Lessons Learned from the Care Quality Commission and the Scrutiny Experience in England

Report to: Board

Date: 6 September 2012

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Report No: B-09-2012

Agenda Item: 9

PURPOSE OF REPORT

To note and approve the attached report into lessons learned from the Care Quality Commission (CQC) and the scrutiny experience in England.

RECOMMENDATIONS

That the Board:

1. Notes and approves the report.

2. Agrees that an action plan is developed and implemented by the Care Inspectorate and Healthcare Improvement Scotland (HIS) to address the recommendations made within the report.

Agenda item 9

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B-09-2012

Version Control and Consultation Recording Form

Version	Consultation	Manager	Brief Description of Changes	Date
1.0	Senior Management	ET		23/8/12
	Legal Services			
	Resources Directorate			
	Committee Consultation (where appropriate)			
	Partnership Forum Consultation (where appropriate)			

Equality Impact Assessment

To be completed when submitting a new or updated policy (guidance, practice or procedure) for approval.

Policy Title:		
Date of Initial Assessment:		
EIA Carried Out	YES ☐	NO x
If yes, please attach the accompanying EIA and briefly outline the equality and diversity implications of this policy.		
If no, you are confirming that this policy will have no negative impact on people with a protected characteristic and a full Equality Impact Assessment is not required.		Name: Colin McAllister Position: CPCI Manager
Authorised by Director	Name: Karen Anderson	Date: 27 August 2012

1.0 INTRODUCTION

The purpose of the appended report is to advise the Care Inspectorate and Healthcare Improvement Scotland Board and Executive Team members of a series of key messages, issues and recommendations that have emerged from recent experience of scrutiny in England, including criticisms of the CQC.

This will help ensure that both the Care Inspectorate and HIS can learn any lessons from action taken in England and, where relevant, take mitigative action to reduce risks and therefore improve the quality of care for people in Scotland.

The recommendations in the report will also support and help to inform the delivery of Care Inspectorate and HIS's corporate outcomes and objectives.

2.0 BACKGROUND

Scrutiny in England has recently faced a number of high-profile challenges. These include abuse highlighted by BBC 'Panorama' at Winterbourne View Hospital (a private hospital for people with learning disabilities), the financial collapse of Southern Cross, and the independent and public inquiries into Mid-Staffordshire NHS Foundation Trust.

In addition to the above there have been several reports into the care of vulnerable groups, including recent reports from the King's Fund and the Commission on Dignity in Care for Older People.

As a result, there is a range of recent material on issues in relation to scrutiny in England.

In Scotland, following the death of a resident at the Elsie Inglis care home and concerns regarding the financial collapse of Southern Cross, the Scottish Parliament's Health & Sport Committee held an Inquiry into the Regulation of Care for Older People, which both the Care Inspectorate and HIS and other partners and agencies gave evidence to.

The Committee concluded that 'the current regulatory system is sufficiently rigorous to identify care services for older people which are failing to deliver high quality care" and made a number of recommendations for improvement'.

3.0 SCOPE OF REPORT AND PREPERATION

The report was prepared by the Care Inspectorate's Policy Team in collaboration with HIS and synthesises the key messages, issues and recommendations from nine separate reports, including four reports specifically into aspects of the performance of the CQC.

4.0 KEY THEMES AND RECOMMENDATIONS

The findings of the report are broken down into key themes, each with a series of recommendations. The themes are:

- new scrutiny models and managing expectations of key stakeholders;
- strategic planning and focus;
- leadership and organisational culture;
- public reporting;
- risk assessment and management of risk;
- quality assurance; and
- delivering the scrutiny model.

In total, 33 recommendations are made to enable both bodies to reduce risk, learn from experience in England and, where appropriate, take action. There may also be implications for the wider scrutiny landscape in Scotland.

5.0 RESOURCE IMPLICATIONS

It is important to note that many of the recommendations build on the existing direction of travel for the Care Inspectorate. Any additional resource implications of the actions that will flow from individual recommendations will be addressed as implementation is considered.

6.0 BENEFITS FOR PEOPLE WHO USE SERVICES AND THEIR CARERS

By learning from the scrutiny experience in England, the Care Inspectorate can reduce risks and avoid some of the difficulties that have been encountered elsewhere in the UK, thereby safeguarding and improving the quality of scrutiny and the quality of care for people in Scotland.

6.0 CONCLUSION

While there is much we do well in Scotland, it is imperative that we do not become complacent. By learning valuable lessons from the problems faced by the CQC in particular, and the wider health and social care environment in general, we can ensure that the Care Inspectorate and HIS avoid some of the potential pitfalls our equivalent bodies have faced.

LIST OF APPENDICES

Appendix 1 - Lessons learned from the CQC and the scrutiny experience in England based on evaluation of recent reports: A joint report for the Care Inspectorate and Healthcare Improvement Scotland.