PUBLIC

Derbyshire County Council

Improvement and Scrutiny Committee – People

12 February 2020

Assurance Measures following LGO investigation

Background

In relation to the death of a resident at The Grange Care Home in 2016, The Council received a notice of prosecution in 2019 from the Care Quality Commission for failure to provide safe care and was subsequently prosecuted in December 2019. A review commenced following the CQC notice and has subsequently taken into account the Local Government Ombudsman (LGO) report published on the 29th November 2019.

Lessons Learnt

The following 6 key Learning Lessons have been identified and these have been used to inform and drive the actions within an improvement plan.

- **Quality Monitoring and Improvement:** Mechanisms for Quality monitoring were not sufficient to ensure problems existing at the Grange were highlighted.
- **Effective Policies and Procedures:** Policy, Process and pre-established systems were not followed by staff at The Grange or some other DCC professionals.
- **Quality Recording:** Recording was inconsistent and not always of high quality. The use of electronic and paper records increased the risk of missed or inaccurate documentation.
- **Safeguarding arrangements:** Processes were not followed appropriately.
- **Quality Workforce:** Mechanisms to ensure staff were clear on their roles and responsibilities and were suitably trained and supported to deliver them were insufficient and more robust arrangements to ensure capability or conduct of individual staff was sufficiently investigated and followed up needed to be in place.
- **Strengthening Communication:** There was recognised missed opportunities in communicating with family members.

Summary of Key Actions

1. A Quality Improvement Board has been established. The Board is chaired by the Assistant Director and involves Group Mangers (Heads of Service) across the directorate in order to ensure that the quality and improvement of the Council's directly provided services is the responsibility of the whole directorate and not just Direct Care. The work of the board has been split in to six critical work streams which were identified in response to the LGO's findings (as above)

2. The Council has conducted a review of all its safeguarding policies, all of which are available on the Safeguarding Adults Board website. This review included an appraisal of the information available regarding communication with families during safeguarding investigations. To ensure that staff working within the Council's directly provided services understand their responsibilities with respect to safeguarding, the Council's Lead for safeguarding conducted two workshops for all Unit Mangers and service mangers to provide guidance and answer questions.

3. An Incident Reporting form has been created where all incidents of harm or possible harm are logged centrally and feed in to the central Dashboard which reports on themes and trends.

4. A pilot is currently being undertaken within the homes to look at having hand held electronic devices for staff to record observations.

5. The Council has employed three additional officers to work within its central Quality and Compliance Team, a Group Manager and two Senior Project officers. The Group Manager has been employed to lead this team with a focus solely on quality and compliance. The two Senior Project officers have been appointed to deliver new, centrally managed, monitoring arrangements within the Quality and Compliance team.

6. The Council has established a central 'Dashboard' which monitors the performance of its care homes by measuring across six key metrics; staffing vacancies, occupancy, incidents (including trips and falls and medication errors), training, complaints and CQC rating. This allows for central monitoring of themes and trends.

7. A quality assurance strategy and Framework has been developed.

8. A report identifying lessons learned, actions taken and actions planned was presented to the Standards, ethics and governance scrutiny committee on 9th January 2020 and a commitment to report on progress to the same committee has been made for six months' time.

9. An independent expert has been commissioned to provide a further report commenting upon the Council's proposals for the continued monitoring and improvement of its services with particular reference to the LGO report and the Action Plan devised by the Quality and Improvement Board.

10. Derbyshire Learning online has been developed for the use by Direct Care and information about completion of mandatory training by all staff is now available centrally.