CQC’s Public Engagement Strategy
Introduction

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high quality care and to encourage services to improve.

Public engagement is central to delivering our purpose. It ensures we understand and focus on what matters to people, helps to build public trust and confidence in our work, empowers people to understand the quality of care they should expect and helps them to choose between services if they want to. It also enables CQC to meet its statutory requirements as set out in the HSCA 2008 (and amended in 2013).

The public have told us very clearly in intensive consultation over the past two years\(^1\) that to engage them better we need to do four things:

1. Raise awareness and understanding of CQC’s role and purpose.
2. Listen to, and act on people’s views and experiences of care.
3. Work with the public to develop and improve our policies, methods and other aspects of our work (how we do our job).
4. Provide high quality information about care services.

Our public engagement strategy is informed by this and by further research, an assessment of our current performance, an understanding of what other organisations do well \(^2\) and the expertise and experience of our staff.

\(^1\) Responses to the consultation on our provider handbooks (October 2014) http://www.cqc.org.uk/content/consultation-response-how-we-regulate-inspect-and-rate-services

\(^2\) Supporting analysis and detailed implementation timescales (October 2014)
1. The continuum of public engagement

The term public ‘engagement’ means different things to different people, and is sometimes used interchangeably with the terms ‘involvement’, ‘participation’, and ‘co-production’. In this strategy the term ‘engagement’ is not distinct from ‘involvement’. It covers a continuum from information and consultation to participation, co-production and sharing our functions, as illustrated in figure 1 below.

A good example of this continuum is the design and delivery of our Handbooks for Providers of Adult Social Care Services. They were co-produced together with the public, directly influenced by people who participated in two-way discussions about them, including discussion online; consulted on during and outside of our formal consultation; and communicated at various stages of their development.

Figure 1
2. **Aim and objectives**

The overall aim of public engagement in CQC is to deliver CQC’s purpose by embedding the voice of the public into our work. To achieve this we need to make significant improvements in all of the four areas set out in Section 1 above. Our objectives are to ensure:

- People from a wide range of population groups feel that CQC is on their side, are enabled and encouraged to understand the standards of care they should expect, and are empowered to encourage improvements to care.
- CQC listens to the views and experiences of care of a wide range of population groups and they are confident that we have acted appropriately in response. When people contact us to share their experiences they judge their customer experience to be an exemplar among organisations with high volumes of customers.
- Co-production, participation and consultation with the public are embedded in our work, making sure that the views and experiences of the public inform our own professional judgement and expertise to produce the best outcome for the people we serve.
- CQC’s public information online and in other formats is extensively used by the public, is available to them in a way and at a time that meets their individual needs and is recognised as an exemplar among organisations providing information about care services.

These objectives are ambitious and we recognise that there will be more work to do from 2016 onwards. Our **objectives for 2014 – 2016** in these four areas are also ambitious, but they reflect our current organisational focus on improving how we listen to and act on people’s views and experiences of care and on providing better information to support people’s understanding and choice of care services. By 2016 we will therefore ensure:

- More people from a wider range of population groups are enabled and encouraged to be aware of and understand CQC’s purpose and role.
- More people from a wider range of population groups are enabled and encouraged to tell CQC about their views and experiences of care in a way that meets their individual needs and which helps us to decide when, where and what to inspect. They are clear about what to expect when they share their experiences with us and they have a good experience when they contact us (our customer proposition).
• We enable and encourage people from a wider range of population groups to participate in CQC’s decisions about how it does its job, and we co-produce key policies which affect them.

• CQC’s public information online, offline and in other formats is increasingly used and highly valued by the public.

3. Who we want to engage

Everyone in England – 53 million people – currently or may, in the future, use health and social care services. Many will be at their most vulnerable when they do so and many will increasingly move between different services in different sectors.

We recognise that we need to develop a robust, evidence-based approach to segmentation of the population in order to target our approach more effectively. In the short term it is useful to consider people in the following population groups, based on the model used by our PMS inspection team:

• People who use health and/or social care services frequently and episodically i.e. older people; people with long term conditions, including people experiencing mental health problems and people with physical, learning or sensory disabilities; pregnant women and mothers of young children; their family, friends, advocates and support workers.

• People who use health and/or adult social care services only episodically i.e. people having elective/cosmetic surgery, one-off procedures or experiencing occasional bouts of ill health; their family, friends, advocates and support workers.

We will use the following criteria to prioritize our work in relation to these population groups over the next 18 months, ensuring a proportionate approach which reflects:

• Population size, to ensure we engage an accurate representation of that population.

• Risk of poor care due to vulnerability of circumstances i.e. people with learning disabilities; people with dementia; people who are experiencing detention under the Mental Health Act; people with no kith or kin.

• Likelihood of experiencing poorer health outcomes i.e. homeless people; gypsies and travelling communities, people who misuse alcohol and substances; sex workers, refugees and asylum seekers.
Equality and diversity i.e. people who have protected characteristic under equalities legislation such as minority ethnic groups, people whose first language is not English, and lesbian, gay, bi-sexual and transgendered people.

The results of research which tells us who currently most values CQC’s information i.e. people choosing adult social care; people using healthcare when long term treatment is necessary; older people preparing to fund future care; people choosing care on behalf of a loved one; people choosing healthcare for a specific, one-off procedure e.g. knee replacement; people choosing maternity care; people choosing private hospitals to have cosmetic surgery.

The requirements of pilot approaches to new style inspections.

The requirements of thematic reviews.

We will use existing and new research, behavioural and consumer insight to understand the best ways of encouraging and enabling people to engage with us in each sector.

We are aware that there are groups of people who do not use services at all, except perhaps when in crisis, and that they include some of the groups described above. We will work with these groups and those who represent them to understand how better to assess whether providers are reaching out to them and to encourage them to do so.

4. Principles

Throughout our work we will be guided by the principles set out in appendix 1.

5. Our programmes of work

Our public engagement strategy for 2014 - 2016 sets out 4 programmes of work to deliver our objectives for that period set out in Section 2:

1. Raising public awareness and understanding of CQC’s role and purpose

2. Listening to and acting on the public’s views and experiences of care
3. Engaging the public in the design and shape of our work (how we do our job)

4. Providing high quality information to help people choose care

We will continue to use the issue tree set out in appendix 2 to further develop our work.

5.1 Raising public awareness and understanding of CQC’s role and purpose

Raising awareness of CQC’s work encourages and enables people to understand the standards of care they should expect, to use our information to choose care if they want to, and to share their experiences of care with us. It promotes our independent voice, building public trust and confidence in our work.

Our **overall ambition** is to make sure that people from a wide range of population groups feel that CQC is on their side, to enable and encourage people to understand the standard of care they should expect, and to empower people to encourage improvements to care.

Our **programme of work for 2014 – 2016** focuses on making progress towards this goal by ensuring more people are aware of and understand CQC’s purpose and role, particularly at the time when we are of most use to them i.e. when they are using or choosing care.³

We will make the most of our **regional and national partnerships** with voluntary and community organisations to raise awareness and understanding of CQC’s purpose among large groups of people who most frequently use care services and local communities.

We will continue to promote CQC in **GP surgeries and via local authority social care teams** and we will expand this work into other healthcare, social care, mental health and community services. We will make sure that signage displayed by providers about our new ratings of services is consistent and effective in promoting CQC’s purpose.

We will continue to enable and encourage diverse groups, those who are rarely heard from and people made vulnerable by their circumstances, to be aware of and understand CQC’s purpose through our **Speak Out programme** and through our regional partnerships.

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³ 20130529 Information seeking behaviour: Opinion Leader full report
We will continue to pilot using consumer channels such as Mumsnet and Gransnet to promote CQC to people using and actively choosing care for themselves and their families.

We will maintain and grow an engaging digital presence. We will develop a social media strategy and policy which encourages and supports more CQC staff to use social media, targeting health or social care presence already on Twitter and using the social media platforms of our partners.

We will raise awareness of CQC’s inspection teams through a programme of local public engagement, including via voluntary and community groups, digital engagement and regional media.

We will carry out further research to increase our understanding and insight into when awareness and understanding of CQC’s purpose is of most value to different people.

5.2 Listening to and acting on people’s views and experiences of care

Listening to and acting on people’s experiences of care is vital to our work. It helps us to decide when, where and what to inspect, supports better registration, inspection, judgements and ratings and results in better information for the public.

Our overall ambition is that CQC listens to the views and experiences of care of a wide range of population groups and they are confident that we have acted appropriately in response. When people contact us to share their experiences they judge their customer experience to be an exemplar among organisations with high volumes of customers.

Our programme of work for 2014-2016 focuses on making progress towards this goal by making sure that people from a wider range of population groups are enabled and encouraged to tell CQC about their views and experiences of care in a way that meets their individual needs; they are clear about what to expect when they share their experiences with us; and they have a good experience when they contact us to do so. It is aligned with our Knowledge and Information strategy, our Operations improvement programme and our Customer experience programme.

As part of this programme of work we will ensure the public continue to take part in our registration and inspection teams as part of our Experts by Experience programme. We will carry out an evaluation of this programme.
and clarify the role of Experts by Experience. We will make best use of their experiences and expertise and make sure that it adds to that of our inspectors, for example in enabling and encouraging people with learning disabilities, people with dementia, and people who use specialised services to talk about their experiences of care. We will continue to increase our expenditure on this programme from £5.6m to £7.5m per annum and from 13,500 experts by experience inspection days to a minimum of 17,900 experts by experience inspection days. As we agree new contracts in 2015 that reflect this, we will begin conversations with each of our inspection teams about the arrangements for Experts by Experience in their sectors.

Our Academy will better support our staff to have a better understanding of people’s experiences of care and of what matters to them. They will support our inspection teams to make sure they have confidence in talking to people about their views and experiences of care in way that is tailored to meet people’s needs, including through training, guidance, observational tools and resource such as access to interpreters. We will also provide them with training, guidance and support to make sure they regularly engage and share information with local groups who work with people using services, including learning disability partnership boards, advocacy groups, older people and carers groups, and groups for people living with dementia.

Across all sectors before and in between inspections our inspection teams will consistently engage, share information and plan our activity with local Healthwatch. They will also consistently request and look at information received from people by other statutory bodies and representative groups including Overview and Scrutiny committees, NHS complaints advocacy services, Health and Wellbeing boards, Foundation Trust Boards of Governors, Patient Participation Groups and CCGs; information from other organisations that collect and collate local views of services such as commissioners of services, regulatory partners and local voluntary and community groups. They will look at information received from people who leave information on websites such as Patient Opinion, NHS choices, the Good care guide; and Most recommended care: from those who contact us via telephone, post, email or via the Share your experience form on our website with their comments, concerns and complaints; information about complaints received by the provider; safeguarding alerts; and comments and feedback from local authority teams and health professionals.

We will build on and establish partnerships with organisations that can promote our inspections and enable and encourage people and communities to routinely share their views and experiences with us, including people in vulnerable circumstances, people who face poorer health outcomes, people from diverse communities and people who are rarely heard from. The voluntary and community sector will play a key role in this work. This will include regional...
partnerships to provide us with service specific or regional reports about the quality of care; our national Tell us about your care partnerships with voluntary organisations that represent people who frequently use services and their families, friends, support workers and advocates; and our partnerships with organisations such as Mumsnet and Gransnet.

We will make greater use of digital engagement methods to encourage and enable people to share their views with us where this is the most appropriate method. We will adopt a phased approach, targeting different groups and testing methods over time. We will design a free CQC App to encourage people who frequently use services and those who care for them to tell us about their experiences of care, based on how the public tell us they want to engage with us. We will use online surveys to crowdsource opinion about particular aspects of care. Our Intelligence team will explore new systems to help us understand what conversations are happening about local care services on social media.

We will improve the Share Your Experience section of our website to enable people to give CQC a snapshot view of a service, as well as more detailed comments about their views and experiences of care.

Where we have identified particular issues that need further exploration with the public, we will do this in the most effective and efficient ways that meet people’s needs.

Our inspection teams will strongly encourage providers of care services to foster a culture of encouraging people to report their experiences of care, including formal complaints, and of responding appropriately. Our comprehensive inspections where we rate services will have a strong focus on the complaints people have made and how they are handled by the provider. We will report annually on the state of complaints.

Our inspection teams will encourage providers to actively promote our announced inspections in advance, for example by emailing people who use the service if they hold lists and contact details. We will continue to provide materials to providers to advertise inspections on site.

We will pilot 2 cross sector public engagement events per year in every region to explain our role, the standards of care people can expect, and to listen to people’s views and experiences of care of all the services we regulate.

We will carry out specific public engagement work to support our thematic reviews and we will carry out a review of how well different types of services involve people in their care.
We will work with our customer experience programme to define what people can expect when they share their experiences with us and to encourage people to understand the broad range of actions we may take in response. We will make clear that we regard people’s views and experiences as valuable information that adds to our understanding of the quality of care. We will signpost people who seek formal resolution of individual complaints to the appropriate organisations, and provide information and tools to support this. We will publish aggregated reports on the action we have taken as a result of people sharing their experiences with us.

Our Intelligence team will introduce systems to improve how we analyse people’s comments, concerns and complaints and make sure that the analysis is more useful for our inspection and registration teams.

We will undertake additional activity in each of the sectors that we regulate. For example, our Intelligence team will make greater use of the wealth of information contained in annual or biannual surveys of people who use some types of services, including looking more at variation of experience (e.g. on the basis of equality characteristics). We will make sure that providers understand that people may have low expectations or little understanding of the standard of care they should expect and we will factor this in to our analysis of national surveys such as the Friends and Family Test.

In relation to acute hospitals, community, health, and ambulances, and independent hospitals, we will also work with organisations such as NHS Foundation Trusts, Healthy Start and Start4Life initiatives, the Private Patients Forum and charities and community organisations to encourage people to share their views with us.

In relation to mental health trusts and community mental health services we will also continue to hold externally facilitated focus groups for people who use the service before each announced inspection of mental health trusts. Our inspection teams will continue to hold drop in sessions and 1-1 interviews on site during the inspection. We will continue to promote the inspection to all local mental health groups and we will pilot the commissioning of trusted intermediaries to provide reports on people’s experiences of care of particular services.

We will pilot and establish ways of encouraging and enabling people with a learning disability to share their views and experiences of care, with an initial focus on specialist learning disability services. We will improve how we work with learning disability partnership boards, Mencap and other Learning Disability networks to raise awareness and understanding of how people with learning disabilities can share their views and experiences of care. We will develop a
package of accessible communication tools to enable CQC to better listen to the experiences of care of people with learning disabilities on inspections.

We will pilot and establish ways of listening to the views of people who use substance misuse services as we develop our approach to inspection in this area.

In relation to primary medical services, we will also pilot ways of hearing the views and experiences of care of people in the criminal justice system and those who use hospice care.

In relation to community and residential adult social care, where inspections are mostly unannounced, we will also encourage and enable people receiving care and their family, friends, advocates and support workers to share their views and experiences by telephoning them or visiting them in their homes, using interpreters, or specialist staff where there are communication barriers.

We will expand our Tell us about your care partnerships with voluntary and other organisations that encourage friends, family, support workers and advocates of people in adult residential and community care to tell us about their experiences. We will develop partnerships with organisations of community volunteers, particularly those who have regular contact with people receiving adult social care, who can share their observations of people’s experiences of care with us.

We will test ways of enabling and encouraging people who use hospices to tell us about their views and experiences of care.

Our public engagement activity will be guided in future by a review carried out by our Intelligence team of what national and local qualitative information we use, the impact it has on our work and the cost associated with its use.

5.3 Engaging the public in how we do our job

Engaging the public in the development of our strategy, policies, methods and other aspects of our work provides insight into how they work in practice, improving our inspections, our intelligent monitoring, and the public information we provide.

Our overall ambition is to embed co-production, participation and consultation in our work, making sure that the views and experiences of the public inform our own professional judgement and expertise to produce the best outcome for the people we serve.
Our programme of work for 2014 – 2016 will enable and encourage people from a wider range of population groups to participate in CQC’s decisions about how it does its job, and we will co-produce key policies which affect them.

We will review the ways we currently encourage and enable people to engage in this work, establishing a menu of options reflecting the continuum set out in Figure 1 and ensuring we engage a representative sample of the population of England with equality of access for all.

We will establish ways of enabling the routine participation of statutory, voluntary and community groups in all of our work, encouraging and enabling groups representing people in vulnerable circumstances, people who face poorer health outcomes, people from diverse communities and people who are rarely heard from to do this, including through our Speakout network.

We will develop our public online community and establish an online people’s panel representative of the population of England to encourage regular and responsive participation in all aspects of our work, offering alternative engagement methods to meet people’s needs and focus groups for specific targeted pieces of work that require expert facilitation. We will introduce regular online surveys of our public groups to crowdsource opinion about particular topics and use digital engagement methods encourage people to have a two way conversation with us.

We will continue to engage the public in our programmes for developing staff, including in developing our training programmes and helping us to deliver training.

We will enable a representative groups of people who use services to influence and challenge CQC’s work at a strategic level.

We will continue to develop an effective forum for sharing research, insight and best practice relating to public engagement with our regulatory partners, stakeholders and other health and social care organisations.

We will establish new processes to ensure that insight from all of our public engagement activity is embedded into the policy-making process and we will make sure people understand how we have acted on what they have said by publishing regular feedback on public insight (research, surveys, focus groups, consultation activity etc) via our website and other channels.
5.4 High quality information to support choice – all sectors

High quality information about the quality of care empowers people to understand the standards they should expect and supports their choice of services. It also increases local accountability and encourages services to improve. By high quality information we mean information that is clear, timely, accurate, and meets people’s needs both in terms of content, format, and the way it is delivered.

Our **overall ambition** is to ensure CQC’s public information online and in other formats is extensively used by the public, is available to them in a way and a time that meets their individual needs and is recognised as an exemplar among organisations providing information about care services.

Our **programme of work for 2014 – 2016** will make it easier for the public to use our information, whether it is on our website, on social media, or in printed formats, to help them choose care. We will also focus on improving the experience of providers of care services and stakeholders while we move towards launching online services for providers.

We will dedicate time and resource to reviewing all of our online and offline **content**, ensuring it is clear, concise, and engaging and enabling people to arrive more easily at the information they need. We will increase the use of **dynamic content** on our website, ensuring it represents the full range of our work and drives people to our website from social media.

We will increase our understanding of the needs of all of our population groups to ensure we provide **the right information in the right format at the right time** for people. We will make sure we provide **alternative formats** to meet the needs of people with sensory impairments or people with a learning disability and, on request, people who use languages other than English. We will work with organisations that already offer high quality guidance in particular areas and co-produce this work with the public.

We will test and develop **how we report on our new style inspections and ratings, and registration of care services**, driving an approach which meets the needs of people who use different types of services. Our Academy will support better inspection report development, writing and presentation, including training and tools for our inspection teams, and testing and research with the public to establish our understanding of what best meets people’s needs where this is not yet clear.

We will establish an **internal governance group** to oversee and lead changes to our inspection reporting and an **editorial panel of members of the public** to provide regular insight into how well our reports meet people’s needs.
We will improve how we publish our inspection findings in national reports, with better visualisation of our findings and open data in line with our Knowledge & Information strategy.

We will optimise our website so that it works as well for people using smartphones and tablets as it does for those using desktop machines. Once our website is fully responsive, we will review the demand for a free CQC App to encourage and enable people who use mobile phones and tablets to easily access our information.

We will increase uptake of our email alerts, which tell people when inspection reports and key reports findings are published, to better engage people, including local statutory and representative groups, in our work.

We will syndicate our inspection information to allow others to build their own products or services using up-to-date, accurate judgements and ratings and to make sure that people who use their information are confident that the information is of good quality.

We will investigate and test options for supporting people’s choice by displaying reviews of care services by the public and information contained in intelligent monitoring. We will introduce a timeline view of the quality of care of a service.

We will work with Registration Improvement and Intelligence teams to capture data that supports the information needs of our population groups and ensure our systems support more intuitive search and presentation of public information.

6. Partnerships

We cannot do this alone. Partnerships are vital to the success of our strategy. They will make sure we present a coherent view of our role in the health and social care system, help us to raise awareness and understanding of CQC’s role, encourage and enable people to share their experiences of care with us, and share with us the insight they hold about the public’s views and experiences of care. We will continue and develop partnerships with:

- Other regulators, commissioners and health and care ombudsmen
- Local Healthwatch and Healthwatch England, as leaders of this network
• Other statutory and representative groups of people who use services, including Overview and scrutiny committees, Foundation Trust Councils of Governors, Patient participation groups, complaints advocacy organisations and learning disability partnership boards
• Providers of care services
• National and local community and voluntary organisations, including groups representing people in vulnerable circumstances, people who face poorer health outcomes, people from diverse communities and people who are rarely heard from
• Volunteers who work with people who use care services
• Other organisations who represent and have extensive reach into the people who we most want to engage
• NHS Choices and Patient / Care Opinion as providers of user reviews and ratings of services.

7. Equality and diversity

One of CQC’s principles is to promote equality, diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will help to ensure that everyone using health and social care services receives good quality care. To put this into practice, we have a human rights approach to regulation and to our public engagement activity that is based on the rights that people hold. It is integrated into our approach as this is the best method to make sure equality and human rights are promoted in our work.

8. Organising ourselves to deliver

Our programmes of work will be delivered by our inspection, policy, intelligence, customer service, Academy and engagement teams, and are dependent on other key programmes of work within CQC. To ensure the success of this strategy the Public Engagement Team will set up cross organisational working groups to develop and deliver the four programmes of work with leadership of each working group shared across the organisation. We will ensure the public are engaged in our work.
9. Dependencies

The success of our programmes of work for 2014 – 2016 depends on:

- Integration of this strategy into the work of registration, inspection, policy, intelligence and Academy teams

- Training, support and tools for our all of staff in skills to better understand the public’s views and experiences of care and provide good customer service; and for our inspection team to better listen to people’s experiences in a way that meets people’s needs and to improve inspection report writing skills

- The capacity and resources of our public engagement team (see Resources)

- The capacity and resources of our inspection teams to undertake public engagement activity (see Resources)

- Successful recruitment to fill vacancies in our Intelligence teams

- Systems to support automated coding of qualitative information

- Systems to support social media monitoring

- Improvements to the way we register and collect information about services delivered by the Taxonomy project and the Registration Improvement Programme

- The development of our Operating model to ensure that we track, monitor and evaluate the impact of information we collect from the public

- Updates to provider handbooks to encourage providers of care services to proactively promote inspections and inspection reports

- Improvements to customer understanding and experience delivered by the Customer Experience programme.
10. How we will know if we’re successful

10.1 Raising public awareness and understanding of CQC’s role and purpose

<table>
<thead>
<tr>
<th>By April 2015</th>
<th>By April 2016</th>
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<tbody>
<tr>
<td>Public awareness and understanding of CQC’s role and purpose has increased from 9% to 18% (unprompted) and from 55% to 65% (prompted).</td>
<td>Public awareness and understanding of CQC’s role and purpose has increased to 36% (unprompted) and from 65% to 75% (prompted).</td>
</tr>
<tr>
<td>We have established a baseline for public awareness and understanding of the standard of care they should expect and whether or not people are at the centre of our work.</td>
<td>We understand the effectiveness of the channels we are using and have adjusted our programme of work accordingly.</td>
</tr>
<tr>
<td>We have established a baseline for who is contacting us and why.</td>
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10.2 Listening to and acting on the public’s views and experiences of care

<table>
<thead>
<tr>
<th>By April 2015</th>
<th>By April 2016</th>
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</thead>
<tbody>
<tr>
<td>Local Healthwatch groups, representative groups of people who use services and our registration and inspection teams are clear about our framework for engagement and information sharing between organisations.</td>
<td>National, regional and local partnerships are in place to encourage and enable people to tell CQC about</td>
</tr>
<tr>
<td>We have established a baseline establishing what information we currently receive from local Healthwatch.</td>
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their views and experiences of care.

We have established a baseline for people reporting a positive experience of contacting us with concerns, complaints and other feedback.

The monthly average number of people telling us about their views and experiences of care via our website has increased by 10% from 1,300 to 1,430.

By April 2016

National, regional and local partners are working with us effectively to encourage and enable local people to tell us about their experiences of care.

The numbers of people telling us about their views and experiences of care via our website has increased by 30% from 1,430 per month to 1,900 per month.

People’s experience of contacting us to share their experiences will have improved by 10% - they will tell us that we managed their expectations of what CQC would do with the information and we made it easy for them to give us their feedback.

We have established an evaluation mechanism to understand whose views we are hearing, the effectiveness of the channels we use in terms of the quality and volume of information we receive and the ease with which we can report back on its impact on our work.

More regulatory activity is driven by people’s views and experiences of care and we are clearer about which sources of people’s views and experiences of care have driven it and have adjusted our work programmes accordingly.

New contractors will be working with us effectively to established service level agreements to provide Experts by Experience for inspections. We have a comprehensive and consistent training offering for Experts by Experience, agreed deployment criteria and built effective, robust evaluation mechanisms built into the programme.
10.3 Engaging the public in the design and shape of our work (how we do our job)

<table>
<thead>
<tr>
<th>By April 2015</th>
<th>We have established an evaluation mechanism to understand the effectiveness of how well we have engaged the public at all levels of our engagement framework, including co-production, participation and consultation.</th>
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</table>
| By April 2016 | 70% of people who have participated in the development of the shape and design of our work feel they have been involved/very involved in our work.  
CQC Policy Teams, Chief Inspectors and CQC Board will report increased confidence that they have heard from enough members of the public to make informed decisions about the development of how we do our job.  
We understand the effectiveness of the channels we are using in terms of the quality and quantity we receive and have adjusted our programme of work accordingly.  
We understand how effectively we report back to the public on the impact of their participation.  
We have established a mechanism to share insight with other public sector organisations to avoid duplication.  
We have increased members of our online people’s panel by c60% from 1307 to 2100. |

10.4 Providing high quality information to help people choose care

<p>| By April 2015 | We have established a baseline for the usefulness of our inspection reports in supporting people’s choice of care services. |</p>
<table>
<thead>
<tr>
<th>Change</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website sessions</td>
<td>c22% increase (10,000,000)</td>
<td>c25% increase (12,500,000)</td>
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<tr>
<td>Mobile phone sessions</td>
<td>c31% increase (1,500,000)</td>
<td>c33% increase (2,000,000)</td>
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<tr>
<td>Tablet sessions</td>
<td>c33% increase (1,400,000)</td>
<td>c43% increase (2,000,000)</td>
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<tr>
<td>Email alerts</td>
<td>By April 2016 100% increase</td>
<td>c5% increase in subscribers</td>
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<tr>
<td></td>
<td></td>
<td>agree our inspection information is clear and easy to understand (75%).</td>
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<tr>
<td></td>
<td></td>
<td>c5% increase in people who use our website agree our inspection information is easy to find (75%).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c5% increase in people who find our inspection information useful (73%).</td>
</tr>
</tbody>
</table>

At least 30% of people coming to our site report they are members of the public looking for information to help choose care for themselves, a friend or relative.

70% of people in general say they got either all or most of what they wanted from our site.
## 11. Resources

<table>
<thead>
<tr>
<th>Allocation</th>
<th>Resources are allocated to the four programmes of work as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Raising public awareness and understanding of CQC: 10%</td>
</tr>
<tr>
<td></td>
<td>Listening to people’s views and experiences of care: 55%</td>
</tr>
<tr>
<td></td>
<td>Engaging the public in improving how we do our job: 5%</td>
</tr>
<tr>
<td></td>
<td>Better information for the public: 30%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pay</th>
<th>It is anticipated that much of the programmes above can be delivered with existing resources which include a reliance on retaining WTE transformation posts moved to business as usual within the Public Engagement team.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>However, to develop our approach to digital engagement to support the inspection process while we continue to deliver our current programme of public listening events for the remainder of 2014 – 2015 will require an additional <strong>two WTEs</strong> within the Public Engagement Team. If our programme of public listening events reduces in 2015 – 2016 as outlined in this strategy, the programme of work for that year can be delivered within existing resources.</td>
</tr>
<tr>
<td></td>
<td>In addition, to develop and deliver an online community while we continue to deliver our current approach to public participation and co-production will require further <strong>two WTEs</strong> within the Public Engagement Team. It is possible that these posts could be absorbed within existing resources once the online community is fully operational and the review of co-production and participation complete.</td>
</tr>
</tbody>
</table>
It is assumed that the regional public engagement of statutory representative groups (local Healthwatch, Overview and Scrutiny Committees, FT Councils of Governors, Complaints Advocacy organisations) and digital engagement will be delivered within existing inspection team resources.

It is assumed that the additional regional engagement of the voluntary and community sector can only be achieved if it is led and supported by the regional Public Engagement Team. As there is currently only 1 public engagement role per region, delivery of this strategy will require a further two WTEs within the Public Engagement Team in each region.

As our work ensures a balanced approach across all of the population groups, it may be necessary to move resource within the wider Public Engagement Team to accommodate this.

It is likely that an additional Web Editor would be required to maintain a CQC App.

The above posts will be subject to the usual internal approval processes.

<table>
<thead>
<tr>
<th>Capital investment needed</th>
<th>£1.2m to deliver the following, subject to individual investment committee papers:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Development of a CQC App</td>
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<td></td>
<td>• Web development to support improvements to email alerts</td>
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<tr>
<td></td>
<td>• Design and web development to deliver a dashboard to allow people to filter and interact with our data more effectively</td>
</tr>
<tr>
<td></td>
<td>• Design and web development to support the delivery of the timeline feature on care service profiles</td>
</tr>
<tr>
<td></td>
<td>• Development of an online community</td>
</tr>
</tbody>
</table>
Appendix 1: Principles

Public engagement has some common principles which we will adopt. They are drawn from a widely accepted understanding of good practice and are set out below:

- Public engagement always supports our role and purpose.
- We treat people with dignity and respect and we make sure they have a good experience when they contact us.
- We are inclusive and proactively engage men and women of different ages, socio-economic backgrounds, ethnic groups and people who are seldom heard from or face more barriers to engagement including people with equality characteristics such as disabled people, lesbian, gay and bisexual people, transgender people, people of different faiths – and other groups identified through health inequalities work – such as homeless people, gypsies and travelling communities, sex workers, refugees and asylum seekers.
- We are responsive and look for the best way to meet people’s needs and level of interest.
- We engage in genuine co-production, using SCIE’s definition of it, i.e. we work with people who use services and carers as equal partners in the design, development, commissioning, delivery and review of our services.
- We work in partnership with others to make the best use of their insight and understanding.
- We value and reward people’s contribution, time and expertise appropriately.
- We offer clear, accurate, engaging, accessible information that meets people’s needs.
- We are transparent about what people have told us and what we’ve done about it.
- We work with our partners and the public to monitor and evaluate our work to ensure it is delivering against agreed objectives.
- We use our powers to make sure providers listen to people and act on what they say.
- We support our staff to engage the public in our work.
Appendix 2: Issue tree