

Serious Case Review

Overview Report

Msaada Care Services

Independent Author:

Anne Carswell

MA, Dip Social Work, CQSW,
Dip Public Services Management

Serious Case Review Independent Chair:

Christopher Moore

SW CQSW BA MA FHES

April 2013

Table of Contents

1. Introduction	3
1.1 General	
1.2 Terms of Reference	
2. Methodology	6
3. The Facts.....	10
3.1 Msaada	
3.2 The experiences of Adam Harris and Jonathan Smith	
3.2.1 Adam Harris	
3.2.2 Jonathan Smith	
3.3 The Agencies	
3.3.1 NHS Milton Keynes & Northamptonshire	
3.3.1.1 General Practitioner	
3.3.2 East Midlands Ambulance Service	
3.3.3 Northampton General Hospital NHS Trust	
3.3.4 Northamptonshire County Council	
3.3.4.1 Service Commissioning and Contract Monitoring	
3.3.4.2 Adult Safeguarding	
3.3.4.3 Care Management	
3.3.4.4 Complaint	
3.3.5 Care Quality Commission	
4. Analysis.....	22
4.1 Msaada	
4.2 Analysis of other Agencies' roles	
5. Conclusion.....	28
6. Multi-agency Recommendations	29
6.1 NHS Milton Keynes & Northamptonshire	
6.1.1 General Practitioner	
6.2 East Midlands Ambulance Service	
6.3 Northampton General Hospital NHS Trust	
6.4 Care Quality Commission	
6.5 Northamptonshire County Council	
6.6 Governance Arrangements	

1 Introduction

1.1 General

1.1.1 This Serious Case Review (SCR) has been commissioned in respect of a care agency, Msaada Care Services (Msaada), and not an individual or individuals. The care agency is also being named and not referred to under a pseudonym.

1.1.2 Msaada was an established provider of a range of care services in Northamptonshire. The services included residential care homes, supported accommodation and a domiciliary care agency. The services were separately registered with the Care Quality Commission (CQC) as required by law.

1.1.3 In 2010 a number of concerns were being raised about the operation of Msaada services and there were a significant number of Adult Safeguarding investigations. These investigations were across the range of Msaada services and included allegations of financial abuse, the deaths of service users and the rape of a young woman who was living in supported accommodation. Not all of these allegations were substantiated.

1.1.4 The safeguarding of vulnerable adults is a function of the Local Authority and is overseen by Northamptonshire Safeguarding Vulnerable Adults (SOVA) Board. Under the terms of the Northamptonshire (SOVA) procedures, the decision as to whether or not to hold a serious case review on any particular case is the responsibility of the Northamptonshire (SOVA) Board and is exercised through their Serious Case Review (SCR) sub-group.

1.1.5 In this instance the SCR sub-group considered the circumstances leading to this review over five meetings from April 2012 until the Terms of Reference were agreed and the decision to proceed to serious case review had been ratified by the SOVA Board in October 2012. During this period there was discussion with the coroner and the police were considering criminal charges against Msaada; these criminal charges did not proceed.

1.1.6 The SCR sub-group agreed that the seriousness of allegations of abuse in respect of this provider gave rise to significant concerns and, while the review would be directed towards the provider organisation, Msaada in this instance, the experience of at least two service users would be used to inform the SCR process.

1.1.7 Jonathan Smith and Adam Harris, both pseudonyms, were two service users in receipt of services from Msaada. Both of these individuals died while in receipt of separate and different Msaada services. Their deaths resulted in adult safeguarding investigations and findings of neglect against Msaada.

1.1.8 Adam Harris was a man of 87 who received domiciliary support from Msaada. Adam and his family arranged and paid for his own care. On 7th October 2010 Adam fell from a stair lift in his own home when being taken upstairs by a carer from Msaada. The cause of death given was ischemic heart disease, a cause with which the family disagrees. What is clear, however, is that Adam was not strapped into his stair lift and the arm rest was not in the correct position resulting in the fall.

1.1.9 Jonathan Smith was a man aged 37 who lived in rented accommodation and whose care plan involved two half hour visits daily from Msaada to provide support and assistance with self medication. On the 16th October 2010 Jonathan was found dead in his home. His family had been unable to contact him for some days and called the police. Subsequent enquiries revealed that Jonathan had not been seen by any carer from Msaada since 11th October, five days prior to him being found. The inquest for Jonathan has still to take place. However, the coroner has indicated that it is appropriate to proceed with the SCR process.

1.1.10 Unlike Children's Services, there is, at present, no clear statutory framework providing duties and responsibilities in relation to the protection of vulnerable adults. There is government guidance in place; however, which requires Local Authorities to ensure that arrangements are made to provide for good and effective inter agency procedures and protocols to improve the protection of vulnerable adults.¹

1.2 Terms of Reference

It is important to understand that the purpose of a SCR is not to re-investigate or to apportion blame.

It is:

- *To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults*
- *To review the effectiveness of procedures (both multi agency and those of individual agencies)*
- *To inform and improve local inter agency practice*
- *To improve practice by acting on learning*
- *To prepare or commission an overview report which brings together and analyses the findings of various reports from agencies in order to make recommendations for future actions²*

The Terms of Reference for each SCR are agreed by the SOVA Board.

The focus of this review is on a provider agency and, accordingly, is reflected in the Terms of Reference as follows:

- a. The Review will seek to understand the overall structure and management of the provider organisation (Msaada) and its delivery of domiciliary care, supportive living arrangements and residential care services.

¹ *No Secrets* – Department of Health 2000

² Northamptonshire Safeguarding Vulnerable Adults Board Serious Case Review Guidance July 2009

- b. Furthermore, it will seek to understand the internal workings of the organisation, its approach to standards of care, management of risk and quality assurance from the time the first safeguarding notification was received to the completion of all investigations and subsequent reviews for the period 1st June 2010 to 30th June 2012.
- c. To assist the Review there will be a focus on the experiences of two customers, namely Jonathan Smith and Adam Harris (now both deceased) who were in receipt of services and both subject to safeguarding investigations to help understand what was happening at the time.
- d. The Review will seek to understand how services were commissioned and how long there had been concerns. How were complaints about service provision managed? What internal and external systems were in place and what did customer reviews highlight?
- e. The Review will consider the overall regulation, scrutiny and contract monitoring arrangements of the care provided in order to determine:
 - 1. Whether regulations policies and procedures were followed and
 - 2. Whether staff received appropriate training and supervision to meet the standards required.
- f. The Review will consider the effectiveness of inter agency working and intra-agency working and communication and whether there had been earlier opportunities to act on concerns about the provider.
- g. The Review will seek to understand whether consideration was given to issues relating to mental capacity and best interest decision making.
- h. The Review will seek to understand if these events could have been avoided and what lessons have been learnt since.

2 Methodology

2.1 The overview report and analysis are based on Independent Management Reviews (IMR) and Chronologies submitted by the following key agencies:

- General Practitioner (GP)
- Northampton General Hospital NHS Trust (NGH)
- Northamptonshire County council (NCC)
- East Midlands Ambulance Service NHS Trust (EMAS)
- Care Quality Commission (CQC)

These agency reports are written by individuals who have had no role in the conduct of the cases and as such are independent of the process. The reports are presented to the multi agency SCR Panel where they are effectively challenged and points of clarification are raised.

2.2 The SCR Panel Chair and the Overview author are independent, appropriately qualified and experienced professionals.

2.2.1 The Chair is a senior academic and qualified social worker with 15 years experience in social work practice and more than 16 years leading and developing social work and social care education. He is the Independent Deputy Chair of the SOVA Board and chairs the SCR sub-group and reviews.

2.2.2 The independent author has 35 years experience of adult social care at operational and strategic levels, in particular with the inter face with health. This has included 5 years with national inspectorates assessing the performance of councils and as a regulator of care services.

2.3 Msaada Care Services was invited to contribute to the SCR process and, indeed, the Chair of the SCR Panel personally spoke with the former director of Msaada to provide reassurance about the process.

Neither Msaada, however, nor any Msaada senior manager or director has provided a report. All that has been received is a limited chronology from an ex employee who had no access to records. Msaada Care Services went into administration in December 2011. As such the ability of this report to fully address the TOR in regard to Msaada's structure and management and its approach to standards of care, management of risk and quality assurance is now limited.

2.4 The Independent Author has met with the families of both Adam and Jonathan and has received impact statements from each family.

These statements give details of the experience and feelings of the families, both of the services received by Adam and Jonathan and also in the aftermath of their deaths.

2.4.1 Adam Harris' family describe him as a much loved husband, father and grandfather. Had he lived just another month he would have known he was to be a great grandfather.

Adam is described as giving a lot of his life to the service of others, he was a physiotherapist first, and then a priest for 51 years. He always did what he could to help and comfort others. The family feel strongly that he did not deserve this kind of end to his life.

Adam's wife, who was 81 at the time, heard the stair lift start its ascent and a few moments later heard a crash in the hallway and saw her husband had landed on his face just to her right. That is a moment she has never stopped talking about to this day. She still lives in the house, sits in the same place and uses the stair lift, and hardly a day goes past without some reference to the event.

One of Adam's daughters was also in the lounge at the time and was at her father's side in seconds after hearing the crash.

Another daughter and her husband were called and arrived about 10 minutes after the fall.

Everyone has been left with feelings of helplessness and inadequacy.

The family feel an acceptance of Adam's death would have been so much easier if he had died in his chair or his bed. His death was undignified and traumatic and the family left wondering, did he know or sense what was coming, was he aware that he was falling, how frightened he would have been as he would not have been able to do anything to help himself or stop what was happening.

They feel very strongly that Msaada put little money into their teams' training and working practices.

Adam's daughter and his wife dealt with, what they describe as, the "many incompetence's" of the carers. They describe a mix of people – some of whom they saw as kind and competent – some who were not – who were in their home twice daily. They describe a high turnover of staff and that new people had to be shown what to do and where things were because the company did not pass on any instructions, guidance or training.

Adam is described as disliking confrontation and was reluctant to have a change in his care as it seemed like an upheaval he did not want to cope with. The family however are now left with a feeling of guilt and remorse that they should have changed companies rather than tried to work with Msaada.

The family question why this company was allowed to practice and was given a 2 star rating now that they understand that there were earlier complaints against the company. Msaada was on a list given to Adam's family by NCC and they thought they were choosing the best available private company.

This has left the family feeling aggrieved and failed by people in whom they feel they should have trust in such matters.

One of the most serious consequences for the family, however, has been the verdict of the coroner of death by natural causes.

Mr and Mrs Harris were married for 58 years and there has been a significant impact on her health and wellbeing.

2.4.2 Jonathan Smith is described as an important part of a close family. He is described as kind and thoughtful, generous to a fault, protective of his family with an infectious chuckle and an encyclopaedic knowledge of pop music.

Jonathan had been buying Christmas presents early and was excited about becoming an uncle for the first time. His sister cannot find the words to describe now how her daughter will never meet her uncle. His other sister describes how she always thought they would grow old together, sharing family jokes, reminiscences, holidays and CD's.

Jonathan's mum describes contacting Msaada on a Saturday because she was concerned about Jonathan not responding to text messages and calls. She recalls finding it unbelievable to be told that they (Msaada) hadn't seen Jonathan since the previous Monday. There were then delays while the Msaada staff tried to locate keys for Jonathan's flat and when his mum phoned again to ask who would contact the police she was told by the Msaada staff that they would not because the Director (of Msaada) did not like the doors broken into and damaged.

The family describes waiting for the keys to be found as the worst hours of their lives.

Jonathan's sister was informed, later that Saturday evening, by the police that Jonathan had been found dead in his flat. She describes telling her mother that her son had died being the hardest thing she has ever done. Jonathan's mum also acknowledges how painful this must have been for her daughter.

Jonathan's mum describes the significant psychological impact Jonathan's untimely and tragic death had on her. She was also unable to return to her home where she had so many happy memories of time with Jonathan. She speaks of her concern for the health of her two daughters – one of whom took on the responsibility of dealing with all of the official enquiries and one who was pregnant at the time of her brother's death.

Jonathan's family describes a lack of human compassion, indifference, lack of respect and contemptuous attitude displayed to Jonathan, to them as a family and to other vulnerable adults by some Msaada staff.

There is a real sense of anger and injustice towards Msaada and towards NCC and CQC for what the family perceives as a failure to investigate Msaada fully after one of its premises had been closed.

Jonathan's family feels that they will never get over losing him and that closure is still in the distant future. They feel they have all missed out on so much with Jonathan's untimely death.

2.4.3 The distress and impact caused to both families is significant and continues.

2.5 Review Panel Members

Independent Chair:

- Chris Moore: Executive Dean, Strategic Partnerships and Social Enterprise, University of Northampton

Panel Members:

- Carolyn Kus: Assistant Director, Adults and Transitions, Northamptonshire County Council
- Peter Boylan: Director of Quality and Outcomes, NHS Nene Clinical Commissioning Group
- Steve Lingley: Head of Protecting Vulnerable Persons, Crime and Justice Command, Northamptonshire Police.
- Jackie Riddett: Northamptonshire Association of Care Homes (NORARCH)

3 The Facts

3.1 Msaada

Msaada was an established provider of a range of care services in Northamptonshire. Those services included residential care homes, supported accommodation and a domiciliary care agency. Msaada went into administration in December 2011. Information provided by CQC indicates that, from June 2010 to June 2012, Msaada was registered to provide the following regulated services:

Location	Regulated activities
Abbotsford Residential Home	<ul style="list-style-type: none">• Accommodation for persons who require nursing or personal care• Diagnostic and screening procedures
Abington Park View	<ul style="list-style-type: none">• Accommodation for persons who require nursing or personal care• Diagnostic and screening procedures
Ashbourne Residential Home	<ul style="list-style-type: none">• Accommodation for persons who require nursing or personal care• Diagnostic and screening procedures
Wilmot's View	<ul style="list-style-type: none">• Accommodation for persons who require nursing or personal care
Brampton View	<ul style="list-style-type: none">• Accommodation for persons who require nursing or personal care
Msaada Community Care Lid	<ul style="list-style-type: none">• Personal Care

Please note; all these services were transitional over to CQC registration on 1 October 2010.

3.2 The experiences of Adam Harris and Jonathan Smith

3.2.1 Adam Harris

Adam Harris was an 87 year old man who lived with a number of medical conditions including heart disease and diabetes. His diabetes had been controlled by insulin and he had a below knee amputation of his right leg due to complications from the diabetes. Adam lived at home with his wife and daughter who provided much of his daily care but required some support following his amputation. He had a stair lift to allow him to move between floors in his home.

Based on a list of care services provided by NCC and the fact that the Care Quality Commission (CQC) had given Msaada 2 stars, - ("Good"), - the family approached Msaada for domiciliary support and a care package was put in place for two short daily visits each day with two carers. This commenced in July 2009. Mr Harris was a "self funder" – i.e., he and his family arranged and paid for his own care. His family is clear that the reason they hired Msaada was because it was an agency on the NCC list and because of the CQC star rating.

Mr Harris used a stair lift to move between floors in his home and NCC notes identify that a risk assessment was completed by Msaada on the 15th July 2009 which identified use of the stair lift as a potential risk area. Within the control measures column of the form, item 5 states *“Staff to ensure that the arm rest is in the down position”* and item 6 says *“Staff to ensure that the seat belt is worn at all times- Adam reminds staff of this saying “clunk, click every trip”*.

It is also noted that on the reverse of this form is an update of the care plan dated 3rd June 2010, which states that the plan was reviewed, and no changes required. There is nothing in either the original risk assessment or the review to show whether Adam and his family were involved in agreeing the document. It is also noted by NCC that this form was not on the customer’s notes that would have been accessible to the carers who visited.

There were also two documents entitled “Service User Daily Schedule” which detail what the carers are to do both morning and evening. It shows that two carers are required in the morning and one in the evening. As well as this there is a “Service User Moving and Handling Assessment” form written in July 2009 which includes reference to the stair lift but does not specify how it is to be used apart from stating that *“Adam will slide himself from seat to seat”*.

Adam’s family said that Adam was used to routine and ‘faces’ and they did have concerns about turnover of staff, with new staff not always knowing what was expected.

On the 7th October 2010 Adam was attended by a carer who had been in post since the end of August 2010 (about 6 weeks). In order to take Adam upstairs she placed him on the stair lift and went to the top of the stairs to start the lift. The seatbelt was not fastened and the arm rest was not in the down position. Adam fell from the stair lift into the hall.

East Midlands Ambulance Service (EMAS) received a call from the carer at 18.25 and a Paramedic arrived at 18.35. The audio recording of the call indicates that the carer informed the staff that Adam had fallen from his stair lift. During the call the carer said that it was her fault she had forgotten to put the safety belt on.

While waiting for the paramedic to arrive, the carer said that Adam was breathing. On arrival at the home address the Paramedic reported that Adam was in Cardiac Arrest.

The Ambulance crew reported that Adam had fallen down approximately 10 steps and proceeded to resuscitate. The resuscitation was discontinued at Northampton General Hospital.

Adam’s death was referred to the Coroner by the Accident and Emergency consultant. This was due to Adam having died suddenly and the cause of death being unknown.

Cause of death was given as:

- 1) Ischemic Heart Disease
- 2) Diabetes Mellitus

The inquest did not conclude that Adam's death had been caused by the fall. Adam's family are still convinced that it was the fall which caused Adam's death.

On 20th October 2010 NCC received a letter from Adam's daughter raising concerns about the circumstances of her father's death. This would appear to have been the first notification of the incident received by NCC. A safeguarding strategy meeting was convened for the 21st October. The matter was investigated and taken to case conference on the 16th November where a finding of neglect against the carer and Msaada was made.

In interview with the Safeguarding Team worker, the carer said that she did not know what a risk assessment or manual handling plan was and had not seen the ones written for Adam. She had had only very basic training described as "office induction" followed by some joint visits with other carers. She said she had, however, been told by the family what she was supposed to do and how to do it.

Subsequently Msaada were advised that the worker should be suspended pending an investigation but this appears not to have happened (or to have happened for a short time only) because not long afterwards the carer had returned to work on a "doubling up" basis. This was agreed in the protection plan but subsequently the carer revealed that she was making lone visits where personal care or manual handling was not involved. Subsequently the carer was dismissed by Msaada and referred to Independent Safeguarding Authority (ISA).

3.2.2 Jonathan Smith

Jonathan was a man aged 37 when he was found dead at his home on the 16th October 2010. Jonathan was autistic, suffered from epilepsy and type two diabetes and had been living in Msaada supported accommodation at this address since February 2008. An inquest was opened and adjourned on 25th February 2011 and a final hearing is now planned for later in 2013. The cause of death was hypertensive heart disease and type two diabetes mellitus.

Jonathan was in receipt of a care package funded by NCC as a spot purchase which had been set up by the Learning Disability (LD) team.

This involved him having two half hour visits by Msaada staff per day plus one "floating" session per week to assist him with collecting his money and paying his rent.

It is apparent that, despite this package being in place, Jonathan had not been seen by Msaada staff in the five days before he was found dead.

Jonathan was visited on the 11th October 2010 by a Msaada carer who recorded that Jonathan was complaining of feeling unwell and had bought himself some “Lemsip Max”.

From information now held by NCC it appears that due to “confusion on the rota” the visit to Jonathan was missed on the 12th October.

On the 13th he was visited by another carer who did not get any reply but did not notify anyone that the visit had failed.

On the 14th October another carer visited and again got no reply so left a note under the door and texted Msaada’s ‘On Call’ person to advise them that she had not made contact. No action would appear to have been taken by the ‘On Call’ person.

A further Msaada visit was made on the 15th October but no action was taken by the carer when she failed to gain access.

On the 16th October the carer again failed to gain access and left the premises intending to return after she had made her other calls.

On the 16th October Jonathan’s family were increasingly worried that he was not responding to telephone calls and text messages. Jonathan’s mother eventually spoke to a Msaada manager who confirmed that Jonathan had not been seen since the Monday.

There would appear to have been some delay and difficulty in the Msaada manager obtaining keys for Jonathan’s flat and Jonathan’s sister, therefore, called the police.

The police found Jonathan dead in his flat.

3.3 The Agencies

The following provides a summary of the individual agencies contributions to the Serious Care Review process.

3.3.1 NHS Milton Keynes and Northamptonshire

3.3.1.1 General Practitioner

The GP report involved reviewing the notes of the two service users and the Panel accepted the legitimacy that this report could not address the TOR in relation to Msaada.

In respect of Adam Harris the information from the GP records was purely clinical.

The information held in the GP records about Jonathan Smith was also clinical but of particular relevance is the fact that he was de-registered by the GP practice in July 2010. From the clinical records entry it transpires that Jonathan had no contact with the practice in the 12 months prior to his de-registration.

In 2008 one of the GP's attempted to visit Jonathan at the recorded home address and was told that he was no longer living there. The GP practice found a new address for him. "At least 5" letters were sent to him and as no response was received Jonathan was removed from the GP list.

There is no formal procedure or written protocol for removing patients. Normal practice would be that someone would be removed after the practice had written on at least 3 occasions without a response.

The IMR also highlighted the fact that Jonathan's name was not on a register of patients with Learning Disabilities that was held by the practice. It is noted that in 2006 Jonathan was referred to the learning disability team. The report states that he had a borderline IQ but did not fulfil the criteria for learning disability services. He was not, therefore, included on the LD register.

3.3.2 East Midlands Ambulance Service

East Midlands Ambulance Service (EMAS) contact with Adam Harris and Jonathan Smith was limited.

EMAS attended Adam Harris on three occasions.

- 27th March 2010 responding to a 999 call and Adam was admitted to NGH.
- 1st August 2010 responding to a request to transport to NGH.
- 7th October 2010 responding to 999 call following fall from stair lift and transporting to NGH.

No safeguarding referral was raised for neglect or acts of omission.

On 16th October 2010 Police requested EMAS to attend a property where Police had discovered a male they suspected may have died. It was confirmed that the male was Jonathan Smith and that he was deceased.

No Safeguarding referral was made.

3.3.3 Northampton General Hospital NHS Trust (NGH)

In respect of Jonathan Smith there was no information for the time frame of the TOR.

In respect of Adam Harris, he was admitted to NGH on two occasions, 1st August 2010 and 7th October 2010.

During the 1st August admission the records note that Adam Harris' family were unhappy with the current care agency involved with Adam. No further information was documented in the notes and there is no detail.

Adam was referred for Social Care Assessment and the Hospital Discharge Team (HDT) made contact with Adam and his family. HDT also gave information to the family regarding interim/respite placements.

The second admission was following Adam's fall from the stair lift.

3.3.4 Northamptonshire County Council (NCC)

Northamptonshire County Council fulfils a number of roles:

3.3.4.1 Service commissioning and contract monitoring.

Most of the services operated by Msaada, with the exception of the domiciliary service, were part of the Framework Agreement (FA) operated by Northamptonshire County Council (NCC). This is an overarching contract between the council and providers that sets out the broad terms and conditions for the provision of services to individuals whether in residential settings or the community. Individual service packages are negotiated with the provider and take place within the overall context of the FA. Supported Living Services provided by Msaada were managed separately by the Supporting People Team and not under the Framework Contract. NCC undertook a number of contract monitoring visits to the range of Msaada services during the period of the review. The IMR also refers to Green Park Nursing Home in 2008 which gave cause for concern out with the period of this review. Green Park has subsequently closed. A strategy meeting in November 2008 discussed concerns about this service including poor planning, low staffing levels and high turnover, poor Health and Safety and questionable financial probity.

The Monitoring Visits are as follows:

Date	Type of Contact	Service	Issues
2008	2 x Contract Monitoring	Green Park Nursing Home	Concern with regard to the fabric of home and staffing levels. 19.11.2008 some improvements made but outstanding issues remain.
July 2009	Contract Monitoring	Brampton View	Generally a positive monitoring visit.
July 2009	Contract Monitoring	Cowper Street Beaconsfield Place	No major issues of concern were recorded following these monitoring visits.
September 2009	Follow up visits	Cowper Street Beaconsfield Place	No further concerns/issues recorded.
July 2010	Contract Monitoring Visit	Community Care Services	No customer files were viewed during this visit; as such the information received is limited.
August 2010	Contract Monitoring	Brampton View	Concerns with regard to Health & Safety identified. The report also stated that a number of other actions are still to be undertaken.
September 2010	Follow up	Brampton View	*No information recorded on file.
September 2010	Contract Monitoring Meeting	Msaada	
September 2010	Follow up visit	Brampton View	*No information recorded on file.
September 2010	Follow up visit	Beaconsfield Place	Some meetings with customers to discuss their views of the service. Customer files were reviewed.
November 2010	Contract Monitoring	The Limes	No information recorded on file. Adults Commissioning and Contracting team did not start monitoring this service until March 2011, prior to this the service was monitored by colleagues in Mental Health.
November 2010	Letters to relatives and customers.	Ashbourne Care Home	A letter informing relatives and customers of NCC concerns with regard to the service provision.
March 2011	2 x Contract Monitoring Visits	Beaconsfield Place	The monitoring visits examined Risk Assessments, Care Planning and Policies at the service.

March 2011	Contract Monitoring	The Limes	The monitoring visit identified Health and Safety concerns.
April 2011	“Drop in” visit	Abbotsford	Generally a positive monitoring visit.
May 2011	Contract Monitoring Visit	Abington Park View	Generally a satisfactory monitoring visit.
July 2011	Contract Monitoring	The Cedars	The monitoring visit identified concerns with regard to the service operating as a residential care home rather than supported living.
August 2011	Follow up contract Monitoring Meeting	The Limes	No information
October 2011	Follow up Contract Monitoring visit	The Limes	The monitoring visit identified a number of outstanding issues including specific Health and Safety matters.

*Note: The Contract Monitoring Officer who was assigned to complete these visits has now left the County Council. An extensive search of our records indicates that this former colleague failed to upload any information recorded during this visits. It is recognised that this failing is unacceptable. Since September 2010 the County Council’s Contract Monitoring Team has strengthened its recording processes and is currently in the process of introducing a comprehensive recording database that will enhance these improvements still further.

In 2011 there is a short contract monitoring report about the Supported Accommodation Service stating that the units needed to be visited, as visits in 2009 and 2010 had focused on “the office” rather than actually seeing what was happening in the service provision itself.

On the 26th October 2010 an email was sent to NCC staff advising them of the decision not to make any new placements with Msaada. At the same time Supporting People had already made a decision to end their contract with Msaada in April 2011. A meeting was held with Msaada to discuss the decision on 10th November and another confirming email was sent out to staff on the 12th November. Formal letters were drawn up to be sent to Msaada although it is not clear whether these were actually sent. Subsequently, the embargo was lifted in February 2011 for four of the Msaada Care Homes.

3.3.4.2 Adult Safeguarding

Between 9th September 2010 and 3rd March 2011 the NCC Safeguarding Adult Team had undertaken 16 safeguarding investigations in respect of service users of Msaada Services. The reasons for the safeguarding referrals included the deaths of two service users, an allegation of rape and a number of financial concerns. There were findings of neglect substantiated in relation to both Adam Harris and Jonathan Smith.

In addition to investigating the individual safeguarding concerns NCC also took other measures in relation to Msaada. This included reviewing all funded service users, placing an embargo on new admissions and setting up consultation meetings with service users and their families.

In December and January 2010/11 a number of meetings were organised for service users and their families to explain the council's concerns about Msaada and to listen to views.

In December 2011 an Audit and Risk Management report was commissioned to look specifically at possible cases of financial abuse at Msaada services. This concluded that there were weaknesses in the processes that Msaada used for client finances. Key issues were:

- Lack of formal Policies and Procedures
- Lack of transparency over what financial arrangements are in place for supporting clients with their finances and lack of clarity over individual clients' financial records.
- Inconsistencies in the recovery of alleged arrears.

In addition the Audit and Risk Management report raised wider concerns about NCC's role in particular in contract monitoring and care management review processes.

3.3.4.3 Care Management relationship with Adam Harris and Jonathan Smith

The arrangement between Adam Harris, his family and Msaada was a private arrangement and, as such, NCC was not involved in making or monitoring the arrangements. Adam's arrangement is what is termed "self funding".

His family is clear, however, that the reason they approached Msaada to provide care was because this agency was on the list provided by NCC and also because the agency had been awarded two stars by CQC.

Jonathan Smith would appear to have first become known to Msaada in 2002.

Jonathan's family had a number of concerns during his early days with Msaada and these were raised by his mum. However, Jonathan told his mother not to complain. Jonathan's family were of the view that this was because he was worried about repercussions if complaints were made.

For the purpose of this review, however, it would appear that Jonathan was in receipt of a supported living package spot-purchased by NCC; this had been set up by the Learning Disability team and involved him having two half hour visits by Msaada staff per day, plus one "floating" session per week to assist him with collecting his money and paying his rent.

In the timeframe for this review, NCC records that Msaada undertook an assessment of Jonathan on the 10th July 2007 and there were further assessments undertaken by them on the 16th June 2009 and the 6th July 2010. The wording of the daily schedules arising from these reviews changes quite considerably between the two dates. In 2009 the emphasis is on social support and general encouragement to eat well and keep the flat tidy. This schedule does not refer to two visits daily (as had been planned in 2007) but only one. It states that “Jonathan manages his own medication”

The 2010 schedule is quite different, reverting to the two visits per day schedule and putting a much clearer emphasis on helping Jonathan with medication and taking his blood sugar levels. At the safeguarding case conference the owner of Msaada claimed that this schedule was incorrect and should not have been on the file despite the fact that it had been signed by Jonathan. She further claimed that the member of staff who had written it had been disciplined. However the case conference rejected this and took the position that as this was the latest signed version it was the schedule that Msaada should have adhered to. There is no evidence however to reflect this change to the schedule, as case notes reflect social support and do not evidence monitoring of blood sugar levels and medication monitoring.

It is also clear that important information about Jonathan’s care was not, as it should have been, kept in the file in his flat. Information from the police describes what was found in the file that was in Jonathan’s flat and which should have contained up to date information about his care needs and running records. In fact most of the information was out of date or irrelevant.

In terms of NCC’s involvement with Jonathan, this appears to have been extremely limited. There is, however, an expectation that service users in receipt of Adult Social Care Services should receive a review at least annually from the Local Authority.

Jonathan had a general review from NCC in December 2007. There was another review in March 2008 although this would appear to have been in respect of day care arrangements. It is recorded that the likely explanation for the lack of reviews after this date is a decision that NCC made not to make Msaada customers a high priority for review as “the packages were small and there was no indication that the customer’s needs had changed or were not being met.”

3.3.4.4 Complaint

Following the deaths of Adam Harris and Jonathan Smith letters of complaint were received from Adam’s daughter and Jonathan’s sister. The concerns raised by Adam’s daughter eventually went to the Local Government Ombudsman although the case has now been closed by that service.

The complaint from Jonathan’ sister did not, in her view, receive a satisfactory response.

There was delay in the Council's original response to her and also this response did not address Jonathan's sister's concerns regarding NCC's failure to properly monitor Jonathan's care.

Another response was sent from the Chief Executive on the 12th April 2011, apologising for the previous reply and also for an invoice that had been sent out from the council's exchequer services. This letter offered a meeting with senior staff to discuss her concerns.

The family has not taken up this invitation to meet with Senior NCC staff.

3.3.5 Care Quality Commission (CQC)

The period of this review covers a transition period in which regulatory responsibilities transferred from Commission for Social Care Inspection, in April 2009, to Care Quality Commission.

CQC awarded Msaada Community Care a 2-star rating (Good) following an unannounced inspection on 28th September 2009. This inspection followed up a previous inspection carried out on 23rd October 2008 and covered the management of Msaada Community Care, complaints and safeguarding issues. At the end of the 2009 inspection, six statutory requirements were set in the areas of staff training, regular review of care plans and environmental risk assessments. Eleven 'good practice' recommendations were also made, including that the acting manager submit an application to register with the Care Quality Commission. This had also been a recommendation at the previous inspection.

In common with other organisations, Msaada Community Care's registration with CQC was transitioned under HSCA 2008 in June 2010 and was registered under HSCA 2008 to provide the regulated activity 'Personal Care', managing it from the head office at 161 Kettering Road, Northampton. A compliance condition was attached to the registration for the provider to ensure that a registered manager was in place by April 2011. This was not followed up by CQC after its expiry.

As previously referred to, during 2010 the Local Authority undertook 16 safeguarding investigations about Msaada services and CQC attended strategy meetings in November and December 2010.

At a safeguarding adults case conference on 16th November 2010 the concerns about Msaada at provider level were discussed. CQC subsequently held a management review meeting on 26th November 2010 involving the compliance manager, three inspectors and a CQC legal advisor to consider the regulatory response to these concerns.

As a result a responsive inspection was carried out at Msaada Community Care Service on 30th November 2010 at which seven regulations were inspected. Judgements of minor concerns with five regulations and moderate concerns with two regulations (Regulation 23: supporting staff and Regulation 10: assessing and monitoring the quality of service provision) were arrived at.

CQC next inspected Msaada Community Care on 29th June 2011. This was a scheduled inspection which was unannounced. At this inspection Msaada was found to be compliant with the six regulations inspected which were:

- Regulation 9 - Care and welfare of people who use services
- Regulation 11 - Safeguarding people who use services from abuse
- Regulation 13 - Management of medicines
- Regulation 22 - Staffing
- Regulation 23 - Supporting staff
- Regulation 10 - Assessing and monitoring the quality of service provision

The inspection included checking that the provider had made the improvements detailed in the action plan provided after the previous inspection.

In both inspections inspectors reported receiving very positive comments about the service from service users and/or their relatives.

On 23rd August 2011 CQC received a complaint from a person using the service. The letter was mostly illegible and so the details of complaint were undetermined. Various attempts were made to contact the complainant by telephone and a letter issued on 16th September inviting complainant to contact CQC again. The complainant did not make contact and the enquiry was eventually closed on 2nd July 2012.

On 14th November 2011, Msaada Community Care ceased to be registered with CQC. Following the transfer of ownership from Msaada Care, Psalmist Group Limited UK trading as Ariel Care was registered with CQC to provide the regulated activity 'Personal Care' from offices based at 161 Kettering Road, Northampton.

4 Analysis

4.1 Msaada

The Serious Case Review multi agency panel recognised that Msaada's failure to provide an Independent Management Review impacted on the Terms of Reference and, whilst there are third party opinions on how Msaada had been run and managed, this was not the same as the organisation looking at themselves and learning lessons from concerns identified.

It is apparent that the services in Northamptonshire were changing over the period of the review timescale and it would be fair to say that at that time there did not appear to be one organisation which had an overview of all of the provision, their registration status and the inspection ratings, the safeguarding issues and the contract monitoring issues.

As well as changes to services provided, Msaada was going through a process of divesting the company of care services. We know from CQC information that Msaada Community Care ceased to be registered with CQC on 14th November 2011. The transfer of ownership was to Psalmist Group Limited UK trading as Ariel Care. Indeed, Care Homes (previously trading as Msaada Community Care), have either closed or been transferred to new companies.

In terms of structure, while it would appear that Msaada was owned by an individual who appeared to have overall control of the provision, day to day running of the services seems to have been undertaken by a service manager.

While the multi agency panel understands that care is no longer being provided in the name of Msaada, the involvement of the previous director and staff in the care sector is unclear. They have not participated in this Serious Case Review, there has been no acknowledgement of lessons learnt and no reassurance that actions are being taken to avoid repetition of previous concerns.

The Panel expressed concern about, and discussed the implications of, individuals and companies who re-appear in the care system even although there has been serious concern and/or findings about their practice and conduct.

Such was the concern about the implications for self funders and other vulnerable adults that the Panel agreed to refer this policy issue to the SOVA Board.

There was a significant amount of safeguarding investigation work during the review period and while there appear to be no issues on inter-agency working, - (reports are good and the investigations seem to be thorough), - the Panel raised concerns about little being known as to what steps had been taken in relation to staff where allegations had been proven. Further information has been received and there remain gaps on whether Msaada has taken appropriate action to refer staff to the relevant regulatory bodies as appropriate.

Again without an Independent Management Review from Msaada, the analysis of the organisation and its approach to standards and to management of risk are informed by the experience of the service users, their families and other agencies.

While there is evidence in relation to Msaada documentation and paperwork being in place, there is less evidence to support the accuracy and completeness of such paperwork and whether it was completed at the appropriate time.

There is no clear understanding of how Msaada's processes for induction training, supervision, quality assurance, reviews and complaints operated.

What is known is that the carer who attended Adam Harris was relatively new. She had had basic training, which she described as "office induction," followed by some joint visits with other carers. She said that she did not know what a risk assessment or manual handling plan was and relied on Adam's family to tell her what she was supposed to do and how to do it.

People receiving care in their own homes should expect to be cared for by staff that possess the knowledge, skills and experience to meet their needs. These care staff should be well managed.

From information provided, Msaada failed to ensure that the care plan was available for and understood by the carer who attended Adam. This was a new and inexperienced carer who, it would appear, had received limited induction and training in her role. She was sent alone into a situation involving personal care and manual handling without adequate training, supervision and access to information. As well as the risk posed to Adam, the lack of induction and training posed a risk to other service users, not to mention the carer herself.

Not detracting in any way from the impact on the Harris family, the consequences of Adam's death for this young woman have been significant and the panel was concerned that she might well have been left unsupported to deal with these consequences, which in a large part was due to her employer's neglect.

During a hospital admission in August 2010, Adam's family, in initial discussion regarding his discharge planning, indicated that they were not happy with the current Care Agency (Msaada). No further information was documented in Adam's notes and the Panel thought it important to note that comments such as these need to be explored and referred to Health and Social Care Commissioners.

In Jonathan's situation it is difficult not to reach the conclusion that the arrangements for planning, carrying out and reviewing his health and care arrangements amounted to systemic failure.

There is no review or re-assessment by Msaada to explain why the client schedule was changed in July 2010 but it is clear that staff were still operating mainly to the 2009 "befriending" version at the time of Jonathan's death.

There are major gaps in case recording suggesting that either visits did not take place or they did and were not recorded. There is virtually no evidence of Msaada carers supporting Jonathan with his medication and all the evidence suggests that visits were not taking place twice daily as required in the schedule. Key documents were not on his file which contained, instead, largely out of date or irrelevant material.

Jonathan was discharged from his GP practice in 2010 apparently because the GP practice could not contact him when sending letters via Msaada, an issue which should have been addressed if Msaada had been operating to the schedule and monitoring his health and medication.

Msaada staff did have a procedure for missed or failed visits but the carers visiting Jonathan did not follow their own procedures resulting in Jonathan not being found until some days after his death. On each day the carer scheduled to visit was different and there appears to have been no mechanism for communication between carers that meant that there was no overview of previous missed visits.

The experience of both Adam Harris and Jonathan Smith points to an organisation that lacked the basics of standards, management of risk and quality assurance.

4.2 Analysis of other Agencies' roles.

While this review is in respect of Msaada, the roles played by other agencies cannot be ignored.

NCC, who had an ongoing responsibility for Jonathan's care and ensuring his needs were met, had not held a review of Jonathan's care needs since March 2008 and that review appeared to be limited.

Service users should expect to receive a review from the Local Authority at least annually to ensure that their needs continue to be met and so that changes can be made as necessary.

A decision appears to have been taken by NCC to prioritise reviews and Msaada service users were not awarded a high priority on the basis of the size of packages. What does not appear to have been taken into consideration is the vulnerability of the individuals in receipt of these services.

We also know that Jonathan had been de registered by his GP practice in 2010 and had not had a prescription issued since February 2009.

Jonathan was de registered by his GP practice on the basis that he had not responded to letters. The Senior Partner advised that there is no formal procedure or written protocol for removing patients resulting in, in this instance, Jonathan's vulnerability not being taken into consideration in removing him from the register. Moreover, the clinical notes referred to in the time frame for this review did not contain annotation or sensible intelligence in respect of Jonathan's autism and learning disability. The Panel felt that this highlighted the

necessary subtleties of record keeping, a lack of triangulation of information whereas the inclusion of such information could potentially have changed the course of events.

The panel was concerned that there appeared to be no reference in the GP records to the fact that both Adam Harris and Jonathan Smith were receiving services from a care agency, the view being that this was another indicator of vulnerability.

As far as Jonathan was concerned there is no evidence that a mental capacity assessment has taken place – again, this would have been important in making decisions regarding Jonathan’s ongoing care. Nor is there evidence of a Health Action Plan being in place which could have assisted communication between agencies.

The Audit and Risk Management report commissioned in December 2011 raised concerns about the role of NCC care management review processes and contract monitoring in respect of weaknesses identified in Msaada’s handling of service users finances.

NCC would have had a responsibility to ensure that the service received by Jonathan was value for money and fit for purpose. However, in NCC’s own IMR there were conflicting records as to whether Jonathan received a service commissioned by NCC or whether he had a personal budget. Jonathan’s service was commissioned (spot purchase) by NCC. The Panel was keen to clarify the service received by Jonathan and it appeared that this was a Supported Living Service. This was not a domiciliary care service.

While there was a finding of neglect against Msaada, following the safeguarding investigations, Jonathan and his family could legitimately have expected more from NCC and the GP practice in ensuring Jonathan’s welfare.

We know that the range of services operated by Msaada (with the exception of domiciliary care) were part of a framework agreement operated by NCC.

It is acknowledged that there was significant amount of contract monitoring activity of Msaada services. The plan was for one formal visit annually with unannounced visits thereafter depending on findings but this is not reflected in the pattern of visits. We know that Msaada had a range of services which spanned across Older People, Younger Adults, Supported Living and Supporting People. While there had been meetings to pull together how the services were operating this had happened in silos with no overarching review.

The Panel found it difficult to get any sense of a clear programme of monitoring visits and a process for follow up. Contract monitoring appeared to be a reactive response and, while issues regarding compliance and performance were discussed at length within NCC, the situation in 2010 and 2011 was complex, involved numerous safeguarding concerns and the ongoing discussions with Msaada about the sale or transfer of their business.

Given the level of concerns about the Msaada organisation, the Panel did feel that NCC acted appropriately by:

- ceasing to make new placements;
- commissioning reviews on individuals that they were responsible for funding;
- consulting service users and their families about what was happening.

Again, however, it would have been helpful to have a strategic overview of all of the issues facing decision makers to include safeguarding, contract monitoring and financial.

CQC were also involved during this period and, as a result of the safeguarding issues carried out an inspection of Msaada on 30th November 2010 at which compliance with seven regulations was inspected. Judgements of minor concerns with five regulations and moderate concerns with two regulations (Regulation 23: supporting staff and Regulation 10: assessing and monitoring the quality of service provision) were arrived at.

The Panel noted and discussed the divergence between the findings of NCC and CQC in respect of Msaada.

However, in this inspection and a subsequent inspection in June 2011, inspectors reported receiving very positive comments about the service from service users and/or their relatives.

The Panel was concerned to note, however, that there had been no registered manager for Msaada Community Care Services since 2008 and while this had been a recommendation from CQC on 3 different occasions it had not been followed up by them. While CQC assured the Panel that there would still be a registered provider who is accountable it is the registered manager who provides the leadership, training and supervision of staff – all of which were deemed to be lacking in Msaada.

The Panel was informed that NCC and CQC held quarterly information sharing meetings although perhaps had not met as regularly as quarterly. In 2010 there would appear to have been issues with information which 'could be' and 'could not be' shared. While processes are now more robust, it is important to note that CQC did not have any major concerns or issues with individual service users at this time which they did not share with NCC.

In acknowledging the steps taken by NCC to protect Msaada service users a key issue for the Panel however, was how people who funded their own care were made aware of those concerns and appropriate action taken to afford them the same duty of care as those whom the council funds.

There is a general issue as to whether people who fund their own care make assumptions about agencies appearing on council lists are somehow endorsed and monitored by them. There is also a question mark as to why Msaada appeared at all on an NCC list when it was not an agency on their Framework Agreement.

The Panel recognised that this was a complex matter but questioned the apparent lack of a strategic overview in respect of decision making on termination of contracts. While it is understood that, given the vulnerability of service users, the termination of services is not a decision to be taken lightly, there was a need for a clear audit trail of decision-making and escalation as necessary.

There is also a general issue around the steps that are taken to ensure financial fitness of organisations. Concerns were raised about Contract Monitoring in the Audit and Risk Management report of December 2011. Given the reliance of vulnerable service users on organisations such as Msaada it is essential that commissioners research with a critical eye and understand the financial probity of organisations with which they contract and fully understand the market in which they operate.

The families of Adam Harris and Jonathan Smith both raised complaints with NCC. The complaint from Adam's family would appear to have been dealt with appropriately.

The complaint from Jonathan's sister however still remains an outstanding issue. Jonathan's sister was shocked to receive in response to her letter of complaint a letter from NCC Customer Services stating that the safeguarding investigation was complete. The letter neither addressed Jonathan's sister's concerns nor acknowledged the distress she must have feeling. It was insensitive in the least and identifies the need for Senior Manager overview of any complaints correspondence where a service user has died.

5 Conclusion

With the exception of Msaada, all agencies have cooperated with this Serious Case Review and the Panel has commended the transparency and key learning which has resulted. Indeed since the time frame for this review individual agencies have moved to improve practice.

It is of significant concern, however, that Directors and managers of the Msaada organisation chose not to participate in the process.

The situation with this provider was complex and fluid requiring considerable input from NCC in particular, and the review has highlighted the need for strategic overview and clarity of decision making in complex situations such as this.

Findings of neglect were made against Msaada following the Safeguarding investigations of both Adam Harris and Jonathan Smith. This review has highlighted that regular assessment and review is critical in ensuring ongoing needs are met.

The SCR Panel was also concerned that vulnerable people can be de registered by GP Practices when, by their very condition, managing commitments such as keeping appointments would be a challenge.

This review has also highlighted the serious concern of professionals and families of the opportunity for individuals and companies to re appear in the care system in different guises.

6 Multi-agency Recommendations

- a) GP clinical records should reflect the involvement of care agencies, assuming that this is an indicator of vulnerability.
- b) Health Action plans should be developed and maintained for people who have a learning disability in order to ensure appropriate communication of health and wellbeing needs.
- c) SOVA Board to ensure positive communication with people who fund their own care to their rights to assessments for social care and Continuing Health Care funding.
- d) SOVA Board to oversee the development of inter agency guidance on escalation and management of large scale complex safeguarding investigations
- e) SOVA Board to be satisfied that partners and provider organisations understand the Mental Capacity Act and the roles of independent advocates.
- f) SOVA Board to consider how they monitor referral of individuals to regulatory bodies following safeguarding findings.
- g) SOVA Board to consider the influence of national policy development to address the issue of individuals and companies who re-invent themselves in the care system in a different form.
- h) To develop or re enforce systems to allow partners to communicate concerns raised by individuals or their families about care agencies.

6.1 NHS Milton Keynes and Northamptonshire

6.1.1 General Practitioner

GP own IMR Recommendations:

“In relation to the annotation of Medical Notes it is recommended that these are annotated appropriately for patients with Learning Disabilities.

Commissioners should emphasize the need of agencies working with vulnerable patients, and it could be argued that anyone requiring a care agency is per definition vulnerable, to work closely together and have clear lines of communication about the patient and the agency’s involvement. As a minimum this should include information to the GP on commencement and termination of an agency’s involvement with a patient and at key points during the period that an agency is involved in a patient’s care.

GP practices should develop a clear policy on deregistration of patients where patients are deregistered for reasons other than the patient moving to another practice or area.”

SCR Panel addition is that the development of the policy and protocol on deregistration of patients must take into account mental capacity and vulnerability.

6.2 East Midlands Ambulance Service

EMAS actions already taken:

“Since the Incidents involving AH and JS there has been very significant development of Safeguarding at EMAS. Safeguarding/Care Concern referral numbers and audit results reflect that safeguarding and associated agendas are embedded. The narrative within the referral forms evidences the consideration of basic needs and the contextual information around families including complex needs, carer’s, care packages, early signs of dementia etc. These developments have addressed the potential learning raised in this case including the bespoke safeguarding education developed for EOC which is currently being delivered.

Issues raised regarding Documentation including of Clinical Observations have been addressed and are being monitored.

EMAS has representation at the Safeguarding Board and is committed to partnership working. An annual Safeguarding Report produced by the Safeguarding Team at EMAS and widely distributed to partner agencies and to the Safeguarding Board summarises the work that has been undertaken and that which is planned in the Safeguarding Work Plan.”

EMAS own IMR Recommendations:

“Continue the roll-out of the bespoke education module for EOC staff with the aim for all staff to have attended my March 2013. Safeguarding referral activity will be closely monitored to note increases. This bespoke course is to be delivered to all new starters.”

6.3 Northampton General Hospital NHS Trust

No IMR Recommendations

SCR Panel addition is to ensure that when individuals and/or families raise concerns about care agencies that these are clearly recorded and passed to the appropriate agency.

SOVA Board addition is that NGH staff positively communicate to patients their rights to assessments for social care and Continuing Health Care funding particularly, but not limited to, when they fund their own care.

6.4 Care Quality Commission

CQC own IMR Recommendations:

“CQC will continue to develop and assess our safeguarding procedures. We will also continue to forge and develop strong working relationships with the relevant lead agencies in the interests of working together to protect people using services from the risks associated with poor care.

The safeguarding protocol underpins our processes for handling information and sharing it with other stakeholders. CQC staff members are all aware of the protocol and will continue to adhere to it to ensure effective communication between stakeholders in order that people using services are protected from the risk of harm and unsafe care.

CQC will continue to develop relationships with local safeguarding teams, commissioners and safeguarding boards in order that each has a clear understanding of one another’s roles so that expectations can be managed appropriately and communication channels kept open on a continuous basis, regardless of personnel and organisational changes to any of the parties.”

SCR addition is to ensure that timely regulatory action is taken when there is sustained failure of a registered provider to have a registered manager

SOVA Board addition is that the CQC SOVA Board representative recommend internally to colleagues leading on GP Registration that as part of their inspection of GP services they ensure that GP Practices are keeping an accurate register of patients engaged in care services.

6.5 Northamptonshire County Council

Actions taken by NCC:

- i. “The service has taken steps to increase the integration of the contract monitoring and safeguarding functions. Where there are concerns about institutional care providers which include safeguarding issues these are combined where appropriate to form a combined protection plan led by the commissioning service that includes a “Red, Amber, Green” (RAG) rating so that the degree of concern can be monitored and addressed.
- ii. Reviews of service users of domiciliary care and supported accommodation who are funded by NCC are now undertaken by a central review team which is linked to the Safeguarding team by having the same Service Manager. Reviews are prioritised using a four band system based on the level of vulnerability with priority being given to learning disabled service users. The approach also takes account of whether people live alone, have mental health problems or are judged to be “non-engaged”. Reviews for most service users now take place annually.
- iii. The younger and older adults commissioning function has now been brought together and there is a contract monitoring and compliance team

for all ages. This currently has 5 WTE posts (4 filled currently) to monitor the 808 provider services in the county. Again work is prioritised with services rated “red” being checked every twelve months and “amber/green” ones every 2 years.

iv. The Framework agreement document has been updated in 2012.”

NCC’s own IMR recommendations:

1. “As part of our revised care pathway it is proposed that we will change the way we review and re-assesses the needs of all service users in receipt of community care services for customers for who we have financial responsibility. There will be a greater emphasis on the use of review scheduling (collation of appointments into dedicated days) to ensure that reviews are not overtaken by assessments and that the services they receive are effective and relevant to their changing needs. Where resources are limited for carrying out reviews, priority should be given to the most vulnerable who should be reviewed at least annually with no service user ever going longer than two years without being subject to a full review.
2. All reviews should ensure that the funding provided for customers in receipt of self-directed support is being used appropriately and is sufficient to deliver the quality and level of service required to meet the assessed needs.
3. Whilst new arrangements for contract monitoring have addressed in part the need to develop a more consistent approach to carrying out compliance visits, we need to ensure that the resources available for monitoring and managing institutional protection plans is adequate to ensure that provider services that are non-compliant are managed back into a compliant position or the contract terminated within a reasonable timeframe. Compliance visits should include measures to test the effectiveness of policies and procedures to ensure that they are working effectively.
4. Where serious or persistent concerns arise about a provider NCC should ensure that there is a clear framework for determining whether that service should continue to be part of the Framework Agreement. This should include confirming who is responsible for making the decision, the criteria for making such a decision (usually this should link to the wording of the FA) and the timeframe. In complex cases a chronology of concerns and actions should be brought together to ensure that there is a clear view of the overall concerns and actions taken.
5. In line with recommendation 4 we intend to develop an Escalation (or Progression) Policy which would show the stages we will follow when a provider persistently fails to comply with the terms of the contract or places service users at risk. Providers will be made aware of this so that they understand where they are in the process and the consequences of not remedying non-compliance concerns.

6. In instances where large scale reviews are carried out as part of a protection plan to ensure the welfare of all service users in receipt of care from the specific provider about which there is concern; these reviews will be brought together as a whole and considered so that the results of the exercise can be fed into the decision making process about the provider service.
7. Where it appears that a provider service is failing to manage its financial responsibilities effectively this will be brought into the overall consideration of its fitness to be part of the Framework Agreement. This will include such things as failure to manage service users' money safely and in their interests, allowing vulnerable service users to accrue debts and incorrect invoicing.
8. Legal advice to be sought in relation to the current information/lists we publish of service providers to the public. Our aim would be to ensure that the public are clear what the status is of the providers (i.e. whether they are part of the FA) and whether this can include a disclaimer that it is the responsibility of service users and their families to ensure that they satisfy themselves about the suitability of the provision. This matter will then be tabled at the SOVA Board for further discussion.
9. The central safeguarding team have take steps to improve the quality of minute taking for strategy meetings and case conferences. This includes standardised format and paperwork. We plan to cascade this to all teams to ensure consistency and standards with all chair persons and business support staff.
10. Develop inter-agency guidance on the escalation and management of complex and large scale investigations. Once agreed and signed off by the SOVA Board these practice requirements need to be reflected within the inter-agency procedures.
11. There are two countywide health action co-ordinators employed within the county who work closely with our two younger adult's teams who work specifically with people who have a learning disability. It is proposed that due consideration of a customers health action plan is added to the existing review tool which provides the overarching framework for this activity."

SCR Panel additions:

Protocols to be developed to provide clarity on the sharing of information with people who pay for their own care.

Senior managers are to ensure oversight of all complaints correspondence where a service user has died.

6.6 Governance arrangements

An action plan from this Serious Case Review has been developed to take forward the recommendations

The plan includes timescales for implementation and all agencies have the responsibility to alert the SOVA Board of any obstacles that prevent the completion of the task within the agreed timeframe.

<END OF REPORT>