Agenda Item: 2
Paper No: CM/01/21/02

Minutes of the Public Board Meeting
Meeting held by video conference (MS Teams)
15 December 2020 at 11.30

Present

Peter Wyman (PW)	Chair
Edward Baker (EB)	Chief Inspector of Hospitals
Rosie Benneyworth (RB)	Chief Inspector of Primary Medical Services and Integrated Care
Robert Francis (RF)	Chair of Healthwatch England and Non-Executive Board Member
Jora Gill (JG)	Non-Executive Board Member
Paul Rew (PR)	Non-Executive Board Member
Mark Saxton (MSa)	Non-Executive Board Member
Liz Sayce (LS)	Non-Executive Board Member
Kate Terroni (KT)	Chief Inspector of Adult Social Care

In attendance

Rebecca Lloyd-Jones (RLJ)	Director of Governance and Legal Services
Naomi Paterson (NP)	Head of Governance and Private Office
Laura Ottery (LO)	Advisor to Chief Executive
Martin Harrison (MH)	Senior Corporate Secretary (minutes)
George Kendall (GK)	Corporate Secretary (minutes)
Chris Day (CD)	Director of Engagement
Mark Sutton (MSu)	Chief Digital Officer
Chris Usher (CU)	Director of Finance, Commercial, Workplace & Performance
Julia Corrigan-Davies (JCD)	Equalities Network Representative
Professor Glynis Murphy (GM)	Author of second independent report into CQC inspections and regulation of Whorlton Hall (item 4)
Mary Cridge (MC)	Deputy Chief Inspector of Adult Social Care (item 4)
Imelda Redmond (IR)	National Director at HealthWatch England (item 7)
Ruth Heron (RH)	Academy Learning Consultant – Lead for Strategy and Intelligence

ITEM 1 – APOLOGIES & DECLARATIONS OF INTEREST

1. PW welcomed Board members and other attendees. Apologies had been received from Ian Trenholm, Chief Executive Officer, who had suffered a recent family bereavement, and Kirsty Shaw, Chief Operating Officer, who was unwell. Board sent their condolences to Ian and also wished Kirsty a speedy recovery. There were no new declarations of interest. PW welcomed Julia Corrigan-Davies, from the Carers Equalities Network as the Equalities Network representative for this month.

ITEM 2 – MINUTES OF THE MEETING HELD ON 18 NOVEMBER 2020 (REF: CM/12/20/02)

2. The minutes of the meeting held on 18 November 2020 were accepted without amendment.

ITEM 3 – MATTERS ARISING AND ACTION LOG (REF: CM/12/20/03)

3. The action log was noted. MSa reported that he was in contact with KS regarding the launch of the Success Profiles (action 1). There were no matters arising.

ITEM 4 – CQC INSPECTION AND REGULATION OF WHORLTON HALL: PART 2 (REF: CM/12/20/04)

4. PW introduced Professor Glynis Murphy and thanked her for producing her report into CQC's inspection and regulation of Whorlton Hall. GM presented part 2 of the report, highlighting the progress that had been made by CQC, despite the challenges posed by the COVID-19 pandemic, and noted the number of closed cultures workstream activities underway or that had been completed.

5. GM reported that, against all six recommendations from part 1 of the report, CQC had made progress, particularly noting the following areas: development of closed cultures indicator dashboards, the completion of more unannounced and out of hours inspections; improved sharing information with other organisations; Mental Health Act Reviewers had completed extended virtual interviews with those who had lived experience of closed cultures; inspectors had been trained in the Talking Mats method to improve their communication with individuals who had limited communication skills; progress on identifying when a more thorough level 2 inspection of service would be triggered due to concerns of a closed culture; and the implementation of the Right Support, Right Care and Right Culture report. This work was to be welcomed but it needed to continue. KT added that work was progressing with Warwick University to develop a quality of life tool to ensure service users had a person-centred care plan and that twice monthly calls with inspection colleagues had been taking place to answer queries or questions about the regulation of closed cultures.

6. GM had completed a review of published research and had identified 48 directly relevant studies, noting that there was cross-over in some of the literature with people management organisational development themes. It was also noted that two-half day workshops were completed with CQC colleagues where academics who had written some of the papers on the detection of abuse presented their findings.

7. GM presented to Board the recommendations from her second report drawing particular attention to the following:
   - The recommendation from the RSS report of not rating a service as Good or Outstanding if they had a high level of restraint, seclusion or segregation should be extended to services which cannot demonstrate how they are supporting whistleblowers.
   - CQC should trial the quality of life tool to enable a focus on outcomes and quality of life during inspections and the Group Home Culture Scale to see if it supported inspectors in identifying closed cultures.
   - The need for guidelines to be developed on the use of surveillance technology.

8. In response, KT welcomed the report and paid tribute to the families who had campaigned to improve outcomes for their loved ones, affirming that there was not only further work for CQC but also for the wider health and care system. On future work into closed cultures, KT reported that CQC would be leading on a programme to identify unacceptable care across the health and social care sector and would use its regulatory powers to ensure that people received appropriate care. Work would be led by Debbie Ivanova, Deputy Chief Inspector in Adult Social Care. In registration, there would be a focus on consistently applying the principles set out in Right Support, Right Care and Right Culture and, in relation to monitoring, CQC would aim to strengthen and improve how it heard directly from those using services and their families and would use this information to inform the location and length of inspections. KT added that there would be a focus on more in-depth inspections to capture service user views which would be described in more detail within reports along with an improved description of culture and if any restrictive practices occur within the provider. From the beginning of 2021, CQC would revisit every service that was currently rated as Inadequate or Requires Improvement to review the standard of care being delivered and to consider if other action was needed. On enforcement action, CQC would be stepping up use of its powers in particular, restriction of admissions to a service where care was inadequate and there was evidence of restrictive practices. KT also noted the opportunity for further exploration of academic research into the links between culture and abuse in organisations.

9. Board members recognised the need to monitor CQC progress towards the recommendations and three areas where there should be a particular focus were suggested: how CQC hears from those using service and their families and how this information was used; ensuring CQC received reliable data and evidence relating to restraint, segregation and seclusion; and ensuring CQC was using its full range of regulatory approaches to identify and act on evidence of abuse.

Decision: Board welcomed the report and would consider how best to take forward the recommendations.

ITEM 5 – EXECUTIVE TEAM REPORT (REF: CM/12/20/05)

10. Executive Team members presented the report to Board. The following matters were highlighted:

11. *Infection Prevention Control (IPC), Designated Settings and Systems Pressures* – KT updated Board on the IPC inspection activity completed and plans to focus on risk-based inspections in the coming months. KT and CD reported that CQC would continue to provide weekly reports to the Department for Health and Social Care (DHSC) on emerging IPC themes and risks within health and social care systems to support decision making at both a national and regional level.

12. *IPC in hospitals* – EB reported that CQC had continued to monitor the COVID-19 situation in hospitals and, where specific issues were identified, inspections had been completed and where necessary, enforcement action had been taken.

13. *Emergency Departments (ED)* – EB updated Board on the COVID-19 challenges faced by Eds, including the impact on patient flow within the hospital and the resulting crowding and delayed ambulance handovers. CQC would continue to monitor the situation and, where necessary, would complete risk-based IPC inspections and take enforcement action where instances of poor practice were found. It was noted that some ED clinicians had developed their own Patient First self-assessment tool to ensure they were using the guidance effectively and would be sharing this with their fellow colleagues.

14. *Maternity Department Inspections* – EB emphasised that, particularly in light of the findings of the Ockenden review, maternity services needed to focus on safety. CQC would be inspecting and assessing the safety of services and would be working with NHS Improvement and other partners to improve safety in maternity services.

15. *DNA CPR Thematic Review* - RB thanked stakeholders for their involvement and contribution to the interim report and reported that the review would share learning and encourage best practice. The final report would be published at the end of February. RB emphasised that people should be supported to take part in the decision-making process and have conversations about their wants and wishes at the appropriate time.

16. *Provider Collaboration Reviews (PCR)* – RB reported that CQC would be embarking on the next programme of PCRs which would focus on cancer services.

17. *COVID-19 Vaccination Programme* – It was noted that CQC was considering its role in relation to the vaccination programme and that CCGs had a clear assurance process on the set up of vaccinations sites. RB confirmed that there were no specific plans around monitoring the effectiveness of communication related to vaccination but, if specific concerns were raised or identified about a vaccination site, these would be followed up.

18. *Performance Report (Oct 2020)* – CU explained that the £1.5 million shortfall on provider income was caused by a variety of reasons including providers leaving the market. The impact CQC finances was being tracked and the income variation was configured into future financial modelling. On the aged debt position, CU confirmed that this was being tracked and that figures remained within KPIs.

19. *2019-2020 Annual Report and Accounts* – PR noted that audit work was ongoing related to the valuation of local government pensions schemes and asset liabilities and this was causing continued delay in publishing the 2019-20 Annual Report and Accounts. It was noted that this was a wider auditing issue and not related specifically to CQC.

20. *Chief Digital Officer's Report* – MSu reported that there were no information or cyber security issues to raise this month.

21. *Recent publications: Community Mental Health Survey (CMHS)* – EB reported that CMHS had surveyed 17,000 patients pre-pandemic and that it was the poorest performing survey on patient perception of care received. It was noted there was increasing concern that mental health services were not joined up effectively and CQC would be taking a pan-sector approach to examine the whole mental health pathway to see what it could do to encourage a joined-up approach. RB added that there would be an opportunity to look at a more holistic approach for care and support for people with mental health problems with the developing primary care networks and the place agenda. The mental health PCR workstream next year would provide an opportunity to capture and share best practice.

Decision: Board noted the Executive Team report.

ITEM 6 – COVID-19 INSIGHT REPORT 6 (REF: CM/12/20/06)

22. CD presented the sixth insight report to Board highlighting two areas of focus in the report in addition to the regular data appendix.

23. The first area of focus was regional data on designated settings. CD explained that the report contained a breakdown of the number of approved settings according to region and the number of designation beds covered by alternative arrangements. The numbers identified a wide variation and would provide an opportunity to understand why happened as well as identifying where potential

pressures might be in the different parts of the system. The second area of focus was on the urgent and emergency care PCR findings. CD reported that, where provider relationships were good, joined up decisions were faster with improved outcomes. Providers had expressed concern about staff resilience however, there were notable examples of collaborations between providers to ensure staff levels were managed well across the system. It was also noted that digital technology was used more widely and that some systems attempted to address some of the negative impact around service user choice and inclusion.

24. On access to services, it was reported that some people missed out on the care they needed either due to a lack of capacity or the closure of some services, particularly in the areas of mental health, dental and primary care. RB confirmed that CQC would continue to monitor access to dental services and that work had begun on a small-scale pilot in London to better understand issues.

25. On designated settings data, CD explained that CQC had continued to register designated settings without delay and that the information included in the report suggested a potential shortage of provision however, it was noted that this was due to bed capacity being unknown in alternative settings. This would be revisited once further information was provided on bed capacities in alternative settings and how this impacted the number of people who needed to be discharged from hospital.

26. CD reported that workforce wellbeing was a concern shared across the system and the Insight report aimed to raise concerns but also share good practice, showing how systems were working well together to deal with staff and capacity issues. It was noted that conversations were ongoing with NHS England on how Integrated Care System leads could be brought together in order to share best practice. The need for good system-wide workforce planning was emphasised. Good culture within providers and systems was also highlighted as important in ensuring staff felt supported and valued.

27. On inequalities within present systems, CD reported that they were present for both staff and those using services, but also noted that there were examples of good practice around how inequalities were managed. RB confirmed that, going forward, PCRs would consider inequalities and would aim to identify what good practice was in place to address them.

Decision: Board noted the COVID-19 Insight Report.

ITEM 7 – HEALTHWATCH ENGLAND UPDATE (REF: CM/12/20/07)

28. RF and IR presented the Heathwatch England (HWE) update as set out in the written report.

29. HWE had continued to publish stakeholder updates and completed work on care home visiting guidance. The annual conference had been a success, attended by over 500 people. IR acknowledged the close working and the information sharing with CQC and

noted an opportunity to work with CQC on future projects, including on the mental health PCR. The hospital discharge project was also highlighted and IR emphasised the value of the work in being able to understand people's experiences of rapid hospital discharge and then share this with NHS England to enable them to learn and support the development of their winter planning.

30. Future work would include a focus on inequalities following the move to digital services in health. There were also plans to build Healthwatch capacity at a local level.

Decision: Board noted the Healthwatch England update.

ITEM 8 – ANY OTHER BUSINESS

31. It was noted that this would be Paul Rew's last Board meeting before his term of appointment came to an end on 31 December 2020. On behalf of the Board, PW thanked PR for his contribution to CQC, including his role in chairing the Audit and Corporate Governance Committee.

32. There was no further business

Questions from the public

33. Time allowed for the following questions from members of the public.

34. Robin Pike raised two questions: *'How does CQC plan to regulate the provision of Covid vaccinations by GPs?'; and 'How does CQC intend to monitor the performance of 111 services now that it has an additional responsibility for booking A&E appointments?'* On the first question, RB explained that CQC would be taking a risk-based approach to inspecting vaccination sites and would follow up any concerns, including any relating to access. On the second question, RB reported that CQC received and monitored sit-rep data from NHS England, completed regular engagement with ED consultants and urgent care specialists and with NHS England, as well as triangulating data from CCGs, providers and other parties. RB confirmed that the transitional regulatory approach had been rolled out in urgent care and that CQC would be contacting services that provided 111 services to assess the impact of the roll out of 111 First.

35. The meeting closed at 13.42.