



National Audit Office

**REPORT BY THE
COMPTROLLER AND
AUDITOR GENERAL**

**HC 1665
SESSION 2010–2012
2 DECEMBER 2011**

Department of Health

The Care Quality Commission:
Regulating the quality and safety
of health and adult social care

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National Audit Office

Department of Health

The Care Quality Commission:
Regulating the quality and safety
of health and adult social care

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Amyas Morse
Comptroller and
Auditor General

National Audit Office

28 November 2011

The Care Quality Commission is the independent regulator of health and adult social care services in England. Its objective is to protect and promote the health, safety and welfare of people who use these services.

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Contents

Key facts **4**

Summary **5**

Part One
The role of the Care
Quality Commission **11**

Part Two
The Care Quality
Commission's resources **17**

Part Three
Registering health and
adult social care providers **25**

Part Four
Ensuring health and adult
social care providers comply
with the essential standards
of quality and safety **31**

Appendix One
The essential standards
of quality and safety **38**

Appendix Two
Methodology **40**

Appendix Three
Events at Winterbourne View **41**

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This report can be found on the National Audit Office website at www.nao.org.uk/CQC-2011

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Key facts

£139m

The Commission's
spending in 2010-11

21,600

The number of
organisations currently
registered by the
Commission

14%

The percentage of the
Commission's staff
positions vacant at
30 September 2011

- 6 per cent** the decrease in the recurring budget for regulating health and adult social care between 2008-09 and 2010-11
- 49 per cent** the decrease in grant-in-aid (for recurring and transitional costs) provided by the Department of Health between 2009-10 and 2011-12
- 58 per cent** of the Commission's spending covered by fees in 2010-11
- 8,500–10,500** GP practices to be registered between September 2012 and April 2013
- 47 per cent** of provider registrations not completed on time
- 47 per cent** of planned compliance reviews completed in the second six months of 2010-11
- Over 90 per cent** of compliance reviews have involved an on-site inspection since April 2011
- 50** the average number of data items available to inform the Commission's risk assessments of adult social care providers, compared with 500 for NHS trusts

Summary

1 The Care Quality Commission (the Commission) is the independent regulator of health and adult social care services in England. Its objective is to protect and promote the health, safety and welfare of people who use these services. The Commission is a non-departmental public body, overseen by the Department of Health (the Department). In 2010-11, its spending was £139 million, funded by grant-in-aid and fees paid by health and social care providers.

2 The Commission was established under the Health and Social Care Act 2008 and began operating on 1 April 2009. It brought together three predecessor organisations – the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. In 2009-10, the Commission ran the three previous regulatory systems while developing its own new system. From April 2010, it began operating using its new powers, set out in the Health and Social Care Act 2008.

3 The Commission regulates health and adult social care through its 'quality and safety assurance' work, which comprises:

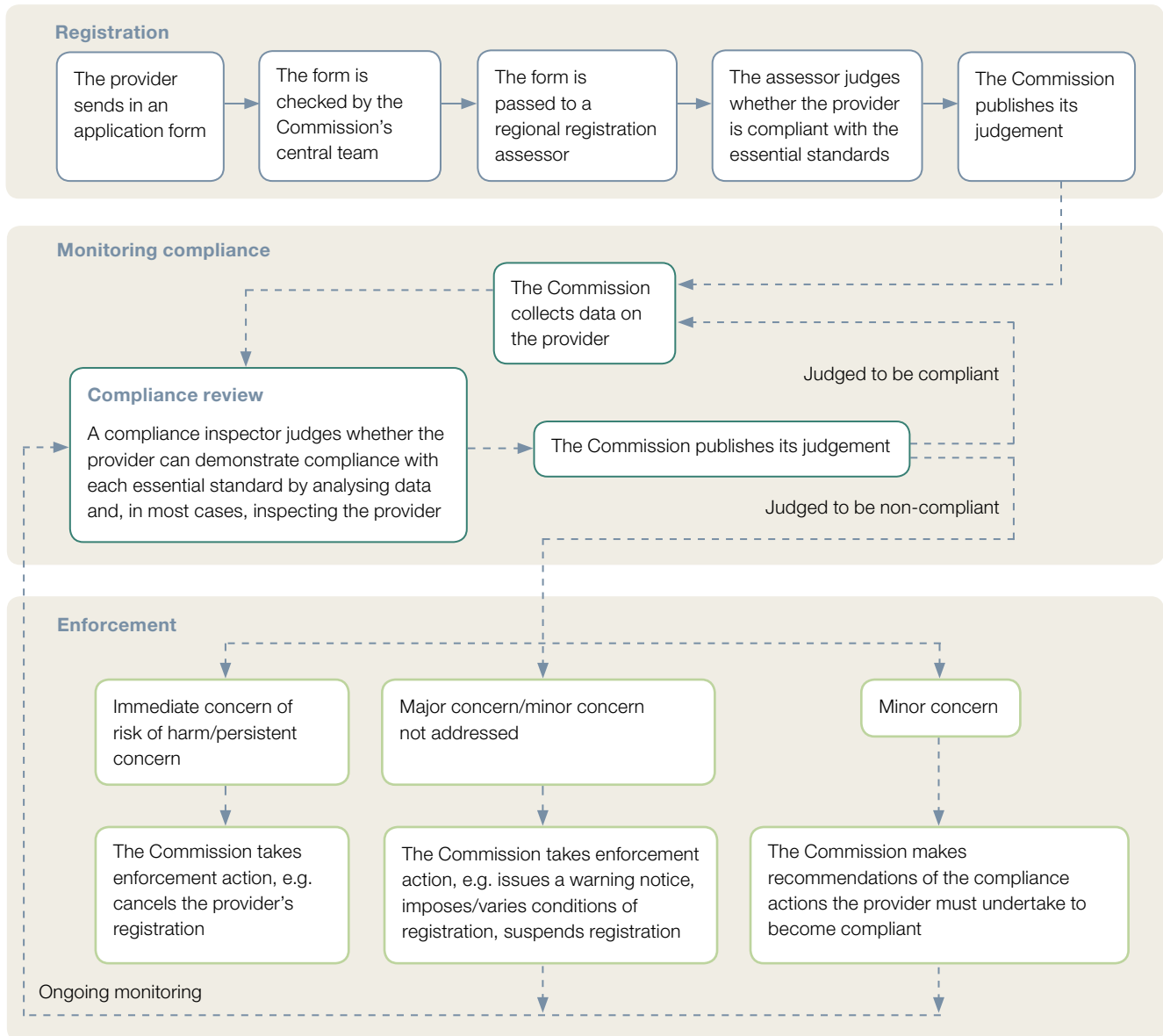
- registering providers against 16 essential standards of quality and safety (Appendix One);
- checking registered providers are complying with the essential standards, including by carrying out inspections;
- taking enforcement action against providers where services fail to meet the essential standards; and
- carrying out special reviews of particular aspects of care, and investigations where concerns about quality have been identified.

Figure 1 overleaf outlines the Commission's regulatory model.

4 This report examines how the Commission has used its resources in carrying out its quality and safety assurance work. Our methodology is summarised in Appendix Two.

5 The Commission also has a number of other statutory functions including visiting patients whose rights are restricted under mental health legislation and publishing information about the services it regulates to drive choice and improvement. These functions are not covered by this report.

Figure 1
Regulating health and adult social care



Source: National Audit Office

6 The role of the Commission in regulating health and adult social care has been the subject of considerable public interest in the past six months because of:

- a BBC *Panorama* programme in May 2011, which exposed serious abuse of patients by staff at Winterbourne View, a residential hospital for people with learning disabilities (Appendix Three);
- the winding-up in July 2011 of Southern Cross, previously the largest care home provider in the UK, with a total of 31,000 residents in 750 homes;
- the Mid-Staffordshire NHS Foundation Trust public inquiry, which is examining the role of the commissioning, supervisory and regulatory bodies in the monitoring of this Trust; and
- the Commission's national report on dignity and nutrition in NHS hospitals, and its investigation report on Barking, Havering and Redbridge NHS Trust, both published in October 2011.

Key findings

7 The regulators for health and adult social care have been subject to considerable change in the last ten years. The Commission is the third regulator for each sector, although it is the first to cover both health and social care providers. The changes have created disruption for providers and confusion for the public.

8 The proposal to extend the Commission's role into new areas risks distracting the Commission from its core work of regulating health and adult social care. The Department proposes that the Commission should take on a variety of additional responsibilities, such as overseeing fertility clinics and responsibility for HealthWatch England, the national consumer body for health and social care.

9 There is a gap between what the public and providers expect of the Commission and what it can achieve as a regulator. Although the Commission's role is clearly defined, it has changed over time and has not always been communicated effectively. The Commission has also not made clear what success in delivering its priorities would look like. The Commission's improved website aims to address this expectation gap by setting out more clearly what the public and providers can expect from the Commission.

10 The Commission's budget is less than the combined budget of its predecessor bodies, although it has more responsibilities. The budget for health and adult social care regulation fell from £175 million in 2008-09 to £164 million in 2010-11, a reduction of 6 per cent.

11 Responsibility for funding the regulation of health and adult social care is falling increasingly on the providers of these services rather than the Department.

The Commission is moving towards full cost recovery and the proportion of its spending covered by fees increased from 34 per cent in 2009-10 to 58 per cent in 2010-11. The grant-in-aid given by the Department has fallen considerably – by 49 per cent between 2009-10 and 2011-12, although 11 per cent of the fall is accounted for by the inclusion of funding for transitional costs in 2009-10.

12 The Commission underspent against its budget for 2009-10 and 2010-11, partly because it had a significant number of staff vacancies.

At the end of September 2011, 14 per cent of staff positions were vacant, of which 40 per cent were registration assessor and compliance inspector posts. The Commission has been unable to fill vacancies promptly and was subject to the government-wide recruitment constraints, which meant it needed the Department's approval to recruit new staff.

13 The timetable for registering health and adult social care providers, set by the Department, did not allow time for the registration process to be tested properly and the process has not run smoothly. Although 21,600 organisations are currently registered, the timetable for two out of three tranches of providers was not met. Providers were critical of the registration process and the Commission's initial processing arrangements were inefficient.

14 The Commission is seeking to learn lessons for the registration of GP practices, which has been deferred by a year. The postponement has allowed the Commission time to engage with GPs at an early stage, streamline the application process, and develop online services to make registration quicker and more efficient.

15 Compliance review and inspection work fell significantly during 2009-10 and 2010-11. The Commission completed only 47 per cent of the planned number of reviews between October 2010 and March 2011. The reduction in compliance activity was due to the Commission deciding to prioritise registration over compliance, as it diverted resources in a bid to meet the statutory timetable for registration. Levels of compliance activity were also adversely affected by the number of inspector vacancies. Compliance work is now increasing and, in the light of the Winterbourne View case, the Commission is proposing to inspect NHS, independent healthcare and adult social care providers at least once a year from April 2012.

16 The Commission has a systematic approach to assessing the risk that providers are not meeting the essential standards of quality and safety, but it depends on good quality information which is not always available. The 'quality and risk profiles' for adult social care contain on average only a tenth of the data items of the profiles for the NHS. Concerns have also been raised that some compliance inspectors do not have the expertise to assess risk effectively and that differences in approach are leading to inconsistency.

17 The Commission has strengthened its whistleblowing arrangements in the light of the Winterbourne View case. Whistleblowing concerns are monitored to make sure they are followed up and the information provided is included in regional risk registers. The registers list providers where 'major concerns' have been identified; in November 2011, the Commission had major concerns about 407 providers, 94 per cent of whom were adult social care providers.

18 The Commission's performance management is constrained by gaps in data and reporting is mainly against quantity-based measures of activity. There are a small number of time-related measures but no quality or outcome indicators for regulating health and adult social care. The Commission has established a project to improve its management information.

Conclusion on value for money

19 The Commission had a challenging task in merging three former regulators to establish a new organisation and in implementing a new regulatory approach, which integrates health and social care, at a time of diminishing resources. It was inevitable that there would be some transitional difficulties and that it would take time for the Commission to settle down into a steady state. In the event the difficulties were considerable.

20 The ultimate measure of the Commission's value for money is the impact of regulation on the quality and safety of care, relative to the cost. In the absence of measures of impact, we assessed value for money in terms of whether the Commission delivered what it set out to deliver in its quality and safety assurance work. With the exception of NHS trusts, the Commission did not meet the deadlines set for registering providers; at the same time, levels of compliance and inspection activity fell significantly, although the Commission was hampered by government-wide recruitment constraints which made it difficult to fill vacancies quickly. We therefore conclude that, although regulation is being delivered more cheaply, the Commission has not so far achieved value for money in regulating the quality and safety of health and adult social care. It is not clear to us exactly where the balance of responsibility lies between the Commission and the Department for failing to achieve value for money, but it is clear that responsibility is shared.

Recommendations

21 The Commission has begun to take steps to improve performance and address some of the issues highlighted in this report. Our recommendations are designed to reinforce these actions and more generally help the Commission deliver better value for money in regulating health and adult social care.

a The Commission has not made clear what success in delivering its priorities would look like. Together with the Department, the Commission should define, as far as possible in measurable terms, the outcomes it wants to achieve in regulating health and adult social care, against which progress can be measured. The Commission could also use its networks of representatives of providers and the public in this exercise, which would help bridge the expectation gap.

- b There are shortcomings in the Commission’s performance management arrangements.** In particular, the Commission needs to:
- develop performance measures that go beyond the current largely activity-based indicators to cover issues of quality, cost and timeliness;
 - address gaps in performance data, in particular by collecting data on the types of enforcement action taken and the timescales; and
 - report more performance information to the public, including on the impact of enforcement action, which will help the Commission demonstrate its effectiveness and provide reassurance to the public.
- c Registering GP practices will be a key test for the Commission next year.** Drawing on lessons from previous registrations, the Commission should develop a detailed plan which specifies key milestones and resourcing requirements. The Department and the Commission should review progress regularly so timely decisions, such as whether resources should be diverted from other work, can be taken if GP registration does not go to plan.
- d The Commission’s compliance inspectors need better support and information to help them make sound, consistent judgements.** The Commission should:
- identify more data sources for adult social care, for example by using information from other bodies such as the Local Government Ombudsman;
 - enable inspectors to view the risk profile across their whole portfolio; and
 - identify how best to support newly recruited inspectors, who will be working from home and who may lack the experience and support networks of existing inspectors.
- e Whistleblowing should be a key source of information for the Commission to detect poor quality or unsafe care.** The Commission should review whether its new whistleblowing arrangements are working effectively, particularly to check that all concerns are being followed up and appropriate action is being taken.
- f There is a risk that extending the Commission’s role will distract it from its core work of regulating health and adult social care.** Before making decisions, the Department should assess the costs and impact of giving the Commission additional responsibilities and determine whether the Commission has the capacity to take on an extended role.
- g It is uncertain how much money the Commission will need in the longer term to regulate health and adult social care effectively.** The Commission and the Department should monitor the resourcing position closely as the Commission gains more knowledge about the quality of care in the various sectors it regulates, and make informed and timely decisions about the resources required, taking account of the level of risk they are prepared to tolerate.

Part One

The role of the Care Quality Commission

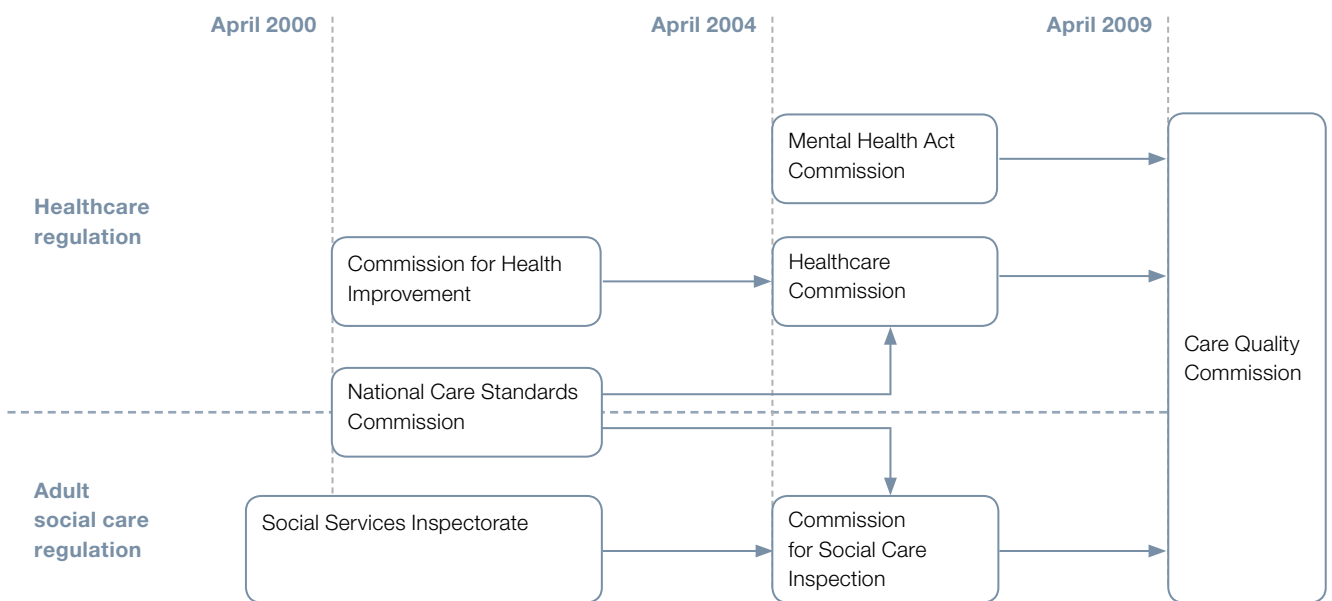
1.1 This part of the report covers the role of the Care Quality Commission (the Commission).

Regulating health and adult social care

1.2 There has been considerable change in the regulation of health and adult social care in the last ten years. The Commission is the third regulator for each sector (**Figure 2**), although it is the first to cover both health and social care. The changes have created disruption and additional work for providers, and confusion for the public. The new system has, however, brought more providers within the scope of the regulator and regulation now focuses more on outcomes than processes.

Figure 2

Changes in the regulation of health and adult social care since 2000



Source: National Audit Office

1.3 The Commission is a non-departmental public body, overseen by the Department of Health (the Department). It was established under the Health and Social Care Act 2008 to protect and promote the health, safety and welfare of people who use health and adult social care services by regulating the provision of such services. It began operating on 1 April 2009, bringing together three bodies – the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

1.4 The Commission regulates services provided by the NHS, private companies and not-for-profit organisations – whether in hospitals, GP or dental surgeries, ambulances, care homes or people’s own homes. The providers of adult social care and independent healthcare range from major companies, such as Bupa, to small agencies providing home care and individual private doctors. **Figure 3** shows the providers that the Commission regulates, which we estimate account for approximately 10 per cent of gross domestic product in England. Currently over 21,000 providers in over 40,000 locations are registered.

1.5 The Commission regulates health and adult social care through its ‘quality and safety assurance’ work, which comprises:

- registering health and adult social care providers against 16 essential standards of quality and safety (Appendix One);
- checking providers are complying with the essential standards;
- taking enforcement action where services fail to meet the essential standards; and
- carrying out special reviews of particular aspects of care, and investigations where concerns about quality have been identified.

Figure 3
Providers regulated by the Commission

Type of provider	Number of providers	Number of locations ¹
NHS trusts	309	2,500
Adult social care providers ²	12,255	25,313
Independent healthcare providers ³	1,169	2,575
Dentists	7,686	9,532
Independent ambulance services	219	303
Out-of-hours providers – from October 2011	221	N/A
GP practices ⁴ – from September 2012	8,500–10,500	10,000–13,000

NOTES

- 1 A provider may deliver services in more than one location.
- 2 Adult social care includes residential homes, day care services and home care services.
- 3 For example, private hospitals, hospices and private doctors.
- 4 The exact number of GP practices and locations has yet to be determined.

Source: Care Quality Commission

1.6 Public expectations of the Commission are high. As a regulator, however, the Commission cannot eliminate every incident of poor quality or unsafe care, nor completely mitigate the risk of it occurring. What it can do is deter poor quality or unsafe care and inspect effectively those it regulates to uncover systematic bad practice.

1.7 While the Commission's responsibilities are clearly defined, we found evidence that they have not always been effectively communicated. For example, our stakeholder consultation and the Commission's own provider survey indicated that providers and commissioners of care are unclear about the Commission's role in relation to quality assurance. Additionally, they consider that the Commission's provision of advice and information has been inconsistent. The Commission's improved website sets out more clearly what the public and providers can expect from the Commission.

1.8 Uncertainty about the Commission's role may also arise because the landscape for oversight of health and adult social care is complex, with a number of other bodies having a role to play (**Figure 4** overleaf). Providers are responsible for the quality and safety of care, and should have appropriate management and control structures to monitor and take corrective action where necessary. Commissioners should satisfy themselves about the quality and safety of the care they are buying, and the nine statutory regulatory councils for care professionals regulate the conduct of individual staff.

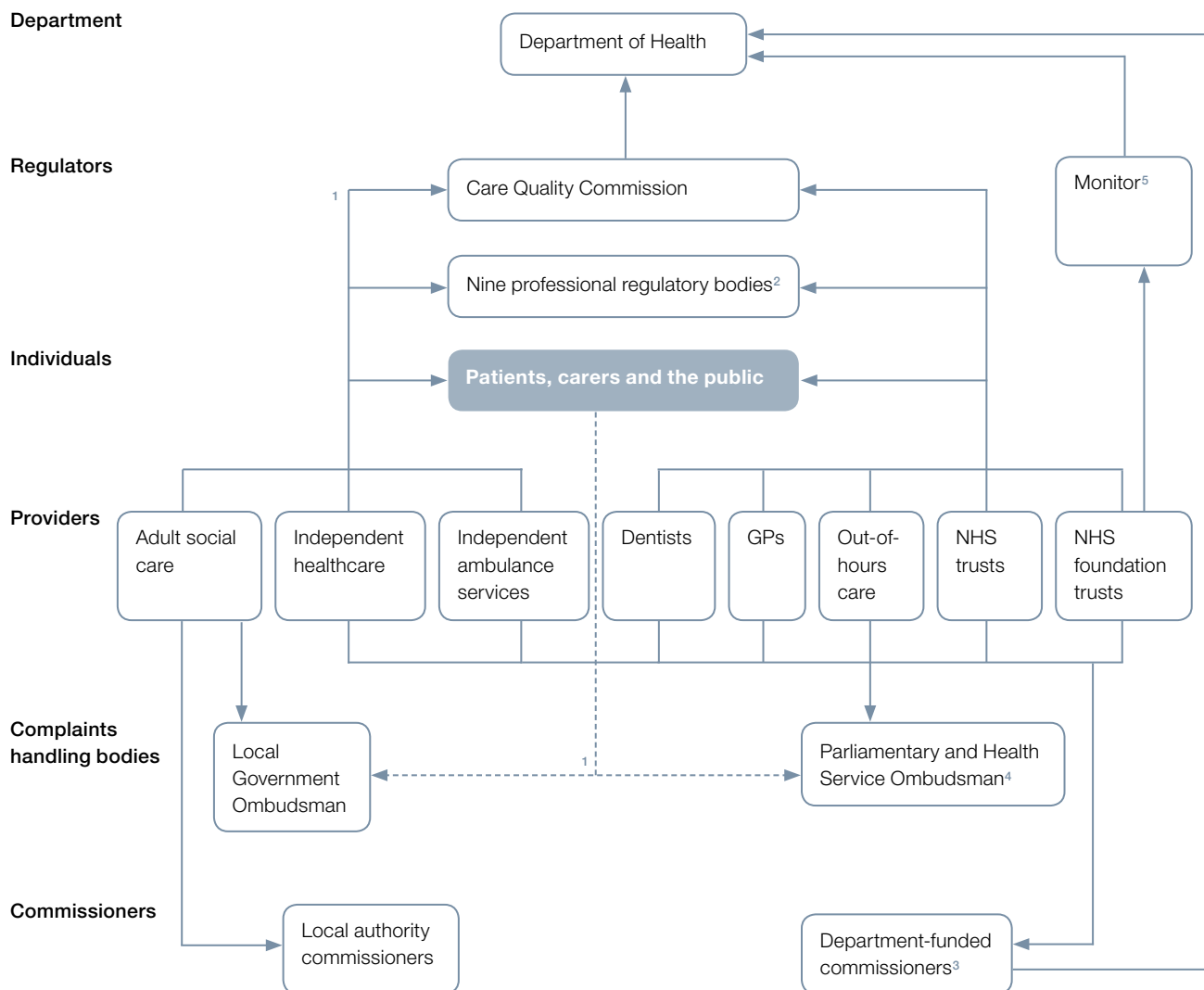
The Commission's other responsibilities

1.9 The Commission has other statutory functions including: visiting patients whose rights are restricted under mental health legislation to ensure that their rights are protected; publishing information about the services it regulates to drive choice, change and improvement; and providing an annual state-of-care report to Parliament.

1.10 The Department proposes to extend the Commission's role to include a number of additional responsibilities. The changes risk distracting the Commission from its core work of regulating health and adult social care. It is not yet clear what additional resources the Commission would receive to carry out the additional functions, which include:

- establishing HealthWatch England, from October 2012, as a statutory committee of the Commission to act as the 'independent national consumer champion' for health and social care;
- some functions of the Human Fertilisation and Embryology Authority, such as the licensing and monitoring of fertility clinics, and of the Human Tissue Authority, such as regulating organisations that remove, store and use tissue for research and other purposes;
- the statutory functions of the National Information Governance Board to promote, improve and monitor information governance in health and adult social care; and
- operating a joint licensing and registration system with Monitor (the regulator of foundation trusts) to make sure that any conditions imposed upon registered providers and licence holders are not inconsistent or contradictory to each other.

Figure 4
The health and adult social care landscape



NOTES

- 1 Solid arrows show lines of accountability; dotted arrows represent complaints referrals.
- 2 The nine bodies cover health and adult social care workers, such as dentists, doctors, pharmacists and midwives.
- 3 Currently primary care trusts commission department-funded healthcare services. By April 2013, these services are expected to be commissioned by the NHS Commissioning Board and clinical commissioning groups.
- 4 The Ombudsman can handle complaints about independent healthcare and private ambulance services only if the care was funded by the NHS.
- 5 Monitor determines whether NHS trusts are ready to become foundation trusts and regulates those trusts that achieve this status.

Source: National Audit Office

1.11 When the Commission was established, it had a role in conducting periodic reviews of the commissioning of health and social care by primary care trusts and local authorities. However, it stopped carrying out this work in 2010 when the Department asked it to focus on regulating providers. The Department proposes that in future this responsibility will be undertaken by the NHS Commissioning Board for health and by local authorities themselves for social care.

1.12 The Commission is not responsible for investigating individual complaints about care services, even if it receives them. In the first instance, responsibility for dealing with complaints rests with the provider concerned. If complainants feel they have not received an adequate response from the provider, they may approach the Parliamentary and Health Service Ombudsman for complaints about the NHS, or the Local Government Ombudsman for complaints about adult social care.

1.13 In June 2010, the Commission stopped awarding star ratings based on its assessments of residential social care. The previous regulator, the Commission for Social Care Inspection, had awarded zero to three stars (poor, adequate, good and excellent) to drive improvements in, and inform the public about, the quality of care. The Care Quality Commission, however, judges simply whether or not providers are meeting essential standards of quality and safety, rather than making more graduated assessments.

1.14 While the Commission does not award star ratings, it does provide information to help the public make informed choices about care providers. Its website¹ received more than 5.2 million visitors in 2010-11. In the light of concerns about the quality and accessibility of the information provided, the Commission launched an improved website in October 2011, with separate sections for providers and the public. It is also encouraging the public to provide details of their experience of individual providers.

The Commission's governance

1.15 The Department oversees and supports the Commission in a variety of ways, including regular meetings with the Commission's senior staff, regular discussions with the Chair and Chief Executive, quarterly accountability review meetings and daily contact at working level. The Department monitors the Commission's financial and operational performance and risks at a strategic level. It does not assess the Commission's regulation of individual providers.

1.16 The Commission has set two priorities: to focus on quality and act swiftly to eliminate poor quality care; and to make sure care is centred on people's needs and protects their rights. We found that the Commission has not made clear what success in delivering these priorities would look like. The definition of success will depend to some extent on the level of risk that the Commission and the Department are prepared to tolerate in regulating health and adult social care. This 'risk appetite' appears to have changed in the light of the Winterbourne View case. A clear understanding of risk appetite should be central to decisions about resourcing and priorities.

1.17 The Commission's Board meets every three months and reviews performance using a corporate scorecard of largely quantity-based measures of activity, with a small number of time-related measures. The scorecard has no quality indicators to measure the Commission's quality and safety assurance work, and in some cases the data reported has been incorrect. In addition, the effectiveness of the Commission's performance management and reporting is limited by gaps in the scope of the data available. For example, data are not available on the types of enforcement action carried out and the length of time taken to register providers. The Commission has established a project to improve the quality of its management information.

Part Two

The Care Quality Commission's resources

2.1 This part of the report covers the Commission's resources and staffing.

How the Commission is funded

2.2 Responsibility for funding the regulation of health and adult social care is falling increasingly on the providers of these services rather than the Department. In 2010-11, the Commission received grant-in-aid from the Department of £92 million and fees from providers of £80 million (**Figure 5** overleaf). For 2011-12, grant-in-aid is £65 million, a fall of 49 per cent since 2009-10. Removing the funding provided for transitional costs in 2009-10 (see paragraph 2.6) reduces the fall in grant-in-aid to 38 per cent.

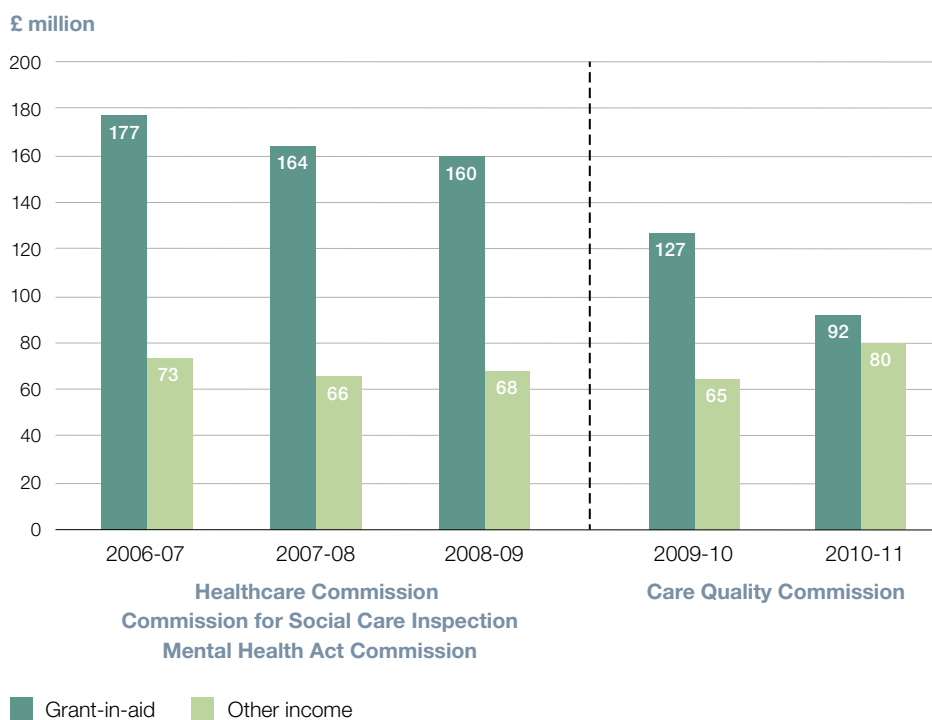
2.3 In line with Treasury guidance,² the Commission is moving towards full cost recovery for its quality and safety assurance work. The proportion of spending covered by fees increased from 34 per cent in 2009-10 to 58 per cent in 2010-11. No timetable has been set for achieving full cost recovery, however, and the rate of progress depends partly on the political appetite for increasing fees, as the Commission's fee scheme has to be approved by the Secretary of State for Health.

2.4 In April 2010, the Commission implemented a new fee structure, which introduced fees for NHS providers for the first time, bringing them into line with adult social care providers. The fees charged depend on the size and type of provider (**Figure 6** on page 19). The fees paid by the NHS are funded by the taxpayer but those paid by other providers are likely to be passed on, at least to some extent, to the recipients of care in the form of increased charges. There is no cap on the fees for residential social care providers as they are charged per location, which their representative bodies regard as unfair.

2 HM Treasury, *Managing public money*, October 2007.

Figure 5

Grant-in-aid and other income for health and adult social care regulation, 2006-07 to 2010-11

**NOTES**

1 Grant-in-aid includes provision for recurring and transitional costs.

2 Other income consists mainly of fees from providers.

Source: Annual reports of the four regulatory bodies from 2006-07 to 2010-11

The Commission's budget and spending

2.5 The Commission's budget is less than the combined budget of its predecessor organisations, although it has more responsibilities. Despite this, the Commission underspent in both 2009-10 and 2010-11, meaning that it did not make full use of the resources available.

2.6 The Commission's budget for its first year of operation was agreed by the Department as part of the work leading up to the Commission being established. The budget consisted of:

- recurring costs, which represented the cost of performing functions inherited from the three predecessor bodies as well as several new activities; and
- transitional costs, which represented the costs of setting up the Commission and designing the new regulatory system.

Figure 6
Fees charged by the Commission

Provider	How fees are calculated	Minimum fee (£)	Maximum fee (£)
NHS	Annual turnover	40,000	115,000
Residential social care	Each location charged separately based on maximum resident capacity	250 per location	11,100 per location
Non-residential social care	Number of locations	1,000	32,000
Non-NHS hospital-related healthcare providers	Number of locations	8,500	150,000
Other independent healthcare providers	Number of locations	1,500	48,000
Dentists	Number of locations	800	48,000
Independent ambulance providers	Number of locations	800	48,000

NOTE

1 The Commission has not yet set the fees that GP practices will pay.

Source: Care Quality Commission

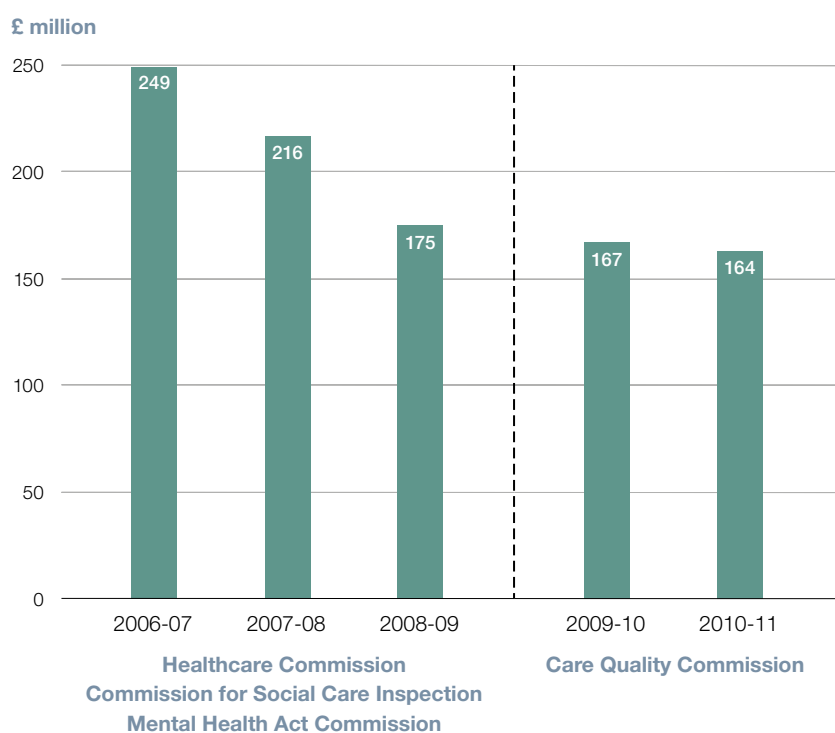
2.7 The Commission's recurring budget (**Figure 7** overleaf) incorporated cost reductions achieved by its predecessors in earlier years, arising from, for example, reducing the number of staff and offices, and changes in working practices, such as introducing home-working for inspectors. In 2010-11, the recurring budget was £163.8 million, a 6 per cent reduction on the combined budget of the Commission's predecessors in 2008-09 of £175 million. The Department and the Commission assumed that efficiency savings would be generated by merging the three bodies, including further reductions in the number of staff and offices. The Commission reduced its offices from 23 to 8 in 2009-10.

2.8 The Commission underspent against its recurring cash budget for 2009-10 and 2010-11 by £3.8 million (2.6 per cent) and £13.1 million (9.0 per cent) respectively (**Figure 8** overleaf). The underspend in 2010-11 was largely the result of:

- an underspend of £9.8 million on staff costs as a result of the number of vacancies during the year (paragraphs 2.13–2.16); and
- an underspend of £2.8 million on external consultancy services owing to the consultancy restrictions applied by the Government from May 2010.

Figure 7

Recurring budget for health and adult social care regulation, 2006-07 to 2010-11



Source: National Audit Office analysis of departmental data

Figure 8

The Commission's initial budget and spending, 2009-10 to 2011-12

	2009-10			2010-11			2011-12
	Budget (£m)	Spending (£m)	Difference (£m)	Budget (£m)	Spending (£m)	Difference (£m)	Budget (£m)
Transitional spending	38.3	29.5	(8.8)	17.5	17.5	0	0
Recurring cash spending	147.8	144.0	(3.8)	144.8	131.7	(13.1)	142.7
Depreciation and non-cash items	19.0	17.8	(1.2)	19.0	15.2	(3.8)	15.0
Accounting adjustments	0	(1.4)	(1.4)	0	(25.3)	(25.3)	0
Total spending	205.1	189.9	(15.2)	181.3	139.1	(42.2)	157.7

Source: National Audit Office analysis of Commission and departmental data

The allocation of resources

2.9 To manage its work effectively, the Commission needs to make informed decisions about the resources it needs and how to allocate them. It is currently moving towards a more evidence-based resourcing model for its regional workforce, with the introduction of activity logs in February 2011, which provide a better picture of how staff spend their time.

2.10 The resourcing model indicates that, if all vacancies were filled, the Commission would have enough inspectors to cover current levels of compliance activity. However, additional work will certainly be involved in regulating out-of-hours providers and GP practices. Furthermore, while the Commission can make assumptions to inform its business planning, it remains uncertain how many resources it will need in the longer term. If the Commission finds more poor quality care, it will need to increase its compliance and enforcement work and may therefore need more resources.

2.11 The Commission has implemented a new integrated approach to resource allocation. For its first year, it allocated its registration and compliance staff to either health or adult social care. For example, inspectors inherited from the Healthcare Commission were assigned to work on NHS trusts. In May 2010, the Commission brought together health and social care regulation with the introduction of mixed portfolios for regionally-based registration assessors and compliance inspectors.

2.12 The Commission's nine regional teams are assisted by intelligence and evidence officers and a shared service centre (**Figure 9** overleaf). The service centre was established in October 2010, bringing together the national processing centre, responsible for office administration, and the national contact centre, the main contact point for providers and users.

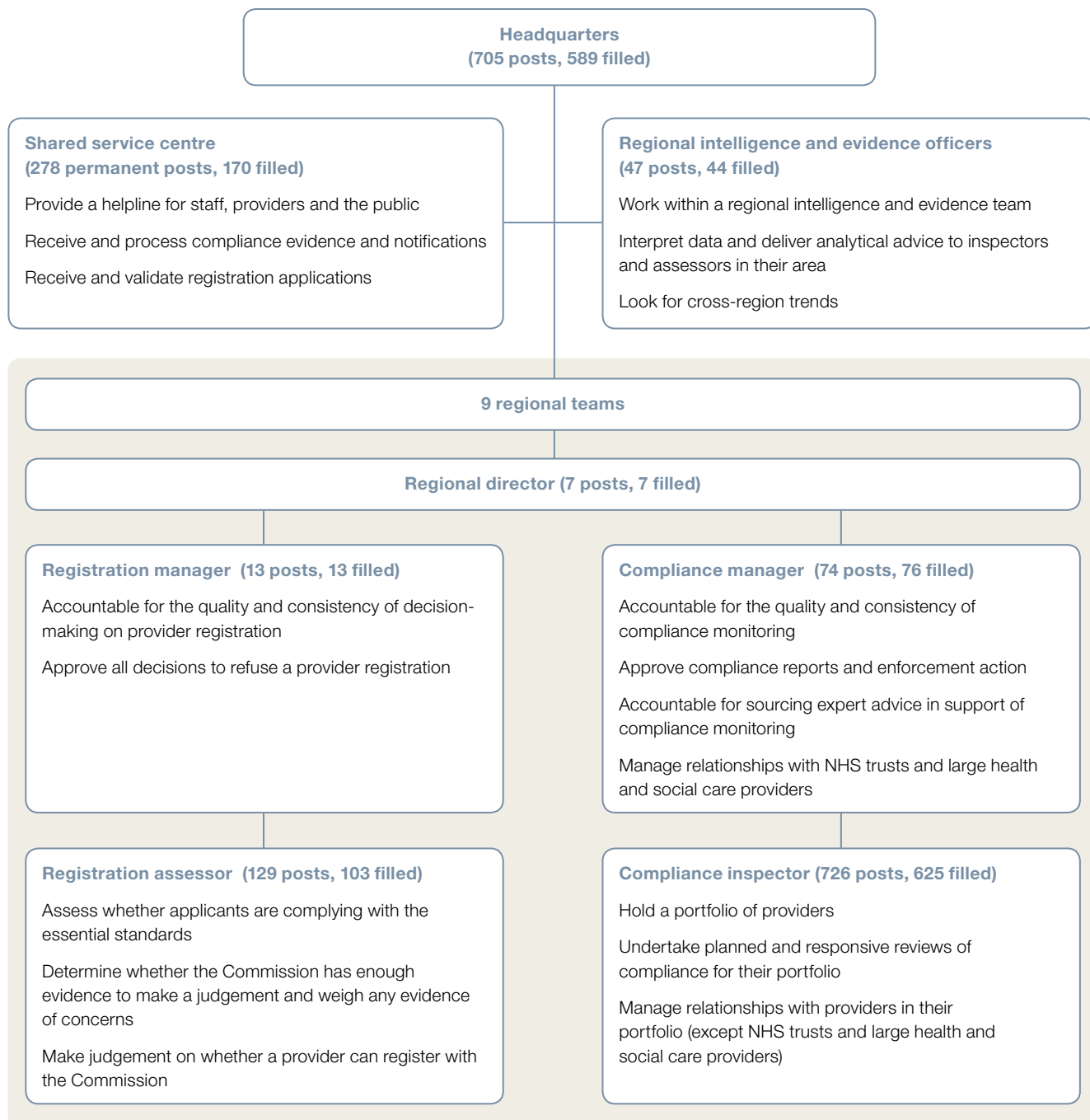
Staff vacancies

2.13 The Commission's operations have been hampered by a significant number of staff vacancies, which it has been unable to fill promptly. The Commission recruited 58 staff between May 2010 and June 2011, but the number of vacancies increased over time (**Figure 10** on page 23). At the end of 2009-10, 6 per cent of staff positions were vacant increasing to 12 per cent by the end of 2010-11. At the end of September 2011, 14 per cent of positions were vacant, equalling 268 staff, including 108 registration assessors and compliance inspectors (40 per cent of the total).

2.14 In seeking to fill the vacancies, the Commission was affected by the government-wide recruitment constraints introduced in May 2010, which meant that only 'frontline' or 'business critical' staff could be recruited. In September 2010, the Department decided that the Commission's staff did not fall within its definition of frontline,³ but that many of the staff, including registration assessors and compliance inspectors, did meet the definition of business critical.

³ Those positions or services that have direct contact with patients and service users in order to provide health or care services, or are critical to the successful operational delivery of such frontline positions or services.

Figure 9
Key roles in the Commission’s quality and safety assurance work



NOTE

1 Number of filled staff posts is at 31 August 2011, when there were 1,979 posts of which 1,627 were filled.

Source: National Audit Office

Figure 10

Staff vacancies, 2009-10 to 2011-12

Vacant positions**NOTE**

1 The negative number represents staff inherited from the predecessor bodies that were surplus to requirements.

Source: National Audit Office analysis of Commission data

2.15 In October 2010, the Commission applied for permission from the Department to recruit to these business critical posts. The Department agreed that the Commission could seek to fill these vacancies from within the arm's-length bodies, NHS and government redeployment pool and from Audit Commission staff. The Commission did not, however, advertise posts until March 2011. In the intervening period, it sought to fill the roles internally from staff being made redundant from a restructuring of its headquarters.

2.16 Insufficient good quality applications were forthcoming from the redeployment pool, and in June 2011 the Commission sought and received approval from the Department to recruit staff on the open market. The Department agreed that the Commission could advertise externally to recruit 106 registration assessors and compliance inspectors. By November 2011, 102 new staff had been recruited.

Staff redundancies

2.17 At the same time as vacancies were increasing, the Commission made staff redundant. In 2009-10, it implemented a voluntary redundancy programme to reduce staff numbers and made 110 staff redundant at a cost of £6.8 million (including 55 inspectors whose redundancy had been agreed by the Commission for Social Care Inspection). In 2010-11, after a restructuring exercise, a further 140 staff were made redundant, at a cost of £9.2 million. Around 50 redundancies resulted from the Commission's decision to scrap the role of local area manager. These staff were given the opportunity to take up compliance inspector roles or apply for compliance manager posts.

Staff morale

2.18 As well as carrying significant numbers of vacancies, the Commission has faced challenges in staff morale. It inherited three sets of pay and conditions from its predecessor bodies, covering some 1,200 staff, and some 600 staff recruited directly by the Commission have a fourth set. Morale has been negatively affected by inconsistencies in pay and conditions, with staff doing the same job on different pay scales. In October 2010, with the Department's support, the Commission contacted the Treasury about its plans to align its pay scales. This would have involved some pay increases. After taking account of the Treasury's views, however, the Department told the Commission that it would not make further representations to the Treasury for an exemption to the pay restraints that are currently in place across the public sector.

Part Three

Registering health and adult social care providers

3.1 This part of the report covers the Commission's registration of health and adult social care providers.

The registration process

3.2 Under the Health and Social Care Act 2008, providers must register for the types of service they provide. Most registrations are based on a review of documentation, but some involve visiting the provider if the registration assessor judges it necessary. Registration means that the Commission is satisfied that a provider is complying with the essential standards of quality and safety. Providers may be registered with conditions and have to provide the Commission with a plan of how they will meet the conditions.

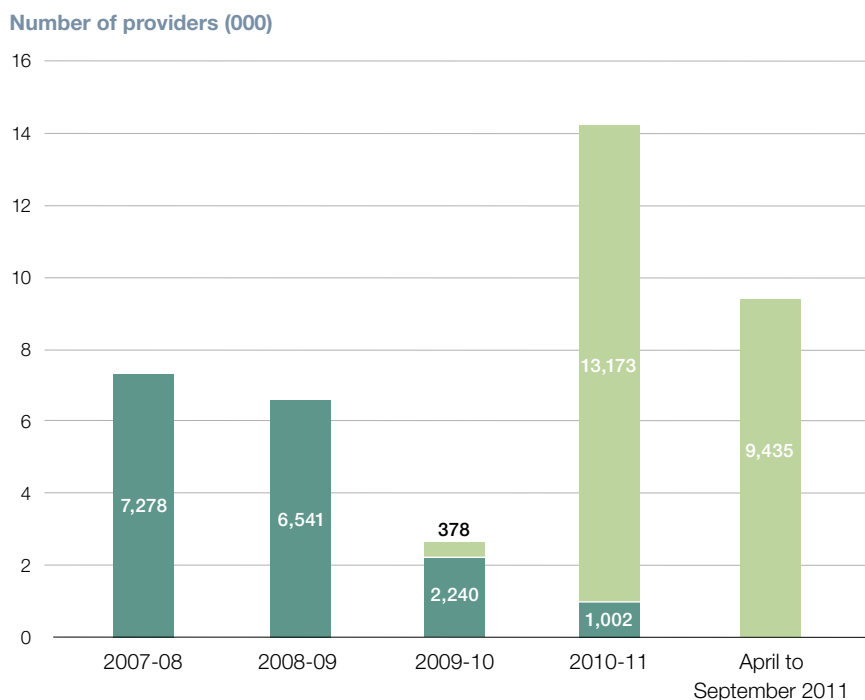
3.3 Registration was a new requirement for the NHS. Providers of adult social care and independent healthcare were previously registered under the Care Standards Act 2000 but had to re-register under the new legislation. Providers' previous registrations could not be transferred because the basis of registration is different (now by service provided rather than establishment). Also, the new essential standards focus more on outcomes (such as users receiving medicines they are prescribed, at the times they need them and in a safe way) rather than processes (such as having appropriate management structures and clear accountability).

Progress in registering providers

3.4 The timetable for registering providers did not allow time for the registration process to be tested properly. The process did not run smoothly and, although over 23,000 organisations were registered in total (**Figure 11** overleaf), the timetable for two out of three tranches of providers was not met. While existing providers could continue operating while awaiting registration, the public had no independent assurance that the providers concerned were complying with the new essential standards.

Figure 11

Number of health and adult social care registrations, 2007-08 to 2011-12



■ Provider registrations undertaken under the Care Standards Act 2000

■ Provider registrations undertaken under the Health and Social Care Act 2008

NOTE

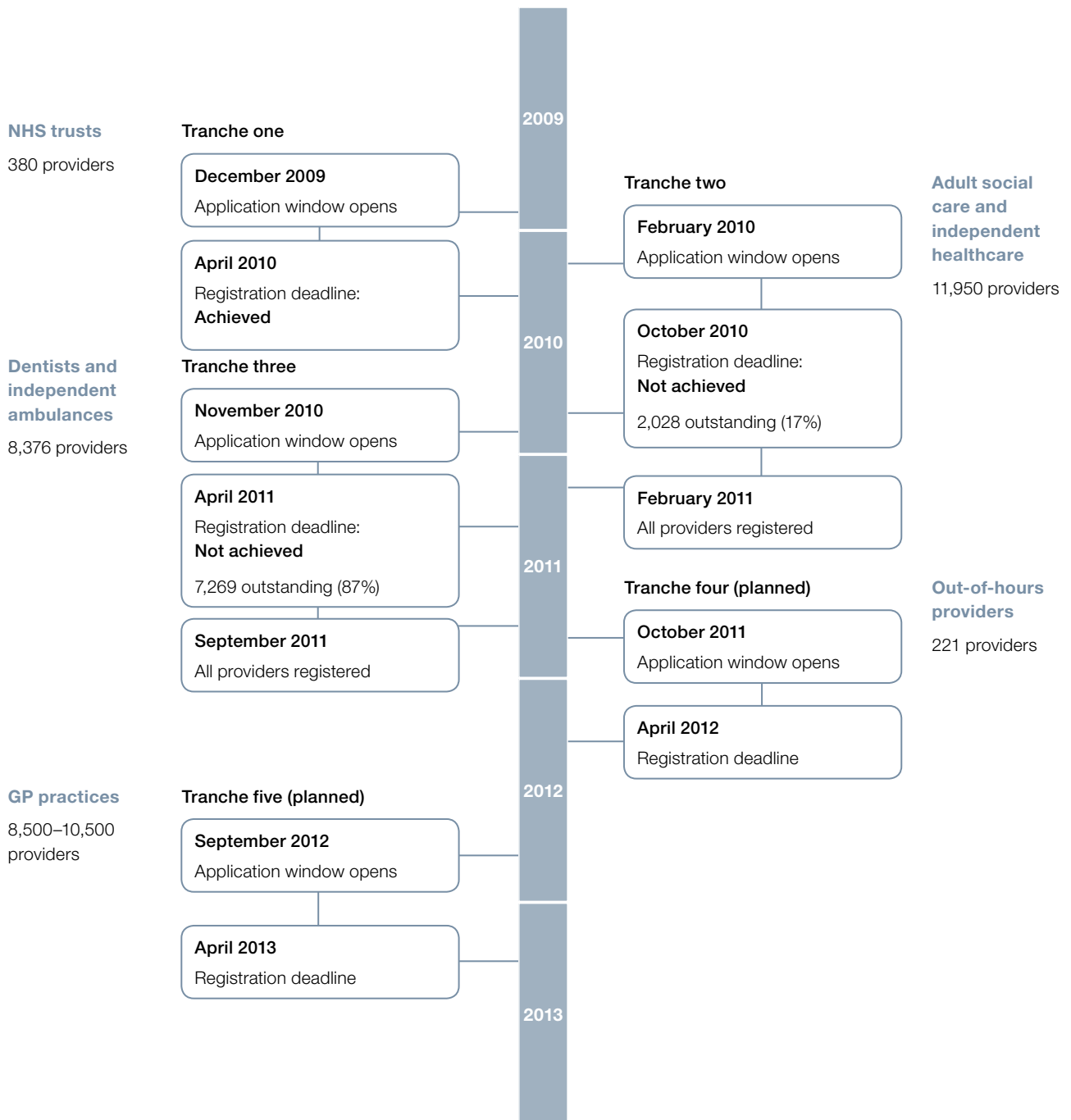
1 The Commission continued to register adult social care providers under the Care Standards Act 2000 prior to the Health and Social Care Act 2008 coming into force.

Source: National Audit Office analysis of Commission data

3.5 The registration timetable was set by the Department and given statutory authority in March 2010. To help the Commission handle the workload, the timetable was staggered with providers split into tranches according to type. A delay of two months in the Department finalising the registration regulations and their approval by Parliament created uncertainty about some of the details of registration for the Commission and providers. In November 2009, the Commission highlighted to the Department that the delay could potentially undermine effective delivery as it would not have time to test the system properly. The Department's view was that there was adequate time to carry out the necessary testing.

3.6 The Commission met the deadline to register the first tranche of 380 NHS trusts by April 2010 (**Figure 12**). It did not, however, complete the registration of the second and third tranches – covering adult social care providers and independent healthcare providers, and dentists and independent ambulances – by the set deadlines. Overall 47 per cent of providers were not registered on time.

Figure 12
The registration timetable and performance to date



NOTE

1 GP practices were originally in tranche four. The Department agreed to delay their registration by a year.

Source: National Audit Office analysis of Commission data

3.7 Registering adult social care providers and independent healthcare providers presented a particular challenge, not just because of the numbers involved but because the Commission had to:

- identify providers not previously registered who now fell within the scope of the legislation, such as some home care providers;
- explain the requirements to social care providers who had not previously had to re-register when a new regulator took over responsibility for the sector; and
- process a greater proportion (17 per cent more) of paper rather than electronic applications, than had been the case with NHS trusts.

3.8 Providers had a variety of concerns about registration. They criticised the process for being cumbersome and bureaucratic, and the use of a 'one-size-fits all' approach for all providers. The Commission's survey of providers, in May 2011, found that approximately 70 per cent of those questioned considered the application forms were 'poor' in terms of ease of use. The Commission rejected around 80 per cent of the forms it received in the first two tranches, and had to return them to providers to make amendments.

3.9 The Commission's initial arrangements for processing registration applications were inefficient: staff worked in separate teams checking different parts of the application; applications were not entered on the supporting IT system until the form was received by a registration assessor; and the software used to record customer interactions did not provide adequate management information.

3.10 The Commission did not collect data on how long it took to register individual providers in each tranche of registrations so it could not monitor this aspect of performance. Backlogs built up by December 2010 and the Commission could not issue notices and certificates for new registrations promptly. The delays meant that some providers' registration details were out of date on the Commission's website for the first nine months of 2011.

Business-as-usual registrations

3.11 The Commission's focus on registering the bulk tranches of providers had a detrimental effect on the time taken to process 'business-as-usual' registrations. The delays were frustrating, and potentially costly, for providers because new services could not be used until they had been registered.

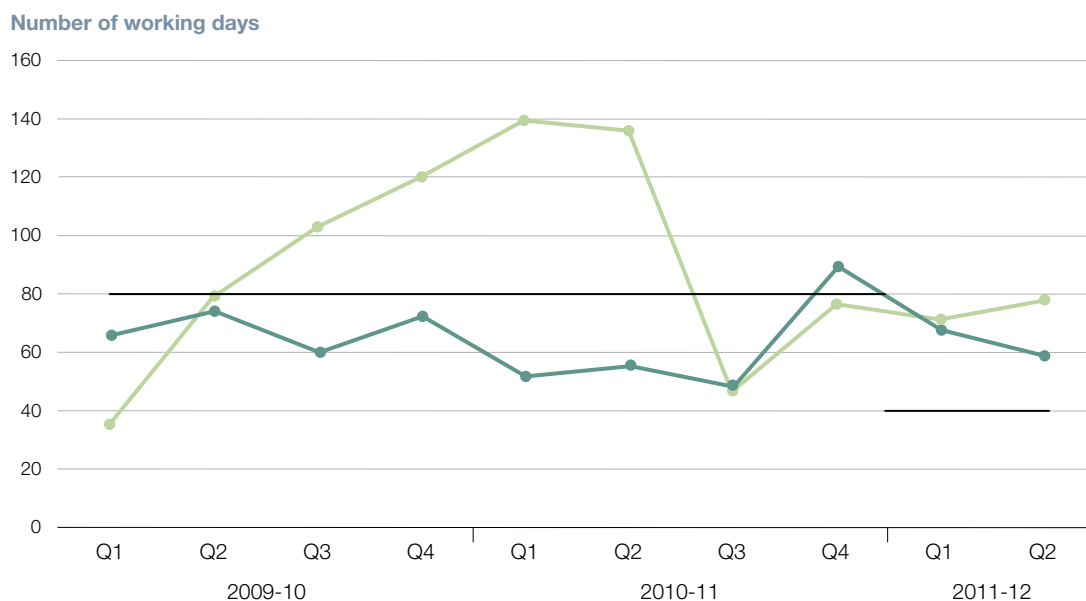
3.12 The Commission has a statutory duty to approve variations in providers' registrations and, along with other new applications, these form business-as-usual registrations. An application to vary registration is made where an existing condition needs to be changed. Minor variations, such as reducing the number of registered beds, require a review of supporting documents, whereas major variations, such as applying for a theatre to undertake procedures not previously specified, require an inspection.

3.13 The Commission has received more applications to vary registrations than it expected – on average over 1,600 applications a month during the first half of 2011-12. While previous regulators charged for all variations, the Commission does not charge for minor variations and providers may therefore be more inclined to register them.

3.14 Unlike the tranches of registrations described above, the Commission did monitor how long it took to process business-as-usual registrations. Performance against target was particularly poor for independent healthcare providers during the first half of 2010-11 (**Figure 13**). The time taken to process business-as-usual registrations has since improved, taking 60 working days on average in the first six months of 2011-12, although this was still above the revised target of 40 working days.

Figure 13

Average processing time for business-as-usual registrations, 2009-10 to 2011-12



	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
	2009-10				2010-11				2011-12	
● Independent healthcare	35	79	103	120	139	136	47	77	71	78
● Adult social care	67	75	61	74	53	57	50	91	69	60
— Target	80	80	80	80	80	80	80	80	40	40

Source: National Audit Office analysis of Commission data

Registering GP practices

3.15 The key test of whether the Commission has learnt lessons will be the registration of GP practices between September 2012 and April 2013. GP registration was originally scheduled to run from October 2011 to April 2012. However, in the light of the difficulties experienced with the second and third tranches and the backlog of business-as-usual registrations, the Commission asked for GP registration to be deferred. The Department agreed and gained the necessary Parliamentary approval, as it considered the delay would allow the Commission to streamline its approach and provide a more responsive service.

3.16 The Commission is seeking to apply a number of lessons learnt from previous tranches to the registration of GP practices, including:

- engaging with GPs earlier than was the case with other providers, and involving them in testing the process;
- developing a streamlined application process requiring considerably less information from providers; and
- developing improved online services (for example through integrated guidance and information on the status of submitted applications), which should reduce the administrative work the Commission has to carry out and make the overall process quicker.

3.17 The Commission has already implemented a streamlined approach for registrations relating to ex-Southern Cross homes. In July 2011, Southern Cross, then the UK's largest provider of adult social care, announced that it was to close down. It had a total of 31,000 residents in 750 care homes (581 of them in England), owned by approximately 80 different landlords. Other providers have since taken over these homes and their registration had to be undertaken quickly to ensure continuity of care, as they could not legally operate until they were registered for these locations.

Part Four

Ensuring health and adult social care providers comply with the essential standards of quality and safety

4.1 This part of the report covers the Commission's work to ensure that registered health and adult social care providers comply with the essential standards of quality and safety.

The Commission's approach to compliance

4.2 The Commission planned to review every provider at least once every two years and, beyond this, to adopt a risk-based approach to compliance. Compliance inspectors monitor the providers in their portfolio. Where information suggests a heightened risk that a provider is not complying with the essential standards of quality and safety (Appendix One), the inspector may carry out a 'responsive' review.

4.3 Each inspector monitors a mixed portfolio of health and adult social care providers. During 2010-11, the average size of an inspector's portfolio increased from about 50 locations to 62 locations. The Commission considers that portfolios should comprise around 30–40 locations, with complex and multiple-location providers shared evenly between inspectors. The recruitment of additional inspectors (paragraph 2.16) should allow the Commission to reduce portfolio sizes.

Information for monitoring providers

4.4 Inspectors need accurate and timely information about providers to make informed judgements about risk. The Commission has a systematic approach to assessing risk, but the effectiveness of the approach in practice depends on good quality data. This is not always available, particularly for adult social care providers, which makes risk assessment more difficult.

4.5 The 'quality and risk profile', which the Commission maintains for every provider, is central to the monitoring of risk. It provides an overview of the information held by the Commission on a provider. The profile is a webpage which sets out the risk, presented as dials, that a provider may not be meeting the essential standards of quality and safety (**Figure 14** overleaf). A red dial does not in itself indicate non-compliance with the essential standards; rather it indicates a higher risk of non-compliance and is intended to prompt inspectors to take action.

Figure 14

Data sources for quality and risk profiles



Source: National Audit Office

4.6 There are significant differences in the volume and quality of data available for health and adult social care providers. The quality and risk profiles for NHS trusts contain on average 500 data items, compared to only 50 data items for social care providers. The NHS is data rich and trusts must collect large amounts of activity, outcome and other data. In contrast, the data for social care is patchy and providing data, for example on staffing and skills, tends to be optional. The Commission is working to obtain more data sources for social care.

4.7 One potentially useful data source is financial information from providers' accounts and business plans. Financial difficulties increase the risk of unsafe or poor quality care as providers seek to cut costs, for example by reducing staffing levels. The Commission does collect financial information but does not use it to assess risk. Another data source that is not used in quality and risk profiles is complaints about adult social care providers to the Local Government Ombudsman.

Whistleblowing

4.8 The Winterbourne View case (Appendix Three) revealed shortcomings in the Commission's whistleblowing arrangements. In that case, timely action was not taken to deal with poor quality care.

4.9 Whistleblowing, when someone employed by a provider reports a concern, is a key source of information for compliance inspectors. When the Commission is contacted by a whistleblower, the information is passed to the relevant inspector. The inspector may use the information in a variety of ways, ranging from simply noting the concern to notifying the police if the information is about possible illegal activity.

4.10 In response to the Winterbourne View case, the Commission established a dedicated whistleblowing team and introduced a ‘track and chase’ system to support regional staff to monitor whistleblowing concerns and ensure they are followed up and issues are resolved. Whistleblowing information is not added to a provider’s quality and risk profile until the concern is substantiated, but is included in regional risk registers and reported to a central team, which monitors risk across the regions.

4.11 Regional risk registers are used to record and monitor the action being taken for providers where ‘major concerns’ have been identified. Major concerns are where service users are not experiencing the outcomes required by one of the essential standards and are not protected from unsafe or inappropriate care, treatment and support. In November 2011, the Commission had major concerns about 407 providers, 94 per cent of whom were adult social care providers. A considerable number of these major concerns were prompted by information provided by whistleblowers.

Compliance reviews and inspections

4.12 Individual compliance inspectors, in association with their manager, decide whether to conduct a compliance review, and then whether an inspection is needed. These decisions are a matter of judgement and there is no guidance for inspectors on how to decide when to initiate a review.

4.13 A report by the Commission’s internal audit team, in March 2011, raised concerns that some compliance inspectors did not have the knowledge and understanding of risk to segment and manage their portfolios effectively. It also noted that differences in approach were leading to inconsistencies within and between regions. We found that inspectors work from home when they are not visiting providers and tend to inspect alone, except for large providers, such as NHS trusts, when they work in teams. This may make it difficult for inspectors to share knowledge with, or seek advice from, their peers, increasing the risk of inconsistency. In addition, we noted that the Commission’s IT system does not allow inspectors to view risks across their entire portfolio, although this view is available to regional intelligence and evidence officers who provide support to compliance inspectors and managers.

4.14 Compliance reviews first consist of desk-based research, drawing on the quality and risk profiles and other sources of information. They cover all 16 essential standards. If the inspector has concerns or cannot confirm that the provider is complying with the essential standards, the inspector will gather more information by:

- asking the provider to send them further information;
- contacting service users and their relatives or carers;
- holding discussions with other stakeholders; or
- conducting an inspection.

4.15 An inspection involves visiting the provider to assess if the essential standards are being met. Since April 2010 most inspections have been unannounced (over 90 per cent since April 2011), although in some circumstances, providers are notified in advance, for example dentists who may have a day of appointments already scheduled. Inspections involve talking to staff, patients and relatives; observing the facilities and working practices; and reviewing written material such as care plans and training records.

4.16 The Commission aims to publish a report on its website within six weeks of an inspection, including its judgement about whether the provider is meeting the essential standards. Where it has concerns, the Commission may:

- set improvement actions, which the provider should take to maintain compliance;
- set compliance actions, which the provider must take to achieve compliance; and
- take enforcement action (paragraphs 4.25–4.27).

The number of compliance reviews

4.17 During 2010-11, the Commission prioritised registration over compliance, with the result that it did not meet its targets for compliance activity. This increased the risk that unsafe or poor quality care went undetected.

4.18 The Commission began compliance reviews under the Health and Social Care Act 2008 in April 2010 for NHS trusts and in October 2010 for adult social care and independent healthcare providers. Until 30 June 2010, the Commission continued inspecting social care providers under the Care Standards Act 2000.

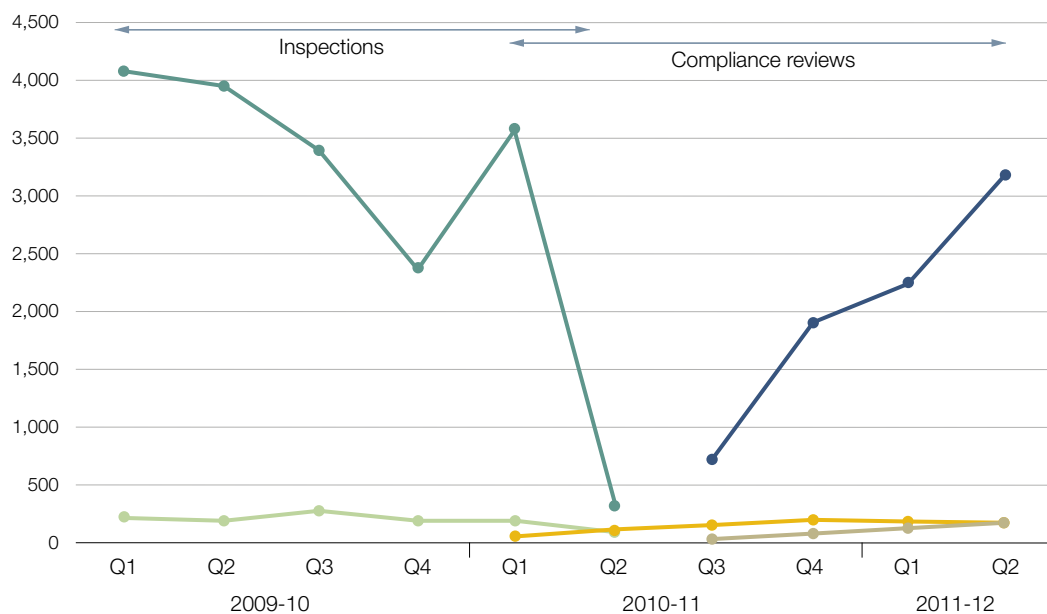
4.19 From a peak of 4,288 in the first quarter of 2009-10, the number of inspections and compliance reviews fell to a low of 511 in the second quarter of 2010-11 (**Figure 15**). However, a dip in activity was expected as the Commission does not carry out planned reviews of providers until at least three months after they have been registered.

4.20 In the first six months of 2010-11, the Commission completed 80 per cent of the target number of planned inspections under the Care Standards Act 2000. In the second six months of 2010-11, however, it completed only 47 per cent of its target number of compliance reviews. Performance is now improving and in the first quarter of 2011-12 the Commission completed 58 per cent of planned reviews, although it has not yet reached the level of activity achieved before registration started.

4.21 The Commission did not carry out the planned numbers of reviews because it switched inspectors to registration work. It judged that the risk of not meeting the statutory registration timetable was greater than that of not completing planned compliance work. The Commission does not, however, have data to show the extent to which resources were diverted or for how long. In addition, levels of compliance activity were adversely affected by the number of inspector vacancies (paragraphs 2.13–2.16).

Figure 15
Compliance activity, 2009-10 to 2011-12

Number of inspections under the Care Standards Act 2000 and number of compliance reviews under the Health and Social Care Act 2008



● Adult social care inspections	4,075	3,957	3,414	2,362	3,560	332				
● Independent healthcare inspections	213	195	271	205	194	85				
● NHS compliance reviews					50	94	152	186	173	179
● Adult social care compliance reviews							713	1,903	2,233	3,139
● Independent healthcare compliance reviews							21	78	121	172

NOTE

1 In the second quarter of 2011-12, compliance reviews of four independent ambulance providers and dentists were also undertaken.

Source: National Audit Office analysis of Commission data

4.22 Compliance reviews have not necessarily involved an on-site inspection, although most now do. In the first half of 2010-11, 30 per cent of reviews included an inspection, but this figure had risen to over 90 per cent by the first half of 2011-12.

4.23 Following the public reaction to the Winterbourne View case, the Commission is proposing to move away to some extent from a risk-based approach to compliance. It considers there is an expectation that inspectors will 'cross the threshold' more frequently and is therefore planning to inspect NHS, independent healthcare and adult social care providers at least once a year from April 2012, and dental and ambulance services at least once every two years. In preparation, inspectors have targets to inspect 75 per cent of their portfolios in 2011-12. The Commission estimates that these additional inspections will require an extra 229 compliance inspectors and 19 compliance managers. The Department has agreed to provide sufficient funding in 2012-13 for these extra staff.

4.24 The Commission is currently piloting a more focused approach to inspections to concentrate on those essential standards of quality and safety where inspectors judge there is a higher risk of non-compliance. The Commission also undertakes thematic reviews on areas where concerns about quality have been raised. For example, between March and June 2011, the Commission inspected dignity and nutrition standards across 100 NHS hospitals, focusing on the experience of older people. Concerns were identified in 55 hospitals. The national overview report was published in October 2011.⁴

Enforcement action

4.25 Where a provider is judged to be failing to meet the essential standards, the Commission can take a variety of enforcement actions (**Figure 16**). It aims to take proportionate but effective action, where possible securing compliance without recourse to more extensive and costly sanctions. There are, however, significant gaps in the Commission's data on enforcement, which make it difficult for it to manage this area effectively.

4.26 The Commission could not give us a breakdown of the types of enforcement action taken or the timescales involved. The type of action will depend on a number of factors, including the potential impact on service users and the provider's track record of compliance. In 2010-11, the Commission took a total of 510 enforcement actions. In adult social care, the number of actions decreased from 480 in 2009-10 to 221 in 2010-11. Over the same period, actions against NHS trusts increased from 5 to 13. In the first six months of 2011-12, the Commission took a total of 383 enforcement actions.

4 Care Quality Commission, *Dignity and nutrition for older people*, October 2011.

Figure 16

Possible enforcement actions

Enforcement action

Issue a warning notice outlining what a provider must do to achieve compliance within a given timescale.

Impose, vary and remove conditions of registration.

Issue a monetary penalty notice of up to £4,000 for failing to meet legal requirement(s) and causing unnecessary harm.

Prosecute the provider for failing to comply with the law and causing unnecessary harm. If convicted, the provider faces a fine of up to £50,000 and/or a prison sentence.

Suspend the provider's or manager's registration.

Cancel the provider's registration, making it a criminal offence for providers to continue to operate.

When used

When a provider can achieve compliance without posing a risk to service users while it makes necessary improvements.

When the essential standards are not being met on a localised level. Avoids disrupting an entire service.

When a provider can achieve compliance without disrupting an entire service. Avoids other lengthy and costly action.

After a provider has been issued with a warning notice but continues not to comply with the essential standards.

If evidence shows a provider or manager is not able to meet the requirements but will be capable of doing so in the future.

Following efforts to achieve compliance or where people are at immediate risk of serious harm.

Source: Care Quality Commission

4.27 Providers have 28 days to appeal against a notice of proposed enforcement action. The process can be shortened by the Commission and the provider agreeing a 'truncated warning notice' of 14 days, or extended if the provider appeals and the case is heard by a care standards tribunal. Under the terms of the Health and Social Care Act 2008, the Commission does not make public information about enforcement action during the appeal period. After the appeal period or if an appeal is unsuccessful, the Commission usually issues a press notice to make the public aware that enforcement action is being taken against the provider concerned.

Appendix One

The essential standards of quality and safety

1 Respecting and involving people who use services	Users are involved in discussions about their care and treatment. Their privacy, dignity and independence are respected.
2 Consent to care and treatment	Where users are able, they consent to the examination, care, treatment and support they receive.
3 Care and welfare of people who use services	Users experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
4 Meeting nutritional needs	Users are supported to have sufficient food and drink to meet their dietary requirements.
5 Cooperating with other providers	Users receive safe and coordinated care where more than one provider is involved or they are moved between services.
6 Safeguarding people who use services from abuse	Users are protected from abuse or the risk of abuse and their human rights are respected and upheld.
7 Cleanliness and infection control	Users experience care in a clean environment where they are protected from infection.
8 Management of medicines	Users have the medicines they are prescribed, at the times they need them, and in a safe way.
9 Safety and suitability of premises	Users are in safe, accessible surroundings that promote their well-being.
10 Safety, availability and suitability of equipment	Users are not at risk of harm from unsafe or unsuitable equipment. They benefit from equipment that is comfortable and meets their needs.
11 Requirements relating to workers	Users are safe and their health and welfare needs are met by fit, appropriately qualified and competent staff.
12 Staffing	Users are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

13 Supporting workers	Users are safe and their health and welfare needs are met by staff who are trained and well supervised, and receive the development opportunities they need to carry out their role and keep their skills up to date.
14 Assessing and monitoring the quality of service provision	Users benefit from effective decisions and the management of risks to their health, welfare and safety.
15 Complaints	Users or others acting on their behalf can be sure that their complaints and comments will be listened to and acted on effectively.
16 Records	Users are confident that their personal records, including medical records, are accurate, fit for purpose, held securely and remain confidential.

Appendix Two

Methodology

Method	Purpose
Analysis of data	To identify the Commission's performance and trends in: <ul style="list-style-type: none">● funding, spending and staffing;● activity levels; and● results against targets.
Review of key documents	To identify: <ul style="list-style-type: none">● key challenges faced by the Commission; and● public and provider views on the Commission.
Interviews with staff at the Commission and the Department	To identify: <ul style="list-style-type: none">● key challenges faced by the Commission; and● reasons for performance trends and actions taken to address issues identified.
Observation of inspections	To identify: <ul style="list-style-type: none">● how the Commission carries out its inspections; and● how inspectors make their judgements.
Consultation with stakeholders	To identify: <ul style="list-style-type: none">● key challenges faced by the Commission; and● user and provider views on the Commission.

Appendix Three

Events at Winterbourne View

1 On 31 May 2011, a BBC *Panorama* programme exposed serious abuse of patients by staff at Winterbourne View, a private residential hospital in Bristol owned by Castlebeck Care (Teesdale) Ltd. Winterbourne View provided services for people with learning disabilities. **Figure 17** shows the inspections that had been undertaken of Winterbourne View.

2 BBC *Panorama* secretly filmed the hospital after being approached by a senior nurse who used to work there. The nurse had previously provided information to the Commission, and the programme was critical of the way in which the Commission had acted on the information it received.

3 Following the programme, the Commission confirmed it had received information from a whistleblower. It stated that the information provided was limited and different in scope to the issues raised in the programme, but recognised that, if it had contacted the whistleblower immediately, it would have been alerted to the seriousness of the situation.

Figure 17
Inspections of Winterbourne View

Date	Event	Detail
1 December 2008	Unannounced inspection by the Healthcare Commission	Result – Not compliant with regulations
24 March 2009	Unannounced inspection by the Healthcare Commission	Follow-up inspection Result – Still not compliant
15 December 2009	Announced inspection by the Care Quality Commission, as part of the registration process	Risk-based inspection following two statutory notices Result – Registered with requirements

Source: National Audit Office

4 Instead, the Commission passed the information received from the whistleblower to South Gloucestershire County Council, in November 2010, but did not follow-up to check what action had been taken. A serious case review has been commissioned by South Gloucestershire Safeguarding Adults Board to investigate why a safeguarding meeting on Winterbourne View was delayed until February 2011.

5 Castlebeck Care (Teesdale) Ltd closed Winterbourne View on 24 June 2011, and launched an internal investigation into its own whistleblowing procedures.

6 Since the programme was broadcast, the Commission has inspected all 23 of the properties and services owned by Castlebeck Care (Teesdale) Ltd. Nearly half were judged to be non-compliant with the essential standards of quality and safety. In four of the non-compliant homes, patients were found to have suffered ill-treatment. Two of these homes have since closed.



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