Agenda Item: 4
Paper No: CM/10/20/04

MEETING	**PUBLIC BOARD MEETING 21 October 2020**
Agenda Item Paper Number	**4 CM/10/20/04**
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:

Chief Executive's report Activity of Interest since the last meeting

1. Activity of interest
2. Upcoming activity of interest

Chief Inspector of Adult Social Care's report

3. Covid -19 response in ASC: Market Oversight
4. Restraint, Seclusion and Segregation update

Chief Inspector of Hospital's report

5. Inspections

Chief Inspector of Primary Medical Services' report

6. PMS update

Chief Operating Officer's report

7. Performance Report
8. People Plan

Chief Digital Officer's report

9. Information and cyber security risk

Executive Director of Engagement, Policy and Strategy Directorate's report

10. Strategy update
11. Mental Health Act (MHA) Update
12. Parliamentary activity of Interest

Recent and Forthcoming Publications

13. Recent Publications
14. Forthcoming Publications

Chief Executive's report

1. Activity of interest since the last meeting

The last month continues to be dominated by Covid -19. Attempts to open up the economy and daily life that we touched upon last month have swiftly re-focused on containing the spread of Covid -19. This means a second wave response has started across the health and social care system and in our daily life as we prepare ourselves for more restrictions going into Winter.

We are however, in a very different position than we were at the beginning of the first wave – where we had to reactively respond to an unprecedented situation.

Last week we published our State of Care report for 2019/20. We set out how health and care has changed over the last few months. One of our main messages was the need for services to adapt to work well in a Covid-era if they are going to avoid exacerbating inequalities.

We have gone live with our Transitional Regulatory Approach delivering streamlined regulation for the coming few months. This approach will iterate as we develop our thinking, ultimately evolving into a Future Regulatory Approach in May 2021.

October is Black History Month and Speak Up month – both are important to us and we have celebrated our corporate commitment to improving diversity, inclusion, openness, and transparency. We have had some incredible external speakers talking at special Zoom events for Black History month and we are building a strong group of Speak up ambassadors who meet regularly

2. **Upcoming activity of interest**

   We continue with our phased approach to *Now, Next and Future* as outlined last month. We will continue our external stakeholder discussions on the 20/21 Strategy.

   Our internal change process continues in parallel with change to our external regulatory approach. Our intention is that this will link in seamlessly with the Strategy and both will be published together. This will mean exhaustive collaboration and engagement with internal and external stakeholders over the coming months.

Chief Inspector of Adult Social Care's report

3. **Covid-19 Response in Adult social care update:**
   Kate Terroni Chief Inspector for Adult Social Care will give a verbal update

4. **Restraint, Segregation and Seclusion/Closed Cultures update**

   RSS update
   The report has been finalised and key messages discussed with stakeholders who have been involved in the development of the report. We are currently in the final stages of sign-off and hope to publish the report on October 22nd, 2020.

   Closed Cultures update

   The Glynis Murphy review is being published in two parts. The first part published on 18 March 2020. We are expecting the second part of the review to publish at our December board on 15 December. This will have recommendations to improve the way CQC regulates, including how to better detective poor cultures. CQC's board will consider these recommendations and respond in due course.

Chief Inspector of Hospital's report

5. Inspections

In September Hospital inspection teams undertook 23 onsite risk-based inspections and published 25 inspection reports. There are currently 12 onsite inspections planned for October although more are expected to be agreed over the next week. The below 9 reports are due to be published in October with a further 20 reports expected to be published in November.

1. Queens Hospital
2. Transsecure NW Ltd
3. Field House
4. The Breightmet Centre for Autism
5. Garrow House
6. Cygnet Appletree
7. Devon Partnership NHS Trust
8. Priory Hospital Burgess Hill
9. Oxleas NHS Foundation Trust

Chief Inspector of Primary Medical Services' report

6. PMS Update to the CEO for Public Board

Provider Collaboration Reviews (PCR): Our programme of reviews continues, with review cycles now running concurrently. At the same time as publishing the first phase full findings via state of care, our on-site delivery continues for the urgent and emergency care module, as development teams also scope and design the cancer review. As we continue to progress the timelines of each of those upcoming, we will see the scoping and design of the learning disabilities and autism and mental health reviews commence. Our teams continue to focus on seeking external stakeholder support, including from those who access services, to ensure the reviews are designed, planned and informed well.

S48 Thematic review: We were pleased to receive the s48 commission request via Nadine Dorries. Our teams are working rapidly to scope and consider the detail of approaches for the review. This will include ensuring DNACPR approaches be

considered within the context of personalised care planning, and the review consider partnership approaches across primary, secondary and social care. Our initial priority has been to engage well with public and professional stakeholders, ensuring we invite partners to share what they know, test and scope review priorities and identify requirements of the review to drive learning and improvement. Our immediate ambitions for the scope of the review as; Review the use of DNACPRs and other related personalised care planning tools used during COVID-19 responses, to understand which approaches best ensure individualised person-centred care that safeguards human rights and meets the needs of all population groups.

Access to GP appointments

Some people are telling us they are unable to 'access an appropriate GP appointment', and therefore potentially not receiving safe care and treatment. If this is the case, there are potential significant impacts on both people and systems.

- People who use GP services are not always getting an appointment they think will meet their needs
- GP providers have significantly improved the way they work, and believe they are offering appropriate access to appointments
- NHSE Appointment data is not fully reliable (and unlikely to be before April 2021)
- NHSE have communicated requirements to GPs and have an engagement plan with providers and the public, starting with 'Help us, Help you' (focussed on cancer)
- Local and National Healthwatch continue to undertake significant user engagement

We need to understand whether clinical risk being safely managed and whether people's needs being met appropriately by GP services and beyond?

We are:

- Commencing an analysis of 'what people tell us' (Including Healthwatch reports, data re concerns, Tell us about Your Care)
- Monitoring all data, we hold re access to GP appointments
- Engaging with providers/stakeholders through citizen lab during October
- Developing a thematic probe, will always focus on 'access' at all inspections triggered through TMA/risk (approximately 250 over 3 months)

- Considering an insight publication and/or a separate report (for further discussion at Independent Voice Panel on 28 October 2020)

Special Measures Inspections

We have commenced a programme of inspecting all GP practices in Special Measures, we aim to conclude these inspections before 31 December 2020. We have had some positive feedback from providers about recommencing the inspections.

We are working in partnership with NHSE/I and the RCGP to ensure there is an appropriate system in place to support GP practices who are either deteriorating and/or placed in Special Measures

GP Focused Inspection Pilot (GPFIP)

We have previously report to the Board progress about the GP Focused Inspection Pilot. Since our last report, progress has continued and all of our Specialist Advisers working on this pilot (20) are equipped with technology that will provide access to patient records and support the pilot and inspectors to complete their work. Changes to our terms of reference mean that we have not completed as many GPFIP inspections as we had planned, as we are waiting for TMA to commence. GPFIP is included as an option for regulatory activity from TMA and consequently we anticipate a significant increase of its use when it commences for GPs on 19 October. To date we have completed 18 GPFIP inspections of which eight required a location visit and nine resulted in regulatory breaches and enforcement action. Of the nine requiring enforcement action, five did not require a location site visit.

Inspection of Safe Houses

The Memorandum of Understanding between CQC and the Home Office has been signed, and the funding agreed to support the delivery of a programme of inspection of Safe Houses, where accommodation and care is provided for those people who are the victims of trafficking and modern slavery. A team of one p/t manager, three inspectors and an inspection project manager is now in place and it is expected that the programme will begin in November. This is the first time such services have been subject to a programme of inspection, anywhere in the world.

Special Educational Needs and Disabilities (SEND): We recently launched the first of three stages of SEND support visits in partnership with Ofsted. The visits are research based and focus on the experience of children and young people with SEND and their families during the pandemic. The second stage will deliver in November and the third in January 2021. We will not publish the local areas by name, however findings will be shared via social media and webinars.

Chief Operating Officer's report

7. Performance Report

1. Performance Report for August 2020

Annex 1 provides a summary of the full business plan and month five performance.

This paper covers the key highlights in month, as well as any measures that were rated amber or red. Amber indicates anything that is within 10% of target (if a set target) or not showing improvement for those measures set to improve within year. Work is ongoing to ensure all measures all captured.

Priority One: Deliver Our Core Business

- **Registration applications** (simple and complex): - At the end of August simple applications (1132 processed in August) have taken 14.5 days to process and complex applications (37 processed in August) have taken 117.6 days. Simple applications are made up of applications processed by NCSC and those which are reduced risk.

- **Registration Quality Measures (3&4):** During the pandemic we have been inspecting due to risk, utilising our intelligence and have ceased routine inspections. We have placed on hold measures 3 and 4 as without inspecting all newly registered services it was not possible to see a complete picture. We have additional internal measures for registration quality which help to ensure this is constantly reviewed.

- **Regulatory Action:** Between April and the end of August, 915 locations have been inspected, 814 with a site visit. Those with a site visit include 300 inspections which were conducted as part of an Infection

Prevention & Control (IPC) thematic in Adult Social Care. Excluding the IPC inspections, 91% of inspections with a site visit were conducted due to risk.

- Inspections continue to be mainly triggered by information of concern or statutory notifications. 59.7% of risk inspections were triggered by information of concern between April and August. Information of concern includes whistleblowing, safeguarding, concerns and complaints.

- Emergency Support Framework (ESF) continues to be utilised with 65% of ASC, 13% of hospitals (applicable locations) and 7% of PMS locations having had an ESF call. 93% of hospital trusts and MH locations have had an Infection Prevention Control (IPC) assessment by the end of August. Ongoing monitoring remains a key focus across all locations and directorates.

- **Report Writing:** ASC have published reports in an average of 28 days compared to 27 in 2019/20. PMS have published in an average of 33 days compared to 31 in 2019/20. Hospitals have published in an average of 51 days compared to 52 in 2019/20. The measure looks at the average time taken in month, therefore it is important to note that the volume of reports produced between April and August are lower than average months over 19/20 due to COVID-19 and the focus of the majority of inspections is on risk which can add an extra complexity to the report writing process.

Priority Four: Equip Our Organisation and People

- **Turnover:** Our turnover remains stable at 8.16%

- **Sickness:** Sickness remains on track against the target of remaining under 5%, currently at 3.54%

- **Finance Revenue:** The revenue budget is forecast to be £4.4m underspent at the end of the year. This includes a potential £1.8m shortfall on provider income.

- **Finance Capital:** Currently forecast to be £3.3m overspent at year end, however this is being actively managed down at present.

8. People plan

Planning for our all colleague virtual conference 'Connect and Share' is reaching the final stages; this inclusive event for all colleagues focuses on our ambition to become a world class regulator.

As we continue to support colleagues working at home through the pandemic, our focus is to encourage ongoing healthy habits. The Good Work Habits Campaign has been launched in October providing helpful tips for colleagues and signposting to our extensive health and wellbeing resources and support.

Chief Digital Officer's report

9. Information and Cyber risk security

Nothing further to report. There are no significant information or cyber security incidents to report.

Executive Director of Engagement, Policy and Strategy Directorate's report

10. Strategy 2021 update

Through a new document we have publicly shared our early thinking on the priorities for our next corporate strategy. Formal consultation will take place in January 2020, but this discussion document how our engagement so far has influenced our thinking and will be used to stimulate conversation where we know there are still areas to develop further. The next few months will be used to engage with key stakeholders, testing out early thinking and refining these priorities.

11. Mental Health Act (MHA) Report update

Monitoring the Mental Health Act report

We have a statutory duty each year to publish and have laid before parliament a report on our activities in monitoring the Mental Health Act (MHA). Both the reporting duty and the monitoring duties to which it relates are established by the MHA itself, independently of the wider role and duties of CQC under the HSCA.

This year, the MHA teams have produced, in discussion with stakeholders, a draft report that principally focusses on the impact of the COVID-19 pandemic on the care and treatment of patients detained under the MHA and on the operation of the MHA. To ensure our statutory reporting duty for 2019/20 is met, the report also provides data, without analysis, on our monitoring activity over the financial year 2019/20, including visits undertaken, complaints received, and Second Opinion Appointed Doctor administration.

Our approach to the report is slightly different from previous years given the ongoing pressures on mental health services during the pandemic, and the likelihood of a long winter period where this will be sustained. We want to use the annual report to provide feedback and lessons learned from this monitoring activity, at a time when it is most relevant and useful to support services and influence best practice.

The report is currently in development and will published in the near future at a date to be confirmed.

12. Research Report publications and HSJ – Strategy & Improvement

Update from Research, Development & Evaluation Committee – publication of research

On 1st October, CQC intended to publish three related reports. These reports had initially been planned for Spring 2020 publication but were delayed by Covid-19. The reports were carried out to look into areas where CQC's regulation contributed to improving quality in health and care, and where this can be improved. The reports are being used to inform our future work, including the next strategy.

a) **CQC's impact on the quality of care: An assessment of CQC's contribution**. This report offers an in depth assessment of the relationship between CQC's regulatory approach and improvement. We are using a number of the findings to inform our strategy and approach from 2021. For example, open and honest relationships between CQC inspectors and people who work for a care provider can contribute to better quality care, particularly if CQC involves partner organisations to help providers improve. The study also found that CQC can contribute to improvement by producing accessible and up to date guidance products for care providers.

b) **Rapid Literature Review on Effective Regulation: Implications for the Care Quality Commission.** To base our Strategy for 2021 and beyond on the best evidence about what works in regulation, we looked at external evidence, working with an academic advisor at the University of Manchester. We carried out a rapid review of the literature on effective regulation, including in other countries and sectors. This was intended to ensure our strategy beyond 2021 is based on the best evidence about what works in regulation. The review identified key learning to inform our strategy,
    a. taking a flexible approach to regulation and adapting it to the circumstances of different providers

b. building ongoing relationships with the providers we regulate
c. working with other parts of the system to achieve improvements in quality
d. meaningfully involving people who use services in our regulation
e. ensuring relevant regulation by keeping pace with the digitalisation, technology, and innovations in the system

c) **Evaluation of the healthcare services well-led framework.** The evaluation showed that:
   a. the framework enables leaders to change leadership practices that have an impact on the quality of care;
   b. the framework needs to focus on both governance and processes and culture and leadership, including a greater focus on diversity and engaging people who use services;
   c. regulators need to look at both leadership in individual organisations as well as how they operate across the broader system;
   d. regulatory and oversight bodies need to ensure providers get support to improve;
   e. Aligned to the findings from the evaluation of the Well Led Framework, the NHS people plan for 2020/21 has emphasised the need for compassionate, distributed and inclusive leadership, and a culture that encourages and celebrates diversity. We have carried out provider collaboration reviews to look at how health and social care providers are working together in local areas and we will be engaging with leaders with NHS trusts about the further development of the Well Led framework.

13. Parliamentary Activity of Interest

Update of Parliamentary activity for the board is as follows:

- As part of the Health and Social Care Select Committee inquiry into 'Safety of Maternity Services in England', Professor Ted Baker gave oral evidence on 29 September, alongside Dr Bill Kirkup, Chair of the Morecambe Bay maternity investigation and East Kent maternity investigation. The evidence covered a range of topics, including the current picture of maternity services, 'blame culture', safety, interventional surgery, whistleblowing and risk-based focused inspections.

- Kate Terroni and Peter Wyman will hold a virtual meeting with Liz Kendall MP (Labour, Leicester West), Shadow Minister for Social Care on 19 October. The meeting is due to cover CQC's new strategy, social care during COVID-19, our response to the Winter Plan, care home visits and the review of restraint, seclusion and segregation. In addition, Chris Day held a virtual meeting with Ms Kendall regarding our key messages ahead of the publication of State of Care 2019/20.

- As part of our wider parliamentary engagement approach following the General Election last year and the ongoing pandemic, Ian Trenholm has continued to hold meetings with members of the Health and Social Care Select Committee to discuss our role and purpose, future direction, response to COVID-19 and how CQC engages with Parliament.

In addition, it is worth highlighting the follow entry which is not parliamentary but is unlikely to be picked up elsewhere in the board papers.

- Following a request from the Independent Inquiry into Child Sexual Abuse (IICSA), Dr Rosie Benneyworth gave oral evidence on 1 October, alongside the HM Inspectorate of Constabulary and Fire & Rescue Services and Ofsted. Rosie spoke about the variation in addressing child sexual exploitation (CSE) across the country and discussed the need for strong local partnerships and information sharing arrangements to target CSE.

Recent and Forthcoming Publications

14. Recent Publications

Draft strategy content for conversation Oct-Dec 2020

On 1 October, we shared our current thinking on our draft new strategy for 2021 and beyond. This is to support our engagement activity up until formal consultation in January. It has been made available on CitizenLab to frame some questions to prompt discussion with key stakeholders.
It will set out our strategic themes and what we mean by each, posing a number of questions as we look to refine our thinking and test the appetite among stakeholders. All of the above objectives for this next phase of engagement will be supported by this publication.

Emergency Departments: Patient FIRST

We published an online resource on 5 October to help providers improve safety in emergency departments, particularly ahead of activity increasing in winter. This work stems from ongoing engagement with a group of senior emergency department

clinicians (predominantly consultants and lead nurses for emergency departments) that is being led by CQC's ED national professional advisor, Prem Premachandran.

Right Support, Right Care, Right Culture

CQC published 'Registering the right support' in June 2017. This guidance set out our policy position on how providers of health and adult social care should meet the fundamental standards in line with best practice when developing services for autistic people and people with a learning disability.
Last year, we decided to review this guidance, so carried out an engagement exercise to explore with a wide range of people how we can make improvements.

We published on the CQC website the updated guidance on 8 October, to better reflect personalised care and outcomes for people.

Mental Health Rehabilitation Inpatients Report

Our report, 'The State of Care in Mental Health Services 2014 to 2017', raised concerns about the high number of inpatient beds across England provided in 'locked rehabilitation' wards. We were concerned that, too often, these facilities did not seem to be providing active rehabilitation or working towards community discharge proactively.

To further investigate these concerns, we sent a data request to all providers of inpatient rehabilitation services in England in 2017. In March 2018 we published our findings and recommendations in a briefing – mental health rehabilitation inpatient services. We recommended that the Department of Health and Social Care, NHS England (NHSE) and NHS Improvement (NHSI) agree a plan to engage local health and care systems in a programme of work to reduce the number of patients receiving inpatient mental health rehabilitation outside their home area.

This latest report, published on 16 October, presents the results of a second data collection we conducted in 2019 to review progress made on the recommendations in the 2018 briefing.

Follow up report to Children and Young People's Mental Health thematic review

This report, published on 16 October, describes the findings of our independent review of how health and wellbeing board areas in England have progressed with implementing the recommendations we set out in our 2018 report 'Are We Listening?'

The report, published in March 2018, was the culmination of a review of children and young people's mental health services commissioned by the prime minister in January 2017. It included recommendations for national, regional and local action. We contacted Health and Wellbeing Boards (HWBs) in England asking them to complete a self-assessment questionnaire outlining how they had implemented the recommendations made in the 'Are We Listening?' report.

Assessment of Mental Health Services in Acute Trusts (AMSAT)

As an organisation, CQC is committed to ensuring a person receives high-quality mental health support. Between September 2017 and March 2019, mental health inspectors provided specialist support on 105 acute inspections to look at how well the mental health care needs of patients were being met across NHS hospital trusts in emergency departments, acute medical wards, maternity wards, and children and young people's services.

This report, released on 16 October, looks at the findings from these inspections and identifies areas where acute trusts, and the wider system, need to improve in order to meet the mental health needs of patients.

State of Care Annual Report 2019/20

CQC publishes an annual 'State of Care' report to fulfil a statutory duty. The report aims to inform parliament about the current state of health and adult social care in England. We aim to influence policy makers and use our independent voice to improve services for people who need care. Using multiple intelligence sources and insight, we focus on themes that have shaped the quality of care in the past year and provide our thoughts about the year ahead. The report was laid before Parliament on 15 October and launched on 16 October.

15. Forthcoming Publications

RSS Thematic Final Report

The Secretary of State asked CQC to review and to make recommendations about the use of force and restrictive interventions in settings that provide inpatient and residential care for people with mental health problems, a learning disability and/or autism. We have found that restrictive practices were being use variably across services and that more of a focus is needed on supporting people in the community. We are publishing the report on 22 October.

IR(ME)R Annual Report

CQC is the enforcement authority under the Ionising Radiation (Medical Exposure) Regulations 2017. The report for 2019/20 gives an overview of the types of notifications we received of incidents involving significant accidental and unintended exposures of ionising radiation. It provides key findings from our investigations of incidents and our wider inspections, so that providers can learn and improve safety. It is aimed at a professional readership. This year we also focus on how providers responded to changes to practice because of COVID-19, and the impact of this.

Give Feedback on Care Campaign: Targeting

Late October-November, we will be launching the second spike of *Because We All Care* - targeting people older people. *Because We All Care* supports and encourages more people in England to feedback on health or social care services, they, or a loved one, have experienced.

Older People Spike

Our research shows that over 55s are most likely to believe providing feedback on care makes a difference. However, this age group is also less likely to think care has improved during the pandemic. With over 55s accessing care more frequently, as well as providing support to family and friends, now more than ever we want to continue to hear about experiences of care.

The campaign seeks to help services identify and address safety and quality issues, in the context of COVID-19, and to encourage longer-term consumer behaviour change, by normalising the act of giving feedback after interacting with health or social care services.

The older people spike will run for four weeks ending at the end of November 2020.

Mental Health Act Annual Report 2019/20

This is our statutory annual report to parliament on CQC's Mental Health Act (MHA) monitoring activities in 2019/20. This year, due to the COVID-19 pandemic, the report will focus on how services have responded to the pandemic, and the impact on patients detained under the MHA. We will then include an appendix of data including SOAD visits, deaths of detained patients, monitoring visits and complaints for 2019/20.

COVID-19 Inpatient Survey

CQC has carried out a survey of adults who spent one or more night as an inpatient in an acute hospital in England and were discharged in April and May 2020. It aims to compare the experiences of people receiving inpatient treatment for COVID-19 in comparison to those with a non-COVID diagnosis and to capture insight that can contribute to the NHS response during any second subsequent COVID-19 spike, as well as supporting the on-going care of those continuing to be admitted with the virus.

Infection, prevention and control in care homes during the pandemic

In our September edition of the COVID-19 Insight report, we published analysis of infection prevention and control (IPC) in 59 high-risk inspections of care homes that took place during the first half of August 2020. We will follow this up in our November Insight report, summarising the analysis from a special programme of IPC inspections in 301 care homes selected as potential

examples of good practice. At the same time, we plan to publish this full report, to provide more detail from the IPC programme, as well as other information about the challenges and response of care homes to the pandemic. By sharing this good practice, we aim to support services to prepare for the winter.