Southern Cross, Orchid View

September 2009 – October 2011

Foreword from Andrea Sutcliffe, Chief Inspector of Adult Social Care

to the Care Quality Commission's analysis of its responses to events at Orchid View identifying the key lessons for CQC and outlining its actions taken or planned

June 2014

In October 2013, the inquest into the deaths of 19 people living at Orchid View care home concluded that neglect had contributed to the deaths of five residents with other residents suffering 'sub-optimal' care.

Newly into my post as Chief Inspector of Adult Social Care at the Care Quality Commission, I was appalled by the descriptions of what had happened at Orchid View. My first thoughts were with the people and their families who had suffered this unacceptable care. But the coroner had also criticised the actions taken by CQC during 2010-2011 and I was determined to take a long, hard look at our role and make sure that any lessons to learn were turned into practical action.

This report is the product of that review. Adopting the formal technique of root cause analysis, we identified the key points where CQC was involved, considered the action we did take, explored why and reflected on any alternative action we could have taken. We also identified what has already changed since Orchid View closed in 2011, the lessons we have learned and further action planned. This is particularly important as we are testing and consulting on our new approach to the regulation and inspection of adult social care and I want to make sure that any further action is fully reflected in our new plans.

When things go wrong in health or social care services, families affected want to make sure that others do not have the same experience. To do this, we need to be honest about our mistakes, be clear about changes that are needed and then make sure they happen.

The report is a difficult read for those of us at CQC and even more so for the families of those living at the home, but we want to be open about our role and what we have done in response.

While the responsibility for the unacceptable care that happened at Orchid View rests squarely with the people providing the service and their owners, Southern Cross, it is clear that in 2010/11 CQC did not fulfil its purpose of making sure the service provided people with safe, effective, compassionate, high-quality care. The way we worked in 2010/11 meant we did not respond proactively to early warning signs, were too easily reassured by the responses of the provider and did not take appropriate enforcement action quickly or strongly enough.

It is over two and a half years since Orchid View closed and the report highlights that since then, CQC is more responsive to safeguarding and other notifications of risk; our inspection techniques have improved; training has been provided in relevant areas; and working with local partners has been strengthened. But we can and should do more and our new approach will take these improvements further.

There are specific actions for CQC:

- Ratings in the new approach will not be awarded if there is insufficient evidence to do so – for example, very low occupancy as in the case of Orchid View.
- Arrangements for quality assurance and monitoring of inspections will be strengthened and specialist teams of inspectors established with smaller portfolios of services to improve regulatory risk management.
- Information systems will continue to be developed so that data collection and analysis is improved, worrying trends more clearly identified and a history and chronology of events for every location is easily accessible to inspectors and managers.
- Information provided by people using services, their families and carers as well as staff who raise concerns will be used to help focus inspection activity.
- Inspections will ask five key questions – is the service safe, caring, effective, responsive and well-led? Guidance will be provided to inspectors to support more consistent and robust gathering of evidence.
- Additional inspectors will be recruited, and resources have been made available to enable this.
- Clear information on the outcome of inspections will be given to providers and shared publicly to encourage improvement.
- Enforcement action will be taken and the full use of our powers deployed when this is required to secure improvement, constraints or closure of services.

CQC's failings in 2010/11 were not the fault of any one individual. The analysis and the actions set out in the report show that the wider circumstances at the time (organisational change, activity pressures, regulatory changes and poor information systems) all contributed to some poor and delayed decisions and we absolutely need to make sure that we do better in future. In this context it would be inappropriate to single out any individual, as the responsibility for the failures in relation to Orchid View rests with, and is accepted by, the organisation corporately.

Since we carried out this review there have been more recent reports of poor care in residential care homes such as reported in the BBC Panorama programme 'Behind Closed Doors: Elderly care exposed'. That programme revealed neglect, verbal abuse and physical violence against people who were frail and vulnerable. It has, quite rightly, provoked a lot of reaction and comment. CQC's inspections are periodic and therefore deliberate acts of poor care or abuse are unlikely to take place in front of an inspector, although we need to be aware of the culture of organisations, which may allow neglectful or abusive practice to persist. The major responsibility for high quality, safe, compassionate and effective care rests with the people running the services and the staff working there as well as with those who commission them. The events at Orchid View that were the subject of this review and report were the result of very different circumstances, when signs of poor practice were not acted upon by the provider or CQC and we have identified gaps in our systems that allowed them to go unchecked. The focus of this review has been to address these gaps.

Before I close, I would like to thank the primary authors of this report, Paula Mansell and Steve Holmes, and everyone they worked with throughout the organisation to reflect honestly on what happened and where we need to improve.

I would also like to thank the families of the Orchid View residents who met with Adrian Hughes, Deputy Chief Inspector during the review. The families told us that CQC must have a higher profile; it should be responsive when concerns are raised and make sure relatives and others are kept informed. These important principles will continue to underpin our work. CQC will always act on the side of people using services, their families and carers, and will ensure that the issues raised by them and the information they share with us is used to inform our regulatory and inspection activity and the action we take.

I am determined, as is the rest of the Board and senior team, that CQC will never again, as it did at Orchid View, lose sight of its central purpose to make sure that care services provide people with safe, effective, compassionate and high-quality care whatever the extent of organisational change taking place at CQC, whether or not individual inspectors change over a period of time, and however complicated circumstances at a particular home might be.

Nothing we can say or do now will change what happened at Orchid View between 2010 and 2011. But the best way CQC can honour the memory of those who died is to use our learning to improve the way we regulate and inspect adult social care and to encourage services to improve for the benefit of everyone who will use those services now and in the future.

Andrea Sutcliffe
Chief Inspector of Adult Social Care
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