Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Witness statement of Kay Sheldon

I, Kay Sheldon, will say as follows:-

1. I make this statement to the Inquiry as a current Non-Executive Board member of the Care Quality Commission ("CQC"). I feel that I cannot continue to be an effective member of the Board of the CQC without making known the grave concerns and worries that I have about the current leadership and absence of strategic direction of the organisation. I have raised these concerns on countless occasions, but to no avail. It is for that reason that I feel I have no option but to come forward and speak to the Inquiry.

2. My concerns particularly relate to the leadership and management of the organisation. I am not particularly commenting on the appropriateness, or otherwise, on work that is currently being undertaken within CQC and my comments relate specifically to the strategic capability and leadership of the organisation which I view as crucial to the effectiveness and sustainability of CQC as a regulator of health and social care.

My Background

3. My professional background is within mental health services. I was a Mental Health Act Commissioner for the Mental Health Act Commission ("MHAC") and then latterly became a Board Member of the MHAC. During my time as a Board member I continued to carry out site visits as a Commissioner as well as undertaking Board duties. I was a member of the MHAC Board for five years.

4. I myself have been a mental health service user, and I have been involved in

working with different mental health bodies and forums over the years. For example, I led a piece of work that focussed on the involvement of people who are detained under the Mental Health Act and I have conducted research with the Mental Health Foundation. I have also have an interest in and am committed to public and patient involvement within health services and helping to give others a voice. For example I have been a trustee of MIND for five years and I was the co-chair of MindLink for a time. I also set up and chaired a local advocacy in Norfolk and I have worked with professional bodies such as the British Psychological Society and the Nursing and Midwifery Council.

5. On the strength of my MHAC background, I was invited to apply for the post as a Non-Executive Board member of the newly formed CQC. Barbara Young, the Chair at that time, was keen for me to apply as I think she wanted to utilise not only my MHAC experience, but also my experience of governance and public and patient involvement issues. I applied and was appointed in December 2008. I was therefore latterly involved in the transition of the regulator from three organisations into one, with the CQC formally coming into existence in April 2009.

6. I am currently a Non-Executive of the CQC Board along with four others – Martin Marshall, John Harwood, Professor Deirdre Kelly and Dame Jo Williams, who is Chair. Olu Olasode, who was another Non-Executive, has recently left. My role is supposed to take up two days a month, however in reality it is at least double that. My understanding is that other Board members also have concerns in relation to the leadership and strategic direction of the organisation, although I am the one primarily raising these concerns.

The early days of the CQC

7. The transitional phase and the early days of the CQC as an organisation was a very turbulent period. It was a difficult and chaotic time and it seemed that there had been little preparatory work for the creation of this new organisation. The Department of Health did eventually send in a consultant to help manage the transition, who did do a lot of work in a very short period of time, but this was too little too late to ensure a smooth transition.

8. Initially there was very little infrastructure that had been put into place, for example systems, process, procedures etc. Barbara Young and Cynthia

Bower were talking to a lot of people during this period and there was pressure on them to design and implement these processes and systems as quickly as possible. When the organisation came together it was also effectively still operating as three independent organisations and there was very little integration. This integration needed to be developed as did the organisation's strategy and vision. At the same time the organisation had to deliver their responsibilities under the existing legislation. It was an extremely difficult and challenging period for all concerned.

9. Whilst this was a difficult period I think one has to be careful not to use that background as a smoke screen for the lack of leadership and strategic direction that now exists within the organisation. The transition cannot be used as an excuse for ongoing challenges although these issues are still impacting on the organisation to some extent.

10. As Chair, Barbara Young was not with the organisation for very long. Initially Barbara Young and Cynthia Bower worked closely, but Barbara Young was always happier in a Chief Executive role (by her own admission) and she effectively operated in this way. I am not sure when things started to deteriorate, but they did so rapidly. Barbara Young is a bright and clever woman, and I have the greatest respect for her, but she started to find things difficult and seemed stressed. I do not know the reason that Barbara Young left the CQC but I do know there was significant tension between her and Cynthia Bower. I believe she left in around January 2010, when Dame Jo Williams (who was vice chair at the time) stepped up to the role of Chair. Barbara Young did have a lot of credibility with stakeholders. I believe she was also aware that achieving the effective delivery of our obligations would always be difficult when the organisation was still being created.

11. Shortly after creation, the CQC developed and set out a five year strategy. I attach a copy of that strategy as my Exhibit KS1 [ ]. There was a lot of engagement with staff and stakeholders when designing the strategy and listening to what people, such as providers, the Department of Health and service users. We also had to consider our legal duties as an organisation and what we wanted our vision to look like – what we wanted to do and how. There was much debate about the strategy in these early days. However, very little consideration was given to the capacity of the organisation to deliver the strategy. The regulatory tools e.g. methods, were not well

developed and the processes and systems to support the governance including audit and risk management were immature. With regards to the financial implications of our strategy, I recall saying to Cynthia Bower that we were going to be doing much more with much less money. Cynthia Bower's response was that we were required to make savings. As a Board we did not have a full discussion about our budget, what we could afford to do or how to allocate our budget.

12. Not long after the five year strategy was published, and in the face of the demands caused by registration, there was a sense within the organisation that we had over-promised, and I think to some extent we did although we (that is the Board) had no way of knowing at that stage. I think the issue with the strategy was that the feasibility and practicability of implementing it was not considered in any detail. This was largely due to the pressures and tight timescales that CQC was working within. It soon became clear that we had been over ambitious. The strategy is still current as we have not reviewed it in a significant or robust way although it is clear that the organisation has departed significantly from the strategy.

13. Approximately one year to 18 months after the five year strategy was published the Executive said they wanted to reduce the strategic priorities to just two – acting swiftly to help eliminate poor quality care, and making sure that care is centred on people's needs and protects their rights. This was directly related to the fact it was clear that we would not be able to deliver on our commitments. We had a strategy day to discuss this change, but the day was not run effectively and as a result we were not able to fully discuss either the changes or implications. The record from the day is minimal and it was clear that the objective was simply to gain endorsement from the Board to effectively depart from the agreed strategy. It is not that I believe we should not have reviewed our strategy but that the Board was not able to play the role it should have in this review which was due to ineffective Board leadership.

14. I did raise this as a concern. The consistent failure to chair meetings in a way that facilitates debate and leads to clearly minuted decisions has been prevalent throughout.

My Concerns

15. For at least the past year, the lack of any strategic direction for the CQC has been a real concern, which I have repeatedly raised with both the Executive and the Board. It is very difficult for me, and indeed anyone else, to do my job when I do not know where the organisation is going and what our role should be.

16. In my view, the organisation's approach to strategy is reactive and led by reputation management. I also believe that the personal survival of those leading the organisation is a main driver and so the impetus to prove that the organisation has changed and is effective.

17. In January 2011 I prepared a document entitled "Reflections and Suggestions", which summarised the issues that I considered were important for the organisation going forward. I sent the document to the Board and the Executive and I attach a copy of that document as Exhibit KS2 [
]. The intention was to set out my concerns so that these could be considered and addressed, but in a sensitive way. I made it clear that I was supportive. I had raised these concerns on a number of occasions prior to sending the document, mostly at Board meetings. However the document really encapsulates the majority of my concerns at that time.

18. In terms of a response, the document was acknowledged, and Dame Jo Williams said that she agreed with a lot of what I said. However my concerns were never formally responded to and I cannot say what particular steps were taken to address the issues I raised.

19. I have set out below in more detail the substance of my concerns. I do not wish to be overly negative about the organisation, and I want to be clear that I think we have achieved some good things, however the reason I am speaking to the Inquiry is to express the concerns that I hold, so that the Inquiry can consider the extent to which the CQC has learned any lessons emerging from the problems at Mid Staffordshire.

<u>Strategy</u>

20. On page one of my "Reflections and Suggestions" document I state, *"I'm not*

clear how the role of the quality regulator interfaces with the various other (relevant) aspects of quality". My concern was, and is, that there are so many other bodies in the field – Monitor, NICE, the National Quality Board and others – that I did not know where the CQC should sit. The landscape was changing with the arrival of a new Government and the environment we were operating in was changing too. My concern was, and is, that we are not addressing or considering that environment and the role we should play. This really is the basics of acting strategically. This prompted my further comment on page one: *"We have an organisation strategy and associated plan(s) in place which were developed in a robust way. It is possible that they are not 'fit for purpose' in the contexts we now face."*

21. I was also concerned about the regulatory vision of the organisation and whether this was clear. On page two of my January 2011 document I stated as follows: *"...we have yet to achieve consensus – or maybe understanding – of what our regulatory model will look like 'on the ground'. I say this because although we have a regulatory model, when I ask myself questions such as 'How will we provided accurate and accessible assessments?' and 'How will be [sic] get to the heart of patient/service user experiences/outcomes of care?' and 'How will we pick up & deal with serious concerns early enough and quickly?' I cannot give clear/full answers. I'm aware of various excellent initiatives but I'm less clear on the crucial issue of how these fit (or will fit) together in a coherent model that can be effectively realised in our regulatory activities".* As a Board member, I consider it a fundamental flaw to have no understanding of such basic issues and strategies.

22. I was also concerned at that time about the process of registration. This is reflected on page three of the document where I say, *"Concerns continue that we may be too reliant on self assessment and that we won't have sufficient presence 'on the ground' and so either won't pick issues up soon enough or at all."* Registration was such a huge task. I knew that it would not be possible for inspectors to visit all providers as a part of the process, and I knew that some inspectors were worried that in the absence of this they did not have sufficient information to make valued judgements. At this stage, registration was the main entry point to being compliant and it was largely based on self-assessment. An over-reliance on this self-assessment did concern me.

Leadership of the Board

23. Board meetings are held approximately once a month. From an early stage I did not feel that the Board could hold the Executive to account, both as a result of the lack of information we received and the culture that permeated at the top. There was no coherent strategy or performance framework against which we could hold the Executive to account. As a Board I feel we have been managed by the Executive and that we have effectively been operating as an advisory group. This is partly due to the way that Board meetings are chaired. As a Board we would discuss a particular issue and I would have expected the Chair to summarise the discussions and formally set out the decisions that had been made. However this rarely happens. It is difficult to explain, but the way the meetings are run mean that it is unclear what the outcomes of the discussions are. This lack of focus and direction of Board meetings is evident when reading through the minutes of Board meetings. The Executive and Chair have said we should trust them, but I cannot accept that this is the role of a Board member. Board member should challenge constructively as this supports robust decision-making.

24. The categorisation of Board papers as public or private documents is also unclear. I have questioned this on a number of occasions, as it often seems to me that papers that are deemed 'private' should in fact be in the public domain. For example, I emailed Alastair Cannon, Head of Governance, about this issue. In response, Alastair Cannon told me to take this up with Dame Jo Williams. We then spoke about the issue at the next Board meeting, the outcome being that the majority of the papers should stay private. I am not convinced that we are as open and transparent as we should be as a public body.

25. Challenges from the Board or its members are frequently side-stepped or disagreed with. It is difficult to do the job and seek to bring the Executive to account when the Board is led in this way. For example, shortly after Dame Jo Williams took over as Chair, there was this big impetus within the organisation to register providers. During this period the Board raised concerns that whilst the focus was on registration we were not doing inspections. However, our concerns were side-stepped and I recall Cynthia Bower insisting that delivering registration as the primary objective. We were not able to have a robust discussion about this. It may have been that we would not have reached a

different course of action but I feel we should have had a more robust debate about the issues and in particular associated risks.

26. Another example of the Board being 'side-lined' can be seen from an exchange of emails I had with Amanda Sherlock back in July 2011 (a copy of which I attach as Exhibit KS3 [ ]). I had read in the staff newsletter that the organisation was going to align the leadership of the Operations directorate with the National Commissioning Board, which I understood to mean that the organisation would have four Director posts that mirror the four areas that will be dealt with by the National Commissioning Board. The newsletter stated that the Board had agreed this, but it was the first time I had heard about it. I therefore emailed Amanda Sherlock and asked for a copy of papers that recorded this agreement, and unsurprisingly she was unable to provide them. Whilst I would not necessarily have disagreed with the proposal for alignment, this was another example of the Board being by-passed.

27. There has always been a pressure for us to agree and support everything the Executive does. Dame Jo Williams' overriding view is that the Board should be supportive and encouraging of the Executive as much as possible and that the Executive are working in a very stressful and difficult environment. This is certainly true and the Board does need to take account of this (and indeed has done) but there is an element of emotional manipulation in the way that the Board is functioning which impedes appropriate governance and oversight. It has often been the case that the Board is simply asked to endorse a decision made by the Executive, effectively just a rubber-stamping exercise.

28. We also receive little useful information at Board meetings or from the Executive than enables the Board to discharge its responsibilities. I have never seen the details of our budget nor a breakdown on what we spend our money on. The budget and allocations may well be reviewed by the Audit and Risk Committee, but as a Board, we do not get to scrutinise that information. We are not given accurate or relevant performance or management information. We are not always consulted on key decisions. For example, the decision to abolish the HCC's investigation team was not brought to the Board for discussion. The only reason we found out about it was from all the bluster that was made. This has made it very difficult for the Board to know what is happening within the organisation. As a result, I have often felt that it is

necessary for me to get out and about and speak to staff in order to fully understand how the organisation is operating. I raised the lack of financial information being provided as an issue in the document I prepared in January 2011 (appearing at Exhibit KS2). At the top of page two I stated that: *"From a financial perspective I'm not wholly clear on how our resources are deployed and the processes for determining this"*. That remains the case

29. In my view, it is the approach taken by Cynthia Bower, Dame Jo Williams and Jill Finney that has resulted in the Board being managed in this way. Dame Jo Williams does not like confrontation. Her approach is always to seek consensus and her response to any persistent challenge from the Board is to get upset or even angry . Dame Jo Williams is also heavily influenced by Cynthia Bower and Jill Finney, to the extent that this is a barrier to the Board being able to hold the Executive to account. I believe that Dame Jo Williams' is under a lot of stress at the moment and the other Board members are sympathetic to her position, as she is inherently a nice woman, but I think she is out of her depth.

30. Just after Dame Jo Williams first stepped into the role of Chair, in around March 2010 she sat down with Cynthia Bower to agree a list of "deliverables". The Board was also asked to provide feedback for the Chief Executive's appraisal. However since then the Board has not had any information relating to the performance of the Chief Executive. I do not know if Cynthia Bower has had an appraisal, but I think we should have been able to feed into this given that the Board has responsibility for the appointment of the Chief Executive.

31. I have continually raised my concerns about the leadership of the organisation, For example, I have emailed Dame Jo Williams and asked her whether she believes that Cynthia Bower's position is tenable. She asked me to "stick with her". A few months ago, at a pre-Board meeting discussion, I again raised the issue of whether Cynthia Bower's position was tenable. The response I got was that "we do not need a high profile sacking at this time". My understanding is that the Board question whether Cynthia Bower can lead the organisation, but the Chair is quite emotional about the issue and I believe the Board feel they need to support her.

32. In the document sent in January 2011, I suggested that one of the things we needed to monitor and review at our February away day and/or strategy

meetings was the "role of commissioners" – commissioners are Board members. I wanted to make it known that I was not sure how the Board was considered able to hold the Executive to account given the way that we were and are currently operating. I also wanted the Board to assume accountability so that we could discharge our duties effectively.

33. In August 2011, I decided to write to all of the Board members about how we discharge our Board duties. While I had been raising these issues informally and in Board meetings, there was no record of this and I felt it was important that I commit my thoughts to writing. I saw it was a matter of integrity (as a public appointee) to raise these issues if I felt that I was not able to discharge my duties effectively.. I attach a copy of the exchange of emails we had as Exhibit KS4 [ ]. In the email I say, *"Whilst I feel we are all making good contributions, I also feel that we could be more effective, and indeed more useful to the organisation, if we had a clear and shared understanding of the role of Board members."*

34. Dame Jo Williams responded to the email. In response she said, *"I've been a little slow in replying because I wanted to check what internal audit had been doing. They have completed a governance review and the issues it raises from the Board will come to our strategy day."* However I am unclear how this was relevant and I cannot recall how, or if, these issues related to the strategy day. I am not sure what I expected in response, but the reply confirmed to me that Dame Jo Williams did not appear to follow – or at least acknowledge - the points I was making

35. Lack of clarity around the role of the Board still persists. We have recently had two Board development days and, as a result of this, we have introduced a new front cover to our Board papers, which sets out the different issues that are coming the Board, but there is still little understanding and/or acknowledgement around our role of the Board.

<u>Staff Morale</u>

36. It became clear very early on that the organisation's strategy, such as it was/is, was not being implemented on the ground. When I did go out and speak to the inspectors on the ground, the message I received was one of disenchantment and disharmony. Morale was low. The inspectors said they

were frustrated; they did not feel listened to by management, they did not have the tools they needed to do their jobs, their training on the regulatory model was not good, they did not feel comfortable making decisions in relation to quality and they did not have the information they needed to make such decisions, particularly in social care. Inspectors also told me that they were unhappy with the management of the organisation, with many good people being made redundant or leaving. The message I received was that the staff felt completely disengaged.

37. I did go 'out and about' more than the other members of the Board and got the sense that others did not really like this; there was a feeling that I was getting too involved. I did go back to the Board and report the disenchantment of the workforce. However, I felt again that my concerns were not being listened to. I therefore pushed for a staff survey to be conducted, and eventually one was. The results of the survey were reported in July 2010 and unsurprisingly the response from staff was very negative. Part of the reason may have been that it was the first survey conducted as a new organisation that had been through much change, and that was certainly the reason given by the Executive. We, as the Board and the Executive, knew that the results would not be great, but my hope was that this would be a catalyst for change.

38. Partly in response to the survey results, the Executive undertook a major internal review focussing on what we do as an organisation and how we do it. This involved roadshows and speaking to staff. I think this was a positive step as at least some of the staff felt listened to. I am not sure to what extent morale has changed since this review. My belief is that there was some improvement, although morale quickly plummeted when the Winterbourne View issues came to light. I have tried to persuade the Board and the Executive that now is the time to conduct another staff survey, however they want to wait until things are more settled in the organisation.

39. Again, these issues were raised by me in January 2011 as well as on numerous other occasions: *"Generally staff are very committed to their work and actively want to do a good job but there is frustration they can't do this..."* (Exhibit KS2).

Culture

40. There is a culture of bullying within some parts of the CQC. There are a lot of good people within the organisation and bullying is by no means widespread across the organisation. However I have been made aware of a number of people who adopt a bullying approach to management.

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advised to tell the individuals that had raised concerns that they should take it up with their line manager.

believe that the bullying is driven by the need to push through changes as quickly as possible and to achieve positive results. There is a lot of pressure on the Executive team but I do not feel this justifies bullying.

44. Staff morale in some areas of the organisation is better than others and parts of the organisation do have good working environments, however, looking into the future I cannot see how the culture of the organisation will unify without a change of leadership.

Governance and Risk

45. I have also repeatedly raised concerns about the lack of governance and related procedures within the organisation. I also have concerns in relation to the approach being taken to risk management.

46. With regards risk management, I do not feel that the organisation has a coherent and embedded approach to risk. This relates to both organisational and regulatory risk. I have seen very little evidence of effective risk management. The Audit and Risk Committee (ARC) has not been functioning well. As a Board member, I did not receive any information from the Audit and Risk Committee for a very long time; not even a set of minutes from its meetings. The Chair of the ARC was a Board member, but yet we would receive no information other than a very brief oral summary. Again this was an issue that I persistently raised. I should say that the Chair of the Audit and Risk Committee has now left the organisation. I do not think that he fulfilled this role in the way it should have been and I think that action should have been taken earlier by the Chair of the CQC to tackle this. Instead, Dame Jo Williams waited until the Chair's appointment had run its course. This was despite the concerns that had been raised. Another Board member has now taken over the role as Chair of Committee temporarily.

47. Whenever I did receive risk or performance-related information it did not tell me much that was useful to my role as a member of the Board. I would therefore

seek out members of staff to find out more. I raised the lack of audit/risk information we were receiving with the Board several times. Eventually Dame Jo Williams spoke to the Director of Governance and Legal Services, Louise Guss, and asked if she could talk me through some of the information. Louise Guss then emailed me in June 2011 and we agreed to meet. I attach a copy of our exchange of emails as Exhibit KS5 [ ].

48. When I met with Louise Guss she talked me through the risk management framework that was being developed. At that point the approach to risk was predominantly a paper exercise . Louise Guss agreed that the framework had not yet been embedded. Developing a risk management structure is a difficult thing to do, but the bottom line is that there has not been an effective approach to risk and risk management within the organisation. Given the maturity of the organisation perhaps this is not surprising and I am aware significant activity has recently been undertaken but, as yet, I have yet to see the impact and benefits of this at Board level. We do now have a strategic risk register, an example of which I attach at Exhibit KS6 [ ]. But again, this has limited value . As a Board member I need better information e.g. how effective mitigating actions are, to be effective in my role.

Stakeholder Involvement

49. I also have concerns about the approach to stakeholder engagement Again, this was an issue I raised in January 2011. On page three of my 'Reflections and Suggestions' document I said, "*We need to be clear – or remain clear – about the differences in relationships for example between service providers and service users, including where our priorities lie as a regulator.*" This is related to public accountability, and having a clear strategic vision. My view is that the organisation is overly influenced by what providers tell us in relation to how we should work and develop, when it is the public and patients who are key. The CQC is accountable to the public and to Parliament and whilst it is important to get views from the health and social care sectors,, it is the people who use health and social care services who should be the most important stakeholders. In fact CQC has a specific duty to involve people who use health and social care services. However, whilst there have been some good initiatives by the CQC Involvement team, the degree of influence by patients and the public is not as central as I feel it should be for a public body.

50. The organisation has had two stakeholder strategies since inception neither of which has been effectively implemented. In my view, the current approach to stakeholders is being very closely managed by the organisation in order to illicit the right response and/or to get support from them. For example, some stakeholders tend to be those organisations that have been negative towards us in the past, such as the NHS Confederation, English Community Care Association, Action for Elder Abuse etc, and these organisations are targeted on the basis that the organisation wants to influence them, not because they should be more involved. Other stakeholders are targeted because they are likely to have the most impact in terms of influencing our reputation e.g. umbrella groups or national organisations. Whilst managing the stakeholders in this way is not inappropriate as such, this should not be done at the expense of listening to service users and others that matter too. Having a stakeholder strategy in itself is not a problem, but what concerns me is the motivation behind it. It seems that the organisation was, and is, making an effort to engage with stakeholders with a view to achieving a consensus and so minimise potential criticism of the CQC.

51. As part of the review of stakeholder input, many advisory-type groups within CQC were abolished which caused significant concern amongst stakeholders. Questions were raised about CQC's own commitment to the value associated with 'nothing about us without us' that are seen as fundamental to Health Watch. The individuals and/or organisations that were involved in these advisory groups have been 'migrated' on to a 'stakeholder register' so that they can be called upon if needed. However there is a belief that this is too passive and not transparent.

52. A single Stakeholder Committee has been set up by the organisation in place of the previous advisory groups which is being very closely managed at present. The Committee is chaired by a member of the Board and it reported for the first time at a Board meeting on 16 November 2011. However, whilst the rest of the Board knew that the Stakeholder Committee was being set up, we were not even aware that the Stakeholder Committee had met. The Board was supposed to approve and agree the membership and the Terms of Reference of the Stakeholder Committee, but we have had no involvement. This is a further example of the Board being isolated from the management of the organisation.

Inspections

53. The lack of inspections conducted by the organisation does concern me, as does the attitude that the Executive takes towards inspections and particularly the interrelation with our performance figures (which I refer to later in this statement).

54. In my view, an absence of inspections, particularly in the fields of mental health and learning disabilities, elevates risk. At the same, whilst the public may want inspectors to go to every ward or unit, every year, this is something we just cannot do with the resources we are given. However, I have always been clear that we need a presence on the ground, particularly for those patients in vulnerable circumstances so I have always been committed to ensuring this physical presence, albeit working with limited resources.

55. However, I have always had a concern about the clarity of the approach that the organisation takes to inspections. I raised this in January when I said *"We had a significant debate around the model for our field force [inspection] model. I would welcome a discussion and review of how well it is working. It is still early days but we have started compliance monitoring in the NHS and I would like some reassurance that we will be able to deliver – in the fullness of time – on both commitments and expectations"* (Exhibit KS2). I was concerned that the current model did not feel achievable, and that we had over promised.

56. I recall attending a site visit with an inspector whose background was in domiciliary care. She expressed significant disquiet about the fact that she was responsible for inspecting a large general acute hospital, during which she would need to speak to the Chief Executive but did not feel she had the knowledge or support to do the job. I also recall accompanying an inspector to a site visit to a care home for people with learning disabilities and the inspector did not have the expertise or knowledge for this environment. The inspector reported to me that she did not have any concerns and that she had spoken to the manager, but I myself could see there were problems and it was clear that inspectors had not received appropriate training or support to work in environments beyond their own area of expertise.

57. On 19 May 2011, I sent an email to a colleague setting out some of the issues surrounding inspections. is a regional

inspector who had facilitated two site visits for me, and I wanted to feed back to her some of the thoughts I had. I attach a copy of my email as Exhibit KS7 [ ]. In summary, I mentioned that there was a tension between a 'risk based' and 'light touch' approach and that this was felt by inspectors, that site visits needed to be dynamic, that engaging with service users during inspections was crucial and that team work was important for the inspectors. Staff had said to me before that they feel very isolated from the organisation that they worked for, so I feel that making sure we support and interact with them is key.

58. I also mentioned that QRPs seemed to be of little value, particularly in the field of inspections in the spheres of care homes and mental health. My view is that QRPs do not work for social care providers. During one of the inspections that I mention in my email, I reviewed the QRP, which contained information from three or four years ago. There is certainly potential for QRPs to be used in some areas such as hospital trusts, but it does have its limitations and is still in development phase.

59. At the same time, as a regulator we have to have regard to the principles of 'Better Regulation', which is all about being proportionate and risk based. However we have not fully considered what this means in the context of health and social care. There has always been some debate about 'light touch regulation' and 'right touch regulation' and my view is that one size does not fit all. Although this was always a debate to be had, inspections are supposed to be risk-based, however it is clear that we do not have up to date information to enable us to do this, especially in social care.

60. On 21 June 2011 I also wrote to another colleague outlining my thoughts on inspection visits. I believe that as I had been on inspection visits, following which it was suggested that I had attend the region's training day to describe my experiences. Unfortunately I could not attend and so instead I set out some of my thoughts in an email derived from my experience as an inspector and as a user of mental health services. I attach a copy of my email as Exhibit KS8 [ ].

61. I did feed back to the Board all of my thoughts on inspections. Since then, some changes have been made. For example our regulatory model is being reviewed, and the number of inspections has increased. However, I am

concerned that these changes have not been thought through in a careful way – everything is being evolved through trial and error rather than careful analysis, discussion and assessment. I refer to this further below.

62. In around June this year, Amanda Sherlock, the Director of Operations, announced that the CQC would be conducting annual inspections of all providers. The Board found out about this commitment from the front page of the Health Service Journal. We were not consulted on this and did not discuss it at all. Yet it is a key issue of principle that should be considered by the Board. If we had been consulted I would have made clear my concerns about inspections, particularly given the recent issues with Winterbourne View. I do not have concerns around introducing annual inspections per se, but I was very concerned that I should find out about this decision via the HSJ, without an understanding of whether this was achievable. I believe the decision to conduct annual inspections was made to pre-empt any criticism that might be levied by the Mid Staffs Inquiry and it is another example of the reactive decision-making approach that is taken by the Executive.

63. The organisation has now recruited more inspectors. I have asked the Executive about the professional backgrounds of the new inspectors and I am due to speak to someone from HR in relation to this as well. It is disheartening, but at the moment I cannot trust what the Executive are telling me so am forced to go to another source if I am to effectively seek to hold the Executive to account; whenever I look below the surface things are never what they seem.

64. As can be seen from above, I have had concerns about particular aspects of the functioning of the organisation for some time. I have raised these concerns with the Board and the Executive a number of times, but my concerns are either ignored or not addressed. As a result of recent events and developments, my concerns have been compounded to such an extent that I felt it necessary to take the step of speaking to the Inquiry.

Recent Events

65. The current regulatory model is based on 16 essential standards (outcomes) against which providers are reviewed to assess whether they are compliant with the standards. There have been tweaks made to the model along the way

in an attempt to make it more workable, for example focussing on fewer outcomes in reviews. The organisation has recently reviewed aspects of its regulatory model. A Regulatory Model Review Group led by Board member Professor Martin Marshall was set up. The review highlighted many of the internal and external challenges and issues facing CQC. These included our approach to regulatory risk and the use of enforcement. This led, in part, to the proposed changes to the enforcement policy and judgement framework that are currently out for consultation. However I am concerned that many of the strategic and governance issues that have been highlighted internally and externally, including the Regulatory Review Group, the Health Select Committee, the Winterbourne scandal alongside the changing environment in health and social care, have not been fully considered and the direction that CQC is taking through changes to its regulatory model

66. The proposed new regulatory approach is designed to simplify the way we regulate by moving much more towards a compliance and enforcement model where we will look for evidence of non-compliance within providers, rather than evidence of compliance as is currently the case. It is proposed that there will be no routine assessments of quality, rather only instances of non-compliance will be followed up. It is also proposed that we do away with improvement actions and just use enforcement actions, such as warning notices and compliance actions. The idea behind the model is to simplify regulation and enable enforcement action to be taken more quickly.

67. My concerns about the proposed changes are that they have not been appropriately considered in a clear strategic context. The Board did not receive full and necessary information to support the proposed changes and potential implications at any Board meetings or from the Executive. In my view we should have had a full discussion about the strategic context and direction. I was also concerned that the Regulatory Impact Assessment and the Equality Impact Assessment did not fully capture and consider potential implications and consequences of the proposed changes.

68. The Board received a copy of the proposals and consultation papers two weeks before the Board meeting at which we were due to consider the proposals. Having reviewed the papers I sent an email to the Board and the Executive raising the queries and concerns I had around the potential impact of the new model and whether that had been assessed. In particular I raised my

concerns around the financial implications, the fact that the proposed model did not seem to fit with the CQC's current legislative obligations or the organisation's current strategy. I did not receive an adequate response to my email.

69. I therefore wrote to the Board and the Executive setting out my concerns and the issues that I thought needed to be discussed. My intention was to get the Board to assume accountability and to hold the Executive to account. I was not saying that the proposals were wrong; in fact this may be the right way to regulate, but I was concerned that the proposals would fundamentally change what we do and how we do it which required a full discussion on our strategic direction. In my view, the changes to the regulatory have been developed too quickly and have not been thought through, from either a financial or a governance perspective. The proposals are a big shift from where we are currently and it is clear that there has been no proper and detailed impact assessment or analysis. For example, I am aware that only a handful of inspections have been analysed and the data extrapolated when putting together the proposals. I also think that thought needs to be given to the fact the issues of non-compliance are not always obvious; it is often the gaps in compliance that help to identify potential areas of non-compliance. The bottom line is that the changes to the regulatory model are too much of a knee jerk reaction by the Executive and it has not been properly considered.

70. At the Board meeting two weeks later I again repeated the concerns I had raised in my email but to no avail. I have been able to secure agreement from the Executive that once the consultation is over the Board will then have an opportunity to discuss the proposals further, although whether this happens in reality is another matter. For the reasons I have set out above, by then, the issue may be a fait accompli.

71. The new approach was put out for consultation in September 2011. The consultation includes the proposed changes that this will made to the CQC's Judgement Framework and our Enforcement Policy. I attach a copy of the consultation document as Exhibit KS9 [ ]. An impact assessment of the proposed changes has also been conducted and I attach a copy of the assessment as Exhibit KS10 [ ].

72. In my view the way the consultation has been constructed is biased. The

questions have been posed in such a way as to encourage a particular response. For example the changes are all called 'improvements' which inherently suggests they are a positive change. I have also asked for a copy of the consultation plan for the proposals but was simply sent the generic stakeholder engagement plan. I have still not received a copy of the consultation which concerns me as it is the role of the Board to ensure that this is in place for major changes to the way we work.

73. As I continued to have concerns about the proposals I met staff who were dealing with the development of the model in order to understand the rationale behind the changes being made. I was shown the costs model and it seemed very simplistic to me, and on the basis of what I was shown I am not confident the proposals have been adequately thought through.

74. At least in part, I think the motivation behind introducing the changes to the regulatory model is for the organisation to make an impact, rather than it being the right thing to do. I also think this move has been reactive in light of the evidence that has been heard during this Inquiry and the events of Winterbourne View. I have certainly heard it mentioned by the Executive that the new model is needed to pre-empt criticisms that may be made by the Mid Staffs Inquiry.

75. I am aware that there are various internal reviews and projects that are taking place, or have taken place, within CQC. For example a review looking at CQC's approach to gathering and using intelligence is about be commissioned. I believe this is – at least in part - to pre-empt criticisms about the QRP. The approach to problems or criticisms is to undertake a reactive course of action including the use of 'reviews'. However as a Board member, I cannot see how the various work streams relate to each other in an overarching approach and do not receive adequate information on the progress and effectiveness Again this directly relates to the lack of strategic direction and oversight as well as the lack of performance information to the Board. I can see parallels in the way the chief executive runs CQC to the way she operated when she was chief executive of SHA: that is not fully aware of what is happening 'on the ground', a disjointed rather than joined up approach and a reactive rather then proactive approach to challenges and not working effectively with the Board.

76. As mentioned above, On 13 September 2011 I wrote to Cynthia Bower,

copying in the Board, to express my serious concerns about how the integration of the Mental Health Act functions within the organisation had been managed by the Executive. I attach a copy of my email as Exhibit KS11 [

]. As already mentioned, since the CQC came into being, Mental Health Act functions have continued almost as a single entity and there has always been a need for these functions to become more integrated in the organisation. On a number of occasions I had raised concerns about the lack of progress around integration of the Mental Health Act functions particularly the lack of executive leadership and oversight, but I was constantly told that "everything was in hand" and that our Mental Health Act functions were an important aspect of our work. As I had been appointed to the Board to ensure Mental Health Act functions were operating effectively, I felt very let down at how the situation developed, that is: the lack of progress, poor executive ownership, bullying and the alienation and lack of engagement of relevant staff and Mental Health Act Commissioners.. I therefore felt compelled to write to Cynthia Bower to hold the Executive to account in relation to this issue.

77. Cynthia Bower did not respond to my email other than saying that Dame Jo Williams would speak to me. Dame Jo then called me up and shouted down the phone at me, telling me that I should not be sending that type of email when "matters were delicate enough already" and that "I will just upset things". In my opinion I was just doing my job. Following my email and the discussion with Dame Jo Williams I did receive an apology for the report on the Mental Health Act functions not being available (which was one of the issues I raised in my email), but I did not receive a substantive response to the points raised in my email.

78. Then on 16 September 2011 I wrote to my fellow Non-Executive Board members, and I attach a copy of my email as Exhibit KS12 [

]. In my email I said, "*I am writing because I am deeply concerned about the functioning of the Board. At the moment it is not possible to discharge our roles and responsibilities effectively. I really feel we need to sort this out properly and soon and, if we don't, it will be (further) detrimental to the organisation... To be frank, if we don't we are not doing our job. I feel we are being prevented (for whatever reason) from discharging our role and responsibilities effectively. As you know this is not the first time I have raised this and it still has not been addressed in any significant way.*"

79. I also raised our relationship with Dame Jo Williams as being an issue, and said I was concerned about her role as Chair: *"Our relationship with the chair is a very tricky and sensitive issue... It is clear that 'the team' is Jo and the Executive team and we are seen as undermining this team approach. I think* [redacted] *is right in that Jo doesn't want us to play much of a role (again for whatever reason)."* No one responded to my email, in writing or otherwise. I think the other Non-Executives are, not surprisingly, edgy about the whole thing.

80. On 29 September 2011, the Board and the Executive attended a strategy and Board development day. This was something that I had really pushed for. In preparation for the strategy day, on 5 September 2011 Dame Jo Williams emailed all of the Board members to ask for our thoughts on the kinds of issues we wanted to discuss, and this was then to be discussed further and agreed at a planning meeting on 8 September 2011. Martin Marshall responded saying that he was keen to discuss how we evaluate our effectiveness as a regulator and monitor the utility of our regulatory model. I set out the areas I was keen to address including the long-term strategy for the organisation and need not to always be reactive, the organisation's model of governance, the role of the Board and stakeholder engagement – largely the issues I have outlined above. Professor Deirdre Kelly and John Harwood also responded with their thoughts. Following our planning meeting, I then set out my further thoughts in an email dated 26 September 2011, a copy of which I attached as my Exhibit KS13 [ ].

81. The strategy and Board development day then took place on 29 September 2011. The morning session was centred around strategy; however at the meeting we did not really discuss strategy to any great degree. A 'strategy refresh' document was presented at the meeting, although it was clear that this was simply a condensed version of our business plan that detailed a list of actions. I attach a copy of the 'strategy refresh' document as Exhibit KS14 [ ]. (The document is dated 16 November 2011, as the paper was later formally presented at this Board meeting, but this was the document we were being asked to consider at the strategy day).

82. On page five this document there appears a list of "successes" that the Executive have defined and alongside this, is a list of ways (measures) that the CQC could use to try and show they have achieved this. even though we have

not yet gathered the evidence needed to support the "successes". Furthermore it is doubtful that these measures of success will provide any meaningful data on the effectiveness and impact of our regulatory duties. To me, the document 'Refresh of Strategy 2012 -2015' is a clear demonstration that the current approach is one of reputation management as opposed to developing a robust and effective strategy.. These actions are guided by the need to pre-empt criticism from the National Audit Office's review, the Department of Health's current review and the Mid Staffs Inquiry. It almost seems to be a PR exercise, the strategy being to convince people we are doing well as an organisation rather than properly reviewing and planning the way forward for the organisation and hence the future regulation of health and social care services.

83. In the afternoon of the strategy day we focussed on Board development and we had an external facilitator there to guide discussion. During these discussions we talked about executives and non-executives working together. Everyone seemed to be saying "the right things" even though what they were saying was not happening in practice. I also recall one person saying that if a Board member did not believe in the organisation then they should resign. I do believe in the organisation, but I got the impression that during the session others thought that I was undermining the organisation as I was challenging a lot of what we do. For example, I believe I said that I was embarrassed at times to say that I am part of the CQC which contrasts with one of the values of the organisation to 'be proud'. The organisation is under a lot of pressure at the moment, as are its leaders, and therefore the session became quite hostile and emotional. In the end I found the tension too much and I got quite distressed and had to leave the meeting. I did not re-join the session.

84. Following the session, Dame Jo Williams contacted me and said she was concerned about my well-being and my mental state. I do have a history which predates my role with the CQC of depression, but I am able to manage my mental health, and I consider myself to be in robust health. For example, I have had the strength to challenge the Executive and raise concerns about the functioning of the Board. The Board and the Executive were well aware of my mental health issues when I joined the organisation. However, Dame Jo Williams said that she felt she had a duty of care towards me and consequently she did not think I should be attending Board meetings. I disagreed with her. My distress - frustrations -were not as a result of my history of mental health problems, but rather the context of the meeting and the various issues that I

had been raising. My reaction at this meeting was atypical and short-lived.. I recovered quickly although the continuing concerns that are being raised about my health are quite stressful in themselves. Dame Jo asked me to see an occupational health nurse so that she could assure herself that I was fit to attend Board meetings.

85. I am firmly of the opinion that my distress was seen as an opportunity to remove me from the Board, either temporarily or permanently. I say this because until only very recently (since I have become more insistent in raising concerns) I have received overwhelmingly positive (and demonstrable) feedback about my contribution and commitment to CQC. In fact I received an OBE in the 2011 New Year's Honours.

86. Whilst I do not have evidence in writing there have been at least three occasions when Dame Jo Williams has said to me that she is very worried and is not sure that I am up to attending Board meetings. I explained that if anything it was the difficult nature of the issues I was raising (and the response to these) that was causing me stress and I referred to the Equality Act to make it clear that there was a duty to address a situation of stress by dealing with the issues creating the stress! .

87. I did go and see the occupational health nurse on the morning before the next Board meeting on 12 October 2011. We had a good meeting and she said I was fine; a little stressed, but fine. I therefore attended the Board meeting that day. It was clear to me that Dame Jo Williams and the Executive had been discussing the situation concerning my mental health as they were wary of me throughout the meeting. I have felt so victimised by the situation to such an extent that I have considered having someone present in the meeting to support my position. A Board member seeking to conscientiously fulfil her role should not be in such a position.

88. Despite the conclusion reached by the occupational health nurse, Dame Jo Williams has continued to say that she has concerns about me; first about my health and the need for me to be robust to carry out my duties (to which I countered that I am robust), and second that she was concerned about the impact my health might have on the organisation. I could not believe what was being said to me. I feel there has been a genuine attempt to prevent me from attending Board meetings and carry out my role as a Board member. I do not

doubt that the issues I have been raising are difficult for the Executive and Board to hear but I believe that it was reasonable and responsible to raise such issues as they are fundamental to the role of the Board and the governance of the organisation. I have demonstrated my commitment and support to the organisation throughout my time with CQC but do now consider it imperative that I raise my concerns about the management and the leadership of the organisation.

89. On 11 October 2011, I sent an email to the Board again stressing the need to be clear about our current organisational strategy. I attach a copy of that email as Exhibit KS15 [ ].

90. Following the October Board meeting I pursued the need to clear about where the organisation stood. I therefore asked various people for copies of the organisation's governance documents, such as our strategy, our operating framework with the Department of Health, relevant legislation etc, and I asked for this to be reproduced into a folder of papers for me so I could be clear about what the organisation's obligations were and how governance worked.

91. In preparing these documents I emailed Jill Finney on 24 October 2011 and asked for a copy of our current stakeholder strategy. I attach our chain of emails as Exhibit KS16 [ ]. As already mentioned earlier in my statement I was already concerned about stakeholder involvement. I was aware that we had had at least two stakeholder strategies/policies in the past that had not been implemented, so I was keen to obtain a copy of the latest strategy. When Jill Finney forwarded me the document it was clear that our approach to stakeholder engagement is now focussed around our reputation as an organisation beyond anything else. As is highlighted in the attached email chain, the strategy was about public affairs and not involvement. As mentioned earlier, the current strategy is still narrowly focussed on influencing dissenting stakeholders and getting influential stakeholders on Board. This "strategy", which I believe was put together by Jill Finney, was not endorsed by the Board. I replied to Jill Finney on 25 October 2011 raising my concerns about "the strategy". I did not receive a reply to this. At this point the Chair was raising concerns about my mental health, so I am not sure whether others had been told not to respond to me.

92. On 26 October 2011, I wrote to the Board and the Executive in relation to the

recent review we conducted into Dignity and Nutrition – also know as DANI. I was querying to what extent a themed review such as DANI fitted with our regulatory model and what the intentions were for the future. I attach a copy of the exchange of emails as Exhibit KS17 [ ]. In my email I stated that these large scale national studies are good for enhancing our reputation, but then noted that, given the Secretary of State had ordered the review, it was not clear whether these reviews would now become part of our strategy and how this would fit. Dame Jo Williams replied to my email simply to say that the Secretary of State had not ordered the review at all. I was still left questioning our strategic model. What is our policy? What can the public expect of us?

93. Dame Jo Williams has tried to dissuade me from emailing my concerns as the issues that the Executive had to deal with were difficult enough already and that she was concerned about the impact my emails could have on their morale. However, I did not feel comfortable burying the concerns I had when they were not being adequately dealt with. I therefore sent an email to the Board on 28 October 2011 a copy of which I attach as Exhibit KS18 [ ]. In that email I said *"I wanted to pick up on the email issue. I appreciate that it is not ideal to raise significant strategic and governance issues by email. However, the usual mechanisms are not working effectively and so, in order to discharge my duties as a Board member, I have to do this through other means"*. I again summarised in the email my the concerns about the lack of strategic focus for the organisation and the weak risk management arrangements saying that *"I have raised these issues many times. All I can do is continue to raise them and, in the meantime, discharge my duties in a way that I see as appropriate and fit."*

94. On 2 November 2011, Dame Jo Williams then wrote to the Board, copying in Cynthia Bower, in advance of a meeting with the Department of Health's capability review team. I replied to the email saying as follows: *"I wonder when we will be told what is our new strategy that is in the process of being signed off? It would be really helpful to have some idea of this as you will appreciate it is quite difficult to function effectively as a Board member without this. I accept that it has been decided that the Board will not set the strategic direction but it is rather embarrassing having to say that I don't know so much of the time..."* I should add that I do not accept that the Board should not have that role, but that is where we are.

95. In reply, Dame Jo Williams referred to the new strategy document as being the 'strategy refresh' document, this being the document that we had all agreed at the strategy day. She then went on to say, *"I am sorry but I don't understand what you mean when you say that the Board does not set the strategic direction, this is entirely at odds with my view and central to our discussion with the Executive."* I replied saying that *"Simply looking back through the Board papers provides clear evidence that the Board has not set the strategic direction"* and *"The 'refresh' of our strategy is quite telling in that it is not a strategy: it is a shortened version of our business plan."* I have since been told in a one-to-one meeting with the chair on November 10 2011 that she considers my recent emails and the fact I have reviewed the Board papers of the last two years as evidence of my mental instability. I attach a copy of this email chain as Exhibit KS19 [ ].

96. On 8 November 2011, Dame Jo Williams then sent a note around to the Board and the Executive to say that the 'strategy refresh' was in fact a note of our discussions from the strategy day in September (the email being attached as Exhibit KS20 [ ]). This 'strategy refresh' document does not reflect my understanding of our discussions and the Board pushed back on this at our Board meeting on 16 November 2011.

97. The National Audit Office ("NAO") has recently conducted a review to examine whether the CQC was using its resources effectively when carrying out its duties. I believe it is due to be published before the end of this year.

98. Given that the focus of the review was on financial information and the use of resources, during the course of the review I was keen to speak to the NAO review team and discuss my concerns about the lack of financial information that the Board was receiving. I specifically asked Jill Finney if I could speak with them and I was told that "they were too busy". I therefore emailed the Comptroller and Auditor General of the NAO, Amyas Morse, and explained that I had wanted to be interviewed by his review team but that I understood they were pushed for time. Amyas Morse responded saying that this was not the case and he invited me to go and see him. I was not sure whether this would be appropriate given that my concerns could potentially raise issues of maladministration within the CQC, particularly as the review was ongoing. I did call Public Concern at Work to ask them if I would be covered by the

whistleblowing policy if I spoke to the NAO, and they said that I would not. I think this may be because of the fact that my role is a public appointment.

99. In the end I did go and see Amyas Morse, but only once the final report had been prepared and shared with CQC. The report was not favourable in any event although I have not seen the final report.

100. When I went to see Amyas Morse I think initially he thought that I was there to change his mind about the findings in their report. During our meeting I did explain to Amyas Morse my concerns, particularly that as a Board member I received no meaningful financial information and I believed that there was poor governance within the organisation. By that stage I did not know where else to go or who to speak to about my concerns.

101. The Department of Health is currently undertaking a capability review of the CQC. The review is designed to provide assurance to the Department of Health about the operation of the CQC. There has been a recent article in the Guardian suggesting that this review is being conducted as a result of the Department of Health's concerns about the CQC, although that is not my understanding. The Department of Health has denied this, so I am not sure where the story has come from.

102. My understanding is that the Department of Health has started a regime of conducting strategic capability reviews of all arms length bodies and the CQC is the first to be reviewed. As Una O'Brien will soon be giving evidence to the Public Accounts Committee alongside individuals from the CQC, I get the impression that the Department is keen to complete the CQC's review before that happens. As far as I know the review is not being conducted because of any specific concerns that the Department has.

103. The review team is being led by Una O'Brien, with Richard Douglas and David Beehan as the CQC's sponsors. There are six or seven members of the review team. The Board has met with the review team and they asked us a series of questions. I felt that they were asking all the right questions, for example about the leadership, strategy and vision of the organisation. Unfortunately, I am aware that concerns have been raised (by the CQC chair) with the review team about my mental health This is of concern to me.

104. The review is still at its early stages, although it is moving quickly, and I

understand that the team is likely to want to speak to Board members further. I did in fact email Una O'Brien when the review commenced and I explained that I was really worried about the leadership and strategic approach of the organisation. Una O'Brien did respond and said she could not speak to me directly due to her diary commitments, but that others in the review team would be speaking to me in due course.

105. Initially, when I first started raising concerns my fellow Board members were quite resistant to the challenges I made. However, as recently as the Board meeting on 16 November, I perceived there has been a shift in approach and I think other Board members are now concerned that the organisation is not working strategically (or are more prepared to acknowledge this). I suspect that the attempt to pass off the "strategy refresh" as a strategic review is at the heart of this. There was also a more strategic focus in the papers for the Board meeting, however there is still a long way to go and the approach that the Board should 'endorse' the decisions rather than make them was still in evidence.

106. At the meeting we discussed the proposed 'refresh' of the organisation strategy. For the first time, at the Board meeting on 16 November 2011 there was a shift in the attitude of the non-executives and, as a Board, said we could not endorse this "strategy refresh" and that it was not in fact a refresh of our strategy. It is the first time I have seen resistance like this from the Board in months and I felt less isolated. I was immensely relieved that the issues I have been raising around the organisation's approach to strategy were being acknowledged by others. This does not immediately take us forward as we still do not have a clear strategy. The Executive are proposing the we have a strategic review in Spring 2012, but I am concerned that we are continuing in the same vein without a clear strategic approach. In fact it is the Board that should decide if and when a strategic review is required and it is the chair who should take forward the impetus for this rather than wait for the Executive to come to the Board. I believe it is the chair who should take responsibility for this but this has not happened to date.

107. At the same meeting proposals were presented about changing the focus away from registration (which had previously been seen as the cornerstone of the regulatory model) to compliance and enforcement. This may be a valid change but, as on other occasions mentioned elsewhere, the proposal was made

without sufficient information and without a clear strategic context.

108. At the meeting we also discussed the current performance figures as regards inspections. The Executive were trying to persuade us to reduce the performance figures for inspections just so that it looks like we are still on target. I attach as my Exhibit KS21 [ ] a copy of our Corporate Scorecard for 2011/12 Quarter 2, which was presented at the Board meeting. It is worth noting that the colours on the document have been manipulated as the Executive was concerned that there might be "too much red". But at the meeting we discussed the 'ASC/IHC' figures (adult social care and independent hospital care), which as can been seen from point 2.52 of the document the achievement of the target for inspections currently stands at 26.7%. This reinforces that the CQC has overpromised on the achievable. During the meeting the Executive told us that we needed to agree to 're-base line' these figures so that the organisation was seen as being on target. This to me is unacceptable. The focus is not on whether we are conducting safe, quality inspections, but rather how the organisation will be perceived externally if we are not meeting our targets.

109. At the meeting it was also confirmed that there is a significant under spend in the organisation to the tune of £10 million. I have only recently become aware of this and up until the November Board meeting my understanding was that this under spend was as a result of restrictions on what we could spend the money on, largely due to the recruitment freeze on all but front line staff. We did have an issue with the recruitment restrictions as initially the Department of Health would not recognise inspectors as being front line staff. We were told by the Executive that it took the organisation some time to dissuade the Department of Health from this view. However, it has now become apparent that in fact only £3 - £4 million is attributable to the recruitment freeze restrictions. The reasons for the remaining under spend are still unclear to me. The financial information has not been made available to us. Therefore, despite receiving an additional £10 million from the Department of Health for next year's budget, in fact this will just act as a direct swap for the £10 million we have not spent this financial year. Again I do not think this is a satisfactory position for us to be in, if this is indeed the case.

110. It is also noteworthy that this was the first Board meeting that we received the first routine report from the Audit and Risk Committee. Whilst this was welcome

I felt that more information should have been included especially how the work of internal audit interfaces with the strategic risk register which is owned by the Board.

111. On the same day we also had a Board to Board meeting with Monitor and one of the things that struck me was just how strategic Monitor are. You could see a clear difference between us and them, particularly the strategic capabilities of the respective Chairs.

112. My fellow Board members do not know that I am speaking to the Inquiry, although they may not be surprised.

113. My main concern is that the organisation is badly led with no clear strategy. The Chair and the Chief Executive do not have the leadership or strategic capabilities required. The Board is asked to ratify decisions about the direction the organisation is moving in, yet we cannot do this without being provided with, for example financial and performance information; at this moment I still do not know what the organisation can afford. I do not see how the organisation can move forward in a robust, coherent or useful way without better leadership. We need a Chief Executive that can manage the organisation, and currently we do not have that.

114. I need to make it clear that I have no personal grudge. I am very worried about the organisation and I have tried to show the evidence as to why.

115. I believe in the organisation, and the concept of regulating services for quality and safety. However, I have no confidence that the organisation is delivering its duties (1) in the way that was envisaged, and (2) in a way that protects the public. I do not see how this can change with the organisation being run as it is at the moment. I am not so naïve to think that if we have over-promised in the past we cannot or should not adjust our approach; we can. But I do not see how we can continue to effectively create our strategy by reacting to events and the latest criticisms. I do not think that is in the best interests of the public. At the moment I do not think that patients and service users are at the forefront of the organisation's mind. In order to do my job as a Board member, I need to know what the organisation is doing, what we can afford to do and what our role is intended to be.

116. As is clear from my evidence, I have tried to raise my concerns internally on a number of occasions. I started by raising my concerns in a sensitive way, to then being more assertive, and then very assertive, but to no avail.

117. For some time I have not known the best person to speak to about my concerns, although I was clear that I would not speak to the press. As mentioned above I did speak to the NAO. I did consider speaking formally to the Department of Health, however I was conscious that, for example, Una O'Brien has previously been the sponsor for the CQC and I am unsure where accountability and responsibility lies.

118. I actually approached the Inquiry after attending the seminar that was being run in Stafford on patient experience. I am aware that I have approached the Inquiry late in the day. I have been trying to address these issues internally for some time and these concerns have gradually been building up. I think the final straw for me was my experience with the Chair trying to undermine me and suggest that I am mentally unstable and attempt to strongly dissuade me from attending Board meetings. I am in good health and I am not unwell; the fact that I was able to chair a conference only a week or so again is further testament to that. These recent attitudes that I have personally encountered have called into question the commitment to the stated values and principles of the organisation such as listening to the voice of service users, acting inclusively and the centrality of equality issues.

119. I know that speaking out does put me in a vulnerable position, but I hope I am making valid points that relate to public accountability and I have tried to raise these issues within the organisation on many occasions. I have considered resigning, but I do not think that I should or that I need to. I wish to remain on the Board, but to fulfil my role effectively.

120. I confirm that I am willing to attend the hearing and give oral evidence for this Inquiry if required to do so.

Statement of Truth

I believe the facts stated in this witness statement are true.

Signed .....

CP VERSION

Kay Sheldon

Dated.....22nd November 2011.....

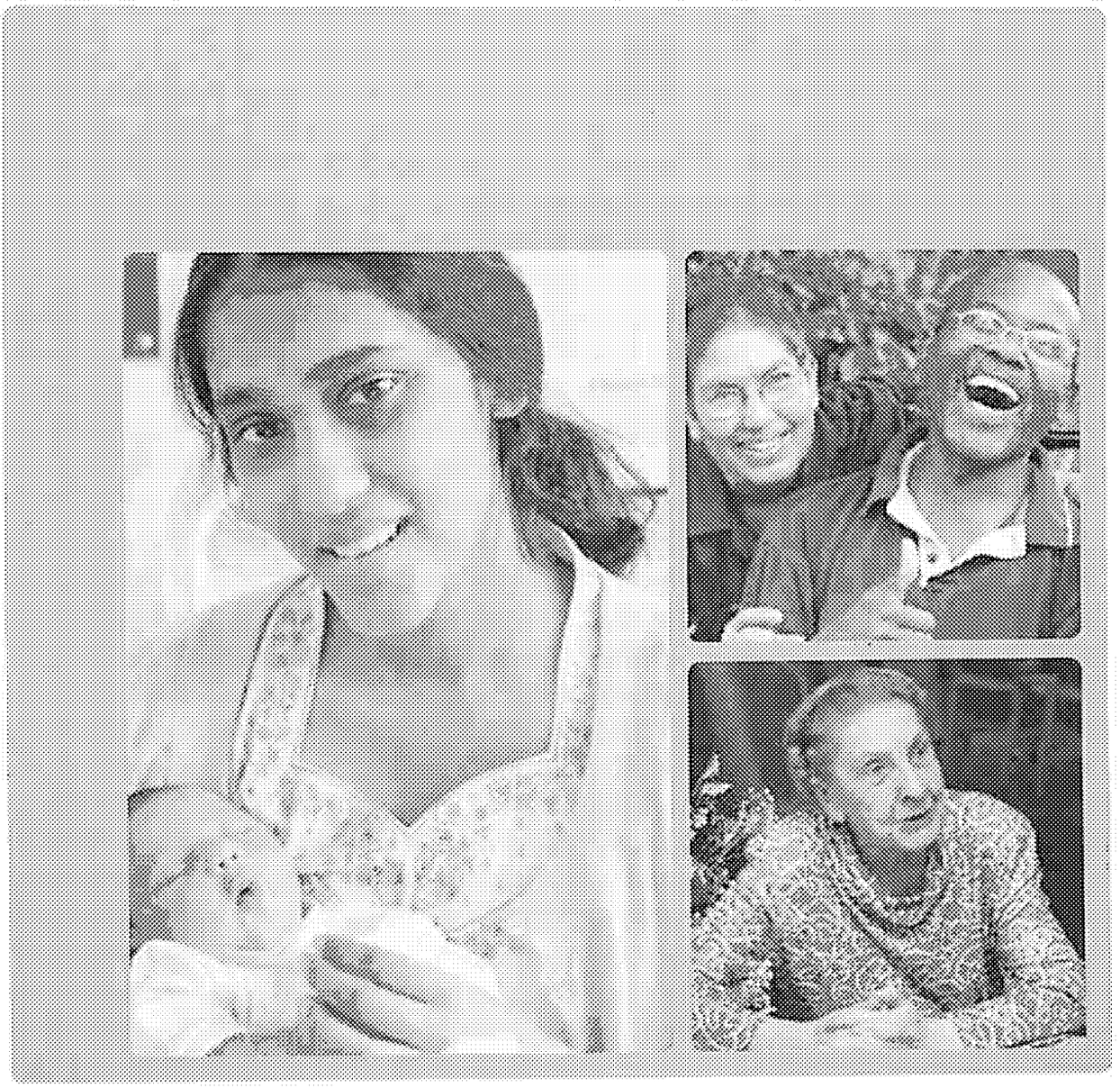
Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS1 [ ] to the Witness Statement of
Kay Sheldon

Care Quality Commission

Our strategy for 2010–2015



February 2010

We make sure people get better care

Our five priorities

1. Making sure that care is centred on people's needs and protects their rights
2. Championing joined-up care
3. Acting swiftly to help eliminate poor quality care
4. Promoting high quality care

5. Regulating effectively, in partnership

What we do to achieve our priorities

Registration, ongoing monitoring and enforcement

Assessments of quality

Mental Health Act visits

Publish information to help people make decisions

The way we work

- We involve people who use services, to focus our assessments on what is important to them
- We are expert and independent
- We promote equality, diversity and human rights
- We engage with those providing and commissioning care

Foreword

Our strategic plan sets out what we want to achieve for people who use health care and social care, and how we will go about our work over the next five years to realise these aims.

Since the Care Quality Commission (CQC) began operating in April 2009, we have consulted widely with people who have an interest in our work. We consulted formally on our proposed strategy for the next five years in late 2009 and are grateful to the many people whose views have helped to develop and shape our final strategy.*

We received widespread support for our plans, which are organised around our five priorities for improving quality of care and outcomes for people who use services. The consultation feedback showed that they are considered to be clear, appropriately ambitious and, if successful, will bring about substantial changes to health care and social care in England.

Equally importantly, some of the feedback raised helpful challenges, which we have addressed in our final strategy. These called for CQC to:

- Be sensitive to the pressures that the changing economic and funding environment is putting on providers and commissioners, and for our assessments to take 'value for money' into account.
- Place more emphasis on safeguarding and on the role we play in protecting the rights of people in vulnerable circumstances.
- Make sure that our regulatory practices are of a high quality and result in consistent judgements.
- Give more recognition to the role that other organisations in the heath care and social care system play in achieving the outcomes for people that we want to see.
- Be clearer about how we go about our work, including our methods of inspection and assessment of outcomes for people, and about our immediate and subsequent priorities so that our stakeholders understand our year-by-year focus.

* A detailed report of the responses to the consultation is available on our website.

Over the next two years, we will be focusing on making sure that providers are meeting new essential standards of quality and safety, as we introduce our new registration system throughout health care and social care. Alongside our registration activities, we will be promoting improvement over time through our published assessments of the quality of services. These will also place more onus on primary care trusts and councils when they purchase care for local people, by making them accountable for its quality.

People who use services are at the centre of all we do and we will make our assessments from their perspective. We will make sure that people's rights are protected, that they have power to make informed choices about their care, and that the services they use work in an increasingly 'joined-up' way to give a seamless experience of care.

CQC is the first regulator in England to work across both NHS and independent health care, and social care. This gives us a unique opportunity to make a real difference for people, by working with a range of organisations in these sectors to drive improvement in local care services and in how well they work together.

As Chair and Chief Executive, we very often meet with people who use services and organisations that represent them, as well as with those who provide or purchase care for local communities. Their views and suggestions are of great value to us and have helped to shape CQC's thinking so far. We will ensure that they continue to do so, in all of our work to deliver the commitment to better care that we have made in this strategic plan.

Dame Jo Williams
Chair

Cynthia Bower
Chief Executive

Contents

1 Our starting point

Health care and social care touches everyone's lives. The quality of care services* can have a profound impact on people, and on their families and carers.

We are an important part of England's care system. As the independent regulator of health and adult social care, we are here to make sure that people's care meets essential standards of quality and safety. We encourage improvement in services, by providing information on the quality of care and how it is provided and commissioned. We promote the rights of people who use services and we recognise the importance of people and communities being empowered to shape their own care services. We have a wide range of powers to take action on their behalf.

Local councils and primary care trusts make a range of services available, and local providers and their staff deliver the services. The regulator does not. And we cannot observe or inspect every interaction of care.

What we can do is set expectations. Providers and commissioners are accountable for the quality and safety of care. Our role, as the regulator, is to reinforce that accountability to the people who use the services and to the public, and to act if organisations are not meeting their legal responsibilities.

Regulation, and hence our work, enables organisations to build their capability. When services are performing well, we will take a lighter touch. But when people are not getting an acceptable standard of care or their rights are not being respected, we will be firm in taking whatever action is needed.

Our powers and duties

We have been given a range of legal powers and duties. These include:

- Registering providers of health care and social care to ensure they are meeting the essential standards of quality and safety.
- Monitoring how providers comply with the standards – gathering information and visiting them when we think it is needed.
- Using our enforcement powers, such as fines and public warnings, if services drop below the essential standards. If we think that people's rights or safety are at risk, we will act quickly – including closing a service down if necessary.
- Acting to protect patients whose rights are restricted under the Mental Health Act.

* We use the word "care" in our strategy generally to describe health care (including mental health care) and social care together. In some instances, we are more specific about the type of care we mean.

- Promoting improvement in services by conducting regular reviews of how well those who arrange and provide services locally are performing.
- Carrying out special reviews of particular types of services and pathways of care, or undertaking investigations on areas where we have concerns about quality.
- Supporting public accountability by assessing performance and by contributing to 'Oneplace' – the joint assessment of how well people are being served by their local public services.
- Seeking the views of people who use services, involving them in our work and publishing a statement on how we do this.
- Telling people about the quality of their local care services. This will help providers and commissioners of services to learn from each other about what works best and see where improvement is needed, and help to shape national policy.

Our role in the wider care system

To carry out our role, we collaborate with a range of other organisations in the health and adult social care system in England.

Primary care trusts and councils commission services and ensure that there is enough quality care to meet the needs of their local people. We will regularly review their performance as commissioners of care, including checking how well they involve local communities in their planning, and work with them to tackle any concerns about local services.

Strategic health authorities (SHAs) oversee the commissioning arrangements of primary care trusts. We help SHAs to ensure that the NHS is meeting the needs of local people by giving them our information on the performance of primary care trusts. Where NHS provider trusts (other than foundation trusts) are not meeting essential standards, we work closely with the SHA to make sure that improvements are made.

The independent regulator, Monitor, determines whether NHS trusts are ready to become foundation trusts and checks that existing foundation trusts comply with the conditions they signed up to. It can intervene when there are failings in a foundation trust's standards of health care or in other aspects of its leadership. Monitor and CQC work closely together to agree which of us is best placed to address concerns about the quality of care at a foundation trust.

The Government Offices of the Regions make sure that the highest quality and value public services are delivered in a region, on behalf of government. The information we produce, particularly about council performance, is used by the Government Offices to improve outcomes for local people.

The Audit Commission appoints auditors to local authorities, SHAs, primary care trusts and non-foundation NHS trusts. It checks that these bodies have proper arrangements for getting value for money in the conduct of their business. For local authorities, primary care trusts and non-foundation NHS trusts, this includes making an annual assessment about their use of resources. It works in partnership with five other inspectorates, including CQC, to deliver the local area assessments of 'Oneplace'.

There are other professional regulatory and review bodies in the health care sector. Each has its own legal requirements that organisations have to meet. We work closely with these bodies, mostly at a local level. Our aim is to share our understanding of the risks in the local health economy and agree which body is best placed to take any action needed.

2 The challenges we see

Our *State of health care and adult social care in England* for 2009 highlights what is working well and where services need to improve, focusing on the needs of the millions of people who use them. It looks, in particular, at the extent to which services are putting people at the centre of their care and joining up around people's needs.

With this perspective, and bearing in mind the real issues that everyone in health and social care faces day-to-day, we see two broad challenges ahead: improving the quality of outcomes for people, and doing so in the context of the weaker financial climate over the next few years.

Improving outcomes for people

People should be able to shape their own lives as they wish and be confident that the services they receive are of high quality, are safe and promote their own independence, wellbeing and dignity.

Everyone's life is touched by health and social care services in some way – a visit to their GP, a stay in hospital, a family member who needs residential care. As people's need for support changes over time, so do their priorities and expectations. Quality and safety have always been a priority but equally important is having a choice and people's care being personal.

Our *State of health care and adult social care* shows that standards are improving and that most people have a positive experience of care. However, people are still not getting good outcomes in some areas of care. In particular, there are a minority of services or organisations that still do not come up to basic standards of quality and safety.

There are 10 key issues that shape our priorities:

1. **People securing fair access to care.** Across the country, people get different levels of social care because of the different ways that the eligibility criteria are applied (with elements of a 'postcode lottery'). This inconsistency, and a lack of care for people who need less intensive support, can be distressing for people and their families and can often result in an extra burden being put on the NHS. People who fund their own social care also face disadvantages, and risk having few options other than residential care before other opportunities have been properly explored. The Government recently published a green paper, *Shaping the Future of Care Together*, in response to these challenges. Within health care, the setting of priorities, access to particular treatments, and decisions on the availability and opening arrangements for services are made by local organisations. It is important to be supportive of local decision-making on priorities; equally, these need to be fair, and meet the needs of local people.

2. **Ensuring person-centred care that supports independence and choice.** People should be in the driving seat when it comes to their own care, with input from their carers and families. The evidence shows that this is not happening consistently. There needs to be a cultural shift – to give people better quality information, a stronger voice and the support they need to understand their options and make decisions.

3. **Investing in early intervention, support and prevention.** Successive policies have supported greater investment in early intervention, to help people become more independent, to prevent ill-health in later life, and to deliver better value for money in the medium term. But implementation has been slow.

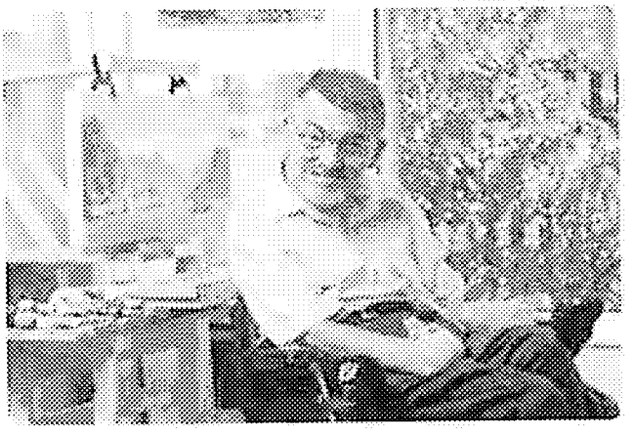
4. **Reducing health inequalities.** There are still wide inequalities in health in England. For example, there is a 23-year difference in life expectancy between the most affluent and most deprived areas. They can be seen between people from different occupational groups, different ethnic backgrounds and different regions. People who live in areas with the worst health outcomes are less likely to have their need for preventive treatment identified by their GP.

5. **Tackling poor performance.** There are also significant differences in the quality and safety of care. Services need to put a greater emphasis on providing safe care and learning from incidents and complaints. There is not enough information on the outcomes of care, and services need to get better at acting on the views of people who use services and their carers.

6. **Bringing openness to the quality and safety of care.** A lot of work has gone into developing and collecting information that measures the outcomes of care, but there is not a full, agreed set of such measures. This includes outcome measures that reflect the views of people who use services and carers. Providers often use different measures, which makes it difficult for people who use services to compare their performance. Sometimes, when these outcomes are published, it leads to accusations of poor quality care, which the responsible organisation feels it must defend to reassure local people about the quality of its services and to protect its reputation. Working with others, we want to create a climate in which variation in outcomes is explored to inform efforts at improvement.

7. **Making sure that staff are properly trained and supported to do their jobs.** This issue comes up often when we report on areas of poor care, with support, supervision and direction sometimes lacking.

8. **Providing the right leadership.** Care that puts people first, takes into account their views and protects their rights, needs effective managerial and professional leadership and accountability at all levels.



9. **Working together across health and social care.** People who need both health care and social care still experience gaps and long waits when they transfer between services. There is a lack of coordination between services – sometimes the care is duplicated, it is not tailored to their individual needs and people are not given enough information about the options open to them. Our *State of care* report explores how better joined-up care will help meet future demand and deliver greater value for money, by reducing reliance on high-cost hospital and residential care. Better links between health care, social care and other local public services such as housing and employment are also needed to support independence and social inclusion.

10. **Supporting people who are made vulnerable by their circumstances and protecting their rights.** We know from some high-profile instances, and in the assessments we make, that the performance of care services in safeguarding adults and children is not consistently high. Furthermore, compared to the general population, people in more vulnerable circumstances – including older people and those with mental health needs, learning disabilities, physical disabilities or long-term conditions – experience worse outcomes. These include inequalities in physical health, employment, education, housing, social networks and community participation. Improving outcomes for particular groups is crucially important within each of the issues above.

The financial climate

Health and social care is a major expense for Government and local councils. Real spending on the health service in England more than doubled from £46 billion in 1999/2000 to the £106 billion planned for 2010/11. In 2008/09, the amount spent on private health care was about £7 billion. Local councils spent £16.1 billion on adult social care, and private expenditure on social care for older people was over £6 billion. Staffing costs account for 80% of social care expenditure. In health care, the figure is around 70%.

But future spending in the NHS is more uncertain. The growth in its budget will be severely constrained. In December 2009, the Chancellor announced that, from 2011/12 to 2012/13, NHS frontline spending will rise in line with inflation. And the Department of Health has stated that the NHS will need to identify £15-20 billion of efficiency savings over the next five years so that it can fund improvements in quality.

There are similar pressures in adult social care. In his 2009 Pre-Budget Report, the Chancellor proposed more preventive approaches to care for older people, to allow them to stay in their homes and so reduce expenditure on residential care by £250 million. The reform of funding and organisation of social care is the subject of much national debate currently – substantial change is likely, but possibly not before 2014.

Over the period of this strategy, the economic environment will inevitably have an impact on health and social care:

- The demand for care and support will increase significantly. Life expectancy for both men and women has increased by 11 years since 1948. By 2026 there are likely to be 1.65 million more disabled adults in England; 1.3 million of these will be over 65.
- There will be potential pressures in the social care market on the quality and availability of care, tough choices on where to spend money in health and social care, and debates over how to invest to produce quality services.
- Individuals and families may have to contribute more towards the cost of social care, and there may be an increasing reliance on self-care.
- Delivering better quality and meeting growing demand for health care at a time of unprecedented financial constraints will present significant leadership challenges for the NHS.
- The health and wellbeing of people and communities may be affected by rising unemployment.

These pressures are real and we need to be sensitive to them as we assess both providers and commissioners of care. At the same time, we are committed to putting people at the centre of our work. We cannot stand by, for example, where essential standards of care are not being provided. Our perspective means that:

- We can identify where services are being innovative, or working well in partnership. For example, an organisation that thinks carefully about the ideal journey for a person through the health and care system can align its resources and deliver services more efficiently.
- Our assessments can take into account the prospects for local health economies weathering the financial climate.
- We will be sensitive to the impact of registration fees on the sustainability of services.
- We will report on the extent to which financial pressures are affecting the availability and quality of care. We will do this in conjunction with other bodies such as Monitor and the Audit Commission.

We are not immune from these financial challenges. In establishing CQC, we have reduced our recurring costs by over £40 million in comparison with the predecessor organisations, as part of the Government's commitment to efficiencies. Furthermore, the Government has recently published *Smarter Government*, which aims to maximise the operational efficiency of arms' length bodies like us and reduce overall costs.

In our planning for future years, we will be positive about the opportunities this presents – for example, thinking creatively about collaborating and partnering with others.

3 Our priorities for change and our activities to support them

In the previous sections, we have set out the key challenges. We need to help improve outcomes for people, by reinforcing the accountability of organisations in meeting their responsibilities. We need to drive improvement in services and act when providers of care do not meet essential standards of quality and safety. And we should make sure that people are at the centre of their care and they have the tools they need to make informed choices and decisions.

Our resources are limited, so we must put in place an effective system of regulation that enables us to meet these challenges. We must be driven by the outcomes that people who use services say are important to them, and focus our activities so that we make a real difference to people. At the same time, we need to be flexible and sensitive to the challenging financial environment, and work collaboratively with others to maximise the impact we have.

We have, therefore, identified five priorities where we believe our unique role as regulator will enable us to bring about visible change and significantly enhance outcomes for people. We will deliver these priorities by carrying out our regulatory activities well.

This section explains our priorities, what we will do to achieve them, and how we will measure the progress we are making.

Our priorities

1. **Making sure that care is centred on people's needs and protects their rights**

   We want people to be able to shape their own care around their needs, and to have a voice. To do this, they need up-to-date, relevant and accurate information so that they can make informed choices about their care.

2. **Championing joined-up care**

   We want to see better coordinated and integrated health and social care, so that the services people receive are joined up and their experience is a good one. We also want better integration within sectors, for example across primary and acute services, and when young people move up into adult care. We want commissioners and providers of care to work together, and with people who use services, so that outcomes for people are improved.

3. **Acting swiftly to help eliminate poor quality care**

   People have a right to expect that, if a service falls below the essential standards expected, this is identified and acted on quickly. We want to have a major impact on these poorer services and we will focus particularly on those that fail to improve.

4. Promoting high quality care

People should be able to access and experience high quality services that put them first and respect their rights. Where we identify care that is improving, we will promote this so that other commissioners and providers can learn from what is working well.

5. Regulating effectively, in partnership

We will be sensitive to the requirements that we put on those we regulate. We work to the principles of better regulation and we will frequently show our progress in doing so. We will work with other organisations to improve the quality of life for communities and local people, and make sure that the benefits we bring to people significantly outweigh our costs, and those incurred by others in meeting our expectations.

In everything we do, we will consistently focus on equalities and human rights. We have published our draft Equality and Human Rights Scheme, which sets out how we propose to do this, and we have asked a wide range of people for their comments on the scheme.*

We will pay particular attention to the needs of people in more vulnerable circumstances, including those with mental health needs; learning disabilities; physical disabilities or long-term conditions; older people; and children and young people.

Better outcomes for people will depend on all parts of the health and adult social care sectors working effectively together with people who use services and their carers. Effective regulation is just one part of that, and we will use our influence to ensure that others play their part too. We will wish to keep the outcomes under review, to make sure that they remain focused on outcomes that people say are important to them.

Our regulatory activities

1. Registration, ongoing monitoring of compliance and enforcement

From 2010, the cornerstone of our regulatory activity is the new system of registration. The system means that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights. It is focused on outcomes for people rather than the systems, processes and policies that providers follow, and puts the views and experiences of people who use services at its heart. We will continually review all the information we have about a provider as part of a new, more responsive and dynamic system of monitoring compliance and, where necessary, enforcement.

* See www.cqc.org.uk/getinvolved/consultations/equalityandhumanrightsscheme.cfm

2. Assessments of quality

Alongside registration and ongoing compliance, we encourage and promote improvement. We do this by providing independent, reliable and up-to-date information about the quality of providers' care over and above that needed for registration, and about the quality of care secured by commissioners for their local communities. We also carry out special reviews and studies across providers and commissioners, looking at pathways of care, specific themes, or value for money. We describe these as "assessments of quality". We have published our plans for our assessments of quality in 2010/11 for consultation.*

The information will be used by people, so that they are better informed about the quality of care and are able to make choices, and are able to hold providers and commissioners to account locally; by commissioners of care to inform their understanding about the quality of care they commission on behalf of local people; by providers in comparing, or benchmarking, their own performance and learning from each other; and by policy makers.

3. Mental Health Act visits†

As part of our work in mental health care, our Mental Heath Act Commissioners monitor the care of people whose rights are restricted under the Act, check how legal powers of compulsory care and treatment are being used, and make sure that people's interests are protected. Our approach to improving mental health services covers both providers and commissioners across health and social care services.

4. Publishing information

In all of our work, we publish information on the quality of care to help people make decisions about their care. We will make the information we provide as up to date and relevant to people as possible.

Bringing it together

In the following table, we set out in detail what we will do to achieve our priorities, and how we will measure the progress that we, and others in the system of health and social care, are making. In consultation with people who use services, commissioners and providers, we will continually seek to improve these measures. We will report on and publish our progress every year.

* See www.cqc.org.uk/getinvolved/consultations/assessmentsofquality.cfm

† We undertake other statutory activities, for example reviewing arrangements for the management of controlled drugs and the use of ionising radiation.

Priority	What we will do ■ Registration, ongoing monitoring and enforcement ■ Assessments of quality ■ Mental Health Act visits ■ Publishing information	Outcome measures
1. Making sure that care is centred on people's needs and protects their rights	▒ Set clear expectations for commissioners and providers that care will be centred on people's needs through guidance on essential standards that is outcome-focused and people-centred. ▒ Improve the information and intelligence that we hold on the views and experience of people using services, and give more weight to people's views in identifying risks that essential standards are not met and in assessing the quality and safety of care. ▒ Have a particular focus in reviewing compliance on how well providers are making sure that people who use services: – Are able to understand the choices available to them; involved in making decisions about their care, treatment and support; have their privacy, dignity and independence respected; and have their views and experiences taken into account in the way the service is provided and delivered (outcome 1 of the guidance about compliance with the essential standards of quality and safety). – Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights (outcome 4). – Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld (outcome 7). ▒ Visit annually all locations where there are people who are compulsorily detained and, where appropriate, meet with people subject to compulsory treatment in the community, to ensure that they are asked about their experience and their human rights are protected.	▒ An increasing percentage of people using services report that they were able to understand the choices available to them; had their privacy, dignity and independence respected; were involved in the design and delivery of services by providers and commissioners; experienced safe and appropriate care that met their needs and protected their rights; and that safeguarded them from abuse. ▒ People have equal access to personal budgets and direct payments and the take-up increases annually. ▒ The experiences of people whose rights are restricted under the Mental Health Act are systematically incorporated within assessments of ongoing compliance with registration requirements, and we can demonstrate the impact that this has on our judgements. ▒ An efficient second opinion service safeguards the rights of people who need this service. ▒ People who use services have growing confidence that our assessments fairly reflect their experiences. ▒ Providers and commissioners can demonstrate how they are involving people who use services and the public in the design and delivery of services.

Priority	What we will do ■ Registration: ongoing monitoring and enforcement ■ Assessments of quality ■ Mental Health Act visits ■ Publishing information	Outcome measures
1. (continued)	▒ Ensure that people who require a 'second opinion' as part of a community treatment order have access to a prompt second opinion service. ▒ Provide the public, providers and commissioners with up-to-date, relevant and accurate information to support the delivery of care centred on people's needs. ▒ Engage people who use services and their carers in our work to promote person-centred care to providers and policy makers. ▒ Embed equality and human rights into our registration activities and ensure our staff are supported by methodology and training that makes them competent and confident in relation to equality and human rights.	▒ Comparative information on the performance of areas in providing person-centred care helps promote improvement in key measures. ▒ People who use services and their carers, and groups representing their interests, consider that CQC has a strong focus on their views and experiences and is successfully championing person-centred care. ▒ Registered services meet the needs of diverse communities, and respect and maintain the rights of people receiving their services.

Priority	What we will do ■ Registration: ongoing monitoring and enforcement ■ Assessments of quality ■ Mental Health Act visits ■ Publishing information	Outcome measures
2. Championing joined-up care	▪ Have a particular focus on reviewing compliance on how well providers are making sure that people who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or where they are moved between services (outcome 6 of the guidance). ▪ Work towards aggregating the findings of Mental Health Act visits to inform the quality of care provided by registered services; and use this to inform our assessment of councils and primary care trusts. ▪ Provide information on how well councils and primary care trusts commission care where people experience care that is 'joined up', supporting them to live independently. Work with the Department of Health to further develop common outcome measures for holding councils and primary care trusts to account for better joined-up care. ▪ Assess the performance of commissioners and providers in delivering high quality pathways of care, for example through special reviews and studies. ▪ Provide information on lessons learned to support improvement in the provision and commissioning of services, and in policy-making.	▪ There is a reduction over time in the number of actions we need to take against providers on the registration requirements that contribute to joined-up care. ▪ People experience better care and public money is used more efficiently and effectively through more joined-up care – with improvement in the performance of key indicators of joined-up care (for example, % re-admission rates; % delayed discharge; proportion of older people in hospital). ▪ There is an increase in the number of people who consider that the services they use are effectively integrated. ▪ Special reviews and studies promote greater focus on the pathways of care, which will achieve higher quality outcomes.

Priority	What we will do ■ Registration, ongoing monitoring and enforcement ■ Assessments of quality ■ Mental Health Act visits ■ Publishing information	Outcome measures
3. Acting swiftly to help eliminate poor quality care	▪ Identify serious issues by responsive and vigilant assessment of risks to the quality and safety of care, and act swiftly using targeted, proportionate and meaningful action to bring about change that improves people's care. ▪ Generally undertake unannounced inspections of services. ▪ Publish information on our assessment of risk, registration judgements and enforcement action. ▪ Create a quality and risk profile for each care provider and commissioner, containing all the information we hold about the quality of care they provide or purchase for people. ▪ Provide information on lessons learned from instances of poor care to support improvement in the provision and commissioning of services, and in policy-making. ▪ Hold councils to account for the quality of regulated social care they purchase; and pilot a similar approach for primary care trusts.	▪ There is an increase in compliance with registration requirements over time. ▪ No serious issues emerge that CQC had the capability and capacity to spot and did not. ▪ The enforcement action we take has a lasting impact, eliminating poor quality care. ▪ Lessons learned from service failures are acted on in other organisations. ▪ We reduce the time that providers take to undertake necessary improvements with regard to registration requirements. ▪ Commissioners are held to account for their performance through our review process, and this leads to improvements over time in the quality of services.

Priority	What we will do ■ Registration: ongoing monitoring and enforcement ■ Assessments of quality ■ Mental Health Act visits ■ Publishing information	Outcome measures
4. Promoting high quality care	▪ Provide independent information (including from our annual *State of health care and adult social care* and annual report on the use of the Mental Health Act) about providers' quality of care above the registration level, and about the quality of care secured by commissioners for their local communities for public accountability and to promote improvement. ▪ Undertake special reviews where we focus on particular outcomes within the registration requirements, to spot trends and nip emerging problems in the bud. ▪ Use evidence from our activities to promote examples of good practice. ▪ Work with other organisations operating within health and social care systems as local improvement partners. ▪ Work with national bodies involved in quality improvement, in order to share knowledge from our regulatory activities, ensuring policy and national improvement programmes have a rigorous evidence base.	▪ The performance of commissioners and providers in our assessments of quality improves over time. ▪ An increasing proportion of commissioners and providers are able to demonstrate an improvement in the value for money their services offer. ▪ An increasing proportion of commissioners and providers make use of our information, have confidence in it, and consider that it helps to improve the quality of care. ▪ Local voluntary and representative bodies, including LINks and council overview and scrutiny committees, make use of our information and consider that it helps to improve the quality of care.

Priority	What we will do ■ Registration, ongoing monitoring and enforcement ■ Assessments of quality ■ Mental Health Act visits ■ Publishing information	Outcome measures
5. Regulating effectively, in partnership	▒ We will exemplify the five principles of better regulation – being transparent, accountable, proportionate, consistent and targeted. ▒ We will work with strategic health authorities, Monitor, Government Offices for the Regions and other audit and review bodies to share information about the quality and safety of care, including through planned collaborative reviews, and on the coordination of regulatory activities. ▒ We will equip and support our staff to deliver effective regulation.	▒ Our collaboration with other organisations reduces duplication in information requests and inspections. ▒ Providers have increasing confidence in the consistency of our decision-making. ▒ We work with our partners to ensure that early warning systems are effective in identifying and managing signs of service failure. ▒ We make year-on-year improvements in the efficiency and effectiveness of our activities, for example in dealing more quickly with new applications for registration and in minimising our costs. ▒ The costs of our regulatory activities are proportionate to the expected benefits for people who use services, their carers, the taxpaying public, and health and adult social care organisations and their staff. ▒ The costs of our regulatory activities are transparent and based on 'cost recovery', which will incentivise good performance by registered organisations. ▒ Staff at a range of levels in organisations we interact with perceive that we are customer-focused, professional and efficient.

4 How we work

This section sets out how we work and how we will phase our work over the coming years.

Our principal task is to operate the new registration system for providers of care, as well as assessing the quality of care and carrying out our duties under the Mental Health Act. Under the new registration system, providers must be able to comply with six main outcome areas:

- Information and involvement – the information that providers make available to people so that they can make informed decisions about their care and support.
- Personalised care, treatment and support – the way in which providers make sure that people get effective and safe care and treatment that supports their individual needs and respects their views.
- Safeguarding and safety – the way in which providers assure people that their equipment and premises are safe and suitable, that they manage risks and that they protect people's human rights and dignity.
- Suitability of staffing – what providers do to make sure that they have suitably qualified, skilled and knowledgeable staff who can competently support people.
- Quality and management – what providers do to manage risk and ensure that they maintain essential standards.
- Suitability of management – what providers and managers must do to show that they are suitable to run the service and to notify us of any relevant changes.

In addition to checking that people can expect services that meet essential standards of quality and safety, we also have an important function in promoting improvement. We do this by providing independent, reliable and timely information about the quality of care above essential standards, to help people make better informed decisions about where to go for their care.

All our activities are inter-related and build on common issues.

1. Bringing together information about the quality and safety of care

We will collect information about all the services that we register, as well as councils and primary care trusts that purchase care for their communities. This information will be wide-ranging. We will seek the views of people who use services, carers and families for every service that we assess, working closely with Local Involvement Networks (LINks). We will look through websites more to capture those views.

Other information will come from our own inspections and service reviews, from providers' declarations of compliance that are part of registration, and from government departments and other regulators.

We will also collect information direct from those who purchase and provide care services – information that they already gather and use in their own work. We expect them to be able to show how they have listened to the views of people who use services and how they have acted on them.

2. Analysing risks to people using services

We can identify risks to the quality and safety of care by analysing information. As part of a dynamic and responsive system, we will continuously monitor compliance with essential standards so that when we get new information, we can make decisions about whether we or other organisations need to take any action.

Analysing information on death rates, and other measures that identify services that appear to be performing less well, enables us to follow up and check if there are problems in the quality and safety of care.

We will also look at the risks to people's wellbeing because they cannot access services.

3. Responding to risks and making judgements about compliance

If, after looking at all the information we hold about a service, we have concerns, we may decide to take further action. This could include:

- Asking them for more information.
- Inspecting the service and, if needed, using outside experts for their advice.
- Asking another organisation to act, for example a strategic health authority, other regulators such as Monitor (for NHS foundation trusts), or the local authority organising care on behalf of its community.

If we decide to carry out an inspection, it will generally be short, focused and unannounced. Inspections will centre on assessing outcomes for people and their experiences of care.

We will be most active in areas where we think the risks of harm are greater, where people are less able to assert their rights, where information on the quality of care is poor, or where providers are failing to improve. We will be less active where services are performing well.

If we decide that a provider is not meeting registration requirements, we will act to ensure that improvements are made. These include issuing improvement letters, statutory warning notices or fines, attaching conditions to registration, or suspending or cancelling registration. Our biggest concern is to protect the safety of people using services.

We will work with others – including those who purchase care for their communities and other organisations – to make sure that improvements happen and are maintained.

4. Assessing and publishing information on the quality of care

We want our information to be as up to date and relevant as possible.

We are creating a 'quality and risk profile' for each organisation that purchases or provides services.

These will bring together all the information we hold and will build up over time to provide a detailed and dynamic view of the quality and safety of care. They will also include our judgements about compliance with registration, which will be continually updated. We will be as transparent as possible in letting people know what information we hold in developing these profiles, in consultation with all our stakeholders.

We will have an ongoing programme of 'quality ratings' for providers of adult social care, where we publish an assessment of the overall quality of the service. Making a judgement about the quality and safety of these services will always involve a site visit. For NHS trusts, we will report on their progress against the national priorities set by Government.

For those that purchase care for their local communities, we will assess how well they are achieving better outcomes for people and how effectively they are using public money, and we will publish the results. We will also hold them to account for the quality and safety of the care they buy from those services we register.

5. Defining 'high quality' care

We believe that 'quality of care' should be broadly defined and should reflect the outcomes of care for people and their experiences of it. Across health and social care there are different sets of criteria, outcomes or competences related to each sector. We have looked carefully at these, including the Department of Health's draft registration requirements, the definitions of quality in the NHS described in *High Quality Care for All*, at the *World Class Commissioning* competences, at the outcomes used in *Our Health, Our Care, Our Say* and those in *Putting People First* and the expectations of care set out in *Shaping the Future of Care Together*.

From these, we have developed six dimensions for informing our work in addressing quality in health care and adult social care – using a common language across different settings in a consistent way:

- **Safe:** People using a service are not put at unnecessary risk of harm, and people in vulnerable circumstances are safeguarded.
- **Improving outcomes for people:** The outcome for people using the service – including the clinical outcome – is the right one. And the care provided is integrated in meeting individual needs.

- **A good experience for people:** People using the service feel empowered to exercise choice and control. They are treated with dignity and respect. They, their families and carers are involved in shaping the service around what is important to them.
- **Independence and wellbeing:** The service is focused on helping people to achieve the best possible health and quality of life, and optimum independence.
- **Access to services:** The service is available to those who need it when they need it, both on an individual and community level.
- **Value:** The service delivers value for money by using resources effectively.

This will help us to work towards our vision of high quality care that enables people to live healthy, independent lives and make informed choices about care, and that responds to each person's individual needs.

We will work in cooperation with people who use services, carers and families and the health and social care sectors to check and improve these dimensions over time.

5 Taking the strategy forward

Our task is to make sure that essential standards of quality and safety are met wherever health care, mental health care and adult social care is provided, and that people experience a better quality of care.

As the first regulator in England to work across both NHS and independent health care, and social care, we have a unique opportunity to take a new approach. Not only will we assess individual services throughout the country, but we are also able to look at how well the sectors work together to ensure that people get better joined-up care.

We want to have an impact – and we know that people who use services, carers and families also want to see improved outcomes and experiences. However, we must be careful not to create uncertainty and unnecessary upheaval to those providing the services.

This is a strategy for five years. Each year, we will publish a business plan that sets out our plans for the year in detail, taking into account the changing environment in which we work. In the period of the strategy, there will be a general election and the economic climate over the next few years will remain uncertain. We recognise that there will be further pressure on the resources available for regulation, and we will need to demonstrate our 'added value' in improving people's outcomes and experiences.

We can signal our intentions clearly over the next two years. However, we must follow a more flexible approach to setting out our activities for the later period of this plan, from 2013 to 2015.

2010/11 and 2011/12

The cornerstone of our activities over the period of this strategy will be ensuring that all providers of health care and adult social care meet essential standards of quality and safety, with the phased introduction of the new system of registration.

In these first two years, we expect to strongly focus on tackling poor performance and giving greater assurance that the essential standards are in place. We will also be particularly aware of the effects that tighter finances may have on quality and safety.

Subject to legislation, we expect that providers will be registered as follows:

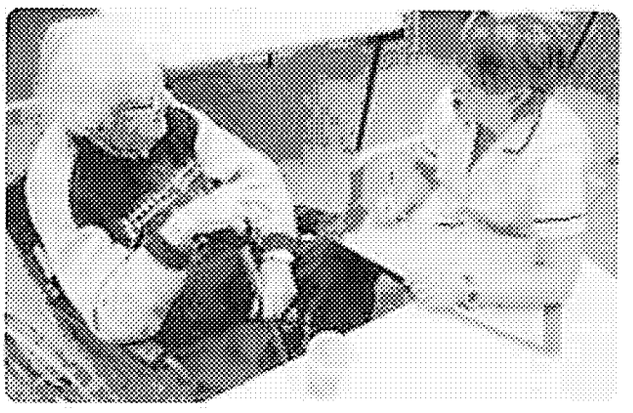
Sector	Date registered and subject to ongoing compliance
NHS trusts	April 2010
Adult social care and independent health care providers	October 2010
Primary dental care (dental practices) and private ambulance services	April 2011
Primary medical services (GP practices)	April 2012

We will also carry out other activities to take the strategy forward:

- Building up quality and risk profiles for each provider and commissioner (see page 21). We will add information about the views and experiences of people who use services, and will give more weight to these views in targeting our visits to providers. We will be open and transparent about the information we hold.
- Building stronger working relationships with commissioning and other regulatory bodies, including the Government Offices, strategic health authorities, Monitor and the Audit Commission. This will show that our activities are aligned, that we are effective in working together to improve outcomes for people, and that we are reducing the costs of regulation.
- Consulting on our approach to assessments of quality in 2010/11. We are clear that most of our resources in 2010/11 will be allocated to the new registration system. We are therefore consulting on what we see as a realistic set of changes, which also seek to reduce the costs of assessment for providers, commissioners and ourselves.
- Piloting new approaches for 2011/12 onwards to help promote better joined-up care. For example, we will develop and pilot common outcome measures for joined-up care and joint service inspections of councils and primary care trusts relating to safeguarding.
- Building on and reviewing our mental health activities to ensure that we have the best possible safeguarding arrangements and opportunities for sharing information within CQC.
- Reviewing and updating our statement of involvement (Voices into Action) to enhance the way we use feedback from people about services and involve people in our work, and to make sure that services properly involve people in their work.
- Ensuring that the knowledge from our regulatory activities is analysed systematically, to identify key issues that should inform our future priorities and to provide an evidence base for policy and for national and regional improvement programmes.
- Reorganising and training our operational teams. This will be completed during the early part of 2010/11, to ensure that our regulatory teams are prepared for the requirements placed on them by the new system of regulation, and properly supported.

2012/13 onwards

Monitoring compliance with essential standards will be an ongoing and dynamic task. But, by 2012/13, we expect registration to be more embedded in the operational activities of providers and for other 'levers' in the system – such as commissioning, performance management and local public accountabilities – to be reinforcing the importance of meeting standards.



As we get more assurance that essential standards are being met, we expect to be able to focus more on providing information on the quality of care, increasingly at the level of individual services and pathways of care. This will help to empower people who use services and provide accountability for commissioners and providers in improving outcomes. As the regulator, we will have a stronger focus on those areas where health and social care services are not producing good information on quality.

During this period, we will also:

- Look at refreshing the requirements of the essential standards and some of our working methods, to ensure that 'the bar' is set at the appropriate level and that the incentives in the system relating to compliance are working well.
- Continuously improve the content of quality and risk profiles, to reflect the outcomes of care that people experience and say are important to them.
- Work with a range of local and national organisations, as part of local improvement networks, highlighting best practice and enabling other organisations to improve by learning from those that perform well.
- Have developed our approach to assessing councils and primary care trusts as commissioners of care, so that the assessments provide effective and proportionate accountability, locally and nationally, for the quality and value for money of services, and help to promote improvement through independent comparative information.
- Increasingly provide information to hold councils and primary care trusts to account jointly for improved outcomes relating to person-centred care and joined-up care.
- Gather evidence to support our commitment that the benefits of our regulatory activities significantly outweigh the costs, and that the costs are reduced over time.

Developing our own organisation

We are developing as an organisation to meet the challenges set out in this strategy. Our effectiveness as a regulator depends on the skills and values of all our staff. To work well, they must not only have the right tools and skills, but also a culture in which they can flourish.

We are working to create a strong, unified organisation in which our staff:

- Understand their role, what is expected of them and where they fit into the organisation.
- Are given clear and frequent feedback on their performance.

- Are able to develop personally and professionally and continually improve their performance through different ways of working.
- Are part of a truly diverse workforce, in which diversity is promoted at all levels.
- Have leaders and managers who are committed to real engagement with others and have the tools they need to develop staff at all levels.

We have already made significant changes within the organisation to improve our efficiency and effectiveness, so that we can deliver the ambitious programme of work within this strategy. More work is underway to make sure that we have the right expertise and capability to match our task, to develop our organisational strategy, to invest appropriately in information technology, and to ensure that we operate efficiently.

We do so in a period where we will face substantial financial and other challenges. We are determined to be alive to all opportunities that will enable us to achieve our priorities. We will deliver year-on-year improvements in the efficiency and effectiveness of our activities, including by working in partnership with other bodies.

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How to contact us

Phone: 03000 616161
Email: enquiries@cqc.org.uk

Registered Office:
Care Quality Commission
Finsbury Tower
103–105 Bunhill Row
London EC1Y 8TG

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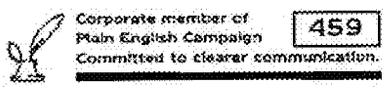

CQC-091-2000-ESP-022010

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS2 [ ] to the Witness Statement of
Kay Sheldon

Reflections and Suggestions

Introduction

I have put together my reflections and thoughts on CQC as we move into 2011 and in response to Jo's note before Christmas. This has helped me order and review my own thinking and I thought it may be worth sharing. My intention is to describe the situation as I see it and in a frank and constructive way. My comments are not intended to be critical in a negative way. I am genuinely in awe of what has been achieved to date (mostly unrecognised within and without the organisation) and believe we have an experienced, talented and dedicated executive team and board. Owing to the challenges and ever-changing environment, I wanted to offer my 'take' on the situation to inform discussions going forward into 2011 and beyond.
I appreciate that some of the points below originate in my own lack of knowledge and some are obvious – I apologise where I appear to be teaching grannies (& granddads) to suck the proverbial eggs…

Where are we?

Successes & challenges: Much has been achieved but we continue to face many challenges and unknowns, both internal & external. There is a constant sense of waiting until we have finished registration before we can really get to grips with our real business of regulating. We spend a lot of time 'fire fighting' without much opportunity to take stock and (re) evaluate. The external landscape has changed, continues to change and contains uncertainties. We are responding heroically to the challenges. However, I think we do need to make opportunities to (re)consider where we're heading, how various issues & developments interface & the (potential) impact of these on us now and in the future. I would like us to be on the front foot rather than the back foot.

External policy and influence: I'm not clear how the role of the quality regulator interfaces with the various other (relevant) aspects of quality. I'm also unclear how we, as an organisation, are involved with the wider changes and whether this is considered in our own strategic context as the quality regulator of health & social care: are we simply responding to external priorities or are we engaging as a partner and, if the latter, what are we saying & doing? The Government & Gov departments are actively looking for answers. This gives rise to questions for us: are we making the most of opportunities? Are we being realistic & not 'over promising'?
Our working relationships with DH & Government are improved and much more constructive. However, the relationship between ALBs and Government always treads a fine line: are we the right side of the line?

Strategy: We have an organisational strategy and associated plan(s) in place which were developed in a robust way. It is possible that they are not 'fit for purpose' in the contexts we now face. I don't think it is enough to either tweak what we currently have or to adapt our approach as each new 'challenge' rears up. I'm not sure if we have a 'whole system' approach as yet – from start to finish.

From a financial perspective I'm not wholly clear on how our resources are deployed and the processes for determining this (I understand that there are significant limitations on this at present).

Regulatory model: In particular we have yet to achieve consensus – or maybe understanding – of what our regulatory model will look like 'on the ground'. I say this because although we have a regulatory model, when I ask myself questions such as 'How will we provide accurate and accessible assessments?' and 'How will be get to the heart of patient/service user experiences/outcomes of care?' and 'How will we pick up & deal with serious concerns early enough and quickly?' I cannot give clear/full answers. I'm aware of various excellent initiatives but I'm less clear on the crucial issue of how these fit (or will fit) together in a coherent model that can be effectively realised in our regulatory activities. This is not about getting into operational details but making sure our strategic approach and priorities can be translated effectively and appropriately 'on the ground'. As many examples have shown us, it is vital that senior managers and board members are aware of what is happening and could/should happen in our frontline activities. Following on...

Field force: We had a significant debate around the model for our field force model. I would welcome a discussion and review of how well it is working. It is still early days but we have started compliance monitoring in the NHS and I would like some reassurance that we will be able to deliver – in the fullness of time - on both commitments and expectations. I know that some staff especially assessors, inspectors & MH Act Commissioners are frustrated that they can't do the job as well as they'd like and are losing confidence in the organisation. Uncertainty & change certainly fuels this but there are also important messages coming through which we need to heed. If these are 'operational' to be resolved in the fullness of time then this is fine, but some of the issues could be more than this and we need to be aware of these in the context of our strategic discussions.

Human Resources: Many staff (especially in middle & upper tiers) are working long hours and under significant pressure. Morale is low as is confidence in 'management'. Staff (especially in 'lower' tiers) feel that senior managers and the board don't understand either what their working environment is like or how to effectively inspect/monitor care. Generally staff are very committed to their work and actively want to do a good job but there is frustration they can't do this and they do not feel empowered to contribute to developments either in their immediate work environment or to wider developments. There are some skills and knowledge gaps including at team level. There are encouraging signs that things are improving but we need to sustain the momentum as morale and 'buy in' from staff are crucial to our success and have a significant impact on organisational performance & reputation

Involvement & Stakeholders: We have undertaken a lot of good work around involvement & engagement. However, we have yet to consider (at board level) how this – much of which has been consultation and laying the foundations for future work – fits with the changing environment including Health Watch.
Eventually, I would like us to be able to describe how the 'user voice' is systematically gathered and used in our assessments.
Externally, some stakeholders are generally positive although are waiting to see how/what we will deliver. Others are openly critical of CQC although there is an

awareness of the challenges we face (some would say 'we all are'). Concerns continue that we may be too reliant on self assessment and that we won't have sufficient presence 'on the ground' and so either won't pick issues up soon enough or at all. This is particularly – although by no means exclusively - concerning for people who are in vulnerable circumstances.
We need to be clear – or remain clear – about the differences in relationships for example between service providers and service users, including where our priorities lie as a regulator.

Performance monitoring: Lots of effort has gone into developing our approach to performance framework and it is notoriously difficult to establish something which is accurate, realistic & not overly burdensome. Whilst I feel we are on the right track with this I'm still not convinced that we necessarily get an accurate picture at board meetings of how well we are performing as an organisation.
Although I have had the opportunity to provide input to the performance framework, this approach feels as those it is addressing symptoms rather then the cause. It is also the case that I'm not always clear as to what we are trying to achieve (as described above) which makes it difficult to say what is needed in the performance framework.

Where are we going?

There is, I think, a general agreement within the board and exec that we need to review our strategy (which is usual for an organisation) and we have yet to do this in a full and frank way. We need to challenge each other – not to pick holes but to achieve optimal decisions. We need to be clear what the outcomes of discussions are.

Below is a basic summary (nothing momentous or new) of what we could consider at our Feb away day and/or at our strategy meetings in 2011:

1. **Agree where we are now:**

- A discussion – and hopefully affirmation – of what our values are.
- An overview of the (developing) policy context in: health; social care; mental health; regulation; quality of care.
- Our current strategy & priorities; overview of progress inc challenges & main risks

2. **Our Strategy going forward**:

- Where we envisage being:
  i) in one years time; when registration is complete
  ii) in 5 years time

- How we will achieve this:
  i) organisational strategy & priorities;
  ii) 'deliverables'; how these relate to the responsibilities of directors & directorates
  iii) identification & management of risk;
  iv) role of Commissioners

3. **How we will monitor & review progress:**

   - Board & strategy meetings;
   - Performance framework; ARC.
   - Role of Commissioners.

Not much really…

Kay. Jan 2011

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS3 [ ] to the Witness Statement of
Kay Sheldon

Subject: Re: Ops leadership

From: Kay Sheldon (kay_sheldon@[redacted]

To: Amanda.Sherlock@[redacted]

Cc: Cynthia.Bower@[redacted] Jo.williams@[redacted]

Date: Thursday, 7 July 2011, 18:56

Hi Amanda

Many thanks for sending the slides which reflect my understanding of the general direction. However there doesn't seem to be any reference to the ops leadership structure aligning with the 'new system architecture'. You will remember that this was the issue I was asking about as I had not heard anything to this effect (and there was reference to this having been discussed by the board), so I'm not clear whether this means anything beyond and above having 2 assistant directors?

On a related issue, I was relieved to see in the presentation that we are retaining the position o[redacted] as it is vital that we retain this dedicated post at this level to ensure we have the credibility and visibility that the MH Act functions need. I am aware that there have been increasing levels of anxiety in various quarters (both internal and external) about our commitment to MH Act monitoring which is frustrating as we have repeatedly said that we we intend to not only protect but improve these functions. Learning from recent media coverage, I wonder if we could be more on the front foot and look at some positive/constructive communication about the work we're doing on 'modernising' the MH Act functions?

Hope all is well!

Best wishes

Kay

— On **Mon, 4/7/11, Sherlock, Amanda <*Amanda.Sherlock*@[redacted]** wrote:

> From: Sherlock, Amanda <Amanda.Sherlock@[redacted]
> Subject: Re: Ops leadership
> To: "'kay_sheldon@[redacted] <kay_sheldon@[redacted]
> Cc: "Bower, Cynthia" <Cynthia.Bower@[redacted]
> Date: Monday, 4 July, 2011, 19:03
>
> Dear Kay
> There is no paper as such except a briefing document prepared for Cynthia and used with Ops team where I have made proposals for new ops structure e.g dedicated Head of Registration, the alignment of regions has evolved through this process but also work that Cynthia, Alan Rosenbach and myself amongst others to consider CQC 'fit' with new system architecture.
> So plan is at senior level our regions or sectors map commissioning board and at local level the alignment will be health and well being / local authority level to maximise our contributions.
> If it would be helpful I will send you the briefing notes on ops posts and I am sure Alan R could provide more on external environment drivers ?
> Please let me know if you do want anything further
> Best wishes
> Amanda
>
> **From:** Kay Sheldon <kay_sheldon@[redacted]
> **To:** Sherlock, Amanda

Sent: Mon Jul 04 09:13:04 2011
Subject: Ops leadership

Good morning Amanda

I noticed your comment in the board newsletter about aligning the operations leadership and the National Commissioning Board but I don't recall having a discussion on this. I'm sorry that this has passed me by but could you point me in the direction of where I might find the paper/discussion? Many thanks.

Best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS4 [ ] to the Witness Statement of
Kay Sheldon

Subject: RE: Board governance

From: Kay Sheldon (kay_sheldon@

To: Jo.Williams@

Date: Thursday, 25 August 2011, 7:42

Hi Jo

Many thanks. This sounds good.

Kind regards

Kay

--- On Tue, 23/8/11, Williams, Jo <*Jo.Williams*@ wrote:

From: Williams, Jo <Jo.Williams@
Subject: RE: Board governance
To: "Kay Sheldon" <kay_sheldon@ "Williams, Jo" <Jo.Williams@
"Deirdre Kelly" <d.a.kelly@ "john harwood" <john.harwood@ "Martin
Marshall" <Martin.Marshall@ "Olu Olasode" <olu@
Cc: "Cannon, Alastair" <Alastair.Cannon@ Brown, Jerina"
<Jerina.Brown@
Date: Tuesday, 23 August, 2011, 12:52

Dear Kay

I think this is a very good idea. It is good practice to review governance on an annual basis.

I've been a little slow in replying because I wanted to check what internal audit had been doing. They have completed a governance review and the issues it raises from the Board will come to our strategy day. I haven't seen the report but I have just had this brief from Alastair and I will pursue it. I think we need to have the discussion and whether there are other things we want to do.

Hope this suffices for now.

Best wishes

Jo

Angela Manroy sent on behalf of Dame Jo Williams

Chair
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG

Telephone:
Internal Extension:
E-mail: angela.manroy@

Statutory requests for information made under access to information legislation such as the Data Protection Act 1998 and the Freedom of Information Act 2000 should be sent to: information.access@cqc.org.uk.

From: Kay Sheldon [mailto:kay_sheldon@
Sent: 19 August 2011 07:10
To: Williams, Jo; Deirdre Kelly; john harwood; Martin Marshall; Olu Olasode
Subject: Board governance

Dear Jo, Martin, Deidre, John & Olu

I am writing to suggest we have a discussion in the near future to establish/clarify how we discharge our board duties and how these relate to the overall governance of the organisation. Whilst I feel we are all making good contributions, I also feel that we could be more effective, and indeed more useful to the organisation, if we had a clear and shared understanding of the role of board members.
We have a wealth of knowledge and experience on the board, including and in particular of senior level governance, which could be put to (even) better use for the benefit of both the public and the organisation. There are no implied criticisms here but a desire to 'raise the game' around board governance so that we can be sure we are discharging our responsibilities and accountability as effectively as possible.

It may be that others feel we doing the best we can. In any case, it is always good to review how things are going preferably through a collective and constructive dialogue.

Very best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS5 [ ] to the Witness Statement of
Kay Sheldon

Subject: Re: Follow-up from CQC Board Meeting

From: Kay Sheldon (kay_sheldon@

To: Louise.Guss@

Date: Thursday, 23 June 2011, 16:38

Hi Louise

Many thanks for your email. I was going to email about setting up a meeting to discuss this as I'm conscious that I still feel unclear about the interfaces within the risk management framework especially at board/strategic level so your email is very welcome.
The next time I am in FT is July 13th. I could either meet you after the board meeting. Or a little later at 3.30pm. I could also do July 14th at lunchtime/early afternoon.

Let me know if any of these are convenient.

Best wishes

Kay

— On **Thu, 23/6/11, Guss, Louise <*Louise.Guss@*** wrote:

> From: Guss, Louise <Louise.Guss@
> Subject: Follow-up from CQC Board Meeting
> To: "kay_sheldon@ <kay_sheldon@
> Date: Thursday, 23 June, 2011, 14:23
>
> Hi Kay,
>
> You may recall that at the June Board meeting I said that I would pick up your point regarding the Board being sighted on significant risks coming out of (but not restricted to) the Audit and Risk Committee.
>
> It would be very useful to me if we could meet up when you are next in London or FT so that I can get a proper picture of your concerns (so that I am not making assumptions). Would that be useful do you think?
>
> Hope that this finds you well,
>
> Louise

Louise Guss

Director of Governance and Legal Services
Care Quality Commission

office:
mobile
email: louise.guss@

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS6 [ ] to the Witness Statement of
Kay Sheldon

Care Quality Commission

Strategic Risk Register

sk Register Owner: CQC Board

ate of last update: 4th November 2011

Strategic Priorities: Focus on quality, and acting swiftly to eliminate poor quality care

Making sure that care is centred on people's needs and protects their rights

ref.	Risk Identification (to incl brief description, the impact & timescale of impact)	Region/Team (if applicable)	Owner of the Risk	Inherent Risk Level: Likelihood (Unlikely/Likely/Almost Certain)	Inherent Risk Level: Impact (H/M/L)	Inherent Risk Level: Risk Rating (Major / Moderate / Minor)	Current Mitigating Actions & Target Completion date	Owner of Action	Residual Risk Level: Likelihood (Unlikely/Likely/Almost Certain)	Residual Risk Level: Impact (H/M/L)	Residual Risk Level: Risk Rating (Major / Moderate / Minor)	Evaluation of Actions (any Management Action required)
SR 1	The CQC fails to create effective regulatory systems or processes to identify or deal with non-compliance leading to persistent poor quality care for users and reputational damage. [Wording amended July 2011]		Board	Likely	H	Major	SR1/1 - Review design of the regulatory model to ensure that it will deliver the CQC regulatory vision, has the confidence of key stakeholders and is sufficiently nimble/agile to deal with foreseeable changes in the policy environment. September 2011 **[To reduce likelihood]**	Martin Marshall	Likely	H	Major	A Board working group established to examine this which will report to the CQC Board in September 2011.
							SR1/2 - Review the operation of the regulatory model to ensure that processes and tools are effective and fit for purpose and are sufficiently flexible to adapt to market and structural changes in the regulated sectors. September 2011 **[To reduce likelihood]**	Cynthia Bower				This is underway and progress is being monitored by the Executive Team. The outcomes will be reported to the Board in September
							SR1/3 - Ensure a suitably skilled, deployed and led workforce to operate the regulatory model. Ongoing. **[To reduce likelihood]**	Cynthia Bower				A review of training forms part of the work to review the effectiveness and implementation of the regulatory model due to be reported to the Board in September.
							SR1/4 - Ensure, through planning for the registration of primary medical care providers, and through the Operations implementation review, that CQC is able to deliver effective compliance monitoring that will identify and deal with non-compliance by existing providers, whilst delivering the significant task of bringing 9,000 GP practices into registration by April 2013. **[To reduce likelihood]**	Cynthia Bower				The Secretary of State has agreed to delay the registration of GP practices until April 2013. Work also is under way to prepare a business case case seeking an increase in the fieldforce to ensure effective compliance monitoring.
							SR1/5 - The Board will approve any changes to the scheme of delegation to ensure that there is proper authority to make regulatory decisions. Ongoing. **[To reduce likelihood]**	Board				There have been regular changes via Chairs' action subsequently approved by the Board made to reflect . A log of all such changes is kept

Care Quality Commission

Strategic Risk Register

Risk Register Owner: CQC Board

Date of last update: 4th November 2011

	SR1/6 - Ensure that joint licensing arrangements with Monitor are such to avoid hampering CQC dealing with non-compliance and are agreed by the Board ahead of the effective date. **[To reduce impact]**	Cynthia Bower	This action is dependent upon the requirements of the health bill, however discussions with Monitor have commenced . This work is subject to formal programme governance
	SR1/7 - The Chair and Board identify and ensure key external stakeholders understand CQC's regulatory mission/requirements. Ongoing. **[To reduce impact]**	Jo Williams	Communication, stakeholder and engagement plans are regularly reviewed and updated
	SR1/8 - The CQC Board is provided with suitable Management Information to be able to judge and monitor regulatory effectiveness, including data evaluating how and the extent to which the user voice is helping identify poor quality/non-compliance. Ongoing **[To reduce likelihood]**	Cynthia Bower	The quality of management information is regularly reviewed by the Executive team and the Board. The A&R Committee also receive reports on regulatory risk processes and risk management
	SR1/9 - Prepare, deliver and update a communications plan to ensure that stakeholders understand the limits of CQC's remit within the health and social care system. Ongoing. **[To reduce impact]**	Cynthia Bower	A communications plan is in place and regularly reviewed by ET and the Board.
	[Added 20 Sept 2011] SR1/10 - Conduct periodic evaluation of the regulatory model to ensure that it remains fit for purpose. Timing to be advised by the Board/Audit & Risk Committee. [To reduce likelihood]	Cynthia Bower	[Requires updating]
	SR2/1 - Ensure that the CQC strategic plan objectives are realistic and achievable and understood by key stakeholders. **[To reduce likelihood]**	Jo Williams	The strategic plan is kept under review. The Board will be considering it next at the Board strategy day on 29 September
	SR2/2 - Ensure that strategic relationships and interdependencies for delivery of CQC objectives are managed effectively. Ongoing **[To reduce impact]**	Jo Williams	The A&R Committee regular reviews the Strategic risk register on behalf of the Board. The Board will wish to review progress on managing strategic relationships at their Strategy day.
	SR2/3 - Ensure that there is a suitable process in place to prepare realistic and achievable business plans. Ongoing **[To reduce likelihood]**	Cynthia Bower	A formal process is in place. Directorate business plans are reviewed regularly by the CE in discussions with Directors

Care Quality Commission

Strategic Risk Register

Risk Register Owner: CQC Board

Date of last update: 4th November 2011

SR 2	The CQC lacks the volume and/or type of resource required to meet the demands placed upon it (by statute or otherwise) leading to unacceptable levels of performance and /or unmet expectations.		Board	Likely	H	Major	SR2/4 - Check that there is an effective process in place to identify, assess and monitor risks – including the level of regulatory risk - to CQC's achievement of strategic and business plan objectives. Ongoing. **[To reduce likelihood]**	Cynthia Bower	Likely	H	Major	There is a risk management framework in place covering business risk and regulatory risk. This was examined by the A&R committee and approved by the Board . The A&R Committee keep the operation of the framework under regular review
							SR2/5 - Arrangements are in place to enable that the Department of Health will meet shortfalls in fee income. **[To reduce likelihood]**	Cynthia Bower				The Director of Finance and Corporate Services is in regular discussion with the DH about the CQC budget and resource requirements including on projected and actual levels of fee income
							SR2/6 - To work with DH and others to ensure successful delivery of the Future of Care Programme **[To reduce likelihood]** Prepare business case to the Department of Health outlining the resources required to ensure successful creation of Healthwatch England. With HFEA, HTA and DH, ensure the adoption of CQC's systems to meet the demands of the new licensing and inspection regimes related to the functions is manageable. With DH ensure procurement of professional programme resource and work with specialist groups to deliver HealthWatch and Health and Social Care Bill 2011 and the Public Bodies Bill changes is not compromised by delays or potential refusal of permission from Government.	Cynthia Bower				The Future of care programme is on track. Discussions are proceeding with DH on the resources for HWE - which is linked to how HWE will operate in practice. Discussion are also under with DH on the drafting of legislation to transfer other functions to ensure that CQC is provided with the sufficient flexibility to make appropriate operational and governance arrangements to discharge those functions efficiently.
							SR2/7 - Review implementation of the regulatory model to ensure whether the commitment to deliver planned compliance reviews of every provider by October 2013 can be achieved in the light of the higher than expected demand for responsive reviews and the resource intensive nature of NHS compliance activity. **[To reduce likelihood]**	Cynthia Bower				This is being looked at actively the by reviewers of the regulatory model.
							SR2/8 - Ensure there is appropriate performance reporting to ensure that the Board can monitor delivery against the business plan. Ongoing. [To reduce likelihood]	Cynthia Bower				The Mgt Info provided by the Board is kept under review, including that to allow monitoring of regulatory performance.
							SR2/9 - Ensure that CQC has the necessary infrastructure and corporate support services to ensure front-line delivery of regulation. Ongoing. **[To reduce likelihood]**	Cynthia Bower				The HQ review in 2010 was designed to ensure that resources to Operations were optimised and that the CQC was structured around supporting Operations

Care Quality Commission

Strategic Risk Register

Risk Register Owner: CQC Board

Date of last update: 4th November 2011

						SR2/10 - Ensure that CQC has appropriate resilience to ensure business continuity and disaster recovery. [To reduce likelihood]	Cynthia Bower				Business Continuity and Disaster recovery plans are being refreshed. These are kept under review by a Business Continuity Gp
						SR2/11- Ensure that there are clear service standards with deadlines. [To reduce likelihood]	Cynthia Bower				These have been developed and are kept under review. For example the CQC has set an 8 week target for processing registration applications
						SR2/12 - Ensure that there are effective capacity planning processes to allocate and flex resource [To reduce likelihood]	Cynthia Bower				The Business Delivery Authority (a subcommittee of the Executive Team) performs this role.
						SR2/13 - Pursue and set targets for continuous improvement efficiencies [To reduce likelihood]	Cynthia Bower				Performance and efficiency is under constant review. The recent focus has been on the improvements in the regulations.
						SR2/14 - Develop an activity-based assessment of Operations resource requirements to ensure resource requirements are based on accurate activity data. [To reduce likelihood]	Cynthia Bower				A method is being piloted to record activity to inform operational business and resource planning. Progress is being reviewed by the ET.
SR 3	The CQC structures and processes (and therefore key relationships) do not permit effective governance and accountability leading to undetected and/or unmanaged risks and failure to meet objectives.		Board	Likely	M	SR3/1 - The effectiveness of the CQC governance structures are kept under review to ensure they are fit for purpose and appropriate leadership provided. [To reduce likelihood]	Jo Williams	Unlikely	M	Minor	There has been a recent internal audit of structures and processes. The agre management actions are ..ng implemented.
						SR3/2 -The corporate governance framework in place supports the governance structure and facilitates appropriate direction, control and leadership. Ongoing[To reduce likelihood]	Cynthia Bower				There has been a recent internal audit of structures and processes. The finding are being implemented
						SR3/3 - Ensure that the governance arrangements for HealthWatch England do not adversely affect the accountability of either the CQC Board or Chief Executive. April 2012. [To reduce likelihood]	Cynthia Bower				Arrangements are being developed to mitigate the accountability risks inherent in the proposal to create HWE as a statutory body within the CQC body corporate
						SR3/4 - Ensure the governance arrangements devised to assume functions from HFEA, HTA and NIGB do not adversely affect the accountability of either the CQC Board or Chief Executive. By the transfer date for the various functions.. [To reduce likelihood]	Cynthia Bower				Arrangements are being developed to mitigate the accountability risks inherent in the proposal to transfer functions to CQC from HFEA, HTA and NIGB

Care Quality Commission

Strategic Risk Register

Risk Register Owner: CQC Board

Date of last update: 4th November 2011

SR 4	CQC's independence as a regulator is undermined leading to loss of confidence in its judgements and/or its ability to safeguard users.		Board	Unlikely	H	Moderate	SR4/1 - The Framework agreement with the Department of Health is such as to define and serves to protect and enhance CQC's independence in regulatory decision-making and is kept under regular review. [To reduce likelihood]	Jo Williams	Unlikely	M	Amber	The Framework Agreement is due for revision; it has been agreed with DH this will be carried out at when the relevant points about the establishment of HealthWatch are known and can be included. However a review of the supporting protocol has commenced already.
							SR4/2 - The value of a having an independent regulator and the key elements that serve to maintain that independence are explained to key stakeholders. [To reduce likelihood]	CQC Board				[Board need to agree what to insert here]
							SR4/3 - Develop a fees model that aims to minimise reliance on grant-in-aid. [To reduce likelihood]	Cynthia Bower				This approach has informed the development of the Fees strategy negotiated with DH
							SR4/4 Ensure that the nature of CQC's relationships with other public bodies in the care system eg Monitor, NHS Commissioning Board, national and local HealthWatch are transparent and do not impinge inappropriately on CQC's regulatory independence. Ongoing [To reduce impact]	Cynthia Bower & Jo Williams				These relationships are actively managed at operational, policy and senior level. Where appropriate there are formal agreements (MoUs) to support this.
							SR5/1 - Policies and controls are in place and are subject to appropriate review to ensure that sensitive and confidential information is handled in accordance with legal and cross-government requirements. Ongoing. [To reduce likelihood]	Cynthia Bower				Information Governance processes and policies - including information security policies and processes are in place and have been reviewed, and have also been subject to internal audit. Agreed management actions are being implemented.
							SR5/2 - Policies and processes are in place and are subject to appropriate review to ensure that Freedom of Information and Data Protection requests are handled in accordance with legal and ICO requirements. Ongoing. [To reduce likelihood]	Cynthia Bower				Information Governance processes and policies are in place and have been reviewed, and have also been subject to internal audit. Agreed management actions are being implemented.

Care Quality Commission

Strategic Risk Register

Risk Register Owner:	CQC Board
Date of last update:	4th November 2011

SR 6	CQC fails to operate in line with required standards of probity and value for money in relation to use of public funds and regularity as regards statements and disclosures.		Board	Likely	H	Major	SR6/3 - Policies and processes are in place and are subject to appropriate review to ensure that there is appropriate handling of gifts and hospitality and the expenses of the Board and Executive Team are published in line with cross government requirements. Ongoing. **[To reduce likelihood]**	Cynthia Bower	Unlikely	H	Moderate	There has been an internal audit conducted and the agreed management actions are being implemented.
							SR6/4 - Business plans and their implementation secure value for money in the use and deployment of resources. Ongoing. **[To reduce likelihood]**	Cynthia Bower				There are processes in place to ensure that business cases are developed which are scrutinised by the Business delivery Authority to ensure vfm and that they are signed off in with the Scheme of Delegation
							SR6/5 - Statutory publications are reviewed in draft and approved by the Board. Ongoing. **[To reduce likelihood]**					Statutory publications are identified and are included in the Board agenda forward planner to ensure the Board sign these off.
							SR6/6 - Policies and processes are in place and subject to appropriate review to detect and deal with fraud. Ongoing. **[To reduce impact & likelihood]**	Cynthia Bower				There has been an internal audit conducted and the agreed management actions re being implemented

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS7 [ ] to the Witness Statement of
Kay Sheldon

Subject: Inspections

From: Kay Sheldon (kay_sheldon@

To: Frances.Carey@

Date: Thursday, 19 May 2011, 9:45

Hi Frances

Many thanks for facilitating my 2 recent site visits which were interesting & instructive. Both inspectors were very helpful and I was able to engage as well as observe. It is clear that there is a high level of commitment and energy amongst our inspectors.
As you will be well aware, we are currently undertaking reviews of our regulatory model and implementation, and I wanted to share with you some general thoughts about site visits (based on the visits I undertook plus conversations with others) and indeed our regulatory model as I would value your feedback as a regional director:

There is strong support amongst inspectors for a model of regulation based on the experiences, views and outcomes of people using services. However I wonder if we have the optimal balance - or interaction - between our processes and what we are seeking to achieve with our regulatory model. There seems to be a - perceived - tension between a 'risk based' & 'light touch' approach and actually finding out what's going on in a service. I'm not certain that our inspectors can always see the wood from the trees through being driven, at least in part, by our processes.
For the 2 care homes I visited the QRPs seemed to be of little value in that they were populated by provider information (usually from corporate docs) from the registration process and some very specific data from previous reports some years ago. There were no recent comments from service users.
On the visits, I was able to walk around the homes to look, listen and talk with service users and the care staff. From this, I was able to gather a wide range of information about the quality of care (that related to essential standards) that would not have been picked up from documents and talking with the manager. This was not particularly time-consuming and prompted specific checks of documents particularly care plans. The inspector (of the first visit) translated our findings into 7 improvement actions with a quick turn around and is planning a follow up visit with a colleague and it was good to see this level of response. However I do think there are issues around how we build up a picture of what it's like for people using the service and that there is not sufficient clarity and emphasis on what's expected and needed in this regard.
My view is that site visits should be 'dynamic' inspections - particularly looking & listening, and talking & probing where necessary. This is not about crawling all over a service but keeping your ears and eyes (and mind!) open. How (and to what extent) inspectors engage with people using the services is crucial, not least an awareness that it is very difficult for a service user to comment freely on the service with members of staff within earshot (as was the case). I guess these observations relate to generic inspection skills and I appreciate it may be a difficult message if we provide 'training' on this to people who have been inspectors for years...

Team work is very important for home workers and it is clear your team has exceptional team spirit and support. I'm not sure we have the breadth & depth of expert input required especially at this still early stage in developing a generic model. I think individual inspectors are having to work well outside their comfort zones at times.The second inspector was very aware of the limitations of her background in relation to inspecting a large acute hospital & liaising with CEOs and senior managers (but very game to do her best). Sometimes it is also the case that inspectors 'don't know what they don't know'.
It seems relatively straightforward to access specialist clinical knowledge but maybe more thought is needed around the nature of support for inspectors at different stages of the regulatory process.

Sorry this has turned into a long email. Rather than expect you to respond in detail, I wonder if we could have a 'phone conversation as I would really value your thoughts on the above as we go forward?

Very best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS8 [ ] to the Witness Statement of
Kay Sheldon

Subject: RE: June 29th

From: Kay Sheldon (kay_sheldon@

To: Rosalind.Sanderson@

Date: Tuesday, 21 June 2011, 16:19

Dear Ros

Most, if not all, Commissioners have been out on inspections with inspectors. The person to liaise with be either Jerina Brown or Lesley Thomas in Finsbury Tower.

I've outlined some thoughts on inspection visits, based on the visits I have done as well as my experiences with the MH Act Commission & the Healthcare Commission, and as a user of mental health services. These are my reflections and are by no means exhaustive or definitive. Therefore:

- need more focus on inspections on building a picture of what it is like to live there. Some information e.g. policies, could be looked at later. Similarly speaking with managers could mostly happen by 'phone if necessary
- therefore spend more time speaking with the people who use the service, sitting with them, looking around.
- use sensitive/appropriate probing & everyday language 'How do you like living here?' 'Are the staff kind/helpful/respectful?' 'Do you think you're treated as individual?' 'What's the food like?' 'Do you get enough to eat?' 'How do you spend your day?' 'What do like to do?' 'Have you any suggestions on how the 'service' could be improved?' 'Do you have any worries about the care provided here?'
- Wherever possible talk with people using the service in private/out of earshot of staff
- I gleaned more information from simply walking around and chatting to people than from other sources of information, as examples, I noticed: no-one was independently moving around; many people were asleep in recliner chairs; that there were few activities; many people had not been outside for months; a lady told me she spent most of the day sitting in her chair & that was probably why she had a sore bottom! a clock was wrong in the sitting area and that a man had a different time (still wrong!) on his watch; a lady had been incontinent of urine seemingly for a while; another lady was still waiting to be got up after lunch; all residents were given drinks in spouted cups irrespective of need.
- Looking at care plans/notes is also time well spent. From above, we were able to glean that some people had pressure sores and that people with dementia were being prescribed anti-psychotics & anxiolytics. Also the care provided was not individualised and the regime rather institutionalised
- Interestingly most people felt the staff were helpful and friendly. However they did not feel they could ask for anything - the service did not encourage views/feedback and there was an implicit assumption that residents would - should - fit into the routine
- Information about the care provided can also be gleaned from staff providing direct care: knowledge of their role, what they do, how they do, what makes the job worthwhile/difficult
- where no recent comments from service users comes up on the QRP - this should raise a question and potentially flag a 'risk' especially if the client group may have particular difficulty voicing views/concerns. Establishing whether this is an active advocacy service that has a regular presence could be seen as mitigating this 'risk'
- Absence of information - gaps - should be as important as where we have data. The QRP is a tool of which the strengths and limitations needed to be understood and, when relevant, accounted for
- There are (complementary) ways of getting access to the experiences and quality of care provided: local groups; relatives/carers (short survey and/or a letter inviting feedback?); advocacy services; the services

own feedback mechanisms (including if there is one and how it works)

- I found myself wondering what was reasonable to expect of services (as essential standards) when there are issues around funding. The outcomes of the visit to the home for older people were: 7 improvement actions (2 moderate, 5 minor concerns); not to agree to an increase in the number of beds (which the owners were seeking) and for the inspector to go back soon with a specialist in dementia. This seemed a proportionate response in the light of the findings from the inspection visit.

These are a few observations. Apologies if I seem to be stating the obvious! Please do share them with your team for discussion. I would be interested to hear any feedback.

Best wishes

Kay

— On **Mon, 13/6/11, Sanderson, Rosalind <*Rosalind.Sanderson@*** [redacted] wrote:

From: Sanderson, Rosalind <Rosalind.Sanderson@[redacted]
Subject: RE: June 29th
To: "Kay Sheldon" <kay_sheldon@[redacted]
Date: Monday, 13 June, 2011, 18:57

Dear Kay

Thank you very much for responding to me. We were very much hoping that you would be able to attend but hopefully you will be able to come to our next regional day in three months. I'm sure as a region we would be able to meet your expenses, Jo Dent, our RD, has suggested this. Do you know of any other Commissioner who may be able to attend who has also had recent experiences if visiting services with inspectors?

The focus of the day this time was about how we can ensure good outcomes for people receiving care services through our regulatory work. I understand that you have recently been out with inspectors and that not all your experiences were as you had hoped for. I wonder if you would be able to let me have a few examples of this so I could put a couple of slides together about your experiences, both good and bad examples to focus people's thoughts for the day. We are holding workshops in the afternoon focusing on dementia care, environments, MCA and DoLS and enforcment processes.

I look forward to hearing from you
Kind Regards

Ros

Ros Sanderson
Registration Manager
North East Region

☎Mobile: [redacted]
☎Home office phone: [redacted]
🖷 [redacted]
✉ **Rosalind.Sanderson@**[redacted]

By post to:
CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS9 [ ] to the Witness Statement of
Kay Sheldon

Consultation

Our proposals for our Judgement framework and Enforcement policy

September 2011

About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care. This is because we:

- Focus on quality and act swiftly to eliminate poor quality care
- Make sure care is centered on people's needs and protects their rights

Contents

Introduction

Since April 2010, the Care Quality Commission (CQC) has brought 22,000 regulated providers of health and social care services into the new regulatory framework governed by the Health and Social Care Act 2008. We have registered these providers against essential standards of quality and safety within extremely challenging timescales and, since registration, we have inspected thousands of care services to judge how well they continue to meet those standards.

We do not act in isolation. CQC plays its role to ensure the essential standards are met, but there are 22,000 regulated providers of 37,000 registered services in England and expectations of regulation must be realistic. Every part of the system – from providers, to commissioners, to professional regulators – has a duty to make sure that poor care is identified and addressed. All of those involved in providing care – senior management, boards of governors, medical professionals and frontline staff – have a part to play in stopping or reporting poor care whenever they see it. If poor care is happening, someone somewhere knows about it and should act.

For our part, we have listened to what providers and the public have told us about some of the challenges of our current regulatory model. In addition, as part of the process of reforming the NHS, the government has sought to strengthen our role to ensure that we focus on our core business: to monitor and inspect providers to make sure that the essential standards are being met and to take swift action where they are not.

Simplifying and strengthening our regulatory model

We are now simplifying and strengthening our regulatory model to reflect this focus, and to build on what we have learned in the last 18 months.

We will continue to be focused on outcomes for people who use care services; risk-based in line with the principles of Better Regulation; intelligent, using the wealth of information that CQC inspectors and analysts have at their disposal; and responsive, ensuring that we act quickly to take regulatory action when we identify that the essential standards are not being met.

We will inspect most services more often, our inspections will be more targeted, and where we find that providers are not meeting their legal requirements we are clear that swift action will follow.

The refinements we are proposing are not about toughening our approach or about 'raising the bar'; our aim is to be clear about whether a provider is meeting the standards or not and, where they are not, what regulatory action will follow.

Because some of these refinements affect our key guidance, we are holding this consultation to give providers, the public, commissioners, our staff and other stakeholders the opportunity to comment.

We are also improving the way we publish information for the public to make sure it is clear, accessible and supports choice. We believe these improvements will give the public and providers greater clarity about whether or not providers are meeting essential standards. Together with the establishment of Healthwatch England as a committee of CQC, they will continue to ensure that the voices of people who use services are always at the centre of our work.

In early October we will also be launching a consultation on our proposed fees scheme for 2012/13. We look forward to hearing people's views on these proposals too.

We will be working with Monitor, who will launch their annual consultation on the compliance framework for foundation trusts towards the end of the year, to ensure that our approaches are aligned.

The key features of our improved regulatory model

Under the Health and Social Care Act 2008, health and social care providers have a legal responsibility to make sure that their services meet the essential standards of quality and safety. The public has a right to expect these whenever or wherever they receive care.

Our core business is to register providers against the essential standards of quality and safety and to monitor and inspect them to make sure they continue to meet the standards.

We will continue to carry out scheduled, responsive and themed inspections of services, and they will continue to be unannounced unless there is a good reason to let the service know we are coming.

We plan to inspect most social care, independent healthcare services, and NHS hospitals at least once a year. By NHS hospitals we mean all NHS hospitals that provide acute services and all NHS ambulance trusts. We intend to inspect at least one type of service[1] in all other trusts. We plan to inspect dental services at least once every two years.

Our inspections will be more targeted to take account of the nature of the care a service provides, the level of information we currently have about it, the risks to people, and the approach relevant to the sector regulated. We will focus our resources on acting swiftly when we identify that essential standards are not being met. We will not necessarily inspect all 16 essential standards every year, but we will usually target our inspections by focusing on a smaller number of standards.

We will not ask the provider to send us information before an inspection, but during or after an inspection we may ask to see further information if necessary to provide evidence of compliance.

In-between inspections, our inspectors and analysts will continue to monitor the information we hold about services and build up a profile of each service (known as the Quality and Risk Profile), which helps inspectors to decide where there is a risk of poor care.

[1] Further information about service types can be found on pages 14-31 in our *Guidance about compliance: Essential standards of quality and safety* www.cqc.org.uk/publications.cfm?fde_id=15413

To support these improvements to our regulatory model, we are proposing to improve some of the key guidance that underpins it – our Judgement framework, Setting the bar and Enforcement policy. This consultation sets out those improvements and seeks your views on them.

Alongside this consultation, the government is consulting on aspects of the Health and Social Care Act (Regulated Activities) Regulations 2010, which are also being reviewed in the light of the experience of regulation; they do not fully function as they were intended and proposals for change have been made to ensure clarity, or to remove unjustified burden on providers. The Government's proposals mainly relate to definitions of the scope of regulation, and clarify various matters of detail in defining providers who are in or out of our regulatory scope.

However, they also set out a proposal for a new form of notice that we will have to serve in advance of using some of our prosecution powers. This would replace the current provision whereby we may only take certain enforcement action following service of a warning notice. Our proposals for amending our enforcement policy take account of these proposals, so that our amended enforcement policy will govern our criminal law response if the new proposals are adopted, or if the current arrangements remain.[2]

[2] The Government's consultation is available at the following web address until 7 October 2011: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_128222

About this consultation

Our regulatory model is currently underpinned by four key guidance documents:

- Our **'Guidance about compliance: Essential standards of quality and safety'** sets out what providers should do to comply with the regulations made under Section 20 of the Health and Social Care Act 2008.
- Our **'Guidance about compliance: Judgement framework'** sets out how we will judge whether or not providers are compliant with the essential standards.
- **'Setting the bar'** sets out how we decide what regulatory response we will take where providers are non-compliant.
- Our **'Enforcement policy'** sets out what that regulatory response will be when we make a judgement that a provider is non-compliant with one or more of the regulations.

We are seeking people's views on our proposals for improvements to our **Judgement framework** and **Enforcement policy**. 'Setting' the bar has been incorporated into the Judgement framework.

We are also seeking people's views on the documents associated with these changes:

- The equality impact assessment, which looks at the impact of our proposed Judgement framework and Enforcement policy on people's equality and diversity. Our policy should promote equality for people and not lead to disadvantage on the grounds of gender, ethnicity, disability, religion, belief, or sexual orientation.
- The regulatory impact assessment, which looks at the costs and benefits of our proposed new approach on providers, the CQC, and people who use services.

The proposals aim to simplify and strengthen the process by which we make judgements. They reduce the regulatory burden on those providers who comply with the essential standards. They also underpin our strategic priority of acting swiftly to help eliminate poor quality care.

The consultation period runs for 12 weeks from 19 September to 9 December 2011. We look forward to receiving feedback from people who use services, their carers and families, providers and commissioners of care, our staff, and anyone else with an interest, by 9 December 2011. Details of how to send us your comments are in the 'How to respond to this consultation' section of this document on page 10.

When the consultation period has ended, we will review the feedback we have received and carefully consider any changes we need to make to the documents.

We will publish the final versions of the Judgement framework, Enforcement policy and impact assessments in early 2012. We do not intend to review the 'Guidance about compliance: Essential standards of quality and safety' at this point in time.

Our proposals

Our proposals are set out in three parts. First, we describe which of the principles that underpin the guidance will not change. Second, we describe the proposals for the improvements we want to make, and third the proposals for the format and layout of the guidance. We have described the proposed changes, and how they differ from current guidance and practice, below.

Principles underpinning the guidance

The following principles that underpin the Judgement framework and Enforcement policy will not change:

- Inspectors will always consider whether they have enough evidence to make a judgement.
- Our approach to regulation will continue to be risk-based and outcome focused.
- We will continue to consider what is reasonably practicable and proportionate (under public law principles) before taking any action.
- The range of enforcement options open to CQC remains the same (subject to the Government's consultation referred to on page 4; if the regulations are amended, we will introduce the pre-prosecution notice; but if they are not, our enforcement options remain the same).

Changes to the Judgement framework and Enforcement policy

This consultation proposes the following changes to the Judgement framework and Enforcement policy:

Proposal 1

Following an inspection or review, we will judge providers to be either compliant or non-compliant.

We will take no action if providers are compliant. Where a provider is compliant, our inspectors will have the opportunity to make comments that may be useful to the provider and to the public about minor improvements that could be made, but there will be no improvement actions or regulatory follow-up.

Where providers are non-compliant, compliance actions are the precursor to formal legislative enforcement action.

How is this different?
Currently, a provider can be compliant but with some concerns for which we set improvement actions. The change will make it very clear whether a provider is compliant or non-compliant, and help us to target non-compliance more effectively.

Proposal 2

Our inspections will be focused on identifying areas of non-compliance, rather than focusing on compliance. Where we see non-compliance we will continue to triangulate our evidence to reach a judgement. If we see compliance, our judgement will be that the provider is compliant.

How is this different?
Currently, we look for specific evidence of compliance during our reviews, so this is a shift in focus to finding evidence of non-compliance rather than compliance.

Proposal 3

Where we judge that a provider is non-compliant with one or more of the regulations, the level of impact on people who use the service (minor, moderate or major) will inform the regulatory response we make. We will judge the level of impact on people who use the service **after** we have reached a judgement of non-compliance with a regulation.

How is this different?
Currently, we judge a level of concern **before** we make a judgement as to whether the provider is compliant or non-compliant. A concern can be graded as minor, moderate or major. We reach this judgement by considering the impact on people who use the service and the likelihood of it happening. Under these proposals, we will no longer refer to a level of concern, and we will consider the impact on people after we have made a judgement of non-compliance.

Proposal 4

Our level of confidence in the provider's capability will not directly affect our regulatory response. Our regulatory response will be primarily based on the significance of the non-compliance and its impact on people who use services.

How is this different?
Currently, our level of confidence in the provider (combined with the level of concern and the number of concerns) directly affects our judgement of compliance or non-compliance as well as our regulatory response. With this proposal, inspectors would instead take capability into account alongside other factors when determining the appropriate response.

Proposal 5

The escalating scale of enforcement action will help inspectors decide which regulatory response to take. We will follow a clearer, more transparent escalation process to ensure providers achieve compliance, referred to as the enforcement escalator. We will not normally issue a second compliance action to follow up a compliance action. We will not normally extend the timescales we give providers to achieve compliance. Failure to respond to compliance or enforcement actions will usually result in an escalation of enforcement activity. However, we will always be proportionate in the action that we take and we will retain our discretion to take individual circumstances into account.

How is this different?
Currently, we may extend deadlines to enable providers to meet compliance actions, or we may set consecutive compliance actions to enable providers to become compliant. The enforcement escalator will be much clearer and transparent in setting out which regulatory response will be applied.

Proposal 6

We will judge the level of impact on people who use the service, including the degree of risk to which they have been exposed, for each one of the regulations where we have identified non-compliance. We will assess whether the impact of this risk is minor, moderate or major, and this will influence our regulatory response.

How is this different?
Currently, inspectors make a risk assessment of concerns that have been identified to determine whether it is a minor, moderate or major concern. The current risk assessment takes account of the impact on people using the service (low, medium or high) as well as the likelihood that the impact will recur (unlikely, possible, almost certain).

Proposal 7

Where we issue a warning notice for non-compliance with a regulation, we will publish a summary of the notice and refer to the warning notice in the compliance report, unless representations about that notice are received and upheld. Where the provider does not comply with this notice, evidence on which the notice was based can be considered again and used as a basis for further action if compliance is not achieved.

How is this different?
Currently any warning notice served is not mentioned in the compliance report. This means that people who use services are unaware of any action being taken on a provider or manager. This can be of major concern to people who use services where it appears that we are not acting upon information received.

The documents we will use in our work

Inspectors will use the new Judgement framework to decide whether a provider or manager is compliant or non-compliant with the essential standards. If a provider is found to be non-compliant, inspectors will identify what the non-compliance with one or more regulations is. The framework will be used to consider the impact of non-compliance on people who use the service. This impact then determines what our regulatory response will be, for which our inspectors will refer to the Enforcement policy.

'Setting the bar', which currently helps inspectors decide whether or not the concerns identified mean that a provider is compliant or not, will effectively be incorporated into Stage 4 of the Judgement framework.

Sector-specific case studies that help inspectors identify the appropriate impact on people will be available on our website rather than within the Judgement framework. This means that we will be able to update them frequently with real examples.

As is currently the case, the Judgement framework is applied only where a provider is non-compliant with one or more regulations for the first time. Where we judge a provider to be non-compliant consistently and more than once with a particular regulation, the enforcement escalator within the Enforcement policy will normally be applied.

Inspectors will refer to the Enforcement policy and its escalator of enforcement action to identify the most appropriate regulatory response to any non-compliance. For example, if a provider was found to be non-compliant after the timeframe for a compliance action has passed, we would choose the next level of action that is appropriate to secure compliance.

Within the Enforcement policy, we have removed duplication on the subject of representations and appeals to help inspectors, providers, managers and others to understand the regulatory principles and methodology. The principles of enforcement under the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) are included for the first time.

How to respond to this consultation

When responding to this consultation, it would be helpful if you could consider the following questions. Please explain your answer to each question.

Overarching questions

1. Do you agree with the improvements that we propose to make to the Judgement framework and Enforcement policy?

2. By using the revised Judgement framework and Enforcement policy, will CQC be able to regulate and take action to help eliminate poor quality care more effectively?

Judgement framework

3. Do you understand the processes our inspectors will follow to make judgements based on the revised Judgement framework?

4. Do you think that the process and associated guidance is clear?

5. Do you think that the revised Judgement framework will enable us to be more consistent in implementing our judgements?

Enforcement policy

6. Do you understand what our enforcement powers are and how we can use them?

7. Do you think that our process of escalating action in response to non-compliance is clear?

8. Do you understand the implications of non-compliance?

9. Does the 'enforcement escalator' help you to understand the range of action that is available to us where providers are non-compliant with the regulations?

Regulatory impact assessment

10. Does the regulatory impact assessment accurately represent the impact of implementing the guidance to providers of regulated activities and others?

11. Does the regulatory impact assessment accurately reflect all the benefits associated with implementing this guidance for providers of regulated activities and people who use services?

Equality impact assessment

12. Are there any proposals contained in the Judgement framework or Enforcement policy that might have an adverse impact on race, disability, gender (including gender reassignment), sexual orientation, religion or belief, or age equality for you or for people who use services?

Please send us your response to the questions above by Friday 9 December 2011

You can respond to our consultation in three ways:

Online

Use our online form at
www.cqc.org.uk/yourviews/consultations.cfm.

By email

Email your response to JFEPconsultation@cqc.org.uk.

By post

Write to us at:
Judgement framework and Enforcement policy consultation
Care Quality Commission
103–105 Bunhill Row
FREEPOST Lon 15399
London
EC1B 1QW

Protecting your rights

Following the Code of Practice

This consultation follows the Cabinet Office Code of Practice on consultation. In particular, we aim to:

- Consult widely throughout the process, allowing 12 weeks for written consultation.
- Be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses.
- Ensure that our consultation is clear, concise and widely accessible.
- Ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy.
- Monitor our effectiveness at consultation, including through the use of a designated consultation coordinator.
- Ensure our consultation follows better regulation best practice, including carrying out a regulatory impact assessment.

Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, in itself, be regarded as binding.

We will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Further information

If you have any comments or concerns relating to the consultation process that you would like to put to us, please write to:

Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Published September 2011

How to respond to this consultation:

Online

Use our online form at
www.cqc.org.uk/yourviews/consultations.cfm.

By email

Email your response to JFEPconsultation@cqc.org.uk.

By post

Write to us at:
Judgement framework and Enforcement policy consultation
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103–105 Bunhill Row
FREEPOST Lon 15399
London
EC1B 1QW

Please contact us if you would like a summary of this document in another language or format.

If you have general queries about CQC, you can:

Phone us on: 03000 616161

Email us at: enquiries@cqc.org.uk

Write to us at:
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

www.cqc.org.uk

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS10 [ ] to the Witness Statement of
Kay Sheldon

Regulatory impact assessment CQC regulatory model

Judgement framework and enforcement policy

Introduction

1. The aim of this impact assessment is to assess the overall economic impact of CQC's proposed changes to its judgement framework and enforcement policy. The impact assessment accompanies CQC's consultation proposals. These proposals constitute an improvement to the way that CQC regulates services registered under the Health and Social Care Act 2008.

2. The impact assessment is required because the proposals will increase CQC's regulatory activity towards regulated providers who are not complying with the essential standards of quality and safety set out in the Act.

3. The purpose of the impact assessment is to identify and assess the overall impact that the proposals are likely to have on regulated providers, people who use services, commissioners, the public and CQC.

4. In line with guidance from HM Treasury, CQC intends to publish both an initial and a final impact assessment. This document is the initial impact assessment which accompanies the consultation proposals. A final impact assessment will be published following an analysis of the consultation responses.

5. The final impact assessment will be published after the consultation has ended and will accompany CQC's final plans for making changes to its regulatory model. The planned date for introducing changes to CQC's regulatory regime is 1 April 2012. More detailed information on CQC's proposals is included in the main consultation document.

6. This impact assessment has been produced in line with standard guidance from the Better Regulation Executive (BRE) and HM Treasury and recognises the Hampton Principles on regulation (HMSO 2005).

7. In line with guidance from HM Treasury, the key criteria for assessing the overall economic impact of the proposals is whether the expected benefits for society as a whole are greater than the expected costs. However the impact assessment recognises that the proposals are expected to change both the level and distribution of costs and benefits among regulated providers, people who use services, commissioners and the public.

Contents

Background and impetus for the proposed improvements

8. Since April 2010 CQC has registered 37,000 NHS, independent healthcare, social care and dental services under the Health and Social Care Act 2008.

9. These registered services are provided by 22,000 regulated providers who have a legal responsibility to ensure that their services meet the essential standards.

10. The essential standards identify the standards of care the public have a right to expect whenever or wherever they receive care.

11. CQC's regulatory model is designed to monitor and inspect registered services in order to ensure that regulated providers are meeting these standards.

12. CQC is now seeking to make improvements to the way that it inspects essential standards. The proposals have been developed from suggestions from providers, the public and our own staff on making improvements to CQC's current regulatory model. The proposals reflect CQC's desire to simplify and strengthen how it regulates against the essential standards.

13. CQC's judgement framework and enforcement policy will continue to be based on the following principles:

    - Inspectors will always consider whether they have enough evidence to make a judgement.
    - Our approach to regulation will continue to be risk based and outcome focused.
    - We will continue to consider what is reasonably practicable and proportionate (under public law principles).
    - The range of enforcement options open to CQC remains the same, subject to the governments' consultation on the Health and Social Care Act (Regulated Activities) Regulations 2010.

14. However, whilst the regulatory principles will remain the same, CQC is proposing to make changes to the way that it operates its judgement framework and enforcement policy.

15. The main changes centre on the proposal to introduce a more simplified system where providers are either assessed as compliant or non-compliant with the essential standards. This change will replace the existing system where some providers are assessed as "compliant with some concerns". In future, providers will be either compliant or non-compliant.

16. CQC believes that the wider benefits to society of its proposed improvements will outweigh any additional costs to both registered providers and CQC. This is demonstrated within the main body of the impact assessment.

Overview and summary of the impact assessment

17. The expected impact of the proposed changes to CQC's judgement framework and enforcement policy can be summarised as follows:

    a) The proposed improvements will shift the focus of CQC's regulatory activities away from providers who are compliant with essential standards towards those who are not.

    b) Providers who we judge to be compliant should expect to benefit from a reduction in CQC regulatory activity, as CQC will take no further regulatory action where providers are judged to be compliant.

    c) Non-compliant providers should expect to face an increase in regulatory activity (including follow up enforcement action) as CQC responds and takes swift action to ensure they achieve compliance with essential standards. CQC will use an escalating scale of enforcement action to achieve compliance and ensure consistency of approach.

    d) This shift in CQC's regulatory activity towards non-compliant providers is in line with the Hampton Principles on regulation (HMSO 2005), which advocates that organisations which breach regulations should be identified quickly and face proportionate and meaningful sanctions.

    e) The main benefit of the proposed changes for people who use services, commissioners and the public is expected to be that poor quality services are identified quickly so that CQC can take appropriate action to make providers compliant with the essential standards.

    f) The introduction of a more simplified judgement framework where registered services are either compliant or non-compliant with essential standards means that any provider which is currently compliant with some concerns and improvement actions will need to make those improvements to become fully compliant by 1 April 2012, otherwise it may be judged to be non-compliant.

    g) The proposals do not change the fact that regulated providers are considered best able to decide for themselves how they meet the essential standards. Each provider will therefore continue to be expected to plan and allocate the resources, including terms of the time, effort and money, required to be compliant with essential standards.

    h) CQC intends to examine any new cost and benefit issues that arise during the consultation and will ensure that its decisions and actions comply with public law principles. These will be used to inform the final impact assessment which will be published later in 2011/12.

Options for implementing the proposals to CQC's regulation

18. Table 1 summarises the key points of the two options facing CQC. It can either make the improvements suggested by providers, our staff and the public, or it can retain its existing regulatory model. There is no third option that involves implementing only some of the proposed improvements. This is because each improvement is required to make the overall change to CQC's regulatory model.

Table 1: Options identified for the impact assessment

Option 1	**Option 1 involves retaining the existing judgement framework and enforcement policy. In practice this means that:** • Providers can continue to be "compliant with some concerns" for which CQC sets improvement actions. • CQC will continue to look for specific evidence of compliance with the essential standards instead of non-compliance. • CQC will continue to judge the level of a concern before it decides whether a provider is compliant or non-compliant. • CQC will continue to identify the level of concern based on the impact on people who use services and the likelihood of occurrence. • CQC's confidence in providers will continue to affect its judgement about whether they are "compliant with concerns" or non-compliant. • CQC will continue to extend deadlines for compliance actions, giving providers more time to become compliant. • CQC's regulatory response will continue to be determined by aggregating numbers and levels of concerns using setting the bar.
Option 2	**Option 2 involves making the proposed improvements in response to feedback from providers, CQC staff and the public, and our operational review of the current model. In practice this means that:** • Providers will be judged to be either compliant or non-compliant. • CQC will focus its resources on identifying evidence of non-compliance. • CQC's confidence in providers will not affect its judgement of compliance or non-compliance with the essential standards. • CQC will judge the level of impact on people who use services after it has reached a judgement of non-compliance with the regulations. • CQC's regulatory response will be determined by a new escalating scale of enforcement action. CQC will not extend the timescales given to providers to achieve compliance, or set the same enforcement action a second time. • CQC will judge the level of impact on people who use services for each regulation where it identifies non-compliance. • Where CQC issues a warning notice for non-compliance with a regulation, it will publish a summary of the notice and refer to it in the compliance report, if representations are not received and upheld.

What work has CQC done to assess the likely impact of the proposed changes?

19. A project team was established to look at CQC's regulatory activity under the Health and Social Care Act (Regulated Activities) Regulations 2010. The project team considered the likely impact of the proposed changes to the judgement framework and enforcement policy on five groups of stakeholders:
    - People who use services.
    - The public.
    - Commissioners.
    - Regulated providers.
    - CQC.

20. The project team examined a random sample of published inspection findings from both planned and responsive inspections for a range of different types of provider. The team analysed the impact of the proposals on both previous and future levels of regulatory activity on the assumption that the proposals were already in effect.

21. The project team identified a variety of different impacts and benefits that were expected to arise from the proposals and analysed how these would be distributed among the five groups of stakeholders.

22. The likely impact on CQC's regulatory activity was then analysed and checked against the feedback and suggestions originally made by providers, the public and our own staff on the current regulatory model. This was to determine whether the feedback and suggestions supported the likely impact of the proposals. This analysis confirmed that this was the case.

23. Accordingly, the analysis is used below to assess the impact of options 1 and 2 to the five groups of stakeholders.

What criteria are used to assess the options?

24. Options are assessed according to the following 10 criteria:
    a) Feasibility of retaining option 1 or implementing option 2.
    b) Comparative costs of options 1 and 2 for regulated providers.
    c) Comparative costs of options 1 and 2 for CQC.
    d) Comparative costs of options 1 and 2 for people who use services.
    e) Comparative costs of options 1 and 2 for the public and commissioners.
    f) Comparative benefits of options 1 and 2 for people who use services.
    g) Comparative benefits of options 1 and 2 for the public and commissioners.
    h) Comparative benefits of options 1 and 2 for regulated providers.
    i) Comparative benefits of options 1 and 2 for CQC.
    j) Management of risks under options 1 and 2.

What is the feasibility of implementing each option?

25. The key test of feasibility is whether CQC has the statutory powers and the capability to operate the existing regulatory model (option 1) or the new improved model (option 2). To be feasible, options 1 and 2 must:

    - Fit within CQC's existing statutory powers under the Health and Social Care Act (2008) and associated regulations.
    - Be affordable.
    - Be delivered within CQC's existing capabilities.
    - Be implemented by April 2012 (option 2).

26. The feasibility of options 1 and 2 has been assessed as:

    - Option 1 – Feasible
    - Option 2 – Feasible.

What are the comparative costs of options 1 and 2 to providers?

27. The overall cost impact on regulated providers will depend on whether they are achieving compliance with the essential standards.

28. Where providers have previously been judged to be compliant with some concerns, they will need to continue to make the necessary improvements to become fully compliant by 1 April 2012. The proposals include removing the matrix system of aggregating concerns to determine whether providers are compliant or non-compliant. This means that where providers have previously been judged as compliant with some concerns, they may find that they become non-compliant if they are not meeting the requirements of the regulation. If this is the case, they will face increased regulatory activity from CQC.

29. If all providers who are currently "compliant with concerns" fail to become compliant by 1 April 2012 then in the short term (6-12 months) we estimate that 9% of providers will move from being compliant to non-compliant.

30. The comparative costs of options 1 and 2 to providers are estimated at:

    - Option 1 – NO CHANGE.
    - Option 2 – Reduced costs for providers judged to be compliant:
        - Potentially increased costs to become compliant for providers who we judge to be non-compliant, or similar costs but within a shorter space of time.

What are the comparative costs of options 1 and 2 to CQC?

31. As above, the overall cost impact on CQC will similarly depend on levels of non-compliance. If any providers who are currently "compliant with concerns" do not make the necessary improvements to become fully compliant with the essential standards by 1 April 2012, then

they may be assessed as non-compliant and CQC will increase its regulatory activity towards those providers.

32. In addition, the overall cost impact to CQC will depend not only on those providers who move from compliant to non-compliant, but also on any deterioration in the position of providers who are currently non-compliant through additional risks being identified.

33. If all providers who are currently "compliant with concerns" fail to become compliant by 1 April 2012, then in the short term (6-12 months), 9% of providers will move from being compliant to non-compliant. In the longer term (less than a year) the costs to CQC are expected to reduce as compliance levels increase among providers.

34. The comparative costs of options 1 and 2 to CQC are estimated at:

- Option 1 – NO CHANGE.
- Option 2 – Where providers are judged to be compliant, CQC's costs will reduce because no follow-up activity will be undertaken:
    - Where providers are judged to be non-compliant, CQC's regulatory activity will increase proportionately to the impact that non-compliance has on people who use services.

What are the comparative costs of options 1 and 2 to people who use services?

35. The costs under options 1 and 2 to people who use services are assessed as:

- Option 1 – LOW.
- Option 2 – LOW.

What are the comparative costs of options 1 and 2 to the public and commissioners?

36. The costs under options 1 and 2 to the public commissioners are assessed as:

- Option 1 – LOW.
- Option 2 – LOW.

What are the likely benefits of the proposed changes?

37. The overall benefits to society of the proposed changes will depend on levels of compliance with the essential standards among providers:

- Under option 1 current levels of compliance and benefits are expected to continue.
- Under option 2, five main types of benefits are identified for the different groups of stakeholders (see below).

38. The five main benefits of the proposed changes (option 2) are:

    a) The proposed improvements will result in a faster regulatory response by CQC because of the introduction of a more robust, transparent escalation process directed at non-compliant providers.

    b) CQC's regulatory response will be more proportionate to the impact that non-compliance has on people who use services.

    c) The focus of CQC's regulatory activities will shift away from providers who are compliant and towards those that are non-compliant.

    d) The new, simple to understand system of "compliant or non-compliant" will result in more clearly informed choices about which services to use.

    e) More effective regulatory activity to address cases of non-compliance will reduce levels of non-compliance in the longer term and so provide stronger assurance that essential standards of quality and safety are being met.

What are the comparative benefits of options 1 and 2 to people who use services?

39. The main benefits of the proposed changes (option 2) for people who use services is as follows:

    - People who use services that are non-compliant will benefit from a faster regulatory response from CQC to improve the services they currently use.
    - People who use services that are non-compliant will benefit from CQC responding proportionately to the impact that non-compliance is having on their personal wellbeing.
    - People who use services will have a clearer understanding of whether the services they use are complying or not complying with essential standards.
    - People who use services will benefit from stronger assurance that regulated providers are achieving and maintaining essential standards of quality and safety.

40. Overall, the assessment of benefits to people who use services under option 1 and option 2 is:

    - Option 1 – NO CHANGE.
    - Option 2 – INCREASE / HIGH.

What are the comparative benefits of options 1 and 2 to the public and commissioners?

41. The main benefits of the proposed changes (option 2) for the public and commissioners is as follows:

    - Both the public and commissioners will benefit from non-compliance in regulated services being addressed more quickly by CQC.

- Both the public and commissioners will benefit because CQC will target its regulatory effort towards addressing issues of non-compliance among services.
- Both the public and commissioners will benefit because they will be more clearly informed about the status and track record of providers who are compliant or non-compliant. This will help inform their choices about which services to use.
- Both the public and commissioners will benefit from stronger assurance that regulated providers are achieving and maintaining essential standards of quality and safety.

42. Overall, the assessment of benefits to the public and commissioners under option 1 and option 2 is:
    - Option 1 – NO CHANGE.
    - Option 2 – INCREASE / HIGH.

What are the comparative benefits of options 1 and 2 to providers?

43. The overall benefits to providers will depend on the value they place on meeting the essential standards. The feedback CQC has received from providers indicates that they would prefer a clearer judgement framework and enforcement policy where they are either compliant or non-compliant. Feedback from providers (especially adult social care providers) indicates that the current system, where they can be compliant but with concerns can be confusing both for them, and for people who use the services and commissioners who make choices based on our judgements. Some providers have raised concerns about the consistency of our judgements. The new model aims to increase consistency.

44. The main benefits of the proposed changes (option 2) for regulated providers is as follows:
    - Providers who are compliant will see savings as CQC shifts its focus onto providers who are non-compliant. For example, providers who are compliant may not be required to submit information to demonstrate compliance.
    - Providers who are non-compliant will benefit because they will receive more timely regulatory involvement to help them address non-compliance.
    - Providers who are non-compliant will benefit because the regulatory intervention they receive from CQC will be proportionate to the impact that non-compliance has on the people who use their service.
    - Providers who are compliant will benefit from the stronger assurance they can offer to people who use their services, the public and commissioners about the quality and safety of their services.

45. Overall, the assessment of benefits to regulated providers under option 1 and option 2 is:
    - Option 1 –NO CHANGE.
    - Option 2 – INCREASE / HIGH.

What are the comparative benefits of options 1 and 2 to CQC?

46. The overall benefits to CQC similarly depend on ensuring that as many providers as possible are complying with essential standards of quality and safety. The benefits of option 1 to CQC is that the current model retains the flexibility of being able to make recommendations for improvement that providers must meet even where the recommendations are not considered so serious that they are non-compliant. However, this is in contrast to feedback that this system is confusing and leads to a lack of consistency in judgements.

47. The main benefits of the proposed changes (option 2) for CQC is as follows:

- CQC (and its staff) will benefit because a faster regulatory response will enable CQC to deliver its organisational objectives quicker.
- CQC (and its staff) will benefit because CQC will operate more effectively by focusing its activity on responding proportionately to cases of non-compliance among services.
- CQC (and its staff) will benefit because CQC will be able to demonstrate that its regulation has achieved its objectives.
- CQC (and its staff) will similarly benefit because CQC's regulation will be able to demonstrate that it is helping to bring about stronger assurance that providers are meeting essential standards of quality and safety for people who use services, the public and commissioners.

48. Overall, the assessment of benefits to CQC under option 1 and option 2 is:

- Option 1 – NO CHANGE.
- Option 2 – INCREASE / HIGH.

What are the main risks of proceeding with options 1 and 2?

49. The main risk of proceeding with Option 1 is that levels and duration of non-compliance among providers will continue at a level that is unacceptable for all stakeholders. CQC will not be as effective as it could be in ensuring providers become compliant as quickly as possible.

50. The main risk of proceeding with Option 2 is that CQC implement a judgement framework or enforcement policy that does not make a difference in levering improvements within providers who are non-compliant with the regulations.

51. Option 2 does bear the risk that there is an increase in non-compliance due to delays by providers who have been judged as being compliant with some concerns in becoming fully compliant with the essential standards. The risk is that this continues beyond the expected 6-12 months.

What is the preferred option?

52. Option 2 is preferred because it offers high benefits. Option 2 will enable CQC to focus its resources on identifying and taking action where providers are non-compliant. The overall benefits of option 2 outweigh any short-term (6-12 months) potential increase in levels of non-compliance among some regulated providers. This short-term increase might be expected as CQC focuses its resources on evidence of non-compliance.

53. Option 1 is not preferred because it offers no change in the current level of benefits for people who use services, the public, commissioners, regulated providers, and CQC. The benefits of option 1 are not considered sufficient in comparison with those offered by option2.

What are the legal considerations of the proposals?

54. **Proportionality**: the consultation proposals are not intended to go further than necessary to meet CQC's aims of strengthening the assurance that regulated providers are meeting essential standards, or that CQC is responding swiftly to cases of non-compliance.

55. **Adverse effects:** the consultation proposals are intended to strike a fair balance between the public interest and those adversely affected by the proposal.

56. **Protections:** the scheme proposals are not intended to remove any protections and or legal rights enjoyed by registered persons, in terms of either those who provide them or those who use them.

57. **Legislation:** the consultation proposals do not require any primary or secondary amendments under the Health and Social Care Act 2008.

58. **Equity and fairness:** the consultation proposals have no implications for minority groups or race equality.

Post implementation review of impact

59. Following the consultation and implementation, CQC will carry out a post implementation review of the impact of the new regulatory model within two years of its start date. Details of the evaluation criteria/methodology will be published as part of the final impact assessment later in 2011/12.

Summary

60. CQC is proposing to make changes to its judgement framework and enforcement policy in response to a review of the way that it regulates registered providers against essential standards of quality and safety under the Health and Social Care Act (2008).

61. The new judgement framework and enforcement policy are intended to be a simpler and clearer process for people who use services, commissioners, the public and providers to understand.

62. Overall, the proposed changes are expected to reduce regulatory costs to providers who are compliant with the essential standards because they will not incur the same level of monitoring costs relating to improvement actions.

63. The proposed changes will result in greater costs for providers who are not complying with essential standards. This is because non-compliant providers will face an increased regulatory response from CQC through its escalation process.

64. The benefits of proceeding with the proposed improvements to CQC's regulatory model are expected to be realised by providers, people who use services, commissioners, the public and CQC during the first year of its implementation.

65. The level of non-compliance among providers who are currently compliant with some concerns may rise in the short-term (6-12 months) before reducing.

66. It is possible that as CQC targets its resources to identifying evidence of non-compliance, more providers will be judged to be non-compliant. However as providers become familiar with the new policy, it is expected that they will take additional action to become compliant.

Conclusion and recommendation

67. In conclusion, this impact assessment has identified that option 2 offers significant benefits over option 1.

68. Consequently, this impact assessment supports the proposals set out in the consultation.

Declaration

69. I have read the impact assessment and am satisfied that the likely impact of the scheme has been identified and set out in an informative way.

Cynthia Bower
Chief Executive, CQC

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS11 [ ] to the Witness Statement of **Kay Sheldon**

Subject: Mental Health Act functions

From: Kay Sheldon (kay_sheldon@[redacted]

To: Cynthia.Bower@[redacted]

Cc: jo.williams@[redacted] la.kelly@[redacted] Martin.Marshall@[redacted] ohn.harwood@[redacted] olu@[redacted]

Date: Tuesday, 13 September 2011, 8:13

Dear Cynthia

I am writing ahead of the board meeting to express my serious concerns and deep disappointment at the way the organisation has handled the 'modernisation' of the our Mental Health Act functions at senior management level:

1. A report was due at the September board. There is no explanation as to why this hasn't happened.
2. As I suspected that the full report would not be ready for the board meeting, I asked for an update on where we are and where we're going. This hasn't happened either.
3. There is a huge loss of confidence in CQC in mental health internally and externally.
4. The situation we are in has been caused by a failure at senior management level. There has been a persistent lack of ownership, leadership and accountability.

The scapegoating of the previous Head of MH ops for the failings is inappropriate and disingenuous.

6. I have heard many examples of bullying which is unacceptable and frankly abhorrent.
7. My confidence in CQC's ability to deliver the Mental Health Act functions has been severely undermined. I have trusted in the organisation but it is clear that we need to move beyond trust to holding senior management to account. On a personal level, I feel let down.
8. There is another programme manager in place. However the ownership and oversight at senior management level remains unresolved. I have heard and seen nothing that provides assurance that we are approaching our duties under the MH Act in a strategic and coherent way. It is impossible to hold senior management to account (indeed I believe this is a wider governance issue that the board and executive team need to tackle).

I appreciate this will not be well received but it is difficult to see how else to approach this in the current context. As a member of the board I feel I have no option but to hold the executive team to account in this way and to continue to do so until there is adequate assurance.

Best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS12 [ ] to the Witness Statement of
Kay Sheldon

Subject: In confidence: the board

From: Kay Sheldon (kay_sheldon@

To: Martin.Marshall@ jharwood.cqc@

Date: Friday, 16 September 2011, 9:04

Dear Martin and John (I have not included Olu in this as he is moving on although acknowledge it may be appropriate to do so)

I am writing because I am deeply concerned about the functioning of the board. At the moment it is not possible to discharge our roles and responsibilities effectively. I really feel we need to sort this out properly and soon and, if we don't, it will be (further) detrimental to the organisation. I want to stress that I am not inciting mass rebellion (or playing power games or even stroking egos!) but genuinely want us to get to grips with this. To be frank, if we don't we are not doing our job.

I feel we are being prevented (for whatever reason) from discharging our roles and responsibilities effectively. As you know this is not the first time I have raised this and it still has not been addressed in any significant way. Trust seems to be mentioned a lot which is obviously important but it is a 2/3 way thing. We have to trust the exec to get on with the job but we also need to be trusted to do our job.

An illustration: the revision of our approach to stakeholders and how it is being managed has gone down very badly and, to be honest, is embarrassing as it represents lack of judgement and understanding (a recurrent theme). I met with Jill & team - at her request - prior to the stakeholder paper coming to the board and made clear (strategic) comments about it which would have helped & supported the transition but these have been ignored (and so not valued). It was clear that the purpose of the meeting was to get my support and reduce the likelihood of it being derailed at the board.

Our relationship with the chair is a very tricky and sensitive issue. I know Jo is under a huge amount of pressure and needs our support, and there is no question of not supporting her. However the nature of this support is very problematic and is long standing: we are expected to provide unconditional support with whatever is done or proposed. Any challenge is treated as disloyal or negative. Yet constructive challenge and debate underpins good decision-making.
It is clear that 'the team' is Jo and the executive team and we are seen as undermining this team approach. I think is right in that Jo doesn't want us to play much of a role (again for whatever reason). We are not engaged in the development of strategy in the way a board should be and a significant reason for this is due to the way we are led and the way board and strategy meetings are chaired.

The work done to support the effectiveness of the board has been pushed to one side.

It seems to me that we either limp along in the same way or we try to address it. If we try to address it in a way that will lead to a change, we risk destabilising the organisation, upsetting Jo, alienating the exec team as well as being seen as egotistical and self serving. We have a strategy day coming up where we are going to look at working together with the exec but I don't feel very confident at the moment, based on previous attempts, that this will lead to the changes that are needed.

I would be very grateful if you could give this some thought and, if you think this would be appropriate, that we discuss/decide a way forward.

Very best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS13 [ ] to the Witness Statement of
Kay Sheldon

Subject: Re: Board Strategy Day

From: Kay Sheldon (kay_sheldon@[redacted]

To: jharwood.cqc@[redacted] Ronald.Morton@[redacted]

Cc: deirdre.kelly@[redacted] la.kelly@[redacted] martin.marshall@[redacted] blu@[redacted] jen.witts@[redacted] o.Williams@[redacted]

Date: Monday, 26 September 2011, 8:07

Dear Jo, all

We seem to have a shared view of the issues which is encouraging. How we address them will be crucial and, in particular, how we do this with the executive team. I think the exec feel we are too involved which contrasts with the fact we feel we are not involved enough. I think it is clear we are not fulfilling our strategic and governance functions effectively. The board papers we receive are indicative of the problem in that the strategic context is muddled (sometimes absent) and, whilst there is a lot of information, it is often difficult to understand the key issues from them. The papers tend to steer us in a particular direction at the expense of a more considered and objective rationale. When I have sought to understand the thinking behind the papers, I have been less assured rather than more (I won't go into the details here). This leads the exec to feel we are not respecting their professional judgement and that we are getting too involved in the detail. In fact I have been very careful not to influence operational decisions but it is clear that these decisions are often reactive and not very joined up, and crucially are difficult to link back into strategy.

It is worth noting that our 5 year strategy is still extant. It is still on the website and there has been no appropriate or formal mechanism for the strategy to be reviewed and changed [rather sadly, I have been through all the board agendas since the strategy was set and there is no evidence that we have reviewed or changed our strategy]. There have been sporadic suggestions that we have 'over promised' or 'things have changed' or 'it has been very difficult' which are used to deviate from our agreed strategic direction. This is not to say that these are not valid concerns but we cannot continue to accept such 'explanations' to justify decisions made by the executive.

It is still unclear (to me anyway) what we can actually afford to do as an organisation. I have not seen any analyses of what our key activities cost, now and in the future, and how/if we allocate and use our resources effectively. We have done a lot of work around 'risk' which is welcome but can only be of limited use in the context of the above. At the moment it is difficult to assess our performance and to hold the exec to account.

Going forward, the leadership of Jo and Cynthia will be crucial in setting the tone and changing behaviour, both in the respective 'teams' they lead as well as the overall relationship between the board and the exec. This will help all of us understand and fulfill our respective roles and responsibilities.
On a personal level I would like to feel that my contribution is useful and worthwhile.

Best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS14 [ ] to the Witness Statement of
Kay Sheldon

Agenda Item: 10
Ref: CM/07/11/08(P)

Care Quality Commission

MEETING:	**PRIVATE BOARD MEETING**
DATE:	**16 November 2011**
TITLE OF PAPER:	**Strategy Days' Summary**

SUMMARY:

Following recent work by CQC to simplify and strengthen its regulatory model and define its core functions and to reassess the relevance of the wording of its strategic priorities, it is timely to update and refresh its published strategic plan.

RECOMMENDED ACTION:

The Board are asked to **COMMENT** on the appended draft strategy and to **ENDORSE** the approach taken.

☐ Executive Decision/ Board for information	☐ Executive and Board decision	☐ Executive and Board shared decision	☒ Executive and Board discussion/Board decision
* Check box as required			

LEAD DIRECTOR:	Philip King, Director of Regulatory Development
AUTHOR:	Amanda Hutchinson, Regulatory Development
DIRECTORATE	Regulatory Development
DATE:	21 October 2011
SUPPORTING PAPERS:	Annex A - Refresh of Strategy 2012-2015

Agenda Item: 10
Ref: CM/07/11/08(P)

GOVERNANCE

AUDIT TRAIL:	This paper has been agreed by the Executive Team, and follows earlier discussion with the Board at their September meeting.
LINK TO STRATEGIC OBJECTIVES AND BUSINESS PLAN	This piece of work is fundamental to ensuring that CQC's objectives and business plan reflect CQC's evolving role and delivery priorities.
FINANCIAL IMPACT:	Resource implications are being addressed in detail as part of our budgetary and business planning.
RISK IMPACT:	No significant risks associated with the issues in the paper. Risks associated with delivery of our business plan will be addressed as part of the planning and risk management process.
REPUTATION IMPACT:	Stakeholder engagement plan to be developed.
LEGAL IMPLICATIONS:	None at this stage.
HEALTHWATCH IMPACT:	N/A at this stage.
EQUALITY IMPACT ASSESSMENT:	None completed.

Agenda Item: 10
Ref: CM/07/11/08(P)

1. Background

1.1 CQC published a five year strategy (2010-2015) in February 2010. The plan was structured around five strategic priorities. Public consultation was undertaken as part of the development process. The Strategy was revisited in December 2010, and the five strategic priorities reduced to two. Although internal messaging was developed in response to this change, a formal externally facing 'refresh' of the strategy was not undertaken.

1.2 CQC has undertaken significant work recently to refine and strengthen its regulatory model and is consulting currently on a revised judgement framework and enforcement policy. Recent internal and external reviews of CQC have prompted further thinking about CQC's core role and functions and highlighted the need to be clear with external stakeholders about CQC's place in the health and social care landscape and its role as a regulator. At its September strategic meeting, the Board considered these issues and highlighted the need for further thinking to be done about how CQC presents itself and articulates its core functions and priorities.

1.3 In response to this, it is proposed that CQC publishes a simplified and updated strategic plan.

2. Executive Summary

2.1 A draft refreshed strategy is attached for discussion by the Board. This draws on discussions at the Board's September meeting to present a refined definition of CQC's role which maintains the important elements of the wording of CQC's strategic priorities. It pulls together key elements of internal work to define CQC's revised regulatory approach and describe its core functions. It identifies a set of key deliverables and also some success measures. There are clear links between the strategy and CQC's business plan.

2.2 It is significantly shorter and less complex than the original plan to ensure that messages about CQC's role and responsibilities are clear to an external audience. It is focussed on CQC rather than broader relationships with the health and social care system and deliberately does not cover HealthWatch and other potential changes to CQC's role and remit.

2.3 The draft strategy was discussed at the Leadership Group event on 3 November, and responses and suggestions from the managers present are being analysed with a view to reflecting these in the refined draft strategy, alongside the Board's comments.

2.4 It is proposed that the document be published at the same time as the final version of the judgement framework and enforcement policy. It is proposed that it should not be the subject of a formal 12 week consultation, but that a plan be developed for stakeholder engagement before and after its publication, focussed on CQC's role and what that means for its work going forward.

3. Conclusion

3.1 Refreshing the strategy will enhance CQC's ability to manage significant risks, including major reputational ones, going forward.

4. Next Steps

4.1 Next steps will be for further refinement of the document following feedback from the Board; input form the Leadership Group; and the development of a plan for stakeholder engagement.

Name: Philip King
Title: Director of Regulatory Development
Date: 21 October 2011

ANNEXES: Annex A – Refresh of Strategy 2012-2015

Agenda Item: 10
Ref: CM/07/11/08(P)

Annex A

RESTRICTED - DRAFT

REFRESH OF STRATEGY 2012 – 2015

CQC's role

Under the Health and Social Care Act 2008, and the Mental Health Act, providers are responsible for meeting essential standards of safety and quality and ensuring care is centred on people's needs and protects their rights.

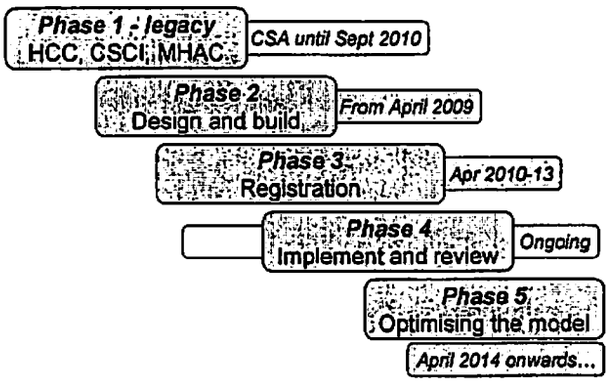
CQC's role is to hold providers to account for meeting these standards. We focus on care that doesn't meet standards and act swiftly to tackle poor standards and thereby drive improvement.

Every part of the system – from providers, to commissioners, to professional regulators – has a duty to make sure that poor care is identified and addressed. All of those involved in providing care – senior management, boards of governors, medical professionals and frontline staff – have a part to play in stopping or reporting poor care whenever they see it. If poor care is happening, someone somewhere knows about it and should act.

Updating our strategy

This updated strategic plan which covers the period 2012-15 replaces the five year plan published in spring 2010. It reflects the work CQC has done in recent months to simplify and strengthen its regulatory approach in order to reflect changes to its remit, operational practice and resources. In line with similar organisations, CQC has been evolving since its establishment, working through the design, build and testing of its approach to regulation, implementing and reviewing processes such as registration

CQC's lifecycle – a five year programme



We have listened to what providers and the public have told us about some of the challenges of our current regulatory model. In addition, as part of the process of reforming the NHS, the government has sought to strengthen our role to ensure that we focus on our core business: to monitor and inspect providers to make sure that the essential standards are being met and to take swift action where they are not.

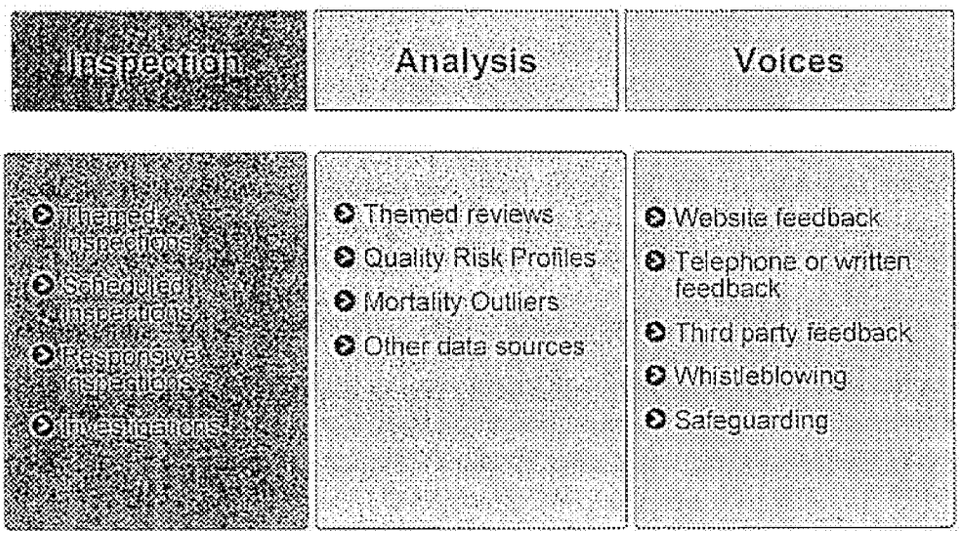
We have recently concluded our consultation on simplifying and strengthening our regulatory model and will be introducing some key changes to the way we do our work.

Firstly, we will inspect most services more often. We intend to inspect most social care services, independent healthcare services, NHS acute hospitals and NHS ambulance trusts at least once a year. In all other NHS trusts, we plan to inspect at least one type of service each year. We intend to inspect dental services at least once every two years.

Secondly, our inspections will be more targeted. They will take account of the nature of the care provided, the level of information we currently have about it and the risks to people. This means we will not necessarily inspect all 16 key essential standards each year, but will usually focus our inspections on a smaller number of standards.

We are not changing our focus on outcomes for people and the experiences of care they receive – these are at the heart of what we do. We will continue to regulate on the basis of risk. And we will continue to carry out scheduled, responsive and themed inspections of services, and they will continue to be unannounced (unless there is a very good reason to let the service know we are coming).

The three essential components of our work will be inspection, analysis and voice



Involvement
Stakeholders

How CQC does its work

We monitor information to identify risks of poor care. The information we monitor comes from our inspections, from third parties nationally and locally and from the public, local groups, carers and care staff, including whistleblowers. When we receive information which indicates that poor care may be happening, we act swiftly to carry out an inspection if we judge that it is necessary.

Whilst CQC has a clear duty to protect the public, it is not CQC's role to act as an improvement agency in the sectors it regulates. Other bodies are better placed to perform this function. CQC promotes improvement by requiring providers to meet essential standards of quality and safety.

Four key functions

CQC's work is delivered through four key functions;

MH Act?

- Registration
- Monitoring and checking compliance with essential standards
- Enforcement
- Publication

The key features of these functions are described below;

Registration

- CQC has a statutory duty to publish a register of providers
- Registration with CQC gives health and social care providers a licence to operate and sets out in a certificate form, a statement of activities which a provider is licensed to undertake, and the locations where services are delivered
- Registration provides an initial assessment of a providers 'fitness' to deliver care to the required standards, on the basis of evidence available at the time
- It means that the provider has a legal duty to comply with specific primary and secondary legislation and CQC's essential standards
- CQC's approach to processing registrations is risk based and may differ between sectors
- In some cases CQC seeks to eliminate risks to those using as service at the point of registration, in others, a decision is taken to manage risk as part of the compliance process

Monitoring and checking Compliance

- CQC monitors and checks compliance with the essential standards through inspection and assessing information from a range of sources
- Inspection is required in order to make a judgement about non-compliance
- CQC uses scheduled, themed and responsive inspections (mostly unannounced)
- Our inspections focus primarily on outcomes for people who use services rather than primarily on systems and processes
- CQC gathers information (locally & centrally) from multiple sources and evaluates it to inform regulatory action
- CQC prioritises according to risk and has the flexibility to check the most appropriate essential standards (1 – 16)
- Its regulatory judgements are supported by appropriate specialist expertise where necessary and experts by experience
- CQC particularly values user voice and information from care staff and whistleblowers
- CQC judges whether providers are compliant, or non-compliant, with essential standards
- If services don't meet essential standards, regulatory action is taken. This includes the use of our enforcement powers

Enforcement

- There is a published scale of regulatory action, including the use of our civil and criminal enforcement powers
- These are used proportionately on the basis of impact (and immediacy) on quality and safety and impact on those currently using the service
- Regulatory action is always swift and is taken urgently when necessary
- CQC follows up on whether non-compliance has been addressed
- CQC has clear systems in place for sharing information with commissioners and other parts of the system
- CQC's judgements about regulatory action against individual providers are not influenced by local context (such as the availability of alternative care provision)

Publication and communication

- CQC publishes information on its website about its regulatory judgements, the evidence that supports them, and the regulatory action it has taken
- Whenever CQC inspects, we publish a report as quickly as possible - the greatest risk is time elapsed between CQC knowing about poor care and telling the public
- Reports say what the inspector saw and heard when they visited , including what users said about the service

- The website is updated after each judgement
  - To inform the public about the quality and safety of local services to assist their choice of service
  - To hold providers to account
- CQC's inspectors take responsibility for the public record (of their portfolio)

We will work in partnership with other regulators and commissioners to share information and to tackle poor quality care where this is identified.

CQC's priorities for delivery

The effective delivery of these four core functions will require a robust infrastructure to be in place. CQCs Delivery Priorities as set out in its Business Plan for 2012-15 are at annex A.

Within in this, key objectives for delivery will be as follows;

- a workforce of xxx frontline inspectors, each with a portfolio of 30-40 providers.
- effective systems for drawing on external expertise and specialist advice to support the inspection process.
- improved access to experts by experience
- a model for carrying out CQC's responsibilities under the Mental Health Act which maintains a strong focus on the rights of detained patients.
- enhancements to the National Customer Service Centre to ensure that it works effectively to support frontline teams.
- Roll-out of on-line services to deliver streamlined interactions with providers
- clear and well-understood systems for transferring information from the NCSC to the frontline workforce which assist them in maintaining up to date provider accounts and prioritising risk.
- Improvements to CQC's website to ensure that it is recognised as an accurate and up to date source of information about whether providers are meeting essential standards of care and which the public are using to help them make choices about care
- a robust system of quality assurance which functions effectively as an integral part of CQC's regulatory processes and ensures that high quality reports are published.
- A sustained national and regional public awareness campaign to encourage feedback on the quality and safety of care from members of the public.
- Processes for evaluating our effectiveness and impact and for reviewing and continuously improving our approach.
- Robust management information which is is up date and used to track progress and drive improvement.

Agenda Item: 10
Ref: CM/07/11/08(P)

CQC will be monitoring and reporting on the following success measures to track its progress against delivering on its priorities

Success	Measure ? impact
CQC is tackling poor standards	o The numbers of providers meeting essential standards of quality and safety o The numbers of providers found to be non-compliant on inspection, and for whom compliance or enforcement action is being taken o The time it takes providers to return to compliance o Number of providers de-registered o The percentage of our inspections that are unannounced
CQC is acting swiftly	o NCSC call handling measures – safeguarding/ whistle blowing o Number of responsive inspections o Website is up to date
CQC is acting on information it receives from the public and from whistleblowers	o NCSC call handling measures – safeguarding/ whistle blowing o Number of responsive inspections
CQC is acting in partnership and sharing information with other regulators and commissioners	o Evaluation of how well CQC is perceived to do this o The future of care programme is on track o Our joint inspection programme is on track
Provider profiles are up to date and CQC's website is a valued source of information	o Website is up to date (specifically provider profiles regularly updated) o Numbers of people visiting the website
CQC's activities are driving improvement (by reducing levels of non-compliance)	o The numbers of providers meeting essential standards of quality and safety o Compliance inspection programme on track o All providers have received inspections within a year/ two years as appropriate o Number of providers and people using services who feel regulation has a positive impact
Reports are produced and published promptly and to high standards	o Reports written within target times
There is good customer service for providers	o Registration applications processed within 8 weeks o Shared services validation/ rejections o Complaints and their outcome
The majority of transactions are on-line	o Tracking of online services project through programme monitoring and Directorate performance reporting
CQC's staff are engaged and positive about CQC as an employer	o Staff survey results report increased engagement and positive feedback
CQC listens to the voices of people using services	o The % of our inspections where we talked to people about their experience of care
Our Mental Health Functions are delivered in a way that safeguards peoples' rights	o Plan of visits to wards that detain patients completed o % of detained patients that we talk to about their experience of care when detained. o Number of providers identified as not following MHA or Code of Practice escalated for compliance action o SOADs review a treatment plan within target time

Agenda Item: 10
Ref: CM/07/11/08(P)

Annex A

Delivering and improving regulation	Registration – process applications for registration required to give health and social care providers a licence to operate. Ensure an effective and streamlined process, aiming with the majority of 'business as usual' applications within 8 weeks. Bring all providers into registration by April 2013.
	Compliance – undertake effective checks of ongoing compliance with the essential standards through regular, mostly unannounced inspections, and assessment of information. Gather information from multiple sources, in particular service user experience and information from care staff. Interact on NHS, Adult Social Care and Independent Health Care provider locations at least once in a business year, and Dental providers at least once every other business year.
	Enforcement – Where services don't meet essential standards, take enforcement action using a range of civil and criminal enforcement powers proportionately on the basis of impact (and immediacy) on quality and safety and impact on those currently using the service. Take action swiftly and urgently, ensuring non-compliance is escalated (i.e. share relevant information with commissioners and other parts of the system).
	Publish information about what services to help users and commissioners make choices and to ensure transparency about CQC's operations. Publish information on the CQC website, updating it after each judgement. Publish reports wherever we inspect, as quickly as possible. Report openly what the inspector saw when they visited and incorporate users' views and about the service. Publish information about enforcement action we have taken.
	Mental Health Act and other duties – Effectively carry out duties to ensure the rights of people subject to the powers of the Mental Health Act are upheld, and like our statutory and other responsible functions in relation to Controlled Drugs, ISMET and joint inspection with other organisations.
The Future of Care	Establish Healthwatch England by October 2013 – providing the opportunity of a rich source of information for CQC, both nationally and locally. Work with HFEA/HTA/NICE and DH to identify the maximum synergies between the regulatory systems and design and agree the future working model to integrate activities into CQC, finding appropriate alternative hosts for those which are not in line with CQC's core business.
Resources /business improvement	Resources and business improvement – Improve our efficiency and performance through effective internal working, productivity and efficient processes. Measure and manage our performance through robust management information. Value our staff: implement a programme of leadership development and the employee offer – job evaluation and new reward strategy for CQC employees.

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS15 [ ] to the Witness Statement of
Kay Sheldon

Subject: Organisational strategy

From: Kay Sheldon (kay_sheldon@[redacted]

To: jo.williams@[redacted] Martin.Marshall@[redacted] d.a.kelly@[redacted] john.harwood@[redacted] olu@[redacted]

Date: Tuesday, 11 October 2011, 19:10

Dear Jo, all

I am extremely concerned that we appear not to have a current organisational strategy. It is difficult to see how we can possibly function effectively without this. We also need this when we respond to the Health Select Committee, the NAO and for the Performance and Capability Review. The 5 year strategy for 2010 - 2015 is still on the website (just checked again!) and there is no audit trail that supports that any review or changes to the strategy have taken place. We cannot possibly fulfill our functions without an agreed and coherent strategy. Indeed we are remiss in our responsibilities if we do not have this. If one does exist and had somehow passed me by I would very much appreciate a copy so that I'm 'on message' in my dealings with stakeholders and staff. I know a chair who insists that board members and exec team always have the strategy in front of them at board meetings to ensure focus and shared understanding. Maybe we could do this?

Best wishes

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS16 [ ] to the Witness Statement of
Kay Sheldon

Print

Subject: Re: Stakeholder strategy

From: Kay Sheldon (kay_sheldon@[redacted]

To: Jill.Finney@[redacted]

Cc: Jo.Williams@[redacted] hilip.king@[redacted]

Date: Tuesday, 25 October 2011, 11:51

Dear Jill, all

Thank you, this is what I was looking for. I am living our value of 'being accountable' through seeking assurance and holding to account...

From a governance/strategic perspective it is quite difficult to see how our current approaches fit with our stakeholder and involvement strategies. I thought the meeting with MH stakeholders was quite telling in that we ended up back tracking on what was said in the paper around the reform of the various advisory groups. I'm not saying this is a bad thing - on the contrary I think it is a very much a good thing as you might imagine - but it does raise questions in my mind as to whether we have this right. Or rather it confirms the questions that were in my mind.

The reform of the advisory groups etc has had the effect of stripping out a lot of input from people who use services, carers and others who are particularly interested in 'user' issues. This, plus our only partial implementation of Voices into Action (this is not a criticism - just a statement of fact), means that large numbers of people are feeling disregarded and devalued. I have sympathy - and indeed empathy - for this. We have gone hell-for-leather for quick impact through targeting stakeholders who we think are influential (and this may be valid) but at the expense of people who matter. Anyone involved in health and social care will know this is risky territory - especially beyond the short term - and it is contrary to many health and social care values - 'nothing about us, without us', for example. Indeed it is contrary to our own 'inclusive' value.

Whilst Health Watch is on the horizon, it will not fit the bill as far as CQC Involvement is concerned, although there is clearly some sorting out to do here. At present it is impossible for me to speak to service users and service user groups as I have nothing to say: I cannot describe our position with clarity or confidence, and so it is difficult to 'be proud'. Similarly the sudden deviations from strategy - and the consequences of this - make it impossible to hold people to account or indeed assume accountability (this is of course part of a wider issue).

It is unfortunate that we have lost momentum and goodwill, not least because it could have been avoided - on a personal level it is disappointing that the issues I raised before and at the board meeting where we discussed the stakeholder strategy were not heard.

I hope we can get to a better position.

[You will understand that I have to raise these issues in this way as part of my general and specific responsibilities as a board member. If I don't do this I am not 'acting with integrity'].

Kind regards

Kay

From: "Finney, Jill" <Jill.Finney@
To: Kay Sheldon <kay_sheldon@ "Trainer, Matthew" <Matthew.Trainer@
Cc: "Thompson, Nigel" <Nigel.Thompson2@
"Williams, Jo" <Jo.Williams@
Sent: Monday, 24 October 2011, 15:25
Subject: FW: Stakeholder strategy

Dear Kay

I attach a copy of our latest stakeholder strategy which I hope is what you are looking for . I think this should be read in the context of our local engagement/involvement strategy and our National Involvement strategy. These are 3 connected but distinctive pieces of work.Nigel Thompson is responsible for the other 2 pieces .
Jill

Jill Finney
Director of Strategic Marketing & Communications
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London, EC1Y 8TG
Tel:
Mobile:
Email: jill.finney@

From: Trainer, Matthew
Sent: 24 October 2011 14:38
To: Finney, Jill
Subject: RE: Stakeholder strategy

Jill,

The strategy came first (October 2010 Board) and included these paragraphs to try to make clear that this is about public affairs, not involvement. More detailed proposals on structure came up in May this year.

From the strategy (my emphasis):

1.1 This stakeholder strategy for the period October 2010 to April 2012 aims to set out how CQC will engage with key stakeholders to achieve its objectives during this period of significant change in health and care services. **The stakeholders given priority in this strategy are those who can have the greatest impact on our reputation – not on delivery of our regulatory functions.** It is linked to the media, user and provider communications strategies which are also the responsibility of Strategic Marketing and Communications

4.1 CQC has a broad and complex range of stakeholders. Their levels of awareness and engagement vary enormously, as do the types of organisation they are and our relevance to them. For this paper, **we have**

concentrated on stakeholders who engage with us in the public affairs sphere and who can have an influence on our reputation. We have not included those whose primary relationship with CQC is delivering regulatory objectives, but who do not have a bearing on our [national] reputation.

Matthew.

Matthew Trainer
Head of public affairs
Care Quality Commission

Internal:
matthew.trainer@

Statutory requests for information made under access to information legislation, such as the Data Protection Act 1998 and the Freedom of Information Act 2000, should be sent to information.access@cqc.org.uk

From: Finney, Jill
Sent: 24 October 2011 14:23
To: Trainer, Matthew
Subject: FW: Stakeholder strategy

pls send me latest version
thanks

Jill Finney
Director of Strategic Marketing & Communications
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London, EC1Y 8TG
Tel:
Mobile:
Email: jill.finney@

"Statutory requests for information made under access to information legislation, such as the Data Protection Act 1998 and the Freedom of Information Act 2000, should be sent to:

information.access@cqc.org.uk"

From: Kay Sheldon [mailto:kay_sheldon@
Sent: 24 October 2011 11:53
To: Finney, Jill
Subject: Stakeholder strategy

Hi Jill

I'm currently getting together a governance resource. I would be grateful if you could forward me our current stakeholder strategy. I have one but I'm not sure it is up-to-date.

Many thanks

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS17 [ ] to the Witness Statement of
Kay Sheldon

Subject: Re: DANI etc. any implications beyond reputation?

From: Kay Sheldon (kay_sheldon@

To: Jo.Williams@ Martin.Marshall@ ohn.harwood@ d.a.kelly@
Cynthia.Bower@ Amanda.Sherlock@ Philip.King@ Jill.Finney@
Louise.Guss@ John.Lappin@ Richard.Hamblin@ Allison.Beal@

Date: Wednesday, 26 October 2011, 12:38

Hi all

I just heard Andrew Lansley on the radio again and this time he used the term 'asked' CQC! He made the point that these were extra inspections to which the interviewer queried why they should be necessary especially as the issues were well known. There was a query around the effectiveness of the 'inspectorate' (mostly in the context of resources). Lansley then went on to say he would expect the issues to be picked up and dealt with at an earlier stage which kind of worried me in the context of the proposed changes to our regulatory model....

We really do need to ensure we have a robust strategic context....

Kind regards

Kay

From: "Williams, Jo" <Jo.Williams@
To: Martin Marshall <Martin.Marshall@ 'Kay Sheldon' <kay_sheldon@ "Williams, Jo" <Jo.Williams@ ; john harwood <john.harwood@ ; Deidre Kelly bham <d.a.kelly@ "Bower, Cynthia" <Cynthia.Bower@ ; "Sherlock, Amanda" <Amanda.Sherlock@ ; "King, Philip" <Philip.King@ ; "Finney, Jill" <Jill.Finney@ ; "Guss, Louise" <Louise.Guss@ "Lappin, John" <John.Lappin@ ; "Hamblin, Richard" <Richard.Hamblin@ "Beal, Allison" <Allison.Beal@
Sent: Wednesday, 26 October 2011, 11:59
Subject: RE: DANI etc. any implications beyond reputation?

Dear Colleagues

These are very good questions but lets be absolutely clear, the Secretary of State has not ordered anything, we have initiated this and it's under our control.

Regards

Jo

Angela Manroy sent on behalf of Dame Jo Williams
Chair
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row

London EC1Y 8TG
Telephone:
Internal Extension:
E-mail: angela.manroy@

Statutory requests for information made under access to information legislation such as the Data Protection Act 1998 and the Freedom of Information Act 2000 should be sent to: information.access@cqc.org.uk.

From: Martin Marshall [mailto:Martin.Marshall@
Sent: 26 October 2011 10:47
To: 'Kay Sheldon'; Williams, Jo; john harwood; Deidre Kelly bham; Bower, Cynthia; Sherlock, Amanda; King, Philip; Finney, Jill; Guss, Louise; Lappin, John; Hamblin, Richard; Beal, Allison
Subject: RE: DANI etc. any implications beyond reputation?

Kay
Many thanks, I agree with your analysis and it would be good to discuss further.
b/w
Martin

Martin Marshall
Clinical Director and Director of Research & Development
The Health Foundation
90 Long Acre, London WC2E 9RA

Telephone: Direct:
BlackBerry: Facsimile
martin.marshall@
www.health.org.uk
www.twitter.com/HealthFdn

From: Kay Sheldon [mailto:kay_sheldon@
Sent: 26 October 2011 10:23
To: jo.williams@ john harwood; Martin Marshall; Deidre Kelly bham; Bower Cynthia; Sherlock Amanda; philip.king@ jill.finney@ louise.guss@ Lappin John; Hamblin Richard; Beal Allison
Subject: DANI etc. any implications beyond reputation?

Dear all

As you know we have completed the first DANI, we are undertaking DANI 2 and a review of LD services. These have been ordered by the Secretary of State as a result of media and public pressure. CQC completed the first DANI creditably and there was widespread agreement that exposure of the issues was both needed and overdue. As we know, there is a long history in health and social care of having high profile reports that raise the issues for a while but then disappear into the background until the next scandal (as I recall this was one of the main reasons for changing our approach to reviews and studies).

There have been occasional references to the fact that we could use the DANI model in our day-to-day inspections. We received an evaluation of DANI but this was around operational issues, and not strategic ones. I raise this for a number of reasons:

1. We would not have undertaken the reviews had we not been ordered to by the SoS
2. It is not clear what we learned *as the regulator* from the study beyond the operational issues associated with a large-scale study
3. Many of the issues would not have been picked up - and certainly not to such an extent - through our current BAU regulatory activities.
4. It is not clear if this would change, for the better or worse, with the proposed changes to our regulatory model
5. We do not have a cost-benefit analysis of DANI and/or the ways of working used in DANI
6. The study could be seen as at odds with our agreed approach to reviews and studies

I know we are using these large national studies as a way of enhancing our reputation. It is good that the first round of DANI generated confidence in us as an organisation. However we should also look at issues objectively and dispassionately. I think we need to consider what they mean for us strategically, as the health and social care regulator, and in the context of our legal and organisational duties. It seems to me that we either view the studies as one-off pieces of work or they inform how we move forward. As I understand it, our new strategy will appear in the not too distant future and maybe some or all of the above have been considered in this context. If not, maybe we should?

Kind regards

Kay

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS18 [ ] to the Witness Statement of
Kay Sheldon

Subject: Email correspondence – a necessity

From: Kay Sheldon (kay_sheldon@

To: d.a.kelly@ Jo.Williams@ Martin.Marshall@ john.harwood@

Date: Friday, 28 October 2011, 10:09

Hi Jo, all

I wanted to pick up on the email issue. I appreciate that it is not ideal to raise significant strategic and governance issues by email. However, the usual mechanisms are not working effectively and so, in order to discharge my duties as a board member, I have to do this through other means. Doing nothing is not an option - in fact I would go as far as to say this would be remiss, not least in the context of holding a public appointment. I appreciate others may have different views but I have individual responsibilities as well as collective ones.

Sometimes it seems that issues I raise are interpreted simply in an operational context. This is not the case - if I pick up on issues, these are always in a strategic or governance context. A recurrent theme is that many operational-type issues cannot be related back to a clear strategic context or seem at odds with what has been agreed. This is not to say we shouldn't be responsive, or even pragmatic, but if this becomes a matter of course, something is wrong and it is a high risk approach in the longer term.

I have been though all our board papers over the last two years. It is clear we do not have a clear strategic context or direction. Our risk management arrangements and performance framework are still not robust enough. I have raised these issues many times. All I can do is continue to raise them and, in the meantime, discharge my duties in a way that I see as appropriate and fit.

I hope that the DH review will provide a catalyst for a different approach. In the meantime I have to discharge my responsibilities to the best of my abilities in the context available to me. My desire is for us to be a high functioning board that supports a well-run organisation. It is within our gift to achieve this.

Very best wishes

Kay

From: Deirdre Kelly <d.a.kelly@
To: "Williams, Jo" <Jo.Williams@ ; 'Kay Sheldon' <kay_sheldon@ 'Martin Marshall' <Martin.Marshall@ 'john harwood' <john.harwood@ "'Bower, Cynthia'" <Cynthia.Bower@ ; "'Sherlock, Amanda'" <Amanda.Sherlock@ "'King, Philip'" <Philip.King@ "'Finney, Jill'" <Jill.Finney@ "'Guss, Louise'"

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS19 [ ] to the Witness Statement of
Kay Sheldon

Subject: Re: DH Capability Review : 09:11:2011

From: Kay Sheldon (kay_sheldon@

To: Jo.Williams@ john.harwood@ d.a.kelly@ DEIRDRE.KELLY@ Martin.Marshall@

Cc: Cynthia.Bower@

Date: Thursday, 3 November 2011, 18:22

Dear Jo

Simply looking back through board papers provides clear evidence that the board has not set the strategic direction: there have not been appropriate opportunities to discuss and review our strategic context and approach. If anything the last board development session provided more evidence that we have not been able to discharge these core governance functions.

The 'refresh' of our strategy is quite telling in that it is not a strategy: it is a shortened version of our business plan. It would be great if we could have a proper strategic discussion from which the business plan etc flows rather than - as is currently the case - the other way around...

Kind regards

Kay

From: "Williams, Jo" <Jo.Williams@
To: Kay Sheldon <kay_sheldon@ "Williams, Jo" <Jo.Williams@ john harwood <john.harwood@ Deirdre Kelly <d.a.kelly@ Kelly Deirdre (RQ3) BCH <DEIRDRE.KELLY@ ; Martin Marshall <Martin.Marshall@
Cc: "Bower, Cynthia" <Cynthia.Bower@
Sent: Thursday, 3 November 2011, 9:55
Subject: RE: DH Capability Review : 09:11:2011

Dear Kay

I am sorry that the strategy document did not go yesterday, it should be with you this morning. This document is a summary about deliberations at our strategy day.

The short time scales given for the capability review have meant that our usual time table is out of step. What I mean by this is that the sign off of the strategy refresh is scheduled for our November Board meeting and ordinarily you will receive those papers next week.

I am sorry but I don't understand what you mean when you say that the Board does not set the strategic direction, this is entirely at odds with my view and central to our discussion with the Executive, specifically at our last meeting we looked at our decision making and determined that the strategic making and decision rest with the Board.

Best wishes

Jo

Angela Manroy sent on behalf of Dame Jo Williams
Chair
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG
Telephone
Internal Extension:
E-mail: angela.manroy@

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From: Kay Sheldon [mailto:kay_sheldon@
Sent: 03 November 2011 08:05
To: Williams, Jo; john harwood; Deirdre Kelly; Kelly Deirdre (RQ3) BCH; Martin Marshall
Cc: Bower, Cynthia; Durham, Paul
Subject: Re: DH Capability Review : 09:11:2011

Dear Jo

Thanks for this. I wondered when we will be told what is on our new strategy that is in the process of being signed off? It really would be helpful to have some idea of this as you will appreciate it is quite difficult to function effectively as a board member without this. I accept that it has been decided that the board will not set the strategic direction but it is rather embarrassing having to say that I don't know so much of the time...

Kind regards

Kay

From: "Williams, Jo" <Jo.Williams@
To: john harwood <john.harwood@ Deirdre Kelly <d.a.kelly@ ; Kelly Deirdre (RQ3) BCH <DEIRDRE.KELLY@ Martin Marshall <Martin.Marshall@ Kay Sheldon <kay_sheldon@
Cc: "Bower, Cynthia" <Cynthia.Bower@ "Durham, Paul" <Paul.Durham@
Sent: Wednesday, 2 November 2011, 17:06
Subject: DH Capability Review : 09:11:2011

Dear Colleagues
As you are aware we are due to meet with the DH Capability Review Team on Thursday, 10th October. On the 9th November we have our session with the Executive to go through the self-

assessment process. I enclose a first stab put together by Cynthia and her team.
The final document which will integrate our appraisal and comments with those of the Executive will only be available to the DH Team at the very last minute.
This is not ideal but I believe it is vital that we have a document with which we are all reasonably content.
The attached documents will I know stimulate thought and help us to work through the issues on Wednesday afternoon.
Paul Durham has written some bullet points below explaining how the Executive tackled the task and how this will be repeated when Commissioners and Executives get together on the 9th.

- the background to the DH review is contained in the paper attached. Points to note include that CQC is the first of all the Arms Length Bodies that will be reviewed as part of this programme but that the timescales set for the review of CQC are very tight. We assume that the timing is driven by the need for DH witnesses to have material for their appearance before the Public Accounts Committee on 12th December for the hearing about CQC.
- the attached CQC Executive Team's draft preliminary assessment was constructed from a two hour interactive session with the Executive Team. We plan to hold a similar session with the Board to consider the same review questions on Wednesday 9th November between 4 and 6pm. We plan to write a report to summarise the conclusions of the Board's discussion in the sessions. At this diagnostic stage some of the front sections on action plans do not have to be completed, but will be completed later in the review process after interactions with the DH Panel. This session should serve as useful preparation for the DH Panel Meetings on the following two days.
- in terms of the Boards involvement in the DH Panel interviews on 10th and 11th November, the current plans of the DH review team (which CQC are helping to shape) are a DH Panel to Board meeting on Thursday 10 November 9.30am to 11.30am.
- After the DH Panel interviews there will be an opportunity at the Board meeting on 16th November to consider any joint self assessment paper that CQC wants to provide to DH to enable them to have some interim findings available for the end of November, a target which is included in their project plan.

I look forward to seeing you next week.
Best wishes.
Jo

Angela Manroy sent on behalf of Dame Jo Williams
Chair
Care Quality Commission
Finsbury Tower
103-105 Bunhill Row
London EC1Y 8TG
Telephone:
Internal Extension:
E-mail: angela.manroy@

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS20 [ ] to the Witness Statement of
Kay Sheldon

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kay_sheldon -

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Re: Board Strategy

Thanks for this Jo.

I think we need to differentiate between a 'strategy refresh' and a short-term focus on getting an infrastructure in place. What we have is a hybrid which cannot be the optimal (or indeed acceptable) position as we will be taking short-term decisions that will inevitably have major impacts on our longer term strategy. I am aware of an urgency to prove our value, effectiveness etc but my challenge would be that we cannot do this without being clear of the longer term benefits for the effective regulation of health and social care. As a member of the governing body I would not be able to support anything that would compromise this and I believe there are significant elements of the 'strategy refresh' that would do this. I would rather we acknowledge the fact we are implementing an 'extraordinary' short term plan to get our infrastructure in place as we work on developing a coherent strategy for the future.

My intention is not to be recalcitrant but to raise the 'public interest' test in keeping with my responsibilities as a public appointee.

Kind regards

Kay

From: "Williams, Jo" <Jo.Williams@ [redacted]
To: john harwood <john.harwood@ [redacted] ohn Harwood <jharwood.cqc@ [redacted]
"kay_sheldon@ [redacted] <kay_sheldon@ [redacted] Deirdre Kelly <d.a.kelly@ [redacted]
Kelly Deirdre (RQ3) BCH <DEIRDRE.KELLY@ [redacted] Martin Marshall
<Martin.Marshall@ [redacted]
Cc: "Bower, Cynthia" <Cynthia.Bower@ [redacted] "Finney, Jill" <Jill.Finney@ [redacted]
"Guss, Louise" <Louise.Guss@ [redacted] "King, Philip" <Philip.King@ [redacted] "Hamblin,
Richard" <Richard.Hamblin@ [redacted] "Lappin, John" <John.Lappin@ [redacted] "Sherlock,
Amanda" <Amanda.Sherlock@ [redacted] "Beal, Allison" <Allison.Beal@ [redacted] "Cannon,
Alastair" <Alastair.Cannon@ [redacted]
Sent: Tuesday, 8 November 2011, 16:02
Subject: Board Strategy

Dear Colleagues

Just a short note to acknowledge Kay's e-mail and to note that we will be meeting tomorrow afternoon when we will cover strategy as well as the other items that will be raised by the DH review team.

The "Strategy refresh 2012-15" document is in fact a summary of our discussions at our strategy events on 29th September and 12th October. Our task at our Board meeting next week will be to determine if it is an accurate record of our deliberations and to express our views and revise if necessary. The rewrite of the Strategy will need to take place in the New Year when we have the benefit of the NAO report, the PAC report and the report from the DH Capability Review.

Best wishes

Jo

Angela Manroy sent on behalf of Dame Jo Williams
Chair
Care Quality Commission

Witness Name: Kay Sheldon
Statement No: First
Exhibits: KS1 – KS21
Dated:

THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Exhibit KS21 [ ] to the Witness Statement of
Kay Sheldon

Corporate Scorecard 2011/12 Quarter 2 (1 July - 30 September 2011)

Outcomes / Reputation

	Measure	Target	Q1	Q2	Trend	Supporting Detail
Priority 1 - Register "new in scope" providers						
Tranche 3 - dental and private ambulance providers						
1.1	Registration applications received of those expected	100% of 8,917	8,568 96%	8,534 92%		The Tranche has now closed, with major elements of the tranche work now achieved. Final activities will be completed and reported in the narrative to the next report. We propose removing the measure from Q3.
1.2	Providers served with all Notices of Decision	75% by 30th June - 100% by 30th Sept	6,661 68%	7,744 80.7%	↑	
1.3	Provider certificates issued	100% of the applications received	2230 25%	6675 74.7%	↑	
Tranche 4 - primary medical care providers						
						This is in the design and planning phase and activity is yet to begin.
Priority 2 - Deliver and evaluate our new regulatory model / Priority 3 - Embed ,improve and refine our regulatory model						
Registration Processing - Business As Usual delivered effectively						
2.1	New provider applications received	-	8,834	11,462	?	
2.2	Applications rejected/ % - Shared services	-	4,745 43%	3,338 36.4%	↑	A number of measures are currently being introduced to reduce the rejection rates.
2.3	Applications validated within 5 days - Shared services	90%	94%	97%	↑	
2.4	Applications completed within 8 weeks	60%	4,664 51%	6,358 65.2%	↑	Target for applications received after 1 July is 80% - performance for these applications is currently 86.9 (w/e 21/10). Volumes of applications increased by 33% in Q2. We propose to use the new target for Q3.
Deliver programme of compliance reviews						
2.5	Planned Reviews completed vs. scheduled	100% across all sectors	1,716 84%			We have updated the scorecard to reflect sector specific measures from Quarter 2 onwards (see measures 2.51 and 2.52)
2.51	Planned Reviews completed vs. completion percentage	NHS 100% by end March 2012		85 93.5%		The number of NHS providers having at least one review between 1/4/2010 and 31 March 2012.
2.52	Planned Reviews completed vs. completion percentage	ASC/IHC 62.5% by end March 2012		2,148 26.7%		Q2 performance was 26.7% (of 62.5%) - 32.8% to w/e 21/10 - improvement is ongoing, with schedules at regional and team level showing monthly targets between now and March. New compliance staff induction and appointment is underway and amber status is forecast for Q3.
2.6	Responsive reviews completed	-	728	740	↑	
2.7	The % of draft compliance reports issued to timescale	90% by day 14 of process	33.0%	43.5%	↑	Following a review, a number of actions are now being put in place to improve performance in this area, ensuring more timely publication of reports. These include addressing data quality issues caused by incorrect entry of data and streamlining the process of report production.
2.8	The % of final compliance reports issued to timescale	90% by day 28/70 of process	29.6%	54.8%	↑	
2.9	Number and % of site visits	75% of reviews	2,180	2,889		The number of site visits has increased in line with the number of reviews increasing, and in line with the pilot compliance methodology, more reviews involve site visits
2.10	% of site visits that involve Experts by Experience /Acting Together	6%	6 0%	40 1.38%	↑	Figures remained low in Q2, with some improvement over Q1. However, a number of induction training events have been held and there are now some 209 Experts by Experience trained and CRB checked, and during October the number of inspections that involved Experts by Experience increased to 106
2.11	QRP: Number of engagement form and 'soft' intelligence items out of all data items: - NHS	No Target - contextual	7,741/ 185,409 (4.18%)	8,937/ 148,893 (6%)	↑	
2.12	QRP: Number of engagement form and 'soft' intelligence items out of all data items: - ASC/IHC	No Target - contextual	2,301/ 1,016,883 (0.22%)	29,209/ 1,079,341 (2.7%)	↑	
2.13	QRP: Number of provider trusts that had one or more red outcome risk estimate dials in each and everyone of the three most recent QRP refreshes - NHS	No Target - contextual	25 out of 389 (6.43%)	15 out of 255 (5.88%)	↑	Number of NHS trusts has reduced as PCTs divest services to other providers (the national programme of Transforming Community Services). Eventually all PCTs will be 'commissioning-only' organisations and not registered with CQC
Enforcement						
2.14	Number of Notices of Proposal to cancel registration issued	No target demand led	3	8	↓	

	Measure	Target	Q1	Q2	Trend	Supporting Detail
2.15	Number of Notices of Proposals served to vary / remove/impose a condition to impose a variation	-	8	22	↑	Warning notice increases are due to enforcement following first round of DANI inspections to check on providers not compliant, and locations where there has been repeated non compliance by providers and compliance action has moved to warning notice stage.
2.16	Number of suspensions	-	0	0	→	
2.17	Number of penalty notices served	-	0	0	→	
2.18	Number of warning notices served	-	43	299	↑	
2.19	Prosecutions concluded with a favourable result	-	0	0	→	
National Customer Service Centre - call handling times						
2.20	Calls answered within 20 seconds - Safeguarding	80%	89%	88%	↑	Call performance has increased across a range of indicators and call types. Mandatory Safeguarding training has taken place in September for CRM release 16. The National Customer Service Centre is considering delivering out of hours training sessions to limit the impact on staff availability during October.
2.21	Calls answered within 20 seconds - Mental Health	80%	87%	92%	↑	
2.22	Calls answered within 20 seconds - Registration	80%	89%	94%	↑	
2.23	Calls answered within 20 seconds - Other	80%	92%	84%	↓	
2.24	Calls abandoned - Safeguarding	3%	1%	1%	→	
2.25	Calls abandoned - Mental Health	3%	0%	1%	↑	
2.26	Calls abandoned - Registration	5%	3%	2%	↑	
2.27	Calls abandoned - Other	5%	4%	2%	↑	
Priority 4 - Deliver our other statutory and related regulatory duties						
4.1	Mental health visits completed	444	318 72%	378 82%	↑	82% visits completed of those scheduled, up on Q1. 7 newly appointed Commissioners completed induction training during Q2. 6 MHA Commissioner vacancies remain, possible negative impact on activity for the rest of the year.
	% Second Opinions completed within set time - Medication (90% within 5 Days)	1,217	469 38%	824 68%	↑	Appointments to the SOAD panel continue with interviews and induction underway. A recent contract has been awarded for the sessions from NHS consultant psychiatrists which will help meet some of this demand over time.
4.3	% Second Opinions completed within set time - ECT (90% within 2 days)	212	71 33%	112 53%	↓	
4.4	% Second Opinions completed within set time - CTO (100% within 28 days)	254	59 23%	73 29%	↑	
4.5	Inspections: controlled drugs; pharmacy; ionising radiation and joint inspections	100% of those planned	299 89%	250	↓	250 requests for pharmacy support activity to reviews relating to registered services were met. IR(ME)R notifications are being investigated but inspections are not currently taking place due to capacity issues. Performance is within regulations' requirements however.
Priority 5 - Provide public - facing information						
Key publications on target/ website visits						
5.1	Key publications on target	100%	100%	100%	→	Third annual state of care report to Parliament published in September; together the Annual Report, Controlled Drug Annual report and Equality, Diversity and Human Rights scheme annual update. DANI report published in October.
5.2	Providers feel informed about CQC regulatory system and have the information they need in order to be regulated by us	-	94%	-		Quarter 2 survey did not include this question because of consultation on changes to the regulatory model. Consideration currently being given to the survey in the light of online services' introduction later in the year.
5.3	Total visits to the website	-	1,446,589	1,325,587	↓	
	Unique visitors to the CQC website	-	-	570,793		
5.6	Regular updates to provider information on the CQC website	100%				Q2 performance rating relates to the old care directory. One major data refresh and critical updates applied during Quarter 2. New CQC website will be refreshed weekly.
5.7	User satisfaction with CQC's new website	-				A web satisfaction survey has been conducted against the current CQC website; a follow up survey will ask similar questions about the new site, with results due post launch in Quarter 3. Alongside this formal survey, we are monitoring website feedback via regular communications and reporting with National Customer Services Centre.
Change						
Priority 6 - Prepare for Future Developments H&SC Bill /Public Bodies Bill						
CQC's 'future of care' work programme is on track						
6.1	Future of care programme delivery, encompassing: - Joint licensing with Monitor - Joint working with HTA, HFEA and NIGB - Healthwatch England - Health sector regulation and oversight - Broader health and social care landscape	Green	A	A	→	The proposed clauses that change the Health and Social Care and Public Bodies Bills are undertaking the parliamentary process and it may be April 2012 before the Bills finally pass. The bills have had a first reading in the House of Lords, and have been reprinted for a second reading in 1 October 2011. This procedure is affecting Programme timelines and is resulting in changes to the scope.

	Measure	Target	Q1	Q2	Trend	Supporting Detail
Investment / Improvement						
Priority 7 Improve our efficiency and performance						
Expenditure is controlled and planned						
7.1	Revenue expenditure plus depreciation variance vs. budget	5% positive variance	33,494 v 40,532 17%	33,518 v 46,030 28%		28% positive variance in Quarter 2 (Quarter 1 was 17%). Although progress has been made on recruitment, the level of vacancies has still contributed to a significant under spend on staff and non staff budget under spends. Due to the delay in the Health and Social care bill, many of the budgeted costs for Quarter 2 have not taken place, however some of this work will occur in the remaining 6 months of this financial year.
7.2	Value of fees invoiced (first two months of the quarter) vs. debt over 30 days	--	15.0m v 1.7m 11%	35.7m v 1.4m 4%	↑	[redacted]bad debt during the quarter, which has reduced the bad debt variance.
7.3	Health and Safety - no. of workplace accidents	--	12	7	↑	There were 7 workplace accidents this quarter, including one, which was not work related, but occurred at work and has to be recorded, all appropriate mitigating actions have been taken.
Delivering a high standard of Corporate Governance						
7.4	Stage 1 corporate complaints received across the organisation	--	147	144	→	
7.5	Stage 2 Corporate complaints received	< 20% of Stage 1 received	10 7%	8 6%	↑	
	Of those closed, no of stage 2 reviews completed in 20 working days	95%	92%	88%	↑	9 stage 2s, 8 closed within target time
7.7	No of stage 2 Complaints Referred for Independent investigation	<10%	0%	0%	→	
7.8	No. of Parliamentary Ombudsman enquiries or investigations made of CQC	--	5	9	↓	
Information access						
7.9	Of closed requests proportion closed within deadline - Freedom of Information	95%	99%	90.0%	↓	
7.10	Of closed requests proportion closed within deadline - Data Protection	95%	100%	100.0%	→	
7.11	Of closed requests proportion closed within deadline - Info Sharing	95%	97%	95.3%	↓	
Priority 8 - Value our staff						
We have an effective and well supported workforce						
8.1	Establishment	-	1,930	1971	↑	Establishment increased from 1930 to 1971.2 following approval for the conversion of temporary workers in the National Customer Service Centre into established posts. All roles below manager tier are now populated with substantive staff resulting in reduction in use of temporary staff by almost 100 posts. Following recruitment of up to 162 compliance inspectors establishment targets for all regions other then London and South East have been met. Induction programme for the recruited Compliance Inspectors underway. A full programme of induction events for has been arranged for all new staff through to next year. Module 1 of the Management Development Programme went ahead during Quarter 2.
8.2	Number of permanent staff	-	1,634	1793	↑	
8.3	No of Vacancies (8.1 - 8.2)	-	296	268	↑	
8.4	Temporary staff in established posts	-	143	71	↑	
8.5	Vacancy Rate (Establishment less permanent staff)	-	15.34%	11.60%	↑	
	Temporary staff in Non established posts	-	75	76	↓	
8.7	Turnover (Number of Leavers FTE/((Staff in Post at Start FTE + Staff in Post at End FTE)/2) x 100)	3.375% per Quarter	2.5%	2.0%	↑	
8.8	Sickness Rate (calendar days lost/calendar days available)	5%	3.6%	3.6%	↓	