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, 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 a brief period 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, pressure ulcers were identified on her legs which ultimately required a period of assessment and treatment in hospital. 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 to 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 of the view that it was possible 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) is 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, especially when quality assurance visits from local agencies in response to locally identified concerns reached sharply 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 worsened. The Panel concluded that there were elements of the services that could 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 Single Case Review 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 that apply specifically to individual agencies. The recommendations below summarise the actions that are needed to reduce the likelihood of the events leading up to Mrs F’s death 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 its 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.
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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 NH1 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 Panal (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