National Audit Office

Report
by the Comptroller
and Auditor General

Care Quality Commission

Capacity and capability to regulate the quality and safety of health and adult social care

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Summary

1 The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. Its purpose, as set out in its published strategy, is to "make sure health and social care services provide people with safe, effective, compassionate, high quality care, and to encourage them to improve". The Commission is a non-departmental public body, sponsored by the Department of Health (the Department).

2 We concluded in 2011 that the Commission had not provided value for money. In March 2012, the Committee of Public Accounts reported that the Commission was a long way off becoming an effective regulator and that, despite evidence of failings, the Department had been slow to act. The Commission has since been working with the Department to implement significant changes, under a three-year transformation programme between 2013-14 and 2015-16.

3 This report focuses on the Commission's progress in putting its transformation strategy in place, and its capacity to implement its new approach. Because it is too early to conclude on what impact the Commission is achieving we will report in due course on how well the Commission's regulatory model works in practice.

4 We explain our audit approach in Appendix One and our evidence base in Appendices Two and Three. Appendix Four summarises the Commission's progress against recommendations that we and the Committee of Public Accounts made.

Key findings

Response to criticisms and new challenges

5 The Commission has made substantial progress since public concerns were first raised in 2011, and is in the process of embedding changes to its regulatory approach. Between late 2011 and early 2013, a series of internal and external reviews recommended changes to the Commission's capability and regulatory approach. In April 2013, the Commission published a transformation strategy for 2013-14 to 2015-16 proposing radical changes to how it regulates health and social care (paragraphs 1.4 to 1.8).

6 The Commission's new regulatory model strengthens the way it expects to monitor and inspect hospitals, adult care providers and GPs. Most providers (91%) the Commission surveyed in 2014 said they were aware of its new approach. The survey shows that providers remain extremely cautious, however, about whether inspectors are equipped to apply the new approach in practice (paragraphs 1.9 to 1.10 and 1.17).

7 The Department has placed additional expectations on the Commission that increase risk to achieving its transformation strategy. The Commission has not yet finished implementing all of the changes in its strategy. However, the Department gave it new responsibilities, from April 2015, to oversee the financial sustainability of the largest adult social care providers. It announced in June 2015 that the Commission would also assess the financial efficiency of hospital trusts. As a result, the Commission has needed to recruit new skills for its market oversight role. It will now need to develop the expertise needed for its responsibilities to assess financial efficiency, and is still evaluating the potential impact of this work on its resource model (paragraphs 1.2 and 2.19).

Staff skills and capacity

8 The Commission does not know how accurate its staffing model is because it relies on assumptions that are still being tested on the ground. The Commission's new regulatory model was introduced for hospitals in July 2013 and adult social care providers and GP services in October 2014. The Commission does not yet know with certainty how many providers will need to be re-inspected, and the consequent workload, because so far 91% of providers have not been inspected and rated under the new model (paragraphs 2.1 and 2.2).

9 The Commission has made progress recruiting new staff, but does not yet have enough people to do all its work. By mid April 2015, it had reached its initial target to recruit 300 inspectors by the end of April. It now plans to make job offers to 300 more inspectors by December 2015. Because of staff shortages, the Commission deferred target dates for inspecting providers. But it also has staff shortages in other parts of its business, particularly among analysts. The Commission decided that it could rely to a greater extent on analysis of mortality risk indicators undertaken by the Dr Foster Unit at Imperial College, and it has reduced the frequency with which it generates new alerts from scanning maternity outliers (paragraphs 2.4 to 2.8, and 3.19).

10 In the 2014 staff survey, 40% of staff agreed or strongly agreed they had the training and development they needed to do their job, and 38% said that the training they received was effective. The Commission established a learning and development Academy to provide role-specific training, which went live in March 2014. The Academy started providing e-learning and face to face training on new enforcement powers from January 2015. New inspectors have one week's corporate induction and six weeks' role-specific training before joining their teams (paragraphs 2.10, 2.13 and 2.14).

11 The Department expects the Commission to make fuller use of its authority. In the past, inspection teams did not know enough about the Commission's enforcement powers to take effective action. The Commission has now made enforcement part of inspectors' mandatory training. It took on new powers in April 2015 that make it easier to bring prosecutions where it finds that poor care is harming service users (paragraphs 2.12 and 2.13).

12 The Commission started overseeing the financial health of adult social care providers before having in-house expertise fully in place. From 6 April 2015, the Commission must notify relevant local authorities if it considers any of the 43 largest adult social care providers is at risk of exiting the market. The Commission's board recognised that building new skills and capability represented a substantial risk, and the Commission is drawing on external consultancy support. When it took on its new responsibilities, senior members of the team were not in post. Two of the three people for these roles joined the Commission in May. In the interim, the Department is sharing responsibility by overseeing the largest providers. The Commission is still recruiting for the third senior post (paragraphs 2.17 to 2.21).

Knowledge and information

13 The Commission rejects many paper applications to register providers because they contain errors. In 2014-15, the Commission processed 81,840 applications to add or change registrations. Of these, 39,061 (48%) were returned, not required or withdrawn, representing wasted effort and cost for both the Commission and applicants. Over 1,700 applicants used the wrong form. After successfully registering GPs online in 2013, the Commission plans to introduce an online system for adult social care providers during 2015-16 (paragraph 3.11).

14 The Commission is using data more effectively to plan inspections, particularly for acute trusts. Sir Robert Francis' second inquiry into failings at Mid Staffordshire NHS Foundation Trust concluded it was essential the Commission improve the way it uses information to monitor risk. The Commission has long used routinely available information to assess risk. It now makes a clearer distinction between indicators of risk (tier 1) and indicators that support inspection planning (tier 2). For acute trusts, the Commission reduced the amount of information it analyses from around 1,400 items to 115 tier 1 indicators (paragraphs 3.1 to 3.3).

15 In contrast to the national datasets available for hospitals and GP services, the Commission does not have access to routine information about adult social care good enough to monitor risk or trigger inspections. Some 13,000 adult social care providers operate services in more than 25,000 locations. However, because there are no national datasets comparable to those available for hospitals and GPs the Commission relies heavily on manual forms to collect information before inspections. It is developing an online system for providers to keep updated that it expects to implement in October 2015 (paragraphs 3.12 to 3.13 and 3.17).

16 There is a risk the public will believe a newly registered provider is complying fully with the Commission's standards when they are not. When it receives a new application the Commission assesses systems and processes, inspects premises, and interviews applicants to judge whether they have the capacity and capability to provide a well led service which is likely to comply with regulations. Registration of a new provider cannot give the same level of assurance as inspection, because it is done before people actually use a new service. There can be more assurance when the Commission registers a change of provider. Even in these cases, however, there may be a new management team responsible for the service, or a provider may be registering to offer new services. The Commission set itself a performance indicator for the proportion of new providers needing regulatory action on first inspection, but has not published a target for what it believes is reasonable. In 2014-15, one out of three newly registered providers needed regulatory action after their first inspection (paragraph 3.10).

Accountability, leadership and governance

17 The Department and the Commission have taken appropriate, and very substantial, action in response to criticism of the Commission's governance and leadership. The Commission's executive team is completely different to when we reported in 2011. The Department appointed a new chair of the Commission in December 2012 and expanded the non-executive board. The Commission's governance structures and processes are now consistent with best practice in many areas. It is not doing the amount of board development work, including periodically evaluating the board's effectiveness, that would match best practice or the Department's expectations (paragraphs 4.2 to 4.7).

18 The Commission published in its 2015-16 business plan a comprehensive and logically structured performance framework. This included measures of timeliness, quality and patient feedback. The Commission set a specific target for 6 of the 37 measures in the business plan. We also found that for 6 of the 37 measures there is no baseline data because the model is different to before. Until it sets specific targets or benchmarks, the Commission risks the public expecting it to be more a guarantor of quality and safety than is realistic (paragraphs 4.12 to 4.14).

19 From 2015-16, the Commission will be able to make a reasonable estimate for the full cost of its regulatory activities. The Commission has adopted a 'top-down' approach based on budget data to apportion costs to the different parts of its operating model based on assumptions about predicted headcount in each function. It validates the costing model annually with a retrospective 'bottom-up' exercise. Updating the underlying assumptions is important because the Commission's approach apportions approximately half of its budget. The Commission's ability to measure its own costs, and demonstrate its cost-effectiveness, will be increasingly important as it increases the proportion of its costs recovered through fees (paragraphs 4.18 to 4.19).

20 Work is still needed to manage public expectations about what the Commission can and cannot achieve. The Commission's public awareness survey in 2014 found that just over half of respondents (55%) had heard of the Commission. This compares with 93% that had heard of Ofsted and 4% that had heard of Monitor. Its national customer service centre handles a high number of enquiries and concerns from the public which informs its intelligence about providers. However, it does not have the power to resolve individual cases. It has been improving links with ombudsmen to help direct concerns to the most relevant body, and is exploring ways to make better use of this information to assess risk (paragraphs 1.13 to 1.16 and 3.6 to 3.7).

Conclusion on value for money

21 Over the last two years and in the face of sustained criticism, the Commission has made substantial progress to change its regulatory model. It is developing a more intelligence-driven approach to regulation, relying more on data to target intervention. The Commission has designed a coherent model that sets out, in principle, connections between resources, activities, outputs and outcomes. From 2015-16, the Commission is better able to estimate how much inspections and other regulatory activities cost. So far, however, it has much more limited information for assessing efficiency or effectiveness, or measuring its overall impact on the quality of care.

22 Further challenges lie ahead to demonstrate value for money. The Commission has made progress but has a substantial challenge to recruit and train all the staff it still needs. The Commission predicts that, when at full complement, a third of staff will have been in post for less than 12 months, and existing staff have experienced significant changes. The Commission needs to build an organisational culture that gives its people the confidence, as well as the skills, to apply the regulatory model assertively, fairly and consistently. It also needs more complete data about regulated bodies, particularly in the adult social care sector, and better quantified indicators of its own performance. Managing public expectations about how far and fast it can achieve this, at the same time as it takes on new responsibilities, is a substantial demand.

Recommendations

a The Commission should reinforce and develop formal and informal mechanisms for sharing knowledge between inspectors across its three directorates. By requiring inspectors to specialise in acute care, adult social care or primary care the Commission has addressed past criticism that inspectors lacked the sector-specific skills they needed. If taken too far, however, there is a new risk that staff in the three directorates may work in too much isolation. This runs contrary to developments in other parts of the health service for more integrated care.

b The Commission should review how useful its intelligent monitoring information is once it has completed the first cycle of inspections. The Commission's ambition is that intelligent monitoring will help it identify risk and increase its efficiency in carrying out inspections. So far, there is limited evidence that it is having this impact, partly because of limitations in the data.

c The Commission should make better use of information from service users as part of its intelligent monitoring data. It has explored partnerships with organisations such as Age UK. It also manually codes around 6,000 comments from websites such as NHS Choices each month. But so far this has not increased the amount of intelligence it can act on. As it develops online systems for real-time monitoring, particularly for adult social care, it should explore the scope to integrate more feedback from users.

d The Department of Health and the Commission should agree quantified performance measures. These should include targets for the Commission's efficiency. For measures of the Commission's impact on the quality and safety of services, it should use 2015-16 data to set a baseline for 2016-17, against which future changes in performance can be tracked. Few of the Commission's published performance indicators currently have a quantified baseline or target. This makes it difficult for the Department to hold the Commission to account, and for service users to assess whether the Commission is meeting the standards they should expect. As well as strengthening public accountability, this would help address a risk that the public expect the Commission to achieve more than it is able to do.

e The Department should not add to the Commission's responsibilities and workload without assessing the impact on its existing capability. The Commission is still in the third year of its change programme, and it is building staff numbers and skills for its existing functions. In April 2015, it took on additional responsibilities, demanding new expertise, for market oversight of adult social care providers. The Department has now asked it to build additional capability for assessing the efficiency of hospitals. There is a risk that the demands of quickly meeting successive new responsibilities will undermine progress the Commission is making to strengthen its ability to regulate care quality.

f The Commission should evaluate its board's effectiveness each year. The Commission reviewed its committee structures in 2015, but had not carried out other reviews for the previous three years. It is good practice for organisations to evaluate their board's effectiveness at least annually.

g Operational changes need to be supported by changes to organisational culture. Staff survey results, so far available up to 2014, show that morale and confidence in the Commission's leadership are improving, but that there needed to be more of an embedded learning culture. It will need to test the impact of more recent initiatives particularly by analysing free-form comments in the 2015 staff survey.