

## Board of Directors – Meeting held in Public

### January 2023

|  |   |                                       |
|--|---|---------------------------------------|
| <b>Paper title:</b>  | Care Quality Commission Update and Developments   | <b>Agenda Item</b><br><br><b>12.1</b> |
| <b>Presented by:</b>   | Grainne Eloi, Interim Director of Nursing, Professions and Care Standards   |                                       |
| <b>Prepared by:</b>  | Grainne Eloi, Interim Director of Nursing, Professions and Care Standards   |                                       |
| <b>Committees where content has been discussed previously</b>                | Quality & Safety Committee (December 2022)  |                                       |
| <b>Purpose of the paper</b><br>Please check <b>ONE</b> box only:             | <input type="checkbox"/> For approval <input type="checkbox"/> For information<br><input checked="" type="checkbox"/> For discussion  |                                       |
| <b>Link to Trust Strategic Vision</b><br>Please check <b>ALL</b> that apply  | <input checked="" type="checkbox"/> Providing excellent quality services and seamless access<br><input checked="" type="checkbox"/> Creating the best place to work<br><input type="checkbox"/> Supporting people to live to their fullest potential<br><input type="checkbox"/> Financial sustainability, growth and innovation<br><input checked="" type="checkbox"/> Governance and well-led |                                       |
| <b>Care Quality Commission domains</b><br>Please check <b>ALL</b> that apply | <input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Caring<br><input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Well-Led<br><input checked="" type="checkbox"/> Responsive   |                                       |

**Purpose of the report**

The purpose of this report is to provide Board with an overview of recent quality assurance activity also received by the Quality and Safety Committee December 2022.

**Executive Summary**

**Response to recent media concerns about closed cultures in mental health units**  
 In response to concerns about closed cultures raised by the September Panorama investigation into the Edenfield and the Channel 4 Dispatches Programme – ‘Hospital undercover – Are they safe?’, the Trust has undertaken a series of ‘unannounced spot’ visits to our inpatient wards to support our existing assurance processes.

Carried out by multi-professional teams and Involvement Partners, and focussing on night time activity, the purpose of the visits was to learn and to use our findings to improve services by informing our organisational response. Whilst recognising the imperative to carry out these visits to test our assurance, we also recognised that the inpatient teams are still under

significant pressure and that visits should be managed compassionately and factually with as minimal disruption as possible.

|  |  |
|--|--|
| Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? | <input type="checkbox"/> <b>Yes</b> (please set out in your paper what action has been taken to address this)<br><input checked="" type="checkbox"/> <b>No</b> |
|--|--|

|  |
|--|
| <b>Recommendation(s)</b>   |
| <p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> <li>Take assurance from the Trust’s response to recent media concerns about closed cultures and our approach to addressing this</li> </ul> |

|   |  |
|---|--|
| <b>Relationship to the Board Assurance Framework (BAF)</b>  |  |
| <p>The work contained with this report links to the following strategic risks as identified in the BAF:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>SO1:</b> Engaging with our patients, service users and wider community to ensure they are equal partners in care delivery (QSC)</li> <li><input type="checkbox"/> <b>SO2:</b> Prioritising our people, ensuring they have the tools, skills and right environment to be effective leaders with a culture that is open, compassionate, improvement-focused and inclusive culture (WEC)</li> <li><input checked="" type="checkbox"/> <b>SO3:</b> Maximising the potential of services to delivery outstanding care to our communities (QSC)</li> <li><input type="checkbox"/> <b>SO4:</b> Collaborating to drive innovation and transformation, enabling us to deliver against local and national ambitions (Board)</li> <li><input type="checkbox"/> <b>SO5:</b> To make effective use of our resources to ensure services are environmentally and financially sustainable and resilient (FBIC)</li> <li><input type="checkbox"/> <b>SO6:</b> To make progress in implementing our digital strategy to support our ambition to become a digital leader in the NHS (FBIC)</li> </ul> |  |
| <b>Links to the Strategic Organisational Risk register (SORR)</b>   | <p>The work contained with this report links to the following corporate risks as identified in the SORR:</p> <ul style="list-style-type: none"> <li></li> </ul>                      |
| <b>Compliance &amp; regulatory implications</b>   | <p>The following compliance and regulatory implications have been identified as a result of the work outlined in this report:</p> <ul style="list-style-type: none"> <li></li> </ul> |

# **The Board of Directors - Public**

## **January 2023**

### **CQC Updates and Developments**

#### **1 Purpose**

The purpose of this report is to provide Board with an overview of recent Quality Assurance visits conducted in our in-patient services following The Edenfield documentary. This report was also received by the Quality and Safety Committee in December 2022.

#### **2 Background and response**

Board members will be aware of two significant television programmes which have raised the profile of closed cultures on inpatient units. These were the September Panorama investigation into the Edenfield Centre run by Greater Manchester Mental Health NHS Foundation Trust and the Channel 4 Dispatches Programme – ‘Hospital undercover – Are they safe?’.

The Trust has a robust process by which it oversees the quality and safety of all our services, including our inpatient wards. We also have a robust Freedom to Speak up strategy and approach which enables us to have a line of sight on the culture of our services.

Whilst, as a leadership team, we take assurance from these processes, we felt it important that we undertook a series of unannounced visits to the in-patient wards to review the patient experience, the see the care and treatment outside of daytime hours. We recognise there are higher levels of agency staff and a greater reliance on on-call arrangements for escalation of issues.

The process has involved a multi-disciplinary team visiting each ward during the night shift and over a period of two weeks. These visits were unannounced and were supported by our Involvement Partners.

Whilst recognising the imperative to carry out these visits to test our assurance, we also recognised that the inpatient teams are still under significant pressure and that visits should be managed compassionately and factually with as minimal disruption as possible. The purpose of the visit was to learn and to use our findings to improve services by informing our organisational response.

#### **3 Next steps**

The report was presented and ratified to Quality and Safety Committee in December 2022. A series of quarterly visits will continue out of hours during 2023. The recommendations will be implemented during the next year and will be monitored through the Care Quality and Operations Meeting and Senior Leadership Meeting.

## **4 Recommendations**

The Board of Directors is asked to:

- Take assurance from the Trust's response to recent media concerns about closed cultures and our approach to addressing this

**Grainne Eloi**

**Interim Director of Nursing Professions and Care Standards**

**December 2022**