PERFORMANCE AND CAPABILITY REVIEW

Care Quality Commission

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PERFORMANCE AND CAPABILITY REVIEW

Care Quality Commission

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Executive summary

Introduction

1. This report of the Performance and Capability Review of the Care Quality Commission (CQC) aims to provide robust assurance to the public, the Department and Parliament that CQC is improving its performance and that action will be taken to build and sustain its capability for the future.

2. The Review ran from October 2011 to February 2012. It was led by a panel of senior departmental officials and external reviewers, chaired by the Permanent Secretary. The Review report sets out recommendations for CQC and the Department based on six key lines of enquiry developed during the Review, which represent the priority areas for action.

3. The focus of the Review is on future capability. The Review took on board the 2011 reports of the Health Select Committee and the National Audit Office. It also incorporated evidence from CQC itself, from Panel discussions with staff and a wide range of stakeholders, including organisations representing patients and service users.

4. The Review is the first of its type and is intended to be meaningful to CQC as it embarks on the next phase of its work. The Department intends to carry out capability reviews of each of its partner organisations as part of a programme of challenge and assurance.

Challenges and Key Findings

5. CQC's achievements are considerable and should not be underestimated. Since 2009 it has brought together three different organisations and developed a new regulatory model, as well as bringing over 21,000 providers into the new regulatory regime and carrying out over 14,000 compliance inspections and reviews. The regulatory framework within which CQC works was developed by the Department and was new; the NHS had never been regulated before and no previous regulator has sought to cover health and social care using a common set of standards.

6. CQC has now set the essential platform from which tougher regulatory action can be taken when needed, if and where standards fall below acceptable levels. On one key point though it is important to be clear; the responsibility to comply with essential standards of safety and quality rests squarely with the provider organisation – be it a hospital, a care home or another type of provider. CQC's role is to inspect, to verify and to enforce when necessary.

7. Alongside these achievements, CQC has faced operational and strategic difficulties, as previously documented. Delays to provider registration, shortcomings in compliance activity and, at times, a negative public profile have seriously challenged public confidence in its role. With hindsight, both the Department and CQC underestimated the scale of the task of

establishing a new regulator, bringing a new regulatory system into place and managing expectations of what CQC's role would be. Even so, CQC could have done more to manage operational risks.

8. Over the last nine months, there is clear evidence to show that CQC has demonstrated a new focus on its core purpose. The operational base is stronger and improving. This view was reflected in comments from CQC staff and many national stakeholders. The Panel's visits to regional offices showed operational improvements and a growing sense of a single organisation. CQC has also strengthened its external engagement. The presence of HealthWatch England within CQC will provide the opportunity to further improve engagement with patients and users of services.

9. Looking forward, important issues will need to be addressed to ensure CQC has the capability and capacity to respond to patient, public and Parliamentary expectations:

   - Firstly, CQC must become more strategic and set out more clearly what success looks like. Current limitations in strategic direction can make CQC too responsive to events and lead to uncertainty both within CQC and externally, about its role in the wider health and care system;

   - Secondly, accountabilities are unclear. There is a blurring of the boundary between the Board and the executive team, with the Board only recently moving to take on a stronger role to constructively challenge the executive team. In addition, the Department's capacity to ensure accountability needs to be strengthened; and

   - Finally, the underlying regulatory model is new and so far there is limited practical evidence of its effectiveness. At a strategic level, there is not yet an assessment of the impact that regulation has or could have on risks at an aggregate or sector level. On implementation, CQC faces challenges experienced by regulators in other sectors, namely balancing consistency with flexibility and building credibility with different stakeholders in different settings.

10. The majority view from the numerous stakeholders engaged in the Review was that they want lessons to be learnt from performance shortcomings of the early years. Recent improvements are acknowledged and there is much work to do to ensure CQC is a sustainably improving organisation delivering a respected regulatory system that protects patients and service users. That said, people that the Panel met wanted CQC to succeed – no-one advocated another re-organisation.

11. For the Department, the way it challenges and supports CQC also needs to be more strategic. Senior level participation in this Review has given us a deeper understanding of CQC, its strengths and where it needs to improve.

Recommendations

Strategy

12. The first set of recommendations focus on developing strategy and strategic capability. They also set out actions to be more explicit on CQC's role and on how to determine success:

- **Recommendation 1** – The Department of Health, through the National Quality Board, needs to build on work already underway with CQC and others to develop explicit statements as to the distinctive roles of national bodies in assuring quality and providing incentives for quality improvement – the 'who does what' for quality.
- **Recommendation 2** – CQC's strategy needs to be revised, explaining what role and impact its regulatory action is intended to have in specific sectors over time.
- **Recommendation 3** – within CQC, action is needed to improve strategic planning and analytical capacity.
- **Recommendation 4** – Clearer measures of success and simple strategic performance metrics should be developed by CQC, working with the Department and other stakeholders, and then used rigorously to track performance.

Resources and Prioritisation

13. On resources and prioritisation, the recommendations focus on strengthening CQC's analysis of risk and improving transparency, and explicitly seek external assurance of plans:

- **Recommendation 5** – Priority should be given to work now underway to improve risk management and to assess how different regulatory options, including thematic reviews, frequency of inspections and possible focus on selected standards, can help to reduce risk.
- **Recommendation 6** – CQC needs to improve the quality and transparency of management information that is used to make resource allocation decisions.
- **Recommendation 7** – CQC to act to ensure that robust and costed plans are in place for taking on responsibilities; that these plans are the subject of independent test and assurance; and that they are agreed with the Department.

Accountability

14. The recommendations on accountability are aimed at strengthening the Board and Board structures, and at improving sponsorship arrangements with the Department. As a priority,

the Department should ensure that the differences that have arisen on the CQC Board do not impair it from undertaking its statutory functions:

- **Recommendation 8** – The Department should take steps to strengthen the Board and Board structures, including changing the Board so that instead of comprising only non-executives, it becomes a unitary board of majority non-executives with senior executives on the board where they can be held to account.
- **Recommendation 9** – CQC needs to review and reinstate the Board support and development programme.
- **Recommendation 10** – Capability at executive team level needs to be strengthened with greater strategic capability, and more and wider sector-specific expertise.
- **Recommendation 11** – The Department should strengthen the arrangements for ongoing assurance and accountability of CQC in a way that is consistent with CQC's status as an independent regulator.

Engagement and Communications

15. The recommendations below cover external engagement, at the centre and frontline, and internal communications:

- **Recommendation 12** – CQC needs to be more proactive and systematic in understanding the expectations of stakeholders and demonstrate it is a learning organisation.
- **Recommendation 13** – CQC should raise its game and take a lead in working more closely with other regulators within the health and care sector to increase joint effectiveness and reduce burden on providers.
- **Recommendation 14** – Greater coherence and consistency is needed between the centre of CQC and its operational frontline, specifically, with the locally-based inspection teams.
- **Recommendation 15** – Links between the Mental Health Act functions and the rest of CQC need to be strengthened, including clearer metrics, information management and communications.

Development of the Regulatory Model

16. These recommendations are aimed at improving the understanding of the model, but also in strengthening how user voice is used:

- **Recommendation 16** – CQC should set out clear plans for ongoing evaluation of the regulatory model and the effectiveness of individual interventions, including working with

the Department to consider opportunities for joint evaluation under the Policy Research Programme.

- **Recommendation 17** – The regulatory model should make use of qualitative information in a systematic way, including drawing on patient and user insights gathered through HealthWatch England.

- **Recommendation 18** – CQC should be explicit about how far the compliance regime should be tailored to reflect the different risks and needs of different sectors and locations.

- **Recommendation 19** – The Department should develop its capability and capacity on the regulation of safety and quality so as to provide ongoing challenge and support to CQC in developing its regulatory model

Delivery of the Regulatory Model

17. Finally, the Review sets out a number of recommendations aimed at improving how the regulatory model is implemented on the frontline:

- **Recommendation 20** – CQC to review and implement improved access to sector-specific expertise for inspectors, specifically, inspectors should be able to call on patient, user or clinical expertise when they need it.

- **Recommendation 21** – Clear actions are needed by CQC to assure consistency and transparency in compliance activity and regulatory decision-making.

- **Recommendation 22** – CQC should develop and share with the Department plans for sustaining sufficient numbers of inspectors with the right skills and capacity to meet future priorities.

- **Recommendation 23** – On adult safeguarding, CQC should continue to work with local government and roll out staff training to improve local engagement and clarify roles, responsibilities and protocols.

Next Steps

18. Based on this Review, CQC will now be expected to set out, as part of its business plan for 2012/13, an agreed action plan providing detail of how these recommendations will be taken forward.

19. The Department has more to do as CQC's sponsor. The Department will set out plans for working with CQC and others to be more explicit about the roles of national bodies in the reformed health and care system, through work underway by the National Quality Board. It is also considering how to improve accountability and performance monitoring arrangements for CQC and its other partner organisations.

20. The Department has a responsibility to ensure that the regulations underpinning CQC's work are kept under review i.e. those deriving from the 2008 Act. An initial review is due to conclude shortly with the laying of new regulations before the Easter recess. The Department is about to commence a more comprehensive review. This review of will look at the regulations as a whole to ensure the framework is proportionate in minimising the risks to people who use services; it will examine the extent to which CQC regulation can mitigate that risk. The review will address issues where the regulations are not supporting an effective proportionate regulatory framework.

February 2012

1. Introduction

- **The Performance and Capability Review of the Care Quality Commission (CQC) aims to provide both challenge and support to CQC in its objective to ensure that services for patients and people in care meet government standards for quality and safety.**
- **The focus of the Review is on future capability. The Review report sets out the challenges and findings across the key lines of enquiry, alongside recommendations for CQC and the Department.**
- **The Review is the first of its type and is intended to be meaningful to CQC as it embarks on the next phase of its work.**

1.1. This report of the Performance and Capability Review of the Care Quality Commission (CQC) aims to provide robust assurance to the public, the Department and Parliament that CQC is improving its performance and that action will be taken to build and sustain its capability for the future.

1.2. The Review aims to provide both challenge and support to CQC in its objective to ensure that services for patients and people in care meet government standards for quality and safety. The Review ran from October 2011 to February 2012 and was led by a panel of senior departmental officials and external reviewers, chaired by the Permanent Secretary. It takes as a starting point the Cabinet Office Capability Review model, considering strategy, delivery and leadership. This framework was used to identify six 'key lines of enquiry', which formed the basis for the Review. A summary of the methodology is provided at Annex A.

1.3. The focus of the Review is on future capability. The timing enables lessons to be learned from the set-up of CQC for the next phase of its work. The Review does not attempt to repeat analyses by the National Audit Office (NAO), the Health Select Committee and the Public Accounts Committee, nor does it repeat critiques in the public domain. However, the Review has taken on board these analyses, including the 2011 reports. It also incorporated evidence from CQC itself, from Panel discussions with staff and a wide range of stakeholders, including organisations representing patients and service users.

1.4. The Review report sets out the challenges and findings across the key lines of enquiry, alongside recommendations for CQC and the Department. This report is in three sections:

- **Challenges** – setting out a description of CQC, its regulatory approach, progress since it was established and a summary of future challenges.

- **Key findings** – setting out for each key line of enquiry the issues identified by the Review and recommendations for future action.
- **Recommendations** – providing further detail on each of the recommendations for CQC and the Department.

1.5. Based on this Review report, CQC will now be expected to set out, in its business plan for 2012/13, an agreed action plan providing detail of how these recommendations will be taken forward. The Department will also take action to help clarify the expectations of CQC's role and to strengthen its sponsorship arrangements.

1.6. The Review is the first of its type and is intended to be meaningful to CQC as it embarks on the next phase of its work. The Department intends to carry out capability reviews of each of its partner organisations as part of a programme of challenge and assurance.

2. Challenges

- **CQC is the independent regulator of health and adult social care in England. CQC provides assurance that health and care provision meets government standards of quality and safety. It was established in April 2009 and formed by the merger of three previous regulators.**
- **CQC's achievements are considerable and should not be underestimated. CQC has set the essential platform from which tougher regulatory action can be taken when needed if and where standards fall below acceptable levels. Yet, CQC has faced operational and strategic difficulties. Delays to provider registration, shortcomings in compliance activity and, at times, a negative public profile have together have seriously challenged public confidence in its role. With hindsight, both the Department and CQC underestimated the scale of the task. Even so, CQC could have done more to manage operational risks while its roles and functions changed.**
- **Progress has been made over the last six to nine months. CQC is getting on a more stable footing. However, looking forward, CQC will need to learn lessons from its early years to ensure it has the capability and capacity to respond to patient, public and Parliamentary expectations.**

Care Quality Commission

2.1. CQC is the independent regulator of health and adult social care in England. CQC provides assurance that care provided by hospitals, dentists, private ambulances, care homes, in people's own homes and elsewhere meets Government standards of quality and safety. CQC protects the interests of people whose rights are restricted under the Mental Health Act. Once registered with the CQC, it is the responsibility of the registered organisation and its Board to comply with the government standards.

2.2. CQC has a key responsibility in the assurance of essential standards of safety and quality of health and adult social services. To enable it to meet this responsibility, CQC has identified two strategic priorities:

- To focus on quality; and
- To act swiftly to eliminate poor quality care.

2.3. To ensure care is centred on people's needs and protects their rights, CQC regulates health and social care through its quality and safety assurance regime by:

- registering providers of regulated activities against essential standards of quality and safety;
- checking providers are complying with the registration requirements;
- using enforcement powers to ensure requirements are met or suspending or cancelling provider registrations where appropriate;
- undertaking special reviews; and
- monitoring the use of the Mental Health Act.

2.4. CQC's potential impact on the quality of care is felt across the health and care system, as its registered providers range from single-handed dentists, domiciliary care and care homes to entire NHS trusts.

2.5. CQC is an executive non-departmental public body, with an annual budget of around £160 million. CQC employs around 2,100 staff, of which more than half are front-line inspectors and assessors. Staff are based in four operating regions and at the customer service centre in Newcastle, with headquarters in London.

Scale and Scope of Regulation

2.6. CQC was established in April 2009. It was formed by the merger of three previous regulators: the Healthcare Commission (HCC), the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission (MHAC). It initially regulated under the Care Standards Act 2000.

2.7. The first year was a transitional period as CQC continued to operate the existing regulatory frameworks of HCC, MHAC and CSCI, while developing the implementation of the new regulatory framework set out in the Health and Social Care Act 2008. The new framework, which was developed by the Department, was designed to be consistently applied across health and adult social care, and to put the needs of service users at the centre of the regulatory system.

2.8. Since April 2010, CQC has registered over 21,000 providers under the new regulatory framework, while simultaneously winding down previous frameworks. Until providers were registered with CQC under the 2008 Act, the new regulatory framework and associated enforcement powers could not apply to them.

2.9. Under the Health and Social Care Act 2008, providers were registered in tranches. As of December 2011:

- 309 NHS providers were registered against the full set of registration requirements under the 2008 Act;

- From October 2010, CQC registered over 12,255 independent healthcare and adult social care providers under the 2008 Act, replacing existing registration under the Care Standards Act 2000;
- From April 2011, primary dental care and private ambulance services were brought into the new registration system, with a further 7,686 providers registered;
- By April 2012, approximately 221 dedicated out of hours primary care providers and walk in centres will come into the registration system; and
- By April 2013, up to 10,500 other primary medical care providers, including GPs, are expected to have been registered.

2.10. Since April 2010, when registered providers first became subject to the new framework, 14,407 compliance reviews of health and social care locations, which usually involve an inspection, have taken place with 626 enforcement actions taken against providers.

2.11. In an average month, the National Customer Service Centre in Newcastle receives 16,350 calls, 4,700 email enquiries and 3,400 electronic applications. These figures include around 284 whistleblowing contacts, 1,990 safeguarding contacts and 19,232 notifications per month. The number of whistleblowing contacts more than tripled from 279 in the first quarter of 2011/12 to 1,161 in the third quarter, although the number of substantive follow-ups as remained relatively stable.

Progress

2.12. CQC's achievements are considerable and should not be underestimated. Since 2009, it has brought together three different organisations and developed a new regulatory model, as well as registering over 21,000 providers and carrying out over 14,000 compliance reviews. The regulatory framework within which CQC works was developed by the Department, and was new at the time. The NHS had never been regulated before and no previous regulator has sought to cover health and social care using a common set of standards. CQC has set the essential platform from which tougher regulatory action can be taken when needed if and where standards fall below acceptable levels.

2.13. CQC also took a number of decisions in its first few years that have been successful, particularly on the operational side. For example, the creation of a centralised customer service centre at Newcastle has delivered savings. On strategy, the postponement of the registration of primary medical care demonstrates an improving understanding of their capacity, although it is too early to judge the impact.

2.14. However, CQC has also faced strategic and operational difficulties. The National Audit Office (NAO) and Health Select Committee reports particularly highlight the delays in

transitional registration and the consequent impact on business as usual activity.[1,2] The Health Select Committee noted the fall off in CQC's compliance activity. The NAO echoed these concerns, but also highlighted the absence of strategic direction and clear measures of success. Both raised concerns about the reliability and quality of information available to inspectors to make decisions.

2.15. This Review reflects many of the concerns raised by the NAO and the Health Select Committee, but also identifies wider organisational challenges around the strategic direction of CQC, its role in the health and care system, and how that role is communicated.

2.16. Some of CQC's decisions have been the focus of external criticism. For example, the 2008 Act gives CQC the objective of 'encouraging the improvement of health and social care services'.[3] However, there has been some uncertainty over how it fulfils this role with CQC focussing on compliance against essential standards, rather than continuing legacy organisations' role to drive quality improvement above essential standards. This decision was supported by the Department and part of the criticism stems from unpopularity of the decisions, as well as the how the changes in role have been communicated.

2.17. High profile cases have brought CQC into sharp focus and the negative public profile has seriously challenged confidence in its role. More generally, public expectations of the regulator can be unrealistically high, and whilst CQC's role is to identify poor care and hold providers to account, it is not its role to provide care. With hindsight, both the Department and CQC underestimated the scale of the task of establishing a new regulator and bringing a new regulatory system into place, while also managing expectations of what CQC's role would be. At times, the regulator has been held responsible for poor provision that is not directly in CQC's control. Even so, CQC could have done more to manage operational risks as its role and functions changed.

2.18. Progress has been made over the last six to nine months, reflected in a new sense of purpose and confidence within CQC, as well as continued passion and commitment from the front-line. This message came from CQC, but also from national stakeholders, including partner organisations and providers. The positive messages included a new strategic focus on essential standards and improving use of data to support more proportionate regulation, as well as a recognition that CQC had created a new identity that was distinct from the legacy organisations.

[1] National Audit Office (NAO) (2011) The CQC: Regulating the quality and safety of health and adult social care
[2] House of Commons Health Committee (2011) 'Annual Accountability Hearing with the CQC'
[3] Health and Social Care Act 2008: Part 1 The Care Quality Commission

Future challenges

2.19. The early transition period has been difficult and lessons will need to be learned for the future. Important issues will need to be addressed to ensure CQC has the capability and capacity to respond to patient, public and Parliamentary expectations:

- Firstly, CQC must become more strategic and set out more clearly what success looks like. Current limitations in strategic direction can make CQC too responsive to events, without being sufficiently clear on the resource implications, and can lead to uncertainty both within CQC and externally about its role in the wider health and care system;

- Secondly, accountabilities are unclear. There is a blurring of the boundary between the Board and executive team, with the Board only recently moving to take on a stronger role to constructively challenge the executive team. In addition, the ongoing assurance and accountability with the Department need to be strengthened; and

- Finally, the underlying regulatory model is new and consequently there is as yet limited practical evidence of its effectiveness. At a strategic level, there is not yet an assessment of the impact that regulation could have and has on risks at an aggregate or sector level. On implementation, CQC faces challenges experienced by regulators in other sectors, namely balancing consistency with flexibility, and building credibility with a wide range of stakeholders in different settings.

2.20. The majority view from the numerous stakeholders engaged in the Review was that they want lessons to be learnt from performance shortcomings of the early years. Recent improvements are acknowledged and there is much work to do to ensure CQC is a sustainably improving organisation delivering a respected regulatory system that protects patients and service users. That said, stakeholders that the Panel met wanted CQC to succeed – no-one advocated another re-organisation.

2.21. For the Department, the way it challenges and supports CQC also needs to be more strategic. Senior level participation in this Review has given us a deeper understanding of CQC, its strengths and where it needs to improve.

2.22. Separately, the Department has a commitment to keep the CQC regulations under review, to make sure they reflect best practice and keep up to date with developments in the provision of services. An initial review of the regulations is in its final stages with the laying of new regulations before Easter. The Department is already working with CQC in early stages of a second-stage review. The second-stage review will be more comprehensive, looking at the regulations as a whole to ensure the framework they set out is proportionate to the risk to people who use services, and will look at the extent to which CQC regulation can mitigate that risk.

2.23. As part of this review of regulations, the Department will consider any relevant recommendations of the Mid Staffs Inquiry, and the Public Accounts Committee and Health Select Committee reviews of CQC. The Department will also consider the effect of changes to the architecture, such as those coming out of the Health and Social Care Bill. The Department will be consulting formally on proposals later in the year.

3. Key Findings

- **CQC is demonstrating a new focus on core purpose and is strengthening its operational base. There is evidence of continuous improvement in operations and a clearer sense of a single organisation.**
- **To be able to meet expectations and fulfil its duties CQC must become more strategic. To help address the uncertainty, the Department needs to continue work on the 'who does what' for quality. However, CQC also needs to provide greater clarity about its three- to five-year strategy, to develop a better understanding of its impact and understand the expectations of its constituents. This clarity needs to start at the Board and senior level. Non-executive and executive teams need to be strengthened as a priority.**
- **The Department also needs to change the way in which it relates to CQC, by being clearer on what is expected, supporting CQC to explain publicly what it and other national bodies do, and giving more emphasis to performance and the sponsorship relationship.**

Meeting the challenges

3.1. The early stage of the Review looked at evidence across strategy, leadership and delivery and identified six 'key lines of enquiry', which represented the main challenges for CQC. These key lines provided a framework for the analysis, but also for considering how CQC can respond to future challenges:

- **Strategy** – Developing a clearer strategic direction and better understanding of CQC's role within the system to provide clarity to patients, to the public and to regulated services;
- **Resources and prioritisation** – Improving CQC's understanding of risks and the quality of management information to inform resource allocation decisions;
- **Accountability** – Strengthening the CQC Board and executive team, to ensure the organisation is equipped at the highest level, while also clarifying the relationship between CQC and the Department;
- **Engagement and communications** – Understanding the expectations of stakeholders and responding as a learning organisation, while continuing to strengthen internal engagement;

- **Development of the regulatory model** – Tightening the regulatory model to ensure a rigorous, evidence-based approach that responds in a proportionate way to levels of risk; and
- **Delivery of the regulatory model** – Improving the effectiveness of delivery, and ensuring the right capacity and capability on the front-line to improve consistency and professionalism in regulatory decisions.

Strategy

Over the last few months, there is evidence that CQC is demonstrating a new focus on core purpose...

3.2. Since early last year, CQC has developed greater internal clarity on its role and purpose i.e. to ensure compliance with essential standards. This message is beginning to be understood externally, although is not always welcome, for example, in relation to CQC's move away from legacy organisation's use of star ratings in adult social care.

3.3. The clearer purpose is reflected in new priorities, articulated by CQC in a strategy refresh from November 2010, which are 'to eliminate poor quality care' and to ensure care is 'centred on people's needs and protects their needs.' This prioritisation has in part been a reaction to experience and external events, but is also recognition of the scale of the task facing CQC, which many stakeholders have said was initially too ambitious.

3.4. The new focus is increasingly well understood within CQC, with a consistent message heard from the centre and efforts to cascade the message to frontline staff. For example, staff in the regions who the Review Panel met gave a consistent message concerning key priorities and regulatory approach.

3.5. To underpin the current strategy, CQC has developed a corporate scorecard, which brings together information on operational activity and key performance indicators. The scorecard and risks are reviewed on a regular basis by the executive team and the CQC Board, and are used to aid strategic decision making.

…but there remains uncertainty on CQC's longer-term strategic direction and its role in the system and the impact of its regulatory model

3.6. The limitations in CQC's strategic direction in part result from uncertainty about their role compared to other regulators, commissioners and providers. While CQC need to be clear on how they carry out their functions within the system – and could take greater opportunities to contribute as a 'thought leader' on quality and quality improvement – the Department has ultimate responsibility for overall system design. To help address the uncertainty on CQC's role, **the Department of Health, through the National Quality Board, needs to build on work already underway with CQC and others to develop explicit statements as to the distinctive roles of national bodies in assuring**

quality and providing incentives for quality improvement – the 'who does what' for quality (Recommendation 1).

3.7. Although CQC's core purpose is recognised externally, its strategic prioritisation of essential standards is not understood at all levels. In part, the uncertainty stems from the legacy of bringing together three organisations, but it also reflects unpopularity of some decisions, including on its role in quality improvement in social care, and limitations in setting new strategic direction. Clearer strategy would give CQC greater confidence on how it carries out its functions and enable push back on external pressures. The NAO report highlighted the need for clearer strategy, concluding that CQC 'has not made it clear what success in delivering its priorities would look like.'[4]

3.8. CQC should consider a revised strategy to clearly express its role and to reflect the changing context within which CQC's role of monitoring and assuring essential standards and minimising risk is delivered. This strategy should include the economic context, the role of provider organisations, and health and care reforms. **CQC's strategy needs to be revised, explaining what role and impact its regulatory action is intended to have in specific sectors over time (Recommendation 2).**

3.9. Understandably, focus so far has been on operations, but this focus has potentially been to the detriment of strategic planning. Consequently, there are risks that strategic direction is implicitly set by operational decisions. For example, decisions to move to annual inspections or on the mechanism for GP registrations may have wider implications for strategic direction of the regulatory model. CQC need to keep under review the effectiveness of the regulatory model, the long-term direction of CQC and wider developments in regulation in the health and care sector, potentially through a dedicated strategy team. **Within CQC, action is needed to improve strategic planning and analytical capacity (Recommendation 3).**

3.10. Although CQC has worked on measuring progress, the scorecard tends to focus on internal processes. In common with many other regulators, the lack of comprehensive performance metrics presents challenges in setting direction and demonstrating success.[5] It can also make it difficult to set clear expectations externally. **Clearer measures of success and simple strategic performance metrics to be developed by CQC, working with the Department and other stakeholders, and then used to rigorously track performance (Recommendation 4).**

Resources and Prioritisation

CQC has strengthened its operational base and work is in train to understand current and future risk…

[4] NAO (2011) The Care Quality Commission: Regulating the quality and safety of health and adult social care
[5] NAO (2008) Regulatory Quality: how regulators are implementing the Hampton vision

3.11. CQC is continuing to develop activity-based information, and using this information to inform both resource allocation decisions and operational efficiency. The management information is also used to understand the costs of activity to inform different approaches to regulation.

3.12. CQC has developed a clearer strategic framework for assessing regulatory risk of certain providers and business risk within CQC, as well as the strategic risks of not meeting certain objectives. This work is important and needs to be accelerated as it should underpin management decisions about future resource allocations.

3.13. CQC has also demonstrated learning from previous experiences. For example, the Newcastle Customer Service Centre has improved the system for handling variations to registration and more detailed plans are in place for managing vacancies. CQC has also set out plans for establishing HealthWatch England, and also for local intelligence and user voice to be gathered from local HealthWatch organisations.

… but further improvement is needed on management and risk information, alongside greater assurance that CQC is able to meet future priorities

3.14. The volume of data is improving through CQC's Quality Risk Profile (QRP), with steps taken to incorporate user voice more widely in decisions. However, CQC recognises that while data gathered on NHS providers is relatively strong, in the social care sector there is a gap. In part, the lower quality of data reflects that the model has only been operating for a short time, but is also a feature of the sector. As a linked point, there are opportunities to use QRP data to identify emerging trends in locations and sectors, and to understand more clearly the impact of how and where it allocates its resources. Both the NAO and Health Select Committee reports found that the implications of different resourcing decisions had not been well analysed or understood. Analysis of risk reduction is essential to underpin decisions about how resources are deployed. **Priority should be given to work now underway to improve risk management and assess how different regulatory options, including thematic reviews, frequency of inspections and possible focus on selected standards, can help to reduce risk (Recommendation 5).**

3.15. The Board raised concerns that while data was available, it was difficult to contextualise. Management information systems are improving, but are still not strong enough to inform strategic decisions. Working the other way, the impact on the front line of national decisions or events are not always clearly assessed and acted on nationally to ensure resources are in place at a local level. Stakeholders also commented that 'CQC need to better understand where the money goes.'[6] **To address these concerns, CQC needs to improve the quality and transparency of management information that is used to make resource allocation decisions (Recommendation 6).**

[6] National Provider Organisation, Stakeholder Breakfast, January 2012

3.16. There remain risks around taking on new responsibilities, for example, inspecting dentists, HealthWatch England, joint-licensing with Monitor and particularly registering GPs. Similarly, the proposals to take on the Human Fertilisation and Embryology Authority (HFEA) and the Human Tissue Authority (HTA), on which the Government will consult, will have both policy and financial implications that the Department and CQC need to understand. To ensure transparency on how they will meet current and future potential commitments, **CQC needs to act to ensure that robust and costed plans are in place for taking on responsibilities; that these plans are the subject of independent test and assurance; and that they are agreed with the Department (Recommendation 7).**

Accountability

There has been a shift in gear since Spring 2011, with the leadership team demonstrating greater confidence and providing more challenge…

3.17. The early years of transition have been a challenging time for the CQC Board and the executive team, but there are signs of stability. Clearer corporate governance structures are now in place. For example, there are regular Board meetings in public and a clearer set of strategic priorities for those meetings.

3.18. The CQC leadership has been more visible and is demonstrating greater confidence. The Board has begun to move from a position of supporting the executive team to one of being more challenging. Board members have more recently been involved in setting strategy, including contributing specific pieces of work on clinical expertise and regulation.

3.19. The relationship with the Department is generally effective, with regular contacts at working level and regular exchange of information. There are regular quarterly accountability review meetings between CQC and the responsible Director General, as well as regular meetings with Ministers. These meetings provide the opportunity for full and frank discussion on performance and on strategic issues.

3.20. Work is also underway within the Department to bring more rigour to the way it sponsors and holds to account the health regulators, including CQC, and the arms length bodies that it funds and sponsors. The Department, for example, as developed clear framework documents and is putting in place a dedicated sponsorship support team.

…but longer-term success will rely on clearer corporate governance and accountability, particularly for the CQC Board

3.21. The supportive and collaborative approach taken by the Board may have been appropriate during transition, but has contributed to an imbalance in the focus towards operational aspects. The Board needs to provide greater challenge to executive team on current performance, but also to take a longer term view to anticipate future changes.

Understanding the role of Board will be of increasing importance with the establishing of HealthWatch England.

3.22. Of more immediate concern, over the last few months, relationships on the CQC Board have become fractured. As a priority, the Department should ensure that the differences that have arisen do not impair the CQC Board from undertaking its statutory functions.

3.23. The Department should take action to address the current vacancies on the Board, and in making appointments and expanding membership, should consider including broader experience, for example, from the charitable and independent sectors, other regulators and the private sector.

3.24. However, the Department should also have regard to the long-term vision for the Board, and will need to ensure that the Board has the right mix of skills and capability. The Review found that there is a strong case for introducing a unitary Board as part of a new corporate governance structure, to enable a tighter accountability relationship between non-executives and senior executives. **The Department should take steps to strengthen the Board and Board structures, including changing the Board so that instead of comprising only non-executives, it becomes a unitary board of majority non-executives with senior executives on the board where they can be held to account (Recommendation 8).**

3.25. More work is needed to enable members of the Board to carry out their roles effectively and operate more clearly as a team, including recognising issues of equality and diversity. A clearer definition of roles and responsibilities would need to include the roles of any new Board members, such as the new Chair of HealthWatch. To help address these concerns, **CQC needs to review and reinstate the Board support and development programme (Recommendation 9).**

3.26. The executive team has been focussed on meeting the operational challenges, particularly the timetable for registration and targets for inspections. Now that CQC has started to establish itself, it faces new challenges The Review heard concerns from stakeholders over the capability of the executives as a whole, including on strategic thinking and organisational design, as well as a perceived lack of hands-on experience of managing health and care services. **Capability at executive level needs to be strengthened with greater strategic capability, and more and wider sector-specific expertise (Recommendation 10).**

3.27. The relationship with the Department has generally been open, but there can be uncertainty over the terms of the relationship on both sides. There also remains uncertainty between the Department and CQC on the strategic risks facing CQC and on how the Board, as well as the Accounting Officer, relate to the Department. **The Department should strengthen the arrangements for ongoing assurance and accountability of CQC, in a way that is consistent with CQC's status as an independent regulator (Recommendation 11).**

Engagement and Communications

CQC have worked hard to bring together the three legacy organisations and clarify their core purpose, and have developed generally good working relationships with their key partners…

3.28. The Review Panel heard positive messages from national stakeholders on CQC's engagement and consultation, including good working relationships with other health and care regulators. The Panel heard that the leadership of CQC are open to feedback, and are willing to listen and to act on issues raised about the organisation. The majority view of stakeholders was that they want to make the existing system work. Improvements are needed and lessons need to be learnt from performance shortcomings in the early years. However, no-one the Panel met advocated for a complete re-organisation.

3.29. At regional and local level, stakeholders indicated that there have been also improvements, at least for some groups and sectors. On the visit to Birmingham, the Review Panel heard that relationships are 'not perfect'. [7] For example, some providers wanted compliance managers to establish greater dialogue and openness. However, improvements had been made. For example, some stakeholders noted 'a positive shift in the organisation' and had found CQC staff to be responsive, providing a constructive challenge to the sector.[8] In terms of engagement with the public, establishing HealthWatch England provides the opportunity to improve links with patients and users of services.

3.30. Internally, CQC have clearly faced challenges on bringing together three different organisations. Individuals have had to give up previous ways of working. However, indications from staff are that legacies of former organisations are being left behind, with new recruitment helping to create a new cadre of CQC inspectors and new identity.

3.31. Similarly, staff morale following transition is improving, with some good examples of staff engagement, including internal engagement by regional managers with frontline staff. Senior management away days and communication through new media was beginning to draw teams together across the country.

…but will need to build on these relationships to understand and manage the expectations of its diverse stakeholders, including regulated providers, staff, patients and users, and the wider public

3.32. CQC has been under high levels of public scrutiny but its record on external communication is mixed. The responsibilities of CQC are not always understood. Many provider organisations that the Review Panel met, although sympathetic to the scale of CQC's task, expressed discontent about CQC's record on engagement. For example,

[7] Provider, Birmingham Visit, December 2011
[8] National Provider Organisation, Stakeholder Breakfast, January 2012

they indicated that key decisions on fees and role in quality improvement had not been sufficiently well explained.

3.33. The introduction of registration and fee recovery, with the Department asking CQC to move to full cost recovery, has made CQC's engagement challenging with some sectors. Although these decisions were made by the Department, providers raised significant questions over planning and handling. At national level, CQC collects views of stakeholders, including for example the provider sentiment survey, but is not explicit on how it manages feedback and takes appropriate action. For example, some providers report that CQC's approach to inspection can drive disproportionate or outmoded activity that does not help to improve patient outcomes. **CQC needs to be more proactive and systematic in understanding the expectations of stakeholders and demonstrating it is a learning organisation (Recommendation 12).**

3.34. Health and care providers face different types of regulation for legitimate reasons, but with risks of duplication and bureaucratic burdens. CQC has carried out work with other regulators to address the burdens. However, stakeholders commented that CQC needs 'to better understand its constituents'.[9] Looking forward, understanding the position of stakeholders will help engagement but also reduce burden across the system. Although not incumbent on CQC alone, **CQC should raise its game and take a lead in working more closely with other regulators within the health and care sector to increase joint effectiveness and reduce burden on providers (Recommendation 13).**

3.35. The first three years have been difficult for CQC. Morale was relatively low, according to staff survey results from July 2010, but commitment remains high as more recent updates to the staff survey demonstrate. The recent focus on staff engagement needs to be maintained and put on a more regular footing to meet future challenges. In common with large organisations with a national footprint, there are risks of a gap in CQC between the centre and localities, which can lead to inconsistency of service. Visits to regional offices and discussions with stakeholders suggested that consistency of service in compliance and inspection was patchy. Stakeholders commented that 'CQC judges providers on a Board to Ward basis. We want to see CQC demonstrate these behaviours' with clearer governance and front-line consistency.[10] Links have been strengthened between the centre and the regions, including recent visits by the executive team and more systematic communications. Building on this work, **greater coherence and consistency is needed between the centre of CQC and its operational frontline, specifically, with the locally-based inspection teams (Recommendation 14).**

3.36. On a specific point, concerns have been raised about how far the former Mental Health Act Commission (MHAC) functions have been integrated. The Panel noted that the important role of the Mental Health Act component of CQC's work receives insufficient

[9] National Provider Organisation, Stakeholder Breakfast, January 2012
[10] Provider, Stakeholder Breakfast, January 2012

profile, both internally and externally. Development of information management systems, metrics and infrastructure has been slow, and the communications challenge is significant given the working patterns of the Mental Health Act Commissioners. **Links between the Mental Health Act functions and the rest CQC need to be strengthened, including clearer metrics, information management and communications (Recommendation 15).**

Development of the Regulatory Model

There is strong commitment within CQC to the regulatory model, with improving information to support the risk-based approach…

3.37. There is strong ownership and commitment within CQC to the regulatory model i.e. the underlying approach to regulations. In particular, there is commitment to making the generic inspector model work, and an understanding of its potential weaknesses. Work is also underway at Board level to review the underlying regulatory model.

3.38. The issues raised by social care and dentistry registrations have been well documented. CQC has learnt lessons, for example, in attempting to build in more flexibility for GP registrations. Work is underway to ensure resources are adequately planned and deployed to avoid delays to new registration or impact on inspection resources, and to ensure front line staff are consistent and proportionate in their approach.

3.39. CQC aims to put service users at the centre of their work and have worked to embed this approach across CQC, including involving people in their inspections. Staff have worked to build relationships with local groups, and listen to the voices of people who use services in planning inspections and responding to concerns. Alongside this work, the development of the Quality Risk Profile provides evidence of CQC developing user voice as part of the regulatory model on a more consistent basis. The incorporation of Health Watch England provides a further opportunity to build in user voice.

…but more work is needed to understand the effectiveness of the regulatory model

3.40. The regulatory model was set up as a light-touch, risk-based model, consistent with other regulators.[11] This approach fits with the features of a good regulator in that it should be accountable, proportionate and transparent. As with all regulators, there are strong arguments that CQC should focus on areas with the greatest risks. CQC will also need to understand how fiscal and economic conditions will impact on risk.

3.41. Evidence on the overall effectiveness of the model in reducing risks remains limited as the model is still relatively new. Even so, CQC is not always transparent on the balance between compliance and deterrence in reducing risk, and providers are not clear on what to expect. More practically, there remain risks that registration is seen as purely an administrative exercise both by CQC and by providers.

[11] Hampton (2005) Reducing administrative burdens: effective inspection and enforcement

3.42. Similarly, feedback from providers and the front-line indicates that increasing numbers of inspections may not be the most effective way of minimising risks.[12, 13] On a more practical level, the impact of individual interventions or how they operate in different settings are not well understood at a strategic level. NAO pointed out the drop off in inspections, but the impact on risk is not known. **CQC should set out clear plans for ongoing evaluation of the regulatory model and the effectiveness of individual interventions**, **including working with the Department to consider opportunities under the Policy Research Programme. (Recommendation 16).**

3.43. The NAO and HC reports both noted that greater breadth and systematic collection of information is needed to assess risk across all settings, particularly for vulnerable groups. Similarly, the Review has recognised the current weaknesses in data in the social care sector compared to the NHS. In part, this issue will be addressed by plans to make greater use of local intelligence and user voice. Establishing HealthWatch England will provide an opportunity to integrate further patient and user information in the regulatory approach. **The regulatory model should make use of qualitative information in a systematic way, including drawing on patient and user insights gathered through HealthWatch England (Recommendation 17).**

3.44. CQC also needs to understand and communicate how the model should be adjusted to suit different locations and sectors in response to different risks. Potential lessons could be learnt from other regulators on how resources can be deployed to ensure proportionality.

3.45. This issue is of particular importance in settings and client groups with increased levels of risk, for example, where people are deprived of their liberty or lack mental capacity. The level of rigour of the Learning Disability inspection programme is commended, but identified existing issues and could be used to influence decision making. Similarly the Dignity and Nutrition review demonstrated how risk varied across particular settings and client groups. **CQC should be explicit about how far the compliance regime should be tailored to reflect the different risks and needs of different sectors and locations (Recommendation 18).**

3.46. While it is not the Department's job to define the model, it needs to have assurance that the model works. Sharing basic activity data would enable the Department to understand the effectiveness of interventions – and how the balance of activity is changing over time. **The Department should develop its capability and capacity on the regulation of safety and quality so as to provide ongoing challenge and support to CQC in developing its regulatory model (Recommendations 19).**

[12] Staff, CQC Visit, November 2011
[13] Staff and Providers, Visit to Birmingham, December 2011

Delivery of the Regulatory Model

There is evidence of strong drive and passion from the front-line, with plans in place for training and development of new staff…

3.47. CQC has implemented a new regulatory model, within a framework set by the Department. The NHS had never been regulated before and no previous regulator has sought to cover health and social care using a common set of standards. Establishing the new model included common standards and the concept of generic inspector with the aim of providing consistency across health and care settings.

3.48. Front-line inspectors that the Review Panel met show strong drive and passion to improve quality of care for patients and service users. The vacancies that had been identified by previous reviews have largely been filled, and plans are now in place to recruit to upcoming future roles.

3.49. Steps have also been taken to improve the training and development, include an eight-week induction programme in place for new inspectors. Once inspectors are in place, there is ongoing peer support and challenge to improve performance and to ensure consistency. CQC is considering the case for developing professional qualifications, such as the scheme in place in Scotland.

3.50. Information to make decisions is improving – particularly for health services – and CQC is continuing to build up other sources of data for the Quality Risk Profile. In particular, CQC is considering how best to incorporate patient voice alongside other sources of qualitative information in making decisions on where to inspect. For example, the Customer Service Centre in Newcastle now has a dedicated team to deal with whistleblowing.

…but to improve the confidence of the system and to improve quality, CQC will need to continue to support the frontline by improve consistency in decision-making and ensure access to expertise

3.51. On delivery, there is a risk of a credibility gap, where the external view does not appear to reflect the positive internal view about consistency of behaviour of front line staff and the strengths of generic inspectors. This issue applies both to the clinical setting, but also to understanding the reality of the business needs of a varied set of providers.

3.52. To improve the quality of inspections and build credibility with providers, the model needs to ensure access to clinical and sector expertise. This work is underway and needs to be built on. **CQC is to review and implement improved access to sector-specific expertise for inspectors, specifically, inspectors should be able to call on patient, user or clinical expertise when they need it (Recommendation 20).**

3.53. As with other regulators, ensuring consistency in decision-making across different sectors and locations remains a continuing tension for CQC.[14] This message also came from stakeholders. Overall, providers taking part in the Review often perceived a mismatch between initial feedback or text of a report, which was often positive, and the final conclusions of a report, for example, failing on one or two essential standards.

3.54. There was also a perception that inspections were overstating minor problems. This perception suggests a greater need for openness and dialogue with providers to explain how inspectors plan to assess quality, why certain standards are important, and on what basis decisions are being taken. Inconsistencies in inspection and compliance activity were more evident from responses of larger provider organisations that span regions – and there is no external validation. To address this concern**, clear actions are needed by CQC to assure consistency and transparency in compliance activity and regulatory decision making (Recommendation 21).**

3.55. A key finding of the Health Select Committee and NAO reports was that growing inspector caseloads should be addressed. However, there remain some uncertainties over vacancies and the right portfolio size. While the large vacancies identified by NAO have been addressed, conversations with stakeholders and with inspectors have raised issues on the size and breadth of portfolios.

3.56. On a related point, there is more training in place for inspectors and ongoing support. However, new responsibilities will provide new pressures on the front line, e.g. inspecting dentists and in future GPs, which may also change the balance of risks. To meet the challenges of volume and skills and ensure access to continuing professional development, **CQC should develop and share with the Department plans for sustaining sufficient numbers of inspectors with the right skills and capacity to meet future priorities (Recommendation 22).**

3.57. The response last summer to a whistleblower's concerns raised questions about the organisation's capability. Since then, work to audit and review safeguarding and whistleblowing policies has been positive and CQC plans to extend new safeguarding training to all frontline staff. A further challenge will be to measure the impact of the training. There remain risks of a lack of clarity on safeguarding roles, and risks that responsibilities are not clear between CQC and local authorities. Given the specific risks, **on adult safeguarding CQC should continue to work with local government and roll out staff training to improve local engagement and clarify roles, responsibilities and protocols (Recommendation 23).**

[14] NAO (2008) Regulatory Quality: how regulators are implementing the Hampton vision

4. Recommendations

- **The recommendations cover each of the Key Lines of Enquiry that were developed during the early stages of the Review. They aim to help build on the progress that CQC has made over the last few months. Based on this Review, CQC will now be expected to set out, in its business plan for 2012/13, an agreed action plan providing detail of how these recommendations will be taken forward.**
- **The Department also has more to do as CQC's sponsor. The Department will set out plans for working with CQC and others to be more explicit about the roles of national bodies in the reformed health and care system through the National Quality Board. It will also take steps to improve accountability and performance monitoring arrangements for CQC and its other arm's length bodies.**

Strategy

4.1. The first set of recommendations are aimed at developing strategy and strategic capability, but also at being explicit on CQC's role and on how to determine success:

Recommendation 1 – The Department, through the National Quality Board, needs to build on work already underway with CQC and others to develop explicit statements as to the distinctive roles of national bodies in assuring quality and providing incentives for quality improvement – the 'who does what' for quality – This work should be taken forward collaboratively with national bodies, and should be reflected in the National Quality Board priorities and the forthcoming Social Care White Paper.

Recommendation 2 – CQC's strategy needs to be revised, explaining what role and impact its regulatory action is intended to have in specific sectors over time – The revised strategy should set out a three to five year vision for CQC, reflecting the changing context within which its role of monitoring and assuring essential standards and minimising risk is delivered, not least the economic context, the role of providers and reforms to the health and care system

Recommendation 3 – within CQC action is needed to improve strategic planning and analytical capacity – CQC should take steps to improve strategy and the use of its analytical capability, including consideration of a dedicated strategy team that would keep under review the effectiveness of the regulatory model, the long-term direction of CQC and wider developments in regulation in health and care and in other sectors.

Recommendation 4 – Clearer measures of success and simple strategic performance metrics should be developed by CQC, working with the Department and other stakeholders, and then used rigorously to track performance –

Measures of success should be developed over the next six months, using currently available data as a starting point and involving key stakeholders. These metrics could include measures of compliance activity and registration, but also measures of quality of service, such as complaints, and outcomes measures, such as rates of improvement.

Resources and Prioritisation

4.2. On resources and prioritisation, the recommendations are aimed at strengthening CQC's analysis of risk and improving transparency and explicitly seek external assurance of plans:

Recommendation 5 – Priority should be given to work now underway to improve risk management and assess how different regulatory options, including thematic reviews, frequency of inspections and possible focus on selected standards, can help to reduce risk – This evidence is essential to underpin decisions about how resources are deployed and the extent to which resources could or should be geared towards areas of highest risk. On an ongoing basis, the review of risks should form the basis of accountability discussions with the Department, alongside finance and performance information.

Recommendation 6 – CQC needs to improve the quality and transparency of management information that is used to make resource allocation decisions – CQC should improve the transparency and analysis of management information systems, to ensure that decisions are based on the best possible information. This work should be considered at the next Board meeting and form part of the ongoing accountability discussions with the Department.

Recommendation 7 – CQC to act to ensure that robust and costed plans are in place for taking on responsibilities; that these plans are the subject of independent test and assurance; and that they are agreed with the Department – CQC should set out the expected processes and resource implications for future work including GP registration, inspection of dentists, joint licensing with Monitor and taking on the additional responsibility of HealthWatch. These plans should be subject to independent assurance.

Accountability

4.3. The recommendations on accountability are aimed at strengthening the Board and Board structures, but also at improving sponsorship and accountability arrangements with the Department. As a priority, the Department should ensure that the differences that have arisen on the CQC Board do not undertaking of its statutory functions:

Recommendation 8 – The Department should take steps to strengthen the Board and Board structures, including changing the Board so that instead of comprising only non-executives, it becomes a unitary board of majority non-executives with

senior executives on the board where they can be held to account – Specifically, the Department should: (i) appoint suitable individuals to existing vacancies; and (ii) revise, during 2012, the regulations that define the board, so that in future, it is a unitary board comprising both non-executive and executive directors. This modern board structure should enable a tighter accountability relationship between non-executives and senior executives. Finally, the Department should: (iii) in future, ensure that there is a broad range of non-executive expertise, including from the charitable and independent sectors, as well as from other regulators.

Recommendation 9 – CQC needs to review and reinstate the Board support and development programme – This programme should ensure effective support and training to enable the Board to carry out their roles and operate more clearly as a team, including on issues of equality and diversity. The development programme should also define more clearly the roles of the Board and executive team, including the new Chair of HealthWatch.

Recommendation 10 – Capability at executive team level needs to be strengthened greater strategic capability, and more and wider sector-specific expertise – Alongside considering how to build the strategy thinking and executive team level, the CQC Board should consider what other skills and training are needed at executive team level, including for example, hands-on experience of managing health and care services, organisational design and managing transition.

Recommendation 11 – The Department should strengthen the arrangements for ongoing assurance and accountability of CQC, in a way that is consistent with CQC's status as an independent regulator – Consistent with current work, the Department should improve accountability mechanisms based on CQC's agreed measures of success, risk management and financial position. Other ways of improving sponsorship include greater consistency of approach to sponsorship of arms length bodies, learning from other Government Departments and improving capability for the Department's sponsorship teams.

Engagement and Communications

4.4. The recommendations below cover external engagement – at the centre and frontline – and internal communications:

Recommendation 12 – CQC needs to be more proactive and systematic in understanding the expectations of stakeholders and demonstrating it is a learning organisation – including continuing and welcoming feedback from providers, commissioners and the public, ensuring full consultation of regulatory changes, and demonstrating action where appropriate in response to analysis of feedback.

Recommendation 13 – CQC should raise its game and take a lead in working more closely with other regulators within the health and care sector to increase joint

effectiveness and reduce burden on providers – CQC should be a leading force in increasing the effectiveness of regulation. Building on a clearer strategy, CQC should set plans for working with and through regulatory partners, e.g. Monitor and professional regulators, to reduce the burden of regulatory action on health and care providers. Reducing the burden should be understood as a 'service' to the regulated and one they are entitled to expect CQC to take seriously.

Recommendation 14 – Greater coherence and consistency is needed between the centre of CQC and its operational frontline, specifically, with the locally-based inspection teams – CQC should take further steps to ensure clear and consistent communication from the centre to the regions. This communication will need timely and clearer messages, and a clear programme for sustained and systematic engagement between the centre, regions and the frontline.

Recommendation 15 – Links between Mental Health Act functions and the rest of CQC need to strengthened, including clearer metrics, information management and communications – CQC should take further steps to integrate Mental Health Act functions including linking to the strategic objectives of CQC, promoting cross working with other frontline staff and improving the performance metrics.

Development of the Regulatory Model

4.5. These recommendations are aimed at improving the understanding of the model, but also in strengthening how user voice is used:

Recommendation 16 – CQC should set out clear plans for ongoing evaluation of the regulatory model and the effectiveness of individual interventions, **including working with the Department to consider opportunities under the Policy Research Programme –** This evaluation should consider the effectiveness of resource allocation, but also the impact of operational decisions e.g. the impact of inspections and of other enforcement activity. CQC should work closely with the Department to identify the potential for overlap with work on the Policy Research Programme.

Recommendation 17 – The regulatory model should make use of qualitative information in a systematic way, including drawing on patient and user insights gathered through HealthWatch England – The Quality Risk Profiling approach has high potential, but the regulator should make greater and more systematic use of local intelligence and user voice, including through HealthWatch. This work is already underway, but will need to be strengthened.

Recommendation 18 – CQC should be explicit about how far the compliance regime should be tailored to reflect the different risks and needs of different sectors and locations – Within the existing system of a unified regulator and standardised approach, CQC needs to identify and be explicit how the model should be flexed to address different geographies and different sectors.

Recommendation 19 – The Department should develop its capability and capacity on the regulation of safety and quality so as to provide ongoing challenge and support to CQC in developing its regulatory model – As part of ongoing sponsorship, the Department should develop an ongoing dialogue with CQC to understand the effectiveness of the model, based on performance data and a better understanding of regulation. This work should include up-to-date assessment of regulation in other health and care systems, and should be a priority for the Policy Research Programme.

Delivery of the Regulatory Model

4.6. Finally, the Review sets out a number of recommendations aimed at improving how the regulatory model is implemented on the frontline:

Recommendation 20 – CQC to review and implement improved access to sector-specific expertise for inspectors, specifically, inspectors should be able to call on patient, user or clinical expertise when they need it – To improve quality and help build credibility, CQC should be explicit in how it recognises and resources the needs of the 'professional inspector', including putting in place transparent plans for ensuring access for inspectors to experts by experience and clinical expertise.

Recommendation 21 – Clear actions are needed by CQC to assure consistency and transparency in compliance activity and regulatory decision-making – To ensure greater consistency across sectors and locations, CQC should build on existing peer review with independent assurance, continue to focus on building better relationships on the ground and ensure provider reports are kept up-to-date.

Recommendation 22 – CQC should develop and share with the Department plans for sustaining sufficient numbers of inspectors with the right skills and capacity to meet future priorities – Now that CQC has a more stable workforce, it should focus on how it plans to meet new pressures and plans for improving the capacity and capability of inspectors. This work should include assessing how people utilise their time and ensuring inspectors do a proper risk analysis of their caseload, including systematic use of user voice information.

Recommendation 23 – On adult safeguarding, CQC should continue to work with local government and roll out staff training to improve local engagement and clarify roles, responsibilities and protocols – New inspection staff receive safeguarding training as part of their induction, including steps to take to ensure the safety of vulnerable adults, clarity on when to attend adult safeguarding board meetings and establishing periodic reviews with safeguarding boards. CQC should expedite plans to roll out such training to all front-line staff. In addition, more work is needed with ADASS and local government to ensure all relevant staff are clear about protocols.

Annex A: Methodology

Approach

The Review took as a starting point the Capability Review areas of delivery, strategy and leadership as a framework for gathering evidence across the organisation.

Based on this evidence, the Review identified six key lines of enquiry, which formed the basis for further testing. This approach drew on experience from the Strategic Health Authority Assurance Reviews.

The Review has not explicitly provided a 'RAG' rating, as the intention was to focus on recommended actions for CQC in meeting future delivery challenges, rather than as a ranking exercise.

The Review collated evidence from three main sources:

- **Stakeholders** – including a stakeholder survey, over twenty-five one-to-one interviews, two stakeholder events and a regional visit to Birmingham;
- **CQC** – including an initial self-assessment, discussions with the Board, Panel to Board meetings, discussions with staff and visits to regional offices, including the West Midlands Regional Office in Birmingham, and the National Customer Services Centre in Newcastle; and
- **Documentary evidence** – including evidence from recent consultations, other reviews, including the NAO value-for-money study and the Health Select Committee Report, and performance data.

The Review was led by panel of senior officials from the Department and external reviewers, chaired by the Permanent Secretary, and with support from a small Departmental team.

The Review team worked closely with CQC through the review to test the approach and to ensure the Review has resonance while not imposing undue burden.

Timetable and output

The Review ran from October 2011 to February 2012 in two phases:

- **Phase 1** – focussed on evidence gathering based on the Capability Review areas to identify key lines of enquiry; and
- **Phase 2** – testing the key lines of enquiry to identify recommendations and to provide the opportunity to test with staff and stakeholders.

The output of the Review was a report and letter from the Permanent Secretary to the CQC Board, including challenges, key findings and recommendations, intended to support CQC in the next phase of its work. The letter and the report, together with a formal response from CQC, will be made public.

Performance and Capability Review Panel

- Una O'Brien (Department of Health, Permanent Secretary) Chair of the Review Panel
- Miriam Rosen (Former HM Chief Inspector of Education, Children's Services and Skills, OFSTED)
- Catherine Bell (Department of Health, Non-Executive Director)
- Candy Morris (Senior Consultant – Strategic Projects for the South of England, recently South East Coast SHA Chief Executive)
- Richard Douglas (Department of Health, Director General, Policy, Strategy and Finance)
- David Behan (Department of Health, Director General, Social Care, Local Government and Care Partnerships)
- Alan Hall (Department of Health, Director of Performance)