Minutes of the Public Board Meeting
Finsbury Tower, London, EC1Y 8TG
16 APRIL 2014 at 09.00

Present

Michael Mire (MM)	Acting Chair, Commissioner and Non-Executive Board Member
David Behan (DB)	Commissioner and Chief Executive Board Member
Louis Appleby (LA)	Commissioner and Non-Executive Board Member
Anna Bradley (AB)	Commissioner, Non-Executive Board Member and Chair of Healthwatch England
Paul Corrigan (PC)	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

In attendance

Eileen Milner (EM)	Director of Corporate Services
Hilary Reynolds (HR)	Director of Change
Claire Luxton (CL)	Corporate Governance Manager
Emma Rourke (ER)	Director of Intelligence (Item 9 only)

ITEM 1 – WELCOME, APOLOGIES & DECLARATIONS OF INTEREST

1. The Chairman opened the meeting. Apologies for absence had been received from David Prior, Jennifer Dixon, Camilla Cavendish and Paul Bate.

ITEM 2 – MINUTES OF THE MEETING HELD ON 19 MARCH 2014 (Ref: CM/04/14/01)

2. The Minutes of the meeting held on 19 March 2014 were reviewed and accepted as a true record of the meeting**.**

ITEM 3 – MATTERS ARISING AND ACTION LOG (REF: CM/04/14/02)

3. The Action Log was noted without further comment. There were no matters arising.

ITEM 4 – CHIEF EXECUTIVE'S REPORT (REF: CM/04/14/04)

4. DB introduced his report, focusing on delivery of the first year of the 2013-16 Strategy. The whole of the organisation had been involved in delivering the first year objectives which included the introduction of a new inspection methodology by 1 April 2014,

publishing the intelligent monitoring reports for Acute NHS Trusts and the launch of the Academy which was now training staff in the new methodologies.

5. Two more signposting documents had been published, for Ambulance services and Independent Healthcare. Eight Provider Handbooks had also been published for consultation accompanied by three overview documents from the Chief Inspectors and a report on the CQC's Human Rights approach for the regulation of health and social care services. The consultation will close on 4 June.

6. DB reported that he expected the Care Bill to gain Royal Assent in mid-May. The Department of Health was consulting on the Regulations regarding the Fit and Proper Person Test, Duty of Candour and the Fundamental Standards. These will conclude in April and the CQC will work with the Department of Health on the regulations which will be included in the Handbooks to be published in September.

7. The CQC had contributed to the Nursing and Midwifery Council (NMC) review on a proposed model of revalidation for the 300 nurses employed by the CQC. The Academy will play a role in the revalidation process. SF reported that he was leading on the medical revalidation process for doctors.

8. The CQC was also preparing a response to the House of Lords Mental Health Capacity Report which included a number of recommendations that applied directly to the CQC. The Board noted that the CQC will be responding to the Department of Health who is coordinating the response. DB suggested it would take three to four years for the recommendations to come into being, should they be accepted. He asked Board to note that the Supreme Court Judgement on the Deprivation of Liberty was more immediately significant for deciding whether arrangements made for the care and treatment of an individual who might lack capacity are appropriate. Guidance for providers and staff have been prepared and circulated.

9. The Health Select Committee had recently published Monitor's Annual Accountability report and had recommended that the CQC and Monitor work together more closely and clarify their regulatory responsibilities. DB observed that this was an opportunity to explain where the two institutions do work together and to further clarify their respective roles. He confirmed that while there was an open dialogue between Monitor and the CQC at a senior level, there was less consistency at a local level. It was now a priority to establish a good working relationship between the two institutions at all levels consistently across the regions.

10. Board members gave their congratulations to the Executive and Staff for delivering the first year's strategic objectives. LA expressed a concern that the intelligent monitoring

methodology was reliant on data currently available rather than designed to reveal what the CQC wants to know in order to deliver its regulatory responsibilities. He asked if there was a plan to build up a database of what the CQC wants to know over a period of time. MM suggested this question was best answered in a discussion about the Knowledge and Information Strategy later in the agenda.

11. LA also asked about the processes for reporting on action taken for failing and underperforming services. DB explained that Non Executives received a weekly update about issues of concern that were not ready to be made public because they were under investigation. If these issues progressed to a serious case review, the lessons learnt from that review would be published. He reminded the Board that the corporate performance report has been re-designed for 2014/15 and will include more data on enforcement activity and outcomes. The State of Care report is also an opportunity to carry out a root cause analysis of any failure of quality or care provision. KS observed that the CQC's role is to encourage improvement but is not an agent for improvement. She suggested that a clear narrative describing the improvement journey was required for each sector.

12. **ITEM 5 – CHIEF INSPECTOR OF GENERAL PRACTICE UPDATE REPORT (Ref CM/04/14/05)**

13. SF introduced his update report and added his thoughts on the Transforming Primary Care report published by the Government that week. He welcomed the significant funding for innovative service provision and the number of points removed from the Quality Assurance Framework, which will encourage a focus on quality service provision for people rather than ticking a box for points. The direction of travel for Primary Care was good but it needs to be embedded before he can judge its effectiveness.

14. He informed the Board that Profession Nigel Sparrow will be the officer responsible for revalidating doctors working for the CQC. He is a senior GP advisor and is on the RCGP committee for revalidation. He also confirmed that Paul Lelliott would work with Professor Sparrow on specific issues relating to revalidating SOADs

15. Since writing his update report, SF reported that 31 Out of Hours services had been inspected in wave one and 23 Quality Panels had been held. 12 more Out of Hours providers will be inspected in the wave two Out of Hours programme. 12 reports will be published in April and a further 19 in May. An overview report will be published in June and will include a review of the 2010 Out of Hours Review. Overall the quality of care found in Out of Hours services was generally good.

16. He also highlighted the Dentistry inspection plan which aims to inspect 10% of practices each year. The Deputy Chief Inspector for Dentists will take up post on 28 April. He confirmed that the Sign Posting document for inspecting Dentistry will explore a number of issues such as testing the quality of information given to the service users and what data is available for intelligent monitoring of Dentistry services.

ITEM 6 – CHIEF INSPECTOR OF ADULT SOCIAL CARE UPDATE REPORT (Ref: CM/04/14/06)

17. AS presented an update report on activity from the Adult Social Care directorate since the last meeting. Wave one of the ASC inspection programme was under way and AS confirmed that she was working with providers to co- produce the new approach which will encourage improvement by identifying what good looks like. She was also considering how to develop consistent intelligent monitoring methodology for Adult Social Care which is not as well developed as it is for hospitals or primary medical services.

18. AS announced the appointment of the fourth Deputy Chief Inspector, Sally Warren, who will lead on the development of the CQC's Market Oversight role. The recruitment of Head of in Inspectors was also underway.

19. She confirmed that a range of regional consultation events were in place to meet with service users and members of the public on the new methodology. The events will be published on the website and circulated to Board members.

ITEM 7 –CHIEF INSPECTOR OF HOSPITALS UPDATE (Ref: CM/04/14/07)

20. MR updated the Board on the development of the new Chief Inspector of Hospitals Directorate, which had been in place from 1 April; four Deputy Chief Inspectors and eight Head of Hospital Inspections have been appointed. Waves one and two of the acute hospital inspection programme have been completed, which account for nearly 25% of all Trusts in the country. All of the Trusts in wave two will be issued with a rating; MR observed that more care is being taken at the factual accuracy stage to ensure the ratings are right when the report is issued.

21. Wave one of the Mental Health and Community Services inspection programme has also been completed. MR confirmed he was reassured that the methodology worked well.

22. LA asked if there was an opportunity for the CQC to learn lessons from variables of health care across Europe as well as learning from English Trusts. He was referring in particular to the media attention given to the UK having the lowest number of beds across Europe which he felt did not address whether there was a correlation between the availability of beds and overall quality. MR agreed that the issue wasn't just about the availability of beds, but how hospitals proactively move patients through and out of the hospital. He also confirmed that hospital inspectors do consider how many people are in the wrong beds which can impact on patient quality, safety and effectiveness. Over time the inspectors will be able to use this information to build up predictors of quality, which will contribute to the improvement agenda.

23. MR also gave a verbal report on his visit to Virginia Mason Hospital in Seattle with the Secretary of State to look at its approach to managing and reporting safety incidents.

ITEM 8 – THEMATIC REVIEW TOPIC SELECTION (Ref: CM/04/14/08)

24. DB recommended to the Board two long thematic reviews on how older people experience joined up care from multiple services and how well people are supported to manage their diabetes in the community. These had been selected because they cut across primary, secondary and social care services giving a view of how the system as a whole delivers for particular groups of people. He also recommended 4 shorter reviews.

25. The shorter reviews have been chosen because they will assist in designing inspection methodology as well as report on what they find. Members observed that the proposed reviews meet the criteria set by the Board, particularly where the CQC can add value by looking at how the health and social care systems are integrated. KS requested that care was taken to ensure that the reviews covered all sectors and didn't just focus on one or two.

26. LA expressed a concern that a decision had been taken not to review IAPT services given it is a key mental health policy but IAPT services are not required to be registered with the CQC. DB and SF explained that consideration is being given the CQC's regulatory reach into IAPT services and suggested LA has a further conversation with Paul Lelliott. SF also agreed to provide the Board with a briefing on IAPT interface with CCGs.

AGREED – The Board agreed the following:

1. **Two long Thematic Reviews and 4 shorter reviews:**
   - **how older people experience joined up care from multiple services (long)**
   - **how well are people supported to manage their diabetes in the community (long)**
   - **Why is DNACPR decisions so variable and how can the CQC encourage best practice? (short)**
   - **How effectively is information form complaints and whistleblowing used outside hospitals? (short)**
   - **How do different types of services involve people in decisions about their care and what does good practice in involvement look like? (short)**
   - **How safe are our hospitals? A review of the implementation and effectiveness of safety guidance. (short)**

2. **Paul Corrigan agreed to be the Board Champion for the long review into how older people experience joined up care from multiple services**
3. **Kay Sheldon agreed to be the Board Champion for the shorter review on how different types of services involve people in decisions about their care.**

ITEM 8A – INEQUALITY IN END OF LIFE CARE THEMATIC REVIEW SCOPE (Ref: CM/04/14/8a)

27. The Board agreed the scope for the thematic review of inequality of end of life care. AS requested that the review includes consideration of what happens with the workforce as well as including social care institutions who can support in improving quality such as SCIE.

28. LA agreed to be the Board Champion for this review.

AGREED – the Board agreed the scope for the inequality in end of life care thematic review and Louise Appleby as the Board champion for this review.

ITEM 9 – KNOWLEDGE AND INFORMATION STRATEGY FRAMEWORK (Ref: CM/02/14/09)

29. Emma Rourke, Director of Intelligence, gave the Board an update on progress in developing the Knowledge and Intelligence strategy framework and the approach to delivering the strategy. The framework has been developed to assist the CQC's ambition to make a cultural shift to become intelligence driven; it provides a narrative that allows all staff to buy into the concept of being intelligence driven. Five work streams have also been developed across the full breadth of the Knowledge and Intelligence directorate; they respond in particular to less data rich areas such as Adult Social Care and Primary Care. A separate report on intelligence data for Adult Social Care is being prepared for the next Board meeting. This will also take into consideration the burden on providers for collecting data.

30. Board members welcomed the strategy framework but expressed a concern that qualitative data, particularly the user voice, could become overlooked because of a focus on quantitative data. How far will the CQC rely on existing qualitative data sources, such as local Healthwatch surveys? There was recognition that "softer" data sources can be a very rich source of information but are hard to get at. PC urged the CQC to develop a "militant restlessness" in its search for qualitative data.

31. ER assured the Board that there was transformation programme project dedicated to developing qualitative analytical tools as well as a better organised sense of what different user groups can offer to support the CQC. She is encouraging the notion that more data is not necessarily good and the CQC should be more discerning about the data it collects and how it is used. ER intended to procure extra support to further develop the data packs being used by inspectors. The Adult Social Care and Primary Care data packs had been launched that week and would be evaluated as part of the Wave One programme. MR confirmed that one of the learning points from the acute hospital inspections had been the need to develop a more sophisticated way of using the data packs.

32. LA encouraged ER to identify the gaps in the data available and say that data sources will be developed over the next couple of years as a matter of strategy to inform the Key Lines of Enquiry. He also encouraged the CQC to develop a "science of complaints" which includes feedback as well as complaints. EM added that work is underway to disaggregate raising concerns, complaints and whistleblowing. She is working with colleagues at the National Customer Services Centre (NCSC) to improve the way concerns and complaints are listened to and recorded.

33. AS reported that she was asking Domiciliary Care service providers for names and addresses of service users as well as sending them a questionnaire; she was also asking service users if inspectors can speak to relatives. It was too early to say how much information was coming back from this route. She is also mindful that people receiving Domiciliary Care are sometimes reluctant to share concerns because they were concerned a complaint might undermine the relationship, despite assurance given about confidentiality.

ITEM 10 – ORACLE DATABASE AND OBIEE LICENCES PROCUREMENT (Ref: CM/04/14/10)

34. The Board approved the procurement of the Oracle database and Data Warehouse licences.

Agreed – the procurement of the Oracle database and Data Warehouse licences.

ITEM 11 – NEW APPROACH FROM HEALTHWATCH ENGLAND PERSPECTIVE (CM/04/14/11)

35. AB tabled a slide which illustrated how Healthwatch (England and Local) should engage with the CQC's new approach to inspection. Engagement took place in three phases: during registration and surveillance; pre and during inspections; and the post inspection and improvement journey. She noted that Local Healthwatch engagement with the inspection process had been patchy, as had CQC engagement with some Local Healthwatch. Healthwatch England has included an objective in its Business Plan and budget to support Local Healthwatch develop capacity and capability.

36. Board members acknowledged strong links with local Healthwatch provided the CQC with an important link into the community. AS commented that the diagram provided a good illustration for hospital inspection but would like to see it further developed for Adult Social Care. She suggested the ongoing relationship between local Healthwatch and local inspection teams and an appropriate exchange of information is essential to enhance understanding of what the CQC is doing at a local level. It is also important for the CQC to consider how to feedback to Local Healthwatch on the local health and social care economy. SF also acknowledged it is important for primary care inspectors to build a strong relationship with Local Healthwatch teams. It was also agreed that it was important to reflect the One CQC concept at a local level rather than a separate relationship with each of the 3 inspection directorates.

ITEM 12 – REPORT FROM AUDIT AND CORPORATE GOVERNANCE COMMITTEE MEETING – 18 MARCH 2014 (Ref: CM/04/14/12)

37. The Board noted the ACG report with no further comment.

ITEM 13 – BOARD FORWARD PLAN (Ref: CM/04/14/13)

38. The Forward Plan was noted without further comment

ITEM 16 – ANY OTHER BUSINESS

39. There was no further business.

ITEM 17 – QUESTIONS FROM THE FLOOR

40. A member of the public asked for an update on the CQC's consultation to make use of video monitoring cameras, particularly on whether the CQC would seek permission and would the use of overt cameras as a preventative measure and highlight good practice. AS

referred to the ASC handbook consultation which had three specific questions about the use of cameras.

41. Another member of the public asked if it was possible to receive email alerts from the CQC about up and coming inspections. EM confirmed that a digital strategy was being developed that will consider how to use the website and digital technology to engage with members of the public.

42. There was a further question about the intention to inspect Out of Hours dental services. SF confirmed that the Deputy Chief Inspector responsible for dentistry starts on 28 April and their role will be to look at joined up care including out of hours dental care.

43. **CLOSE**

44. The meeting closed at 12.25.

Signed as a true and accurate record

…… Date:…….
Chair