Care Quality Commission

# Business plan

## April 2018 to March 2019

# Contents

# Foreword

## Achievements in 2017/18

Our strategy for 2016 to 2021, published in May 2016, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care. In its October 2017 report, the National Audit Office (NAO) concluded that we had made "substantial progress" in strengthening the way we monitor, inspect and regulate hospitals, care homes, general practices and other services across the country. A Committee of Public Accounts report in March 2018 similarly recognised the significant improvements that we have made and the areas that we are continuing to work on.

In 2017/18 we have been delivering inspections at frequencies determined by rating and potential changes to quality (improvements or deteriorations). We have also published our State of Care and other reports in which we used our independent voice to comment on the quality of health and social care and the major issues facing the sectors. We continue to reduce our costs and we are on target to deliver savings in line with the government's comprehensive spending review. We have used our resources more efficiently and have invested in our people, developing their skills to deliver our regulation, but also commissioning and delivering our Inspire leadership development programme. We have made important appointments: a Director of Quality Improvement, and a new Director of Intelligence. We have embedded an approach to medium-term planning for our organisation and we now have work underway developing the detailed programme of change that will take us through to 2021. This has informed the 2018/19 business plan.

## Priorities in 2018/19

We have a significant task in the year ahead. We are delivering a further phase of transformation to take us through to 2021. The priorities we set out for the year in this plan will enable us to further implement a responsive model of inspection with improved information for the public, and providing greater efficiency for ourselves and providers. The plan will also help us to manage ourselves more effectively, so CQC is better able to encourage improvement, innovation and sustainability in care.

As a result of our work in 2018/19:

- **Providers** should have a clearer understanding of our expectations and a better online experience, and an intuitive system that encourages them to supply information not already available to CQC.
- The **public** will see information that continues to help them make decisions about care, not only from inspections but from our work monitoring providers before and between inspections.
- Our **staff** will have timely, accurate data with better insight, and better technology so they can perform essential aspects of their work, especially when mobile. They will also have increasing expertise so they have the skills and experience to make the right improvements to the way we work.

Our plan reflects what we see as the most critical things for our organisation, but also the views of our stakeholders, including the NAO and Public Accounts Committee. Our priorities align with the NAO action plan that our Board agreed in December 2017.

Finally, this business plan focuses on the work we will undertake in 2018/19 to continue to change while improving day-to-day delivery for the public, providers and those who use health and adult social care services. We hope you will find this plan useful if you work with CQC, or work for CQC. We will use the plan to track our progress and report publicly on this through our Board meetings during the coming year, and in our Annual Report in 2019.

**Peter Wyman**
Chair

**Sir David Behan**
Chief Executive

# Introduction

This business plan sets out nine key priorities to be delivered. The **benefits** of this work and the business plan **priorities** that will achieve them are set out here:

| **Benefits** in 2018/19* | **Priorities** in 2018/19 |
|---|---|
| In **registration**<br><br>An improved registration process that:<br>• For providers, makes clear our expectations and provides a better online experience that gives a positive first impression of CQC.<br>• For the public, gives a clear and accurate picture of the organisations that deliver care, and the history of their quality.<br>• For our staff, gives an accurate base of information that enables us to regulate organisations effectively, including information on who owns them and who is accountable for the quality of care. | **Transform registration** so it focuses on high quality services, supports innovation, improves information, and uses a risk-based approach that is more proportionate for providers.<br><br>**Deliver a digital programme** of user-focused technology that drives efficiency. |

| **Benefits** in 2018/19* | **Priorities** in 2018/19 |
|---|---|
| In how we **monitor**<br><br>Better collection of data from providers - more reflective of risk in real time. This improvement will mean:<br>• Providers have an intuitive system that encourages them to supply information not already available to CQC, and enables them to update it whenever it changes.<br>• The public will see information that helps them make decisions about care not only from inspections but also from our work monitoring providers before and between inspections.<br>• Our staff and stakeholders will have access to better quality information from which to make regulatory decisions and will have a more complete picture of the care provided in each local area. | **Enable CQC to become intelligence driven** - making best use of data about quality of care to deliver enhanced insight, and an always-on service to collect information from providers.<br><br>**Deliver a digital programme** of user-focused technology that drives efficiency.<br><br>Ensure CQC is able to respond to changing models of care, including use of new technology. |

| | |
|---|---|
| Using improvement in registration and monitor, we will also improve how we **inspect and rate.**<br><br>For our staff:<br>• More timely, accurate data packs with better insight from qualitative data.<br>• Better technology to make essential work easier, especially when mobile – in particular, making evidence collection easier on-site.<br>• Reports will be focused and have fewer review points so that inspectors feel ownership - and reports will be published more quickly.<br><br>For the public and providers:<br>• Improved report structure so that providers and the public can better access the information they need.<br>• CQC is better able to encourage improvement, innovation and sustainability in care through a responsive model of inspection, implemented in line with our funding model.<br>• Continue to develop our independent voice to help improve health and care services locally and nationally. | Develop CQC's approach to **assessing the quality of care in a place,** enabling improvement.<br><br>Roll out **changes to the regulation of independent health providers,** introducing ratings for the first time to some.<br><br>**Strengthen CQC's independent voice and engagement**, including with local stakeholders to build relationships and maximise intelligence to support our inspectors. |
| **Benefits** in 2018/19 | **Priorities** in 2018/19 |
| Across **all our work**:<br>• Increased staff engagement – providing the right support for front line managers to engage effectively with their teams to have good and effective conversations that help improve the organisation.<br>• Continue to have people with the right skills and experience.<br>• Transfer of expertise in quality improvement to staff so they have the skills and experience to make the right improvements to the way we work.<br>• CQC can improve its performance and its consistency. | **Improve the experience of staff within CQC.**<br><br>**Develop a quality improvement culture within CQC.** |

*Some technological benefits commence in 2018/19 but will also be delivered over subsequent years; the later deliverables sections contain further detail.

# Our plan in summary

CQC is the independent regulator of health and adult social care services in England

**OUR PURPOSE**

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve

## Our role

| Register | Monitor, inspect, and rate | Enforce | Independent voice |
|---|---|---|---|
| **We register health and adult social care providers** | **We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings** | **We use our legal powers to take action where we identify poor care** | **We speak independently, publish views on major quality issues in health and social care, encourage improvement by highlighting good practice** |

## Our strategy priorities

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| **Encourage improvement, innovation and sustainability in care** | **Deliver an intelligence-driven approach to regulation** | **Promote a single shared view of quality** | **Improve our efficiency and effectiveness** |

## Our values

| Excellence | Caring | Integrity | Teamwork |
|---|---|---|---|

## We will know we have succeeded when…

| | | | |
|---|---|---|---|
| People trust and use our expert, independent judgements about quality of care | People have confidence that we will identify good and poor care and take action where necessary | Providers improve quality as a result of our regulation | Our staff believe we display our values and behaviours |

**OUR BUDGET AND STAFFING**
**£223 million**
**3,300 full-time equivalent staff (approx)**

## Our business plan priorities in 2018/19

### Develop how we deliver our role and manage our organisation…

| 1 Transform registration | 2 Ensure CQC is able to respond to changing models of care, including use of new technology | 3 Develop CQC's approach to assessing the quality of care in a place | 4 Roll out changes to the regulation of independent health providers | 5 Strengthen CQC's independent voice and engagement |
|---|---|---|---|---|
| So it focuses on high-quality, supports innovation, and uses a risk-based approach that is better for providers | So we can effectively register and inspect them | Enabling improvement, and efficient information gathering and sharing | Inspection frequency based on ratings for some and other changes in line with what we have done in other sectors | Including building relationships with local stakeholders to maximise intelligence to support our inspectors |

### …in line with our strategy and our values

| 6 Deliver our digital programme | 7 Enable CQC to become intelligence-driven | 8 Develop a quality improvement culture within CQC | 9 Improve the experience of CQC staff |
|---|---|---|---|
| User-focused technology that drives efficiency | Making best use of data about quality of care to deliver enhanced insight, and an always-on service to collect information from providers | Transfer expertise in quality improvement to staff so they have skills and experience to make improvements to the way we work | Increase staff engagement - ensure we continue to have people with the right skills and experience |

### ...improving how we deliver our role to:

| | | | | |
|---|---|---|---|---|
| • Register new services; determine variation and cancellation applications | • Monitor and share information about risk and concern across inspection directorates and with partners<br>• Respond appropriately to enquiries, complaints, safeguarding, and whistleblowing concerns | • Inspect newly registered services, based on risk<br>• Inspect previously rated services, based on risk or potential improvement<br>• Work with NHS Improvement, assessing and rating NHS trusts' use of resources | • Take action to protect people and hold providers to account, working with commissioners and using all our enforcement powers<br>• Take prompt action when alerted to unregistered providers | Publish:<br>• Mental Health Act report<br>• State of Care report<br>• Local systems review final report<br>• Thematic reports and other publications |

# Part 1

**This describes:**

- **Who we regulate**
- **How we define achieving our purpose**
- **How we measure this**

# Who we regulate

## Hospitals, mental health and community services

- **134** acute hospital providers (NHS non-specialist) with **647** locations
- **18** acute hospital providers (NHS specialist) with **160** locations
- **132** acute hospital provider (independent non-specialist) with **343** locations
- **482** acute hospital providers (independent specialist) with **881** locations
- **10** ambulance service providers (NHS) with **12** locations
- **249** ambulance service providers (independent) with **306** locations
- **18** community health providers (NHS) with **352** locations
- **111** community health providers (independent) with **245** locations
- **18** community substance misuse providers with **110** locations
- **81** mental health – community and hospital providers (independent) with **273** locations
- **53** mental health – community and residential providers (NHS) with **492** locations
- **85** residential substance misuse providers with **153** locations
- **81** non-hospital acute providers with **190** locations
- **146** hospice/hospice service at home providers with **190** locations

## Adult social care

- **4,457** care home services with nursing
- **11,801** care home services without nursing
- **8,935** domiciliary care services
- **60** specialist college services
- **62** community-based services for people with a learning disability
- **528** extra care housing services
- **134** shared lives services
- **1,805** supported living services

## Primary medical services and integrated care

- **10,569** dental care locations
- **7,463** GP practices
- **93** GP out-of-hours services
- **145** prison healthcare services
- **27** remote clinical advice services
- **147** urgent care services and mobile doctors
- **963** independent consulting doctors
- **51** slimming clinics
- Children's safeguarding and looked-after children's services inspections with partner organisations
- Medicines optimisation (across all sectors)

## Local system reviews

- CQC's programme of local system reviews looks at how health and social care providers and commissioners work together to care for people aged 65 and older, including how delayed transfers of care are avoided. Staff across our sectors are involved.

# How we define whether we are achieving our purpose

## Impact

### Health and social care services provide safe, effective, compassionate and high-quality care, and improve

### Because:

## Outcomes

### People who use services, their carers and the public…

| | | | |
|---|---|---|---|
| Trust and use our expert, independent judgements about the quality of care | Have confidence that we will identify good and poor quality care and take action where necessary so their rights are protected | Understand the quality of care they should expect and have information to help them choose between local services | Tell us that our mechanisms for them, that tell us about the care they receive, are effective |

### Providers…

| | | | |
|---|---|---|---|
| Improve as a result of CQC activities; take action when required to improve; f they are a Trust, then in addition, they improve use of resources | We anticipate high-risk providers when they apply to register. We have a powerful insight into the quality of care which helps us focus where we inspect | A single shared view of quality is evident in the way providers work; enables them to make improvements; and enables efficient information gathering and sharing | Providers think that inspection teams have the correct skills and expertise to effectively inspect their service |

### Partners and others…

| | | | |
|---|---|---|---|
| Understand and can improve quality of care for different population groups and geographies because of CQC information | Use our information to improve services and say we work with them to support continuity of care when we close services | A shared view of quality is evident in the way commissioners and other bodies work; it helps them to encourage improvement and information gathering and sharing is coherent | Tell us that our mechanisms for them, that tell us about the care they receive, are effective |

### Our staff...

| | | | |
|---|---|---|---|
| Are engaged | Feel supported and listened to | Have the technologies they need | Can perform at their best |

## Quality and performance

### Because we are clear about what is expected and…

| | | | |
|---|---|---|---|
| Our **registration** processes are robust but also streamlined for lower risk providers; they establish expectations and commitments; and they support innovation in the ways services are provided and organised | We seek people's views and experiences; analyse and respond to them; **monitor** information to make decisions about the action to take; use **inspection** to make thorough assessments of the quality of care, and form valid, reliable and timely judgements and **ratings** | We take targeted and proportionate **enforcement** action to protect the public from harm and make sure people's rights are protected, and we hold those responsible to account, publishing details where we can | We use our **independent voice** to share what we find locally and nationally, making this accessible to the public and people using services, providers, our partners and stakeholders, to inform and encourage improvement and innovation |

## Internal capability

### Because we are an organisation that manages itself effectively and…

**Our values** of excellence, caring, integrity and teamwork are expressed in everything we do

**Our quality framework** ensures we are accurate and insightful, reliable, timely, cost effective, and we reflect and learn in order to improve

**We have effective arrangements in place to manage** people, performance and risk, quality, our finance systems, and information and evidence, so that we plan effectively and deliver.

### We understand and manage the costs of regulation…

| | | |
|---|---|---|
| We understand our costs and how we can make the best use of our resources and use this to reduce our cost base | We understand our cost impact on **providers** and our revised systems and tools save time for them | We understand wider system costs - there is efficient sharing of information between CQC, providers, and local and national system partners that reduces burden |

# How we measure this

**Organisations that deliver care improve quality as a result of our regulation:**

## Outcomes

### People who use services, their carers and the public…

| | | |
|---|---|---|
| Say they trust that CQC is on the side of people who use services | Say CQC uses information from them to inform judgements and ratings | Say our inspection reports are useful and help them make choices |

### Providers…

| | | | |
|---|---|---|---|
| Say our relationships with them, guidance, registration, inspection, and reports help them to improve<br><br>Services improve on re-inspection or they are removed from the market if they remain poor<br><br>Trusts say assessment of use of resources is robust and helps them improve | Proportion of newly registered providers which are rated as 'inadequate' or 'requires improvement' at first inspection is reduced | Say that we focus on what matters to them, and use our approach in their governance and communications, and that reporting requirements to oversight bodies are reducing | Say that inspection teams have the correct skills and expertise to effectively inspect their service, and that our revised systems and tools save them time |

### Partners and others…

| | |
|---|---|
| Say we work with them effectively and our information helps services improve | Our strategic partners say we share a single shared view of quality |

### Our staff…

| | | |
|---|---|---|
| Believe CQC employees display the values and behaviours of the organisation | Tell us that their learning and development needs are being met | Our engagement index score increases |

## Quality and performance

### Because we are clear about what is expected and…

| | | | |
|---|---|---|---|
| **Register**<br>We meet our key performance indicators (KPIs) for timeliness of registration | **Monitor inspect and rate**<br>We meet our KPIs for responding to safeguarding, we produce reports quickly and we meet our inspection KPIs | **Enforce**<br>Services improve on re-inspection or they are removed from the register | **Independent voice**<br>Partners say our information helps services improve |

## Internal capability

### Because we are an organisation that manages itself effectively and…

| | | | |
|---|---|---|---|
| Complaints upheld by the Parliamentary Health Services Ombudsman are under 3% of those received | We respond to the public and providers in a timely way, meeting our KPIs for calls and correspondence and responding to complaints | We meet our KPIs for managing our budgets and levels of sickness | Our management assurance assessments show we are increasingly meeting our standards |

### Because we understand and manage the costs of regulation…

| | | |
|---|---|---|
| We see a reducing cost of delivery within CQC | Providers say our revised systems and tools save time for them | Partners say we work with them effectively and our information helps services improve |

# Part 2 – Activities in detail

**This describes:**

1. The deliverables we will take forward under each element of our role – to **deliver** it; and to **develop** it:

   - Register
   - Monitor
   - Inspect and rate
   - Enforce
   - Independent voice

   These are measured and reported through KPIs which are published on our website in public performance reports to the CQC Board

2. The transformational work that enables this development:
   - Digital and intelligence
   - Quality improvement
   - People

   These are measured and reported as milestones* and published on our website in public performance reports to the CQC Board

3. The work we are doing to manage our organisation

* Activities indicated as being ongoing work or that commence in 2018/19 but conclude in 2019/20 have a delivery date of Q4, indicating conclusion of 2018/19 work for the activity.

The annexes set out our structure, budget, KPIs we will use to measure our performance and risks we are managing.

| 1 | **Register** health and adult social care providers | |
|---|---|---|
| **KPIs** | **Registration processes completed within 10 weeks:**<br>- **new**<br>- **variation**<br>- **cancellation**<br><br>**(% targets shown in annex 4)** | |
| | **Activities** | |
| | **Deliver Registration** | |
| | Determine registration applications from providers for new registrations, variations and cancellations, delivering judgements that are robust, consistent and fair, and evidenced by quality controls and quality assurance. | Measured by KPIs (see above) |
| | **Transform Registration (Priority 1)** | **Due date** |
| | Start to implement registration for those responsible for 'directing and controlling care'. | Q3 |
| | Roll out the policy to ensure the regulatory history of a service continues even when the legal entity of the provider changes. | Q3 |
| | Start to implement our approach to risk-based registration and develop the taxonomy to support new care models. | Q3 |
| | Develop the assessment framework for adult social care and health in registration. | Q3 |
| | Develop the CQC register so that there is appropriate information for providers, our partners, and the public (ongoing). | Q4 |
| | **Deliver our digital programme (Priority 6)** | |
| | Develop and implement the first phase of a new digital service for registration which is clearer and less burdensome for providers to use.<br>• Online registration service for personal care (e.g.: domiciliary care agencies<br>  ○ Public Beta followed by live<br>• Online registration service for primary medical services<br>  ○ Discovery and Alpha | <br><br><br><br>Q3<br><br>Q4 |

| 2 | **Monitor** the quality of care in health and adult social care providers | |
|---|---|---|
| **KPIs** | • **Safeguarding alerts referred to local authority within 0-1 days**<br>• **Safeguarding alerts and concerns have one of 4 possible mandatory actions taken in 0-5 days**<br>• **Safeguarding or mental health calls answered in 30 seconds**<br>• **Mental Health Act visits planned each quarter completed**<br>• **SOAD (second opinion appointed doctor) requests undertaken within target time** | |
| | **Activities** | |
| | **Deliver Monitor** | |
| | Ensure that all enquiries, complaints, safeguarding and whistleblowing concerns are responded to appropriately and in a timely fashion in line with our KPIs. | Measured by KPIs above |
| | Share information about risk and concern across inspection directorates and with partners, to ensure we better understand local risks and can take the most appropriate regulatory action, and that partners and commissioners can help enable improvement. | |
| | Carry out Mental Health Act visits. | |
| | Continue to respond to requests for SOADs. | |
| | Continue to respond to Mental Health Act complaints. | |
| | Undertake regular assessments of the financial and quality performance of 'difficult to replace' adult social care providers within the market oversight scheme, using corporate provider quality assessments, and improve the sharing of information about quality with registration and inspection. | |
| | **Enable CQC to become intelligence driven (Priority 7)** | **Due date** |
| | Develop the CQC Insight tool:<br>• incorporate qualitative information, (continues into 2019/20)<br>• develop it for additional sectors<br>  • ambulances<br>  • independent health<br>• Develop it for cross-cutting services<br>  • systems<br>  • new care models (continues into 2019/20) | Q4<br>Q3<br>Q3<br>Q4 |
| | | |

| | | |
|---|---|---|
| | Develop next stage of NHS survey programme including a digital platform (continues into 2019/20). | Q4 |
| | **Deliver our Digital Programme (Priority 6)** | |
| | Information exchange improvement Andy Switzer Keith Wear<br>• Provider information return (PIR) - adult social care<br>  • Private Beta<br>  • Public Beta<br><br>• Share your experience care<br>  • Private Beta<br>  • Public Beta<br><br>• PMS (GP futures)<br>  • Private Beta<br>  • Public Beta | <br><br>Q1<br>Q2<br><br><br>Q1<br>Q2<br><br><br>Q1<br>Q2 |
| | Depending on the outcome of further programme prioritisation activity, commence discovery stage of either:<br>• cross-sector statutory notifications; or<br>• hospitals' routine PIRs and evidence flows from them | <br><br>Q3 |

| | | |
|---|---|---|
| **3** | **Inspect and Rate**<br>• **Inspect and rate new services registered with CQC**<br>• **Inspect previously rated services**<br>• **Undertake specialised, themed, or joint inspections, or inspect non-rated services** | |
| **KPIs** | • **Inspect and rate new services registered with CQC – within one year**<br>• **Inspect previously rated services within maximum time periods (see annex 5 – inspection frequencies)**<br>• **Publish inspection reports within 50 days, except hospitals inspections of more than three core services (within 65 days)** | |
| | **Activities** | |
| | **Deliver Inspect and Rate** | |
| | **Inspect and rate new services** | Measured by KPIs, above |
| | Inspect and rate new services registered with CQC. | |
| | **Inspect in response to potential changes to quality** | |
| | Inspect previously rated services, and non-rated services, in response to risk and at frequencies determined by their rating and type of service (as set out in annex 5). | |
| | Medicines optimisation team will support in excess of 1,000 inspection units across CQC, including attending the inspections where medicine risk is highest. | |
| | Use our influence in cross-sector work to reduce the use of and risks associated with restrictive practice in mental health wards, and then measure adherence to good practice during inspections. | |
| | Work to strengthen CQC's approach to assessing the delivery of care and treatment in hospitals where 'high secure' is a core service. | |
| | **Undertake specialised, themed or joint inspections** | |
| | Carry out inspections of children's services, health and justice and military health services, as set out in annex 5. | |
| | Lead a cross-directorate approach to the inspection of local health and social care systems in a local authority area. Known as local system reviews, these are undertaken at the joint request of the Secretary of State for Health and Social Care (DHSC) and the Secretary of State for Housing, Communities and Local Government, and they are dependent on continued funding in 2018/19. | |

| | Develop Inspect and Rate (Priorities 2, 3 and 4) | Due date |
|---|---|---|
| | **Ensure CQC is able to respond to changing models of care, including the use of new technology (Priority 2)**<br>• Develop CQC's approach to new innovative or technology-based models of care. (Continues into 2019/20) | Q4 |
| | **Develop CQC's approach to assessing quality of care in a place (Priority 3)**<br>• Develop CQC's approach to 'place', and shared view of quality, enabling improvement. (Continues into 2019/20) | Q4 |
| | **Roll out changes to regulation of independent health providers (Priority 4)**<br>• Roll out the changes to independent health, including introducing ratings for the first time for some. | Q4 |
| | Strengthen how we assess services at provider level (continues into 2019/20). | Q4 |

| 4 | **Enforce** – take action where we find poor care | |
|---|---|---|
| | **Activities** | |
| | **Deliver Enforcement** | |
| | Work with commissioners and take action to protect people who use services, holding providers to account through the appropriate use of all our enforcement powers, including prosecution in line with our enforcement decision process. | Enforcement activity is reported in performance and annual reports |
| | Take prompt action when we are alerted to unregistered providers and take enforcement action commensurate with identified risk. | |
| | Take action in relation to urgent and unplanned closures of care services in line with agreed protocol agreed with NHS England and the Association of Directors of Adult Social Services. | |
| | Working with partners, share information to identify and respond to risk, ensuring that timely action can be taken to protect people who use services. | |
| | **Develop Enforcement** | **Due date** |
| | Evaluate what we have achieved to date through a quality improvement programme and ensure lesson learned reviews take place and improvements are implemented through an agreed action plan (ongoing). | Q4 |
| | Improve our working across the adult social care, primary medical services and hospitals sectors when there are quality failures with combined/complex providers, to ensure our enforcement decisions are consistent. | Q3 |
| | Introduce a formal system of reviewing criminal enforcement cases through case management review panels. | Q3 |
| | Provide advice and expertise to take forward civil and criminal enforcement cases in court (ongoing). | Q4 |
| | Procure and implement a regulatory skills programme for CQC staff so they have better knowledge and experience to take robust decisions about civil and criminal enforcement. | Q3 |

| 5 | **Independent voice –** speak independently, publishing regional and national views of the major quality issues in health and social care | |
|---|---|---|
| | **Activities** | **Due date** |
| | **Deliver Independent voice** | |
| | Work with partners including the National Quality Board; National Information Board; National Improvement and Leadership Development Board; Quality Matters Board; and others, to encourage improvement and foster a single shared view of quality | Q4 |
| | Publish Mental Health Act Report 2017/18 | Q4 |
| | Publish State of Care Report 2017/18, including specialist content on Deprivation of Liberty Safeguards and equality, diversity and human rights. | Q3 |
| | Publish report on local system reviews | Q2 |
| | Publish report of the 'Never events' safety thematic review | Q3 |
| | **Strengthen CQC's Independent voice and engagement (Priority 5)** | **Due date** |
| | Embed and support CQC's independent voice model across teams at regional and national level. | Q4 |
| | Redevelop our internet/web presence and presentation. | Q4 |
| | Develop and deliver new engagement strategies and products for internal and provider audiences. | Q4 |

| 6 | Enabling our development through a programme of transformation | |
|---|---|---|
| | **Activities** | **Due date** |
| | **Deliver a Digital Programme (Priority 6)** | |
| | Agile methods: Test our digital products with users as an integral part of the digital product development cycle. This means that there are regular check-ups with users to see that the product is working. As the digital products are closely aligned to user needs, the final products are then fit for purpose. | Q4 |
| | Technology and equipment:<br>• Roll-out of lighter weight devices to frontline staff<br>• Roll-out of machines that meet analysts' requirements to enable data science<br>• Begin the replacement of all Blackberry devices during 2018/19 (continues into 2019/20)<br>• Upgrade for all staff to Windows 10<br>• Continue the migration of applications to cloud-based services<br>• Integration of Cygnum and CRM<br>• Replace IMS 3, which is the platform that supports our software (continues into 2019/20) | <br>Q3<br>Q3<br><br>Q3<br><br>Q3<br>Ongoing<br>Q1<br>Ongoing |
| | Support the design and development of **new digital services** in these areas:<br>• **Registration**<br>• **Information exchange**<br>• **Evidence collection**<br>• **Authoring and publication**<br>(Continues into 2019/20) | Q4 |
| | Continue the roll-out of extended **information exchange services** to change the relationship with providers, offering simplified mechanisms for providing, updating and viewing data<br>(Continues into 2019/20) | Q4 |
| | **Enable CQC to become intelligence driven (Priority 7)** | |
| | Develop CQC's **intelligence** capability:<br>• Products and services roadmap<br>• Data strategy creation<br>• Data science<br>• Analytical capability (commences 2018/19, completes 2019/20) | <br>Q2<br>Q3<br>Q4<br>Q4 |
| | | |
| | | |

| | | |
|---|---|---|
| | **Develop a Quality Improvement culture within CQC (Priority 8)** | |
| | Design and deliver quality improvement (QI) capability building for teams across CQC, with a focus on experiential learning so they can improve the way we work in CQC (staff who experience a problem are at the core of researching, acting and learning to resolve it). | Q4 |
| | Working with directorates in CQC, carry out QI activity areas they have identified as a priority. To include, but not restricted to:<br>• Report timeliness<br>• Improve CQC's consistency in quality, performance and how it implements its approach to regulation (ongoing ) | Q1<br>Q4 |
| | Implement a partnership approach with world-leading experts that will support QI building and the transfer of knowledge at all levels within CQC. | Q4 |
| | Develop, manage and support change communication for CQC's three-year change road map. (Ongoing) | Q4 |
| | Embed a new governance structure and ensure that CQC staff have a clear understanding of, and access to, our corporate governance. | Q4 |
| | **Improve the staff experience at CQC (Priority 9)** | |
| | **Ensure CQC improves its efficiency and effectiveness** | |
| | Develop an overarching CQC workforce strategy. | Q3 |
| | Pilot through the Resourcing Board a new approach to the agile deployment of resourcing so we can meet changing levels of risks in the sectors, increased cross-sector working and meet urgent requests for new work. | Q2 |
| | Deliver an 'always on' approach to inspector recruitment across CQC in order to meet new demands (including the requirement for additional inspection staff in 2018/19). | Q3 |
| | Complete project on attraction and retention to support workforce development. | Q3 |
| | Implement the management of change process in support of organisational redesign with minimal disruption to delivering CQC's purpose and maximum involvement of staff and trades unions (ongoing). | Q4 |
| | Exit interviews undertaken with a sample of people who leave CQC, including permanent staff, specialist advisers and bank inspectors, to gather feedback on experience of the organisation (ongoing). | Q4 |
| | Use exit interviews and other data to inform our approach to reducing turnover of staff in 0-2 years. | Q2 |
| | | |

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| | **Enable CQC to use QI to build a high-performance culture** | |
| | Improve the quality of performance management and development conversations, in support of development of a quality improvement culture, to ensure staff are enabled to be the best they can be.<br>• Launch<br>• Deliver improved quality conversations | <br><br><br>Q1<br>Q4 |
| | Listen to and act on feedback from staff gathered in the annual staff survey 2018/19. | Q3 |
| | **Encourage CQC to be a well-led organisation** | |
| | Develop leadership skills of all line managers across CQC to ensure managers can engage their staff and unlock the potential in their teams. | Q4 |
| | Put in place a talent management strategy to support career development. | Q3 |
| | **Develop people's skills and capabilities** | |
| | Define the directorate and organisation learning needs in 2018/19 to deliver CQC outcomes. | Q1 |
| | Build the skills, knowledge and competencies of inspectors and the wider workforce (ongoing). | Q4 |
| | Build and maintain professional capability of all staff to support their wider development (ongoing). | Q4 |
| | **Foster an inclusive and healthy working environment where everyone exemplifies the CQC values, so people feel motivated and proud to work at CQC** | |
| | Build upon the strength of our equality networks and enable everyone to contribute to making CQC an inclusive environment (ongoing). | Q4 |
| | Develop a strategy and approach for enabling line managers to support staff wellbeing. | Q2 |

| 7 | Manage our organisation | |
|---|---|---|
| **KPIs** | • **95% of complaints acknowledged in three days**<br>• **< 3% of complaints upheld by the Public Health Services Ombudsman**<br>• **Variance from revenue and capital budget between £0 and < £2m underspend (capital) and £0 and £4m underspend (revenue)** | |
| | **Activities** | **Due date** |
| | **Equality objectives** | |
| | Deliver current equality objectives and set new equality objectives for 2019-2021,which improve how we consider equality in our regulation of health and social care services | Q4 |
| | **Cross-sector working** | |
| | Drive improvements in cross-sector collaboration, networking, partnership working and sharing of information across~~,~~ teams and regions:<br>• Improve the way we schedule inspections for cross-directorate providers, including annual plans for new and complex integrated care systems.<br>• Lead a cross-directorate approach to the inspection of local health and social care systems in a local authority area (see also Inspect and Rate).<br>• Respond to new and complex integrated care systems by making changes to our operating model. | Q4 |
| | **Financial management** | |
| | Manage our budgets and resources efficiently, continuing to reduce our costs to deliver savings in line with the government's comprehensive spending review. | Measured by KPIs above |
| | **Financial management systems and controls** | |
| | Consider the needs of the CQC financial systems and start the procurement of a new system. (The current outsourced contract comes to an end in 2020, with a break in 2019, so this work continues into 2019/20). | Q4 |
| | **Estates strategy** | |
| | Move forward with negotiations to prepare for moves to government hubs and consider our requirements in London.<br>• Deliver London office changes to floor occupancy<br>• Move into Bristol government hub<br>• Extend lease/memorandum of terms of occupation for Leeds & Newcastle to meet hub deadline | <br><br>Q2<br>Q3<br>Q3 |
| | Technology: We will align our estates strategy with the growing move towards flexible working which will be further enabled by the digital strategy. | Q4 |
| | | |

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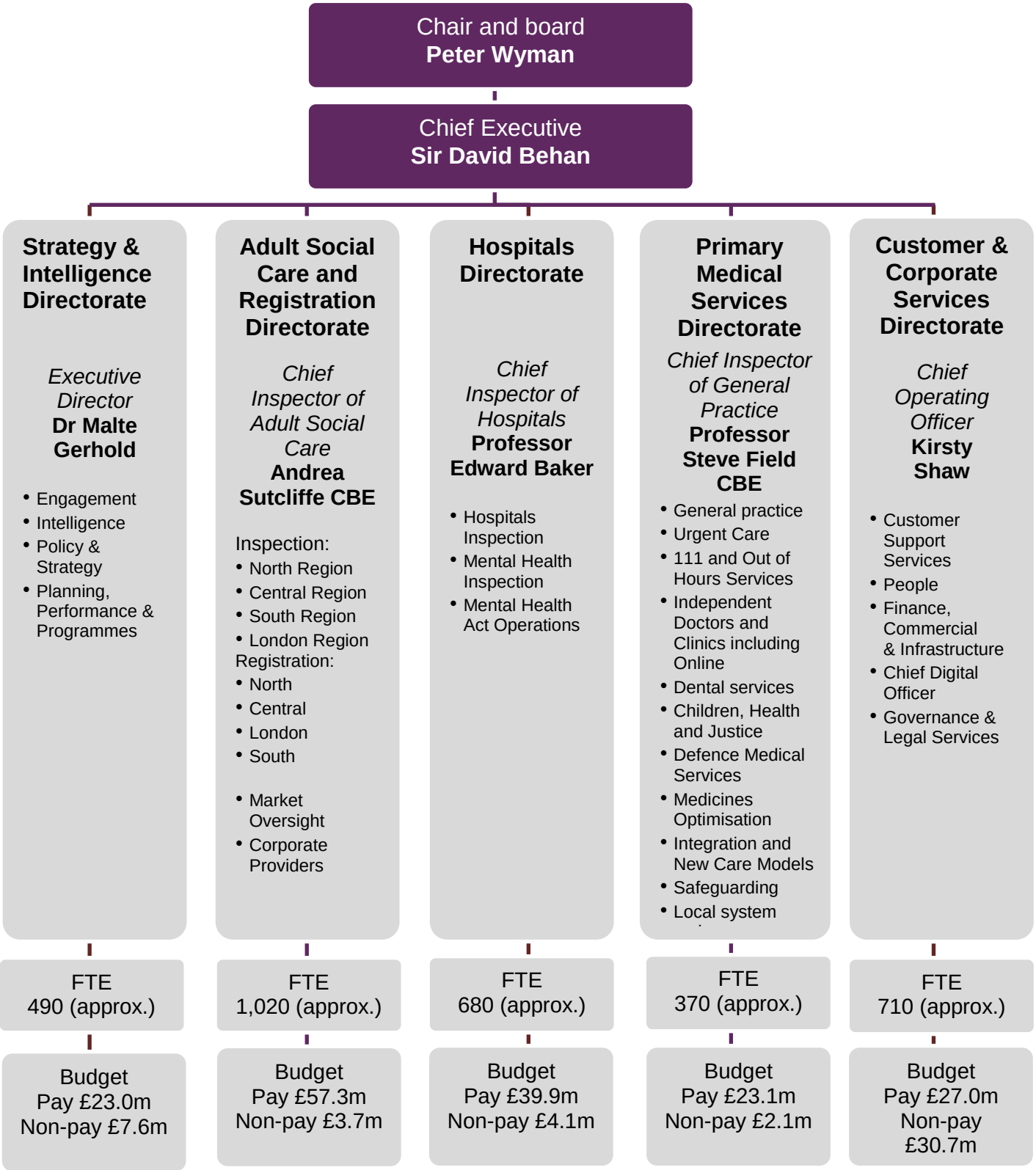
|---|---|---|
| | **Develop future channels of communication choice to enhance our customer accessibility (NCSC)** | |
| | Introduce alternative communication channels and live webchat. | Q3, Q4 |
| | Introduce actions to meet accessibility standards. | Q3, Q4 |
| | Introduce customer behavioural insight and measures of satisfaction. | Q3, Q4 |
| | **Evaluation** | |
| | Evaluate CQC's progress against our strategy, focusing on the following areas:<br>• Consistency<br>• Efficiency<br>• Impact on the quality of care (stage 1*)<br>• Impact on the public and people who use services (to be scoped)<br>*Commences in 2018/19, concludes 2019/20 | <br>Q4<br>Q4<br>Q4<br>- |
| | **Management assurance** | |
| | Introduce a new set of standards for management assurance and carry out assessments against those themes to help us improve how we manage CQC, and to inform our annual report governance statements. Management assurance assessments drive improvements in how we manage ourselves in respect to:<br>• Planning<br>• Performance and risk management<br>• Quality management<br>• People management and development<br>• Financial management, systems and control<br>• Information and evidence management<br>• Governance and decision-making<br>• Continuous Improvement | Q2, Q4 |
| | **Development of performance measures** | |
| | • Develop and utilise management information to report and manage our work in relation to unregistered providers.<br>• Develop and utilise management information to report and manage our enforcement work and the outcomes of these activities. | Q4 |

# Annex 1: The CQC Board, Executive Team and Directorates




1. Excludes Healthwatch England, Chair/CE and central budgets
2. FTE as at March 2019

# Annex 2: Budget

| | Budget 2018/19 £m | Budget 2017/18 £m | Budget 2016/17 £m |
|---|---|---|---|
| Pay | 173 | 174 | 175 |
| Non-pay | 50 | 52 | 61 |
| Expenditure | 223 | 226 | 236 |
| Depreciation | 8 | 9 | 12 |
| Total net expenditure | 231 | 235 | 248 |
| | | | |
| Fee income | -201 | -196 | -151 |
| Grant in Aid | -27 | -34 | -85 |
| Non-cash | -3 | -5 | -12 |
| Total funding | -231 | -235 | -248 |
| | | | |
| Capital expenditure | 13 | 10 | 12 |

# Annex 3: Risks to our plan

| | Risk | Mitigation |
|---|---|---|
| 1 | We do not have impact in encouraging improvement innovation and sustainability in care | • Delivering our role including registration, inspection and enforcement action<br>• Engaging locally with providers and other stakeholders, including commissioners, to ensure they enable improvement<br>• Monitoring the quality of care across sectors for signs of deterioration<br>• Developing our approach to new care models innovation and technology in services<br>• Working with national partners and stakeholders to support improvement<br>• Using and strengthening our independent voice, and continuing to share what we know about improvement<br>• Evaluating our impact<br>• Training all registration and inspection staff to have skills in encouraging improvement |
| 2 | A change of external environment in health and social care or more widely could have implications for CQC's role - for example, integration | • Horizon-scanning the external environment in health and social care, ongoing relationships and conversations with stakeholders; services; people who use care |
| 3 | We do not implement our operating model effectively because we do not:<br><br>• make accurate, insightful, reliable, timely and lawful regulatory decisions;<br>• encourage people who use services, their relatives and carers to engage with CQC;<br>• respond quickly and effectively to public concerns | • Develop a quality improvement approach across CQC<br>• Continue to undertake quality sampling, and monitor our performance through performance indicators and reporting<br>• Deliver training and mentoring |
| 4 | We do not effectively collect and process the information we need to be an effective, intelligence-driven regulator, and accurately predict quality | Develop CQC's intelligence capability, including:<br>• provider information collection;<br>• a products and services roadmap;<br>• a data strategy;<br>• data science; and<br>• analytical capability. |

| | | |
|---|---|---|
| 5 | We are unable to deliver our strategy because we are not well supported by IT and systems, which in turn requires efficient processes to support agile delivery | • Deliver improvements to CQC's digital products and services, aligned to the priorities agreed with the Board in October 2017 |
| 6 | We fail to respond adequately where our people feel we are not developing a high performing culture and embedding our values | • Develop a quality improvement approach across CQC<br>• Create a model across CQC so staff who experience a problem are at the core to researching, acting and learning to resolve it<br>• Develop, manage and support change communication for CQC's change road map |
| 7 | We fail to implement an effective approach to regulating place-based and emerging new models of care – in particular we do not work effectively across CQC to do this | • Implement the cultural change, we need to achieve the transformation set out in the business plan, and in particular through our values and behaviours<br>• Communicating with staff as we make developments and listening to their feedback<br>• Involving staff in changes, including designing and testing<br>• Embedding quality improvement so that CQC staff who experience a problem are at the core of researching, acting and learning to resolve it |
| 8 | We fail to address the health, safety and wellbeing needs of CQC staff | • Health and safety strategy<br>• Health and safety policies<br>• Information and training<br>• Health, safety and wellbeing committee oversight |
| 9 | We are unable to deliver our programme of public commitments as a result of CQC's own capacity issues | • 'Always-on' recruitment processes and well-managed induction<br>• Resource planning |
| 10 | We are unable to reduce our costs in line with our reduced budget or our fees are not received in a timely way | • Effective medium-term planning, investment appraisal and benefits monitoring<br>• More use of direct debits and debt management |
| 11 | We are not protecting or securely managing our information in accordance with regulatory requirements, agreed standards and legislation | • Information management and governance policies, induction and mandatory annual awareness training and cyber security activity, and security culture development |

| | | |
|---|---|---|
| 12 | A difficult-to-replace adult social care provider fails and CQC hadn't spotted it to give early warning to local authorities | • Market oversight function; information on the function in performance reporting<br>• Agreed processes in place for when failure occurs<br>• Closer working between market oversight, inspection and registration teams<br>• Information sharing with providers / local authorities and clinical commissioning groups<br>• Relationship with DHSC and HM Treasury<br>• Relationship with the market place |

# Annex 4: Key performance indicators

| KPI | 2018 target | 2017 target/indicative baseline<br>(baseline shown is Q3 2017/18)* |
|---|---|---|
| Registration processes completed within 10 weeks:<br>- new<br>- variation<br>- cancellation<br>[illegible] within 10 weeks | <br>80%<br>90%<br>90% | <br><br>90% (84%) |
| First inspections of newly or recently registered locations undertaken within 12 months (services where we give ratings)<br>Adult social care<br>Primary medical services<br>Hospitals**<br><br>* ASC locations that are not completely new to regulation will be inspected at a time taking into account previous rating; the last inspection date; known risks and any additional risks from the changes in registration. This means that some will be earlier and some later than a year. New to regulation locations will be inspected within one year of registration.<br><br>** In the case of new registrations following NHS mergers, only the well-led key question will be inspected | <br><br><br>80%*<br>90%<br>90% | <br><br><br>100% (84%)<br>90% (100%)<br>N/A |
| Re-inspections of previously-rated services undertaken within the agreed maximum time periods (at annex 5)<br><br>Adult social care – requires improvement or inadequate<br>Adult social care – good or outstanding<br>Primary medical services<br>Hospitals (NHS core services)<br>Hospitals (other service types)<br><br>*ASC good and outstanding moved to 80% in 2018/19, it would be expected this would return to 90% in 2019/20 | <br><br><br>90%<br>80%*<br>90%<br>90%<br>See annex 5 | <br><br><br>90% (82%/93%)<br>90% (65%/83%)<br>90% (95%)<br>N/A<br>N/A |
| Inspection reports publishing times: | | |
| Within 50 days: | | |
| Adult social care<br><br>Primary medical services<br><br>Hospitals which are either Independent Health or focused NHS inspections of 1 or 2 core services | 90%<br><br>90%<br><br>90% | 90% (85%)<br><br>90% (84%)<br><br>90% (28%) |
| | | |

| | | |
|---|---|---|
| Within 65 days:<br>Hospitals which are NHS and the inspection is of 3 or more core services*<br>*Comprised of two sub-targets: 50% of reports published within 50 days; 40% within 51-65 days<br>Primary medical services or adult social care inspections that are part of an inspection of Hospitals which are NHS and the inspection is of three or more core services | 90%<br><br>90% | 90% (35%)<br><br>N/A |
| Safeguarding alerts referred to local authority within 0-1 days | 95% | 95% (97%) |
| Safeguarding alerts and concerns had one of four possible mandatory actions taken in 0-5 days | 95% | 95% (89%) |
| Mental Health Act visits planned each quarter completed | 90% | 90% (83%) |
| SOAD) requests undertaken within target time: medicine; electroconvulsive therapy; community treatment order | 95% all | 95% (89%) |
| Complaints acknowledged within three working days | 95% | 95% (99%) |
| Complaints upheld by the Parliamentary and Health Services Ombudsman | <3% | <3% (0%) |
| Calls answered in 30 seconds – general (including registration and online services) | 80% | 80% (80%/82%) |
| Safeguarding/mental health calls answered in 30 secs | 90% | 90% (92%/89%) |
| Correspondence answered in three days | 90% | 100% (85%) |
| Engagement score increased | 64% or more | 63% (n/a) |
| Sickness | <5% | <5% (3.8%) |
| Variance from revenue and capital budget | Between £0 and < £2m underspend (capital); Between £0 and< £4m underspend (revenue) | Between £0 and < £2m underspend (capital); Between £0 and< £4m underspend (revenue)<br><br>2017-18 performance will be reported in Q4 Performance report to the CQC Board |

*Full year figures are published in our Annual Report and Accounts

# Annex 5: Inspection frequency

## Hospitals

We will conduct a well-led inspection for every NHS trust on an approximately annual cycle.

Frequency drivers for re-inspection will be applied to the NHS core services against their rating as of 1 April 2017:

| Current core service rating | Frequency of core services inspections |
|---|---|
| Inadequate | Within 1 year |
| Requires improvement | 2 years |
| Good | 3.5 years |
| Outstanding | 5 years |

Additional services are not subject to the frequency drivers and are inspected based only on risk.

Frequency drivers for re inspection will be applied to hospice locations against their rating as of 1 April 2018 using the new framework:

| Current core service rating | Frequency of location inspections |
|---|---|
| Inadequate | Six months |
| Requires improvement | 1 year |
| Good | 2.5 years |
| Outstanding | 3 years |

We will inspect the locations of the below independent sectors, based on continuously monitoring and responding to risk.

Rated services

- Independent acute
- Single specialty services: long-term conditions (neuro-rehab)
- Independent mental health

Currently non-rated services

- Independent acute hospitals (cosmetic surgery only)
- Single specialty services including: termination of pregnancy services, dialysis, refractive eye surgery, diagnostic imaging and endoscopy services
- Independent community services
- Independent substance misuse services – residential and community
- Independent ambulance services
- Non-hospital acute independent doctors

For the currently non-rated services, which we have now been given the powers to rate, we will start to inspect them in 2018/19 in order to award them a rating for the first time. This will begin from June 2018 for some services, subject to the consultation on how we will rate these services and once we have published our consultation response and our provider guidance.

Subject to the current consultation, and once services have been rated for the first time, the frequencies of location inspections will be:

| Current rating | Frequency of location inspections* |
|---|---|
| Inadequate | 1 year |
| Requires Improvement | 2 years |
| Good | 3.5 years |
| Outstanding | 5 years |

We will inspect the locations of the below services, which will not be subject to ratings, based on continuously monitoring and responding to risk:

- Minor cosmetic surgery
- National screening programmes
- Hyperbaric chambers
- Blood and transplant Services
- Services licensed by the Human Fertilisation and Embryology Authority
- Independent pathology laboratories
- Independent podiatry services

## Adult social care

Schedule and inspect previously rated services according to their latest rating or sooner according to risk or potential improvements in quality as follows:

| Current rating | Frequency of location inspections* |
|---|---|
| Inadequate | 6 months |
| Requires improvement (with one Inadequate) | 6 months |
| Requires improvement | 1 year |
| Good | 2.5 years |
| Outstanding | 2.5 years |

*Measured from report's publication

# Primary medical services

In this section the term 'GP+' is used to designate GP practices; GP out-of-hours services; remote clinical advice services; urgent care services and mobile doctors.

Inspect and rate GP+ services

| Current rating | Frequency of location inspections* |
|---|---|
| Inadequate | 6 months |
| Requires Improvement | 1 year |
| Good | 5 years |
| Outstanding | 5 years |

*Measured from report's publication

Complete the first inspections of independent consulting doctor/digital services/slimming clinics (approximately 600). Subject to our current consultation, these services will be rated in the future, but not as part of our activity in 2018-19.

We will test our approach to regulating new and complex providers in an area.

Inspect up to 20 GP-at-scale providers.

Lead a cross-directorate approach to the inspection of local health and social care systems in a local authority area. Known as local system reviews, these are undertaken at the request of the secretaries of state (see page 16). Twelve areas have been reviewed during 2017/18; a further eight have been identified and will be reported on during 2018/19. They are: Bradford, Cumbria, Hampshire, Liverpool, Northamptonshire, Sheffield, Stockport, and Wiltshire.

Inspect 10% of all active dental locations (these services are not rated).

In conjunction with HM Inspectorate of Prisons, inspect 60 Health & Justice Services (these services are not rated):

prison services
olice custody services
mmigration removal centres
ecure training centres
outh offending institutions/teams

In addition during 2018/19, based on 2017/18 activity and provisional plans, it is estimated that the health and justice team will:

- Inspect 40 sexual assault reference centres led by CQC
- Carry out 26 focused inspections within the criminal justice and immigration detention sectors in response to concerns or to follow up regulatory breaches
- Provide some resource for two thematic inspections led by partner inspectorates that include site visits
- Secure schools – inspection of these are being developed with initially two pilots. The actual inspections will not take place next year but we will need to engage in the policy development.
- Begin to provide input into inspections of secure children's homes, led by Ofsted. 2018/19 is likely to include methodology development and a pilot inspection.

Inspect 60 children's services:

- 20 children looked after and safeguarding services
- 9 services as part of the joint targeted area inspection programme
- 31 special educational needs and disability services

Inspect 39 defence medical services:

- 27 comprehensive inspections of GP facilities
- Conduct nine follow up inspections of GP facilities
- 3 comprehensive inspections of dental facilities