**MEETING:**  CQC PUBLIC BOARD MEETING  

**DATE:**  
18 September 2013  

**TITLE OF PAPER:**  CHIEF EXECUTIVE’S REPORT TO THE BOARD  

**SUMMARY:**  
This report from the Chief Executive to the Board provides an update on a selection of developments and key issues not otherwise covered on the Board’s agenda.  

**RECOMMENDED ACTION:**  
The Board is asked to note the content of the report  

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<td>The Board has been consulted in order for the Executive Team to make a decision</td>
<td>This is a shared decision between the Executive Team and Board</td>
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* Check box as required  

**LEAD DIRECTOR:**  David Behan  

**AUTHOR:**  Naomi Paterson  

**DATE:**  12 September 2013  

**SUPPORTING PAPERS:**  None
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Introduction

This is a paper for the Board to note.

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

1. Consultation – A new start
2. Progress on the inspection programme
3. Care Bill
4. Government response to Francis report
   4.1 Patient safety review (Berwick)
   4.2 Complaints review (Clwyd / Hart)
   4.3 Bureaucracy (Farrar)
5. Review into the regulation of cosmetic interventions
6. Memorandum of Understanding with the PHSO
7. Transparency about quality in social care
8. Letter to the Secretary of State following the Grant Thornton review
9. Independent inquiry into UHMB
10. Registered Managers
11. Looked after children reviews
12. CQC website improvements
13. CRM – for Board approval
14. Decisions under the Scheme of Delegation
15. Security breach
16. Committee hearings
17. Progress on appointments

1. Consultation – “A new start”

The deadline for comments on our consultation, ‘A new start’, was 12 August 2013. Over 6000 people were involved in responding to the consultation in some way, including 4,521 through a survey on the CQC website and 736 formal responses (61 from staff). Regional events included staff, members of the public and providers. Responses were positive overall, including favouring better use of intelligence to inform inspections and a new inspection methodology for the NHS acute sector to allow for more robust judgements, with more varied support for ratings. At the time of writing, the findings are being analysed.

2. Progress on the inspection programme 2013/14

The inspection programme is on track to be achieved for the full year, but with some sectors under plan for the period. Year to the end of July figures show that 11,427 inspections had been undertaken, an increase of 92% compared with the same period last year. There are some risks associated with delivery in Q3 and Q4 as the new inspection programme is introduced. However, mitigating actions such as the recruitment of Bank Inspectors are in place.

The acute hospital inspection programme will be discussed under agenda item 8.

3. Care Bill

Consideration of the Care Bill will resume on 9 October with the Report Stage in the Lords. Government amendments cannot be laid (other than very
exceptionally) once this Stage has commenced, so we anticipate that any
government amendments will be set out within the next month. CQC’s powers
and responsibilities as set out in the Health and Social Care Act 2008 were
amended by the Health and Social Care Act 2012 and will be amended further
when the Care Bill is passed. I have previously set out relevant changes that the
Bill will introduce, including ratings, the hospital failure regime, and market
oversight in social care. The Bill as it currently stands is likely to be amended
further to allow for a response to the Mid Staffordshire Public Inquiry report and
the additional reviews set up following publication of that report (as discussed
below).

More detailed information is provided in the separate paper under agenda item 5.

4. Government response to Francis report

Following the publication of the Mid Staffordshire Public Inquiry report by Robert
Francis QC, the government announced several reviews. I have previously noted
the report into aggregated assessments conducted by the Nuffield Trust and the
report focusing on healthcare assistants by Camilla Cavendish. CQC is part of a
task group in responding to the 18 recommendations in the Cavendish report. It
is expected that when the government responds in full to the Francis report that
these two reports, along with the three reports itemised below - patient safety
(Don Berwick), complaints (Ann Clwyd and Tricia Hart), and the work on data and
information burden (Mike Farrar) - will form part of that response.

4.1 “A promise to learn – a commitment to act. Improving the safety of
patients in England” report published

Following the publication of the Francis report, Don Berwick was asked to
conduct a review focusing on patient safety. This report was published on 6
August. It is available online here:
226703/Berwick_Report.pdf

Key things to highlight include how we assess whether providers:
- make safety their first priority and monitor achievement against specific
goals;
- focus on learning from mistakes (both from inside and outside the
organisation concerned) and put preventative measures in place to
reduce avoidable harm in the future;
- foster a culture of openness and transparency, including sharing
information with patients when something goes wrong; and
- ensure that staff are adequately trained and present in sufficient numbers

Recommendations aimed more specifically at the wider system include:
- the need for the regulatory/supervisory system to be simplified with a call
for ‘unprecedented levels of cooperation’ between CQC, Monitor, the
NHS TDA, professional regulators and NHS England;
- the need to involve and empower patients and carers at all levels,
including in the development of the fundamental standards; and
- the requirement for all health care professionals, including managers and
executives, to master in quality and patient safety sciences, both during
initial training and lifelong education.

Finally, whilst the report stresses that individuals should be supported and not
punished for making mistakes, it clearly states that rare cases of harm caused
by neglect or wilful misconduct should attract severe sanctions. One of the
overriding messages of the report is that regulation is not the answer to
wholesale improvement. Major cultural change is what is required.

We have reviewed the report to look at the implications of the
recommendations for CQC. We have also been clear that the primary
responsibility for quality and safety rests with the provider.

We are incorporating the recommendations into our methodologies around the
culture, effective, caring, responsive to people’s needs, and well led) and the way we will work with Monitor and the NHS Trust
Development Authority. We will not only look at evidence of past harm but also
how organisations and services proactively manage safety, including
openness and learning from past events. Our new inspection processes will
include greater opportunities for patients and their carers to contribute their
views, either directly or via local Healthwatch, including being part of
inspection teams, as well as appropriate specialists.

In respect of staffing, CQC already considers staffing levels in our current
assessments. In the future CQC will consider whether or not providers have
applied a sound methodology in setting and monitoring staffing levels, based
on recognised guidelines as well as demand and dependency.

We will also be strengthening our information sharing and operational ways of
working with other regulators, and our new model with will be responsive to
risk. Subject to secondary legislation, we will give further consideration to how
we hold Boards accountable. We are working with the Parliamentary Health
Service Ombudsman and Healthwatch England to provide guidance on how to
complain about poor care. We are also working with the Department of Health
on drafting regulations and associated guidance in relation to candour.

4.2 Complaints review

The Department of Health hopes to publish the Clywd / Hart review into
complaints in the autumn. Over the summer, as part of this review, key
partners were asked to commit to some pledges to accompany the final report.
CQC’s pledge is:

CQC is committed to putting people who use services at the centre of our
work, and including people’s experiences as a core focus of our inspections. CQC has recently announced our intention to gather and use a
much wider range of information from patients and the public, and CQC will
use the outcome of this review to inform our regulatory assessment of the
NHS and other health and social care services where relevant. In
particular, over the next year we will improve how we looking at leadership,
governance and culture, and will:

- develop the way we use complaints information as well as other views
  and feedback from people who use services in our surveillance model
to ensure they are embedded consistently and given significant
  weighting (winter 2013/14);
- analyse the number and themes of complaints and feedback we
  receive directly;
work closely with and share information with our regulatory partners about complaints; and
strengthen how we consider complaints as we develop our approach to assessing quality and safety of hospitals and other services (autumn / winter 2013).

4.3 Bureaucracy burden review

We anticipate that this report will be published in the autumn. We will consider each recommendation relevant to CQC and report to the Board on our response once the report has been published.

5 Review into the regulation of cosmetic interventions

Sir Bruce Keogh led a review to look into the regulation of cosmetic interventions, published by the Department of Health in April 2013. The review looked into the regulation of all cosmetic interventions, many of which are not regulated by CQC. There are 44 recommendations in the report. Only a few of these recommendations refer to CQC by name, and those recommendations directed at CQC are either already in place or are part of CQC’s strategy. Recommendations include unannounced inspections and ensuring that inspections include appropriate expertise.

Some of the recommendations made are not possible to implement, such as a requirement on providers to publish CQC concerns on their own website, as there is no legislative basis for this.

A representative from CQC will attend an Advisory Board and Delivery Board to be set up by DH. The government response is expected to be published in the autumn.

6 Memorandum of Understanding with the Parliamentary Health Service Ombudsman

An updated Memorandum of Understanding between CQC and the PHSO is in the process has been signed.

7 Transparency about quality in social care

On 9 July I attended a roundtable discussion with the Secretary of State for Health and representatives from DH, NHS England, local government, care providers, and trade bodies, to discuss increasing transparency for quality in social care.

9,000 providers have signed up to manage their online quality profiles on the NHS Choices website, launched earlier this year. CQC, with DH and NHS Choices, will need to consider how to respond to provider’s concerns about the way CQC information about the Essential Standards is presented on the NHS Choices profiles. CQC has committed to ensuing user experience is taken into account in our methodology for inspection and ratings and how this is balanced against other information.

8 Letter to the Secretary of State following the Grant Thornton review
At the Board meeting on 19 June, when we published the Grant Thornton report, I confirmed the commitment made to the Secretary of State to write to him within two months of publication to update him on progress regarding the report findings. On 8 August David Prior wrote to Jeremy Hunt to fulfil this commitment.

The letter will be published on our website on the date of the Board meeting.

9 Independent Inquiry into UHMB

On 12 September, the Secretary of State for Health announced the terms of reference for the independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services of UHMBT (January 2004 – June 2013). This inquiry will be chaired by Dr Bill Kirkup. The investigation will primarily focus on the service provided by the Trust, and the response of the Trust to shortcomings previously identified. The terms of reference states that the investigation should “consider the actions of regulators and commissioners insofar as they appertain directly to the safe provision of maternity and neonatal services”.

At the time of writing the terms of reference for this inquiry are not available on the DH website, but I will provide this to the Board when it is available. Jeremy Hunt’s statement to the House on 12 September is available at: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130912/wms text/130912m0001.htm

10 Registered Managers

An unacceptably high proportion of services are operating without having a registered manager (RM). In June 2013 there were over 3900 locations which did not have a RM, and of these over a quarter had not had a RM for over two years. This represents 2% of locations where a RM is a required condition of registration. The original requirement for registered managers, which first appeared in the Care Standards Act 2000, came from the Longcare Inquiry in 1997, and the Serious Case Review into Winterbourne View highlighted the dangers that can arise when services do not have a RM.

When a provider registers with CQC they commit to meet the requirements of their registration. The failure to have a registered manager, where this is required, without reasonable excuse is a breach of a condition of a provider’s registration and an offence under Section 33(b) of the Health and Social Care Act 2008 (the Act). It is the provider’s legal obligation to comply with such a condition. Analysis of our inspection findings shows that adult social care locations without a RM have had significantly higher non-compliance rates than those with a RM at some point over the last two years.

As a failure to comply with a condition of registration is an “offence” under the Act, CQC can take criminal action, which includes a caution, fixed penalty notice, or prosecution. To date the usual response from CQC is to write to providers informing them of the need to take action in this regard. One warning notice has been served. We therefore need to take more effective and robust action against providers who have failed to comply with the conditions of their
registration with regard to appointing a RM. We propose to focus initially on providers where active locations have been in breach of this condition over the longest period of time (initially over two years – i.e. those least likely to have “reasonable excuse”, and with no application in the process of being considered). These providers will be alerted to CQC’s intention to issue a fixed penalty notice. We need to have a consistent and proportionate approach, whilst not fettering our discretion.

Ongoing monitoring and surveillance will include being alerted of any absence of a registered manager for more than six months at any given location. We will also remind providers that they need to ensure that RMs apply to cancel their registration when they cease employment, and the provider to ensure that an application for a new registered manager is submitted promptly to CQC.

We have looked at the resource that would be required in order to carry out this work, including any increase in applications and additional registration assessor time to process new applications quickly, although much of the work will be conducted within existing resources. If the penalty notice is not paid we will look at the reasons and decide whether to recommend proceeding towards a prosecution. If necessary we will outsource prosecution cases.

We expect to commence issuing fixed penalty notices from October 2013. Having looked into each location without a RM for 24 months for phase 1, we will evaluate the work and aim to move on to those locations which haven’t had a RM in place for 12 months as phase 2 of this work.

11  Looked after children reviews

I have written to Chief Executives of providers and commissioners in the NHS to announce the start of CQC’s inspections into how services safeguard children and promote the health and wellbeing of looked after children. As discussed at the Board meeting on 22 May, these inspections will be conducted using our powers under Section 48 of the Act, for a two year period. We aim to commence these inspections from 30 September.

We will inspect those areas where we believe there is the greatest risk within health services, and where we identify that there are deficiencies in the effectiveness of safeguarding arrangements and services for looked after children in the NHS. We will be inspecting health services within a local authority area and spend five days on site. After each inspection we will publish a report for each local area, and also publish a national report bringing together findings from across the country. Further information about these inspections is available on our website.

12  CQC website improvements

In September 2013 the digital team will be launching major changes to the website’s home pages and improvements to the site search. All the changes have been tested with a cross section of users over 3500 members of the public have taken part in the research that supports these changes, including seven rounds of testing with the public in developing the new search function.

13  CRM – for Board approval
The CRM hosting and support contract approved by the Board on 30 July 2013 was for a total spend of £1.14M, excluding VAT, over two years. An oversight of the application support costs for year two of £53,760 excluding VAT was not included. The revised figure is therefore £1.19M + VAT. I am therefore seeking Board approval for this revised sum.

14 Decisions under the Scheme of Delegation

Following the transition from the IMS2 IT system delivered by Computer Services Corporation (CSC) to IMS3, supported by Atos, I have been asked to consider the options to allow back-up tapes of emails from the old infrastructure to be restored to the new infrastructure. The recommended option, on balance of cost, length of time to put in place, and meeting the needs and requirements placed on CQC, was to adopt a restoration service via Iron Mountain. This will ensure that we are not prevented from accessing emails that have not been specifically saved as a record when responding to Freedom of Information or Data Protection Act queries or other enquiries. Although back-up tapes are not, and are not intended to be, the CQC records system, they provide an important source of information in responding to such requests. Under the Scheme of Delegation Board approval is not required for this, and I have therefore approved that the option outlined above is pursued.

Separately, as the Chief Inspector of Hospitals is now in post and the remaining Chief Inspectors will be taking up their respective posts over the next month, amendments are required to the Scheme of Delegation.

I have previously alerted the Board to the need to change the delegation arrangements in relation to enforcement action decisions regarding NHS Trusts, where I proposed that those decisions were made by Mike Richards without me being involved in the decision making process, enabling me to remain independent to consider any representations should they be made. This was agreed at the Executive Team meeting on 24 July.

The Scheme of Delegation will be discussed with the new Executive Team when all Chief Inspectors are in post, including arrangements for decisions to be made between executive members of staff where a named individual is on leave or otherwise unavailable when a decision is needed.

15 Security breach

I have been alerted to a security breach in September whereby an internal briefing was unintentionally copied to an external distribution list, for organisations within the food standards industry. This distribution list was available to all DH users and to CQC staff as part of the new IMS3 IT system, but has since been disabled by DH as this particular distribution list was no longer needed.

We do not believe the briefing contains any substantive information that is not already in the public domain or readily available to the public. Immediately following the incident, the email was recalled and contact made with all recipients explaining that it had been sent in error and requesting that it be deleted without being read. We have now had confirmation in respect of all
recipients that the email was either undelivered; recalled successfully or has been deleted. The two individuals referred to in the briefing have been contacted to advise them of the incident. A full internal investigation is underway to ascertain how the incident happened and to identify any actions required to stop something similar happening again in future.

16 Committee hearings

The Health Select Committee annual accountability hearing for CQC has been scheduled for 22 October 2013.

We have also been asked to give evidence to the House of Lords Committee on the Mental Capacity Act on 29 October 2013.

17 Progress on appointments

I have previously informed the Board of the appointment of Andrea Sutcliffe as CQC’s Chief Inspector of Social Care. Andrea will start on 7 October. On 7 August we announced the appointment of Oliver Delany as Executive Director of Corporate Services, who plans to start on 7 October. In addition, on 28 August we announced the appointment of Steve Field as Chief Inspector of General Practice, who will start on 30 September.

These appointments complete CQC’s new executive team.

The Board is asked to note the content of the report.

Name: David Behan
Chief Executive
Date 12 September 2013