Summary of the Care Quality Commission's internal review regarding Autumn Grange, Nottingham

This is a summary of an internal review the Care Quality Commission (CQC) completed in August 2016. The review examines our inspections and regulatory action at Autumn Grange Residential Home in Nottingham during 2012. This summary provides an overview of the main findings, conclusions and recommendations and has been published to inform the public on the action we have taken as a result of the learning from the review.

Autumn Grange Residential Home closed in November 2012 after CQC began proceedings to cancel the home's registration due to concerns surrounding the safety and welfare of people living there.

Shortly after the home closed Mrs Ivy Atkin, who had been a resident at the home, died. Her death was subject to a police investigation and this resulted in the company that ran the home, Sherwood Rise Limited, being fined £300,000 for corporate manslaughter, the first of its kind in England.

A company director and manager of the home pleaded guilty to offences in relation to Mrs Atkin's death at the same hearing and were sentenced in February 2016 to custodial and suspended sentences respectively. We would like to express our sympathy to all those who received care which fell a very long way short of what they, and we, should have been able to expect from the provider.

CQC subsequently conducted an internal review of its actions at the home to examine what lessons it could learn. It is common practice in CQC to undertake learning reviews when concerns about our performance have been identified. The judge in the case against Sherwood Rise Limited had also requested that CQC review its activity and oversight of the care provided by the service during 2012.

The review looked at whether CQC could have better discharged its duty and although the way CQC inspects has changed since 2012, the findings were used to inform future methodologies to ensure we learn lessons and protect people.

The review identified areas of good practice, there was good partnership working with other agencies including the local authority when the service closed in November 2012. The inspection team worked well with the local authority staff to ensure that the safety and welfare of residents was maintained until they were safely moved out and relocated to other services by the local authority.

The review identified a number of areas where improvements were required. There was too much focus on the evidence collected the day of the inspection in September 2012 rather than ensuring that our methods for assessing the provider's regulatory risk was based on all the information available including past regulatory history, whistleblowing and safeguarding referrals and concerns from other agencies. The review also identified that record keeping, storage of information and inspection planning was poor.

A number of recommendations were made in the following areas:

Risk Management

- The CQC Risk Framework (produced in 2016) must be used by staff and developed to ensure all information received about a provider or service must be thoroughly checked, including information from providers and other agencies.
- Services where there has been a history of concern and inability to make improvements must be risk assessed and closely monitored by inspectors and managers.
- Managers must ensure there are quality checks on the completion, usage and storage of key inspection documentation. This is particularly important as we move to a risk based model of inspection (in line with our strategy for 2016 to 2021, our regulation of adult social care will be more targeted, responsive and collaborative so that more people get high-quality care), which means that we focus on services that are higher risk to ensure people are adequately protected.
- When a service transfers between inspectors relevant documentation must be completed to ensure the newly allocated inspector is updated about the history and risk of the service.

Inspection Planning

- Inspectors must ensure inspection planning documentation is completed appropriately and effectively based on risk issues. These may span a number of years where a service has a history of providing poor care. All inspection plans must be stored appropriately.
- Inspection planning should cover all areas of current risk, historical risk and information to suggest improvements. Information received from partner agencies and commissioners must be clarified during the inspection.

Support for Staff

- Managers must ensure sufficient time is given in team meetings and during supervision sessions with inspectors, to discuss risk services to ensure the appropriate action is taken to safeguard and protect people.
- If inspectors or individual teams are particularly busy managing risk services or enforcement activity, managers must ensure appropriate support is provided.

CQC has taken action with regard to the recommendations of the internal review. The learning from this review has been shared with teams across the adult social care directorate and with colleagues in other teams in CQC such as the primary medical services and hospitals directorate.

We undertook a national consultation of our methodology in adult social care, the findings of our internal review fed into this consultation. To help us manage risk more robustly we have restructured the way we work in the adult social care directorate. Risk services are shared more evenly across teams and we have improved how we engage with external stakeholders.

CQC held a multi-agency workshop in Nottingham in January 2017, this involved CQC and other partner agencies, to further improve and develop partnership working and relationships.

Our Section 28 response is now published on the Chief Coroner's website https://www.judiciary.gov.uk/publications/ivy-atkin/.

At the inquest into Ivy Atkin's death, in October 2016, the Coroner said: "It was heartening to see that CQC had made changes to its inspection methodology and procedure."

The Coroner said she was reassured that CQC was in a position to robustly inspect and actively take steps where homes are failing and where measures to support them are not successful. She was also assured that matters had moved on dramatically since 2012 and reassured by evidence from the Local Authority and CQC that relationships between them are good at staff level and senior level. (See page 21-22 of the Safeguarding Adults Review http://www.nottinghamcity.gov.uk/health-and-social-care/adult-social-care/adult-safeguarding/nottingham-city-safeguarding-adults-board/)