CQC Board meeting 16th September 2020

Wednesday, 16th September 2020 at 11:00am

Apologies and Declaration of Interests

…the September board meeting of the CQC. I have no apologies; we're all here. Are there any declarations of interest that need to be made? Fine. Thank you. I'd like to welcome (UNINTELLIGIBLE) who is the co-chair of our Race Equality Network and he's our network

Minutes of the Public Meeting held on 15 July 2020 Matters Arising and Action Log

representative today. You are very welcome. Minutes of the meeting of the 15th of July - are they a true and accurate record of everything we discussed? That's good. On the action log, there are only two items: the first is completed and the second is
not yet due. Were there any matters arising that anybody wanted to raise? OK, so Ted can… Sorry, not Ted. Ian, can I go straight on to you, please? Thank you. Thank you very much, Peter. We've got a fairly long agenda today and it outlines
the work that we have been doing and are going to be doing over the next few weeks but I thought I'd just take a moment just to outline some of the context for the work that we're doing. I think going into the crisis, so
going into the COVID-19 crisis was, in some respects, a straightforward activity in the sense that many of the institutions that we regulate were closing services down and society as a whole was limiting its own ability to move around and our ability to move around
and do the work that we do was somewhat curtailed. I think we always knew back in March that, in some respects, closing down things was easier than opening things up and we were even then recognising that we would enter a period of time, and

Executive Team's Report

I think we are now entering that period of time, where we have to make much more complicated and sophisticated decisions, in terms of how we open up and resume our core work. I think it's worth reiterating though that we've never stopped regulating during this
time period. We've used new and different approaches all through this period and we will continue to iterate and produce new and different approaches to the act of regulation. So I think the challenge coming out of regulation… Sorry, the challenge, rather, of coming out of
COVID for us as a regulator, is that we need to move quickly as circumstances change, and circumstances are changing both nationally and locally simultaneously. And we need to make the public aware of what we're doing, so they can have the assurances that we offer
around the safety and quality of health and social care. And we need to inform providers about what we're doing and keeping them on board in terms of our approaches so they know what we're doing and, at the same time, we need to take the
opportunity to change the way that we do things internally and continue with the work we're doing on transformation. So there are lots of groups and people that we need to keep on side and I think the question that challenges us as a board, is
how do we continue to operate as an effective regulator in this fast-changing world. And I think that's the context in which a number of the things on our agenda today should be seen. So as I said, I think, in overall terms, the road map
that I set out - that sort of headline road map - that I set out at our last meeting around now, next and future, is on track. We've started our training, started the roll-out of our transitional regulatory approach and we're confident that we'll be
able to be going into providers in early October with that new approach. But also, I think it's also worth saying that we need to stay flexible. I think the way that the coronavirus performs is, to some extent, better known than it was back in

March but I still think it still remains a topic of much debate and concern. So in the event that the coronavirus increases, we will have to stay fleet of foot and agile in terms of our response to that. But I think what we have
done over the last last few months is we've went and learnt some important lessons, we've built some important technology, we've built some important processes and I think our approach to a second wave may very well be different to our approach to the first wave.
I just want to just make a detailed point around testing. I think as board members will be aware, there's been some press reports around the need for CQC inspectors to be tested prior to going into the people that we regulate. It's worth being really
clear: our teams have undergone training, they've been issued with PPE, they've undergone personal risk assessments and we also do individual provider risk assessments before we go on-site. This is a topic that we've taken very seriously right from the start and, as I said, we
have continued to regulate during this time period. We have continued to go on-site with providers all the way through this time period. So, in some respects, nothing has changed in absolute terms although the volume of the work that we're doing on-site is now increasing.
We made a request to the Department of Health and Social Care that our inspectors should be tested on the same basis that other visiting professionals, particularly in care homes, should be treated and the Chief Medical Officer has come back to us formally and said
that given the nature of the work that we do, that our colleagues are not engaged in hands-on, close, personal care with people, there isn't a need for us to receive the weekly testing that other people, particularly care workers, are currently receiving. That's a conversation
which will continue and if, in the event that events change, then of course we'll revisit that topic. But as I say, we're doing so many other things in terms of PPE and training and risk assessments and so forth, that I'm confident that our teams
don't represent a significant risk to care homes. We have been approached… We have found that some providers have attempted to be proactive with us and try and stop us from visiting their sites. We have been very robust with those providers and made it very,
very clear that we will continue to visit where we think that is necessary; that's entirely our decision to make. So I think that's an important point to make and, Kate in particular, has been very direct with some providers who've attempted to see that this
lack of testing is in some way a block to us coming on site but it absolutely isn't and I want to reassure the board and reassure the public that that's absolutely not the case. I think, as I said, we're going to be talking a lot in this meeting about the technicalities of what we've been doing over the last few months and what we're going to continue to do in terms of our strategy and so forth but I would like to just take a moment just to pay tribute
to a number of my colleagues who've made some very significant contributions to their own communities. I think we often forget that people have lives outside work and I think never has that been more true than over the last few weeks. Each week I run
two all-colleague calls and invite guests to talk about what they've been doing and we've heard from colleagues who have returned to work as ICU nurses, I've heard from colleagues who've started up community groups to feed and support thousands of people right across the country,
I've heard from colleagues who've helped at the Premier League with their infection prevention and control. And our colleague, (UNINTELLIGIBLE) who is actually a network representative on this call with us today, also came on one of the calls and talked to us about what it
feels like during Ramadan to be in lockdown and the challenges spiritually and practically that that offered, which gave us an insight into different cultures and ways of living. So, as I say, I'm really grateful to my colleagues for, A - going the extra yard
from a work point of view but also there's been fantastic examples of fantastic work outside of work.
Looking ahead: I think in the coming months we will be going live with our new approach, our transitional regulatory approach which Ted and others will be talking
about later on in the agenda. We'll be looking to publish State of Care during October so that'll be our annual review of what's going on in the health and care world. We'll continue to design our strategy and we'll be commencing conversations with our stakeholders,
with providers, with the public around some of our thinking around what our strategy - due out in the early

part of next year - will be all about. And, of course, we will continue to work hard on our own internal transformation. Although we've made
lots of changes in terms of externally, I think it's also worth noting that as the health and social care system, in the round, transforms and changes, we, as a regulator, need to transform and change and bring in new approaches and reorganise ourselves internally in
order to be as effective a regulator as we possibly can be. So a fair amount going on, it would be fair to say, and some exciting new ways of thinking and doing things. Thank you, Peter. Peter, I think you might be on mute. I
was on mute. I thought I was cleverly unmuting myself but I was actually muting myself. I apologise. Thank you. I was saying, does anybody want to come in or shall we move on? Nobody wants to come in. Kate, I think it's over to you.
Thank you, Peter. So I'm just going to give board a quick update on where we are with our COVID activities and then I'm going to talk specifically about Market Oversight and closed cultures. So we've been very busy in adult social care, having conversations with
almost 65 active providers in the country. So got over 25,000 adult social care active locations. Of those, we have had almost 17,000 Emergency Support Framework discussions and we've gone out and crossed the threshold on 724 occasions and each time we cross the threshold, we
publish our findings so that our most up-to-date information is out there with the public. So we've been doing Emergency Support Framework, monitoring conversations, all of our inspectors, early on into COVID, did a piece of work where they looked at their portfolio and they identified
those services that were most at risk, according to a matrix that we developed and in circumstances where inspectors have not been able to get sufficient assurance from conversations with providers and intelligence that sits in a variety of other places, including Give Feedback on Care
and Healthwatch, we've gone out and crossed the threshold. But because infection prevention and control is so critical to how well care services are coping at the moment and ensuring that people are kept safe, we developed some specific IPC methodology at the start of the
summer. So we are really keen that when we were going out and crossing the threshold, that we wanted to have an absolute focus on how providers were ensuring good infection prevention and control, so we developed this new IPC methodology with a set of bespoke
questions about ensuring providers have had up-to-date training; that they are using PPE effectively; that they have the ability to zone and cohort people, should there be the need for them to do so. So we developed a set of questions, we developed a set of
best practice examples with links to guidance and organisations that can help providers and we shared that all externally. So this was about being really transparent with the sector about what we were looking for when we were going out and doing our IPC inspections. So
IPC was looked at every time we crossed the threshold because of risk but also we were really keen to see what best practice looks like when it comes to IPC, so we can talk about it and encourage other providers to be as prepared as
possible for a potential wave two or difficult winter. So we've done a bespoke 300 inspections where we went out to services where we thought we were likely to see good IPC practice and that happened during August and the findings of that are that in…
We found about 90 percent of assurance across all areas with those providers. So I want to take the opportunity to thank the care sector for doing, in general, an absolutely fantastic job when it comes to good infection prevention and control. In a very small
number of instances we found providers who didn't have up-to-date IPC policy and who were not using PPE effectively. So in those circumstances, we are quick to respond and are able to take swift regulatory action to ensure that people are kept safe and that can
look anything like a kind of warning notice which is published through to restricting the provider's ability to take on new residents or even to close, if we are so concerned about the safety. So my main message is: we've gone out, IPC is a key
area of focus in everything that we do. Broadly, the sector is doing a really good job with this and in a small number of cases where we have significant concerns, we won't hesitate to use our regulatory tools to ensure that people are getting safe
care rapidly. So looking forward in terms of IPC, our plan is to continue to focus on infection prevention

control through our monitoring conversations. We will continue to look at it on any inspection; so if we go out because we're concerned about safeguarding, we will
still have a focus on IPC. We plan to continue to do bespoke IPC inspections where we think we're going to find good practice so we can keep on talking about that and due to the increasing concerns at the moment about care homes and we're
starting to see an increase in outbreaks, when we receive information that causes us concern about IPC practice, we will go out and cross the threshold. So this will remain a real focus for us and, as I say, every time we go out and cross
the threshold, we publish our findings so that we're being really transparent with the public about what's going on with those individual services and then the themes from that will feed into our Insights Report as it does in the report we're going to talk about
later today and we will revisit the topic again in November. Probably one final thing I'd like to say on this is we've been looking at the relationship between the quality of care, the quality of previous ratings of care services and COVID outbreaks, and it's
preliminary at the moment but to date we are not finding a link between the quality of the care provided and the COVID outbreaks. There is a question about the speed with which a provider - once it's been identified - can manage, contain it and
stop it from spreading but the fact that a provider has had a COVID outbreak in the last six months does not equate to that being a poor provider. So I'd just like to make that point. So I'm going to go on and talk about Market Oversight. Do you want me to pause, Peter, and just ask if anyone's got any questions on what I said around our COVID approach to date? Shall we go to Robert? Yes, Robert, please. Thank you, Peter. Firstly, Kate, please congratulate your team on, obviously,
what is fantastic work going on in very difficult circumstances in relation to infection control. There's a point I'd like to raise in relation to that, which is about the effect some of these controls are having on the rights of residents in care homes but
it may also be the recipients, it seems to me, of other services. I think we sometimes forget - at our peril - that residents of care homes have a right to a private life and they have a right to make choices and if they're not mentally competent to do that, then other people have to do that for them in their best interests. And it seems to me that there's been an assumption that those interests are best served by protecting residents of care homes - at all costs -
against the risk of infection, to the extent of isolating some of them - now for months - from actually seeing anybody from their family or, alternatively, only seeing a member of their family on very limited occasions in very artificial circumstances and I think there
is evidence that this is potentially leading to a serious decline in the mental health and maybe even physical health of some residents. My feeling is that if you asked some elderly people, not all, of course, and gave them the choice of running a risk
- quantifiable or not - of getting COVID and maybe risking their lives and being able to see, in the latter stages of their life, their family, they would choose the latter. Now I appreciate that that can cause huge complications in relation to how one
administers a home and protects everybody's interests but what concerns me is that I don't see that aspect - hugely important aspect - being taken into account at all in some places and therefore I just wonder what we at the Care Quality Commission and you
and your inspectorate can or are doing in relation to promoting what is the law and actually, clearly, good policy - which is to promote independent living so far as is possible within the abilities of the individual and I just very much fear that has
been forgotten about as this pandemic has progressed and I fear it will get worse if it is the case that we approach a second wave or whatever one wants to call it. Thanks, Robert. So I think that really important issue you've just raised, just
amplifies the challenge our providers have been wrestling with for 6 months; so that balance of keeping their service safe, keeping their staff safe, keeping their residents safe, and the very natural instinct I can imagine many providers had of just wanting to lock down and
just maintain a bubble and we saw care workers moving into care homes. So we saw, I think, people trying to do the right thing but that balance of keeping people safe and not ending up with large numbers of people whose mental health has been

significantly affected through isolation and not being able to have contact with families, so I think it's a very real, ongoing dilemma. We have seen some really good examples where providers have struck that balance and we will be sharing it in publications where we talk
about where providers have made garden rooms available, where they've had rotas, where they've done things virtually in the home, so that family members can still come in. The Care Provider Alliance put out a message to all adult social care providers a couple of months
ago, where they talked about the importance of being person-centred in the approach and I wholly support that. So my message to providers is: we've got government policy that needs to be adhered to. Providers need to be aware of their local risks, so the direction
given from their local directors of public health about what the risk level is within the place they operate. But we absolutely expect to see bespoke approaches to visiting. So if you were a small supported living service for three adults with learning disabilities, you might
have a visiting policy that looks like this; if you are a large nursing home where all your residents on the ground floor have double doors that open up onto the garden, I'd expect to see something different and then one layer below that is that
individual care plan that says that so-and-so has capacity, we've weighed up the risk and this is a decision that's been made in partnership with an emphasis on enabling it to happen. So it's a hugely tricky balance that our providers have had to strike and
our position on this is our expectation as we see high quality, person-centred care plans demonstrating to us how they've weighed up the individual's capacity and ability to make informed decisions with the risk potentially for other residents or care staff as well but a very
tough juggling act that people are doing on a daily basis. Thank you. Just one question, really, arising out of that is whether you see the care home providers being influenced at all by, as it were, risk avoidance for themselves in terms of their fear of criticism
or worse or litigation in relation to the outbreaks that will potentially happen and whether that has been informing their policy more perhaps than it should be or whether there's anything could be done to alleviate their concerns in that regard? So I think that's a
very real concern and the point I made earlier about there not currently being evidence of a link between poorer quality services and outbreaks is really important. I think it could be easy to make a leap that says, if a service gets an outbreak it's
because they've done something wrong and that's not what we're saying. So you can absolutely understand why providers err on the side of caution; issues with insurance, issues with encouraging new people to move into the home and I'll mention that under the Market Oversight item
in a minute but I absolutely think that fear of litigation, fear of being blamed, fear of the ability to run a sustainable business if people start leaving the home or not moving into it because of an incorrect assumption that if a provider gets an
outbreak they must be a poor provider. Thanks. Thanks, Robert. Thanks, Kate. Ian, you wanted to come in? Thanks. I think, Robert, you make a really good point and I think it's at the heart of what our job is as a regulator. I mean I think our job
is, as a regulator, is to ensure that there are a set of standards which are unarguable and if people drop below those standards then we will absolutely take enforcement action, up to and including prosecution and closure if that's appropriate and Kate was describing that
in her remarks. But I think we also have a parallel activity which is to support those providers who are genuinely ambitious for their service users and so in the circumstances you were describing there around a provider that is interested in taking a managed risk,
in order to improve the overall quality of life for one of their residents, then that is something that we can have a sensible conversation with them about and that's exactly what Kate's team are doing on a day-to-day basis. So I don't see this as
a binary either/or, there are a set of standards which are unarguable but I think also that supporting ambitious providers is something, again, which I think is part of what we're about as well. It's a perennial challenge of a regulator, I think, but it's been
brought into particularly sharp relief during COVID and particularly on this topic around IPC. Thanks, Peter. Thank you, Ian. So, Kate, back to you. Ok, so if I just move on and give you an update on Market Oversight which relates to the conversation we've just had. So when we look at occupancy levels

in care homes since the start of the financial year, so we've seen - as you know - significant increase in deaths and for a number of months, minimal slash zero new admissions for some services, some care home services around the country. So there's been
almost a 10 per cent drop in care home occupancy levels and then care homes have had the additional challenges around the extreme PPE costs that were experienced in the beginning and are still now for some and then the significant financial implications of having staff
off sick and needing to backfill, etc. So that has presented a massive challenge for the care home sector which has been supported through short-term but much-needed investment from government which has been passported to care homes by local government. In home care the situation has
been less stark but it's still been notable that for home care providers that fall within our Market Oversight Scheme, that those providers were reporting delivering 5 percent less care than they've been commissioned to by local authorities or by people who fund their own care.
So when we've looked into that, that has often been - certainly in the beginning - people declining to have a care worker visit or having a family member move into the home to provide that support. The financial impact to date has been less because
local authorities have continued to fund at the level they're commissioned rather than the level that the hours were actually delivered at. There is a wish, should the conversation arise, about whether providers should have to back pay some of those costs but the main issue
has been in care homes and the thing to flag is that short-term investment from central government through local government to care homes and the ability for care homes to defer their PAYE and their National Insurance contributions, all of that is winding up now, at
the point that we are moving into autumn and winter. So we will continue, through Market Oversight, keep a very close eye on the stability of those providers within the scheme. And then if I just move on to restraint, seclusion and segregation and closed cultures.
So 100 percent of our staff have had training now on the supporting guidance, so training to support our staff to identify where closed culture may be occurring and to support them to understand how they should go out regulate services in those… Advisory group about
two weeks ago where 50 percent of the 50 people who were in the room with me were people with lived experience of segregation or seclusion or family members of people who have experienced it. And the purpose of this expert advisory group is, from the
very start of our closed cultures work, that we are working incredibly closely with providers, other commissioners, people with lived experience, families, and a variety of other people, to think about how do we develop the best tools. So our first conversation at the first group
was around how should inspectors… What are the key ingredients for identifying high quality, person-centred plans? And how do you triangulate that to ensure that that is the experience that someone is having? So you can have a fabulously glossy, person-centred plan but actually how are
we assured that that is what's happening for individuals on a day-to-day basis? Couple of the highlights is: we are doing work, as you know, about drawing together the various intelligence we have about what could indicate a closed culture into our transitional monitoring app that's
going live in autumn that Ted will talk about later on in this session. Two publications that are going to be happening during autumn and again, just to pick up something that comes up in the later paper, so we are due to publish very shortly
our refreshed approach to how we register care services for people with learning disabilities and/or autism. So previously known as registering the right support, refreshed and refocused and it will now be called, it's now called Right Support, Right Care, Right Culture. So that is about
how we use our powers and leverage we have as the regulator when it comes to registering services to ensure that when new services are coming into the market, they can demonstrate the fact that they are small, person-centred, focused on supporting people having a life
and accessing their community, etc. So that publication will be coming out imminently and we've got restraint, seclusion and segregation shortly following. So just to flag there's a few important publications that, kind of, link together; we've almost got a triangle of closed cultures and how
we regulate Right Care, Right Support, Right Culture about how we register services that are the right model and then our approach to restraint, seclusion and segregation, so that we can really change people's experiences of how they're receiving care in those sorts of crisis windows.

Thank you. Thanks, Kate. A really, really important subject and I'm really impressed with the work that you and colleagues are doing to try and get on top of this. Does anybody want to come in? No. In which case, Ted, we'll move on to you. Ok.
Thank you, Peter. Just reflect again what Ian was talking about earlier on, how much our approach to regulations have changed because of the COVID pandemic and I want to pay a real tribute to colleagues across the CQC who've adapted so well in these difficult
circumstances. I think there's been a really enormous effort to focus on the safety and quality of care, despite the fact we were approaching our regulatory process in a different way, reflecting the risks of the COVID pandemic and I'm really proud of what they've achieved
and I think there's a lot we can build on and when we talk later about the transitional regulatory approach, it is building on what we've learnt over the last six months which I think has been extremely important. I just want… just focus on two
areas: one - we're monitoring providers very closely and that means close contact with them but also looking at the data they produce and any intelligence we have on providers, such as whistle-blowing, user feedback, serious incidents, safeguarding concerns, etc. And that is enabling us to
identify where there may be risk in providers. Some of that may be COVID-related but a lot of it is risk that we've seen before in providers that is still present and where we find that we are taking action. We are continuing inspections - risk-based,
targeted, inspections - there's some detail of that in the report. The numbers now are 66, so it's increased since the paper was produced, and I think where we find concerns, we are still taking enforcement action and we're still taking a full spectrum of enforcement
action where we're finding concerns in services. It's important to emphasise that that is still going on and has been going on throughout the pandemic and we will continue that going forward. But also, not only looking at specific risks in individual providers, we're looking at
system risk and this comes back to the infection control issue that Kate was talking about in social care. We identified early on in the pandemic, the importance of good infection control across hospital providers to make sure that patients who did not have COVID could
be treated safely. And working with partners such as NHS Improvement and NHS England, guidance was produced for providers across the board to ensure that they had the best possible standard and an assurance tool was produced, at our request, which we sent out to all
providers and asked them to use to ensure they were compliant with the best quality infection control standards. And I have to say, the feedback from providers on that has been very positive; they found the tool really helpful. And now we have contacted - to
update the data - we've contacted all NHS Trusts and many independent healthcare providers, we're continuing that work to discuss with them how they've got assurance around their infection control practice. And some of the outcome of that is reported in the Insight Report which we're
coming to later but essentially, again, as Kate has described, we've seen a lot of very good practice and I want to pay tribute to the standards in infection control we found in many trusts and I think that is excellent and it is ensuring that
trusts can reinstate non-COVID services safely for patients which, of course, is increasingly important as we move forward. Having said that, where we found some trusts that don't have assurance, we've challenged them, and sometimes we've been able to challenge them to change, sometimes we've brought
in support from the NHS Improvement team that is leading on this nationally and working very closely with NHS Improvement, I think, has been really, really important in this. Where we found real concerns that we don't feel are being addressed, we've done inspections around infection
control and we have taken enforcement action against a small number of providers where we found that there have been problems with their infection control standards. And so, we are again focused on taking action where necessary, but equally driving improvement and supporting trusts to deliver
high standards in infection control generally and, as I say, we've seen a lot of that delivered and we'll come back to that in this Insight Report in a moment. Just one other area I want to cover - Chris is going to talk about it
later, in his section - but I expressed after last winter real concern about how the NHS was able to cope with winter pressures in emergency departments and the board will remember we inspected a number of emergency departments over winter and had concerns about how

they were coping. I said to the board and also publicly that, as we go into the next winter, we've got to be better prepared and, of course, that was before the COVID pandemic came and the COVID pandemic has created extra pressure on emergency departments.
During the height of the pandemic, of course, fewer people went to emergency departments and the figures superficially improved but talking to emergency departments across England now, it is clear now the number of people attending is going steadily up and pressures are building up again
and we're not yet into winter and when COVID comes back, if it does, or other respiratory viruses which are bound to come back, that is going to create extra pressure for emergency departments and it is really important that those departments but also the trusts
that house those departments and the systems they work in, are well prepared for winter because this could be a very difficult winter for emergency services going forward. What we've been doing over the summer is working with our specialist advisers from emergency departments across England
to ensure that we have the best possible clinical advice about how emergency departments can be kept safe and we'll be putting that guidance out shortly and again we'll be asking trusts how they are complying with that guidance going into winter and, where necessary, we
will be inspecting against that guidance to ensure people are delivering the right standards. So, again, it's very much - as we've learned around infection control - it is about supporting trusts to improve but taking action where necessary and I think that it's going to
be a really important part of what we do going forward. That's all I want to say at the moment. Thanks, Peter. Ted, can I just ask a question? And it kind of links to two points you were making. As we go into what is
undoubtedly going to be a very difficult winter, whatever happens, is there a risk that the better quality infection prevention and control that you're now seeing in trusts starts to slip back just because of the pressures they're under? And if there is that risk is
there anything that we should or could be doing now to try and minimise that risk? As I say Peter, I think the fact that trusts have assured themselves against a high standard of infection control over the last six weeks or so, is really good
start but, of course, they've got to maintain that going into winter and as the work increases, that's important. And part of our advice, part of the guidance we're producing for emergency departments is around how do you maintain good infection control under pressure? And that's
one of the key elements of it. There are two aspects of that: one is, you've got to protect people against the cross-infection but, equally, the fact you're maintaining social distancing, etc., it reduces the capacity of the emergency department but also inpatient beds. Inpatient beds
in many hospitals because of the social distancing and the other infection control have been reduced in capacity by 20, 30 percent in some cases. So clearly that is having an impact on the ability to get patients into the hospital and maintain flow through the
hospital which is the key element in keeping emergency departments safe. So it is absolutely important that while hospitals maintain the highest standards of infection control, they take into account the pressures that causes for the emergency pathway and they've got to balance both, and as
we go into winter, as I say, we're going to be inspecting against this guidance where necessary. I mean, generally, I think we want to approach this in a supportive way but where necessary, we'll inspect against it and we will be looking very clearly at
the level of infection control that they achieve. Thank you, Ted. Thank you very much. Nobody wants to come in? Rosie, we'll come on to you, please. Thank you, Peter. So as both Ted and Kate, our teams have been doing a lot of work in
terms of monitoring services. That's involved looking at the data, that's involved lots of stakeholder engagement, particularly with clinical commissioning groups and with local Healthwatch to identify where there are any concerns, and we've also been undertaking Emergency Support Framework calls and IPC calls, which the
IPC information is in the Insight Report. Alongside that, we have been doing inspections where we have underseen risk and we've also been piloting a new methodology which enables us to access many of the systems in a GP practice without being on-site and this is
hugely valuable, so we can respond to immediate risk without actually having to cross the threshold and we are piloting that and evaluating that at the moment and that's sitting with the transitional methodology which

Ted will mention later on. In addition to that, we are
responding and returning to all of our special measures practices because I think it's very important that we follow up and make sure that the improvements have happened within those special measures practices or practices with significant breaches. So there's a lot of work going along
with that. We're also working across all of the other sectors in PMS to look at how we make sure that we're working with other regulators, such as the work we're doing with HMIP in Health and Justice, the work we're doing with Ofsted around SEND
services to look at how we're making sure that all the populations that we look at within the PMS portfolio are monitored carefully. I just want to mention some concerns that we are particularly worried about and working on at the moment, and this is about
access. I think if we talk about access in all services I think there are concerns, but particularly just want to mention general practice access because there has been a lot in the media and on social media about this. And we are hearing a lot
of anecdotes from members of the public and also from people like A&E consultants who are saying they're not able to access appointments or their needs are not being met when they access a digital appointment and turning up in A&E is a result of that.
We can't quantify this at the moment and I suspect it's probably a minority rather than the majority; we know that GPs are working and their teams are working very hard and have adapted hugely over the last few months to make sure patients get the
care they need but we are trying to quantify that as it is going to be important going forward, particularly as we go into winter and particularly to make sure that people get the right care at the right place in the right time, and we
wonder if some of it is actually around communication to patients and how a practice has actually communicated how they're working and the new ways of working to their patients and engage with patients around that and certainly we are encouraging practices to make sure that
those lines of communication out to patients who use services are really strong and people can understand how to access the services they need. We've got a working group looking at this, looking at the data we have available, working with our hospital colleagues to understand
what's happening in the local A&E departments and making sure that there isn't any increase as a result of access to general practice. We would like very much public feedback if they are having any problems around this and we are also working with Healthwatch through
our primary care quality board and, for example, I think yesterday we heard from Healthwatch how they'd heard of one practice that had a blanket policy of not seeing any one between the age of 15 and 60 face-to-face or, actually, I think 16 to 50
but I think what we would say is absolutely is not acceptable to have blanket policies about virtually everything, I think, in this situation, but if people do need to be seen face-to-face and that might be for a clinical reason but it might be for
another reason, such as they're in an abusive relationship at home and they don't want to talk about their problems in front of their abusive partner or they need to actually explain something that they can't do that on the phone, so we very much need
to make sure that people are getting the appropriate access that they need going forward. So I'll stop there for any questions. Yes, Liz, you want to come in? Thanks very much, Rosie. I just wanted to pick up, you mentioned the joint work with Ofsted in relation to disabled children, children
with complex health needs, etc., and I just wonder… I mean there have been some reports elsewhere of disabled children, children with health conditions, kind of getting quite isolated and families being under some pressure; it's been in the media as well, where, for example, educational
of schools haven't been able to cater for people in the usual way and support, there have been constraints on the support that children and their families need. I just wondered whether that's something that we're picking up and whether there's anything that, jointly, we're able
to do about that if it is coming up as an issue with Ofsted. Yes, certainly it is something that the teams are very much following up if they're hearing any concerns and Ofsted and the CQC have developed a new joint methodology, a transitional methodology
to go into local areas where there are concerns, so we can specifically look at how local areas are responding to people's needs and looking at, for example, their EHCPs - their Education, Health and Care Plans - and

making sure they're fit for purpose and
following a person's journey through the system. So I think it is something that we're very alive to and very much following up where there are any issues. Good. Thanks, Rosie, very much. The issue of access is a long-standing problem, isn't it? And getting the
balance right between what you can do digitally and what you can't is so important. Right. Nobody else wants to come in? Liz, do you want to put your hand down? Otherwise I might think you want to come back. Thank you. Kirsty, you've got a
big section coming up in a bit but have you got some updates that you want to give under the ET update? Kirsty, you're either on mute or you've left or you're not talking to me. Sorry. Most of what I was going to say is
covered off in the update so I can pick it up then, if that's easier? OK. That's fine. Mark, anything you need to raise on cyber or anything else? The same applies to me, just to confirm there's no information or cybersecurity issues to raise this
month. OK, excellent. Thank you very much. So, Chris Day, that comes to you, I think, then please? Yes. Just a couple of things to report on. As Ian mentioned earlier, there's been a significant amount of engagement, both internally and externally, with colleagues as we
develop our thinking around the strategy. We're aiming to produce a document which outlines our ambitions for the next part of our transition and we want to make sure that, not only we've set out the ambitions but we've got the ability to deliver them. The
document we've produced will enable us to have good conversations between October and December with a view that we publish a consultation document - a formal consultation document - in January, that is not only a good summation of what we want and what we know
people who use services, providers, and others want, but also is able to be effectively implemented. So have a look out for those conversations in the coming months and obviously we'll report back to board members how those conversations are going over the coming months. In
terms of parliamentary activity, we submitted some important information to the Women and Equalities Committee on the impact of COVID on BAME colleagues and this will probably be followed up with a formal request for information which we'll put some colleagues up for in the coming
weeks in the coming weeks. Ian and Peter continue to meet with members of the Health Select Committee and again we will talk a bit about our future direction, about our response to COVID. I also wanted to bring to the board's attention the fact that
we've recently launched a new campaign for Give Feedback on Care; it's a year-long campaign but it's been supported by a number of organisations and, particularly, as Robert said, I'd like to thank Healthwatch England, also local Healthwatches for their support at the launch and the
ongoing support throughout this year. The next phase of the work is to focus on people with long-term conditions and I'm really pleased that we have already achieved a massive increase in Give Feedback on Care information - up some 60 percent in the last few
weeks. This is not just Give Feedback on Care itself but also information that people feel confident to give us around whistleblowing and around safeguarding, and that, in turn, has been able to improve the way we are able to responsively go out and inspect and
take forward that information and you'll see later in the Performance Report how we've used that information to guide our inspection activity. As colleagues have already mentioned, the problem is we're (UNINTELLIGIBLE) already starting late. We've got 10 significant reports coming out in the next eight weeks, designed to drive change and improvement across the sectors that we regulate. I won't go back over some of the information but I just think there's some really important information in the Insight Report which I'll talk about later but also Ted talked about the
outstanding ED report. I think the critical thing for me about that report is, it gives really practical information about how people who are working in emergency departments can think about their operation as they approach winter. Not just for themselves, not just for the hospital,
but also about their interactions with primary care and with adult social care. As Kate has already talked about, there's some important information on the restraint, seclusion and segregation report. We had initial findings in May last year. This is really to try and nail what
has to happen, who has to deliver what in the coming weeks and months and I think it's important that we've got actions that are supported by people who use services and also by sector partners, so that's some

conversations we'll be having over the coming
weeks with an aim to launching that report in late October. And finally for me, the 16th of October marks the publication of our annual assessment of quality in the State of Care. Again, as this report would not be possible without all the work that
goes on across each of the inspecting directorates, all the information that we gather from our inspection activity and our monitoring activity in intelligence, gives us the ability to have an authority view about how services are performing. We've got some key issues that we want
to talk through when that report comes out on the 16th of October and it will be an assessment of the time before COVID, if you can remember that time, and also the time since the COVID outbreak. That's it for me, Peter. Thank you, Chris,

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very much. Is there anything anybody else wants to raise under the ET report? In which case, let's move on. Kirsty and Chris, the performance update, please. Thank you, Peter. Chris is going to take the lead on this one. Yes, I'll pick that up, thanks,
and just to help colleagues, this starts from page 53 on diligent. So just to say, we obviously review performance each month, however this is the quarterly update including July, so it allows us for a first view at the full dashboard pack, the first time
this financial year. Hoping the pack demonstrates three things, in terms of our performance so far this year, one of which is that we've kept operating during COVID, we've still carried out our monitoring activity, responded to risk, enforcement activity. The second is that we've adapted
our approach - both during COVID for the new normal, have introduced ESF and IPC frameworks that we've talked about already. We're also focussing on our transitional and future strategic approach, and the third one is that we've been working hard to improve existing processes. For
example, registration, the availability of our systems and also how we support our people. I'm going to pull out four areas that I think, hopefully, demonstrate this and then happy to open it up for questions about anything in the pack. And, sorry, I should have
said also, we've have got Steph Tarrant joined us for this bit, who works in my team and who pulls all this pack together as well. So the first area just to pull out is registration. This is slide 5 at page 57 in diligent. So, hopefully, an example about how we've been working hard to improve existing processes. We've talked about this previously, about how we're leaning out our process in here, we've split our work into simple, normal, and complex applications and we're really aiming to just improve the average
day's end-to-end process. You can now see the graphic around that which shows that simple and normal processes are improving, complex is still settling down, it's still moving around but it's worth noting the really low volumes for complex cases. A second area to pull out
and focus on, is in terms of our regulatory reaction. So slide 7 which is page 59. This shows how we've kept operating during COVID. We've carried out 228 inspections with a site visit since April and 90 percent of these are based on intelligence and
information we've received. It also demonstrates that 35 percent of inspections were triggered by information of concern that we've received from staff or public, as Chris just mentioned. Slide 8, which is the next one, the next page, also just also brings out how we've had
to adapt our approach. So the ESF framework that we've brought in, has allowed us to assess 15,500 locations based on risk - which is 32 percent of applicable registered locations. In addition to that, 86 percent of 226 applicable registered services have received an IPC
call and then the last one to pull out for me would be slide 10 which is page 62. Another example of how we've kept operating. Volume of whistle-blowing cases is increased by nearly 20 percent compared to last year, a likely contributor to this is
the launch of the Give Feedback on Care, so that those volumes have increased and keep coming in. A final bit from me, just before I open it up, would just be around our money - our revenue budget. So at start of the year, in
order to prudently plan for delivery of our Change programme, we intentionally set a 5 million deficit budget for the financial year. Current financial projections mean it's likely we'll be able to deliver within our funding envelope, excluding the deficit budget. So that would result in
circa two to three million net underspend on a revenue budget which incorporates a potential 1.8 million

shortfall on income from providers that we're monitoring. In terms of the capital budget, we've currently projecting 3 million overspend on that due to… which is something that we're
aiming to manage down in the year. That was it for me, the headlines I want to cover, but happy to open it up for any questions on any part of the pack. So, Ian, it seems to me that our colleagues have been incredibly good during the
last few months, in adapting rapidly to new ways of working, as Chris has just been saying, really kept show on the road. I'd really like just to thank everybody and congratulate them on what they have achieved. So various people want to come in. Jora.
It may be for you, Chris, or it may be for you, Kirsty and Mark. I just wondered, as we're seeing the changes over time that are happening in the information pack that you just shared and the initiatives that we're doing, is there a way
of seeing the impact of the initiatives that Kirsty, through improved QI or improved digital, sort of, technology solutions, is there a way that we would sort of overlay, going, well, we're expecting to see improvements because that is what the business cases are based on.
As I look at it and I'm, sort of, afar, it's difficult to connect the two, sort of, systems. Yes, so that's all around our benefits realization piece of work that we are doing at the moment. So we are currently mapping out what the benefits
are, both in terms of financial benefits and non-financial benefits. So I think we've obviously started to realise some benefits through the programme now. For instance, digital foundations programme has delivered on time, under budget and is now starting to realise savings going forward. So we're
mapping those, plus we're also looking at what the non-cashable benefits are - the sort of quality-type benefits as well. That work is happening in the PMO at the moment, we've just had a couple of key people off sick for a while which is slightly
giving us a bit of delay but I'm hoping we'll be able to start to put that into the pack, as a regular reporting, so you can see how the benefits are tracking. And if you look at the Change pack, you can see the benefits are RAG rated as well but we want to bring that a bit more to life rather than just a red, amber, and green square on a page but we'll just hopefully start to see that coming through in the next few months. Yes, I was just thinking, Kirsty, on the sort of new registration and work that's going on, would we expect maybe KPIs of simple, normal, and complex to weed out more challenging KPIs because we've brought in… So just on that one: in terms of KPIs, we've not set…
we're wanting to set percentage improvement targets so that… because what I don't want to do is set a target that everyone goes to, then they relax and go, "we've hit that" and then it's just constantly driving that improvement. So the other piece on registration
is we're starting to track the actual financial benefits involved in the time savings that we're making through the new services and those are being captured and are fed into the RAG ratings but we can certainly look to bring those forward in a bit more
detail, certainly in future reports. Thank you. Sorry, didn't mean to cut you off. Chris. Chris Day? Chris? Put my hand down. Mute. Yes, sorry. I'm back on now. Just to make a practical example of what Kirsty was saying, Jora, without the changes that we made to Give Feedback on Care in a technical sense, without improving the way
that form operate and the campaign that we run, we would not have seen a 60 percent increase in the Give Feedback on Care or indeed the increase in safeguarding and whistleblowing, in my opinion, and without those we would not have seen the 300 or
so responsive inspections that we've done because it's that information that has driven those responsive inspections. So I appreciate that's not a stats answer but that's a very practical example of a change to our systems and an improvement in a campaign that's led to an
increase in feedback, that's led to an increase in responsive inspections. I think that's a critical path of things that we've done as result of, which started with a technology change and improvement. Thanks, Chris. Mark and then Liz. Thank you, Chairman. Chris, thanks for the report. I wonder if I could just
draw your attention to the section which we call, 'Equip our people and organisations to deliver our purpose now and in the future' and the only KPI we have there is employment and sickness. It seems to me in the month where we've been told in
the Change Report that there's a new people and analytics data hub, that we could provide some richer information in terms of how we are performing against managing and equipping our people for the future,

especially around training or progression, and I wonder whether it's also
an opportunity for us to also highlight at board level our performance and focus on some of our WRES standards. Kirsty, were you going to reply or Chris? You're on mute, Kirsty. So, yes, Mark, we do have a much bigger wealth of data now around our People Performance. These were the metrics, I think -
I'm just looking at the start - that we put into the timetable at the front but we certainly have a bigger pack of information that we share, that the managers now use, that they can use to manage their performance and their management capability more
closely. I think there's a balance, isn't there, between how much information we share - we were happy to share everything - but there's a balance between what's sensible at a board level and then what the managers need to manage their business on a day-to-day
basis. So, perhaps we could take it off-line and you and I can have a look through our data and then we could say which ones we think we might want to report on more regularly to the board rather than the whole detailed pack. Thanks, Kirsty.
I'd really like to do that, thank you. Ian. I know I said Liz next but, Ian, did you want to come in on that point? It was to come back on - excuse me - Jora's benefits points. Just, again, as Kirsty described, we're doing a very sophisticated piece of work around benefits realisation in cash and non-cash terms but I think another stat which we've looked at during this time period. It's between the 1st of
April and the 15th September last year. We did the just less than about 8,000 inspections. If we look at exactly the same time period this year, predominately - almost entirely - during the COVID period, we've done 19,000 visits and regulatory contact. So I think
that the shift that we've made has meant that our reach into more providers has been greater, despite the COVID situation. But I think as we have started to develop our methodology then we'll start to see what works and what doesn't work and what we
need to do more and less of, but we've done more than double the number of regulatory contacts this year than last, albeit in a different context. Thank you. Thanks, Ian. Liz? Yes. Thanks very much, Chair. I was very interested in the regulatory action response to
risk slide that you highlighted, Chris, and what looks like a very interesting example of how we're using our inspection tool in response to very live information intelligence that's coming in, less constrained by the sort of… We do inspections on a particular level of regularity,
depending on ratings, etc. So I imagine there's a lot of learning from that for our future approaches but what I wondered: we've categorised the information here in terms of how it comes in - safeguarding, whistleblowing, and so on. Do we have other ways of
categorising this intelligence? I'm thinking both of theme and also who's giving it. We had a very interesting discussion yesterday in the regulatory governance committee about the triangulation of our intelligence. So, you know, it might be that some is coming from whistleblowers, members of staff,
some is coming from people using a service or their relatives or other people. I just wonder whether, as we go into this, really further developing our intelligence-driven approach, whether we do or will have other ways of categorising as well as this, which is very
useful. Yes, we do, is the short answer. So we can identify themes of who they've come from and also the themes of what. So we can look at how we bring that into a report and if that would be helpful, Liz. I'd certainly find
that interesting at some point. I don't know if it needs to be in every time but maybe there's a point where that could be discussed on an agenda. I think it would be quite illuminating. Thanks very much. Yes. Good. Thanks, Liz. Anybody else want
to come in on the performance report? So it strikes me that we had a coffee break just over an hour ago and we probably need a comfort break now; we're about halfway through the agenda. So shall we give ourselves literally just five minutes and

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then come back and we'll get into the Change Report? Ok. Over to you, Kirsty. All right. Thank you, Peter. So this is our quarterly Change update in terms of just an update of what we've been doing through the transformation programme and I'll cover off most bits there but
I'll hand over to Mark to pick up some of the digital aspects as well. So we have continued to make really good progress across the portfolio as a whole. We have seen some small variation within programmes but

generally, I think we're making some really,
really good progress across the breadth and complexity of our portfolio. Whilst COVID-19 has proved to be a bit of a challenge - to put it mildly - over the last quarter or so, it's also presented some real opportunities for us to learn and adapt
and evolve and to work in a different way and the organisation in the Change space has really responded well to that, enabling us to move some things forwards and try out new ways of working at pace. I think one of the things we've really
been able to do is to look at how we implement and how we work across the organisation, in multi-disciplinary teams, how we've approached the concept of testing, putting stuff out there, and then adapting it and iterating as we've gone, so that we learn as
we go and I think that's been a really helpful lesson for us and one that we want to continue to build on going forwards. So some highlights from the last quarter: our transitional regulatory approach is on the agenda later and Ted will talk a
little bit more about it but this really does exemplify our new ways of working: how we have taken an idea of through from the original concept of the Emergency Support Framework; how we've been able to build on that digital platform, working really collaboratively across
the organisation to put in new ways of working into practice at pace, to really adapt to the changing environment which we find out there in the world in which we regulate. I won't say any more than that because I don't want to steal Ted's
thunder but a really, really positive story, I think, for us. Transforming our organisation is our major change programme which is a piece where we're developing our new target operating model to support the delivery of our new strategy. We have been working really hard on
this over the last quarter or so and the team have now moved into a detailed design phase, which will culminate in - about towards the end of September - with a new blueprint. This blueprint will, sort of, set out how the operational model -
the target operating model - will work into practice and how it will actually support the realisation of our strategy and continue and support us to deliver benefits to service users and out into providers providing a… How we can really help us provide that really
good regulatory experience where we're able to provide right touch style of regulation. The regulatory platform piece of work… Sorry, the regulatory platform piece of work is a core enabling technology; this is replacing our legacy CRM system. We have been building on this, it's key
underpinning piece of capability for us for the future and we are making good progress on that in terms of bringing in our delivery partner and developing a delivery road map to set out the progress that we're going to make, the releases that we are
going to make, in order to bring forward benefits at the earliest opportunity. There's a huge digital component to that and I'll let Mark talk a little bit more about the process that's going on with that programme shortly. The intelligence-driven enablers, again, is another critical
programme to support our ambition to be intelligence-driven. We are currently working on building out a proof of concept to test and understand what the foundational capabilities we need in this space and Mark, again, will give you a little bit more detail on what we're
actually doing in this space in terms of building our capability. I am pleased to announce we had a major success with our Digital Foundations programme. We had a major milestone achieved with this programme, in that it delivered on time and to budget and we've
been able to close out that programme on the 28th of August. This is a huge piece of work that we have done, transferring all of our IT provision from our legacy provider into a new service and new ways of working. I must want to
say to Mark and his team that they have done a fantastic job in enabling this to happen. It is a very, very complex piece of work and to have delivered on time and under budget, for such a big digital piece of work is a
serious achievement, to be perfectly honest. I'm sure Mark will want to add a bit more to that but one that I think we really want to reflect on as a job well done. The registration transformation programme is our programme where we are improving and
modernising our registration services. We have developed a new digital service called Register with CQC, and this went live back in the summer for the first minimum viable project. We have now scaled that out to

incorporate both community-based adult social care partners and sole traders.
That's happened on schedule and we have received really positive feedback from providers, saying that this is actually a really simple, easy-to-use system. It's saving them a lot of time and effort in being able to do that, which is really positive. It's also had some
real benefits in terms of our internal workings and we've noticed that we've been able to save significant amounts of time in terms of our back office processing for that service. We're now looking to expand that service over the coming months and rolling out that
into public beta, which is, again, a positive story. Improving regulation today is a complex collection of programmes and projects which improve how we regulate today. It brings all those together into a programme of work so we can manage it in a coordinated way. Over
the last quarter, we have been focusing this one on developing our approach to regulating in closed cultures and responding to the recommendations of the two independent inquiries that happened in this space and bringing that together. We've also got a huge amount of work in
there on other areas such as safeguarding and whistleblowing and what we're doing with that programme of work is prioritising things, bringing them forwards on a backlog, on a conveyor belt, if you like, as we work though them, making sure that we resource these out
properly to deliver on the important areas in a timely fashion. This is the first year of our Quality Improvement programme. It's its first year anniversary, we brought this in last year and we have made some good progress in this area, I feel, over the
last 12 months. We have established our CQC bespoke methodology. We've delivered a range of training programmes to upskill our colleagues across the organisation, ranging from experts to gold standard to practitioner level and a broad baseline knowledge to the organisation. We have also facilitated a
range of other projects and programmes across the piece to support the cultural change required around transformation and we've put in place some fairly large scale programmes to support some of the work that we need to do across the piece, including a large element of
our registration transformation programme to drive our process improvement, improving our enforcement processes, to lean those out and make them as simple and as effective as possible, and work on notifications from providers to make sure that we can make that as effective and efficient as
possible. We are continuing to build our maturity in this area, continuing to roll out training and bringing forward projects and we're now starting to see some of those benefits starting to be realised across the business. And as we do that, it starts to reinforce
the value and the benefits of working in this QI way and we're starting to really see that cultural change taking effect throughout the organisation. More work to do but a really, really solid start, I think. So that's the Change piece - I'll come on
to the People in a minute. So I don't know, Mark, do you want to just add in your bits before we move on to the People piece? Thanks, Kirsty. So just adding to that: a few… I've extra colour here…
(UNINTELLIGIBLE) program as Kirsty was
talking about is now complete. That means that this (INAUDIBLE) shared services (INAUDIBLE)… in the IMS3 (INAUDIBLE) and it administrates itself and that includes new service (INAUDIBLE) centre and a new internal capabilities. We've successfully separate (INAUDIBLE) completed the… (INAUDIBLE) and now we're focusing on (INAUDIBLE)
improvement. I'd really like to thank (INAUDIBLE) and his team and all of our technology (INAUDIBLE) significant piece of work (INAUDIBLE) the transition a success. Mark, I think you might want to turn your (OVERLAPPING) Mark, your broadband is really glitchy. You might want to turn
your camera off because we can hardly hear you. I've turned that off. Can you hear me now ok? Yes. Can you hear me? Ok, great. So, actually, let me cover that again just in case you didn't get it all. So digital (INAUDIBLE) and we've exited from our previous IMS3 shared services (INAUDIBLE) of
service provision which we (INAUDIBLE) includes a service desk and new security operation centre and new internal capabilities. Mark… …completely at the end. Mark, it's still… we're still not really hearing you, Mark. You losing me? Yes, we really are. So (OVERLAPPING) I thought it was just me with broadband issues today but I think you've joined my club. Can we come back to you in a bit when perhaps the broadband is better? Yes. Absolutely. Kirsty, do you want to go onto the People? And then we'll come back to Mark. I will do. Ok. So, again, a pretty packed agenda around the work we're doing around supporting our people development across the organisation. So obviously

the Transforming Our Organisation is a big piece of work that impacts across the whole organisation and it's really important that we, as part of this work, that we create a real, positive momentum around this so that there is… People both understand the need for
change but actually also feel that they're fully involved and able to contribute to shaping the future of our organisation. So in order to facilitate that we've been running a whole range of cross-organisational workshops where we've been gathering people together to understand both their… Get
their views, their ideas, their frustrations, so that we can get, collate, pull that information together to help us inform our detailed design. Those have been really positive workshops, they've been really well-attended, been very vibrant, lots of conversation and discussion, great ideas coming forward from
there and we want to continue with that as we go forward but I think those first tranches of workshops have been really helpful, in terms of helping us without with our thinking, and I think have been really well received. Other areas of work: we
have a detailed People Plan and one of the areas we have been looking at is building leadership and management capability. In order to start that we wanted to build a foundational stone, if you like, from which we can then build out from that and
that has been the work we've been doing around our success profiles. The success profiles, I think, in previous iterations or previous years were called competency frameworks but I think success profiles sounds better. We've been building… We've been doing this work to really start to
codify behavioural excellence - the expectations of behavioural excellence - and the capabilities we want to see at each grade in the organisation, right through from the most junior grades to the most senior grades. Those have been pulled together again through collaborative workshops where people
have really talked about what good looks like in their jobs and we've been able to translate that into a framework. That will be launched across the organisation in November and it will provide that framework now to support our leadership development moving forwards and a
whole host of other HR and people-type policies that we want to bring in. A key one of those is our line management capability building programme. That will be based on the success profiles and what we've been doing there is looking at developing pathways, development
pathways for line managers to align some success profiles and equip them with a really solid range of practical skills, of management skills that are right for the right level of their job in the organisation, and also a pathway so they can see what they
need to do to build capability to progress through to the next levels. What we've done to do that is, we have trained up some of our HR experts within the academy to deliver some of these training programmes through so that we're able to tailor
them to support CQC and we're are able to flex them as where we like. That's about to be launched as well to start to drive those skills. We've run a few pilots, those have been really well received in terms of that real, practical type
of training that people can use - lots of things like role playing and things they actually get to learn to do difficult things in a real-life situation rather than just dry training through textbooks and things like that. We're also continuing our refresh of our
people policies; those are on track to complete by the end of 2021. These are the policies that govern our leadership, management, and how we work as an organisation with regards to our people. What we want to do with these is we're updating them so
they reflect a modern working environment but what we also want to do is to bring forward these into an app-enabled capability so that they really provide that support and guidance to managers so they are able to do the right thing in the right way
in a timely fashion with those apps which will guide them through in a really helpful way. Inclusion: we have something on the inclusion agenda on the agenda later but we are continuing to focus quite heavily on this; we have a big piece of work
around inclusion which is based around our DNI strategy. We have been focusing recently more on our recruitment process and practice to ensure that our recruitment process practices are fair and open and that everybody, regardless of their background or their protected characteristics, has a fair
shot at getting through the process. As well as doing that, we are also looking at our development programme for leaders, including a big programme around cultural awareness, and also formalising reverse mentoring for our senior leaders to really help both encourage understanding but also really

raise awareness of the importance of this issue. We also, following the Black Lives Matter protests and the response to that, we held a number of listening events and, as a result of that, we had some really powerful stories, as a result of that, we
pulled together a new Race Equality Action Group which are going to address some of these concerns and really ensure that we are driving through significant improvement, in a timely way, in these important areas. Then, finally on the people front, we have been planning to
run a series of Pulse Surveys to temperature check of our organisation on a regular basis. We are planning running the next one of those in autumn which again gives people an opportunity to feed back what they're feeling. I think this one will be particularly
important as this will be the first one we've run since… The second one since lockdown but I think we really want to focus this one on wellbeing and seeing how people are coping and responding to the changing ways of working through COVID so that
we can make sure we're tailoring our policies and the ways of working to support people in these new and interesting times. That's all on the People front. Happy to take questions on that or the Change programme. So not much going on then, Kirsty. No, it's pretty quiet really.
Anybody want to raise anything? Liz? Thanks, Peter. Yes, I just wanted to touch on the new Race Equality Action Group and very much to welcome it and welcome what I've heard about its focus on action and on really solid engagement with colleagues from across
the organisation. And I've agreed to be a link - a non-exec link - to that group so I'll be able to, hopefully, update the board in future on issues coming up. I just wanted to ask immediately, what's the sort of join up between some
of these different strands of work in the People Strategy? So, for example, line management capability. I know that a number of organisations on race equality have found there's really strong strategic intent, strong leadership backing for good practice on race equality but it can get
lost in parts of the organisation just in the busy day-to-day, you know, the huge numbers of priorities that managers are dealing with and I just wondered whether the inclusion strategy is threading into the line management capability work or if it will be? Yes. Yes, so
the success profiles have a very strong element of inclusion woven through them, so if you think about it, the success profiles being the building block for us in terms of all the other things, so that will be a core competency or a key expectation
of the behaviours and things that we want to see. So inclusion will be picked up through performance management and all those sort of areas because it is absolutely critical to the organisation going forwards. We want to be a truly inclusive organisation and that has
to start right at the basics, in terms of how we manage people day-to-day, how we assess people in terms of their progress and their performance. So it has been absolutely hardwired into our day-to-day activity, if you like. Mark, you wanted to come in. Mark,
you're on mute. Yes. Thank you, Peter. Thank you, Chairman. Echo Liz's comments and very pleased to hear that Liz is a link for us to the Race Equality Action Group. I think that's going to be very positive for us as a board. Kirsty, very,
very busy and, you know, super report around People. Could I just ask, in terms of transforming our organisation, there's quite a few comments - and you've referred to it as well today in your verbal report - around the emphasis on communications and opportunities to
contribute to the transforming of our organisation? And I just wonder whether, in terms of the Pulse Survey, I totally support the focus on wellbeing after this major transformation in working practices, but I wonder if there's not an opportunity in the next Pulse to check
how we have connected and the effectiveness of our communications and engagement in terms of the transforming our organisation? So, absolutely, Mark. So I think, if you remember back to previous conversations on our Pulse Survey, we have a thread, we will have a common thread
of questions that we ask every time, so that we can always benchmark where we are and our ability to communicate around change is one of those areas so we can just keep a track of it and it's really important that we're able to do
that as we go through this busy period of with a huge amount of change that affects the whole organisation. Great. Thank you. So, Chris, did you want just to follow up on that and then Paul Rew to come in, please? Yes. I think that it's a

really important point, Mark. I think the key thing for me is the relationship between the TOO and the strategy, so that we're having a single conversation with our colleagues, with providers, with people who use services, about what our intent is during this transformation and
what our longer term intent is as we move towards the next strategy. So it isn't just about the act of engaging on Transforming Our Organisation, it's a link between that and our wider strategy that I want to make sure we do and what we're
trying to do with each of the people who lead in the work stream of working in Transforming Our Organisation space, is to agree with our team, what are the opportunities to engage, what are the messages, and, importantly, how will the feedback be used to
drive each of the strands of work in the Transforming Our Organisation space. Good. Thanks, Chris. Paul? Yes. Thanks, Peter. I have to say I think this is an amazing amount of work that's been going on over the period. It's quite a phenomenal programme that is being managed through the business in not
the best of circumstances. I had a couple of questions. I had one observation, I think, which Mark might come back in later on with Digital Foundations Programme, that has been an incredible success in getting that through on time, I think maybe on or even
under budget, and successfully implemented and off the other systems. That really is sign of an IT function, I think, which is performing well. I had one question though which was around COVID and the pandemic and the impact upon what we're doing: Has it been
a help to have the pandemic for this programme? In that, I guess it has driven some things around being agile and moving faster, get some things that really had to be done, done. But has it been a help because we've had people who might
otherwise have been out doing inspections on the ground, able to actually act as SMEs and so on and bring in to the system or has it been a hindrance? That was one question. Then the second question was around the linkages between all the different
strands as we go forward, are those interdependencies going to become more important and more limiting? So as we start to get things coming to when they should be completed, if one thing depends upon another, are there risks that we're going to be finding problems
around that or have we got that really mapped out well and clear and totally on top of it? And I think, the third thing is, I'd echo what Mark was saying about bringing into the Pulse Survey around this. But I think particularly is not
only for people… How do they contribute to Transforming the Organisation and the strategy but also, do they understand what's going on here? Do they feel that… Because there's so much going on, how do we communicate in a way which helps them understand what they
feel they need to understand around it? Those are the three questions. Shall I pick those up? Yes, if you want to. I'm not sure, Kate, were you? And Ian and Chris have all got hands up. I don't know if they're all coming to your aid here, Kirsty. (OVERLAPPING) …answer technically, if that helps and then should I just knock off some of the technical ones, if that helps, around the interdependency piece? (OVERLAPPING) Yes. I think the interdependencies is… If there's one bit that keeps me awake at night, it's that, because there's a lot of moving parts to this programme and if you
start to unpick it, it looks like a spider's web of dependencies. The key thing that we need to learn is a blueprint for the TOM and once we've got that landed at the end of September, that then starts to say what it, in terms
of our holistic programme of activity, or have we got everything we need in order, in place, to deliver against this to make sure we realise the strategy? And what's the timing of these things? What things need to go first and is that currently in
the right order? And also are we making sure that where we've got dependencies coming through, that we're aligning them up to make sure that we understand what needs to happen and if things slip, what does that then mean? So the team are on with
this at the moment but we're still waiting for that final blueprint to just absolutely nail this down but it is something that we are talking about regularly, day in, day out, because I think it is really important but we just need that final blueprint
which is, I suppose, the key to all this to then enable us to put all those moving parts absolutely in the right order and then really map a decent scenario planning about what happens if this moves, what are we going to do, etc.? Peter

Wyman Thanks. Ian? Thanks, Peter. I think Paul asks a great question. If I could link that to the other point about digital fundamentals in general. I think the digital fundamentals programme has done two things: A - it is a sort of rip and replace
- which I know Mark won't thank me for saying - around some of the core things that we already had like, an e-mail system and a file storage system and so forth. So in many senses, for the average colleague, they'll look and just go,
"Well, I've got an e-mail system that looks very similar to the way it did yesterday." The fact that some of the plumbing has been changed is of no import to them. But what it has done is it gave us a set of digital capabilities,
particularly the ability to use video conferencing and mass broadcast technology within Teams to talk to the whole organisation in one go. So what I do is, I talk to the whole organisation twice a week. So I've got a routine, I've an audience of around
2,000 regular people that I am… I would try regularly rather talk to 2,000 people every week with a set of messages; they hear them directly from me. Colleagues on the Exec. Team take it in turns to run leadership calls which are once every week
to two weeks. And I know individual Exec. Team leaders will be talking to their own directorates on talk calls as well. So we've been able to blend written material with the voices of leaders directly delivering that material. We've been able to jump on the
misconceptions that often run round an organisation and deal with them in real time sometimes. On my calls, I get people putting something in the chaff and I'm able to deal with it straight away, whereas in the old world, it would have taken weeks before
we'd realise that people had got the wrong end of the stick on something. So I think COVID has helped because, in my old way of thinking, I have to say I'm pretty guilty of saying I disliked digital communications because I didn't think it was
authentic. I would far rather stand in front of a group of people and talk to them directly and I think we probably have all been brought up in a leadership culture that said face-to-face is always better, and I think what COVID has done is
it's forced us to stop doing that and forced us to really give digital a go and, in doing that, we've also had a great digital platform off which to do it. So I think those two things coming together has been a real positive and
I've certainly learned the lesson that I don't think any exclusively digital communications set up is completely the right thing to do but it's probably far more important than I ever realised and I know other colleagues feel the same way. I think the final point
is around… Kirsty was talking about things like blueprints and moving our thinking on to how we design the detail of future regulatory platform. I think that the big downside of COVID for me is, we may have people potentially more available because they're not travelling
so much and they're able to jump on calls quickly but the depth of creativity that we get digitally is probably not necessarily as good as it would be if we got those same people in a room. But there's a trade-off there and I think
the breadth of access, the number of voices we've been able to pull into conversations is a real positive. I think the thing we don't know is what the negative of that creativity thing is and whether, in the long term, there's a creativity deficit, if
you will. And I think most organisations are feeling the same way. You know, if they're doing work which is new and different and spontaneous, are we necessarily getting that from this sort of interaction versus the face-to-face interaction. But if we can blend the two
together, I think COVID has undoubtedly helped us in this area and helped us from a communication point of view. Thanks, Peter. Thank you. Kate, did you want to come in? Just very briefly. So feedback from inspectors. I don't think they've ever felt as plugged in or able to contribute to something so, you know, if you're an inspector in Stoke or in Newcastle, the ability to hop onto a workshop to talk about the way our workforce should deliver the ambition. The feedback from inspectors I've heard is loud and clear that the tech solution to enable them to engage in
these discussions in a really tidy way is brilliant. I think our staff feel highly engaged, pretty optimistic. I think we sometimes get the challenge of sharing stuff and trying to co-produce stuff at such an early stage means that often we and leaders and managers

don’t have the answers. But that is the kind of pros and cons of doing it, people have the chance to really shape what something looks like. But you can’t look to the managers to respond, to have every answer up their sleeve but, generally, I
think, you know, we would absolutely want to retain what tech has given us, in terms of inspectors based throughout the country being able to plug in and engage to these conversations stations in a really timely way. So Chris Day and then, unless anybody’s got
anything more on this subject, we’ll go back to Mark and hopefully his broadband is working. Chris? Just one thing finally to say on… I agree with everything that colleagues have said. I think the really important bit for people, both internally and externally, is to
link our ambition to a simple to understand outcome. I think Paul asked the question, do people understand what they’re doing? We often use a language in business or a programme language which is useful for us but when we’re describing things that are meaningful to
our colleagues, meaningful to providers, meaningful to the public, I think the ambition of the outcome that we’re seeking is the most important thing - the most important language - that we can use in that communication and for me, I think, there’s a thing to
describe (UNINTELLIGIBLE) there’s a squeezed middle so those managers that have to have frontline interactions with staff, it’s really, really important that they understand the reasons why we’re making the change that we’re making. And if they understand the outcome and the outcome benefit, they are
better able to describe somebody what that means for them. So rather than trying to have a generic communication that tries to talk to everybody, trying to be clear about the outcomes and giving those managers opportunity of having good conversations with their team about what
the outcome has been for how they work, those two things that are key to me outside what the digital impacts, those are the things that have mattered, I think, in a way we’ve communicated today. Thanks, Chris. Right. Mark, is your broadband back on? I
hope so. I’ve switched to another provider, so I hope you can hear me ok. Loud and clear. Fantastic. Ok. So very briefly, we talked briefly there about Digital Foundations. We would describe that programme now as being complete; we’ve exited from the previous IMS3 shared
service contract and we’ve established our own managed, with a new internal capability, model of service provision. So we are now masters of our own digital destiny, we have a new service desk, we have a new security operation centre and, as of the end of
August, we’ve cut our network ties with Atos and we are now successfully on our own. Our focus now is on embedding and on continuous improvement and making sure that we can leverage the benefits that we’ve got from this investment. But I’d really like to
thank Ian Lovatt and his team and all of our technology suppliers, including Atos, who made this really significant transition a success. And I think to Paul’s point earlier on about whether working from home may have made this more challenging or not, I think it
was a challenge - certainly in terms of this specific programme but I’m really grateful for the team. I think we have worked incredibly hard to make this happen and I think it’s the commitment of the extended team and of CQC colleagues that have really
made this a success. The regulatory platform is now working, we’ve got a new supplier on board to help us with the implementation. We’re in a design phase at the moment, which is going to complete next month and then we’ll start the foundational build of
our Dynamics 365 system which will support all of our regulatory activities with new applications that goes right the way through from registration to inspection to rating to reporting, publication enforcement, and all of our other administrative activities and will also be flexible enough to support
the changes that come with our future strategy. That Dynamics platform is also the thing that has underpinned all of our very quick work that we’ve done in response to the COVID pandemic and is currently supporting our transition activities such as the Emergency Support Framework
and now the new transition monitoring app and we’ll be building out our future foundational components which includes things like security and authentication and new data model and integration with existing systems, which will allow us to continue in this very agile way of working that
allows us to build out functionality and to deliver functionality and deliver that benefit to the organisation in a way that is very quick to enable us to get the benefit of that early. We’re also building out now a new intelligence data platform and that

architectural design work is now complete and has been validated externally and we're going to start to build that out now, working with the teams internally and externally to build out two or three use cases of how that technology can underpin our intelligence and data
business use cases. The underpinning architecture that sits behind that involves ingesting data from a variety of different sources into a new data lake, a new analytical and data marketplace solutions to enable us to really deliver those new insights to our regulatory colleagues which is
very exciting and we'll be taking advantage of new technology, such as machine learning, to enable us to support the professional judgement of our colleagues. We've also very recently successfully implemented a new underpinning technology for our contact centre, which is a significant milestone for us,
and that launch will continue to support an evolution of our ability to offer different ways that people will be able to contact CQC above and beyond the current methods that we have. I'd just like to reiterate the point early on that it's been a
really successful quarter of delivery under some unusual circumstances and some really notable achievements and that's been successful because of the hard work of people within CQC but also our technology partners who've carried on working under these circumstances of working remotely. It seems to me that
we are already in a better place and doing our job better than we were able to in many, many respects pre-COVID and as and when we're able to get back out again, we're just going to be in such a good place and I really,

Insight Report

again, congratulate you, Mark, and indeed everybody, for what's been achieved. Does anybody have any questions, comments, or are we happy to move on? Right. In which case, let's move on to the Insight Report. Chris, Rosie. You're on mute, Chris. Sorry. This Insight Report has two main things,
alongside the regular information that we publish as part of our Insight Report, we wanted to look in particular at some of our early findings on the provider collaborator reviews and also some of what we've learned from our infection prevention control, so if I hand
over to Rosie just to go through some of the PCR work first. Is that OK, Rosie? Yes. Certainly. Thank you, Chris, and, as we've discussed many times on the board, we think quality of care that people receive partly depends on the care they've received
within a provider but actually also depends on the care they receive as they transfer from provider to provider or how providers work to really make sure that the person and the population needs are met. So there's two aspects to provider collaboration reviews. I'm just
going to ask Charles to just briefly remind the board about what we did and Carolyn is going to feed in the high level results of the report from the provider collaboration reviews with a view that much more detail will be in the next State
of Care report in October and there's going to be a whole chapter dedicated to the findings from the provider collaboration reviews. The next agenda item, which Victoria is here for, we will be discussing the next step in the provider collaboration reviews but that will
be after the Insight Report. So if I could just briefly hand over to Charles and Carolyn. Thanks, Rosie. So I was just going to cover off the methodology again for the provider collaboration reviews. So methodology for the first phase of the reviews is focused
on the interface of health and social care for people aged 65 and over and has looked at how providers in the system have worked together to ensure that there's high quality services for those people. In between July and August we've looked at 11 integrated
care systems and STPs and in each system we had a small team of inspectors working remotely. Each team was supplied with a range of data. Firstly, it was around system indicators based on the experience of over-65s moving through the system and that data was
based on the data packs which we developed when we did the local system reviews. They also had a range of demographic data around deprivation, population, age, ethnicity, and then also some data on COVID-19 outcomes and for each system we also had the local inspector
information so we got intelligence from the local inspection teams. For each area, we did a deep dive review into one or two local authority areas and then we interviewed a range of organisations in that area from, for example, primary care networks, NHS Trusts, acute

ambulance services, and adult social care providers and for each area we asked around, based the work around four key lines of enquiry. So the first one is around ensuring that people are at the centre, so how providers have worked together and responded to COVID-19
around ensuring that people move through health and social care systems safely and were in the right place at the right time, cared for by people with the right skills, etc. The second one was around system leadership, so was looking round, was shared plans across
systems and we looked at governance, arrangements, and leadership during the COVID period and how they were coming out of the initial COVID period. The third one, we looked at workforce capacity and capabilities. We looked at how workforce have been deployed across systems and how
providers had worked together to deploy workforce and, secondly, how providers had worked together to ensure that staff were kept safe, and the fourth, could I raise around digital solutions and technology, so it's looking at what impacts the digital solutions and technology had on providers
collaborating and the services they provide and how those services have been accelerated. Once we've done the reviews, findings were fed back locally via high level presentations and then all those findings have been pulled together to bring out the detailed findings in the State of
Care Report which Rosie has just discussed. So I'll just hand you over to Carolyn to go through some of the high level findings. Thanks, Charles. So I'm Carolyn, I'm one of the heads of inspection and I'm leading the PCRs. We know there's lots of

Provider Collaboration Reviews Update

emerging high level messages coming out of this and we'll go into a lot more detail in the State of Care report but just some of those clear messages at the moment are around understanding of local populations. So where a system really understands the cultural
differences within their population - that was really important. We found the quality of existing relationships between local providers played a major role in the coordination and delivery of joined-up health and social care services and that was without a doubt. We found that there was
an increased focus on shared planning and system-wide governance but the pre-existing plans that were already in place, you know, those plans to deal with a major incident and deal with a pandemic even, they weren't really fit for purpose to cope with COVID-19. I don't
think we heard of anywhere say that their plans were enough to deal with what they had to deal with. Staff across health and social care worked above and beyond their roles. We spoke to lots of dedicated, passionate, committed staff that really committed to supporting
everybody in their care. But, equally, we also heard a lot of initiatives by providers themselves to care about their staff as well and to look at the wellbeing of their staff and that was really refreshing to hear about. Then, from a digital point of
view, we heard about the move to enhance and to accelerate digital solutions, were a really big part of the period but we also heard about how that had impacted on access to services as well. So we heard the positives and negatives of the digital
scenarios but we certainly heard about digital solutions, supported data and how data was shared across health and social care. But I think we've got a bit of time to answer any questions, if anyone's got any. Thank you, Carolyn, and can I just add to
Charles and Carolyn because I think that all the teams involved - the intelligence team, all of the policy team, the inspectors, have worked tirelessly to pull this off and so I just want to say a very big thank you in public for them. But
really useful learning coming out that hopefully the systems will listen to and start to think about how they can embed. So back to you, Chris. On mute, Chris. Sorry. It's just… No, we love you on mute. Yes. I know, yes. It's just not good for your (UNINTELLIGIBLE) to be on mute, I find. So just to add my own thought on that, there are some tremendous examples,
I think that the point of these and it's great that people are through at such speed because we want other systems to learn from this work and to learn from what others have done well and also where they haven't and if I just move
on to the other theme, which was infection prevention control; you've heard Kate talk about this a bit earlier. The reason why to talk about infection prevention control was partly about sharing reflection on what has gone well, understand and learn from what hadn't and help

all health and care systems prepare for the future over the next few months. What we did see, we did see in some of this work, some really good triaging systems to help people get the right service early, and where we saw teams come together
to assess risk, to communicate well, to make sure that everybody in different roles in an organisation knew their responsibility. There was good audits carried out to make sure things were happening in the right way and, obviously, good training, good cleaning both in terms of
staff and also contractors. Where we had some concerns they were mainly around training of staff in the use of PPE and also in having some of those procedures and some of those audits regularly carried out. We published the information that goes into the COVID
Insight Report, as Kate said, this is primarily about helping organisations prepare for the future but also, if we do see any issues that concern us as part of these audits, we don't hesitate in taking up the appropriate regulatory action to make sure people and
services are safe, but from what both Kate and Ted and, in fact, Rosie, have said is a lot of good practice that's going on locally in organisations, we want other organisations to learn but we will continue to take action ourselves if we feel that
there are some concerns. I'm conscious of time, so I wanted to give you a brief overview of those things. Obviously, it's in the COVID Insight Report, as we always do with the COVID Insight Report, we'll seek stakeholder feedback after it's out, to make sure
people can understand and hear the message and we'll continue to promote them over the coming weeks. Thanks, Chris. Ted? I just wanted to say that the work that all three sectors have done on infection control, I think, is really very important and it gives
oversight of the levels of infection control - infection prevention control - across the whole of health and social care and I think this is unique insight into it. So I think that this aspect of the report is really very important. Thanks. So what I'm
going to suggest - unless you all think something better - is that we take the next item, which is Rosie and update on PCRs, and then have a short break for lunch because we've got about another hour of the board to go - the
public board to go - if we stick roughly to the time we've allotted and that's going to take us way past 2 o'clock if we carry on. Does that sound like a good plan? Lots of noddings of heads. Right. So let's deal with PCRs
because they're really, really important. I don't want to rush it, Rosie, but at the end of it, there's a break. Thank you, Peter. So I would like to welcome Victoria Watkins, who's the Deputy Chief Inspector in PMS to talk through the paper in front
of you but before I hand over to Victoria, just to say I think this is a really important stepping stone in terms of how we move from where we've been, in terms of our provider regulation, to our thoughts and hopes for system regulation and
I think this is going to give us, firstly, a huge amount of learning in terms of how we can really support systems to work effectively together to deliver really good joined-up, person-centred care going forward. But also - much more immediately - help support systems
as they're going through the next few months to really learn about how they're working and also how they can learn from other parts of the country. So, Victoria, do you want to take us through the paper? Thanks, Rosie. Afternoon, everybody. Victoria Watkins, DCI. Really
pleased to be here about the PCRs. I'm going to keep it brief, if that's all right, in terms of the overview, recognising everybody will have had access to the paper. So it's really focused on what comes next for PCRs, particularly 2021 and beyond. So
the 2021 first. So we're going to and we've agreed we will review all system areas, using a variety of topic modules, and we've agreed those as urgent and emergency care, cancer, learning disabilities and autism, followed by mental health. Important to flag that each and
every one of those reviews will shine a spotlight in terms of inequalities, particularly for BAME population groups. Each one of those topic modules will report nationally, in a similar way to what we've heard for Phase One, so firstly through Insight as a headline summary,
and followed by a full topic report afterwards. The difference for Phase Two onwards comes in the publication of the local level summary of findings. So for each review, we'll continue to feed back the summary of findings to the system and then we will publish

the entire set of those summaries at the same time as that full national report. We're going to focus on hearing the experiences of those accessing care through the reviews and we're going to continue to use our section 58 powers in terms of the PCR
approach. So that's 2021, a summary of. In terms of the beyond, as Rosie said, this is absolutely aligned to our strategic ambitions in the system space, the reviewing across systems, and the PCR programme in itself, we're hoping from April '21 onwards to transfer from
national level to regional level, in terms of its ownership. By then, we'll have a range of the topic methodologies, so the regions will be able to tailor the best fit PCR programme based on the regional risks, issues, and opportunities for learning. So I think
I'd probably leave it there. That's a very brief summary but realise we want to focus on discussion. So could I ask, in the PCRs that you've done so far, what was the quality of the feedback? How did those sessions work? I've read the reviews and
they look really good but how did it work when you went back to the providers? Shall I start with that and then Carolyn and Charles and Victoria might want to chip in? So I sat in on several of the feedback sessions and they were
very well received by the systems that I sat in there. I think they'd found the process very useful in terms of giving that opportunity to reflect on what they had done and what their areas of development and learning were. I think the fact that
we were able to have such a broad view of what was happening in their local systems, including looking at what was happening in pharmacies, including what was in medicines, including what was happening in the local hospices, and the dental provision, as well as the
other parts of the local system, really gave a very comprehensive overview that actually some of the system leaders said, "Well, actually we hadn't considered this about the dental provision" or "We hadn't considered this about hospices and things" and so I think because we have
that very clear overview of all parts of the system, we were able to feed back some of the areas that aren't necessarily as visible in the day-to-day discussions, but I'll hand over to Victoria and Carolyn and Charles if they want to add to that.
I could just add to that. It's Carolyn. There is something about perceptions. We were able to play back perceptions, in terms of the system might have felt - the leaders might have felt - that communication was really good with providers but, actually, we might
have heard a slightly different story. So we were able to share some of that richness about those perceptions that were out there, which is useful because perceptions whether they're based on reality or facts or whatever, they're still important, aren't they? So, Carolyn, was the reaction from the system providers, you know, one that, 'this has been a useful thing and we're going to take away and we're going to do things differently' or were they just sort of nodding and did you leave with a feeling that nothing was going to change as a result?
That was really what I was trying to get to. Yes. Because it's not like with the LCRs, where there was a full, formal, published report. Yes. I mean, I think it would be fair to say I don't think - hand on heart - every one of those 11, I got the feeling that they
would make huge changes based on what we said but there were some that were more open to things than others and I think it will vary. We know we've seen a difference in how the different systems have responded to us definitely and you can
see a level of maturity among systems and it varies. So we're going to have to find a sort of loop back mechanism, aren't we? Whether that's through our individual provider inspections and dialogue or back through the system because this is pointless unless it drives
change and improvement. One of the consistent bits of feedback from most - I want to say most - of the system for these first 11 was around actually how useful it had been for this opportunity to be driven via the PCR for them to get together,
particularly thinking about the responses to COVID and the pace of some of that work had not allowed the opportunities to reflect and pull together the story, the highlights, the challenges, the learning, all of it, in one. Resoundingly, that was a consistent message about how
useful it was. One of the systems, we have got another follow-up session with them, so they've come back to us and said, "Actually, can we have another session with you to talk about it a bit more?", once they've had a chance to, you know,

digest that verbal feedback that we've given them. So that's positive and it's new for them, isn't it? As well, so… That does sound positive. Let me bring Liz in. Wants to raise something and then Paul. Thanks very much. I just wanted to look to
the future and these sound like a really useful and important set of future modules and I was thinking that in the regulatory governance committee, we've had a number of discussions about cross-cutting issues. So, for instance, if you take people with learning disabilities and autistic
people, obviously what matters to people is not only the specialist service they might get from say, adult social care, but also what happens in primary care, what happens if you're admitted to an acute hospital ward, etc. And at that time - this is going
back a while - when we had those discussions, it flushed out the issues of how we, as an organisation, work across those boundaries as well and I just wondered whether there's any learning coming out of this work or whether you think there may be?
For how we work across, to think about the people and their experience of the whole system. And I think we've done a huge amount, as an organisation, to work across those boundaries ourselves but I just wondered if you had any reflections on that. So
I've had a huge amount of feedback from inspectors that actually it's been fantastic because they've got to know people in other directorates. And, firstly, it's really started to, I guess, open their eyes in terms of what happens in other sectors and really understand some
of the issues in those sectors and understand the importance of both us working together internally but also how important it is for those providers to work externally together as well. So that's been certainly a very strong message for me and also I think that
the teams have found the data packs really useful. So this very rich data pack and thank you to the intelligence team because they are really fantastic and the amount of information is immense in them and that ability to help understand that local picture across
all of the sectors has been something that's been well received by the local teams. So does anyone want to add to that? All I would add is that the feedback and that positivity from the teams has been around the kind of mindset shift as
well, in terms of thinking about entire journeys for population groups. So your example about learning disabilities and autism, we will see that again come through, I think, but here in these first 11, very definitely this was our teams working together to knit together the
entire story, including the bits in between the providers which is new and a development for our teams' way of working and thinking and really positive to see, yes. And I've got a queue of people wanting to be involved in the next one, so I think that tells us it as
well. It certainly does tell us a good story. Paul, you wanted to ask something or raise something? Yes, it was a very quick question, actually. I'd noticed that what we'd focused on in the Insight Report is the good practice, we don't say anything about
poor practice and I'm just wondering, just a confirmation that we are going to bring up poor practice somewhere and (UNINTELLIGIBLE) report on that? So it will feature in… We always try to… The reason why we're pulling out - picking out - good practice is
we want people to focus on what they can do between now and Christmas but we always do focus on what's working well and what isn't and we'll do that in State of Care and in the next wave of these reports as they come forward,
but we wanted to give people a sense of what do they have to do between now and as we move in to a sort of a winter period around their system collaboration. That's why the focus is as it is in this Insight Report, Paul.
Yes, and sorry, might just add, so for Phase Two onwards as well, just building on that theme: the local system summary feedback details that go to the system, we will invite responses to those including any intended actions and that will enable us to continue
that oversight and work with the system. So we are very definitely future-proofing in the sense of… So once we've got the findings, once we know what's gone well but also the areas for future focus, how can we keep engaged with the system, with the
momentum (INAUDIBLE) Good, thank you. Mark? Thank you, Chairman. Yes, really interesting report.
I'm just sort of focusing on the word 'collaboration' and wondering whether, in your experience, you're seeing a different type or a need for a different type of collaboration when you apply that word to a broader geography.

So distance, for instance, making a bigger challenge to collaboration and perhaps to an STP area that's much closer. So in my experience of working in an STP that had great problems collaborating over 40 miles and I'm currently sitting in a county where from Berwick
to Morpeth is being covered by one STP. So I just wonder whether there isn't an approach that needs to acknowledge the challenges of that distance in geography. So, really interesting point, Mark, and part of what we've done through this process is identify different areas
with different demographic make-up and areas with different challenges such as rural and urban areas, and one of the things we've consistently heard, actually, through the work and the pandemic, is how much technology has been able to transform that collaboration so those distances have become
- in some ways - with those discussions that need to happen across those providers, have become a lot easier because of the use of technology and multi-disciplinary team working across bigger geographies because of the technology used. I don't know if the team have got
any other insights into that, I think it's certainly something that we will be looking as we go forward and making sure that we capture those differences between the different geographical places that we attend. Yes, I think we've certainly heard from some of the systems
that there is, maybe, a feeling that some of them are too big. There's such a variety across the country, in the size of them and I've heard our teams comment on that they think that some of the systems just cover too big an area
for them to be truly meaningful enough, in terms of really understanding their populations. I mean, I think it plays back to the maturity point again where we've included and heard from those systems where they are more mature than others. We've certainly felt that represented
in who is, kind of, coming along, who's representing the system, are we getting voices from every corner of the sectors, for example. So I would think that it's about the evolution of and the current status of some of the systems that we've visited as
well. Thank you. Good. Right. Robert, you wanted to come in? Thank you. Firstly, this is a fantastic-looking project. The question I wanted to ask, perhaps not surprisingly, is about engagement with people who use services with which you identify there have been problems and I wondered…
I mean, I can see why that would be difficult moving in, from our point of view, to immediately find out what people are saying but can we have some expectation that, in their collaboration, the providers actually are seeking the feedback themselves? Point one. And
point two, has Healthwatch - local Healthwatch - had any role to play, so far, in what you've been doing? So, really important point and something we want to strengthen far more in the second round of PCRs. We think it probably has been a gap
in the first round of PCRs and we want to absolutely get this right in the second round. So, Victoria, do want to respond to that? Yes. We have connected with Healthwatch in each of the 11 areas but what we've heard through those connection points
has varied in terms of the detail and the quality of the information coming through. I mean, Charles can come in if you want the full detail, but we have made significant efforts, it's fair to say for Phase Two onwards thinking about how we can
connect, particularly through Experts by Experience as well, and connect to patient forums and user groups, so absolutely this is at the forefront of our priorities to get this right and learn from our own experiences of Phase One, I think, to really focus on pulling
these voices through but, Charles, do you want to give any more detail? I suppose it's quite good to signpost that one of the good practice examples is about how local Healthwatch had worked in Brighton and Hove and the contribution they've made to supporting the
whole system, and secondly, yes, we're doing a lot of work with how we can work with Ex by Exes for the next reviews and we've got quite a few quite substantial plans of how that will work better in the next reviews, as well as
working with local Healthwatch and as well as engaging with local scrutiny committees and others like that. Can I just make an offer, if Imelda's listening to this and I'm sure she won't thank me, but we obviously have direct communication with all local Healthwatches and
if there's anything you want us to push out in advance to them of your reviews, then that might give them a bit of time to think about it. Not all of them, of course, are in a position - stretched as they are - to suddenly do something different to what they're already doing but we can at least tell them what you're

doing. (OVERLAPPING) Imelda's team has actually already organised that for us, so I'm doing a presentation to the local Healthwatches next week. Fantastic. And we've recently had sight of the Healthwatch surveys, haven't we? Which we hadn't for Phase One and they are so incredibly informative, the quality
of the quantitative and qualitative data in there is superb and we'll definitely feed into our PCRs, yes. Great. So look, I'm going to bring this to an end. I think the work you have been doing has been superb, both on the 11 that you've done but also as
a stepping stone for what we might do in the longer term, in looking at systems as well as individual providers. So Carolyn, Victoria, Charles, thank you very much indeed and please thank everybody else that's been involved in this work. So there was a bit
of a bidding war going on for how long we had a break for, but I'm going to start again at a quarter to two and if you're not here, that's up to you, but that's when I'm going to start. So let's give ourselves a

Provider Collaboration Reviews Update **Transitional Regulatory Approach Update**

quick break. Thank you very much indeed. And, Ted, we come to you now on the transitional regulatory approach, please. Ok, thank you, Peter. So the transitional regulatory approach is an umbrella term, covering the work we're doing between now and the introduction of the future
regulatory platform in 2021 and I'm going to give you an overview of it now, very briefly. There's a lot of details in the paper that you've got in front of you and then have an opportunity to discuss it. Now, first of all, the teams
that have been working on this, across the whole CQC, have been working very hard and making great progress and we're ready to roll this out in the early part of October across all three sectors and I think that's a great achievement, to have done
that in record time. The principle of this is to build on our experience from what we've done during the pandemic and you've already heard in the board already how much we have learnt during the pandemic, in terms of changing our approach, building monitoring into
the centre of it, monitoring of risk and then reacting to that risk, moving away from our previous approach of a timetabled programme of inspections to a risk-driven approach to inspections. And we've learned an awful lot about that over the last six months and we're
building on that, going forward, in the transitional regulatory approach but, equally, we're building on what we've learnt from the roll-out of the Emergency Support Framework during the pandemic and we've done a detailed evaluation of that which we built into our learning for introducing the
transitional regulatory approach but we are still bringing in the best from our previous methodology. So we haven't totally stood away from our previous methodology, we are using that but we're using that in a slightly different way, as I'll try and explain. Now there are
five elements really, to the transitional regulatory approach: right at the centre of it, is enhancing and creating a structure to our monitoring of risk and building that on a digital platform, as we did with the ESF, and that is the work that's been going
on over the last six weeks or so and, as I say, that is the work we'll be rolling out in October and we're taking very much a continuous improvement approach to this. So what we'll roll out in October will be a first iteration and
we expect to develop it over time so we build a really good bridge through to the future regulatory platform when we're ready to roll that out next year. And so this is a continuum and we'll will learn and develop our approach as we go
forward. The monitoring activity, as I say, is built on a digital platform, the transitional monitoring app that Mark has already mentioned and that will be a way of assessing risk in a structured way, looking at all five key questions from our current assessment framework,
focusing particularly on safety and well-led but incorporating elements of all five key questions, and we'll use that to assess risk in our interactions with providers. Most of these interactions will be remote but the approach can be used for on-site visits as well and we
envisage that occasionally will happen, as we go forward. Now depending on what comes out of that, we can either decide that no further regulatory action is required at the time, or we can identify risk and then make a decision about whether further regulatory action
is required. The second element of the approach is risk-based, targeted inspections. Now we've already

discussed, we are doing those at the moment and we intend to continue doing those, driven by assessment from the monitoring activity to determine where we need to target those inspections going forward, and those risk-based inspections, we will continue throughout this process. So where we identify risk, if necessary, having considered all the options, if we need to do an on-site inspection, we will do an on-site inspection and we'll take the necessary action after that.
The third element is a relatively small part of the total but an important one and this is where we need to re-rate organisations. Now the approach is not driven by ratings particularly but we recognise there are some organisations where the ratings will need to change. For me, I suppose, the biggest example of that are trusts in special measures where we need to make a decision about whether they stay in special measures or come out of special measures, or trusts that might need to go into special measures, where we need to assess them. And so we still need a methodology that allows us to do ratings and for that we'll use our previous methodology, streamlined. So it'll be streamlined in the sense of we will minimise the amount of on-site activity, streamlined in the sense of we will only ask for the evidence we have to absolutely to identify, to make a rigorous rating assessment, and streamlined in the sense of we'll produce streamlined, simpler reports which are more targeted at identifying the key problems and informing the public about the issues we found in those providers. So we will still do those ratings inspections but they will not be a large part of what we do, but where necessary, we'll have the means of doing those. The fourth element is a completely new approach and this is piloting in adult social care and primary medical services - a form of assessment we can do without crossing the threshold. And Kate and Rosie may well want to talk about this but I think this is really very exciting. We're piloting it in limited areas and we will learn from those pilots and we may well, over the transitional period, extend it to other areas, depending on our learning from those initial pilots. So that gives us the scope to develop, as we go forward into the future, the regulatory platform and approach to assessment without on-site inspection but that is still very much early days and we need to learn as we go along to make sure we could maintain the rigour and quality of our assessments using that approach. The fifth element that comes under the overall umbrella of the transitional regulatory approach is the provider collaboration reviews, which we've heard about just a little earlier on before lunch, and of course they are very much part of this transition as well and we'll be learning from those and you've heard a lot about those, we've had a chance to discuss them as well but they're very much part of the overall picture. As I say, we will be improving this over the next six months or so, so when we move into the new future regulatory platform, we will have learnt a lot from the transitional process and that will help inform us going forward into the new approach. So that's a summary of where we are, there's a lot of detail in the paper. I'll open it up to any questions or anything anyone wants to feed back. That's really good. Kate? Thanks, Peter. So if I can just do a quick minute on the home care pilot that Ted referenced because I think Rosie covered off what they're doing in NGPs earlier on in the session. So, very briefly: in partnership with the trade association for home care, we've been having some discussions throughout COVID about actually what is the added value of an inspector going to a small home care office where there's no one there who is receiving care and actually (UNINTELLIGIBLE) we want to work together in partnership to look at whether we can spend that increased time not travelling to sit in an office but actually spend more time speaking to members of staff who are delivering that care and speaking to more people in their own homes and we are also looking at the role of Experts by Experience to have those conversations with people in receipt of care. So we are working with 60 home care providers who have volunteered to be part of this. As Ted says, it will be heavily evaluated and the emphasis is on spending the increased time hearing directly from staff and people with lived experience. Good. I think that's really, really important. Does anybody want to come in at this stage? Gosh, I'm surprised. (OVERLAPPING) Yes. Liz? Liz, you're going to not support it. No, I am. I just wanted to ask who… I mean, you've talked, Kate, I think about involving

home care providers, for example, but in terms of this type of approach - moving away from the large set-piece inspections or set regularity
to risk-based approach and more use of other forms of intelligence, what have our stakeholders had to say about this, in as far as we've so far talked to them about it? Because, obviously, it's really important that we are planning to take robust action where
that is needed and people need to be very, very confident about that and I just wanted to understand what kind of feedback we've had and how we've dealt with that, if people have raised any concerns. Well, can I talk about the bigger stakeholder picture?
I think you may have targeted that particularly at Kate but can I just talk about the bigger stakeholder picture? Because we have been sharing our plans with stakeholders and received positive feedback on this. I think stakeholders, of course, are still working under the pressures
of COVID-19 and are looking for us to be proportionate and, of course, we are keen to do that and, of course, we are using methodologies that minimise the risk of us visiting providers on a regular basis, so this is all tied in to the
pressures that the stakeholders face and I think they are supportive of that. In terms of the direction of travel that we're taking, again, I think stakeholders - providers particularly - have found that the monitoring approach, the interaction with providers through the monitoring approach has
been really very positive and positive feedback on that. I think there are a couple of things that are really important for us going forward and that is capturing the use of voice in our risk assessment and we've been talking a lot about that and
it's actually key in the guidance for the monitoring activity that the user voice is actually central to that and if we don't have sufficient feedback from users of services then that itself is a risk for us that we need to take into account. So
we need to hear what the experience of people using services is. But also, as we develop this, I think we need to understand better when we need to be on-site and when we don't need to be on-site. We want to minimise the on-site activity
but we don't want to get too - what's the word? - rigid in 'this is on-site or that's not on-site' and I think we need to have some flexibility in some of these inspections to do more on-site or less on-site, depending on the individual
circumstances. I suppose I was thinking particularly about the non-provider stakeholders. I mean I can see that from a provider's point of view, anything that's simplifies and streamlines is going to be welcome but I was thinking about the public confidence point. May I respond to that, Peter? Yes, please, Chris,
do. So, you're absolutely right, Liz, it is very important. I was in a conversation with Choice Support, who are our Experts by Experience partner at the moment and they're really excited about this, as are the Experts by Experience involved with it, and this is
sort of similar to what other public stakeholders have said. If we are able to use the information that they can gather all the time and if it drives our regulatory action both in terms of inspection and other activity, then I think people will grow
in confidence in our ability to use this approach, as opposed to having the periodicity of the inspections be the guide for when and how we inspect. As I go back to what I said earlier, without re-running the same message. If you look at what
we've done in the Performance report, if you look at how we've used the voice of people to drive our inspection activity, I think that's the confidence that they are seeking but certainly Choice Support were saying that they're excited by the prospect to be able
to provide the information on more regular basis. I think one of the challenges that remains is how we present this information alongside our inspection reports, so that this 'always on view' of quality is meaningful to people who use services. I think that's a challenge
that we have but it is a good challenge to have and I think the richness of the information that we get, as people begin to trust us more, will help us in our regulatory activity and will help us provide better care for people. Thanks, Chris. Ian?
Thanks, Peter. I think the key thing with this for me, is this represents a series of things we're doing to sort of prototype our longer term position, and I think the real key benefit is it enables us to almost codify the information we have.
It means we are interacting with providers - either directly on-site or off-site - probably more frequently than

has ever been the case before, so from a public point of view, they may not necessarily be terribly interested in the details of all of this but
the practical reality, as Chris was describing it, that 'always on view' of quality becomes a reality, and if we recognise that the information we've currently got, is largely held within a series of PDF reports and a lot of manual work has to go on
so we can derive insight, I think this starts to give us an opportunity to create data which can then be analysed and interrogated and starts to give us unique and much more sophisticated insight. It's one of the themes that's come up again and again
in the meeting is this idea of defining what good looks like around a particularly good culture and that sort of thing. Actually, that's a pretty unsophisticated activity at the moment but actually with this approach and that ability to analyse data and turn qualitative information
into quantitative information, this could get really interesting in terms of our ability to contribute to the wider conversation around what good looks like and things like a safety culture in a hospital or, you know, those sorts of things. So I think the opportunities here
are just enormous and I think what this current COVID period gives us is an opportunity - a bit of space, I suppose - to try this out and it allows us to accelerate our original plans but I think it was Jora who said a few meetings ago that what COVID has done is it's taken the 2022 Strategic Plan and made it your 2020 delivery plan and I think he's probably spot on, actually, in terms of what we're doing now. So I think, taking the bigger picture view of
this, I think I would completely agree with Ted's excitement about this because it genuinely is about changing the way we regulate and I think providers would see it as a reduction in the perceived burden. The public though, I think, will get a better service
and can be more assured as consequence of this. Thanks, Peter. No, thank you, Ian. Paul? Thanks. I don't disagree with the direction of travel at all on this or what's being proposed and I certainly applaud the enthusiasm that Ian referred to. I have a question though, which is:
if we are really basing this upon risk and so we select those providers who we see as being more at risk in order to go (UNINTELLIGIBLE) through this process on, should we also be selecting some of those that we don't think are at risk?
And actually going and testing this on them to see whether actually we're discovering things that's coming through that our risk processes aren't throwing up. So, Kate, were you going to answer that or Ted? Well, I'll come back on that. Yes, we have built that into our thinking, Paul, in that determining what our priorities are within each directorate. The
priorities are driven by what we perceive to be the risks in different providers but, equally, some of that is about providers who we regard as low risk to see whether the system works for them as well. So I think we will do that, I
mean clearly we need to prioritise risk, so we can't go out and look at low-risk providers and spend too much resource on that but I think it is part of the pattern. I think one of the things that the old system - the timetabled
approach to inspections - gave us was the sense that we were going out and inspecting low-risk providers and putting our resources into inspecting low-risk providers when, in actual fact, we needed those resources for the higher-risk providers. Kate, did you want to add to that?
I was just going to very briefly flag. So, obviously, over the summer we've been prioritising crossing the threshold for high-risk services but we have also used our IPC methodology to go out and look at services where we thought we would find good stuff, which
we did, and the benefit of being able to test out that our methodology works in both scenarios, but also the added value of being able to describe what good looks like so I think I will absolutely support Ted's comments that the bulk of the
resources need to be responding to risk but we absolutely need a methodology that works across all different types of services with different levels of quality. And I think, Paul, it seems to me that it's really important that over time we look at all providers
and whether we do that on a time basis for those that we think are low risk or whether we do it on some sort of more random basis, I think it's all for discussion as we go along. But I don't think we're ever going
to be in a position where we can be so confident that there is very low risk in those that we think are low risk that we don't even need to go at all. Yes, I'd agree with that. What part of the risk assessment will be what

the last
rating was in that provider but also how long since we last assessed them. So as a provider is not assessed for an extended period, even if we perceive them to be low risk, our risk score and assessment of them will go up. So what
we don't want is to have some providers that are perceived to be low risk and never rise to the top of the risk assessment. Ok, thank you. Robert? I'm just building on that point. I think there may be, out there, an anxiety that we're
going to stop looking at places that we have rated as good and now I'm reassured that is not necessarily the case. But also to point out that the rate, the speed, at which places can change or deteriorate varies considerably, as do units within particular
organisations. But if you take a smallish care home, I think that you can find that that can go from really quite good indeed to appalling in a very short space of time and unless our intelligence is absolutely sensitive enough to pick that up, then
we need to factor that into our thinking. Well a combination of the triggers that we know that cause that rapid deterioration, change of manager or whatever, plus, you know, all the alerts that we get from service users ought to get us to a point
where we are on notice that there might be a change and therefore we would need to go. And our aspiration is that our risk assessment will pick that up and identify that. I mean, clearly, if there are no external signals of the risk then
it's difficult for our monitoring to pick it up but I suppose our hypothesis here is there will be external signals of the risk, if we can find them. And just one other thing if I could add… So if we think about the way we've
worked differently during COVID and the emphasis on supportive but challenging conversations between inspectors and providers and building that relationship up, A - providers and inspectors have absolutely welcomed the approach but B - we've experienced more, because those relationships are in-situ, providers have been picking
up the phone and just sharing something early days that's developing in their service with the inspector so I think that emphasis on us having that more week-to-week view of what's going on in the service plus the focus on understanding what's going on in the
system as well, I think adds to that confidence we should have that we will have a grip on what's going on in those services. Good. Mark? Thanks, Chairman. I just wanted Ted to ask you a question about experience of service users and the use
of Experts by Experience because we will now be using them in a different way, i.e. remotely, is there going to be some training to the Expert by Experience to be able to glean the information we want but instead of face-to-face through a different medium?
Chris? Shall I take that? So, absolutely. There's a really important programme going on at the moment with Choice Support around what people need, not just to have direct conversations with service users in direct assessment so we hear first-hand from them, not just around that
but also around how they might bring together different groups, virtually or actually, to have conversations about how services are performing. So Choice Support have been working really well with our team to understand what the training needs of each individual group are and it's not
the same across the different groups of Experts by Experience and providing that tailored training and, as Kate mentioned, some of the early work around what we'd been doing around domiciliary care and those direct conversations with service users has taught them and us a lot
about what training and support we need to provide to the wider group so, as I said before, they're really excited about it, they see that as an important part of what they do. It also means, on a very practical basis, that I suppose, Experts
by Experience can do more, can have more activity, can do more things and I think that's important as well.
That's good to hear. Can I just ask a supplementary? Does that training include a focus on inequalities? As this is a big issue for us
going forward and want to make sure that our Experts by Experience are reflecting the people we are serving. It does and, as Choice Support, who are a strong leader on understanding inequalities in different types of health and care situation from their other work, have
been working closely with those central organisations about how to give people the right information, the

right support to do that. So it absolutely does include a look at inequalities and access. It includes support people whose first language isn't English, it also supports a wider
conversation about why and how they access services so it's a much richer picture than perhaps the picture we got when we were on inspection talking to service users, and that richer picture, I think, will help us in our regulatory activity. Thank you. Great. Ted,
I think this is… and colleagues, this is really, really again another exciting development and I can't speak but I can congratulate you all on what's been achieved so far. So, Imelda, welcome and sorry we are running slightly out of schedule but you won't be

Healthwatch England Update

surprised by that. And, Robert, can I come to you on the Healthwatch? Yes. Thank you. I won't steal Imelda's thunder too much but, firstly, I'd like to pay tribute to the immense work she and her team have done under quite challenging circumstances, as everyone
has, and the work of the organisation really has gone on pretty seamlessly, bearing in mind that fact. I'd just like to draw attention to perhaps a couple of things which, I think, directly affect the CQC. You will see from Imelda's report which she may
talk about in detail a bit, we've started a conversation with the Department of Health and Safe Care about the funding of local Healthwatch, which is Byzantine to say the least, and doesn't really enable the Department of Health to work out whether it's getting value
for money but has led to a slow erosion of the money that's actually getting through to local Healthwatch and this at a time when there is an increasing appreciation, both in the department and the system generally, but also CQC, I would say, as to
the value of local Healthwatch in terms of the information it can provide. So I'm hoping that there will be improvements, it's too early to say - those conversations are at an early stage but it is something I think that could directly affect CQC. Secondly,
we, as a committee, have made it our business, I think, to ensure that the Equality, Diversity and Inclusion agenda is absolutely integrated into everything we do. So we are now asking that every report that comes to us in relation to work being done includes
the impact that work is having in that particular area, both internally and externally, so far as Healthwatch England is concerned. And finally, I'd like to report to you that we too, like CQC, have appointed a Freedom to Speak Up Guardian who gave an illuminating
presentation to our last committee meeting. So I'd like to assure you that every part of what is, in effect, your organisation, is now fully signed up to the Freedom to Speak Up agenda but I'll hand over to Imelda to deal with the report generally.
Thank you, Robert. I won't go into too much detail because you've got a written report there and I can see that you've got a very full agenda today, and I am actually quite pleased that you've overran because I got to hear that very interesting
discussion, so thank you very much for that. There's just a few things that I would highlight: we continue to share the insight that we receive from the public with whole parts of the system and last week published our latest one. It won't surprise any
of you to know that the biggest issue that's coming up from the public is about reintroducing different types of treatment and surgery; that's coming through very strongly, the anxiety from the public, the poor information, access to treatment. We've been doing some work with Chris
Moran NHS England who is leading on the elective surgery part of this to make sure that we get the messaging right and I think they're doing quite an impressive piece of work on that. Another piece of work I'll just highlight quickly for you is
a piece of work that we've been doing on hospital discharge. When COVID hit we got the rapid hospital discharge - the 2-hour turnaround. So we wanted to find out what that was like for people and what was good about it and what could be
improved and, again, working quite closely with NHS England and with the people who drew up that guidance, we've gone out through 107 local Healthwatch, so 107 parts of the country have responded. We've done a combination of getting information back from people who are directly
affected but also interviews with people who work in the sector, either as care workers in care homes, social workers who are making the decisions, the people who are dealing with the rapid hospital discharge, so we

got quite a rounded picture. We're just doing the
analysis of that and we'll be publishing that in the next few weeks. Again, working really closely with NHS England so that we're helping understand all that in time for winter and the demand going up on the NHS again. Just also, a piece of work
I think you'll be interested in: we published a report which was about people's experience of the rapid change towards the digital access to primary care, to GPs in particular. The report is called 'The Doctor Will Zoom You Now' and that's laid quite a good
foundation for us in understanding what people really like about it and what needs to be improved. We're, at the moment, scoping to do a piece of work and we're talking to all the relevant stakeholders to look at how we can make sure that no
one is left behind in the move to digital. Who are the people likely to be left behind? How can we make sure that we work with them to make sure that they get full access to care? So I think that's it. The final thing is that our work with the network is incredibly vibrant. I mean it's been growing over recent years but during the COVID pandemic, it's been really interesting, the engagement has been fantastic; we couldn't ask for better. There's a real lively debate all the time across
the organisation's real, proper, sharing of information which I don't think we had that sense of community; it takes years to build real community but I really feel it's building so I am very, very pleased about that. And we're in the middle of planning for
our annual conference which we've moved online. The main theme with that will be around equalities and on what role Healthwatch across the country can play in reducing inequalities. So far we know that we've got the Secretary of State is going to open it and
Sir Michael Marmot will be doing the opening speech. So we've got quite an interesting four-day long online conference so you might have to pick me up at the end of those four intense days. And then, finally, we're working very closely with the committee and
staff on refreshing our strategy which is now halfway through the one that was set two and half years ago, so we're looking to see what's the directions that we should put in place and so that process is well underway at the moment. They were
the things I thought I'd highlight for you. I am very happy to take questions or comments outside of this meeting if you're short of time. Thanks, Imelda. I'm just trying to get my mind around a four days conference on video, I'm struggling with a
one-day board meeting if that's any… I think you might find Robert and I fast asleep somewhere in a darkened corner at the end of that week. Actually, it's four and a half days because we'll probably have awards on the final day. Well, send us
a postcard and let us know what it was like. Does anybody want to… It was a brilliant written report, as well, so you have covered a lot of ground. Is there anything anybody wants to to raise? Mark, you've got your hand up but I
think that's from a previous thing. Ted? Yes. Imelda, thanks for the report. It's really, really fascinating to hear but The Doctor Will Zoom You Now is, as Rosie said, a great report. I suppose my concern is that an awful lot of virtual consultations are
actually phone calls; they're not digital. I mean everyone says it's digital and virtual technology but, in truth, an awful lot of outpatient clinics are being done on the phone these days and I suspect in primary medical services as well, it's on the phone. I
just wonder whether we should be, you know, not including all virtual consultations as one and whether you've got any sense about people's perception of that. Well, that's a very good point. In fact we decided to do this piece of work because of the move
to online and telephone triage anyway. So we had decided to do this as part of our work plan but then with that rapid move to online and on phone initial triage, we thought we'd step it up and what we're really interested in is if
it's causing widening inequalities in any parts. That's our focus and, yes, it will cover phone, video, and all those methods. Good. Mark? Yes. I did want to ask another question, Chairman. Imelda, great report, as always. I zoomed in on The Doctor Will Zoom You
Now. I'm just thinking that this report that you're going to bring out on the potentially excluded groups, if we look at the previous reports you've produced, such as maternity and mental health, and I always remember the transport report with just these incredible patient stories

embedded into the report that actually created some traction with NHSE, so I would really hope that the report on the potentially excluded groups will have that richness because I certainly can relate to some of the frustrations of the the Zoom process that to you're
alluding to in your report, so I really look forward to that. Thank you and, yes, it will. In fact we've seconded somebody in from the network to do some in-depth work on working through local Healthwatch to very excluded groups so that we can get
some real insight and people stories because I think you're right, that's what changes your heart and mind. Yes. Thank you. Could I just add to that particular point, Peter, if that's ok? Yes, of course. Because I just wanted to say thank you to Imelda, because Jacob
Lant joins our Primary Care Quality Board Meetings and has been really helpful and we discussed this yesterday and we're going to be doing some specific work with Jacob as to how we can pull together what we're doing around making sure that people get… This
is particularly around accessing primary care and pulling in those local stories and local knowledge that you have so we can make sure that we can address it as appropriate. That's great. Yes. Great. Imelda, thank you very much. Seriously, really, really good written report which I think
we all enjoyed reading. Good, quick presentation now. Wish you every success with your four and a half days and rapidly counting conference but thank you. You're very welcome. Thank you. And do stay with us for the rest of the board meeting if you want to. We move on now to the response to

CQC's Response to the Independent Medicines and Medical Devices Safety review

the independent medicines and medical devices safety review. I think Matthew Tait's joining us. Matt, you're welcome but, Ted, do you want to start? Yes. So thank you for this. This was an important report that came out in July of this year and I think
what we want to present to the board now is really some assurance that we're dealing with the immediate issues that were raised in the report, the recommendations to the CQC but also a recognition that the underlying issues in this report reflect similar underlying issues
from previous reports and that the challenge is not just to deal with the immediate recommendations but to tackle some of the underlying issues. So in a sense, there's a temptation just to deal with the symptoms of the problem rather than the underlying causes and
I think the challenge is the underlying causes and what Matt and his team have done is drawn out some of the underlying themes from this report and from the Patterson Report and the Gosport Report, all of which have occurred recently but I suspect if
we'd look back for previous reports, including Robert's report on Mid Staffs, we would have similar underlying themes in all of them, quite honestly. And I suppose the real message here is the system, as a whole, including us as CQC, have not tackled sufficiently the
underlying themes with the result that individual failures occur and we keep coming back to just dealing with the immediate process of the failure and don't address the underlying issues. And the underlying issues that we've identified here and, clearly, this is the analysis we've come
to are, kind of, outlined at the start of this paper, where there's a sense of the system doesn't involve patients effectively as equals in their care and when things go wrong, patients find it very difficult to be listened to and we don't listen to
patients' concerns. When things do go wrong, the system tends to act defensively and gets into a mindset of blame and trying to find fault and then that moves to an issue of just identifying individuals to blame for particular problems, rather than looking at the
system issues beyond it. There's an inability in the system to monitor concern, so, in all these cases, there was a sense of: the evidence was there, why did we not pick it up? Why did we wait for the patients to form lobby groups and
to actually have to fight very hard to be listened to before we recognised the problem? And then there's another issue that comes out of all these reports and that is that the regulatory framework is enormously complex in healthcare and we've discussed this previously as
a board and there's a sense of, does it act in a coordinated way to deal with problems or is it still too uncoordinated? And is there a role for us, as CQC, to bring the regulators together so we can act in a much more
coordinated way when things are problematic? So that's briefly all I wanted to say about this, about these

underlying issues. I mean, clearly, we need to consider these when we come to consider our strategy going forward. I think we've touched on some these already but
I think there's an opportunity perhaps to address it again on the basis of this summer's report. I think, in terms of the detail recommendations involved - as in the report - they're outlined in the annex and we will be producing a summary of our
actions in response to those in due course and bring them back to the board. That's all I want to say. Matt, is there anything else you wanted to add? No, you've covered everything I was going to say. Thanks, Ted. So I guess the other
way of looking at this, through the other end of the telescope, is that as we've developed a strategy and all the other things we've been talking about throughout this meeting, do we think we have reduced the chance of just history constantly repeating itself, with
things going wrong all the time that have gone wrong in the past? So we need to probably come back and look at it from that end of the telescope, don't we, Ted? I think that's right and I think it's a big challenge, Peter, I
don't think any of this is easy and so I do think we need to test ourselves about whether we - working with others because we can't do this by ourselves - but working with others can address some of these fundamental issues because if we
don't, there's going to be another report in another couple of years about something else that we haven't spotted yet, gone wrong. And that's my concern, we've got to get on top of these underlying issues to stop these failures occurring. Yes. I agree. OK, we'll

Regulatory Governance Committee: Report of meeting on 15 September 2020

move on then. Thank you, Matt and Ted. So, Liz, the RGC meeting last night. I'm sorry I couldn't be there; I was interviewing, as you know. But you want to give us a quick read out from what you discussed? Yes, definitely. Thanks very much.
So we discussed two substantive items: the first one was touched on by Ted earlier and that was about the work that's in progress on emergency departments and the improvement agenda. And, essentially, whilst there's very good practice in many emergency departments, there are some that
haven't really improved and what this work is about is really working with the clinical leaders across the country, including those from outstanding trusts who are really doing this well, to identify what does good look like. And then drawing on that for guidance which then,
I think, people are really waiting for in anticipation to see what this guidance looks like and then coming back to that in terms of this is what we're expecting and this… you, know, it's a framework and I think we had a good discussion about
the importance of that sort of positive, proactive work that is positively motivating. Alongside, of course, using enforcement powers where that's necessary but enforcement is always kind of after the event and sometimes has a less systemic impact. I think that the committee's view was very
supportive of this work and supportive of the intention to address not only the leaders within emergency departments but also the system leaders who because a lot of what goes on, of course, is, you know, the flow of people whether they can leave… Whether they
need to go to A&E in the first place but also how they move through the system. So that was a very positive discussion. We then had a discussion about both Experts by Experience and the wider question about how people's voices and views and engagement
are part of our methodology and our future plans, and we talked about how the plans for Experts by Experience to be deployed in different ways because there's less use in inspections because we're not doing so many inspections at the moment. For example, supporting, securing
user voice in different, sort of, pilots that Kate was talking about earlier with home care and that type of work. But we also, sort of, talked more broadly about the huge significance of being able to bring together and analyse all the different kinds of
personal evidence and information and views that come in through lots of different, sometimes fragmented, routes into CQC but being able to turn that - both the sort of qualitative and quantitative material in that - into a dashboard that can be easily used as part
of our future methodology and also, of course, more proactively working with people with lived experience in a kind of mode of co-production when we're developing regulatory approaches and going out proactively

when we're looking at particular places or particular types of service, etc. So it
was a good discussion that I think said the voice of service users and families is a core part of the intelligence that we need to be properly intelligence-driven. It enables us to triangulate what the different players in the system are saying and it's important
to give weight to that experience of service users alongside the weight of providers or other people in the system and I think it was a rounded and very lively and good discussion, I think. So, hopefully, it can feed into our future operating model and

Any Other Business

strategy. Good. Thank you. Right, so is there any other business? So in the absence of any other business, it takes us on to questions from members of the public and you may remember at the end of the July board, we were asked whether there was a way, through
a different use of Teams perhaps, that we could improve the experience for people wanting to watch the public board meeting while we're not able to meet in person with them in the room. I just wanted to say to anybody that's interested in this, that
I don't have an answer at the moment but we are looking at a couple of options and we'll come back hopefully by the next board meeting to say what we think we can do, if anything, in this space but it's certainly not forgotten. We
then had got two questions from Robin Pike that are new to this meeting. The first is: How does CQC explore patient experiences in making formal complaints to NHS hospital trusts? Patients seem to find that it takes at least nine weeks to get a response
and is generally difficult. Ted, I don't know if you could answer that one? Yes. Thank you, Peter. So response to complaints is a feature of our responsive key question and there are key lines of enquiry that address that and, as part of our inspections,
we would always look at a service's response to complaints to make sure they are responding effectively and where we find problems with that, we will ask for improvement in the service. Well-led, we look at how the process of managing complaints is managed and that
includes how timely the responses are and the learning that comes from complaints. So we also look at well-led to make sure that the process for managing complaints is satisfactory and as part of every inspection, every comprehensive inspection, we would look at a sample of
complaints, just picked at random, so they're not selected in any way, and just to see how effective the response is in terms of the quality of the response, but also how well the process has been managed by the trust. And again, if it's not
being managed well, we would include that in the improvements we ask the trust to make. So we do look at complaints routinely as part of our inspections and, quite honestly, it's quite a frequent area where we have to ask for improvement. So I think
that reflects Robin's concerns about this and I think it's an area we need to keep focused on going forward. Great, thank you, Ted. And then the second question was how does CQC monitor the requirement to prominently display ratings within surgeries and care home premises? So it's both
surgery and care homes, so, probably similar answer but Rosie and then Kate, please. Rosie? Yes, certainly, Peter. So our inspectors always check the current ratings are displayed in GP practices through both their monitoring and their inspection activity. Usually for GP practices we would expect
that this includes the display of ratings on the practice website. Practices who fail to display their ratings would be reminded to do so before we took any formal action. We can and we have issued penalty notices to those who persistently fail to display ratings
but this is rare. Thanks and, Kate, similar for you? Yes. So nothing particular to add, so the same approach in adult social care. Great. Well, we're only running about an hour behind where we should have been but that is the end of the public board meeting. Thank you all
very much indeed. Do we want a five-minute break or do we want to go straight on? A couple of nods, so look, literally five minutes and then we are going to go through the rest of the agenda without any breaks, even if we're still
here at midnight. So just to concentrate your minds but five minutes now. We're starting at 14:40.