Coventry City Council

# Briefing note

**To:** **Cabinet Member (Health and Adult Services)** **14th January 2014**

**Subject: Health and Social Care Scrutiny Board (5) consideration of the Executive Summary of the Serious Case Review (Mrs D) (CSAB/SCR/2013/1).**

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## 1 Purpose of the Note

1.1 This briefing note is intended to provide the Cabinet Member (Health and Adult Services) with the outcomes from consideration by the Health and Social Care Scrutiny Board of the Executive Summary of the Serious Case Review (SCR) into the death of a vulnerable adult (Mrs D) .

## 2 Recommendations

2.1 The Scrutiny Board recommends to the Cabinet Member that the Action Plan outlined in the SCR be approved.

2.2 The Cabinet Member is further asked to note that the Scrutiny Board has requested an additional briefing from the Executive Director - People on the implementation of the Action Plan contained in the Report. The Board has asked for this to be scheduled for a Scrutiny Board meeting in the early summer.

## 3 Information/Background

3.1 The Scrutiny Board considered a Report and Executive Summary of the SCR into the death of a vulnerable adult, Mrs D at their meeting held on 18th December 2014. The Board were supported in their scrutiny of this matter by the Executive Director People, acting also in his capacity as Chair of the Coventry Safeguarding Adults Board. They were also supported by several members of the Safeguarding Adults Board including representatives of key agencies covered by the SCR as well as the independent author of the review.

3.2 At the beginning of the meeting following a brief summary of the function of a SCR and an introduction to the circumstances covered in the document representatives of the City Council, University Hospitals Coventry and Warwickshire (UHCW) and Coventry and Warwickshire Partnership Trust (CWPT) each expressed their condolences to the family of Mrs D and apologised for any failings which had contributed to her death.

3.3 In considering this matter in detail the Board questioned Safeguarding Board members on a number of issues including:

- Record keeping in general by professionals regarding the interventions they performed with patients.
- Communications between different professionals and how these might be improved to ensure consistent information is provided regarding the needs of vulnerable patients.
- Referral processes and the importance of written referrals identifying clearly the reason for the referral and relevant circumstances (linked to the above).

- The discharge process and how information was shared between different organisations regarding the needs of patients being discharged.
- Nursing practice around care for elderly patients vulnerable to pressure ulcers, processes for recording and monitoring pressure sores in the community and whether this practice was consistent across Coventry and Warwickshire.
- Programmes of training for staff working in the local health economy, particularly in regard to agency staff being ready to operate within established safeguarding processes. Whether or not these training programmes are compulsory for all staff or not.
- The availability and co-ordination of intermediate care for patients leaving hospital.
- The outpatient appointment made for Mrs D and the lack of clarity regarding the purpose of the appointment which resulted in the associate specialist not fully understanding the District Nurses intentions in making the referral, also issues related to whether or not the pressure ulcer would have been noticeable at the time of the appointment.
- The nature of the neck brace supplied to Mrs D and whether appropriate clinical processes had been followed in identifying the most appropriate piece of equipment for her needs.
- Whether appropriate advice was given to family members/carers of Mrs D to support them in meeting Mrs Ds needs in general and particularly related to the neck brace.
- The learning across the Coventry health and social care economy about identification and treatment of pressure ulcers and the role that all staff interfacing with the community have to play in this.
- Issues around the testing for and identification of septicaemia.
- The role of the GP and how communication with him could have improved Mrs Ds care.
- Issues related to the social services involvement with clients having capacity but declining to receive services.
- Whether individual organisations allowed external inspection regimes, targets or data collection procedures to divert from the priority of providing quality care and focusing on the outcomes of individual patients.
- Safeguarding processes and procedures and the lack of prompt reporting and investigation of concerns regarding Mrs D.
- The recommendations in the Action Plan and the role these will play in improving multi-agency safeguarding arrangements.

3.4 The Board received repeated assurances from all of the agencies represented that policies and importantly practice has improved significantly since the events described in the SCR. Many of the recommendations in the SCR already largely implemented. Members were particularly pleased to learn that discharge arrangements at UHCW and referral processes between CWPT and UHCW had been improved and that new arrangements were felt to be working well.

3.5 In concluding all of the organisations present gave an assurance that the recommendations of the SCR would be fully implemented and that all that was possible would be done to ensure that the events described in the SCR were not repeated. The Chair of the Safeguarding Adults Board gave an assurance on behalf of the whole safeguarding community that his Board would lead this work requiring regular updates on this work.

3.6 Representatives of both UHCW and CWPT noted that their Trust Boards had led work on their individual organisational plans to reflect on the circumstances of this case and had led the implementation of the recommendations of the SCR.

3.7 The Scrutiny Board was content with the Action Plan (page 5 and 6 of the Executive Summary) and recommended only that a briefing be provided to the Board in approximately 6 months' time detailing the implementation of the recommendations.

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