HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Care Quality Commission's State of Care Report, HC 1590

Tuesday 30 October 2018

Ordered by the House of Commons to be published on 30 October 2018.

Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Derek Thomas; Martin Vickers.

Questions 1 - 114

Witnesses

I: Peter Wyman, Chair, Care Quality Commission; and Ian Trenholm, Chief Executive, Care Quality Commission.

II: Andrea Sutcliffe, Chief Inspector of Adult Social Care, Care Quality Commission; Professor Steve Field, Chief Inspector of General Practice, Care Quality Commission; and Professor Ted Baker, Chief Inspector of Hospitals, Care Quality Commission.

Written evidence from witnesses:

– Professor Ted Baker, Care Quality Commission

Examination of witnesses

Witnesses: Peter Wyman and Ian Trenholm.

Q1 **Chair:** Welcome to the Health and Social Care Committee. This session is for us to hear, predominantly, about your "State of Care" report, and to have an accountability session for a number of issues raised with us as a Committee that we would like to put to you. For those following from outside the room, may I ask you both to introduce yourselves?

Peter Wyman: I am Peter Wyman, the chair of the CQC. It is a great pleasure for me to introduce our new chief executive.

Ian Trenholm: Good afternoon. I am Ian Trenholm, the chief executive of the Care Quality Commission.

Q2 **Chair:** Welcome to both of you, and thank you for your excellent report. Could you tell us what the key messages are from that report for the public, those in frontline service roles and the Government?

Ian Trenholm: There are two key messages. The first is that people are generally getting good care. When people consume care, if you will, at a particular location—when they see their GP, or in a hospital or in home care—they generally get good care. Over a number of years, we have seen an upward trajectory in the quality of care that people receive at a location.

What we identified this year is that people's access to that care is becoming more and more difficult. People are waiting longer to see their GP and are finding it much more difficult to get the care in their own home that they need, which means that they are more likely to end up in hospital and more likely to end up staying there, once they are there, and less likely to be able to leave. The system is not necessarily working as it could do.

That was the first message. The second message is that there is a need for a long-term funding solution for social care. In recent days, we have seen welcome funding going into social care, but in "State of Care" we identified the need for a long-term and sustainable solution for how social care is funded in this country.

Peter Wyman: To build on what Ian said, for providers and commissioners of services, the system point is one we have been aware of for a while. As you may know, we were asked last year to look at 20 areas, to see how the system works, and it usually does not work very well. Even if individual parts are good, where they join up and when the citizen has to navigate a way through multiple different services, it is really quite problematic. Our big ask of the systems locally is to work better together to reduce the difficult edges that people have to navigate. Our review was on elderly people, but exactly the same point works for anybody with multiple, long-term conditions and for frequent users of lots of different services. They struggle.

Chair: Thank you. We will come back later to look in more detail at your system reviews. Rosie will start the questioning.

Q3 **Rosie Cooper:** My question is to the chair. Before your last chief executive's appointment, we had a number of quite serious debates in this Committee about the CQC and its performance. It is safe to say that, after Dame Jo Williams's disastrous performance here, it was not long before she left, because she could not adequately describe how the CQC was making a difference in the lives of the people whose health it was supposedly monitoring. Indeed, she expressed a view that you could not possibly go into people's homes, because that would be confidential, so the people most at risk were not being looked at.

Given that your chief executive is sitting next to you, I would like to pose this question to you. The new chief executive's health and care experience is a lot more limited than that of David Behan. What steps has the board taken to manage the loss of experience and, potentially, of credibility, at a time when you are losing Andrea Sutcliffe and Steve Field, people who have been the backbone of the improvement in your reputation?

Peter Wyman: My starting point would be to say that, actually, Ian has a bit more experience than you may have realised. Interestingly, he was chief executive of a local authority, so he understands some of the local authority issues very well, as well as previously having been chief executive of NHS Blood and Transplant. He is not without experience.

The more fundamental point is that we have strength in depth. One of the things that David Behan and the three chief inspectors have done over the last few years is to build a really strong team, or teams. You could take any one of us out and the organisation could carry on extremely well.

Q4 **Rosie Cooper:** Is there any point in you being there?

Peter Wyman: That is a good question.

Q5 **Rosie Cooper:** I am being deadly serious. If you are not making a difference, get off the bus.

Peter Wyman: I see my job as ensuring that that strength is maintained. The other thing I was going to say is that we have built a strong board of non-executives; that is something I have personally been quite involved in. We have a vast range of experience now of the skills we need on the board. We do two things in the non-executive element of the board. First, we hold the executives to account, making sure that they are doing everything you want them to do. Secondly, it is about making sure that their additional knowledge and experience can be used productively within the CQC.

To go back to when David was first appointed, he and David Prior, the then chair, were very clear that the CQC was not fit for purpose. I have

sat here with David in the past, and we have said to you that it is now a good organisation. We do not think that it is perfect by any means and there is a way to go to improve, but it is not in a bad place. Having strength in depth and big teams of really good people is very important.

Q6 **Rosie Cooper:** What is the level of churn on your board?

Peter Wyman: On the board, we normally work on the basis of two three-year terms. When I came to the CQC, there was a bit of bunching, so we staggered the times so that they are not bunched. We probably have one or two people retiring each year and replaced by one or two others.

Q7 **Rosie Cooper:** You just described it as bunching. How many left in the last year and how many are due to go next year? You described your strength as being in the non-execs and the board itself and the depth of the organisation. Do you know what the level of churn is? How many people went last year and how many are going next year?

Peter Wyman: Last year, one of the non-executives left, coming to the end of their term. Next year, two people will come to the end of their term, which feels about right to me.

Q8 **Rosie Cooper:** The truth is that David went and, of the board as a whole, two went last year.

Peter Wyman: There are 14 people on the board, to put it into context.

Q9 **Rosie Cooper:** If two are going next year, how many execs? Two or three?

Peter Wyman: As far as I know, only two of the execs are retiring.

Q10 **Rosie Cooper:** That is at least four, so it is six out of 14. We are approaching—

Peter Wyman: No, hang on. Over the past 12 months, one non-executive has gone.

Q11 **Rosie Cooper:** And one executive.

Peter Wyman: And one executive. That is two.

Q12 **Rosie Cooper:** Good grief, we can count.

Peter Wyman: I am an accountant—I can count.

Rosie Cooper: Lovely.

Peter Wyman: Next year we will have—

Rosie Cooper: Two execs.

Peter Wyman: Two execs and—

Q13 **Rosie Cooper:** Two non-execs, as you have just said, which adds up to

six. Six out of 14 is nearly half.

Peter Wyman: But that is over a two-year period. You would expect that; it is about right.

Q14 **Rosie Cooper:** You might think that. In a two-year period, half the strength in depth that you have described has gone, and quite strong strength in depth. But that is fine. Thank you very much for that answer.

Peter Wyman: That is the board. You were saying that Steve and Andrea are going and David has gone. My point is that there are teams beneath the board of highly talented people, at one level and levels below. That is the strength in depth; it is not just at the board. That is the continuity.

Q15 **Rosie Cooper:** I have chatted to many of them, and they want to see how you two are going to get on, and they will decide whether they still have absolute confidence in the CQC. Forgive me for that.

Ian, what steps are you taking to strengthen your depth of experience in this field?

Ian Trenholm: In relation to the board?

Q16 **Rosie Cooper:** And the new challenges you face with the CQC, because your previous experience is not really in this kind of regulation.

Ian Trenholm: It is not. My role as chief executive at the CQC is to build on the legacy that Sir David Behan created, along with Peter and others, to take the organisation on to the next stage and make us an easier organisation to do business with and a more attractive place to work. I want to make the organisation more public facing. We gather an awful lot of information that we process and use for our own judgments, but I would like to make that information more widely available to the public, so that the public know what we know. That means doing a number of things.

As you know, Andrea Sutcliffe and Steve Field are leaving for two—in my view—very positive reasons, and they will go on to make some very positive contributions to the health and social care fields in their respective futures. I shall be replacing both of those people, and I hope that the CQC's reputation will attract a very strong field. I am also building the executive team by adding a chief digital officer, and we will shortly be going out to the market to do that. We are doing that to enable the CQC to be seen as a genuinely easy place to deal with, and an easy organisation to work with, with a good suite of digital services. I am looking to strengthen my very senior team.

To reiterate Peter's point, there is strength in depth in the managerial team at the various layers, which ensures that on a daily basis we do a good job. It is worth noting that 80% of our employees have been employees for longer than two years and, as of 31 March, we had a vacancy rate of just over 3.5%, which feels like a good story in relation to

where the CQC may have been in previous years, when there was high turnover and a high vacancy rate. We do not have those any more.

Q17 **Rosie Cooper:** Could you describe what you mean when you say, "The public should know what we know"? Shouldn't they know what you as the regulator know now?

Ian Trenholm: They do. I meant specifically that we collect together a lot of public domain information, process it and gain insights from it. Then we deliver those insights in the form of reports on individual settings, or we do thematic reports.

Q18 **Rosie Cooper:** Do you see your future as a data repository? I need a good regulator out there making sure that people get good care, and that people who operate poorly are taken out of it. Describing yourself as a data repository does not really give me a great feeling; you are going to spend more time collating stuff as opposed to actually doing stuff.

Ian Trenholm: It is an issue of presentation. We are not going to spend our time as a data repository, but we have to collect an awful lot of data and information as part of our day job. We use that internally. I am saying that it would be great to be able to make those data streams more available than they currently are so that the public can access them. It is a question of making them more easily accessible, rather than getting into a completely new line of work. I am definitely not saying that.

Peter Wyman: To give you reassurance, we are not saying that we are going to stop doing the things we have been doing. We are going to continue to regulate as you have just said you want us to do.

Rosie Cooper: Forgive me, but look at the history. Look at LCH, for example, where you missed it all. You were absolutely missing from the field when that was going badly wrong. It was down to me getting whistleblowers to see the CQC. You gave Liverpool prison a good report, then a bad report, then a good report. So forgive me for not sitting here and being absolutely enamoured of your ability to handle the data. We need to see you deliver more.

Q19 **Chair:** To expand on the issue of data, you will be aware of the King's Fund report, which showed that the quality indicators used in the CQC's intelligent monitoring datasets had little or no correlation with the subsequent ratings. Most worrying is that 172 practices that received an inadequate rating were not predicted at all. How can you reassure us, on two fronts? What kind of data will you use to make sure that you are prioritising practices that could be in the risk group? How will that make a difference subsequently? How will you improve your data collection and what you collect?

Peter Wyman: The starting point is to reassure you and the Committee that we are not stopping our normal cycle of inspections. Right across the various sectors, there will be inspections on a timed basis. The intervals of time can in part be informed by our previous experience; we now know

a huge amount more about every provider than we did a few years ago. I want to use the intelligence we can receive from multiple sources, including whistleblowers and many others, to say that a particular provider appears to be getting into some difficulty and we need to go and look, and either bring forward a scheduled inspection or do an inspection that we had not planned to do.

Q20 **Chair:** Would that be on the basis of a single report from a member of the public, or would you need to see it from multiple sources?

Peter Wyman: It hugely depends on what the report is. Normally, it will not just be based on one report, but it might be something really alarming from a credible source. It might not necessarily immediately start an inspection; it might start a conversation with the provider. We may ask for the background on a particular issue, and we may or may not be convinced by what we are told. It is a more nuanced approach. To put it the other way round, it would be wrong for us to say that every two or three years we will routinely go back, regardless of any information we have had in the meantime. This is about sharpening our focus but not replacing the routine nature of going back.

Q21 **Chair:** In other words, the way you will be effective is not just through inspections; it will be through conversations with people or bodies that you inspect.

Peter Wyman: The King's Fund makes the point that, if you have a relationship with the provider, you are better able to understand what is going on. That is something we want to build on. It does not replace inspections, which will be as they are today; they are inspections, and our ratings will follow an inspection, not a conversation. Quite often we are made aware of something that appears to be going wrong in a hospital, for example, and, in talking to the medical director and chief executive and understanding the issue, we may or may not get a sufficient response to enable us to say, "Fine, you've dealt with that; thank you." If we do not, we will probably need to escalate our process and, possibly, have an inspection. It is about understanding what is going on.

Ian Trenholm: Can I add to that and perhaps add some numbers? During last year, we received about 8,000 concerns in the way you have just described, Chair. In about 180 cases, they directly triggered an inspection, so they were obviously of some seriousness, and it was obvious that we needed immediately to trigger an inspection. On just under 500 occasions, we brought forward a previously planned inspection, and, on just under 2,000 occasions, we referred the concern to another agency that might perhaps more appropriately deal with the matter.

Q22 **Chair:** Did you follow that up? Once you had referred it to another agency, would you then have a conversation with them to see whether they were satisfied?

Ian Trenholm: In some cases we would, but not in all cases.

Q23 **Rosie Cooper:** I have a fear after some of the words that I have just heard about having a relationship with a trust. In the case of the Liverpool community trust, of those people you would have been having a conversation with, the chief nurse is now before the NMC, the medical director is before the GMC, and the board did not even turn up to be interviewed by Bill Kirkup. How would you spot that one?

Peter Wyman: I would hope—

Q24 **Rosie Cooper:** Hope is not a strategy. We need something a bit better than that.

Peter Wyman: The strategy, as I said, is that we continue to inspect and to use intelligence. We will listen to whistleblowers and we will listen to you, in future. You build a picture. You learn a lot from talking to people.

Q25 **Rosie Cooper:** But you missed it all.

Peter Wyman: That was in the past, and I think we are getting better.

Q26 **Rosie Cooper:** What you are describing does not give me any comfort that you will inspect properly. That trust was rapidly going to become an FT, before I exposed all this. Well, I did not know about it; the whistleblowers came to me and I gave them to you. But they had been to you and to the NMC. How is your inspection, intelligence and listening going to not miss something like that?

Peter Wyman: I repeat that our inspection process has hugely improved over the last few years, and we will continue to inspect. In hospitals, we will do an inspection every year, so there is something taking place all the time. It is an inspection process I have confidence in. This is then building on top of that, so that—

Q27 **Rosie Cooper:** But that was not a hospital; it was a community trust, so that does not count.

Peter Wyman: Everything registered with us we will inspect on a periodic basis. We are not replacing inspections with something different; we are adding to the inspection process. That is the point I am trying to make.

Next time you come to us with some intelligence, you would not expect us to ignore it. We will take you very seriously, and we will take very seriously anything that whistleblowers bring us, or any other information we get. The question then is what we do with it. As I said, the response depends on what the information is, and the response could be that we need to understand whether the problem has been sorted out to our satisfaction, or whether we do not have that satisfaction, and then we will go back and do a further inspection.

The other point is that we are increasingly looking at leadership. I strongly believe, as my colleagues do, that the quality of leadership in

any of those organisations is fundamentally important. That is something we have been developing over the last few years. It is not just clinical leadership; the broader leadership is also necessary.

I cannot guarantee it to you, but I would like to think, if Liverpool happened all over again, that now we would respond rather better than we did before, because we have better processes and we have learned a lot.

Q28 **Chair:** Do you want to add to that, Ian Trenholm?

Ian Trenholm: We have to recognise that we have relationships with a range of different people, some of whom are doctors and nurses in individual care settings and some are voluntary organisations and patient groups. It is a very complex picture. If we are going to talk about quality in the round, we have to recognise that we alone are not going to fix it, but we have certainly improved how we are going to take feedback, process it and act on it.

Chair: Luciana wants to follow up on that point.

Q29 **Luciana Berger:** In the context of you sharing with us that you are listening, in some of the evidence that we have received, we have heard concerns raised by a group of experts by experience that, over the course of the past year in particular, you have drastically reduced the use you make of the views of service users and carers. You have just told us that you listen, but that does not chime with what we have heard in our evidence.

Peter Wyman: I think it is the exact opposite. We are getting more and more information from a variety of people who are service users. They are really important, and, as Ian said, they have caused us to act in ways that we would not have done without that information. Experts by experience are really important, but they are not the only source of information from the public. They are particularly useful in services that it is hard to get your mind around, if you do not have whatever the condition is or whatever causes people to use that service.

We all use general practice, and we all go to see our GP, and we understand what happens when you go to see a GP, but most of us do not have learning difficulties. An expert by experience who has a condition that most of us do not have is particularly important to us. We are refocusing how we use experts by experience, and some of our experts are a bit unhappy that we do not see their particular expertise as being where we need their help, but there are plenty of other cases where we will use more experts by experience. As I said, they are only one source of information for us.

Q30 **Luciana Berger:** I shall draw from one particular experience. You will be aware of the inquiry into the Southern Health NHS Foundation Trust that took place in December 2015. In response, NHS Improvement made a number of recommendations, in particular on working much more closely

with yourselves. In the wake of that, could you share with the Committee what exactly the CQC has been doing to work with NHS Improvement to ensure that what happened at that trust will never happen again?

Peter Wyman: It comes back largely to what I was saying previously. It is about an improved inspection process, listening to all the intelligence that we are given, and being willing to use all the powers we have.

Q31 **Luciana Berger:** Sure, but to bring you back to the question about NHS Improvement, can you outline what you are doing?

Peter Wyman: We work very closely with NHS Improvement, all the time.

Q32 **Luciana Berger:** Can you explain what that means and give us a bit of detail?

Peter Wyman: It can mean different things in different contexts. At a high level, we want to make sure that we have a shared view of what quality looks like; that is in our strategy. We want to make sure that we have really close relationships—I am sorry to use the word again—with the key people across the organisations, so that they can communicate, often at short notice, at weekends or whatever, if there is an issue. It means taking joint action where it is appropriate to do so. It is a close working relationship with NHS Improvement, and one that over time is getting closer.

Q33 **Luciana Berger:** Can you give an example of joint action that you have taken in the past six months?

Ian Trenholm: I can give two examples: the hospital in Shrewsbury and the hospital in Dudley, where we identified concerns on the back of inspections. We know that colleagues from NHS Improvement were working alongside those hospitals, so we worked jointly with them to help the hospital with an improvement plan. We have to have a relationship and be supportive, but, at the same time, we have to ensure that we are independent. We ourselves are not driving improvement; it is NHS Improvement that is doing that. Those are two topical examples of where we have worked alongside NHS Improvement for the benefit of local people.

Q34 **Mr Bradshaw:** You have just acknowledged that those examples arose from inspections. Can you give any examples from the last 12 months of services or trusts you have closed down, or whose management you have cleared out, as a result of information that originated from whistleblowers and/or staff?

Peter Wyman: I am sure that, given notice, I could think of some.

Ian Trenholm: Perhaps we could write to you with that information, Chair.

Q35 **Mr Bradshaw:** It would be really helpful if you could give us a summary

list. Although the perception may be wrong, there is a perception out there, because of the way you have changed how you operate, that it is more difficult now for action to be taken as a result of those things. If you could provide us with a few examples of where that has happened, it would be really helpful.

Ian Trenholm: Sure. We are happy to do that.

Peter Wyman: Can I just come back to that, because we have not really changed in the way it has been portrayed?

Q36 **Mr Bradshaw:** That is exactly why it would be really useful, if you cannot think of any examples now, if you could write to us with some.

Peter Wyman: We would be very happy to do that.

Q37 **Rosie Cooper:** You talked about Dudley. There is a real difficulty. You want to work with NHSI to get improvement, but why can't you just be the regulator? Frankly, Dudley is still in a mess. How have you actually helped? What I have a problem with is the regulatory regime. NHSE and NHSI are going to be working more closely together and they might as well be one. Then you are saying that you are working with them, but you have to remember that you are a regulator. I need you to be a regulator.

Peter Wyman: I agree with you totally. The point that Ian was trying to make is that our job is to find out what needs to change. NHSI's job, among others, is to help to bring about that change. There is a difference.

Q38 **Rosie Cooper:** I do not think that you are articulating that difference in your role very well. It feels to me that, unless you are a lot clearer about what you are doing, you will just roll into this NHSE and NHSI mess.

Peter Wyman: If you look at any of our inspection reports, you will see that they have quite clear recommendations.

Q39 **Rosie Cooper:** I genuinely get that. The point I am trying to make is that you were asked a question and you used Dudley to answer it. You talked about working with NHSI and having to remember that you had a regulatory role. What did you do that you could show is a real improvement? What did you spot? You have a finance director who was required to move, who passed your fit and proper persons test.

Peter Wyman: It was not our fit and proper persons test, with great respect.

Q40 **Rosie Cooper:** But Dudley is a special case, and I am astounded by the fact that you could think that you have contributed to it getting better, because I think it is not in a good place at all.

Ian Trenholm: That was not what I said. I was asked a specific question about where we have worked with NHSI, and I am explaining where we have worked with NHSI. We have carried out inspections, and we will be

looking at the degree to which enforcement action is appropriate or not, in that location. At the same time, NHSI will be looking at what we have found and they will work with the hospital specifically to create an improvement plan, working alongside hospital managers to create that plan.

Chair: Rosie, there are other questions.

Q41 **Rosie Cooper:** I will stop, but I really need you to decide what enforcement needs to take place. You cannot be doing that across the piece.

Ian Trenholm: That is exactly what I am saying. I am saying that we are very clear about where we need to take enforcement action. I do not think that is a challenge. There are clear times when we can take enforcement action, and we have done that. There are times, particularly in social care, when we have closed down locations that we felt were unsafe, but we have to make a judgment about whether a place is genuinely unsafe as opposed to some variant of "Requires improvement." That is a difficult judgment to make in a large, busy hospital accident and emergency department. But we are really clear about what we think needs to happen, and, where necessary, we take enforcement action.

Q42 **Derek Thomas:** You have set out clearly what kind of action you can take and what action happens. It is also true that you can pitch up and give a rating to a care home, and the impact immediately is that it is not commissioned by the local authority. I am a Cornish MP. The work that your inspectors do has a huge impact on careers; it can make or break careers and have a massive impact on morale. That obviously helps to set the direction of how things go forward.

Are you completely confident that your inspectors have all the skills, are appropriately prepared and have the knowledge and experience to involve themselves in that level of intervention—I won't say interference—particularly at board level? When your inspectors go in, do they have an understanding of what the role entails for the board running the hospital or whatever the establishment might be, to have an impact on how things go forward?

Ian Trenholm: There are a number of things. We take our role incredibly seriously. Individual inspectors do not, alone, make a judgment on a rating. An individual inspector, certainly in larger institutions, works as part of a team; that team will form the judgment and write a draft report, which will go through an internal quality assurance process where other, more experienced, colleagues will review the process. Then the provider will have an opportunity to comment on factual accuracy, and so forth. It is not about whether one individual inspector is experienced or not; it is about a number of people working together to create that rating.

We are very much alive to the fact that, in certain parts of the country, if we rate a care home in particular as requiring improvement, it is less

likely that a local authority will commission services from it, and the impact locally can be quite significant, particularly in your part of the world. We have to balance taking that into account with the idea of patient safety. Frankly, we cannot compromise on safety. If we think that something needs to be called out, we have to do that, but we do it by taking our role incredibly seriously. We have certainly done a lot of work over the last year around consistency, to make sure that our ratings of similar institutions with similar performance are appropriately managed.

Q43 **Derek Thomas:** That was my next question, so thank you for that. I have experienced in my constituency some queries about your judgment on homes and their record-keeping, not necessarily about the care of patients or the people who lived there, and, as a result, they were not commissioned. For a small care home, that really threatens its existence.

You are new to the role, so you have had time to take a helicopter view. What are your real concerns about the organisation, the CQC, and where will you prioritise your attention?

Ian Trenholm: I shall prioritise my attention on how we go about doing what we do. It is fair to say that the CQC's reputation is broadly positive at the moment; we have come a long way in a relatively short period of time. I want to look at how we go about doing our business. Are we an easy organisation for providers to work with? Are we producing reports and information that the public can rely on and that are clear to the public? Are we a great place to work? I have to make sure that we can attract and retain the best possible people, and that the work we do is consistent and of a high quality. A lot of my work will be quite internally focused, for now.

Q44 **Derek Thomas:** If an NHS hospital is not performing well, and you move in and increase your inspections but we see no progress, how do you manage and review that, and identify how you change and go forward?

Ian Trenholm: It would depend on the exact circumstances, but, in broad terms, we would identify specific areas for improvement, as part of an action plan, and we would bring in NHS Improvement and make sure that it engaged with the hospital, health institution or whatever it was. Then we would revisit and reinspect. If we did not see a level of improvement, we would consider whether enforcement action was appropriate, and, depending on the circumstances, we would take enforcement action. We might then go on to place restrictions on what the organisation could do, which could ultimately lead to closure. It is a staged process, and that applies in primary medical services, hospitals and adult social care.

Q45 **Martin Vickers:** I represent an area in north and north-east Lincolnshire, where we have seen a number of care homes closed and rated poorly over the last couple of years. The numbers seem to have increased. Is that because your criteria are much more robust than they used to be? Are you taking a harder line?

Peter Wyman: No, we are trying to take exactly the same approach. We may be getting better at identifying issues, but I suspect that what is actually happening is a deterioration in quality in the homes you are talking about rather than that we have moved the goalposts.

Q46 **Martin Vickers:** We have just been talking about consistency. Constituents have come to me expressing views, because of the number of those reports. In effect, they question your level of consistency in judging different establishments. I take the point that it is not an individual view and that it comes back and is reassessed, and so on, but can you give me reassurance that you have a fairly consistent approach? Certainly, at local level, that does not appear to have been the case.

Peter Wyman: I can give you the general assurance that you are looking for, but we have to be honest and recognise that, with a large number of inspectors, there will be a small level of inconsistency, I hope in unimportant areas. We are trying to drive it out; I am not trying to be complacent about it, but, equally, I do not want to sit here and say that I am absolutely confident that in every single case we are completely consistent.

When it comes to the ratings, as Ian said, processes are in place that give me a lot more assurance about the level of consistency. I know that occasionally an inspector will be unhappy with something when another inspector does not have a problem with it, and that slips through the net. When people discover that, it leads them to say that we are not being consistent. We are consistent on the big judgments, but not always on the very small issues, and we need to do everything we can to be as consistent as we can across everything.

Ian Trenholm: Can I build on that last point? I was out with an inspection team on Friday, and one thing that struck me was that what we do is not just about the numbers. When people talk about consistency, they tend to think in numerical terms about place A and place B, but we set a great deal of store by the interviews and conversations we have with patients, people being cared for and employees in a particular organisation, and we try to put some sense of calibration around that.

We try not to take on board disgruntled employees, and, equally, we try to recognise when people are trying to talk up an institution. Interpreting that can sometimes be a matter of judgment, and there is definitely an element of judgment in our ratings, as is probably right and proper, given that we are trying to bring together the voice of the employee and of the patient in the ratings process. Otherwise, we could just sit in our office and look at numbers, and we want to do more than that.

Q47 **Martin Vickers:** Finally, to clarify your role in the follow-up, if you closed two or three care homes in any local authority area, it would have a major impact on the local service. I take it that you work with NHSI, and so on, but is there adequate follow-through? As I said, I have had a

number of care homes close, which has drastically reduced the number of spaces available. How much are you involved in follow-through?

Peter Wyman: I think that Andrea Sutcliffe will confirm this when you talk to her later, but we close homes only as a last resort. We are very conscious of the impact it has on a locality if there is a shortage already and there is another home gone. We close a home only when we believe that it is not safe for residents to continue to stay in that home.

We try to set out what needs to be done by the home to improve, so that it does not need to close. A lot of closures blamed on the CQC are not due to us closing the home—although some are—but, very often, because the home owner is not prepared to put in place the improvements that we deem necessary to make it safer for residents in future. We take no pleasure in reducing the availability of social care; that is not what we are here to do, but sometimes there is no alternative.

Q48 **Chair:** It is very reassuring to hear that you are going to use people more in your intelligence-driven approach, but, undoubtedly, you will continue to be dependent on IT systems, and that has been identified in your corporate risk as a red risk area. A question for you, Mr Trenholm, is how you are going to address that.

Ian Trenholm: We have a number of systems at the moment that are functional but do not necessarily give us the flexibility that we would like for the future. We have a programme of system renewal; we have just replaced large parts of our desktop equipment, and we are in the process of replacing phones, and all that sort of stuff. We are starting from that point, but we also have a programme of work to replace some of the systems that providers will interact with, to move towards a position whereby providers can register with us digitally and give us updates to their registration, and so forth.

In the background, we have an intelligence team using the systems that we already have to create new intelligence products, as they call them—datasets, in effect—that we use in a range of different ways. There is a range of different things as part of a programme of work. Ultimately, there will be a set of fairly flexible IT platforms that exist in the cloud, which will enable us to scale what we do, and enable us easily to take data sources from other people and move into a position where we can process that data and try to extract insights from it.

Q49 **Chair:** Thank you. Can we move on to some of the future challenges and look at your integrated health and social care system reviews, which are a very welcome development? Do you think that legislation will be required to allow you to move to a model whereby you can carry out those system-level reviews?

Peter Wyman: At the moment, system-level reviews have to be commissioned and funded by the Secretary of State. You could make a perfectly good case for saying that is fine and that we should carry on without any legislative change. It would be nice to have an ongoing

rolling programme, but that is for the Secretary of State. In an ideal world, there might be legislation whereby we could do that ourselves, without being commissioned by the Secretary of State.

Q50 **Chair:** Does that require legislative change?

Peter Wyman: Yes, it does. There is a perfectly good work-around, although I use the word ill-advisedly, which is that the Secretary of State carries on commissioning us. It is not that we cannot do it without legislation, but it would be easier to plan it on an ongoing basis, as we would like, with greater certainty about what we would be doing, and to plan it in, if we had the ability to do it ourselves rather than waiting for the Secretary of State.

Q51 **Chair:** The reason why I asked was that, as you may be aware, this Committee produced some recommendations in one of our previous reports that asked for the NHS and the voluntary sector to come forward with proposals for legislative change, to allow better integrated working. Clearly, the CQC would need to be part of that. Will you be working directly with NHS England and others to contribute to those legislative proposals?

Peter Wyman: Yes, definitely. We absolutely recognise that, first, looking at how commissioning as well as how provision is working in an area is very important, which is what these reviews have been doing. Secondly, as I said, looking at how the different parts of the provider system work together is very important. We certainly want to do more of that. We can either do it with legislation or carry on with it on the basis that we have. There is that bit. Then separately, as you and the Committee know, there are a lot of very interesting developments happening in integrated care, with different parts of the system trying to join up in very different ways. We need to be absolutely with that process, as it develops.

If primary and secondary care are working together, either in new legal forms or just working closely together, we need to be sure that our regulation and inspection of primary and secondary care providers is as joined up as it can be, so that we understand what is going on. That poses some challenges. They are not theoretical challenges; they are just challenges of scheduling, and everything else.

We currently inspect secondary care providers more frequently than we inspect primary care providers, and I think that is entirely right. If you want to do the two together, it poses a logistical problem, and we need to get our brains around how that works. These things are not insuperable. As the system develops, and it is now beginning to develop quite fast, we will adapt and make sure that we are not a barrier to development and that, at the same time, we can give the independent reassurance needed that what is changing is working well.

Q52 **Chair:** We heard a very clear message that the steer for legislation

should come from the service itself rather than top-down from the Department of Health, so it would be really useful to have your detailed thoughts on how the legislation should be tweaked going forward. I am not expecting you to comment on that in detail now, but I wanted your assurance that you will be part of that moving forward.

Peter Wyman: Yes, definitely.

Q53 **Chair:** Thank you very much. A specific area that has been raised with us as a very deep concern is the issue of online prescribing, and how patients can be protected from websites dispensing prescription-only medicines, which we understand the CQC is currently unable to regulate, as the websites are overseas. We would like to hear your thoughts on this very worrying situation, which is clearly putting people at risk.

Peter Wyman: We can separate what I would call traditional consulting and prescribing practices that would happen if you went into your GP surgery, but are now being delivered online, from overseas online prescribing. There are two different situations. We are very supportive of the convenience to the medical practice and to patients of being able to access online; we think it is a good thing. Many GP practices do that as an adjunct to what they do in the consulting room, which is terrific, and we can inspect that exactly as we have always done.

There are a number of mainly private sector specialist online primary care prescribers and providers, and they, effectively, operate in the same way. They are under our jurisdiction. We inspected them and we had a number of problems with many of them, which have largely been corrected, although there are still some where we have concerns. We have the toolkit to be able to deal with them, because everything they are doing is registered with us and happens here in England. That is straightforward. The only bit that is not quite straightforward in that scenario is when they use pharmacists to do the prescribing, which is outwith our remit, but we work closely with the General Pharmaceutical Council to deal with that.

That is all manageable, although there is work to do. What worries me much more is that you can go online and very quickly find something that looks like a British medical practice with, possibly, GMC-registered doctors, which to the ordinary person looks perfectly reputable, but it operates outside this country, not just outside our legal jurisdiction but outside our practical jurisdiction. That is a real challenge. It looks like something very English, but if it is based in some far-away part of the world you cannot regulate it. Something the system needs to look at is the end part of that: the dispensing of the drugs. If that happens in this country, there are opportunities to put regulation in place at that point. But in practice those overseas online prescribers are just putting stuff in the post, and it gets through.

Candidly, anybody on the Committee, within five minutes, could get any lethal combination of drugs they want, which could be delivered to their home the next day. All they need is a credit card. That is hugely

concerning, and it is outwith any capability of regulation to deal with it. An education process is needed to put the public on notice that if something is not CQC registered, or similar in the devolved nations, they should be very cautions.

Q54 **Chair:** It is about public information, as far as you are concerned.

Peter Wyman: In my mind, I cannot see any other practical way of dealing with it, because you can never regulate what happens on the internet in another country.

Q55 **Chair:** The issue of private screening clinics sometimes generates a great deal of anxiety for individuals and cost for the NHS. Is that an area that you are going to take an increasing interest in?

Peter Wyman: We have to look at what is within our remit, but, yes, if it is within our remit, we are interested. We are certainly well aware of the general concern.

Q56 **Chair:** Which aspects of that are you able to regulate and take an interest in?

Peter Wyman: I shall defer—

Chair: To our next panel.

Peter Wyman: Perhaps you would like to ask that question of my colleagues, who will give you an absolutely precise definition of what we can and cannot do, rather than for me to risk misleading you by giving you an off-the-cuff, inaccurate answer.

Chair: Thank you very much. Do colleagues have further questions for our first panel? No. Thank you very much for coming this afternoon.

Examination of witnesses

Witnesses: Andrea Sutcliffe, Professor Field and Professor Baker.

Q57 **Chair:** Welcome to our second panel. Welcome back Professor Steve Field and Andrea Sutcliffe. Welcome for the first time, Professor Ted Baker. For those following outside the room, could you introduce yourselves?

Andrea Sutcliffe: Thank you very much. I am the chief inspector of adult social care at the Care Quality Commission.

Professor Baker: I am Ted Baker, chief inspector of hospitals at the Care Quality Commission.

Professor Field: I am Steve Field, a GP and chief inspector of general practice. My remit, for those who do not know, is general medical practice, dental practice, urgent care and online consulting, as well as health and justice, which is about prisons and safeguarding, and which

we have spoken about before. It most recently includes the local system reviews. That is to be clear about my remit.

Q58 **Chair:** That is very helpful, and it might be a good place to start. You will have heard the questions that I posed to the previous panel. Professor Field, how well supported are your inspectors by the information that they receive and by the IT systems?

Professor Field: Do you mean specifically on the local system reviews?

Chair: Just as an opening question.

Professor Field: Most recently, in the last few years, we have had some very good information and have been able to synthesise it and put it together into some very good data packs. Working backwards in time, the best data packs we have produced in the CQC have been for the local system reviews over the past 18 months, and are the sum of information on each practice, care home and hospital in a local area. For example, when we went to Stoke-on-Trent, we had very detailed information on the providers. In addition, we produced data that the local leaders found very helpful on delayed transfers of care and flow through the system. While in the past we provided information about providers, we can now follow people through the system. That was specifically about people aged over 65. I personally found it extremely helpful, and the feedback was that it was helpful.

Q59 **Chair:** It was helpful, and you feel sufficiently well supported by the systems.

Professor Field: Now, yes.

Q60 **Chair:** Now, right. Given that you are shortly moving on from your role, will you have time before you leave to feed in your detailed thoughts on legislative changes that would support those detailed system reviews?

Professor Field: Absolutely. As you heard from our chairman earlier, under the Health and Social Care Act 2008, we are not able to look at commissioning of services, but we can look at provision. Personally, I think that we should be able to review those areas, not just for people aged over 65 but, for example, in the health and justice system in prisons. The quality of care provided is the sum of how you commission and contract, as well as the provision. If you are not putting enough money in, or you have a contract that does not work, providers have no chance.

What we have learned from the local system reviews is that if you are aged over 65 and you happen to be in Northampton, for example, the quality of care you receive is not just from your GP or the hospital; it is how you pass in the hand-offs between them, particularly in social care. We have learned some big lessons about domiciliary care, for example. If the contract changes or is underfunded, it can cause problems right the way through the hospital and back into primary care. My strong

recommendation would be that we should be able to continue, as the CQC, to look at local systems and areas. It does not mean that you need a duty, but the ability to do that is very useful.

Q61 **Chair:** To do it yourselves without being directed by the Secretary of State.

Professor Field: Correct.

Q62 **Chair:** Can you tell us a little more about your other key learning points from the local system reviews?

Professor Field: I would be delighted. We published a report called "Beyond barriers," but there are also 20 reports on local areas that are well worth a read. Although we brought everything together, you can learn lessons specifically from the individual reports.

As you are probably aware, we were commissioned to look at 19 of the worst areas in the country for delayed transfers of care and another group of metrics, and we were asked to go to Bradford to look at a good area. Our report is slanted towards what is not good, but we found good practice in each system, even if the system was bad. We found a lot of dedicated staff working in health and in social care, often not paid a great deal. I personally found it very difficult seeing, in social care, some of the poorest paid people in society doing some of the most important jobs looking after vulnerable people.

It is very difficult to judge outcomes in the review, but we looked at experiences, and we found cases where people were in hospital and then had to go into care when they could have stayed at home if the care had been better. Care was good when the leaders had a vision and worked together on the vision, so that people all the way down the workforce tree, to those caring for them on the ground, in social care and hospitals, understood what was going on. We found a number of barriers, including funding streams, that caused problems. To cite Bradford as an example of good practice, they looked at patients' needs on the ground where they lived and then looked at the locality and neighbourhood. Services worked with the voluntary sector for patients across health and social care, and things went well.

My final point is a bit of a hobby horse, but it is important. What I do not understand in health and social care in this country is why, when there is perfectly good evidence, leaders do not use that evidence to improve the care of patients. An example, which I have been banging on about since I first came here as chairman of the Royal College of General Practitioners, is that, if you commission GPs to go into care and nursing homes, the outcomes are better. There is great academic evidence from the vanguards and from north-east London, but, time and again, we find that people know that and do not commission it, for all sorts of reasons. That is just one powerful example of how, without any extra money in the

system, if we commissioned more intelligently, we could improve the care and life of people.

Q63 **Chair:** How do you think the CQC can play a role in driving that good practice?

Professor Field: We are seeing evidence already, to a small extent. When we go into these 20 areas—we have three more on the go at the moment—by the time we have finished our 14 weeks, people are taking notice and there is change. But we have not been commissioned to review more than three of those areas. If I was looking for changes in how the CQC works once I have gone, it would be to go back and review those areas to look for progress and improvement. We have had the discussion in this room before about prisons and how you can do that. You have to measure the impact, and we have not been able to do that so far.

Chair: Thank you. I am keen to move now to Rosie and acute care.

Q64 **Rosie Cooper:** Professor Baker, what are your main concerns about the sectors you regulate in terms of the sector's own performance and the CQC's ability to regulate it?

Professor Baker: I come back to what Professor Field has just said about local system reviews. It is important that we do not look at that in isolation from what we are all doing. As we have said, we represent hospitals, social care and primary healthcare services, but health and social care are a continuum and they work together. Hospitals are facing a lot of pressures at the moment; last winter was difficult and the summer has been difficult, too. We are coming into another winter and we are worried about the ability of hospitals to cope with the pressures. Those are front-door pressures, with patients on the acute pathway, attending A&E and needing acute medicine. That is all being driven by the fact that systems are not working well together. Professor Field just gave an example of how, if services are commissioned in the community, it reduces the number of patients going unnecessarily to hospital. We know that hospitals take a lot of patients who do not need to be admitted, and a lot of patients in hospital stay much longer than they need to, which creates pressures on capacities in the system.

To come back to what you asked about the CQC's role, first, its role is to tell the truth about what is going on. I hope that our reports give a very clear indication of our concern and the concerns of patients and frontline staff about the pressures they work under. I visit a lot of A&Es, and I see staff working under very pressurised conditions who are doing a magnificent job of maintaining a service. The majority of A&Es we go to come out well in our inspections, but we have concerns about some of them. Working with healthcare professionals from emergency departments across the country, we have drawn up guidance for them about how to preserve safety in the A&E over the winter.

As a regulator, we are getting to the space of helping people to share their concerns and good practice to ensure the safety of patients in A&E. I am sure that will have an impact going into the winter, but, fundamentally, unless we do the system reform that we have been talking about, the situation will not change. Undoubtedly, there will be more patients attending A&E this winter than last winter, and, if we do not do anything next year, there will be more patients attending A&E the winter after. The CQC needs to shout from the rooftops about the importance of systems being sorted out and working well together to provide integrated, collaborative care for patients.

Q65 **Rosie Cooper:** I absolutely agree. I have been involved in healthcare since about 1973, and to some extent we are still singing the same tune. Bed blockers is a dreadful phrase, but in the 1970s we were talking about people being trapped in hospital, and we are still talking about it now. Commissioning affects the quality of care; you do not need to be Einstein to work that out, yet we still do not commission. You identified a correlation between leadership, safety and quality. When do we stop talking about it and actually make it happen? What are you doing right now that is driving that, as opposed to saying that we all know about it and we are talking about it?

Professor Baker: I feel that we have had a big influence on the sector in that regard. I talked about the local system reviews, but we have also talked about leadership and culture. We have published a whole series of reports, and they are having a real impact. If you go out and talk to hospitals and NHS trusts now, they are telling a very different story from two or three years ago, when the leadership talk was all about getting a grip and staying on top of targets. Now it is about values, culture, staff engagement and driving constant quality improvement at the frontline of healthcare.

I have been in healthcare since 1973 as well, so we have that in common. Working in health care, one thing I have learned all the way through is that quality comes from the frontline and from frontline leadership. One of the things that some trusts have problems with and have lost account of is that they think they can just drive quality down from the top. You drive quality in healthcare by enabling frontline staff to drive improvements every day of their working lives and focus on the needs of patients.

The good trusts are learning that. We have seen some trusts turn around their quality really dramatically. They are still working under pressure and they still say that things will be difficult in winter, but they have turned around their quality dramatically. There are others, a minority, that still have not done so. Overall, our ratings are gradually improving. The one area where they are not improving is A&E.

Q66 **Rosie Cooper:** I read the reports, which show that good has improved in acute sectors from 55 to 60, but that is not the same as quality at all. Quality is variable.

Professor Baker: Quality is variable within hospitals and within services in hospitals as well as between hospitals. Absolutely. One of the striking things that has come out of our inspections is that variation. We highlight that geographically in "State of Care," where we talk about the fact that there is injustice, and some people have less good access to good quality care in their area than in others. That is pure chance, depending on the quality of local services and on how well the systems work together in their local area.

Q67 **Rosie Cooper:** How does the system work, as described by your chief exec and chair—the intelligence and the listening? My view of the CQC was tempered in the LCH tunnel, where you missed everything. If you had used those very parameters, you would still have missed it, because the whole system ignored it. I do not just mean the regulators; I mean all the people around the greater area of Liverpool. Everybody ignored it.

Professor Baker: And the NHS is littered with stories about systems that have ignored problems and not done anything about them. There is a whole history of those; that is entirely right. I am determined that the CQC will not be part of that culture, moving forward. We should be there to shine a light on areas where there are concerns and make sure that something is done about them. That is very much what our role is.

Our inspections have moved on a lot over the last few years. I chaired the very first of the new hospital inspections way back in 2013, and I am in charge of running inspections across hospitals in 2018. They have moved on a long way. We have learned a lot, and we learned it with the people we are regulating. We have learned it from them and have managed to help them to move forward as well.

Q68 **Rosie Cooper:** Can I go on to independent hospitals and healthcare providers and ask you your view of their performance?

Professor Baker: We have now inspected all independent acute hospitals. There are 221 of them, and 65% come out as good in our rating, with 26% as "Requires improvement" and 8% as outstanding. The whole picture across acute independent hospitals is varied, just as we described in the NHS, but it is broadly similar to the quality levels that we found in the NHS. People always want to say that one is better than the other in terms of quality, but, actually, we have no evidence of that.

Rosie Cooper: But the level of complexity of what goes on in them is not the same at all.

Professor Baker: They serve a different population. They do not usually provide acute care; they provide elective care, but those that provide it often do so very well. We have to judge them on the basis of what they provide. Very few independent hospitals provide A&E or acute medical services, for instance, and they will not look after patients with complex needs. They want to admit patients with straightforward conditions, and often for elective surgery, and they often do that very well. That is not to

say that there are not unique issues in independent healthcare that we have told them they need to address, which are different from what we found in some NHS trusts.

Q69 **Rosie Cooper:** I have two things to ask about that. What protocols or pathways do we have for transferring patients in grave need to the NHS? Is there an agreed protocol, or does it just happen because there is a crisis, and off they go?

Professor Baker: We found in our inspections of independent hospitals that not all of them had safe, thought-out protocols or processes for managing patients who deteriorate unexpectedly, and transferring them to critical care facilities, typically in local NHS hospitals. Many did, but some did not, and with some of them we had to take enforcement action and tell them to do that. Where we found that, we took action. That is one of the key areas they need to get right.

Q70 **Rosie Cooper:** Are you assured that they have all got it right now?

Professor Baker: We have been to every hospital and, where we have not found it happening, we have told them that they must do it.

Q71 **Rosie Cooper:** But do you know that they have all done it?

Professor Baker: Where we have found real problems, we have followed them up.

Q72 **Rosie Cooper:** So you know that they have all done it.

Professor Baker: We know that they have all done it, and we will go back and reinspect them in due course.

Q73 **Martin Vickers:** I noticed when you introduced yourselves that nobody claimed responsibility for ambulance services.

Professor Baker: That's me.

Q74 **Martin Vickers:** Right. I have a straightforward question. What are you doing to secure improvement in the ambulance service?

Professor Baker: Interestingly, across the country what we have found in ambulance services—I am talking about NHS ambulance trusts, of which there are 10—is that there is variation, just as there is in the other NHS services. There is one outstanding ambulance service, one that is inadequate and in special measures, and a variety in between. There is the variation in performance that we see in other parts of the NHS. The root of that is often exactly what we have found elsewhere: issues about leadership, culture and engaging frontline staff. That may be more challenging in ambulance services because, clearly, they are dispersed, and, like many NHS organisations, sometimes they have difficulty recruiting key staff, particularly paramedics.

To come back to your question, we have produced a detailed report on each trust, and rated each trust, and we have held to account for

improvement those that need to improve. Individual ambulance trusts, particularly the London ambulance trust, have made significant improvements over the last few years as a result of our intervention. There are others that still need to make improvements, and there is variation, for example, in response times across the country. Most ambulance trusts are fairly consistent in delivering the highest level of response time, but if you look at the lower priority calls there is quite a degree of variation. Where we have inspected those trusts, we have told them where they need to improve.

Q75 **Martin Vickers:** Sadly, the trust that serves my area is the East Midlands trust, which you will be aware is not among the highest performing ones. We also have Thames providing our patient transport, which, if anything, has an even poorer record. Obviously, you are aware that when people read that their local ambulance service is in special measures, rated inadequate or whatever, it causes some anxiety. What do you do to follow through, right the way through? I take note of what you have just said, but it is no good just publishing one report and a year later saying that a service is still in special measures, still inadequate or whatever.

Professor Baker: That summarises the special measures regime. East Midlands comes under "Requires improvement"; it is not in special measures. They need to improve, and we will follow them up to inspect them and make sure that they improve.

For the organisations in special measures, including ambulance trusts, the special measures regime is one that we recommend, but it is instituted by NHS Improvement, which puts in extra support for trusts to make the improvements they need to make. The improvements are driven by what we find in our report. Essentially, when we recommend special measures, NHS Improvement intervenes, and provides extra support and resources. We monitor that as necessary, and go back and inspect. If we find inadequate services, we usually go back and inspect within a few months; if there are special measures overall, we reinspect within a year. By that time, hopefully, in a year they will have turned themselves around. In practice, for most special measures trusts it takes longer than a year before we can recommend that they come out of special measures.

Q76 **Martin Vickers:** My local newspaper, over the last year or so, has published numerous stories about ambulances failing to turn up even to road traffic accidents. Clearly, that is totally unacceptable.

Professor Baker: Absolutely.

Q77 **Martin Vickers:** How do incidents like that feed into your inspection regime?

Professor Baker: When we do an inspection, we review all their serious incidents and make sure that they have investigated them and taken steps to improve. Ambulance services are under pressure, just like the

rest of the acute services. Last winter, we saw a lot of ambulances held up at hospitals, unable to hand their patients over. I made it very clear to hospitals that it is unacceptable for them to leave patients in ambulances on the forecourt rather than admitting them to the hospital. The hospital may be crowded, but the patient will be better off in a hospital than in an ambulance, and, of course, that ambulance is needed elsewhere.

The pressures on ambulance trusts because of that were quite severe over last winter and, to some extent, going into the summer. Some of them have risen to that; they recruited extra staff and bought extra ambulances. Ultimately, we come back to where we started; if we do not reform the system and organise for fewer people to be admitted to hospital unnecessarily, there will be constant pressures, and we will always exceed capacity for the ambulance trust or the hospital to cope with.

Q78 **Mr Bradshaw:** I am sorry to raise another specific example, but there were concerns about bullying in the west country ambulance service, which I think you looked into. Can you assure me, or reassure me, that if those problems existed they have been satisfactorily addressed and you are happy with the culture there?

Professor Baker: We have inspected and reported on the ambulance service, so we would have looked at that, yes. In terms of the specific issue, can I take it away and come back to you rather than answer off the cuff?

Having said that, bullying in the healthcare system is still a worry for us. It occurs in all organisations and is a worry not just because it affects staff but because it affects the safety and wellbeing of patients. We are very clear: if we identify significant bullying in trusts, it will reflect very strongly in our reports on their leadership.

Q79 **Mr Bradshaw:** Will you write to me with where we have got to on that one?

Professor Baker: Yes, I will write to you.

Q80 **Chair:** While we are on the issue of CQC inspection of the South Western Ambulance Service NHS Foundation Trust, one issue raised time and again is the variation in the service that people receive, depending on where they live. That is particularly an issue in rural areas, where it may be distorted by the fact that a good service is provided in towns, because that is where the ambulances are tied up, when in rural services people face exceptionally long waits. Are you going to look at the challenge for rural services?

Professor Baker: In our latest inspection, we challenged the South Western ambulance service to improve their response times. In that inspection, they had made significant improvements in several areas, but response times were still a concern, and we told them that they need to improve them further.

What you say makes entire sense in terms of geography, but we do not have any data as such that tells us that rural services get less prompt treatment, although there are clearly good reasons why that might occur. We have certainly heard that some ambulance trusts, by positioning ambulances in the right geographical places and predicting where the demand will be, can speed up response times. If we see good examples of that, we will certainly use them to demonstrate to the sector how it can improve.

Chair: You identified the issue in your earlier answer; they then get sucked in, because they are delayed in handovers. It is a concern.

Q81 **Derek Thomas:** I have come across a few examples, over years and not just recently, where the time it was reported that the ambulance arrived was different from the experience on the ground. Do your inspections look at the quality and accuracy of recording? Obviously, if they are trying to meet a certain target, there is, unfortunately, the opportunity maybe to record something different from what actually happened on the ground. Can your inspections get into that much detail?

Professor Baker: Yes, we do get into that much detail. One of the great strengths of our inspections is that we talk to frontline staff and ask them how it is. We talk to patients as well, of course. We do not just take the organisation's view of the world. Frontline staff are usually very honest with us if they feel that they are being asked to present data in a way that is not accurate and does not reflect patients' experience. We find that across all the areas we inspect. We see it in A&Es, in waiting lists and in ambulance turn-arounds, and when we see it, we challenge it.

It comes back to leadership, culture and values. If we create an NHS in which people are so target-focused that meeting the target overrides everything, eventually people start to behave in that way. That is clearly unacceptable and completely loses sight of why they are there in the first place. When we see it, we always challenge it.

Derek Thomas: That is good, thank you.

Q82 **Luciana Berger:** My questions are on mental health, and this question straddles the previous one on ambulances. You will be aware that in yesterday's Budget the Chancellor announced that he would be funding ambulances specifically for those in a mental health crisis. How confident are you of your ability to assess the safety of those particular services, alongside your current responsibilities for ambulance services?

Professor Baker: I very much welcome the focus on crisis care for patients with mental health needs. It is an area we have identified as a problem. We do not look at the commissioning of services, as you heard, but we have heard from patients and we have observed real problems in crisis services. There is a big surge in patients with mental health crises arriving in accident and emergency departments, which clearly in many cases is not the right place for them to be. Creating an environment, be it

in an ambulance, a hospital or a community mental health crisis centre, where they can be looked after better, is clearly a priority. We very much welcome that.

There is a lot of innovative work by ambulance trusts on looking after patients with mental health. To go back to the London ambulance service as an example, they are doing work on that. They do not take patients with mental health needs directly to A&E; they take them to community third sector centres or to community mental health crisis centres. That is exactly the right way forward. There is good practice out there. If the money coming in is to be well spent for the benefit of patients, people need to learn from the best, and we shall try to ensure that they do.

Q83 **Luciana Berger:** One question on which we need clarity, which I do not think that any of us have, is that it is not clear that these ambulances will necessarily be provided by existing ambulance trusts, and that then there would be a specific role for you.

Professor Baker: As and when the ambulance services are set up, we will register and inspect them.

Q84 **Luciana Berger:** Indeed. It is very striking going through the summary of your "State of Care" report that particular things stand out about mental health. One in five NHS mental health core services needs to improve is one of the headlines. There are particular challenges around workforce in the mental health sector. It says: "Low staffing levels were the most common reason for delays in children and young people receiving care." In particular, your report tells us that "the number of patients waiting to start treatment in hospital 18 weeks after being referred rose by 55% from 2011 to 2018. Some people who need inpatient mental health care and support are having to travel long distances to obtain it, and this varies considerably depending on where people live." We are told that that impacts negatively on recovery and patients' ability to keep themselves safe. Professor Baker, can you indicate what resources are necessary to ensure that each patient is seen in a timely and safe fashion?

Professor Baker: Mental health services are doing a lot to improve, and, as you will see in our report, on our inspections their ratings are going up. Often the message is that, if you get into a service, you get very good care. The problem that we hear from patients time and again is the problem of access; people cannot access the service they want. You were talking about out-of-area placements. Certainly, we saw patients sometimes being placed 600 miles away from home, which, clearly, is not appropriate for in-patient services for patients with mental health needs.

We have discussed this with NHS England and with commissioners of services, and argued that they need to focus more on commissioning services nearer people's homes. That will be very important in turning things around. There is still a capacity and access problem. You mentioned children and young people's mental health. The report we

published in January, "Are we listening?," is a very strong message from young people themselves about the difficulty they face in accessing mental health services. There is a story from a young girl who asked, "Do I have to threaten suicide before I can get any care?" That is the kind of crisis that some patients with mental health problems have to go through before the system provides care for them.

We need to look at capacity and resources, but, equally, we need to look at how services are organised. Again, there is a sense that they are organised as individual services rather than as an integrated pathway of care for patients, to make sure that every patient gets the care they need at the right level. It is not just about resources; it is about how we organise them, and the system in which mental health services work. New resources, of course, are very welcome.

Q85 **Luciana Berger:** On that theme, you said earlier that you welcomed the investment in crisis services, and we all share that welcome. However, it was striking yesterday in the Budget that all the investment going to mental health seems to come at the very end, when someone is in a crisis, rather than much earlier, in earlier intervention and prevention. Is that a concern you share?

Professor Baker: I welcome the investment that is going into the services now, but that does not mean that there are no other services that need investment. Children and young people's mental health is an example of that; there have been capacity problems for many years. It is not a recent thing.

Q86 **Luciana Berger:** Many people on acute mental health wards for adults of working age are detained under the Mental Health Act. We have seen from the figures that the number has, regrettably, increased over recent years, and you will know that a piece of work is going on by Professor Simon Wessely, looking specifically at that Act. Does the CQC have sufficient powers to protect the rights and wellbeing of people currently held under the Act?

Professor Baker: We extensively inspect in-patient mental health units to ensure that the Mental Health Act is implemented effectively, and the code of practice is being followed. We produce a report on that every year. We have discussed very closely with Sir Simon Wessely, in regard to his report, about where we think the direction of travel needs to be, and we are very much looking forward to his conclusions, which I hope will come out fairly soon. To some extent, we have worked with him to strengthen our role and to clarify it in relation to the Mental Health Act. A lot will depend on his conclusions about the future of the Mental Health Act itself.

Q87 **Luciana Berger:** From what you have just said, the fact that you want to strengthen your role suggests that you feel that currently you do not have sufficient powers to protect their rights and wellbeing.

Professor Baker: If you look at our reports on a year-by-year basis, you will see that in all of them concerns are expressed that the Mental Health Act code of practice is not always being followed as it should, if that answers your question.

Q88 **Luciana Berger:** As an extension to what you have just said, does that mean that you have the power as an organisation to ensure that you are doing the very best by patients detained under the Mental Health Act?

Professor Baker: I shall wait for Sir Simon Wessely's report to conclude that.

Q89 **Luciana Berger:** I am sorry, but that is not an answer. My question is to you. Do you currently believe that you, as the CQC, have adequate powers to look after the thousands of people across our country whose rights are taken away from them and who are detained under the Mental Health Act?

Professor Baker: We have powers to report on their detention and how the code of practice is being implemented, and we have powers through second opinion appointed doctors to provide alternative opinions. In 28% of cases, our opinions change the care of the patient. We already have quite considerable powers. On whether they are sufficient, I shall wait to see whether Sir Simon Wessely suggests anything different.

Q90 **Luciana Berger:** Forgive me, but, as the person in charge of mental health for the CQC, you should be able to tell us whether you think you have the powers necessary to do everything that you possibly can to protect the rights of people who are currently detained. I do not think that was an answer.

Professor Baker: It is as far as I can go at the moment.

Q91 **Rosie Cooper:** What happened to strong and independent? Either you think it or you don't.

Professor Baker: There is an expert review going on into the Mental Health Act.

Q92 **Rosie Cooper:** But you are being asked what you think.

Professor Baker: To some extent, we are interested in the outcome of that expert review. We are working very closely with it, but we do not want to tell it what it should say. We want to hear its expert view.

Q93 **Luciana Berger:** But you can have your own position and view as a person currently with overall responsibility in this country for mental health for the CQC. You can have a position on whether you think you have adequate powers, essentially, to protect the rights and wellbeing of the thousands of people detained in this country under the Mental Health Act.

Professor Baker: If you widely believe that it needs to be reviewed, and our powers in the wider context need to be reviewed, I totally accept

that. But I would like to see the expert opinion of the people looking at this before I come to a conclusion.

Luciana Berger: But you are an expert, because you are currently the person in charge.

Q94 **Chair:** Perhaps the question should be about what advice you gave to the panel when it asked you whether your powers were adequate.

Professor Baker: I can give you a written account of that, rather than one given off the cuff here, if I may.

Q95 **Chair:** That would be helpful. If you could send us what you are advising the Mental Health Act review to say about your own powers, that would be useful to us.

We come now to primary care, and Professor Steve Field. What are your main concerns about the sector that you are regulating? You have touched on some of that already, but could you narrow it down to primary care rather than talking about the whole system aspects?

Professor Field: As a GP, you know that primary care is very broad. Would you like to talk about online consulting?

Q96 **Chair:** That is an area I specifically wanted to ask you about. Obviously, it is a rapidly emerging area, and the new Secretary of State will be focusing on it. There are various aspects; it is not just the use of health apps, which nobody seems to regulate. It seems to be about trading standards, and NICE does not have a role, and nor does the CQC, it seems. It is about looking both at the role of apps that patients rely on and at systems such as Babylon and GP at hand.

Professor Field: Obviously, the MHRA has a role as well. Our specific role, as you heard earlier, is for patients in England consulting doctors and nurses online, either by video, over the phone or by paper email systems. What we do not do is exactly the same as it would be if they were pharmacists; that is down to the general pharmaceutical regulator. There is a division. If it involves a doctor and nurse, we are responsible. We started our work in 2016 and brought the speed of the work forward because we were hearing lots of concerns. We completed our work in July 2017. Of the 35 organisations or providers we looked at, only five were fully safe in everything they were doing at the time when we first went in. We have seen an improvement in their provision of care, because we go back and inspect soon afterwards. Partly due to the impact of that report, there has been change, and we will be able to rate those services from April onwards.

On one hand, I would support the introduction of those alternative ways of consulting, because they could save time for clinicians and, certainly, will save time for patients who want to use those services; but they have to be safe and effective, just like traditional, face-to-face consulting. One of my concerns is to make sure that, as those services are rolled out to

more patients across the country, they receive safe and effective care. The evidence is that they are improving.

Q97 **Chair:** Do you also have concerns that they may have a destabilising effect on the wider system? In other words, are you looking not just at that individual alternative model but at the effect it could have on the models around it, particularly in semi-rural and rural areas?

Professor Field: I understand what you are saying. The problem we have as CQC is that, although we are an independent, strong regulator, we have no responsibility for the commissioning or contracting. We are observers of services that may have started recently in London—if you are alluding to the impact on other patients there. We can observe that, and we will look at the surgeries that might be impacted in the quality of care that they provide.

Under the radar, there are surgeries providing exactly the same care for their patients, with a brilliant service. Marple Cottage Surgery in Stockport, Manchester, is outstanding. It uses Skype and exactly the same systems as others, and reduces the number of home visits and things. One of the big new providers of general practice, Modality, which covers 400,000 patients, has recently signed a contract with one of the other online providers to roll that out across its services for those already on its list, using its records.

There is a high-profile case at the moment that may be having an effect on patients in their locality, but other things are happening at the same time. With respect, that is a question you should ask NHS England, as the overarching body.

Q98 **Chair:** You mentioned some of the safety concerns, and you said that only five of the 35 that you originally inspected were fully safe. What were the safety concerns that you identified and that needed to be addressed?

Professor Field: Thirty had problems, and of the first five or six that we saw, a couple of them stopped work very quickly, because we had gone in. In answer to Rosie's question about whether we are strong, we are, and we have had a big impact, particularly in that sector. We will not tolerate providers providing very unsafe services.

Q99 **Chair:** What did you observe that was very unsafe?

Professor Field: I could give a number of examples. One would be the prescribing of large amounts of opiates—phenomenal amounts, in some cases. We found examples where providers were not checking the identity of the patient consulting them, and we were worried that children might get access to medications if they were masquerading as an adult and were not adequately checked. As a GP, you will recognise that, when you see a patient in a surgery, you have the list and you know who they are. It is very difficult to do that, if it is a service provided in one part of the country remotely for somewhere else.

Information-sharing is an interesting one. The GMC has that in its code of practice. Patients should be asked and encouraged to share the information from that consultation with their own GP. Of course, there are particular circumstances in sexual health, which you will be aware of, where that is not the norm, but it is generally good practice. If you are prescribed medications such as thyroxine, or other drugs such as asthma inhalers, you should be followed up by the provider; you should have the relevant blood tests, and you should not be able to access large numbers of inhalers or opiates without appropriate checks.

That said, we found some very good practice as well. One of our concerns was safeguarding, but we found one provider doing a really good piece of work. We know that those providers can provide safe, effective care, because many do, and even more do now that we have intervened. I am an optimist about this; it will improve access and add to the variety of care that patients can get. It is about access to medical records; it is about communication, and making sure that things are safe. That is what has been exercising our mind.

The other issue, as you highlighted very well earlier, is the regulation problem. If one of those providers moves outside England, we do not have regulatory responsibility. If the service closes from a doctor consulting point of view and becomes a pharmacy consulting service, a different regulator looks after that, and it exercises its powers differently from us. A consultation has just finished about how it should do that. I have put together all the regulators across the UK; we converse very closely as part of that with the MHRA, the GMC and the NMC, and try to look at what we can do about having standards across the UK, but I am worried about those who move offshore and into Europe.

Q100 **Chair:** Yes, it is very worrying. When you see phenomenal amounts of opiates being inappropriately prescribed, do you directly take it up with the GMC and report concerns?

Professor Field: There is enforcement action that we can take ourselves.

Q101 **Chair:** You have enforcement action, but do you also take action—

Professor Field: And we report to the GMC.

Q102 **Chair:** You report to the GMC.

Professor Field: Oh, definitely. I have a duty as a doctor, as well.

Q103 **Chair:** I assumed that was the case, but I just wanted to check that it was happening.

Professor Field: Of course. This is serious stuff about patient safety. Of course we would.

Q104 **Chair:** What do you see as the key challenges for your successor? What will you suggest that they focus on?

Professor Field: It is a wonderful job—seriously—doing the heavy lifting as I have been doing as chief inspector, bringing in a regulation system for general medical practice and for dentistry, creating things against some considerable opposition at times. My successor will be in a very good place for taking forward local system review work, if that expands, because the job description includes a lot about work on integrated care.

The challenge in general medical practice, for example, will be how we regulate larger providers, which are similar to large dental providers or large care home providers. How do you look at the controlling mind and work in a different way from having 8,000 small practices? That will be quite challenging, but it is a great challenge for whoever takes over, because of the system work.

Chair: Thank you. We come now to social care.

Q105 **Derek Thomas:** Andrea, thank you for being so patient. You heard briefly my concern about the risk to care homes when there is any sort of query, challenge or judgment against them. Obviously, you have to balance that against the safety of people in care homes, and there have been high-profile occasions when various investigations have picked up some horrendous practice. How do you balance the availability of the right kind of care with the work you do in making sure that it is all safe, so that you do not end up putting more pressure on a system in which there is already a declining number of care home beds available to the community?

Andrea Sutcliffe: I shall answer in two ways; one specifically around care homes and, secondly, around what the system as a whole needs to do, building on the work that we did in the local systems review.

Specifically on care homes, no one here would want us to compromise on quality or safety for people using care services. I am certainly not going to, and I am certainly not going to expect my staff to. We are very clear about our expectations. If those expectations are not met, we are very clear about what people need to do to improve the service. If they do not improve the service, if they put people at risk and expose them to severe harm—by looking after people completely inappropriately when they are at risk of choking, for example, and feeding them food that would cause them to choke—we will not tolerate that. As you heard from our chairman earlier, it is not an action that we take lightly. We would much prefer that services improve, but, if we have to close a service because it has a high level of risk, we have to do it. I do not think we should compromise on that; if we do, we are kind of saying that it is okay to allow poor services to exist. We should be very clear about the standards. That is the first thing.

The second thing is what we do to prevent it and to make sure that we are not in that situation. The CQC has a very important role, but so have others. Our important role is to be clear about the standards, and to monitor, inspect and rate the services, and share that information with

the provider and with the public, so that everybody is very clear about what we are expecting and seeing. We also need providers to respond to that and take what we say seriously. Earlier this year, we produced a document called "Driving improvement," which looked at services that had progressed from being inadequate through to good. One key aspect was that providers took what we said seriously and responded to it; that is absolutely what we need to see.

We need to see commissioners sharing our view of quality and ensuring that, when we identify concerns, they do not put more pressure on the individual service by forcing it to take additional people. All that does is to spread the problem more widely and impact on more people. As my dear colleague has already said, we need the health service to step up to the plate. The NHS does not stop at the care home door. Sadly, sometimes, it feels as if it does. We need to make sure that GPs provide appropriate support and that community services do so too, and that acute hospitals work in tandem with those services, particularly if people are admitted and then discharged back. I hear awful stories of people being discharged from hospital where their medication was changed, and the care home was not told. That is not acceptable in terms of the pressure it then puts on. A whole-system response will help us to prevent problems worsening.

Our concern about adult social care in general is that our infrastructure to support improvement is quite thin. There is not as much. You had conversations earlier about our work with NHS Improvement, but we do not have the same level of resources in adult social care. We have recently produced publications called "Learning from safety incidents." We have done six of them; they look at where we have prosecuted providers or taken significant enforcement action, what the problem was, what we did about it and what people can do to stop it happening in future. Things do not fly off the shelves in the digital world, but it has been like that with the number of downloads we have had. People are looking at those documents and wanting to know how they can do it better. That is another way we can help.

Q106 **Derek Thomas:** I doubt that you have had time to reflect, as you come to the end of your tenure, but is there more to what you have said? What has really niggled you, and what have you really felt is a problem in the sector, other than the infrastructure, which you described? As the CQC, in getting on top of the challenge and doing the job well, is there a particular thing that you just do not feel content that you have properly resolved or made progress on?

Andrea Sutcliffe: To answer that question, I would think about the pressures on adult social care and, therefore, how we can respond to them. The first is that quality is variable. We can see that in the "State of Care" report, but what we are seeing now is a particular concern. When we say that a service is inadequate, it generally improves. The figure in "State of Care" is 89%, but 42% of services that we say require improvement do not improve, and we are going back to services now that

we rated as good that are deteriorating. Some 20% are deteriorating to "Requires improvement," and 3% to inadequate.

What troubles me is why that is happening. At the root of it is concern about the workforce. These are difficult jobs that we expect people to do. They are not low-skilled jobs; they are highly skilled jobs, supporting people with complex and difficult needs. We do not pay staff enough or recognise them enough, and we do not esteem them enough. As a consequence, we have a problem with recruitment and retention, which is at the root of a lot of the problems that we see in individual services, particularly around safety. There is a need for enough people who are sufficiently capable and confident in supporting patients.

The second area is around leadership. Again, we know how important a registered manager is in a care home or in a domiciliary care service—absolutely vital. There are high levels of vacancies and turnover in those posts, which have a direct impact on people's experience of care. We have to do a lot more to support and enhance the leadership capacity in adult social care to take things forward.

There is a problem with access. Age UK has said that around 1.4 million people are not getting the care that they might have done previously, which is obviously impacting on everybody. At the stage when they eventually access services, they will probably have a higher level of need; they are sicker and frailer.

Last, but not least, providers are struggling in an economically challenged environment. We see them hand contracts back to local authorities because they cannot sustain them; we also see services going out of business. Sometimes that is not because we said they should go; it is because they do not feel that they can sustain the service they want to provide.

The sector as a whole is very fragile. We said two years ago that we thought it was approaching a tipping-point. For some people, it has already tipped, because they are not getting the care that they might have done previously, or they have had a change in care and suffered a discontinuity of care because somebody has gone out of business or handed a contract back. They experience poor care because of that variability. We are not the only people to change all that, but we are part of it, which leaves work to be done for my successor.

Q107 **Derek Thomas:** I have one final question, and any of the panel could tackle this one. You have clearly set out what the challenges are, where we are creaking and where people are not getting the care they need because of sheer unavailability, which is certainly the case in Cornwall. Are you involved in the development of the NHS 10-year plan, and can you contribute to how that is shaped, moulded and developed? Perhaps you can tackle that, Andrea, and then maybe the others could contribute.

Andrea Sutcliffe: There are two things. One is that it is a 10-year NHS plan, not a 10-year NHS and social care plan, which personally I would prefer to see, given that it is actually a whole system. We have the Green Paper coming around social care. Something that comes out of the local system reviews is that we need an integrated vision so that we can truly deliver person-centred, co-ordinated care. That has to come out of the NHS plan and the social care Green Paper. It is not just for older people; it is for all ages. Social care can transform people's lives in all sorts of different ways. It is not just there to help the health service to survive; it is there to support people and ensure that they are able to live their lives as well as they can.

Ted co-chairs the National Quality Board, and we recently had a conversation there about the NHS plan, so I was able to contribute, and other conversations are going on. My key thing would be that we should not just think about the NHS or about what is happening in hospitals. We should think about what is happening in the community and about what people need, because patients are people before they are patients, so that the whole system can proceed.

Q108 **Derek Thomas:** Do you want to add anything, Professor Field?

Professor Field: I thought that was a really good answer.

Andrea Sutcliffe: Thank you.

Professor Field: Seriously, I support that. I do not think that I could do any better. We are involved in different ways of inputting information, and we have lots of meetings with the National Quality Board and others. I chair a governance board for general medical practice, and we have one for dentistry, where we meet NHS England.

It is similar to what Andrea said earlier; in primary care, we do not have the support of NHS Improvement for improvement. It is very different. Other people, including the Royal College of GPs, have been involved in helping to turn around general practice. My message would be that we are doing work on systems. Whether it is people aged 65, children transiting into adolescence, or adult mental health or prisons, you have to look at the needs of the people we are all serving and build from that, rather than just looking at a hospital in Truro, a GP surgery in St Ives or a care home in Penzance. It is how everybody works together for the good of those people.

Professor Baker: I agree with everything my colleagues have said. I have seen a lot of plans for change in the NHS, and they often change a lot of the structures, names and acronyms. Plans that matter change the care of patients and people using services. Whatever comes out of this 10-year plan, I am sure that it will be a great vision. In 10 years a lot can and will change in healthcare. What is important is the implementation and the effect it has on the ground. If the plan is not credibly going to change things on the ground, it will not do what we need it to do. We

have talked a bit about leadership culture and staff engagement, which is all very important, but the focus has to be on the experience of patients and people using services, not on corporate structures. That is very important.

As I said earlier, the system is under a lot of pressure, and the plan needs to deliver some real system improvements quickly. Ten years is a long time for the system to remain under pressure. We need the next 10 months to change things.

Q109 **Derek Thomas:** That was really my point in asking. The CQC has this wonderful opportunity to really get into the systems or the individual bits and understand them. If there is any organisation that could fashion change or hold change to account, it has to be yours.

Professor Field: We can, if we can continue our work on systems. But without either the Secretary of State giving us a section 48 letter and funding, as it stands, or a change in legislation/regulation, we will be focusing mostly on provision. That, for my successor, is really sad.

In your county of Cornwall, we did a review of the system as one of the pilots before the local system review, and I hope you recognised the problems. The problems in Cornwall are not dissimilar to the problems in many other areas we have been to. We need leaders who talk together and produce a vision together. We do not actually need merged budgets; it is about how they respect each other and use budgets for the people they serve. You need local politicians to help and be constructive despite the election cycles, which in some areas we find is awfully difficult. For Cornwall, it is about everybody working together for the needs of the people who live there.

Q110 **Chair:** Andrea, you set out very clearly how fragile the system is in social care and the importance of the workforce. How concerned are you about the impact of a very welcome "Agenda for change" increase in pay for nurses in the NHS that does not apply to nurses working in social care? Do you see that as having a further destabilising effect on the nursing workforce in social care?

Andrea Sutcliffe: It certainly has the potential to destabilise further. We can see that already. When there are local recruitment drives in the local hospital, I know where they are getting those nurses from. They will get some of them from the local nursing home, because the terms and conditions are better. My colleague, Glen Garrod, who is the current president of the Association of the Directors of Adult Social Services, described the pay increase in "Agenda for change" as "eye-wateringly high," which is probably not the way people in the NHS would describe it. From an adult social care perspective, he was very worried about the impact, and he is right to be. There are concerns. It is not just about the pay; it is about the terms and conditions and, sometimes, the learning development opportunities.

For many people working in adult social care, it is a lonely, tough job, and there is not the panoply of people that you have around you in a large acute trust, or even in a community mental health service. There are lots of things we have to think about in attracting people into adult social care, rewarding them appropriately and ensuring that they have training and development, as well as absolutely getting rid of the myth that there are no career opportunities in adult social care. It is an amazing place to work; there are incredible things that you can do, and people have very fulfilling careers. But too often, we have the comparison, compounded as you rightly say by some of the terms and conditions and the pay, that suggests that working in adult social care is somehow second class, when it is not.

Q111 **Chair:** It is not. That reflects your point that care does not just stop at the hospital; there is an interface. In our nursing workforce inquiry, we came across real issues for the nursing workforce in district nursing. How are you seeing that impact in your inspections?

Andrea Sutcliffe: The King's Fund and the Health Foundation did a very interesting study over a year ago that demonstrated, using NHS figures, the drop-off of community and district nurses. That is having an impact on the ability to support people to maintain their health and wellbeing in their normal place of residence, which could be their own home or a nursing home or care home. We have seen that again and again in the local system reviews.

The data packs that Steve talked about earlier demonstrated that in some local areas we were seeing pressures not only in adult social care but in local community services, which increased the pressure on local hospitals, because people could not be supported in the community. That is not how I would want my mum and dad to be cared for and supported; they absolutely want to stay at home. My father hates going into hospital, and if that could be prevented by having proper support in the home it would be a much better way to do it. We have to see the whole picture. Something I will take with me into my new role is an understanding that nurses work in many different settings and have an incredibly important role across all those settings, and we have to cherish and nurture that.

Q112 **Chair:** My final question is about the interface with the voluntary sector. In many parts of the country, certainly in my constituency, wonderful voluntary groups work closely in tandem with social care. Do you have a remit for inspecting their work?

Andrea Sutcliffe: Our remit extends only if a regulated activity is being provided, which typically is personal care. If a voluntary sector organisation is providing personal care, they will be registered with us and we will inspect them. A whole host of other organisations support people and work with adult social care providers. When we look at providers and ask them whether they are well led, we also look at their connections with the local community and how they ensure that those connections are developed for the benefit of the people using their

services. In some of the outstanding and very good services we see, some amazing relationships and partnerships have been built up, which bring the community into the care service and take the care service out to the community. People can get some really positive benefits from that.

From the wider system point of view, one very sad thing that we have seen in the local system reviews is that typically co-ordination and integration between health and social care extends to the statutory sectors—the NHS and the local authority—but not to adult social care providers and not necessarily as far as it should to the voluntary and community sector. One of the recommendations we have made is that people need to recognise the significant contribution that adult social care providers and the voluntary and community sector can make to the overarching wellbeing and health support that people need in the community.

Chair: Do my colleagues have other points to raise?

Q113 **Rosie Cooper:** I am quite encouraged by the second panel, but you guys are not going to be around, so we will have to forge new relationships. Although we talk about leadership in health services, I really worry about leadership in social care. We are not paying enough to everybody involved. I share your view, before this next comment gets taken out of context, that, if it is not good enough for my dad, it is not good enough for anybody, but I wonder whether we go for it and penalise social care owners really hard, and we find it much more difficult to do in an acute setting. We have to do it hard in both. This question was asked before, but can you tell us about any acute or GP services that you have really gone in and sorted out, and not just made a recommendation? I know there are some, but there you go. I am giving you an opportunity.

Andrea Sutcliffe: There is one point that I would like to make after Steve has answered.

Professor Field: Sorted out is an interesting phrase. We have been to court and closed surgeries; we have been to NHS and private surgeries and been in court recently, but we are very reluctant to do that because we would prefer that they improved. It is very difficult in general medical practice in some areas, because we do not have the same NHS Improvement support that would go into a hospital. The Royal College of GPs has been in and published a report, and practices have improved. Some will be merged out of their current provision into bigger organisations. We can provide you with lots of information about how we have acted very robustly for patients. Not only that, we can restrict surgeries from taking on new patients so that they do not expand and expand. There are all sorts of things we can do.

Andrea Sutcliffe: I hope that part of my answer will help to reassure you for the future. One thing that we are very clear about is that our enforcement policy in the Care Quality Commission needs to be consistent. We need consistent principles. Debbie Westhead, one of my

deputy chief inspectors, the one who covers the north—your patch—is the corporate lead for CQC on enforcement. Debbie absolutely has the bit between her teeth for the entire organisation in being very clear about our standards. We have a decision tree that takes people down the pathway to reach decisions about enforcement, and it is consistent across all three of our sectors. We are putting in place a variety of support mechanisms, and regulatory skills training, to strengthen our enforcement approach.

I think you are right. If you look at the spread of activity, more of it happens in adult social care, but that is not to say that it does not happen in the other two areas. That is particularly so in criminal enforcement; we have taken prosecutions forward in the hospital sector as well as in the adult social care sector. There is more volume in adult social care, because our regulation is for 25,000 locations, so there will always be more numbers, but I think you will see other action taken elsewhere.

Q114 **Rosie Cooper:** Perhaps you could pick up on it a lot more. I think that is what I was trying to reflect. Let me make a point on the record. Liverpool community trust should have been in special measures, but you actually only put it into "Requires improvement," which I think was because you took the system view that you did not have the resources to man special measures, and, if it had been another part of the organisation, your view would have been different. That jaundices me, when I look at what you do.

Professor Baker: To reassure you, we are taking more enforcement action in hospitals and we are still putting hospitals into special measures when necessary. That is still going ahead. We cannot close NHS trusts in quite that way, but we have closed independent hospitals.

Chair: I am sorry, we have to finish. Thank you very much Andrea Sutcliffe and Professor Steve Field for your work for the CQC. Thank you all.