

# Review of CQC's impact on quality and improvement in health and social care

April 2017

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## Foreword

CQC's purpose is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage care services to improve. Our challenge is how we measure that we are achieving our purpose and how we measure the impact that we are having on quality and improvement.

For the first time, this year, people in England will have a full and independent judgement about the quality of health and social care across the country – with CQC's reports and ratings allowing them to differentiate between providers and services that are outstanding, good, requires improvement or inadequate.

In our annual State of Care report to Parliament, published in October 2016, this unique view across all the different types of care enabled us to highlight our concerns that adult social care services were approaching a tipping point. This led to national and high-profile debates (including in Parliament) about how quality can be improved in adult social care.

Subsequently, in our report on the state of care in acute hospitals, published in March 2017, we highlighted that the model of acute hospital care is a 'burning platform' – a model that once worked well, but which cannot continue to meet the needs of today's population.

Our inspection reports and ratings show that there is a large variation in the quality of services. Many are very good; others can be poor. Our evidence shows that services are improving, although this is by no means universal. In one way or another, the public pay for these services and they have a right to know how good each of them is. It is the creation and publishing of this objective set of ratings that stands out as having the greatest impact.

We have a legal obligation, written into our purpose, to ensure people receive high-quality care and to encourage improvement – so we need to understand our impact to fulfil this obligation. We also have a moral obligation: to serve the public better, we have to learn how to improve our impact on the providers of health and social care, to ensure that improvement in service delivery, after our inspections, becomes the norm. In this report, we set out the start we have made in building this understanding, and our commitment to embedding it into our future reporting.

**Sir David Behan**  
Chief Executive

## Summary

CQC's purpose is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage care services to improve. Our evidence shows that the quality of care that people are receiving is improving with CQC's involvement.

This report is the first of its kind from CQC and considers what we know about how effective we have been. With our first full inspection programme complete, we are able to offer the clearest independent picture ever of the quality of health and care services in England. This is the result of tens of thousands of individual, independent CQC reports on the quality of care at services. These reports can be a catalyst for safer, higher quality and improved services for people. We want to be transparent and learn about our impact, on how we fulfil our purpose.

### Ensuring high-quality care

We have provided guidance and information to providers on what they need to do to meet the fundamental standards of quality, and we have agreed with the sectors a set of characteristics that we expect to see from a service with a rating of 'good'. This gives providers and the public clear expectations of what good care looks like.

We have now completed our first full phase of inspections of NHS trusts under our new approach, with ratings for all NHS acute, mental health and community trusts, and we have completed our inspection and ratings programme for adult social care services and GP practices. As at 31 December 2016, we had given ratings to more than 26,000 locations and providers, and carried out more than 30,000 individual inspections overall (including re-inspections). We are carrying out more enforcement action (1,462 in 2016; 1,073 in 2015) and we know that this protects people from poor care, for example with some adult social care services providing poor care having left the market.

In our surveys, a majority of new providers and registered managers responding told us that our guidance and standards are clear. After registering with CQC, three-quarters of new providers and registered managers responding to the survey said that the process helped them to think about their plans to deliver care. Eighty-six per cent of respondents to our provider post-inspection survey told us that our standards and guidance focus on the issues that matter most to their services, and there is evidence that our approach to regulation and our standards have an influence on how some providers measure their own quality.

The majority of people responding to our inspection report survey said our inspection reports were useful to them and more than 1,450,000 reports were downloaded from our website in 2015/16. Care providers tell us our ratings can be a positive motivation for staff. In our post-inspection survey, 71% rated good or outstanding said this, while

a third of those responding to our survey who had a rating of requires improvement or inadequate said that ratings were a catalyst for positive change. However, 45% of providers with lower ratings who responded to our survey said that their rating demotivated staff. We will consider what we can do to better help staff understand the reasons behind a lower rating, so that they can feel encouraged to support improvement.

### **Encouraging improvement**

We often see improvements in quality on re-inspection. By the end of 2016:

- 79% (492 out of 622) of adult social care services originally rated inadequate had improved their overall rating.
- Out of 11 hospital providers or locations originally rated inadequate, six had improved to requires improvement and three had been re-rated as good.
- 78% (91 out of 116) of general practices rated inadequate had improved their rating – 56 moved to good and 35 moved to requires improvement.

There is evidence of wide-ranging and positive changes following our inspections. In our post-inspection survey, 69% of respondents (1,928 out of 2,803) stated specific changes that they had made or were planning to make because of the inspection process. Nearly half of respondents to our post-inspection survey (45%, 1,027/2,803) told us that they had made changes to their services that they would expect to lead to improvements to the safety of the care they provide.

Many providers put into the special measures programme have achieved substantial improvements, often with a wide-ranging package of support from partners, such as NHS Improvement, responding to CQC's findings.

We know that CQC has a positive impact through its national reports on a range of health and social care issues. Many providers responding to the annual provider survey said that they made changes to their services as a result of CQC's publications. Some felt that the changes they made had resulted in improvement in care for people who use services. More than half of all adult social care (69%, 1,074/1,546) and hospital (55%, 101/184) respondents told us there were improvements because of CQC publications, as did nearly a third of GP practice respondents (106/331).

### **Developing our understanding of our impact**

Measuring and understanding our impact is a complex task and there are many factors to consider in approaching an assessment. CQC is not responsible for making improvement in health and care services happen but, if we are to have any real impact on services, we need to carry out our regulatory work so as to ensure that providers are motivated and encouraged to improve their services, and that they are supported in this by others.

This report shows that we have made a start on this. To serve people better, we have to learn how to improve our impact on the providers of health and social care, to ensure that improvement in service delivery, after our inspections, becomes the norm.

This report constitutes some of the key elements of our impact that we know about so far. It is too soon to offer a full assessment and we are still learning about the impacts of some of the key components of our operating model – for example, the results of re-inspection and timescale for improvement will vary in different contexts: re-inspecting an inadequate care home and its road to improvement is different compared with the improvement journey for a mental health trust. What we learn about our impact on improvement and quality of care will differ after 12 months, or three years, or a decade.

We are continuing to strengthen our framework for reporting on our effectiveness. We will strengthen the robustness and completeness of the evidence we collect so that we can have a stronger evidence base to inform our learning and improvement as an organisation. This will include reviewing how we collect information so that we are able to better understand the breadth of our impact on all providers, people who use services and stakeholders, rather than this being limited to those who have provided us with feedback.

# 1. Introduction

The Care Quality Commission (CQC) is the independent regulator of quality in health and adult social care in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage care services to improve.

CQC has a broad range of responsibilities in a complex health and social care environment. The population is changing, people are living longer – and often living longer with long-term and complex care needs, especially towards the end of their life – and demand for care is growing.

CQC contributes to good quality care in two ways. Firstly, we aim to ensure that standards of care do not drop below an acceptable level (the [fundamental standards](#)). Secondly, and just as importantly, we encourage improvement up to and beyond the fundamental standards, and improvement in all providers, no matter what their quality of care.

Others must also play their part in ensuring that care meets the needs and expectations of people who use services. Regulation alone cannot maintain or improve quality. Ensuring high-quality care requires action from five broad sets of influencers – and all five need to be present and act together for sustainable improvements in quality:

- Commissioners and funders of care
- Providers of care at board and executive level, service level and practice level
- Care staff and clinicians
- Regulators and national bodies
- The public and people who use services.

We want to identify CQC's influence on the quality of care and on quality improvement. In this report, we demonstrate what we currently know about the extent to which we are achieving our purpose:

1. Are we ensuring high-quality care?
2. Are we encouraging improvement?

Understanding impact is complex and we are only just starting to understand the extent to which we can assess our impact. This is a long-term process and will require continual assessment. Improvement in the quality of care can take different lengths of time to achieve – for example, this will depend on the type and scale of the change required, with complex organisations sometimes taking longer to turn around – and understanding our impact in this context will be important as we go forward.

## Our evidence base

This is the first time we have considered our impact in this way; our methodology is new and our findings can be only as meaningful as the qualitative and quantitative data sources available to us at this time. These sources include:

- analysis of ratings (as at 31 December 2016) that we have given to providers and locations after their first comprehensive inspection, any re-ratings from further or follow-up inspections
- self-completion surveys (taken at different points in time) of providers, people who use services and the general public
- CQC's internal management information
- case studies of 27 providers' experience of being regulated by CQC: qualitative research conducted by Ipsos MORI, an independent research organisation.

The appendix provides further detail about these sources, their dates, and some of their limitations. We have used the latest data sources available to us at this time, and this means that time periods covered by each type of data are not consistent. Some of the sources of evidence were collected on our behalf, including case studies undertaken by Ipsos Mori. While the evidence was collected independently, this report presents our interpretation of this evidence.

In addition to overall findings across all health and social care sectors, we report on some sector-specific findings for the following:

- **Adult social care** – covering residential and community services including care homes, nursing homes, home care services and hospices.
- **Hospitals** – covering both NHS and independent acute, community and mental health providers and locations.
- **GP practices.**

While we have made some comparisons across sectors in this report, those based on survey data should be treated with some caution due to the number of responses in some cases and the lack of a representative sample from each sector.

The focus for this report is on our main activities of registering, monitoring, inspecting and rating care services, enforcing against regulations and using our independent voice. Other activities we carry out such as monitoring the Mental Health Act and Deprivation of Liberty Safeguards, and our Market Oversight function in adult social care, are not included in this report.

## 2. Are we ensuring high-quality care?

### 2.1 Registration sets the bar for quality of care

To provide health or adult social care services in England, providers and certain managers must be registered with CQC. When new providers register, they are making a legal declaration that they will be able to meet the fundamental standards set out by law, once their service starts.

CQC's registration process sets a bar for potential providers: we want to see good providers that understand what they need to do to deliver high-quality care. Where we are not satisfied that the provider will be able to meet the fundamental standards, we can issue a Notice of Proposal to refuse an application or to impose conditions on their registration. From January to December 2016, we issued 343 such notices.

A majority of providers and new registered managers who responded to our post-registration survey said that the guidance and standards provided by CQC were clear. This included:

- 91% (71 out of 78) of adult social care providers and 97% (989 out of 1,020) of new registered managers
- four of the seven GP providers and 57 of the 74 (77%) new registered managers
- seven of the nine new registered hospital providers and 64 of the 65 (98%) new registered managers.

In our post-registration survey, 76% (1,041 out of 1,376) of new providers and registered managers that responded said the registration application helped them think about their plans to deliver care. For newly registered providers, advice from CQC led to changes in plans in 57% (70 out of 122) of cases.

*"I was asked about specific practice for specific categories of care, how I would implement them, what I might change or add to existing practice to improve it and how I would respond to specific situations."* (Adult social care, post-registration survey)

*"It drew attention to things which would need to be changed or upgraded, which have been carried out now."* (Independent consulting doctors, post-registration survey)

Figure 1 shows the examples most often noted, for each key question, of where improvement was stimulated by the registration process. The most common improvements noted were 'openness and transparency' and 'recruitment checks' – both cited by 46% of registrants overall who responded to our survey (631 and 636 respectively out of 1,376).

**Figure 1: Most commonly noted improvements stimulated by registration**

	Improvements noted most often	Adult social care	Hospitals	General practices
<b>Safe</b>	Recruitment checks	47.4% (520/1,098)	37.8% (28/74)	33.3% (27/81)
<b>Effective</b>	Staff appraisals, supervision and training	46.0% (505/1,098)	36.5% (27/74)	28.4% (23/81)
<b>Caring</b>	Collect feedback from people who use services and those close to them to improve the service	44.6% (490/1,098)	36.5% (27/74)	27.2% (22/81)
<b>Responsive</b>	Tailor care plans to meet individuals' needs better	44.5% (489/1,098)	28.4% (21/74)	21.0% (17/81)
<b>Well-led</b>	Openness, transparency	47.5% (522/1,098)	37.8% (28/74)	29.6% (24/81)

Source: Post-registration survey, January to June 2016

In terms of CQC's processes, overall 90% (1,236 out of 1,376) of new registered providers and managers who responded to the survey said that they had a good or very good experience of registration.

*"The process looked at all the areas you describe in detail and supplementary questioning and inspection revealed areas which were open to change and improvement. This we welcomed and found helpful. The preparation was stressful, and the level of apprehension about the process was palpable. In the end the team and lead inspector were very approachable, kind, thorough and polite."* (GP practice, post-registration survey)

*"Very comprehensive assessment, with evidence required both during the phone call interview and face to face interview with the registration inspector. Clearly referenced to registration requirements and personal ability, skills and knowledge in role."* (Hospitals, post-registration survey)

However, some providers did tell us they find the process of registration frustrating or time consuming. In particular, there were challenges with having to re-submit forms multiple times for purely administrative reasons. We are working to make registration easier for applicants, including moving to online processes, and early indications show this is improving the number of application forms accepted first time. Another complaint is that the process is slow. From October 2015 to March 2016, completing a registration ranged from 40 to 62 days. As part of our strategy for 2016 to 2021, we plan to speed it up while retaining its rigour.

## **2.2 We monitor and inspect providers and services, and give them quality ratings**

We monitor providers' quality of care by collecting and analysing a wide range of information from different sources. This helps to inform us when and where to inspect, and to guide what we look at when we inspect. The information includes national data, provider information returns, safeguarding alerts, statutory notifications, feedback from our *Share your experience* programme and local partners, and whistleblowing.

We carry out inspections of services to assess the quality of care that they provide. We re-inspect where we have substantial concerns after a previous inspection and we want to check improvement, or if we receive new information of concern.

### **2.2.1 Setting standards and providing guidance**

We provide guidance and information to providers on what they need to do to meet the legal requirements: the fundamental standards of quality. In addition, working through co-production with providers, the public and other stakeholders, we have agreed a set of characteristics that we expect to see from a service with a rating of 'good'. This gives providers and the public clear expectations of what good care looks like, and a clear goal for providers to achieve in terms of the quality of care they provide.

In our post-inspection survey of providers, 90% of all respondents said that our standards and guidance makes it clear what is expected of them (850 strongly agreed and 1,673 agreed, out of 2,803). Most respondents (86%) also said that our standards and guidance focus on the issues that matter most to their services (787 strongly agreed and 1,631, agreed out of 2,803). This response was least positive for general practices, with 60% of respondents agreeing that there is a focus on the things that are most important (48 strongly agreed and 287 agreed, out of 555).

For the minority of providers who do not think CQC focuses on the things that matter, qualitative comments in the post-inspection survey and in the Ipsos MORI case studies suggest that CQC is focused too much on process rather than quality of care, and that our standards and guidance could be clearer, more concise and less open to misinterpretation.

### **2.2.2 Ongoing monitoring of quality**

Through our monitoring function, we collect information from providers before inspections to help inform what we look at. While this collection is not primarily aimed at helping services to improve, almost a fifth of providers (546 of 2,803) who responded to our post-inspection survey indicated that the provider information request (sent to them in advance of a comprehensive inspection) had helped them carry out or plan for improvements to their services. However, there is evidence from the surveys and the case studies that the system of providing information to us can

be time-consuming for providers, and in some cases duplicates information provided to other bodies. We are proactively addressing this through our new strategy and consultations we are carrying out in 2017 on our regulatory approach.

### **2.2.3 Influencing providers' assurance processes**

There is evidence to suggest that our approach to regulation and our standards and guidance influence how some providers measure quality. For example, some of the providers involved in the in-depth case studies undertaken by Ipsos Mori adapted their quality assurance processes to align with CQC's key questions or conducted mock inspections using CQC's framework.

#### **Using CQC's key questions to support high-quality care**

##### **Adult social care**

A domiciliary care agency had failed to ensure that records were accurate and complete. In response, the agency developed an audit framework of care records to test if the service was safe, effective, caring, responsive, and well-led. The audits were then conducted quarterly, and a score calculated for each of CQC's five key questions, as well as an overall score.

##### **NHS acute care**

The assessment system of one NHS acute trust collated and corroborated data (such as quality safety measures, complaints, internal patient experience surveys and audit documentation) by ward, based on CQC's five key questions of safe, effective, caring, responsive and well-led.

From this, wards were awarded ratings of bronze, silver, gold or platinum and results are fed back to the board. A ward that achieved a platinum rating was entered into an independent accreditation process. The trust felt that this gave the board a good awareness of ward level performance, that they could identify 'hotspots' needing attention, and that ultimately they were delivering better care as a result.

### **2.2.4 Inspection programme and quality ratings**

We have now completed our first full round of inspections of NHS trusts under our new approach, with ratings for all NHS acute, mental health and community trusts, and we have completed our inspection and ratings programme for adult social care services and GP practices. Figure 2 shows the number of inspections completed and ratings as at 31 December 2016.

This means that for the first time there is a comprehensive understanding of the quality of care being provided by health and social care services across England. Figure 3 shows the high-level profiles of ratings as at 31 December 2016. Sector comparisons are fraught with risks. On the face of it, GPs have the highest combined percentage of good and outstanding ratings, but it is probably incorrect to assume that conversely, NHS trusts or some adult social care providers are not as good just

because they have fewer good and outstanding ratings overall. For example, it could be that, as more complex organisations, it is harder for NHS trusts to achieve good or outstanding ratings at an aggregate level of the whole organisation, even though they may have many good aspects of their services.

**Figure 2: Published ratings and inspections, as at 31 December 2016**

	Published ratings/ new approach inspections	Registered to provide services
Acute independent healthcare*	83	1,630 locations
Acute NHS care**	158	166 NHS trusts
Adult social care community*	5,319	8,841 locations
Adult social care residential*	14,523	16,447 locations
Community healthcare services***	30	131 providers and 597 locations
Hospices*	169	222 locations
Mental health services***	272	53 NHS providers registered and 278 IH locations
Primary dental services****	1,574	10,518 locations
Rated primary medical services* - including 5,990 GP practices rated at 31 December 2016	6,011	8,027 locations
Unrated primary medical services****	57	1,120 locations

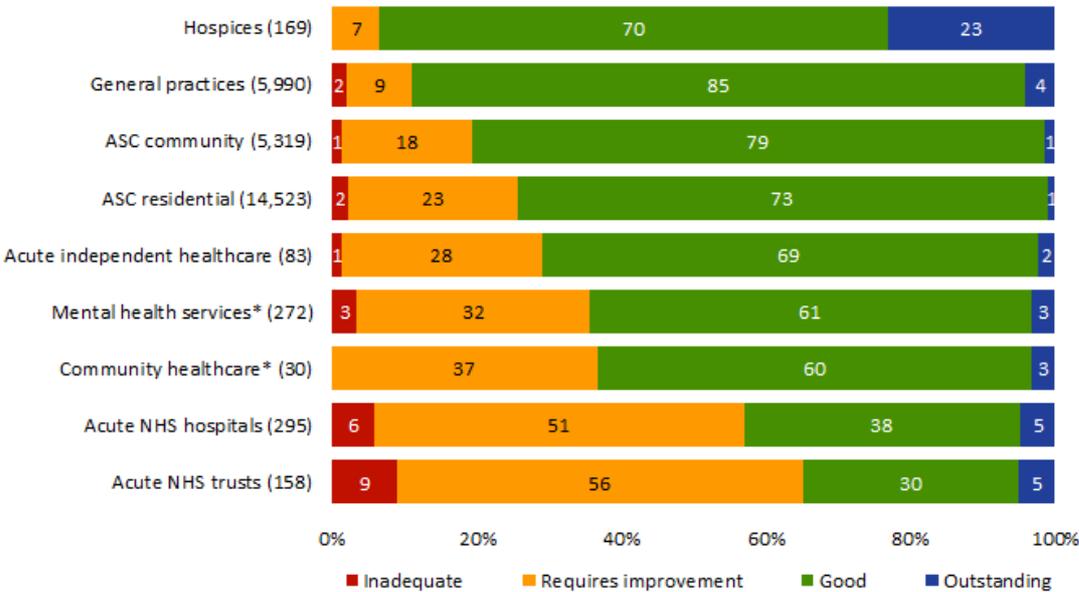
Source: CQC inspection and ratings data as at 31 December 2016

\* Inspected / rated at location level

\*\* Provider numbers shown here. Rated at both provider and location level.

\*\*\* Some inspected / rated at provider level and some at location level \*\*\*\* Inspected but not rated

**Figure 3: Ratings profiles for each main sector as at 31 December 2016**



\* NHS trusts and independent locations. Numbers on bars are percentages and may not sum to 100 due to rounding

Source: CQC ratings data as at 31 December 2016

## 2.2.5 Reporting on what we find on inspection

In total, there were 1.43 million unique downloads of CQC new approach inspection reports in 2015/16. Sixty-eight per cent (3,651) of the 5,398 public respondents to our inspection report survey said they were accessing adult social care reports.

- Of those using adult social care reports, 90% said they found them useful.
- Of those using hospitals reports, 87% said they found them useful.
- Of those using GP practice reports, 79% said they found them useful.<sup>1</sup>

Seventeen per cent (172/1,000) of respondents to our public awareness survey said they had seen or read an inspection report), and those who had chosen a care home were twice as likely to have seen or read a CQC report (36%, 82/227) compared with the total sample. Research undertaken on behalf of CQC looking at the public's understanding of CQC ratings suggests that this may be because people are more likely to access information about the quality of services when they feel they have a choice, such as when choosing a care home.

There are many factors affecting the market and CQC ratings do appear to have some influence in adult social care. In our post-inspection survey, 14% (76) of those rated requires improvement or inadequate said they had lost business because of their rating. Ratings appear to have less influence in other sectors: seven out of 71 GP providers and two out of 25 hospital respondents with these ratings said they lost business as a result.

This is echoed in the Ipsos MORI case studies. One care home reported that somebody had enquired about their service for her husband. She then called back to say that she had since seen the CQC report rating of requires improvement and no longer wanted their service. Though impacting negatively on the provider, the potential customer is likely to have chosen better care. Conversely, there were examples in the case studies where providers reported that their good or outstanding ratings were good for business. One community-based adult social care provider was aware of three paying customers who wanted to use the organisation on the basis of their good rating.

## 2.2.6 Impact on staff and morale

There is evidence that inspection and the subsequent rating can affect staff morale and motivation. The impact on staff correlates with the rating that their organisation or service was given. In response to our post-inspection survey, 71% of providers who had been rated good or outstanding said the rating had motivated staff (1,426/2,005). The case studies also highlighted examples of how a good or outstanding rating helped to foster good morale:

*"I think a benefit is the morale of staff... knowing they are doing a good job."*  
(Practice manager, GP practice)

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<sup>1</sup> This may include a small number of reports for out-of-hours and urgent care services.

Ratings can also be a catalyst for positive change: 33% of providers across all sectors rated requires improvement or inadequate who responded to our survey said that the rating had motivated staff (205/621). This is illustrated by a provider in the Ipsos MORI case studies who said that the changes that resulted helped to lift them from “rock bottom”.

On the other hand, 45% of providers rated inadequate or requires improvement said the rating had demotivated staff (279/621).

Most of the staff at providers interviewed (independently) in the case study research made reference to the impact of CQC activity on their staff. The inspection period can be very intense and stressful for those involved (even in a trust found to be outstanding where a senior nurse said “it gave staff the validation of what they are doing is good”).

A poor rating often resulted in despondency and friction among the staff. A comment from care home operations manager was:

*“Team meetings were a real balance between not pointing the finger and addressing the areas raised... I think as a company we felt pretty deflated about the outcome and like all of the hard work and challenges didn’t count.”*

A residential social care provider in the case study group reported that after the care home was rated inadequate, some staff took time off sick or left the care home, while staff at one large acute NHS hospital said that a requires improvement rating left some staff “deflated and demoralised”.

Ratings within NHS trusts are becoming influential as a measure of success for trust leaders. In February 2017, the Health Service Journal (HSJ) reported that five of the 10 trusts awarded an outstanding rating saw their chief executive make the top 15 of the HSJ’s list Top 50 Chief Execs. Three within the top five run trusts rated as outstanding.<sup>1</sup>

### **2.2.7 Corporate monitoring, oversight and engagement**

We engage closely with large and corporate providers that operate a wide range of services and locations. With this oversight at a corporate level, we aim to identify performance issues and trends that are not evident to individual location inspectors. Our engagement with them at their corporate level provides scrutiny and challenge and holds them to account on matters of performance, risk and corporate governance. The positive impact of this has been evident with a number of providers:

- We challenged a large provider about the poor quality of care that was evident across the whole of their portfolio of services. As a result they halted their growth strategy in order to focus on improving the quality of care in their existing services first.

- We identified that a provider had many services in its portfolio where people were not receiving their medication in a safe way. This was being addressed by inspectors at each one of the locations. However, by also challenging and holding them to account about this at their corporate level, they changed their overall policy and invested in new staff to improve their approach to medication management across all their services. This corporate response was not being considered by the provider before we raised it at a corporate level.
- After sharing examples of different management structures that had resulted in improved care for people, one provider changed their own management arrangements to better replicate one of the successful models. They increased the number of managers they employed and were able to have better oversight of care delivery and provide more support to staff as a result. At another provider, the executive team and CEO started regular, personal visits to their locations because we had shared with them the correlation we have observed between visible leadership and high-quality services.
- In response to our corporate level challenges about poor quality across their portfolios, several providers have improved their corporate governance and quality assurance arrangements, strengthening their line of sight from board to location, and taking greater corporate ownership of improvement rather than relying on individual location managers to do this.

### **2.3 Enforcement activity is acting as a deterrent to poor care**

Where we find poor care, we can and have used civil and criminal sanctions to force providers to meet fundamental standards of care and to hold providers to account for providing poor care. Our enforcement powers include warning notices, fixed penalty notices and cancellation of registration. The most important impact of enforcement activity is the action that CQC takes to protect people from poor care. We have powers to prevent services, where absolutely necessary, from operating in breach of regulatory requirements.

In 2016 CQC carried out 1,462 enforcement actions. This compares with 1,073 enforcement actions in 2015. We expected this increase in activity in enforcement. During 2015/16 we worked hard to raise awareness of our new enforcement policy. Internally we have focused on embedding our new enforcement policy and improving the skills and knowledge of our inspectors in enforcement.

We take the most enforcement actions against adult social care providers (figure 4). We would expect to take more actions in this sector as it is the largest sector we regulate. However, we take a relatively higher number of actions in this sector; in 2016 adult social care services accounted for 78% of the locations we regulate, but 87% of enforcement actions.

**Figure 4: Proportion of total enforcement actions, 2015 and 2016**

Sector	2015	2016
Adult social care	87%	87%
Hospitals	4%	3%
GP practices	9%	10%

Source: CQC enforcement data, 2015 and 2016

Warning notices are the most frequently used enforcement tool in the adult social care sector, but we began to use more criminal actions in 2015/16, particularly fixed penalty notices. We have carried out some high profile prosecutions in this sector, which we intend to act as a warning message to the wider system.

In the hospitals sector, we have seen considerable variation in standards across and within hospital trusts and locations and increasing numbers of enforcement actions. This could be down to two key factors: our new inspection methodology, which has uncovered more instances of poor care, and our new enforcement policy which has raised awareness of our powers. The most common enforcement actions used in the hospitals sector to drive improvement are urgent conditions and warning notices.

In the GP sector, we take enforcement action against a small proportion of services that provide inadequate care.

The impact of enforcement may differ among the sectors we regulate – responses to our annual provider survey indicate that enforcement is perceived as a more effective deterrent to encourage regulatory compliance in adult social care than it is in general practices or hospitals (figure 5).

**Figure 5: Do you think the prospect of enforcement action is an effective deterrent to encourage compliance?**

	ASC (n=1,495)	HOS (n=141)	GPs (n=334)
Yes	69% (1,034)	49% (69)	39% (131)
No	16% (232)	31% (44)	34% (112)
Don't know	15% (229)	20% (28)	27% (91)

Source: Annual provider survey, October 2015

Compared with NHS hospitals and GPs, there is a less clear support network for adult social care providers. For NHS hospitals and GP practices, there is practical help and assistance, as well as public organisations to turn to, such as NHS Improvement – and they are more likely to receive financial support throughout special measures.

Of the 27 providers interviewed by Ipsos MORI for our case studies, three had experienced CQC enforcement action. Two of these were residential adult social care providers, and the other a mental health hospital trust. All three organisations had received warning notices; one organisation received two. They found it difficult to separate the impact of the CQC enforcement action from the other action they took following their inspections, because they tended to address all CQC actions as a whole. A consistent theme across feedback from these providers was the immediacy of the organisations' response to address the problems identified by CQC.

### **Examples of enforcement**

The following examples illustrate where CQC's enforcement action has addressed poor care. In a number of the examples, the action we took also led to improvements in care. We look at improvement in more detail in the next section.

#### **Holding provider to account for poor care**

We prosecuted a nursing home provider that failed in its duty to provide safe care and treatment; it was fined £190,000 and ordered to pay £16,000 towards the cost of the prosecution and £120 victim surcharge in 2016. The prosecution was brought after a man died after falling from a shower chair at a nursing home. The registered provider pleaded guilty to an offence of failing to provide safe care and treatment resulting in avoidable harm to people using the service.

#### **Enforcement can lead to improvement in services**

In 2015/16 we served an urgent enforcement action to stop a care home from admitting any more people without our prior written agreement. This condition was imposed following an inspection where serious concerns were identified in relation to the health, safety and wellbeing of people who used the service. Two further CQC inspections found the service had improved and there were no further breaches of regulations – the desired effect had been achieved and we subsequently removed the condition.

#### **Preventing poor care**

In 2015/16 we issued a notice to use an urgent action to impose conditions against a trust that we identified on inspection as failing to manage emergency care services appropriately. The trust sent us an action plan which we felt addressed and mitigated the risk such that urgent action was no longer required. The trust had put measures in place immediately to deal with ambulance services and engaged with other stakeholders to ensure that control measures were being embedded to prevent further poor care in the emergency department.

### **Reducing patients risk of harm**

A GP working in a GP practice took six months to register with CQC. Once he was registered, we prioritised an inspection of the practice and found that their patients were at risk of significant harm.

Issues identified included him not responding to clinical letters (in some cases for months) relating to patients' conditions, including abnormal test results, and we found evidence that patients' medicines had been changed without any discussion with them. The practice was suspended for three months.

On re-inspection we judged that the practice had improved in some ways. For example, all outstanding test results and clinical letters were being systematically followed up and referred to other agencies and health professionals in line with current guidelines.

At about the same time that we inspected the first GP practice, we were notified by NHS England that the same GP had entered into a partnership at another practice. Eventually the GP submitted an application to add the new practice to his registration. We carried out an unannounced inspection of this second practice, collecting evidence of him carrying or managing a regulated activity without registration, and other regulatory breaches. We refused this GP's application to add this location to his existing GP practice registration.

### 3. Are we encouraging improvement?

#### 3.1 Many providers show improvement on re-inspection

By the end of December 2016, we had re-inspected 4,230 adult social care services, 785 rated general practices and 76 hospital providers/locations.<sup>2</sup> These re-inspections were mainly of providers where we had substantial concerns after a previous inspection or inspections, and we wanted to check improvement. Some providers may take more than one re-inspection to improve their rating, and in some cases we find that the quality of care has deteriorated, resulting in a lower rating. We may also re-inspect if we receive concerning new information.

Among adult social care services:

- 79% (492 out of 622) locations originally rated inadequate improved their overall rating on re-inspection. Of these, 150 locations improved from inadequate to good.
- 50% (1,465 out of 2,906) locations originally rated as requires improvement had improved. In 43% of cases (1,245), there had been no change, and in 7% of cases (196), quality had deteriorated, resulting in an inadequate rating.

Among hospitals:

- Six out of 11 hospital providers/locations that were originally rated inadequate had improved enough for us to rate them as requires improvement when we re-inspected, and three had improved to good.
- Of 47 hospital providers/locations that were originally rated as requires improvement, 19 improved their rating to good following re-inspection, 24 stayed the same, and four deteriorated to a rating of inadequate.

Among general practices:

- 78% (91 out of 116) practices originally rated as inadequate had improved sufficiently to receive a better rating when we re-inspected. Fifty-six improved their rating to good, and 35 changed to requires improvement.
- Of 257 GP practices that were originally rated as requires improvement, 80% (206) improved their rating to good following re-inspection, 16% (40) stayed the same, and 4% (11) deteriorated to a rating of inadequate.

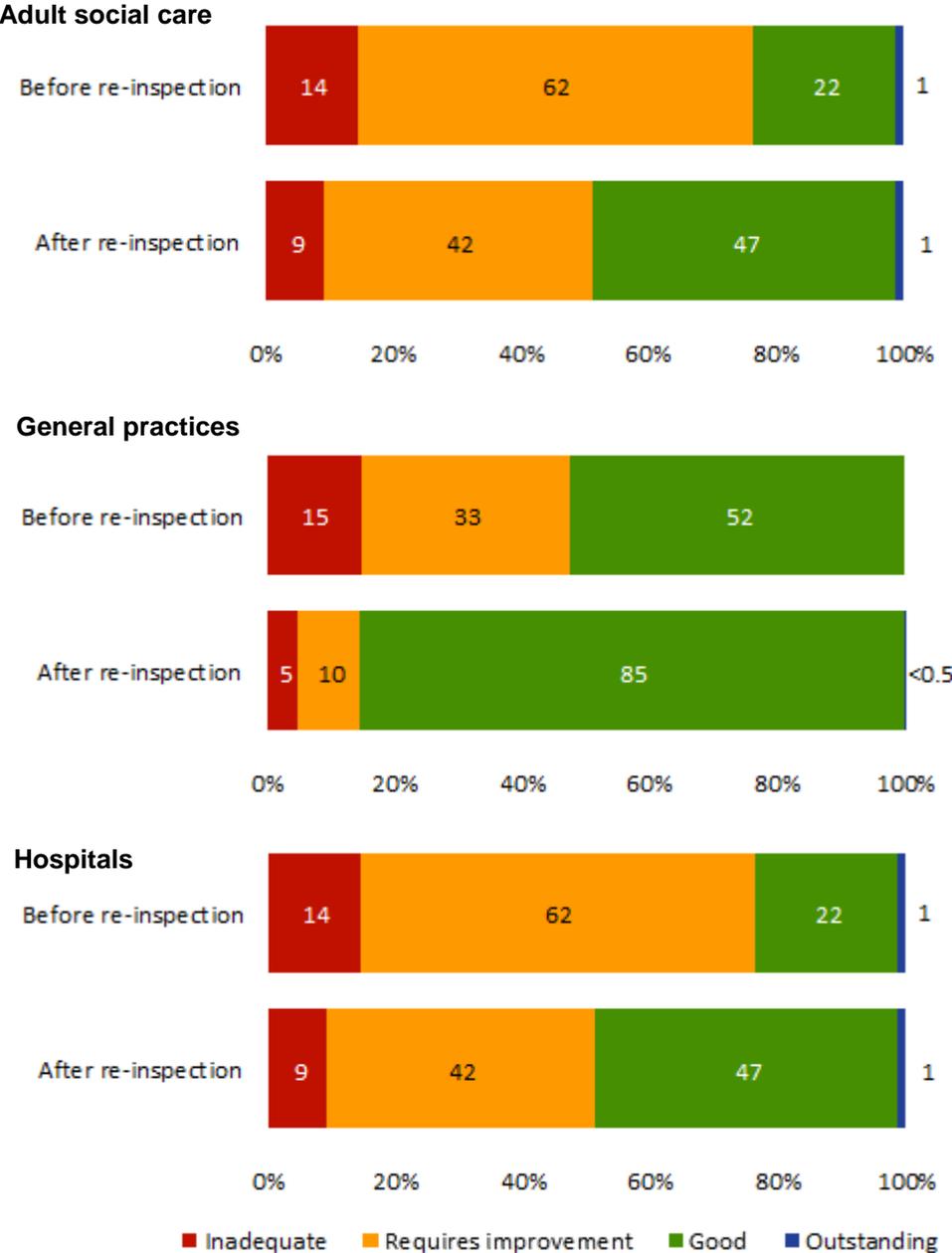
Figure 6 shows the rating profiles of those services that had been re-inspected up to 31 December 2016, comparing the position from the first inspection to the last re-inspection. It should be noted that there may have been more than one re-inspection, and some services have been re-inspected where their first overall rating was good or outstanding. This will either be due to the emergence of new information or to

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<sup>2</sup> Figure of 76 comprises NHS and independent healthcare providers and locations.

follow up specific areas where lower level ratings were requires improvement or inadequate.

**Figure 6: Ratings profiles for those providers or services re-inspected up to 31 December 2016, comparing position from first to last re-inspection**



Source: CQC ratings data. The data for hospitals is a combination of ratings for NHS provider trusts and independent healthcare locations. While not shown here, the picture for changes to ratings at core service level within hospitals is broadly similar.

## 3.2 We are seeing improvements through the use of special measures

Where there are serious failures of care – usually when a provider or service is rated as inadequate – we place them (or in some cases recommend they be placed) into special measures. The purpose of special measures is to ensure that providers that provide inadequate care make significant improvements. It is different from enforcement action in that it provides a structured framework where, in certain cases, we can work with or signpost to other organisations in the system to ensure improvements are made.

There are some differences in the process we use for special measures in different sectors. For NHS trusts there is a clear defined route to receiving extra support and help; for GP practices there is some help available from other organisations, but in adult social care this does not exist. The timescales for improvement in special measures can differ markedly, especially in NHS trusts which are large and complex organisations. For example, Cambridge University Hospitals NHS Foundation Trust exited special measures after 16 months (September 2015 to January 2017), compared with more than three years for Sherwood Forest Hospitals NHS Foundation Trust (July 2013 to November 2016).

Many providers have improved while in the special measures programme. From January to December 2016, 551 providers exited special measures (figure 6a). Of these, 386 had improved sufficiently to exit special measures, 93 were de-registered and 72 had their registration cancelled.

**Figure 6a: Special measures exits and entrants, 2016**

	Entrants in 2016	Exits in 2016	Of which			In special measures on 31 December 2016
			Improved	De-registered	Registration cancelled	
Adult social care	593	433	311	64	58	407
Hospitals	5	4	4	0	0	16
GP practices	162	114	71	29	14	127
Total	760	551	386	93	72	550

### **Improvement and special measures**

One remarkable example of improvement at the trust was Wexham Park Hospital, which went from inadequate to good in just over a year. The hospital managed to reduce its deficit and its number of staff while markedly improving quality of care. Behind this impressive turnaround was a huge investment, including financial assistance, in changing the organisational culture and supporting leadership at all levels.

A six-month follow-up inspection in 2015/16 of a GP practice in special measures identified that there had not been satisfactory progress in rectifying the issues for which it had been placed in special measures. CQC issued a notice to suspend the provider as CQC did not think other options would bring about the improvement necessary. In order to provide continuity of service to patients, another provider took responsibility for the location and support had been provided by other stakeholders such as NHS England and the clinical commissioning group. At the end of the suspension, the other provider assumed responsibility for the location and had the location added to their own registration.

### **3.3 Providers make changes because of CQC inspections**

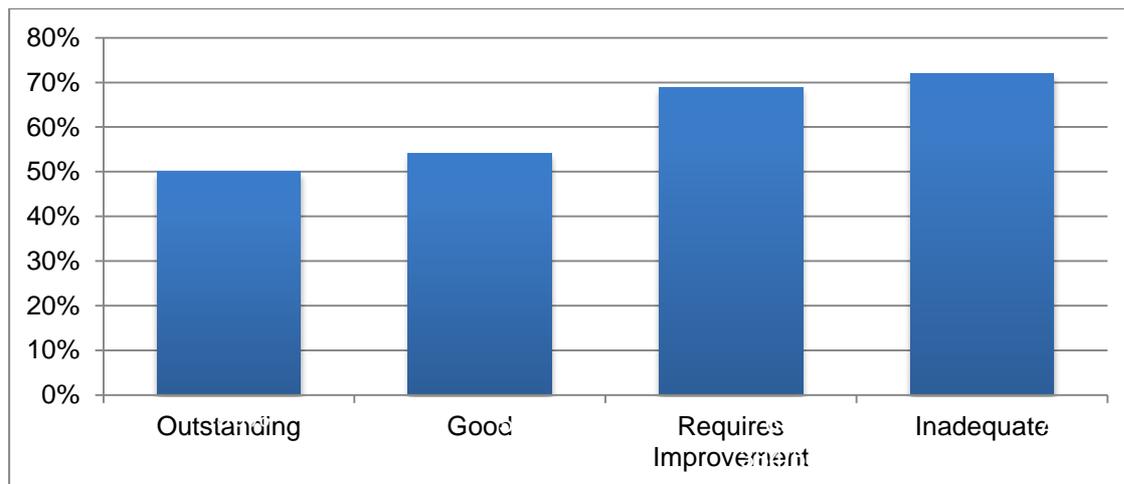
*“Inspection reports all helped. We followed up every action. I don’t believe we’d have got the rate of improvement and acceleration without the reports and action plans.”*

Chief Executive, University Hospitals Morecambe Bay NHS Foundation Trust

Providers have told us they make a wide range of improvements as a result of our inspections. In our post-inspection survey of providers, 69% of respondents (1,928 out of 2,803) stated specific changes that they had made or were planning to make because of the inspection process.

Respondents to the post-inspection survey with a rating of inadequate or requires improvement appeared more likely to say they made improvements than those rated good or outstanding as a result of the inspection (figure 7).

**Figure 7: Providers making changes as a result of inspection, by rating**

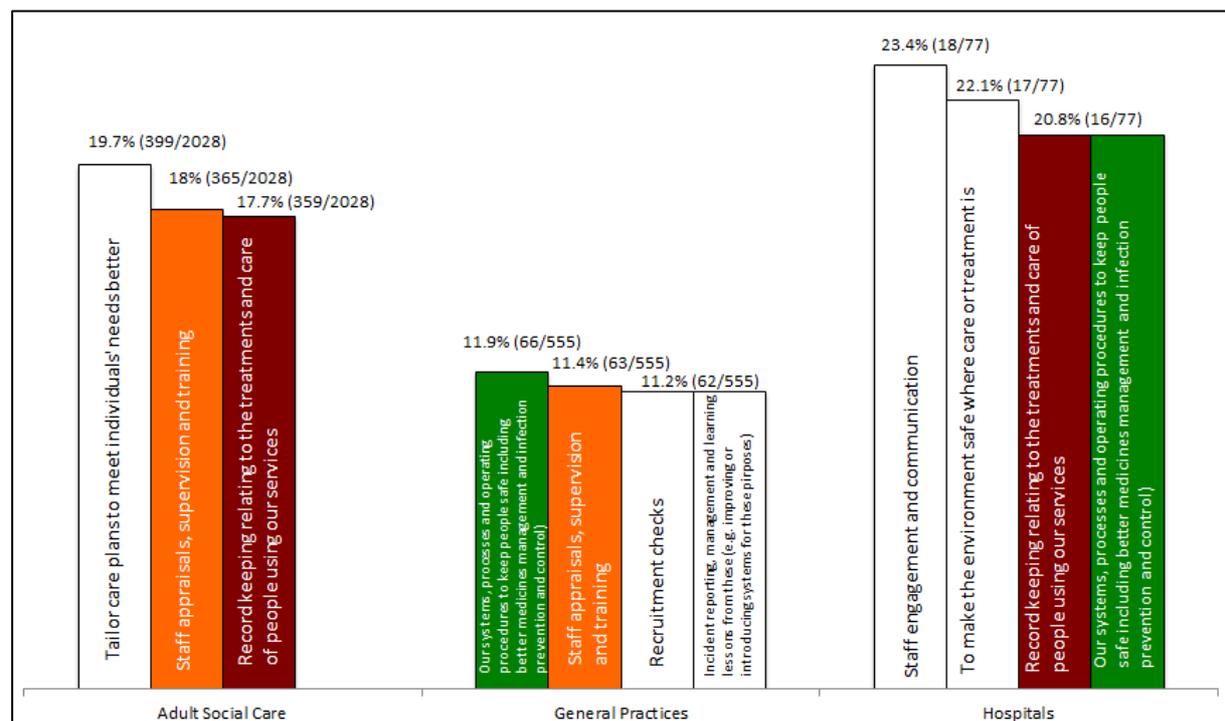


Source: Post-inspection survey, January to June 2016

Across all sectors, many of the changes made by providers responding to our post-inspection survey related to administrative activities, such as process, procedure and record-keeping (figure 8). While these things are not normally thought of part of the quality of frontline care, our evidence shows that they are an influence on quality.<sup>2</sup>

We look at these processes because they are fundamental to quality – for example, strong governance and good leadership. We know from our experience of inspecting and regulating services that these activities are often not as ordered or systematic as they could be, which poses a risk of poor quality care.

**Figure 8: Three most common changes made as a result of an inspection visit**



Source: Post-inspection survey, January to June 2016

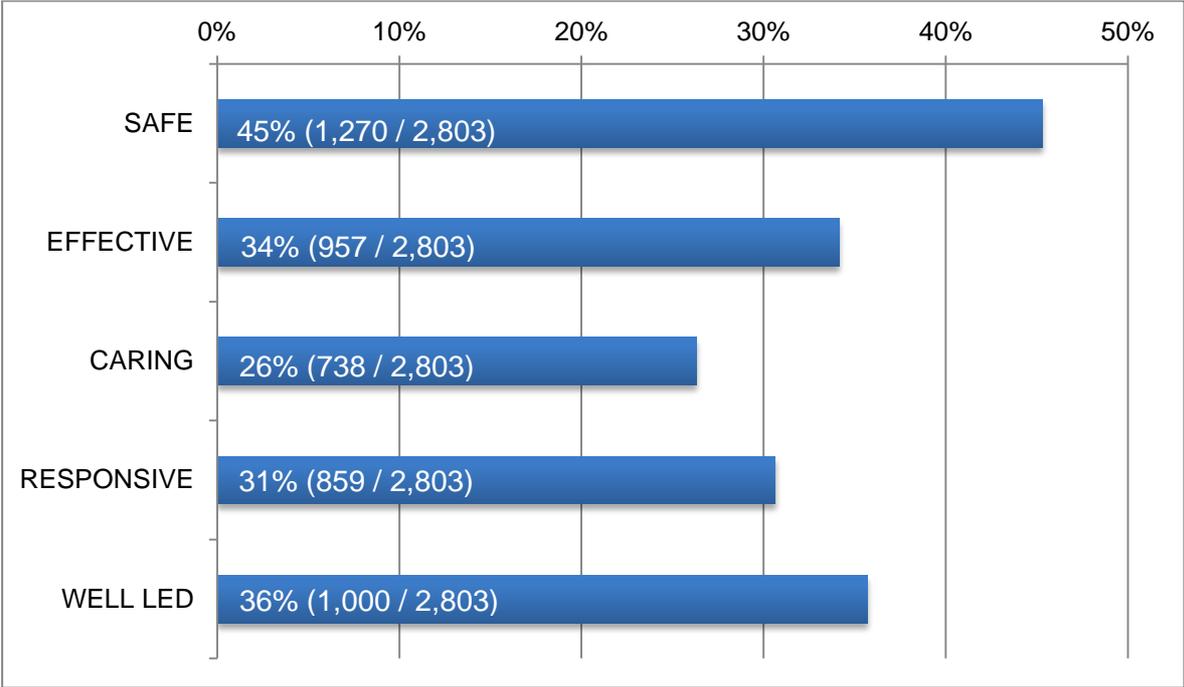
Some providers make improvements prior to inspection, and there were examples of this within the case studies we carried out, such as the review of documentation and improvements made to the physical environments, such as refurbishments.

Providers also use our standards and guidance to inform changes and improvements they make to their services. Overall, 80% of providers responding to our post-inspection survey said that CQC standards and guidance helped them to improve the quality of their services (of 2,803, 671 strongly agreed and 1,583 agreed). Compared with other sectors, this finding was less strong among general practices, with 56% of those responding (39 strongly agreed and 272 agreed, out of 555) saying that CQC’s standards and guidance helped them improve quality.

**Safety improvements**

Nearly half of respondents to our post-inspection survey (45%, 1,027/2,803) told us that they had made changes to their services that we would expect to lead to improvements to the safety of the care they provide (figure 9).

**Figure 9: Areas of quality where providers make changes due to CQC inspections**



Source: Post-inspection survey, January to June 2016

There were also instances in the case studies of inspection (and registration) leading to or speeding up changes in safety. In one large acute hospital, the inspection highlighted that some areas of the Emergency Department were not as clean as they should be, and that infection control practices needed prioritising. As a result, the cleaning team’s work patterns were changed and time for deep cleaning was added, in addition to tightening up infection control practices. In a residential social care provider, the deputy care home manager described how, following inspection, they

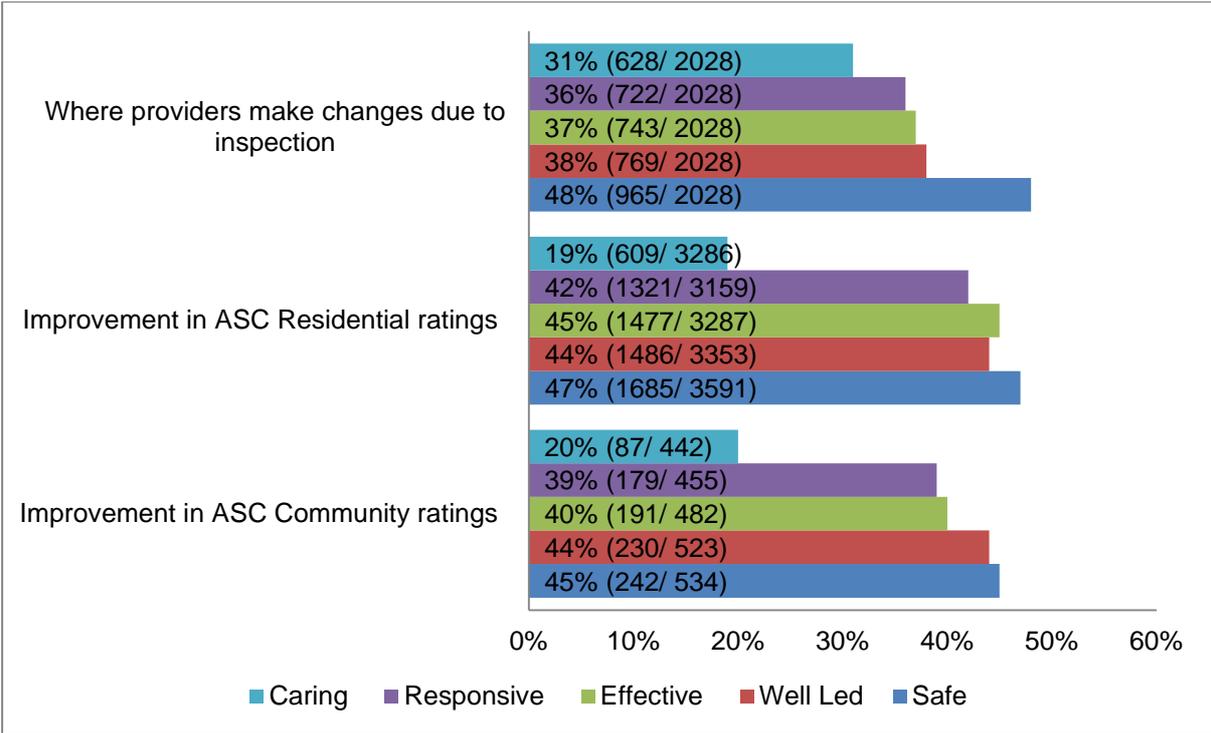
had a more rigorous approach to checking and auditing medication. In a medium-sized GP practice, the practice nurse described activities that she conducted more rigorously since CQC registration. For example, she carried out a daily inspection of all clinical rooms to ensure optimal infection control and removed clinical waste safely. She also held annual infection control sessions with all clinical staff.

**Adult social care**

Of the providers in adult social care that responded to the post-inspection survey, 89% (1,795 out of 2,028) told us that the inspection visit had made them think about how they deliver care, and 82% (1,664 out of 2,028) said the inspection report helped them take action to improve their service.

Figure 10 shows the areas of quality that adult social care providers have told us they have changed or plan to change as a result of inspection. These are also the areas where we are more likely to see improvements when we go back in on re-inspection.

**Figure 10: Improvements in rating on re-inspection and the areas where providers made changes in adult social care**



Sources: Top set of bars, post-inspection survey January to June 2016, covering all inspections, including first inspections and re-inspections; Bottom two sets of bars, ratings data from re-inspections only, as at 31 December 2016

## General practices

Among general practices responding to our post-inspection survey, 58% reported planning or undertaking improvements as a result of CQC inspections (321 out of 555). Changes were most likely to be related to the safety of care, with 51% (285 out of 555) of GPs making or planning to make changes in this area. Safety was where we saw most improvement on re-inspection, with 87% (721/831) of GP practices improving their rating for this key question. It is also where providers are most likely to be rated requires improvement or inadequate on first inspection.

Overall, the changes reported by general practices were most commonly around personnel matters, such as recruitment checks and training.

## Hospital providers

Hospital providers are usually much larger and more complex organisations than provides in other sectors and can need more time to turn around problems. Of the hospitals that responded to the post-inspection survey, 92% (71 out of 77) told us that the inspection visit had made them think about how they deliver care, and the same percentage mentioned the report had helped them take action to improve their service.

When we go back and re-inspect providers we find most improvement in hospitals on the questions about safe and well-led, with 45% (33/73) and 37% (23/61) of locations or providers improving, respectively. Safety is the area where hospitals report, in the post-inspection survey, making most changes as a result of our inspections: 62% (48 out of 77), followed by effective 60% (46 out of 77) and well-led 56% (43 out of 77).

In hospitals, evidence suggests that the inspection process may speed up improvements that were already planned, and can enable funding to implement change. In other cases it can instigate new changes to be identified.

*“CQC did highlight some areas where we need to change and improve. Some of these we knew of already, but another – the learning disability side – was a blind spot. Practice had fallen out of step.”*

(Chief operating officer, large acute hospital)

Some respondents to the hospitals post-inspection survey reported that the inspection visit and inspection report had prompted changes to staffing levels and/or caseload management (10 out of 77). CQC has previously identified and reported that getting staffing right is not simply about having the right number of staff, but having the right mix of staff, with the right skills, to meet people's needs. Inspectors ask providers to see where they have identified suitable staffing levels for each department and assess how this compares with actual numbers, and they make recommendations if there are shortfalls.

However, even though hospitals tell us that inspection can be a catalyst for staffing changes, evidence does not necessarily suggest that inspection leads to an overall increase in staff numbers. Changes made as a result of inspection may reflect a change in skill mix or address issues in particular departments or wards, but there appear to be no significant changes in overall numbers of permanent staff.

CQC carried out an analysis of acute NHS trusts rated requires improvement to assess whether staffing levels had increased following inspection. The approach tested whether there was any change in the rate of staffing (that is, increases or decreases in the numbers of staff per unit patient volume) occurring at, or after, the date of an inspection. Out of the 27 trusts analysed, 14 had seen staffing changes after inspection. The point in time at which the changes were observed was different in all providers, which could reflect the time in getting the inspection report, or making the changes. Or it may be coincidental and other factors were at play. There was also little consistency in the pattern in staffing changes between trusts.

Review of the inspection reports found that, in eight of these 14 cases, inspectors had highlighted that staffing was a concern. However, there were many examples where the overall change in staffing levels did not reflect the specific recommendations in the report, suggesting that there are other factors that influenced these decisions.

Inspection alone is not enough to drive sustainable improvement. CQC recognises five sets of influencers which, when working together, can make positive changes:

- Commissioners and funders of care
- Providers of care at board and executive level, service level and practice level
- Care staff and clinicians
- Regulators and national bodies
- The public and people who use services.

Each of these have the ability to influence and support improvements in care. While we encourage improvement in hospitals, responsibility for implementing change lies with trusts, working alongside our strategic partner, NHS Improvement. We work closely with NHS Improvement to ensure together we support and encourage improvement, while reducing the burden on providers. We are committed to greater alignment between our organisations (for example, working to remove duplication between our organisations) so that our definitions, measurement and operations are based on a single shared view of quality.

### 3.4 We produce publications and work with others to encourage improvement in quality

We publish information and reports about a range of health and social care issues for the public and people who use services, care providers, commissioners, our regulatory partners and our own staff. This reporting, along with our published inspection reports, represents thousands of individual exercises in using CQC's independent voice each year.

We draw on our understanding of the quality of care across the health and adult social care sector to publish an annual report to Parliament, called *The state of health and adult social care in England*. Our 2015/16 State of Care report, which warned that adult social care services were approaching a tipping point, led to important debates (including in Parliament) about how quality can be improved in adult social care and, in this case, discussions about additional funding for the sector.

We work closely with providers and partners in the system, and we carry out thematic reviews that highlight what good practice looks like and how care can improve. Our most recent thematic reports have included:

- Our report on neonatal care – a review of how risks for newborn babies are identified and managed and of the care for infants in the community who need respiratory support.
- *Not seen, not heard* – a review of the arrangements for child safeguarding and health care for looked after children in England
- *My diabetes, my care* – a report on people's experiences of diabetes care and the support they are given to self-manage their condition.
- *Better care in my hands* – a review of how people are involved in their care and what better involvement looks like.
- *Building bridges, breaking barriers* – a report on well care for older people is integrated across health and social care, as well as the impact on older people who use services and their families and carers.
- *Learning, candour and accountability* – our report on the way NHS trusts review and investigate the deaths of patients.
- *A different ending* – a review of end of life care.
- *Safe data, safe care* – a review of whether personal health and care information is being used safely and is appropriately protected in the NHS.

Many providers responding to the annual provider survey said that they made changes to their services as a result of CQC's publications. The most impactful reports in all sectors in 2015 were *Complaints matter* (32% - 877 out of 2,703 mentioned); our *Deprivation of Liberty Safeguards* report (45% - 1,237 out of 2,743 mentioned), and *Celebrating good care, championing outstanding care* (30% - 818 out of 2,707 mentioned).

Some providers who responded to the annual provider survey felt that the changes they made had resulted in improvement in care for people who use services. More than half of all adult social care (69%, 1074/1546) and Hospital (55% 101/184) respondents told us there were improvements in care because of CQC publications, as did nearly a third of GP practice respondents (106/331).

In recent feedback from key national stakeholders, we found that CQC publications, inspection reports, ratings and ongoing engagement helped some of our strategic partners to:

- foster a greater understanding of the health and social care landscape and wider policy context
- benchmark a single view of quality
- flag particular risks and informed their own organisation's intelligence or recommendations
- prompt regulatory action by their organisation.

We have created two new online tools for general practice: one brings together examples of innovative and outstanding GP care that providers can learn from, and the other shows examples of the main features of the inadequate practice we find.

It is too early yet to assess fully the impact of our work with others to drive improvement. In our strategy for 2016 to 2021, we have a commitment to strengthen our relationships with partners in the system, as well as working with providers and the public to agree a definition of quality and how it should be measured based on our five key questions,

However, we know we are part of a complex system, with many influences on quality. Improvement first and foremost should happen because of efforts from the providers themselves and with support they receive from other statutory bodies and strategic partners. Also, capacity for improvement is different in different services – some get more help than others with improvement. For example, NHS Improvement may provide a package of help for an NHS trust in special measures, but similar support may not be available for other organisations regulated by CQC. We must also get a clearer idea about why some organisations do not improve, despite inspections, enforcement action or other support activity from system partners.

## 4. Future reporting and next steps

Understanding our impact is essential to the way we work and improve as an organisation, so we will build this into our approach to planning and reporting. However, assessing the impact of any regulator – and particularly in such a complex area as health and social care – is a challenge.

This report constitutes some of the key elements of our impact that we know about so far. It is too soon to offer a full assessment and we are still learning about the impacts of some of the key components of our operating model – for example, the results of re-inspection and timescale for improvement will vary in different contexts: re-inspecting an inadequate care home and its road to improvement is different compared with the improvement journey for a mental health trust. What we learn about our impact on improvement and quality of care will differ after 12 months, or three years, or a decade.

In May 2016 we published our five-year strategy. Our approach to understanding CQC's impact will be intrinsically linked to the way in which we assess whether we are achieving the ambitions we set out in that strategy. There will be impact measures built in to each annual business plan as we progress the delivery of our strategy. We will then strengthen our reporting of these measures through our quarterly performance reports, which are scrutinised in public by our Board, and through our annual report and accounts, which is laid before Parliament. This will help us to ensure that we remain accountable and that we use this evidence to learn and improve as an organisation.

To continue to understand when and how our activity results in improvements in the care people receive we will ask ourselves a number of questions including:

- What is the impact on providers of the changes we make to our regulatory approach?
- How do we contribute to better, innovative and sustainable care for people who use services, and what enables or limits this?
- Do the public and commissioners use CQC evidence and ratings when making decisions about care, and what influences this and what effect does it have?

We will focus on areas where we know less, including the effects of our enforcement activity and how we encourage improvement through our publications, and through our relationships with providers and our local and national strategic partners. This will involve continuing to understand how the impact we have on quality interacts with other drivers of quality in the system.

We will strengthen the robustness and completeness of the evidence we collect so that we can have a stronger evidence base to inform our learning and improvement as an organisation. This will include reviewing how we collect information so that we are able to better understand the breadth of our impact on all providers, people who use services and stakeholders, rather than this being limited to those who have provided us with feedback.

We recognise that we need to continue to develop our understanding of our efficiency and effectiveness more broadly, and develop greater insight into the cost for providers of engaging with regulation and making resulting changes to their services. We have undertaken initial work to understand the cost to providers of regulation. This has proved difficult for providers to estimate, so we will continue to work with them to develop our understanding of this further. We will continue to strive to better understand our own costs, the effects of changes we make to our cost base and through that, the fees we charge providers of care.

We will continue to work with partners and other organisations to bring about improvements in the quality of health and social care, such as through the Five Year Forward View, the National Quality Board and the 'Quality Matters' initiative within adult social care, work with the Royal Colleges and other bodies that represent professionals and providers, and the work going on across the country on new care models.

## Appendix: evidence sources

We have used a range of surveys and other evidence for this report (figure 11). These sources were not designed to provide us with a conclusive view about the impact of our work on the providers we regulate or the quality of care in the health and social care system where we regulate. The development of this publication has helped us to identify our next steps to build a bigger picture.

In drafting this report, we were mindful to only draw conclusions backed by the evidence available to us. With regards to the surveys:

- Survey findings refer only to respondents, not their respective population groups, with responses to the post-inspection and post-registration surveys from around one in four of those surveyed.
- We know that the respondents to our post-inspection survey are not entirely representative of all providers. This is because providers with better CQC ratings are more likely to respond to the survey. The public awareness survey is based on a representative sample of the population. For the others surveys we do not know if the respondents are representative, because the responses are anonymous or we do not hold the information to check if the samples are biased. We have to be cautious in drawing comparisons between sectors due to the number of responses in some cases and the lack of a representative sample from each sector.
- The post-inspection and post-registration surveys are not anonymous at the point of completion and this is so that information about the type of provider can be used to better inform our analysis. However, only those involved in analysis are given access to identifiable information. Respondents are assured that no one involved in making regulatory decisions will be aware of their individual responses and that all findings will be presented anonymously.

The evidence we have at this stage is indicative of our impact. Our evidence will become more robust by having a clearly defined framework – we will improve how we collect information from our stakeholders, as well as better understanding how and when impact occurs, so that it is more measurable.

**Figure 11: Sources of evidence**

Source	Methodology
<b>Ratings analysis</b>	Initial ratings following a first comprehensive inspection. Observed movement in ratings following re-inspections of rated providers/locations. All rated providers until 31 December 2016.
<b>Post-registration survey</b>	An electronic survey of providers who undertook registration activities from January to June 2016. Figure 12 shows the number of email invitations issued and responses.

<b>Post-inspection survey</b>	An electronic survey of providers following publication of their inspection reports from January to June 2016. Figure 13 shows the number of email invitations issued and responses.
<b>Inspection report survey</b>	CQC website survey of users searching for inspection reports between April 2015 and March 2016. This uses a 'convenience' sample as it is based on those who access our reports on the web and choose to complete the 'pop-up' survey. It may therefore may not be representative of all those who read our reports. There were 5,398 responses, of which – 45% were members of the public and 42% providers of care.
<b>Public awareness survey</b>	Annual nationally representative online and telephone survey of 1,000 members of the public, to provide CQC with a clear understanding of how its information and reputation are perceived. Survey conducted in April 2016.
<b>Annual provider survey</b>	This survey is conducted annually and is sent electronically. It is anonymous and was sent in October 2015 to more than 70,000 provider nominated individuals and registered managers on our customer relationship database. Follow-up email and bulletin reminders were also sent. Results presented here are based on 4,740 responses (2,764 in adult social care, 384 in hospitals and 1,592 in primary medical services (including primary dental care services)). The approach to the survey means that we do not know how representative the results are of all providers.
<b>Case studies</b>	Research agency Ipsos MORI provided 27 case studies, based on qualitative telephone interviews and face-to-face site visits. The sample was constructed to include a range of providers from all sectors; a mix of geographical areas; different sized providers and a range of inspection ratings.
<b>Management information</b>	Data gathered for management information and planning was added to the other sources to provide comprehensive evidence from all available data. Unless stated otherwise, management information covered in this report refers to January to December 2016.
<b>Public ratings research</b>	Qualitative research into the public's understanding of CQC ratings conducted in January and February 2016. It included 120 intercept interviews at 6 health and social care sites (2 hospitals, 2 GP surgeries and 2 care homes; 20 interviews at each site). There were also two pre-tasked focus groups with six users of health and social care services in each group.
<b>Stakeholder feedback</b>	We asked 32 organisations with whom we have joint working relationships for feedback on how effectively we have been working with them. Of these, 15 responded to our short email survey which consisted of nine questions.

**Figure 12: Response rates for the post-registration survey**

	<b>Responses Jan-Jun 2016</b>	<b>Invites sent Jan-Jun 2016</b>	<b>Response rate</b>
Adult social care services	1,098	4,593	24%
Hospitals	74	411	18%
GP practices	81	557	15%
Primary dental services	123	1,149	11%
CQC overall	1,376	6,710	21%

Note: in addition to the responses above, there were 47 responses from: out-of-hours GP services (3), urgent care services and mobile doctors (3), joint inspections with partner organisations (2), and unrated primary medical services (39). These have been excluded from the analysis for this report.

**Figure 13: Response rates for the post-inspection survey**

	<b>Responses Jan-Jun 2016</b>	<b>Invites sent Jan-Jun 2016</b>	<b>Response rate</b>
Adult social care services	2,028	8,102	25%
Hospitals	77	272	28%
GP practices	555	2,091	27%
Primary dental services	143	653	22%
CQC overall	2,803	11,118	25%

Note: in addition to the responses above, there were 13 responses from: urgent care services and mobile doctors (1), joint inspections with partner organisations (3), unrated primary medical services (8) and unknown (1). These have been excluded from the analysis for this report.

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<sup>1</sup> <https://www.hsj.co.uk/hsj-knowledge/top-leader-lists/top-chief-executives/revealed-the-nhss-top-trust-chief-executives-in-2017/7015523.article>

<sup>2</sup> <http://www.cqc.org.uk/content/state-of-care>