Coventry City Council

Agenda

Cabinet Member for Health and Adult Services

Time and Date
1.00 pm on Monday, 14th December, 2015

Place
Committee Room 2 - Council House

Public Business

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the Previous Meeting** (Pages 3 - 4)

   a. To agree the minutes of the meeting held on 12th October 2015

   b. Matters arising

4. **Recommendations relating to the Serious Case Review for Mrs E** (Pages 5 - 28)

   Report of the Executive Director of People

5. **Recommendations relating to the System Wide Review for Mrs F** (Pages 29 - 46)

   Report of the Executive Director of People

6. **Transfer of 0-5 Public Health Commissioning Responsibility to Local Authorities** (Pages 47 - 52)

   Report of the Executive Director of People

7. **Ensuring the Quality of Care and Support in Adult Services.** (Pages 53 - 82)

   Report of the Executive Director of People

8. **Any other items of public business which the Cabinet Member decides to take as matters of urgency because of the special circumstances involved**

Private Business

Nil

Chris West, Executive Director, Resources, Council House, Coventry

Friday, 4 December 2015

Note: The person to contact about the agenda and documents for this meeting is Lara Knight 024 7683 3237 Email: lara.knight@coventry.gov.uk

Membership: Councillor K Caan (Cabinet Member)

By invitation Councillors J Clifford (Deputy Cabinet Member), Councillor K Taylor (Shadow Cabinet Member), Councillor D Welsh (Chair, Health and Social Care Scrutiny Board (5))

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

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Coventry City Council
Minutes of the Meeting of Cabinet Member for Health and Adult Services held at 1.00 pm on Monday, 12 October 2015

Present:

Members: Councillor Caan (Cabinet Member)
Councillor K Taylor (Shadow Cabinet Member)
Councillor J Clifford (Deputy Cabinet Member)

Employees:

People: P. Fahy, M. Greer, I. Merrifield, V. Miller, D. Watts

Resources: C. Sinclair

Public Business

6. **Declarations of Interest**

There were no declarations of interest.

7. **Minutes of the Previous Meeting**

The minutes of the meeting held on 20 July 2015 were signed as a true record. There were no matters arising.

8. **Adult Social Care Annual Report 2014/15 (Local Account)**

The Cabinet Member considered a report of the Executive Director of People which set out the Adult Social Care Annual Report 2014/15 (Local Account). This annual report described the performance of Adult Social Care and the progress made against the priorities for the year.

Although there is not a statutory requirement to produce an annual report, it is considered good practice as it provides a public record of the performance of Adult Social Care to local citizens. The report also provides an opportunity to be open and transparent about the successes and challenges of the year and to show how outcomes are improving for those supported through Adult Social Care. The production of an annual report is part of the Local Government Associations (LGA) approach to Sector Led Improvement, launched in 2011. This approach was launched following the removal of national targets and assessments with the aim of driving improvement through self-regulation, improvement and innovation.

In the completion of the 2014/15 report, engagement activity has been undertaken with Healthwatch Coventry, the independent champion for health and social care in Coventry alongside Partnership Boards across Adult Social Care in order to obtain feedback about our progress on last year's priorities and to enable discussion on key areas of activity for the coming year.

Feedback on readability and content was also noted and as a result of this the 2014/15 Annual Report is shorter than previous years.

RESOLVED that the Cabinet Member for Health and Adult Services

1. **Noted and accepted comments from the Health and Social Care Scrutiny Board (5) that future annual report use the same data measures year on year to enable comparisons of performance through trend data.**

2. **Approved the publication of the Adult Social Care Annual Report 2014/15 (Local Account)**

9. **Recommendations relating to Serious Incident Review for Miss G**

The Cabinet Member considered a report of the Executive Director of People which presented the action plan in relation to a Serious Incident Review carried out on behalf of the Coventry Safeguarding Adults Board. The paper informs the Cabinet Member for Health and Adult Services of the outcome of the Health and Social Care Scrutiny Board (5) consideration of the Serious Incident Review which took place following the death of Miss G.

The Health and Social Care Scrutiny Board (5) considered the Serious Incident Review at their meeting on 9th September 2015. The Board were concerned that the Action Plan accompanying the report did not contain an action to ensure care plans were regularly reviewed, as this had not happened in Miss G's case. The Board were also concerned that the voice of carers, including family and friends as well as paid carers, had not been listened to and felt it was important this be addressed in the action plan. Finally, the Board felt that where reviews needed to be undertaken, the action plan should highlight that these need to be done in a timely manner. These actions formed part of the recommendations made.

RESOLVED that the Cabinet Member for Health and Adult Services requests that Coventry Safeguarding Adult Board amend the Action Plan to include the following actions:

1. **To ensure that care plans are regularly reviewed in a timely manner, particularly when concerns are raised.**

2. **To ensure that the views / concerns of everyone involved in a person's care including carers, family, neighbours and friends are taken into account**

10. **Any other items of public business which the Cabinet Member decides to take as matters of urgency because of the special circumstances involved**

There were no other items of public business.

(Meeting closed at 1.30 pm)

Coventry City Council

Public report
Cabinet Member

Cabinet Member for Health and Adult Services 14th December 2015

Name of Cabinet Member:
Cabinet Member for Health and Adult Services, Councillor Caan

Director Approving Submission of the report:
Executive Director for People

Ward(s) affected:
N/A

Title:
Recommendations relating to the Serious Case Review for Mrs E

Is this a key decision?
No

Executive Summary

This report presents the action plan in relation to a Serious Case Review (SCR) carried out on behalf of the Coventry Safeguarding Adults Board. This report informs the Cabinet Member for Health and Adult Services of the outcome of the Health and Social Care Scrutiny Board (5) consideration of the SCR which took place following the death of Mrs E.

The Health and Social Care Scrutiny Board (5) at their meeting on 18th November 2015, gave detailed consideration to the Executive Summary report and associated action plans, which presented the findings of a Coventry Safeguarding Adults Board Serious Case Review, which followed the death of Mrs E. The Board questioned at length representatives from a number of partner agencies involved in Mrs E's care in the weeks leading up to her death. .

Recommendations:

That Cabinet Member for Health and Adult Services is recommended to:

1. Reiterate to the Coventry Safeguarding Adults Board the importance of ensuring that all the health organisations take account of the views of family, friends, neighbours and carers relating to an individual's care and that all the concerns raised about communications in this case are also addressed by those agencies involved.
2. Endorse the action plan at Appendix 2.

List of Appendices included:
Appendix 1 – Executive Summary
Appendix 2 - Multi Agency Action Plan

Other useful background papers:
None

Has it been or will it be considered by Scrutiny?
The Health and Social Care Scrutiny Board (5) considered the Executive Summary and Multi-Agency Action Plan at their meeting on 18th November 2015.

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?
No

Will this report go to Council?
No

Page 3 onwards
Report title: Recommendations relating to Serious Case Review (SCR) for Mrs E

1. Context (or background)

1.1 A serious case review (SCR) was undertaken by the Coventry Safeguarding Adults Board following the sad death of Mrs E. The final report and action plan was presented to Scrutiny Board 5 on the 18th November 2015. The Scrutiny Board felt that the inclusion of the family statement, was helpful to understanding the case and the impact for the family.

1.2 Mrs E was 66 years old when she died. She lived in housing with care and was the main carer for her husband who was dependent on her support. Her daughter and son were both close to their parents and took an active part in supporting them.

1.3 Mrs E required hospitalisation following the fall as she sustained a fracture to her spine. Following a short period in hospital she was discharged home. Her health deteriorated over a short period and her GP recommended that a period of residential rehabilitation may improve her recovery.

1.4 After a short period in residential rehabilitation, Mrs E deteriorated further and was transferred to hospital as an emergency. Mrs E failed to respond to the therapeutic intervention and unfortunately died 5 days later.

1.5 During the time under analysis for this review, Mrs E was cared for in her own home (Housing with Care), in hospital and in a residential care setting.

1.6 The SCR made recommendations to improve practice and these recommendations are incorporated into the multi agency action plan (appendix 2). The organisations involved in this SCR are committed to ensuring that the issues identified are addressed. The Board will monitor the implementation of improvements within individual organisations.

1.7 The Health and Social Care Scrutiny Board noted the findings of the Serious Case Review and the recommendations, actions and progress. During the robust questioning of agencies on Mrs E's care, a number of issues were explored, these included;

- Concerns about the length of time taken for this review to be completed and the number of missed opportunities by agencies prior to Mrs E's death.
- Asked for further information about measures already implemented to improve communication and clarification about why information had not been passed between agencies and staff during Mrs E's receipt of care. Clarification that processes have been put in place to ensure a repeat of the communication issues in this case do not happen again was sought.
- The Scrutiny Board explored the role of the family, as the guaranteed constant for a patient and therefore the importance of all agencies listening to their views. The Scrutiny Board questioned how much notice was taken of information provided by families.
- Person centred care was discussed at length to seek assurance that the individual would be considered when planning care and each organisation was asked to explain what they were doing to ensure they had time to care for the individual.
- The Scrutiny Board sought clarification on hospital discharge procedures and whether these have been amended since Mrs E's death.
- In complex cases with multiple agencies involved, the Scrutiny Board wanted to know who takes responsibility to ensure a patient is taken through the correct healthcare pathway for that individual between the hospital and the community. There was concern that there is often not a clear lead professional who is co-ordinating care.

- Questions were asked about how to ensure all staff treat patients and their families with dignity and respect.

1.8 Following the questions, the Scrutiny Board agreed to write to Mrs E's family to offer their condolences for their loss, and to thank them for providing their insightful, moving and informative statement. They have also asked the Safeguarding Adults Board for an update in 6 months time on progress to the Action Plans.

2. Options considered and recommended proposal

2.1 Health and Social Care Scrutiny Board considered the SCR at their meeting on 18th November 2015 and referred the matter to the Cabinet Member for Health and Adult Services, recommending the following action:

1. Reiterate to the Coventry Safeguarding Adults Board the importance of ensuring that all the health organisations take account of the views of family, friends, neighbours and carers relating to an individual's care and that all the concerns raised about communications in this case are also addressed by those agencies involved.

2. Endorse the action plan at Appendix 2.

3. Results of consultation undertaken

3.1 The SCR is a multi agency report with input from all agencies to ensure learning across the adult safeguarding system. The family of Mrs E were involved in the process.

4. Timetable for implementing this decision

4.1 Implementation of actions within the Action Plan will be monitored by the Safeguarding Adult Review Sub Group and reported to the Safeguarding Adult Board.

4.2 Health and Social Care Scrutiny Board (5) requested an update on progress with the implementation of the action plans to be presented to the April 2016 meeting

5. Comments from Executive Director, Resources

5.1 Financial implications
None

5.2 Legal implications
None

6. Other implications

6.1 How will this contribute to the Council's priorities?

http://www.coventry.gov.uk/councilplan

The objectives within the action plan will support the Council deliver their objective to keep vulnerable people safe within their community and to be able to live healthier more independent lives.

6.2 How is risk being managed?

The key risks have been identified within the SCR process which led to the production of this report. The action plans have been developed to address these risks. The Safeguarding Adult Review Sub Group is accountable for monitoring the implementation of these plans in practice and for assuring the Safeguarding Adult Board that these have been delivered according to plan.

6.3 What is the impact on the organisation?

None

6.4 Equalities / EIA

No negative impacts are anticipated in relation to this review

6.5 Implications for (or impact on) the environment

None

6.6 Implications for partner organisations?

Coventry Safeguarding Adults Board will monitor the actions delivered by partners as set out in the action plans attached.

Report author(s):

Name and job title: Margaret Greer – Interim Serious Case Review Coordinator

Directorate: People Directorate

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Enquiries should be directed to the above person.

Contributor/approver name	Title	Directorate or organisation	Date doc sent out	Date response received or approved
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Margaret Greer	Interim Serious Case Review Coordinator	People		01/12/15
David Watts	Assistant Director – Adult Social Care	People		30/11/15
Other members				
Victoria Castree	Scrutiny Co-ordination	Resources	24/11/15	24/11/15
Names of approvers for submission: (officers and members)				
Finance: Ewan Dewar	Finance Manager	Resources		01/12/15
Legal: Julie Newman	Legal Services Manager (People)	Resources		30/11/15
Director: Pete Fahy	Director Adult Services	People		26/11/15
Members: Councillor Caan	Cabinet Member for Health and Adult Services			25/11/15

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Coventry Safeguarding Adults' Board Serious Case Review
Executive Summary of Case No: CSAB/SCR/2015/9

1. Reason for establishing the Serious Case Review (SCR)

1.1 The SCR was established by the Coventry Adult Safeguarding Board (CSAB) to review the circumstances leading up to the death of Mrs E on 24th May 2013 who was 66 years of age. The SCR criteria was met because Mrs E was an adult at risk, and neglect may have been a contributory factor.

2. BACKGROUND AND PERSONAL HISTORY

2.1 CSAB has sought to ensure that Mrs E remains at the forefront of this Review and therefore, it is important to provide some brief biographical detail provided by the family, while ensuring the anonymity of the family is protected.

2.2 Mrs E led a busy and fulfilling life, and she and her husband were a devoted couple who liked spending time together, and with their family. Church also formed an important part of her life. Mrs E's intelligence and skills shone through in many different ways – not least in one of her favourite pastimes in solving complex crosswords. She was a talented musician, giving lessons privately after working as a secretary for many years. From 1996 onwards, Mrs E became her husband's main carer after he suffered several serious illnesses. They moved to a Housing with Care Scheme so that Mrs E's husband could receive additional support with some of the more physical aspects of his personal care.

2.3 Mrs E was described as thoughtful, considerate and always putting everyone else first. She never wanted to be any bother, never made a fuss about any health or other problems and was appreciative of any help or thoughtful behaviour shown towards her. These aspects of Mrs E's personality were to play a key part in the chain of events which led to her tragic and untimely death. The extent to which Mrs E was popular and well respected was reflected in the high turn-out at her funeral.

3. SUMMARY OF KEY EVENTS AND MAIN FINDINGS

3.1 This section provides a chronological summary of events, followed by an overview of actions taken by professionals in respect of some key issues.

Fall and Admission to Hospital

3.2 On 23rd March 2013, Mrs E fell on the ice when visiting a local shop, but for several days declined to act on advice to seek medical attention. Subsequently, she was taken by ambulance on 1st April to the University Hospital Coventry and Warwickshire (UHCW) where she was assessed as having a small crack in one of her vertebrae. This diagnosis was reached without the usual radiological investigations being carried out. Mrs E re-attended A&E 2 days later because of increasing pain and being unable to move, and x-rays and a CT scan revealed a compression wedge fracture of the lumbar spine. She was fitted with a back brace, and remained in hospital until 15th April. Mrs E was severely constipated for 10 days, and when this did not respond to oral laxatives, the condition finally resolved after being given an enema. Mrs E found this painful and experienced abdominal pain afterwards.

3.4 Mrs E displayed considerable anxiety when engaging in physiotherapy because of the pain in her back, leg and abdomen, but progressed to walking with the aid of a stick. Although the therapists noted how the pain from the fracture was affecting her ability to

mobilise, AB, Mrs E's daughter, felt that some nursing staff displayed a lack of person centred care - underestimating the pain and difficulties Mrs E was experiencing.

Hospital Discharge Issues

3.5 Mrs E was discharged on 15th April at short notice, and a day earlier than planned, probably because her bed was required. No screening took place to establish if Mrs E would require additional support on returning home, and there was no liaison with the Housing with Care Scheme which may have enabled them to plan for Mrs E's return. It must be noted that Mrs E did not receive significant support from the Housing with Care scheme herself, their residing there was primarily for support to Mrs E's husband.

3.6 There remains some uncertainty as to whether Mrs E was medically fit for discharge, which stems from the different conclusions reached in 2 reports on the significance of the abnormal blood test results of 09.04.13 which showed a raised C reactive protein (CRP). The interpretation reached by the internal Mortality Review (MR) was that this result suggested that Mrs E was probably becoming unwell, and therefore the discharge was not well thought through. The Individual Management Review (IMR) for this SCR arrived at a different conclusion that this high figure was to be expected because of inflammation after a fracture. This view was reinforced by the lower CRP figure when blood tests were carried out on her readmission in May.

3.7 Irrespective of these different findings, the SCR established that the blood test results were not looked at prior to discharge, and therefore the opportunity was missed to carry out repeat tests to see if the position had improved. The discharge decision was also taken without knowing the result of the abdominal x-ray carried out on the day of discharge which subsequently confirmed that there was no blockage in the bowel. Given that Mrs E was never weighed during her stay, this meant that the decision to discharge Mrs E was made without taking account of 3 important pieces of information. There were some gaps in the discharge summary as this did not include an explicit alert for the GP to check these results, nor did it include any information about the severe constipation problems and how these were resolved.

Care after Return Home / Discovery of Pressure Sores

3.8 On return home, Housing with Care staff immediately made referrals to the Fast Response Team (FRT), and Adult Social Care, because of concerns about Mrs E's reduced mobility, and the likely impact on her ability to care for her husband. The response to these was slow. A social work assessment visit was not planned until 2nd May, and 11 days elapsed before Mrs E was visited on 26th April by a community physiotherapist (CP1) because at that time, the 48 hour response service for priority referrals, which was introduced subsequently, had not been established. She and the Housing with Care scheme felt that the discharge had been "unsafe" due to the lack of advance planning. The community physio quickly secured all the necessary equipment but did not consider whether further physiotherapy would be helpful given Mrs E's continuing difficulties in mobilising.

3.9 On discovering that Mrs E had broken skin on her buttocks area, the physio made an immediate referral to the fast response team. She also arranged for a twice daily intermediate support service to augment the care being provided to Mr E by the Housing with Care Scheme. A District Nurse examined Mrs E the following day and found 3 grade 2 breaks in her skin and 2 small sores on her buttocks area. A Pro Pad pressure relieving cushion and single mattress was ordered and advice given on diet and regular repositioning. A safeguarding referral was also made to the Social Care Older Adult &

Physical Impairment Team in line with the CAB's safeguarding procedures, and a social worker visited on 30th April 2013, and organised additional domiciliary support.

3.10 The panel considered that although the District Nurses were diligent in providing care and monitoring the pressure sores, they did not consult Mrs E about her preferences when ordering a single mattress, which resulted in this being rejected when it was delivered because it was important to Mrs E to continue sharing the double bed with her husband. Their approach showed a lack of flexibility, and the panel concluded that they could have explored things in a more person centred way to find a practical solution which would be acceptable to Mrs E.

3.11 Mrs E continually declined the help offered with her personal care, which together with the rejection of the mattress, led to health and social care professionals sharing their concerns that Mrs E might be suffering cognitive impairment and might lack mental capacity. Given their concerns about the risk of the pressure sores worsening, on 2nd May, a short term admission to a Nursing Home was identified as the best way forward. This option was put to Mrs E by the GP, and there is some evidence that Mrs E felt pressured by the GP into agreeing to the admission.

Response to Constipation Problem

3.12 During the period at home, Mrs E's nursing care was provided by 5 district nurses (DNs) because of the way the service is organised. They became aware that Mrs E was again suffering with severe constipation, but the number of nurses involved resulted in duplicated activity and conflicting conclusions about the extent of the problem. Their assessments at times lacked the necessary depth, and they continued to request prescriptions from the GP for stronger oral laxatives rather than considering whether there was a need for treatment such as administering an enema. Their response may have been different had they been aware of the recent history in hospital and how the problem had been resolved. Equally, the GP at this point did not review Mrs E's changed circumstances, health needs and medication following her return home, and could have been more proactive given the increasing evidence of the continuing constipation. At the point of admission to local Nursing Home, Mrs E had probably been constipated for the last 12 days.

Admission and Care at local Nursing Home

3.13 On 4th May, Mrs E was admitted to a local registered nursing home. The rapid implementation of this plan, due to the impending bank holiday, created two problems. It resulted in a poor admission experience because the nurse on duty claimed to be unaware that the admission had been agreed, and also full information was not provided to the nursing home in advance about all Mrs E's circumstances and health needs to help them plan their care.

3.14 At the nursing home, Mrs E continued to suffer pain and discomfort from the back pain, pressure sores, constipation and a urine infection, There were serious deficits in the level of care and speed of response to these issues, which in part was due to there never being an over-arching care plan to address Mrs E's identified health needs. Instead, individual plans were drawn up piecemeal to address each health issue in isolation, and often there were delays before these were done. No active work was carried out in helping Mrs E improve her mobility, and the deterioration resulted in her using a walking frame and wheelchair for longer distances.

3.15 When Mrs E's overall physical condition worsened, diet and fluid charts were commenced, but these were only completed on 3 of the 9 days during the remainder of her stay. In the meantime, according to the family, Mrs E continued to lose weight noticeably. The evidence points to Mrs E having remained constipated throughout her stay, and by 11th May, Mrs E was reporting severe abdominal pain, and subsequently there were several recorded instances of other symptoms that may indicate serious constipation such as faecal impaction and leakage. From 15th May, Mrs E had episodes of vomiting.

3.16 Following plans drawn up at the first safeguarding case conference on 15th May for further investigations and blood tests, Mrs E's family raised their concerns on 18th May that Mrs E was looking profoundly unwell, and pressed for the bloods to be taken urgently - offering to take these to hospital to speed the process up. Later that evening, Mrs E fell in the bathroom and hit her head. No medical assistance was sought, and family were only informed on their visit the next day when her daughter also pressed for an ambulance to be called as she was worried about Mrs E's grossly distended stomach, and because Mrs E had not been drinking and eating for several days. The nurse on duty did not immediately act on this request as she was busy dispensing medication, but after a short delay the paramedics were called.

3.18 The failure to seek immediate medical attention on 18th May 2013, either when the grossly distended abdomen was first observed, or following the fall, was negligent, and resulted in a delay before Mrs E's serious condition was assessed. Staff should have sought immediate medical help given Mrs E's existing back injury, the fact that the fall may have involved a possible head injury, and because Mrs E was vomiting and complaining of acute abdominal pain. Mrs E's family should also have been informed. The seriousness of this inaction was recognised by the provider's Management given their subsequent disciplinary action and reporting of the outcomes to the relevant national bodies.

Second Admission to UHCW

3.19 On 19th May, following the attendance of paramedics, Mrs E was admitted to UHCW. On examination, Mrs E was found to have severe sepsis, a perforated diverticulum, and a large pelvic abscess. X-rays showed that the original wedge fracture in her spine remained unchanged but also revealed the existence of a second wedge fracture. Although it has not been possible to establish when the second fracture occurred, it was confirmed that the consequence would be that Mrs E would have been suffering considerably more pain in the same area. Mrs E was vomiting brown liquid, had a urine infection and was doubly incontinent. Mrs E also had multiple pressure sores – 1 at grade 3. She was found to be dehydrated and had suffered significant weight loss.

3.20 It was concluded that Mrs E was too unwell for surgical intervention and she was transferred to the Critical Care Unit for guided percutaneous drainage to be carried out as soon as possible. However, there was a delay of around 36 hours before this was carried out which was in part due to problems in arranging radiologist support.

3.21 Mrs E died on 24th May 2013. The cause of death was recorded as pelvic abscess, sigmoid perforation, and fracture of the L1 vertebrae.

Overview of Professionals' Response to Mrs E's Constipation

3.22 The analysis of professionals' actions has led to the conclusion that after her discharge from hospital, there were several missed opportunities both during her time at home, and at the nursing home, to assess fully Mrs E's constipation and to escalate the treatment when the problem persisted. The decision to continue with laxatives appears misplaced

when the problem persisted for so long and the symptoms were becoming more extreme. The analysis indicates that there was insufficient note taken by professionals of the guidance issued by the National Institute of Clinical Excellence (NICE) as Mrs E displayed several of the symptoms / factors listed as potential indicators of a serious problem. Although it will never be known when the perforation of the bowel occurred, Mrs E's bowel pathology was clearly worsening by 15th May 2013 by the increasing severity of symptoms. It is possible that had alternative action been taken by clinicians in the community at this time, a different outcome may have occurred. It must be emphasised however, that this suggestion is clearly speculative.

Overview of Professionals' Response to Mrs E's Pain and Symptoms

3.23 A major challenge for professionals was that there was often a marked difference between what information Mrs E shared with family about her symptoms, and what she shared with professionals. The earlier profile of Mrs E provides some helpful insights as to why this might have been, with Mrs E's desire not to be a burden or make a fuss. However, notwithstanding this, professionals were not sufficiently pro-active in checking these out with Mrs E, and there was a lack of depth to many of their assessments, for example in respect of the degree of pain Mrs E was experiencing and how this was impacting on her life. Professionals rarely established a full picture, and although Mrs E contributed to this in not sharing full information, there were missed opportunities by some professionals to adopt a more pro-active and structured approach to assessments. More probing may have uncovered the extent of her problems sooner and triggered further medical assessments and treatment. When Mrs E did disclose the extent of pain and problems, there were many instances where insufficient consideration was given to her accounts.

Overview of Mental Capacity Issues

3.24 It proved difficult to get a sense of what changes were observed in Mrs E's cognitive functioning which led to some professionals assessing whether Mrs E's cognitive functioning was impaired, and whether she lacked mental capacity, in the light of what were perceived as Mrs E's potentially unwise decisions. Assessments that were carried out concluded that Mrs E had mental capacity but was experiencing some confusion and impaired memory. The panel agreed that there was considerable uncertainty and ambiguity in this case, and where this exists, it is difficult for professionals to know when to act, and how to evaluate someone's behaviour and responses. Where assessments were initiated, the panel agreed that they were acting in accordance with the Mental Capacity Act which requires assessments to be decision specific at the time that decision needs to be made.

First Safeguarding Processes

3.25 Mrs E's case was not well considered through either of the two safeguarding processes. The conclusion of the first process that the pressure sores were due to self-neglect and Mrs E's "non-compliance", stemmed from professionals' lack of knowledge and understanding about Mrs E's personality and values. The panel found no evidence or indication of self-neglected – she was a proud and previously independent person, who was reluctant to accept help through a combination of not wanting to make a fuss, and wanting to maintain control of her life and privacy.

Second Safeguarding Process

3.26 A second safeguarding investigation was commenced after AB raised a safeguarding alert with the Social Care Team on 21st May, once the seriousness of Mrs E's condition had been established, raising her concerns about the care provided during Mrs E's stay at the

Nursing Home. This second process was poorly managed. The decision not to hold a strategy meeting in line with approved procedures, not only resulted in no consideration being given to notifying the police, but meant that there was inadequate planning of the investigation. This, and the weak chairing at the three case conferences, resulted in drift in gathering answers on several key issues, and a shift away from the original focus of the second alert. The fact that the UHCW Root Cause Analysis Report, and Mortality Review were not shared also impacted on the effectiveness of the safeguarding process. Ultimately, the process ran out of steam which was shown by the lack of reasons recorded for the conclusion that Mrs E had suffered neglect during her time at the nursing home.

Post Mortem Issues

3.27 A post mortem was not held which may have provided answers to the unresolved questions of when the second fracture occurred, and the cause of the perforated diverticulum and abscess. While the panel could see why this decision was made, it was concerned that the checks and balances built into the referral system did not work in this case. The decision not to inform the police about the first safeguarding alert, and the long delay before notifying them of the second alert, proved significant as this meant that there was no "flag" in the Coroner's office systems about the previous or current safeguarding issues which might have triggered further enquiries. The sudden death notification form sent to the Coroner's Office by UHCW did not identify any safeguarding issues even though by the time Mrs E died, agencies had been informed of the second alert made by family, and the further alert raised by UHCW because of the pressure sores. As there was a doctor willing to sign the death certificate, the Coroner made a decision not to request a post mortem.

3.28 The panel considered the issue as to whether Mrs E's death should be viewed as "expected" or "not expected". One view was that this was expected death given the seriousness of Mrs E's condition when she was re-admitted. Some other panel members took the view that looking at the whole time period covered by the SCR, and Mrs E's generally good health prior to the fall, her death could be viewed as "unexpected".

4. KEY LEARNING

4.1 The key learning covers a number of issues within the following themes:-

- Clinical Assessments
- Hospital Discharge
- Case Planning and Continuity of Care
- Person Centred Practice
- Risk Management
- Mental Capacity
- Safeguarding Processes

Clinical Assessment of Back Injuries

4.2 It is important that when patients present at A&E with back injuries, doctors should ensure assessments are in line with national guidelines. Where there are reasons for departing from these, for example not calling for an x-ray or other scans, the reasons should be documented along with whether the patient was given a choice or declined these. In addition, the patient's previous level of mobility should be established to provide a benchmark for assessing the impact of the injury on the ability to carry out basic daily activities, and whether there is a need for further support to aid rehabilitation.

Assessing Pain

4.3 The analysis has identified the importance of professionals adopting a more pro-active approach in carrying out holistic pain assessments, making full use of national guidelines and checklists such as those issued by the Royal Society of Physicians and the British Pain Society in 2007. To help professionals gain greater understanding of how patients may experience pain, training should make use of Help the Aged studies which include patients' descriptions of their experiences.

Assessment and treatment of constipation

4.4 Agencies need to ensure that staff have received training which covers the NICE guidance, and apply this in their assessments.

Diagnosis and Treatment of Sepsis

4.5 Given the delays that occurred in treating Mrs E's sepsis, it will be important for CSAB to agree how professionals' awareness can be increased on recognising the possible signs and symptoms, and the importance of rapid diagnosis and treatment to improve the chances of survival. CSAB should also require assurances from local agencies that staff have been reminded that emergency medical help must be sought immediately when patients vomit brown, or coffee grained, liquid.

Hospital Discharge

4.6 A number of actions have been agreed to improve hospital discharge planning. The term "now medically ready for discharge" should be recorded in the medical notes and discharge summary. A patient's home circumstances must be explored in sufficient depth to ascertain what support will be available post discharge, and whether this appears sufficient. When there is an indication that the patient, or anyone living with her, has carers, this must always act as a trigger to probe further. A protocol should be drawn up for liaison between hospitals and Housing with Care schemes to facilitate smooth transition from hospital to home with all necessary support and equipment in place prior to discharge.

4.7 Discharge summaries must comply with national guidance to include a brief summary of all relevant information covering all investigations, new diagnoses, and why medications have been started or stopped including constipation. Clear instructions must be given as to whether the provision of a back brace is essential to aid recovery, or is optional to provide comfort and support. Patients' needs for ongoing physiotherapy post discharge will also be included when there has been an injury affecting mobility or dexterity.

Care Planning and Continuity of Care

4.8 A key recommendation from this review is that health and social care organisations implement an integrated assessment process so that care planning is person-centred, effective and coordinated. This requires full sharing of information, trusting other professionals' judgements, reducing duplication, so that the range and complexity of an older person's needs are properly identified and addressed in accordance with their wishes and preferences. As part of these developments, the pro-active contribution of GPs will be crucial in ensuring continuity of care, particularly when patients are discharged from hospital or residential settings. A key element for ensuring effective planning will be agreement at all stages of involvement as to which professional / agency is to be the lead professional to co-ordinate services. Similarly, there should always be a key worker within residential settings.

Person Centred Practice

4.9 This SCR has highlighted that in any professional involvement, the needs, views and choices of the individual takes centre stage at all times, and that they are fully involved in decisions about the support they need. Decisions need to take account of all relevant factors including age, gender, living arrangements, personal relationships, lifestyle, and culture - as well as their illness or disability. When dealing with pressure sores, professionals need to look for creative solutions in negotiation with service users where standard service options are not acceptable.

4.10 Although guidance states that information gathering should be of a depth and detail "proportionate to the person's needs", a recurring theme within this SCR, was the lack of knowledge about Mrs E's background, attitudes, values and use of language which would have helped inform assessments and decisions. Agencies therefore need to ensure that professionals bring to their work the necessary level of "professional curiosity" to probe issues - particularly where patients and service users do not share information, and are reluctant to accept help or act on advice.

Risk Management within Housing with Care Settings

4.11 The SCR has identified the need for further guidance for Housing with Care staff on their roles and responsibilities in approaching situations where there may be a tension between respecting tenants' rights to independence in decision-making, and the need to safeguard tenants who are perceived to be placing their welfare at risk.

Mental Capacity

4.12 All agencies have identified the need for more training around assessing mental capacity. Within this, it will be important to include a reminder of the possible causes of short term impaired cognitive ability which was not apparent in this case.

Safeguarding Process

4.13 This SCR has identified the need for additional training on all aspects of the safeguarding arrangements and formal processes, including the importance of strategy discussions to scope the investigation, and the organisation and conduct of case conferences. In addition, more detailed guidance should be provided on the type of situations where the police should be notified. Where professionals are uncertain how to proceed, advice should be sought from their safeguarding lead at an early stage, who may assist in discussions with their counterparts, when necessary, to agree a way forward.

Post Mortem Issues - Liaison with the Coroner's Office

4.14 To ensure due consideration is given to the need for a post mortem in circumstances such as this case, CSAB should make an approach to the Coroner to seek agreement to the drawing up of a formal protocol to establish a two way liaison process. The protocol would specify the circumstances where relevant information will be shared about cases or services where there is a known, or potential, safeguarding issue, and during the conduct of a Safeguarding Adults Review (SAR). Alongside this initiative, the format of the hospital sudden death notification form should be revised to make it clear when there has been a safeguarding issue.

Safeguarding Adults Reviews (SARs) Methodology

4.15 The future conduct of Safeguarding Adults Reviews (SARs) has now been placed on a statutory footing through implementation of the Care Act 2014 from 1st April 2015. Key learning from this SCR is that the model adopted for future SARs should involve managers and practitioners as this will enable more direct exploration of key events, how their view of the case at the time shaped their actions, and identify any organisational or "system" issues which affected their approach. It will also be essential for CSAB to agree a protocol to cover how any parallel investigations will feed into the SAR and those reports are shared.

5. MULTI-AGENCY RECOMMENDATIONS

5.1 The multi-agency recommendations are organised around the 3 key themes underpinning the learning from this SCR.

Safeguarding Processes

1. CSAB should assure itself that there is a clear framework and methodology for conduct of SARs, including a protocol for agreeing how any parallel investigations and reports will be shared during the SAR process.

2. CSAB should implement a quality assurance system to check the effectiveness of its safeguarding procedures, with a particular focus on the use of strategy discussions, quality of investigation reports, skills in chairing case conferences, and time-limits for distributing case conference minutes.

3. CSAB should be assured that either through the revised Pan West Midlands Procedures, or additional local practice guidance, there is detailed guidance on the circumstances when the police should be notified of safeguarding alerts including a requirement that if a vulnerable adult, who is the subject of a safeguarding alert, dies in hospital, an automatic referral will be made to the police to explore whether neglect or mistreatment contributed to their admission, or to their death.

4. CSAB should be assured that a protocol has been established with the Coventry and North Warwickshire Coroner for sharing information in cases where there is a safeguarding issue which may require a post-mortem, or an investigation through the safeguarding procedures.

Assessment and Treatment Issues

5. CSAB Members should develop a protocol on how agencies will work together in cases where multiple agencies are involved including agreement on which professional will take the lead.

6. CSAB Members should assure themselves that their staff have received appropriate training, and are working to national guidance issued by Department of Health, NICE, and professional bodies to implement the learning from this SCR on the identification, assessment and treatment of pain, constipation, back injuries, sepsis and mental capacity.

7. CSAB Members should assure themselves through supervision and case audits that staff have sufficient skills to engage effectively with persons in a personalised way, in gathering relevant information to guide assessments and care planning, particularly in risky situations when patients and service users are reluctant to accept help or act on advice.

Continuity of Care, including Hospital Discharge Arrangements

8. CSAB Members assure themselves that when patients / service users are moving to a different environment, their organisation shares all relevant information, and contributes fully to multi-agency planning.

9. CSAB request an update report from NHS England on progress on ensuring the pro-active contribution of GPs in the development of multi-agency care plans and review of patients discharged from hospital.

10. CSAB should be assured that hospital discharge procedures include guidance on:-

- factors which should trigger screening for post discharge support;

- the inclusion of all relevant information in discharge summaries, including clear prompts for community professionals on follow up action where there are any outstanding test results;

- the importance of pro-active liaison between the hospital, community services and housing with care schemes.

APPENDIX 1: MULTI AGENCY ACTION PLAN

Coventry Safeguarding Adults Board, Serious Adult Review Action plan

Name of Review SCR Mrs E	
Date 17th September 2015	**Updated on 30th October 2015**
Completed by	**Organisation All Agencies**

Actions must be **SMART (S**pecific **M**easureable **A**chievable **R**ealistic **T**imed) and **RAG rated – Red =**Not achieved and seriously behind schedule, **AMBER =** not achieved and slightly behind target, **GREEN =** on track to be achieved within timescale

Recommendation	**Source of recommendation** (Overview report or IMR)	**Action required**	**Lead Officer and Job title**	**Update and on progress and evidence**	**Outcome – what is expected to be achieved from these actions**	**Target Date**	**Rag rating**
Coventry Safeguarding Adults Board							
1. CSAB should assure itself that there is a clear framework and methodology for conduct of SARs including a protocol for agreeing how any parallel investigations and reports will be shared during	Overview Report	Develop a SAR Toolkit to provide professionals with guidance required to support the delivery of the SAR process	SAR Coordinator		All SAR's are conducted to be compliant with the required Care Act 2015 standards	Jan 2016 onwards	Green on track

the SAR process.							
2. CSAB should implement a quality assurance system to check the effectiveness of its safeguarding procedures, with a particular focus on the use of strategy discussions, quality of investigation reports, skills in chairing case conferences, and time-limits for distributing case conference minutes.	Overview Report	CSAB to mandate Quality Assurance Monitoring and Reporting as an agenda item for all CSAB meetings	Quality Assurance and Performance sub group		Safeguarding case reviews are consistently completed within the timeframes set out in Coventry Safeguarding policy and procedure guidance (2014) and the process applied is compliant with best practice guidance (Care Act 2015)	January 2016 onwards	Green on track
3. CSAB should be assured that either through the revised Pan West Midlands Procedures, or additional local practice guidance, there is detailed guidance on the circumstances when the police should be notified of safeguarding alerts including a	Overview Report	Review West Midlands and local safeguarding policy and procedure guidance, and if necessary update the local guidance to include the circumstances when the police should be notified of safeguarding alerts by all agency providers.	Policy and procedure task and finish group		The Police notification process standards for safeguarding cases are achieved by all partner agencies in accordance with local policy guidance.	January 2016 onwards	Green on track

requirement that if a vulnerable adult, who is the subject of a safeguarding alert, dies in hospital, an automatic referral will be made to the police to explore whether neglect or mistreatment contributed to their admission, or to their death.							
4. CSAB should be assured that a protocol has been established with the Coventry and North Warwickshire Coroner for sharing information in cases where there is a safeguarding issue which may require a post-mortem, or an investigation through the safeguarding procedures.	Overview Report	Review West Midlands procedure to ensure that it includes the circumstances and the process for notifying the Coventry and North Warwickshire Coroner in cases where there is a safeguarding issue which may require a post-mortem, or an investigation through the safeguarding procedures.	Policy and procedure task and finish group Legal advisor to Board		Clear Policy guidance in place which are fit for purpose.	April 2016	Green on track

5. CSAB Members should assure themselves that agencies are working to local safeguarding protocols on how agencies will work together in cases where multiple agencies are involved including agreement on which professional will take the lead.	Overview Report	CSAB to establish a 'key issues' agenda item to ensure that agencies understand the impact of organisational and service changes on safeguarding	Board Business Manager		Individual service users receive, coordinated care which improves their quality of life as standard.	January 2016 On going	Green on track
6. CSAB Members should assure themselves that their staff have received appropriate training, and are working to national guidance issued by Department of Health, NICE, and professional bodies to implement the learning from this SCR on the identification, assessment and treatment of pain,	Overview Report	Training programmes delivered within partner organisations will be a standard inclusion in the CSAB Annual report Work Force Development sub group to review the available capacity to deliver training in relation to these key issues, and ensure that the training resource is able to meet the required need.	Board Business Manager Work Force Development sub group		Services are delivered in a way that is informed by best practice. All staff can access training to meet their individual needs	January 2016 April 2016	Green on track Green on track

constipation, back injuries, sepsis and mental capacity.		Provide a lessons learnt event which ensures staff are informed of the issues identified within the SCR findings, and able to improve their practice as a result Assurance given annually by each member agency that their mandatory training compliance figures meet the agreed local standards	SAR coordinator Workforce Development sub group		Improved service user experience Training compliance figures across all agencies meets the agreed local standards	December 2015 On going April 2016 On going	Green on track Green on track
7. CSAB Each agency must assure themselves and the Board Members through supervision and case audits, that staff have sufficient skills to engage effectively with persons in a personalised way, in gathering relevant information to guide assessments and care planning, particularly in	Overview Report	Supervision audit to be carried out by each agency and results reported to Quality Assurance and Performance sub group Ensure that personalisation is effectively reflected in training programmes	CSAB Board member of each relevant agency / Quality Assurance and Performance sub group Work Force Development sub group		People receive personalised care, that is delivered in partnership.	March 2016	Green on track

risky situations when patients and service users are reluctant to accept help or act on advice.							
8. CSAB Each agency must assure themselves and the Board Members that when patients' / service users are moving to a different environment, their organisation shares all relevant information, and contributes fully to multi-agency planning.	Overview Report	Interagency information sharing audit to be conducted. Each agency will provide an audit report for the Quality Audit and Performance (QA&P) sub group	Agency member of QA&P sub group / sub group chair		People receive personalised care, which is delivered in partnership.	March 2016	Green on track
9. CSAB request an update report from NHS England on progress on ensuring the pro-active contribution of GPs in the development of multi-agency care plans and review of patients discharged from hospital.	Overview Report	Request report from NHS England GP representative, to be considered at full Board	Board Manager/ SAR Coordinator		Board are assured, or able to take corrective action to ensure that, the role of the GP in relation to care planning for patients on discharge from hospital is clear.	January 2016	Green on track

10. CSAB should be assured that the hospital discharge procedures include guidance on:- - factors which should trigger screening for post discharge support; the inclusion of all relevant information in discharge summaries, including clear prompts for community professionals on follow up action where there are any outstanding test results; - the importance of pro-active liaison between the hospital, community services and	Overview Report	Request report from CCG, UHCW, CCC and CWPT on effective hospital discharge to be considered at full Board	Board Manager/ SAR Coordinator		Board are assured, or able to take corrective action to ensure that, hospital discharge is effective and person centred.	January 2016	Green on track

housing with care schemes.							

Coventry City Council

Public report
Cabinet Member

Cabinet Member for Health and Adult Services — 14th December 2015

Name of Cabinet Member:
Cabinet Member for Health and Adult Services, Councillor Caan

Director Approving Submission of the report:
Executive Director for People

Ward(s) affected:
N/A

Title:
Recommendations relating to the System Wide Review for Mrs F

Is this a key decision?
No

Executive Summary

This report presents the action plan in relation to a System Wide Review (SWR) carried out on behalf of the Coventry Safeguarding Adults Board. The report informs the Cabinet Member for Health and Adult Services of the outcome of the Health and Social Care Scrutiny Board (5) consideration of the SWR which took place following the death of Mrs F.

The Health and Social Care Scrutiny Board (5) at their meeting on 18th November 2015, gave detailed consideration to the Executive Summary report and associated action plans, which presented the findings of a Coventry Safeguarding Adults Board System Wide Review, which followed the death of Mrs F. The Board questioned, at length, representatives from a number of partner agencies involved in Mrs F's care in the weeks leading up to her death

Recommendations:

The Cabinet Member for Health and Adult Services is recommended to endorse the action plan - Appendix 2.

List of Appendices included:
Appendix 1 – Executive Summary
Appendix 2 - Multi Agency Action Plan

Other useful background papers:
None

Has it been or will it be considered by Scrutiny?

The Health and Social Care Scrutiny Board (5) considered the SWR at their meeting on 18th November 2015.

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?
No

Will this report go to Council?
No

Page 3 onwards
Report title: Recommendations relating to SWR for Mrs F

1. Context (or background)

1.1 Mrs F was 80 years old when she died. Although she lived alone, in a variety of housing settings prior to her death, her granddaughter remained a major part of her family support network. During the time under analysis for this review, Mrs F was cared for both in hospital and in residential care setting. She had chronic vascular disease which she was aware would be life limiting if she declined any surgical intervention. Following discussion with health professionals and her granddaughter she made the decision not to proceed with any surgery.

1.2 Mrs F was discharged to a care home when it was agreed by her clinicians that she was medically ready for discharge from hospital. It was acknowledged that she would require significant support from health care professionals when she left hospital, therefore, she was transferred to a care home where she could receive the required level of support. While in the care home Mrs F developed tissue damage which became infected. As a result she was re admitted to hospital, where she died 5 days later as a result of the infection.

1.3 The organisations involved in this SWR are committed to ensuring that the issues identified are addressed. The recommendations within the SWR report form the basis of a Coventry Safeguarding Board action plan. The board will in addition, monitor the implementation of improvements within individual organisations.

1.4 The legal and policy framework and context (and associated practice experience and case law) was developing across the timeframe scrutinised by this review. The direction of travel in terms of national policy links closely to key lessons from this review.

1.5 The Health and Social Care Scrutiny Board noted the findings of the System Wide Review and the recommendations, actions and progress. During the robust questioning of agencies on Mrs F's care, a number of issues were explored, these included;

- Clarifications about the monitoring process for the quality and standards of care homes in the city
- Concerns about the on-going financial viability of care homes in the current austerity climate and the impact of introduction of the living wage. The Scrutiny Board asked whether there were any concerns about the current viability of care homes in the City, following press reports that national care home providers may withdraw services? The Scrutiny Board recommended writing to the Secretary of State for Health regarding these concerns and have added care homes, the standards and financial viability of this onto their work programme for future investigation.
- Details were sought about funding by the Local Authority to care homes with financial difficulties.
- The use of regulatory tools where there are concerns about care homes and the support provided to those care homes that need it from the Local Authority.
- Clarification about the improved reporting and treatment of pressure ulcers by agencies involved.
- Sought information on the progress of the Action Plan.

The Scrutiny Board agreed to follow up progress of the action plan in six months time and to write to Secretary of State for Health outlining the concerns raised through the meeting regarding potential quality implications of operating within the current resource constraints due to a lack of funding for adult social care.

2. Options considered and recommended proposal

2.1 Health and Social Care Scrutiny Board (5) considered the SWR at their meeting on 18th November 2015. The Board referred the matter to the Cabinet Member for Health and Adult Services, and that the Cabinet Member be recommended to endorse the action plan at Appendix 2

3. Results of consultation undertaken

3.1 No consultation has been undertaken as part of this report. However the granddaughter of Mrs F was involved in the system wide review.

4. Timetable for implementing this decision

4.1 Implementation of actions within the Action Plan will be monitored by the Safeguarding Adult Review Sub Group and reported to the Safeguarding Adult Board in accordance with local/national policy guidance.

4.2 Health and Social Care Scrutiny Board requested an update on progress with the implementation of the action plans to be presented to the May 2016 meeting.

5. Comments from Executive Director, Resources

5.1 Financial implications
None

5.2 Legal implications
None

6. Other implications

6.1 How will this contribute to the Council's priorities?

http://www.coventry.gov.uk/councilplan

The objectives within the action plan will support the Council deliver their objective to keep vulnerable people safe within their community and to be able to live healthier more independent lives.

6.2 How is risk being managed?

The key risks have been identified within the SWR process which led to the production of this report. The action plans have been developed to address these risks. The Safeguarding Adult Review Sub Group are accountable for monitoring the implementation of these plans in practice and for assuring the Safeguarding Adult Board that these have been delivered according to plan.

6.3 What is the impact on the organisation?

None

6.4 Equalities / EIA

No negative impacts are anticipated in relation to this review

6.5 Implications for (or impact on) the environment
None

6.6 Implications for partner organisations?

Coventry Safeguarding Adults Board will monitor the actions delivered by partners as set out in the action plans attached.

Report author(s):

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Directorate: People Directorate

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Enquiries should be directed to the above person.

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Members: Councillor Caan	Cabinet Member for Health and Adult Services			25/11/15

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Coventry Safeguarding Adults' Board System Wide Review
Executive Summary of Case no: CSAB/SWR/2015/1

What is a System Wide Review?

A System Wide Review (SWR) is held when a vulnerable adult has died or been seriously injured or impaired, and abuse or neglect is known or suspected to have been a factor, and broader system issues, rather than just issues relating to a single case, are believed to have been a significant factor. The purpose of a System Wide Review is to carefully consider the circumstances surrounding the death or serious injury, in order to learn lessons to avoid a similar situation arising in the future, and to determine whether system improvement will reduce the likelihood of the recurrence of this sort of concern or, ultimately, death. It is important to understand that this means that most deaths do not lead to a System Wide Review, only those that meet these criteria.

System Wide and Serious Incident Reviews are undertaken as part of the overall National Government requirements, described in the Care Act 2014 and, formerly, "No Secrets", which provides a framework for Safeguarding Adults, and in accordance with the policies and procedures set out by Coventry Safeguarding Adults' Board (CSAB). Serious Incident and System Wide Reviews are not inquiries into how a vulnerable adult died or who is to blame.

This System Wide Review was conducted in line with the procedures and systems agreed across the city, by the CSAB. These procedures include the appointment of an independent author with significant experience, credentials and, most importantly independence from all of the organisations concerned to write the SWR. There is also the requirement of each organisation involved to undertake an Independent Management Review (IMR), and the submission and testing of those reviews to an SWR committee.

Once the IMRs are all received and analysed, a report is drafted by the Independent Author and considered by the CSAB Serious Incident Review subcommittee. A final report is then presented to a specially convened CSAB meeting, and an action plan developed by the agencies and organisations concerned, in order to meet all the recommendations in the SWR's conclusions. This review addressed concerns relating to the care of a female adult, Mrs F and also relating to aspects of the Commissioning and Regulation of Residential and Nursing Homes in Coventry.

The Facts of the Case, Summary & Overall Analysis

Mrs F died during the spring 2013 whilst residing in a Nursing Home in Coventry. Born in 1933 she was 80 years old when she died, lived in the city all of her life, and, especially towards the end of her life, had significant and caring support from her close family, particularly her granddaughter. Mrs F had been moved from a Housing with Care facility at the end of 2012 following a brief period in hospital. This move was made because it was decided that a level of nursing care would be necessary for her ongoing care.

During her stay at the nursing home, pressure ulcers were identified on her legs which ultimately required a period of assessment and treatment in hospital. Soon after her discharge from hospital Mrs F died. A referral to the Safeguarding Adults arrangements had been made approximately a month before Mrs F's death to a Tissue Viability specialist nurse following her identification of a Grade 4 pressure ulcer. The first Safeguarding Case Conference was held four days after her death.

The Safeguarding Adults Serious Case Review Sub Group reviewed the circumstances of her death in the early summer of 2013. Whilst it was agreed that the case met the criteria for a Serious Case Review (SCR), the Sub Group felt that there were wider issues which would benefit from review, particularly as there were a number of people subject to Safeguarding arrangements residing at the nursing home concerned at the same time as Mrs F. The SCR Sub Group were aware that a number of different sources of information existed in relation to care at Nursing and Residential Care Homes which could assist agencies in placement decisions and the overall monitoring of care quality including:

- Reports available from the Regulatory body, the Care Quality Commission (CQC).
- Reports arising from Health and Safety inspections.
- Information available to Health and Social Care Commissioners about the quality of services available at Residential and Nursing Homes.

The SCR Sub Group were of the view that it was possible that the information deriving from these sources might not directly influence placement decisions in as timely way as it should. They were aware of similar such concerns from earlier work carried out with a Residential Home within the city. They concluded therefore that a Serious Case Review in relation to the case of Mrs F by itself would not necessarily address the possible "system wide" failures suggested.

As a consequence the Sub Group proposed that a "System Wide Review" (SWR), incorporating the individual case of Mrs F, should be commissioned in an attempt to address wider concerns. The process proposed for undertaking this System Wide Review (SWR) is informed by West Midlands guidance for Large Scale Investigations within the Safeguarding framework.

Reviews of this kind are not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of vulnerable adults in the future. In this instance the Safeguarding Adults Serious Case Review Sub Group identified a number of targets for improved practice which a wider review might help to address. In relation to the individual case (Mrs F) they identified:

- Issues related to the direct management of Mrs F's care.
- Issues related to mental capacity.
- The role of the GP.

In relation to the wider service system they identified:

- Improvements needed to the way in which organisations work together to safeguard adults across the wider "system".

- Improvements to practice, systems, and processes, used in the management of poor practice within “large scale” settings such as care homes.

The complexity of this review was exemplified by the number of factors and conclusions identified, and the involvement of so many organisations and agencies. The limits of regulators activity, especially the limited routine inspection regime, was an area of significant concern, especially when quality assurance visits from local agencies in response to locally identified concerns reached sharply differing conclusions to the routine inspections undertaken shortly before by the national regulator. National regulatory activity and responsibilities undertaken by the CQC were outside the scope of this review’s conclusions, but the relevant findings were shared with the relevant agencies as required, and improvements have been implemented subsequently.

Conclusions

The review demonstrated that Mrs F had a complex range of needs. For a number of years these had been addressed by local Agencies in a sensitive and person centred way. However, in the last year of her life, as individuals and agencies sought to react appropriately to changes and increases in these needs, her health worsened. The Panel concluded that there were elements of the services that could have been better during that period, and had they been, this would have resulted in a better experience for Mrs F. It is impossible to say whether this would have delayed her death.

The Parallel Review emerged from consideration of the issues raised by the care of Mrs F in relation to Commissioning of places in Residential/Nursing Homes and the Regulation of these providers. The Single Case Review found shortcomings in the services provided to Mrs F. The Parallel Review found that some of these failures were the responsibility of a Nursing Home which had been assessed by the Regulator and Commissioners as meeting minimum standards. However, the IMR conducted by the Nursing Home covering the same period found significant failings not only in the care of Mrs F but also in the wider system of care at the Nursing Home. This suggests that the Commissioning and Regulatory processes were not as effective as they should have been. Based upon this concern and similar issues arising in relation to a Residential Home, recommendations for more effective Commissioning and monitoring of services in this sector are set out below:

What Happens Next?

Recommendations from the review form the basis of an action plan, which is regularly monitored to ensure that the recommendations are put into place. The action plan will be reviewed regularly until all of the agreed actions have been completed and implemented.

Summary of Recommendations

Recommendations have been developed that apply to all agencies, and also that apply specifically to individual agencies. The recommendations below summarise the actions that are needed to reduce the likelihood of the events leading up to Mrs F’s death recurring in the future.

Coventry Safeguarding Adults Board should:

- Assure themselves that Safeguarding training programmes make staff are aware that the Safeguarding procedure should be re-engaged in circumstances where concerns re-emerge and that decisions to close Safeguarding procedures must be properly recorded.
- Ensure that local guidance related to capacity and self-neglect assessment and training for staff is updated and disseminated as soon as national guidance is available.
- Review its guidance to staff for grade 4 pressure ulcer management and police notification to ensure that it is fit for purpose and, through its routine audits of cases, that this specific aspect of guidance is being followed
- Assure themselves that, where there are different Safeguarding arrangements for different client groups, these arrangements work to the same standards
- Assure themselves that the outcome of investigations are properly audited to ensure that standards of decision making, recording, risk assessment and attendance are being monitored and maintained.
-

Coventry and Warwickshire Partnership NHS Trust should:

- Audit their new processes for referral to their Mental Health Services to ensure that they are clear, and effective and overcome the previous weaknesses identified by this review.
- Ensure that the purpose and outcome of Community Psychiatric Nurse (CPN) contacts with clients is properly recorded
- Review their new arrangements for referral to the Tissue Viability Service to ensure that they are now clear and effective.

Coventry City Council Adult Social Care Department should:

- Review their guidance to practitioners relating to care planning to ensure that reviews of plans are timely and responsive to changes in need

Coventry City Council and Coventry and Rugby Clinical Commissioning Group should:

- Ensure through their joint monitoring and contract management that NH1 continues to meet minimum standards in the care which it provides under contracts with these agencies.
- Review current joint monitoring arrangements to ensure that they are now fit for purpose and their reporting into the Provider Escalation Panal (PEP) is timely and effective.
- Ensure that Agencies participating in PEP review with CQC whether an appropriate mechanism can be found for sharing “whistle blower” information and agreeing relevant prompt investigation.
- Review the existing safeguarding recording system and either improve the links between existing systems or bring forward plans to replace the Safeguarding record system to ensure the availability of timely effective information to Practitioners
- Review their separate and joint commissioning of Residential and Nursing Homes to ensure that an adequate level of satisfactory capacity remains available within the financial constraints that exist.

NHS England should:

- Evaluate the findings of this review to determine the most effective way of using its Commissioning role with GPs to ensure that the learning related to the coordination of care and proper follow up of referrals is addressed.

All Agencies should:

- Ensure that their local training continues to emphasise the importance of involving and communicating with family members including where the next of kin is a younger person.
- Jointly review the role and function of the PEP to improve the timeliness and effectiveness of its action. A regular auditing process reporting back to participating agencies should be considered.
- Evaluate through PEP whether an efficient system of collating low level concern information in relation to residential and nursing home facilities can be achieved simply and reliably and if so implement it.
- Review their current in-service training and quality assurance arrangements to ensure that efforts to improve standards of recordkeeping are maintained and that appropriate audit processes are in place to ensure compliance with standards set for record keeping.

If you would like to know more about Coventry Adult Safeguarding please go to:
www.coventry.gov.uk/safeguarding

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SCR Action Plan System Wide Review –Parallel (Mrs F)– Updated: 12th October 2015
PLEASE NOTE the actions below should be SMART Specific, **M**easurable, **A**chievable, **R**ealistic and **T**ime specific. We need to know what is happening who is leading on it, any progress to date and when it will be completed. Also RAG ratings need completion as follows: **RED**– not achieved and seriously behind schedule; **AMBER**– not achieved and slightly behind schedule; **GREEN** – specify whether on track to be achieved within the timescale or completed.

Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
Participating Agencies should								
1	Jointly review the role and function of the Provider Escalation Panel (PEP) to improve the timeliness and effectiveness of its action. A regular auditing process reporting back to participating agencies should be considered.	Overview Report (8.1.1)	Review structure and processes of PEP to ensure fit for purpose	March 2015	Head of Strategic Commissioning	Restructuring of PEP – including introduction of standardised reports and a pre –PEP meeting	Effective and robust monitoring of quality and safety of care in care homes and timely escalation of concerns	Green Completed
2	Evaluate through PEP whether an efficient system of collating lower level concerns about services provided by residential & nursing homes can be achieved simply and reliably and if so implemented	Overview Report (8.4.1)	Review information flows to PEP and include • What is reported • Timeliness of reporting	March 2015	Head of Strategic Commissioning	Safeguarding regularly attend PEP and pre PEP and provide safeguarding information regarding providers discussed. Raising concerns form is in place and reiterated for use with SW/partner teams.	Escalation of safeguarding reporting.	Green Completed
3	CSAB should ensure that all agencies review their current in-service training and quality assurance arrangements to ensure that efforts to improve standards of record keeping are maintained and that appropriate	Overview Report (8.7.1)	**CCG care home quality monitoring team –** Undertake audit of quality assurance reports and records to ensure meeting required standards	May 2015	Deputy Director of Nursing & Quality CCG	Audits completed and reports significant assurance	Commissioners have robust QA and assurance in place	Green Completed

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
	audit processes are in place to ensure compliance with standards set for record keeping		**UHCW –** Review of audits from 2011 – 2014 underway	October 2015	Safeguarding Lead UHCW	Audit in progress - Sept 2015 completed	Show who has attended Safeguarding awareness training.	Green Completed
Coventry City Council and Coventry and Rugby Clinical Commissioning Group should, building on the start that has been made since April 2013								
4	Review current joint monitoring arrangements to ensure that they are now fit for purpose and their reporting into PEP is timely and effective.	Overview Report (8.2.1)	Reviewed and updated structures and processes	March 2015	Head of Strategic Commissioning	Single CCC and CCG quality monitoring team in place April 2015	Assured fit and proper monitoring process in place	Green completed
5	Ensure that Agencies participating in PEP review with CQC whether an appropriate mechanism can be found for sharing “whistle blower” information and agreeing relevant prompt investigation.	Overview Report (8.2.2)	Explore current processes and associated issues. Develop new guidance in line with Freedom to speak up	May 2015	Head of Strategic Commissioning	Reviewing freedom to speak up published February 2015 Agreed mechanism in place for CQC to share whistleblowing information with commissioners in a timely way	Clear criteria for level of appropriate action for whistleblowing	Green Completed
6	Review their separate and joint commissioning of Residential and Nursing Homes to ensure that an adequate level of satisfactory capacity remains available within the financial constraints that exist.	Overview Report (8.6.1)	Review the commissioning of care homes jointly with CRCCG and Warwickshire	Sept 2016	Head of Strategic Commissioning	Baseline work completed and draft services specification commenced. (Warwickshire lead)	An adequate level of satisfactory care home capacity at affordable rates.	Green

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
7	Pep Tor review including Roles & responsibilities	IMR	PEP Tor to be updated	Dec 2014	Head of Strategic Commissioning	Update reported at Q & A sub group	New process and TOR started in December 2014	Green – completed
8	Triangulation of Safeguarding information	IMR		Dec 2014	Head of Strategic Commissioning, Assistant Director safeguarding, Performance & Quality, and – Head of Business Systems	Reports produced from Safeguarding Team data base. Care Director in place		Green - completed
9	Review of Residential Contract and Service Specification	IMR	Review Contract and Service Specification	March 2016	Head of Strategic Commissioning and CRCCG Commissioning	Progress is being made and specification is currently in draft. Timescales for implementation have moved to October 2016 in light of a joint approach across Coventry & Warwickshire with consultant input relating to price for care.	New contract and services specification in place	Green
10	Provider Forum to be used as a method of feeding back in respect of lessons learned	IMR	Feedback on lesson learned from review	April 2015	Head of Strategic Commissioning	The Council and CRCCG have also supported and implemented a pressure ulcer awareness called "React to Red". This is a accreditation scheme for providers to ensure preventative pressure ulcer care management	Provider awareness of key issues and action to be taken on agenda	Green Completed

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
						is in place.		
Coventry City Council should								
11	Review the difficulties of using both paper based and computerised systems for safeguarding information and either improve the links between existing systems or bring forward plans to replace safeguarding record systems to ensure the availability of timely effective information to practitioners	Overview Report (8.3.1)	Ability to record Adult safeguarding on Care Director only	Feb 2015	Head of Business Systems	Safeguarding Adults recording introduced on Care Director in Feb 2015 for Older People and All Age Disability.	All recording in one place, easily assessable and timely	Green – Completed
				Jan 2016	Assistant Director Safeguarding, Quality & Performance	Task and Finish group in place to ensure Mental Health Teams record safeguarding on Care Director	All recording in one place, easily accessible and timely	Green
Coventry Safeguarding Adults Board should								
12	Ensure that the different arrangements for Older Adults, Mental Health and Learning Disability work to the same standards for adult safeguarding.	Overview Report (8.5.1)		April 2015	Safeguarding Boards Manager	West Midlands Policy & Procedures in place from 01.04.2015	Consistent policy and process for all teams	Green completed
13	Ensure that the outcomes of investigations are properly audited to ensure that standards of decision making, recording,	Overview Report (8.5.2)	Team audits to be developed	May 2015	Chair of Q & A sub Group	Full process of 22 Social Care and Mental Health files undertaken in November 2014	Identified areas are Audited for compliance to procedures and	Green

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
	risk assessment and attendance are being monitored and maintained					Plan for further audits including partner audits to be taken to Q & A sub group on 11.05.2015 with regular slot in future meetings for all partner agencies to feedback their audit findings and actions	actions taken if not.	
			System developed to track and report risk(bearing in mind high risk can be related to chosen user outcomes)	April 2015	Assistant Director Safeguarding, Performance & Quality	Systems and reports for tracking risk scores during safeguarding process introduced on Care Director in April 2015	System in place from April 2015	Green Completed
				July 2015	Performance Manager and Head of Business System and Data Warehouse	Reports requested from Care Director.	Report to be produced to monitor risk management.	Green

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating

Coventry City Council

Public report
Cabinet Member Report

14 December 2015

Name of Cabinet Member:
Cabinet Member for Health and Adult Services – Councillor Caan

Director Approving Submission of the report:
Executive Director of People
Director of Public Health

Ward(s) affected:
All

Title: Transfer of 0-5 Public Health Commissioning Responsibility to Local Authorities

Is this a key decision?
No – Although this matter may impact on all wards across the City, it is not expected to be significant.

Executive Summary:

As part of the Health and Social Care Act 2012, it was agreed that the commissioning responsibility for 0-5 public health would transfer to the NHS National Commissioning Board until April 2015, which was then extended until October 2015. This responsibility in the main covers the Health Visiting and Family Nurse Partnership services (FNP). The services are currently commissioned from Coventry and Warwickshire Partnership NHS Trust (CWPT) and costs in the region of £5.35m pa.

Guidance was published by the Department of Health to support the transfer of the contracts for the services from the NHS to Local Authorities and financial allocations for Local Authorities from October 2015 were subject to consultation and finally published in March 2015.

Reports regarding the transfer were submitted in January and July 2015 and it was agreed that a further update would be provided post transfer. This report outlines the current position and the work that has been undertaken to ensure the safe transfer of the commissioning arrangements for the commissioning of 0-5 public health services from 1 October 2015.

Recommendations:

(1) The Cabinet Member for Health and Adult Services is requested to note that responsibility for 0-5 public health commissioning transferred to the Council on 1 October 2015 and that a re-commissioning exercise will be undertaken during 2015/16 and 2016/17 relating to 0-19 public health services. A report will be submitted to Cabinet in the future to seek approval to take this work forward.

List of Appendices included:

None

Other useful background papers:

None

Other useful document:

Transfer of Commissioning Responsibilities to Local Authorities – Initial contracting guidance for NHS Commissioners, NHS England, November 2014 http://www.england.nhs.uk/wp-content/uploads/2014/11/0-5-trans-contrct-guid-1114.pdf

Transfer of 0-5 Public Health commissioning responsibilities to Local Authorities: baseline agreement exercise, DH, December 2014
https://www.gov.uk/government/publications/allocation-of-funding-for-0-5-public-health-services

0-5 Public Health Allocations March 2015
https://www.gov.uk/government/publications/transfer-of-0-5-childrens-public-health-commissioning-to-local-authorities

Has it been or will it be considered by Scrutiny?
No

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?
No

Will this report go to Council?
No

Page 3 onwards

Report title: Transfer of 0-5 Public Health Commissioning Responsibility to Local Authorities

1. Context (or background)

1.1 In January 2014 there was a national announcement that commissioning for 0-5 Public Health services would transfer to Local Authorities from NHS England from 1 October 2015 and not 1 April 2015 as previously outlined as part of the transfer of Public Health to Local Authorities. This responsibility covers Health Visiting and Family Nurse Partnership services (FNP).

1.2 The transfer joins up public health services for children (0-5) and young people (5-19) to ensure seamless transition between services and that children are given the best start in life to maximise their potential.

1.3 Guidance was published in November 2014 regarding the contractual and financial arrangements for the transfer and significant work has been undertaken to ensure a safe handover of this service between the two organisations.

1.4 Since the start of 2015 work has been undertaken to finalise the financial and contractual arrangements regarding the transfer with NHS England to ensure a smooth transition takes place in October 2015.

2. Options considered and recommended proposal

2.1 There were limited options to consider in relation to this transfer as it is a national requirement. The contracting guidance included two options regarding the transfer of the commissioning responsibilities – to agree one contract for 2015/16 with a mid year legal transfer (novation) or to agree 2 separate six month contracts.

2.2 Following legal advice on the guidance, it was agreed to pursue Option 1 for 2015/16. One contract was therefore agreed for 2015/16, which was initially held by NHS England and legally transferred to the Council in October 2015. The contract is a NHS Standard contract similar to those that transferred to the Council as part of the Public Health transfer in April 2013.

2.3 During the year, work was undertaken with NHS England (NHSE) to negotiate a contract for 2015/16 with the provider that meets the needs of both commissioning organisations and to ensure that the financial allocation will cover the contractual costs which will be incurred by the Council. Joint contract performance management meetings have been held with the provider since April 2015 with NHSE to aid the handover of the services.

2.4 In March 2015, revised financial allocations were published which means that the Council receives a part year allocation of £2.807m to cover the contractual costs and associated quality incentive payments within the contract for 2015/16. In addition, a small element of funding has been included to cover the staffing costs associated with the additional commissioning responsibilities which transfer to the Council.

2.5 Nationally work has been under taken to develop the governance arrangements to support the transfer. In August 2015 a novation agreement was signed by all parties to support the transfer of the contracts over to the Local Authority. In addition, national templates have been developed for a handover pack of information from NHSE to the Local Authority regarding the contract and associated documentation. There have been some delays

nationally regarding the handover pack, due to information governance concerns. It is hoped that these concerns will be resolved shortly to enable the handover to be completed.

2.6 It is currently planned to recommission the 0-5 public health services from 1 April 2017, alongside other associated public health services, to form integrated children's public health services in the future. A consultation exercise to inform the new service model will commence in the Autumn of 2015.

3. Results of consultation undertaken

3.1 As this is a national transfer of responsibilities between organisations, all of the consultation has been undertaken on a national basis and no local consultation has been undertaken in relation to this transfer.

4. Timetable for implementing this decision

4.1 The formal transfer was implemented from 1 October 2015. The contract for 2015/16 and associated deed of novation has recently been signed off by the Authority.

5. Comments from Executive Director of Resources

5.1 Financial implications

The public health grant for 2015/16 includes resource to fund the 0-5 children's public health services for 6 months. From April 2016 the public health grant (including the 0-5 transfer) is expected to move towards a distribution based on population needs. The fair shares formula would be based on advice from the Advisory Committee on Resource Allocation (ACRA). ACRA plan to run an engagement exercise on overall changes to the public health grant formula starting in the New Year. A consultation on the future public health funding formula was published in October 2015.

Consultations on the financial arrangements for the transfer of 0-5 public health responsibilities in 2015/16 were undertaken in 2014/15 and officers submitted technical responses as appropriate. The proposed allocation for 2015/16 is £2.8m which covers the associated contractual costs which is an increase of £0.5m against the previously proposed allocation of £2.3m.

5.2 Legal implications

The transfer of commissioning responsibilities for 0-5 public health to local authorities is being undertaken at a national level under the Health and Social Care Act 2012. National guidance to support the transfer of contracts has been published and is being adhered to locally.

6. Other implications

6.1 How will this contribute to achievement of the Council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / Local Area Agreement (or Coventry Sustainable Community Strategy)?

The transfer of 0-5 Public Health commissioning responsibilities is being undertaken at a national level. Local responsibility will support the Council's objectives of reducing health inequalities and Health and Wellbeing Strategy and the national Healthy Child programme. The transfer will allow services to be integrated and joined up from 0-19 to allow children, parents and carers in the City to be supported to live long, healthy lives and maximise their life opportunities.

6.2 How is risk being managed?

The key risks relate to the legal novation of the contracts and contract performance. Work is being undertaken with NHS England to ensure that the local risks are minimised.

6.3 What is the impact on the organisation?

There is minimal impact on the organisation. Additional mandated responsibilities are assigned with the transfer regarding:

- Antenatal health promoting visits
- New baby review
- 6-8 week assessment (excluding GP check)
- 1 year assessment
- 2-2.5 year assessment

The additional responsibilities relate to the commissioning of services rather than the Council providing any additional services.

6.4 Equalities / EIA

This is a national transfer of a service to Local Authorities. In the short term there will be no changes to the current service which would have an impact on equalities or EIA. If any changes are proposed to the services, an EIA will be undertaken to ensure that the Council's equality duties are met and that no particular group is disadvantaged as an impact.

6.5 Implications for (or impact on) the environment

The transfer of 0-5 public health responsibilities has no impact on the environment.

6.6 Implications for partner organisations?

Coventry and Warwickshire Partnership NHS Trust is the current provider of the services and is a significant partner to the Local Authority across a range of issues. The services will remain with the Trust in the interim.

Coventry and Rugby Clinical Commissioning Group will have a significant interest in the services and is a stakeholder of the services due to their interface with other health services commissioned by the CCG and primary care services.

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Names of approvers for submission: (officers and members)				
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Director: Jane Moore	Director of Public Health	People	05/11/15	05/11/15
Members: Councillor Caan	Cabinet Member (Health and Adult Services)		10/11/15	
Executive Director: Gail Quinton	Executive Director (People)	People	10/11/15	01/12/15

This report is published on the council's website:
www.coventry.gov.uk/meetings

Coventry City Council

Public Report
Cabinet Member report

Cabinet Member for Health and Adult Services — 14th December 2015

Name of Cabinet Member:
Cabinet Member for Health and Adult Services – Councillor Caan

Directors Approving Submission of the report:
Executive Director of People

Ward(s) affected:
All

Ensuring the Quality of Care and Support in Adult Services.

Is this a key decision?
No. Although this matter affects all wards in the City, the impact is not expected to be significant

Executive Summary:

The Council is committed to ensuring that it commissions or delivers the best quality services possible within the available resources.

In Coventry the quality assurance of organisations that provide social care funded by the City Council is led by the Council's Adult Strategic Commissioning Team but involves a significant amount of work with Coventry and Rugby Clinical Commissioning Group (CRCCG) and the Care Quality Commission (CQC). This work is co-ordinated through the Provider Escalation Panel which is led by the City Council and provides a forum for intelligence to be shared and co-ordinated between organisations so that appropriate and proportionate action is taken.

The level of input dedicated to managing quality for a specific provider is subject to an assessment of risk which helps to ensure that resources are focussed on areas where they are most needed as opposed to a standard approach to all providers.

Where issues arise, the City Council is committed to taking an approach that results in an improvement of standards and to deliver this works in close partnership with health colleagues. A small team of nurses employed by CRCCG are incorporated within the City Council's adults commissioning function to further support co-ordination of improvement activity.

Positively, a recent CRCCG internal audit in relation to the joint quality assurance system for care homes concluded that: "significant assurance can be given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives".

A key requirement of the Care Act (2014) is a duty on local authorities to ensure safe and sustainable care and support provision through effective market shaping. In addition local authorities are required by have plans in place to be used should there be failure of either a single provider organisation or a number of organisations.

Recommendations:

The Cabinet Member for Health and Adult Services is recommended to:

1) Approve the approaches taken in Adult Social Care to manage market risk through quality assurance processes

2) Approve the contingency plan to be used in cases of market failure

List of Appendices included:

Market Failure Outline Document

Other useful background papers:

None

Has it been or will it be considered by Scrutiny?

No

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?

No

Will this report go to Council?

No

Report title: **Ensuring the Quality of Care and Support in Adult Services.**

1. Context (or background)

1.1. The Council is committed to ensuring best value in its commissioning and procurement and requires on-going assurance that the quality standards for care and support outlined in its service specifications and contracts continue to be met. This includes requirements for individual outcomes to be delivered by providers working with service users and their families with dignity and respect being central to the quality of services.

1.2. Quality Assurance (QA) led by the City Council through the Adults Strategic Commissioning function (Coventry City Council) with support from Coventry and Rugby Clinical Commissioning Group (CRCCG).

1.3. A requirement of the Care Act 2014 is that local authorities must develop their local knowledge in respect of potential provider failure, and focus, where appropriate, on supporting providers at risk of failure. Local authorities are also required to have plans in place to manage exits from the market to ensure continuity of care. The Care Quality Commission (CQC) has parallel duties in relation to larger providers where provision spans several authority areas and there is a requirement for co-operation between CQC and local authorities. The report describes the approach taken to manage this requirement through contingency planning.

1.4 Delivering Quality Assurance

1.4.1 The City Council has been actively operating a Quality Assurance Framework since 2010 across adult social care. The quality assurance framework had the following benefits:

- Set out a clear and consistent standard for the quality assurance of services (both internally and externally provided)
- Supports the assessment of outcomes delivery
- Ensures that users, carers, relatives and providers themselves are actively engaged in the assessment of quality
- Drives the delivery of personalisation
- Provides a sound basis for evidencing that measures are being taken in relation to safeguarding
- Provides an appropriate balance between reactive and proactive management, informed by risk
- Requires commissioners to evidence effective use of resources and educate and work with the market to improve standards

1.4.2 Quality standards are defined throughout the commissioning process and set out within contracts. A key role for the Strategic Commissioning Team is monitoring contracts against these standards, including supporting providers to develop and implement action plans where improvement is required.

1.4.3 All contracted provision within the City has a minimum of one planned quality assurance review per year. The amount of scrutiny is based on a risk based approach to ensure appropriate focus on those contracts where risks are highest. Level of risk is determined through a number of factors including numbers of people receiving particular provision, spend, CQC ratings, safeguarding activity and intelligence from professionals and wider stakeholders.

1.4.4 There are a number of mechanisms that enable stakeholders to alert the Strategic Commissioning Team to issues outside of formal meetings and these are always thoroughly investigated.

1.4.5 For home support services Electronic Care Monitoring (ECM) is utilised which provides contract monitoring officers with evidence around components of quality including missed visits, visit times and duration and the number of different carers providing support to an individual.

1.4.6 A significant recent development has been the incorporation of CRCCG employed clinical quality nurses to the Strategic Commissioning Team. This has enabled a much more integrated and co-ordinated approach to quality assurance with invaluable clinical expertise supplementing the Council's staff for example in areas such as infection control, tissue viability, dementia care; falls prevention and end of life care.

1.4.7 Where people are placed in out of City provision the same contractual conditions as in-city provision applies. Quality is assured through liaison with the host authority commissioners, scrutiny of Care Quality Commission reports and through service user annual reviews.

1.4.8 In order to provide some assurance of processes in place a recent internal audit of CRCCG's quality assurance approach was conducted. The audit concluded that: "significant assurance can be given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives". Some suggestions for improvement have been made which will be incorporated into quality assurance process going forward.

1.4.9 Quality Assurance is co-ordinated across agencies through the Provider Escalation Panel (PEP) which is a multi-agency process, led by the Council's Strategic Commissioning Team, the aim of which is to share intelligence relating to the quality of services and manage risks across the city. Monthly meetings take place with representatives from CRCCG, Arden and GEM Commissioning Support (who monitor care home contracts on behalf of CRCCG) safeguarding, operational staff and the CQC. The PEP formally reports on a quarterly basis to the Quality and Audit sub-group of Coventry's Adults Safeguarding Board (CSAB). There are also annual reports to CSAB from the Head of Strategic Commissioning and learning from serious case reviews is considered.

1.4.10 The Provider Escalation Panel makes recommendations in respect of sanctions, for example, placement stops, and coordinates quality improvement approaches and actions.

1.4.11 Working with Care Quality commission as key stakeholders in the Quality Assurance process. The latest available information (14th October 2015) shows the following information for published service inspections. These results relate to a mix of care home and home support services.

Social Care Organisations with published CQC ratings as at 14th October 2015

	National	Coventry
Outstanding	12 (1%)	0 (0%)
Good	633 (60%)	44 (68%)
Requires Improvement	326 (31%)	19 (29%)
Inadequate	78 (7%)	2(3%)
Total	1049	65

1.5 Market Shaping and Commissioning

1.5.1 Local authorities are required to facilitate markets that have a diverse range of high quality and appropriate services having regard to ensuring continuous improvement of those services.

1.5.2 The City Council have responded to this requirement through the publication of a Market Position Statement which highlights how the market needs to develop in order to meet the challenges of providing a modern social care service to the residents of the city in the context of increased demand and policy and legislative changes. The document incorporates our approach to quality assurance and is used as the basis for engagement with providers including through various workshops and targeted soft market testing across care sectors with both national and local providers.

1.5.3 The Council's market shaping work incorporates the development of the personal assistants market to ensure an adequate workforce for those citizens opting to use direct payments to purchase their care and support.

1.6 Market Failure Plan

1.6.1 The Care Act 2014 introduced Local Authority responsibilities for ensuring continuation of services in the event of provider failure. This responsibility applies to self-funders affected by provider as well as local authority funded.

1.6.2 The approach to planning for market failure has been taken with Coventry and Rugby Clinical Commissioning Group (CRCCG) who are a key partner in supporting this process and a commissioner of community health services as well as having its local NHS duties.

1.6.3 There are a number of scenarios which can cause a provider / market failure. Some of these are sudden (although very rare) and some are as part of national / local financial pressures which are well publicised and / or communicated to Council's through regular dialogue with organisational leads.

1.6.4 In order to provide a framework for managing failure the City Council has developed a market failure plan (see appendix one) which includes the following elements: -

- Assessing the local market and potential risk
- Developing a range of actions to be taken in different scenarios and based on various Types of provision
- Ensuring continuity of service for people and minimising disruption to their lives
- Having CRCCG as a key partner and ensuring relevant sign off / buy in from Stakeholders
- Engaging the market through both contracts (as part of formal tendering arrangements) and provider forums to ensure a level of understanding and commitment is apparent in the City

1.6.5 The Council takes a proactive approach to working with providers that is based on investing in providers relation. This enables the Council to liaise with providers at an early stage where concerns around possible failure are emerging. The Council acts to support providers wherever practicable and works jointly to manage situations effectively.

2. Options considered and recommended proposal

2.1. Recommended option.

The delivery of a risk based approach to quality assurance which ensures that resources are focussed on those commissioned services where the likelihood and impact of quality and safeguarding issues is greatest, with other services being scrutinised to a degree proportionate to risk.

This option is also recommended as it targets resources to areas that have greatest impact on delivering improvement.

A legal requirement of the Care Act (2014) is to have plans to address market failure (part of market shaping) which is key to ensuring the Council's response is robust to support people receiving care and support services where a provider exits the market.

3. Results of consultation undertaken

No specific consultation was undertaken in respect of the proposals within this report however, the methodology described in well communicated and developed with partner organisations and providers.

4. Timetable for implementing this decision

The market contingency process will be implemented immediately and will be used in the next instance of provider failure.

5. Comments from the Executive Director of Resources

5.1. Financial implications

There are no direct financial implications arising from this report

Whilst action is taken to support providers and minimise the likelihood of failure, there is a risk of significant cost pressures in the event of a provider failure, where another provider may have to be paid to meet the needs of service users affected or if the local authority is required to staff a home.

5.2. Legal implications

The majority of the Care Act (2014) came into force on 1 April 2015, reforming the law relating to care and support for adults and support for carers. The Act is supported by Regulations and Statutory Guidance.

This includes duties around market shaping and commissioning of adult care and support. With implications for facilitating the care and support market to offer a diverse range of high quality and appropriate services.

Where the Council and / or CCG are faced with taking responsibilities of services and / or staff where market failure occurs within a registered provider setting, there is a temporary legal duty upon the local authority to meet an adult's needs for care and support and the support of a carer within its area. This duty continues until such time as the authority considers it necessary.

6. Other implications

6.1. How will this contribute to the Council's priorities?

http://www.coventry.gov.uk/councilplan

This proposal would contribute to the Council's key objectives through a contribution to citizens living longer, healthier, independent lives.

6.2. How is risk being managed?

Quality assurance risks are managed using a number of mechanisms including People Directorate monthly commissioning meetings, Provider Escalation Panels and Quality and Audit Subgroup of Adult Safeguarding Board

6.3. What is the impact on the organisation?

None

6.4. Equalities / EIA

Not applicable

6.5. Implications for (or impact on) the environment

None.

6.6. Implications for partner organisations?

CRCCG benefits from the joint approach to quality assurance and the market shaping and market sustainability activities outlined in this report.

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Appendix: Market Failure Outline Document

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1) Executive Summary
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3) Key legislation
4) Stakeholders
5) The care market in Coventry
6) Scenarios / scope of risk
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Appendices

1) Coventry City Council's approach to quality assurance
2) Regionally developed risk tool to identify step by step approach

1) Executive Summary

This document aims to detail the fundamental steps to be taken should a provider of social care and / or health services fail within the market place in Coventry.

This is in light of enhanced duties under the Care Act and is further highlighted through market failure across the care and support sector over the past 5 years (most notably Southern Cross and a range of smaller home support / care home providers) in the City.

Key to this approach are agreement and collaboration with partners (CRCCG / UHCW / third sector / private providers) to mitigate risks to vulnerable people in Coventry who may or may not be funded by a statutory body.

Inevitable longer term holistic market impact will be a factor to consider where providers, depending on scale and / or specialism, fail and cease to provide services within Coventry. This work programme will be fundamental to the Market Position Statement (2015) through market shaping and integral to future contracts and payment mechanisms to mitigate provider failure through a more robust arrangement to support provider growth in the City.

2) Current / previous related documents

Draft market failure contingency plan

In light of the Southern Cross scenarios in 2009, the City Council led on developing a market contingency plan which focussed, in the main, on planning for that particular case (although it gave a template for a wider contingency plan).

The work was shared with colleagues from Health (then known as PCT) and was agreed as a principle by Cabinet Member and Council. However, no formal sign off of the document was obtained and thus the plan has not been widely publicised and / or circulated.

Business continuity plans (BCP)

BCP's are a pre-requisite of every organisation contracted to the City Council (across all sectors). These plans vary in detail but all will have a focus on provider assurances to facilitate a range of actions should an incident (small or large) require so.

BCP's are checked as part of the annual monitoring regime by City Council contract officers.

In line with provider BCP's, there will be scenarios, as identified within this document, where the Council will need to mobilise actions and support swiftly. This Market Failure Outline Plan will be used, through market engagement and planning, a mechanism to react to such scenarios.

3) Key Legislation / duties

Care Act

- Local authorities have a temporary duty to ensure that, when a care provider fails (unable to continue to provide care due to market failure), people's needs are met – regardless of funding arrangements
- This level of intervention may vary dependent on individual circumstances of individuals and there may be instances where the local authority can charge individuals for arranging 'emergency care'
- Specific duty on CQC* to mitigate the risk of provider failure is present in the Act, although it is focussed on supporting providers through sustainability plans and business reviews as opposed to stepping in to prevent failure.
- The Act allows CQC to request financial information from providers for the first time whilst ensuring that information sharing across all stakeholders is in place.

*CQC specific duties

- Market oversight – oversee financial sustainability of providers that would be difficult to replace if they fail

- Duty of Candour – ensure that providers are open and transparent when things go wrong and expect actions to be in place to ensure improvements

It should be noted that CQC have, in some cases, instigated restrictions on placements on providers which is a new power that they have as part of their enforcement process. This can have a detrimental effect on Council and CCG plans in particular around capacity management during pressure periods throughout the year. However, a clear balance between provider capacity and client safety needs to be paramount to any decisions.

4) Key Partners / stakeholders

Coventry and Rugby Clinical Commissioning Group (CRCCG) – where clients have an element of health funding attached to them (usually nursing / CHC provision) then market contingency plans will need to be implemented jointly and risks and finances shared accordingly.

However, it should be noted that all people receiving a social care service (funded or not funded by the Council) will have a health need and GP involvement thus peoples health needs should be a consideration regardless of whether health / CHC funding is in place.

CRCCG also fund community health services (provided through CWPT) which will need to be mobilised in certain scenarios.

5) The Care Market in Coventry

The following section provides an analysis of the care market (care homes / home support and supported living) based on the national tools developed by Cordis Bright and using the Council's own intelligence.

The analysis is detailed as: -

Current Social Care Market in Residential and Nursing Care (OP & Adults)

	National			Regional			Local			
	Large	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Total**
Providers / schemes within the local market	26	0	0	0	18	1	0	0	30	**75**
Funded packages / number of people funded by Host LA	364	0	0	0	155	2	0	0	268	**789**
Number of providers / schemes with at least one service with a CQC 'inadequate' rating	1	0	0	0	0	0	0	0	1	**2**
Number of providers / schemes with 20% or more of their services with at least one CQC 'inadequate' rating	1	0	0	0	0	0	0	0	1	**2**

Current Social Care Market for Home Support

	National			Regional			Local			
	Large	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Total**
Providers / schemes within the local market	4	0	0	0	4	5	0	0	16	**29**
Funded packages / number of people funded by Host LA	322	0	0	0	110	115	0	0	544	**1091**
Number of providers / schemes with at least one service with a CQC 'inadequate' rating	0	0	0	0	0	0	0	0	0	**0**
Number of providers / schemes with 20% or more of their services with at least one CQC 'inadequate' rating	0	0	0	0	0	0	0	0	0	**0**

Current Social Care Market for Supported Living

	National			Regional			Local			
	Large	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Total**
Providers / schemes within the local market	11	0	0	32	8	1	0	14	3	**69**
Funded packages / number of people funded by Host LA	18	0	0	123	14	2	0	48	4	**210**
Number of providers / schemes with at least one service with a CQC 'inadequate' rating	0	0	0	0	0	0	0	0	0	**0**
Number of providers / schemes with 20% or more of their services with at least one CQC 'inadequate' rating	0	0	0	0	0	0	0	0	0	**0**

Current Social Care Market for Housing with Care

	National			Regional			Local			
	Large	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Large**	**Medium**	**Small**	**Total**
Providers / schemes within the local market	9	0	0	1	0	0	10	0	0	**20**
Funded packages / number of people funded by Host LA	237	0	0	23	0	0	255	0	0	**515**
Number of providers / schemes with at least one service with a CQC 'inadequate' rating	0	0	0	0	0	0	0	0	0	**0**
Number of providers / schemes with 20% or more of their services with at least one CQC 'inadequate' rating	0	0	0	0	0	0	0	0	0	**0**

Key points

- The Council buys a significant proportion of it's care home placements small local organisations which are in the main from spot purchase arrangements
- The Council's block contract arrangements are with large national organisations (Anchor / MHA)*
- Home support provision in the City is split, in the main, across small local and large national organisations
- Housing with Care provision provided by Coventry City Council accounts for over half of the funded provision (Local – Large)

*this includes Council run provision

6) Scenarios / scope of market failure

The below table details those stakeholders with a regulatory and/or quality assurance interest in each service type, who will need to be involved should market failure materialise and what type of resource is required.

Service / Provider Type	**CCC**	**CRCCG**	**CWPT**	**CQC**
Residential (national)	Financial / Operational	Operational	Operational	Oversight
Residential (local)	Financial / Operational	Operational	Operational	Oversight
Nursing (National)	Financial / Operational	Financial / Operational	Financial / Operational	Oversight
Nursing (Local)	Financial / Operational	Financial / Operational	Financial / Operational	Oversight
Extra Care (national)	Financial / Operational	Operational	Operational	Oversight
Home Support (National)	Financial / Operational	Operational	Operational	Oversight
Home Support (local)	Financial / Operational	Operational	Operational	Oversight
Day Service (National)	Financial / Operational	Operational	Operational	Oversight
Day Service (Local)	Financial / Operational	Operational	Operational	Oversight
Sheltered (non-social care)	Information	None	None	None
Third Sector (Large)	Information	Information	None	None
Third Sector (small and local)	Information	Information	None	None

Scope of risk mitigation by organisation

The following section aims to outline the pro-active process of managing a provider where significant risks are presented which may impact on their ability to continue providing services.

CCC

Initial scope

- Identify key issues
- Engage with provider through senior level meetings including CQC where applicable
- Identify all people in receipt of services including private clients and out of city placements
- Action plan developed, implemented and monitored on a weekly basis
- Instigate at Provider Escalation Panel
- Instigate large scale investigation if required
- Identify social care resource for reviews of all people
- Communication plan including letters to users / carers, media response as appropriate
- Member briefings
- Liaison with OOC placing authorities
- Initial checks for alternative capacity

Continuous scope should provider continue to be on the verge of failure

- Liaison with CQC at a greater level to jointly work on provider failure
- Communication (face to face meetings) with users and carers where applicable
- Reviews of all clients including mobilisation of advocates and IMCA / DOLS assessments (and Best Interest processes where applicable)
- Ensure ICT / Council systems are set up to react to potential changes
- Liaison with providers regarding their own ICT systems and use of e-systems
- Engagement of wider provider market to ascertain definitive capacity and the ability to : -

a) Accept current cohort of users
b) Potentially TUPE staff over

- Ensure measures are in place for continuity of care for current clients through staff levels and competencies
- Explore the potential of using the existing building

CRCCG

Initial scope

- Joint meetings with City Council
- Joint communication plan where necessary
- Identification of review resource for health funded clients
- GP engagement
- Identification of nursing team (tissue viability / falls / health checks etc)
- Identify risk to UHCW re: capacity and discharges for both current and future intended placements
- Ensure continuity of medication supplies as appropriate

Continuous scope should provider continue to be on the verge of failure

- Mobilisation of nursing team to work jointly with CCC social work teams

CQC

- Joint meetings with Council
- Establish and communicate de-registering position
- Ensure compliance notices are in place and implemented

7) Examples of failure and actions

The following section details the high level actions and decisions that will need to be taken should market failure occur. These scenarios are detailed as: -

Provider Type	Key Factors	Risk Management Process
Care Home	Building closed down	Approach 1
Housing with care	Building still available	Approach 1
Home Support	Branch closed immediately	Approach 2
Day Centre	Building closed down	Approach 1

Approach 1

Issues	Options	Key Involvement / Factors
Accommodation	Source alternative accommodation	- Building availability within CCC and private market - Cost of building (rent / charges etc) - Suitability of building and adaptations needed - Where no capacity exists an option to use cross border accommodation
	Use existing building	- Suitability of building and adaptations needed - Arrangements with current landlord (this may be a creditor) - Risk assessments to be undertaken (CCC Health and Safety to be mobilised)
	Re-provide service in another building (e.g. HWC or another vacant care home)	- Building availability within CCC and private market - Source increased staffing levels - Health input mobilised - Suitability of building and adaptations needed - Change of tenure / tenancy arrangements – cost implications and

		arrangements to be formalised
Staff	CCC / CCG TUPE staff	- Policies and processes to be implemented swiftly - Council / CCG terms and conditions – do they become permanent statutory services employees with same conditions? -
	A new provider takes over the staffing	- Agreement of which provider takes over and agreed mobilisation period - Which terms and conditions and policies and procedures are used? Existing or new providers? - The need to line up providers within procurement processes for this type of scenario -
	Enhanced rates for new provider	- Short term enhanced rates for new provider - Agreed cost split between CCC and CRCCG
Clients	Reviews	- Social Care reviews on all residents including private clients where needed - Options appraisal / risk assessments - Advocates / IMCA arrangements in place
	Health and well-being checks	- CCG / CSU health reviews on all residents

Approach 2

Issues	Options	Key Involvement / Factors
Staff	CCC / CCG TUPE staff	- Policies and processes to be implemented swiftly - Council / CCG terms and conditions – do they become permanent statutory services employees with same conditions?
	A new provider takes over the staffing	- Agreement of which provider takes over and agreed mobilisation period - Which terms and conditions and policies and procedures are used? Existing or new providers? - Integrate calls within new providers existing staff group - The need to line up providers within procurement processes for this type of scenario
	Enhanced rates for new provider	- Short term enhanced rates for new provider - Agreed cost split between CCC and CRCCG (where joint packages exist)
Clients	Reviews	- Social Care reviews on all residents including private clients where needed - Options appraisal / risk assessments - Advocates / IMCA arrangements in place
	Health and well-being checks	- CCG / CSU health reviews on all residents

Holistic actions across all approaches

Clear communications strategy – consistent across stakeholders, clients and families. To involve: -

a) Letters to clients and families
b) Meetings with clients and families
c) Cabinet Member briefing
d) Local media press release / plan for press release
e) Provider engagement throughout
f) Shared information across neighbouring authorities

Safeguarding / Large Scale Investigation protocols instigated. To involve: -

a) Information gathering of users needs
b) Mobilisation of CCC / CRCCG / CSU operational teams and / or nursing / therapist staff
c) Current provider engagement
d) Contract and commissioning site visits (daily)

Planned pro-active work

Market analysis

The Council and CCG are aware of and have up to date information regarding market capacity across all sectors within Coventry. In addition to this information regarding capacity in Warwickshire is readily available and up to date.

Market engagement to support major events

A focussed engagement exercise has taken place with a selection of key providers in the City from which the Council has developed a framework of providers (across all sectors) who have committed to mobilise support at short notice should the need arise.

Market programme to instigate

The following section details the key actions from the above scenarios and the options / procurement methods to ensure that Coventry has a sustainable market able to deliver quickly when / if a provider fails.

Area / Issue	Key Project to initiate	Timescale
Care Home contingency	Care Home procurement	November 2016
Home support contingency	Home support procurement	July 2016
Housing with care contingency	ABCS programme / new developments (Village / Tile Hill)	End of 2016 for Village and Tile Hill project
Day Centre contingency	Internal provision / contracted provision	Capacity exists within existing provision
Advocacy support (general)	New pilot project with Age UK / Grapevine	Part of current contractual arrangements
IMCA / IMHA / Dols support	Within existing contracts	Part of current contractual arrangements

Sign off of process

CCC

- Market Management
- Cabinet Member
- Care Act Implementation Board
- Joint Adult Commissioning Board

CRCCG

- CDG
- Joint Adult Commissioning Board

Appendices

1) **Risk Based Approach to Quality and market analysis**
2) **Regionally developed risk tool to identify step by step approach**

1) Joint Quality Assurance and Risk Based Approaches

The City Council quality assurance processes deliver a transparent monitoring process across contracted providers within Coventry. Key areas within this process focus on the quality of in addition to environmental / accommodation standards.

The quality assurance approach is working towards a model which has the fundamental principle of a risk based approach where providers are targeted by the Council to manage risk within the market. This approach is a significant change from a uniform approach to quality monitoring and allows a degree of flexibility within the team to react accordingly where providers are presenting, or are on the verge of, sub-standard levels of quality.

It is intended that key data sets and intelligence will inform this risk based approach. These include, but are not limited to: -

- Provider capacity / size / type and City Council / CCG spend
- Number of complex clients / spend across CCC and CCG
- Provider history through officer intelligence e.g. previously on placement stops / on-going issues and concerns (including formal complaints)
- Numbers and severity of safeguarding incidents
- Approach and evidence around pressure ulcer management
- CQC rating
- Stakeholder views and evidence (e.g. District Nurses / Social Workers / CSU staff / Families)

The factors considered vary across service types (i.e. different factors for a care home as opposed to a home support provider – a home support provider may be judged on number of high cost packages / high hours linked to staff workforce and skills).

Each area / domain has been rated in terms of significance and an overall rating given to each provider. This will form the basis of contract monitoring / management work / visits.

This approach also allows for a focussed approach on specific areas. For example, the ability to target those providers with holisitic spend/ income of over £1 million per annum.

By using this approach, it is envisaged that the Council will be able to reduce the volume of scheduled monitoring visits whilst focussing resources to specific providers / areas.

Links to key groups

A monthly report of quality assurance is presented to Market Management Group which will outline the work within the team on specific providers which highlights providers presenting significant risks.

In addition to this, officers will present an analysis of the whole care market with recommendations around those areas / providers which present new risks and will be targeted within the next month.

The Risk Based Approach, both the concept and workplan, has been presented to Quality and Audit Sub-Group of Adult Safeguarding Board

Key points of approach

- Supports the Care Act changes in particular the identification of provider failure and the early identification of emerging issues within the market
- Approach focusses on pro-active work to manage market risk

- Emphasis on this approach being a Coventry City Council led process. Senior Management – through Market Management – will determine the influence factors and set programme of monitoring
- The tool is only the indicator for information – key to the process being a success are officers challenging views and data to identify risk areas
- The process is a fluid methodology. It is dependent on data / information being updated on a monthly basis – this will be built into a role within commissioning
- Enables a joint approach across CCC and CRCCG with stronger data sharing protocols and data analysis to identify risks

Summary of risks and how this translates to action

Low Risk

- A single annual check and a verification visit
- Service user feedback / questionnaire

Medium Risk

- A site visit by commissioning immediately
- A health visit immediately
- A focussed user feedback / engagement exercise with users and / or carers
- Notification to CQC for information
- Discussion at PEP
- Quarterly visits planned in from that point of identification and follow ups as necessary
- Instigation of action plan and ICP / Health and Safety and Medicines Management review as appropriate
- A meeting with the owner to go through all key points identified in the tool

High Risk

- A site visit by commissioning immediately

- A meeting with the owner to go through all key points identified in the tool
- Weekly visits by commissioning
- Gathering of more detailed information from stakeholders i.e. health information / hospital admissions
- Potential reviews of residents by social care / health
  Consideration of Large Scale Investigation process with all parties

2) Regionally developed risk tool to identify step by step approach

PROVIDER FAILURE CHECKLIST						**Appendix B**
Area		**√ or x**	-	**Date Planned**	**Progress**	**Date Completed**
Communications					Establish legal status and full details/intentions of existing provider/Administrator/Receiver.	
					Check that the actions of other local authorities affected by the failure do not affect our plan.	
					Establish urgent dialogue with potential alternative provider(s).	
					Set up a Communications/Project Group with relevant representatives.	
					Secure permission to make urgent payments (if not already covered).	
					Confirm the full contact details for new/alternative provider.	

					Telephone call to our customers using predefined script by appropriately briefed workers.	
					Telephone call to private customers using predefined script by appropriately briefed workers.	
					Letter to our customers to confirm new provider and transfer arrangements.	
					Letter to private customers to confirm new provider and transfer arrangements.	
					Telephone call to existing staff.	
					Approach In-house services (e.g. Re-ablement) to allocate capacity and other external providers.	
					Inform new providers re In-house and external cover providers' contact details.	
					Communication to members/unions/Health/CQC.	
					Communication to internal teams and other relevant managers.	
					Staff consultations/measure letters for new provider.	
					Change resource/service directory to show new provider details.	

Provider					Administrators to confirm if existing office can continue to be used/rented etc.	
					Address use of ICT systems e.g. continued temporary use and access issues.	
					Payment of staff through the Administrator or the provider (new or old).	
Management					Issue letters of Intent to new provider.	
					Sign actions letter from Administrator and return.	
					Issue contract to new provider (and subsequently chase).	
					Issue service Proposals to new provider.	
					Update client record system for all customers.	
					Ensure new provider set up on finance systems.	
					Ensure team administration and finance officers made aware of changes.	
					Inform CQC re registration change and ensure provider complies.	
					Check and implement if required the need to underwrite risk of staff challenge by staff on T&C's.	

					Ensure new provider entered on Contracts Register system.	
Data					Confirm to existing provider that the Council is acting as intermediary for data exchange.	
					Transfer of customer information to new provider.	
					Transfer of staff information to new provider.	
					Check and implement any retention of information needed by the Council.	
Finance					Compile a list of all outstanding invoices.	
					Compile details of any counter charges.	
					Audit Administrator's accounts i.e. what paid against what they require - seek unused amounts.	
Legal					Prepare defence against factoring company as required.	
Market shaping					Discussion with other providers re building capacity/viability in the affected area.	
Review					Arrange for process from lessons learnt/pre-planning for future.	

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