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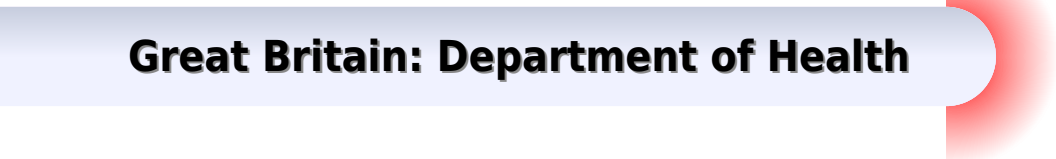
Outstanding 



CareQuality
Commission

Care Quality Commission Together Relating

Great Britain: Department of Health



Care Quality Commission Together Relating:

The Care Quality Commission Great Britain: Parliament: House of Commons: Committee of Public Accounts, 2012-03-30
The NAO report on this topic published as HC 1665 session 2010 12 ISBN 9780102977011 Annual accountability hearing with the Care Quality Commission Great Britain: Parliament: House of Commons: Health Committee, 2011-09-14 Following its annual review of the work of the Care Quality Commission CQC the Health Committee reports that the bias of the work in the CQC away from its core function of inspection and towards the essentially administrative task of registration represents a significant distortion of priorities The Committee reports that the CQC was established without sufficiently clear and realistic definition of its priorities and objectives the timescales and resource implications of the functions of the CQC were not properly analysed the registration process itself was not properly tested and proven before it was rolled out the CQC failed to draw the implications of these failures adequately to the attention of ministers Parliament and the public Consequently the Committee welcomes the government's decision to postpone registration of GP practices and recommends that proper planning including piloting of the model for registration should be undertaken before the revised date of April 2013 is confirmed The Committee also welcomes recent announcements that the CQC intends to undertake annual visits of all NHS and social care providers It goes on to stress the importance of the role of inspectors in assessing the culture in care providers especially concerning the obligation which rests on all healthcare professionals to raise concerns if they recognise or ought to have recognised evidence of failure of professional standards Each provider organisation should recognise and respect this professional obligation and provide proper security to those professional staff who discharge it effectively

2012 Accountability Hearing with the Care Quality Commission Great Britain: Parliament: House of Commons: Health Committee, 2013-01-09 The failures of Care Quality Commission CQC prompted the Department of Health to undertake a performance and capability review which produced a wide range of recommendations The decision by CQC board member Kay Sheldon to give evidence as a whistleblower added to the controversy She identified serious failings within the management organisation functions and culture of the CQC and it is unacceptable that the CQC failed to address and act on them before she felt compelled to approach the public inquiry It is clear from the evidence presented by the CQC's outgoing Chair Jo Williams and recently appointed Chief Executive David Behan that the regulator is aware of the reforms that must be implemented The CQC's primary focus should be on ensuring that the essential standards it enforces can be interpreted by the public as a guarantee of acceptable standards in care The CQC's essential standards in their current form do not succeed in this objective Equally the CQC must be far more diligent in communicating the outcomes of inspections especially to residents in social care and their immediate family In the long term the CQC has a role to play in facilitating a culture of challenge and response across health and social care so that identifying and addressing failings becomes a standard process for staff and management Providers must support staff in raising concerns in order for those staff to meet their own

professional duties Those organisations who fail in this obligation should be refused registration by the CQC **Any of Our Business?** Great Britain. Parliament. Joint Committee on Human Rights,2009 Any of our Business Human rights and the UK private sector first report of session 2009 10 Vol 2 Oral and written Evidence **Department of Health: Hard Truths: The Journey to Putting Patients First - Cm. 8751** Great Britain: Department of Health,2013-11-19 The Government's initial response Patients First and Foremost Cm 8576 ISBN 9780101857628 set out a radical plan to prioritise care improve transparency and ensure that where poor care is detected there is clear action and clear accountability This document now provides a detailed response to the 290 recommendations the Inquiry made across every level of the system It also responds to six independent reviews commissioned to consider some of the key issues identified by the Inquiry This document sets out how the whole health and care system will prioritise and build on this including major new action in vital areas including transparent monthly reporting of ward by ward staffing levels and other safety measures a statutory and professional duties of candour legislate at the earliest available opportunity on Wilful Neglect a new fit and proper person's test which will act as a barring scheme all arms length bodies and the Department of Health have signed a protocol in order to minimise bureaucratic burdens on Trusts a new Care Certificate to ensure that Healthcare Assistants and Social Care Support Workers have the right fundamental training and skills in order to give personal care to patients and service users and the Care Bill will introduce a new criminal offence applicable to care providers that supply or publish certain types of information that is false or misleading where that information is required to comply with a statutory or other legal obligation It looks at preventing problems detecting problems quickly taking action promptly ensuring robust accountability and ensuring staff are trained and motivated **Legal Aspects of Health and Safety** Bridgit Dimond,2016-06-27 Presented in a clear and concise format that makes for easy reference and understanding this revised and updated edition covers issues that are becoming increasingly important to health professionals managers and educators including proposed changes to the law since Lord Young's 2010 report Common Sense Common Safety Topics include cross infection and the spread of MRSA greater regulation of health and safety standards stress and bullying and the laws relating to notifiable diseases such as HIV AIDS Illustrated with case studies throughout this book is designed to provide a clear introduction to the laws relating to health and safety case law and statute law so that the health professional has a sound understanding of the law *Creating Healthy Organizations* Graham Lowe,2012-09-28 The current global economic environment is defined by unprecedented uncertainty a premium placed on knowledge and the threat of future talent scarcity Key to an organization's success under these conditions is its ability to strengthen the links between people and performance *Creating Healthy Organizations* provides executives managers human resource professionals and employees an action oriented approach to forging these connections by creating and sustaining vibrant and productive workplaces A healthy organization operates in ways that benefits all stakeholders including employees customers shareholders and communities Using a wide range of examples from

a variety of internationally based industries Graham Lowe integrates leading practices with research on workplace health and wellness quality work environments employee engagement organizational performance and corporate social responsibility to make a compelling business case for creating healthy resilient and sustainable organizations Creating Healthy Organizations offers readers whether CEOs or front line workers an innovative framework and practical tools for planning implementing and measuring healthy change in their workplaces Organising care around patients Naomi Chambers,Jeremy Taylor,2021-09-07 Organising care around patients is not for the fainthearted Naomi Chambers and Jeremy Taylors have curated twenty five accounts from people who agreed to tell the story of what happened when they or their loved ones came into contact with the NHS The authors defy you not to laugh or cry or hold your breath in disbelief at some point when reading this book In these true and compelling accounts we learn the experiences good and bad of people grappling with birth and death caring for loved ones living with mental illness coping with long term conditions and struggling in older age This book is a call to action aimed at healthcare professionals managers and politicians a manifesto for more patient centred care These stories show the NHS at its very best and also when it falls significantly short Patients or carers currently battling with the system will derive some hope and encouragement and clues about what to expect what to ask for and from whom *Legal Aspects of Pain Management 2nd Edition* Bridgit Dimond,2016-06-01 This revised and updated edition explores the law relating to pain management in recent years It considers the legal issues which have arisen in recent high profile cases and discusses the implications of legislation extending prescribing powers The text is written in a user friendly readable form for the non lawyer It aims to provide a succinct useful basis from which practitioner and others can extend their knowledge of the law for the protection of their patients their colleagues and themselves Scope and contents Human rights law Criminal law and procedure Negligence Professional registration Consent in relation to adults children and mentally disabled adults **Quality Improvement in Primary Care** Stephen Gillam,Niro Siriwardena,2022-02-14 This book provides readers with an invaluable set of tools to convert the endless challenges for quality and myriad opportunities for improvement into meaningful and useful change It considers how to manage primary care organisations in order to improve quality of care how general practices are regulated and held accountable various techniques used for assessing and measuring and commonly used quality improvement frameworks

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