City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Minutes of a meeting of the Health and Social Care Overview and Scrutiny Committee held remotely on Tuesday, 23 March 2021 at 4.30 pm

Commenced 4.30 pm
Concluded 7.30 pm

Present – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT & INDEPENDENT GROUP
Greenwood **Mir** **Godwin** **Lintern** **Humphreys**	**Hargreaves** **Goodall**	**Griffiths**

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer

Observer: Sarah Ferriby (Portfolio Holder, Healthy People and Places)

Apologies: Councillor Hussain

Councillor Greenwood in the Chair

64. DISCLOSURES OF INTEREST

No disclosures of interest in matters under consideration were received.

65. INSPECTION OF REPORTS AND BACKGROUND PAPERS

There were no appeals submitted by the public to review decisions to restrict documents.

66. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

There were no referrals made to the Committee.

67. CHAIR'S NOTE

The Chair opened the meeting by thanking Gerald 'Sam' Samociuk who was standing down as a co-opted member of the Committee after five and a half years. She remarked that Sam's contribution to the Committee's work had always been greatly valued especially when ensuring that the wellbeing of health and social care staff was part of the discussion. On behalf of the Committee she wished Sam well for the future.

68. CARE QUALITY COMMISSION QUALITY REPORT: CYGNET WOODSIDE

On 23 December 2020 the Care Quality Commission published its Quality Report on Cygnet Woodside a copy of which was appended to the agenda. Members were aware that Cygnet Woodside was a private mental health hospital providing assessment, treatment and rehabilitation for adults with learning disabilities and autism. The hospital received a rating of inadequate and had been placed in special measures.

The Strategic Director of Quality and Nursing at NHS Bradford District and Airedale Clinical Commissioning Group attended the meeting to update Members on the report and the impact on Bradford residents.

A summary of the inspection included the background to Cygnet Woodside; the rationale for conducting the inspection; how the inspection was carried out and detailed findings from the inspection.

A detailed presentation was provided which included CQC themes and trends; a response to the concerns; safeguarding and safety and future plans.

Members expressed concerns that despite the purpose of scrutiny reports being to provide reassurance it was felt that they almost never had that satisfaction. They expressed concern that the service had gone from a rating of Good to Inadequate in a short space of time and that issues highlighted in the inspection had not been identified prior to the CQC visit. Concern was also expressed that members of the management team were not in attendance.

In response Members were advised that there had been an immediate response to the concerns and that the new host commissioner role and responsibilities recently published would strengthen the powers of the Local Authority and regular visits would be undertaken. The Host Commissioner role would provide a central point of contact and would hold partnership meetings including with the CQC and the Safeguarding board. The Local Authority had also identified a resource for support to be proactive and preventative with independent hospitals and that would include Cygnet.

A number of additional queries and concerns were raised to which the following responses were provided: -

- There had been long term placements at the facility. The CQC report did refer to a person staying at the Cygnet Woodside for up to five years.
- Conduct issues raised in the report may be confidential, however, generally could refer to capability or other concerns. Those issues would need to be considered on a case by case basis.
- At the time of publication of the report there were nine people using the

facility. Since that time four people had transitioned to alternative provision. The CQC and partner organisations were meeting with Cygnet on a weekly basis to look at the safe transfer of those service users remaining and wellbeing checks were being conducted to support those people.

- The response and work carried out would not be wasted as the service model changed. The new model would transfer to the local authority which would act as lead commissioner. The response and work carried out since the inspection would not be wasted and would enhance the future provision.
- The home first approach was adopted wherever possible to support people in their home settings.
- There had been many concerns at the hospital during the pandemic. Many service users did not tolerate staff wearing masks. Officers had worked with the hospital to mitigate risks and reduce the risk of infection.
- It was not possible to provide a breakdown of the age and ethnicity of current service users but it was confirmed that they were aged 18+.
- The CQC report identified access to advocacy and communication between personalised commissioning or social workers who were involved to support service users after the findings. Positive feedback had been received regarding improvements put in place and how loved ones were supported, from their families.
- Specialist Autism training was identified in the report and had been delivered. It was not known if additional specialist support from a Learning Disabilities perspective had been provided.

In response to all the issues highlighted in the report Members were extremely concerned that those issues had not been picked up prior to the CQC inspection. The monitoring arrangements between CQC visits was questioned and it was stressed that Members needed to have the confidence that a similar situation would not recur at any of the district's facilities or if they did interventions would be made.

In response it was explained that the new host commissioner role provided the local authority with the power and responsibility to carry out regular visits. There would also be partnership meetings including the CQC Safeguarding Board to triangulate data. The Local Authority had also identified a resource to support independent hospitals which would include Cygnet. Assurances were provided that an immediate response was made to all concerns.

A Member expressed disappointment that she had not had the opportunity to comment on the CQC report and questioned who was speaking up for service users. She was also disappointed to note that the mandatory autism training for one for one day and that the rate of pay for a support worker was so low. It was queried if the facility, as it moved to its new model of operation would involve the same personnel and if so would they have better training and provide more support and help for service users. In response it was not possible to comment on future staffing provision but assurances were provided that facility received support to facilitate appropriate discharge and provision for users and that support would be continued. The possibility of inviting managers of the facility to a future meeting was suggested for Members to gain assurance from that provider. The oversight of the facility would transfer to the Local Authority in the future.

A Member with significant experience in mental health referred to a model which revealed how facilities can deteriorate from conscious competence to incompetent complacency and questioned why there were so many agency staff employed. It was believed that this often evidenced an inability to recruit in places seen as not good places to work. He questioned if the number of agency staff was because of an inability to recruit or high levels of sickness. In response it was explained that confirmation from the provider would be required to answer those questions.

It was confirmed that the CQC visit had been unannounced although it was not possible to confirm if that had been in response to concerns from the Local Authority; family members; staff or other professionals. It was agreed to discuss with Local Authority colleagues to ascertain where concerns had originated prior to the inspection.

A Member raised the Department of Health review into the Winterbourne View Hospital in 2012 and intentions to ensure similar incidents were not repeated. Concerns were raised that, because of austerity measures, this had not occurred. It was explained that the 'Winterbourne Review' was regarding out of area placements and measures were now in place. The Local Authority was responsible agency for safeguarding and moving forward the Host Commissioning Role would strengthen its control.

Members referred to information they required which was not presented in the report under discussion, that there had been no input from the Local Authority and that it should not be down to patients and families to raise concerns. It was explained that the officers had been asked to provide an update on the response to the inspection and the situation regarding people currently residing at the facility. It was hoped that they had responded to that request. There were a number of concerns raised from the report and consideration would be required to ascertain if that information could be shared. The questions raised at the meeting had been noted and officers would liaise with partners to provide a further report as soon as practicable.

Resolved –

That the issues and themes raised by the Committee including around monitoring and adult safeguarding be added to the Committee's programme of work for 2021/22 for further scrutiny.

Action: Overview and Scrutiny Lead

69. UPDATE FROM THE CARE QUALITY COMMISSION (CQC)

The report of the Quality Care Commission Inspection Manager, Document "X" provided a current update from the Adult Social Care Directorate based upon published reports.

Members were assured that throughout the pandemic the CQC's regulatory role did not change and the core purpose of keeping people safe remained. The

routine inspection programme paused, however, an Emergency Support Framework (ESF) was launched and used as a monitoring tool.
Infection Prevention and Control (IPC) thematic reviews and risk inspections were in place together with Designated setting inspections and Infection Prevention Control (IPC) outbreak inspections.

Thematic work reviewing the use of do not resuscitate decisions during COVID-19 was also presented.

Appended to Document "X" was an update from the CQC Adult Social Care Directorate in the Bradford district. This included a summary of the current situation; COVID-19 response priorities; developments in the monitoring approach; responding to risk; rating providers and reporting on findings including statistics for Bradford services; piloting new ways of working; lessons learnt and the future of adult social care.

A definition of 'culture' contained in the presentation was requested and it was explained that this was how services were run, how things were done and learnt behaviours. A closed culture indicated a service where people had worked for a number of years, they all knew each another, not many visitors were allowed and rules where not always followed as staff believed they knew what they were doing. Closed culture produced bad, learnt, behaviour. Rather than do what was correct staff would do as older staff exhibited. There would be inspections if a closed culture was suspected as closed cultures were not good for service users.

Members raised a number of questions to which the following responses were provided: -

- Key Lines of Enquiry would be conducted by telephone and in response to comments that this could not be independent if conducted whilst managers were present assurances were provided that calls were made to staff outside of their working hours.
- There had, at the start of the pandemic, been huge difficulties in getting Personal Protective Equipment (PPE) to staff. If problems were identified in IPC decisions were made and enforcement or a S164 letter issued highlighting concerns with 24 hours to respond were issued. Other agencies such as the IPC team in Bradford were contacted and made aware.
- Visits to Care Homes were not allowed. There should not be blanket restrictions and reports of that would be a concern. Care must be taken with the management of gifts but care homes would be expected to facilitate contact.
- The Government were considering compulsory vaccinations of care home staff, however, refusal would impact on staffing levels. All Inspectors were vaccinated and tested weekly. Lateral flow tests were also conducted on the day of inspection visits.

In response to concerns that there were approximately one quarter of services in the District rated as inadequate or requiring improvement it was reported that

these were monitored closely and enforcement action taken.

A Member was anxious that the normal inspection routine was paused and believed that visits to facilities were required to get a feel for a facility and notice the behaviour of service users which zoom facilities would not reveal. It was also questioned if targeted inspections would ignore any concerns not regarding the targeted topic. Assurances were provided that issues identified during targeted inspections would be addressed. A pilot of inspections had taken place on Domiciliary Care Agencies and it was agreed to check if any pilot inspections had taken place in care homes and report back to the Overview and Scrutiny Lead.

A Member suggested that the Healthwatch, Bradford and District, could be utilised to increase inspection capacity and it was confirmed that work was undertaken with the Local Authority and other partners but those suggestions would be taken on board.

In response to reliance on other professionals, such as GPs, it was confirmed that work was undertaken with other professionals including GPs, ambulance services, district nurses and hospitals who have an eye on services.

The Quality Care Commission Inspection Manager was thanked for the provision of an informative report and it was confirmed that the CQC were invited to the meeting annually.

Resolved –

That the report be noted and the Inspection Manager be thanked for her informative presentation.

Action: Overview and Scrutiny Lead

70. COVID-19 PUBLIC HEATH UPDATE

The Director of Public Health provided a presentation on the Department of Public Health's strategic Covid-19 plan including updates on testing, NHS Test and Trace, outbreak management and the vaccination programme. To enable Members to consider the most up to the minute information the presentation was not available prior to the meeting and was subsequently published on the Council's website.

The presentation outlined: -

- Bradford's Local Outbreak Management Plan
- A summary of the national Road Map between 8 March and 21 June 2021.
- Key statistics on vaccinations; hospital admissions; deaths; infection rates and testing
- The management of outbreaks including those in education; care homes and the work place
- Local contact tracing
- Testing for those symptomatic; asymptomatic and challenges faced
- Bradford District and Craven COVID-19 Vaccination Programme

The Director was thanked for a very informative presentation and the impressive work conducted in the area. It was noted that the Prime Minister had referred to the great leadership shown in the District.

Infection rates were discussed and it was requested that a breakdown of all cohorts in addition to the Over 60s be provided in future.

The effectiveness of Lateral Flow Testing (LFT) was questioned and the need for people who had been vaccinated or were young and less likely to be harmed to be cautious was debated. The Director acknowledged the points made but stressed the need to be careful until all people were vaccinated and to avoid further lockdown measures.

A Member referred to difficulty he witnessed in getting workers who needed to be tested to take those tests. He believed that it was those very people who should be checked and referred to a recent webinar he had viewed which suggested 80% of people broke COVID rules.

The accessibility of testing centres in the Keighley West Ward was raised as a matter of concern as it was believed that people in that area were having to undertaken long and difficult journeys to the nearest facilities. It was requested that GP surgeries be organised to vaccinate residents. In response it was agreed that those comments be forwarded to the appropriate bodies.

In summation the Committee thanked all the staff and leadership teams involved for their assistance in the District.

Resolved –

That the Department of Public Health and all Council staff be thanked and commended for their work throughout the Covid-19 pandemic.

No Action

Chair

Note: These minutes are subject to approval as a correct record at the next meeting of the Health and Social Care Overview and Scrutiny Committee.