Agenda Item 7

Overview: Inspection Reports and National Publications

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Falkirk IJB Clinical and Care Governance Committee

27 November 2020

Overview: Inspection Reports and National Publications

For Noting

1. Executive Summary

1.1 The purpose of this report is to provide an overview of the inspection reports and national reports published since the last meeting of the Clinical and Care Governance Committee (CCGC).

2. Recommendations

The Clinical and Care Governance Committee is asked to:

2.1 note the contents of this report.

3. Background

3.1 The report presents to the CCGC a summary of recently published inspection reports and national reports in an overview paper. Where there are significant issues arising from these reports, more detail will be provided in the report. Committee members can highlight if they think that more detailed consideration of any paper is required, and if so, what the appropriate reporting route would be.

4. Inspection Reports

4.1 Due to the pandemic Mental Welfare Commission visits have been suspended. There has been one Care Inspectorate (CI) reported published for in-house services since the last CCGC meeting. This was for Burnbrae Care Home on 24 August to evaluate the service on “How good is our care and support during the COVID-19 pandemic?”. The inspection graded the service as 2: Weak, with one requirement and one area for improvement.

4.2 The service has made significant efforts to address these issues working with colleagues in Falkirk Council facilities team and the Public Health Team. The CI carried out a follow up visit on 8 October 2020 and recognised the progress made from their inspection, and have given the service until 30 November to complete the remaining work.

4.3 Burnbrae Care Home is now participating in the pilot of the Care Inspectorate Gold Standards Care Home Infection Prevention & Control Assurance Tool pilot. The care home has previously received a positive

report about the work being done. The tool has 9 standards, each with a rationale for the standard, and a number of questions for managers to complete a self-assessment against. These standards include:

- Standard 1: Leadership in the prevention and control of infection
- Standard 2: Education to support the prevention and control of infection
- Standard 3: Communication between organisations and with the patient or their representative
- Standard 4: Infection surveillance
- Standard 5: Antimicrobial stewardship
- Standard 6: Infection prevention and control policies, procedures and guidance
- Standard 7: Insertion and maintenance of invasive devices
- Standard 8: Decontamination
- Standard 9: Acquisition of equipment.

4.4 The care home will continue to participate in the pilot and use the findings from the self-evaluation to make any required changes to practice.

4.5 In addition to the CI follow-up visit, through our local arrangements an assurance visit was completed with senior health and social care managers on 23 October 2020. The visit did not find any areas of concern and commented positively on the building and staff adhering to infection prevention and control procedures.

4.6 Further information is provided in appendix 1, which also includes an update on previously reported inspections. This will ensure the Committee are able to monitor progress with the implementation of any inspection recommendations.

4.7 Under the duties placed on the Care Inspectorate by the Coronavirus (Scotland) (No.2) Act, the CI report to the Scottish Parliament fortnightly on their inspections activity. These inspections place a particular focus on infection prevention and control, personal protective equipment and staffing in care settings and the arrangements put in place by care services to respond to the Covid-19 pandemic. This enables inspectors to focus on these areas while also considering the overall quality of care and impact on people's wellbeing.

4.8 Appendix 2 provides a summary of the fortnightly reports to the Scottish Parliament on Care Inspectorate inspections where these relate to service providers in the Falkirk Council area.

5. National Publications

5.1 An overview of the national publications of interest to the CCGC since the last report is attached at Appendix 3. There have been 8 reports published.

5.2 In February 2020, the Committee received a report published by the Mental Welfare Commission on their findings in relation to an investigation into the care and treatment of a woman with learning disability, whose discharge from an acute orthopaedic ward was delayed by 18 months. This was not a Falkirk case.

5.3 The report set out the establishment of a Task and Finish Group to consider the recommendations and give an assurance around our Adults with Incapacity (AWI) processes and Delayed Transfers of Care and the outcome of the case reviews for those in a hospital setting within an AWI process.

5.4 The MWC requested a formal response from the HSCP by 16 October 2020 and this has been submitted.

6. Conclusions

6.1 This report provides an update on local inspection activity, as well as national reports which have been published since the last report to the CCGC. Updates on ongoing inspection improvement plans is also included.

Resource Implications
There are no resource implications arising from this report.

Impact on IJB Outcomes and Priorities
The inspection reports and national reports will provide standards and recommendations that the IJB can assess itself against to ensure delivery of the Strategic Plan and the national Health and Social Care Standards.

Directions
A new Direction or amendment to an existing Direction is not required as a result of the recommendations of this report.

Legal & Risk Implications
There are no legal and risk implications arising from this report.

Consultation
There are no consultation implications arising from this report.

Equalities Assessment
There are no equality implications arising from this report.

7. Author Signature

Suzanne Thomson, Senior Service Manager

8. List of Background Papers

The inspection and national reports are set out in the appendices.

9. Appendices

Appendix 1:	Summary of inspection reports
Appendix 2:	Fortnightly reports to the Scottish Parliament on Care Inspectorate Inspections
Appendix 3:	Summary of national reports

Appendix 1

Care Inspectorate Reports

Publication Date	Inspection: type and date	Service	Evaluation of Service		Areas for Improvement	Progress report as at November 2020
24/08/20 08/10/20	Unannounced Unannounced	Burnbrae Care Home Burnbrae Care Home	How good is our care and support during the COVID-19 pandemic?	2 - Weak	To ensure that peoples end of life and palliative care needs are known and supported each individual should have an anticipatory care plan available. Reference is made to https://ihub.scot/acp-covid-19. To ensure that people experience a high-quality environment with equipment and furnishings that meet their needs a programme of refurbishment should be progressed. The service is advised to prioritise work with local Public Health services and have a risk assessed plan for improvements to communal bathrooms to minimise the risk of infection and improve the quality of the environment for those resident. This is in order to ensure that care and support is consistent with the Health and Social Care Standards 5:22	The inspection led to a requirement being placed on the service to ensure the service has evidence of an enhanced cleaning schedule in place. This included a schedule for the cleaning of care equipment. The CI carried out a follow up visit on 8/10/20 and recognised the progress made from their inspection, but that not all the measures have been met for their requirement. In recognising the improvements made, the CI have given until 30 November 2020 to complete the remaining work. The cleaning schedules have been implemented and staff have now received training on how to complete them appropriately, which was advised by the CI on 8/10/20. The cleaning of equipment is being recorded as advised by the CI. Management are currently liaising with Facilities on the refurbishment requirements of the building to the communal bathrooms to minimise risk. The service is working on risk assessed plan with facilities to improve the environment in this area. An area of improvement identified was to ensure that peoples end of life and palliative care needs are known and supported each individual should have an Anticipatory Care Plan (ACP) available. ACP's have been implemented for all residents. This identifies peoples end of life and palliative care needs. The CI recognised this has been met.

Appendix 1

24/01/2020	Unannounced	Torwoodhall Care Home	How well do we support people's wellbeing	5 very good	The service should ensure copies of all relevant Adults with Incapacity documentation for residents are retained and that all staff have training in Adults with Incapacity legislation in practice to ensure residents' rights are upheld and safeguarded. This is to ensure care and support is consistent with the Health and Social Care Standards which state "if my independence, control and choice are restricted, this complies with relevant legislation and any restrictions are justified, kept to a minimum and carried out sensitively" (HSCS 1.3).	In response to the recommendation, the Care Home Manager has proactively worked with residents, their families, GP's and the Office of the Public Guardian to ensure the required AWI documentation is held for those residents this applies to. Progress has been impacted due to challenges accessing services that are closed or limited due to Covid-19. The AWI documentation is being retained in the residents files at the service. During 2019, a number of care home staff attended Adults with Incapacity Training. This was provided by the Nurse Specialist, Care Home Liaison Psychiatry Team. This training provided to Care Homes has not happened this year due to COVID – 19. An alternative on-line module is being looked for to ensure staff still receive this training, which has been added to the Annual Training Plan for the Home. This has been happening throughout the pandemic as the most viable way of training staff members.
			How well is our care and support planned?	5 very good		
19/12/2019	Announced	Falkirk Council Mobile Emergency Care Service	How well do we support people's wellbeing	5 very good	In order to safeguard the health, safety and wellbeing of service users, the provider should ensure all appropriate risk assessments are undertaken and regularly reviewed. This is to ensure care and support is consistent with the Health and Social Care Standards which state "I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm" (HSCS 3.21).	Complete and ongoing.
			How well is our care and support planned?	4 good		

Appendix 1

Mental Welfare Commission

Publication date	Inspection: type and date	Service	Summary of recommendations	Progress report as at November 2020
17-Jun-20	Announced 14-Jan-20	Loch View, Larbert	1.Managers should undertake a review of the psychology service that is provided to the wards.	This is a duplicate of the report published on 18 March 2020. The action is now complete.
20-May-20	Announced 27-Feb-20	Bellsdyke, Trystpark	1. Managers should ensure that patients on the ward have access to OT for purposes of assessment, rehabilitation and input towards discharge planning. 2. Managers should ensure that any restrictions are the least restrictive necessary in order to keep the patients and others safe. 3. Managers should ensure that illicit drug use or suspected illicit drug use, is considered in an individualised way and is part of a person-centred care plan. 4. Managers should ensure that the cigarette ends are cleaned up from the garden and ward entrance areas.	The OT post has been recruited and the action is now complete. Ongoing education on care planning is taking place including ensuring the care plan is individual and person centred.
15-Apr-20	Unannounced 18-Feb-20	Bellsdyke Hospital, Trystview	1. Managers should review their audit processes to improve the quality of care plans and ensure that care plans are person-centred, reflect the holistic care needs of each patient, and identify clear interventions and care goals. 2. Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council Code, and professional standards of practice and behaviour for nurses, midwives and nursing associates.	Initial training with staff is complete and ongoing audit and action takes place to ensure nursing notes are of an acceptable standard.
18-Mar-20	Announced 09-Oct-19	Bellsdyke Hospital, Russell Park	Managers should ensure specified persons procedures are implemented for patients where this is required to authorise room searches, or other restrictions.	Complete
18-Mar-20	Announced 14-Jan-20	Lochview	Managers should undertake a review of the psychology service that is provided to the wards	Complete

Appendix 2

Fortnightly reports to the Scottish Parliament on Care Inspectorate Inspections

Publication Date	Service	Evaluation of Service	Further action
11 Nov 2020		There were no reports for service providers operating in the Falkirk area	
28 Oct 2020	Burnbrae care home, Falkirk	A joint follow-up inspection visit with NHS Forth Valley, was done on 8 October. There were no changes to the service evaluations.	Refer to update in report and Appendix 1
14 Oct 2020	-	There were no reports for service providers operating in the Falkirk area	-
30 Sept 2020	-	There were no reports for service providers operating in the Falkirk area	-
16 Sept 2020	-	There were no reports for service providers operating in the Falkirk area	-
2 Sept 2020	Burnbrae care home, Falkirk	Unannounced inspection of the care home on 20 August 2020	Refer to update in report and Appendix 1
19 Aug 2020	-	There were no reports for service providers operating in the Falkirk area	-
5 Aug 2020	-	There were no reports for service providers operating in the Falkirk area	-

National Publications

Publication date	Organisation	Report title and summary	Implications for the HSCP	Timescales
28.10.20	Public Health Scotland	Public Health Scotland Report: Discharges from NHS Scotland hospitals to Care Homes The main points from the national report are as follows: ▪ There were 3,599 discharges from hospital to a care home between 1 March and 21 April. The majority (81.9%) of which were not tested for COVID-19, in-keeping with clinical guidance which restricted testing to those with symptoms of infection. Of the 650 who were tested, 78 received a positive result while in hospital. ▪ There were 1,605 discharges from hospital to a care home between 22 April and 31 May. The majority (1,493, 93%) were tested for COVID-19, in line with the changes in clinical guidance. Of these, 1,215 tested negative and 278 tested positive. Of those who tested positive, 233 had a negative test result prior to discharge. ▪ It is important to note that there are valid clinical reasons for individuals not to be tested prior to discharge, relating to their capacity to consent to testing and avoiding causing distress, and to appropriateness of testing, e.g. in end of life care situations ▪ 843 of the 1,084 care homes received hospital discharges between 1 March and 31 May ▪ Using laboratory confirmed cases, 348 (32%) of care homes in Scotland experienced an outbreak of COVID-19 in the home between 1 March and 21 June ▪ In the statistical modelling analysis: o Care home size has the strongest association with outbreaks of COVID-19, and this association persists after taking account of other care home characteristics including discharge from hospital. Risk of a care home outbreak increases progressively as the size of care home increases.	The outputs from the study will be taken into account along with any other emerging evidence in the review of care homes, plans for models of care and commissioning. The IJB and CCGC has received regular updates on the care home assurance work being completed. This work is included in the CCGC Overview report of oversight arrangements on the agenda.	Ongoing

Publication date	Organisation	Report title and summary	Implications for the HSCP	Timescales
		○ Hospital discharge is associated with an increased risk of an outbreak when considered on its own. However, after accounting for care home size and other care home characteristics, the estimated risk of an outbreak associated with hospital discharge reduces and is not statistically significant. ▪ Between 1 March and 31 May 2020, there were 5,204 discharges from NHS hospitals to care homes (4,807 individuals), this accounted for 5.3% of all hospital discharges during the same period.		
20.10.20	Health and Social Care Alliance Scotland (the ALLIANCE) and Self Directed Support Scotland (SDSS)	'My Support My Choice: People's Experiences of Self-directed Support and Social Care in Scotland The aim of this research was to gain a better understanding of people's experiences, filling a data gap and complementing the work of other independent evaluations. Between November 2018 and February 2020, researchers heard about the experiences of 637 people who used, or had applied for, SDS in the previous 12 month period. Although the research took place before the pandemic, it represents the most recent and comprehensive reflection of people's experiences. As such, it provides vital evidence, analysis of good practice and recommendations for improvement in the review and reform of SDS/social care, based on people's experiences. The majority of participants believed SDS had improved their social care experiences, and many acknowledged it as important to achieving a higher quality of life and independent living. However, the research findings demonstrate that there are some key improvements required to address people's concerns, build on existing good practice and increase the	The report makes several recommendations, many of which echo other independent reviews of SDS, including: ▪ targeted work is needed to ensure all population groups can exercise their right to make a meaningful choice between all four SDS options ▪ there are concerning gaps in national and regional SDS data gathering and analysis. ▪ action is required to ensure that SDS budget cuts and tightened eligibility criteria do not negatively impact people on low incomes who access or are applying for SDS/social care, given that they can lead to people having to manage without support, deteriorating physical and mental health, and demands on family and friends to assume roles as unpaid carers. ▪ improvement is needed to guarantee short waiting times at various points during the SDS process ▪ people value and use independent advocacy, advice and support organisations, and these services need sustainable resources to continue their important role. The report is being considered by the HSCP Management Team.	

Publication date	Organisation	Report title and summary	Implications for the HSCP	Timescales
		effectiveness and reach of positive SDS/social care experiences. Separate thematic reports about the experiences of particular population groups, including: women as users of SDS; blind and partially sighted people; Black and minority ethnic people; people with lived experience of mental health problems; and people with learning disabilities will be published.		
09.10.20	Mental Welfare Commission	**The MWC published a statement on the practice of moves from hospital to care homes for people who lack capacity.** During the Covid-19 pandemic, emergency legislation was introduced outlining easements to s13za of the Social Work (Scotland) Act 1968. These easements were never enacted and have now expired. The statement gives advice to services on the existing legal position when considering these moves.	The MWC has written to Chief Officers to advise that the Commission intends to work with HSCP's to independently review the practice in recent months with specific reference to moves from hospital to care homes. This will also include further inquiries as to the rights based practice and legal authority supporting the moves. The focus of this piece of work is to identify any learning and ensure learning takes place where required to support individuals. The Partnership is responding to information requests from the MWC to support their inquiries. It is anticipated these will be concluded and reported on by end January 2021.	January 2021
30.09.20	Mental Welfare Commission	Adults with Incapacity Act Monitoring Report 2019-2020 The MWC report shows a continued rise in the use of guardianship orders in Scotland – up from over 6,400 people in 2012, to almost 16,000 at March 2020. This is the highest figure ever recorded. Guardianship orders are used to safeguard those who lack the capacity to make their own decisions. The report's main findings are: • a total of 3,199 guardianship orders were granted in	The report has been circulated to operational managers for information and consideration of the findings.	

Publication date	Organisation	Report title and summary	Implications for the HSCP	Timescales
		2019-20, a 7% rise on the previous year • the majority of guardianship orders granted were for people who either have a learning disability (49%), or dementia/Alzheimer's disease (36%) • the majority of guardians are private individuals (74%) in 2019-20. Local authorities have a duty to make an application for welfare guardianship where it is needed and no-one else is applying. • almost half (46%) of guardianship orders granted last year were for a period of five years or less, while 47% were more than five years and 7% were indefinite orders. The proportion of orders granted that are indefinite has declined steadily over time. • there has been a marked decline in indefinite guardianship orders, from 48% in 2010-11 to 2% in 2019-20. Key gaps identified • the lack of support and supervision for private guardians; only 76% had received a visit from a supervising officer in the past six months • only 76% had the correct medical certification from doctors for their medical treatment • for 67% of individuals with a do-not-attempt CPR form, it was either unclear if guardians had been informed, or guardians had not been informed.		
24.09.20	Care Inspectorate	**Delivering care at home and housing support services during the COVID-19 pandemic: Care Inspectorate inquiry into decision making and partnership working**	The report's primary conclusion is that HSCP's and service providers worked well to deliver key services despite the impact of the pandemic. It also recognises the commitment from care at home and housing support staff who, despite the fears about their own	

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		The report draws together the views of health and social care partnerships and service providers about their experience of care at home and housing support services during the first phase of this pandemic. It is intended that it helps to inform future planning for, and improvement in, these services. The inquiry looked at responses to the pandemic in relation to care at home and housing support services across all HSCP's in Scotland. Through this, the CI has identified common themes and challenges which they have set out as key messages from the inquiry. The report recognises there are key issues from the inquiry that will require further consideration or follow-up action as we move through remobilisation and recovery phases of the Covid-19 pandemic.	health, worked hard and worked flexibly to ensure there was capacity to meet people's needs and keep people safe. The report notes that all HSCPs prioritised support for people with critical needs and that almost all made changes to packages of care to do this, as was the case for Falkirk HSCP. In terms the immediate challenge, the report advises there are substantial risks from Covid-19 to the ongoing resilience of the care at home and housing support sector. It also notes that 'staff are by now tired and may be less able … to continue to go the extra mile on an ongoing basis.' In response to the report, Scottish Care, commented that the report shows that 'effective solutions have been reliant on good partnership arrangements at a local level. Looking further ahead, the report highlights the importance of ensuring that all stakeholders are included in discussions about recovery and decisions are based on what is right for service users and carers. The inquiry report sets out 16 recommendations, many of these for HSCP's. It recognises that across Scotland's HSCPs and service providers they are at different stages in relation to addressing the issues behind these recommendations. The HSCP Management Team is considering the recommendations arising from the report and will advise the IJB as required.	
23.09.20	Public Health Scotland	**COVID-19 Shielding Programme (Scotland) Impact and Experience Survey** This publication presents the findings of the Public Health Scotland COVID-19 Shielding Programme (Scotland) Impact and Experience Survey. This online survey, which ran	A large proportion of the respondents followed the shielding guidance: • 41% followed all shielding guidance • 33% left their home against shielding guidance • 52% of those who left their home (for any reason) only did so	

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		between 1 and 14 June 2020, was open to individuals who had received a letter from Scotland's Chief Medical Officer advising them to follow shielding guidance. Individuals caring for someone else who had received a letter were also able to participate. The publication covers the following topics: shielding behaviour, negative impacts of shielding, shielding support and unmet needs. The report is based on 12,851 individuals on the shielding list (approximately 7%). The survey explored a range of experiences of those people shielding, including the impact that shielding had on their emotional and mental wellbeing and their thoughts on the support they had received.	less than once per week Respondents reported negative impacts • 87% - quality of life • 85% - physical activity • 72% -mental health • But 71% felt that they were coping okay with shielding The negative impacts of shielding were more common among socio-economically vulnerable respondents • 48% felt that they were coping OK with shielding vs 71% for all respondents • 88% reported a negative impact on their mental health vs 72% for all respondents • 26% struggled to access food that met their needs vs 7% for all respondents. The report has been shared with Community Planning Partnership colleagues to consider the findings in relation to the development of the next CPP plan and ongoing service responses to the further local restrictions.	
03.09.20	Mental Welfare Commission	Hope for the future: A report on a series of visits by the Mental Welfare Commission looking at care, treatment and support for people with eating disorders in Scotland The report looks at care, treatment and support for people with an eating disorder. It includes a mapping exercise – the first of its kind in Scotland – showing significant variation in the organisation of services across the country. The Commission visited 10 specialist services and heard from people with eating disorders, their families/carers, and a range of professionals through meetings, surveys and questionnaires.	The report has made a number of recommendations for partners to consider. The report is being considered by the Eating Disorder Consultant, NHS FV and the Interim Service Manager, Primary Care & Mental Health Directorate. A report will be presented to the MHLD Clinical Governance Group on 19 November and will be shared with the partnership. A response is also being prepared, as requested, to the Mental Welfare Commission by 3 December 2020.	December 2020

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		Key findings include: • While families/carers reported positively about excellent care, particularly inpatient care, they said that there was not enough support for them as they tried to manage the situation at home. • Without exception, families/carers said that caring for someone with an eating disorder had devastating and long-lasting effects on the whole family • Inequalities of service across the country, including the availability of psychological therapies, with some people accessing support privately. • While early intervention and access to psychological help is critical, there is often a lack of support, and delays in accessing services, particularly in the community. • Confusion and conflict over responsibility for physical health monitoring between GPs and psychiatrists. • Concerns about the focus on BMI (body mass index) alone as a criteria for referral and as an indicator of recovery, with less attention paid to co-existing mental health conditions.		
28.08.2020	Mental Welfare Commission	Covid-19 Mental Welfare Commission Advice Note In response to enquiries for advice on mental health care and treatment related to this pandemic, the Mental Welfare Commission have produced an updated advice note (version 14) for practitioners who are using the Mental Health Act and Adults with Incapacity Act when caring for patients. The main changes in this update are: ▪ Updated: Visitors to care homes (6.2) ▪ Updated: Visiting to and from residential settings other than care homes (6.9)	This has been widely circulated to operational managers across the HSCP for information and implementation.	Complete and implementation ongoing

Publication date	Organisation	Report title and summary	Implications for the HSCP	Timescales
		▪ Faculty of Public Health briefing on the implications of Covid-19 law and regulation for health professionals in Scotland (11.1) ▪ Updated: additional easy read Covid guidance materials (11.3) The MWC note that it will likely be updated frequently as the situation develops.		
25.06.20		A review of Psychiatric Emergency Plans in Scotland The report sets out how and why the MWC undertook this work including a summary of how PEPs from every health board in Scotland matched against key themes and issued this to all health boards across Scotland, along with a new template outlining what the Commission believes would be helpful to include in all PEP's.	**Update since 28.8.20** Meetings with the Custody Nursing Service provided on a regional basis through NHS Lothian are ongoing and need to be concluded to inform the local PEP. It is anticipated the draft plan will be available in early 2021, however this timescale will be dependent on the impact of the pandemic on key staff involved in this work.	February 2021