MEETING	**PUBLIC BOARD MEETING 12 December 2018**
Agenda Item Paper Number	**6 CM/12/18/06**
Agenda Title	**14 Colne Road Care Home (Hillgreen Ltd)**
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Presenter	**Andrea Sutcliffe – Chief Inspector of Adult Social Care**

PURPOSE OF PAPER:

Actions required by the Board:

- Note recommendations following the independent review have been satisfactorily addressed
- Agree actions in progress are monitored by the organisational leads

IMPACT:

The implementation of the recommendations from the 14 Colne Road Care Home independent review have informed the improvement of many aspects of CQC's regulatory functions, for example, evidence gathering and enforcement. Media or political considerations

1. Summary

The independent investigation into CQC's regulatory oversight of 14 Colne Road operated by Hillgreen Care Ltd was conducted by Sir Paul Jenkins QC (Hon) and David Noble QSO and was published 13 June 2018. The report made 14 recommendations for CQC to consider. Many of these had already been addressed following the internal review of our actions and improvements identified. This paper provides an update on the progress made for each recommendation.

2. Recommendation

This paper sets out the progress made in the implementation of the recommendations and proposes that the further work required is now managed by the relevant organisational leads and no further reports to the Board are expected.

3. Background

3.1. In July 2017 The Times reported on the actions CQC had taken in relation to 14 Colne Road Care Home operated by Hillgreen Care Ltd following the alleged

rape of one resident by another. The Times accused the CQC of covering up the alleged rape and failing to prosecute the provider.

3.2. The then Chief Executive, Sir David Behan ordered an independent inquiry which was undertaken by Sir Paul Jenkins QC (Hon) and completed by David Noble QSO following Sir Paul's sad and untimely death in February 2018. The report was presented to the CQC Board and published on 13 June 2018.

3.3. Sir Paul concluded that "*I have rejected the notion of a cover-up as completely without foundation. It is nonsense*." He stated that "*there was a strong, clear focus at CQC on ensuring that people were safe; and to do so in ways which were most expeditious and effective.*"

3.4. However, the report also concludes that "*Not everything was perfect in the regulation of 14 Colne Road and Hillgreen. Nor was everything perfect in the CQC's policies and practices in place at the time*", and points to a "*loss of momentum*" in taking further enforcement action against the provider; unclear policies about whether serious incidents could be referenced in inspection reports; and a failure to keep the families affected informed.

3.5. The report made fourteen recommendations to improve CQC's consistency, policies, processes and training. All recommendations were accepted in full by the CQC Board building upon the improvements already made and acknowledged in the independent report. Section Four of this report sets out the progress made against each of these recommendations.

3.6. The Board will recall that CQC began the process to cancel the registration of the Colne Road service in February 2016. The registration of Hillgreen Care Ltd was cancelled altogether in September 2017.

3.7. The Board will also be aware that CQC has prosecuted Hillgreen Care Limited for failing in its duty to protect people in its care, exposing them to the risk of sexual abuse. The provider was found guilty on the two counts brought, was fined £300,000 and CQC was awarded full costs in a judgment made on 15 November 2018.

4. Discussion and implications

Recommendation 1: Consistency
CQC should ensure consistency of approach across all its activities in the application of policies.

Guidance has been updated and implemented across all operational Directorates on the inspection approach, referring to incidents in reports, *Fit and Proper Persons*,

procedures for sharing information and for action when there is no registered manager in post.

Recommendation 2: Learning and Development
CQC should ensure there is a strong and consistent focus on excellence in [learning and development] training.

The induction programme for new inspectors has been revised, extended from 12 to 16 weeks and encompasses experiential learning with dedicated support from an induction buddy. The new induction programme is being trialled in Adult Social Care and will be introduced into other inspection directorates by Q4 2018/19. This programme will increase the levels of support provided to inspectors during their initiation stage and improve consistency of practice across inspection directorates.

A professional regulatory training programme is in the final stages of procurement and it is expected the contract will be awarded in December 2018 with delivery of the programme commencing in Q1 2019/20. This training will increase inspector confidence and capability in using CQC's enforcement powers.

Recommendation 3: Risk
CQC should ensure that inspectors are properly trained to understand and manage the risks of challenge by providers and are properly supported when dealing with such risks.

A health and safety support package was launched in November 2018. A zero-tolerance statement has been introduced and a '*potentially violent persons*' register is being developed with completion due January 2019.

Recommendation 4: Information
CQC should adopt a more proactive approach to the collection, retention and deployment of information about providers and services. Such information should be retained as far as possible in a single, readily accessible form.

Information received by CQC and stored in CRM is being made available to CQC's Intelligence team to generate improved insights for Inspectors. A prototype timeline presenting all this information in one place, enabling more effective and efficient monitoring of providers, is currently being tested with rollout to inspectors across all sectors planned for Q4 2018/19. Improvements to guidance on relationship management have been introduced setting out more consistently the approach inspectors should take to their ongoing interactions with providers. CQC Insight continues to be enhanced, improving the view of quality and risk, and further improvements to data, insight, and processes needed to support regulatory decision making are being planned as part of the revisions to the Monitor programme under consideration.

Recommendation 5: Escalation

CQC should improve escalation systems to ensure information, including about specific provider and service inspections and enforcement issues, is better transmitted through the CQC hierarchy.

The Risk Steering Group has worked with staff and key stakeholders to develop a revised Risk Framework that will enable improved identification, assessment and management and escalation of risk with our regulatory duties, including the use of enforcement and the mitigation of cross sector risk. The framework, and implementation plan, will be launched in mid - January 2019 and will include a communication plan and a learning and development offer. The Risk Steering Group is developing metrics, reporting and monitoring tools that will provide operational assurance on delivery.

Recommendation 6: Inspection oversight

CQC should improve inspection oversight to ensure a more consistent approach, especially in relation to ratings.

Following a review of ASC's internal quality control of inspections (2018), inspection manager review of those being rated Good and RI has been strengthened with management information introduced that demonstrates the high proportion being scrutinised. Inspection manager review has also been extended to cover inspection planning. Heads of Inspection continue to review and approve all reports awarding services an Outstanding rating and Inadequate rated services are scrutinised at Management Review Meetings. Cross sector Case Assessment Progression Panels have been introduced to ensure there is close scrutiny of investigations that may lead to prosecution.

Recommendation 7: Inspection reports

CQC guidance on inspection reports should ensure clarification and improvement in relation to the following: references to ***incidents****; references to ongoing* ***enforcement*** *activity; references to state of services at the time of publication; references to a provider's claims to* ***special expertise*** *and how those are to be monitored.*

In November 2017 the assessment framework for Adult Social Care inspections was fully revised and updated, including the inspection handbook and report template. The updated handbook included guidance on: considering all information, more detailed characteristics against each Key Line of Enquiry (KLOE) and guidance on reporting serious incidents. The report template and guidance for Hospitals has also been updated and PMS will update their report template by December 2018 but have produced guidance for inspectors in the interim.

CQC is currently restricted from referring to ongoing ***enforcement*** activity by our regulations. CQC will continue to pursue with the Department of Health and Social

Care a change to these regulations so that it can refer to enforcement activity before its completion and therefore provide more transparency for people using services.

Specific ***training*** programmes and support are being established to support areas of special interest for inspectors to enhance their confidence and understanding of service types, what good looks like and how to assess the ***specialist expertise*** of providers. This has been a priority in the ASC 2018/19 learning plan.

Recommendation 8: Enforcement oversight
CQC should improve enforcement oversight to ensure a more consistent approach to both decision making and monitoring of progress.

The Enforcement Oversight Board has implemented a substantial programme of work to ensure more consistent decision making and there is active scrutiny of this work by the Executive Team. The recent internal audit provided moderate assurance with outstanding for governance.

Recommendation 9: Victims and next of kin
CQC should proactively keep victims and next of kin informed of enforcement activities.

The Professional Regulatory Skills Programme (PRSP) will also ensure that inspectors '*are properly trained and have the confidence to have difficult conversations*'.

CQC is seeking a change in the regulations to enable us to publicise our enforcement action so that both victims and people using services, their carers and families are aware of the issues and the action CQC is taking.

A leaflet for families to assist inspectors when discussing cases with victims and/or their families was published in July 2018 to ensure that timely and proactive communication with people affected takes place in an appropriate way.

Recommendation 10: Representations
CQC needs to keep closely under review their evolving approach to criminal enforcement.

A dedicated Representations team was established December 2017. Members of the team receive training and legal support, which is resulting in consistent decision making in accordance with CQC's responsibilities under Section 27 of the Health and Social Care Act 2008. The pilot period showed a clear shift to earlier resolution (due to an inherited backlog) and the team expect to be operating within the KPI of 20 working days in Q4 2018-19.

Recommendation 11: Criminal enforcement
CQC needs to keep closely under review their evolving approach to criminal enforcement.

CQC has strengthened the availability of legal advice through the restructure of the legal team. Additional support is now being provided by the Evidence Review Officers, appointed in September 2018.

The introduction of the Professional Regulatory Skills Programme in January 2019 will also cover the balance between improving care and prosecuting.

Recommendation 12: Criminal enforcement – legacy issues
CQC should consider whether the legacy from their lack of preparedness to use their powers of prosecution when newly acquired in 2015 has been properly examined to identify incidents which should be considered against current prosecution criteria.

An enforcement decision tree tool has been introduced to determine the most appropriate action an inspector should take. The enforcement decision tree supports consistency of decision making. The decision tree template prompts inspectors to fully consider and record all breaches and level of risk applied. It encourages consideration of all sections of the decision tree and has aided consistent decision making across all sectors.

Recommendation 13: Primacy in investigations

CQC should establish a protocol with National Police Chief's Council (NPCC) and any other relevant prosecuting authorities to ensure clarity about who is the lead prosecutor for offences which CQC can prosecute

Discussions with the NPCC have been underway during the course of this year. Following recent agreement not to wait for a more wide-ranging Memorandum of Understanding involving additional different parties, a free-standing MOU has now been agreed in principle, with formal sign-off expected by the 14 December 2018.

Recommendation 14: Legal resources
In the light of apparent capacity, capability and recruitment concerns, CQC should consider reviewing the strength and grading of their legal resources available to assist and guide enforcement activities

The legal Services Team has been reviewed and restructured. Generally, this has been successful, with better support now available to the ASC directorate in particular. However, recruitment continues to be a challenge, and it has not yet been possible to reach full establishment across the team. Work is underway to look at reward and retention across the organisation. Resourcing more generally continues to be kept under review, alongside enforcement trends and improving capability in other areas.

5. Conclusion and Next Steps

The independent review highlighted areas for improvement, many of which had been identified by the internal review carried out in 2017. Good progress has been made in most areas and outstanding actions are now being managed by operational leads.

It is therefore recommended that this report serves as the conclusion of the specific reports to the Board.