Coventry City Council

Public report
Cabinet Member

Cabinet Member for Health and Adult Services 14th December 2015

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

Director Approving Submission of the report:
Executive Director for People

Ward(s) affected:
N/A

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

Is this a key decision?
No

Executive Summary

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

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

Recommendations:

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

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

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

Other useful background papers:
None

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

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

Will this report go to Council?
No

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

1. Context (or background)

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

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

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

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

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

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

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

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

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

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

2. Options considered and recommended proposal

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

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

2. Endorse the action plan at Appendix 2.

3. Results of consultation undertaken

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

4. Timetable for implementing this decision

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

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

5. Comments from Executive Director, Resources

5.1 Financial implications
None

5.2 Legal implications
None

6. Other implications

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

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

6.2 How is risk being managed?

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

6.3 What is the impact on the organisation?

None

6.4 Equalities / EIA

No negative impacts are anticipated in relation to this review

6.5 Implications for (or impact on) the environment

None

6.6 Implications for partner organisations?

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

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