

**Minutes of the Public Board Meeting  
Finsbury Tower, London, EC1Y 8TG  
21 January 2015 at 09.00**

David Prior (DP)	Chair and Commissioner
David Behan (DB)	Commissioner and Chief Executive Board Member
Louis Appleby (LA)	Commissioner and Non-Executive Board Member
Paul Bate (PB)	Commissioner and Executive Director of Strategy & Intelligence
Steve Field (SF)	Commissioner and Chief Inspector of General Practice
Mike Richards (MR)	Commissioner and Chief Inspector of Hospitals
Kay Sheldon (KS)	Commissioner and Non-Executive Board Member
Andrea Sutcliffe(AS)	Commissioner and Chief Inspector of Adult Social Care
Paul Rew (PR)	Commissioner and Non-Executive Board Member
Paul Corrigan (PC)	Commissioner and Non-Executive Board Member
Robert Francis (RC)	Commissioner and Non-Executive Board Member
Camilla Cavendish (CC)	Commissioner and Non-Executive Board Member
Jennifer Dixon (JD)	Commissioner and Non-Executive Board Member

**In attendance**

Eileen Milner (EM)	Executive Director of Customer and Corporate Services
Hilary Reynolds (HR)	Executive Director of Change
Rebecca Lloyd Jones (RLJ)	Legal Advisor to the Board
Alexandra Jones (AJ)	Board Secretary
Dr Jonathan Fielden (JF)	Chair of CQC's inspection of Hinchingsbrooke (item 4)
Fiona Allinson (FA)	Head of Hospital Inspection (item 4)
Tracey Dennison (TD)	HR Lead (item 4)

**ITEM 1 – WELCOME, APOLOGIES & DECLARATIONS OF INTEREST**

1. The Chairman opened the meeting. Apologies for absence had been received from Michael Mire and Anna Bradley. There were no interests declared.

**ITEM 2 – MINUTES OF THE MEETING HELD ON 17 December 2014 (REF: CM/01/15/02)**

2. The Minutes of the meeting held on 17 December 2014 were reviewed and agreed.

**ITEM 3 – MATTERS ARISING AND ACTION LOG (REF: CM/01/15/03)**

3. The Action Log was noted without further comment. There were no matters arising.

**ITEM 4 – CHIEF EXECUTIVE'S REPORT (REF: CM/01/15/04)**

DB introduced the Chief Executive's report, moving straight to a presentation on the Hinchingsbrooke inspection (item 4 in his report). Dr Jonathan Fielden (JF) and Fiona Allinson (FA), who had led the inspection, were in attendance. JF was a doctor with experience in intensive

care and currently Medical Director at University College London Hospital. FA was a registered nurse, experienced in critical care in the NHS and the private sector, then an inspector at the Health Care Commission and CQC. She had worked in regulation for ten years, and participated in nineteen inspections under CQC's new methodology. Both spoke further about the inspection findings.

They highlighted two key aspects, namely the process and the issue of possible conflicts of interest. To place the inspection in context, MR noted that this had been CQC's sixty-eighth 'routine' inspection, and had been expected to be 'low risk'. The inspection team had been substantial, with 29 people, including 6 CQC inspectors, 8 doctors, and 11 nurses or midwives.

The CQC team had been shocked by what they found. FA had immediately reported concerns to MR, and the Trust had been advised to reduce pressure on Apple Tree Ward immediately. There were major concerns regarding Accident and Emergency and surgery, which were found to be inadequate. A series of meetings had taken place with the Trust and Circle, and normal processes and communications had been followed. The final report was sent to the Trust on 5 January 2015, and special measures were recommended. Ruth Rankine had also been present as an observer, and she had confirmed her view to MR in advance of this meeting that the report was fair, and that there had been no bias on the part of the team, as observed through the team's 'corroboration and challenge' process.

The team had not anticipated the problems they encountered at Hinchingsbrooke. The inspection team had a good group-working dynamic and focused on patient interests and appropriate care. They found that neither the concerns of patients nor of staff were being heard by management. There was a lack of clarity between the Trust Board and Circle regarding accountability for quality, with each claiming the other party was accountable. When the CQC team highlighted serious concerns, they were surprised that the Trust did not respond more swiftly. The Trust's response to CQC's concerns was not one of 'appreciative enquiry' and constructive challenge, but of denial.

FA had contacted MR during the inspection, raising her concern that this was one of the worst situations she had ever witnessed. The inspection team had observed disrespectful and abusive behaviour by carers, and serious understaffing, especially on night shifts; the team observed patients being painfully manhandled or verbally abused by nurses; care delivered in A&E and on surgical wards was poor, the response to call bells was too slow, and there were no paediatric nurses on A&E. The staff-patient ratio in A&E was barely the minimum. Patients were told to 'soil the bed' because staff could not get to them in time; doors to medication rooms were left open, and not immediately closed, even after inspectors raised concerns. JF noted, however, that critical care and maternity were significantly better.

An urgent management review meeting on the Friday at the end of the inspection resulted in a letter instructing the Trust to reduce pressure on Apple Tree Ward immediately.

KS enquired whether the situation had now improved; FA responded that CQC's inspectors had returned on Sunday 21 September 2014 and spent time observing practice, and improvements were witnessed and corroborated by patients. CQC had visited again on 28 September 2014, but still had concerns about A&E. A further visit took place on 2 January 2015.

The Board asked for some more factual and statistical information context. MR responded that Hinchingsbrooke was a small facility, with just over three hundred beds. It had previously been placed in band 6 of intelligent monitoring. MR noted that intelligent monitoring is screening, as distinct from inspection, and would never be a 100%-accurate predictor of inspection findings. Eight Trusts had to date been put in special measures, of which two or three had not previously been banded as 'high risk'. It typically took an inspection two months to arrive at the full report stage, followed by a fact-checking stage. FA responded that the data did not provide a full picture of organisational culture and staff behaviours. The Trust had reviewed staffing levels and sought to recruit, but, like other Trusts, they had staff shortages which they found hard to fill. JF noted the additional difficulties with obtaining adequate specialist skills, as in paediatrics, especially when dealing with surges in admissions.

The main conclusion was one of very compromised safety and quality of care. MR noted that inspections took into account frequency or intensity of patient- or staff-reported concerns.

Consistency between inspections was also important. CQC employed standard lines of enquiry; guidance and criteria on what constituted 'inadequate' care; experienced and well-trained inspectors; and corroboration and challenge sessions on-site during the inspection. Each prospective 'inadequate' rating was interrogated by the team.

JD enquired, regarding CQC's 'well-led' measure, what the inspection findings had been regarding the culture of management at Circle itself. MR responded that Circle was responsible for financial rather than clinical management, and that this had not been a central focus of the inspection; CQC's concern was quality of care. The allegations that inspection staff were somehow 'anti-private sector management' were unfair and baseless. JF noted that governance oversight and challenge by the managing entity had been lacking, and staff did not feel that they could raise concerns.

DP raised the question of possible conflicts of interest, and DB clarified that the specific question had been whether the inspection team had 'any other memberships, interests or involvements', over and above the normally declarable personal or business relationships, or financial interests. AJ reminded the Board that CQC would bring a revised paper back to the Board at their meeting in February 2015, regarding Declaration of Interests (DoI) by Board members, which would offer greater clarity of guidance on categories of interests, and ensure consistency with DoI policy for staff, and now also for inspectors, special advisers and Experts by Experience, for which groups CQC was also immediately adding an additional question regarding 'other involvements'.

MR noted that, if a trust being inspected raised an objection to any individuals on an inspection team, these would be carefully considered. No such instance had arisen at the Hinchingsbrooke inspection.

CC commented that many excellent doctors held views on NHS, and were needed to serve on inspections; the issue should be transparency, not such individuals' personal views. TD added that even where potential interests might be declared, in practice such conflicts seldom actually arose.

DB then turned to other matters covered in his Chief Executive's report. He provided an update on recruitment, and the target of recruiting up to 600 additional inspectors. As of 16 January 2015, 111 successful offers had been made. CQC was just commencing recruiting inspection managers, and a campaign to recruit analysts. Concerning staff development, four courses were now being run, on subjects including mental capacity, the 'fit and proper person' test, and the duty of candour.

DB summarised for the Board that his report also provided updates on: acute ambulance trusts; progress on primary medical services; and criminal justice inspections (for people receiving care in prisons). DB and DP had also recently met with Health Watch England.

With regard to children's safeguarding, DB had responded to the DH Secretary of State in respect of his letter regarding Alexis Jay's report, and also communicating with Ofsted. CQC was reviewing our Code of Practice on confidentiality of personal information. The government's 'one year on' update on their response, 'Hard Truths', to RF's Mid-Staffordshire enquiry report, was expected soon. The Board sought clarification of CQC's role in children's safeguarding. DB responded that the roles of different organisations were evolving, and the Alexis Jay report had focussed specifically on adolescents and young adults. The key issue for CQC was to clarify our role in this area, and that was to investigate whether quality of care was present: one could not 'regulate quality into services'.

LA enquired about the leaflet on covert surveillance, for relatives of those in care; the most common situation was a person with dementia, whose relatives were asked to consent to use of cameras to monitor quality of care. AS also noted that those actually living in care homes were often less in favour of cameras than their relatives; and/or that the absence of objections did not of itself constitute consent. LA noted that there was much public interest in this area, and the issue appeared at times a little wearisome. CQC's latest draft was a significant improvement, but it not yet attained the required result. Board approval was important and should not become perfunctory or rushed. He sought assurance that there would still be time to make further amendments if needed.

AS noted this issue had last been discussed by the Board at its meeting in November 2014, during a full conversation that provided clear guidance that produced a policy statement affecting all three sectors of CQC's work. CQC had taken Board members' feedback on board. CC had assisted with the first draft, as had Mr Hogarth, a member of public present at the meeting. A difficult balance needed to be struck. PB noted that CQC had taken necessary advice from the information commissioners, and had to operate within the Data Protection Act and human rights legislation; explicit consent was important, and establishing the capacity to give consent.

The Board urged CQC to find a balanced 'middle way', providing a brief, clear and straightforward document for the public, clearly expressing what the legal position is and provide clear advice for families. CQC had a duty to customise its documents to their intended audience, explaining to the public in user-friendly terms what they needed to know.

DP drew this discussion to a close, noting that a further Board discussion was unlikely to progress matters. He requested DB to sign this off matter for the Board, after talking to LA and CC.

**ACTION: DB to confer with LA and CC, then approve a final version of the surveillance leaflet.**

**ITEM 5 – ENFORCEMENT POLICY (REF: CM/01/15/05)**

PB introduced this paper. This policy was complemented by the guidance on standards, and used to holding providers to account and encourage them to improve, using both civil and criminal enforcement sanctions. CQC's in-house legal team, and legal counsel David Lock QC, and DH had already seen this document and were content. PS summarised the four steps in the process, which were set out in the 'decision tree' in Appendix B of the paper: initial assessment, legal and evidential test, selection of appropriate enforcement action, and final review.

DP asked AS whether her team felt this process was feasible, and AS responded that lessons had been learned from the Orchid View case. The revised policy provided CQC with a much better framework, proportionate and evidence-based. However, CQC had to be mindful of the impact upon our legal, inspection and other teams, as enforcement work was extremely time-consuming.

KS enquired how CQC would prioritise and select the cases for enforcement action; whether there would be an element of 'demonstration effect' and deterrence; and if so, how CQC would respond to charges of inconsistency or of singling organisations out. The impact assessments would be of interest to the Board, to see and comment, although not for formal approval. It was important to communicate in a manner that did not intimidate front-line staff from raising concerns.

PB stated that the Board was welcome to see the assessments. He noted that CQC could not take enforcement action over every single breach, but that it had specialist enforcement inspectors, and clear criteria including seriousness, persistence, and multiplicity of breaches. CQC was in the process of instituting standards and logging systems to monitor consistency and variation, in the face of very high workloads; and instituting team training at Levels 1, 2 and 3, planned for introduction from April 2015. Attention would also be paid to defining reasonable timeframes for expecting corrective or remedial action.

**ACTION** – DP noted that DB was to finalise and sign off the agreement with the Health and Safety Executive.

**ITEM 6 – FORWARD PLAN (REF: CM/01/15/06)**

The forward plan was accepted without discussion.

**ITEM 7 – ANY OTHER BUSINESS**

There were some questions from the floor. Mr Pike enquired, regarding intelligent monitoring, how 'never events' were captured, and PB responded that there was an absolute requirement that they be reported.

Mr Pike enquired how many inspections of CAMHS (child and adolescent mental health services) there had been. MR responded that there had been nine such inspections, which constituted a core service and were included in the scope of inspections.

Mr Hogarth commented that the report on surveillance was an improvement, but urged that CQC should be encouraging use of every available piece of evidence, and that individual homes and care providers should not be allowed to ban cameras.

There was no further business.

**CLOSE**

The meeting closed at 11:10.

Signed as a true and accurate record

Chair ..... Date .....