CQC – Safeguarding Alerts Incident - Report of Independent Reviewer

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APPENDICES

1. Executive Summary

In July 2018, CQC identified a technical issue within its data management system which meant that inspectors were able to tick a referral to safeguarding (RtS) box, which it was intended should only be ticked by National Customer Services Centre (NCSC) staff once they had passed a safeguarding referral to the relevant Local Authority (LA). The result of this was to delay or prevent the timely referral of some safeguarding information to LAs. An initial investigation identified that this issue related to 120 concerns. Within a week of the issue being identified, the concerns were shared with the 56 local authorities affected, and action was taken to correct the system and process error.

As a consequence of this issue, CQC initiated a special advisory review of its safeguarding alerts process conducted by the Government Internal Audit Agency (GIAA), and CQC's Safeguarding and Responding to Concerns (SGRC) Committee was tasked with identifying areas for organisational improvement and learning. In addition, CQC commissioned an independent review, to consider consequences and impact of the delay in making the referrals, including recommendations for further improvement of CQC's existing safeguarding practice, with a particular focus on how CQC can work more effectively with local authorities in making referrals.

The independent reviewer found examples of good practice across CQC, including in the response to this incident. Interviews were held with staff across the organisation who were professional, committed to improving outcomes for people, and keen to share their own perspectives and suggestions for practice improvement.

This independent review presents findings and makes recommendations for further improvement in three key areas;

- The consequences for individuals arising from the delay in making referral. The review identifies a small number of people where there may have been some impact. However, it is difficult to establish conclusively the extent of impact, and the report makes recommendations for CQC to complete actions after discussion with the LAs directly involved.

- Implications for safeguarding practice. The report outlines some of the challenges arising from the very high volume of safeguarding alerts, and inconsistencies in practice, and a number of recommendations focus on further improving safeguarding practice. This section also makes some points about wider organisational learning.

- Work with LAs. Recent years have seen improved partnership work with LAs at both an individual and more strategic level. Recommendations include a focus on the revised CQC /LA protocol as a means for further improving joint work.

2. Review Methodology

The Independent Reviewer interviewed key personnel within CQC including managers and staff in CQC who were directly involved in this incident and others e.g. a focus group of frontline inspectors and a Head of Inspection who shared their experience of safeguarding practice. Interviews were also undertaken with a small number of staff in key external organisations; LAs, Association of Directors of Social Services (ADASS), and Local Government Association (LGA).

The reviewer considered relevant documentation. This was focussed on the reports from the two internal reviews, and information shared between CQC and LAs. The information from LAs was collated by CQC in summary form, and in addition the reviewer looked at detailed timelines in a sample of 4 cases. Other relevant information was made available e.g. notes of Gold / Silver Command meetings, guidance for operational staff undertaking the triage of individual cases, and reports to the CQC Executive.

The two internal reviews undertaken by CQC were focussed on systems changes (the GIAA review) and safeguarding practice (the SGRC Committee) within CQC. In order to ensure a timely report to the CQC Board, this independent review ran 'in parallel' with those internal reviews, though the reviewer spoke on a number of occasions with lead staff and received copies of their internal reports as soon as these were available in November. The internal reviews have identified themes that are consistent with this independent review, and both give some more operational focus to some of the high-level findings in this report. A CQC report summarising internal findings and recommendations is included at Appendix A.

The findings and recommendations in this report are split into three sections consistent with the key elements of the Terms of Reference; consequences for individuals; management action and safeguarding practice within CQC; and work with LAs. In each of these sections there is an outline of relevant events and findings from the review, and a summary of recommendations at the end of each section.

Terms of Reference for this review are included at Appendix B, and a list of all recommendations is included at Appendix C.

3. Findings and Recommendations

3.1 Consequences of delayed referrals for individuals

In July 2018, CQC initially identified over 750 referrals that had not been sent to Local Authorities (LAs) during the period July 2017 and July 2018, all due to inspectors checking the RtS button in error. A team of experienced inspectors and mangers, supported by one of the national safeguarding leads, was brought together to look in detail at all 750+ cases. This process of triage, checking and re-checking took this number down to 120 where the CQC records showed that there was an issue that met the threshold for referral to the LA, and where there was no evidence that the issue had been picked up via another route e.g. a phone call from the inspector to the LA, or separate regulatory activity by CQC in the case of a concern about a regulated service. Of these 120 cases, some related to concerns about an individual person, others related to practice in an establishment supporting more than one person, so the number of people potentially affected was more than 120. The triage process included checking whether there were any cases which needed urgent and immediate escalation to an LA as there was possibility of 'immediate risk'. No cases fell into this category.

Telephone contact was made with each of the 56 LAs and a new written referral was made by email to each LA by NCSC. LAs were asked to notify CQC of the outcome of their investigation into the referral. In many cases, LAs quickly looked at the referral and responded to CQC to confirm action taken. CQC chased up LAs where feedback had not been received. At the time of writing this report, the outcome of investigation was still awaited from LAs on 30 cases.

CQC again utilised a team of experienced inspectors to review LA responses and to form a view about the potential impact for people arising from the delay in referral. Each case was placed into one of a number of categories ranging from those where there was evidence that the delay had caused 'harm' to those where evidence pointed to there being 'no harm'. Due to outcomes still awaited from some LAs, and some cases being difficult to determine, a number were categorised as 'Insufficient Evidence'. The position at 15th November 2018 is summarised as follows:

- There were no cases where harm was found
- There were 85 cases where no harm was found
- There were 9 cases where there was some question of harm, but determination was inconclusive.
- There were 26 not determined due to outcomes still awaited from LAs

In any safeguarding investigation it can be difficult to determine harm caused, and in this incident, even harder to determine whether further harm may have been caused by the delay in the referral being made by CQC. CQC did not ask LAs to form a judgment on potential harm caused by the delay but undertook a review of all cases internally to reach indicative conclusions, with these judgements being 'signed off' at a senior level. The reviewer did not review the decisions made by CQC in this categorisation but did 'dip sample' a number of cases. This reinforced a number of the findings and recommendations outlined in this report.

It is proposed that CQC should contact the LAs involved in the 9 'inconclusive' cases, on a case by case basis, to discuss and determine, if possible, whether there was any impact as a direct result of the delay.

Confirmation of outcomes by LAs. Safeguarding investigations can take several months, but it is of concern that, four months after sending the referral to LAs, feedback on findings is still awaited on a quarter of all cases. The later section on work with LAs, will look at this point in more detail, but for this section, it is recommended that senior CQC staff make contact with named / known contacts in LAs to check progress and outcomes, so that as soon as possible CQC has as full an understanding as possible of the consequences of this incident for individuals.

Contact with individuals. When this issue first came to light, CQC issued a press release and notified key partners and external agencies. At this point no contact was made with individuals who were the subject of the referrals, or any family members. The reviewer found that the approach of CQC was one of openness and transparency and this did prompt consideration of whether, in that same spirit of openness, contact should have been made with individuals and families at that point. This was considered and discussed with senior managers. Under 'normal' circumstances, contact with families would be made by the LA as part of a safeguarding investigation. This practice of contact with individuals by the LA is an agreed part of established safeguarding practice and is consistent with the role and duty of the LA to arrange / undertake enquiries. In these 120 cases, whilst there was a delay in making the referral to the LA, it was considered appropriate for these referrals to be considered in the normal way, with the LA making judgements about individual and carer contact as part of any investigation.

There is however, a question about contact now with those individual and/or carers in the 9 cases where the outcomes of the LA investigation have been fed back to CQC and the subsequent review by CQC raises questions about whether there was any harm caused by the delay. It may be that in some cases this has already been picked up by local CQC staff being involved in local safeguarding meetings. In addition to contact with LAs to determine possible impact, a discussion with each LA would establish whether contact had already been made and, if not, would help CQC decide what, if any, contact should be made, including considering offering a meeting, and an apology for the delay arising from CQCs error. The same consideration should be applied to any other cases where feedback is still awaited from LAs where CQC then determine that there was any indication of harm as a result of the delay.

Recommendations

1. That senior CQC staff make contact with named senior staff in LAs to consider further the impact in the 9 'inconclusive' cases, and to check progress / outcomes in those cases where LA feedback remains outstanding.
2. In the 9 'inconclusive' cases that there is also follow up with the LAs concerned, to check what contact has been made with the individuals concerned and / or their carers, and for CQC to use this to determine what, if any action, should be taken to contact people directly. The same consideration should be applied to any other cases where feedback is still awaited from LAs where CQC then determine that there was any indication of harm as a result of the delay.

3.2 CQC Safeguarding Practice and Organisational Learning

The findings of the two internals reviews are relevant to this section of the independent review. The reviewer had access to lead officers and early sight of findings of these reviews and can provide assurance to the CQC Board that findings across all three different reviews, whilst different in particular focus, were consistent in the themes raised. The internal reviews are summarised, and recommendations included in the report at Appendix A. This section does not repeat those recommendations, which in most cases are more targeted operational recommendations, but highlights particular findings which the independent reviewer considered relevant to draw to the Board's attention.

The issue of the RtS button being open for Inspectors to tick, and then inspectors ticking this in error first came to light in July 2017. The associated risk and impact of this issue was not recognised at this point and it was deemed to be 'a minor issue'.

The review found that there were a number of missed opportunities at that point to address this issue;

- While the national safeguarding leads were alerted, the potential wider implications were not identified.
- Because the wider implications were not identified, the issue was not escalated to more senior managers in CQC, including the DCI responsible for safeguarding.
- It was reported that the RtS button could be disabled to prevent inspectors ticking this in error. An email identified that this could be actioned if a Change Request (CR) was raised, but it appears this was not followed through.
- The communication to inspectors to advise them to not check the RtS button was sent out via the routine bulletin and was missed by many inspectors.

These 'missed opportunities' point to a number of learning points about; communication, clarity about roles and responsibilities; work across different areas of CQC business; and learning for future system changes.

In July 2018, the issue was identified again, but now a year on, a far greater number of referrals had been missed. The seriousness of the matter was quickly recognised, and steps taken accordingly. At corporate level, the Gold / Silver command process was instigated and operationally there was a detailed process of triage, checking, and double checking. This resulted in the 120 cases being referred to LAs within a matter of days of the issue being raised. This process included a process to 'fast track' any urgent cases direct to LAs – there were none that fell into this category. The operational response at this point was strong and it is clear that staff involved went 'beyond the call of duty' to ensure that actions were taken to ensure all cases were checked and passed to LAs where appropriate. This review saw evidence that the actions of staff involved were rightly commended by the Chief Inspector for Adult Social Care.

Telephone contact was made with all 56 LAs, both through a telephone call from a senior CQC officer (Head of Inspection or DCI) to a senior LA Officer (Director of Adult Services, or one of their team) and followed up by letter. This letter was sent from the NCSC in the usual way for referrals to LAs, and it included information on each referral for that authority. Whilst these letters did make reference to the delay in referral and did convey the relevant information the LA would need to follow up the case, they did not do this with any sense of urgency. The letters were addressed 'Dear Safeguarding team' and were signed 'Best

wishes, The Care Quality Commission'. The letters did ask for a response 'as soon as possible' to a dedicated email address but gave no timescale for this, and it was not clear who to contact in event of query. This may have been a factor in the delayed response from some LAs.

The Gold / Silver command process gave strong leadership and corporate oversight of the issue, and it is evident from discussions and notes of these meetings that there was proactive management of the issue. CQC has also taken learning from its implementation of the Gold Silver Command process – with a learning session held with staff involved and a report to the CQC Executive considered in October 2018.

The Gold / Silver Command response 'stood down' by mid-August 2018. This review found that at this point, there was a loss of momentum in the follow up. For example, more detailed review of the timeline in a small sample of cases where LAs had not responded showed that these were not chased up until 10th October 2018. It was only when this review got underway that this activity appeared to regain some momentum.

Practice issues. Consideration of written evidence, and discussions with staff identified a number of practice issues. The reviewer interviewed staff who were passionate about their work, and committed to quality outcomes, but who also expressed some frustrations about current practice, linked to this incident and more generally.

- There were inconsistences in practice, with differing interpretations by individual inspectors about definitions and thresholds for referral. Of the 750+ cases, just 120 were referred on to LAs. Of those not referred on to LAs a proportion had already been picked up by other routes, but a significant proportion did not meet the threshold for referral to the LA. Even within the 120 cases passed to LAs, more recent work has identified that some of these did not meet the threshold for referral.
- Staff involved in responding to this incident reported a. that information was not always recorded accurately and b. that it was often difficult to navigate / find information on the system. Discussion with inspectors has confirmed these to be common issues.
- The 750+ cases involved in this incident amount to just a small proportion of all cases raised with CQC in a year. This in itself can be regarded as a success story; people have a better awareness of safeguarding issues, and of CQC as an organisation with some responsibility in this area. However, this does present some challenges. Whilst NCSC has a clear methodology for handling calls, this process does not usually triage cases out, it simply helps decision about where to pass a referral to. This means that cases that need either no or only minimal follow up are passed on to inspectors. Additionally, any new call to the NCSC, even if it relates to a case already referred, generates a new 'enquiry' number, and a new case passed to an inspector, not necessarily linking it to previous referrals already made. All of this results in large numbers of cases passing back and forth between NCSC and inspectors, and on to LAs, taking inspector time away from important regulatory activity and more complex safeguarding tasks.
- All inspectors are responsible for making referral from their own caseloads, and the high number of inspectors involved can contribute to issues of inconsistency. In

some areas, teams are piloting new ways of working which includes having a named practitioner taking lead responsibility.

Recommendations are made below to support improved practice and address the issues arising from the high volumes of referrals.

Staff training and development. This review looked briefly at training and development for staff, and the reviewer heard about further work planned to enhance training in safeguarding practice. CQC's model of remote working is now well established and is a model other organisations could learn from. This does however require consideration of implications for staff training. It requires a mix of remote/online training, but also face to face learning and opportunities for practice development. Consideration should also be given to mandatory vs voluntary training. The October Safeguarding week was an excellent example of learning opportunities being made available for staff but was available on a voluntary basis, accessed by staff who were available, and probably those staff already enthused and keen to further their learning. Firm proposals for staff learning and development are included in the action plan arising from the SGRC review.

Change / Project Management. The absence of clear change management arrangements was a contributing factor in this incident, particularly when the issue first arose in 2017. Both the GIAA and the SGRC Committee reviews, have recognised this and actions proposed for the future.

Communication. At a corporate level it is evident that there was open and clear communication within CQC and with partners when this incident first arose, although a number of issues have been identified. For example, at the outset there was a reliance on the routine bulletin to share essential information which required a more 'bespoke' approach. The written communication with LAs, as already described, was insufficiently targeted and failed to convey the urgency of actions required, and there was then a time lag before this was chased up.

Cross Directorate Working. When this issue first arose in 2017, there were some gaps in communication and working across directorates within CQC, and the reviewer found a number of occasions where there was a lack of clarity about roles and responsibilities and ultimately about accountability. The system issue was very much seen in isolation and there was limited involvement from the 'business' in developing and testing changes. The GIAA report identifies these issues, and recognises some key actions already taken to address this, for example via the Operational Systems Board (OSB). It is recommended that the CQC Executive considers how arrangements can be further consolidated for the future. It may be that the relatively new post of 'Chief Operating Officer' may have a role to play in this.

Recommendations

3. That a programme of work is undertaken to improve consistency of practice about definitions of safeguarding and thresholds for referral to LAs.
4. That CQC considers arrangements to better triage safeguarding cases, both coming in to CQC and for referral on to LAs from CQC. This could include exploring more experienced safeguarding practitioners being based at NCSC, and /or considering a model of safeguarding lead or duty roles in locality teams.

5. That the CQC Executive considers how arrangements for work across directorates can be further improved.
6. In areas with wider organisational implications - change management, cross directorate working and communication - the reviewer recommends that CQC continues to improve practice in these areas, and endorses more operational recommendations outlined in the internal report at Appendix A.

3.3 Work with Local Authorities

The 120 cases were linked to 56 LAs. In most cases there were just one or two referrals to the LA; but in four cases there were five or more referrals, with two of these having seven referrals each.

The quality and inconsistency of referral to LAs referred to in section 3.2 is likely to have had some impact on LA responses. Nonetheless, it is concerning that at the point of writing this report, confirmation of outcomes is still awaited from LAs on 30 cases. Interviews and consideration of a small number of timelines also showed that for some LAs, CQC did not have up to date contact details for the Director and / or safeguarding lead. It is not the remit of this review to comment or make recommendations to LAs, but recommendations addressed to CQC, on individual cases, and more generally, may be helpful in addressing this for the future.

Work between CQC and ADASS. CQC and ADASS – the representative body of Directors of Adult Social Services in England - are currently updating a 'Joint Working Protocol between CQC and ADASS'. This relates to joint work between CQC and LAs more broadly but is very relevant for work in relation to safeguarding. The protocol sets out principles for working together and includes guidelines for meetings between CQC and individual LAs and also for regional meetings, where CQC Heads of Inspection meet with the Directors of Adult Social Services (DASSs) in each of the nine ADASS regions. The guidance includes proposals for sharing intelligence about individual providers of concern, through to suggestions on looking at more strategic issues and trends, and suggestions about including other partners e.g. CCGs in these meetings.

Some adjustments have been made to this document in the light of this review, and it is currently in the process of being 'signed off' by both ADASS and CQC. Within CQC the draft has been shared among senior staff in the Adult Social Care Team. It will then go to the Chief Executive for approval, then shared with the wider organisation via the bulletin. There appears to be strong reliance on the bulletin to share information and in line with the point made in the previous section, consideration could be given to how this is best shared with the Executive and senior managers so that it is well understood beyond the ASC team.

This review of this guidance document is well timed and provides a platform for CQC to further build partnerships with LAs, both to ensure that basic practical arrangements are in place, not least named contact details, but also providing an opportunity to build links with LAs and ADASS at a more strategic level. Once approved it will be helpful for the document to be shared across the CQC leadership team, and to ensure that this is well understood among senior social care inspection managers and used pro-actively to guide their work with LAs and other partners.

The issues identified in the previous section in relation to thresholds and definitions is not unique to CQC. Interviewees identified this also being an issue in some LAs and provider organisations, and the 2017 report by Action on Elder Abuse 'Patchwork of Practice' refers to a 'postcode lottery' of responses by LAs citing variation of interpretation of what constitutes an inquiry as defined by s42 of the Care Act. The Local Government Association (LGA) with ADASS is leading work with LAs to develop a set principles and ingredients for making s42 decisions. The work is aimed at achieving improved and more consistent decision making. A similar piece of work in relation to 'concerns' is planned for the coming year.

This review found evidence of increasing joint work across partnerships, which will be helpful in building consistent system wide approaches. For example, one of CQC's national safeguarding leads is involved in the local government work described above. In addition, the DCI with lead responsibility for safeguarding is now a member of the ADASS led national Making Safeguarding Personal Steering Group. It will be important for this practice to continue. LGA and ADASS colleagues have expressed their willingness to support work that CQC will be taking forward in the coming year; an opportunity that CQC should take up.

Recommendations

7. For CQC to ensure that the revised protocol is 'signed off' as soon as possible and is used to further improve working with LAs and ADASS, and other partners.
8. For CQC to continue work in partnership on practice development, including involving LGA / ADASS colleagues in their own development activity including the forthcoming work on definitions and practice improvement.

4. Conclusion

In the course of this independent review, a number of people have described CQC as being 'on a journey'. The organisation has grown significantly over the last 10 years, and new systems and ways of working have been implemented to enable the considerably larger organisation to work effectively. This review has identified a number of areas where current arrangements for working, within CQC and with partners, could be further improved.

The values of the organisation, and its focus on openness and learning came across in this review. Staff from all parts of the organisation contributed openly and with a genuine commitment to learning for the benefit of people the organisation is here to serve. The reviewer would like to pass on her thanks to all who contributed.

Some of the recommendations included in this report had already been identified. This report presents an opportunity for the Board to endorse and encourage some pace behind these actions. As a final recommendation the reviewer proposes that the SGRC Committee is asked to take the lead role in co ordinating and ensuring that actions arising from this review and the internal reviews are implemented, with further reporting to the Board and Executive to be timetabled.

Recommendation

9. That the SGRC Committee is asked to take the lead role in overseeing all actions arising from this review, with further reporting to the Board and Executive to be timetabled.

Appendix A

CQC Report on Internal Reviews

Safeguarding Alerts Incident – Report of the internal reviews

1.0 Summary

Following the Safeguarding Alerts incident being discovered in July 2018, a number of internal and external reviews were commissioned in order that the CQC could provide assurance to those impacted that it had maximised the learning to prevent any further failures and had taken all necessary actions to protect individuals.

This report focusses on the 2 internal reviews;

A) An internal review of CQC change processes, particularly as they related to system and process change
B) Implications for safeguarding policy and practice within CQC

These two reviews were overseen by the Director of Legal and Governance and the Deputy Chief inspector with the CQC lead for safeguarding.

The reviews were then shared with the specialist commissioned to provide the independent external review, who was asked to provide assurance to the Executive Team and Board about the robustness of the reviews, the appropriateness of the recommendations and the associated timescales for change.

This paper summarises the methodology and key findings of the two internal reviews and should be reviewed alongside the independent review.

2.0 Background

In July 2017, a new Safeguarding Alert referral process was introduced utilising CQC's Customer Relationships Management (CRM) system. This replaced the previous manual process that required Inspectors to send emails to the Concerns team at NCSC. The rationale behind this change was to automate the existing manual process and utilise functionality present in the CRM application.

The new automated process within the CRM system incorrectly enabled inspectors to use the pre-existing Referral to Safeguarding (RtS) button/option that had been in place previously for when referrals were to be made to Local Authorities (LAs).

It was identified, following implementation on 17th July 2017 that, in a small number of instances, inspectors were not notified or updated on referral cases. A brief investigation by the National Customer Service Centre (NCSC) Operation Manager found that in a small number of instances (approximately five), inspectors were ticking the 'RtS' button/option in the CRM application, that should not have been made available to them. This caused the referral to be marked as 'completed/sent to Local Authority' in the CRM application and removed the send referral action from the NCSC job queue with no further action being required. The associated risk and impact of this issue was not recognised at this point and as such, it was deemed to be 'a minor issue'. The issue was escalated to the National Safeguarding Advisors, who provided guidance and information on safeguarding matter to CQC staff/inspectors, but not to the CRM support team, and the matter was not escalated to more senior staff in CQC at this stage. Communication was released via an internal news

bulletin that instructed inspectors not to check the RtS button/option. The issue was deemed to have been resolved at this point.

In July 2018, it was identified that there had been continued use of the RtS button/option by inspectors. Initial work identified over 750 cases where this box had been checked. At this point CQC recognised the high-risk nature of this issue, and set up the emergency Gold / Silver Command process. Immediate steps were taken, including;

- A team of experienced staff was set up to triage / analyse all 750+ cases and make referral to LAs where cases met the threshold for referral and where there was no evidence that the case had been picked up via other routes. In total 120 cases were referred to LAs.
- Access was removed for inspectors to select the RtS button/option within CRM;
- Communication was issued to Inspectors including 120 follow up for those inspectors with significant usage of the RtS button.
- External communication was issued including a press release and direct communication with key partners e.g. ADASS, DHSC.

As a consequence of this issue, CQC initiated a special advisory review of its safeguarding alerts process conducted by the GIAA, and the CQC's SGRC Committee was tasked with identifying areas for organisational improvement and learning. In addition, CQC commissioned this independent review, to consider consequences and impact of the delay in making the referrals, including recommendations for further improvement of CQC's existing safeguarding practice, with a particular focus on how CQC can work more effectively with local authorities in making referrals.

3.0 Terms of Reference

This review had the following terms of reference

- To review the service management process followed when the breakdown was noted and follow through the process to resolve the issue.
- To review the service management process, particularly prioritisation and resolution of defects, and integration into the change control process to develop and release the resolution
- To make any appropriate advisory suggestions based on the findings from the above for the future safeguarding process and system, and also with a view to ensuring that the risk of similar failures in the future is minimised.

3.1 Approach

The review included a review of the policies and procedures in place in July 2017, when the original change to CRM was made. The team also reviewed changes that have been made since 2017, in order to advise on any continuing organisational risk and make further recommendations. The team also interviewed key members of staff both from 2017 and current, to validate the records and to assess the cultural and other issues that impact on successful change.

3.2 Key Findings

The review found that there had been several opportunities, both during the process change and after its implementation, when the incident might have been averted or its impact minimised. The issues identified included:

- Lack of oversight
- Inadequate information gathering and user testing pre-change
- Lack of ongoing oversight post implementation
- Inadequate training and support for users
- Failure to use a recognised software development tool, that could have provided assurance and support.

However, the review did acknowledge that there had been a number of key changes in both approach and culture since 2017 that meant that many of these risks were already mitigated, but it advised some further actions especially about the role and membership of the Operations Service Board, the strengthening of user acceptance testing and the full adoption of the JIRA software development tool.

3.3 Next Steps

These findings have been shared with the responsible leadership within CQC and an action plan is being developed that will be overseen by the Strategic Change committee and the OSB.

4.0 Implications for safeguarding policy and practice within CQC

This section of the review was led by the Safeguarding and Responding to Concerns Committee, which is a sub-committee of ET and is chaired by Professor Ursula Gallagher and has members from across all the directorates and teams within CQC. It already had a development programme for the 2018/19 with 5 workstreams

i) What does ‘good’ look like – defining the strategy and ambition for CQC
ii) Data and Knowledge management – how do we ensure that we are using our data and intelligence to protect individuals and improve the effectiveness of our regulation
iii) Products and Materials – ensuring that handbooks and other support materials are accessible and effective in supporting best practice
iv) Learning and Development – developing the learning and development staff to ensure that CQC staff are aware of their responsibilities and confidence to act to protect people at risk of harm
v) Responding to concerns – ensures that we are acting in line with our duties to act on information shared as well as protecting whistle-blowers.

Approach

The work done to manage the incident and ensure that the necessary referrals were sent effective meant that almost 800 decisions to make a referral were reviewed, their quality assessed as well as the quality of the recording and the other actions taken. The outcome of this work and the key themes identified were presented to an extraordinary meeting of the committee in August and each of the 5 workstreams was asked to consider the implications of these findings for the current work programme. Some interim findings were discussed at

the September meeting and the final conclusions were agreed at the meeting on the 16th November.

Summary of key findings

The findings of the review confirmed a number of issues with policy and practice that the committee were aware of and was trying to address through its work programme but the scale of the issues was greater than had been appreciated. In particular, the findings highlighted

- Significant inconsistencies in assessment of the safeguarding risk and decisions taken
- Poor and incomplete record keeping especially of the rationale for the decision
- Variable quality in the referrals made to LA
- Inconsistent decision making on the regulatory implications of the information and evidence of actions taken
- Structure of the CRM record made reviewing cases and tracking actions difficult
- Errors in recording the identity of people raising concerns made it difficult to go back to them to get additional information or feedback outcomes.

Principles behind recommendation

When considering what the most appropriate recommendations and actions might be the Committee was very mindful of the scale of the practice issues identified. It also considered the potential timescales, cost and feasibility of any actions as well as their potential impact. The clear conclusion was that the findings of the investigation meant that we needed to make some radical changes as the inherent risks in the current model could not be confidently addressed by the current work programme.

Key proposals

1. **Creation of a specialist resource to screen and process all referrals**

The Committee concluded that the current model, namely a pathway that involved NCSC staff linking with potentially every inspector in CQC, was inherently risky especially given the background and experience of inspectors and the other pressures on them. The fact that almost 800 cases resulted in only 120 re-referrals and that even then inconsistencies in decisions were still being identified lead the committee to the conclusion that this function needed to be performed by a smaller, more specialist team resulting in higher quality referrals and a speedier response. It was also anticipated that this would improve our credibility and partnership with external partners particularly Local Authorities who should expect to receive high quality and highly appropriate referral from CQC.

It was recognised that a specific risk of the proposal might be that the sense that safeguarding is everybody's might be dissipated, so any changes to the operating model would need to ensure that the safeguarding information and action was integrated into the provider record and that all necessary regulatory implications were identified and acted upon.

A specific piece of work will need to be undertaken to develop a specific model and to redesign the pathway, including how to integrate fully with NCSC processes and the rest of the operating model.

2. Data and Record Keeping

As part of the review the implications for recording keeping both in terms of standards and technical system issues. In order to maximise impact of the proposal above a number of changes and improvements in both processes and data recording will be required. These proposals will be underpinned by a pilot on improving decision making and the subsequent recording which is being led by the ASC North team. The pilot is using an audit tool to assess the quality of the safeguarding decision as well as the quality of the recording in CRM. It is administered by the Inspection Manager, who audits 1 referral per month. The results of the audit will be available by early December and will also inform the work on materials, and learning and development.

Support will be required to ensure that these changes are prioritised within the CRM change programme.

3. Materials

The SGRC committee has launched an updated version of the Safeguarding Handbook in April 2018 with the intention of undertaking a major piece of work to produce an on-line, and more interactive, version accessible via the intranet later in 2018. However, the launch of the new intranet has since been delayed and the committee agreed that the updates required could not wait and work is well advanced on the new version (which has been designed in a way that should mean it is easily transferable to the new format), and should be launched early in 2019, with further iterations planned to reflect the implementation of all the recommendations in this report.

4. Learning and Development

Following the incident will held a safeguarding learning week with daily events for inspectors, managers, safeguarding champions and colleagues from NCSC. The events were accessed by over 400 staff and have been used to inform our wider learning solution. We have developed a new learning solution for adult safeguarding for new Inspectors and assistant Inspectors.

There is also a Strategy in place and work is underway to commission the educational partner. The strategy aims to ensure that staff understand the wider safeguarding landscape and includes the following learning objectives:

- Understand your regulatory role in safeguarding adults.
- Understand how to monitor services to identify themes and trends to drive improvements.
- Know how to manage regulatory risk to ensure robust safeguarding decisions are made and recorded.
- Be able to apply the safeguarding learning into practice across all regulatory activity.

A one-day workshop on CRM and safeguarding is also provided for new Inspectors. The guidance document aligned to this has been updated and is provided as part of the learning and key messages reinforced.

We will need to introduce a benchmark assessment to determine where individual gaps are in learning and what aspect of the learning they need to access to increase knowledge, skill and practice. This way, we don’t sheep dip all Inspectors through an entire programme but

have a key modular programme where relevant learning is accessed based on need. Learning interventions could vary then from face to face workshops, webinars/Skype, learning sets, self-paced learning (e.g. eLearning, videos, access to online learning materials, case studies etc) and all of these have an end of learning assessment element and a way of taking forward the discussions around learning into practice.

Children safeguarding is provided separately as a Skype session and we are currently working on an eLearning safeguarding children product. Also, to note we are now looking at relevant learning solutions to meet the learning outcomes related to Think Child.

RECOMMENDATIONS

1. **Note the work undertaken in response to the Safeguarding Alerts incident**
2. **Agree the following:**
    a. **That a project should be set up with the aim of specialist resource to assess and manage safeguarding referrals. The team should be in place by June 2019 and earlier if possible.**
    b. **That any required (and feasible) changes to CRM should be prioritised in the 2019/20 plan**
    c. **That the roll out of the audit tool should proceed in 2019/20 including the necessary training of inspection managers**
    d. **That the delivery of the training strategy should be prioritised**

Appendix B

TERMS OF REFERENCE FOR INDEPENDENT REVIEWER

Following identification by CQC of a processing error within its system for making safeguarding referrals to local authorities, to consider;

1. the special advisory review of CQC's safeguarding alerts process conducted by Government Internal Audit Agency (GIAA);
2. the information provided to CQC by local authorities concerning the [120] safeguarding referrals made to them following the identification of the processing error;
3. any reports or proposals for future work made by CQC's safeguarding committee for organisational improvement and learning, including the skills and confidence of CQC's workforce in relation to safeguarding.

And in the light of these, to prepare a report for publication on the consequences and impact of the delay in making the referrals, including recommendations for further improvement of CQC's existing safeguarding practice, with a particular focus on how CQC can work more effectively with local authorities in making referrals.

Appendix C

Summary of Recommendations

1. That senior CQC staff make contact with named senior staff in LAs to consider further the impact in the 9 ‘inconclusive’ cases, and to check progress / outcomes in those cases where LA feedback remains outstanding.

2. In the 9 ‘inconclusive’ cases that there is also follow up with the LAs concerned, to check what contact has been made with the individuals concerned and / or their carers, and for CQC to use this to determine what, if any action, should be taken to contact people directly. The same consideration should be applied to any other cases where feedback is still awaited from LAs where CQC then determine that there was any indication of harm as a result of the delay.

3. That a programme of work is undertaken to improve consistency of practice about definitions of safeguarding and thresholds for referral to LAs.

4. That CQC considers arrangements to better triage safeguarding cases, both coming in to CQC and for referral on to LAs from CQC. This could include exploring more experienced safeguarding practitioners being based at NCSC, and /or considering a model of safeguarding lead or duty roles in locality teams.

5. That the CQC Executive considers how arrangements for work across directorates can be further improved.

6. In areas with wider organisational implications - change management, cross directorate working and communication - the reviewer recommends that CQC continues to improve practice in these areas, and endorses more operational recommendations outlined in the internal report at Appendix A.

7. For CQC to ensure that the revised protocol is ‘signed off’ as soon as possible and is used to further improve working with LAs and ADASS, and other partners.

8. For CQC to continue work in partnership on practice development, including involving LGA / ADASS colleagues in their own development activity including the forthcoming work on definitions and practice improvement.

9. That the SGRC Committee is asked to take the lead role in overseeing all actions arising from this review, with further reporting to the Board and Executive to be timetabled.

Appendix D

About the Independent Reviewer

Cathy Kerr has worked as statutory Director of Adult Social Services (DASS) and has extensive work experience in both the NHS and local government over a career of 35+ years. She has managed significant operational services and budgets, and led major change programmes; hospital resettlement, health and social care integration, and in her final substantive role, establishing a single Adult Social Services 'shared service' to serve two local authorities.

She trained as a social worker, and gained front line experience in the London boroughs of Haringey and Barnet, before moving into more senior roles in Hertfordshire, initially in NHS provider services, then as senior NHS commissioner. She then moved back into local government as Assistant Director with responsibility for establishing and managing integrated services. She was DASS for 2 London Boroughs, Richmond and Wandsworth, until April 2017,

Cathy was an active member of the Association of Directors of Adult Social Services and was a trustee of the Association until April 2017. She continues this involvement now as co-chair of the Associates network of former Directors.

Since leaving her full time DASS role, Cathy has worked as a Care and Health consultant choosing assignments which allow her to use her expertise to support care and health systems. Key assignments in the last year have included acting as Special Advisor on the CQC Local System Reviews and supporting ADASS in developing a new leadership programme with partner Newton; and representing ADASS in national work with NHS partners on integration.