MEETING	**PUBLIC BOARD MEETING 20 November 2019**
Agenda Item Paper Number	**4 CM/11/19/04**
Agenda Title	**Executive Team report to the Board**
Sponsor	**Ian Trenholm, Chief Executive**
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PURPOSE OF PAPER:

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

Introduction

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

1. Parliamentary event on State of Care 2018/19
2. Improving regulation in closed environments
3. JCHR report into 'detention of young people with learning disabilities and/or autism'
4. Upcoming publication: Community Mental Health Survey
5. Information and cyber security risk

Chief Executive's report

1. Parliamentary event on State of Care 2018/19

Ian Trenholm, Ted Baker, Kate Terroni, and Rosie Benneyworth spoke at a parliamentary event on our State of Care 2018/19 publication on Wednesday 23 October in the House of Lords. The purpose of the event was to brief parliamentarians and stakeholders on this year's findings and recommendations and discuss their feedback and insights.

Chief Inspector of Adult Social Care's report

Nil report.

Chief Inspector of Hospital's report

2. Improving regulation in closed environments

Regulation of similar environments

We have rated 13 mental health hospitals that admit people with a learning disability and or autism inadequate since May 2019.

Closed environments update

Workstream 1 & 2 update: improving our regulation and Engagement:

- **Supporting Information on closed environments published on 1 November.** This followed engagement with people with lived experience and their families, inspectors, Mental Health Act colleagues.

The two *independent reviews* we commissioned are progressing:

We are committed to accepting and implementing the full findings of these when they are released.

1. David Noble is leading a review into how we dealt with concerns raised by Barry Stanley-Wilkinson in relation to the regulation of Whorlton Hall. A verbal update will be provided at the meeting.

2. Glynis Murphy is Chairing a wider independent review of regulation of Whorlton Hall from 2015 to 2019. We anticipate this to be complete by early 2020.

Review of restraint, prolonged seclusion and segregation

Letter to parliamentarians

- We wrote to Parliamentarians, all English MPs as well as targeted Peers, on Friday 25 November to update them with progress of our review. The purpose of this was to ensure they are aware of how the review is progressing, as well as to ask them to feed any local insight they may have.

International summit with BILD (British Institute for Learning Disabilities)

- CQC convened a domestic summit which brought together experts in restrictive practices alongside BILD, NHS England and DHSC on 13 August that started work to deliver recommendation 2 of CQC's interim RSS report. The purpose of this is to design a better system for people with a learning disability and/or autism, at risk of being placed in segregation or seclusion.
- BILD hosted the second summit with an international perspective, and the final event in this series, on 11 November.
- The summit was facilitated by the Restraint Reduction Network and Valuing People Alliance, with support from CQC and the Department of Health & Social Care

Independent case reviews

- The Secretary of State for Health and Care made an announcement on 5 November, committing to delivering CQC's recommendation to review everyone identified as being in segregation in its interim RSS report released in May 2019. The reviews will be overseen by an Independent Panel, chaired by Baroness Hollins.

3. JCHR report into 'detention of young people with learning disabilities and/or autism'.

The Joint Committee on Human Rights has published its report into 'detention of young people with learning disabilities and/or autism'. The report considers CQC's a judgements and response to Whorlton Hall and St Andrew's, including responding to concerns from individuals and families.

The report makes a number of recommendations for CQC including: unannounced inspection including at weekends and evenings; the use of covert surveillance where appropriate; reacting to concerns raised by patients and family members; changes in legislation to enable CQC to act more swiftly where concerns have been raised; and a review of the system which currently allows a service to be rated as 'Good' overall even when individual aspects, such as safety, may have a lower rating.

Many of the recommendations that relate to CQC are already in place or under way – although we are clear that there is much still to be done.

4. Upcoming publication: Community Mental Health Survey

The Community Mental Health Survey has been running annually as an established part of the NHS Patient Survey Programme since 2003. The 2019 survey received feedback from 12,551 service users, who received specialist care or treatment for a mental health condition between 1 September and 30 November 2018.

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. We will use data from the survey in our system of CQC Insight, which provides Inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections.

Chief Inspector of Primary Medical Services' report

Nil report.

Chief Operating Officer's report

Nil report.

Chief Digital Officer's report

Nil report.

Executive Director of Strategy and Intelligence's report

5. Information and cyber security risk

There are no significant incidents to report.