Minutes of the Public Board Meeting  
151 Buckingham Palace Road  
23 September 2015 at 09.00

Michael Mire (MM)  
Interim Chair and Non-Executive Board Member

Robert Francis (RC)  
Commissioner and Non-Executive Board Member

David Behan (DB)  
Commissioner and Chief Executive

Louis Appleby (LA)  
Commissioner and Non-Executive Board Member

Anna Bradley (AB)  
Commissioner and Non-Executive Board Member

Paul Bate (PB)  
Commissioner and Executive Director of Strategy & Intelligence

Jennifer Dixon (JD)  
Commissioner and Non-Executive Board Member

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

In attendance  
Eileen Milner (EM)  
Executive Director of Customer and Corporate Services

Rebecca Lloyd-Jones (RL-J)  
Legal Advisor to the Board

Alexandra Jones (AJ)  
Board Secretary

Katherine Arthur-Botchway (KA-B)  
Corporate Governance Manager

ITEM 1 – WELCOME, APOLOGIES & DECLARATIONS OF INTEREST

1. MM welcomed all Board members and members of the public. Apologies for absence had been received from Paul Corrigan. There were no interests declared. MM moved straight to Item 5, the presentation by Andrew Foster and Dr Umesh Prabhu from Wrightington, Wigan and Leigh Foundation Trust (WWL).

ITEM 2 – VALUES-BASED ORGANISATION AND LEADERSHIP (REF: CM/09/15/05)

Andrew Foster (AF) introduced the presentation. He noted that there were 52 slides in the presentation which he and Dr Umesh Prabhu (UP) would skim through in their presentation. Their presentation would be about quality, excellence, caring and ‘going the extra mile’. AF noted that ten years ago, a focus on quality was not systematically institutionalised in the NHS. Seven years ago, in 2008, WWL had introduced the ‘WWL Wheel’ for institutionalising quality. AF cited a number of statistics such as declines in MRSA and C-Dif and improvements in hospital-based mortality rates as evidence substantiating the success of this strategy.

WWL had adopted IHI guidelines in pursuing a safer culture. About 300 deaths per year had been averted. WWL set itself the challenge of continuing improvement. This required setting up systems such as having the file on each unexpected death carefully reviewed and analysed by an allocated consultant and having designated ‘quality champions’. Staff engagement was also
critically important. A staff survey result in 2011 showed WWL to be below the NHS average, leading senior management to focus on improving Teamwork. Strenuous efforts were made to speed up resolution of problems, improving staff motivation. Staff engagement now focused on desired outcomes in terms of the important feelings and behaviours of staff, and the factors influencing these. Team awaydays and team ‘charters’ were important tools for change. Over the four years since 2011, dramatic change had been recorded, quantified and documented. AF felt that WWL’s achievements were replicable and instructive for other Trusts and also for CQC. Staff in the NHS were highly values-based so the differential extra individual effort could be very great.

UP noted that the NHS could be very easy to manage because staff were so values-driven. He noted a mistake he made earlier in his career when two babies with the same names and dates of birth were confused, resulting in a misdiagnosis and a major jolt to his professional self-esteem. This had caused him to focus acutely on issues of governance and systems robustness. He had also embarked on methods for averting practitioner error, and on mentorship programmes.

UP then mentioned a personal ‘light-bulb’ moment in his career, when he realised his personal mission was ‘making the NHS the safest and the best’, shortly before the opportunity to work at WWL arose. Success was always an outcome of shared team effort and values, not individual effort. The core values were: ‘the patient first, always’; ‘happy staff, happy patient’; accountability and governance; forward thinking; respect, dignity and compassion. ‘Success is contagious’ UP said. WWL had achieved enormous progress in workplace diversity and the professional advancement and empowerment of BME clinicians and managers, firmly based on merit and values. He commended CQC too in this regard. However, staff feedback, UK-wide, showed that BME staff were disproportionately de-motivated because of entrenched workplace patterns of treatment. UP felt that non-executives, whilst appointed for their technical skills, should also espouse and demonstrate the required values.

MM praised the achievement of WWL and the inspiring presentation, and invited comments from the Board. JD enquired what the implied investment was for such quality improvements. AF noted that savings could be identified by consulting staff for their suggestions. UP pointed out that poor patient care was expensive. KS was interested to hear more about patient engagement. AF responded that WWL Trust Board was very active in this regard: patient panels consulted on documentation, care pathways, quality champion activities, patient surveys and in other ways. UP referred to WWL’s ‘always events’. LA enquired about WWL’s view of CQC and its methods. He also expressed concern about BME doctors’ professional treatment in the NHS. AF responded that WWL had been very impressed with the new inspection models. They had conducted four internal or ‘mock’ inspections, which had yielded very striking and illuminating findings. However, they found some of the criteria for CQC’s bandings very abstract.

UP was concerned that CQC inspections could lead staff to cover up ‘never events’ through fear and apprehension. He also shared the concerns about the discriminatory treatment of BME practitioners. He had taken to tweeting to get his messages across, but would prefer not to have had to resort to this. MR noted the message that organisational turnaround could be effected surprisingly quickly. He commended WWL for having undertaken four internal inspections. Regarding ‘never events’, MR noted that CQC’s main concern was how Trusts and
staff responded to and addressed them. He also felt that addressing BME professional motivation and advancement was critically important.

PB noted that intelligent monitoring could only ever be a guide; he was interested to know how a Trust would handle situations where there was inconsistent feedback between staff feedback and patient feedback. AF was concerned that ‘organisations that are deemed to be successful can become victims of their own arrogance’. However, securing ‘good’ rating would be motivating but showed that there were still areas for improvement.

DB was interested to know how WWL brought together the ‘hard’ pursuit of accountability and the ‘softer’ values and behaviours. AF responded that all senior managers had to go through an annual 360-degree assessment that reviewed ‘living the values’. UP responded that 80% of staff were ‘unproblematic to amazing’. The 20% who presented problems did so because of pressures and flaws in NHS systems, and most of them could reform and improve, given clear feedback and the opportunity to change.

MM offered AF and UP profuse thanks on behalf of the Board. He had been greatly impressed by WWL’s combination of hard data and commitment to values.

### ITEM 3 – MINUTES OF THE MEETING HELD ON 29 JULY 2015 (REF: CM/09/15/02)

3. The Minutes of the meeting held on 29 July 2015 were accepted without amendment. RF (as acting Chair at that meeting) confirmed that the minutes were accurate. MM was glad that the meetings at Frimley Park Hospital had gone so well and been a valuable example of off-site Board visits to providers.

### ITEM 4 – MATTERS ARISING AND ACTION LOG (REF: CM/09/15/03)

4. The Action Log was noted. There were no matters arising.

### ITEM 5 – CHIEF EXECUTIVE’S REPORT (REF: CM/09/15/04)

DB introduced the Chief Executive’s report. He noted that the monthly performance report was attached as the Board had requested and agreed. The main finding to note was the number of inspections expected to be completed by the end of the first phase. The current trajectory indicated a likely shortfall against original targets. Senior colleagues were currently at work on realistic revised inspection plans to reach the targets, and that the action plans would be brought back to the next Board meeting.

KS noted that this had been discussed at the previous day’s Regulatory Governance Committee, and that AB had asked what CQC’s ‘Plan B’ was, which KS found useful, especially if it included ‘lighter-touch’ inspection regimes. AB clarified that she had been particularly concerned that, whilst a number of providers had yet to be visited, CQC should prioritise early inspection of providers likely to be found problematic. SF had found the debate the previous day very helpful and informative for helping to plan how the inspection programme should evolve in future. AB emphasised that she did want to see a robust ‘Plan B’ at the next Board meeting.
DB referred back to the WWL presentation’s emphasis on safety ‘trumping all else’. He assured the Board that the report back to the Board would set out revised inspection activity targets in the light of human resources available and needed. MM felt that, beyond October, the Board should reflect more fundamentally on how CQC was operating. An inspection rate, in ASC for example, of one inspection per month was concerning; CQC needed to establish whether this could be materially raised.

On other matters, DB summarised recruitment figures: 538 inspectors hired, of whom 386 had gone through role-specific induction, and 79 managers brought on board. He also summarised the main highlights of recent activity in the three inspectorates. SF noted that the first GP practice to come out of special measures would be reported on, the following day. Special measures were intended to support improvement, not to be punitive.

In this regard, KS commented on the coverage of Addenbrookes the previous day, and would have wanted the supportive element brought out more clearly. LA felt that the Addenbrookes findings demonstrated that CQC would have to show sensitivity to the financial pressures on Trusts and rigorous identification of possible, more complex or less obvious, safety risks. MR confirmed that he had stressed these points in his pre-recorded media interviews, but not all the points had survived the cut into broadcast material.

RF queried whether there was more CQC could do to interpret its findings in language accessible to the public and laypersons. He also noted the impact of CQC reports in terms of triggering senior staff resignations and expressed concerns about a ‘culture of fear’. Chief Executives were prone to move on every couple of years. MR felt that CQC was gaining expertise and confidence in the factors driving poor performance and resulting poor inspection ratings. PB clarified his understanding that RF was asking both for deeper diagnosis in individual inspections as well as better system-wide patterns at local and national level.

AB was concerned that CQC should seek to ensure it was having the right effect on senior executives’ movements, rather than ‘perverse effects’. JD had been struck by WWL’s having its own self-diagnostic and felt that many other trusts could usefully adopt this methodology, and that CQC could encourage this. MM noted that WWL’s self-diagnostic was closely modelled on CQC’s own methodology and that this was an encouraging demonstration of the CQC’s impact.

DB reported that the Staff Survey would be published internally on this day with detailed breakdown by directorates and teams. There would be consultation and discussion with staff. There would be more detailed presentations to the next Regulatory Governance Committee meeting.

**Decision: The Board noted the Chief Executive’s report.**

**ITEM 6 – FIT AND PROPER PERSON (REF: CM/09/15/06)**

MR introduced the item. The onus was on providers to ensure they employed, as directors, people who were ‘fit and proper persons’, and it was for CQC to satisfy itself that providers had done so. CQC also had to respond to concerns. There had been 68 such concerns raised, which were assessed by a panel within CQC established for the purpose. Trusts would be asked to
take appropriate steps to address concerns, and sometimes Trusts were asked to provide greater detail. The FPPR was probably having some deterrent or preventative effect but might also be ‘displacing’ unsuitable individuals into employment positions not subject to FPPR requirements.

RF noted the probably irresolvable tension between employment confidentiality obligations and transparency to the public and that CQC could not oblige Trusts to disclose the remedial actions they might have taken. LA stressed that CQC was only one part of the system, and enquired whether anyone had in fact been ‘caught’ by the FPPR provision. MR explained that the CQC could not name individuals until there was a clear finding of breach: a number of investigations were still ongoing. There had been resignations and suspensions which might be circumstantial evidence.

MM asked RL-J to comment on the definition of ‘mismanagement’ in Annex A, 3(d). RL-J responded that evidence would be required that led back specifically to the individual person potentially to be found not fit or proper (not just to the organisation or entire management team). Other, or organisation-wide, concerns could be addressed through other provisions in the fundamental standards. KS enquired about the impact of a finding of ‘not fit or proper’ on an individual’s career; the bar should be set fairly high. RL-J confirmed this, and concurred that the reputational implications for individuals were potentially severe.

DB noted that individuals were appointed to specific portfolios and that there was a pattern in the NHS of individuals ‘reappearing’ after some years in other positions, and being ‘re-cycled’. It was incumbent on the hiring organisation to do due diligence in researching the background of applicants for employment. CQC was not in the business of running a register of people not ‘fit or proper’: it was overseeing the administration of a required regulation. MR noted that sometimes people were ‘over-promoted’ into sizeable jobs for which they were not yet qualified experienced enough, though could be developed or mentored for (as opposed to their being ‘unfit’ or ‘improper’).

**Decision: the Board endorsed the further development and implementation of CQC’s approach to this regulation.**

**ITEM 7 – DUTY OF CANDOUR (REF: CM/09/15/07)**

PB introduced the item. The reason for bringing this item to the Board’s attention was to highlight the further work intended to clarify and develop CQC’s approach to this regulation, and the lessons being learned, for example, on samples of safety incidents. CQC was one of five ‘influencers’ with regard to the Duty of Candour.

MM then invited comments. KS enquired how CQC would know there had been a breach or an insufficient response. PB responded that people might approach CQC or CQC could review hospital records of incidents. MR added that patients, relatives and whistleblowers might also inform CQC. LA was concerned that the application of the provision could too easily become bureaucratic, ritualised and insincere. Genuine candour in the system was what mattered. AS agreed that a culture of awareness, openness and of rectifying errors was important. RF also
Agreed, and enquired that CQC should seek to learn from instances where the provision had been successfully applied. MR agreed.

**Decision: the Board endorsed the further development and implementation of CQC’s approach to this regulation.**

**ITEM 8A AND 8B (REF: CM/09/15/08)**

8A – FULL REPORT FROM REGULATORY GOVERNANCE COMMITTEE 29 JULY 2015
8B – REPORT FROM REGULATORY GOVERNANCE COMMITTEE 22 SEPTEMBER 2015

MM invited LA to introduce items 8A and 8B, noting the importance of LA’s metaphor of the ‘fraying’ rope for an incipient, as yet undetected, safety risk. LA said that both meetings had been concerned about the inspection trajectory. On the other hand, inspection should not become a ‘numbers game’ at the expense of quality and depth of inspections, or health and wellbeing of CQC staff. The detailed assessment at the RGC had been really helpful in clarifying ways forward for Phase Two of inspections. There was a ‘story to tell’ in terms of the lessons learned through CQC inspections that could inform an improvement trajectory for providers. AS informed the Board that her inspectorate was looking at how such lessons could be more widely shared with colleagues. MM noted that he had been very impressed with the often complex judgments made by CQC’s inspection teams.

**Decision: the Board noted and commended the reports.**

**ITEM 9 - ANY OTHER BUSINESS**

There was no further business.

**QUESTIONS FROM THE PUBLIC**

David Hogarth noted that he was involved in community befriending projects. He had befriended an elderly patient with dementia, and had raised concerns about possible ill-treatment detected through covert surveillance by a recording device that he, DH, had installed. He had been disappointed by CQC’s response that he should not have installed the device, and was unpersuaded that other approaches such as observational monitoring, or speaking with care-home staff, would be as effective as surveillance. He was in the process of drafting an article for ‘Caring Times’. LA mentioned that he had concerns about the large percentage of providers rated well on the ‘caring’ indicator and the quality of the evidence base.

AS noted that DH had written to her and she had responded. However, CQC had a responsibility to respond appropriately to concerns raised and that the providers involved had to take responsibility for any required remedial action. At the general policy level, there were varying opinions on surveillance cameras, but privacy and proportionality considerations were important. Surveillance could never be the only method of monitoring; it was supplementary, and the key thing was to employ staff who had the right values and behaviours.

Bren Mcinerney enquired about Trusts in special measures. He wanted to know to what extent lead inspectors bore responsibility for the findings arrived at and how they were conveyed to Trusts. MR responded that this was important and was a reason why Quality Summits were
held at the conclusion of Inspections. BI enquired further about obtaining data from CQC: he had wanted to acquire data underlying the aggregated inspection ratings, and wanted to know how this could be done. MM and PB responded that this data would be available in the ‘State of Care’ report. CQC was committed to making the aggregate data available to the public in more ‘granular detail’.

CLOSE

The meeting closed at 11:47.

Signed as a true and accurate record

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