# Report to Coventry Health and Social Care Scrutiny Board – 10 December 2014

# **CQC Inspections – Coventry and Warwickshire Partnership NHS Trust**

## 1. Purpose of Report

1.1 To provide Covetry HOSC with an overview of the progress made by the Trust to address matters raised by the Care Quality Commission (CQC) following the Wave 1 Inspection that took place in January 2014 and subsequent re-inspection of Quinton Ward, Caludon Centre in July 2014.

#### 2. Background

- 2.1 The Trust was the first mental health trust in the country to be inspected by the CQC using their new inspection regime. These inspections took place between 20<sup>th</sup> and 24<sup>th</sup> January 2014.
- 2.2 The CQC raised one Enforcement action (Warning Notice) against Quinton Ward, Caludon Centre and issued five compliance actions to five locations. The table at Appendix 6.1 summarises the actions issued.
- 2.3 In response to the findings the Trust developed a series of action plans to address the matters raised and to achieve compliance. This report focuses on the progress made with the completion of these action plans.
- 2.4 External oversight of the action plans resides with Coventry and Rugby Clinical Commissioning Group (CCG), who act as the host for other relevant CCGs with additional oversight from the NHS Trust Development Authority (TDA).

#### 3. Key issues

- 3.1 The associated action plans developed in response to the CQC enforcement and compliance actions can be found at Appendix 6.2. All required action has been taken and services continue to embed the changes into practice.
- 3.2 **Enforcement Action:** All actions detailed on the enforcement action plan were completed by the identified deadline (30<sup>th</sup> June 2014). Notification was submitted to the CQC who carried out an unannounced inspection of Quinton to check compliance and implementation of the action plan on the 2<sup>nd</sup> July 2014.
- 3.2.1. The CQC judged that improvements had been made and found Quinton Ward compliant removing the enforcement action. The subsequent quality report was published in July 2014.



- 3.3 **Compliance Actions:** Completed action plans have been submitted to the CQC. The NHSTDA and CCGs have been notified.
- 3.4 The Trust is currently awaiting re-inspection by the CQC to confirm compliance. These inspections will be unannounced.

#### 4. Recommendations

4.1 The HOSC is requested to receive this report.

### 5. Implications

5.1 Failure to address the enforcement and compliance actions may lead to further enforcement action being taken by the CQC.

### 6. Appendices

6.1 Summary of Issued Enforcement and Compliance Actions

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November 2014



# **Appendix 6.1 Summary of Enforcement and Compliance Actions**

#### **Enforcement Actions**

Regulation		Location
9 (1) (a)(b) (i) (ii) (iii) Care and Welfare of Service Users: Regulation	The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of:  a)The carrying out of an assessment of the needs of the service user  b)The planning and delivery of care and, where appropriate, treatment in such a way as to: i. Meet the service user's individual needs ii. Ensure the welfare and safety of the service user iii. Reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to care and treatment.	Quinton Ward, Caludon Centre

# **Compliance Actions**

Regulation		Location
13 Management of Medicines	The registered provider was failing to protect patients against the risks associated with the unsafe use and management of medicines.	Caludon Centre
	The registered provider was failing to protect patients against the risks associated with the unsafe use and management of medicines.	Wayside House: Community Mental Health Teams
15 (1) (a) (b) Safety and Suitability of Premises	People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because the design and layout of seclusion rooms was not suitable or safe and the security measures in place were not safe.	Brooklands
17 (1) (a) Respecting and Involving People who Use Services	The registered person had not as reasonably practicable made suitable arrangements to ensure the dignity, privacy and independence of service users.	Caludon Centre St Michaels Woodloes
20 (1) (a) (b) (i) (2) (a) Records	People who use services were at risk of unsafe or inappropriate care and treatment from a lack of proper information about them and the safe keeping of their information.	Caludon Centre St Michaels Woodloes
23 (1) (a) Supporting Workers	The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care and treatment to service users and to an appropriate standard, by receiving appropriate training, professional development, supervision and appraisal.	Caludon Centre