Coventry City Council
Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 2.00 pm on Wednesday, 10 December 2014

Present:

Members: Councillor S Thomas (Chair)
Councillor M Ali
Councillor J Clifford
Councillor P Hetherton
Councillor J Mutton
Councillor J O'Boyle
Councillor D Skinner
Councillor K Taylor

Co-Opted Members:

Other Members: Councillors A Gingell

Employees (by Directorate)

S Brake, People Directorate
V Castree, Resources Directorate
P Fahy, People Directorate
L Knight, Resources Directorate
J Reading, People Directorate

Apologies: Councillor D Howells

Public Business

37. **Declarations of Interest**

There were no disclosable pecuniary interests declared.

38. **Minutes**

The minutes of the meeting held on 19th November, 2014were signed as a true record. There were no matters arising.

39. **Serious Case Review - Mrs D (CSAB/SCR/2013/1) - Progress Report**

Further to Minute 44/13, the Board considered a briefing note of the Executive Director, People which provided an update on the progress of the Mrs D Serious Case Review Action Plan. A copy of the action plan was set out at an appendix to the note.

The briefing note set out the background to the Serious Case Review which followed the death of Mrs D, a woman in her late 80s in the summer of 2011. The review had identified a number of recommendations and actions to improve practices which were detailed in the action plan. A key recommendation was

focused on the referral into safeguarding of avoidable grade 3 and 4 pressure ulcers via the implementation of an effective pressure ulcer protocol. To raise awareness of the risk of pressure ulcers, the six month 'Your Turn' campaign was launched in May 2014. Reference was made to the considerable work undertaken to ensure that the protocol meant that safeguarding concerns were referred appropriately. This included the establishment of a Task and Finish Group who reported to the Coventry Safeguarding Adults Board on 3rd December, 2014. In addition, from November, 2014 the number of cases reviewed and frequency of quality checks had been increased by undertaking regular in-house peer reviews on a rolling programme basis.

The Board were informed that all single actions included on the action plan had been completed and there were no outstanding actions. The two non-specific multi-agency recommendations would continue to be monitored by the Safeguarding Board.

Members questioned the officer and responses were provided. Matters raised included:

- Whether lessons had been learnt from previous Serious Case Reviews and the reasons behind the increasing problems around tissue viability issues
- Details about the number of pressure ulcer alerts
- Further information about the introduction of sticky labels on hospital patient records to highlight information that staff need to be aware of
- Clarification that all actions had been completed and the lessons learned had been shared with all relevant organisations
- The arrangements for awareness training for staff in the partner organisations
- The consistency of standards when dealing with pressure ulcers
- The importance of 'on the job' vocational training and the requirement to ensure that patients feeling cared for
- Staff recruitment and retention
- The levels of quality and consistency of GP care in the city.

RESOLVED that:

(1) The Dean of Life Sciences, Coventry University and the Dean of the Medical School at Warwick University, or their representatives, be invited to attend a future meeting of the Board to present an item on clinical training linked to the education sector, including the vocational nature of courses. Consideration to be given to the recruitment and retention of staff.

(2) The Quality and Audit Sub Group of the Safeguarding Adults Board be informed of the Board's recommendation that consistent standards are validated and in place for dealing with pressure ulcers.

(3) The Board's sympathies be conveyed to the family of Mrs D in any final correspondence to be sent to the family.

(4) Board members to be provided with detailed information on the number of pressure ulcer alerts.

40. **Coventry and Warwickshire Partnership Trust (CWPT) - Update on Progress following the Care Quality Commission Inspection**

Further to Minute 71/13, the Board considered a report from Coventry and Warwickshire Partnership Trust (CWPT) which provided an overview of progress following the Care Quality Commission (CQC) Wave 1 inspection which took place from 20th to 24th January, 2014 and the subsequent re-inspection of the Quinton Ward at the Caludon Centre in July, 2014. The action plan detailing the CQC enforcement and compliance actions was set out at an appendix attached to the report. Josie Spencer, Deputy Chief Executive and Director of Operations, CWPT attended the meeting for the consideration of this item.

The report indicated that the Trust was the first mental health trust in the country to be inspected by the CQC using their new inspection regime. The CQC had raised one enforcement action (warning notice) against the Quinton Ward and five compliance actions to five locations. In response, the Trust developed a series of action plans to address the matters raised and to achieve compliance. External oversight of these plans resided with Coventry and Rugby CCG.

The Board were informed that all the required action had been undertaken and services continued to embed the changes into practice. In relation to the enforcement action against the Quinton Ward, all actions were completed by 30th June, 2014 deadline. The CQC subsequently carried out an unannounced inspection of the ward on 2nd July. Quinton Ward was found to be compliant and the enforcement action was removed. The Trust was currently awaiting re-inspection to confirm compliance with the compliance actions.

The Board questioned the representative on a number of issues and responses were provided. Matters raised included:

- The privacy of patients and activities for patients at the Caludon Centre
- Why issues hadn't been addressed at Quinton Ward when the Trust were aware of problems prior to the inspection
- Difficulties for patients and their families when patients are located at the Brooklands hospital, Marston Green
- The recording of incidents when patients were violent towards staff
- The work undertaken to identify on-going concerns across the Trust
- The actions carried out to ensure the safe management of medicines
- The sharing of good practice across the Trust
- The use of agency staff
- The quality of staff at all levels across the organisation including training and performance management
- Clarification about safety and security at the Brooklands hospital
- The measures implemented to ensure the safety of employees including lone workers and the actions used if staff fail to adhere to follow necessary policies and procedures.

RESOLVED that the progress made by Coventry and Warwickshire Partnership Trust to address matters raised by the Care Quality Commission be noted.

41. **Discharging Responsibilities for Winterbourne View**

The Board received a briefing note and presentation of the Executive Director, People which provided an overview of the action taken within Coventry and Warwickshire in response to the Winterbourne View Report which placed a number of requirements on local areas including a joint plan for high quality care and support services. A copy of the document 'Coventry and Warwickshire's Local Response to Winterbourne: A Work Programme for 2014-16' was set out at an appendix to the report.

Key requirements also included the development of a local register of patients with learning disability or autism and challenging behaviour in Assessment and Treatment units by April, 2013; a duty on local areas to review all hospital placements by 30th June, 2013; and to move everyone inappropriately placed to community based support by 1st June, 2014. The Board were informed that all timescales had been met. An appendix to the report provided details of the individual patients identified as being part of Coventry's Winterbourne cohort.

Attention was drawn to the co-ordinated response from the Care Quality Commission; NHS England; Coventry and Warwickshire Partnership Trust; the City Council and Coventry and Rugby Clinical Commissioning Group and to the responsibilities for each organisation.

The presentation also included information on the 91 people with learning difficulties who were currently placed out of the city; detailed an individual case study; and highlighted the next steps to be undertaken.

The Board questioned the officers on a number of issues and responses were provided. Matters raised included:

- Clarification about the roles and responsibilities of the partner organisations
- The monitoring of standards and quality throughout the city
- Details of the development of potential new supported housing schemes to provide additional places in the city and proposals to relocate Coventry residents currently placed out of area
- Comparisons with other local authorities and concerns about a lack of data
- An assurance that the requirement for a 'duty of candour' for providers is in place and that any bad practices are picked up and dealt with
- Does the Council's whistle blowing policy apply to third party providers
- Further details about the 91 out of city placements
- Monitoring by other local authorities and reciprocal arrangements
- The potential development of the Hawthorne Lodge site
- Proposals for dealing with future numbers of young people who are likely to want to live as independently as possible.

RESOLVED that:

(1) Officers to work to continue to ensure a speedy repatriation of Coventry residents currently placed in accommodation outside of the city, back to Coventry when it is safe and appropriate to do so.

(2) Officers to continue to work to ensure that there will be adequate future provision for young people with learning disabilities or autism who have high support needs and/or challenging behaviour.

(3) Opportunities be taken to share appropriate bench marking data and best practice with other local authorities.

(4) Board members to be provided with the detailed list concerning Coventry adults with learning disabilities and autism who are placed out of the area.

42. **Outstanding Issues Report**

The Scrutiny Board noted that all outstanding issues had been included in the Work Programme for the current year.

43. **Work Programme 2014-15**

The Scrutiny Board considered the work programme for 2014-15.

RESOLVED that:

(1) The work programme be updated to include an item on clinical training, minute 39 above refers.

(2) At the next Board meeting, Coventry and Rugby Clinical Commissioning Group to provide a short verbal update on patient transport (to be raised under 'matters arising').

44. **Any other items of Public Business**

There were no other items of urgent public business.

(Meeting closed at 4.30 pm)