Care Quality Commission (CQC)

briefing for Bath and North East Somerset council

Wellbeing Policy Development and Scrutiny Panel

On 21 September 2012

Dear Mr Pritchard and scrutiny panel members

I am sorry I will be unable to attend your meeting in person on 21 September 2012. Unfortunately, I have a long standing commitment to a national CQC management conference, which is the reason why we also are unable to send another manager to meet with the panel.

There is a lot on documented information that I could have sent, some of which no doubt the panel will have already read. So I have given some thought to the most appropriate briefing in respect of Winterbourne View specifically. I will be attending your next meeting on 16 November 2012 and this will be an opportunity to discuss local issues in Bath and North East Somerset and the communications between the CQC, the panel and other local agencies.

I have set out a briefing below, as follows

1. **Extract from Dame Jo William's briefing to CQC staff following the publication of the Winterbourne View SCR**

2. **Extract from the CQC Individual Management Review (IMR) submission to the Serious Case Review (SCR) panel**

   - Actions the Care Quality Commission has taken

3. **Extract from the CQC IMR**

   - Recommendations

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1. Extract from Dame Jo William's briefing to CQC staff following the publication of the Winterbourne View SCR

Winterbourne View was a watershed moment for CQC. It demonstrated very clearly where our systems needed to be stronger, it showed where we needed to reinforce our model, and it was a terrible illustration of the vulnerability of people in hospitals like Winterbourne View.

It also reinforced that no single organisation can stop abuse of this kind. Panorama focused on our role in the events, but as the serious case review points out, there are many organisations involved in protecting people from the kind of abuse uncovered at Winterbourne View and all of them let down the residents there in some way.

Our actions since Winterbourne View have shown how seriously we have taken our responsibilities to improve and - as Margaret Flynn, the author of the serious case review, acknowledges - how honest we were about what needed to be done.

Among other things, we now have a specialist team in the NCSC taking whistleblowing calls (up from around 50 a month before Winterbourne View to over 500 a month now) and each one is tracked until it is resolved. Our revised model acknowledges the higher risk that hospitals like Winterbourne View carry with more frequent unannounced inspections. And we were able to go to the Department of Health and ask for more inspectors - an extra 250 - so that we can visit more providers more frequently. Our own internal management review made 13 recommendations for changes which we are adopting.

Our inspections of 150 services for people with learning disabilities was a landmark piece of work. It brought to light that this sector is not nearly good enough - almost half the locations we inspected were non-compliant. Among the failings were too many people in assessment and treatment for too long, and people fitted into services, rather than having services designed around their needs.

We have already done a lot to make sure there is no repeat of Winterbourne View. We cannot guarantee that abuse like that will never take place, but we have more people, better systems and a revised model that makes us much stronger. As the serious case review makes clear, preventing abuse is not only a matter for CQC; good care starts with providers and their staff, relies on effective commissioning and safeguarding procedures, and is informed by the views of people who use services and their families. We must all work better to ensure people are protected from abuse.

2. Extract from the CQC IMR

Actions the Care Quality Commission has taken

216. The end-to-end review of the service, from the time it was first registered and regulated by the Healthcare Commission through to the closure of the service following the BBC Panorama expose, was significant in helping us make improvements to our management practices and regulatory model:

- The way in which we now weight and track the concerns of whistleblowers has been improved.
- We are sharpening up the supervisory arrangements between Compliance Inspectors and Compliance Managers and Compliance Managers and Regional Directors, so that there is always a focus and tracking on services where safeguarding concerns have been highlighted through any relevant data and information sources including from whistleblowers.
- Inspectors and mangers must sign off the outcomes arising from any actions taken in response to safeguarding alerts.
- The evidence from the Mental Health Act Commissioners and the Second Opinion Appointed Doctors is increasingly an integral component of our regulatory evidence set.
- We are actively engaged in the way in which we liaise and work with Adult Safeguarding Teams and Boards across England, including developing protocols and agreements covering information sharing, attendance and sign off of multi agency action plans.

217. Since the abuse at Winterbourne View was exposed, the Care Quality Commission has begun a programme of unannounced inspections of all those services that are delivering care to those with learning disabilities, challenging behaviour and mental health needs.
218. The work is being supported by an advisory group who have helped to shape the methodology and also provide access to experts by experience and professionals who will be part of the inspection teams.
219. This programme of inspection will be completed by January 2012 and inspection reports published soon after.
220. This approach to inspecting services will not be a one-off activity. The Care Quality Commission is proposing to carry out unannounced annualised inspection of, all independent hospitals and adult social care providers from April 2012. We are currently consulting on changes to the judgement framework and our enforcement policy19 and subject to an endorsement for those changes we will deliver a simplified inspection process.
221. Whilst the Care Quality Commission can never ensure that abuse does not take place in the myriad of regulated care settings, we are committed to making sure that our management processes and the delivery of our regulatory activity play their part in the overall system attempts to protect those who are most vulnerable.

3. Extract from CQC's IMR - recommendations

RECOMMENDATION 1
The Care Quality Commission should highlight in our quality and risk profiles (QRP) that services defined as providing regulated activities in residential institutions for people with learning disability, challenging behaviours and mental health needs are inherently higher risk institutions. This is consistent with the DH guidance on models of service delivery for this group of patients. This higher risk status will act as an alert system to our staff when looking at data and information and when carrying out inspections of these institutions. This change should be implemented immediately.

RECOMMENDATION 2
The Care Quality Commission should take account of the inherent risk of different types of service provision and the different characteristics of the people using those services throughout its work. This will include collated intelligence about corporate providers as well as individual locations which will help to identify risks across a provider group as well as at individual location level.

Although the Care Quality Commission now has a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.

RECOMMENDATION 3 Compliance inspectors should record the outcome of the investigations from safeguarding alerts and compliance managers should sign off the agreed actions from those investigations. Where CQC cannot agree the outcomes from the investigation this should be communicated back to the Safeguarding Adult Team and if necessary to the Adult Safeguarding Board.

RECOMMENDATION 4
Although the Care Quality Commission now has a legislative remit to follow up on action plans, and to take action where there is a lack of improvement, further action should be routinely taken to follow up investigations of incidents which have been notified to the Commission under Regulation 18. These need to be formally recorded in the QRP and where there is limited progress that must be highlighted to the compliance manager by the compliance inspector.

RECOMMENDATION 5
The Care Quality Commission should build new protocols about working with local Safeguarding Adults Teams and Safeguarding Adult Boards to ensure there is timely investigation and intervention of relevant safeguarding alerts, and to ensure that all relevant parties are involved in the investigation of the incident(s) leading to the alert(s).

RECOMMENDATION 6
The Care Quality Commission should develop its analysis of safeguarding alerts to look at particular trends at individual locations, and across service providers. This is particularly important in looking at concerns across chains of providers which cross the Care Quality Commission's geographical boundaries.

RECOMMENDATION 7
The Care Quality Commission should evaluate and embed the process it has commenced of integrated, routine and on going exchanges of information between the Compliance Inspectors and Mental Health Act Commissioners and, where appropriate, for joint inspections to take place. This needs to be managed through the supervisory arrangements between the Compliance Managers and their inspectors and the Mental Health Act Commissioner Managers and their Commissioners.

RECOMMENDATION 8
The information and intelligence that the Second Opinion Appointed Doctors may capture regarding concerns that they have for patient safety as part of their statutory remit should be systematically and routinely recorded and made available as part of the intelligence and risk information used by CQC in its work. CQC should review the mechanisms by which SOADs receive pre-visit relevant information and how they feed back to CQC on concerns observed during the discharge of their statutory function.

RECOMMENDATION 9
When the Care Quality Commission Mental Health Act Commissioners set out their comments and suggestions for the provider following a visit these should be monitored through an action plan submitted to the Care Quality Commission, and linked with the QRP for the location. There should be follow up to ensure that the agreed actions are being implemented as agreed. Where there is failure to do so the Adult Safeguarding Team should be notified.

RECOMMENDATION 10
The Care Quality Commission should review how it collates information and looks at risk at provider level as well as at location level. This is particularly important for chains of providers where systemic issues could be overlooked because of a focus on location level information.

RECOMMENDATION 11 The Care Quality Commission's Board should receive a report on the whistle blowing arrangements that are in place on a six-monthly basis. This should be a public report setting out in detail the scope, volume and actions taken by the Care Quality Commission in response to the concerns raised by whistleblowers.

RECOMMENDATION 12
The Care Quality Commission should audit, on an annual basis, the effectiveness of the case management arrangements in place to ensure that

supervision is systematically considering the services with the most serious concerns as part of a quality assurance process. The outcomes of this audit should be reported to the Board, and the report should be made public.

RECOMMENDATION 12 The Care Quality Commission should immediately audit the interaction that it has with Safeguarding Adult Teams and Boards across England. The audit should focus on which staff normally represent the Care Quality Commission at meetings, the circumstances which trigger our attendance at a meeting and how we sign off the actions agreed at a multi agency safeguarding meeting.

RECOMMENDATION 13
The Care Quality Commission should now develop a protocol about the way in which we will work with the Safeguarding Adult Boards and Teams across England. The protocol should take account of what the proposed legislation may set out and also take account of what has worked effectively in Children's Safeguarding Boards.