



House of Commons
Committee of Public Accounts

Care Quality Commission

Twelfth Report of Session 2015–16



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**Care Quality
Commission**

Twelfth Report of Session 2015–16

*Report, together with formal minutes
relating to the report*

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The Committee of Public Accounts

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Summary

The Care Quality Commission has made substantial progress since the Committee last reported in 2012. But it is behind where it should be, six years after it was established, in that it is not yet an effective regulator of health and social care. Because of staff shortages it is not meeting the trajectory it set itself for completing inspections of hospitals, adult social care and primary care. There are also concerns about the consistency and accuracy of draft inspection reports, and the time the Commission takes to finalise a report after carrying out an inspection. At the same time, the Commission is not yet ready to implement new responsibilities it takes on in April 2016 to assess the efficiency with which hospitals use their resources. In addition, the Commission does not yet have the quantified performance measures, linked to explicit targets, that are needed to show whether it is satisfactorily performing its statutory duties. We will be returning to this subject to review what further progress the Commission makes in the coming year.

Introduction

The Care Quality Commission (the Commission) is the independent regulator of health and adult social care in England. Its purpose is to “make sure health and social care services provide people with safe, effective, compassionate, high quality care, and to encourage them to improve”. The Commission is a non-departmental public body, sponsored by the Department of Health (the Department). The Committee of Public Accounts last took evidence from the Department and the Commission in 2012. In its report the Committee expressed serious concerns about the Commission’s governance, leadership and culture, and its failure to intervene quickly or strongly enough in failing providers of health or social care services. The Commission has since been working with the Department to implement significant changes, under a three-year transformation programme between 2013–14 and 2015–16.

Conclusions and recommendations

1. **The Commission is behind on its inspection programme and is not, therefore, fulfilling its duty to be sighted on risks to the quality and safety of health and adult social care services.** The Commission has struggled to recruit inspectors and analysts with the right skills. By mid-April 2015, the vacancy rate was 34% for inspectors, 36% for senior analysts and 35% for managers, and it did not expect to reach full complement for inspectors until June 2016. Staff turnover in 2014-15 was nearly 8%, much higher than the Commission's 5% target rate, and was still at this rate for the first two quarters of 2015-16. Because of these staff shortages, the Commission is behind its original target dates for completing its programme of inspections. The Commission forecast that by the end of March 2016 it would be below its planned trajectory by 6% in adult social care and 8% in primary medical services. It expects to have completed its inspections of hospitals by June 2016, six months after its original target date of December 2015. It is likely that it will need to look for alternative solutions to its recruitment problems and is already, for example, using people on secondment to supplement its full time inspectors on mental health. The Commission's current plans for inspection are based on funding plans made before the 2015 spending review. The Department has asked the Commission to model the impact of reductions in funding of 25% and 40% and, unless the Commission finds alternative solutions to its recruitment problems or changes its methodology, the Commission made clear that any such cuts are likely to lead to further delays to its inspection timetable.

Recommendations:

We are very concerned about the effect being below staff complement has had on the Commission's ability to carry out its full programme of inspections. The Commission should write to us in July 2016, with an update on staff turnover rates and whether it has met the recruitment targets it gave us in evidence. Specifically, the Commission should set out: whether it has reached a full complement of suitably skilled and qualified inspectors; whether it has sufficient analysts; and what impact staff shortages have had on its forecast trajectory for carrying out inspections.

The Commission needs to demonstrate how it will deliver its programme of inspections in the face of substantial funding reductions. This should include a robust and transparent analysis of risk if it adopts a more flexible approach or prioritises resources. It needs to be clear to the taxpayer and the organisations it inspects about changes of approach.

2. **Too often the length of time between an inspection and a report is too long, and the Commission's draft reports contain too many basic factual errors.** At a time when the Commission is asking providers to pay substantially more towards the cost of their inspection it is more important than ever that the Commission can demonstrate the quality of its work. However, providers told us they find too many errors in draft reports, reports take too long to produce and there is too much variation in the quality of initial judgements. On average, inspection reports are not completed within the target of 50 days — reports take an average of 49 days for adult social care, 67 days for general practice and 83 days for hospitals. The

chief executive of Warrington and Halton Hospitals NHS Foundation Trust told us they had identified over 200 errors in its draft report. Some of these were just grammatical errors or duplicated points, but some were inaccuracies in the data that could have been resolved while inspectors were still on site. She told us that the Commission had accepted 64% of the points raised and amended the draft as a result. The Commission told us it had strengthened its internal quality assurance processes, but this had lengthened the time it takes to complete a report.

Recommendation: *The Commission should set out how it will improve the quality of initial draft reports, and ensure that the time between inspections and publication of reports is shorter. We expect to see progress on this in the next 12 months.*

3. **The Commission has not always made best use of vital intelligence from patients, carers and staff about the quality of care, or acted quickly enough on their concerns.** We are concerned that the Commission's data suggests that one out of three safeguarding alerts is not acted on within the Commission's two-day target. The Department acknowledged that there have been long-standing problems with how the Commission has dealt with safeguarding alerts, and assured us that new processes are being put in place. More generally, the number of calls the Commission receives from the public and whistle-blowers in response to concerns about the quality and safety of care is increasing. During inspections, the Commission also takes time to talk to patients, staff and carers. Providers told us, however, that inspection reports could place too much emphasis on potentially anecdotal evidence inspectors heard on the day of the inspection.

Recommendation: *As it continues to build user feedback into its work, the Commission should publicise its role, make it easier for people to say what they think of care, and prioritise action in response to safety concerns. It must work with other bodies - including the ombudsman, central and local government and the third sector — to ensure that concerns are addressed quickly, particularly those raised by whistleblowers. It also needs to improve the quality of information available to people who are choosing a care provider.*

4. **There is no way for parliament or the public to know whether the Commission is performing its statutory duties to protect the health, safety and welfare of people who use health and social care services.** In its March 2012 report the previous Committee criticised the Commission's lack of adequate performance measures, but over three years' later the problem is still unresolved. The Commission has developed a new performance framework, but only 6 out of the 37 performance measures included in it have specific, quantified, targets. Reporting performance against clear targets is vital for both transparency and accountability and measuring improvements over time.

Recommendation: *The Commission should publish quantified baselines and targets for its performance across the board from 2016–17 onwards.*

5. **The Commission will become responsible for assessing hospitals' use of resource in April 2016, but it will take over a year for it to implement these responsibilities in full.** The Commission plans to pilot its new approach in April 2016, but it does

not believe it will be ready to roll this out to all hospitals until January 2017. The delay risks giving the public the impression the Commission is providing full assurance over the use of resources by all hospitals when it will not be doing so until January 2017. The Commission published a consultation document on the morning of our evidence session asking for views on how it should implement its new responsibilities. But it is not yet clear how the Commission will coordinate with, and draw on the expertise of Monitor and the NHS Trust Development Authority to avoid duplication of effort by providers. We are concerned that there is not adequate preparation for this important additional area of work, which has been introduced before the Commission has the capacity to implement it and while it is struggling to fulfil its existing responsibilities.

Recommendations:

The Commission should set out what its approach will be to provide assurance about the use of resources by hospital providers. It should do this as soon as possible as it takes on these responsibilities in April 2016.

The Department should clarify the roles of the Commission, Monitor, and the NHS Trust Development Authority for assessing the use of resources by health bodies, to avoid duplication of effort and unnecessary burdens. We have serious concerns about adding this responsibility to the Commission when it is not yet delivering its inspections.

6. **The current regulatory system focuses on single providers and does not give adequate assurance over patients' experience of the overall quality and safety of care they receive.** It is becoming increasingly important for providers and commissioners to collaborate in order to integrate the services patients, particularly those with long term conditions, need from their GP, hospital and local community care services. But existing regulatory systems, including those operated by the Commission and Monitor, focus on services operated by individual providers, and do not look enough across organisational boundaries. A further complication is that providers' performance is influenced by decisions taken by local commissioners, but the Commission has no power to scrutinise clinical commissioning groups or local authorities. The Department is developing, but has not yet completed, what it described as a 'scorecard' to assess the performance of clinical commissioning groups. The Department hoped that the Commission would be able to use this information, once available, populated and published, to assess the economy, efficiency and effectiveness of services to people living in a given locality.

Recommendation: *The Department should report back to the Committee by the end of 2016 about how it will support the Commission to ensure that inspections take proper account of the needs of users in ensuring services provided by different health and social care organisations are properly joined up. The Commission will need to work with other key bodies including, for example, the ombudsman, patient representative groups and local delivery partners to collect sufficient information to inform its judgements.*

1 Effectiveness

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and the Care Quality Commission (the Commission) on the Commission's capacity and capability to regulate the quality and safety of health and adult social care.¹ We also took evidence from Warrington and Halton Hospitals NHS Foundation Trust, Quantum Care, and a GP and Partner of the Jenner Practice in Lewisham who is also Chair of Lewisham Clinical Commissioning Group.

2. The Commission is the independent regulator of health and adult social care in England. Its purpose is to “make sure health and social care services provide people with safe, effective, compassionate, high quality care, and to encourage them to improve”. The Commission is a non-departmental public body, sponsored by the Department of Health (the Department). Its 2015-16 budget is £249 million, funded by grant-in-aid from the Department and fees charged to regulated bodies.²

3. The Committee of Public Accounts last took evidence from the Department and the Commission in 2012. The previous Committee then expressed serious concerns about the Commission's governance, leadership and culture, and its failure to intervene quickly or strongly enough in failing providers of health or social care services.³ The Commission has since been working with the Department to implement significant changes, under a three-year transformation programme between 2013–14 and 2015–16.⁴

The Commission's ability to carry out its inspection programme

4. The Commission originally set out to inspect and publish ratings for all acute hospitals by 31 December 2015, all adult social care providers by 29 February 2016 and all GP providers by 29 February 2016. In July 2014, the Commission's board agreed to revise the inspection timetable for 2014–15 and, in March 2015, the Commission published revised targets to complete all NHS acute hospital inspections by April 2016 and rate all adult social care providers and GPs by 1 October 2016.⁵ By September 2015 the Commission had inspected 75 against its planned trajectory of 132 hospitals by that date. It has a target to complete inspections of 585 hospitals by March 2016. The Commission expressed confidence that it would have inspected all acute hospitals by March 2016, and all community and ambulance trusts by June 2016. For adult social care and primary care services, however, the Commission confirmed that it was running behind the trajectories it had set. By September 2015 it had inspected 4,487 adult social care providers, against a planned trajectory of 5,992 by that date and 13,286 by March 2016. The Commission had inspected 1,217 GPs against its planned trajectory of 1,924, and had a target to inspect 5,087 by March 2016. At this rate, the Commission forecast that at the end of March 2016 it would be below its planned trajectory by 6% in adult social care and 8% in primary

1 [C&AG's Report, Capacity and capability to regulate the quality and safety of health and adult social care, Session 2015-16, HC 271, 22 July 2015](#)

2 [C&AG's Report](#), paras 1, 2, 1.3

3 [Committee of Public Accounts, The Care Quality Commission: Regulating the quality and safety of health and adult social care, 78th report of Session 2010-12, HC 1779, 30 March 2012](#)

4 [C&AG's Report](#), paras 2, 1.4, 1.6

5 [C&AG's Report](#), para 2.8

medical services.⁶ The Department agreed that the Commission was not meeting the ambition the Department set for it but emphasised that it was important for inspections not to be a tick box exercise and for them to reach the right judgements.⁷

5. The Commission has struggled to recruit and retain the number of staff it needs to deliver its inspection programme. By mid-April 2015, the vacancy rate was 34% for inspectors, 36% for senior analysts and 35% for managers. The Commission told us that it was on course to achieve its target to make job offers to 600 new inspectors by December 2015, and that the Department had given sufficient funding for this. The Commission does not expect to reach its full complement of 263 hospital inspectors until June 2016. It explained that it was essential, given past criticisms of the Commission, to raise the quality of staff joining the organisation. The need to attract high quality staff, however, had made it harder to recruit people.⁸ It has also had to recruit more people because staff turnover, running at 7.5% in 2014–15 and around 8% in the first two quarters of 2015–16, continues to be higher than the 5% rate the Commission had planned for.⁹

6. The Commission has used contractors to fill gaps in its capacity, particularly in areas where it needs specialist expertise to transform the way that it works. Using contractors can be more cost effective than employing permanent staff when people with specific skills are needed for short periods. However, in 2014–15 the Commission spent £17.2m on contractors, many of whom worked in central functions like information systems and technology. Some of these staff were involved directly in providing services to the public, in the National Customer Services Centre, or providing business services support to inspectors. The Commission told us that if it had been able to recruit the permanent staff needed earlier, and relied less on bank staff to carry out inspections, then it would have spent less.¹⁰

7. The Commission's ability to achieve its inspection schedule for adult social care providers and GPs will be influenced by budget allocations and fee decisions for 2016–17, which were yet to be finalised at the time we took evidence. As part of the Government spending review, the Commission had been asked to model the impact of grant reductions of between 25% and 40%. The Commission told us that one of the consequences of any reduction in its grant could be fewer staff, and that would impact on the Commission's ability to do all its work. The Department confirmed that costs could be passed on to providers in the form of higher fees, subject to consultation with regulated bodies and final approval by the Secretary of State for Health.¹¹

The quality and timeliness of draft inspection reports

8. The Commission is not currently achieving its target to complete inspection reports within 50 days and the Department accepted that performance both on timeliness and accuracy needs to improve. In September 2015, on average, it took 49 days from the end of the inspection for the Commission to complete and publish its reports on adult social care providers and 67 days for reports on GPs. The Commission told us that they did not

6 [Qq 81-84, 88-89](#)

7 [Qq 85-86](#)

8 [Qq 61-65, 101, 108-110; C&AG's Report](#) para 2.5

9 [Qq 102-103; C&AG's Report](#), para 2.6

10 [Q 66 - 69; C&AG's Report](#), para 2.7

11 [Qq 90, 92-96](#)

think it would ever be possible to deliver an inspection report for a hospital in 50 days, due to the scale and diversity of these organisations. Currently reports for hospital inspections are completed in an average of 83 days but the Commission believes a more realistic target would be between 60 and 70 days.¹²

9. Providers told us they too were concerned with the time taken to receive inspection reports. In particular they were frustrated by the lack of consistency between the feedback they received at the end of their inspection visit and the report they received some months later. The chief executive of Warrington and Halton Hospitals NHS Foundation Trust told us that their draft report identified some areas as ‘requiring improvement’ despite having received positive feedback during the inspection itself. The Chief Executive of Quantum Care added that reports contained a lot of surprises.¹³ The Commission told us they now write to hospital trusts if they identify concerns during an inspection so that the trust can take action without waiting for the report to be produced. The Commission expects the trust to take that letter to the board in public.¹⁴

10. Providers also told us they had to spend too much time dealing with factual inaccuracies in draft inspection reports. Warrington and Halton Hospitals NHS Foundation Trust told us it had identified about 210 inaccuracies in the draft report. Some of these were minor, for example grammatical errors, but the report also contained inaccurate evidence that could have been corrected at the time of the inspection. The Trust told us that the Commission had accepted 64% of the points raised and changed some of the ratings in the report as a result. The Chief Executive of Quantum Care told us that the Commission’s process for dealing with inaccuracies was not working as well as it had in the past.¹⁵ The Commission said that it has strengthened its internal processes to ensure greater consistency and quality of judgements, but that building in internal checks and balances had also led to delays in publishing reports.¹⁶

Listening to patients, carers and staff, and acting on their concerns

11. The number of concerns raised by whistle-blowers, complaints about providers, safeguarding calls and statutory notifications from providers increased from a total of 173,931 in 2013–14 to 208,720 in 2014–15. However, the National Audit Office found that one out of three safeguarding alerts raised with the Commission was not acted on within the Commission’s two-day target.¹⁷ The Department acknowledged that the Commission had long-standing problems with how it reported and responded to safeguarding alerts but assured us that the Commission had now put more rigorous systems in place.¹⁸ As part of its inspections, the Commission also looks at how hospitals, care homes and paramedical services respond to complaints. It has developed its methodology by speaking to people who have raised complaints about the quality and safety of care, as well as other organisations that people go to when they have a complaint.¹⁹

12 [Qq 131-134, 138, 140, 143](#)

13 [Qq 1-3](#)

14 [Qq 138-139](#)

15 [Qq 1, 3-5](#)

16 [Q 132](#)

17 [C&AG’s Report](#), paras 3.6-3.7 and Figure 9

18 [Qq 177-179](#)

19 [Q 188](#)

12. The Commission takes the time to talk to patients, staff and carers during an inspection. However, providers were concerned that this only provided the views of people inspectors met on the day of the inspection and meant the Commission could be at risk of placing too much reliance on anecdotal evidence. The Commission organises formal patient and carer consultation events in advance of its inspections, but these may not necessarily be well attended or representative of all people using the services inspected. A GP and Partner of the Jenner Practice in Lewisham told us that, for general practice, the Commission uses a patient questionnaire. However, he felt that the central questionnaire was not very sensitive to local circumstances. He also made the point that responses might reflect an unrealistic or outdated view of what people thought GP services ought to be, rather than how primary care is changing to best meet patients' needs.²⁰

2 Accountability

Adequacy of the Commission's performance measures

13. Performance measures are indicators which allow an organisation to see whether it is achieving its strategic objectives and compare itself against similar organisations as well as its own performance over time. For example, the Commission's performance measures include the time it takes to respond to safeguarding concerns and the proportion of providers rated as inadequate or requires improvement that improve when re-inspected.²¹

14. In its March 2012 report, the previous Committee criticised the Commission's lack of adequate performance measures.²² The Commission has since updated the framework it uses to measure and report its performance, but not all the measures can be quantified and only 6 of the Commission's 37 performance measures have specific targets. Without targets, members of the public and Parliament cannot know whether the Commission is performing well against its statutory duties to protect the health, safety and welfare of people who use health and social care services. The Commission told us that "as we develop our business plan for 2016–17, we will make sure that for every one of the things that we are committing to do, there is a performance indicator that is clear and can be counted".²³

The Commission's new responsibilities

15. Since April 2015, the Commission has been responsible for market oversight of difficult to replace adult social care providers. From April 2016, it will also take on responsibility for providing assurance over how efficiently hospital trusts use their resources.²⁴ We challenged the Department about how the Commission's new responsibilities for assessing financial efficiency would fit alongside work already carried out by Monitor and the NHS Trust Development Authority to assess the financial sustainability of NHS trusts. The Department told us the Commission would provide the "single independent version of the truth" about a trust's quality, safety, effectiveness, leadership and use of resources. It said that Monitor and the NHS Trust Development Authority would work together as a joint partnership, known as NHS Improvement, to provide professional support between inspections.²⁵ The Commission added that it would focus on whether trusts are using resources to add value to the quality and safety of care, in contrast to work carried out by Monitor, which focuses on the trust's balance sheet and whether it is in surplus or deficit.²⁶

16. Providers told us that the Commission's reporting requirements already overlap with those of other bodies, which raises concerns that its new responsibilities will result in further duplication of effort.²⁷ The Commission published a consultation document on the morning of our evidence session asking for views on how it should implement its new responsibilities for assessing the efficiency with which hospitals use their resources. It told

21 [C&AG's Report](#), para 4.12

22 [Committee of Public Accounts](#), The Care Quality Commission: Regulating the quality and safety of health and adult social care, 78th report of Session 2010-12, HC 1779, 30 March 2012

23 [Q 170](#); [C&AG's Report](#), paras 18, 4.12-4.13

24 [C&AG's Report](#), para 1.2

25 [Qq 24-30](#)

26 [Q 36](#)

27 [Q13 – 15](#)

us it expected its assessments to draw extensively on data already collected by Monitor and the NHS Trust Development Authority, as well as information published in trusts' audited accounts. However, at this stage, it was unable to explain to us how, in practice, it would coordinate with, and draw on the expertise of these bodies.²⁸ The Department acknowledged that there was a risk of duplication in the system and said the Department and oversight bodies would need to work a lot harder to eliminate unnecessary burdens for providers.²⁹

17. The National Audit Office reported that the Commission had not recruited the staff with the skills it needed to support the new responsibilities it took on from April 2015 for providing financial oversight of difficult to replace adult social care providers. By October 2015, the Commission had recruited four out of the five senior posts it needed. As a result, the Department shared responsibilities with the Commission by overseeing the largest five providers of adult social care on a temporary basis until October 2015.³⁰

18. The Department told us it was providing the Commission with sufficient time to develop and pilot an approach to carrying out its additional new responsibilities for assessing use of resources by acute hospital trusts.³¹ However, the Commission admitted that it would not be ready to roll out its assessments of hospital efficiency to all hospitals until January 2017, almost a year after it takes on that responsibility in April 2016. It said it planned to pilot its new approach from April 2016, but it would take longer to consult on, and refine, its methodology.³² The Commission said it anticipated the work would be most likely to involve desk-based reviews of existing information, rather than substantial new fieldwork or data collection. To do this it expects to need a small pool of staff with analytical skills.³³

19. After our evidence session the Department wrote to us on the subject of the Commission's new responsibilities. On assessing the use of resources by hospital trusts it pointed out that the Health and Social Care Act 2008, as amended by the the Care Act 2014, gave the Commission powers to carry out reviews and performance assessments of registered providers. It quoted the 2008 Act that "the assessment of the performance of a registered provider is to be by reference to whatever indicators of quality the Commission devises". The Department argued that the Commission "is not under a duty to commence the use of resources ratings until it determines that the indicators are sufficiently robust to do so, nor does it have to do this work by a specific date".³⁴ The Department's position is therefore that the Commission not being ready to carry out its new responsibilities until 2017 is not in breach of the relevant legislation. The Commission has, however, told the public that it will start assessing the use of resources by April 2016. There is therefore the risk people will make the legitimate assumption that the Commission will be providing a level of assurance over the efficient and effective use of resources that in reality will not be the case until much later.

28 [Q 39- 40, 149](#)

29 [Qq 31-34](#)

30 [Qq 127, 148](#); [C&AG's Report](#), paras 12, 2.20-2.21

31 [Q 23](#)

32 [Qq 152-154](#)

33 [Qq 40, 149](#)

34 [letter from Department of Health to PAC Chair, 23 November.](#)

The quality and safety of care provided in integrated local services

20. It is becoming increasingly important for providers and commissioners to integrate services around the needs of patients, to improve people's end to end experience of the health and social care services they receive. For example, the Chief Executive of Warrington and Halton Foundation Trust told us this was particularly important for managing the discharge of patients from hospital. In this example, the trust has to work closely with community and intermediate care providers to ensure a smooth transition and avoid a situation where patients stay in hospital longer than needed.³⁵

21. The Department and providers all agreed on the importance of regulation being focused on the needs of patients and local populations. However, providers told us that the current regulatory system is too heavily focused on single providers in isolation and does not do enough to look at the experiences of patients who receive care from more than one organisation. This can be particularly important when organisations have more than one area of responsibility or when they depend on others, for example when patients are discharged from hospital to community or intermediate care.³⁶ The Department recognised that evaluating the quality of care across and between providers remains a key challenge.³⁷

22. A further complication is that a provider's performance is influenced by decisions taken by local commissioners, but the Commission has no power to scrutinise clinical commissioning groups or local authorities.³⁸ The Department told us it is developing, but has not yet completed, what it described as a 'scorecard' to assess the performance of clinical commissioning groups. It hoped that the Commission would be able to use this information, once available, populated and published, to assess the economy, efficiency and effectiveness of services to people living in a given locality.³⁹

35 [Qq 17](#)

36 [Qq 1, 17-18](#)

37 [Q 191](#)

38 [Q 118](#)

39 [Qq 189-190, 196](#)

Formal Minutes

Wednesday 2 December 2015

Members present:

Meg Hillier, in the Chair

Mr Stewart Jackson

Stephen Phillipson

Nigel Mills

John Pugh

David Mowat

Karin Smyth

Mrs Anne-Marie Trevelyan

Draft Report (*Care Quality Commission*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 22 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Twelfth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Monday 7 December at 3.30 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's [inquiry web page](#).

Wednesday 28 October 2015

Question number

Melany Pickup, Chief Executive, Warrington and Halton Hospitals NHS Foundation Trust, **Dr Marc Rowland**, GP and Chair, London Clinical Commissioning Groups, and **Maria Ball**, Chief Executive, Quantum Care

[Q1–22](#)

Dame Una O'Brien, Permanent Secretary, **William Vineall**, Director of Quality, Department of Health, and **David Behan**, Chief Executive, Care Quality Commission

[Q23–197](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's [inquiry web page](#). CQC numbers are generated by the evidence processing system and so may not be complete.

- 1 Department of Health ([CQC0003](#))
- 2 Independent Age ([CQC0002](#))
- 3 NHS Providers ([CQC0001](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the Committee's website at www.parliament.uk/pac.

Session 2015–16

First Report	Financial sustainability of police forces in England and Wales	HC 288
Second Report	Disposal of public land for new homes	HC 289
Third Report	Funding for disadvantaged pupils	HC 327
Fourth Report	Fraud and Error Stocktake	HC 394
Fifth Report	Care leavers' transition to adulthood	HC 411
Sixth Report	HM Revenue & Customs performance in 2014–15	HC 393
Seventh Report	Devolving responsibilities to cities in England: Wave 1 City Deals	HC 395
Eighth Report	The Government's funding of Kids Company	HC 504
Ninth Report	Network Rail: 2014–2019 rail investment programme	HC 473
Tenth Report	Care Act first-phase reforms and local government new burdens	HC 412
Eleventh Report	Strategic financial management of the Ministry of Defence and Military flying training	HC 391
First Special Report	Unauthorised disclosure of draft Report in the previous Parliament	HC 539