Coventry City Council

Agenda

Health and Social Care Scrutiny Board (5)

Time and Date
2.00 pm on Wednesday, 9th September, 2015

Place
Committee Rooms 2 and 3 - Council House

Public Business

1. **Apologies and Substitutions**

2. **Declarations of Interest**

3. **Minutes** (Pages 3 - 6)

   (a) To agree the minutes of the meeting held on 1st July, 2015

   (b) Matters Arising

4. **Serious Incident Review - Miss G** (Pages 7 - 18)

   Report of the Executive Director of People

   David Smithson, West Midlands Fire Service Station Commander, Chair of the Review Board and Jane Lawson, Independent Author of the Review Report have been invited to the meeting for the consideration of this item.

   The following have also been invited for this issue and for item 5 below:

   Joan Beck, Chair, Coventry Safeguarding Adults Board
   Representatives of:
   University Hospitals Coventry and Warwickshire
   Coventry and Warwickshire Partnership Trust
   Coventry and Rugby Clinical Commissioning Group

5. **System Wide Review - Mrs F** (Pages 19 - 44)

   Report of the Executive Director of People

   Simon Brake, Director of Primary Care Sustainability and Integration, Coventry Council, Chair of the Review Board and Laurence Tennant, Independent Author of the Review Report have been invited to the meeting for the consideration of this item.

6. **Outstanding Issues Report**

Outstanding issues have been picked up in the Work Programme

7. **Work Programme 2015-16** (Pages 45 - 52)

Report of the Scrutiny Co-ordinator

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

Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

Private Business

Nil

Chris West, Executive Director, Resources, Council House Coventry

Tuesday, 1 September 2015

Notes: 1) The person to contact about the agenda and documents for this meeting is Liz Knight, Governance Services, Council House, Coventry, telephone 7683 3073, alternatively information about this meeting can be obtained from the following web link: http://moderngov.coventry.gov.uk

2) Council Members who are not able to attend the meeting should notify Liz Knight as soon as possible and no later than 1.00 p.m. on 9th September, 2015 giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.

3) Scrutiny Board Members who have an interest in any report to this meeting, but who are not Members of this Scrutiny Board, have been invited to notify the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors M Ali, K Caan (By Invitation), J Clifford (By Invitation), D Galliers, J Innes, T Khan, J O'Boyle, D Skinner, D Spurgeon, K Taylor, S Walsh and D Welsh (Chair)

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 Health and Social Care Scrutiny Board (5) held at 2.00 pm on Wednesday, 1 July 2015

Present:

Members: Councillor D Welsh (Chair)
Councillor M Ali
Councillor D Galliers
Councillor J Innes
Councillor H Noonan
Councillor J O'Boyle
Councillor D Skinner

Co-Opted Member: David Spurgeon

Other Members: Councillors J Clifford and A Gingell

Employees (by Directorate)

V Castree, Resources Directorate
J Forde, Chief Executive's Directorate
M Godfrey, People Directorate
L Knight, Resources Directorate
J Moore, Chief Executive's Directorate
T Richardson, Chief Executives Directorate
H Shankster, Chief Executive's Directorate
L Welton, Resources Directorate
R Young, Place Directorate

Apologies: Councillor K Taylor

Public Business

8. **Declarations of Interest**

There were no disclosable pecuniary interests declared.

9. **Minutes**

The minutes of the meeting held on 22nd April, 2015 were signed as a true record. There were no matters arising.

10. **Reducing Health Inequalities in Coventry**

The Scrutiny Board received a presentation and considered a report of the Director of Public Services which provided an overview of how the Public Health Department was working in partnership with colleagues across the City Council to reduce health inequalities in Coventry. Councillor Gingell, Chair of the Health and Well-being Board and Councillor Clifford, Deputy Cabinet Member for Health and

Adult Services attended the meeting for the consideration of this item. Officers from the Council Directorates also attended to report on individual projects.

The report provided information about the impact of health inequalities; the way Public Health had worked to reduce health inequalities; the projects and initiatives that aimed to make a difference and the outcomes of those initiatives to date; and the proposed next steps for reducing health inequalities over the next three years.

The presentation referred to the different life expectancies in different areas of the city using the number 10 bus route. Reference was made to Coventry's role as a Marmot City and to the successful Marmot City Conference held in Coventry on 26th March, 2015. Professor Sir Michael Marmot was now holding up the city as an example of best practice for adopting Marmot principles when speaking at international events. Coventry had been chosen to continue on the Marmot programme for a further three years.

The Board were informed about a number of projects whereby Public Health worked with other Council Directorates to reduce health inequalities across the city. These included The Acting Early programme which involved integrated teams operating in six priority areas to give disadvantaged and vulnerable children the best start in life and a readiness for school; The Pod, a social brokerage for people with longstanding mental health issues to support them to take control of their own lives and to identify what would help them to live healthy and fulfilled lives; and placing a mental health worker in the Council's Job Shop for a six month period to help existing staff extend their knowledge and develop skills to help those with mental health difficulties to find suitable work. Other projects included Cycle Coventry which aimed to reduce health inequalities by improving facilities for cyclists and pedestrians and over 1,100 children had accessed cycle training and bike maintenance sessions and the implementation of the Social Value Policy which enabled the Council to ensure that services across the city were improving the economic, social and environmental well-being of the city.

The proposed next steps for reducing health inequalities over the next three years included the partnership work with the Marmot Team; the development of a Marmot Strategy alongside the development of the Health and Well-being Strategy; a focus on 'good growth' and the continued partnership working across the Council and other agencies.

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

- Further details about the life expectancy figures for the city including healthy life expectancy and ill-health and a request for detailed information relating to areas such as ethnicity and disability
- How successful was information sharing following the introduction of the information sharing agreement between partners working in the Acting Early programme
- The funding implications for the Acting Early programme
- Working with GPs to encourage early prevention and diagnosis
- The work to change lifestyles in relation to smoking and obesity and the importance of health checks for the over 40s
- The importance of healthy foods and the healthy eating initiatives

- The support given to schools and to individual families
- The marketing of the Cycle Coventry programme
- The work of the Community Development Team, with particular reference to engagement with communities including the hard to reach and working in the deprived areas
- The importance of people being in a safe and well cared for environment with residents taking pride in their area
- Further details about the number of citizens suffering with dementia
- The work with the local universities to reduce the number of people in the city with sexually transmitted infections.

It was agreed that further data about health outcomes for the city would be submitted to the Health and Well-being Board prior to being circulated to all members of the Council.

RESOLVED that:

(1) The suggested approach for continuing to reduce health inequalities in Coventry be endorsed.

(2) A specific Health Inequalities question be included in the Cabinet/Cabinet Member report template to measure how Marmot aims will impact on any decisions being made.

(3) The Communities and Neighbourhoods Scrutiny Board (4) be requested to consider how the Community Development Team works in the neighbourhoods, with particular reference to the hard to reach and disadvantaged communities and individuals, and how support is offered to the most vulnerable.

(4) The Cabinet Member for Health and Adult Services be requested to explore further budget sharing opportunities in relation to health inequalities.

(5) The Cabinet Member for Business, Enterprise and Employment be requested to continue on-going discussions to explore opportunities to continue funding TESS in the Job Shop.

(6) A progress report be submitted to a future meeting of the Board in six months on the work undertaken by Public Health to reduce health inequalities, with particular reference to the environmental aspect.

(7) A briefing note be circulated to all members informing of the marketing for Cycle Coventry, with particular reference to what is happening in the deprived communities.

11. **Outstanding Issues Report**

The Scrutiny Board noted that all outstanding issues had been included in the Work Programme for 2015-16.

12. **Work Programme 2015-16**

The Scrutiny Board considered their Work Programme for the new municipal year.

RESOLVED that an item on dentistry and out of hours care be included in the Work Programme.

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

There were no additional items of public business.

(Meeting closed at 3.45 pm)

Coventry City Council

Briefing note

To: Health & Social Care Scrutiny Board (5)

Subject: Serious Incident Review *(CSAB/SIR/1)*

1 Purpose of the Note

1.1 The attached report presents the findings of a Coventry Safeguarding Adults Board System Wide Review and the associated action plan with learning from the case.

2 Recommendation

2.1 Health & Social Care Scrutiny Board (Scrutiny Board 5) is asked to note and consider the contents of the report, and make any recommendations considered appropriate to the Coventry Safeguarding Adults Board & the Cabinet Member (Health and Adult Services)

3 Information/Background

3.1 This report presents the findings of a Coventry Safeguarding Adults Board Serious Incident Review.

3.2 The review was commissioned following the death of Miss G. Miss G died in a fire in her home.

3.3 A serious incident review was undertaken to learn lessons arising from the case.

3.4 The reports will progress to the Cabinet Member (Health and Adult Services) and the Coventry Safeguarding Adults Board will monitor delivery of the action plans.

Cat Parker
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Coventry Safeguarding Adults' Board Serious Incident Review
Executive Summary in respect of Miss G, died 2013 (CSAB/SIR/1)

The purpose of the Serious Incident Review

A serious incident review (SIR) takes place because an adult has died or has been seriously injured or impaired and abuse or neglect is known or suspected to be a factor.

The process is about learning lessons, not about apportioning blame (Care Act 2014)

Background

Miss G was 40 years old when she died. She was part of a loving and supportive family. During the time under analysis for this review, Miss G was supported extensively by her mother and her brother, and was herself a mother to two girls aged 17 and 18 years. Miss G had regular contact with her daughters, they had lived with her mother from a very early age, her mother lived with her stepfather. Miss G's birth father lives in Portugal, and she maintained contact with him.

Miss G developed a long term degenerative neurological disease after the birth of her eldest daughter, 18 years previously, this progressively inhibited her ability to mobilise, cognition, memory function and her behaviour. This condition is also life limiting. The physical effects of the condition also gave rise to problems which meant that Miss G was confined to a wheelchair for most of the time in the period under review.

Miss G enjoyed smoking, and declined to stop as advised by her GP. She managed to reduce her smoking to 7 cigarettes a day. She also experienced significant weight gain to over 20 stone; this resulted in her requiring specialist equipment to support her specific needs. Advice and support on her diet was at times successful in enabling Miss G to lose weight.

Prior to moving into independent accommodation in March 2006, Miss G lived in a specialist residential a care home for younger people with complex needs for a period of 2 years. Miss G moved to a bungalow 2006 where she received 22 hours support a day, which was funded by adult social care. This included periods during the day when the support was doubled to facilitate the use of equipment that required two people to operate it. Miss G was able to go out with support from her carers or family and was compliant and readily agreed with most things. Miss G was very trusting of people, which made her vulnerable. Her speech deteriorated making communication difficult and her hand to mouth coordination was poor affecting her manual dexterity and ability which was frustrating for her and put her at risk, especially from fire, during the 2 hour unsupervised period when she was smoking.

In 2010 her step father developed dementia and her brother took more responsibility for her care, this arrangement lasted until 2012 when her stepfather went into residential care, which allowed her mother to resume caring for her.

Miss G liked the carers being in her home, and did not appear have a problem with someone being there all the time. This was a positive for her, and continuity of care

staff got better as time went on and was important. She and her family, acknowledged the special relationship she had developed with one of her male carers, who was recognised by them all "as going the extra mile".

Her mother said that Miss G did not want to go into a home, as she valued her independence. This was reinforced by Miss G's social worker who agreed that she wanted to be as independent as possible and to continue to make her own choices.

A summary of facts and findings of the case

In March 2006, when Miss G moved out of the care home, the care plan developed by Coventry City Council (CCC), adult social care set out an overall aim to: "enable Miss G to live independently in her own home with an emphasis on developing her current independent living skills further". Miss G was keen to live independently whereas her mother had reservations. Despite ambitious aims and objectives, there is no record of substantial input from her carers in terms of proactive measures in motivating and enhancing her independence. The need to motivate Miss G was identified as a key consideration, therefore, its absence in the records is noteworthy.

A psychology report in 2007 included important insights, which should have been shared across all agencies involved with Miss G's care, and should have precipitated a thorough multi-agency review. The report stated:-

"Across all measures assessed, all appear to have deteriorated to a very significant degree, to the extent that I am concerned that Miss G may require additional support in making everyday decisions and has apparently little insight into her difficulties."

The aim of the care plan remained largely unchanged despite these insights.

Alongside this her mother repeatedly raised concerns about the sustainability of the care plan, and indicated that her own situation meant that she could not sustain the level of demand on her from Miss G. She expressed concerns at a significant number of points that carers were not adhering to the care plan. Reviews did not take place in a timely way when these genuine concerns were raised.

In 2008, despite reservations, her mother agreed to be an agent for the Direct Payment on behalf of Miss G. She was assured of support from Penderels Trust. It seems that her mother had little understanding of the Direct Payments process and the potential that this offered to provide care in a flexible and creative way.

There were recurrent concerns and issues raised by Miss G's mother and brother relating to care provision, risk assessment and record keeping. In 2010, Miss G's mother continued to ask for a change of care agency. The issues and options were not robustly addressed and Miss G's mother and Miss G decided to continue with the existing care agency. At no point was there any creative discussion about how things could be done differently.

During this period there were three safeguarding referrals all relating to concerns expressed about care/carers. These were not adequately addressed, nor progress on actions adequately reviewed or acted on.

When a decision was made in 2011 to withdraw the Health component of funding to Miss G there was insufficient attention given as to whether the existing package of

care needed to continue irrespective of the funding provider. An assessment of need and risk should have followed and a separate multiagency decision agreement developed to address any service gaps. There was an absence of any clear documented risk assessment around the decision that Miss G could, and would, be left alone for a 2 hour period. It was clear that Miss G was deteriorating and was still smoking. Despite this the information and implications were not amalgamated into one holistic assessment in order to assess the advisability of leaving Miss G unsupervised for a 2 hour period.

Risk relating to fire associated with her smoking while unsupervised was not sufficiently explored in the assessments or care plan, despite acknowledgement of Miss G's lack of awareness of hazards coupled with knowledge of her smoking habit and her difficulties in coordination and dropping items.

Analysis
The analysis within this review of the above circumstances that preceded Miss G's death is focussed on the following key themes:

- Practice in relation to assessment, care planning, reviews and decision making
- Working with risk
- Risk of fire
- Person centred outcomes, focussed practice and working with carers
- Recording
- Considerations in respect of the Mental Capacity Act
- Key policy frameworks central to the case of Miss G
    - Continuing NHS Healthcare Assessment
    - Direct Payments
    - Safeguarding Adults

Conclusions
In respect of the areas detailed in the analysis, conclusions were drawn and form the basis of a commitment to action across organisations in Coventry, to learn lessons and aims to prevent such a situation occurring in the future.

Alongside this there needs to be clear guidance and awareness raising around the responsibilities associated with identifying those most at risk from fire and the need for professional agencies to refer these individuals to West Midlands Fire Service (WMFS), and to work with them to develop appropriate safety plans.

Analysis of practice in safeguarding adults from abuse and neglect provided evidence of failure to work in line with local policy. In particular safeguarding investigations were not always sufficiently comprehensive in addressing relevant concerns nor was the monitoring of the agreed actions sustained. There are a number of indications that prevention of abuse/neglect is an area that needs to be strengthened.

In the context of the assessment for NHS continuing healthcare and the decision making and practice regarding the integrated package of care there was a need for interagency working and information sharing, care planning, risk assessment to be included in the records. The need for greater understanding of the roles,

responsibilities and accountabilities across health and social care in terms of assessment of on going need and joint decision making was also identified as an issue. Had these factors been acknowledged, alternative decision relating to the Continuing Health Care funding may have been agreed. There were questions too about the extent of Miss G's (and her family's) understanding of, and involvement in, these decisions as well as the failure to include front line carers in the process of gathering relevant information. Since the Continuing Health Care assessments in the case of Miss G took place, policies and procedures in respect of lead commissioner arrangements have been reviewed and strengthened to ensure that they are more robust. The principles at the heart of Direct Payments (which are about creativity and choice and meeting outcomes) seem far removed from the experience of Miss G and her family who had no real understanding of Direct Payments. Miss G's mother was not empowered by the offer of a Direct Payment. The respective responsibilities of social work/care management and the Direct Payment support provider were not understood/not interpreted effectively in practice for Miss G. The guidance is clear that reviews of Direct Payments arrangements must address whether needs are being met and whether they have changed. Implicit in this are considerations of risk. The Care Act, 2014 states:-
"the Direct Payment review is not intended to be a full review of the person's care and support plan. However, if this review raises concerns or requires actions that affect the detail recorded in the care plan, then a full review of the plan would need to be carried out".
A shared understanding across organisations and members of the public as to what can be expected of whom when a person is in receipt of a Direct Payment needs to be an integral part of the decision to use this form of funding support.

Irrespective of the mechanism by which services are purchased, all interventions must be outcomes focussed and outcomes must be robustly reviewed. The current national context and an apparent clear direction and commitment locally towards an outcomes approach will support improvement in this respect There are also indications within the review that there is a need to support practitioners in their practice in the context of the core principles of the Mental Capacity Act, 2005 and in particular in supported decision making (principle 2 of this Act).

The significant care and affection of Miss G's mother for her daughter was apparent. She supported Miss G extensively and advocated tirelessly on her behalf. The degree to which support of Miss G's mother was effective indicates a further area for practice improvement in the context of the Coventry Carer Strategy.

Miss G died in a fire which was intense and took hold rapidly, the likely cause of the fire is from a dropped cigarette or cigarette ignition source. Her lack of mobility significantly affected her ability to react to or escape from the fire. If the fire had been discovered at an early stage, the presence of a carer would have increased the likelihood that the fire could have been dealt with in its infancy and/or the carer could have supported Miss G to escape the fire, however, it cannot be concluded that the absence of a carer or the practice issues highlighted were responsible for Miss G's death. Practitioner understanding of how behaviours and conditions such as smoking alongside limited mobility increases the individuals vulnerability from fire needs to be recognised as a priority area for training.

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. Embracing this locally will support the necessary improvements.

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

What Happens Next?

The specific actions within the plan aim to change the way organisations work together, and separately, so that similar circumstances experienced by Miss G do not happen again. The action plans will be reviewed regularly by the Coventry Safeguarding Adults Board, in accordance with their local procedures.

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Serious Incident Review Action Plan Miss G

Ref	Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
		Indicate the actions or series of actions to be taken to achieve the desired outcomes. These must be: Specific, Measurable Achievable Realistic and Timed			*Please provide evidence of progress*	*What improvements do you expect to achieve from the actions you have identified?*	*Blue, Red, Amber, Green (see below)*
1	Service commissioning contracts across all partner agencies including the private sector, must be compliant with the West Midlands Fire Service (WMFS) specification standards	WMFS will work with all the commissioning agencies, including the private sector commissioners, to ensure that they are sufficiently briefed in terms of the practice standards required within contract to enable agency compliance across Coventry. Commissioning contracts across all partner agencies including private sector partners, are developed to be compliant with WMFS standard practice requirements	Sept 2015 - March 31st 2016 March 31st 2016	Head of Community Safety/Area Commander Ops Intelligence & training NB - all individual agencies are accountable for the delivery of their local plan		All the partner agency commissioning contracts meet the WMFS Standards.	
2.	Basic Fire Safety Risk assessments must be included in all Health (acute and community providers) and social care risk assessment tools	WMFS will work with Coventry Health and Social care teams to develop basic fire safety risk assessment tools All health and social care assessment tools will be amended/updated to include basic fire safety risk assessments, alongside the health risks associated with smoking.	Sept 2015 – Nov 2015 January 2016	Jill Ayres – Chair of Policy & Procedures		All Health and Social Care agencies assessment tools include a basic fire safety risk assessment, alongside the standard heath awareness risks associated with smoking	

Blue – completed, Red – not achieved and seriously behind schedule; Amber – not achieved and slightly behind schedule; Green – on track to be achieved within the timescale

Serious Incident Review Action Plan Miss G

Ref	Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
		Indicate the actions or series of actions to be taken to achieve the desired outcomes. These must be: Specific, Measurable Achievable Realistic and Timed			*Please provide evidence of progress*	*What improvements do you expect to achieve from the actions you have identified?*	*Blue, Red, Amber, Green (see below)*
3	Fire Health and Safety Interventions are included as standard within all care support packages for vulnerable people who are living independently	WMFS will ensure that all agencies have the relevant Fire Health and Safety training materials to support the delivery of local training to the standard required. All agencies training must include the fire health and safety interventions that staff must consider as part of the support package for a vulnerable adult in order to keep them safe when living independently.	Sept 2015 – Nov 2015 January 2016 On going	Head of Community Safety/Area Commander Ops Intelligence & training Workforce development leads from all partner agencies		All agency staff will have access to training which includes the fire health interventions to support them with the development of care packages which will keep vulnerable adults safe when they wish to live independently.	
4	Safeguarding policies across all agencies need to include triggers for notifying partners where there is a pattern of behaviour or clinical deterioration , which may indicate an increased risk in the individual's vulnerability	Safeguarding policies are updated to include the triggers which will generate a notification of the change in circumstances to the partner agencies All agencies will include this in their safeguarding mandatory training programmes	Dec 2015 Dec 2015 ongoing	Business Manager to Safeguarding Board Service leads in Health and Social Care		Safety risks relating to vulnerable adults are responded to, in a timely way, by all partner agencies	
5	Person Centred outcomes are embedded in practice, and in practice guidance, ensuring that practitioners can engage effectively with service users and carers	Multi Agency training includes the principles underpinning the delivery of person centred care as a core component All agencies will update their local practice guidance to include the principles of person centred	On going Nov 2015	Workforce development leads from all partner agencies Service leads in Health and		All agencies can demonstrate that service users and carers are receiving person centred care as mutually agreed within their care plans	

Blue – completed, Red – not achieved and seriously behind schedule; Amber – not achieved and slightly behind schedule; Green – on track to be achieved within the timescale

Serious Incident Review Action Plan Miss G

Ref	Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
		Indicate the actions or series of actions to be taken to achieve the desired outcomes. These must be: Specific, Measurable Achievable Realistic and Timed			*Please provide evidence of progress*	*What improvements do you expect to achieve from the actions you have identified?*	*Blue, Red, Amber, Green (see below)*
		outcomes in care The multi agency audit programme will include the evaluation of service user and carer satisfaction in relation to the person centred outcomes agreed in their care plans.	Dec 2015	Social Care Isabel Merrifield Chair of Quality & Performance sub group			
6	Safeguarding Adult procedures are consistently compliant with the national practice standards (Care Act 2015)	The multi agency audit programme will include the compliance monitoring of local safeguarding adult procedure in practice against the National standards (Care Act 2105)	Dec 2015	Isabel Merrifield chair of Quality and Performance sub group		Safeguarding adult procedures will be consistently compliant with national practice standards.	

Blue – completed, Red – not achieved and seriously behind schedule; Amber – not achieved and slightly behind schedule; Green – on track to be achieved within the timescale

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Coventry City Council

Briefing note

To: Health & Social Care Scrutiny Board (5)

Subject: *System Wide Review (CSAB/SWR/2015/1)*

1 Purpose of the Note

1.1 The attached report presents the findings of a Coventry Safeguarding Adults Board System Wide Review and the associated action plans, for both the system wide review and the learning from the case.

2 Recommendation

2.1 Health & Social Care Scrutiny Board (Scrutiny Board 5) is asked to note and consider the contents of the report, and make any recommendations considered appropriate to the Coventry Safeguarding Adults Board & the Cabinet Member (Health and Adult Services)

3 Information/Background

3.1 This report presents the findings of a Coventry Safeguarding Adults Board System Wide Review (SWR).

3.2 The review was commissioned following the death of Mrs F, in Spring 2013. Mrs F died at age 80 and had been residing in a Coventry Nursing Home. Mrs F had received treatment in hospital in relation to pressure ulcers, and soon after a discharge from hospital she died.

3.3 Due to the nature of concerns a SWR was commissioned to ensure that learning from the case of Mrs F, and wider learning related to placement decisions and monitoring of Nursing and Residential Care Homes.

3.4 The reports will progress to the Cabinet Member (Health and Adult Services) and the Coventry Safeguarding Adults Board will monitor delivery of the action plans.

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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. She had 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 two brief periods 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, vascular ulcers were identified on her legs which ultimately required a period of assessment and treatment in hospital. Whilst in hospital it was agreed that surgical intervention should not be pursued because of the significant risk that she would not survive it and that therefore she should continue to receive treatment for the symptoms she was experiencing, rather than for the underlying clinical cause. 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. The referral was made by 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 concerned 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) was 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. This was especially the case when quality assurance visits from local agencies in response to locally identified concerns reached 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 deteriorated. The Panel concluded that there were elements of the services that could and should 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 review also 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 some that apply specifically to individual agencies. The recommendations below summarise the actions that are needed to reduce the likelihood of the failures similar to those identified in Mrs F's care and in the management and regulation of organisations providing that care 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 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 the Nursing Home reviewed 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 Panel (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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Action Plan System Wide Review – (Mrs F)

Indicate the actions or series of actions to be taken to achieve the desired outcomes. These must be: **S**pecific, **M**easurable **A**chievable **R**ealistic **T**imed
RAG ratings - Red, Not achieved and seriously behind schedule, **Amber** not achieved and slightly behind target, **Green** on track to be achieved within timescale

Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
Coventry & Warwickshire Partnership NHS Trust should:								
1	Audit their new process for referrals to their Mental Health Services to ensure that they are clear and effective and overcome the previous weaknesses identified by the SWR review	Overview report **(7.1.1)**	Single Point of Entry (SPOE) to develop an audit tool and to carry out an audit to ensure that the referral process is clear and effective	Dec 2015	Manager SPOE	Meeting to be arranged with SPOE – Email sent on 10.03.15 and reminder 07.05.2015 *Meeting to be planned for June 2015.* audit tool being produced and will then be implemented in line with Trust Audit processes. Assurance has been provided from the Central Booking Services that they have robust admin processes for referrals in place (each being time, date stamped / recorded phone calls / all refs scanned into system at point of receipt so cannot be lost) The creation and	That all referrals for mental health services are effectively processed	Green

Action Plan System Wide Review – (Mrs F)

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
						registration of audit is slightly behind schedule but is expected to be archived by 31st Dec as planned		
2		IMR	To add to the Safeguarding level 2 training the need to confirm diagnosis relating to mental health and dementia		To add to the Safeguarding level 2 training the need to confirm diagnosis relating to mental health and dementia	Slide entered into training package 08.04.2015	Slide to be entered into training package	Green Completed
3		IMR	To review training regarding leg ulcer / pressure ulcer and referral information	Dec 2014	Tissue Viability Service (TVS)	Training has been reviewed by TVS April 2015	For there to be effective training to identified staff re training package leg ulcer/pressure ulcer and referral information	Green Completed

Action Plan System Wide Review – (Mrs F)

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
4	Ensure that the purpose and outcome of Community Psychiatric Nurse (CPN) contacts with clients is properly recorded.	Overview Report **(7.1.2)**	To ensure all staff are aware of the implications of thorough recording in notes. Continue to routinely audit health records /documentation	Oct 2015	Coventry & Warwickshire Partnership Trust (CWPT) Safeguarding team and Safety & Quality / Audit	Continual and implemented Audit forward programme in place Reviewed annually by clinical audit and effectiveness committee Included in Training material	Improvement in recording of client contacts On going / routine practice	Green
			Safeguarding training has been reviewed to reiterate the need to clearly record contact with clients.		CWPT Safeguarding Team			Green completed
			CWPT Safeguarding newsletter to highlight the need for clear recording.		CWPT Safeguarding Team	Safeguarding newsletter to be finalised by end of 2015		Green

Action Plan System Wide Review – (Mrs F)

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
5	Coventry & Warwickshire Partnership NHS Trust should review their new arrangements for referral to the Tissue Viability Services to ensure that they are now clear and effective.	Overview Report **(7.4.1)**	Review and dissemination of information regarding the process of referral	March 2015	Tissue Viability service lead	Review of referrals to tissue viability have taken place, and recorded via CWPT minutes Letter of confirmation dated 10.03.2015 from Tissue Viability Nurse (TVN).	Clear and effective process in place	Green completed
Coventry Safeguarding Adults Board should:								
6	All partners should ensure through their training programmes that staff are aware that the Safeguarding procedure should be re-engaged in circumstances where concerns re-emerge and that decisions to close Safeguarding procedures are properly recorded	Overview Report **(7.2.1)**	Coventry City Council Email sent out to remind all staff involved in safeguarding of these issues.	Sent 30.4.2015	Jill Ayres			Green Completed
			To be incorporated in new training programme for 15-16	March 2016 .	Liz Kiernan	This is being discussed in the Workforce development sub Group 22.07.15 and is on going	Better understanding of procedures relating to the recording of concerns and outcomes	Amber

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
			To be included in lessons learned from SCRs training	Oct 2015	Margaret Greer	Event planning in progress	To reiterate the lessons learnt.	Green
7	Ensure that local guidance and training for staff is updated and disseminated as soon as (further) national guidance is available on capacity and self-neglect	Overview Report **(7.7.1)**	Completion of Care Act compliant West Midlands Policy and Procedures which includes the new abuse category of self-neglect.	West Midlands Policy and Procedures in place on 1.4.2015	Jill Ayres	Policy and procedures on City Council web site		Green Completed
			Further more detailed regional guidance on self-neglect.	Sept 2015	Jill Ayres	Regional Self-neglect guidance being written. 1st draft completed 21.04.15 2nd draft circulated 01.07.15 CSAB Executive Committee 23.7.2015 and Board in September	Clear guidance for staff handling self-neglect cases. Leading to more consistent practice.	Green

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						2015.		
			Self-neglect include in City Council of procedures	July 2015	Chair of Workforce development Sub Group	Manual of procedures has been launched July 2015	Clear guidance for staff handling self-neglect cases. Leading to more consistent practice.	Green completed
8	All partners should ensure that their local training continues to emphasise the importance of involving and communicating with	Overview Report **(7.8.1)**	Training issue to be addressed through Lessons Learned training	October 2015	Margaret |Greer	Event planning in progress	To reiterate the importance of family involvement	Green

Action Plan System Wide Review – (Mrs F)

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
	family members including where the next of kin is a young person.							
9	Review its pressure ulcer guidance to staff to ensure that it is fit for purpose in respect of appropriate notification and involvement of the police and, through its routine audits of cases, that this specific aspect of guidance is being followed.	Overview Report (7.9.1)	Pressure ulcer protocol being revised to include this action	Sept 2015 Dec 2015	CSAB Policy and Procedures Sub Group Jill Ayres	Protocol taken to March 2015 CSAB. Further work requested. To take back to September CSAB Audit schedule to include this area	Audits show appropriate referrals to the police where wilful neglect is suspected.	Green Green
Coventry City Council and Coventry and Rugby Clinical Commissioning Group should:								
10	Ensure through their joint monitoring and contract management that Nursing Home 1 continues to meet minimum standards in the care which it provides under contracts with these	Overview Report (7.5.1)	Review and update monitoring processes to ensure that consistent and integrated between health and social care.	March 2015	Inderjit Lahel	Joint monitoring and escalation processes in place and operational	Assured regarding the quality and safety of care at NH1.	Green

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
	agencies.							
NHS England should:								
11	Evaluate the findings of this review to determine the most effective way of using its Commissioning role with Practices to ensure that the learning related to the coordination of care and proper follow up of referrals is addressed	Overview Report **(7.6.1)**						
12		IMR	Through the monthly safety newsletter reiterate the responsibility of the general practitioner to ensure that referrals to other agencies are followed up and any actions noted and implemented.	30th Sept 2014	Associate Medical Director	GP's are regularly informed of Safeguarding themes and actions they should take through distribution by the Primary Care Team. The next GP newsletter will include an update on safeguarding requirements.	GPs routine follow up referrals to ensure actions are noted and implemented	

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
Coventry City Council Adult Social Care Department should:								
13	Review their guidance to practitioners relating to care planning to ensure that reviews of plans are timely and responsive to changes in need	Overview Report **(7.3.1)**	Policy and procedures to be reviewed as part of implementation of Care Act 2014	April 2015	Ian Bowering	External partner has been commissioned to update Adult Social Care procedures Manual Staff development activity to equip staff to work to new requirements of Care Act 2014	Adult Social Care Procedures Manual published and launched July 2015. Staff training activity has taken place regarding legislative changes, assessment and support planning and practice guidance as part of Care Act 2014 implementation	Green Completed
14		IMR	The ability to record all safeguarding issues on Care Director	March 2015	Head of ICT and Care Works	To be implemented March 2015	All Safeguarding forms have been revised and put onto Care Director	Green Completed

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
University Hospital Coventry & Warwickshire Should								
15		IMR	Review the outcome of annual the UHCW "Standard for Record Keeping" case file audits for the audits period 2011 – 2014. Compare findings for each year and ensure any remedial actions are monitored and on target for delivery within the agreed time frames	June 2015	Area Matrons Group Managers	The annual audits are completed and the required information is in the process of being collated. To be presented to patient safety committee on July 16th 2015, revised from June 2015. Feedback for this report 17.7.15	Improvement year on year in compliance with the " UHCW Standards for Record Keeping" in relation to legibility, formatting of signature and documented time of report entry as evidenced in the audit review outcome, With a minimum of 95% compliance with standard achieved by January 2015 within the audit	Amber

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
							sample group	
Care Quality Commission Should :								
16		IMR	Additional training for enforcement and processes	April 2015	CQC Academy (training department)	Ongoing – initial training scheduled for Sept/Oct 2014. Started January 2015 and completed April 2015 – Training Department	CQC Academy has a training plan to cover enforcement. This has been completed for the majority of inspectors across the commission and continues to be developed to support inspectors within their role.	Green Completed
Age UK Coventry Should :								
17		IMR	Pressure Ulcer awareness training for staff who home visit	Dec 2014	Moira Pendlebury	Made contact with Louise McKeeney to arrange appropriate session / communication Action completed. Awareness raising presentation provided by Jackie Wells (Tissue Viability service) to full staff meeting on	Have now identified that full training is not appropriate for our staff, none of whom deliver personal care. Will now explore best approach for general awareness raising for staff around the React to Red	Green completed

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress and evidence of progress	Outcome – what improvements do expect to achieve from the actions	RAG rating
				June 2015		10 June. Written information provided and disseminated. Informal feedback from staff was very positive	Skin campaign. Louise McKeeney will attend AUKC June 2015 full Staff meeting to present a React to Red Skin Awareness Raising session. The information will be disseminated to staff not in attendance. Improved general awareness of 'React to Red Skin' message, which staff will share with clients, volunteers, new starters and others	

Action Plan System Wide Review –Parallel (Mrs F)
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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 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	Jon Reading, 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	Jon Reading, Head of Strategic Commissioning	Improved regular reporting of indicators – still experiencing difficulty with accurate and timely reporting of safeguarding. Waiting for reports from Care Director. July 2015.	Escalation of safeguarding reporting.	Amber

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
				July 2015	Short term Paul Ferris – Performance Manager Long term reporting Scott Taylor, Head of Business Systems with Data Warehouse	Reports to be written	Reports requested form Care Director and the Data Warehouse. In the interim Performance review producing reports	Green
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 audit processes are in place to ensure compliance with standards set for record keeping	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	Glynis Washington Deputy Director of Nursing & Quality CCG	Audit office preparing reports	Show who has attended Safeguarding awareness training	Red
			UHCW – Review of audits from 2011 – 2014 underway	October 2015	Carmel McCalmont Safeguarding Lead UHCW	Audit in progress - Sept 2015	Show who has attended Safeguarding awareness training	Amber
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	Overview Report (8.2.1)	Reviewed and updated structures and processes	March 2015	Jon Reading, Head of Strategic Commissioning	Single CCC and CCG quality monitoring team in place April 2015	Assured fit and proper monitoring process in place	Green complete

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
	and effective.							
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	Jon Reading, Head of Strategic Commissioning and Glynis Washington	Reviewing freedom to speak up published February 2015	Clear criteria for level of appropriate action for whistleblowing	Amber
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	Jon Reading, 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
7	Pep Tor review including Roles & responsibilities	IMR	PEP Tor to be updated	Dec 2014	Jon Reading, 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	Jon Reading, Head of Strategic Commissioning, Isabel Merrifield Assistant Director safeguarding, Performance & Quality, and Scott Taylor – Head of	Reports produced from Safeguarding Team data base. Care Director in place		Green - completed

Action Plan System Wide Review –Parallel (Mrs F)

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
					Business Systems			
9	Review of Residential Contract and Service Specification	IMR	Review Contract and Service Specification	March 2016	Jon Reading, Head of Strategic Commissioning and Glynis Washington CRCCG Commissioning	Presented to Adult Joint Commissioning Board in January 2015 and project started. To be signed off by relevant bodies. Joint work across Warwickshire and CRCCG to be commenced by April 2015	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	Jon Reading, Head of Strategic Commissioning	Quarterly provider forums in place and feedback to be scheduled for future meeting possible in June/September 2015	Provider awareness of key issues and action to be taken on agenda	Amber
Coventry City Council should								

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
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	Scott Taylor – Head of Business Systems	Safeguarding Adults recording introduced on Care Director in Feb 205 for Older People and All Age Disability.	All recording in one place, easily assessable and timely	Green – Completed
					Isabel Merrifield – Assistant Director Safeguarding, Quality & Performance	Task and Finish group in place to ensure Mental Health Teams record safeguarding on Care Director		Amber
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)	Ian Bowering or David Watts to complete re operational systems	April 2015	David Watts – Assistant Director Adult Social care	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, risk assessment and attendance are being monitored and maintained	Overview Report (8.5.2)	Team audits to be developed	May 2015		Full process of 22 Social Care and Mental Health files undertaken in November 2014 Plan for further audits including partner	Identified areas are Audited for compliance to procedures and actions taken if not.	Green Completed

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Ref	Recommendation	Source of Recommendation	Action required	Target Date	Lead officer	Update on Progress	Outcome	RAG rating
						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		
			System developed to track and report risk(bearing in mind high risk can be related to chosen user outcomes)	April 2015	Isabel Merrifield 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	Paul Ferris – Performance Manager and Scott Taylor Head of Business System and Data Warehouse	Reports requested from Care Director	Report to be produced to monitor risk management	Green

Last updated 01/09/15

Health and Social Care Scrutiny Board (5) Work Programme 2015/16

1 July 2015
Addressing Health Inequalities across Coventry
9 September 2015
Serious Case Reviews
7 October 2015
Emergency Dentistry Winter pressures including delayed discharge Adult Social Care Annual Report (Local Account) 14/15
Tuesday 3 November 2015
Improving Accommodation for Older People
18 November 2015
Serious Case Review Adult Safeguarding Annual Report
6 January 2015
Progress on developing the Primary Care agenda and update on the Prime Ministers Challenge Fund Implementation of the Director of Public Health Annual Report recommendations regarding primary care
3 February 2015
Independent Living Fund Update on reducing health inequalities with a focus on the environment
2 March 2015
Date to be Determined
Clinical Management of Large Scale Chronic Diseases – Progress reports on pilots Director of Health Annual Report 2015 (Request for October 2015) Care Act – Implications following April 2015 Care Act – Managing the Introduction of the Care Cap (Implementation April 2016) Section 117 Policy Deprivation of Liberty Implications Better Care Programme and Health Integration Health and Wellbeing Strategy Update (Request for November 2015) Adult Social Care Complaints and Representations Annual Report 2013-14 Coventry and Warwickshire Partnership Trust – progress following CQC Inspection Community Mental Health Services/ Mental Health Pathways Patient Transport PALS Service at UHCW Adults' Homes Performance Review A&E 4 Hour Wait Performance Review Social Care Finance

Date	Title	Detail	Cabinet Member/ Lead Officer	Source	Outcomes
1 July 2015	Addressing Health inequalities across Coventry	To identify the work taking place, and impact of that work, to address the health inequalities across Coventry, as highlighted by the 'Coventry's Life Expectancy along the number 10 bus route' diagram in the Director of Public Health's Annual Report 2014.	Jane Moore		
9 September 2015	Serious Case Reviews	To consider the outcome of serious case review	Joan Beck (Independent Chair)		
7 October 2015	Emergency Dentistry	For the Board to review the provision of out of hours emergency dentistry across the City including how other NHS services can assist with dental issues out of hours.	David Williams (NHS England)		
7 October 2015	Winter pressures including delayed discharge	To include review of effectiveness of 2014/15 winter arrangements and preparations for 2015/16. To include CCG, provider organisations and social care. To include A&E targets and performance. The Chair will meet with UHCW to decide whether this needs a full review by the Board To look at the challenges around delayed discharge across health and social care. The Chair will meet with UHCW and Social Care to decide whether this needs a full review by the Board.	UHCW/ Cllr Caan/ David Watts		
7 October 2015	Adult Social Care Annual Report (Local Account) 14/15 – Report to be circulated	This is the annual report of the Council related to services provided to Adult Social Care clients. The report summarises performance,	Pete Fahy/ David Watts/ Gemma Tate		

Date	Title	Detail	Cabinet Member/ Lead Officer	Source	Outcomes
		provides commentaries from key partners and representatives of users and sets strategic service objectives for the future. The report will be circulated with the agenda and Members given the opportunity to ask questions briefly on it at the end of the meeting.			
Tuesday 3 November 2015	Improving Accommodation for Older People	The Council are looking at changing the housing options for Older People to bring the accommodation offered up to a higher standard. SB5 will have an opportunity to feed their views into the consultation at this meeting.	Pete Fahy		
Tuesday 3 November 2015					
18 November 2015	Serious Case Review		Joan Beck (Independent Chair)/ Cat Parker		
18 November 2015	Adult Safeguarding Annual Report	responsible for co-ordinating arrangements to safeguard vulnerable adults in the City. The Annual Report sets out progress over the 2014/15 municipal year and provides members with some data to monitor activity. Representatives of the Safeguarding Board to be invited.	Joan Beck (Independent Chair)/ Cat Parker		
6 January 2016	Progress on developing the Primary Care agenda and update on the Prime Ministers Challenge Fund	Review of what good primary care looks like and whether different models of provision produce better outcomes. Invite 2 or 3 GP practices and patient panel representatives and	Simon Brake		

Date	Title	Detail	Cabinet Member/ Lead Officer	Source	Outcomes
		Healthwatch in relation to patient engagement. Needs to include information on the recruitment and retention of GPs, access and out of hours provision. (Needs to link with any Health and Well-being Board work)			
6 January 2016	Implementation of the Director of Public Health Annual Report recommendations regarding primary care	The Board would like an update of the implantation of the recommendations contained within the DofPH annual report 2014.	Dr Jane Moore	SB5 19/11/14	
3 February 2016	Update on reducing health inequalities with a focus on the environment	A progress report be submitted to a future meeting of the Board in six months on the work undertaken by Public Health to reduce health inequalities, with particular reference to the environmental aspect.	Dr Jane Moore	SB5 01/07/15	
3 February 2016	Independent Living Fund	The Independent Living Fund is ending and a grant being transferred to the Local Authority for 12 months aid the transition. After the 12 months, it is possible that those supported by ILA will need social care services to fill the void left by the fund ending. In 2014, this fund was accessed by 127 people in Coventry. Date requested by Pete Fahy August 2015.	Pete Fahy		
TBC	Clinical Management of Large Scale Chronic Diseases – Progress reports on pilots	Future progress reports on the pilot projects are brought for consideration by the Scrutiny Board as and when appropriate.	Dr Jane Moore	SB5 11/02/15	
TBC –	Director of Health	The DPH has a statutory opportunity	Dr Jane Moore	Annual Report	

Date	Title	Detail	Cabinet Member/ Lead Officer	Source	Outcomes
Request for October 2015	Annual Report 2015	to issue Annual Reports which provide a commentary of local public health profiles and priorities. (Depending on focus of the report, this could be considered by Scrutiny Co-ordination Committee instead).			
TBC	Care Act – Implications following April 2015	To look at the Care Act and understand the possible implications for the Council and Residents.	Mark Godfrey		
TBC	Care Act – Managing the Introduction of the Care Cap (Implementation April 2016)	To look in early 2016 at the preparations for the introduction of the Care Cap			
TBC	Section 117 Policy	To be taken in 2015/16 – Check	Lavern Newell	Forward Plan	
TBC	Deprivation of Liberty Implications	To inform the Board of the current position with regards to Deprivation of Liberty assessments.	David Watts	Forward Plan Jan 15	
TBC	Better Care Programme and Health Integration	Regular updates to look at progress		Referred from health and wellbeing board April 15	
TBC – Request for November 2015	The revised Health and Well-being Strategy			SB5 22/4/15	
TBC	Serious Case Reviews	To consider any serious case reviews at an appropriate time.	Isabel Merrifield		
TBC	Adult Social Care	To review levels of complaints, the	John Teahan		

Date	Title	Detail	Cabinet Member/ Lead Officer	Source	Outcomes
	Complaints and Representations Annual Report 2013-14	way they are managed and how they are used to learn lessons and deliver improvements.			
TBC	Coventry and Warwickshire Partnership Trust – progress following CQC Inspection	To review progress against the action plan put in place following the Care Quality Commission's review of the Trust, particularly in relation to the enforcement notice and issues relating to Quinton Ward.	CWPT	SB5 30/04/14	
TBC	Community Mental Health Services/ Mental Health Pathways	To provide information to the Board on the services provided through the shared budget of the Better Care Fund in relation to community mental health services and integrated team working.	Josie Spencer	SB5 10/9/14	
TBC	Patient Transport	To look at the patient transport service, with specific reference to renal dialysis, and how well the new contract is serving Coventry residents visiting UHCW. The new contracted started in April so review Oct/ Nov time to enable it to bed in.		SB5 19/11/14	
TBC	PALS Service at UHCW	To look at the PALS Service at UHCW following feedback from the Quality Accounts meeting		Quality Accounts March 2015	
TBC	A&E 4 Hour Wait Performance Review	To review performance against the A&E waiting targets which are nationally set. Where issues have arised, to understand the remedial action which is being put into place.		Informal Meeting June 2015	
TBC	Adults' Homes Performance Review	To review performance of Adults' Homes that Coventry adults are	Pete Fahy		

Date	Title	Detail	Cabinet Member/ Lead Officer	Source	Outcomes
		placed in and procedures for what happens if a home is judged inadequate by Ofsted.			
TBC	Social Care Finance	With the pressures on finance increasing, the Board will look at the pressures and what actions are being under taken to address these.	Pete Fahy	SCRUCO	

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