Agenda Item: 2
Paper No: CM/04/20/02

Minutes of the Public Board Meeting held by Microsoft Teams 18 March 2020 at 11:00am

Present

Peter Wyman (PW)	Chair
Ian Trenholm (IT)	Chief Executive
Edward Baker (EB)	Chief Inspector of Hospitals
Rosie Benneyworth (RB	Chief Inspector of Primary Medical Services & Integrated Care
Kate Terroni (KT)	Chief Inspector of Adult Social Care
Robert Francis (RF)	Chair of Healthwatch England & Non-Executive Board Member
John Oldham (JO)	Non-Executive Board Member
Mark Saxton (MS)	Non-Executive Board Member
Liz Sayce (LS)	Non-Executive Board Member
Jora Gill (JG)	Non-Executive Board Member
Kirsty Shaw (KS)	Chief Operating Officer

In attendance

Chris Day (CD)	Director of Engagement
Chris Usher (CU)	Director of Finance, Commercial, Workplace & Performance
Mark Sutton (MSu)	Chief Digital Officer
Pauline Rouse (PRo)	Corporate Secretary
Rebecca Lloyd-Jones (RLJ)	Legal Advisor to the Board
Holly Sutherland (HS)	Equality Network Representative
Professor Glynis Murphy (GM)	Independent Review Author (Item 4)
Stuart Dean (SD)	Director, Corporate Provider & Market Oversight (Item 6)
Ursula Gallagher (UG)	Deputy Chief Inspector PMS and Integrated Care, Childrens Health and Justice and Lead Nurse (Item 4)

Kevin Cleary (KC)	Deputy Chief Inspector Hospitals Mental Health and Community Services (Item 4)
Apologies	
Paul Rew (PR)	Non-Executive Board Member

Item 1 – Apologies & Declarations of Interest

1.1 PW welcomed Board members and other attendees. HS was this month's Equality Networks' Representative. Apologies were received from Paul Rew. There were no new interests declared.

Item 2 – Minutes of the Meeting held on 26 February 2020 (CM/03/20/02)

2.1 The minutes of the meeting held on 26 February 2020 were accepted without amendment.

Item 3 – Matters Arising & Action Log (CM/03/20/03)

3.1 The action log was noted.

3.2 There were no matters arising.

Item 4 – Regulation in closed environments: Independent Report (CM/03/20/04)

4.1 PW welcomed GM to the meeting and thanked her for an excellent and informative report.

Analysis of Whorlton Hall (WH)

4.2 GM was asked by CQC to look at the regulation of WH between 2015 to 2019 and consider if abuse could have been detected earlier. Information on CQC systems were looked at and interviews conducted with CQC inspectors and others outside of CQC, including clinical commissioning group representatives and local safeguarding representatives. Five ex staff from the provider for most of the above period were also interviewed. Service users, carers and other witnesses were not interviewed because of ongoing police investigations.

4.3 WH was inspected six times before abuse was exposed and two of those were comprehensive inspections that rated the facility as 'Good'. Other inspections were unannounced as a consequence of complaints or allegations and these rated WH as 'Requires Improvement'. Over the period a number of visitors from partner agencies visited the establishment and none of these recognised abuse taking place.

4.4 Inspection reports showed that service users and carers were content with the service. However, it is now known that serviceusers were interviewed in the presence of staff members and carers were selected specially to give feedback. Interviews of junior staff members by inspectors took place in the presence of other colleagues.

4.5 Investigations showed that allegations were escalating over this period and that the provider was aware of them and also the toxic culture at the facility.

4.6 Recommendations

1. **Data** – There is a need for more accessible data of the dashboard type to aid inspectors. Dashboard data should include abuse complaints, staff training, staff turnover, sickness, bank staff use and levels of restraint.
2. **Inspections** – More unannounced inspections should be done and should include evening and weekend visits. Provider information requests should be done every six months and all inspections should provide ratings. There is an issue with the speed of providing inspection reports.
3. **Allegations** – Abuse allegations, safeguarding and whistleblowing should be looked at holistically and not seen as individual issues, especially in high risk environments.
4. **Users** – Service users' and carers' interviews should be given greater priority in the inspection process. Communication skills between inspectors and people with learning disabilities and autism needs to be improved. Interviews should be in private, without staff from the facility being present.
5. **Level 2 inspections** –More in-depth inspections should be done when red flags are raised regarding a service. This should include interviews with ex staff and the use of covert surveillance.
6. **Registration** – WH was an unsuitable building that operated an outdated model with largely untrained staff and should not have been registered. How to deal with services like this that are already in the system needs to be considered.

Discussion

4.7 The Board welcomed the report and agreed with its recommendations. They noted that some things have been put in place since the WH exposure and the David Noble report:

- Supporting guidance was developed to equip and help inspectors going into closed environments. It includes advising listening to those with lived experience of the service, their families and partner agencies. This guidance will be refreshed in the light of GM report.
- Work is being done around restraint, seclusion and segregation in mental health services and adult social care settings. Included are those in the community and children in secured units. This work with users and families will help to identify the key recommendations from GM report that will make a difference to people's experience.
- Regulating models of care for the last four years have been supported with the publication of guidance (Registering the Right Support). This looked at best practice and NICE guidance as a model for ASC and has been used to register. The guidance is in the process of being refreshed.
- Lessons learnt show that CQC should target their inspection methodology in a way that takes into account the risks of different service sectors. It should help identify the key risks and abuse in closed environments.
- Work is being done on better communication between inspectors and users, especially those that are non-verbal and will be kept under review.
- A workstream has been set up to look at the findings and recommendations in the GM and David Noble reports.

4.8 The Board agreed that there were important lessons to be learnt for CQC and partner agencies who are involved in regulating high risk environments across all regulated services. Transformation work taking place in CQC has been focused on putting the best intelligence in place to assist inspectors and support their decisions by allowing them to have all relevant and recent data in one place. The Board is looking forward to the next phase of reporting which will focus on service users and their families.

4.9 The above report will be published at 1pm today.

Item 5 – Executive Teams Report (CM/03/20/05)

CQC's Response to Coronavirus (COVID – 19)

5.1 IT informed the Board that routine inspections were suspended on 16 March, with inspectors responding to specific risks and concerns as and when necessary . Rating services were also suspended and enforcement action will not be taken unless in extreme circumstances. It will be a priority to register establishment that provide COVIS-19 services.

5.2 Each member of the Executive Team (ET) gave an update regarding their team's response to COVID-19:

Hospitals

5.3 TB noted that as routine inspections have ceased, this has freed up capacity for hospitals to focus on COVID-19. The directorate is aware of reports of provider staffing shortages and reports of lack of personal protection equipment (PPE) facing front line staff. Our overall approach is to seek to support providers in any way possible without putting extra burden on staff and services. Hospital staff are being encouraged to raise any concerns about safe care with CQC and users and carers can do so via Give Feedback on Care, with a view to us feeding back concerns to government and NHSE.

Primary Medical Services & Integrated Care

5.4 RB reported that there were mixed responses to the outbreak of COVID-19 from GP surgeries, some seeing less visitors to premises and others more. There is an increase in people using 111 service. Concerns remain around the lack of PPE for dental staff and ways are being explored about how to communicate with private dentists more effectively. The Defence Medical services Programme has been suspended and colleagues are working to support them with any major risks identified. Work continues with the Department of Health and Social Care, Justice and children's services to ensure that these vulnerable groups have access to safe care. The Medicine's team is looking at supporting the messaging about over-ordering of medicines. Integrated care is looking at the overall local position and intelligence coming from regional teams to support the sharing of best practice to minimise risks. There will be messaging to discourage profiteering during the current crisis. GPs and others are being encouraged to raise concerns about lack of equipment or poor care.

Adult Social Care

5.5 KT noted the role of the directorate in the coming months in having an overview of how the virus affects individuals that use social care sector and escalate any concerns and support conversations between government and regional areas. Conversations are ongoing with hospitals to ensure that enough beds are available if demand increase and also that services are in place when people are discharged from hospital. There has been a positive response from providers following the announcement of stopping routine inspections, and the move to a risk based approach. KT agreed that the independent voice of CQC should articulate the urgent need for help and PPE in the social care sector.

5.6 RB joined other Chief Inspectors in noting that where inspectors felt a place was not safe then intelligence should be collected and any issues flagged to feed into the national and regional response. In addition, CQC will support new models of care being set up to ensure high standards, governance and safety are built in from the beginning. We are looking at ways of following up on providers rated as inadequate either by re-inspections in a desktop way, analysing data and intelligence or collaborative working with partner agencies in the region.

Engagement, Policy and Strategy

5.7 CD said the team is working closely with national partners on how CQC can join and support other regulators, NHS England and Public Health England to imbed messaging to users and providers. Webinars aimed at providers are being tested and conversations had with trade associations to adopt the new methodology. Experts by experience will be helping to promote Give Feedback on Care and we are exploring how Experts by Experience can use social media to contact people remotely. Daily briefings are sent to all CQC colleagues and every two days to managers. Engagement continues with national and local media to ensure CQC's and partners' approach is understood and maintained.

RCCO

5.8 KS informed the Board that work has been done on contingency planning and identifying resources to enable the must do areas of work in the event of critical threshold levels being reached. The last week saw stress testing of IT systems to see if they would successfully support working at home and policies and guidance have been produced to support colleagues at home or who are sick. Data recording has developed to keep track of these people as well as those on loan or secondment supporting other

government departments in the response to COVID-19. The team is looking at ways of utilising the knowledge and expertise of CQC colleagues that are not currently on inspection duties.

5.9 The Board asked KS for the number of people that have been redeployed into front line services and whether line managers were able to stay in touch with them to maintain a relationship and to check on wellbeing. They also wanted to know how many colleagues were registered as 'self-isolating' as opposed to ordinarily sick. KS confirmed that this information can be found in the performance dashboard. It includes figures for colleagues volunteering in the health sector. The usual arrangements for colleagues on secondment will continue and clinical colleagues are being urged to volunteer for front line services.

Digital

5.10 MS reported that the team has been working continuously at pace for the last few weeks to ensure technology is in place to support providers to continue to deliver safe and improved services. Workshops took place on the new streamline methodology and Microsoft has assisted with quick design solutions to enable the rapid collection of data and to support providers remotely. Work is continuing on data collection to support adult social care work.

5.11 ET continued with a general update and the highlights were as follows:

- ***Promoting sexual safety through empowerment: A review of sexual safety and the support of people's sexuality in adult social care*** report was published on 27 February and has been well received by provider organisations and charities. The report contains recommendations on enhanced training for the social care workforce on sex, sexuality and relationships. The DHSC will be funding the training and CQC will increase focus on this issue when inspecting social care settings again.
- A report was published on 5 March and looks at how quality improvement was sustained in four trusts. It was well received and will be an important report going forward on how to maintain quality in the health sector.
- The Assessment Framework consultation has been delayed due to the COVID-19 outbreak.
- The second sandboxing report has been published. It demonstrates how CQC can work with providers collaboratively to ensure new services can are registered.
- The People Plan update was highlighted, as set out in page six of the ET report.

Item 6 – Market Oversight (MO) Update (CM/03/20/06)

6.1 SD updated the Board on the last six months of MO activity as follows:

- There are currently around 65 corporate providers included in the scheme with visibility on a further five. The increase in the number of providers has been driven by broader market consolidation and the ongoing Four Seasons leasehold restructure.
- Risk profiles show a 20% deterioration in risks across the scheme. Whilst this deterioration is 7% less than reported last June, it hides a significant increase in risk in our highest risk classification prior to CQC issuing a LA notification.
- Unseen influences that have helped to improve the financial discipline across the sector have included resolving uneconomic positions, cash injections to preserve liquidity and holding providers that have issues to account.
- The outbreak of Coronavirus will have a significant effect on the ASC sector. The impact will hit providers and staff because of the limited cost base flexibility across the sector and because providers are paid for care delivered. In addition, the older ASC workforce is more likely to be affected by the virus and the younger workforce will be affected by schools closing and child care costs.
- The MO team has undertaken a one-off review of the portfolio to consider providers that may be exposed to coronavirus 'fall out' and the review has identified 15% of providers in the portfolio where there is an immediate financial challenge. The team is engaging with these providers on contingency operational and financial planning. Challenges will have a knock-on effect to the NHS and the team is working with partners across government to influence and inform thinking. Conversations are also being had locally and nationally about the impact on the workforce and provider funds.

6.1 The Board thanked SD for the report and said that it showed the benefit of the detailed financial knowledge the Market Oversight team have of the sector.

Item 7 – Regulatory Governance Committee – Verbal report from meeting on 17 March 2020 (Verbal)

7.1 LS summarised the highlights from the above meeting as follows:

- A discussion took place on the implications of COVID-19 in the context of regulatory risks. The next meeting will look at particular regulatory methodology being developed during the crisis period.
- The committee discussed medicines optimisation and proposals to reduce medication errors by 50% by 2023. This included the role of CQC in sectors where there is no independent reporting structure.
- Trends in CQC's enforcement activities were looked at and it was noted that there has been an increase in appeals being allowed with conditions. The committee debated whether improvement encouragement with providers could be done earlier before cases get to tribunal stage. They then went on to discuss the future plans for enforcement and where enforcement activities will be concentrated, particularly in closed environments.

Item 8 – Any Other Business

8.1 There was no other business from the Board.

8.2 Three questions were received from members of the public:

8.3 David Hogarth: ***For some years my local hospital has been giving me appointments to discuss my prostate problems on the telephone. They tell me to be ready to receive the call half an hour both before and after the stated time but I do not think they have ever kept to that time frame themselves and on the last occasion there was no call at all. Does the CQC hospitals' conduct of telephone appointments? If not, could you start?***

8.4 TB said that inspectors already considered telephone consultations when inspecting out-patients facilities. However, there could be an opportunity to develop the current approach to assessing telephone and virtual services in more detail.

David Hogarth: ***For 18 months now I have been urging CQC to think about simple video communications into the technology resource. In November PW told me that there would be a general piece about it and thought it would be ready by January. Why hasn't this happened?***

8.5 KT said that CQC has published a document called ***Driving Improvement Through Technology*** which highlights best practice when it comes to technology across health and social care. In addition, CQC has a specific workstream looking at surveillance and

how that should be used by the regulator in closed environments. The workstream will take into account the recommendations from Professor Murphy's report.

8.6 Robin Pike: ***How do inspectors review access to secondary care from GPs' surgeries?***

8.7 RB said that the assessment framework contains five key questions instructing inspectors to look at records kept and referrals made by providers. Integrated care work is being developed and tracking individual progress through the system could be explored and extended further.