Agenda Item: 2
Paper No: CM/06/20/02

Minutes of the Public Board Meeting
151 Buckingham Palace Road, London, SW1W 9SZ
20 May 2020 at 10:30

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
Robert Francis (RF)	Chair of Healthwatch England and Non-Executive Board Member
Jora Gill (JG)	Non-Executive Board Member
John Oldham (JO)	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
Kirsty Shaw (KS)	Chief Operating Officer
Kate Terroni (KT)	Chief Inspector of Adult Social Care

In attendance

Naomi Paterson (NP)	Head of Governance and Private Office (minutes)
Chris Day (CD)	Director of Engagement
Farah Islam-Barrett (FIB)	Interim Policy Adviser to the Chief Executive
Beth Matthews (BM)	Equalities Network Representative
Mark Sutton (MSu)	Chief Digital Officer
Chris Usher (CU)	Director of Finance, Commercial, Workplace & Performance
Kiran Prashar (KP - item 7)	Head of Organisational Development
Mary Cridge (MC - item 10)	Outgoing Freedom to Speak Up Guardian
Uma Datta (UM - item 10)	Incoming Freedom to Speak Up Guardian
Carolyn Jenkinson (CJ - item 10)	Incoming Freedom to Speak Up Guardian
Julie Lindsay-Ayres (JLA - item 10)	Incoming Freedom to Speak Up Guardian

ITEM 1 – APOLOGIES & DECLARATIONS OF INTEREST

1. PW welcomed Board members and other attendees. No apologies for absence had been received from Board Members. It was noted that Rebecca Lloyd-Jones had given apologies for today's meeting. There were no new interests declared. PW noted that this week was mental health awareness week and welcomed this month's equality networks representative, Beth Matthews, chair of CQC's LGBT+ Network.

ITEM 2 – MINUTES OF THE MEETING HELD ON 22 APRIL 2020 (REF: CM/05/20/02)

2. The minutes of the meeting held on 22 April 2020 were accepted without amendment.

ITEM 3 – MATTERS ARISING AND ACTION LOG (REF: CM/05/20/03)

3. There were no actions on the action log and there were no matters arising.

ITEM 4 – EMERGENCY SUPPORT FRAMEWORK (REF: CM/05/20/04)

4. IT and KT presented the Emergency Support Framework (ESF). IT introduced the item by noting that since start of the current Covid-19 pandemic CQC had stopped routine inspections, but that we had continued to engage with providers by telephone and to assess risk remotely, using information from various sources including information from the public. Our National Customer Service Centre colleagues have continued to offer full service and that processing of information from the Give Feedback on Care portal also continued. We have also conducted a small number of enhanced desktop reviews and in other cases we have conducted on site inspections. We have adhered to PHE advice to make every effort not to spread the virus.

5. We have been using the lockdown period to make changes that will help the way we regulate in the future. One of the biggest changes we have made relates to the introduction of the ESF. The ESF provides a structured approach to assessing the safety of care that people are receiving, particularly in the context of Covid-19. It is designed to be conducted over the telephone, where the inspector contacts a provider and asks a number of targeted questions to determine if that provider needs support, and if so what kind of support and who best placed to support them. Inspectors also enquire about whether Care Act easements are being utilised and ensure people's human rights are fully considered by providers. It is not a means of inspecting and rating. IT anticipates that, over the coming weeks, where necessary, inspectors can visit premises and ask questions face to face. We will be reporting to the public on what we find from the ESF via a fortnightly Insight report (see item 5).

6. KT reported that the ESF has been designed at pace, with good engagement from inspectors throughout the process. The tool has been used in Adult Social Care (ASC) for about two weeks. It brings together a number of intelligence sources, including data from the home care tracker tool, where providers are reporting any issues around personal protective equipment (PPE), workforce, testing, and so on. A number of providers have contacted us to thank us for the supportive nature of the conversation and the action taken as a result. KS noted that she had spoken to approximately 200 ASC inspectors and shared positive quotes from two of these individuals. KT stressed that whilst this is an intelligence-led process, an inspector's judgement is key. So far, we have initiated 1,466 ESF conversations (this is updated data from that in the appendix), with 864 being completed. The provider summary is shared with the provider, who is encouraged, where appropriate, to share it with their local authority or Clinical Commissioning Group (CCG). KT noted that we can aggregate information from the ESF to regional or local authority level, to inform our regional conversations about risk and enabling us to report on emerging pictures at that level. In addition, for example where a local authority is using Care Act easements, we can use that information to focus conversations accordingly if we have concerns.

7. The ESF is a monitoring mechanism. We have continued to weigh up the risk of going into services against the risk of not doing so. KT reported that as this risk shifts she expects to see a rise in on-site, targeted inspections, especially where there is a closed culture and where there are concerns about the ability of the service to respond to requirements. IT confirmed that the ESF will go live in PMS shortly, and Hospitals after that. PW noted that the ESF demonstrates CQC's ability to respond quickly in developing this tool, and links to the next phase of CQC being intelligence-driven. PW thanked colleagues involved in developing ESF and inspectors who are applying it.

8. RF noted that this was a fantastic development in short period of time and agreed with the priority given to the adult social care sector in deploying it. Commenting that it was an understandable decision not to cross the threshold of services during the emergency period, RF noted that the support offered as a result of the ESF conversations provided some protection for residents, even though CQC was not doing an inspection. He asked, given that the ESF is driven by information the provider gives to inspector, how is that information verified? KT responded that inspectors are using their inspection and travel time not only conducting these calls but also to have more conversations with other agencies and advocacy groups in the wider system to bring together collective knowledge. The importance of data that feeds into ESF from other sources such as from Give Feedback on Care, safeguarding concerns and so on, was noted, and that information from District Nurses, for example, is also informing ESF. There has been a significant increase in use of Give Feedback on Care since it was revamped earlier this year, although there is more to do where people are unable to go online. We are considering how to use our experts by experience resource to gather information and will update the Board when we have done more work on this.

9. IT referenced page 4 of the slides which gives inspectors a high level view of provider risk within their portfolio, assisting them in prioritising calls on any given day. There was also training given to inspectors to assist them in drawing out information during these conversations. MSu asked about staffing arrangements and protections from abuse. How does ESF flag up warning signs (such as high agency use, multiple shift patterns, inadequate line management training, high staff turnover, absence and vacancy rates) to inform a view on a location? KT responded that locations where we have those concerns were prioritised for these calls, noting that there are some environments where there is a more urgent need to cross the threshold and observing in person. EB noted the intention to roll-out ESF in sub-sectors of hospitals from the start of June and our ongoing monitoring our sources of intelligence, including Give Feedback on Care, whistleblowing, serious incidents and so on. As with all the sectors, as the prevalence of Covid-19 in the community decreases, we will increase inspections. In relation to the Mental Health Act (MHA), we have developed a new way of reviewing this using some desktop and remote reviewing, and crossing the threshold where necessary.

10. LS supported CQC being increasingly active in conducting inspections as the risk of infection reduces and noted the importance of inspectors being able to see all the information available to them in one place. In addition to its usefulness during this pandemic, will this access to having a consolidated set of information continue? MSu responded that this was the intention. ESF is the initial minimal viable product, which we will continue to add to. JO asked about non-Covid health care and whether we will look at this as part of the ESF assessment. RB responded we are looking at how we support general practice to return to routine care and capture good practice to share with others. EB added that he too was keen to see the re-establishment of non-Covid services as soon as possible, as long as it can be provided safely and providers adhere to good infection control.

11. PW concluded that we all recognised that there are instances where crossing the threshold of services is essential. CQC, in being a regulator rather than an inspectorate, had a role wider than just inspection. The ESF enhances our monitoring capability and capacity, supporting our future regulation.

ITEM 5 –COVID-19 Insight (REF: CM/05/20/05)

12. CD presented this item, the first edition of our Insight document. The purpose is to make the data we gather as part of our regulatory activity publicly available and to offer analysis to create a picture of the impact of Covid -19, to guide decision-making now and inform planning. By regularly updating and publishing this report we can show changes and identify where things are improving or deteriorating. This edition includes information on outbreaks, deaths and testing in ASC, PPE in home care and the wider effect on Covid-19. Findings include:

- There have been significant improvements in the distribution of PPE, but we want to make sure this is in place in all environments. We are prioritising this as part of our ESF activity.
- On wider infection control, NHS England has recently issued guidance on infection control for health services during the epidemic. We have had some reports from staff that infection control standards are not being implemented consistently and effectively in some non-Covid and communal areas**.** CQC is exploring with system partners and individual providers how they have addressed the risks of cross-infection and have appropriate assurance that they consistently meet the standards set out in the guidance. We will share good practice where we find it and will seek further assurance where necessary, including targeted inspections.
- We remain concerned about discharge of people from hospitals to ASC settings without appropriate information-sharing that would allow the care setting to make an assessment of risk and to protect their residents and staff. We are investigating a small number of cases where care homes have told us this has occurred and will take action as appropriate.
- We have concerns about closed environments, partly about how they manage Covid-19 and partly about how we ensure they continue to provide safe care. As CQC discussed at the Joint Committee on Human Rights (JCHR) on Monday we intend to increase our inspection activity in this area.
- As the infection rate declines, we want to test how NHS, Primary Care and ASC services are working together to prioritise the reopening of care for non-Covid patients. We want to be clear how services understand the risk in their area and how they safely improve access to care for different groups.

13. Future publications will revisit issues but also focus on other key topics, including how other services like dentistry can provide care safely. We will use examples of how technology is changing the way health and care is delivered. PW made two points: that the slides include data to 18 May 2020; and that this is not all the data CQC has access to. More recent, and additional, data is available internally to inform our work on a day to day basis. EB welcomed the report, noting that we will build on it in future. He stressed the importance of transparency of information and data in driving improved safety and quality. This need for transparency is something he will be championing at the next National Quality Board meeting. Transparency across the system enhances trust.

14. JO endorsed the point that transparency is extremely important, allowing people to feel the necessary trust and confidence as we emerge from the lockdown, and encouraged all organisations to ensure they demonstrate transparency. JO asked about the level of confidence in the testing system applied to care homes to assure safety of residents. KT welcomed the government's commitment to testing, including a-symptomatic care home residents and staff. In the early days of this pandemic, and in the absence of a national system such as exists in healthcare, CQC supported DHSC with provider information to facilitate booking of care worker testing and also supported DHSC and PHE with the piloting of residents testing. This temporary assistance has come

to an end and a government portal is now in place. At no point was CQC responsible for the tests and we have no ongoing role. It was noted that some providers are reporting issues in getting access to timely testing.

15. JO noted that care workers, as healthcare workers, have done an incredible job in distressing circumstances. What support is available to them? KT responded that people working in care, whilst used to caring for people at the latter stage of life, are impacted by the scale of this pandemic on those they care for. The Samaritans has extended their helpline for health workers to now include care workers. KT always asks that whenever an offer of support is made for health workers, that the same level of support is offered to social care workers.

16. LS agreed with previous comments on the benefits of transparency, and the importance of maintaining regular insight reports. One of the benefits of transparency was the ability to highlight other groups of people such as those detained under the MHA where there are high levels of deaths. What are we doing, and what more can we do, to satisfy ourselves that organisations are doing what they need to do to protect those who are detained. EB responded that we are working to ensure compliance with NHSE's infection control guidance in both NHS Trusts and independent providers. In addition to publishing this data, Kevin Cleary (Deputy Chief Inspector and lead for mental health) has written to mental health providers to reiterate the importance of infection control. We are following up specific issues as part of our regulatory activity. RB added that we are doing further work to get a better understanding of the impact of Covid-19 on vulnerable population groups.

17. MSa further commented on the impact on care staff and KT said that we had an important role to play in shining a spotlight on social care and celebrating the success of the workforce. KT referenced previous State of Health and Care finding around the need for clear career pathways and appropriate reward and recognition. The government has promoted the 'CARE' badge to give an identity for the social care workforce.

18. PR asked what we are learning from the intelligence to help people determine what the issues are that leads to some places getting the infection and others not, and the severity. KT noted that there were various contributing factors, including good infection control processes and PPE. Challenges faced by care home included small nursing and residential buildings and caring for people with dementia where it wasn't possible to restrict their access around the home. We welcome the government's commitment that no one should be leaving hospital without a test, so that a provider can make appropriate arrangements when accepting someone into the home. CD added that this Insight report is a way of sharing information on what we know promptly, rather than waiting to form views on answers, and that we intend to bring in the voice of other experts into future Insight publications. RB also noted that there has been wide variation in system-wide working, between health and care, and we are exploring this in more detail. IT observed that the north west of England was often in the news in the early stages of the outbreak in care home, and this data (e.g. page 10 of the

pack) supports that. By being transparent with this data we are allowing people to explore and accelerate their collective response and promoting active learning by providers.

19. RF endorsed the points already made about the importance of transparency and encouraged everyone in the system continue to be transparent. Have we received feedback from care homes and others on how helpful guidance on public health issues is? KT responded that we have supported providers, as some have found hard to keep on track of the changing guidance. CD added that we have created a page on our website for providers to bring together the guidance from other organisations that relates to them.

20. RF asked if there was more we can do in relation to feedback from staff and people using services in ASC, noting that HWE has received some feedback that people have been afraid to use domiciliary care services due to lack of PPE for people coming into their home, and similarly for people who are afraid to have non-Covid treatment. KT gave an example of Lucy, an inspector in Surrey East, working with some learning disability services, who has been joining zoom meetings with staff and service users and is planning to increase her conversations with staff virtually to understand emerging issues. Home care providers have said they have seen a reduction in people receiving home care during Covid-19, primarily due to concerns around infection being brought into their home. EB added that there is a need to ensure providers do all they can to ensure good infection control is in place to give people the confidence to receive treatment. Linked to transparency, any information on cross-infection should be made freely available so that people could trust that this was being monitored and dealt with.

ITEM 6 –FINANCIAL IMPACT OF COVID-19 ON THE CARE SECTOR

21. Stuart Dean joined the meeting to give verbal update on the financial impact of Covid-19 on the care sector from the perspective of the Market Oversight (MO) team.

22. SD noted that the challenges presented by Covid-19 for the care sector were substantial. To effectively understand emerging risk, the team has continued to engage extensively with the providers captured by the MO scheme, and then share this to inform cross-government thinking. For care homes, there was a typical occupancy decline of over 6% in April and a current expectation of a further decline of over 10% owing to a continued mismatch between the number of deaths and admissions. The number of deaths is now consistently reducing, albeit with variability between providers. Admissions remain depressed as the private pay market has collapsed and both NHS and local authority referrals are lower than would ordinarily be expected. If this level of occupancy were to continue, the impact on profitability would be profound, even before factoring in the impact of increased costs associated with PPE and staffing. On a best-case basis, the occupancy recovery period is likely to be around 2 years.

23. Turning to home care, there has been a reduction of weekly hours has typically decreased by over 7% across the MO portfolio. This is driven by infection risk concerns, families resuming or increasing their caring responsibilities and reduced commissioning activity. Home care operators frequently have low profit margins (3-5%), this is having an adverse impact on profitability, with the additional staffing and PPE costs adding to this.

24. In terms of increased costs, the PPE expenditure is driven by both increased usage as well as higher individual unit prices. The staff costs have been driven by an increase in eligibility for statutory sick pay and increased absenteeism (peaking around 20% and still being elevated at around 10%), self-isolation and shielding.

25. Responses from MO providers have suggested that some form of Covid-19 support has been offered by around 60% of local authorities (although this was variable, averaging at around 7% uplift), but that they were much less likely to receive any offer of support from (around 10% having made an offer). The provider response to the uncertainty that the Covid pandemic presents has understandably been to preserve cash in various ways (seeking additional commissioner support, not making scheduled PAYE and NI payments to HMRC and securing support from owners, lenders or landlords). Without additional commissioner support, capacity can be expected to leave the sector with the consequential impact of increased uncertainty for people using services, additional costs for local authorities and a knock-on impact for the NHS.

26. PW summarised that the already fragile situation in the sector is now more so, and short-term means of securing cash do not provide a long-term solution. SD added that if support is not adequate, it would be reasonable to expect capacity in the sector to be reduced. JO asked what capacity reduction might look like. SD responded that some analysis of MO providers (equating to 10% sample size of CQC registered beds) had been undertaken. Using an average occupancy decline in April of around 7% and a forecast occupancy decline being broadly a further 10% to calculate occupancy reduction, and assuming operators flex their capacity to be around 80%, this would suggest a vulnerability of around 50,000 beds. However, this is based on assumptions on information that is changing, and only a 10% sample size. PW added that it is important to note that this only relates to the larger MO providers and thanked SD and the MO team for their work.

27. The meeting paused at 11:50 and resumed at 12:00.

ITEM 7 – EXECUTIVE TEAM REPORT (REF: CM/05/20/07)

28. IT, with Executive Team members, presented the Executive Team report to Board. The following matters were highlighted:

29. IT noted that there had been significant effort from a number of colleagues over recent weeks, and was expecting to be able to report next month that we are in more sustainable position. We continue to need to be able to flex in light of changing circumstances and advice from government and PHE. In relation to testing, as of the beginning of last week as we have stopped all our previous temporary assistance with the digital booking system and the government has launched two portals, for staff and for care home residents. As mentioned previously, CQC did not lead any testing process, handle any results nor provide any clinical leadership on any aspect of this testing. We have written to parliamentarians in response to their queries about our role. It was noted that we continue to receive queries from providers about testing. Over coming weeks we will continue to roll out ESF (as discussed in item 4) and an Insight report (as discussed in item 5) will be published every two weeks. It noted that he was anticipating more on-site activity and, where necessary, enforcement activity.

30. Focusing on ASC, KT reminded the Board that ESF for ASC providers went live two weeks ago, and information from home care providers is provided daily. We have also worked with Think Local Act Personal and local government to understand the impact of Care Act Easements. The interim restraint, segregation and seclusion (RSS) report was published a year ago and CQC moved on to phase 2 (including social care settings) but we have not yet concluded this work. We have been working closely with people with lived experience and stakeholders, but in discussion with people we have delayed publication until after the summer to ensure that the report's recommendations get appropriate focus. On closed cultures, David Noble and Glynis Murphy's (part 1) recommendations have been brought together. The Annex provides: a summary of what has been delivered; what is in progress for this current quarter; and future work. KT reported that good progress has been made and we have a plan to address those areas where more work is need. When this work is completed, we need to ensure we have appropriate assurance, focusing on the improved outcomes as a result. LS noted that she supported the decision to postpone the final RSS report to ensure the recommendations have impact, but asked what monitoring we are we doing in the interim, if we have concerns in this area now. EB responded that we are monitoring the current risk carefully and we will be re-inspecting these services, as Kevin Cleary made clear at JCHR on Monday. He noted that the solution in these high-risk environments is a different model of care.

31. EB provided an update on hospitals work. Having previously commented on the work the acute sector did with increased intensive care capacity in the earlier stages of the pandemic, the focus has now moved to restoring services for non-Covid patients. Issues that providers have told us about include shortages of drugs and PPE. Emergency departments are working in a very different environment, with significantly reduced capacity in order to avoid cross-infection. As demand increases, such as the usual winter pressures in the months to come, this is a concern, particularly with a backlog of appointments and ongoing concerns around Covid-19. We are working with the system (not only hospitals) to ensure non-Covid patients are given the right care at the right time. There has been positive collaborative working, but also some problems that need to be addressed for services to be fully integrated. JO asked about whether a triage system (such as those in Denmark and Sweden) was in place. EB responded that trials of this are underway.

32. MSa asked about integrated care and the impact on our hospital inspection model as we return to increased inspections. EB noted that there were examples of work to support integrated care of the frail elderly prior to the pandemic, including outreach from acute care into community and admissions to acute care only when needed. There continues to be a need to look at care as received by a patient rather than through the eyes of provider, which requires us to think about our inspection model in the future to reflect increasingly integrated care. It links to our work on local system reviews, and RB added that this is an opportunity to understand system responses, including innovation and also issues.

33. Turning to primary care, RB raised the recent media attention on private dentists and the Chief Dental Officer and Public Health England guidance. RB clarified that whether or not a dental service decides to open is that provider's decision. CQC cannot require a dental provider to close unless there is a breach of our regulations. We are assessing the extent to which providers are adhering to infection control guidance, particularly where aerosol-generating procedures are being undertaken. Further clarification is being sent to dental providers today. In relation to General Practice, the ESF roll-out commenced this week. The sandboxing work undertaken last year around digital triage has helped us understand what good care looks like and RB noted positive examples of innovations of continuing care being delivered. There are also a series of calls with CCGs this week, which are including ASC colleagues. Regarding antibody testing being conducted by some independent health providers, RB noted that some of these providers, but not all, are within the scope of CQC's regulation. We have issued guidance and RB stressed the importance of testers ensuring that people understand that a positive antibody test may not result in immunity. Finally, in relation to 111 services, RB noted the pressure faced by those services. RF asked about the regulation of providers of antibody tests being sold to people. RB stated that if a provider was providing treatment for disease disorder and injury (TDDI) that is within CQC's regulation. Where a provider is only providing diagnostic tests, this is not within the scope of our regulation. We are working closely with MHRA where providers are not within scope of CQC regulation.

34. As part of the COO update, Kiran Prashar joined the meeting at this point to update on the culture work underway. This work aims to develop a baseline view of our organisational culture, using an enquiry approach and working with colleagues across the organisation to observe and highlight ways we work, enabling changing or enhancing of behaviours. This work was due to start in March through face to face, regional workshops, but it was paused to focus on more immediate priorities. This pandemic period has also been an additional opportunity to capture positive learning as colleagues adapt to new ways of working. The sessions have been redesigned to be delivered virtually during June and July 2020. This work will continue to inform our People Plan and future strategy development work.

35. MSa asked about how we are capturing the learning from our response to Covid-19. KP responded that we have adapted the workshop to focus on new and adapted behaviours, and that the pulse survey includes a free text question to identify positive

change over the last two months. LS asked how people will be involved in drawing out the conclusions and actions of this work. KP confirmed that we are encouraging people involved in this work to take action immediately. There is work to do to merge our analysis of the outputs of workshops alongside evaluation and recovery work. PW confirmed this item will come back to the Board as this work develops, and KS confirmed that we will run cultural enquiry workshop for Board members.

36. KS handed over to CU regarding the report and accounts: CU confirmed that we anticipate a delay to laying the annual report and accounts to September due to delayed response in relation to pension assurance and certification. He confirmed that the rest of the accounts are running to timetable.

37. For an update on the Engagement, Policy and Strategy directorate, IT handed over to CD, who noted our attendance at the JCHR on Monday and that we are responding to a study by NAO on the readiness of the NHS and social care in relation to Covid-19. In relation to Give Feedback on Care, we will be focusing on people who work in health and care. In terms of innovation, we are keen to share this good practice and include this in our annual State of Care report.

Decision: Board noted the Executive Team report.

ITEM 8 – PERFORMANCE REPORT FOR Q4 (2019/20 YEAR END) (REF: CM/05/20/08)

38. IT presented an update on 2019/20 performance and finance, as set out in the written report. In particular, as in 3.2 (page 2) around return to rate inspections, and also responding to safeguarding issues (3.3), he noted the focus of activity where there is greatest risk. There continue to be challenges in producing timely hospital inspection reports. In terms of registration, the Board is aware that the change work has impacted KPIs but we anticipate significantly improved performance over this year. In terms of revenue and capital we finished the year underspent, largely driven by our change programmes that we knew had end of year spend. Turnover and sickness levels are within expected ranges. KS referenced the risk register, which we are working through with updated risks and measures.

39. In terms of registration (slide 5), 94% of this work was complete. There had been significant work to address the backlog, which has had temporary negative impact on data. However, KS was confident that changes will lead to marked improvement in performance. PR asked about new registration applications on this slide. KS responded that a lot of more complex applications were forming the backlog and a number of non-urgent applications were on hold whilst this change work was underway. However, the backlog has been addressed and the new system is in place. In relation to return inspections (slides 6 and 7), ASC met the KPI; PMS and Hospitals narrowly missed the target but had improved performance during the year. PW added that even where a target is missed,

it does not mean that inspectors are not having visibility of the service. RB noted that PMS delays were due to reasonable external factors. Regarding safeguarding (slide 10), improvement in this area was noted. On slide 11, inspection report timeliness, hospitals continue to underperform on this area, as discussed at previous Board meetings. A Quality Assurance initiative is underway and EB noted the need to grasp the current opportunity to drive improvements as the backlog has largely been cleared.

Decision: Board noted progress as set out in the written report.

ITEM 9 – CHANGE QUARTERLY REPORT (REF: CM/05/20/09)

40. KS presented this report, noting that good progress had been made despite the impact of resource of Covid-19. Three areas were highlighted in particular: registration transformation (where we have launched a digital end to end process (private beta) for domiciliary care agencies, with over 50 new registrations to date); digital foundations; and regulatory platform.

41. KS noted that new technology has enabled delivery of our Covid-19 response (particularly data collection and ESF). Our transformation vision will be launched internally shortly. It was noted how quickly we have been able to move from a hybrid to a full home-based model, providing colleagues with equipment and supporting wellbeing. The work on transforming our organisation, aligned to our strategy, has begun – the 'as is' mapping is now complete and we are commencing 'to be' state, using a co-design approach across the organisation. The QI capability programme has been impacted by Covid, but KS noted that various webinars for the Silver cohort are being put in place, and have online training available for Bronze.

42. In terms of our people, we have facilitated people returning to front line work and our People Plan continues to develop with clear deliverables. We transitioned to a new payroll provider last month without any issues. We have developed a new dashboard to support managers and we launched the pulse survey last week. We have created draft success profiles for key competencies for each grade in organisations, which we are finalising and looking to embed. Our reward and recognition work is progressing well. KS concluded with the focus for the next quarter, as set out in the report.

43. MSu noted that work is progressing well on digital foundations. The team have been able to achieve this work whilst supporting colleagues at home. On the regulatory platform, we are in the final stages of procuring a new partner. We have been working on data design processes. The ESF has demonstrated that our new technology enables us to work at pace, in a secure and scalable way.

44. PW congratulated Executive colleagues and their teams on the scale and pace of activity across the change programme and noted the oversight of board committees on this work. JO underlined how impressive it is to maintain delivery when people are stretched

and at the same time to have the agility, robustness and pace to take on additional work. MSa echoed these congratulations and stated that he was pleased to see MHA advocates being put in place. Noting the electronic learning (such as the Silver and Bronze programmes and the e-training for ESF), he asked if weare looking at digitising other people processes, including bringing new colleagues on board. KS confirmed that the People Plan was the priority for 2020/21, but would be looking to do more of this in 2021/22. KS noted that there had been some new recruits inducted online during Covid-19 which has been successful.

45. IT concluded with giving his support to Executive colleague for the work they have done, and to non-executives for the patience and challenge they have shown.

The meeting paused at 13:22 and resumed at 13:45.

ITEM 7 – FREEDOM TO SPEAK UP GUARDIAN'S SIX MONTHLY REPORT

46. Mary Cridge (CQC's outgoing Freedom to Speak Up Guardian), with Julie Lindsay-Ayres, Uma Datta and Carolyn Jenkinson (recruited into this role from 1 April 2020), joined the meeting for this item.

47. MC presented her reflections, as follows:
    - We really believe in speaking up, but we don't always live up to our own expectations.
    - Speaking up is relational and like all good relationships needs to be worked on and nurtured, inviting people to speak up and responding well (including 'disagreeing well')
    - Compassionate and performance cultures go together, although some find that surprising. MC reported seeing habits change and busting the myth that there is a choice between politeness and efficiency. Civility is important, particularly noting communication by email.
    - Guiding lights have made a difference (including Robert Francis, Henrietta Hughes, Megan Reitz, the many Guardians encountered in inspections)
    - It has been important to work with our Equality Networks, trade unions and staff forum, recognising our shared agenda
    - Ambassadors within CQC are having an impact
    - We have 'moved the dial', with the Speak Up people survey question having increased 6% to 47% in 2019.

48. PW asked about the first point. MC referred to the results of Megan Reitz's research, which were described as "very average" - the barriers that exist in other organisations exist for us too. It is important to disagree well and accept that we won't be perfect all the time. MSa asked about engagement during Covid-19. MC stated that there has been a decline in engagement, where some people

have been putting some things on hold due to prioritising their efforts on other things. MC confirmed we are remaining in touch with people who are having these conversations. RF thanked MC for her work and reflected that that disagreeing well and listening was at the heart of speaking up. The problems encountered with implementing a speaking up culture exist everywhere, as human nature resists receiving perceived criticism. As a regulator, we have a responsibility to continue to get our own house in order, to demonstrate to the world we regulate that it is possible. RF acknowledged that we need patience as change in this area does not happen quickly.

49. BM asked as to whether bullying might have increased or decreased as a result of office workers temporarily moving to homeworking. PW added that with such large proportion of workforce homeworkers, it was important to understand what we had learnt during lockdown. MC responded that some people are not used to homeworking. By way of example, in our all staff calls people were encouraged not to ask questions anonymously so that their questions could be answered after the meeting. PW invited JLS, CJ and UD to introduce themselves, and each briefly explained why they had applied for this role. Following on from the report in October 2019, the six month report will be presented at the June meeting.

ITEM 11 – ANY OTHER BUSINESS

50. There was no further business and the formal meeting closed.

Questions from the public

51. PW read out a question from Robin Pike: “I understand that CQC currently has a role in facilitating access to Independent Hospitals by NHS patients for their elective surgery. How will this access work? Will it require authorisation by Local Commissioners or Integrated Care Systems?” In response, EB referred to the good work independent hospitals had been doing to support the NHS during the pandemic, largely for non-Covid services. There is an opportunity in the recovery period for such hospitals to be Covid-free environments. Local independent hospitals are often paired to local NHS trusts, with patients transferred by the provider to ensure people who need care receive it.

End: 14:12