HOUSE OF COMMONS

Health Committee

Oral evidence: Care Quality Commission accountability hearing, HC 778

Tuesday 6 December 2016

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Mr Ben Bradshaw; Rosie Cooper; Dr James Davies; Andrea Jenkyns; Andrew Selous; Maggie Throup; Helen Whately.

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Witnesses

I: Peter Wyman CBE DL, Chair, Care Quality Commission, and David Behan, Chief Executive, Care Quality Commission.

Written evidence from witnesses:

Care Quality Commission

Examination of witnesses

Witnesses: Professor Peter Wyman CBE DL and David Behan.

Q1 **Chair:** Good afternoon. Thank you very much for coming to this afternoon's accountability session with the Care Quality Commission. For those following from outside the room, could I ask you to introduce yourselves, starting with you, David?

David Behan: Good afternoon, everyone. I am David Behan. I am the chief executive of the Care Quality Commission.

Peter Wyman: I am Peter Wyman. I am the chair of the Commission.

Chair: Thank you both for coming. Andrew is going to open the questions.

Q2 **Andrew Selous:** Good afternoon to both of you. Back in February 2014, the previous chair of the CQC, David Prior, said, "The CQC has failed totally and has not won the trust of the public or the doctors and nurses in the system. We are not fit for purpose at all. We have started to put things right but it does not happen overnight." I want to ask you a general opening question of what you feel your achievements have been in recent years.

Peter Wyman: I am very happy to say that I think we are now fit for purpose and a great deal has been achieved in that time—not in any way due to me; the heavy lifting was done by my predecessors and my current colleagues.

We have almost completed the total round of inspections of all the providers in the sectors that we regulate. That is going to give us a baseline of information, which I think is unparalleled anywhere, and I have a lot of confidence in the findings that we have arrived at. There is a very strong starting point for what we do next. While there are still people who like to criticise us, by and large we have the confidence of most of the providers and other organisations we work with. It is a totally different picture from what it was when my predecessor made his now quite famous remark about not being fit for purpose.

There is still a lot to do, and it would be quite wrong if, having completed the first round of inspections, we just repeated the process. We have spent most of the year—my board, myself and my colleagues—working out what comes next as we complete this particular round. As you probably are aware, we published a strategy in May that set out some key next steps around use of technology and using the baseline of data we have—a combination of the two—to get more focused: to put our resource where it is most needed, with those providers that are known not to be performing and be less conscious of the good providers, putting less effort into looking at them, so having much more focus in what we do.

Technology will also make us much more efficient in the way we use it internally. If we can lighten that burden, we are going to work much more closely—and we are already working much more closely—with our other regulators to try to reduce as far as possible, if not totally eliminate, any regulatory overlap. There are some quite big steps for the next two or three years as we build on what is already there.

Q3 **Andrew Selous:** David, is there anything you would like to add to that?

David Behan: We set out to change completely the way we regulate health and care services. I believe we have done that, and, as Peter said, by March we will have completed these baseline comprehensive rating inspections. I do not believe there is a health and care system in the world that will have a baseline assessment of the like that we have, and we look forward to the next stage.

We survey providers on an annual basis and they feed back to us what they think of us. Our 2016 survey is out now, but in the 2015 survey 93% were positive about the benefits and impacts of what we do. Independent hospitals and adult social care were the most positive at around 90%; 57% said that the inspection helped them make specific improvements in their services. I think the staff in the CQC have worked hard over this period since 2014 and there are some real achievements.

Personally, I was incredibly pleased and proud of the "State of Care" report that we placed before Parliament in October this year. I thought it was authoritative and that we could be confident about what we said because it was based on applying these new inspections, which I think are more robust and more substantial than the previous inspection regime.

We are not complacent. There is still a lot more to do. There are lots of things that we need to improve on, and we are ambitious to improve on them as well as respond to the future changes, so I am absolutely with Peter.

Q4 **Mr Bradshaw:** The NHS and social care are facing unprecedented financial pressure and you have had to take huge cuts in your budget. How can the public have confidence that you have the capacity to do the job as you have just described?

David Behan: As Peter and I have outlined, Ben, we have looked at what the next round of inspection is, and, having established this baseline, our view is that we do not need to go round and repeat those very detailed inspections. We can use intelligence—that is, the data we get—from statistics, but also the knowledge we get from local healthwatches, from local people, to inform our inspections so we can be much more proportionate, targeted and risk based as we go forward.

We do not need to do a full, comprehensive inspection next time of Frimley Park or Salford Royal, for instance, but there are some places where we are concerned, they are still in special measures, and we will

go back and do a full inspection. We have taken what we think we need to do next year on re-inspections; we have made some allowance for the unknown that we need to respond to that is going to occur during that year; and we have assessed how many people will need to undertake that work next year and the year after to 2019-20.

By applying our new inspection methodology, being much more risk based and proportionate, we can make the money and ensure we have the number of staff that we will need available to carry out the inspections without any drop in the quality of what we will do. It is by being smarter, basically, that we can do that.

Our budget for this year is £236 million. We are going to come in about £8 million under that. We know we will have an operating budget next year of about £230 million, so we are there or thereabouts as we come to the end of the year on what we will need next year. If we manage this through turnover, we will go from 3,300 people down to about 3,000, and I think with those 3,000—we need to work at our methodologies—we will be able to do the job you are asking us to do.

Chair: We are going to come on to some questions in detail about workforce later on. We will expand on that later and move to Andrew.

Q5 **Andrew Selous:** There is one last question from me. Moving on to slightly more current criticism, there is a letter in today's *Times* newspaper, which you may have seen, that has some criticism of the CQC. What would your response be to that letter?

David Behan: We have acted—and this goes back to before 2014—on the concerns that have been raised with us. We have done specific work with people who have raised concerns. We have developed our inspection methodology. Every single inspection will address the issue about what system exists in this hospital or in this care home for raising concerns, and we will use our reports to comment on those where we undertake them.

Since October 2014, we have carried out over 2,500 responsive inspections. This is where a concern has been raised and we bring forward an inspection because of the concerns that are raised that we listen to and then act on. This year, there have been about 4,000 concerns. In about 10% of those, we have brought forward inspections, and, in another 40%, the issue that has been raised has informed our inspections of what we do, when we do it and how we do it. I think we have a good story to tell in the way that we respond to concerns that are raised. Clearly, that is not always to everybody's satisfaction, but my staff listen hard.

We have numerous examples that I could share with the Committee of where concerns have been raised and we have brought forward an inspection. We have done this for Marie Stopes International over the summer where, as a result of concerns in our inspections, we brought

forward some of our inspections. We had a member of the public raise concerns in Bristol about a particular procedure, and this was through our "Tell us about your care" helpline, and we responded to those.[1] We raised it with the director of nursing; she took action. Also, on the "Tell us about your care" helpline, that particular member of the public came back to us and said thank you for taking the action; it has led to improved patient care. A local healthwatch down in Torbay raised concerns about the domiciliary care arrangements at Mears. We brought forward an inspection and rated that service as inadequate.

We think we have worked very hard to listen to whistleblowers. It is not a perfect science—we are not going to get it right all the time—but do we respond and take actions when concerns are raised with us? Yes, we do. Our figures, which we report to the board on a quarterly basis in some detail, demonstrate the action that we have been taking. Again, we are not complacent, but we have a good story to tell.

Q6 **Rosie Cooper:** I have a nice easy, almost "yes or no", beginning—very unusual for me. Will the CQC complete its inspections of primary medical services and adult social care services by March next year?

David Behan: Yes, we will.

Q7 **Rosie Cooper:** Lovely. Now I will go into the not so easy questions. Bearing in mind your warning that adult social care has reached a "tipping point", how worried do you think patients, their families and carers should be about the quality of care in what is an as-yet un-inspected service? Also, have you prepared plans should you need to step in if care homes close or chains of care homes close—a really difficult situation, which the newspapers are forecasting—so how individuals deal with the care they get and whether you are ready should we have a major catastrophe?

David Behan: There are three bits in that. The first was about confidence: should people be confident? In the "State of Care" report we had rated over 73% of adult social care as being good or outstanding, so I think people should take some confidence from that figure.[2] That still leaves over a quarter that is not of the standard that people should expect. Where we rated services as inadequate, 76% of those improved. Where we rated them "requires improvement," the picture is much more mixed; 43% did not improve and 8% deteriorated.

We are worried about "requires improvement" that has stuck, and in adult social care in particular it is hugely significant, in our view, that there is no improvement capacity. For the NHS, you have NHS Improvement, who have a clear brief to improve trusts, and for general practice there is resource made available through NHS England to the

[1] The CQC clarified that in this case concerns were raised via email.
[2] The CQC clarified that in the State of Care report 72% of adult social care providers were rated as being good or outstanding.

Royal College of GPs, about £10 million that they can use, but in adult social care there is no national improvement capacity and capability that is available. SCIE and Skills for Care offer their services, and a number of organisations will take and use them, but there is an issue about how those services that are "requires improvement" can improve and get better.

In reference to "approaching the tipping point"—and the language we used in the "State of Care", Rosie, was "approaching the tipping point"—we meant that services do not improve next year from this year; secondly, there are more people not being supported by local authorities to get access to services. We defined what we meant by "approaching the tipping point." There were five contributing factors to us arriving at that view in our "State of Care" report. Three come from our own evidence and two from others. First, ADASS is providing financial support to fewer people this year than it did last year and the year before that. Secondly, the amount of unmet need, as assessed by Age Concern, has increased.

The three areas from our own evidence were, first, that the number of nursing care beds and residential care beds that we are registering had gone down for residential care but had plateaued for nursing care, and since we extracted the figures for the "State of Care" report in July there has been a reduction in the number of nursing care beds. In the previous five years to 2015, they had increased by 9% over that period of time, so we have seen a plateauing and then a decrease in the number of beds.[3]

Secondly, improvement is becoming difficult; they are the figures I have already shared with you. The third area is that contracts are being handed back by providers because they cannot deliver the quality for the price that they are being offered. We argued that it is those five areas in combination that led us to express our view that we were approaching a tipping point in relation to adult social care.

I have worked in adult social care now for 38 years, and I do not think I have ever seen those five elements combine together. We are not saying it will fall to pieces next year, but we are saying there are a number of things that are happening here that, in combination, Parliament needs to consider and debate. That was the issue on tipping point.

In relation to stepping in, the Act that gave us the responsibility for market oversight does not say we have step-in powers. On market oversight, we have to flag where we think there is a risk to the continuity of care from the 40 largest providers of adult social care in England. It is not a step-in power. We are not an insolvency organisation: it is to monitor the way that the market is going and to flag where continuity is at risk. The issue is that the responsibilities we were given were

[3] The CQC clarified that there had been an 8% decrease in nursing care beds over the time period specified.

appropriate for the risks that existed in 2010-11, when Southern Cross was at risk.

The issue that we have now is smaller providers handing contracts back, not the larger providers handing contracts back. So the issue about risk in the market is not the same one that existed in 2010-11 when Southern Cross got into difficulties. Companies have been bought and sold. The buying and selling of companies is not the issue: the issue is companies that are leaving the market and replacement care not coming in. That is the concern that we are raising.

It is important to say that we do not have step-in powers; we were never given them. So, people can criticise us for not acting when we were not given the powers to act. Our job is to have oversight of the market and then flag that back to local authorities where there is a risk to continuity of care. That is what the 2014 Act put in place.

Q8 **Rosie Cooper:** Thank you. I have another question, but just to follow on from that, if the local authorities themselves are really cash strapped, how do you think they will be able, first, to step in, and, secondly, do you have any big chains flagged up on your intelligence network currently?

David Behan: We have over 52 providers in the programme.[4] Volumes of activity and the financial value of the organisation are the qualifications to get into the programme. We have over 52. The key issue here is about market intelligence. We do not want to set an alert running about an organisation that then leads to people not making placements, which means their income drops and their financial viability drops.

The reason why we do not put this into the public domain is that the information is commercially sensitive. We have published our methodology, though, and there is a six-point scale, with 1 being lowest and 6 the highest: 6 will be a notification to a local authority that requirements under section 56 of the legislation have not been met, and that is us pressing the bell, if you wish. We currently have no providers that are at that level. We have some that are approaching that level, but none at that level.

Q9 **Rosie Cooper:** Thank you. My final question is: have your inspections produced evidence that a lack of funding—either in adult social care or in the NHS—is compromising standards of care? An additional part to that is: are you able to scrutinise community-interest companies, especially as one is being planned in Liverpool? No one has been consulted about it, and it is combining a seriously underfunded NHS contract with a seriously cash-strapped local authority. People fear that this is happening—this contract for LCH—and fear that we are going to have a rerun of LCH very soon. Members of staff do not want to work for this new company but want to continue to work for the NHS in other parts. How did you inspect those? Can you foresee or have you any powers to help in that situation?

[4] The CQC clarified that there were 50 providers in the programme.

David Behan: At the minute, do we assess the financial resilience of organisations? We do not. We are doing—and we will publish this after it has been to our December board later in December—a joint consultation with NHS Improvement about how we will take forward what we have been asked to develop, which is to assess the value for money of NHS organisations, so we will be building in a value-for-money assessment as part of our process of rating NHS trusts. If there is an element of community-interest companies—we regulate community-interest companies now in their different forms, and we will regulate them in the future, but the value-for-money assessment is just on NHS trusts at the minute—we will develop that.

In terms of registration, we will register the new models of care, the new arrangements. We are reviewing the way that we are registering new models of care now, different organisational forms and different combinations of organisations. That is work that we are taking forward now.

As to the arrangements in Liverpool, Rosie—and I know you have taken a particular interest in all matters to do with the health and care services on Merseyside—as you know, there is a trust that is about to come to an end. The contracts for the re-provision of those services are currently out to tender. We have been inspecting some of those trusts. We are just about to take our inspection reports through our internal quality assurance process and I expect that they will be published in the next few weeks in relation to that.

Q10 **Rosie Cooper:** Have your inspections produced evidence that a lack of funding has affected the standards of care? Have you seen any of that so far?

David Behan: I do not think we go in through the prism of a lack of funding. We will go in through the prism of the five questions that we ask: are services safe, effective, caring, responsive and well led? Certainly, we will make recommendations to both trusts and care homes where we feel, for instance, that the appropriate staffing levels are not in place so that people are not receiving—another story from this morning—the appropriate nutrition and hydration in care homes and in hospitals. Also, issues around the appropriate clinical as well as nursing staffing level in trusts are the kinds of things that we will make recommendations on, in our reports. Indeed, if we are particularly concerned, we will issue warning notices and take enforcement action.

So, while we do not go in through the prism of finance, we go in through the prism of whether there are sufficient staff to provide safe, high-quality levels of care, and we speak with an independent voice and challenge trusts and care homes if there are insufficient staff or if the staff are insufficiently responsive through our inspections. One issue we have been challenged on, in a sense, by some of our critics is that we do too much of that. Our view is that we are on the side of people who use

services; that has to be the lens through which we view this and that is what we have been doing.

Q11 **Mr Bradshaw:** Nevertheless, your findings on social care are pretty worrying, and you said just a moment or two ago that you did not think social care had the capacity to improve, which would imply that there is a connection between funding and the quality of care.

David Behan: Yes, I think you are absolutely right, Ben. We are asked by Parliament to produce this report and place it before Parliament. Personally, I think the way that you, as parliamentarians, have used the report, and the opportunity to talk about it today, is us discharging our responsibility. If I may say so—I have worked in other jobs in the sector in government at a time when you were there, and I know all Governments have considered this in the past—we are flagging that it is time for Parliament to have its debate about what is a pressing social policy matter. Our job is not to say how it should change or how much should go in, but to flag that the impact on the quality and safety is something that needs to be attended to.

Q12 **Mr Bradshaw:** In that report, as well as talking about a tipping point, you called explicitly—and unprecedentedly, in my view, for a health and social care regulator—for extra money to go into social care. What is your reaction to the fact that the Government did not come up with any extra money?

David Behan: I think we did. You are not the only one who has used the term "unprecedented." Peter and I, and senior colleagues, talked about this for a long time, about whether we had the evidence to say, "That is our evidence adding up to that." Our view is that we would not have done our job if we had not made the comment that we did.

We did it in the full knowledge of what it was that we were doing, but it is pure coincidence that our report for 2015-16 was laid in October immediately before an autumn statement. There are other moments in the parliamentary cycle where I think our report can inform the debate, not just the autumn statement; there is a local government settlement yet to come and there will be a budget in April, so there is a time for Parliament to have its debate about these important issues.

We were not aiming to try to influence the autumn statement. Our job was to provide a report to place before Parliament. We cannot do it in July, which is the closest to the end of the year, while Parliament is sitting. The only time when both Houses are sitting immediately after the summer is October, so in the four years that I have had this job, our "State of Care" report has always been placed before Parliament in October.

Q13 **Mr Bradshaw:** Nevertheless, it was an unprecedented call, and you were not alone; this Committee made the same call, and almost everyone in the health and social care sector—and Simon Stevens himself—made the

same call. I ask the question again: what is your reaction to the fact the Government did absolutely nothing?

David Behan: We think there is a debate—thank you for the question—for Parliament, and you, as a Committee, have made this point. I really hope that our report gives you the hard evidence, based on an improved inspection regime, that you need to have your debates in this place. The Chair has raised her concerns and I am sure you will do it. Our job, it strikes me, is to place a report before both Houses of Parliament to inform your discussions.

Q14 **Mr Bradshaw:** Lastly on this matter, a lot of the STPs around the country, including the ones in the Chair's and my own patch, are wholly dependent on adequate funding for social care because they involved a big shift of resources from beds and buildings into better care at home. What do you think the implication will be for those services and for services in general if there is no increase or uplift in social care funding?

David Behan: I have worked on the Five Year Forward View. We have supported that as an organisation, and we are working along with the new models of care and the STPs; we have been heavily involved. We have senior colleagues who are linked with each of the STPs. So, as to the argument that social care is helping fewer people at a time when demand is going up, we were saying in the "State of Care" that the impact of that will be more unmet need. It is not just the impact on the NHS.

My career in social care says that the real problem here is people not being helped and people being at home without the help that they need. Some of that will go into the NHS, and that is an issue that needs to be addressed, but the real challenge is, where we have a rise in population of older people—a 31% increase in people aged over 85 between 2005 and 2015—how that need or demand is going to be met.

Social care plays a fundamentally important role in supporting people in the community. There is a 26% reduction in the number of community nurses. So, this is not just about social care; it is about the community infrastructure supporting people to remain at home. If social care continues to help fewer people and the unmet need goes up, that will mean there are more people not getting help, and there will be implications for the design and development of area-based solutions to meeting people's needs, as you have down in Exeter, Devon and in north Devon.

Q15 **Mr Bradshaw:** It will make them undeliverable, will it not?

David Behan: It will make it difficult to deliver. "Undeliverable" is an absolute and I think there is more that can be done. In our "State of Care" report, we were flagging again that there is huge variation and variability in the NHS, and we see places that are shifting resources in the community and changing their re-provision. You have the fantastic work in Wakefield and down in south-east London in relation to GPs working

with care homes where you have pretty impressive reductions in pressure sores, leg ulcers and admissions into A&E as a result of those new models of care.

One challenge is whether it is possible to deliver some of those projects in other parts of the country and boast similar results. Similarly, in terms of some of the MCPs and the PACs, there is very important work being done. Yes, social care will have an influence on that, local government does need to be involved more generally in terms of the public help provision, but social care is critical to it. There is no point in pretending that it is not.

The increase of people with complex comorbid conditions means that most people who are getting help now will need more than one organisation and one agency to be co-ordinated around them. The 85-year-old who has intellectual and physical frailty will probably be using a GP, domiciliary care services and community healthcare, and perhaps even acute healthcare. How those services come together to provide help for people in those circumstances is what the STP should be doing. It is not just about reconfigurations or acute healthcare; it has to be about an area-based solution to meeting future need.

Q16 **Chair:** Before we come on to Heidi's questions, can I pick up on a point you mentioned earlier: that your powers when it comes to smaller care home providers are limited to flagging up the continuity of care issue with local authorities? It is certainly an issue in my constituency around care providers not being able to provide home care packages outside certain towns, because there are just not the care staff there or funding available to make it worth while for that to happen.

People are ending up in more expensive settings where they did not want to be for the want of a care package. Could you clarify for the Committee how widespread this is around the country? It is certainly an issue in my area. In how many areas are you flagging this up with local authorities, and is there more you would like to see given to the CQC in the way of powers to address this?

David Behan: If I may, Sarah, there are two issues in that. Our market oversight responsibilities that we were given through the 2014 Act—I think I might have said 2012 earlier, but it is 2014—effectively asked us to provide oversight for all those large providers of adult social care, and size was defined by financial value and the size of activity. The majority—and I think there are 54 providers in the scheme—of them are residential care providers, not domiciliary care, although there are some domiciliary care providers.[5] Our job is to assess that they continue to be viable, that there is not a risk of them being unable to continue to provide care.

Effectively, post-Southern Cross, we are being asked to have an oversight of that market to ensure that there will be continuity of care for

[5] The CQC clarified that there were 50 providers in the scheme.

the people receiving that care. It is not to stop companies going out of business. If they fail as a business, then they fail as a business, which is why I said to Rosie that we do not have step-in powers. We do not do that for the smaller providers. Local authorities were given the market oversight responsibilities for the smaller providers. We are saying that what has changed since these powers were shaped and formulated post-Southern Cross is that the greater risk to continuity of care is from the small and medium-sized providers, and we do not have oversight of those.

Q17 **Chair:** You have no oversight, but you are flagging up to local authorities that there is an issue.

David Behan: We are.

Q18 **Chair:** My question is: are you also flagging up the risk in terms of domiciliary providers, because that seems to be an enormous problem as well, where people are pulling out of providing care to people in their own homes, so they are ending up in more expensive residential settings where they do not want to be for the want of a care package at home? Is that something you are also doing—flagging up that risk—and how widespread is it?

David Behan: The way we have chosen to flag that risk is through contracts handed back. The vast majority of contracts that are handed back in our experience, although not exclusively, have been domiciliary care contracts, where providers are saying they cannot deliver the quality of care and the volumes of care at the price they are being offered. That is effectively a commissioning issue.

Q19 **Chair:** How widespread is that now?

David Behan: Again, it is very variable, and we do not do a systematic review of contract prices paid. That is not the way that we are going. We do not have any oversight of commissioning responsibilities of local authorities, but we know from our responsibilities for provider oversight that there are a number of providers—some of the larger ones—that are handing contracts back. Mears have just done this; Care UK have said they cannot provide domiciliary care at the price and quality, and so on. There are some significant players that have expressed their concern about the continuity of care.

Q20 **Heidi Alexander:** I have a couple of questions about your use of the enforcement powers that you have available to you, but before I move on to those I want to pick up on the market oversight issue as well. I know from my own constituency's experience the problems that can be caused when a small provider goes out of business, but you did say, David, that you thought that the large providers were not causing you huge concern at the moment, or something similar—perhaps I am paraphrasing you.

David Behan: They were not at level 6.

Q21 **Heidi Alexander:** I would like your thoughts on Four Seasons in this context because I think they told their creditors last week—and, of course, they are the biggest care home provider in the country, I think—that their £515 million debt burden was "not appropriate for the long-term needs of the business." That sounds to me as if they might be going broke. I wonder if you share my concerns about Four Seasons and what your plans would be around providing continuity of care and ensuring continuity of care were that provider to go out of business.

David Behan: We are aware of it. Four Seasons are in the scheme and we have seen the announcements this week and last, so we are aware of this. As well as the statement that you have made, I think Four Seasons will have their plans; I suspect they are looking at what can be sold and what cannot be sold. I do not know. I am not making that announcement.

My answer to Rosie was that none of our oversight is put in—any of our concerns, on the top level of our concerns—so businesses like Four Seasons having debates about how they refinance, whether something is sold or not sold, is a normal part of the way that they do business. The responsibility for the provision of the continuity of care for the residents of Four Seasons homes will sit with the local authorities that have assessed the needs of the individuals that are in there. This is the point about step-in powers. The step-in powers for those residents sit with the local authorities.

If we can go back to Southern Cross, then each of the individuals, the 30,000 people, who were in those Southern Cross homes got continuity of care. Effectively, Southern Cross was broken up and sold off and the continuity of care went that way. As to the step-in powers, there was no CQC; there were no step-in powers; it was the local authorities that made local arrangements by each local authority coming together. There was some collaboration through the LGA and ADASS based on the experiences that have happened in Southern Cross.

Q22 **Heidi Alexander:** Can I interrupt? That assumes a willing purchaser. Does your overview of the care home market at the moment give you confidence that there are the purchasers out there who would step in to result in that continuity of care being provided to individuals?

David Behan: I do not think they were all willing in 2011 on Southern Cross, though, Heidi. That is my point: that the market is tougher than it was then. This is what is being flagged. You are absolutely right that it does require a willing purchaser. We are not an economic regulator. We are not sitting there assessing the viability of willing purchasers.

Are there willing purchasers there? I honestly do not know, and my view is that we need to cross that bridge when we get to it. Part of this issue about step-in powers is, if they go bust, then there will be an insolvency regime and insolvency agencies will come in. They have a specific job to do in those kinds of arrangements and they will provide some continuity

of care for that immediate period, but I do not want to talk Four Seasons into that position. They have their plan and they will have to account for it.

Q23 **Heidi Alexander:** Moving on to your use of enforcement powers, what internal processes of quality assurance do you have in place to ensure that you are using your enforcement powers appropriately?

David Behan: This will go right across adult social care, hospitals and primary medical services. When inspections are completed, inspection reports are drafted to slightly different degrees because they are different beasts of complexity. We have an internal quality assurance mechanism. For instance, Mike and his deputy chief inspectors will personally quality assure every hospital inspection report.

Steve, in relation to PMS, has regional quality assurance panels, and Andrea—and she has the bigger volume—has her managers to provide the quality assurance. We go through those to make sure that our judgments—the calibration—have consistency. One of the biggest challenges we have had is about the consistency of our judgments. There is a legitimacy about that. We work hard at trying to get consistency, but when it comes to enforcement action, the operational staff and managers will arrive at that view.

In some cases, we do not wait for the quality assurance; we take urgent action. We have taken urgent action over the past 12 months. We have a variety of different mechanisms in place depending on how quickly we need to move. In the six months to this year, we have taken over 1,000 enforcement actions.[6] Last year, across the whole of the year, we took 1,000 enforcement actions. Last year, about 7% of total inspection activity resulted in enforcement and it is running at about 11% in this year to date, so we are taking more enforcement action, which reflects us getting tougher about poor quality. In about 76% of the enforcement action, we take warning notices, although on two occasions over the past 12 months we have taken criminal prosecutions as well, which were some of the powers that were given to us by the recent legislation changes.

Q24 **Heidi Alexander:** Have there been any occasions in the past where, with the benefit of hindsight, you should have used your enforcement powers and did not do so?

David Behan: Gosh, I am sure that is right, Heidi. I cannot think of any, if I am being brutally honest, but hindsight is a fantastic thing and these are very fine judgments. Decisions on whether to take urgent closure action in relation to a care home, which means 30 people need to be relocated in a very short period of time, or to let it continue with a requirement that service is improved, are very difficult and fine judgments, which inspectors are taking on a daily basis, quite frankly.

[6] The CQC clarified that they have taken 993 enforcement actions in the time period specified.

I am sure there are times when, in hindsight, we could have acted sooner, and we never know whether we should have acted later if we have acted, but I would not be so bold as to claim there are never any circumstances, with the benefit of hindsight, where we got it all right. I think we have become clearer and tougher.

This goes back to Andrew's question of how we have improved steadily year on year, and I think we have become more confident about taking enforcement action. We have beefed up our legal team; we now have in-house lawyers; we have increased that team by over six over the past 12 months. The evidence that we require to take enforcement action and to go to court has increased, so I think we are increasingly confident about this.

Peter Wyman: Could I add an answer to your last question that goes to the question before that, because these were areas that greatly concerned me before I joined the CQC? Were we consistent and were we using our powers appropriately? I spent quite a lot of time in my first few months at the CQC sitting in on some of the panels that David has referred to, to see whether "good" in Bradford was the same as "good" in Birmingham and Bristol and so on.

Also, on your point about using our enforcement powers, were we using these consistently? At the end of that process, I was very reassured by what I saw, so I cannot, any more than David can, give you a guarantee that we did not use powers when we could and should have done, but, overall, I have a lot of confidence in what I have seen.

Q25 **Heidi Alexander:** Can I ask you, finally, about adult social care providers and the numbers that are coming out of special measures? I think I am right in saying that this year it is only 16% of adult social care providers that have made sufficient improvements to come out of special measures. That is hugely concerning to me and I wonder what your reflections are on that. You talked about the lack of an organisation to help with improvement in adult social care, but what more can be done to improve and increase the speed at which institutions are making improvements to the quality of care?

David Behan: Yes. We are concerned about organisations that go into special measures and cannot come out quickly enough. This was one reason that led us to our assessment about approaching the tipping point as well. I will not repeat those points, but I think you are right in terms of the worry.

I see a difference in the NHS, where there is a pretty substantive and significant organisation in NHSI that works alongside trusts and supports them to improve, and where you see trusts that went into special measures that have been able to come out. They have been able to come out because they have been given assistance. There is some evidence that, where we see a general practice go into special measures and come

out, it is because of some of the assistance that has been provided, whether that is from CCGs.

Outside of Skills for Care, which is really the training organisation for the care sector, and the Social Care Institute of Excellence, where a lot of their help is in publishing aspects of good practice, there is little that is available in capacity and capability that can go into care homes and work alongside care homes to help them improve. Some of the larger groups—the big groups such as BUPA—will have training organisations and quality assurance groups, but it is those small and medium-sized groups, with 20 homes and less, where they are unlikely to have a training section or a quality assurance section, so there is not any capacity or capability in residential care.

Some far-sighted local authorities that are worried about the supply of care homes into the sector have put together teams that will go into care homes and work with them to improve the quality of what they have on offer, because they know they cannot afford to lose that capability and capacity from their system. It is something that we continue to be worried about, and it goes back to your question about the benefit of hindsight.

We do worry about these homes that are "requires improvement" and have been so for a long time, and we do not know where the capability is going to come from for them to improve. They appear to be stuck. We can go in and say they need to improve on, say, medicines management, and when we go back in they have improved on medicines management; but it is the staffing levels that are worrying next time. Then when we go again they have improved on staffing levels. The next time we go in it is something else that is of concern. They bounce along the bottom. This is an issue we are flagging around the 25% or so that are not improving when we have been to inspect them and when we go back and inspect they are still stuck; they are not moving.

Q26 **Helen Whately:** Can I follow up on one point you made about trusts coming out of special measures and saying that you attributed that to assistance that they have received, and that is quite a significant point? Would you say that assistance is a major factor for trusts coming out of special measures or part of a broad picture of where trusts come out of special measures?

David Behan: It is one of the contributing factors, Helen. If I look at East Lancashire Hospitals Trust, which is in my home town in Blackburn, of which my father has been a frequent user recently, they were in special measures on the Keogh inspections back in 2013, when Bruce Keogh did his review. They have come out of special measures. They have been given some assistance, but I think the work is down to the people who work in that trust.

The leadership changed; the board leadership changed; the executive leadership changed; and I think there was a change in clinical leadership.

I think it was a combination of help and some changes in the leadership, but to all intents and purposes the same number of staff who worked at Blackburn and Burnley hospitals that ended up in special measures are the same people who have got out of special measures. What they have had is a clearer, more purposeful governance and leadership probably, and some additional help.

Being open to help and not being in denial that you have a problem is key to it. If you look at the number of the trusts that have made the good progress that they have and come out of special measures, it is as a result of a mixture of different things. For Heatherwood and Wexham Park, the help they got from Frimley was significant, but at Basildon and Thurrock the new chief executive, new board leadership and some help from NHSI has helped. In Medway, I think Guy's and St Thomas' are helping with them, going in and providing some help. You have a mixture of different buddying arrangements, support that is being offered. A number of these trusts are using quality improvement methodologies, which engage staff and draw on the expertise that exists in staff. I think it is a combination of different things.

Q27 **Helen Whately:** Thank you. I was concerned that there might be a message coming out that an organisation could not expect to come out of special measures unless they were given a lot of help. Although help is part of it, they can do a lot themselves is what—

Peter Wyman: All our inspection reports make clear the areas where improvement is expected to happen. What needs to change is made clear by us. It is the how to do that that is not our role, and it is, as David said, about how you find out how to do what needs to be done. These are complex organisations and big changes, which usually would involve some external input, whether that is bringing new people in or working alongside other providers or a combination of the two—help from NHS Improvement. That will all be up to the trust and it will vary from circumstance to circumstance. It is quite hard to turn one of these big organisations around with exactly the same people that you had before without any external help, I would suggest.

Q28 **Helen Whately:** I was not suggesting the latter.

David Behan: I think special measures puts a timescale on by which improvements need to take place rather than letting it drag on. There is a hard end on special measures now, and that is the biggest difference to the world where there were no special measures.

Q29 **Mr Bradshaw:** You have closed down failing GP practices and care homes but you have not closed down any hospitals, and the potential for harm is far greater from failing hospitals. Is that because of the political difficulty in closing down a whole hospital?

Peter Wyman: No. We do put in restrictions on what hospitals can do, where it is appropriate, so you do not necessarily have to close the whole hospital down. If we found some service was completely unsafe, then

until it was made safe it would not be allowed to continue, for example, or beds would be reduced. It is a different response, if you like, but it is exactly the same point. It does not just continue and it is certainly not because of any sort of political pressure.

David Behan: To add to Peter's point, we have restricted numbers going into A&E and the number of admissions that can be made into a hospital where we have been concerned about the hospital's ability to cope. Closing an A&E in one place will send 3,000 people to the next place, which will put them under pressure, so I think there is a different criterion, but we have taken enforcement action where we have been concerned in relation to the ability of a hospital to cope.

Q30 **Mr Bradshaw:** Nevertheless, the public do show an extraordinary loyalty and affection for their local hospital, even if it is killing them. Can you give any examples of where you have stood up to this and explained clearly to them that they would be better off without it?

David Behan: We try to explain through our "State of Care" report, but I would argue it is for the board to explain to their local population how best they are going to provide care to meet the needs of their population.

Q31 **Mr Bradshaw:** Come on, David—boards, by their very nature, do not want to admit the hospital is killing people and to close themselves down. That is your job, is it not?

Peter Wyman: I do not think we are at a point where we are saying there is a hospital that should be closed down and we have not closed it down because of either political pressure or other pressure; and, as I have already said, there are service restrictions that are put in place where it is appropriate.

It is a pretty public process. You go into a hospital and you will see how we have rated it. I have certainly had people come up to me—friends and acquaintances and other contacts—saying, "You have just rated my local hospital as inadequate. Should I still go there?" People are aware of what we have said. That is really quite powerful. I think our job is to say what we find—and very publicly say that—and make sure it is displayed. Certainly, as you all know, local newspapers will immediately pick up on any of our reports, particularly if they are bad ones.

I think the public are aware. There is a lot of loyalty. It is quite interesting that, even where there is choice, people very often do not exercise the choice. You would think, certainly in big cities, where there is a lot of choice easily available, that people would all be moving to the outstanding hospitals and not going near the "requiring improvement" hospitals. It does not seem to quite work like that, so I accept your point.

Q32 **Chair:** Thank you. Can I move on to some questions about the intelligence-driven regulation? As the CQC moves from a comprehensive approach to a risk-based approach, how are you going to make sure that some providers do not slip through the net?

Peter Wyman: Our starting point is this baseline of information, as I said, so we know what we found when we last inspected. We will then go on receiving intelligence, and that is from staff, the public and the media, and from social media—a whole pile of different places.

Healthwatch is a really important contributor to that intelligence. If we suddenly start building a picture that we had previously seen as being good and we are now beginning to build a picture that suggests it may not still be good, then we can quickly start looking into that and inspecting and taking whatever action is appropriate. That is the first general point to make. The second point I would make is that this is not to say that, if something is good, we will not go back at all.

Q33 **Chair:** Could you set out what the intervals are for the three sectors that you are inspecting? What is the maximum interval for each?

Peter Wyman: We are about to consult on our next steps for hospitals, but our intention is that there will be a visit—I say visit; it will be an inspection but not a comprehensive inspection—every year, so we will cross the threshold at least once a year.

Q34 **Chair:** That is for hospitals.

Peter Wyman: For hospitals. For general practice, it is between three and five years—again, we have to consult on this, but this is the thinking—for outstanding and good general practices, down to being in very frequently, more than once a year, for the inadequate ones, so in that range. For adult social care, again, subject to further consultation, it is a range of two years down to very frequently.

Q35 **Chair:** Two years would be the maximum.

Peter Wyman: That is our current thinking.

Q36 **Chair:** One issue that you highlighted with your inspection of Mears was that staff were being expected to dissuade users of the service from making complaints. How are you going to change that culture and how are you going to pick up complaints and encourage people to come forward? Do we need another route that feels less personally threatening for people who are within care homes?

Peter Wyman: I am not sure we need another route, but you are right in saying that we need to encourage people to come forward. I would say that there is no really bad provision that nobody is aware of: somebody somewhere will be aware of it. Very often, that will be other professionals, and we need to encourage other professionals to tell us. If a GP is aware of, or has concerns about, a particular care home, we need to encourage that GP to tell us.

Q37 **Chair:** But is there not an issue that sometimes you find a care home inadequate and in fact you have not received complaints from professionals? How often is that the case?

Peter Wyman: David may know how often it is the case, but it certainly can be the case.

David Behan: I would not want to put a number on that. If we have it, I will write to you and come back to you, Sarah.

We have different channels by which we can get different feedback. Local healthwatches is one channel, and, as we develop and grow our relationship with Healthwatch, we have more and more information coming back from those local people who are on the ground in local areas.

We had over 80,000 contacts at our contacts centre last year, with people ringing up saying, "We want to make contact and feed back to you." We have a contract, which we are just in the process of re-letting, with some voluntary-sector organisations that have telephone helplines, who, if they get a call into them, will immediately transfer the information on to us. We have different mechanisms by which we can get that feedback from local people around concerns that they may have in relation to care homes.

Q38 **Chair:** There is one group that is particularly vulnerable. There is the group that has family members who can raise complaints on their behalf, but there is a group of people within care home settings who have no family who are there. Do you think there should be a greater use of advocacy services to go in and be able to raise complaints or concerns on behalf of people in care homes who do not have family?

David Behan: Where the mental capacity legislation and the deprivation of liberty safeguards apply, there is provision in the legislation for an advocate, and we have commented on whether there are sufficient advocates involved. But local healthwatch—not Healthwatch England—do have "enter and view" powers, and I know a number of local healthwatches use those "enter and view" powers where they can go in and speak to local residents. Where our relationship with local healthwatches works well, that information will be exchanged with us, and, as I say, that could lead us to bring forward an inspection and change what we look at next time, but this is an area we need to continue to develop. I would not want to say that we have this at the point of its maximum maturity. We need to do more work on it.

Q39 **Chair:** There are concerns that the deprivation of liberty safeguards are not being fully implemented anyway, first. Is that something that you are concerned about?

David Behan: We publish an annual report on the state of mental health and the operation of the mental health legislation, and we flagged deprivation of liberty safeguards in the "State of Care" report also as being a key issue.

Q40 **Chair:** We have received representations that greater use of advocates should be made to ensure that there is full compliance with those

safeguards. Would you agree with that?

David Behan: Somebody speaking for those people who do not have capacity and who have no family members would ensure that those rights are being maintained. That is a particular issue if people are self-funding and did not suffer a problem with capacity when they entered a care home, but, as a result of their condition, go into a situation where they do not have the capacity to make decisions. Somebody needs to represent their interests to make sure their human rights are maintained.

Q41 **Chair:** Going back to the letter in *The Times* today, I understand why it is difficult for you to take on individual complaints—you are not able to do so—but do you feel that you are giving sufficient weight to concerns raised by whistleblowers in order to guide your inspections? Certainly, this is the concern that is raised in *The Times* today—that the CQC is not taking sufficient note.

David Behan: Yes, and I think some of the signatories to the letter have been making this point for four years. I come back to my earlier answer, which is that we listened to the concerns that were raised in relation to how we did that; we have developed our approach to whistleblowers; each of our inspections looks at how concerns are being raised by members of the public. We know that this year we have had over 4,000 cases where members of staff, or ex-members of staff, have raised concerns, and that has led to us bringing forward inspections. As I said, since October 2014 over 2,500 of our inspections have been responding to issues raised by people who have raised concerns, so, again, we are not complacent.

This goes back to Heidi's question about whether, in retrospect, we are confident about all the decisions that we have made. I think we are confident in those 2,500 cases where we have brought forward inspections and in other cases we have made a commitment to take forward a concern that was raised in the very next inspection that we did. We did not bring it forward, but we did build it in. I am satisfied that, since 2013, when we began to introduce these changes in the way that we operate, we have significantly changed the way we engage around concerns raised by members of staff and ex-members of staff. I can point to inspections that we have done as a direct result of those and action that has been taken by trusts and care homes to drive improvement.

Peter Wyman: Can I add to that? Two things come out of this morning's letter for me. One is that we probably need to be better at making clearer where we have taken action as a result of what people have said to us. There is a learning point—which was there anyway but it absolutely came out of this morning's letter as well—that we need to think about how we consistently make it clear that we have received the evidence and done something with it.

Q42 **Chair:** Thank you for that. That was the point I was going to ask: how are you going to build confidence with the public? That would be your

point— that you are going to make it clearer where their concerns have led to action.

Peter Wyman: That is an important thing. The other thing that comes out of this morning's letter for me is an expectations gap. It is the point you were making that there are definitely some people who feel that we should do more than we have the power to do and is our role to do, and there is that expectation gap. Other than to keep talking to them and to explain what the limitations of our power is, I do not know what else we can do for them.

Q43 **Andrew Selous:** I want to ask about the quality and timeliness of your draft report submission after you have inspected. What are you doing to increase the quality and the timeliness in those areas, please?

Peter Wyman: "Requires improvement", which is the shorthand, is something we need to get better. David and his team have put in a number of steps that will improve that quite quickly, but the real step change is when we can use technology in a different way, and this comes back to something I was trying to say earlier on. We can make much better use of new technologies to record what we find on inspection visits and have that as the basis of a report.

Once that is done—and we still have to go through all our quality assurance, factual accuracy and so on—that process will be a lot quicker. Candidly, it is probably a couple of years away before we will have that up and running across the whole of the CQC. It is quite a complex thing. These are complex inspections. It will have the whole methodology on a template that does not even exist at the moment, so it will take time, but we are very keen to start. Once that is there, that will shorten the timescale considerably.

Q44 **Andrew Selous:** You talk about a couple of years but you have a target date for March next year for timely submission of quality draft reports to providers who have been inspected. Are you going to meet that target date?

Peter Wyman: I was saying that there are some short-term things that have been put in place that are using the existing process, if you like. That will shorten the time between the inspection and getting the report out to get towards the target, if not actually meeting it.

The target, in my view, is still too far; it is too big a gap and we can do better, but only when we have more technology. It is a two-stage process, if you like: existing methodology with additional help, which is being put in place at the moment, and then new technology to follow in due course, which will make the step change.

Q45 **Andrew Selous:** Being very specific, I want your target for March 2017 for timeliness and quality. Do you believe you are going to hit that date for achievement in those two areas?

David Behan: As to the specifics, we are at 80% this month for adult social care, and they will be there or thereabouts. For PMS, it is 60% in 50 working days, and I do not think they will get it. In relation to hospitals it is 17% in 50 days, so they are not going to get it. What are we doing about this? We have a standardised shorter report template that we will use in the hospital directorate.

We will have a separate evidence table from the narrative comment—the judgment that we make—and that will sit at the back; and that evidence template will be prepopulated before we go on site and carry out the inspection. We have looked at the quality assurance process. We are addressing the issue about consistency.

In the first couple of years of this methodology, a lot of effort went into making sure we had a quality assurance process that meant we were consistent. The consequence of that is that some of these reports have taken too long to get out. We are really not satisfied.

Q46 **Andrew Selous:** Going back to where you have the worst problem, which is the hospital inspections on a wider range of services, and that is the one where you are furthest off, by when do you think you will be hitting your target? You said you are not going to meet it by March 2017, so by when can we expect that?

David Behan: This is our target. I think the target of 50 days for a hospital inspection report, which is longer than a PhD thesis—

Q47 **Andrew Selous:** When are you going to meet it?

David Behan: We are not. I think we will change the way that we are producing the report.

Q48 **Andrew Selous:** You are not going to meet it, ever.

Peter Wyman: I think David is trying to say that if we left the reports in their present form we would not meet the target. First, we are not likely to be doing many comprehensive inspections. They will be more focused, as we have already said, so that immediately simplifies the task. Secondly, the reports themselves, for whatever we are doing, will be shortened. Thirdly, there are some other steps we can put in place. I would hope that by this time next year we are on that target, but it will not be doing exactly what we are doing at the moment.

Q49 **Andrew Selous:** The other area I wanted to move on to was the inspections for providers of care for people with learning difficulties, a number of which have been rated good, despite there being very high levels of practices such as prone restraint, which is against national guidance. Could you comment on that? How can you get a good when you have substantial use—in one case I think over 1,300 episodes—of a policy that is against national guidance?

David Behan: I am sorry, I am not familiar with the case.

Q50 **Andrew Selous:** I think it is Abbey Healthcare in Northampton that was rated as good overall and in the safe domain on 16 September, so only a couple of months ago, this year. But there were 1,307 episodes of restraint, and 46% of those had been in the prone position. Your report said that prone restraints were used across all wards, but prone restraint is against national guidance. How can you have a good rating when there is such significant use of a prone restraint, a position which is against national guidance? That is my question.

David Behan: The issue about the use of restraint is an issue that I have discussed on numerous occasions with our senior team, including our senior clinicians, and we have specialist advisers on these. I am sorry, Andrew, I need to come back to you and give you a written response on that.

Q51 **Andrew Selous:** We all understand the need for restraint for the safety of patients themselves and of others; I have some experience of this within the prison and youth justice sectors. That is not the issue. It is a question of how restraint is done and whether it is being done appropriately. It just seems to be a worrying discrepancy in that area. Perhaps you could follow it up if you are not familiar with it, which I understand; you cannot—

David Behan: I have some familiarity with it, but I do not understand your point that somehow we have allowed something that is against national guidance. I will come back to you and give a full answer in relation to that.

Q52 **Chair:** It is probably best if you can do that.

David Behan: I understand the issue, absolutely. My own practice is that I would much prefer positive relationships to be developed so that there is no need for restraint. If restraint is used, it needs to follow national guidance, and it is my belief that that is what our inspection teams do, advised by our clinicians. But, clearly, you have received evidence from somebody who is suggesting differently, and I need to come back to you on that.

Andrew Selous: Thank you. I appreciate that.

David Behan: It is not acceptable that we are not following national guidance, if I can just be unambiguously clear about it, but I need to come back to you. If you have a particular location where we have done that, we will come back with it specifically.

Andrew Selous: We will provide you the details and look forward to your response, so thank you for that.

Q53 **Dr Davies:** Could I move on to the issue of recruitment and the workforce at the CQC? Clearly, as you have already described, you are moving across to a targeted and risk-based regulatory and inspection system. How do you expect to be more successful in recruiting analysts

with the skill set to deliver this than you have been in terms of expert inspectors thus far?

David Behan: We have done really well in terms of recruiting inspectors. We are currently at 93%. I have 1,200 inspectors whom we have employed. We set out to recruit more inspectors and we have done that. I am currently doing my open-door sessions. Last Friday, two of the mental health inspectors came to one of those sessions and I have to say I was hugely impressed by their professionalism and commitment to the work they are doing. We have recruited some great people.

In terms of analysts, we do this in a variety of different ways, but this is a very competitive market, and here in London is a very competitive market. We have a graduate analyst scheme that we run out of the Bristol office. There are probably about 50 graduate analysts down there that we recruit. We have a programme for them. They do rotations of six months in different jobs and then they come out of that into graduate roles. We have recruited some incredibly talented people.

We are currently out to recruit for a director of intelligence and we are keen to recruit somebody from a data science background. We can offer interesting work. We might not be able to offer the money, because we are a public sector body, but we can offer work that is incredibly interesting.

We will also develop some partnering arrangements. We have been having conversations with the Big Data Institute at Oxford and the Alan Turing Institute, which are all organisations that are developing around data science. Through those relationships, we think we can have secondments and offer a masters and doctoral thesis to people through some of our work. So we are thinking creatively and laterally about how we can get people in and partnering, rather than thinking we can do it all by ourselves.

Q54 **Dr Davies:** I accept that you have reached a better position in terms of recruitment, but it is true that it was a bit of a struggle to get to that point. Is that not the case? You are satisfied that under the new set of arrangements it will be easy enough to locate those members of staff.

David Behan: It is not going to be easy; it is going to be hard. Anybody who says that recruiting appropriate staff is easy, quite frankly, is daft. It is very difficult. It is a very competitive market. We were keen to recruit inspectors who had a background in health and care. I think we have managed to do that. We have people on secondment who come to us for two years and then go back to their trust. Looking backwards, it was tough. Looking forwards, our reputation is better and people will come and work for an organisation that has a better reputation, so I think we can draw people in through there.

In terms of analysts, there is no point in London in trying to compete with banks, oil companies and a whole raft of other organisations, but we can

offer interesting work for people who are committed to a public sector period. We are going to need to grow our own, which means a graduate recruitment campaign.

I can see us running a development programme for analysts in data science, and I think we are going to have to do an internal training programme to make sure we can grow some of our own. We are not just going to do this by being able to recruit. We are keen to be able to do that and I do not think we are being naive. The evidence from our graduate recruitment programme is that we have taken on some incredibly talented people, and two, three and four years later they are still working for us.

Q55 **Dr Davies:** How would you counter the argument by some that the new regulatory approach is a response to the fact that there were not sufficient inspectors to be recruited out there for a more demanding approach of inspection?

David Behan: I would just say it is not true. You can have a longer answer if you want, but it is just not true.

Q56 **Dr Davies:** Mr Wyman, could I take you back to our pre-appointment hearing that we held with you as chairman? Were you given the opportunity to spend time in clinical settings at the start of your tenure, as we recommended, and what did you learn about staff morale in those settings?

Peter Wyman: I think I failed in my pre-appointment hearing to get across just how much engagement I had had with clinicians in the nearly five years I was at Yeovil; I just make that point. But the answer to your question is yes in that—not that I was given the opportunity, but one of the few things you can do as chairman is to decide what you want to do—I made it my normal policy to spend either a whole day or part of a day every week with a provider. That is right across everything we do; it is sometimes with clinicians, sometimes shadowing one of our inspection teams and sometimes with a board or with managers. I have tried really hard to be out and about to pick up how it is feeling in "provider land" at the moment.

A lot of the things we have touched on earlier go to that. In the last few weeks, I have been to hospitals in Bradford, Birmingham, Bath, London and Liverpool, and around the place. I have been to some GP practices. We have had discussions with people coming to us in London, which is a slightly different point, both clinicians and managers, so I am absolutely out there.

As to morale, there are some very positive things that come back from our own people, and most positive is how valuable they think the role that they have is and the CQC has, so that is a good starting point. But there are aspects that are concerning—fundamentally, around people feeling under a lot of pressure. The way that we address that, apart from

understanding as much as we can, is some of the things I was talking about earlier. If we can really make technology work for us and our people, that takes pressure off and will improve morale quite significantly all on its own. So, absolutely, that is on the issue, and, hopefully, steps are being put in place so that, this time next year, we will start to see some improvement and over the next few years it will get even better.

Q57 **Dr Davies:** We hope. Thank you.

Peter Wyman: We hope, yes.

Q58 **Andrea Jenkyns:** Staff turnover has been an ongoing issue. The current rate is at 8%. Why does the Care Quality Commission continue to fail in meeting its own target for staff turnover?

Peter Wyman: Before David, as chief executive, answers that, I said to David when I first came in that I thought the turnover target we had was daft, to use an expression you used a moment ago, David. I think we should have a healthy rate of turnover; I do not think we should expect everybody to be with us for life. There are people who should see this as part of their career, and I would like to encourage people to come out from providers, work with us for a period and then go back into providers as well as people who are coming in towards the end of their career. I think a more realistic turnover rate is somewhere round about 10% or 12%, and that will vary. We will expect a faster turnover rate for some of our analysts, as David said, and a slower turnover rate for others.

Q59 **Andrea Jenkyns:** Do you not think a higher turnover is going to impact care even more?

Peter Wyman: If you had a 10% turnover rate, you are saying the average length of stay in the organisation is 10 years. That feels about right to me for an average. When it was 5%, you were saying the average was 20 years. That is a very long time. Frankly, I think the target was wrong. We now have a more realistic target.

Q60 **Andrea Jenkyns:** Is that an area that you are looking at—the targets?

Peter Wyman: It would be nice to reach the target. Obviously, we want the good people to stay and we want them to stay for an appropriate length of time and then go and build careers. It is a more modern way of thinking about career progression. People do not spend their whole life in one organisation, but, David, it is something you look at as well.

David Behan: The very first interview I gave when I took the job was a vision of people who worked in services, then came to work in the regulator and then went back into services and perhaps came back into the regulator. This bit is really tough, of handing out long-service awards in a regulator when you want people to be up to date about what current professional practice is.

The issue we need to balance, that we attend to, is: are we a good employer; do we give our people a good experience, whether they are

staying five, 10 or two years on a secondment? We need that transfusion of new energy, new blood, new ideas and new thinking coming into our work. It is about striking a balance in terms of an appropriate level of turnover. I do not want people leaving because they have burnt out because the workloads are too high—we have had bits of that, if I am being truthful, and we need to attend to that—or they are not happy with the amount of support they get from their manager.

We have just completed our staff survey for this year and there are some incredibly positive things in there about people being supported by their line manager, but there are also some things about which we are concerned as to which we need action, which is whether we are providing the right development and training experience for people.

We need to look at these metrics and say: what does this mean for how effective we are, whether we are a good employer, and are we doing everything that we can do in terms of the environment we provide? I am clear that successful organisations engage the staff who work in those organisations in the way that they operate, and we do reasonably well on this. Our engagement score is about 61, which benchmarks with most public sector organisations, but I think we can be better.[7] My ambition is that we should be better. We need to be hungry to be the best employer we possibly can, and we are not there.

Q61 **Andrea Jenkyns:** Thank you. Still tied with high staff turnover, do you think it threatens the implementation of intelligence-led regulation?

David Behan: This comes back to Peter's point about what the figure actually means. If you have people constantly turning over, you train people in a methodology and then they leave, so you are back training people in a methodology and then they leave, so your churn and change are two different things, and change is a good thing.

Q62 **Andrea Jenkyns:** Do you have a strong succession plan in place, then, to develop people within the organisation?

David Behan: We are looking at succession planning for managers, but for inspectors we need to recruit. James's questions about whether we have a recruitment process or are recruiting the right people is to your point. We need a degree of stability so people can get experience in applying the methodologies and taking them forward, but we need some change because we want fresh blood and fresh ideas coming in, and it is how we strike the balance.

Q63 **Andrea Jenkyns:** Getting the balance right, yes.

I turn to bullying. To what extent do you believe a culture of bullying still exists within the CQC?

[7] The CQC clarified that the engagement score is 63.

David Behan: I do not think we have a culture of bullying, but I think we have a number of staff who feel they have experienced bullying over this past year.

Q64 **Andrea Jenkyns:** What sort of figure is that as a percentage?

David Behan: It is 11% and I think that works out at about 300 people who will have said they have experienced some form of bullying during that year. It is something that we survey on an annual basis. We publish that survey, we make it public and we discuss it with staff. That detailed survey material is just going out to staff over the next few weeks.

What happens is that this Friday the detailed directorate results are going out to each directorate, and then the written comments that come out will go out just before Christmas so people can have the full data and the detailed comments. Discussions are going on in work teams and work groups about what we can do to improve the way that we are operating.

Q65 **Andrea Jenkyns:** How seriously do you take bullying? Do you discipline people when they are found to be bullying? Do you manage them out of the business?

David Behan: We take it very seriously. We do not see any place for it. We are particularly clear about this.

Q66 **Andrea Jenkyns:** Have you instances where you have managed people out of the organisation because they have been caught bullying?

David Behan: Where it is known, yes. The other side of this is that there is some fabulous material in our staff survey about staff feeling supported; 95% feel committed to the organisation's purpose and the work that it does. It is right that you challenge us on where we are not doing well, but it is also important that we put that into a context of an organisation that has an awful lot to be proud of in what is achieved as well.

Q67 **Andrea Jenkyns:** Still tied to bullying, the independent report stated that a number of these cases are due to staff members wanting "to make more thorough inspections than their line manager felt was necessary." What are you doing to address this, because clearly this can affect the quality of care if you have those on the frontline really wanting to improve standards?

David Behan: Again, it comes back to striking the balance. I do not want to sound like I am on the fence on absolutely everything, but Andrew pursued us on whether we are meeting our target and will we complete our inspection programme by the end of March, and then there is the issue that if you push staff too hard they will experience that as being punitive. What is my role as chief executive? It is to strike a balance between being able to come here and account to you for our delivery against the programme and then account to staff for whether we are

managing them in an appropriate way to get the maximum out of them. We get huge discretionary effort from our staff.

Q68 **Andrea Jenkyns:** I understand that, but specifically regarding wanting really thorough inspections—the people on the ground as opposed to the line managers—how have you dealt with instances of this?

David Behan: We look at workloads and a balanced workload between people. I have visited teams where, if an inspector has taken enforcement action, they will have a heavy demand on their workload, particularly if the matter is going to court and there is a prosecution. Members of the team then take away dealing with safeguarding alerts that need to be dealt with to allow them the time to do that.

Local teams have different arrangements, which are about balancing the work and the workload, and we need to continue for managers to support staff. Again, I come back to the point that a very high figure—83%-plus, I think it is—of our staff feel that they are supported by their immediate line manager. That tells me that this balance is being struck in some cases, but the figure on bullying says not in all cases.

The question is how we can challenge inappropriate behaviour and support appropriate behaviour in the way that we go forward. We have made massive progress. I am incredibly proud of what we have managed to do in relation to this, but we cannot be complacent about this figure. It has no place in a public sector organisation, and we will give it our best effort. We have introduced initiatives around mental wellbeing, which are providing support to staff.

We are currently rolling out a programme around mental wellbeing to support managers. We have a contract with Ashridge to do a management and leadership development programme, and every leader from the executive team, myself included, through to people who are in their very first line management job, have been through this. Then we have a consistent approach to leadership and management, and we are developing this. So there is not one response; we are trying to take a multi-level response because we want staff to feel supported and engaged in our business. We want to challenge bullying and we want to support the very best practice.

Q69 **Mr Bradshaw:** Please do not take this personally, but how would you respond to the potential criticism that you are both of the top people in the organisation, steeped in the NHS and social care professionally, albeit with great achievements, but you do not come from a consumer, patient or regulatory background?

Peter Wyman: My original background was as a partner in PwC. I had a lot of clients to keep happy, so it is not a consumer background but it is absolutely having customers, if you like. When I was chairing Yeovil hospital I used to annoy our consultants enormously by talking about patients as customers. I said, "Imagine a world where they are customers

and they have real choice, and we actually want them to come to our hospital." They would get very cross with me and say, "No, you do not understand about patients," and I would say, "I do understand about patients but I also understand about customers."

I understand absolutely what we need, and that is why it is important that we work with all the stakeholders. We are absolutely first and foremost here for service users, patients and users of social services, but we also need to work with all the other people, including the providers, and our own staff. Unless you are working with all those people, you are not going to succeed. That is my answer.

Mr Bradshaw: That is great, thank you.

Q70 **Heidi Alexander:** That probably leads us quite nicely to the questions I have about the arrangements that you have in place for the use of experts by experience. As I understand it, these are patients or carers who are used by inspectors to provide that different perspective when different institutions are being inspected by the CQC. Of course, you brought in new arrangements in December last year—I think it was—and so I would like to ask you how happy are you today with the Remploy contract for providing experts by experience?

Peter Wyman: Let me allow David to answer the detailed question, but the point I would make up front is that experts by experience are really important to us and there is absolutely no intention to reduce our reliance on them. In fact, the contract was to increase it, so it is a really important thing. Because you are dealing daily with Remploy, David, do you want to say where we are at?

David Behan: Just on that point, the contract that we had for the provision of experts by experience had expired; we were beyond the life of it and we needed to re-tender, so that is what the re-tendering exercise was. We increased our investment in experts by experience by £1 million from 2014-15 into 2015-16, so the contract went from £4.8 million to £5.8 million to get this in. That reinforces Peter's point about this being a significant contribution.

The original contract had its difficulties; that is a matter of public record. We issued a "requires action" notice, which is a formal notice under the nature of the contract, because improvements needed to take place. That "requires action" notice was lifted in October. There is month-on-month improvement in relation to the performance of the contract in Remploy, so progress is being made, but we were concerned. We would not have issued a "requires action" notice if we were not concerned. Improvements, as I say, are taking place and will continue to do so.

Internally, we did a "lessons learned" exercise from the way the procurement went. This was not about Remploy but about how we organised ourselves internally. We took that report to a public board meeting and it was discussed there. We have tried to be very transparent

in the way that we have dealt with this and have been very open in the way that we have taken it to both the board and the way that we have engaged with Remploy.

Q71 **Heidi Alexander:** Am I right in understanding that for the first six months of the contract there was an agreement to pay the experts by experience more than what Remploy had initially intended to pay them because—cast your minds back to the beginning of this year—there were concerns that the experts by experience were going to be paid somewhere in the region of £8 or £9 an hour, less than what some people might pay a cleaner, and then you found the resources to increase that hourly rate for six months? What is the situation now with new experts by experience who are being recruited by Remploy to be part of CQC inspections? How much would they be paid?

David Behan: I need to come back to you on the precise figure. I think it is £16 an hour. I need to come back to you on that. I am reasonably confident, but I do not want to get it wrong, Heidi. The controversy around this contract was in relation to the original tender, which did not specify what the remuneration levels would be.

During the procurement process and before any contracts had been signed, there was a disclosure by one of the parties that was not tendering about what the remuneration package would be. That then set concerns by a number of different organisations and bodies in relation to the remuneration level.

We were still in the procurement process. The CQC team had numerous conversations with people around the remuneration package. As part of the negotiations, a remuneration level has been set and that is the level that we are running on. I think it is £16 an hour, but I would like to come back to you on that. I will write to you on that; it is not at cleaner levels.

Q72 **Heidi Alexander:** No, but there certainly was a suggestion earlier this year that Remploy was going to be paying £8 or £9 an hour depending on whether it was in or out of London. At the point at which the contract was awarded, were you aware they were the pay rates that they were proposing?

David Behan: They were not the levels the contract was awarded at. The contract was awarded at these higher levels—at £16.

Q73 **Heidi Alexander:** Okay. Now is it the case that Remploy does not hold the contract for experts by experience in all regions? I understand there is another provider in the central region. Are experts by experience paid a consistent rate across the country if you set to one side the question of the London weighting?

David Behan: You are right that Remploy provide north, south and London regions, and an organisation called Choice Support provide the central region. There was a deliberate decision to break the experts by experience contract into four blocks, so potentially we could have had

four different providers, not two providers. Remploy succeeded in relation to the invitation to tender. In answer to your question, the remuneration level in the central region through Choice Support is higher than the remuneration level in relation to Remploy.

Q74 **Heidi Alexander:** Are you comfortable with that?

David Behan: It is absolutely important that for this service we went out to procurement, and that is the result of the procurement. We have scrutinised the procurement process. We have had independent engagement in the procurement process. That is where we have let the contracts. What I am less than comfortable with, Heidi, is the distress that has been caused to some of the serving experts and the changes that have been introduced.

To Peter's point, here we had a contract that had lapsed, that we did not think gave us the value for money that we needed to secure from this. One reason we re-tendered was that we needed a contractual basis for this, but we also needed to secure better value for money from the contracts that we have. It is our view—it is my view—that we were not getting the appropriate value for money from the contracts that we had. We were out of contract, so we needed to re-tender, but we needed a contract that allowed us to secure the best value for money.

Q75 **Heidi Alexander:** This is my final question on this. You said that the remedial action notice was lifted in October. Are you keeping this under review?

David Behan: Yes.

Q76 **Heidi Alexander:** You took a report to the board in November that set out the contractual levers that might be possible or might be avenues to be used if performance did not meet your requirements. What is the process for reviewing this going forward now?

David Behan: We will keep it under review. There are monthly contract meetings. The contract team and the team that oversee the experts are having regular meetings. Because of the controversy in relation to this, I have met the senior team at Remploy on a reasonably regular basis to impress upon them the importance. I think they understand that. I think they have worked hard to get this contract to the performance levels that it needs to be at, but if there is any falling back in performance levels, we will take the appropriate action within the terms of the contract.

Peter Wyman: Just to give you absolute reassurance, the board is really concerned to make sure this contract delivers what we want from the contract. So, as David said, there is a monthly report to the board on this. With hindsight, we would definitely have done the actual contract negotiation differently, and, as David said, there was a very open and thorough "lessons learned" process so that in future we will not make the same mistakes. We are now in a position where it is settling down and it is working "well'ish". There is still a way to go. We are monitoring it.

Q77 **Heidi Alexander:** It would be useful to have that confirmation in writing about the rates that are paid to Remploy staff—people who were existing staff and new recruits to doing that job.

David Behan: I will come back to you.

Q78 **Helen Whately:** First, I would like to ask a follow-up question on Ben's earlier questions about the action you can take when you are concerned about a service, particularly bearing in mind the level of pressure that the NHS is under, and whether there are any circumstances where you have thought that a unit or a service was unsafe, inadequate, and ought to be closed but you have been unable to make that happen because you are concerned about the knock-on impacts on neighbouring services and whether they in turn might then be made unsafe. Is that a situation that has happened or you are concerned might happen?

David Behan: I do not believe that is a situation that has ever arisen. I think we have had those conversations about what would be the consequence if we were to do this, particularly around A&E and particularly in London, but I do not think we have ever decided not to do that because of those arrangements.

This is the point that we were pursuing earlier about why it is important that there is improvement capacity and buddying arrangements. I know that, in some places where there has been insufficient senior clinical cover and concern, a senior clinician from another trust has gone, literally within hours, into another trust to make sure that there is appropriate clinical cover. Those arrangements are possible in the NHS because of the way it operates but would not be possible in a care home, which is why you have some of those differences.

I do not believe I am aware of any circumstance where we have not acted because of concerns about safety because we have felt unable to do that. The action has been different, so maybe in a care home we have taken urgent action to close somewhere, whereas in a hospital it might have been urgent action to ensure there is sufficient clinical cover to provide it. The legislation that sets us up says our job is to encourage improvement as well as to take action. I think we can use the full range of our powers. It is often NHS Improvement that will make the arrangements for a clinician or for some additional support to go in.

Peter Wyman: There is always a huge judgment call. If you are going to close a service, it will have implications. Whatever the state of finances and resources and everything else is, it has implications for the people who have been using those services as well as working in them, so it is a judgment call every time and you have to balance where is the greater risk, the greater harm; but the decision—arriving at what judgment—is not, as I said earlier, influenced either by a political or a financial consideration. It is a judgment as to what is the best thing to do in those circumstances.

Q79 **Helen Whately:** That was exactly my concern. Given that you have a judgment call there and the NHS is under a great deal of pressure, that means your judgment is more likely going to be to try to keep something going than possibly to take more radical action.

Peter Wyman: Not necessarily. If you have a hospital where the next hospital is an hour away and you want to close a service at that hospital, whatever the resources and whatever the financial situation of the NHS, that has big implications for the population.

You have to be sure it really is necessary to close that service or whether you can take other measures or have the provider take other measures so that the service can continue under some sort of supervision, which, as David says, is where a lot of the buddying and so on comes in. Can you make something that was unsafe safe quickly enough so that the service can continue? If you cannot, then you have to stop it, if it is that bad—whatever we are talking about, a hospital service, a care home or anything else—but that has implications and we need to be aware of that.

Q80 **Helen Whately:** Thank you. I am going to ask some questions about the assessment of the resource efficiency, which is a new responsibility that came your way, announced in 2015, that you would take on looking at resource efficiency of trusts alongside quality. I understand in the past that there were value-for-money inspections but they were dropped. What would be different about the proposed assessment of resource efficiency?

Peter Wyman: The use of resources is something we are developing jointly with NHS Improvement. Coming back to something I said right at the start, we are very anxious to avoid regulatory overlap and duplication, so working with NHSI, the people who have responsibility for the financial sustainability of trusts—and, by the way, the use of resources is just for NHS trusts at the moment—is a key part to avoid any unnecessary duplication or contradiction.

It is looking at a variety of measures—pure financial measures, how close you are to your budget or your control total, how good is your financial control—but it is also looking at metrics around your efficiency. Over time, it will be developed: what would be the norm for any part of a service, how much would you be expecting to pay, and where would your efficiency be on that range, which is a lot of the work that Lord Carter has been doing. That gets factored in.

We still continue, obviously, with all our existing work on safety and the quality of care and so on, but then there is a third element to this, which I think is going to be increasingly important: that is, the combination of finance and quality and how that is affected by leadership. We want to get to a point where we are looking at the leadership of the trust and its ability to ensure that there are safe, quality services, but at the same time there is a financial efficiency, which then is also into sustainability—both financial sustainability of services and sustainability of the quality of

service. It is quite a big piece of work that has been going on. We have made a lot of progress, we have worked really well with NHS Improvement and we will be consulting on the next steps fairly shortly.

Q81 **Helen Whately:** I understood that it is due to be rolled out in January 2017, so in a month's time.

Peter Wyman: No. Consultation, I think, will hopefully be this side of Christmas, but certainly very early in the new year if it is not, with a view to starting to pilot this in April. There then needs to be a period where we pilot it, get the feedback from the pilot and make refinements as necessary before it becomes hard-wired later in the year.

Q82 **Helen Whately:** Thank you; so we are going to start to see some more imminently. How do you expect that rating to be used, and how will the public be able to interpret what the resource efficiency rating means?

Peter Wyman: The policy origin of this was to try to make sure that finance was not trumping quality and quality was not trumping finance. I still think that is a really important thing, because we all know that the financial resources are very constrained, but it would be terrible if, as a result of that, it became acceptable to have lower quality and, equally, there was some suggestion that quality was being achieved by having a disregard for the financial consequences of getting there.

This is absolutely an effort to make sure that we have this balance, and again that is a different but important reason why I want to work jointly with NHS Improvement, so the same messages are coming. I think this will be taken very seriously by trusts.

I have no better idea than you as to how the public will view this, but my experience is that the public look very much at the service level within a hospital rather than the overall ratings. This is my personal experience. If they are going to use the maternity service, people will look very much at how the maternity service was rated and be less worried about how the accident and emergency was rated.

They are looking more at the service level and this is at the trust level. We need to consult further on exactly what trust-level ratings we give in the future anyway, as we move into new models of care, and you are getting very different organisations. Trusts may no longer be just a hospital or a group of hospitals. So there is some separate—separate from the use of resource work—work to do around that.

Q83 **Helen Whately:** If you are saying that members of the public, as you see it, tend to look at a particular service that they might be concerned about, such as maternity, do you think this rating is aimed to inform the public, or is it more about regulators and commissioners being able to have—

Peter Wyman: My personal expectation—and I absolutely use the word personal—is that this will be of much more interest to commissioners,

regulators and trust boards than it will be to the public at large, but I may be wrong. We will see how it turns out, but, either way, it is not to diminish its importance. It is really important that we get this balance between finance and quality.

David Behan: I think it will allow benchmarking. I do not know that my dad would be interested in it, apart from as a general comment, but he is interested in how the medicines services at Blackburn are provided because he is using those services. This is Peter's point, in answer to Ben's point, about consumers being interested in the service that they are using at a particular point in time, but I think the value for money in the use of resources will allow benchmarking across different services and across the sectors.

Peter Wyman: In some circumstances it will also help improve quality, or at least not allow quality to diminish, because, if you can demonstrate that you are an efficient user of resource but you need more resource, then more resource should be made available. At the moment, in the last year or two, we have had some very—I cannot find quite the right word—broad-brush targets being set and people talking about things such as, "Let's reduce agency spend," and "Let's have less staff on wards," without having, as David said, the right benchmarks, and not just on financials. I think this will be positive.

Q84 **Helen Whately:** In the work that has been going on, have you found examples of trusts appearing to make efficient, effective use of resources but they are struggling financially, and possibly struggling with quality as well, so the case should be made that their financial situation needs addressing?

Peter Wyman: I am not sure it has come out of the work we have been doing in developing the use of the resource metric as yet, but certainly there are examples of trusts that have big deficits that are very efficient. One reason for that is that, if you have a trust with a nice balance of elective and emergency work, it will have a financial balance.

What we have seen happening is that as pressures have built, as elective work has been cancelled, the mix has changed, and the way tariff works is in many cases that less money comes in per patient if it is an emergency case than an elective case. So it is nothing do with the efficiency or inefficiency of the hospital, at least not directly, but we are seeing where an efficient hospital is under financial pressure, certainly.

David Behan: To add to that, we have found, and I think the NAO was making this point when it published its report a couple of weeks ago on sustainability, that, as to the relationship between trusts, the trusts that are delivering high-quality services tend to be the better financially managed organisations and those that are delivering the poorer quality services tend to be not as well managed financially. There is quite a strong correlation that we reflected in our work and the NAO reflected in a report a couple of weeks ago. This will help us to advance some of

those conversations and that analysis in a richer way than we have managed to do hitherto.

Q85 **Helen Whately:** Thank you. A moment ago, Peter, you referred to the need to align and integrate your work with NHS Improvement, and we know there are concerns about there being a level of duplication. How far have you got in drawing up a shared understanding of quality between the CQC and NHS Improvement?

Peter Wyman: Let me answer at a high level and David can put more flesh on the bones. There is a huge commitment at board level, particularly at chair and chief executive level, across the two organisations to work together. It is a commitment that I do not think was as clear in the past; it is certainly very strong now. I meet with the chair of NHS Improvement on my own regularly and with the chairman of NHS England; the three of us meet.

Q86 **Helen Whately:** I am going to interject there. I can appreciate a desire to work together, but this is something very specific that needed to be created and written down.

Peter Wyman: I accept that. The point I am trying to make, just to finish, is that David meets with his opposite number, so there is a real strong commitment—

Q87 **Helen Whately:** Of course. I get that.

Peter Wyman: It is a really important starting point. I am not sure that those meetings used to happen in the same way—I was not here—but it is a really good starting point. Out of those meetings comes the ability to have the discussion about, "Are we absolutely clear where we are both going in terms of the shared view of quality?" I think there are several dimensions to this. The big prize, in addition to the one we have just been talking about—use of resources and so on—is to have a single dataset that comes out from trusts that is in an agreed format, which is something that is capable, therefore, of being mechanised and comes out to both of us, and indeed to commissioners as well. I think we are on the way to getting to that point.

Q88 **Helen Whately:** Only "on the way."

Peter Wyman: We are only on the way—there is still more work to do—but it is really important and we need to get to that point as quickly as we can.

Q89 **Helen Whately:** When do you expect to get there?

Peter Wyman: I think it is going to take a while to get there in its totality, but we are making steps in that direction now.

David Behan: There are three concrete things I would offer to you, Helen, in relation to the work with NHS Improvement. To your very specific question, we are developing a joint approach to the assessment

of "well led." At the minute, if you are in a trust, you will experience NHS Improvement's assessment of leadership and CQC's assessment of leadership, broadly based on some of the same principles, but they are two different frameworks. Our teams are actively working on producing a single definition of "well led" so that trusts will not experience two different conversations about leadership. We expect that to go out to consultation before Christmas, so this is real and is taking place now.

As Peter has said, we are actively working on the assessment for the use of resources, which I think will be different from what has gone hitherto. We have not done that for over five years, so it is a long time since that was done. We are also aiming for that to go out before Christmas and then we can begin to pilot it from April next year.

So there are two very concrete pieces of work on which I think we have made massive progress over the past few weeks to get that up and out of the door. That is all predicated on the back of working together so we can remove duplication that exists between the CQC and NHSI. I expect us to be judged on what we do, not on what we say, and there are two examples of things where people can judge us on whether that has made a difference.

The third area that I would offer is that yesterday we announced the joint appointment of chief digital officer between CQC and NHSI. Instead of having two people to do this, we have a single appointment, which will help us put down some of the changes to our infrastructure and information systems that we need, which will also support a single view of quality and single datasets.

We are building this architecture about how we work collaboratively, and again I would offer those three as specific examples of how we are converting that commitment, those words, into something practical that is taking place on the ground. As to the point of convergence—so, when?—it will be chief digital officer; consultation before Christmas; and then changes in the way that we apply those methodologies from April next year.

Helen Whately: Thank you.

Q90 **Andrew Selous:** Following on from what Helen was asking, I am tempted to ask you if you think you should go further than sharing a chief digital officer. Is there greater scope for reducing duplication across the two organisations rather than just sharing a chief digital officer?

David Behan: How does a mouse eat an elephant? One bite a time. It is not "just a chief digital officer"; it is a big deal to get a joint appointment and this is absolutely crucial to our strategic future. Can we go further and will we go further? Yes, we will. I think we are committed to ensuring that the people whom we regulate should experience us as being more joined up. The important thing—and I think the important thing for this

Committee—is that we do not just do the NHS. NHS Improvement do the NHS, but we do general practice and adult social care as well.

There are points of convergence, to pick up on Helen's point, but there are also points of difference between us where our set of responsibilities is much broader. NHS Improvement is not doing independent ambulances, cosmetic surgery and independent clinics, dentists, and so on, but that is the expectation that Parliament has placed on us and that is what we take forward.

Your challenge to us, Andrew, about completing our programme, and so on, and Peter's answer about what we will do then, is that we have a broader range of responsibilities—it is not a competition—than NHSI, but as to that which we do with the NHS, it is right that you expect us, and we expect to do it, to collaborate.

In Ed Smith and Jim Mackey, at the most senior level, I am absolutely clear that we have good partners who are equally committed to taking this forward, and how we both move two big organisations to do that is part of why it is very difficult to answer Helen's question, "When will you do this by?" But we will start one bite at a time and make these changes, and we will start with resources. I am sorry, Sarah.

Chair: Thank you, but can we have slightly shorter answers, if possible?

Q91 **Andrew Selous:** I tempted you. It was quite a big question, so forgive me, Chair. Going on with the value-for-money theme, to what extent are providers bearing the brunt of the move to full cost recovery at the moment?

David Behan: They are. That is the purpose of it. The Treasury's policy is that arm's length bodies and regulators should move towards full cost recovery. We will move to a position where the balance between grants from Government and fees paid by providers will change. This 2017-18 year will be the second year of a two-year progression towards full cost recovery. From 2018-19, we will be at full cost, apart from the £20 million or so that we will get in grant from the Department, and that is for those services for which we cannot recover a fee.

Q92 **Andrew Selous:** To what extent are you bearing down on your own costs to try to improve value for money? For example, I note that next year you are proposing a 75% fee increase to be borne by single and multiple-location general practices. That strikes me as a pretty steep rise.

Peter Wyman: But there are two quite different things running here. One, as David said, is that full cost recovery pushes the burden on to providers. The reason that you see such a big percentage increase for that group of people is they were furthest away from full cost recovery with the start of this process, so the jump will be bigger to get there. The second and separate point is how efficient we are.

As David said much earlier on this afternoon, we are on a reducing budget and we will continue, as far as we can, to push down our costs, which then in turn will keep as low as possible what we have to charge the providers.

Q93 **Andrew Selous:** Could you say a little more about what you are doing to improve the efficiency of your own organisation, and I note, in the evidence provided to us, that the National Care Agency says that you as a regulator have "consistently…failed to meet" your own internally set targets, yet you "penalise providers who fail to meet the targets" you set them. How would you respond to that?

Peter Wyman: On budget, as David said earlier, we will come in under budget this year, as we did last year, so not only is it a reducing budget but we are coming in under budget. That is an objective measure of reducing and trying to control costs.

Two things will change this, and they are all things we talked about earlier. One is by changing both the frequency and the nature of inspections; you can put resource in different places and overall get a lower cost. The other—and I apologise for repeating it again—big prize at the end of the day is making much greater use of digital technology. That is not something that is going to impact in any significant way next year, but by the end of the cycle of our current strategy to 2021, I think you will see that has made a very big difference to our cost base.

Andrew Selous: Thank you.

Q94 **Rosie Cooper:** David, this is almost a continuation of the points I was making at the beginning of the meeting. The Public Accounts Committee felt the CQC were not making sufficient progress in supporting new models of care. That leaves me wondering whether you, as an organisation, have the capacity to take on a new and difficult role in assuring quality on a place-based basis.

I am not wanting to go back and rehearse LCH, but when there is one organisation and everybody in a health community missed the problems with it, are you sure that will not happen again? What have you learned from the pilots of your place-based quality assessments?

David Behan: We have been very closely associated with the new models of care and the STPs. We have link and lead staff from the CQC to those new care models. Andrea on the care homes and general practice has had a number of meetings with people in those projects. The document we published in the summer, in July this year, talked about learning alongside the new care models.

There is not a template for these. They are developing in real time, so we have been involved and positioned ourselves to be involved in those conversations so we can learn. Mike has had a couple of meetings now with the trust chief executives who are developing chains and federated models of care so that again we are learning in real time. We have had

conversations with the Royal Free and with Northumberland about the work they are doing around chains and accountable care organisations, so we are connecting to those organisations and developing our methodology.

I think we are involved, Rosie, and I do not see a problem with us getting involved in this. The strategy was predicated on the back of the population, and the needs in the population are changing. As the population changes, services will change, and, as services change, we need to change the way that we regulate services. That is effectively what we have been taking forward, and we will publish in the consultation in December some of the changes we are making around new models of care. On area-based work, we did this in three different ways in these three areas and we learned that the key question is about who is accountable for the delivery of care in an area. That is the key question. If something goes wrong, who gets the coroner's letter?

Rosie Cooper: Absolutely.

David Behan: One issue about the work that we need to do is clarity as to who is accountable for the quality and safety of care; who in the new models is going to be accountable; and does our approach to both registration and inspection have clarity about those accountability issues? We will do two further area-based pieces of work next year, one in Cornwall and the other in Sutton, so we will continue to develop this alongside our thematic work. I think we are responding to new care models and learning how best we can regulate these, but, ultimately, in any of your constituencies, there is going to be an organisation that is accountable for the delivery of that care, and I think it is our job to regulate the quality and safety of that care, whatever the governance arrangement is for its delivery.

Peter Wyman: May I briefly add that there is no greater supporter and enthusiast for new models of care than me, but we have to be careful in not thinking that we have got further ahead than we have and most care is going to be delivered in traditional formats? The organisational structures are changing, but the actual delivery will still take place in a general practice surgery or in a hospital.

I do not think we are about to move to place-based regulation and replace our existing regulation. There is more scope for thematic reviews, and, as things develop, we want to work out how we are most closely co-ordinating the different inspections of different services in an integrated way, but I do not think this is suddenly, "Let's just tear everything up," and that what happens in a hospital no longer matters because it is somehow part of a wider system.

Q95 **Rosie Cooper:** Nobody is suggesting for one minute that you need to rip up what you have. I would be looking for a greatly enhanced and delicately nuanced look at stuff, when I know—and we know—that I could prove that, yes, you have changed stuff but you missed some really big

stuff. I was interested in reading that the place-based approach to regulation would depend on data and information from, including others, CCGs, ombudsmen and patient representative groups to inform its judgment; and you talk about a balanced score card, and in all of that it was a challenge to get the information from CCGs.

The real question I am getting to is: who assesses CCGs? I understand it is NHS England now, but that is really far from adequate. Do you think that you should have a role in that? I look at the dreadful case of Liverpool CCG, where to me there is little evidence of good-quality governance or, indeed, much financial governance. Their approach to cost-cutting recently has been a simple stripping out of non-recurrent spending, no matter that non-recurrent spending is being spent and provided for each year for recurrent services.

You do not have power currently to scrutinise CCGs or local authorities, and I note that you reject Dame Julie Moore's call for NHSI and the Care Quality Commission to be joined because you have different powers. I agree, but the big thing here is, if you are not looking at CCGs and you are not looking at local authorities, do you think you should have those powers? If not, how could you sit there and say you feel, over a place-based system, that you are going to be adequately able to look at me and say, "This is safe"?

David Behan: Blimey, there is a lot in that, but just to unpick it—

Rosie Cooper: There is!

David Behan: In some parts of England, those new models of care will be in, and up and running, next year, and services will look different from how they look this year. There will be other places in England that will not look any different from how they look this year and last year, and our job to assess the quality and safety of that care remains.

At the same time—so this is not binary; it is not an either/or; we have to do both at the same time—our challenge is whether we can continue to regulate, for the health and care system, the quality of that care. Then, when new services develop, such as Northumberland where there will be an accountable care organisation from next year, where we will need to do some of these things differently, are we developing our methodologies so that we can arrive at those judgments? I believe we are. Do we have—and you answered your own question, in a sense, Rosie—the power to regulate CCGs and local authorities? No, we do not.

Q96 **Rosie Cooper:** Do you want that power? Somebody needs to do something about CCGs—absolutely.

David Behan: At the minute, it is NHS England that has that responsibility.

Q97 **Rosie Cooper:** They seem to be a little asleep on the job at the minute.

David Behan: Nobody has that oversight of local authorities at all. If Government or Parliament want that to be done, there are a number of us who have worked in regulators in the past who have had that oversight of CCGs and local authorities, and I can see how it will be done, but we are not making a proactive grab for other people's responsibilities. Earlier, we were pursuing working with NHSI.

Rather than merge, which is where Julie Moore is, I think our responsibility is to work with NHSI to do that. In the same way—I will come to your point, Rosie—we need to work with NHS England in the way that their oversight of commissioning and the work that we do around area-based provision comes together. In accountable care organisations, Northumberland will have the commissioning budget as well as the provision budget from next April, so that will mean that we will have to work with NHS England as well as NHSI about how we take that forward. Those are exactly the conversations that we are having.

Q98 **Rosie Cooper:** But, David, can I make this point? If you do not have the ability to inspect and scrutinise the commissioning, and you have an accountable care organisation where you can look at, almost, bits of it, how do you look right across from commissioning to local authority budgeting? Bringing it all together sounds fine, but where will your reach be and how far can you get in there? If you cannot get down to that individual person, you—we—are putting at risk elderly, infirm people, and that would be a disgrace, hiding it under an accountable organisation?

David Behan: I think our reach is down to the individuals.

Q99 **Rosie Cooper:** Do you mean in an accountable organisation?

David Behan: Yes, because that is my point about accountability. Whoever is commissioning those services, they are still being provided by people, and that is our reach. We are the regulator of the provision of health and care and that is what we will look at.

As to whether there is a policy question to be asked, there probably is a policy question to be asked into the future, but I am not sure how many accountable care organisations with commissioning powers there will be on 1 April next year. The only one that we know about is Northumberland.

Q100 **Rosie Cooper:** Let me tell you privately that there will be Liverpool, and Lancashire County Council is looking. All the big councils that provide social care are in dire trouble, with their backs against the wall. They see the NHS as a mechanism for bringing in real money, and they are going to go for it and go for it hard.

If you cannot look at local authority spend and the quality of that provision, which you say you cannot do now, and that goes into this organisation and, for example, Liverpool will be—Bridgewater is outlined at the minute to probably get it—£5 million light and the council is absolutely on its uppers, if you put those two together, how do you

provide good quality care and who is going to be responsible? Will you actually inspect Liverpool City Council's input into that local accountable care organisation? Will you inspect, right across the piece, employees from both local authorities and the former NHS organisation?

David Behan: Our responsibilities are for the regulation of the provision of health and care. That is the legal framework we operate in. If there is a policy position that invites us to change that, then I can see how we can take that forward, but at the minute I do not see a problem from 1 April, Rosie, in relation to the quality of provision in Bridgewater or any other provider trusts.

Rosie Cooper: Believe me, I have been at this for four years; I will be back.

Q101 **Chair:** Perhaps it would be helpful for you to write to us to tell us where you feel you could have more powers to enable you to do your job in regulating these kinds of organisations if you feel there should be a change.

Peter Wyman: I am happy to do that, and I know time is short, but the point I was trying to make—and obviously badly, because you did not respond as I was hoping you might—is that we will look, as David has just said, at the provision of care in each part, and that does not change just because it is a new model of care.

People will still be having domiciliary care, they will be in a care home, they will be having primary care or be in a hospital, and we will still look at the quality of the provision of all those services right across everywhere. That is not changing. If it is clear, because of the change of arrangements, that some part of that provision is not working well, we will say that.

The second point is that we have, as David said, increasingly been doing thematic reviews—how a pathway works in an area. That is very important, because we all know that you can have good provision at each point, but the journey through the system is a bad experience. We still do that.

The bit we do not do is whether the commissioners are commissioning in the right way and using their budgets properly. We do not do that. That is not our responsibility. I am not sure that that is a responsibility we should have, to be honest. We are very clear anyway that we can say whether the provision of services from that commissioning is good, bad or indifferent. That is the important message.

Rosie Cooper: I will not continue this. There are some really good questions in there.

Q102 **Chair:** Thank you. Can I ask one final question, unless colleagues have final points, around care staff and access to training for those working in social care? We have heard that the very high turnover rates are linked to

lack of access to continuing professional development. Is there anything further that the Care Quality Commission can do to encourage better access to training, and is this something you are looking at?

David Behan: We do place a premium on workforce development; it is a key part of our inspection methodology. This goes back to the capacity and capability that is in the system, so I think we do encourage it. The role sits with Skills for Care. That is not to pass on the responsibility—we have a close working relationship with Skills for Care—but I think the image of the sector, the remuneration packages, and so on, are all part and parcel of what makes that attractive as well as the training.

Q103 **Chair:** As inspectors, do you feel there is enough effort going into this, to improving access to training? Do you feel encouraged or that there is not sufficient progress being made?

David Behan: This is more a personal view, if I am being honest, Sarah, but we have some of the most dependent people cared for by the people who have the lowest remuneration and the lowest levels of training. You can dress this up in all kinds of different ways, but that is the basic issue, which is one of the reasons why we always look at whether people are being developed and have access to training.

You do have high levels of turnover in adult social care; people are making decisions to move in and out of the sector. The turnover levels are very high. We have churn in that sector, not change, and that leads to all kinds of issues about stability, but we know 80% of residents in care homes have some form of dementia, are heavily dependent and need to be cared for.

Chair: It is certainly an area of concern to this Committee. Thank you very much for coming this afternoon.