National Audit Office

Report
by the Comptroller
and Auditor General

Care Quality Commission

Care Quality Commission – regulating health and social care

HC 409 SESSION 2017–2019 13 OCTOBER 2017

Key facts

£222m

the Commission's operational expenditure in 2016-17 (see Figure 10)

13%

reduction in the Commission's funding between 2015-16 and 2019-20

49,355

number of active provider locations regulated by the Commission as at June 2017

January 2017	date at which the Care Quality Commission (the Commission) completed its inspection and rating programme of hospitals, adult social care providers and GP practices
82%	proportion of all providers (hospitals, adult social care providers and primary medical services providers) with a 'good' or 'outstanding' rating as at quarter one 2017-18
66%	proportion of the Commission's funding that came from provider fees in 2016-17
1,910	number of enforcement actions that the Commission took during 2016-17
£13 million	reduction in the Commission's spending in 2016-17 compared with 2015-16 (see Figure 10)
6%	vacancy rate for inspectors as at the end of June 2017

Summary

1 The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. It is a non-departmental public body accountable to Parliament, sponsored by the Department of Health (the Department). The Commission has two main purposes: to make sure health and social care services provide people with safe, effective, compassionate, high-quality care; and to encourage providers to improve the quality of care.

2 The Commission regulates providers across three sectors: hospitals, adult social care and primary medical services. It registers, monitors and inspects providers, and publishes its assessments and provider ratings. The Commission can also take enforcement action when care falls below fundamental standards.

3 We have reported on the Commission twice before, in 2011 and 2015. Our 2015 report found that the Commission had made progress in updating its regulatory model. However, challenges remained around its ability to assess its overall impact, establish a stable workforce, improve its data on regulated bodies and monitor its own performance. Following the Committee of Public Accounts' (the Committee) report in December 2015, the Committee requested further work to assess the progress the Commission was making.

4 Since our 2015 report, the Commission has introduced a new five-year strategy, which includes a move to a more intelligence-driven regulatory approach, and its funding will reduce by 13% between 2015-16 and 2019-20. These changes come at a time when health and social care providers are facing very high levels of demand and financial challenge. The Commission has also implemented new responsibilities, including from April 2015 the market oversight of 'difficult-to-replace' providers of adult social care.

5 This report looks at whether the Commission is taking appropriate action to address the risks to people's care through examining:

- the extent to which the Commission's current performance is ensuring high-quality care and encouraging improvement;
- how the Commission uses its resources and measures its performance; and
- how the Commission is preparing to implement its new strategy with a smaller budget and for potential longer-term changes in the delivery of care.

6 In looking at the Commission's regulatory activity we focus on its core functions of: registration; monitoring; inspecting and rating; and responding to concerns and taking enforcement action.

Key findings

Undertaking the Commission's core regulatory functions

7 **The Commission has completed its inspection and rating programme, comprising more than 28,000 provider locations.** The Commission fulfilled its programme to inspect and rate NHS hospitals, adult social care providers and GP practices in January 2017. For the first time, this provides a baseline assessment of the quality of services across England. The Commission completed the programme in line with its 2016-17 business plan commitments, having missed earlier target dates due to difficulties in recruiting inspectors (paragraph 2.14).

8 **There remain a number of operational issues with the Commission's registration of providers.** In 2016, the Commission established a registration improvement programme to address a number of issues, including the speed and burden of registration. For all three sectors the Commission regulates, it did not meet its key performance indicator to complete the registration process for 90% of cases within 50 days during 2016-17, although performance on the indicator did improve (paragraph 2.2).

9 **The Commission introduced a new key performance indicator in 2017-18 for when it inspects newly registered providers, which in quarter one it met for primary medical services providers but did not meet for adult social care providers.** Registration is the point at which the Commission assesses a provider's potential to provide a good-quality service; inspection provides assurance about the actual quality of services. For 2017-18, the Commission has introduced a key performance indicator of 90% (100% for adult social care) of newly registered locations to be inspected within specified time periods based on the date of registration. Figures for quarter one 2017-18 show that 100% of newly registered primary medical services providers received a first inspection within the target timescales, with 94% of newly registered adult social care providers inspected within targets. In this quarter, 49% of the primary medical services and 42% of adult social care first inspections were undertaken within one year of the provider being registered (paragraphs 2.3 and 2.4).

10 **The Commission's systems for bringing information together on the quality of services are not supporting inspectors effectively.** Inspection staff must deal with a high volume of both centrally collated data and local intelligence to assess the quality of services and decide what action to take. A major part of the Commission's plan to improve its central support for inspectors is its new Insight model. This brings together key indicators on provider performance and service quality. Our focus groups with inspection staff highlighted concerns about how well the broader information systems currently supported them, in particular the main system (the Customer Relationship Management system) used to collate information. Our focus groups and interviews with inspection staff and local stakeholders also highlighted variations in local working relationships and information-sharing (paragraphs 2.6 to 2.12).

11 Most providers and inspectors think that the Commission's judgements are fair but some stakeholders have concerns about consistency. The Commission's surveys show that the majority of providers and inspectors think inspection judgements and ratings are fair. However, some stakeholders we spoke to raised concerns about inconsistency in the Commission's regulatory judgements. They cited examples of individual inspectors being subjective or inconsistent and questioned the consistency and profile of ratings within and across sectors. The Commission seeks to address consistency issues through its quality assurance processes and training (paragraphs 2.15 and 2.16).

12 The Commission has not met its timeliness targets for publishing reports. Across the three sectors it regulates, the Commission did not meet its overall target of publishing 90% of inspection reports within 50 days during 2016-17 and quarter one 2017-18, although performance did improve. The biggest gap between target (90% in quarter one 2017-18) and performance (25%) was for hospitals with less than three core services. It is taking a range of actions to improve its performance (paragraph 2.17).

13 The Commission introduced new key performance indicators in 2017-18 for when it re-inspects providers, which it met for primary medical services and did not meet for adult social care in the first quarter. The Commission introduced a key performance indicator in 2017-18 to undertake 90% of re-inspections within agreed maximum time periods. Performance in quarter one 2017-18 against the new performance indicator was 84% for adult social care and 93% for primary medical services. Prior to this, it committed to re-inspect adult social care providers within specified guidelines for 2016-17, of which 84% were undertaken in line with the guidelines (paragraph 2.18).

14 The Commission meets its target for referring safeguarding alerts within one day, but does not meet its timeliness target for taking further action. The Commission receives a significant volume of concerns about the quality of services from people using services, carers and staff (whistleblowers). Safeguarding alerts are particularly important as the Commission is the first organisation to receive the information, and the Commission met its target for referring safeguarding alerts to the appropriate authority within one day during 2016-17 and quarter one 2017-18. However, although performance is improving, it missed its 95% target for taking further action within five days following a safeguarding alert or concern during 2016-17 and quarter one 2017-18 (89% in quarter one 2017-18) (paragraphs 2.19 to 2.21).

15 The Commission increasingly takes action when care falls below fundamental standards. The number of completed enforcement actions increased over 2015-16 and 2016-17, while the number of providers entering special measures remained steady. The Commission links the increase with a focus on improving its inspectors' skills and knowledge about enforcement. However, poor recording means the Commission cannot be assured that enforcement action is always completed (paragraph 2.22).

Encouraging providers to improve

16 There is evidence that the Commission is influencing providers to improve. Over the course of 2016-17 and quarter one 2017-18, most of the providers rated either 'inadequate' or 'requires improvement' improved their rating on re-inspection. The Commission does not provide direct support to providers to improve but seeks to influence quality through other routes. The Commission's 2017 provider survey shows that most hospitals and adult social care providers think the Commission is helping them to improve, but GPs do not value the Commission's regulation as highly (paragraphs 1.2, 2.23 to 2.25).

The Commission's use of resources

17 The Commission is focusing more on savings and has a better understanding of its own costs. The Commission underspent on its budget between 2012-13 and 2016-17. Until 2016-17, this was mainly because it did not meet target staffing levels. In 2016-17 most of its underspend (£8 million out of £14 million) was made up of non-pay cost savings. For the first time since 2011, the Commission reduced its year-on-year spending, by £13 million, or 6%. The Commission has a better understanding of its own costs, through developing a more comprehensive costing model. The Commission is also moving to recover the full cost of its core regulation activities from provider fees, and will need to manage future relationships with providers carefully (paragraphs 3.2 to 3.5).

18 The Commission's staff vacancy rates have fallen. The Commission has run successful recruitment campaigns including the 'project 600' campaign for inspectors. By the end of June 2017, vacancy rates were 6% for inspectors, 0% for inspection managers and 16% for senior analysts, compared with 34%, 35% and 36% respectively in April 2015. Overall staff turnover rates increased from 7.6% at the end of March 2015 to an average of 12.2% for the 12 months ending June 2017, so the Commission must continue to manage the risk of staff shortages (paragraphs 3.6 and 3.7).

Performance measurement and accountability

19 The Commission has improved how it measures its performance and takes action to correct poor performance. Since our 2015 report, the Commission has: introduced targets and baselines for its operational key performance indicators; published a report of its impact on quality and improvement; and identified a set of indicators to measure the impact of its new strategy. The Commission is transparent about its performance and publishes a wide range of information. We found examples where the Commission has taken action to correct poor performance, for example setting up the registration improvement programme (paragraphs 3.8 to 3.10).

20 The Commission is held to account appropriately by its board and the Department. A recent independent review of the Commission's board concluded that it was effective. We assessed that the Department has put in place an appropriate framework for holding the Commission to account, although it will need to maintain an adequate level of oversight, challenge and support with reduced resources (paragraph 3.11).

21 The Commission has made reasonable progress against the Committee's recommendations. In 2015, the Committee made six recommendations covering areas such as staffing, measuring performance, publishing inspection reports and engaging with people who use care and the public. The Commission has made good progress against three recommendations, good/adequate progress against one, adequate progress against one and adequate/poor progress against one (paragraph 3.11).

Developments in the Commission's regulatory approach

22 The Commission made progress in implementing its new strategy during 2016-17, but missed some important milestones. During 2016-17, the Commission made good progress against many of the activities set out in its business plan. However, it missed milestones on rolling out use of resources assessments, designing its approach to the next phase of inspection and improving the way it collects information on providers (paragraphs 4.5 and 4.6).

23 Within the risks that the Commission has identified, we have highlighted three areas where effective management is particularly important for its implementation of a more intelligence-driven approach to regulation and meeting savings targets. These comprise:

- programme management and governance of digital transformation;
- aligning developments in collecting and collating information with other elements of the Commission's strategy; and
- maintaining flexibility to adapt to changes in the external environment. (paragraph 4.7)

24 The Commission is preparing for new ways that care might be delivered. New models of care could have implications for the Commission. For example, providers may work more in partnership and potentially change their legal structure. The Commission and the Department are confident that the current legislative framework is sufficiently flexible to cater for emerging new models of care. The Commission is taking action to ensure that it remains engaged with providers as new care models emerge. It is already responding to changes such as online primary medical services (paragraphs 4.8 to 4.12).

Conclusion on value for money

25 The Commission has improved as an organisation. It has completed its inspection and rating programme, which provides a benchmark of the quality of health and social care services. It has significantly reduced staff vacancies and is increasing its focus on cost savings. It has improved how it measures its performance. There is evidence that it influences providers to improve quality. There remain some concerns about the consistency of its regulatory judgements. Value for money is improving and the Commission can secure further improvement, if it continues its current direction of travel.

26 The Commission needs to overcome some persistent issues with the timeliness of some of its regulation activities if it is to sustain further improvement. Its ambition to base more of its regulatory activities on intelligence and risk-based information introduces significant challenges. These must be carefully managed and supported by digital systems and capabilities if it is to minimise the risk of missing poor care. The Department and Commission must also be realistic about its capacity to take on new responsibilities in this period of change. It must fulfil and improve upon its core responsibilities, in an environment of changing health and social care delivery, and continuing pressures on service quality.

Recommendations

27 Our recommendations are designed to reinforce the current actions the Commission is taking, and to help it refine and adapt its regulation approach.

28 The Commission should:

a Clarify key dependencies within its new strategy and the impact any delays in development might have on other aspects of its strategy. Two key areas are its development of its digital capacity and its work to develop information collection and systems.

b Ensure that digital systems effectively support inspection staff by bringing information together and helping to identify emerging risks to people's care.

c Assess how inspection staff engage with other local stakeholders and share information. The results should be used to develop approaches that will support staff in improving local engagement and maximise local intelligence.

d Review the activities it currently uses to test and demonstrate consistency in inspection approaches and judgements. This review should include: discussions with providers, provider representative organisations and its own inspection staff to understand the concerns they have about consistency; and engagement with other regulators to understand how they approach this issue.

e Set out how it will get assurance that its inspection staff are taking consistent and appropriate decisions about regulatory action in response to intelligence. This might involve, for example, in-depth review of a sample of concerns or providers.