

MEETING	PUBLIC BOARD MEETING 20 March 2019
Agenda Item Paper Number	4 CM/03/19/04
Agenda Title	Executive Team report to the Board
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PURPOSE OF PAPER:

This is a paper for the Board to **note**.

Introduction

The report this month provides an update on the following matters:

1. Performance report: January 2019
2. Sexual safety on mental health wards report: 6-month update
3. Preparing for the UK's exit from the EU
4. Parliamentary activity
5. Recent publications
6. Upcoming publications
7. Information and cyber security risk

Chief Executive's report
1. Performance report: January 2019

Board is asked to note the changes to performance indicators in 2019-20 detailed in the separate Business Planning paper on this agenda.

On Plan Performance

- a. We are on plan against our re-inspection targets in PMS and Hospitals with at least 90% of inspections taking place within the frequency rules we have committed to in our Business Plan. Our National Customer Service Centre responsiveness indicators remain on track and we continued assurance that more than 90% of services in breach have an action in place, either and inspection in progress or planned or enforcement action.
- b. Year to date PMS has published 91% of reports within 50 days, the first directorate to meet this target. And although under plan year to date, ASC also met a milestone publishing 90% of reports on time in December and January (91%). Year to date, Hospitals has published 58% of reports overall, which is under plan but continues to show improvement and exceeds the PAC commitment of 50%.

Under Plan Performance

- c. Year to date **timeliness for registration** (Annex 1, slide 7) stands at 69% for new applications against a target of 80%. Performance of variations and cancellations remains consistent at 89% against a target of 90%. On-going improvement projects are contributing to better performance, but some areas have noted increased demand, for example, there have been 471 Notices of Proposal (typically for refusals), compared with 377 in the same period last year.
- d. Year to date performance stands at 94% for **Safeguarding (Annex 1, slide 13)** Alerts referred to a Local Authority within the one-day compared with a target of 95%. January performance stood at 95%. Where a mandatory action should be taken within 5 days in response to a Safeguarding Alert or Concern stands at 90% for the year, against a target of 95%. The Safeguarding and Responding to Concerns Committee continue to implement process improvements.
- e. **Inspection activity per inspector** (Annex 1, slide 9) continues to be under plan however, as expected, there has been a significant increase following the Christmas period. This indicator is being changed for 2019/20 and will be replaced by a 'weighted unit or activity' measure consistent with the NHS.
- f. This year there have been 9,862 **ASC inspections (Annex 1, slide 15)**, of which 76% of 4,399 Good or Outstanding services were undertaken within agreed timescales, against a target of 80%. 62% of 3,097 inspections of Requires Improvement or Inadequate services were undertaken within agreed timescales, against a target of 90% (up from 57% at the end of Q2). Notably of those inspections outside plan around a half are undertaken within one month.
- g. Our **inspection reports (Annex 1, Slide 11)** commitment is to publish 90% within 50 working days (65 for Hospitals NHS reports with 3 or more core services). Year to date, CQC performance stands at 85%. There has been a consistent quarter on quarter improvement which has continued into January with 91% of reports published within 50 days. Analysis of the backlog of inspection reports, (or 'In Progress' reports) has been undertaken to assess if this performance is sustainable. It shows a notable decrease in the volumes across all sectors and a significant decrease in reports aged 75 days or more. Overall there is assurance that performance in this area is improving on the back of the improvement project initiated last year.

Executive Team Performance Focus – Board update

- h. The ET Performance Deep Dive this month was a follow up to a previous one on enforcement. ET considered the work that was underway to address inconsistencies of enforcement processes. Heads of Inspection from each directorate presented interventions, including training, improved guidance and process and system changes to make the process easier and more consistent. They also reviewed information about the timeliness of our actions considered to be urgent and agreed to commit to a target for urgent actions in our 2019/20 Business Plan. A further detailed paper on enforcement priorities will be presented to the Executive Team in April.

Appendices Annex 1: Performance Report – January

Chief Inspector of Adult Social Care's report

Nil report

Chief Inspector of Hospital's report**2. Sexual safety on mental health wards report: 6-month update**

The sexual safety on mental health wards report was published in September 2018. Since then the following activity has taken place:

- *The establishment of an arms-length body oversight committee* – The committee meets every other month and is attended by relevant arms-length and other national bodies (NHS Improvement, NHS England, Health Education England, Royal College of Psychiatrists, Royal College of Nursing) and is chaired by CQC. These bodies were consulted and contributed to the recommendations in the report. It monitors the progress being made on each of the recommendations for action;
- *The establishment of a sexual safety collaborative* – NHS Improvement has commissioned the Royal College of Psychiatrists National Collaborative Centre for Mental Health to take forward work to improve the sexual safety of patients admitted to mental health inpatient services. The initial meeting has taken place to start scoping this work. This will include the development of a set of co-produced standards for sexual safety; the involvement of trusts through a QI collaborative to develop good practice; and the bringing together of resources such as on-line training to support providers and other organisations;
- *Guidance for inspectors* – A brief guide has been co-produced with inspectors to support them in the regulation of this topic. This will be ready for publication shortly;
- *Ongoing engagement* – This work has produced interest nationally and internationally, leading to ongoing speaking engagements and sharing of good practice.

Chief Inspector of Primary Medical Services' report

Nil report.

Chief Operating Officer's report

Nil report.

Executive Director of Strategy and Intelligence's report**3. Preparing for the UK's exit from the EU**

The UK is expected to leave the EU on 29 March. The terms of this departure will be confirmed through a series of votes in Parliament (as it stands at the time of writing [March 13], the UK is expected to leave the EU on 29 March). A dedicated team, overseen by me as SRO, have been working with the Department of Health and Social Care (DHSC) and other partners to ensure that we are prepared for the impact of the EU exit on our own operations, as well as the impact on our regulatory work with health and social care services, particularly under a 'no deal' scenario. Our

current readiness assessment indicates a low risk for our own staff, processes and data.

As independent regulator for quality in health and social care, during this time our first priority remains to make sure that people receive safe, compassionate and high-quality care. We will continue to monitor and inspect the quality of care against our existing frameworks, and respond to risks where they may arise. Working closely with DHSC, providers and our other partners, we will also ensure that our approach is proportionate when accounting for the potential impact of the EU exit on providers, and clearly communicated.

4. Parliamentary activity

Health and Social Care Select Committee: The Kark Review - Professor Ted Baker, Chief Inspector for Hospitals gave evidence at the Health and Social Care Select Committee in Parliament on 12 March, as part of a one-off session into '[the Kark Review](#)' on the fit and proper persons requirement. Ted gave evidence alongside Baroness Dido Harding, Chair of NHS Improvement.

All Party Parliamentary Group for Autism - Dr Paul Lelliott, Deputy Chief Inspector for Hospitals (mental health) gave evidence at an inquiry hosted by the All Party Parliamentary Group (APPG) for Autism on 14 March. The session touched on health inequalities and diagnosis, as well as the Transforming Care programme and the thematic review of the use of restraint, prolonged seclusion and segregation.

The Independent Group - Due to 11 MPs resigning from their political parties and sitting as the new Independent Group (TIG) in Parliament, we have updated our processes for briefing parliamentarians on relevant national announcements and publications. As the joint third largest political grouping in England in the House of Commons, the spokespeople for health and social care in TIG will receive pre-briefing on major national engagement as relevant, to mirror the approach taken with the Liberal Democrat Party.

5. Recent publications

The state of care in independent ambulance services

On 7 March, we published our *State of care in independent ambulance services* report which brought together the findings from CQC's comprehensive inspection programme of independent ambulance services, based on an analysis of published inspection reports, interviews and focus groups with CQC staff.

The report details evidence of good practice and improvements in individual services but raises ongoing concerns about the overall safety of the sector including poor recruitment and training, medicines management, and poorly maintained vehicles and equipment. The report calls for providers and those commissioning their services to do more to ensure people are safe from risk. It also highlights some concerns about those independent ambulance services that fall outside of CQC's scope of registration, such as medical cover at events. We will continue to work with

the DHSC to close gaps in the regulation where it means that services falling outside of our remit could pose a risk of people being exposed to poor care.

The report has led to national and trade media coverage and was welcomed by the Independent Ambulance Association.

6. Upcoming publications

Independent doctors and clinics providing primary medical services – learning from good practice

Based on a sample of our inspection reports, expert opinion and engagement with the public, the report shares findings from our unrated inspection programme of independent consulting doctors and clinics that provide primary medical services (private GP services, travel clinics, slimming clinics, allergy clinics etc). We are publishing the report on 14 March.

The analysis enabled us to understand the common issues identified on inspection, identify good quality practice in this setting, and the improvements that we found on follow-up inspections. We found variable practice in this sector, and concerns in respect of safe, effective and well-led. We were pleased to see that on re-inspection there was some improvement. However, there are still more improvement needed. We begin rating these providers from April 2019.

CQC fees scheme and response to our consultation

We will publish our legal scheme confirming the fees that we will charge providers in 2019/20, in line with the requirements of the Health and Social Care Act 2008. We will also publish our response to the consultation on these fees, that we carried out between October 2018 and January 2019.

We are aiming to publish the scheme and response in week commencing 18 March, subject to the consent of the Secretary of State. They will be accompanied by supporting documents, including a regulatory impact assessment and an independent summary of the feedback we received to our consultation.

Our engagement plan includes messages to registered providers, our staff, the media and other stakeholders.

Learning from deaths

We conducted a review in 2016 looking at the way NHS trusts review and investigate the deaths of patients in England, resulting in the report '*Learning, candour and accountability*'. As a result, DHSC established a Learning from Deaths programme board to oversee the implementation of the recommendations which issued national guidance for NHS trusts in April 2017.

We will be publishing this report on 19 March looking at what early progress has been made since April 2017. The report aims to provide NHS trusts with examples of good practice from which they can learn by comparing to their own practice and from the approaches taken to make progress.

7. Information and cyber security risk

There are no significant issues or incidents to report this month.