Consultation on Care Quality Commission Compliance Guidance

The Royal College of Nursing submission

Executive Summary

1. Regulation of health and social care is undergoing a major period of transition as the new Care Quality Commission begins its work as a new regulator in England. It replaced the three regulators (Commission for Social Care Inspection, Healthcare Commission and Mental Health Act Commission) which used cover social care, health care, and mental health respectively.

2. This consultation is focused upon the CQC’s draft guidance on compliance. This guidance should provide guidance to providers about what they will need to provide in terms of self assessment and evidence to CQC that they are meeting registration requirements set out in legislation (which is not yet finalised, but we understand will be laid in Parliament at the end of 2009 or early 2010). It should also set out what patients and individuals using services should expect. If CQC does not believe that providers are meeting these requirements then the CQC can investigate and use a variety of enforcement powers. In the extreme, CQC can stop a provider from operating.

3. The CQC is operating a changing NHS. Particular changes include:
   - Commissioning, either undertaken by Primary Care Trusts (PCTs) or commissioning outsourced to independent sector providers deciding what to buy and from whom;
   - Patient choice and voice allowing patients choice over their provider and more consultation and engagement with patients. In addition, the potential for greater scope of personal or individual budgets for some service users in both health and social care to purchase those services which best meet their needs;
   - Plurality of providers including Foundation Trusts, the independent sector, and the third sector (including for example, charities and social enterprises);
   - A renewed focus on quality as part of the Next Stage Review; and
   - A new NHS constitution.

4. The RCN makes the following overarching points in relation to the compliance guidance:

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1 See also RCN Policy Briefing 01/2007 Mergers; Markets; and Monitor: An Update on NHS Foundation Trust Developments

2 More detail is available in RCN Policy Briefing 12/2008 NHS Next Stage Review
a) The RCN wholeheartedly supports the aspirations set out in this document.

b) The RCN supports the involvement of patients and those using services and is pleased to see the involvement of individuals who use mental health services as part of CQC’s work on mental health. We wish to see this engagement across all of the work of the CQC going forward across all services.

c) The RCN does not believe that the compliance guidance as it is currently drafted, provides sufficient information for providers to know what they need to do, what evidence they need to provide, and where to find out what appropriate tools and guidance is relevant for their sector which would support compliance. We understand the CQC’s desire not to set out policies, systems and processes used to deliver care. We see this as part of CQC’s desire to allow providers to get on with providing, and allowing them to determine the best way to achieve safe, effective, high quality care. However, we do believe that there is a necessary balance to be struck between setting out the ‘vision’ and providing more detail so that providers are clearer about what constitutes acceptable evidence of compliance (for example making reference to RCN work on Ward Sisters).³

d) We are also concerned about how legally enforceable the regulatory regime is, given the lack of detail set out about what evidence providers need to provide in order to demonstrate that they are compliant with registration requirements. Our understanding is that the compliance guidance has legal status.

e) We appreciate that the compliance guidance says that there are plans for more detailed implementation guidance, however the timetable for this is not known. This is needed so that there is:
   i) Sufficient clarity for providers about what is expected of them
   ii) Sufficient reassurance for the public in the new regulatory regime
   iii) To minimise the risk of legal challenge

5. We would also hope that the CQC can make use of ‘smart’ online reporting tools (both in the provision of information and for self assessment purposes) which could be both user friendly but also make the best use of data as part of a primarily self assessment based approach to system regulation.

6. We would also wish to know more about the content of the ‘quality and risk profile’ and what will trigger an investigation by CQC that is alluded to in the draft compliance guidance.

7. We would also wish to know whether lay assessors will play a role in CQC plans for inspection. We also wish to know more about CQC plans for visiting providers, and the involvement of a service user or carer in such visits. This is particularly important in mental health.

8. The RCN calls for a truly effective regulatory regime given the increase in providers involved in the delivery of health and social care. This includes sufficient levels of monitoring, investigation, and inspections, appropriate

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metrics and timely intervention by the regulator where quality is poor. This means a regulator with teeth.

9. The RCN would also hope that the CQC will assess in a transparent manner its own approaches and be willing to adapt over time as appropriate. This includes independent evaluation and full reporting in the public domain. We would also hope that the CQC would work with other inspectors when issues arise in providers who provide care to patients from outside of England.

10. The **RCN is also calling for ‘intelligent’ regulation.** This means avoiding a box ticking approach but rather allowing for the use of professional judgement. It also requires **investment in leadership** by the CQC. This can be achieved by providing continuing training and support to assessors and inspectors and allowing standards to be measured through a mix of questions and indicators. The RCN recognises that this is a longer term agenda but hopes that it will be a focus of the first year of the new regulatory regime and going forward. Regulators need to understand the essence of high quality care and the difference this makes to the experience felt by patients and the outcomes of their care and treatment. They need to see beneath the data and get under the skin of the organisation they are reviewing.

11. This also means recognising the long term **link between quality staff and quality services** and the need for the regulator and providers to take along term view on investment in training and in appropriate payment to staff working in both health and social care providers. This is evidenced in previous work from the Healthcare Commission and ongoing work for the Boorman Review on Health and Wellbeing. For example, in the 10,000+ responses to the staff questionnaire as part of the Boorman review over 80% of staff believe that their state of health affects patient care. We also note that the interim report recommends that any replacement for the annual health check can be clearly related to staff health and wellbeing.⁴

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Introduction and context

12. The Royal College of Nursing (RCN) is the UK’s largest professional association and trade union for nurses, with almost 400,000 members. The RCN works locally, nationally and internationally to promote high standards of care and the interests of patients and nurses, and of nursing as a profession. We welcome this opportunity to respond to the above document.

13. This consultation is on the draft compliance guidance set out by CQC. This guidance should provide guidance to providers about what they will need to provide in terms of self assessment and evidence to CQC that they are meeting registration requirements set out in legislation (which is not yet finalised, but we understand will be laid in Parliament at the end of 2009 or early 2010). It should also set out what patients and individuals using services should expect. If CQC does not believe that providers are meeting these requirements then the CQC can investigate and use a variety of enforcement powers. In the extreme, CQC can stop a provider from operating.

14. The CQC is operating in a changing NHS and social care environment which includes:
   - Commissioning, either undertaken by Primary Care Trusts (PCTs) or commissioning outsourced to independent sector providers deciding what to buy and from whom;
   - Patient choice and voice allowing patients choice over their provider and more consultation and engagement with patients. In addition, the potential for greater scope of personal or individual budgets for some service users in both health and social care to purchase those services which best meet their needs;
   - Plurality of providers including Foundation Trusts the independent sector and the third sector (including for example, charities and social enterprises);
   - A renewed focus on quality as part of the Next Stage Review; and
   - A new NHS constitution.

15. With more providers involved in the delivery of health and social care, the RCN calls for a truly effective regulatory regime. This includes sufficient levels of monitoring, investigation, and inspections, appropriate metrics and timely intervention by the regulator where quality is poor. This means a regulator with teeth.

16. We have some overarching points regarding the compliance guidance as it is currently drafted before setting out some responses to specific consultation questions below.

17. The RCN wholeheartedly supports the aspirations set out in this document. We wish to see providers embrace person centred care in the widest sense.

5 See also RCN Policy Briefing 01/2007 Mergers; Markets; and Monitor: An Update on NHS Foundation Trust Developments http://www.rcn.org.uk/__data/assets/pdf_file/0012/24024/mergers_markets_and_monitor.pdf
18. The RCN also welcomes the desire and practice that we see in relation to work on the future of mental health of involving those who use services.

19. The RCN understands the desire to set out what ‘good’ means for patients and those using services and allowing providers the freedom to innovate and deliver in the most appropriate way care according to their setting. However we believe that there is a balance to be struck. We would prefer to see more detailed guidance, including more signposting to relevant guidance and tools, to enable providers to know what evidence will be acceptable to the CQC to demonstrate compliance. For example:

   a) What evidence CQC will consider demonstrates compliance that outcome 4 (regulation 7) is met and that staff will quickly recognise when a person becomes seriously ill etc in long term conditions facilities
   b) What evidence CQC will consider demonstrates compliance that outcome 1 (regulation 15) is met and that people are involved in decisions about the way the service is run
   c) What evidence CQC will consider that demonstrates compliance that outcome 5 (regulation 12) is met and that those who use services are able to make choices about when to eat etc. We would also ask that a choice is available about drinking in addition to the choice about eating
   d) What evidence CQC will consider that demonstrates compliance that outcome 11 (regulations 19,20, 21) is met and that staff have undertaken induction and training. We would also ask that depression is added to this list.
   e) We would ask that there are clearer references made to national guidance (for example the national strategy on end of life care) and also that in the context of community services that there is not just a narrow focus on end of life care but also upon the wider contribution of community services to the prevention of disease and contribution to long term improved health and quality of life. We suggest that community health services relating to the well being of children and young people needs to be referred to.

20. We believe that this is required in order to provide:
   a) Clarity for providers
   b) Assurance for the public
   c) Minimise any risk of legal challenge given the relatively loose requirements that are set out in the current compliance document

21. We would also hope that the CQC can make the best use of technology. This is to provide easy to use tools both on compliance and what evidence is acceptable and signposting to relevant accreditation, national guidelines etc but also for self assessment purposes.

22. We would also wish to know more about the content of the ‘quality and risk profile’ and what will trigger an investigation by CQC.

23. We would also wish to know whether lay assessors will play a role in CQC plans for inspection.
Consultation questions

What do you think about the layout and design of the guidance – is it easy to follow and understand?

24. **No**, we do not find the document easy to follow and understand. The document is large and repetitious. We understand that it needs to be ‘generic’ to be fit for purpose across the whole of health and social care, however we recommend that:
   a) The generic portion is a stand alone document
   b) The guidance for specific activities are separate and much more detailed documents (which include references to existing tools and guidance for example, NICE guidance etc)
   c) That both are placed online in more user friendly searchable formats that both sets out what evidence is required in more detail, but also provide links to other relevant tools and sources of information etc

Is the guidance written in language that is easy to understand?

25. **Broadly yes**, however we expect that it may not be for all types of providers. We hope that providers respond to provide their views to CQC on this issue.

Does the guidance provide enough information on meeting the needs of individuals – including race, age, disability, gender, sexual orientation, religion and belief?

26. **No**, although the guidance makes reference to human rights, dignity and the equality strands. It does not provide explicit clarity on what organisations must actually do to ensure that these values characterise the lived experience of patients and service users. We are conscious that service providers have suggested that there is a paucity of practical and meaningful guidance in this area. We are also mindful of a recent report produced by the 7Equality and Human Rights Commission following their Inquiry into the application of the Human Rights Act in the UK. The report suggests that inspectorate and regulatory bodies should integrate human rights and equalities within their framework. We would also recommend that the CQC give consideration to the Equalities Measurement Framework (EMF) which has been produced by the Equality and Human Rights Commission. It outlines a number of indicators specifically for the health care sector that may be of use to the Commission when developing or applying measurement frameworks.

Part B, Section 1: Involvement and information

Does this section clearly describe what providers are expected to do to comply with the registration requirements?

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27. The CQC is asking for responses to guidance on regulations which are still in draft form, and which have not been approved by Parliament. This seems premature. The recent Department of Health consultation has closed but it is not clear what changes will be made to the draft regulations as a result of that consultation. It would be preferable for CQC to issue consultation guidance on confirmed regulations rather than on draft regulations.

28. Regulation 15 sets out the legal requirement for all providers in relation to their legal duties to respect and involve people who use services. It appears that CQC is trying to rewrite this regulation in its draft outcome, but in so doing, misinterprets the legal requirement.

29. Regulation 15 (1) places two clear legal duties on providers. The first is to make suitable arrangements to ensure the dignity, privacy and independence of service users. The second is to make suitable arrangements to ensure that service users are enabled to make decisions relating to their care or treatment, or to participate in making those decisions. The CQC has redrafted the emphasis in its outcome by changing the order of these two duties. The RCN would suggest these are switched around. The CQC has also reduced the impact of the legal requirement for dignity by reducing the legal requirement to one that informs providers their duty is to “respect” dignity. There is a considerable difference in the way that a provider will approach using resources where there is a legal duty in regulation (albeit in draft form) to “make suitable arrangements to ensure” (the legal duty) from the “respect” and “maintain” (the regulator’s interpretation in the draft outcome).

30. The draft regulation gives a considerable amount of authority to the provider itself in relation to its duties for respect and involvement. It sets out that the arrangements to be made by then provider can be “so far as is reasonably practicable” and that the arrangements must be “appropriate”. The draft regulation does not appear to give much room for additional guidance to be added to this legal requirement by the CQC. The extensive draft guidance from the CQC in this section therefore seems to be unnecessary for providers and indeed at a degree of odds with the draft regulations themselves.

31. The NHS Constitution covers the rights and pledges made by the NHS for these issues. The draft regulations set out the extent of the legal duty for providers. The most useful approach from the CQC in this section would be to act as a signpost for relevant external sources that already exist that would assist providers in coming to their own decisions about how they meet these legal requirements.

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

We want this guidance to apply to all health and social care providers. Are there additional areas that the guidance needs to include?
32. We have no additional comments on these questions to our general comments made earlier in this document.

Part B, Section 2: Personalised care, treatment and support
Does this section clearly describe what providers are expected to do to comply with the registration requirements?

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

33. We have no additional comments on these questions to our general comments made earlier in this document.

We want this guidance to apply to all health and social care providers. Are there additional areas that the guidance needs to include?

34. We note that in relation to outcome 6 (co operating with other providers) there is often an issue where premises/sites are shared e.g. who is responsible for repairing the potholes, security on the ground or removal of asbestos? We would like the compliance guidance to make it clear that there is a duty under health and safety law to co-operate and communicate with organisations where premises are shared and identify responsibilities. Lack of communication and co-operation presents risks to service users and staff. It may be wise to make a link to outcome 9 (safety and suitability of premises).

Part B, Section 3: Safeguarding and safety
Does this section clearly describe what providers are expected to do to comply with the registration requirements?

35. No. We make some suggestions for amendments below.

36. We would ask if reference could be made to staff protection on p.49. For example, we would suggestion that the last bullet point on p.49 be amended to read “protect others, including staff, from the effect of the person’s disturbed behaviour”.

37. We would ask if further reference could be made to HSE and other regulatory body guidance and materials. For example:
   a) specific reference to HSE guidance and materials under design and layout (for windows and prevention of falls from heights) and maintenance and renewal (for scalding water temperatures and clear procedures for the storage and handling of chemicals).
   b) Communities and Local Governments’ guidance on fire risk assessments in residential care homes and healthcare premises.
   c) to the requirement to have a ‘competent person’ to advise on health and safety issues.
38. We would ask if further reference could be made under outcome 9A to the physical security of buildings (patient and staff safety is dependent on secure environments e.g. protection from intruders at night, well lit outside areas etc).

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

We want this guidance to apply to all health and social care providers. Are there additional areas that the guidance needs to include?

39. We have no additional comments on these questions to our general comments made earlier in this document.

Part B, Section 4: Suitability of staffing
Does this section clearly describe what providers are expected to do to comply with the registration requirements?

40. No. We make some suggestions for amendments below.

41. We would ask if reference could be made under outcome 11 to access to occupational health advice.

42. We would also ask if reference could be made to actions to prevent and assess the risks of violence.

43. We would also ask if reference could be made to the Working Time Regulations under outcome 11b. This is to ensure that staff are not made to work excessive hours which can impact on patient safety or pressurised to sign an opt out.

44. We would also ask that in relation to staff learning and development it is made clear that staff undertake mandatory training as part of their working time and not on their own time. We suggest that text is amended to say “the staff learning and development programme takes account of the working patterns of staff and mandatory and statutory training takes place during working hours”.

45. We would also ask that reference is made between the duty to consult with staff and the positive link that those staff who are consulted with will feel more engaged.

46. We also note that in relation to fitness that employers should be aware of the role of professional regulators such as the NMC.

47. We also note that on page 69 in relation to having enough staff who are well managed to mention the availability of different working patterns around the needs of patients and work/life balance of staff.

48. We also note that there is a need to reference the European Working Time Directive and how employers will be able to demonstrate that these regulations are met.
49. We also found page 71 difficult to understand. We would ask that learning and development should be linked to patient needs and any envisaged service development. There is then a learning needs analysis that arises from staff’s personal appraisal and training is then commissioned or provided on the basis of where the gaps are and what is required.

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

We want this guidance to apply to all health and social care providers. Are there additional areas that the guidance needs to include?

50. We have no additional comments on these questions to our general comments made earlier in this document.

Part B, Section 5: Quality and management
Does this section clearly describe what providers are expected to do to comply with the registration requirements?

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

51. We have no additional comments on these questions to our general comments made earlier in this document.

We want this guidance to apply to all health and social care providers. Are there additional areas that the guidance needs to include?

52. We would ask that under outcome 13 that there is reference not just to decision making but about clear lines of accountability and responsibilities.

Part B, Section 6: Suitability of management
Does this section clearly describe what providers are expected to do to comply with the registration requirements?

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

We want this guidance to apply to all health and social care providers. Are there additional areas that the guidance needs to include?

53. We have no additional comments on these questions to our general comments made earlier in this document.

Part C: Specific guidance about compliance
We have developed guidance for specific services in Part C in addition to the generic guidance (Part B). Does this guidance cover the services you provide, use or are interested in?

54. Yes. The RCN has an interest in the full range of health and social care provided in England both in the interests of our members who work in these providers but also as a professional body with a strong commitment to working on professional issues and in the public interest.

Does the guidance in Part C clearly describe what providers are expected to do to comply with the registration requirements?

55. No. Please see our earlier overarching comments.

The guidance about compliance aims to reflect the essential standards of safety and quality; this means including the right things at the right level. Have we done this?

56. We have no additional comments on this question to our general comments made earlier in this document.

Impact assessment

Does the impact assessment accurately represent the cost of implementing the guidance to providers of regulated activities and others?

57. No. We do not believe that it does. This is because:

   a) It is not currently clear what providers will actually need to do to provide evidence that is acceptable to the CQC that they are compliant, so it is not clear how it is currently possible to estimate the incremental cost to providers of implementing the guidance. Failing to include this will underestimate the full cost of system regulation. We note that the impact assessment itself states that it does not include key costs such as “the costs to the regulator” and the “cost of fees to providers”. The impact assessment is therefore explicitly incomplete.

   b) It is not currently clear how much information that CQC will need to review as part of self assessed returns so it is not clear how it is currently possible to estimate the cost to CQC of implementing this guidance.

   c) The impact assessment does not provide any detail on how these costs are arrived at by CQC, so it is impossible to assess whether they are realistic or not.

58. We also note that the impact assessment is entitled “Impact assessments – short version”. We believe that the full version should be made available for the public to be able to assess the impact assessment properly.

Does the impact assessment accurately reflect all the benefits associated with implementing this guidance for providers of regulated activities and people who use services?
59. **No.** We do not believe that it does. This is because:

a) It is not currently clear what providers will actually need to do to satisfy the CQC that they are meeting registration requirements, and how far this activity is successful in contributing to the avoidance of mortality, morbidity and potentially higher quality of life.

b) It is not currently clear what the incremental benefit of CQC regulation is in addition to many other factors which are likely to influence the avoidance of mortality, morbidity and potentially higher quality of life.

c) It is not currently clear the exact approach CQC will take and how successful it’s approach will be (for example how often it will inspect, what will trigger an investigation etc).

d) The impact assessment does not provide any detail on how these monetarised benefits are arrived at by CQC, so it is impossible to assess whether they are realistic or not.

60. We also note that the Healthcare Commission themselves say that:

   “Disentangling the contribution of regulation amidst the range of influences on patients and the public, clinicians, commissioners of care and managers is, therefore, extremely challenging. In particular, in the NHS it is clear that independent assessment by the regulator is closely connected to increased local public accountability, and to performance management by the leadership of the NHS and oversight of foundation trusts by Monitor.”

61. We also note that although the publication is no longer available from CQC (which we are surprised at, given the important lessons for health care system regulation contained in that report) that the Healthcare Commissions’ report, Making a difference, An evaluation of the performance of the Healthcare Commission 2004-2008, noted that it could not monetarise the benefits of their regulatory approach. We therefore find it difficult to understand how the CQC has been able to determine the incremental benefit of their, as yet, not fully specified regulatory regime.

62. We therefore believe that the impact assessment is aspirational at best, and with no transparency on how the estimates of significant financial benefit have been arrived at.

**Equality impact assessment**

*Are there any proposals contained in the guidance about compliance that might have an adverse impact on race, disability, gender (including gender reassignment), sexual orientation, religion or belief, or age equality for you or for people who use services?*

63. The failure to properly integrate a robust human rights framework into the compliance process will necessarily create an adverse impact across the existing equality strands. We fully support the recommendation that a full equalities impact assessment process is implemented and seek assurances from the CQC.

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that evidence of adverse impact will be acted upon We also support the recommendation that further work is done to fully understand the implications outlined in section 6:12. We also reiterate our suggestion that consideration is given to reviewing the outcome of the Equality and Human Rights Commission’s work on the Equality Measurement Framework.

Other observations

64. We would also ask that there is a definition of personal care provided. The lack of a definition poses difficulties for implementing regulation. Similarly a definition for an establishment.

65. We wish to draw CQC’s attention to broader points we have made in a number of recent consultation responses. These are repeated below.

66. System regulation is currently undergoing a period of major change into the transition to the CQC. The RCN sees a need for clear investment in leadership across the CQC in both culture and in individual staff as the CQC continues to develop. This is to enable staff to act as leaders in every setting and in particular for assessors and inspectors when they are out in the field.

67. The RCN also notes that in this period of change there may perhaps be greater risk of poor quality services being delivered (not just because of the transition in regulation but also as wider forces such as the economic downturn place additional pressures on providers who may be forced to make redundancies).

68. The RCN also notes that the CQC will need to work effectively with other regulators; and not just in the health and social care field but also others such as Ofsted.

69. The RCN would also wish to see the scope for information sharing with other agencies and the CQC. For example, the NHS Supply Chain holds data on purchases of needle safety devices which could be useful to the CQC as part of assessing against the hygiene code.

70. The RCN also notes that delivery of high quality care relies on a range of factors; not least of which is the attraction and retention of a high quality workforce. This requires a long term perspective to be taken on the part of providers and of the regulator, and widening the scope of regulation to include appropriate investment in staff. It also requires appropriate payment for staff; an illuminating example is the current way in which some staff within residential and domiciliary care are paid. Some staff are only paid for the provision of care in 15 minute episodes and travel time is not reimbursed. In order for these staff to attend their appointments on time they essentially have to ‘shave’ 5 minutes

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9 For example, research by Dr Veena Rayleigh of the Healthcare Commission examined the Patient experience survey and staff survey and found a correlation between positive patient experiences and good HR and health and safety practice.
from the 15 minute episode. This approach to payment simply fails to cover the true costs of providing the service, at the expense of care delivered to the service user. The CQC has scope to influence approaches to payment by explicitly recognising the link between staffing (including training, payment etc) and quality.

71. The RCN is also calling for ‘intelligent’ regulation. This means avoiding a ‘tick box’ culture and allowing trained and wise professionals who assess and inspect to apply their expertise, and exercise professional judgement.

72. For example, the RCN wholly supports programmes to improve nutrition; however the focus on the current red tray scheme by the Healthcare Commission in their inspections may inhibit other and better ways of delivering the outcomes of improved nutrition. This is because providers who do not use the red tray scheme, but who may use other more locally appropriate approaches, are penalised. Similar issues apply to the placement of hand washing basins. Trusts are penalised for failing to re-site their hand washing basins despite the physical infrastructure prohibiting them from making such changes, and evidence of a good track record on infections. The RCN prefers the outcomes to be the focus of the regulatory regime; and not take a too rigid approach on the process. Organisations must feel free to be creative in terms of what works well for patients in their particular setting.

73. The RCN recognises that this poses a difficulty in terms of ensuring consistency in the way in which the regulations are applied and approached by individual assessors and inspectors, however believes that this can be overcome by:
   a) Allowing standards to be measured both by indicators and also by questions (eg what systems and processes are in place and in use to support improved nutrition?). Evidence from the site visit can be used to provide a qualitative answer, and to inform the assessment.
   b) Providing sufficient and regular training for staff.

74. The RCN recognises the significant task for CQC, and notes that for CQC to be able to fulfil its vision it will itself need significant resources.

75. The RCN believes developing an ethos of ‘intelligent’ regulation will benefit patients/service users (who will have improved outcomes), providers (who will have the freedom to be creative and innovative), and the CQC itself (in building up a reputation as a credible and intelligent regulator).

Royal College of Nursing
August 2009