Behan: We are doing 16 inspections; we will release them in batches of four. The first will come out in November, then December, January and February, which means they will be coming out approximately eight weeks after we have completed the inspection. That will be the schedule coming through. Thereafter, we will release them as we go. We are doing that with these first batches so that we can extract the learning and make sure we have the calibration across all of them so that the rating and the judgment we arrive at in the first will be similar in the 16th one—which is why we are doing that.

Q4 Chair: Do you have any public process for assessing your own assessments—in other words, public feedback either from the hospitals themselves or from other people who may be able to provide a user's view of your reports?

David Behan: On our current methodologies, Chair, we survey those that we have inspected about how they have found us and we use that information in the way that we move forward. The returns we get on that survey work show that most people are satisfied. This links to and correlates with—

Q5 Chair: But they cannot know that because they have not seen the report yet.

David Behan: That is on these new ones, but on the current ones we ask people and we will continue that practice. We have also recruited Keiran Walshe of Manchester Business School to do an evaluation of wave 1 and wave 2 inspections, and we will do that along with our own internal evaluation capacity. We have built that up over the past few weeks to make sure we have the capability to do it. Certainly in Barking, Havering and Redbridge, the chief executive was keen to point out both to myself and Mike at the feedback meeting that staff had valued the way that we had conducted ourselves and conducted the interviews with them; they felt that it had been a proper process and one that they could give to.

David Prior: Can I add to that? When the inspection report has been written, there is then a quality summit held where the commissioners, local patient groups or anyone can come to discuss the report, which is again an important part of the process.

David Behan: We think we are writing these reports, Chair, for people that use services, so they will be written in a style that is accessible to patients, relatives and residents—your family members or my family members—so it is accessible to people. We do not see these as being written essentially for the providers of care. We see them being written for people who are using care. We are keen to adopt a style that is less bureaucratic, less legalistic in a sense, and much more about answering these five key questions around safety, effectiveness, caring, responsiveness and how well led a service is. That is the challenge. I was looking yesterday evening at one of the ones we are doing out of the first four inspections and will continue to work at that so that we are couching these reports in a language that is accessible to ordinary people and is not written for the boards of the chief executives and executive teams.

Q6 Chair: The implication of my line of questioning is to ensure that it is not just your opinion of the work that you are doing but that you are seen, real time, to be subject to assessment by precisely the kind of user groups that you are targeting, to ensure that they believe that you are speaking truth unto power, because if they do not believe that then we have not made the progress we need to make.

David Behan: Quite so, and one of the things we have done is this. Every inspection has people that use services as part of the inspection teams. They are not just speaking to other users of the service but to the executive teams and non-executive directors as well, so they are making a contribution to that. We use a people's panel to test our language. Our strategy and consultation documents will frequently use a people's panel to check that the language we are using is accessible and the right language to be using. We are constantly trying and testing our approach. You and Robert Francis have said that any of our work needs to be understandable to ordinary people, so we have taken that literally and seriously to make sure we are testing our language as we go.

Last Tuesday evening at Barking was a session with people who are using services in that hospital, so we are not just testing our methodologies—we are conducting our inspections based on the experiences of people who are using services and making sure we are testing those as well.

Q7 Valerie Vaz: I have a quick question on the report. Effectively, the report is a final report, is it, and no one can challenge what is in it, including the hospitals? Is that right?

David Prior: We provide the first draft of the report back to the hospital for them to check for factual accuracy, but it is our report—it is a final report—and it will be published.

David Behan: Of course, a key issue is that we are committed to introducing a rating scheme. We will produce three ratings by December, so three of the 18 inspections will drive a rating. We will publish those ratings, so it is absolutely essential that the judgments that we arrive at in these inspections are our judgments because it will then drive the rating.

Q8 Chair: Will the rating apply to Barts and its 15,000 employees as a single rating or to different departments within Barts if Barts is one of them?

David Prior: There will be 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. There will also be a rating for whether it is well led and whether there is compassionate, safe, effective care and responsiveness. So there will be a number of ratings. Ultimately, we want to be able to rate every department in the hospital—diabetes, radiology and the like—and we think we will be able to get there by working very closely with the royal colleges, using the peer reviews and clinical audits that they do already.

David Behan: Initially, the rating will be of a trust, but our ambition is that we will rate services within a trust. The key point here is that, if I have just had a stroke, I may be more interested in how the stroke service is going to operate; if I am pregnant and about to give birth, I might be more interested in how the maternity service is. It is that degree of granularity that we think we need to serve, hence David's point about the work we are doing with the medical royal colleges in relation to what potential use we can make of their clinical audits and how that can inform service level judgments as well as overall organisational judgments. But the background work that Jennifer Dixon did when she was at the Nuffield was saying that the degree of granularity we need about ratings needs to be about the quality and safety of services rather than overall organisations because that is ultimately what members of the public—patients—are interested in knowing about. That is our ambition, but it will take us time to get to that.

Q9 Chair: There is a final question and then I will move to others. The danger in this conversation so far is that we are making the old mistake of focusing on big acute hospitals. How does that methodology translate into inspections at primary care and small care homes and so forth?

David Behan: Absolutely. The approach we will take will extend across all of our services. Indeed, when Jennifer Dixon was carrying out the tasks that the Secretary of State asked her to, the appetite within the adult social care sector for what they saw as a return of ratings was huge because they had seen it having two advantages: first, it

provided people who were choosing care services with a guide to what they chose; secondly, they argued that it led to services being able to drive improvements because they all aspired to be good or better. That is the way that the adult social care sector has received this. Andrea only started two weeks ago, but she has got off to a flying start in relation to that work. In the document that we published last week on "A Fresh Start"—I think that was the title we gave it—we set out how we would work with the sector to develop those ratings. We have used the phrase "co-production." We are committed to that and that is what we will see through.

Q10 Chair: When will the first batch of those reports reach the public domain?

David Behan: We are saying we will begin our wave 1 inspections in relation to adult social care in 2014. We will begin to make our changes from spring 2014 in relation to producing our reports in a narrative style against the five questions of safety, effectiveness and caring and so on. We will begin formal consultation on the standards. We are waiting for the regulations from the Department and we expect those in the next few weeks. We will then consult on our guidance so that guidance and regulations are available from April and begin to use those through 2014-15. Our new model will be fully rolled out to all providers on adult social care from October 2014. Our ratings initially will come in from October 2014 for adult social care and we will have completed our inspection and rating of every adult social care provider by March 2016. We are on a three-year journey to make sure we can get through all of what is effectively 25,000 services—17,000 residential and 8,500 domiciliary care.

Q11 Chair: You have not mentioned primary care.

David Behan: Primary care has a similar time line. To be brutally honest, we need to do more work on developing that methodology and model. We will publish a signposting document at the end of November, similar to "A Fresh Start" that we published last week, which will set out some of our ambitions. We will be bringing in our changes in relation to inspection of out-of-hours services from April 2014 and will be piloting our new approach to general practice from January 2014. That is the approach we are taking, with ratings to follow as we build that methodology. We have pretty much nailed in quite firm detail how we will go through the period between now and 2016 to complete the transformation of the way that we operate across all three sectors over that three-year period.

Q12 Andrew George: Moving on to the issue of the chief inspectors— the three that have now been appointed—what was the fundamental weakness of the CQC for which the appointment of chief inspectors was the solution?

David Prior: The fundamental weakness was that we had a generic inspection model so that the same inspector would go into a dentist, an acute hospital and a care home. Now we are organising ourselves in, if you like, three separate units, so there will be a much greater degree of specialisation than we had in the past. That is not to say that we do not recognise fully that the trend of health and social care is towards greater integration. Within the capacity of each inspector, at least 20% of their time will be set aside to work across the patient pathway from social care into health care and primary care. We have gone for a much more specialist inspection model.

Q13 Andrew George: In relation to the status of each of those three inspectors, I notice that the chief inspector of hospitals is a board member but the other two inspectors are not—or at least not so far as we are aware from your submission to us. Has that position now changed?

David Prior: Yes. All three are board members.

Q14 Andrew George: In terms of the function and oversight role of the chief inspectors and the chief executive's role in relation to the chief inspector, how would you describe that relationship and in what way can the chief executive, if you like, negotiate priority or indeed even direct those priorities of the chief inspectors?

David Prior: The three chief inspectors report directly to the chief executive, who is accountable to the board. That is the management accounting structure within the CQC.

Q15 Andrew George: Can the chief executive, the board or the chairman challenge the judgments or conclusions of the chief inspectors?

David Prior: Yes. There will be a very robust discussion at times about what they want to do and how they want to do it. What is critical is that the judgment is independent of the NHS system and independent of the Secretary of State for health.

David Behan: The thing that I would emphasise, Andrew, is that, in a legal sense, Parliament has given the CQC as a body the power to inspect and regulate. The 2008 Act sets out our duties and responsibilities and they will be amended by the Bill that is currently in the Lords, which will be coming into this House soon. When that Bill secures Royal Assent, it will introduce new powers and amend some of the powers that were in the Act. It is through the delegations document from the board to me, from me to the chief inspectors and from the chief inspectors through the organisation that we carry out our responsibilities. 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. Of course people can go externally to tribunals and other places, but I think it is clear. I know there has been a lot of discussion about the nature of the role, the responsibility and so on, but I see the power and authority to act as being with the commission, and then through our system of delegations to me, and then, through me, to the chief inspectors, and through the organisation to others as well. There is no way, with 25,000 inspections, that Andrea is going to do every inspection in adult social care. So you need a system of delegations that is clear about who is delegated to do what, when, where, why and how, and that is the work that we will do as we continue the transformation and change within the organisation, to set out an organisational structure that can deliver our purpose with a set of systems and processes that allow us to do that. I do not wish to be boring and bureaucratic about this, but process has its place and we need to make sure it has its proper place in the way that we set up the organisation to move forward.

Q16 Andrew George: If we as a Select Committee, for example, undertook an inquiry in the adult social care sector and felt we needed to look at the quality or the outcomes of inspections within that sector, would it be you, Mr Behan, as the chief executive of the CQC,

who would come and take overall responsibility for the actions of the CQC in that respect, and not the chief inspector?

David Behan: I think this is a good question. Just to pick a way carefully through the difference between accountability and responsibility, I would see myself as being accountable for the work that goes on in adult social care and Andrea as being responsible for the way that is taken forward. But I would account to the board for that work. This is my point about the power that we have under the legislation, which is for the organisation as a body, not for us as individuals. 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. The powers that exist are for the Commission.

Q17 Andrew George: So they are accountable to you in the sense that you take an oversight of their work, but at board level you are accountable to them. How does that work?

David Prior: I do not think that is—

David Behan: We have got a unitary board—

David Prior: Let us take a case in point. Andrea is in the room. If we felt that she was not performing, that she was not up to the job—I am sure that is not the case, so this is highly hypothetical—the board would say, "Sorry, Andrea, you're not making it, so we're going to recruit somebody else." To that extent she is accountable to us.

Q18 Andrew George: That is helpful. The Department of Health in its evidence to us says that establishing the position of the chief inspectors on a permanent statutory footing will "ensure that individuals who are appointed to the roles are able to speak up for patients and provide clear judgments about quality of care." In relation to that role, will they be sufficiently independent to be advocates and champions within their sector?

David Prior: They will be, and so will the CQC. The whole thrust of this change to the Care Bill, and what lies behind it, is to make us demonstrably more independent.

Q19 Andrew George: Finally, on inspections of hospitals, there has been a lot said, both in the Mid Staffs report—the Francis inquiry—and elsewhere about how one objectively measures the quality of care at hospital ward level. Given that there is now a lot of professional pressure, and some political pressure, I should admit, including from myself and others, to address the issue of adequate registered nurse staffing levels on the hospital ward, and since you are going into much more specialised inspections—in this case, of hospitals—will you establish, before you even go in and see what it is like on the ground, in terms of the inputs going into the service itself, any objective measures or new objective tools that you will use to assess how the hospital is doing?

David Behan: We are working with NICE and NHS England on exactly this issue, about a tool that can assess the adequacy of staffing. The fundamental standards will also address this issue, so the regulations will need to address the appropriateness of staffing. We continue to work with, as I say, NHS England, NICE and the Department of Health on exactly this. For our new inspections, one of the key issues that we are exploring is the adequacy and appropriateness of staffing to ensure that people receive safe high-quality care. Just this week Mike has met with colleagues in NHS England and had conversations with

them about exactly these issues. So we continue to make good progress on this—and, yes, we will.

The issue is really whether we will just assess against a particular ratio, and whether the ratio will be set. That presents more difficulties because I do not think all services, hospitals, care homes or primary medical services are homogenous in the way you can set the ratio. The geography, the physical environment, is different and the ratio needs to be appropriate to the particular set of circumstances at the time. But we also know from our experience that the quality of care that people receive is related to the number of staff on duty, and actually making sure that there are sufficient staff on duty is an essential assessment, an essential judgment, that we need to make around the quality and safety of care that we are assessing.

Q20 Andrew George: Yes, okay. You recognise that obviously, in the acute setting—although I know there is no standard acute ward—that is quite different, because in your answer you provided a whole range of different scenarios as to where staffing levels might vary, and quite rightly so. But in terms of the acute hospital ward, you would at least acknowledge the fact that adequate staffing—this is very important, because you use the word "staff"—includes the clinically trained registered nurse levels on those wards. That is very much the focus of where the professions are pushing both the inspectors as well as the hospital providers.

David Behan: Absolutely. We see it as being an absolutely fundamental issue that we need to look at, so there is the skill mix, and ensuring that the number of qualified staff is sufficient to meet the acuity of the people that are in those services, but there is also the geography of those services. The physical geography of the wards can be very different. If you have single room occupancy as distinct from more open wards, that is going to have a very direct impact on the number of people and the skill mix that you are going to need on duty to make sure that people are adequately assessed. There is also the difference between intensive care units and acute admission wards. So, yes, we do think that is an important issue, and we are looking carefully at it.

The other thing that we want to see is not what the establishment is, but how many people are actually there. This last week at Barking I was with a qualified nurse looking at A and E and that is what we were exploring: what was the difference between the establishment and the number of staff that were on duty? That is exactly the conversation we had. So it is also about being granular in the questions we are asking as we go through and do our inspections to make sure that we have an accurate understanding, not of what people's plans are but of the actuality of the delivery.

David Prior: We need to know that the hospital knows that it has done a proper assessment of the right levels of staffing in their wards. If we know they have done that work—that they have done a proper dependency audit, an acuity audit—we take a lot of confidence from that.

Q21 Barbara Keeley: This is on the same point. I am rather astonished that we keep going round and round and round this issue, and it gets terribly frustrating for us here that you are still talking to people in NHS England and NICE about this. Our latest report included an example of how it is done in one hospital, which is one of the safest hospitals in the country—how they use a safe staffing tool and how they publish both the numbers of how

many staff there should be on duty, and how many there are. They have been doing that since the summer, so why on earth you have to keep going round and round this, I do not know. Questions have been raised here today.

This is an incredibly important time, as the chief inspectors' roles are established, and I understand it was reported that Robert Francis called a meeting with you recently for a rethink on safe staffing levels, and said that minimum staffing levels should be an alarm bell for questions about safety. It seems, to a certain extent, that people fall back on the fact that the original Francis report did not recommend minimum levels. But he has had a rethink. He has looked at the evidence from the Safe Staffing Alliance and it is reported that he says that he is convinced that this should be the alarm bell for questions about safety—the level below which you cannot be safe. But we understood from reports of that same meeting—it was your meeting—that Sir Mike Richards was not planning to include staffing levels in his surveillance model, but will look at things like unanswered care bells. Unanswered care bells come from not having enough staff, and I am still talking to and getting information from people working in hospitals where the ratio falls to 2:28 and 2:23. I was talking to somebody at the weekend who was saying that on nights they are expected to look after people on a ratio of 2:23. Lots of patients, or people visiting older family members, for instance, will tell you that on a ward it is not uncommon to see the nurses totally stretched and running round.

The Secretary of State today, answering questions in this House on the troubled hospitals that have been in special measures, was reporting how one of them had recruited 257 nurses. It is absolutely obvious—obvious from what Robert Francis said and obvious from where the level is right—that this is the answer. So why are you still talking to NHS England, and why is it all so agonised? Why can you not just do it? Look at our Committee's recent report and adopt what it says.

> ***David Prior***: We are in huge agreement on this. Mike was slightly misquoted. He absolutely believes that staffing levels are critically important. He was saying that just having a minimum of 8:1, for example, on its own was probably not the right way to go. He absolutely is looking at staffing levels and, as for the hospital that you referred to—I think it is the Salford Royal—we will be looking to see whether or not hospitals have made an assessment of what the right staffing level is for wards. We will be looking exactly at that. So we are on the same page as you on this. The difficulty is whether or not there should be a minimum level of 8:1 across the piece.

Q22 Andrew George: I need to correct you. The Safe Staffing Alliance are very clear that that is the fundamental standard, and that if you are at that level the alarm bell is already ringing—bearing in mind that the nurse in charge is supernumerary to that assessment. In other words, that is the fundamental standard, and once you are at that level you need to start asking questions about the safety of patients on that ward. But they are not saying that that is the target. That is the fundamental standard, which is a different concept to that of a mandated minimum, as it were.

Barbara Keeley: The second part of what we included in our report was about transparency. It is okay for you to check, but you would not have to check if that information was published on wards, would you—if that information was available to the public? You have talked a lot about your reports making sense to the public, so why not let us all push for having that information out there?

Q23 Chair: Can I recommend that you look, as we suggested in our last report, at the Salford Royal precedent, where information is publicly available to clinicians, to people on the wards and to patients' families, so that they can make their own assessment and contribute to the discussion? But let us not take over the session with nursing numbers.

David Behan: Can I just add something—not to extend it, Chair, but just to pick up on Barbara's point? We are not just talking about this. We are building it into the six inspections we have done. Indeed, today we started our inspection of Salford Royal. We chose the 18 so that there were six low-risk hospitals, six medium and six high-risk, so that we can learn not just where these things are not done well but where they are done well, and we can publicise where they are done well. So today, as I have said, we have begun at Salford Royal. We will be there over the next three days, and we will be able to pull these out. When we publish our reports, if this is what we find, we will be able to demonstrate that as being good practice. Salford Royal is held up as an example by many, and we will be given the opportunity to do the same in our inspection. I do not want to give the impression that we are just going round and round having conversations. We are actively building an assessment of the adequacy of staffing into our new inspection model. We are doing that from now, and when we write our reports we will comment on how that contributes to the safety and quality of services.

Barbara Keeley: That is good.

Q24 Valerie Vaz: Can I push you on that? Do you have an end date for your chats? Have you said to Mike, for instance, "Report back to me before Christmas"?

David Behan: Yes.

Q25 Valerie Vaz: What is the end date then?

David Behan: I have already given you a sense of what the end date is. We have said that we will complete our wave 1 pilot inspections by December.

Q26 Valerie Vaz: On this issue.

David Behan: We will learn from those and build that into wave 2, which will get carried out between January and March next year, and then from March next year we will begin wave 3, and they will be the inspections that we intend to run through that next wave.

Q27 Valerie Vaz: I was talking specifically about the safe staffing issue. You said that Mike is looking at it, so I was asking basically to pin you down. Have you given him an end date to report on this particular issue?

David Behan: On that particular issue there is an end date that we have agreed between us as a senior group of colleagues—that we will have a new inspection methodology up and running and finalised from 1 April next year.

Q28 Valerie Vaz: Will you let us have it and publish it on your website?

David Behan: Absolutely. We will start to publish our wave 1 reports, which will give you an indication of how we are dealing with this, from November. Those four will be in November. The next four will be in December, the next four in January and the next four in February.

Chair: Barbara, you were half way through.

Q29 Barbara Keeley: Going back to a further question around the introduction of the chief inspectors for hospitals, primary care and social care, the Foundation Trust Network have said that they believe this introduction may delay the development of new regulatory approaches in other areas, such as ambulance services, community services and mental health services. How do you guard against your regulatory work just focusing on the core remits of the three chief inspectors and other things becoming less important or not attended to?

David Behan: They are not less important. We have a good relationship with the Foundation Trust Network and we have a good and robust conversation with them about what is going well and what they would like us to move more quickly on. You as a Committee have challenged us historically about being all things to all people and not being clear. If everything is a priority, nothing is. The only thing we have said, Barbara, is that our focus, for very obvious reasons—you have mentioned Robert Francis on three occasions now—is to sort out what we are doing around acute hospitals. We will then begin to tackle what we are doing around independent healthcare, mental health, community trusts and ambulance services. We have accelerated the work we have been doing.

We have had a number of accelerated solution events—if I can use that jargon—during October in relation to how we will inspect mental health and community health-based services, and we will begin to pilot our mental health and community health substance misuse out-of-hours service from January next year. The only thing we are saying is that we cannot do everything at the same time. We do not want to build in delay. We are acutely conscious that there is a foundation trust pipeline that people are keen to get through and we have given commitments, working with Monitor and the TDA, about how we will do that.

In answer to Valerie's question about time lines and whether we can guarantee them, we have set those time lines out. They are a plan, but we do not intend them to slip—we are working very hard to deliver on them—and we know that others are dependent on us. We are trying not to promise to do everything at the same time and fail, but to be absolutely clear what we are going to do and when. Our strategy was a three-year strategy of reform. The bigger issue, quite frankly, is not, "Can we hit these dates?", but, "Can we change the attitudes and behaviours within the organisation so that we can move from a system of compliance and generic inspection to one which is about assessment and judgment led by professionals?"

Q30 Barbara Keeley: Moving on to a different point, you recently announced that an internal disciplinary inquiry had cleared Anna Jefferson of any wrongdoing in relation to the instruction to delete the report on the registration of Morecambe Bay NHS Foundation Trust. Clearly that announcement, which was very brief that day, contradicts the findings of the Grant Thornton report, which said otherwise. Can you explain the basis for the disciplinary inquiry's conclusions?

David Behan: When we were here last time we were asked if we would consider any action against either past or current employees. We said we would take that away. We reported publicly in the summer, in a letter to the Secretary of State about past employees, that we did not think there was anything that we could do in relation to those individuals,

and said we would carry out disciplinary investigations into the two employees who were still employed by us. We have carried out a proper investigation. We took external legal advice and found that there was no case for Anna Jefferson to answer. She has returned to the organisation and commenced a period of training. We do not think this contradicts the major findings and substance of the Grant Thornton report. We have also advised that we have updated our website in relation to a formal complaint that we have had from solicitors acting for one of the previous employees of the CQC, but that we will continue to move forward in the work that we are doing to change the way that we operate. We do not think there is anything that is contradictory at all.

Q31 Barbara Keeley: Can I ask you another question about that? That is a peculiar conclusion to come to. When that was a key element in that part of the report—as we said in a previous hearing here, that is an important issue because it was about a situation in a hospital where babies and mothers had died; that is why it was serious, and I drew your attention to that before—it is hard to see how members of the public affected by what was in that report can have confidence in it when, effectively, you have now said you have looked into a part of it and it was not true. Apparently it was not true that she issued the "delete" instruction, and you have cleared her of any wrongdoing. That part, which seemed quite clear in the report, did accuse people of wrongdoing. There were all kinds of accusations and things said around that report. It does not stack up.

The question that people outside here will want to ask is, "How about the rest of it?" There were questions that were asked about how Grant Thornton went about their investigation, the fact that they did not feed back to people, did not allow notes of meetings, that notes were not taken contemporaneously and people were not allowed to correct notes that were written when they were submitted afterwards. There were all kinds of issues like that. If you have looked into this and found it was not true in the case of one particular person, how can you say that the substance of the investigation and the report is not queried in any way and you have confidence in it? To me, that does not stack up.

David Behan: You need to look with precision at Anna Jefferson's involvement in that—that is exactly what we looked at, and we did not look at what other people were said to have done or did not do in relation to it—and go back to what we said at your last hearing specifically on this, which is that we commissioned Grant Thornton as a reputable independent body to carry out their review of what happened in relation to Morecambe Bay.

Q32 Barbara Keeley: And you found part of what they investigated and what they reported to be wrong, and you cleared the person that they had accused of doing something of any wrongdoing. You have effectively, through what you announced, contradicted what they said in their report.

David Prior: No. They raised issues about the behaviour of certain individuals, which we looked at very carefully. They raised issues but did not come to a 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. It 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. The two are very separate.

Q33 Barbara Keeley: But this does call into question the way that they investigated—presumably the way that they spoke to people, the way they did not keep contemporaneous notes, and the way that they did not offer the people that they were making conclusions about an opportunity to correct the note of a meeting, for instance. All of that was submitted to us as evidence, from people mentioned in that report, that there were great concerns about it. It seems to me that you have agreed with at least certain aspects of that in the case of Anna Jefferson. You were saying that there was no wrongdoing and there was not a "delete" instruction. If you will excuse me saying this, it does not stack up that part of it is wrong and the rest of it is okay.

David Behan: There are two different issues, Chair: one is a report into the events and the circumstances that went on, and the other is that we were asked—and we agreed, and it was the right thing—to consider whether there was an employment case to be answered. That is what we have done.

Q34 Chair: To be clear, you are saying that when there was an allegation that Anna Jefferson was involved with a decision to cover up a critical internal report claiming, "This can never be in the public domain or subject to FoI," that allegation stands but it is not a disciplinary issue.

David Prior: That allegation was not proven, Stephen.

David Behan: The issue is where the contemporaneous evidence sat in relation to what went on in Grant Thornton, and we have contemporaneous evidence in relation to other things that took place and that were set out in the Grant Thornton report and set out in relation to Louise Dineley. In relation specifically to Anna Jefferson, in the disciplinary investigation we did not see any contemporaneous evidence in relation to the allegation against her. In relation to the others, there was contemporaneous evidence, and that is the basis on which this difference has actually taken place.

Q35 Barbara Keeley: Indeed. We can leave this point here because there are lots of other questions to be answered, but I think we questioned the appointment of Grant Thornton last time when we covered this in more depth. There was a fair amount of evidence given to this Committee about the way they went about it being very defective, the way that they ran the meetings—they were hostile and aggressive—and very many other issues. Given that, it might be something that really needs thinking about if there were anything similar to that report to commission in future, because it does seem to have been a faulty decision to appoint them, and they do not appear to have carried out the work in the way that they should. It really does not stack up for you to say you can find fault with part of it but the rest is okay. I would not be surprised if questions about this ran on and on, but that is probably enough for today

Can we go back to the way that hospitals are categorised, because there is a question that flows on from the point David Behan made about inspecting hospitals that are at different levels of performance at the moment? It is perhaps a concern that, even if a hospital is categorised as outstanding, there are questions sometimes about individual departments, about individual services. Things go wrong even in hospitals that are overall very safe and providing very good service. There is a concern that a hospital that becomes categorised as outstanding might start to think, "Well, we're not going to be inspected for three to five years," and they could easily become complacent. How can that concern be squared up? How

can you keep the good and outstanding hospitals where they are, and not let them become complacent? This used to happen in schools with Ofsted, did it not? If you knew you were not going to be inspected, did you really keep on your toes and keep up to the standard you were at?

David Prior: We have developed not a perfect but quite a sophisticated surveillance model that comprises 150-odd indicators, largely around mortality, complications, safety issues, patient surveys, staff surveys and the like, which enables us to monitor hospitals in between inspections. We will be publishing the results of the first cut of that model on Thursday—I think we have sent a copy of it to the Chairman today. That will help us keep an eye on all hospitals in between inspections, and, if there is a risk indicator that goes off in between, that will trigger an inspection. So just because you have an outstanding rating, it does not mean that you will not get inspected in between times.

Q36 Barbara Keeley: Would that apply to individual services? Can you see a situation where there might be an outstanding hospital—in an overall sense, outstanding—that had problems in one department or—

David Prior: Or in a ward. Yes, I can see that.

Q37 Barbara Keeley: That would be triggered to you. How would that happen?

David Prior: No. The critical thing for us is that we do not expect hospitals to be perfect. I do not think there is any hospital in the world which is perfect, but we will expect the managers to know where the issues are. They will know they have a problem in urology, for example, or know they have a problem on a certain ward, and they are aware of that and will be doing something about it. But we certainly do not expect hospitals to be perfect.

Chair: David.

David Tredinnick: Thank you very much, Chair. I thought you were going to say I had been "very patient".

Chair: Indeed. Since you have put words into my mouth, I am happy to speak them for you.

Q38 David Tredinnick: Thank you, Chair. I want to return to standards—I say "return" because they have been fairly comprehensively covered in many respects—and ask a few questions. How do you react to the English Community Care Association's criticism that detaching expected standards from fundamental standards will confuse the general public?

David Behan: This goes back to what I said earlier about working with the adult social care sector to make sure that that confusion does not arise. We are working on the fundamental standards. We 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. So if we need to take action we will take action against those fundamental standards. That is how we will do it.

Q39 David Tredinnick: Earlier you were talking about setting up—I forget what they were called—something along the lines of "clarity panels" with the general public, to make sure—

David Behan: People's panels.

David Tredinnick: —that what you were saying was understandable. Will you apply that standard in this case, to make sure that the general public thoroughly understand this change?

David Behan: Yes, we will, in short.

Q40 David Tredinnick: So it will be scoping groups. You will go out and ask people, "Do you understand what is going on?"

David Behan: Yes.

Q41 David Tredinnick: Good, thank you very much. I think you touched on this earlier, but just for clarity I will ask again: will your fundamental and essential standards apply to all providers across all sectors, or do you expect to tailor them for different parts of the health and social care system?

David Behan: The fundamental standards are going to be set out in regulations. They will apply to everything that we regulate, but the way we inspect and the questions we ask—this comes back to Andrew George's question about the rationale for differentiation—in a three-bedded home for somebody with autism are likely to be different from the questions we will ask in an international teaching hospital on numerous sites, for pretty obvious reasons. But, ultimately, what we can enforce in law will be set out in the regulations and they will apply across all the services that we register and regulate.

Q42 David Tredinnick: Talking about the law, you have said that tough action will be taken against social care providers that fail to meet acceptable standards. What sort of sanctions will you be able to apply?

David Behan: Our ultimate sanction is that we can close a service and they can fail to operate. Indeed, just this week in Nottingham we are taking action to remove from operation a care home that we think has consistently failed to meet standards. We can also take a range of actions, from issuing warning notices to issuing fixed penalty notices.

Q43 David Tredinnick: So in this particular case you were going to take criminal action. Do you think criminal prosecutions might be suitable in certain circumstances?

David Behan: Yes. A fixed penalty notice is indeed a criminal prosecution.

Q44 David Tredinnick: Yes it is, but, if I get a fixed penalty notice for parking badly round the corner, that is at a different level to being taken to a magistrates court or a Crown court. When I talk about prosecution I am not thinking about a fixed penalty notice particularly; I am thinking about prosecutions of members of the staff for failing to comply with the law.

David Behan: We can take action where a service is failing and we can take action against the boards—this will be one of the changes that comes through when the Care Bill is introduced—but any criminal prosecutions, as in the case of the staff in Winterbourne View, for instance, are taken by the police and not by the CQC. Robert Francis raised the

issue of Health and Safety Executive prosecutions—indeed, I think they have taken a prosecution in relation to Mid Staffs—and we have been working with the Health and Safety Executive and the Department of Health as to how that recommendation from Robert Francis is going to be taken forward.

David Tredinnick: Thank you. I have no further questions.

Q45 Chair: Can I pursue the question of one of the five fundamental standards, which is safety? You will know that this Committee on more than one occasion in the past has disagreed with the Government on the moving of the NPSA responsibility into the Commissioning Board. I seek your view on whether the most effective way to follow up this fundamental standard of patient safety is for it to be divided, essentially, between the CQC and the Commissioning Board.

David Behan: The important thing here, Chair, is that the intelligence collected through these incidents being reported to the national patient reporting system, which is currently held by NHS England, is passed to us on a regular basis and we use it as the basis of our inspections. Indeed—nothing to do with today's hearing—Mike met NHS England on this very point yesterday evening. It was genuinely nothing to do with this; we are not that clever at the minute, I have to say.

Valerie Vaz: You are working to be clever.

David Behan: This is all just moving too quickly, to be honest, to schedule meetings to coincide—as important as this meeting is, he hastens to add. We are also going to agree with NHS England what the safety dashboard and its content will be. I am meeting Imperial in a couple of weeks' time because they act in a capacity to carry out some of the analysis of this. So we do understand why you are making your recommendation and why that should not be separated and split. If we were to be asked to take on that responsibility, we would take it on. At the minute—

Q46 Chair: If this Committee were to commend to the House an amendment to one of the bits of legislation coming through that would have that effect, would you be supportive of it?

David Prior: In principle, it is something that we feel ought to be with us, not with NHS England.

Q47 Chair: Patient safety responsibility should be with you.

David Prior: Yes.

Chair: Thank you.

David Behan: But in making that recommendation, Chair, there is a broader set of issues around sending out alerts. A lot of these alerts relate to machinery and equipment, not just critical incidents about where patients have been badly cared for. There is an important judgment to arrive at ultimately, as you push this to a conclusion and then to a decision, about our range of responsibilities. That is a point that needs teasing out, in a way. You may well have questions on this later on other issues.

Q48 Chair: You know that a specific case has been raised with the clerk and with me on behalf of the Committee by Professor Toft around neuraxial connectors—that is the technical

term. A patient safety-orientated recommendation now 10 years old has still not been implemented. The question is, first, is this something that the CQC should follow up on during its inspections, and, secondly, would not a national patient safety reporting system reporting to the CQC be an effective means of delivering something that was first recommended 10 years ago and has been endorsed repeatedly since then, but still not implemented?

David Behan: Yes, I think that is absolutely right. If you take away the ownership—who is owning that, and where that function sits—the important issue is that information is coming to us and being built into our inspections. Indeed, on Friday Mike, who knows about this because of his own clinical background in cancer services, did ask about this and found that that neuraxial system is not yet in place in Surrey. So we are able to build that aspect in.

One of the challenges for us, Chair, is that everybody wants us to build things into our inspection. We were criticised for having a rules-based system which generated a tick-box approach to inspection and we have said we will cease to do that. There is a balance to be struck here about how far we build things into our inspection. I am not saying this is not important. Indeed, we did ask about this, and how we avoid creating another approach where every inspection has to run through a list of things we need to check, which then drives us into a tick-box culture yet again rather than judging the quality of the experience of people using these services and ensuring that the service they get is safe and of high quality. So there is a balance and a judgment to be struck here.

Q49 Chair: I do not want to prolong this, because I think you are agreeing with us, but this specific case should surely simply be a safety requirement, whereby a green box means there is nothing for anybody to discuss and a red box means there is something for somebody to do as a matter of urgency.

David Behan: Yes. I think NHS England are going to issue something on this. That is my advice in relation to making sure that this is picked up.

Q50 Valerie Vaz: Don't get us wrong, as we do not underestimate the task that you have and we appreciate that you are putting all your best efforts into it, but I am just going to focus on another slight overlap now. In your "A Fresh Start for the Regulation and Inspection of Adult Social Care" you mention that you are going to carry out financial checks on a small number of providers. Could you explain what sort of financial checks those are, and whether you see some sort of overlap with Monitor in that?

David Behan: There is no overlap. This is specifically a responsibility we have been asked to take forward in relation to adult social care, not in relation to the NHS. This is as a result of quite a considered consultation by the Department of Health following Southern Cross and its financial collapse. Southern Cross exposed the fact that for national organisations there is no oversight of service continuity and financial resilience. For single homes and small care groups, local authorities deal with the 70 or so services that go bust each year quite successfully, and have done for the past 30 years. Financial failure at a local level is picked up by local authorities and is managed quite successfully. Southern Cross raised a challenge in that when you have a national organisation which goes across—I think, from memory—over 70 local authorities, there is an issue about who takes responsibility and acts to ensure there is a continuity regime in the interests of people

who are in those services. As a result of that consultation the CQC was asked if it would take on this responsibility, and the Care Bill is providing some responsibilities for local authorities in relation to continuity of care at the local level, and will also ask us to take some financial oversight over between 50 and 60 large-scale national groups of adult social care providers. That will be a responsibility that we will take on from April 2015, so we will spend the period between now and 2015 building both our capacity and our capability to take on that responsibility. We do not have those skills in the CQC at the moment.

Valerie Vaz: That was my next question.

David Behan: Therefore, either we will need to make some arrangement to buy those skills in from organisations that do insolvency work—this is not about economics but about business continuity—or we will need to recruit them. The first judgment we need to make is: what are the skills that we need to discharge this responsibility? Then we need to ask: where are they, do we have them as part of our permanent establishment or do we go to some of the organisations that specialise in this work and have a specific contract with them to act with us and on our behalf?

Q51 Valerie Vaz: You mentioned Southern Cross, which I was going to mention. There was a complex financial arrangement of selling off their homes and then a leaseback. Are you satisfied that, with the new skills that you have, you would be able to pick up that sort of financial arrangement, given—

David Prior: At the moment, the answer is no. We do not have the financial skills that are required and it is highly unlikely that we would want to have them in-house. These tend to be private equity companies with very complex capital structures. We will require external help to do that.

Q52 Valerie Vaz: Will you ever be able to?

David Prior: I am not sure we would want to. It is something we will need to debate more in-house but my gut feel is that we would want to outsource that.

Q53 Valerie Vaz: Yes, but you have been given these powers to try and prevent the situation from happening. My point is that it is a commercial arrangement. How are you ever going to know that people who are in the financial management of care homes are ever going to do this kind of thing? You will not be able to do that, will you? You would not be able to avoid another Southern Cross, because you would not be able to look behind their accounts to see that they are doing lease and leaseback procedures, or that they are in trouble. You are not going to be doing that, are you?

David Behan: It is possible to review some of these companies in terms of those that are publicly listed, and so on, in terms of their accounts and the robustness of the arrangements.

Q54 Valerie Vaz: Is that what you will be doing?

David Behan: The Sunday newspapers have had three or four stories this year of these big groups that were in some financial difficulty either because they are overleveraged or because their income is insufficient to pay back the loan.

Q55 Valerie Vaz: I am trying to go a bit further and be more robust. You are not going to rely on newspapers.

David Behan: No.

Q56 Valerie Vaz: Have you got some system in place? I know you are getting it up until 2015, but—

David Behan: We will establish a financial monitoring system and the issue is whether we—

Q57 Valerie Vaz: To monitor these companies.

David Behan: —buy that in as a return from a specialist company, or whether we recruit, as David has said. At the minute we favour buying this in, but we need to work through the arguments for and against that, and plot with precision exactly what it is we are asking people to do.

Q58 Valerie Vaz: Would it not be better to put that into Monitor? Is that really something that you also need to get expertise in?

David Prior: Can I answer that in two ways? First, there is a close correlation between a company or business that has financial problems and poor quality, as we have seen with Southern Cross. Making the distinction between finance and quality is a false distinction. They are two sides of the same—

Q59 Chair: But the trouble is that is built into the regulatory structure. Why is this case an exception?

David Prior: It is built in for health care. It is not built in to adult social care. My own personal view is that Monitor and the TDA are very much in the improvement space. We are very much in the "holding-up a mirror" space. That is the way our two organisations will go over time, but I do believe that monitoring quality and financial health are two sides of the same coin.

David Behan: If you look at the history of Southern Cross, what began to happen was they were not able to pay back on this complicated loan structure and operating structure that they had. Quality was falling because they could not pay that back so they started skimping on support staff, training and managerial staff. Quality fell even further. There was effectively a race to the bottom as the revenues could not pay back and the quality was suffering. The relationship between quality and finance was quite apparent in Southern Cross.

When I did the job in the Department, the question I kept asking myself was, "Was it possible to predict Southern Cross?" and then, "Was it possible to prevent Southern Cross?" On the basis of the intelligence that people were gathering at that particular point in time, I do not think any one agency would have been able to gather the intelligence together and assemble it in such a way as to predict that there would have been a failure at Southern Cross. We need to see whether it is possible, in a sense, to put together surveillance metrics which will be about quantity and quality in the way that that market operates, because the relationship between financial resilience and the quality of services

was pretty much established in the way that Southern Cross collapsed. So it is possible, I think, for us, as we have done on healthcare, not to be definitive about where failure will take place but to have some smoke alarms that cause us to ask questions about whether there is sufficient resilience. If you looked at the external management-to-homes ratio in somewhere like Southern Cross, they had got very large managers-to-homes ratios, whereas the better large groups—the Barchesters of this world—have very small ratios of external managers to homes; that means that managers are there to supervise and support those homes. That was one of the financial compromises in Southern Cross. I learned from that to ask the question of the large groups, "What is your manager-to-homes ratio? If a home gets into difficulty, do you have sufficient managerial support to get it out of difficulty and support it to provide quality care?"

So there is learning to be extracted from Southern Cross and we need to set up the capability and capacity to do it. Whether we own it or buy it, we need to establish that capability and capacity, because we do know that there are a number of these large groups that are still financially fragile, some of them because they were overleveraged from 2008 but some because they were just fragile.

Chair: Charlotte wants to ask a question and then Barbara.

Q60 Charlotte Leslie: Thank you. I have a couple of things. First, there have been concerns raised with me that CQC staff are using personal e-mail accounts to engage with patients. Is this something that you are aware of, and what is your policy on such engagement?

David Behan: Blimey!

Valerie Vaz: Give us the names.

David Behan: I think there is a more specific bit to this—but, no, people should not be engaging directly with people from personal e-mail accounts. It goes back to the accountability of chief inspectors—a point raised before you arrived, Charlotte. The powers that we have as on organisation come from Parliament to the board through the health and social care legislation and the Care Bill, and people do not act on their own account. They act on behalf of the CQC. That is what their warrant says—so, no, people should not be e-mailing patients from their personal e-mail accounts. A number of our staff are home workers. In fact, all our inspectors are home workers, but they should be e-mailing through a CQC address, not through a personal e-mail.

Charlotte Leslie: Thank you. I will see if I can provide you with some more information on that as I get it.

David Behan: Yes, please.

Q61 Charlotte Leslie: The second issue is that one of the things holding back the CQC in its mission to—I would not think this is too strong a term—reinvent itself from the misdemeanours of the past is the legacy mistakes that still hang over it, such as north Lincolnshire and Morecambe Bay. Is there any move towards, or do you think there is any benefit in, setting up a special investigations unit to look at some of the bigger legacy cases where the CQC did get it dramatically wrong and over which questions still hang?

David Prior: You are talking about a truth and reconciliation commission or something. We can learn from the past. For example, when we were doing the new surveillance model we applied that to Morecambe Bay and applied it to Mid Staffs, to see whether or not it would pick up those hospitals early enough. We are going to be doing a root-cause analysis of the problems at the home that was reported on in the papers on Friday and Saturday, for example. That methodology is something that we are very keen to use.

Q62 Charlotte Leslie: Before I move on, the concerns about personal e-mail addresses were raised with me by a member of the public, who is hoping to provide me with some more information, so I am not in a position to affirm whether or not this is actually the case. I just wanted to hear your view on the situation before we get more information on it, if indeed there is any.

David Behan: To add to David's point, Charlotte—this was an earlier question—we have built some evaluation capacity into the CQC so we can learn from what has gone wrong in the past and from what we are doing now to make sure we are learning these lessons in real time, not historically because something has gone wrong. We have asked Keiran Walshe of Manchester business school to do an evaluation of our hospitals inspections waves 1 and 2, and we know that the Secretary of State has asked that there be an investigation into maternity services at Morecambe Bay. Of course we will co-operate with that investigation. Dr Bill Kirkup has been asked to lead the investigation, and as he looks at maternity services in Morecambe Bay, because we have in the past looked at maternity services in Morecambe Bay—there was an investigation—we would expect to co-operate with that. We will do that both to assist in the investigation and to continue to be open to any learning that can come to us as well.

Q63 Charlotte Leslie: But, very briefly, the trouble is that there are victims of exactly the practice you want to see—whistleblowing—who are still out of a job and watching people who they perceive as responsible for some of the problems which they alerted us to, who are still very happily in a job. What can the CQC do to help these people who have been shown to have whistleblown with good merit but who still cannot find a job? I would like to know who the whistleblowers who have been proven to have saved lives in alerting us to dangerous practice are applying to for jobs, and why, if they do not get those jobs, they are rejected—on what grounds. Then I would like to know what those organisations have to hide. We have all said that if an organisation wants to make sure it does not have mission drift and is serving patient safety—if it is an organisation with nothing to hide—it would want to employ whistleblowers so that they know exactly what is going on at the coal face. What can the CQC do to help here?

David Prior: The culture is changing, Charlotte, on this. We have taken on James Titcombe and we have re-engaged Kay Sheldon on our board, for example. Helene Donnelly, who was a nurse at Mid Staffordshire, is now working as an ambassador in another hospital. There is a similar person, Delilah—I can't remember her name—who is a safety ombudsman working at Brighton. It is starting to happen. One of the things I have learned over the last six months is that, to be a whistleblower, you have to be very brave. I have spoken to a couple of surgeons, for example, alpha male types, whose careers have been severely limited because they expressed concerns about what was going on in their hospitals. How we enable people to raise concerns with us at a much earlier stage, in confidence, is incredibly important. We have set up a new committee of our board to look

precisely at this issue. I hope that next time we meet we will have done a full audit of our own whistleblowing activities and also of how we can encourage other people. We go in to inspect for a day, or three days, once a year or once every two years sometimes. We need to get continuous flow of information from staff, patients, residents and carers in between times. That is our best source of information. How we can lower the threshold to enable that information to come to us is critically important.

Q64 Charlotte Leslie: We would all welcome the employment of James Titcombe.

David Behan: We have made a public commitment as well, in relation to making an assessment of how robust complaints handling is in services as part of our inspection methodology. We have also made a commitment to look at how organisations deal with and handle whistleblowers. This week in Surrey we did have a discussion with a hospital about whistleblowing and how they handled it. They provided two examples of whistleblowing action that they had received and went on to describe what they had done with it. We came away with a sense of, "This is an open organisation that is prepared to talk about these issues and deal with it." Without giving our assessment away, we were positive about the way they had dealt with that. We will build into our wave 2 hospital inspections—the work we will do from January onwards—how we undertake this.

As David said, we have made a real effort at the most senior level to reach out to whistleblowers, whether that is the group in Mid Staffs—Will Powell, Helene Donnelly and Kim Holt—or a whole range of others that had made contact with us. We have met with them to discuss and try and learn from them about their experiences. We have been fortunate to have the ability to appoint James to come and work with us, and, although he is not a whistleblower, to build in the dimension that he brings from his work in the nuclear industry, as well as from being the father of a child who died while receiving services. We are trying not to walk away from the issues about whistleblowing but to build them into the way that we are developing our inspection. We are trying to take a lead in this and demonstrate why this is important in the way that we move forward. We will continue to do that—to test and to take that forward.

Q65 Charlotte Leslie: If you ever feel leant on by a Minister, please can you come and tell us?

David Prior: I do not think that Ministers at the moment want to lean on us. They are going the other way, actually. I think they genuinely want us to be independent, and that is shared across most people in the House of Commons.

Q66 David Tredinnick: Just on this point about whistleblowers, David Prior, you mentioned two alpha male surgeons whose careers have been severely limited. Do you think you have a duty to monitor these two alpha males—not that "alpha male" has anything to do with it, so let us take that out of it—these two surgeons whose careers have been severely limited? It seems that unless we track effectively what has happened to those concerned—and these are surgeons rather than nurses working in a hospital—we will be failing in our duty of care. What do you say to that?

David Prior: In these cases they have retired and time has gone on.

Q67 David Tredinnick: I did not know that. You did not say that.

David Prior: They have retired now, and this relates back to issues that happened two, three or four years ago. The most chilling phrase that came to my notice after the Francis report into Mid Staffs was from a very distinguished clinician saying, "Where were the doctors?" Where were the doctors? For years this dreadful care went on and no doctor put his head above the parapet. Why is that? In part, the answer is, I am afraid, that they are frightened. Even if you are an alpha male surgeon, you are frightened. We might well say that is not good enough, but that is the situation. We have to be absolutely sure when we do an inspection that hospitals have proper whistleblowing—raising concern—procedures within the hospital, that the culture in that hospital is open and that there is good clinical engagement. But we also have to have that safety net, which is that we need to be available to people like that at a much earlier stage, so that they can ring us up, get in touch with us and that can precipitate an inspection.

David Behan: Could I add that I think that what Francis said was about the importance of listening to people? The big issue about whistleblowing is that there is a failure to listen. The fact that people feel they need to whistleblow means that the system internally is not listening, so part of our inspections and the assessment that we make is about how open the hospital—or the service or care home—is to listening to the concerns that people are raising internally, as well as about how whistleblowers are handled. That will be part of what we do. So it is not just about whistleblowing: it is about how concerns are raised, listened to and dealt with.

Q68 David Tredinnick: It is, but, since you have come back to it, it is also about organisations closing ranks so tightly that if anybody steps out of line they are finished. This is a kind of Mafia code—Omertà comes to mind—where, if you do anything against the status quo of the organisation, you are finished. That surely is something that has to be broken.

David Prior: It is. You have to recognise that we are tribal people. We all have our tribes—clinicians, hospitals, the CQC and the House of Commons all have their tribes—and one tends to be quite defensive about one's tribe, but we need to break those walls down. I completely agree with you.

Chair: Rather than going into the metaphysics of tribalism, we will go on to Barbara.

Q69 Barbara Keeley: Indeed, but I feel a need to express an alternative view to that we have just heard. There is a view on our side of the House that Health Ministers just want to hold the whole of the NHS at such a distance that nothing would be their responsibility at all. I think there is a happy medium. So there are two views of that.

Can we move on to specialist inspection teams? Your inspectors were recruited, largely, years ago to service a generic model of inspection, but in their evidence to us the Relatives & Residents Association say that they remain concerned that recruitment of expertise in the care of older people in residential and nursing care is still thin on the ground. They would like to see you publish data on the number and range of experts and specialists that you have recruited or that you intend to recruit. They say—I do not know where they get this from—that their intelligence is that specialist teams for care homes are not yet fully in place. You might want to comment on your recent skills audit about work force challenges and what training is still needed to transfer inspectors into those specialist teams.

David Behan: Since last year we have not been recruiting any inspectors unless they have a health or a care background. We have not been recruiting generic inspectors for a good period of time. 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 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. The team will have our inspectors, who will come from a health or a care background, and people from the field. If it is in adult social care and we are going in to look at a service for people with autism, I would expect that that team would have somebody who has some experience and knowledge of autism, whether they are employed by the CQC or whether we need to bring somebody in from outside the service to make sure that they have that specialist background. That is what we are committed to and have set out. "A Fresh Start"—the document we published last week—went in and explained this, and began to set it out. I hope that the issues that the Relatives & Residents Association have put in their evidence to you have been addressed by what we have set out in "A Fresh Start" as to how we intend to take that forward.

Q70 Barbara Keeley: Do you still need an extensive recruitment programme, or how extensive would it be, to make sure that you have enough experienced and even senior specialist inspectors? A secondary point is: will it be necessary to replace people and will there be redundancies as part of that process? Do you still have a fair amount to do? That 2,000 is a lot of people to change roles. To what extent will you have to recruit people specifically into certain senior or very specialist roles?

David Behan: There will be a mixture. We have a significant proportion of our staff that have a health and care background. The issue, though, is not what the background is—just to play on this point that David was making about tribalism. Just as important a question is, "How long is it since you practised?" I hold my social work registration but actually it is 30-odd years since I practised as a social worker, so I would not claim that I can actually go in and assess, with the detail, the practice of today's social workers in the same way as I once could. The issue is about how we get contemporary knowledge. This is why we are building inspection teams in both health and care where we have inspectors that come from a professional background, but they will be accompanied by people who are currently active in their practice. Last week at Barking, Havering and Redbridge, as part of my time there, I went round the accident and emergency service with a nurse who is currently in practice, and her contemporary knowledge about what current practice should be assisted in us arriving at a judgment about the quality of that service. So it is not just about what your background is, but how contemporary your knowledge is as well.

Q71 Barbara Keeley: Will that mean you will still have an extensive recruitment programme? People's concern—this has been raised in earlier hearings that we have had with you and in this one, and it might be out of date, but they expressed it—was about care homes and nursing homes. I understand that you have probably picked up for your hospital inspections, but that is not going to help when it comes to inspecting nursing homes, is it?

David Behan: It is, because I want nurses going into nursing homes who have contemporary experience, not people who were nurses 15 years ago. People's registration is an important part of their professional identity. That is why I think over 90% of the nurses we employ in the CQC have maintained their professional registration—because they draw their professional identity from it. They have invested their time and energy in maintaining their registration. In future I want us to support those individuals to continue to keep their registration live. But if you were a nurse 12 years ago, it becomes an issue about whether that is sufficiently contemporary knowledge in terms of current nursing practices. We want to ensure—this is my point about inspection ceasing to be an individual pursuit and becoming a team pursuit—that we have a mixture of people who know inspection and regulation, so if enforcement action is required they know how to do that. But they will do their inspections with experts by experience—people who have used services, and clinical and professional experts. Those clinical and professional experts will bring contemporary knowledge of current standards of practice.

Q72 Barbara Keeley: I still do not quite get the sense of how far through the process you are, though. You are targeting 1 April. Are you 30% or 50% through the recruitment?

David Behan: What we have said, Barbara, is that we will begin to make our changes in relation to adult social care—to stick on this aspect—from April next year. We are now beginning the restructuring of the CQC so that from 1 April next year we have specialist teams. We will have managers and inspectors working to Mike Richards in relation to health care inspection—hospitals, mental health, community health and ambulances—and inspectors and managers working to Andrea who will undertake the 25,000 inspections of residential and domiciliary care. Those inspectors will go out—

Q73 Barbara Keeley: I am fine on the process, but it is a question about numbers. Is it that you have not started yet because you have—

David Behan: No, because we are going to begin that from April next year, so we are planning to deliver that. But on our residential and domiciliary care inspections we do have professional experts going out. To answer specifically, if there is a medicines management issue within a care home, we would ask a pharmacist to be part of the inspection team in a care home.

Q74 Barbara Keeley: But they are not full-time staff of the CQC. They are additional—

David Behan: Some are. We have pharmacists. We employ over 30 pharmacists who will go out on pharmacy inspections.

Q75 Barbara Keeley: Perhaps you could send us an answer later, but the question is how far you have gone through this? What is the scale of the challenge? How extensive a recruitment programme is going to be required? Perhaps if it is difficult to formulate—

David Behan: This is in process. I am not being evasive here. We are not going round and round, to use one of your earlier phrases. We are moving an organisation from where it was to where it needs to be, and that will take time.

Q76 Barbara Keeley: Could you send us a note of how far through you are, because that is all I am asking?

David Behan: I will send you a note on our milestones and where we expect to be on health care, adult social care and general practice.

Barbara Keeley: I am fine with the process, but I do not have a feel for where you are on the path.

Q77 Valerie Vaz: I want to follow up on what Barbara is saying, because I cannot hold in my hand exactly how many you need. You must have done a cost analysis of how many extra staff you need. You have all these teams going round, so you must have an idea of how many you are going to recruit.

David Behan: Yes, we do have that. We have a model of, taking our inspection programme—

Q78 Valerie Vaz: How many is that?

David Behan: We currently have 955 inspectors and we calculate we will need about 1,100 inspectors.

Q79 Valerie Vaz: So have you asked for more money from the Department?

David Behan: This year, 2013-14, we have an additional £20 million that has been made available to us.

Q80 Valerie Vaz: Just for these inspections.

David Behan: It is partly on a recurrent and some on a non-recurrent basis, and there is a commitment that next year we will get £29 million available to us as we build towards this new inspection process.

Q81 Valerie Vaz: So what is the balance between the two—the recurrent and the non-recurrent? Presumably you mean you buy in the experts, like the pharmacist or the nurse that you do not have.

David Behan: That is right.

Q82 Valerie Vaz: So they are on an agency or consultancy basis.

David Behan: Yes.

Q83 Valerie Vaz: How much would they charge you for doing an inspection, or how much would you pay them?

David Behan: At the minute—for the 18 that we are doing on wave 1—there are no charges being levied: people are giving their time and assisting us without any charges.

David Prior: Can I add, in answer to Barbara's point, that we are now recruiting, for example, in adult social care, four deputy chief inspectors? We hope they will be in place by January. We then will need to recruit, as David said, probably between 150 and 200 more inspectors. That new recruitment campaign will start early in the new year.

Barbara Keeley: Perhaps we need you to send us a note, if it is clear. It is just that I was not getting a sense of it, apart from the process. I was hearing the process but not the numbers. We need the breakdown of the numbers as well.

Q84 Valerie Vaz: I am staggered that in an organisation of your size you do not know how much it is going to cost. You have asked for more money.

David Prior: We do know what it is going to cost. We have a three-year plan. We have only just recruited Andrea Sutcliffe and Steve Field, who have been with us for two weeks. We want them to be part of developing the detail of this plan, but we do have a three-year indicative plan, and we have the financials and the numbers of people that we think we will need, but we are just nailing down the details with the new chief inspectors.

Q85 Valerie Vaz: Yes. You must have had that, because otherwise you would not have been able to ask for more money. But I am just trying to work out on what basis you are going to buy in the expertise.

David Prior: A lot of the inspectors will be employed inspectors, but we will have a big bank of people—clinicians, experts—who we will draw down as and when we require them.

Q86 Barbara Keeley: One final detail, so as not to lose it, is that I did ask whether there would be redundancies. From your generalist staff, do you think there are people that you will have to let go?

David Prior: There may be some people who do not make the move.

Q87 Valerie Vaz: But some people are there already, are they not? You have made some redundancy payments, have you not?

David Behan: On the senior team, yes. The previous senior team have gone, some on redundancies and some because they went to do other things.

Q88 Valerie Vaz: What is the total cost of the redundancy payments?

David Behan: There were various redundancies. I think in total it was about £800,000 over a two or three-year period.

Q89 Valerie Vaz: I want to go back to the inspectors. I think you had already been moving towards the specialist inspectors before the chief inspectors came in, and I was not sure from our last accountability hearing, Mr Behan, whether you were in favour of this. I do not think you were in place, Mr Prior. Could you set out what your view is, please? I know you have to work within the system, but it seems to me that you now have another, additional, layer of deputy chief inspectors. Are there then going to be the deputies to the deputies? How much further down are you going to go in these bureaucratic layers?

David Behan: 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.

Q90 Valerie Vaz: You were working towards that, I think, yes.

David Behan: That is what I set out at the interview for the job. I wanted to be absolutely clear that if they gave me the job they knew exactly how I was going to do it, and that was to reintroduce specialism. It is not tenable, for me, that you can go round A and E with somebody who is not clinically qualified to judge it. It is just not tenable. My dad would not understand that, quite frankly, and therefore we needed to change it.

Q91 Valerie Vaz: I think you have misunderstood what I am trying to say, as to initially when you first came to the job. Nobody thinks you are going round to individual organisations asking them about it. Obviously you are going to have inspectors doing it, however you organise it. This process has been going on for a while anyway, so I am just saying that at our last accountability hearing none of us had the idea that chief inspectors were going to be put in place, and now we hear that there are deputy chief inspectors. I am just wondering when the process is going to stop.

David Behan: To come to your question, "Have we been modelling the numbers we have got?"—yes, we have. Taking adult social care, we have been planning that each adult social care inspection will probably have one or two inspectors. They will have an expert by experience and a specialist. That specialist might be a pharmacist or somebody with knowledge of dementia services, depending on what the service is. The numbers will depend on the size of the home. There are some homes that have 180 beds and some that have 16 beds. The size of the team, and so on, will need to flex. We think a typical inspection, from preparation and inspection to report writing, should take between three and five days. We have taken those assumptions, multiplied by 17,500 residential, 8,000 domiciliary—we have done exactly the same on hospital inspections in terms of the numbers, the amount of time that we will spend—and that is what we are using as our financial model to drive the numbers of the inspectors and managers that we will need to support and oversee that work. We have done exactly the same on primary medical services. So we think we will need about 2,700 staff in the future to discharge our responsibilities. If you just move by a fraction whether we visit once every two years or once a year, that changes those numbers quite dramatically. We have a model which we can flex based on that, so arriving at the cost is literally the work we are doing in real time now—but we worked with the Department last year about our changing model and they made an additional £20 million available to us for this year, which is sufficient for us for this year.

The assumptions that we made this time last year—to come back to what has changed between now and the last time we were here—is that we thought we would do intensive inspections of only 70 hospitals when we planned the resource, and we are now going to do intensive inspections of all hospitals. That means the resource requirement is larger rather than smaller. That is why the numbers have changed since last year.

I am fully supportive of having specialist teams under the chief inspectors to take this forward. Steve Field—I think David has already alluded to this—will have a deputy chief inspector who will be responsible for looking at integrated services, looking at people's care careers, particularly for those people who are using health and care services, so we are not just looking at the individual services but at people's experiences.

Q92 Valerie Vaz: Don't get me wrong—I think you need people to do the job—but I was just wondering why there is another layer of management. It is really the people on the

ground that you need, the people who are going round doing the inspections. But obviously you have not built in, if someone gets a good rating, anything for additional inspections.

David Behan: Yes, we have.

Q93 Valerie Vaz: You have, okay. So why do you think that frequency of inspection will not add value? I think you have said that, haven't you—that if you do it more frequently it will not add value? Or do you not think that?

David Prior: We will be visiting and inspecting the homes that are not good more frequently than the ones that are good, because we feel they need to be inspected more often. So they do add value, we think, yes.

Q94 Valerie Vaz: So I suppose the feeling is, "What happens in between?"

David Behan: Between inspections, do you mean?

Q95 Valerie Vaz: If you have a "good" and then there are five years before you go back and—

David Behan: No. We got a very clear message from our consultation that five years is out. Nobody is interested in anything being on a five-year frequency. The support was for three years or less—but David referred earlier to our intelligent monitoring function. This is the announcement that will be made on the 24th in relation to the next wave of inspections. In order to make sure we are inspecting the places that have the highest risk, we have developed a surveillance scheme—"intelligent monitoring" is how we are describing it—of 150 quantitative indicators: mortality rates, hospital readmission rates and other indicators, alongside qualitative information such as staff satisfaction, patient satisfaction surveys and the number of complaints. We will use that intelligent monitoring tool continually through the period between inspections. If we think there is an increase in, say, patient dissatisfaction, that might be a smoke alarm that causes us to ask questions of the service such as, "Are things deteriorating here? Do we need to come back?" There may be a critical incident—a never event or an untoward incident—that means we need to go back and do a reactive inspection because there is a worry in that alert, in that nomination. I think this is behind the Chair's point about patient safety alerts—making sure that they are coming through in real time and that we assess whether there is any risk, and perhaps go and do further inspections as a result of that. Our assumptions about inspection frequencies of, say, two years are on the basis that people continue to improve and maintain the quality and standards of care. If we saw deterioration through the monitoring of those hospitals, one of our reactions could be to trigger a reactive inspection to go back and look at that, whether that is of the whole organisation or just of a particular service.

Valerie Vaz: Thank you.

Chair: David Tredinnick has been very patient once again.

Q96 David Tredinnick: May I return to the ratings system, which has already had some thought applied to it earlier? Are you not trying to square a circle—that might be impossible to do—in providing a ratings system which has an appeal to the general public but at the

same time has to be used by health commissioners who must make detailed decisions about various aspects of service provision?

David Prior: Are you talking about the hospitals?

Q97 David Tredinnick: Yes. You are really trying to address two audiences, are you not? You are trying to give confidence to the general public and also trying to provide enough information for commissioners and people who are in authority in the health service to make proper decisions based on your inspections.

David Prior: I do not think it is a circle that needs squaring. I think it is a circle. It is true that commissioners might want more detailed information than members of the public, but wait till you have seen some of our inspection reports, David, and see what you think of them. I think they will address both issues.

Q98 David Tredinnick: We have seen, in looking at food standards and other standards generally, that the easiest system for the public to understand is the traffic light: you have a green light for "good" and "outstanding", then, using your proposed hospital ratings, obviously you would have an amber light for "requires improvement" and a red light for "inadequate". Have you thought about putting a traffic-light symbol on the front of your reports to make it crystal clear what you feel at first sight?

David Prior: For hospitals, we have adopted the Ofsted terminology, if you like, of "outstanding", "good", "requires improvement" and "inadequate", which are pretty well understood by people. That is where we are with hospitals.

Q99 David Tredinnick: You misunderstand me, if I may say so. I am saying use the Ofsted ratings but put colour coding on, so that people can look at it and see: if it is "inadequate" it has a red lamp, if it "requires improvement" it has an amber lamp, and if it is "good" it has a green light. That is very understandable. Coming many years ago from an advertising background, we would always try to encapsulate what we were trying to say in not more than a sentence—hopefully in a phrase—or with a symbol.

David Behan: If it helps, Chair, in our literature to date—our consultation documents—outstanding was blue, good was green, requires improvement was amber and inadequate was red, in the way that we have actually described this, so that plays exactly to your point about aligning a colour to the descriptor, and that is what we will do. But on a four-rate scheme we needed to bring blue in.

Q100 David Tredinnick: Thank you for that. Have you started to think about how the rating system can meet the Government's objective of one that can quickly "respond and reflect new information about a provider's performance"?

David Behan: We do think that the rating system will be an assessment of a provider's performance across a range of services. So ratings will follow an inspection. They will be made on a four-point scale. We will give them a level that is meaningful to the public, at trust—and at service—level. We will rate—this is where a lot of our effort is going at the minute—safety, effectiveness, how caring and responsive a service is and how well led it is. We think the primary audience for ratings is indeed the public. We would expect hospitals to be looking at more data in more detail than we will look at, because we expect them to know their own story about their effectiveness. We also think that ratings are

something that providers can appeal against: people need the right to come back to us in relation to the ratings, and that is how we are setting up the approach that we are making to ratings.

Q101 David Tredinnick: Have you identified any services where you believe that it would be inappropriate to provide a rating?

David Prior: I am not aware of that, no.

Q102 David Tredinnick: Finally, the CQC plans to introduce the same ratings scale for hospitals and social care providers, but Professor Nigel Sparrow has said that GP practices will not be given a single overall rating. Won't this inconsistency ultimately prove confusing to patients and the public? So could not having two different systems sow the seeds of confusion in the future? Is that something you should address?

David Behan: I am not aware of where Nigel has said that.

Q103 David Tredinnick: Would you agree that it would be sensible to go and have a look at what he said there?

David Behan: Of course. Nigel works for us, so we will think about what he is saying and we have brought Steve Field in to lead this work. I am not wanting to deflect this in any way, but there was—

Q104 David Tredinnick: I am trying to be helpful. I am in a sense throwing you an opt-out clause right now for you to say, "I will go away and look at it."

David Behan: I will take it away then, and beat a retreat. We know broadly how we are going to approach ratings in relation to hospitals. We will issue something before December in relation to this. Andrea is leading the work on the design of the ratings around adult social care, and the framework we will use will keep these four descriptors, the four categories. Steve will lead that work on how we rate primary medical services as well—so again, at the risk of saying that we are still in a process, I come back to the point that we will do these in an order. We cannot do everything at the same time. I make no apology for that, but we will build our approach to it and our endeavour is to have a consistent approach to ratings.

David Tredinnick: Thank you.

Chair: Andrew, you have been even more patient.

Q105 Andrew Percy: Yes, I have been patient. On the subject of ratings—and then I have another question as well—I know the Ofsted regime quite well, being a school teacher, and when we have an Ofsted inspection the school is required to write to all parents. It got a bit silly at one point and we had to write to the pupils, which was a bit odd—writing to six-year-olds. Is that going to be a requirement? Obviously for a hospital it is a bit more complicated, but for a care home is that going to be a requirement, explaining what the inspection has said, what it means for residents and what the improvement plan is going to be?

David Prior: We had a meeting with Ofsted on this very subject last week. I like the idea of doing that, and I think we are 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."

Q106 Andrew Percy: Following on from that, schools got very good at predicting—and perhaps even fiddling—their way through Ofsted inspections and doing certain things when they were being inspected that would not ordinarily occur in our schools. Certainly I saw that in my old school. When we were "Ofsteded" things were very different—the entire regime was different—from how I ever recognised the school. Sure enough, the day after the inspectors left hell was let loose yet again and everything returned to normal. How are you going to ensure that we do not have people acting up, as it were, predicting the regime and then responding, accordingly, to, in some cases—and it is a minority of cases, I would hope—fiddle their way through?

David Prior: The best way of answering that is that we are going to a professional judgment-based system, not a compliance, tick-box system. The people making the judgment will be experienced clinicians when they go into a hospital, for example. It is much more difficult to game those sorts of people. Also the surveillance model that we have used has over 150 indicators in it. They are not capable of being gamed in a way that five or six may be. But I recognise exactly what you are saying. You do raise a good point, though, and it is worth saying to this Committee that inspection is not the whole game on this. 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.

Q107 Andrew Percy: When you identify failure in the school context you have a governing body which has parent representatives on it, who are charged with running the school. Obviously in a private care home you do not have that, so I think it is important that you have some system of engaging families and residents, where possible, whenever there is an inadequacy found, to ensure that there is regular communication with them as to how that is being addressed. That is not really a question but more of a comment, unless I add, "Don't you agree?"

David Prior: I do agree.

David Behan: This is why in this document we set out that one of the things we want to do is put the views and experience of people using services at the heart of what we do. That raises an issue about unannounced inspections, about how you can get relatives' comments in before an unannounced inspection. Therefore, one of the things we are looking at is how we can give short notice of an inspection, which I think is what Ofsted do—that was perhaps your experience—and/or how we might return after an initial inspection, where we do the unannounced bit and look at what it was like, and then go back and create an opportunity to meet with families, carers and people who might not have been available during an inspection, to ask them how they have experienced care. We are thinking about how we can flex our approach to do that.

Thinking about the last care home I was in—this is going back to your question, Valerie, about why we need more than one inspector in a care home—it is not possible to be a single inspector in a care home. Somebody needs to be speaking to the staff and looking at

the systems and processes. Relatives and residents will be in, and it is important that somebody spends time speaking to them about how they experience it, not just when they are visiting, but we need to create the opportunity to speak to them outside of an inspection. This is particularly the issue about domiciliary care, where we are not attending somebody's own home when they are receiving personal intimate care. We need to think creatively and laterally about how we are going to look at that. There are the same issues in relation to community healthcare. A lot of our methodologies are built on being able to observe care, which is where Ofsted are, 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.

Q108 Valerie Vaz: You are not considering cameras.

David Prior: That is part of the consultation. There are circumstances where, for example, we had real concerns about abuse going on. There are, of course, human rights, confidentiality and dignity issues, but there may be some circumstances where we would wish to use covert cameras.

Andrew Percy: I should say, for the record, having accused schools of gaming the system to pass Ofsted, that when I was rated "good" it was thoroughly deserved— just to make that clear.

Valerie Vaz: And you will never work there again.

Q109 Andrew Percy: I did get a "satisfactory" for geography but that was not my subject anyway—"Wasn't my fault, governor."

On registration, obviously there is going to be joint registration or joint licensing with Monitor. What are the practical implications for you and your registration process in implementing this joint licensing arrangement with Monitor?

David Prior: Do you want to answer this, David? I think the issue is that Monitor will not enable somebody to become a foundation trust unless they have had a proper inspection from us. So it is not a joint licensing situation. They are licensed by Monitor but they only get the licence if they have had a good inspection from us.

David Behan: But we are setting a tougher test around registration more generally. This is post-Winterbourne View, as well. We are looking, as David has said, at how, for foundation trust status, Monitor can take our assessments of the quality of the service, and we have said we will do that through a full inspection. They will not award foundation trust status to any organisation unless it has a good, or better, rating from the CQC. If a hospital gets an inadequate or poor rating, it will not proceed through to foundation trust status. That is how we have set that up.

Q110 Andrew Percy: In terms of registration for the system and the fit and proper person test, there is not going to be an application or an approval process through the CQC, is there, for somebody to be designated as a fit and proper person?

David Behan: I am sorry, but will you ask that again to make sure I have got the question?

Q111 Andrew Percy: The fit and proper person test which is coming in means that an individual who sits on a board or who is a responsible person in an institution has to comply with that test—but I am thinking of other examples. For example, I was chair of licensing in our local authority for 10 years, and people were designated premises supervisors. The only way they could hold a licence for the premises to operate was if they were a designated premises supervisor, and they had to apply to receive their designated premises supervisor authorisation. Without that, obviously, the licensed premises could not operate. For this fit and proper person test, there is not an application process for somebody to be deemed to be a fit and proper person, so how do you test the test? Are you relying on somebody coming forward and raising concerns about a trust board chairman, or a private health care organisation's board membership? Are you relying on people to come forward in that situation?

David Behan: Regulations will be required for this to be taken forward, and as I understand the way the regulations are being established, in terms of a hospital trust, it will be for the chair of the trust to determine that the people being appointed to that board are fit and proper people. They must pass that test.

Q112 Andrew Percy: Who regulates the regulator? Who ensures that the chairman fulfils that test? Presumably they have to fulfil the fit and proper person test as well.

David Behan: They will be appointed by the Secretary of State.

Q113 Andrew Percy: But if there is a concern, then, you are not directly responsible, or you do not think you will be, because there is no approvals process.

David Behan: The regulations governing this will need to be revised to ensure that specific checks are undertaken prior to directors being appointed to the board. That information needs to be made available to us. When we inspect we need to assess that the appointments are of fit and proper people.

Q114 Andrew Percy: But if there is a concern raised, and that comes directly to you as opposed to, say, a trust board, will you have the power to remove somebody?

David Behan: I do not know. I will need to come back to you on that. The legislation and the regulations are just being drafted.

Q115 Andrew Percy: I am thinking about how that works out practically. It is a great test to have in place, but there has to be proper monitoring of it. I am guessing that in a hospital trust situation you would not expect there to be a problem, because there is so much transparency in terms of who are the accountable people and what is the accountable body, but with a privately-run care home, is it clear who the fit and proper person test needs to apply to? How do you, as a lot of these people may not necessarily be well known, either to users of the service or to yourselves—

David Prior: Lying behind the purpose of this is that there have been a number of care homes where we found problems, they have been deregistered, and then the same people have cropped up again, setting up a new home. That is why, when they come up for new registration, we can apply the fit and proper test.

Q116 Andrew Percy: But how do you know, though, if they do it through somebody else? We know there are various mechanisms by which people can shade their involvement, particularly in a private company. It is the robustness of that test in those circumstances that I do not understand—unless someone comes forward and alerts you—because there is not a required application process.

David Behan: Yes. We are not a licensing authority in the way that you would have experienced in a local authority, where the local authority does act as a licensor.

Q117 Valerie Vaz: They would be directors of the limited company, would they not, so you could get them under directors' disqualification?

David Behan: Where they are directors, yes.

David Prior: Perhaps we need to come back to you on that.

Q118 Chair: A negative approvals process is what you envisage.

David Behan: You have got it, Stephen. Yes, it is.

Q119 Chair: The assumption will be that somebody is fit and proper unless it can be demonstrated that they are not. There will not be a register of fit and proper people from which directors can be drawn. Is that correct?

David Behan: Can we come back to you on this, to make sure we are absolutely right? This is tied up in the drafting of the Care Bill, the amendments that are being made and the regulations that need to be laid. We will send you a note, Chair, setting out our understanding of this. In addition to the fit and proper person test, we have committed to having a more rigorous approach to registration, particularly for care homes and private health care services. Winterbourne View was a private hospital; it was not a care home. The issue there was ensuring that we have a rigorous test of those people who sat behind Winterbourne View, to make sure that they were taking their responsibilities around quality seriously. If you remember, the staff of Winterbourne View were convicted and a number were imprisoned, but the people who sat behind the organisation were not. This strengthening of registration allows us to hold people who sit behind the service provision to account for the way that they are promoting quality within those services.

Q120 Chair: Exactly that thought invites a series of further questions, does it not, about who is in control of care, particularly in a large organisation?

David Behan: That is absolutely right.

Q121 Chair: What is the name on the writing paper, and who are the people in control?

David Behan: And, where equity finance is involved, how far can you go back in relation to all of those things?

Q122 David Tredinnick: Moving on, we have this new duty of candour. Do you think it is the right vehicle to develop a broader culture of openness among health and social care providers? Do you think it is the right vehicle?

David Behan: It is not the only solution, but it is an appropriate solution. People have campaigned for this for a long time. I think Robert Francis considered it, weighed it and came out with his recommendation. We have been asked by the Department to, in a sense, ensure that our regulations have the duty of candour as something that we inspect against, and we think it is one of the contributions to making the system more open and transparent.

Q123 David Tredinnick: What are you going to do to make people apply the duty of candour in spirit rather than just going through the motions?

David Behan: We are going to inspect. That is what we will do. The issue about the duty of candour, going back to the previous conversation and David's point, is that it is the providers that have a responsibility to make sure that they are being candid. It is the commissioners, and so on. That does not just sit with the CQC, but we will inspect against the duty of candour, so a part of our inspections will be to assess that organisations are indeed carrying forward their responsibility in that respect.

Q124 Chair: Can I ask you two questions, in conclusion, that we went over in earlier stages about internal housekeeping? First relating to finance, in 2012 it was said to be an objective of the CQC to wean itself off grant in aid by, I think, 2015, at which stage you were planning that you would be financed entirely by charges on registrants. Is that still your objective?

David Prior: No.

Q125 Chair: If it is not, what is your objective?

David Prior: At the moment we spend about £153 million, 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. That will be up for consultation. So I think the grant in aid that we will require—

Q126 Chair: Presumably one of the consultees in that case is Her Majesty's Government.

David Prior: It will be, but Her Majesty's Government have wished us to become an effective strong regulator, and there is a cost attached to that.

Q127 Chair: Yes. Going beyond facetious comments on my part, if all this description of the process that we have been discussing this afternoon depends upon resources yet to be agreed with the Treasury, that is a significant issue, is it not?

David Prior: They have been substantially agreed with the Department of Health. I am not sure how far they have agreed it with the Treasury.

David Behan: We have had constructive conversations. I think this was behind Valerie's question. We have been doing our numbers, we have been working them out—and when you change the assumptions the numbers change. We are honing those down so we can be absolutely confident. We are committed to changing the organisation from April next year and we need to know that the changes we make are going to be sustained. We need to know that the income—the revenue that we need to do the job we are being asked to do—is going to be forthcoming. We think we have that understanding from the Department, but we want to secure and confirm that, because, from the original business plan for

2013-14—this year—we have changed some of our assumptions. We think we have agreed those changed assumptions with the Department, but we need to lock that down so that we have a three-year strategy and a three-year financial plan to support the delivery of that strategy. We will need more staff to do the job we are being asked to do, and therefore we will need the resources to buy those staff.

Coming back to Valerie's and Barbara's point, if we are buying in experts from services, they will need to be replaced so we are not taking them away from the front line, and as for people who are giving their time—experts by experience—we will need to buy their time back as well. So there will be a cost to a new model.

Q128 Chair: But the precise financing of this model is still work in progress, you are saying.

David Behan: Yes.

David Prior: This year it is fully financed. Thereafter, for the next two years, the details are still being nailed down, but in principle we have full support from the Department.

Q129 Chair: This is the final question. We have talked a lot this afternoon about culture in your registrant community. One of the criticisms of the CQC in the recent past has been not only the culture in the registrant community but in your own organisation. What steps have you taken within your own organisation to address staff culture, and what is the visibility? How do we test what you say is happening? What is the external evidence?

David Prior: Our governance structure has been completely changed. Do you want me to go into that now?

Chair: A written note might be the simpler way of doing it.

David Prior: I will drop you a note on that; it has been fundamentally changed. There has been the change in the senior leadership team, with David and the three chief inspectors, and our director of intelligence and strategy; all have been changed. So in the top management there has been 100% change. That is making a very big difference. What is really interesting—this is a tribute to David, not to me or to anybody else—is that if you look at our staff survey this year, despite the change that we are making, it is markedly more positive, upbeat and supportive than was the case the year before. So I think there is some strong evidence that we are making good progress.

Q130 Chair: But even accepting that it is improving, there are, no doubt, parts of the organisation that are not as good as you would want them to be. Can you demonstrate that there is a culture within the organisation that encourages your employees to raise concerns, as you are encouraging people within the registrant community to allow concerns to be raised?

David Behan: Robert Francis, when he attended our board meeting, talked about the way that we had handled some of the challenges to us as an exemplar, and said that perhaps we could demonstrate, by the way we were dealing with some of our challenges, how things could be taken forward. We did a staff survey in July this year in which 83% of our staff participated. That is very high compared to any staff survey. Of those, 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. I am not

happy to be average and I am certainly not happy just to beat the best of the public sector. We need to have more ambition than that and benchmark ourselves—and that is what we will do. 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. They are good challenges, and we are mindful of that.

I was worried by the number of e-mails I was getting from people who wanted, in confidence, to talk about their concerns about the culture in the CQC, so we commissioned a completely independent person—somebody I had never met before—to do a report on bullying and harassment. We received that report and published it. This week at the leadership team we will spend time for a second period looking at what we are going to do to take forward the issues that were raised from that. I currently have a number of concerns that have been raised with me by staff, which we are pursuing both within the organisation and by people who we have brought in to look at those specifically.

Just last week, Chair, we had the 300 managers in the CQC—whether they manage one person or 300 people—all together to discuss the changes that I was speaking to Barbara about: the fact that we need to change everybody's job. The feedback from that conference was incredibly positive about the direction of travel, about specialisation and about what we are doing. People are incredibly anxious about having to change their job. We have this classic paradox of people being very supportive of the changes, as demonstrated through the staff survey, but very anxious, because for some people this will be about the fifth or sixth change they have been through in 10 years. That generates anxiety. We are trying not to be closed about that, but to talk about it and support people through the change, because we need to take the energy that people have about wanting to change and harness that and carry it forward, as well as acknowledging the anxiety.

We will do a pulse survey in December. Through GfK, an external survey company, we will do a staff survey every July and a pulse survey every December. We will use the organisation that did the report on bullying and harassment to speak to staff teams and staff groups, and I will invite it back next spring to do a review of whether we have made progress or otherwise. That will coincide with the height of the changes, but we need constantly to ensure that we are testing the robustness and resilience of the culture that we are creating within the CQC. My belief is that it is moving—but is everybody happy all of the time? No they are not, and we need to do more.

Chair: That is a comment on the human condition. Thank you very much for your contributions this afternoon. We will publish a report in due course. Thank you.