Coventry City Council
Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 2.00 pm on Wednesday, 18 December 2013

Present:

Members:	Councillor S Thomas (Chair) Councillor M Ali Councillor J Blundell Councillor J Clifford Councillor P Hetherton Councillor J Mutton Councillor H Noonan Councillor H S Sehmi Councillor S Walsh (substitute for Councillor Fletcher)
Co-Opted Members:	Mr J Mason, representing Mr D Spurgeon
Other Members:	Councillors G Duggins and A Gingell, Cabinet Member (Health and Adult Services)
Employees:	P Barnett, Resources Directorate S Brake, People Directorate P Fahy, People Directorate M Godfrey, People Directorate M Greenwood, People Directorate L Knight, Resources Directorate M McGinty, People Directorate S Roach, People Directorate B Walsh, Executive Director, People
Other representatives:	P Greenaway, Coventry and Warwickshire Partnership Trust (CWPT) J Hill (CWPT) M Radford, University Hospitals Coventry and Warwickshire Tracy Redgate, Coventry and Rugby Clinical Commissioning Group Laurence Tennant, Independent Author
Apologies:	Councillors C Fletcher and A Williams D Spurgeon

Public Business

42. **Declarations of Interest**

There were no disclosable pecuniary or other relevant interests declared.

43. **A Bolder Community Services - Report on Outcome of Consultation**

Further to Minute 26/13, the Scrutiny Board received a presentation by the Assistant Director, Commissioning and Transformation, which informed of the outcome of the A Bolder Community Services (ABCS) consultation and resulting proposals. The Board also considered a briefing note of the Executive Director, People which provided an overview of the broad themes which emerged from the consultation. A report on outcome of the consultation was due to be considered by Cabinet at their meeting on 7th January, 2014. Councillor Gingell, Cabinet Member (Health and Adult Services) attended the meeting for the consideration of this issue.

The presentation set out the breadth of the consultation exercise undertaken between 27th August and 15th November, 2013 which included 90 consultation meetings; 1,100 people being spoken to; and 8,500 directly contacted. The major themes that arose were the potential impact on families and carers; the potential impact on other organisations; the need to vary implementation timescales; the impact on City Council jobs; and people recognising the proposals could impact on them in the future.

In light of the responses, a number of changes were proposed to the original proposals as follows:

- Retain the weekend Dementia Day service at Maymorn Centre
- Keep the Aylesford open at this stage as the Clinical Commissioning Group had agreed to fund for six months while the reablement strategy was developed
- Provide transitional funding to the Risen Christ to sustain the luncheon club
- Housing Related Support – take an organisation by organisation approach dependant on alternative funding and vulnerability.

The presentation also highlighted the significant service changes:

- Cease provision of care services at Jack Ball House and George Rowley House
- Two Older People Day Centres to move to Gilbert Richards in Earlsdon
- Two Learning Disability Day Centres to relocate to Frank Walsh House
- In-house Home Support Short Term Service to close
- Reductions in voluntary sector capacity across four organisations.

It was emphasised that support would not be withdrawn from anyone who met the City Council's eligibility criteria for support. The implications for staff and service users were also outlined along with how the phased implementation would be managed.

The Board questioned the officer on a number of issues and responses were provided, matters raised included:

- The impact of the funding reductions on voluntary organisations
- The arrangements to be made for supporting service users
- The reasoning behind the proposal to subsidise the Risen Christ luncheon club for six months

- How the consultation was undertaken with the different communities in the city.

The Board expressed support for the consultation undertaken and the efforts that officers had gone to consult widely and with a large variety of different groups and localities.

RESOLVED that:

(i) The Board support the proposals developed following the recent public consultation and Cabinet be informed of the Board's considerations and support at their meeting on 7th January, 2014.

(ii) A report on the development of a Reablement Strategy be submitted to a future meeting of the Board.

(iii) A progress report on the implementation of the proposals outlined in the Cabinet report be submitted to a future meeting of the Board in April, 2014.

44. **Serious Case Review - Mrs D (CSAB/SCR/2013/1)**

The Board considered a report of the Executive Director, People which presented the findings of a Coventry Safeguarding Adults Board Serious Case Review (SCR) which followed the death of Mrs D, a woman in her late 80s, in the summer of 2011. The Chair and Members of the Safeguarding Adults Board attended the meeting for the consideration of this item. The report was also to be considered by the Cabinet Member (Health and Adult Services) at her meeting on 14th January, 2014 and Councillor Gingell attended for this issue.

Mrs D was a vulnerable adult who died following an accident and a brief period of treatment in hospital and the community. A neck injury was treated using a supporting neck collar. The collar caused friction to her skin resulting in a pressure ulcer which became infected. Mrs D then died as a result of septicaemia.

Following a safeguarding investigation, the Chair of the Coventry Safeguarding Adults Board directed that a Serious Case Review be undertaken as a result of the circumstances of Mrs D's death and the events leading up to it. This review was chaired by the designated local authority senior manager, written by an independent author and supported by a multi-agency panel of senior practitioners, including representatives from Coventry City Council, NHS Coventry (and subsequently Coventry and Rugby Clinical Commissioning Group), Coventry and Warwickshire Partnership Trust, University Hospitals Coventry and Warwickshire NHS Trust and West Midlands Police. Mrs D's General Practitioner had also made a significant contribution to the review.

The executive summary of the case was appended to the report submitted.

The representatives in attendance expressed their condolences to the family of Mrs D and apologised for any failings which had contributed to her death.

The Board questioned those present on a number of issues relating to the circumstances of the case, with specific questions on Mrs D's situation being put to attendees from the Safeguarding Adults Board. Matters raised included:

- 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 Nurse 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 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.

The Board were given repeated assurances from all of the agencies represented that policies and practice had improved significantly since the events detailed in the SCR. Many of the recommendations of the review had already been implemented. All of the organisations present gave an assurance that the review's recommendations would be fully implemented and that all that was possible would be done to ensure that the events described in the SCR would not be repeated. The Chair of the Safeguarding Adults Board indicated that his Board would receive regular updates on this work.

The Board were supportive of the Action Plan included in the Executive Summary.

RESOLVED that:

(i) The Cabinet Member (Health and Adult Services), at her meeting on 14th January, 2014 be recommended to approve the Action Plan outlined in the Serious Case Review, which was endorsed by the Board.

(ii) The Safeguarding Adults Board be requested to report back to the Board in six months to review the implementation of the Action Plan contained in the Report.

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

There were no additional items of public business.

(Meeting closed at 4.20 pm)