Briefing note

To Health and Social Care Scrutiny Board (Scrutiny Board 5) **Date 10 December 2014**

Subject: Mrs D Serious Case Review – final progress report

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1 Purpose of the Note

1.1 To update on the progress of the Mrs D Serious Case Review Action Plan.

2 Recommendations

2.1 Health and Social Care Scrutiny Board is asked to note the report and the completion of the Action Plan (the Action plan is attached at Appendix 1).

3 Information/Background

3.1 This Serious Case Review followed the death of Mrs D, a woman in her late 80s, in the summer of 2011. Following a full 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 & Rugby Clinical Commissioning Group), Coventry and Warwickshire Partnership Trust, University Hospitals Coventry & Warwickshire NHS Trust and West Midlands Police. Mrs D's General Practitioner also made a significant contribution to the review.

3.2 The Review identified a number of recommendations and actions to improve practice. These are detailed in the Action Plan at Appendix 1. A key recommendation was focused on the referral into safeguarding of (avoidable) grade 3 and 4 pressure ulcers via the implementation of an effective Pressure Ulcer Protocol. This Serious Case Review was not the first to focus on pressure ulcers, so this was a significant cause for concern for the Board.

3.3 To raise awareness of the risk of pressure ulcers, the “Your turn” Campaign was launched on 9.5.2014. This was a joint initiative between Coventry and Warwickshire Partnership Trust, Coventry and Warwickshire Clinical Commissioning Group, University Hospitals Coventry and Warwickshire and Coventry City Council and focused on residential homes. The campaign ran for 6 months, and included an accreditation scheme about pressure ulcer recognition and management.

3.4 A lot of work has been done to review the Pressure Ulcer Protocol and its implementation in order to ensure that safeguarding concerns are referred appropriately. Following a rolling programme of training in the use of the Pressure Ulcer Protocol, we saw a significant rise in the number of referrals (an indication that the awareness raising had been successful). However, many of the cases referred were found not to be appropriate - only in a small number of cases were safeguarding concerns substantiated. This raised questions about the application of thresholds.

3.5 In May this year a meeting was held to review progress including a review of progress of the Mrs D Serious Case Review Action Plan. The meeting agreed that the protocol needed further revision, to review thresholds for referral and to focus on avoidable pressure ulcers at grade 3 & 4 and multiple 2s. A task and finish group was set up to progress this work. A progress report will be brought to the Coventry Safeguarding Adults Board on 3 December.

3.6 A number of recommendations relate to quality of practice and assessment; specific actions have included the introduction of a revised supervision policy and training in the Mental Capacity Act.

3.7 Within Adult Social Care a case file quality audit has been undertaken annually with results reported to the Safeguarding Adults Board Quality and Audit Subgroup. For the last exercise four cases out of 1,000-plus cases were examined in detail.

3.8 From November 2014, the number of cases reviewed and frequency of quality checks will be increased by undertaking regular in-house peer reviews on a rolling programme basis, in addition to the Quality and Audit Subgroup led annual audits.

3.9 The majority of actions in the Action Plan were single agency actions and the Safeguarding Board has a role in monitoring completion of these within agreed timescales. All single actions have now been completed and there are no outstanding actions.

3.10 There are 2 non-specific multi-agency recommendations:

- Ensure that staff understand their responsibilities in relation to Safeguarding Adults and that the preventative opportunities of Safeguarding referrals are fully recognised and utilised as a positive way of achieving effective joint working in the best interests of vulnerable adults;
- The Safeguarding Board and the Partner agencies should satisfy themselves that there is commitment from all Partners to the philosophy and principles of Safeguarding, that this is owned at all levels within the respective organisations, and communicated effectively through joint and single agency training.

3.11 Whilst the specific actions identified have been achieved, these recommendations are by nature general and on-going responsibilities that the Safeguarding Board will continue to monitor.

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