

Coventry City Council
Minutes of the Meeting of Health and Social Care Scrutiny Board (5) held at 1.30 pm on Wednesday, 18 November 2015

Present:

Members: Councillor D Welsh (Chair)
Councillor N Akhtar - substitute for Councillor M Ali
Councillor J Innes
Councillor J O'Boyle
Councillor D Skinner
Councillor K Taylor
Councillor S Walsh

Co-Opted Members: David Spurgeon

Other Members: Councillors K Caan and J Clifford

Other Representatives: Joan Beck, Chair, Coventry Adults Safeguarding Board
Mark Radford, University Hospitals Coventry and Warwickshire
Donna Reeves, Coventry and Warwickshire Partnership Trust (CWPT)
Jamie Soden, CWPT
Glynis Washington, Coventry and Rugby Clinical Commissioning Group

Employees:

S Brake, People Directorate
V Castree, Resources Directorate
L Knight, Resources Directorate
C Parker, People Directorate
D Watts, People Directorate
J White, Resources Directorate

Apologies: Councillors M Ali and D Galliers

Public Business

37. Declarations of Interest

There were no declarations of interest.

38. Minutes

The minutes of the meeting held on 3rd November, 2015 were signed as a true record. There were no matters arising.

39. Serious Case Review - Mrs E

The Scrutiny Board considered a briefing note of the Executive Director of People attached to which was the Executive Summary report which presented the findings

of a Coventry Safeguarding Adults Board Serious Case Review which followed the death of Mrs E in the spring of 2013. Appended to the summary report were the associated actions plans from both the review and the learning from the case.

Joan Beck, Chair of the Safeguarding Adults Board and David Watts, Chair of the Review Group attended the meeting for the consideration of this item along with Mark Radford, University Hospitals Coventry and Warwickshire Jamie Soden and Donna Reeves, Coventry and Warwickshire Partnership Trust and Glynis Washington, Coventry and Rugby Clinical Commissioning Group. The report was also to be considered by the Cabinet Member for Health and Adult Services at his meeting on 14th December, 2015 and Councillor Caan and Councillor Clifford, Deputy Cabinet Member also attended the meeting.

Mrs E was 66 years of age and led a busy and fulfilling life. She lived in a Housing with Care Scheme with her husband so he could receive additional support. Mrs E had received treatment in hospital in relation to a fracture to her spine as a result of a fall and had returned to her own home. She was subsequently admitted to a Coventry Care home for rehabilitation when her GP felt her recovery could be improved with a period of residential rehabilitation. Her health deteriorated while she was in the care home which led to an emergency admission to hospital. She was critically ill on admission to hospital and died 5 days later.

The Chair of the Safeguarding Adults Board expressed her condolences to the family and apologised for the length of time that it had taken to reach this stage in the review process. She read out a very moving and informative statement from the family about their experiences and the impact that this has on them.

The summary report highlighted that a serious case review took place because Mrs E was an adult at risk and neglect may have been a contributory factor. The report set out a chronological summary of events followed by an overview of the actions taken by professionals in respect of some key issues. Key learning was outlined along with the multi-agency recommendations which were organised around the following three key themes: Safeguarding Processes; Assessment and Treatment Issues; and Continuity of Care, including Hospital Discharge Arrangements. The action plans set out recommendations with actions required, gave target dates and appropriate lead officers as well as highlighting expected outcomes.

The Board questioned those present on a number of issues relating to the circumstances of the case and responses were provided, matters raised 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 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. They 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.
- Clarification on hospital discharge procedures and whether these had been amended since Mrs E's death.
- In complex cases with multiple agencies involved, who took responsibility to ensure a patient was taken through the correct healthcare pathway for that individual between the hospital and the community. There was concern that there was often not a clear lead professional who was co-ordinating care.
- Questions were asked about how to ensure that all staff treat patients and their families with dignity and respect.

RESOLVED that:

(1) The findings of the Serious Case Review and the recommendations, actions and progress in the action plans be noted.

(2) A letter be sent to the family of Mrs E expressing the Board's condolences for their loss and thanking them for their moving and informative statement.

(3) The Cabinet Member for Health and Adult Services be requested to reiterate to the Coventry Safeguarding Adults Board the importance of ensuring that all the health organisations take account of the views of families, 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.

(4) A progress report be submitted to a future meeting of the Board in six months.

40. System Wide Review - Mrs F

The Scrutiny Board considered a briefing note of the Executive Director of People attached to which was the Executive Summary report which presented the findings of a Coventry Safeguarding Adults Board System Wide Review which followed the death of Mrs F in the spring of 2013. Appended to the summary report were the associated actions plans from both the review and the learning from the case.

Joan Beck, Chair of the Safeguarding Adults Board and Simon Brake, Chair of the Review Group attended the meeting for the consideration of this item along with Mark Radford, University Hospitals Coventry and Warwickshire Jamie Soden and Donna Reeves, Coventry and Warwickshire Partnership Trust and Glynis Washington, Coventry and Rugby Clinical Commissioning Group. The report was also to be considered by the Cabinet Member for Health and Adult Services at his meeting on 14th December, 2015 and Councillor Clifford, Deputy Cabinet Member also attended the meeting.

Mrs F was 80 years old when she died and had been residing in a Coventry Nursing Home. She had chronic vascular disease which she was aware would be life limiting if she declined any surgical intervention. She received hospital

treatment in relation to pressure ulcers. She was discharged from hospital and transferred to a care home where she could receive significant support from health care professionals. Whilst in the care home she developed tissue damage which became infected and was re-admitted to hospital. She died 5 days later as a result of the infection.

The Chair of the Safeguarding Adults Board expressed her condolences to the family, in particular to Mrs F's granddaughter and apologised for the length of time that it had taken to reach this stage in the review process.

The summary report highlighted that a system wide review took place when a vulnerable adult had died or had been seriously injured or impaired, abuse or neglect was known or suspected and broader system issues were believed to have been a significant factor. The report set out the facts of the case, a summary and overall analysis and conclusions. A summary of the recommendations that applied to all agencies were highlighted along with those for the individual agencies. The action plans set out recommendations with actions required, gave target dates and appropriate lead officers as well detailing progress and expected outcomes.

The Board questioned those present on a number of issues relating to the circumstances of the case and responses were provided, matters raised included:

- Clarification about the monitoring process for the quality and standards of care homes in the city
- Concerns about the on-going financial viability of care homes in the current austerity climate and the introduction of the living wage
- Whether there were any concerns about the viability of care homes in the city in light of press reports that national care home providers could withdraw services
- Details about funding by the Council to care homes with financial difficulties
- The use of regulatory tools where there were concerns about care homes and the support provided to those care homes that needed assistance from the Local Authority
- Clarification about the improved reporting and treatment of pressure ulcers by the agencies involved
- Further information on the progress of the action plans.

Particular discussion centred on the implications for Care Homes of the introduction of the living wage which was not funded by the Government.

RESOLVED that:

(1) The findings of the Serious Case Review and the recommendations, actions and progress in the action plans be noted.

(2) A report on the current state of care homes in the city be submitted to a future meeting of the Board.

(3) The Chair, Councillor Welsh, be requested to write on behalf of the Board to the Secretary of State for Health outlining the concerns raised about the financial pressure on Care Homes and concerns they may be exacerbated by

the compulsory introduction of the living wage, which whilst welcomed is unfunded by Government. There is a concern that this unfunded pressure could lead to a potential reduction in quality of care and the health and safety of patients/residents.

41. Coventry Safeguarding Adults Board Annual Report 2014/15

The Scrutiny Board considered a briefing note appended to which was Coventry Safeguarding Adults Board Annual Report for 2014/15. The Board also received a presentation on the Annual Report from Joan Beck, Independent Chair of the Adults Safeguarding Board.

The Safeguarding Board was required to publish an annual report and business plan. The report provided an introduction to safeguarding; detailed the responsibilities of the Board; highlighted the key achievements of the individual sub-groups and reviewed progress against priorities. The report concluded with the Board's business plan. A performance dashboard was set out at an appendix.

The presentation set out the Board's accomplishments; successes and challenges along with the priorities for the future. Accomplishments included the implementation of the Care Act, working more closely with other Boards, completing three multi-agency reviews and developing the performance dashboard. Priorities for the future included using performance information to drive improvement; Care Act compliance; Transforming Care; making safeguarding personal; and working across Boards.

Members expressed support for the excellent report and questioned about the importance placed on dealing with mental health issues.

RESOLVED that the Annual Report of the Coventry Safeguarding Adults Board for 2014/15 be noted.

42. Outstanding Issues Report

The Scrutiny Board noted that all outstanding issues had been included in the Work Programme for 2015-16.

43. Work Programme 2015-16

The Scrutiny Board noted their work programme for the current year.

44. Any other items of Public Business

There were no additional items of public business.

(Meeting closed at 4.35 pm)