Dear Dr Wollaston,

Health and Social Care Committee Inquiry into CQC’s ‘State of Care 2017/2018’

I am writing in follow up to the oral evidence session held on 30 October, as part of your inquiry into the Care Quality Commission (CQC) and our ‘State of Care 2017/18’ report. I wanted to provide further information on some of the topics that were discussed during the session as well as on the issues that the Committee requested we wrote back to you on:

- CQC’s intelligence-driven approach
- How CQC engages the public
- CQC’s work with NHS Improvement
- The NHS 10-year plan
- The local system reviews
- How CQC is supporting innovation in health and care
- Whistleblowing concerns
- Allegations of bullying at South Western Ambulance NHS Foundation Trust
- CQC’s position on the Mental Health Act (MHA) Review
- The regulation of private screening clinics

Delivering an intelligence-driven approach to regulation

During the session we discussed how one of the key priorities in our strategy for 2016 to 2021 is to deliver an intelligence-driven approach to regulation.

Our role in monitoring the quality of care nationally and locally, underpins our intelligence-driven approach to regulation. It is important that robust data and information, together with local knowledge, drive our decisions of when, where and what to inspect.

Our commitment to an intelligence-driven approach to regulation is not about replacing our inspection process. Rather we are increasing the quality and coverage of the information we receive from the public, providers and elsewhere to ensure that we

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1 CQC’s 2016-21 strategy can be found at https://www.cqc.org.uk/about-us/our-strategy-plans/our-strategy-2016-2021
carry out our existing inspection role and duties more efficiently and effectively, whilst also taking steps to reduce the burden of data collection on providers.

**Experts by Experience and our work with the public**

Experts by Experience are central to how we engage the public during our inspections. In 2017/18, 7,693 Experts by Experience took part in our inspections and engaged around 50,000 people.

Experts by Experience are people with lived experiences of the types of services we inspect. They join our inspection teams for the purpose of improving the evidence we gather and often talk directly to patients. This evidence helps inform and improve our inspection findings, reports and ratings.

Experts by Experience had taken part in Primary Medical Service (PMS) inspections until June this year. Following consideration of the value and practicalities, Expert’s by Experience will no longer participate in PMS inspections primarily due to the limited number of patients present during an inspection. Instead, we use a range of other sources of information from the public, which is vital in informing our regulatory activity of PMS and other health and care services. For example:

- Our inspectors regularly talk to local groups such as Local Healthwatch and Patient Participation groups to find out more about people’s experiences of care services and to share our findings.

- We work in close partnership with organisations that represent the public such as Carers UK, Relatives and Residents Association and Disability Rights UK to encourage and enable people to share their experiences of care with us.

- We co-produce our strategies, policies and other aspects of our regulatory work with the public and the organisations that represent them, including local and national charities.

- We gather vital insight from the public’s use of our ‘Share Your Experience’ form on our website to let us know about their experiences of care, both good and bad. We are currently improving our digital service to make it easier for the public to share information through a new ‘Share Your Experience’ portal. We will launch this new service in 2019.

**How we work with NHS Improvement**

During the session, Committee members requested that we set out how we work both strategically and practically with NHS Improvement (NHSI). We work with NHSI in a variety of ways:

- We are currently working with NHSI to achieve greater strategic alignment in several areas:
Promoting a single shared view of quality, through our involvement in the National Quality Board (NQB). Leading work on aligning regulation and oversight for the National Improvement and Leadership Development (NILD) Board. Working with NHSI to update and align the Well-Led Framework, based on a single shared view of quality that draws on the same sources of evidence. We also work together to assess, rate and report on NHS trusts’ use of resources.

We work with NHSI across all aspects of our regulatory/oversight model at both a national and local level through strong cross organisational relationships:

- We share data and aim to use a single, shared standard of measurement, to review performance and to decide where to target support or oversight.
- We coordinate how we gather evidence to plan site visits, using information from NHS Improvement as evidence to inform our judgements on inspections and improvement activities;
- We share information on the results of our inspections and regulation/oversight, including enforcement actions, special measures and areas of good practice;
- We coordinate how we engage with individual providers as well as with wider health care systems.

Some specific examples of our current work with NHSI:

- **Southern Health NHS Foundation Trust:** Following our inspection in January 2016, we shared our concerns regarding the Trust’s management with NHSI. As a result of this, NHSI put an action plan in place and informed the Trust of their intention to make changes to management if no progress was made to address our findings. We set up a monitoring group with NHSI to closely monitor the Trust, and over the last two years we have seen significant improvement in the governance at Southern Health. Following our inspection report in October of this year, we found further improvements in the leadership and the management of the Trust and have now taken the decision with NHSI to end special monitoring.

- **The Dudley Group NHS Foundation Trust:** Following a number of focussed inspections in which significant concerns were raised, we took enforcement action against the Trust earlier this year. We are working with NHSI to ensure that there is sufficient external oversight of the service and that Trust is taking action to address our concerns, including that there are sufficient numbers of staff who are suitably trained and competent. We will be working with NHSI on a Quality Oversight Committee to oversee improvement at the trust.

- **Hampshire NHS Foundation Trust:** In September 2018, we found significant concerns regarding the safety of paediatric care in the Emergency Department. These concerns were escalated immediately to the NHSI Medical Director and Director of Nursing who ensured external oversight of the department over weekends. By involving NHSI at this early stage, we able to quickly come to joint decision that urgent enforcement action was necessary to ensure patient safety.

- **Shrewsbury and Telford Hospital NHS Trust:**

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3 [https://improvement.nhs.uk/resources/developing-people-improving-care/](https://improvement.nhs.uk/resources/developing-people-improving-care/)
In October 2018, following our inspection and ongoing discussion between our two teams on our findings that patients were at risk at Shrewsbury and Telford Hospital NHS Trust’s maternity and emergency departments, we wrote to NHSI to recommend urgent support for the Trust ahead of our report publishing. NHSI acted on this recommendation immediately, placing the Trust in special measures, with the accompanying support, on receipt of our recommendation.

**CQC and the NHS ten-year plan**

We are actively involved in contributing to the workstreams in the NHS ten-year plan that fall within our regulatory remit. This includes the NHS’s Clinical Priorities: cancer; cardiovascular and respiratory; learning disability and autism; and mental health. There is a role for us to use our regulatory activity to help drive improvement at the provider level in these areas. We are particularly focused on improving the provision of care for those with mental health issues, learning disabilities and cancer, building on our work for the existing Five Year Forward View.

We are also involved in the Enablers aspect of the ten-year plan, in particular the System Architecture work, which is looking at how to further develop Integrated Care Systems and is also considering models that better support integration and collaboration. This relates to our local system reviews\(^4\) and our ‘Beyond Barriers’ report\(^5\) which looked at how well health and care systems are working together to deliver improved outcomes for people using services.

We are in regular contact with colleagues at NHS England (NHSE), and I frequently meet with the Chief Executive of NHSI as well the other arms-length bodies involved in the plan, to receive updates on progress made and to discuss what is required to drive improvement in health and care. As part of these discussions with NHSE and NHSI, we have determined that there is no urgent need for new legislation granting additional powers to CQC as part of the ten-year plan, but the Government should keep this under review.

**The future of our local system reviews**

We believe that we should continue to have a role in reviewing systems and that the Government should continue to commission local system reviews (LSRs) which focus on different areas and topics, to ensure we have the greatest impact on quality of care.

Alongside the local system reviews, we are working to strengthen the impact that we have on local area quality through our regulation of providers. This means:

- holding providers to account for how they are contributing to quality of care in their local area;
- collecting more information about quality of care in local areas and making better use of the information we already have;
- using our independent voice to say more about quality in local areas and encourage improvement; and

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\(^4\) [https://www.cqc.org.uk/local-systems-review](https://www.cqc.org.uk/local-systems-review)

- working closely with providers and system leaders in the areas that are moving most quickly on integration to understand how regulation needs to respond.

We do not believe there is an urgent need for legislative change, although we do think that the Government should keep this under review. We already hold providers to account for how well they work with partners in their local area as part of our business as usual activity, and are working to strengthen this part of our regulation.

We cannot inspect systems on the same basis as we inspect individual providers. The Government can ask us to carry our reviews at system level, under section 48 of the Health and Social Care Act. If ministers are committed to continuing with this activity, and giving CQC the flexibility to select the topics and areas that will have the greatest impact, then no legislative change is required.

We had received assurances from DHSC that further reviews would be commissioned given the benefits we have seen coming out of the programme nationally and locally. However since we appeared at the Committee we have not been asked to carry out any more reviews beyond those planned in 2018. Given the support from the Secretary of State and DHSC ministers for the programme, I remain hopeful that the programme will be renewed in the new year.

In the longer term, ministers might want to change section 48 to allow us to use the powers more flexibly, without the need for ministerial approval. This could help us to target risks and priorities more effectively. However, ongoing funding would need to be identified, since we cannot charge providers for this activity.

Crucially, the Government should not give us any new duties to regulate or rate systems, since this would risk undermining our flexibility to focus on the issues and geographies that are most relevant to the needs of local people.

**Our support for innovation**

Health and social care providers are increasingly using digitally enabled services and new technologies to assist in the provision of care.

I want us to be a collaborator, working with innovators, to help to guide change. The public are going to expect the best digital enabled services and we need to be intelligent as a regulator about how we are balance ensuring the delivery of safe and effective care whilst at the same time not stifling innovation.

Through its Regulators’ Pioneer Fund, the Department for Business, Energy and Industrial Strategy (BEIS) has awarded us £500,000 to explore how we can work with providers to encourage good models of innovation.

This funding will allow us to investigate and test new ways of engaging with innovative providers to meet the needs of an ageing population, while making sure that patient safety is kept at the heart of developing services. This could include ‘regulatory sandboxing’, where implementation of technology can be tested against the regulations in a controlled way, to ensure that regulation achieves the best outcome for people using services.
Whistleblowing concerns

During the session, Committee members requested that we provide examples from the last 12 months of cases in which CQC had taken enforcement action as a result of whistleblowing.

Whistleblowing is an essential part of the information that we use to form a picture of how well a service cares for the people who use it. Whistleblowing concerns, alongside a range of other types of intelligence help us to plan our inspections, respond to potential risks and can prompt us to bring forward an inspection or other regulatory activity. For example, in the period September 2017 to August 2018 we received 8141 whistleblowing concerns. We used these whistleblowing concerns in the following ways:

- In 6,427 occasions the information was used to support future inspections;
- 180 responsive inspections were triggered;
- 464 inspections were brought forward;
- In 1,978 occasions the information was referred to a more appropriate organisation, such as a local authority.

A decision to take enforcement action would not be taken solely on the basis of a whistleblowing concern. Such a decision would be based on the range of evidence we find during inspections and from other sources of information, such as whistleblowing. I have provided three examples of how whistleblowing concerns have contributed to a decision to take enforcement action:

- **In June 2018, CQC recommended that Norfolk and Norwich University Hospital NHS Foundation Trust be placed into special measures, in part as a result of information provided by whistle blowers.**
  Between 15 and 16 November 2017, a team of CQC inspectors visited the trust and inspected urgent and emergency care, surgery, end of life care, outpatients and diagnostic imaging services. The inspection highlighted a number of concerns and a general deterioration in how the Trust was being run. Following our initial inspection, we received information of concern from several whistle blowers regarding the leadership of the Trust. In response, we undertook a number of announced and unannounced inspections with regard to the well-led key question between January and March 2018. We found that that a bullying culture at the trust remained, and a culture of fear of reprisal amongst staff if they raised concerns. In June 2018, we rated the Trust as Inadequate, including for the well-led key question and recommended that the Trust be put in special measures.

- **In March 2018, CQC cancelled the registration of a General Practice in Worcestershire, following a responsive inspection that was triggered following a whistleblowing concern.**
  We received information from a whistle blower on 5 March 2018, who made a range of allegations, including: insufficient staffing; a 10-day backlog of prescriptions waiting for signatures; a build-up of several months’ worth of scanning which had not been actioned; a bullying culture at the practice leading
to high staff turnover, and unsafe clinical practice by one of the GPs with a lack of clinical supervision. As a result of this information, we carried out an unannounced comprehensive inspection on 14 and 15 March with a further unannounced visit on 19 March. The evidence gathered on these visits corroborated much of the whistle blower's information and supported an extreme level of concern, triggering a successful application for urgent cancellation of the provider’s registration on 21 March with immediate effect.

- In January 2018, CQC de-registered the registered manager at a care home in Nottinghamshire, following a responsive inspection that was triggered by whistle blowers.
  In June 2017, we received concerns from a whistle blower regarding the conduct of a registered manager. The whistle blower advised that the registered manager had been abusive to another staff member in the presence of the care home’s residents. We scheduled an urgent responsive inspection. In the days prior to the inspection, further whistle blowers came forward with other concerns regarding the conduct and practice of the registered manager. During the inspection, these concerns were confirmed, with Inspectors finding safeguarding concerns, unsafe care and treatment, poorly maintained equipment as well as poor leadership and governance. There was clear evidence that many of these issues stemmed from the conduct of the registered manager and as a result, CQC moved to de-register the manager. The registration of the manager was successfully cancelled in January 2018.

Allegations of bullying at South Western Ambulance NHS Foundation Trust

We inspected South Western Ambulance NHS Foundation Trust in June (core services) and July (well-led) 2018. The Trust was rated as Good overall, including for well-led, but with a Requires Improvement rating in emergency and urgent care, where the issues around bullying, harassment and abuse are the most prevalent.

We are in regular contact with management and staff at the Trust and were aware of these issues through the Trust’s staff survey, what staff were telling us during inspection, and the independent review that had been commissioned by the Trust.

The Trust is not an outlier for the metric of bullying, abuse and harassment, in that reporting was below the national average. However, the levels were still high with 28% of staff reporting the experience of physical violence from patients, relatives and members of the public in 2017/18. Alongside this, 24% of staff said they had experienced bullying from other staff.

The Trust had responded to both the staff survey, and a rise in complaints from staff about bullying and harassment. These issues were raised to the Trust board in reports both in March and May 2018. The actions the Trust had decided to take were reported to the board. These were:
  - Launching an awareness campaign to encourage more reporting from staff.
  - Developing a zero-tolerance campaign around sexual harassment to include education and targeted briefings from management.
  - Training for managers in handling disciplinary and performance management cases.
The Trust has also commissioned an external review into bullying led by a Professor Duncan Lewis from Plymouth University. The Trust informed us that any actions that arise from this report will be available to us when it is completed.

In the light of the concerns we identified on our inspection we issued the Trust with two actions:

- To look again at the areas relating to culture and where 2017 NHS Staff Survey results have deteriorated to improve staff motivation, recognition of their work, and satisfaction with the quality of work and care they deliver. Consider the views of staff representatives we have reported and how to improve engagement with and morale of staff.

- To tackle the findings of Professor Lewis’s report when published and identify measures to be able to judge the success of actions taken to resolve this.

We will continue to monitor the trust and will report on their progress following our next inspection.

**Our position on the Mental Health Act (MHA) Review**

As an independent arm’s length body with a role in the Mental Health Act 1983, it has been important to be clear on our role in the review. To support this, we wrote to the Secretary of State in November 2017, confirming that we would act in an advisory role but would be sensitive to conflicts of interest when the panel looked at the way we apply our own powers and duties, protecting people subject to the Act.

We set this out in our ‘Monitoring the Mental Health Act in 2016/17’ report, along with our initial views on the areas of practice that we believed require change.

This year, we have been working to support the panel by preparing summaries of information and accounts from our previous mental health publications, and sharing information we gather during our activities. Our Mental Health Act visiting teams have raised awareness of the review and supported patients who are currently detained to share information directly with the panel. They have also encouraged patients to complete the survey or feedback their experiences of how the MHA is working.

In practice, this has meant we have been represented at all levels of the MHA review governance structure — Advisory Panel, Working Group and Topic Groups — and supported individual requests for information, evidence or analysis of the unique data we hold.

In recent discussions with the Review Chair, panel and working group our position has been that existing legal powers and duties are sufficient, when applied with our parallel roles in the Health and Social Care Act for regulation and enforcement.

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6 [https://www.cqc.org.uk/guidance-providers/mental-health-services/mental-health-act](https://www.cqc.org.uk/guidance-providers/mental-health-services/mental-health-act)
We have suggested revisions to the MHA provide an opportunity to include a statutory basis for that monitoring to be recognised as part of the UK’s National Preventive Mechanism (NPM) under the United Nations Optional Protocol Against Torture. At present this role is recognised as an NPM function only by ministerial announcement.

In light of the new evidence and analysis generated by the review and the recently published report, we also welcome the opportunity to work with ministers and the Department of Health and Social Care to clarify and restate in ordinary language our intention and priorities for our operational activities with patients.

Now that the final report has been submitted to the Prime Minister, we will begin a programme of work to look at how we can secure quick and immediate change to respond to the reviews recommendations for improvement. This will include working with our Board and operational teams to prepare a formal response to the review, with timings to be aligned with the Government response. A progress update will be included in our MHA report 2017/18, due for publication in early 2019.

The regulation of private screening clinics

We regulate a range of services providing diagnostic and screening procedures. Where specified services (regulated activities) are provided, the provider must be registered with us and is subject to our range of regulatory activities.

The type of private screening clinics that you referred to during the session, market their services directly to the public, inviting them to self-refer for services whether they have any symptoms or not. Most of these types of screening clinics are subject to our regulation. They include clinics carrying out diagnostic procedures involving the use of any form of radiation (including x-ray), ultrasound or magnetic resonance imaging to examine the body. They also include screening clinics that carry out blood tests for the purpose of discovering the presence, cause or extent of a disease, disorder or injury.

However, there are specific regulatory exemptions that may apply to some types of private screening clinics, for example, fitness screening procedures carried out in a gymnasium and the taking of blood samples to ascertain the existence of a genetically inherited disease or disorder.

We have recently started our inspection programme of diagnostic imaging services and will report our inspection findings, the ratings we award and any enforcement activity we undertake.

It is also important to add that many of these services which use ionising radiation are subject to the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) regulations which we are active in enforcing\(^7\). We also receive notifications of significant accidental or unintended exposures as required under Regulation 8(4) of IR(ME)R. This is irrespective of the fact that they do not carry our regulated activities under the Health and Social Care Act.

\(^7\) https://www.cqc.org.uk/guidance-providers/ionising-radiation/reporting-irmr-incidents
Going forward as an organisation

Andrea Sutcliffe CBE and Professor Stephen Field CBE have asked me to pass on their thanks for the Committee’s kind words, which rightly recognise the great work they have done in their respective sectors during their time at CQC. I am confident that they will continue to make a great contribution to the quality of health and care in their future endeavours.

Finally, I would like to reassure the Committee that during this time of change, we have the strength in depth of leadership, both in our Executive Team and in our Deputy Chief Inspectors, which will ensure our success as an organisation in the months and years ahead.

I trust this letter is useful for your inquiry and provides the Committee with the information that you require. If you have any queries, please do not hesitate to contact Chris Hares, Parliamentary and Stakeholder Engagement Manager (Christopher.Hares@cqc.org.uk) or Mark Hudson, Senior Parliamentary and Stakeholder Engagement Officer (Mark.Hudson@cqc.org.uk).

Yours sincerely,

Ian Trenholm
Chief Executive