Public Accounts Committee

Oral evidence: Care Quality Commission, HC 501

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Members present: Meg Hillier (Chair), Mr Richard Bacon, Deidre Brock, Caroline Flint, Kevin Foster, Mr Stewart Jackson, Nigel Mills, David Mowat, Stephen Phillips, Bridget Phillipson, John Pugh, Karin Smyth, Mrs Anne-Marie Trevelyan

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

Witnesses: Melany Pickup, Chief Executive, Warrington and Halton Hospitals NHS Foundation Trust, Dr Marc Rowland, GP and Chair, London Clinical Commissioning Groups, and Maria Ball, Chief Executive, Quantum Care, gave evidence

Q1 Chair: Good afternoon and a warm welcome to the Public Accounts Committee. If you are following on Twitter, our hashtag for today is #CQC. We have two panels today. The first is made up of experts in the field who have been through a CQC inspection, so they are very much at the frontline. I am pleased to welcome Maria Ball, the chief executive of Quantum Care, representing the social care sector, and Dr Marc Rowland, who is a GP and chair of the London Clinical Commissioning Council. Thank you very much for coming at such short notice, Dr Rowland.

Dr Rowland: I am also the chair of Lewisham CCG.

Chair: Thank you very much. We also have Melany Pickup, the chief executive of Warrington and Halton Hospitals NHS Foundation Trust.

We have asked you along because you represent three of the key sectors that the CQC inspects. Will you please make a brief opening statement about your experience working with the CQC on recent inspections? We will then go around the Committee asking other questions. Maria Ball, will you kick off?

Maria Ball: I guess the experience was in two parts. We were also part of the initial pilot, so we had two or three inspections pre-April. They went well and were very positive.

We thought the new framework or model—the whole process—felt very good. Dialogue was good and feedback was good. Since April it has been a lot more mixed. We have not experienced reports with content of the most consistent quality, or consistency between reports—one likes our care plans, one doesn't; one likes our needs process, one doesn't. So there is quite a lot of inconsistency.

The reports are also inconsistent with both our own ratings, which are obviously more personal, and our local authority and CCG assessments. There has been quite a lack of understanding of new models of care. We do a lot of intermediate care and enablement care, and there is a lack of understanding of where responsibilities in that pathway lie.

Proportionality is an issue. One minor comment in one unit of a whole home with perhaps six units would seem to reflect the rating given to that home. It is quite worrying that there are a lot of positive comments in our reports, but really all the feedback from staff, users, relatives and visitors gets one line at the bottom of each section, if we are lucky, and they are all very positive. It is almost as though our user experience—the lived-in experience—is not as important as some of the inspected experience on one day.

Feedback on the day is inconsistent with what we get in the report, so we get a lot of surprises. A report arrives and it is quite a surprise. It certainly doesn't reflect my very experienced staff's ability to absorb feedback at the end of the day. We had a visit in April, but the report arrived in September, so there is quite a long timeframe. That was a report where we did have some "requires improvements", so we were quite surprised.

We used to have a really good dialogue about factual inaccuracies and we had the ability to feed back factual inaccuracies, but at the moment that doesn't seem to be happening. In fact, one of our reports was put up before the time period to correct factual inaccuracies had finished, and we thought there were quite a lot. So we have some practical issues. We are disappointed because it felt much better before the process started in April. But apart from that, we're positive.

Q2 Chair: That is very helpful. What is your experience, Dr Rowland?

Dr Rowland: We have had one inspection—

Chair: This is at Lewisham.

Dr Rowland: Five practices have been inspected in Lewisham. I have some feedback from those other practices and from pan-London, if that would be helpful.

Chair: Yes, that will be helpful.

Dr Rowland: Basically, our experience is quite good. It felt quite benign, quite pleasant, and it was a reasonable experience. The feedback on the day was quite good. That was our personal experience. Dare I say it, but we are a reasonable practice and it seems that if you are reasonable, it works quite well.

The experience in other places has not always been quite so good. The trouble is that the training and experience of some of the inspectors seems incredibly variable. I have one example of a health centre that was inspected and had different teams on different days for two different practices within that health centre. The cervical smear rates were almost identical, but one team completely honed in and focused on that and put a very negative report in and the other team did not even ask about it. There is a lot of variability.

Things like oxygen defibrillators are expected to be available as a "must". You might think that would be useful, but that is not a regulatory requirement. How much is the report dependent on the regulations and how much on what the inspectors may wish to focus on?

Q3 Stephen Phillips: Did you get the impression that different inspectors might take different views in relation to that particular example?

Dr Rowland: I cannot come back to you definitely on that one, only on the cervical smear rate one. My impression is that the answer is yes, but I cannot give you concrete evidence.

The other thing is that the reports often take three months to come back, yet you have only two weeks to correct factual inaccuracies, which is extremely difficult. That is a similar problem to Maria's.

Overall, I would say that it is good, but the problem from the general practice point of view is that we are being asked to transform, change and develop—I am strongly in favour of that—but the process does not seem to be helping that. It does not seem to link in with all the other many, many regulatory processes that are going on. I would wish to see the question asked of any process, "Is this helping to transform and improve general practice?" rather than it just being a straight regulatory process.

Chair: Thank you. That is very clear.

Melany Pickup: I have had a number of dealings in the past with the CQC, so I anticipated that our inspection, which was at the end of January this year, would be somewhat of an ordeal, and I found it not to be so. There has been a tangible change in the style and methodology used throughout the inspections, although that is not to say that they are not robust in the extreme and quite intense and intrusive.

In terms of the preparation that is required, we sent more than 700 pieces of evidence in advance of the inspectors arriving. If you could choose when you might have your inspection, the middle of January is not necessarily the easiest time. People will be well aware that this particular January was a real challenge for acute trusts. The inspectors arrived. I was able to give a presentation the day before, and I think I was very honest about where I saw the problems, issues and challenges in the trust. I was very open and we welcomed the inspectors into the organisation—42 of them across three sites over three days.

I would echo what colleagues have said. The feedback on each of those days was quite positive and in some centres a little incongruent with the final report, where a number of areas that we felt we had done quite well in were found to be requiring improvement. The

report was delayed somewhat. We had been given a date, and that was elongated because the drafts were not ready. When the reports came and we went through them to check for factual inaccuracies, which we are allowed to do, we submitted about 210 of those.

Q4 Chair: Can you say what level of factual inaccuracy they were? Were they major errors?

Melany Pickup: Some of them were just grammatical errors—sentences that finished mid-sentence and did not make sense at all. Some of them were a lot of duplication. Some of them were wildly inaccurate, where the numbers or the data were wrong. We were able to challenge those inaccuracies, and in actual fact our chief inspectors met me and allowed a number of hours to go through those errors in detail. The consequence of that was that 64% of the inaccuracies were upheld and the changes were made. That led to changes in certain ratings pertaining to some domains, but not the overall rating for the organisation.

I echo what colleagues have said about our experience of the inspectors: that they are incredibly helpful and open and they were able to get the best out of staff. Staff reported quite positively at the end of the experience that the inspectors seemed very well informed and interested in what the staff had to say and that they were looking for really good things and good examples, as well as wanting to know what the issues were. But I think there is a tendency to rely on anecdote and to quote comments made by individuals. Running hospitals is very difficult at the moment and you cannot have all the staff on board with everything that you are doing all the time. Having to make massive cost savings is not easy when the majority of your costs are around staff salaries. They know that there are changes that they have to make, not all of which the staff are on board for, and a disgruntled member of staff may make a very damaging comment that gets translated into the report as an overall theme. That is an issue.

My final point is that inspecting institutions is not helpful when we are now talking about health systems and care pathways for patients that transcend institutions within themselves—all the sectors that you see represented today.

Q5 Chair: Certainly that will be a theme of our Committee over the next five years—watching the user. That is an interesting point which we may pick up with the CQC.

I was interested, Melany, that you talked about the number of inaccuracies in the report and I wondered whether the other witnesses would give a flavour of whether, when you did the fact checking, you found a similar picture.

Maria Ball: Yes, we find quite a lot of inaccuracies, sometimes just grammatical, but sometimes basic stuff that clearly could have been picked up and asked about on the day, and should have been asked about rather than taken as gospel. We feel that there could be more during the visit and I think the timeframe could be quite different.

Going back on each of the reports, we have had 10 so far. The CQC is in one of my homes as I speak, so I am a little worried today. It is hugely time-consuming and extremely

demoralising for the care staff and the sector. It is a most challenging time for the sector. It doesn't help.

Dr Rowland: I was just checking with our practice manager. To be honest, no, we did not have inaccuracies there. It is more the problems beforehand of getting the documentation. There is no standardised documentation required from us. The data collected from general practice is usually 18 months out of date at least. Corrections and re-inspections six months later are usually delayed so if you have a negative inspection it is very difficult to get that changed in a reasonable time, even though you put the time and work into doing that.

Q6 Chair: On re-inspections, perhaps I can bring John Pugh in on the delay? Is that something you have experienced direct? Have you expected re-inspection?

Dr Rowland: Yes, I have evidence of that.

Maria Ball: Yes.

Chair: I suppose it hasn't applied to you, Melany Pickup.

Q7 John Pugh: There are two criticisms made of inspections the world over. One is that they are sometimes over-bureaucratic and too much of a paper exercise, and the other, which was made of the CQC, is that sometimes people are inspected by people who really don't know what they were looking at or what to look for—chiropodists examining dentists and that sort of thing. As the process hit you, did you feel that the people inspecting you understood your field effectively and that it was an assessment with real experience, as opposed to a bureaucratic tick-box exercise?

Dr Rowland: Our inspection was done by a GP who had retired because he was burned out and couldn't carry on with the workload.

John Pugh: That is why I was sympathetic.

Maria Ball: I can't match that, I'm afraid. I think they are informed, but I also think they are there to look and inspect. They are not listening to the lived-in experience. The inspection should take the views of people in that service as much as of the person there on the day for a few hours a day.

Yes, we do have, but sometimes the care sector has over-qualified people. It is very daunting for a care staff person doing medication to have an experienced nurse hovering around them and following them around for hours. So there is another balance.

Q8 John Pugh: Bureaucracy is more a problem perhaps for a smaller provider than for you. Is that the case? It is fair to say—

Maria Ball: Yes. Sort of mid-size.

Q9 John Pugh: You are probably more attuned to it. Melany?

Melany Pickup: I take some comfort from the fact that a significant number of the inspectors are plucked out of delivering services and are experts in their own field. So that has been a concern of mine in the past, but it is less so now. They are more experienced and better equipped, arguably, than some of the people who make being an inspector their career. You can see a tangible difference.

In terms of whether it is a tick-box exercise, there is a degree of inevitability, if you are submitting 700 documents and a continuous stream of queries and questions looking for more evidence, that there is potential for that to happen.

Q10 John Pugh: My local hospital had a series of meetings with all the staff to get their stories straight before the inspectors arrived. Did yours?

Melany Pickup: No, I think we laid ourselves bare; we told it as it was. I was very open and up-front. In fact, in the feedback that we got at the summit at the end of the process, when the draft report was about to be published, fewer issues were brought to our attention by the CQC than I had brought to its attention. So no.

Dr Rowland: Two points. First, general practices are small, so you have a small inspection team. That is why there is possibly more variability—in a small team like that. Secondly, you mentioned people pre-meeting, but it will become gamed, because everything will become gamed. If you have an inspection system, it will get gamed. That is a negative thought.

Q11 Karin Smyth: Dr Rowland, I am interested in your view as a commissioner—in your role as chair—of the assurance you are getting from the CQC inspections, particularly in light of the other inspections that go on around the sector. Talk us through some of that.

Dr Rowland: There are so many different things. I would prefer that general practice became more organised, larger and developed, and I hope that that transformation will occur, so that more quality control can occur within organisations, then with larger inspections occurring of the transformed organisations, rather than things being done at the very small practice level. But that is a few years off. At the moment we now have NHS England, the Royal College of General Practitioners possibly, clinical commissioning groups, local medical committees and everyone keeping an eye on what is going on. It becomes extremely complex and it is extremely time-consuming. This is something that general practice is just learning.

Q12 Karin Smyth: I appreciate that perspective from general practice, but I am more interested in how the commissioner pulls all that together to look at the sector for which you are responsible.

Dr Rowland: Interestingly, I had a meeting with someone this morning about personal medical services reviews—

Karin Smyth: PMS reviews is a subject close to my heart.

Dr Rowland: We can talk later. This does link up with the quality of practices and what is happening. I come back to my earlier point, that I would wish that this work all points towards transforming. If we just continue the salami-slicing and the minutiae of what practices and organisations do, we will just fail. We need to use this as a tool for transforming and improving care for the population generally.

Q13 Chair: Before I bring Kevin Foster in, I want to say something. You mentioned the points about the number of different agencies looking at a GP practice and, earlier, about standardised or non-standardised paperwork. Is there something that could be done better to ensure that all those organisations are asking the same things? Or are they all asking for completely different datasets and paperwork? Perhaps across the three sectors—starting with you, Dr Rowland.

Dr Rowland: Very much different datasets. NHS England is always asking us for information with zero notice to come back on something—"It has to be done by next week"—and that really takes the eye off the ball of care delivery, which I am sure my colleagues would say.

Q14 Chair: Is there something simple that could be done to make that better—if every organisation was seeking data from the same source?

Dr Rowland: Yes—integrate it together.

Q15 Chair: Would that be easy to do?

Dr Rowland: No, very difficult. Everyone is going to have their own—

Chair: I figured it probably wouldn't be.

Maria Ball: The care sector is slightly different. The information is similar—it is fairly standard stuff. I understand the complexities in health. I think it is a bit different. My issue is more how much regard is taken, how that is used intelligently and how they align. We have seen consistencies in the outcomes of those different processes.

Melany Pickup: I agree with Dr Rowland. There have been attempts on any number of occasions to streamline the amount of information and use it more commonly. I do not feel that has really had much of an effect.

Q16 Kevin Foster: I come at this with a certain interest: there is quite an elderly population in Torbay, with 9% of the population in my ward aged over 85. We have just

taken the step of creating an integrated care organisation on 1 October. We heard, particularly from Dr Rowland, about different people keeping an eye on different things, and then the comment from Ms Ball that things are slightly different in the care sector—of course, where I am now, it is integrated and that model is going to spread; there are no two ways about it. What challenges do you see from a practical point of view, in the positions you are in, of bringing this sort of monitoring approach to an integrated care regime?

Dr Rowland: It is kind of my London day job. I really want that to happen, so I am extremely positive. I refuse to be negative; that will not help.

Melany Pickup: It is absolutely the right thing to do. Having seen the inspections purely from the lens of an acute trust, they are incredibly challenging logistically, I have no doubt. Expanding that to the health economy presents its own challenges, but it is absolutely the right thing to do because we should be focusing on the experiences of the patients as they transcend different parts of the sector, as opposed to the bricks and mortar of institutions.

Q17 Kevin Foster: I am looking at the NAO Report's recommendations. It says that there are effectively three workstreams at the moment for the CQC, which each one of you come from. Obviously, with an integrated care organisation, the effect is that they become one. What you do not want is a report on one bit that does not really reflect any of the others. How would you see the change being made to that system?

Melany Pickup: As I say, I do not know. I think that in not only this arena but in the arena of looking at sustainability of whole health economies—whether you are Monitor, the Trust Development Authority or whomever—all of those organisations are looking at how systems work together. To give you an example, one of the CQC's criticisms of our organisation is around patient flow, and one of those big issues for us is how we get patients out of hospital in a timely manner. I am not a community care provider, nor an intermediate care provider—that would be someone like Maria, local authority colleagues or community trust colleagues—and yet my report is heavily critical of us as an organisation. It gives a nod to the health economy needing to do something, but it is our report as an organisation that says, "Patient flow is an issue and requires improvement."

Dr Rowland: I was excited, probably naively, that the Public Accounts Committee was interested in this, because I hoped you could become part system leaders to help with that, because it is very difficult with the sections within health.

Maria Ball: Social care is quite a different business and a different market. It is independent providers, so the issues are more challenging—many are commercial rather than not-for-profit providers—which adds an interesting dimension. Our experience is of a lack of understanding of where we have integrated care—we do run a lot of intermediate care. My strongest comment from the CQC is that there does not seem to be that understanding of the regulator, of how that operates and how you have more than one area of responsibility.

Q18 Mr Jackson: May I ask about extra care facilities? Do you think that to tackle the tension between acute hospital care and adult social care in the long term, given the demographic changes that will happen over the next 20 years—I am not asking you to make a

policy pronouncement—it is likely that the proliferation of extra care facilities will assist that pinch point? As you know, every Christmas and every winter, in every acute hospital trust more or less across the country, there are people in A&E who need an acute bed and many people in acute beds who are ready for discharge. How do you see, for instance, extra care facilities for older people playing a part in the future to try to solve that issue?

Maria Ball: I think social care itself does some of that. We are working very closely with one of our local acute trusts, which has particular issues of flow, and we are providing that release in the system. I think extra care is part of a range of solutions for people, although it is not the be-all and end-all. Long-term care is another one. Equally, the ability to look at that mix of care and the pathways people experience is the key. To be able to inspect and drive improvements in those areas is really important.

Dr Rowland: I think what will happen, and what is happening nationally, is that people will integrate their care into accountable care organisations, in which you fund for the outcomes for the population, rather than having separate organisations. Within that, there may be different commissioning occurring, but unless we have a completely broad view between health and social care and integrate the funding, it is going to be extremely different, because each little bit will get judged and funded on its own.

Q19 Mr Jackson: So do you have a methodology in your organisation for capturing the experience of Torbay, for instance, where they are going down the route of integration? Obviously, they have more older people than most parts of the UK. Are you taking that as best practice and sharing that in the reports you do with other local authorities and other NHS providers?

Dr Rowland: Absolutely. I recently spent a day and a half away with the local ADASS, hospital providers and so on to sort out what we might do locally. I know about the process in Torbay. They are very forward-looking, and I would be very interested to see how it works out.

Melany Pickup: There is the new care models team at NHS England, and their vanguard sites, which are designed to test out what you are talking about. That is the route by which we will all benefit from the learning that exists in Torbay and places such as that, which are piloting varieties of different ways of looking after people. I take issue with the word "proliferation", because from where I sit there is an absence of a proliferation of alternatives to hospital care right now, and that is part of the problem.

Q20 Chair: I think we are in danger of straying into policy. I have one last question. Maria Ball talked about the user experience not being reflected, in her opinion, in the reports. We know from the NAO Report that the CQC tends to use NHS Choices and other vehicles to manually input feedback. I did a bit of mystery shopping on NHS Choices, and I was a bit shocked, when I knew the institutions, about what people said. Dr Rowland and Melany Pickup, can you give your experience of how the user voice was captured in the inspections you have gone through, and do you think it was a fair representation?

Melany Pickup: As part of the preliminary work that is done, a number of invitations are sent out to the public, so they can come to events hosted by the CQC to give their feedback on their experiences, whether they want to speak positively or negatively. In our instance, although there were at least two events, as I understand, in the two health economies that we serve, attendance was very low. I am sure feedback was obtained by other means, such as patient choices, complaints, ombudsman data, etc. The face-to-face feedback wasn't particularly well attended, but what the inspectors do—we observed a lot of this—is that while they are inspecting, they are talking constantly to the people in the wards, the departments and all over the hospital, and they obtain feedback that way.

Q21 Chair: As you said, that is anecdotes and individual comments.

Melany Pickup: It can be.

Q22 Chair: Thank you. We know it is a challenge, but it is interesting to hear that.

Dr Rowland: For general practice, it can be based on the patient questionnaire. The problem with the questionnaire is that it is a central questionnaire and not very locally sensitive, and it is always a little out of date. It is also based on what people think general practice should be rather than what general practice is moving into. If you ask patients whether they could get an appointment exactly when they wanted and whether they got what they wanted from the appointment and so on, it could be that they did not need to see a GP at all, or that they wanted antibiotics and did not get them. That might make them unhappy. The questionnaire is part of a transformative process and that has not been taken into account.

Chair: Okay. We know that is a big challenge. Thank you very much for travelling to join us today. It is very helpful to hear what it is like from the coal face. You are welcome to stay for the remainder of the hearing. We will send you a copy of our report when it is published in a couple of months.

Witnesses: **Dame Una O'Brien**, Permanent Secretary, **William Vineall**, Director of Quality, Department of Health, and **David Behan**, Chief Executive, Care Quality Commission, gave evidence.

Q23 Chair: We welcome our second panel of witnesses. David Behan is the chief executive of the CQC. Thank you for coming, David. Dame Una O'Brien is permanent secretary at the Department of Health—a bit of a regular visitor between now and Christmas. William Vineall is the director of quality at the Department of Health.

Today's hearing is on the CQC. It is vital for patients to know how good their hospitals, GPs and care homes are. The Committee has visited the subject before. Since the CQC was set up in 2009, it has had, I think it is polite to say, an uncertain trajectory. The last time the CQC was before us, we thought you really were not up to the job. That was in January 2012. We welcome the changes that have been made. You are now three years into the programme of change but the NAO Report says that there are still many risks. Mr Behan, the following jump out: the lack of qualified staff; the extra responsibilities that you are

taking on; and the issues of using data for good risk assessment. We will revisit all of these issues in a year or so to see how they bed in.

Before I hand over to Stephen Phillips, who will lead our questioning today, I want to ask you, Dame Una, why you have been adding extra responsibilities to the CQC. From April next year, those responsibilities will include the financial monitoring of hospitals and of large social care providers. It seems that while the organisation is going through a major change, it is an awful lot more to ask them to go into quite specialist areas. Can you explain why the Department of Health has added those responsibilities?

Dame Una O'Brien: Yes, I can. Thank you for the opportunity to talk about the progress that we are making and the further work that is to be done on the CQC. The central answer to your question about why these additional responsibilities have been asked of the CQC is because the Government have increasing confidence in the CQC, and in the quality of the changes that it has made and is in the process of making to improve the work that it does. Of those additional responsibilities, the main one is on the judgment about the economic and efficient use of resources. The important thing to note about that—I am sure we can talk about the detail—is that we are not just throwing in additional responsibility and asking for it to be done in one go. We are allowing time for it to be developed and piloted, and for the CQC to work in conjunction with other players so that we get one version of the truth.

Q24 Chair: Can I just step in? Monitor does that for hospitals so the big question is: if you have Monitor, why do you have the CQC taking on this responsibility as well?

Dame Una O'Brien: Yes, as you will have seen, we are making a number of adaptations to the way the system works nationally. The Government's view is that Monitor and the TDA should come together in a stronger partnership to be more focused on the work that needs to be done between inspections, which is supporting organisations to really improve.

Q25 Chair: Are we talking about a merger then, effectively?

Dame Una O'Brien: It is effectively a single operating model and a really joint partnership between those two organisations.

Q26 Chair: Then how does the CQC fit in?

Dame Una O'Brien: For the CQC, you can see it emerging now as the single independent version of the truth as to what is going on in any given provider, and you can be absolutely confident that the CQC can go in without fear or favour and make that judgment. It has improved the way it does that and there are more improvements to be made, as we have heard from witnesses before.

Q27 Chair: You just said the "single independent truth", but we have got Monitor as well. I still don't understand how those two fit together and why you have got this separate organisation doing much the same thing.

Dame Una O'Brien: We want to bring together in one place a judgment about quality, safety, effectiveness, the quality of leadership and the use of resources, because they are inextricably interrelated. David can talk more about the details, because the methodology for doing this is in development, but we will draw on all the information that Monitor and the TDA have got about these trusts.

Q28 Chair: To drive home my question, if you are going to do that and have that integrated approach, why do you need Monitor as well?

Dame Una O'Brien: Because we know that we need an organisation to provide support and help to providers to improve. And this has been a gap, actually—

Q29 Mr Bacon: Sorry, could you just say that again?

Dame Una O'Brien: We need a capability in an organisation that will support providers to improve.

Mr Bacon: "We need a capability in an organisation that will support providers to improve".

Dame Una O'Brien: So for example, we now have operating in TDA/Monitor a team of specialists who can go in to an A&E department and provide advice and information rapidly about how to improve examples of good practice from other trusts and on-the-ground evidence about how trusts can change. And that is already having a big impact on A&E departments—

Q30 Chair: So what you are saying really is that Monitor is the professional support.

Dame Una O'Brien: Correct.

Q31 Chair: But there is still a danger of duplication across the two.

Dame Una O'Brien: I think there's always a danger of duplication in our system, and it is the job of both the chief executives and of the Department to strip that out wherever it occurs. But I think we have got a clearer distinction now than we have had before, and I am confident that having this organisation going in and helping between inspections, which may be years apart, and helping organisations out of special measures is what we need.

Q32 Chair: So one is the helper or the adviser and one is the inspector?

Dame Una O'Brien: Correct.

Q33 Chair: But you heard from our previous witnesses—and we hear this from other places as well—that there is a lot of different sorts of paperwork and information needed by the different teams, so how will you make sure that you don't have unnecessary duplication for the local provider on the ground?

Dame Una O'Brien: Having worked in a provider myself, this is something that I am absolutely passionate about. And you never really get there. It is a constant frustration that as soon as we manage to get rid of one load of bureaucracy, we have—

Q34 Chair: So what are you going to do about it?

Dame Una O'Brien: I think that we will have to work much harder. The sort of evidence that we have heard today is really helpful, and I know that David and his team are always getting feedback on the quality of inspections and the way they're done. But I think that as CCGs now come into their third year of operation, their interaction with NHS England needs to mature further, so that we haven't got the same demands for information.

Q35 Chair: Wouldn't the simple thing be for the CQC just to demand the same financial monitoring data that Monitor would require?

Dame Una O'Brien: I don't know if you want to comment on that, David.

Chair: Briefly, David, and then I just want to move on to one more question for Una O'Brien.

David Behan: To your point, Chair, one of the criticisms in the 2011-12 report was that we didn't do this with other organisations, so I made it a priority to make sure that CQC's relationships at a senior level and operationally with Monitor are strong. We have got examples—I can use them—of where we have inspected together, where there has been something that we think is a mutual issue. With one particular hospital, we weren't clear whether the issue was about governance of the way the organisation was run or about quality and safety. That was resolved by a joint inspection. We did that together; we arrived at the conclusions together. Another example of where we are likely to do that in the next few weeks is an example of where we work together.

This morning we published a signposting document on the use of resources. We have set out how we will go about doing that. One thing we are very clear on is that we will work with others and use their data. We have referred to the work that Patrick Carter is doing, and we will use some of the data that he is generating as part of the assessment of the use of resources, so we can build that in without building in further duplication.

Q36 John Pugh: Assuming that you get two sets of financial data that do not agree in every respect—say, the traffic light system at Monitor does not back up the alarm spread by a

CQC inspection—which data ought to be trusted? Which do you act on in that circumstance? To whom does the Department of Health respond, with the possibility of two of them giving you two different views of the financial situation? You have to react one way or another, so whom do you trust?

David Behan: I think it is important—to come back to your question, Chair—to be clear what the difference is between what Monitor is doing. It is largely looking at the balance sheet that exists and whether a trust is in deficit or not. We are not going to comment on whether a trust is in deficit, but whether the trust is using the resources to add value to the quality and safety of care provided. We tried to set that out clearly, but your point about duplication is about a slightly different thing.

Q37 John Pugh: Just in my scenario, Monitor gives an amber signal in terms of financial viability, and the trust produces a report that says that there is a serious and critical financial situation that we need to look and act further on. Who do you act on? Or is that scenario never going to happen?

Dame Una O'Brien: That is precisely why David is consulting on a way to do it.

Q38 John Pugh: It is why you should have one system, yes.

Dame Una O'Brien: These are the questions we need to answer. There will have to be one single view of the financial status of the organisation. We are not going to try to set up a competing approach to it. If you go back to the 2008 legislation, it was written in that CQC should pay attention to the utilisation of resource. Another way of looking at this is that we have not come to this as quickly as we should have done, but we are now determined that we get an overview of the use of resources alongside the delivery of safety, quality, effectiveness and being well led.

Q39 Chair: I know that Stephen Phillips wants to come in on some of this, but, going back to the expertise issue, you talk about sharing information and so on. You do not have staff to fill the posts you have at the moment. You have this new responsibility from April. How confident are you that you are going to have the right experts in place to do this extra inspection?

David Behan: We need to be clear about what it is we are being asked to do. To come to your point—"Will we use the data of others?"—and John's point about whether there is a single data source, we are in active discussion with others who use data in relation to financial balance—

Q40 Chair: What about staff who will go in and inspect on this basis?

David Behan: What we will do in taking on this responsibility is this. An inspection where we need a field force to be deployed? I think not. Or, if we are using other people's data, do we need a smaller number of people to verify that data and build that in? Remember,

what I said is that we are looking at value for money, not whether an organisation is in balance or not, so I do not think we need a huge number of people to do this. Predecessor organisations of CQC—the Commission for Social Care Inspection and the Healthcare Commission—did some of this work and they used the work generated by the then Audit Commission, which was data that was generated by accounts. I do not think it follows that we a big field force to collect data that have not been collected before or duplicate other people's data. All public sector organisations have accounts. They are audited; there is a standard accounting system that is used. So the challenge is: can we use that information to build the judgments around value for money.

Q41 Chair: So, more desktop work. This is my final question for now. We learnt on Monday, Dame Una, that data security is now a responsibility of the CQC—I have the transcript here somewhere; your colleague from the Department of Health said that. I wonder whether it is sensible to add even more responsibilities to the CQC when it has still not bedded in the new inspection regime. Why did you decide to add that to the CQC and how confident can you be that it will be able to do it?

Dame Una O'Brien: Obviously there is work to be done. I think my colleague also mentioned Dame Fiona's work. As it is with use of resources, it is one thing to say that we are going to do it, and we are committed to bringing one integrated view about how the organisation is run and delivering for patients, and the methodology that is used to do that. We have got several steps to go on resolving what that methodology is. I don't know whether we would make any apology for including that in the overall regime, because, fundamentally, from the patient's point of view, you need to know that the organisation you are dealing with and your data are safe and well regarded.

Q42 Chair: My concern is not that the Department of Health thinks it is important that safety and security is important. I would hope that that is the case. The fact is that we are six years on from the CQC being established, after much criticism. It is now three years into its new programme, and yet more responsibilities are being added before that new programme is bedded in. The Report is very stark on the challenges faced with recruitment of staff and all the other things that we know are in there. So how can you be confident that this will happen, and can you tell us the timescale for when that particular responsibility will be fully enacted? I will hand over to Stephen Phillips shortly.

David Behan: We are not being asked to take responsibility for data security; what we have been asked to do is carry out a thematic review of the capability for data security within health and care organisations, so it is a one-off. Section 48 of the 2008 Act allows us to do what they call "reviews". We can be requested to do this by the Secretary of State.

Q43 Chair: Sorry, is that across the whole sector all in one go, or is it an inspection the first time you go to an organisation?

David Behan: There are two bits to this. What we have been asked to do is a one-off thematic review, and we will carry that out over the period until the end of January. I was

asked to carry out this review and I made a commitment to give the Secretary of State a report by January. The way we are going to do this is we will work with Fiona Caldicott, the national data guardian—by absolute coincidence, I met with her yesterday evening to oversee the progress that we are making. We will do field work in between 50 and 65 organisations. There will be a number of acute trusts, general practices and social care organisations[1]. Our purpose will be to review whether they have got policies and processes in place around data security, then see what penetration testing they have done for those tests. My expectation is that the majority will have policies and procedures; the issue will be whether they are being applied and tested.

We have recruited some reviewers. They are external people. Some colleagues from the Health and Social Care Information Centre, who I think you saw yesterday, will be part of those teams, as will some of my staff and an organisation called QinetiQ, which has experience in doing reviews. They will be the review teams. They will go and meet between 50 and 65 providers. Why that number? Because that is a representative sample out of the totality. We will then look at whether they have standards and how they meet those standards, and we will bring together a report that we will give to the Secretary of State in January next year.

Q44 Chair: This is a yes or no question. Is that being funded out of your existing budget or have you had extra money from the Department of Health?

David Behan: That is being funded out of the underspends that I have currently got in the budget. I am projecting a £7 million underspend and we will use that.

Q45 Stephen Phillips: Dame Una, before you became the permanent secretary, you were responsible for devising the scheme of regulation that led to the creation of the CQC. Is that right?

Dame Una O'Brien: Yes. I was the DG responsible for it.

Q46 Stephen Phillips: And you told our predecessor Committee in January 2012 that the intention was to implement the new regulatory regime, presumably in a fully effective way, over a three-year period from 2009. Do you remember that?

Dame Una O'Brien: I think—I am sure—

Q47 Stephen Phillips: That was the intention, wasn't it?

Dame Una O'Brien: I think that was the intention, yes.

[1] Correction: this should read: "There will be a number of acute trusts and general practices. The data security review will not apply to social care providers.

Q48 Stephen Phillips: We are now in October 2015. As you sit here today, would you describe the CQC as a regulator that, three years after it was supposed to be fully effective, is in fact fully effective?

Dame Una O'Brien: If we go back to the original date, the answer is that—we went through this very thoroughly at the hearing in 2012—we recognised then that there had been failings and that we certainly had not achieved what we wanted to achieve.

Q49 Stephen Phillips: I am asking you a different question. You are sitting here in October 2015. Would you describe the CQC today as a fully effective regulator?

Dame Una O'Brien: I think the CQC today has made outstanding progress in a very difficult three years. We have fundamentally changed the shape and the leadership of that organisation. Those people have then taken on, in the midst of great difficulty and a lot of adverse publicity, reforming of the organisation.

Q50 Stephen Phillips: I do not disagree with you, but I am going to interrupt because you are not answering my question. I think the CQC has made fabulous progress over the last three years, but as we sit here today it is not a fully effective regulator in the way that was intended.

Dame Una O'Brien: I would accept the judgment that a lot is being done and there is more to do. That is absolutely the case, and it is a huge undertaking. I can see, in the recommendations of the NAO and the comments made by the previous witnesses, that of course there is more to do.

Q51 Stephen Phillips: Dame Una, I am going to ask the question once more, and you'll get on a lot better and we'll get on a lot faster if you just tell us what you are telling us. As we sit here today, in October 2015, the CQC is not a fully effective regulator, is it?

Dame Una O'Brien: I think it is an effective regulator that needs, and will continue, to improve.

Q52 Stephen Phillips: Will you look at paragraph 2.2 of the NAO Report, please? It states: "The Commission does not yet know whether the model accurately predicts the number of staff it needs in practice. This is because"—then the first bullet point states that "by the end of March 2015, 91% of organisations had not been inspected and rated under the new regulatory model." A fully effective regulator, I suggest, is a regulator that has inspected more than 9% of those that it is responsible for regulating. That is right, isn't it?

Dame Una O'Brien: Sorry, can you ask me the question again? I missed that.

Stephen Phillips: A fully effective regulator would have inspected more than 9% of the organisations that it was responsible for regulating.

Dame Una O'Brien: It is a question of whether you regard inspection as being exactly the same as regulation. I think we have had a thorough, busy programme of inspection, which has ratcheted up significantly since 2012.

Stephen Phillips: We'll come on to that.

Dame Una O'Brien: That work continues. As I said, there is more to do. I have confidence that the organisation will continue to improve. I have never said, nor have I claimed, that everything is perfect. I think the judgment that has been made in the NAO Report is a reasonable one.

Q53 Stephen Phillips: If I had done 10% of the work that I was supposed to do as an MP—no doubt lots of people think that I do only 10% of the work—most people would think I was a pretty ineffective MP.

Dame Una O'Brien: But I don't think that is 10% of the work, if I may say so. There is a much more rounded view of the CQC and what it has been able to achieve. William, do you want to comment on the data?

William Vineall: You are talking about the new regulatory model and you are right: it says 91% of organisations had not been done. The new regulatory model has been running for basically two years in hospitals and a year for social care and GPs; and as of now, they have done 59% of hospitals, 31% of adult social care and 11% of GPs.

Q54 Stephen Phillips: I am going to come back to the figures in Mr Behan's paper to the board last week, but at the moment I am with you, Dame Una, and I am suggesting that an effective regulator would have done more than 9% of its work by March of this year—two years into the new model. Do you disagree?

Dame Una O'Brien: I think we could put the entire resources of the national system into the CQC and it still would not be enough, so we have to make a judgment. I stick by my judgment that it has become progressively more effective and has achieved more in these three years than in 2012 I thought was possible.

Q55 Stephen Phillips: Let's just look at adult social care. Presumably you pay very close attention to the annual adult social care survey in England.

Dame Una O'Brien: Of course we do.

Q56 Stephen Phillips: Do you remember some of the findings in the latest survey, which was published in December last year? In some local authority areas, up to 50% of those in adult social care said they felt unsafe because they believed that they were at risk of abuse or physical harm. In some areas, nearly one in 10 said that they did not get enough to eat or drink. And almost half of those relying on carers to perform basic washing duties said they did not feel as clean or presentable as they would like to be. This is important, isn't it?

Dame Una O'Brien: Yes.

Q57 Stephen Phillips: And it's far more important than inspecting only 9% or, in fact, now about a third, as Mr Vineall says—we'll come back to the figures—of those who are providing adult social care.

Dame Una O'Brien: That data is shocking and I was appalled by it when I saw it. That is precisely why we will continue to support, fund, challenge and seek improvement from the CQC. Let me just be clear that the responsibility for the quality of care delivered by a provider is that of the provider. It is only by exposing these things and making them transparent that we can support people in making their choices—

Q58 Stephen Phillips: Which is what happened with Winterbourne View, but if we have inspected only a third of adult social care providers, we don't know that there aren't other Winterbourne Views out there, do we?

Dame Una O'Brien: Well, we are expanding. We have a new—well, she is not so new anymore—chief inspector of social care, which we did not have before. She has an expanded team. David can give you the data about the programme that they have in place.

Q59 Stephen Phillips: By all means, write to us if you think you need to supplement anything after the hearing, but at the moment, I just want my questions answered.

Can we look at CQC staffing, please? Look at paragraph 2.3 of the Report. The Chair may want to come in on this. The Report correctly records in paragraph 2.3 that our predecessor Committee reported that "staff vacancies caused compliance activity to fall" in 2009-10 and 2010-11, so it is right, is it not, that inadequate staffing—I would have thought this is pretty obvious—causes the CQC not to be able to perform the functions with which it is charged under the Acts of Parliament?

Dame Una O'Brien: It is very frustrating that when we are able to provide resources, we simply cannot get people of the calibre to do the work that we want. You heard from the witnesses earlier that actually it matters a lot that you get the right people. When we came to the Committee before, in 2012, I think we accepted quite a profound criticism that we had too many generalists undertaking inspections.

Q60 Stephen Phillips: Dame Una, forgive me, you are anticipating where I may or may not be going with my line of questioning. At the moment, I am asking you something very simple: inadequate staffing causes the CQC not to be able to perform the functions with which it is charged—that is right, isn't it?

Dame Una O'Brien: I would say that it affects its ability to fulfil the totality of its commitments, but it does not mean to say that it is not performing its duties.

Q61 Stephen Phillips: If you look at paragraph 2.5 of the Report, by mid-April, the vacancy rate was 34% for inspectors, 36% for senior analysts and 35% for managers. The CQC has, as we know, set itself a target of making 600 employment offers by the end of 2015, but even if they reach that target, they do not have sufficient staff to perform the functions with which they have been charged this year, have they?

Dame Una O'Brien: David can comment on how staff are deployed, because obviously, there are choices to be made about how staff are deployed, but I do say that it is very difficult to get people of the right calibre to do this work, because you cannot just send people off the street to be inspectors.

Q62 Stephen Phillips: I am not suggesting you can for one moment, Dame Una. What I am suggesting is that if the CQC is down a third in every area in which it should be staffed, it is not going to be able to do the job that is required of it this year.

Dame Una O'Brien: I would like those vacancies to be filled and we would like the CQC to do more.

Q63 Stephen Phillips: Why don't you just agree with me?

Dame Una O'Brien: Because I want to be very clear that the organisation has improved, that it continues to improve, and that no stone is being left unturned in order to fill these vacancies and get the inspectors out there on the ground.

Q64 Stephen Phillips: Let us lay this myth to rest once and for all. I am asking you questions about this Report. This Committee—or its predecessor—published a Report three years ago, which was absolutely damning about the CQC. I accept that under Mr Behan's leadership, if I may say so, incredible progress has been made in the last three years. What I am concerned with is where we stand now. You are going to get from this Committee praise in spades for what the CQC has done. What we are looking at is how taxpayer money has been spent and what the position is today. I am not seeking to ensnare you into criticising the CQC for what it has done over the last few years. I think it has done a fantastic job.

Now, let me go back to my question. Staff numbers are down by a third in every single area. The CQC will not be able to do what is required of it this year as a result—yes or no?

Dame Una O'Brien: I will have to ask David the precise answer to that question, because he can judge—

David Behan: Yes.

Dame Una O'Brien: He is saying "yes", because he is responsible for deploying those resources against the tasks. Clearly, from my point of view, I would like to see the vacancies filled.

David Behan: So, I think you are absolutely right. I reported publicly to the board last week that we were at risk of delivering the target to September—that is 10 months away. There is a spending review and a budget to settle before we get to that, so I was, in a sense, publicly reporting on that.

On your question about vacancies, Stephen, we had a target to recruit 600 new inspectors—offers, this was—by December this year. As of last week, we stood at 563 offers made.

Q65 Stephen Phillips: That was also in your minute last week, but I am afraid that it was also in answer to a question that I am not asking. Can you do the job that you have been asked to do in the year 2015 given that for most of the year, you have been a third down on your staff?

David Behan: No, and this is why we said last week that we were at risk of delivering on what we had hoped to achieve during the year. The issue is not the resourcing of the Department; the Department has given us the money to allow us to do this.

Stephen Phillips: I am going to come back to money.

David Behan: Good. The money buys people, and the issue for us has been to buy people. As you have already heard, in the challenges we got from this Committee and the Health Committee, and we have had some more this morning from providers who consume the service we give, there are issues about consistency, which we accept and we will work on. But it was absolutely essential, given the criticisms historically of CQC, that we raised the bar on the quality of the staff that we were recruiting. That is what we have done, and the consequence of that is that it became harder to recruit people. There was a trade-off here: do we hold a standard and recruit people to the standard, or do we go for a lesser standard? I have gone for holding the bar at the standard, and that means that we have got vacancies.

Q66 Stephen Phillips: Well done you. You have also spent £17.2 million during the period covered by this Report on contractors. How much public money has been wasted because you did not have the staff in house? How much would it have cost to have that function in house which we have had to pay £17.2 million to contractors for?

David Behan: Not all the £17.2 million has been spent on people doing inspections, but because of the pace at which we have had to move, we have needed to have some help. We had a question earlier about whether we have all the intelligence that we need[2].

Q67 Stephen Phillips: Mr Behan, forgive me; I am a stickler for having an answer to my question. That is what the function of this Committee is. How much would it have cost if

[2] Note from witness: "Of the 17.2m spend on contractors, none of this was used to pay for inspectors/inspection staff. This was allocated transformation money to implement the new strategy and the contractors were used to fill temporary posts in change, policy and admin support etc., which were necessary to develop and roll out our new methodology, with the appropriate IT etc. to support it.

the functions that those £17.2 million-worth of contractors were performing had been in house?

David Behan: What I am trying to say—I am not trying to digress; I will give you a straight answer—is that the issue is: do we have all the skills to do the things that we need to do in development and setup, and should we have those people on our books permanently? The answer to that is no, so there are times when we will have to buy in some skills to help us to do something. If we go into a hospital to look at paediatric cardiac surgery, I cannot have a paediatric cardiac surgeon on our staff for a full year. We are going to have to bring people in. The same is true on things like information systems and technology. What we need to do is blend. Would it be good if I had got more people earlier on our books, and would we have spent less in terms of bank? The answer is yes.

Q68 Stephen Phillips: Looking at that £17.2 million, how much of that figure represents cover for the fact that you did not have these 600 posts filled that you are seeking to fill now?

David Behan: Very little of it. That £17.2 million has largely gone on helping us in terms of changed methodologies—we need to go through all of them—and work on our website. There was an awful lot that was about information systems.

Q69 Stephen Phillips: I do not want to tax you, but is it really very little? If we look at paragraph 2.7 of the Report, there are some numbers about how the number of temporary staff has gone down, I think, to 36 at the time the report was published from 207. In fact, it looks as though you have been paying for about 161 staff that you would not have needed if you had those functions in house. *[Interruption.]* Could you just move that piece of paper away from your microphone?

David Behan: It was not a ploy, Chair. Will you just allow me to unpick that? I promise I am not digressing. Those 207 people—Robert, you will have to help me on this—I do not think were inspectors. I think they were people who were working in our information and IT sections. As we changed our methodologies—the way we inspect and the way that inspectors went about doing those inspections—we needed to change our IT systems as well. I think I am right that those 207 that are referred to in the report were the people that we had bought from, effectively, IT houses to advise us on the changes that we needed to make.

Stephen Phillips: Let's bring Robert in from the NAO.

Robert White: I cannot recall the precise split, but a majority of those individuals were assisting with IT and systems.

Q70 Mr Bacon: Were none of them inspectors?

David Behan: If there were any, Chair, I will write to you, but I am pretty clear that there were not. What we did was this. The inspectors that we do not hold full time are on our

bank, and we draw them off the bank. That is how we have done it. Or, to your point, we have run vacancies.

Q71 Chair: If you look at figure 4, which is a very instructive and dramatic diagram of what you are facing, for hospital inspectors you have got 55% vacant posts, and for mental health managers 66%. You talk about bringing in expertise from the NHS, and we think that would be sensible, but why is it so difficult to fill a hospital inspector position? It is not necessarily going to be permanent—it may be people coming in on secondment from somewhere else.

David Behan: May I really land this point? The vacancies in inspectors are a different issue from the contingent labour and the contractors we are about to bring in.

Q72 Mr Bacon: For the sake of clarity, obviously no one expects you to keep a paediatric cardiologist on your books. That would be crazy. But the 55% of posts under hospital inspectors are establishment posts—full-time posts—that are not filled at the moment. That is right, isn't it?

David Behan: That is right.

Q73 Mr Bacon: How much would the salary be for a common or garden variety hospital inspector?

David Behan: Between £40,000 and £50,000[3].

Q74 Mr Bacon: And what sort of background do they have to have to meet your skills standards?

David Behan: Basically, we are not getting an 8B nurse for that. There are a number of issues—

Mr Bacon: I was not asking what you were not getting. I was asking what sort of background they have to have to meet your standard.

Q75 Chair: Is that because the nurse is not going to go for that money to do this job?

David Behan: There is partly an issue of whether there is a financial incentive for people to move. One of the things we have done on mental health is that people have come on secondment for two years—

[3] Note from witness: The actual pay scale for inspectors is £37,228 to £44,535 outside London and £41,818 to £48,684 for those based in London.

Mr Bacon: Can we stick with hospital inspectors for a second? We will move on to mental health. I am just trying—

Chair: Sorry, Richard, we need it to be one of us at a time.

Mr Bacon: It would be really helpful—

Chair: Richard, one of us at a time.

Mr Bacon: I agree. I haven't had an answer to my question yet.

Chair: I was going to get Mr Behan to answer that. He was just finishing the answer to that other question.

Mr Bacon: He was actually answering a different question, which I had not asked.

Q76 Chair: He was answering my question. Mr Behan, could you answer Richard Bacon's question, please?

David Behan: I am very sorry if I haven't, Richard. How did we get to the number of inspectors we needed? We sat down and we worked out how many inspections we would need to do in a year.

Q77 Mr Bacon: Again, that is not my question. With respect, I will ask questions, and if people think I haven't asked the questions that they need the answers to, they can ask different questions. I am simply interested in this: 55% of establishment posts for inspectors are not filled—you have agreed with that statement. You said it was £40,000 to £50,000 to pay a person to fulfil such a role, so people looking at the adverts are looking at a £40,000 to £50,000 role. I was simply asking what sort of background a person would have to have. Presumably there is more than one background that might be suitable, so what sort of background would a candidate who was likely to be successful have?

David Behan: The vast majority are either nurses or people who have worked in management—they might be graduate trainees who have progressed into management jobs in a hospital, or they could be people who have been involved in corporate and clinical governance in a hospital.

Q78 Mr Bacon: So the vast majority are likely to have a nursing background?

David Behan: We are only recruiting people into these posts from a healthcare background.

Q79 Stephen Phillips: It was tempting during that exchange to point out that you had both interrupted me, but I did not. Attached to your report to the board last week—you will obviously have seen this, but I do not know whether Dame Una has—was the abridged

version, for the board, of the monthly performance and finance report. Do you remember that?

David Behan: Yes.

Q80 Stephen Phillips: And that contains graphs of inspection targets in each of the three areas for which you are responsible: adult social care, hospitals and primary medical services.

David Behan: Yes.

Q81 Stephen Phillips: I just wanted to look at those numbers together, Mr Behan. If we take adult social care, on the trajectory you have given to the board, which was already a deferred trajectory, you should by September 2015 have inspected 5,992 providers. You have inspected 4,487; the total number you are supposed to have inspected by next March is 13,286.

David Behan: Yes.

Q82 Stephen Phillips: So you have done about a third, you are behind the trajectory that you gave to the board and you are way off meeting the target for adult social care inspections by March of next year, aren't you?

David Behan: Yes.

Q83 Stephen Phillips: Thank you. If we look at hospitals, you have managed to inspect 75. On the trajectory, by this point that should have been 132. The total number you are supposed to inspect is 585. Now, as I understand this morning's press release, you are a little bit more confident that you can pull us back to the trajectory and get to all 585 hospitals by March 2016. Is that right?

David Behan: As a consequence of the review we did to present this work to the board, we think we will hit what we committed to do, which is to do all acute hospitals by March, and community and ambulances by June.

Q84 Stephen Phillips: I think you can add mental health trusts to that as well, on the basis of your press release this morning. If we look at primary medical services—GPs, if you like—you should be doing 5,087 inspections by March next year. The trajectory was 1,924, and you have done 1,217. Again, you are way behind, aren't you?

David Behan: We are, yes.

Q85 Stephen Phillips: Are you aware of this, Dame Una?

Dame Una O'Brien: We are aware of the fact that we set an ambition for the organisation and that it is not meeting how we would like it to be. However, I think the commitments that David has given: we do know that he has signed up to them. Obviously, we want to do more; we really do. I think we have got this balance between the quality of the inspection—you heard some of the issues earlier on about making sure that you get the right people in there that make the right judgment. The last thing I want to do is get into a tick-box exercise around inspections where I get the wrong people going in and making poor judgments.

Q86 Stephen Phillips: I follow all of that. I don't want to interrupt you, but we are back to the fully effective regulator thing. It should have been fully effective, you thought, by 2012, when it was set up in 2009. You came before the predecessor Committee, when, frankly, it was a complete shambles, three years ago. We are now three years down the line and still the targets are being pushed out for the inspections of critical facilities: adult social care facilities, where there might be another Winterbourne View; acute hospital trusts where there might—God forbid—be another Mid Staffs. We just don't know, because all of these targets for inspections are being pushed out further and further and further. The CQC is not at the moment functioning as an effective regulator, is it?

Dame Una O'Brien: I want it to be more effective at what it is doing. In the midst of the three years we have changed the regulatory regime. We have fundamentally changed what it does, so we are not even comparing the same thing. We have got a much stronger regime. Of course I want all of those trajectories to be met.

Q87 Stephen Phillips: But they are not going to be. You have just heard from Mr Behan. We may get acute trusts; we are not going to get adult social care providers and we are not going to get GPs.

David Behan: Are we effective—

Q88 Stephen Phillips: That is not the question, Mr Behan. Are you functioning as an effective regulator today, to what you were supposed to be doing, what the predecessor Committee was told three years ago—where we would now be?

David Behan: Let me do this a different way. What I also said to the board was if you work out how we are going to miss the target by the end of March it will be a 6% miss in adult social care and an 8% miss in primary medical services. What we have said is we will work hard to get that back in the way that we do this, but we never committed to have done all inspections by this particular time. What we said is we would apply this new methodology over a three-year period to September. What we are committing to do, and what we are building to do, by recruiting people, training them, making sure they go, doing our quality assurance, is ensuring we are in a position so that you as politicians and people in the House

can have confidence in what we do and the judgments we arrive at: so the public can and so providers can. But we never said we would do all the inspections until September 2016.

Q89 Stephen Phillips: Because if I look at the graph it implies that you will do them by March next year. Is that wrong?

David Behan: We regulate three sectors and for primary medical services and adult social care we said we would complete the inspection programme, the roll-out of the new inspection methodology, by September 2016. In acute healthcare we said we would do all acute hospitals by April 2016, community, mental health and ambulances by June 2016 and independent healthcare by December 2016.

Q90 Stephen Phillips: Let us move on. I want to look at funding. You are being asked to look at making savings, because you have been asked to potentially make reductions to your grant in aid—that is the money you get directly from the Department of Health—of either 25% or 40%. That is right, isn't it?

David Behan: It is.

Q91 Stephen Phillips: And do you remember what you said in your report to the board last week about that?

David Behan: I do.

Q92 Stephen Phillips: What you said is that "Undoubtedly, with CQC being asked to consider 25% and 40% reduction in 'grant in aid' there will be implications." Those implications are that inspection dates, or targets, when you have finally inspected everybody, are going to be pushed out even further. That is right, isn't it?

David Behan: That is one of the consequences. If that is how it works, if I have got a 25% reduction—most of my costs are in people—that will mean I will have fewer people. If I have got fewer people that will mean we will be able to do less. It is a pretty straight equation that we get to that. That was exactly the argument why we were given additional resource and we have been recruiting additional people.

Q93 John Pugh: Can you pass your costs on to the providers themselves?

William Vineall: They would do and they would do more of it.

Q94 John Pugh: And you are free to raise those costs as you wish.

David Behan: No, we are not free to raise those costs as we wish. We are obliged by regulations to consult, and the ultimate decision is the Secretary of State's. We are on a trajectory, if I can use that phrase, of full-cost recovery, and we have been since I took the job in 2012.

Q95 Chair: So is it 9% in the past year or the past three years?

William Vineall: It is 9% last year. It was £10 million on fees—1% is about £1 million, so it is a 9% increase.

Q96 Stephen Phillips: Dame Una, you heard that. I do not know whether you are hearing that for the first time, but they are behind already. They are not, Mr Behan accepted earlier, going to meet their own trajectory targets for inspections. The Department is considering imposing a budget cut to the grant in aid of 25% or 40%, which will push the targets out further, at the same time as—we will come back to this—you are imposing further requirements on the CQC. It is a disaster, isn't it?

Dame Una O'Brien: The first thing to say is that David set out the dates by which the inspections will be completed, and I accept those. Secondly—we talked about this in a different setting earlier on—every part of the Government machine, whether it is inspectors, non-departmental public bodies or Departments themselves, has been asked to model as part of the spending review a reduction in overall costs of 25% or 40%, and that is the basis on which the CQC has been asked. It has not been singled out one way or the other.

Q97 Stephen Phillips: I am not suggesting that it has, but you must be aware, as a result of what you are hearing today, even if you have not heard it before, that one arm's length body of Government that cannot have a 25% or 40% cut is the CQC. That is right, is it not?

Dame Una O'Brien: All of the information that organisations put back into the host Departments will be fed into the discussions about the spending review. It is not my place to make a judgment about what will happen on the outcome of all that. What has been important about that exercise is that it has forced everyone to look in a more radical way at how they use resources. The evidence from the private sector is that you only make transformational change around efficiency and use of resources if you look at reductions of around 20%, so illustratively the exercise is important to understand where new ways of doing things could result in lower cost, but that is a generic point. The specific requirements on each of the Department of Health's NDPBs will be looked at with great care by the ministerial team when the decisions come after the spending review to allocate money to the different organisations. I point out that we raised significantly the amount of money available to the CQC following the challenges of 2012 and the recommendations of this Committee.

Q98 Stephen Phillips: It is a comment, because I know you will not be prepared to tell me what your advice will be, but the advice to Ministers must be that this is one arm's length body that cannot make cuts.

Dame Una O'Brien: All of the evidence, not only from the organisations themselves, but from outside and from Ministers' own views, will be put into the pot when those decisions are made, depending on the outcome of the spending review as a whole.

Q99 Stephen Phillips: Have you read the consultation that CQC published this morning, "Building on Strong Foundations", yet?

Dame Una O'Brien: I am aware of it; I have not read it in great detail.

Q100 Stephen Phillips: Let me tell you what Mr Behan says in his foreword. Among other things, he says, "This document sets out the challenges as we see them and, because we do not have the resources to do everything we would like to do, some of the choices we face in considering how we carry out our role." What is essentially being said is that the CQC does not have enough money to do what it wants to do at the moment, let alone to make further cuts as a result of a reduction to its grant in aid.

Dame Una O'Brien: David can expand on what he said, but all I can say is that in the midst of reductions for many other parts of the national system, the Department of Health has prioritised giving resources to the CQC in the past three years. Where many others took no increase or a reduction, money has been moved out of other areas to give additional resource to the CQC. Of course, the challenge, as David said, is to make the best use of that money when they have got it. All these arguments, I know, will be fairly weighed. I think William wanted to come in on that point.

William Vineall: I think one of the things they are trying to say in the report that has come out today is that they need to pick up on some of the issues that we heard about from the people who gave evidence before us: consistency in application of the new model; focusing on efficiency; responding faster when concerns are raised; publishing reports on time; and catching people's experience as they move between services and so on. Some of those things, I think, would enable the CQC to do the job at the same quality and more efficiently. That is a challenge that everybody has got to face, given the spending situation.

Q101 Stephen Phillips: Let's go back to staffing. You will have read the section of the NAO Report dealing with staffing resources. Your own staff think that they are under-resourced, don't they? Some 53% of staff who responded to your last staff survey said that what would most improve their morale was having the right staffing resources to do their work. In other words, they do not think that they have got the right staffing resources to do their work at the moment.

David Behan: Yes, and again we have laid that out a bit. We are absolutely transparent about the vacancies we have had and we have been on a campaign to recruit staff to do the job. One of the reasons why you are questioning on the trajectories and what we had

hoped to have achieved, the gearing that has affected our ability to do that is not having sufficient staff.

I think we need to be more efficient and more productive. You quoted a paragraph from the publication this morning and the paragraph above that says that we need to play our part in becoming more productive and more efficient, and I believe that we do. So we have got a role to play. But we calculated at the beginning of the year, and I think NAO colleagues commented on this: we had a model to work out how many inspections we needed to do and how many staff we needed for that. That is the number that we have been working towards and, to Una' s point, the resource that we got from the Department was sufficient to allow us to buy the number of staff to do the work that we needed to do. The problem we have had is being able to recruit people of the right calibre to do the job.

Q102 Stephen Phillips: That is one problem. I will finish on this and then let colleagues in before I start again. The other problem you have got is that you predicted your staff turnover would be 5% and it is actually nearly 8%. What are you doing about that?

David Behan: Yes, we did predict it to be at 5% and it is 8%. If you get behind those figures—I cannot remember them off the top of my head—a number of those are retirements. If you look at the figures, a number are people who have worked for us for over 10 years. And I think we have got a number of people who, quite frankly, did not want to apply the new approach to our inspection methodologies and are leaving, whereas the new people—

Q103 Stephen Phillips: Those figures are for last year. Has it got better or worse? We do not know because that is not in the public domain. Is it still at 8%?

David Behan: The performance report, which will go to the board in November for the first two quarters, will actually talk about—from the top of my head—staff turnover being at about 8%[4].

Stephen Phillips: So it is still at 8%.

David Behan: Yes.

Q104 Mr Bacon: You have got 145 hospital inspector vacancies and the vast majority, you say, get filled by nurses. We have just had evidence from Melany Pickup who trained as a nurse 25 years ago and is now the chief executive of a foundation hospital. The median salary of a nurse is £22,875—I am looking at payscale.com—and, for the first five to 10 years in this position, pay increases modestly, but any additional experience does not have a big effect on pay. You could recruit experienced nurses on considerably less and offer them a post at £40,000 to £50,000 with the possibility of spending a few years with you and then going on into senior management in hospitals and possibly ending up like Melany Pickup as a chief executive of a hospital trust. It ought to be an extremely attractive possibility. There are over 400,000 nurses in the UK, so why can't you recruit?

[4] Note from witness: Staff turnover is currently 8.9%.

David Behan: We are recruiting.

Q105 Mr Bacon: You have got 145 vacancies—55% of the posts are vacant.

David Behan: To your challenge to me earlier, as of last Friday we were working in hospitals to get, by the end of quarter 4 2015-16, 251 people in. Ultimately, we need 263 people in hospitals and as of today we have got 143.8 people. That is 67% occupancy. That means we are down 33%.

Q106 Mr Bacon: How many inspectors have you not got that you need? The Report says 145.

David Behan: Yes. At the end of quarter 3 this year, I want to be at 215. So that says that I am down by about 70.

Mr Bacon: You have 70 fewer than you need.

David Behan: Yes.

Q107 Mr Bacon: How soon do you expect to fill those 70 vacancies?

David Behan: We have got recruitment activity going on at the present time and a number of interviews are fixed. I expect to get a number of people into those vacancies over this next period of time.

Q108 Mr Bacon: How soon do you expect to fill those 70 vacancies?

David Behan: All 70 vacancies?

Mr Bacon: Yes. When will you get to establishment for hospital inspectors?

David Behan: Our plan is to get to full establishment of 263 by the end of quarter 1 in 2016-17.

Q109 Mr Bacon: Quarter 1 in 2016-17. In other words, April next year.

David Behan: Yes.

Q110 Mr Bacon: You mean June next year—so nine months before you get up to that level.

David Behan: Yes. I expect to be at—

Mr Bacon: Blimey. It seems rather slow to me.

Q111 Deidre Brock: On Mr Phillips's point, what are you doing about staff retention? The turnover figure does seem quite high at 8%.

David Behan: Go way back to the problems in the CQC. Did people feel supported? Did they feel clear about their purpose? Did they feel that they had access to training and development? The answers to those questions in the staff surveys were no, they did not. We have just run a staff survey. The results have improved year on year. We have still challenged in supporting staff to do the job that we are asking them to. All new staff go through a corporate induction and then a six-week role-specific induction. If they are inspecting hospitals, it will be specific to the task of inspecting hospitals—adult social care and so on. They are supported to do that. We offer mentors and buddying support so that people can begin to develop.

Q112 Deidre Brock: So when were they introduced and when do you expect to see that start to affect your retention figures in a positive way?

David Behan: Of the 563 job offers that we have made, 469 are actively engaged in carrying out inspections now and 94 are in what we call the welcome process—going through the corporate induction—and they will work their way through. We have a sequence of interviews scheduled over the next few weeks. It is a rolling, ongoing programme. Every two weeks we have a corporate induction. I personally attend each one of those. On average, there are about 50 people at each of those sessions. We have a rolling programme and we are increasing the numbers of staff.

Q113 Deidre Brock: So by this time next year, there should be a difference in that staff retention rate. You are expecting that and that is what you will present to your board.

David Behan: Yes.

William Vineall: The reason for emphasising the need to do all of the training that David mentioned is that we know from the first incarnation of the CQC that part of the reason that the inspections were not expert was because people were not sufficiently trained. I accept your point—

Q114 Stephen Phillips: That is the recommendation that was made, Mr Vineall, and it was acted upon, for which everyone deserves credit. I just want to try to finish this topic before we have to vote at 4 o'clock. Quite apart from these staffing problems, it is pretty clear that the CQC is not functioning in the manner that it was intended to as a regulator either. There are quite a lot of examples I could take, but paragraph 2.12 of the Report shows that the Department of Health told the National Audit Office, in terms, that CQC was not using the enforcement powers that Parliament gave it in the Health and Social Care Act 2008. There is another way of putting that, which is that quite apart from the woeful failure to meet

the inspection targets of this supposedly fully functioning regulator, the CQC does not know its own powers. Its inspectors do not know what they have the ability to do. What do you have to say about that, Dame Una?

Dame Una O'Brien: We have changed the regulatory regime. That has been the most significant thing that we have done in the past three years.

Q115 Stephen Phillips: I am sorry; you told the NAO that the CQC was not using its enforcement powers from the 2008 Act in the new regulatory regime. In other words, it is not doing its job.

Dame Una O'Brien: It is doing its job.

Q116 Stephen Phillips: Not as regards enforcement.

Dame Una O'Brien: It is identifying hospitals that need improvement or are inadequate. It is putting hospitals into special measures. This has never been done before. We actually have hospitals coming out of special measures as a result of enforcement action. That is just that example. William can give others.

William Vineall: It had made little use of the powers because the way they were set up under the central standards did not work because they had to issue a warning notice before they could prosecute. We changed that. We introduced new regulations in April this year. They do away with the warning notice, and mean that you can move directly to prosecution and make it much clearer that you can do that in cases where there is apparent harm. All that was in response to Robert Francis's recommendations. There was a difficulty with the construction of the original regulations. We have changed that and they can now be used more fully.

Q117 Stephen Phillips: Mr Behan, do you think that is the case? I noticed that on the "What we do" section of your website, you say, "We take appropriate action if care services are failing to meet our standards." That is the ninth bullet point under "What we do". Yet, here is the Department of Health telling the NAO that the CQC is not using its enforcement powers.

David Behan: The facts in the report you referred to—it will be in the public report to the board as well—are that in 2014-15 we took enforcement action in 1,179 cases. In 2013-14, enforcement was 4% of all our activity. In 2014-15, so far, it is 7%. So we are increasing the amount of enforcement action we take, not in an actual sense, but as a proportion of our activity, and as Una has already mentioned, there are 14 hospital trusts in special measures. That has never, ever happened before. Ten of those trusts have exited from special measures[5].

[5] Note from witness: To clarify, there are currently 14 hospital trusts in special measures. A further 10 trusts have been placed in special measures and have now exited. A total of 24 trusts have been in special measures at some point.

The evidence is that where we are taking enforcement action, improvement is arising as a result of that. One of the functions that we have got is to encourage improvement.

So I do believe that we are taking more enforcement action. We are using the palette, if you wish, of enforcement action. We had not previously taken issues with spot fines. I think we have taken 12 to date this year. So I think we are using the palette of enforcement action more than we have done hitherto. A number of homes have closed as a result of the action we have taken. A number of general practices have closed as a result of the action that we have taken as well. I think we have got a tougher regime, and I think we are clear about taking action where we find unacceptable care, and I think we are clearer—this goes back to the questions at the beginning—about the role that Monitor and TDA—NHS Improvement—will play in supporting improvement in those trusts who require improvement. The whole definition of "require improvement" is that they need help to improve the quality and safety—

Q118 Stephen Phillips: Thank you. I will move on to a different topic. Dame Una, the Chair has already discussed this with you a little. Since last April, CQC has been responsible for overseeing the financial health of difficult-to-replace providers of adult social care. From next April it will also start evaluating hospitals' financial efficiency—yes? Why have you given CQC these additional responsibilities at a time when, as we have established—and we can look at your evidence on this—it is still not functioning as an effective regulator?

Dame Una O'Brien: William can comment in more detail, but the first point is very specifically to do with care providers, were they to exit the market or not be available to—

Stephen Phillips: I know what they are. I asked you why you had given the CQC these additional functions.

Dame Una O'Brien: Because they are in the best position to be able to fulfil that function. That is a very specific piece of work, where we have got a much better regime for monitoring the finances of the 46 providers that are in that regime.

Q119 Stephen Phillips: Let us pause there and take that one first. Mr Vineall, I will come back to you if I need to. Mr Behan, you identified in autumn 2014 that in order to carry out that function you would need to recruit senior financial capability. That is what the NAO tells us in paragraph 2.19. You started a campaign to recruit the relevant expertise, and yet we read in paragraphs 2.20 and 2.21 of the NAO Report that none of the necessary personnel had been recruited when you took over these responsibilities last April, that the Department has had to share those responsibilities by overseeing five of the largest providers of adult social care on a temporary basis, and that you would have to use consultants. Dame Una says you are the people best placed to do it. Did she know that you did not have the people in place in April 2015 when the responsibility transferred to you?

David Behan: We have a very open relationship with the Department, so did she know? Yes. The position today is that we recruited a head of healthcare lending from RBS—

Stephen Phillips: I know you have got them now. Please stop answering questions that I am not asking. I just asked you whether the Department of Health knew that you did not have that expertise in place.

David Behan: Yes.

Q120 Stephen Phillips: So why, Dame Una—Mr Vineall if you really want to come in—Dame Una, you are the accounting officer, you are the permanent secretary. Why hand over a bunch of responsibility for supervising the financial health of large providers of adults' social care to the CQC if you know they have not got the expertise to do the job?

William Vineall: We consulted on this first of all in December 2012 with a choice of Monitor or CQC, and the decision was CQC. We announced it in May 2013. We deliberately, in 2013-14, did not press CQC on the development of this because of all the other things that they were doing to get back to rights. We deliberately, therefore—the Department kept a responsibility for this function, and as we moved to April 2015 they did start to recruit the staff, and they now have four out of the five staff available. We knew this all along. We therefore had a further six-month period in which the Department retained responsibility, more or less, for the function, while the CQC was getting up to speed with the new staff. We have now handed over the baton. We have a further three-month contract that we can use, which we intend to taper to the end of December. Overall, it has actually been a three-year process to get to a position where CQC has been able to take on this responsibility.

Q121 John Pugh: What does "more or less" mean? Who would have been responsible, had something gone wrong?

William Vineall: We would have been responsible until the end of September.

Q122 John Pugh: Okay—legally? In every sense?

William Vineall: We were very clear about that when we set it up. The reason we put the function in CQC, having consulted, was that CQC is the only organisation that really has an oversight of social care, and we had a very big risk to deal with. We had learnt from the Southern Cross issue in 2011 that if large providers go bust, the people they care for—30,000 in the case of Southern Cross—can end up on the street. That is probably not a risk worth taking, and therefore it was appropriate to put the function in CQC as the organisation with the best knowledge of social care. We have done that. We did it over a three-year period, and it is now in place.

Q123 Chair: Can I bring in the Comptroller and Auditor General?

Sir Amyas Morse: I am not trying to find fault with what you are saying, but I thought what was said earlier was that CQC would look at the efficient use of resources and Monitor would look at the balance sheet viability of entities. You have just described looking at the

financial viability of an entity, and I would have thought that that, almost by definition, is a Monitor activity, is it not? You see why I am asking the question.

William Vineall: That is why we consulted on it. I was doing that policy at the time, by fluke. We consulted on it, and one of the arguments put forward was, "Monitor knows about markets; it should do it." The other argument put forward, not least by Monitor, was that they did not know about social care so they should not do it, and that was played out in the consultation.

Sir Amyas Morse: You described CQC's role rather differently in earlier testimony to what you are now saying, if I may say so. You described it as having a more operational bias, and now you are describing it as being about the financial sustainability of entities. Which is it? Which do you think you are responsible for, David—the viability of entities or examining the efficient use of resources?

David Behan: The legislation about our role is pretty clear: we have a responsibility for quality and safety. Section 3 of the 2008 Act says we must have regard to the "efficient and effective use of resources" in the delivery of those services. It has been in since 2008. It was in with our predecessor bodies. As Una said, it should arguably have been done earlier.

Sir Amyas Morse: But that is not viability of the entity; that is efficient use of resources.

William Vineall: The social care powers have separate responsibilities that were taken in the Care Act 2014 and gave something specific, as Una said, to CQC about the oversight of social care. The efficiency work being done on the NHS is based on the initial 2008 legislation that talks about efficiency and effectiveness of services, so they operate to different pieces of legislation and are slightly different things.

Chair: I think we are all very confused, as I said at the beginning, about what the roles of all these different bodies are.

Q124 Caroline Flint: The discussion about what responsibilities the CQC should have, and whether that is the quality of services or financial monitoring, is one thing, but Mr Vineall, you kept saying that you consulted and took a decision to pass these responsibilities over, knowing full well that CQC did not have the capacity to fulfil the functions being handed over. Whether it is about the quality of services, the CQC's ability to inspect when it is down so low in terms of staff capacity or, for that matter, the CQC now having financial responsibility, do you think it is fair to give the public a sense of expectation that the organisation is not able to deliver because it does not have the staff or skills within the organisation?

William Vineall: I don't think we gave a sense of expectation that it could not deliver. We consulted—

Stephen Phillips: There are no staff—how can it deliver with no staff?

Q125 Caroline Flint: Let me understand this better. You decide the amount of resource that will go to CQC from the Department and what it can get from providers. Part of what it gets from providers is the ability to do inspections. It cannot expect the providers to pay the fees if they are not doing the inspections, as far as I understand. You do a model of how they can deliver on inspections, based on a staff model of how many people they should be employing. If they are not employing those people, they cannot do the inspections and therefore meet the requirements you, as a Department, are asking of them. Is that right?

William Vineall: That was the exact logic behind why we did not give the functions overnight to CQC for the market oversight.

Q126 Caroline Flint: But it still does not have the staff resources. Am I right?

William Vineall: It has the staff for the market oversight.

Q127 Stephen Phillips: Three out of four, Mr Vineall.

William Vineall: Four out of five now.

Chair: We now have to vote, so I suggest to the Committee that we come back as quickly as possible, and as soon as we are quorate, we will resume.

Sitting suspended for a Division in the House.

On resuming—

Chair: Okay. We have witnesses and we are quorate, so back to Stephen Phillips.

Q128 Stephen Phillips: Before we go back to that point, yes, I accept that progress has been made, but although all three of you keep telling us how wonderful the new regime is, you heard the pre-panel earlier. Certainly you were in for that weren't you, Dame Una?

Dame Una O'Brien: Yes.

Q129 Stephen Phillips: We heard about arbitrary judgments being reached, about significant delays and insufficient time being given to those who were inspected to respond to draft reports, and about a lack of factual accuracies, which in one case—I think it was Warrington—resulted in there being 210 factual inaccuracies in the draft report. That is one of the examples I could have used earlier when we looked at the regulatory position. It is not working that well, is it?

Dame Una O'Brien: I think all the examples, good and bad, given by the previous witnesses are feedback that I am extremely interested in.

Q130 Stephen Phillips: That's another way of saying, "No, it's not working."

Dame Una O'Brien: I think it is working, and it will improve. That is my view. There were all those examples, and we take feedback all the time from the people who have been inspected, but it is one heck of a lot better than it was.

Q131 Stephen Phillips: It couldn't have got any worse after the Committee's previous report.

Dame Una O'Brien: My job is to ensure that the progress that has been made is sustained and that we get more down into the detail about what needs to improve. What came through quite consistently in the evidence earlier today was that the completer, finisher aspect of the inspection, the timeliness of the reports, the initial accuracy of the reports—those are things that we can absolutely see, and we will be looking for evidence of improvement on that. At the same time, you have to understand that other elements of data and information go into the reports, not solely that which comes from the inspection. The points today were very well made and I am sure that we in the sponsor team in the Department will be following up on them.

Q132 Stephen Phillips: Good. Mr Behan, do you want to comment on the same point? It arose out of the pre-panel and no one has yet dealt with it. Given what you heard from the pre-panel, do you think it is working well? They seem to be very disappointed.

David Behan: Nobody loves a regulator, so we're damned when we do and damned when we don't. Are there things that we can learn? Yes, there are. To address your point, on the timeliness of reports, we began this year—April 2015—and the average length of time it was taking to get an adult social care report out was 68 days. Our own target is 50 days and, as of last month, they were in at 49 days. That is an average, so by definition some will be too long. One of the points was about the delay between the inspection taking place and a report. Quite frankly, we have worked hard to improve that, but there is more we can do. I have exactly the same figures for primary medical services.

The key challenge for us is about consistency, and I think that was the point that was being made. Some of the delay in publishing reports is about ensuring that there are internal quality panels, which are set up and designed to check that an outstanding service in Northumberland is the same as an outstanding service in Essex, because a key issue we have been challenged on historically is how, as a national organisation, we can get consistency in our judgments. We built in some internal checks and balances to ensure that we have greater assurance, but the paradox is that that led to delays in the reports coming out. We have worked on and improved our internal systems and processes over the year, and I think we are beginning to see improvements working their way through.

Q133 Chair: We heard some delay times from the first panel of witnesses; what is your expectation about the speed and how much have you improved, if you have?

David Behan: I have said that our target is 50 days for adult social care and primary medical services. My expectation is—

Q134 Chair: Let's be clear: where are you now, as of today?

David Behan: In September this year, adult social care was 49 days and primary medical services was 67. It is different for hospitals because of the size and complexity we are looking at.

Q135 Stephen Phillips: But it is your target. If it is different, why did you set a target of 50 days if you think 67 is going to be the appropriate mean?

David Behan: Sorry, I haven't said that. I said that my expectation is that we will begin to work towards hitting our target.

Q136 Stephen Phillips: You said it is different for hospitals. I assumed you were trying to distinguish between the 49 days, which is the now figure for adult social care, and the 67 days, which is your now figure for acute hospitals.

David Behan: Sorry, I misunderstood you.

Q137 Stephen Phillips: So you are going to get it down to 50 days, but even now you might be hitting it for adult social care and you are not hitting it for hospitals?

David Behan: I don't think we are ever going to get a report out, with the complexity of looking at—

Stephen Phillips: That is the point I was putting to you: your target of 50 is wrong.

Chair: Stephen, let him finish his point.

David Behan: I would like to finish my answers, Chair. I am being asked a question and I am quite happy to help the Committee in the best way I can. I would just like to answer the question.

Q138 Chair: Exactly, please go on.

David Behan: Can I take Barts Trust? It is three hospitals and there are numerous sites. Some of the mental health trusts have upwards of hundreds of sites that we need to go into—hundreds of locations. If we are going to produce a report on a trust, we are trying to bring together intelligence from across it all. For Halton, there are two hospital sites with core services in each. Because of the complexity of that, in all honesty I don't think we are ever going to bring forward a report in 50 days, so I think we will end up setting a different target to do that.

The important issue is that we feed back at the end of the inspection so that people know. One of the changes we have introduced in hospitals is that Mike will send a letter to the trust after the inspection, where we have got concerns, so we are not waiting for the report to be produced, and the action that needs to be taken quickly can be taken.

Q139 Chair: Two questions: is the letter that goes to the trust public?

David Behan: We expect the trust to take it to the board in public, yes.

Q140 Chair: And, as Mr Phillips has been asking, why have you got a target of 50 days for a report if you are saying that is unrealistic? If you think it is unrealistic, what are you looking at as a modified target for getting a report out on a complex hospital trust?

David Behan: On average, it is taking us about 83 days to finish and publish on trusts and hospitals. I think that between 60 and 70 days is more realistic. I expect that when we do the business planning for next year on hospitals, we will be looking at a figure of between 60 and 70 days.

Q141 Chair: So two to two and a half months, roughly.

David Behan: Yes.

Q142 Stephen Phillips: Mr Behan, the only question I asked you is, why did you set a target of 50 days, given that you told us the first time that the average is 67 days and you have now said it is 83? You actually agreed with the Chair that 50 days is the wrong target. That is the only question I was asking you.

David Behan: I am sorry if I was not clear. I said that our performance in September for primary medical services was 67 days. That is where the 67 came from. I said that our performance in September for the average number of days to publish final reports for hospitals was 83 days.

Q143 Stephen Phillips: Right, but in any event we can all agree that 50 days is too short. You are the expert.

David Behan: Fifty days is too short for hospitals. I think it is about right for primary medical services and adult social care.

Q144 Stephen Phillips: Right. Can we come back to overseeing the financial health of difficult-to-replace providers of adult social care, which is the function you have had since

last April, albeit with help from the Department? From what Mr Vineall was saying, you knew months, if not years, in advance that you would be taking over that function. Yes?

David Behan: Yes.

Q145 Stephen Phillips: And yet by April—the time you were supposed to have taken over that function—you had recruited none of the relevant staff to perform it. Why?

David Behan: This goes back to the issue that, in accepting the responsibility, it was incumbent on me to make sure we appointed the right staff. The worst thing I could have done is appointed somebody who couldn't do the job. We were absolutely clear that to do the job we needed people from a financial background—people who had expertise in financial restructuring, accountants who had operated at a senior level and people with banking experience. We thought we could take the job forward with a small number of people. The team we are building is a small number of people, not a large number of people. We have been on a recruitment exercise, and we have recruited senior people from financial services, from both the accountancy and banking sectors, to assist us in doing this. There was a risk share with the Department in relation to this. Part of the question you asked me was about consultants, and we recruited KPMG, which had expertise in this, to assist us in the set-up of the role and in some of the analysis we needed to undertake.

Q146 Caroline Flint: Do you think it would have been better if you had recruited staff and inducted them into the organisation before you accepted a formal sign-over date?

David Behan: You are always wise in retrospect. This was geared by the changes that were introduced through the legislation, and the way the legislation came in. So it would have been ideal, Caroline, yes. But the key issue, from everything I have learned in my career, is that you don't fudge the staffing issues. If you make the wrong decisions on staffing and don't get the right people in, you are going to end up in difficulties. The right thing to do, in my view, was to hold our nerve and make sure we got the right people. While that was going on, we recruited KPMG, and the Department kept hold of the oversight of the top four providers, where the risk was.

Q147 Caroline Flint: Given all the problems you had in recruiting staff on the quality inspections side of your responsibilities and what we have just heard about the targets you set as an organisation for getting reports done, I would have thought that there had already been a bit of hindsight within the organisation, so that when you negotiate with the Department of Health you can get a better outcome.

My concern is about the public's expectation. We all hear a huge hurrah about what is going to be done, and then, unfortunately, when public bodies let the public's expectations down, they can always come up with a reason: "We didn't have enough staff", or, "We didn't do this." Isn't part of the planning of all this to make sure you can hit the ground running and deliver the public's expectations as best you can?

David Behan: You are absolutely right, it is part of my responsibilities to do that. My staff and I have worked incredibly hard to set up that scheme and to make sure that it is in place with competent staff to do the job that we are asking them to do. I do not pass legislation.

Q148 Caroline Flint: No, but the Department of Health, despite the fact that you had not got the staff, expected you to take the duty over at that time without the staff to do it.

David Behan: No. I come back to the issue about there being a shared approach to this. The Department knew that we did not have the people in place to do the job that it had asked us to do—that I think this House asked us to do actually, because it was part of the Care Act. What we agreed with the Department was that it would keep the oversight that it had had since Southern Cross in relation to the top—in terms of volume—providers of adult social care where there was risk. The Department would continue to do that and we were to work with them in relation to the handover of those responsibilities. The metaphor that I would use is of a baton being handed from the Department to us, so we are taking on those responsibilities—the baton was to be handed over to us when we had the capacity to do that. The Department took the risk that was implicit in us not having the staff in place; in my view, that was a shared risk, but we had a plan to hand over that baton. I believe that we managed that successfully and those people are now in place and, to come back to an earlier question, being effective. "Effective" is, "Are they doing what they have been set up to do?", and "efficient" is, "Are they doing it in all cases?" I believe that we are being effective.

William Vineall: The Care Act was introduced in April 2015, because the previous Government wanted to get the Act introduced, including a lot of the other changes to the CQC. We could have said, "Because we introduced the Act in 2015, every single thing goes over to the arm's length body at the same time", but we did not—we managed the process, as David says, and we had this six-month transfer period.

Q149 Stephen Phillips: The problem with all of this, Mr Behan, is that next April you assume responsibility for the financial health of trusts. That is the nub—

Dame Una O'Brien: No.

Chair: The use of resources.

Stephen Phillips: All right, the use of resources. The track record from last April is that you knew you had to get the right staff in place and you very rightly and properly said that you wanted to get appropriately qualified people in place, and yet you did not have those people in place when the responsibility transferred. Now we have another responsibility that is being imposed on you by the Department, next April, but how can we be confident that you will have the right people in place by next April to assume the responsibility?

David Behan: By inviting me here for these sessions, so you can scrutinise me in terms of what we are going to be doing in relation to it. I feel accountable to you; I feel accountable to the people whom we regulate; and I feel accountable to the staff, as well as to the Department. We have set out what we will do in this morning's publication, "Delivering

cost effective care in the NHS". So we have set out our thinking about how we will go about doing this. You asked me earlier about how we will work with Monitor, with the TDA and NHS Improvement. We have set out in here that we will work with them and we will use the information that is generated by other organisations, picking up on some of the things that were said this morning about one single dataset, to move that forward. I do not have in my head that we need lots and lots of people to do this. I think it is largely an analytic role to be undertaken and we will build it into our inspections.

Q150 Chair: May I ask the NAO to come in on this point? Do you agree with what Mr Behan has just described?

Robert White: In terms of whether it is just an analytic role? I think the document that was published today raises a number of questions about avoiding duplication and making sure that there is a clear distinction between what Monitor does, with its financial responsibilities to risk-rate trusts, and what the CQC intends to do on measuring the efficiency in use of resources. Coming back to Amyas's point about sustainability and viability, those are two distinct things. So the document raises a number of questions. It is very early in terms of having solutions in place.

Q151 Stephen Phillips: This is really important. Do you know what this document says about your preparedness to assume this responsibility next April?

David Behan: Which document?

Stephen Phillips: The document you just held up—the "Building on strong foundations" document which was published this morning.

David Behan: Sorry, we published two documents today.

Stephen Phillips: The one that I am looking at is "Building on strong foundations". Under "Assessing how providers use resources" it states: "On 15 July 2015, the Secretary of State announced that CQC would start to assess NHS trusts' use of resources." This is on page 21. It continues: "This means we will begin to check that hospitals are using their resources (for example staff, equipment and facilities) in the best way possible." Then it says: "We will begin to pilot our approach in NHS acute trusts from April 2016."

David Behan: Yes.

William Vineall: And in the other document—

Q152 Stephen Phillips: Mr Vineall, I have not asked a question yet. Mr Behan, what is said in this document is that next April, you are going to begin to pilot your approach to a responsibility that will be transferred to you next April.

David Behan: Yes.

Q153 Stephen Phillips: So you are going to pilot something after April, when you are assuming the responsibility in April. Is that right?

David Behan: We set out in the other document we published this morning, which goes into more detail, the timeline for what we are going to do. We will meet key internal and external stakeholders to develop the methodology.

Q154 Stephen Phillips: Mr Behan, I am asking you a different question. Listen very specifically to the question. Next April, you are going to begin piloting your approach to assessing NHS trusts' use of resources, in circumstances where you are assuming the responsibility for that next April.

David Behan: What we say in page 13 of the document that we also published this morning is that from January 2017, we will have the full roll-out of the use of resources assessment in NHS acute trusts[6]. We will begin it in April, and the full roll-out will take place from January 2017. It is a gradual build-up of developing the methodology, consulting on the methodology, trialling it and piloting it. When we have a methodology that works, it will be rolled out in full from 2017. We do not occupy a space where we think we can design this from a standing start and implement it from April. It will be developed and piloted.

Q155 Stephen Phillips: Again, the responsibility will transfer to you in April. You will not actually be in a position to do it properly until the following January. I might add, because it has been mentioned a number of times, that this is a statutory responsibility imposed by section 3(2)(c) of the Care Act 2014. The responsibility transfers to you next April, but you have said, in terms, that you will not be able to do it until the following January[7].

David Behan: I have said that, and I have laid out quite clearly that we will develop a methodology of how we are going to do this. Any organisation that assesses other organisations needs to engage with those organisations, build the model and operate on best practice. You challenged us earlier about avoiding duplication. We need to make sure there is no duplication. What we will do is build a model using core production, working with the people we will be assessing to ensure we have a viable, effective model that allows us to move forward.

Q156 Stephen Phillips: The way I understood government to work—of course I am a novice at this—is that you have a pilot to see if it works, and then you transfer the

[6] Note from witness: Currently there is no other body which is carrying out this function, although other bodies have done so previously, notably the Audit Commission, the Commission for Social Inspection and the Healthcare Commission. This is in the Health and Social Health and Social Care Act 2008 and is outlined in various places including s3.

[7] Note from CQC: Section 3 of the 2008 Act sets out CQC's responsibilities in terms of 'the efficient and effective use of resources in the provision of health and social care services'. No other body is currently carrying out this function to transfer to CQC—it is the application of extant legislation.

responsibility. You do not transfer the responsibility, have the pilot, hope it works and then have full effectiveness from a period eight months later. Is that wrong?

David Behan: I think one needs to distinguish between two things: the responsibility and the methodology that will be used. What we are saying is that we are clear what our responsibilities are; they are laid out in statute. A number of you will have contributed to that statute's coming into being. We are saying that we will develop a methodology, working with others. We have advisory groups where we have what we think are some of the best brains available in relation to how to assess the use of resources and value for money, and we will take those techniques and build them into a methodology that we will use.

Q157David Mowat: Listening to your evidence, Mr Behan, I have been struck by two things. One is that your Department is always struggling for people. You are behind with all that, and it is causing an issue about how quickly you can take up some of the things that we are talking about, as well as do inspections in general. The other is how rigorous you have been in your evidence about how under no circumstances you will hire the wrong people. You have said that very strongly, and all the rest of it.

I wonder whether those positions are entirely consistent. On one hand, you have got this responsibility, which you have taken, and you need this many people, but you do not want to hire them, because you are imposing a standard. Is your position on that entirely tenable? I am not saying that you should be hiring substandard people, but there is a big grey area when you hire people as to whether they can grow into the job, become effective inspectors on the job, and all that goes with that. I wonder whether you and your organisation have that balance right.

David Behan: We began this session by being reminded that this Committee in 2011 viewed CQC as not being fit for purpose. One criticism was in relation to the quality and standard of staff in CQC at the time, and it was incumbent on us, when I took the job in 2012, to be absolutely clear about the quality of staff we would recruit. I do not think it is incongruous; I think it is entirely consistent that we hold a line on that.

Q158 David Mowat: Okay, but there is still the issue that, with a considerable shortage, you are not able to fulfil some of your statutory responsibilities. Who is responsible for the balancing process?

David Behan: Ultimately, the board of CQC and, as the accounting officer, me.

Q159 David Mowat: When you do an audit—excuse me if this is something I should know—do you use people from the organisation as part of the team under any circumstances? Is that something you ever do?

David Behan: The inspections we would do if it was a hospital—I think this was referred to earlier with the team going into Halton being 40 strong—there will be probably 10 or 15 inspectors from CQC. I return to the question of what would be the background of those people. There will be clinicians and people from other hospitals. They will be peers in effect:

doctors, nurses and managers from other hospitals. There will also be about 10 experts by experience: people from patient groups, user groups and family carers. That is the inspection team, so we have the clinical perspective, the user perspective—

Q160 David Mowat: I understand that, but what I asked was a little different. I asked, I think, would any of those in the Halton example you cited have worked for Halton and come into your team as part of the process? Obviously, that might expedite things.

David Behan: No, none of them would be from Halton because the essential issue—

Q161 David Mowat: That is a point of policy, is it?

David Behan: It is a very deliberate point of policy that our inspections are independent of the organisation and not coloured by the perspective.

Q162 David Mowat: It can be independent if you have a joint team. I understand that an inspection must be independent, but a joint team with some input from the organisation will not necessarily undermine your independence, or do you think it would?

David Behan: A number of patient groups would say it absolutely does.

Q163 David Mowat: What would you say?

David Behan: I think it does. I think we need independence. One of the issues that we need to assess when considering how well led an organisation is is to find out how effective its services are, how safe its services are and how that quality exists. I know hospitals, for instance, that have taken our methodology and applied it by using their staff or the staff of a neighbouring organisation. They have used it as an improvement tool in its own right and that is absolutely fine as far as we are concerned, but people expect our reports to be independent of the organisation we are inspecting.

Q164 David Mowat: I also agree that your report must be independent. I have been involved in audit and inspection processes and the point I was making was that it is not necessary for every single person on a team to be from outside that organisation for the overall conclusions to be independent. All I was suggesting was that, given that you are struggling to get the right complement that you would like because you can't find people out there who reach your standard, that might have been an approach. But I understand what you are saying and that is fine. Thank you.

Q165 John Pugh: A fair-minded observer listening to this long session would say that you have been charged by Parliament with a series of tasks that frankly you do not always have the personnel or resources to do. I noted in the report that one way in which you are trying not exactly to cut some corners, but to do something more than blanket inspection of the whole system is by using an intelligence-led approach, which presumably means you have analysts who cleverly analyse data and look at where problems will occur. I understand that in the acute sector and how it might work because that sector generates huge amounts of data all the time.

You are a bit exposed, though, in the adult care sector—aren't you?—which is much more variable. I note that in the Report it says that you scour websites, NHS Choices, Patient Choice and so on, to pick out where the next crisis or problem might come from.

I want to ask you about how you interact with the remnants of other inspection systems that probably pre-existed this, for example, local authority directors of social services who have some responsibilities. There are overview and scrutiny committees on most councils. There is a new beast called Healthwatch. Are there any formal links between any of these bodies and your organisation, particularly on the issue of adult social care?

David Behan: Yes.

Q166 John Pugh: How do they operate?

David Behan: Differently. We will have local meetings with directors of social services and regional ADSS, as well as at a national level. Staff from CQC will attend overview and scrutiny committees.

Q167 John Pugh: You would automatically get the minutes of every local authority overview and scrutiny committee concerning adult social care in that area. Would your analysts have that data?

David Behan: Not automatically.

Q168 John Pugh: Does Healthwatch share data with you?

David Behan: Yes. I paused on whether I have confidence on 152 overview and scrutiny committees' minutes coming in to CQC. No I do not have confidence, but if concerns are being raised by overview and scrutiny, I do think they are being referred. As we get recognised and people begin to have confidence in what we do, yes, I believe those links are there. I know my staff meet with directors of social services in a liaison role. I know that my staff are attending and speaking to politicians on overview and scrutiny committees. That is not everywhere and all the time but as we develop we are beginning to do that.

Healthwatch published its annual report yesterday.

Q169 John Pugh: It was very, very vague, wasn't it? I picked up a copy.

David Behan: There are numerous references to the local liaison between local Healthwatches and CQC inspectors, where intelligence from Healthwatch was being fed back to local inspectors, who include that in the inspections.

Going back to one of the issues that has been a theme of the meeting—Chair and John—we are prioritising in our inspection programme those inspections where we think there is risk in the services. One way we will do that is by this "intelligence" that we get from organisations such as local Healthwatch, because there is a concern. You referred to our website. I am not sure that we scour websites, but our website asks "Tell us about your care". We use that data and I believe colleagues from NAO were flagging in the Report that we need to pay more attention to that.

We have a signed memorandum of understanding with Healthwatch. I have regular contact with colleagues in Healthwatch. I believe that is a relationship that is developing and growing and is a rich source of information from Healthwatch to CQC.

Q170 Stephen Phillips: I have three final topics to finish on and I am going to rattle through them. Just listen to the question and answer it, if you would. Please look at paragraph 4.13 of the Report. This is under the heading, "Understanding the quality, outcome and impact of regulation". It says: "There are, however, still gaps in the Commission's performance information." If you drop down to the third bullet: "The Commission set a specific target for no more than 6 of the 37 measures in its published business plan."

The NAO has said it will have to come back because it does not know how well your regulatory system is functioning, which is in paragraph 3 of the Report summary. How are we supposed to know—how are you supposed to know—how you are doing when you have got specific targets for only six of the 37 measures in your business plan?

David Behan: We regularly report to our board and in public. You have quoted that back to me this morning, so we will continue to do that. Our action plan went to the audit and corporate governance committee of CQC earlier this month. We took the NAO Report to the audit and corporate governance committee. Alongside the Report were the actions that we were going to take against each of the recommendations that colleagues from the NAO made. I will now account to the audit and corporate governance committee of the CQC for how we take that forward. What we have said is that as we develop our business plan for 2016-17, we will make sure that for every one of the things that we are committing to do, there is a performance indicator that is clear and can be counted, so when the NAO comes back, I expect to be able to write, "There are x number of performance indicators that report on—

Q171 Stephen Phillips: You have identified what the problem is with measuring your effectiveness as a regulator at the moment: you have only six targets or indicators in relation to the 37 measures in the business plan. The fact that you are going to change that is an acceptance that at the moment we cannot measure whether you are doing a good job or not.

David Behan: We were challenged on how transparent we were as an organisation. Goodness me, we're transparent! We report everything to our board—what we get right and what we do not get right. I think I report very, very comprehensively to the board on a monthly basis. The challenge from the NAO is a legitimate one; I have accepted those recommendations. We have taken a report to the board about what we are going to do about it, and I expect to be held to account for what we both do and don't do.

On the issue of impact, we have consulted Frontier Economics about a framework for assessing our impact. We have gone to people whose job it is to do this and said, "How would you do it?" We have had Manchester University come and help us and do an evaluation of phase 1. We have commissioned the King's Fund and Ipsos MORI to look at the impact of what we do. We are trying to generate the material so that I can come here and say to you not "This is what we intend to do," but "This is what we have done and this is what material we have." We are building that picture and I am very, very happy to account to you—

Q172 Stephen Phillips: I am sure we will have you back, Mr Behan, but could I just turn to Dame Una on this point? Do you remember what you told this Committee three years and nine months ago was one of your greatest concerns about the CQC?

Dame Una O'Brien: I had a range of concerns at that time.

Q173 Stephen Phillips: Well, you identified three specifically. Let me help you with what the second one was: "performance metrics, where we definitely have more to do to be able to measure and understand the impact". That was three years and nine months ago and we are still in a position where, if you look at the first bullet point in paragraph 4.13 of the NAO Report, "The Commission does not yet measure and report on the overall impact of its regulatory activities." That was one of the things keeping you awake three years and nine months ago and it still has not been done. Why not?

Dame Una O'Brien: I think all the evidence today has pointed to a single theme—this is a work in progress. We have made great progress and we have more to do. I am not in denial about anything. I have absolutely got KPIs on my agenda as we go into the next round of the business planning—improving those in terms of relationship with the Department. David and I have often talked about the next phase in improving these performance measures. So it is on our agenda and we are going to continue to do it. I never claimed for a moment that it would be perfect.

Let me just say one more thing, because I think it is important. Alongside the position we had in 2012, what has happened subsequently is a scale of change that was not anticipated at that time, because it was before the Mid Staffs inquiry report. I do think it is important for the Committee to recall the chronology. We met here in January 2012. It was after that—a year later, I think—that we had the report from Robert Francis. That was a profound moment that caused the Government—subsequently, in September, we had the response of the Government to that report. It meant that we had a really significant change in the regulatory framework. If I stand back and look at the whole three years, that is what has occupied our attention and David's attention, going in there as the new chief executive. Things that I

thought we could do more quickly in 2012 had to be reprofiled, because we realised that we had a much bigger thing to change as a result of that.

Stephen Phillips: I understand that explanation.

Dame Una O'Brien: I think it's important to look at that perspective as against a precise thing that I said in good faith—

Q174 Stephen Phillips: I just think, Dame Una, it's a little difficult to turn around to constituents and say, "Look, this was a key thing the accounting officer and permanent secretary identified three years and nine months ago and she still hasn't done it."

Dame Una O'Brien: I have made progress. I will continue to make progress, and I will continue to be worried about it, because that is my job.

Q175 Stephen Phillips: Right. Next brief topic, if I may. Dr Pugh touched on this. This question is really for you, Mr Behan. On page 32 of the NAO's Report, paragraph 3.15, about intelligent monitoring, says you are working towards a surveillance model that is based on concerns that then trigger actions and target resources where the risks are greatest. Can you look at figure 11, please, over the page, on page 33? What the figure shows, if we look at "Inadequate or requires improvement (50 providers)"—in other words, organisations that were given that inspection rating—is that 40% of those who were given a rating of inadequate or of requires improvement were in the lower risk bands of your intelligent monitoring system. It is not working, is it?

David Behan: I believe it is. Let me say why. It is a work in progress and we will do further work on this—

Stephen Phillips: There is a lot of work in progress.

David Behan: I have looked at what they do in America, Australia and Canada. I do not believe that there is a regulator across any of those countries that is combining intelligence and inspection in the way we are using them to arrive at a view about what we do—about directing the work that we do on inspection to make sure we are inspecting those services that present more risk. If you look at independent experts, many will say that what we are doing is leading-edge thinking in relation to the combination of data and intelligence. It is not me saying that—it is other people saying that.

Q176 Stephen Phillips: Surely if the system was working, if someone was rated in the lower bands—in other words, if they were someone you should not be concerned about—when you subsequently went in for an inspection you would not find that four in 10 of those supposedly lower risk providers were inadequate or required improvement.

David Behan: The issue is whether intelligent monitoring, or any surveillance, can predict, with precision, the quality of care that people are going to use. We have built it as we move forward, and, as we have developed this, the strongest correlations between our

ratings—it is not all 150 indicators, but the strongest correlations—are on things like whether staff would recommend the trust for their family: where 50% of staff would not recommend the trust for their family, it is highly likely that in our inspection we will find the quality and safety of care to be inadequate. Others are what communication is like through the organisation, or how effective they are in incident reporting procedures. From those, we begin to get a correlation between the quality and safety of organisations and our rating.

What is critical—and this is what we said in the state of care report last week—is the relationship between the leadership and the culture of an organisation, and the quality and safety of care. The more we have worked and developed this—and I do not think that there is a regulator in the world that has cracked this with precision—the more we have begun to improve the way that we operate. Have we got the perfect system? No, we have not. Are we working at developing this and improving it? Yes, we are. I would offer to the Committee that there is not a system in the world that has got this sorted. We are developing a way of doing that.

Q177 Stephen Phillips: My final point is for you, Mr Vineall. Will you look at paragraph 3.7 of the Report, please? It says: "Work by the Commission suggests that the figures it uses to track action taken in response to communication from the public are still not robust…The latest figures suggest that one out of three safeguarding alerts is not acted on within the Commission's two-day target." That is appalling, isn't it?

William Vineall: There have been some long-standing problems with how safeguarding alerts have been reported and dealt with, and a much more rigorous system has now been put in place to handle safeguarding alerts, to have proper thresholds for how you should respond, and to respond faster. It is something that the CQC has been picking up and trying to improve.

Q178 Stephen Phillips: You are the director of quality for the Department, yes?

William Vineall: Yes.

Q179 Stephen Phillips: I do not understand how you can have a figure of one in three when someone raises a safeguarding concern.

William Vineall: Part of the problem is that the number of safeguarding alerts have gone up by a large amount. Another difficulty has been the processes in place to make sense of them in CQC. This has been to the board of CQC and new processes are being put in place.

Q180 Stephen Phillips: Do you remember that this Committee recommended that there should be a dedicated whistleblower line, when it made its report, following a session in January 2012?

William Vineall: Yes.

Q181 Stephen Phillips: The Government turned down that, didn't they?

William Vineall: We did not proceed with it at the time, but there is now a whistleblowing hotline within CQC. Indeed, that is going to help support the new whistleblowing function in the organisation.

Q182 Stephen Phillips: Right, so when the Treasury minutes said that we are going to turn down this recommendation and that a dedicated team of call handlers is enough, in response to the Committee's previous recommendation, that turned out to be wrong, didn't it?

Dame Una O'Brien: I don't think it turned out to be wrong. It was the decision taken by the Government at the time.

Q183 John Pugh: It can still be wrong.

Dame Una O'Brien: No, it was not wrong, because there was already a capability within CQC to do it.

Q184 Chair: But there is a change now.

Dame Una O'Brien: Subsequently changes have been made. As members of the Committee will recall, there have been several very significant revelations about the role of whistleblowers in the intervening period, and we have recognised that and responded to it.

William Vineall: And we wanted to ensure that the intelligence from whistleblowers is captured in the organisation.

Chair: Better late than never.

Q185 Stephen Phillips: Dame Una, a final one from me, as I want to wrap up. There is a lot of work in progress. It is not yet a fully effective regulator, is it?

Dame Una O'Brien: I wish that I could provide organisations readymade that were able to work nationally with fully competent people doing everything from day one. Real life is not like that; it takes time to do this well.

When we came here three years ago, I got a very clear message from the Committee that you do not just throw responsibilities over the fence, you make sure that the organisation is supported, that it receives resources, that it is well led and that time is taken to implement new responsibilities. I heard that very loud and clear from this Committee and that is what I have done.

I am absolutely proud of the team that has gone in there, against all circumstances, where there has been public criticism as well as a lot of external vigilance. They have got on

with the job and are moving exactly in the correct direction. My job and that of the Department is to continue to provide the right balance of support and challenge to enable them to get to where we all want to be. In this room we have a common purpose to ensure that we have a highly effective regulator.

Q186 Stephen Phillips: Which we do not have yet.

Dame Una O'Brien: I think we have a regulator that is progressively more and more effective.

Q187 Stephen Phillips: Just answer.

Dame Una O'Brien: I am sorry, but I will use my own words.

Q188 Chair: I have a couple of quick things to mop up. Please be brief because we are now over time. Accountability is a really important issue. All our constituents—all patients—find it hard to know who is in charge, unless it is the hospital, and where they can go to make a complaint. David Behan, do your teams look properly at accountability, whether it is the CCG, the GP practice, who patients can go to to complain and how well they are treated in that, and how accessible that is? Could you give us a brief precis of what you do in that respect, because it is a big issue for us?

David Behan: Our responsibilities: we do not have responsibility for CCGs, or for oversight of commissioning. What we do is look at hospitals, care homes and primary medical services and how they respond to complaints is part of what we look at when we go in. We built that methodology by speaking to people with complaints, by some of the complaints organisations, and the methodology we apply is built using that feedback.

Q189 Chair: That's great that you are doing that, but what you have highlighted there is the gap—the CCGs' accountability or oversight of that role. Dame Una, would you like to come in on that?

Dame Una O'Brien: Absolutely. CCGs are accountable to NHS England. We are currently strengthening that by developing a CCG scorecard, where we will have much greater consistency and visibility.

Q190 Chair: Will the public understand that?

Dame Una O'Brien: Absolutely, because it is going to be looking at the performance of the CCG on behalf of the local population. We are currently developing an approach, very strongly led by the Secretary of State, to ensure that the public in any given area can see how well their CCG is performing in securing good care for them.

Q191 Chair: And there will be good links through from that accountability regime to the accountability regime that David Behan's teams are processing.

Dame Una O'Brien: There is a new chapter that we have not really touched on today, but earlier witnesses did mention. It is a big challenge for CQC and all of us. How do we evaluate the quality of care when we look across and between institutions? How do we look at what is being done for a population as a whole? That is set out now in the forward look from CQC and what they are going to have to take on. They are already doing some work in the Manchester area—Trafford and Salford—to look at that. It is a really interesting challenge because accountability—

Chair: Absolutely, and it is something this Committee set out to examine, so when we have you back in a year—we will have you back well before then—but when we have the next CQC session we may well check on progress.

I have some quick-fire questions. There was anecdotal evidence from the first panel and concerns from some of those inspected that inspectors chat with people, and I have heard this from other people outside this session. A junior member of staff had a conversation with an inspector which then figured fairly highly in the report. Do you have any comments on that, David Behan? Do you think it is good practice and is it something you would accept, or would you challenge it?

David Behan: This is so tricky. When does an anecdote become a whistleblower? When does a careless comment from a member of staff in an aside become something we need to act on? I think we have to take all those seriously. Someone might perceive a comment to be an anecdote and another person might advise us of their concern that an organisation is not running appropriately. We must make a judgment.

We have already had a question about concerns and I will go back to that if I may. A concern will mean that another organisation will deal with it. We deal with 90% of alerts on the day they come in and we have introduced a new system to make sure we can do that. That is the balance[8].

On the challenges that came through, we have been very open about the new methodology on receiving feedback. I meet chief executives and chairs of health care trusts, through NHS Providers and the NHS Confederation when people say, "This was the inspection you did. This is our view of how you did."

Q192 Chair: So they are inspecting the inspectors.

David Behan: We are also trying to model an organisation that is open to feedback and to challenge and that will take that on board and use it to seek to improve the way it operates. It is difficult to do that at times. We expect people to do that, but we have to model doing that. Your challenges today are completely legitimate. The issue for us is how we can take that and improve. As Una said, you don't turn things round overnight.

[8] Note from witness: This should be 80%.

I think we have been effective and I want to get my bit on the record. We are an organisation that has been effective in what we are doing, but are we good enough at the moment? No. We have improvements to make and more work to do. But we should not ignore the significant amount of work that my staff have done to change the way we regulate health and care in England, which is completely different from what existed in 2012. It is a fantastic achievement.

Q193 Chair: I think we would acknowledge that, Mr Behan.

David Behan: But we have more to do, and we have set out today the challenges around place and pathways. I have personally been to Manchester three times. We are working in Trafford and Salford, looking at place and pathway, and we are actively engaged in how we do this in future.

Q194 Chair: No one doubts that there has been progress. Frankly, it was a disaster three years ago. I was on the Committee then and I remember that hearing vividly. It is good to see leadership determined to make a change, but you have heard from us concerns about a number of the challenges with your staffing, capabilities and extra responsibilities you are taking on. Those are all concerns. You have indicated that you are willing to grapple with those and to continue to improve, and that is good news.

I have one final point about a fact that I want to make sure is on the record because I cannot remember whether it was answered absolutely. In your consultation strategy that was launched today—the 2016-21 strategy—you said that by June 2016, all trusts in England and Wales will have been inspected under the new regime. Do you stand by that?

David Behan: All trusts, yes. That is what we are working to. Independent health care will be done by December 2016, but all trusts will be done by June 2016.

Q195 Chair: Okay.

Q196 Bridget Phillipson: Bringing together the points you were making about informing the work of the CQC in terms of oversight of clinical commissioning groups, what will the Department do to make sure the CQC can properly consider how clinical commissioning groups are performing in the outcomes of CQC inspections? Surely, the two cannot be separated.

Dame Una O'Brien: That is a really important challenge for the next phase. We haven't got the CCG scorecards yet. We are currently working on them. When they are available, populated and published, they will be evidence available to the CQC when, as I hope will happen in future, it will be able to do an overview of the equality, efficiency and economy of health care for the given population in a given locality. That has to be the vision in the end: that we can bring all of that together, as well as looking at and never losing sight

of issues involving safety inside individual organisations. After Mid Staffs and Winterbourne View, there is no going back on that.

We will have to combine both those approaches and I think there is a real opportunity to reduce bureaucracy and data collection by having one version of the truth as to what is happening for a given population. That is the next phase for the next two to five years: to work out how to do that and then to deliver it effectively.

Q197 Chair: That highlights many of the challenges we have underlined in our questions today. We will be seeing you again, at least in a year, and Dame Una more frequently than that. Thank you very much for coming to this long session, and apologies that the vote interrupted us. I also thank the witnesses and the public.