ACTION PLAN – PURBECK CARE – LAST UPDATED 12/01/2015

	key learning points	Planned Outcome	Actions	Lead	Timescale	Progress/Immediate Action
1.	*Low level incidents and cumulative evidence of risk:* There was a history of incidents of resident on resident violence at PC. That the majority of such incidents led to no serious injuries was probably a factor in staff and managers not recognising the requirement for safeguarding alerts. However, if the triage service had received alerts following every incident, this would have provided more cumulative evidence of risk. The risk would not only be from significant physical injury – which in fact did happen to one resident who suffered a fractured hip and arm - but also from psychological and emotional harm to residents who may have been living in fear of violence from fellow residents. The same principle applies to allegations of thefts of residents' money and other property, including the potential psychological harm caused to residents who do not feel that their money and personal belongings are secure in their home environment. Whilst an isolated and unproven allegation of a theft of a resident's	1. An information sharing system is established that can report on low level incidents and identify cumulative patterns within respective provider agencies	(a) A monthly intelligence meeting (teleconference) is to be established between CQC, DCC safeguarding, Dorset Police, Dorset CCG and DCC Contract Monitoring to share information about low level incidents and trends. (b) The bi-monthly multi agency Care Quality Monitoring Group (CQMG) should review the findings from the intelligence meeting and ensure any necessary action has been/is taken. (c) The CQMG should advise the DSAB QA Sub Group about trends and concerns related to particular provider agencies	SW. VR. PS. JC. RG CQMG Chair CQMG Chair	Nov 14 Nov 14 Nov 14	(a) Monthly intelligence sharing meetings will commence from 28th November 2014. (b) The CQMG is in place and operational (c) The DSAB QA Sub Group is in place and operational

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	property may have limited significance, when similar allegations are repeated by different residents over a relatively short period of time, this should raise serious concerns about the ability of the service to provide a safe and secure home for vulnerable people. If the triage service is not notified of each incident, the nature and level of risks within the establishment is unlikely to be properly identified.		(d) A multi agency legacy group should be established to ensure service user finances and other belongings are properly dealt with.	MG	Feb 15	(d) MG contacting commissioning leads during February to set up first meeting.
2.	*Clarity and consistency of alert thresholds:* This lack of clarity - and therefore consistency - around thresholds for safeguarding alerts, notifications and referrals to the Safeguarding triage service. This may indicate a need to revise / clarify the Multi-Agency Safeguarding Adults Policy and Procedure in this area. This problem is compounded by confusion about the terminology used, with terms such *as alert / referral, vulnerable adults referral being* used interchangeably by different agencies. Some commonly agreed terminology and definitions, to be included in multi-agency adult safeguarding training programmes,	2. Policy and Procedures and Thresholds are clear, including use of consistent language and terminology.	(a) The Pan-Dorset Policies and Procedures Group will review the Pan Dorset Safeguarding Policy and the range of terminology currently in use	DV Chair of P&P Group	Apr 15	Work is in progress by the DSAB P&P Sub Group

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	would assist in establishing more consistent approaches.					
3.	*Need for effective IT data base systems:* One factor in the failure to recognise a body of concern was that the triage team's computerised recording system is apparently unable to extract historical data on alerts relating to an individual residential care home, as the system is only able to search according to the victim, rather than their place of residence. This appears to be a very basic and fundamental design fault, meaning that it is less likely that potentially significant patterns and trends of safeguarding alerts within a residential establishment will result in effective investigation and actions to safeguard vulnerable residents.	All agencies are able to identify alerts by victim, location and provider that can be provided to Triage and the intelligence meeting (see 1 (a) above)	(a) A Manual system is put in place a.s.a.p to extract data to an individual residential care home level. (b) A computerised system to be commissioned as soon as possible that can achieve the planned outcome.	NB/SW HC/AW	Jan 2015 2016	(a) Terms of Reference are being agreed to commence the system from Jan 2015. (b) Careworks (Care Director system) has been awarded the contract for Poole Borough Council's Case Management. DCC is currently considering the use of Careworks.
4.	*Risk assessment training, skills and resources* Whilst the above (no.3.) is a key learning point, it is also important to emphasise that this is not simply an IT systems problem. Whatever manual or electronic recording systems are in place, it is essential that staff are sufficiently resourced, trained and	(4a) Introduction of a Risk Assessment Tool for all staff. (4b) Staff are trained sufficiently and	(a) A suitable Risk Assessment tool is identified for use by all staff (b) Appropriate training is provided to staff, including the need to	PCAPG T&WDG	March 15 immediately	(a) A Dorset Police Risk Assessment Tool is currently being considered by the PCAPG (b) Appropriate training is being provided to staff as outlined in the agreed

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	supported and skilled to evaluate risk based on all of the relevant evidence relating to a residential care home, including historical alerts.	supported to confidently assess and evaluate risks.	identify and deal with low level concerns			T&WDG Action Plan. Dealing with low level concerns appropriately will be factored into future training.
5.	*Whistle blowing policies and procedures* Staff members at PC did "blow the whistle" which may be a positive indication that whistle blowing policies and procedures were effective in this case. It is also noted that this case emphasises the value of regular checks (by contract monitoring staff and through CQC statutory inspection processes) that providers have effective whistle blowing policies and procedures and that staff at all levels have a good awareness of - and confidence in – them.	(5a) All agencies' contract monitoring staff review provider agency staff awareness of whistle blowing policies during monitoring visits. (5b) CQC routinely monitors use of whistle blowing policies by provider agency staff.	(a) All agencies' contract monitoring test or sample staff during visits to providers to ensure staff are aware and are confident about raising safeguarding or other related concerns and what process to use (b) CQC will review how it monitors whistle blowing policies in provider agencies.	NB RG	Immediately immediately	(a) Provider staff awareness is currently checked as part of all agencies' full monitoring process. Checks will now be integral to every visit including themed monitoring visits. (b) A new CQC Comprehensive Inspection methodology has been agreed from October 1st and will address monitoring of whistle blowing policies.
6.	*Systematic sharing and collation of concerns:* The Quality Monitoring Group is a positive initiative, aimed at sharing key information and ensuring that	(6a) 'low level' concerns about standards of care provided is systematically	(a) See actions at 1 (a), (b) and (c) above.	PCAPG	Nov 14	(a) Monthly intelligence sharing meetings will commence from 28th

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	commissioned care services deliver the highest quality care possible. The evidence from the audit confirms that many organisations had what may be described as 'low level' concerns about standards of care provided to some PC residents. If all of this information had been more systematically collated and presented to the Quality Monitoring Group, this may have led to more assertive investigations and interventions, at an earlier stage.	collated and presented to the Care Quality Monitoring Group. (6b) A written proforma is shared for scrutiny if the CQMG is cancelled	(b) The DCC commissioning lead should be regularly represented as a core member of the CQMG (c) The Dorset Police lead should regularly attend the CQMG as a core member. (d) The CQMG Terms of Reference to be updated to include this requirement to share low level concerns	NB PS Chair of CQMG	Nov 14 Nov 14 Jan 15	November 2014. (b) Nicky Beaton, DCC commissioning lead has joined the CQMG (c) Paul Smith Dorset Police will attend future CQMG meetings (d) For agreement at the next CQMG in January 2015
7.	*Cooperation between CQC and local commissioners / contract managers:* This case has confirmed ongoing concerns about a sense of "disconnect" between CQC as the statutory inspectorate for registered care services	(a) All parties to improve levels of communication, cooperation and sharing of local intelligence	(a) See 1 (a), (b) and (c) above	PCAPG	Nov 14	(a) Monthly intelligence sharing meetings will commence from 28th November 2014.

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	and local commissioners, contract management & monitoring functions. There is a clear need for all parties to improve levels of communication, cooperation and sharing of local intelligence. It is recognised that some positive steps have been taken, including the Dorset-wide Care Quality Monitoring Group, of which CQC is a key member. However, the evidence reviewed by the audit suggests that there is still major room for improvement in this area, including the need for CQC inspectors to more proactively seek and utilise intelligence from local agencies (e.g. care managers, commissioners, contract managers, adult safeguarding leads, advocacy services) as an important element of the inspection and quality evaluation process. The audit also found that more continuity of CQC managers and lead inspectors would assist greatly in establishing effective multi–agency approaches to safeguarding vulnerable care home residents.	(b) intelligence from Advocacy agencies is considered more routinely and acted on (c) CQC provide continuity of Inspectors for improved multi agency working	(a) All agencies' commissioning teams will review communication with advocacy agencies and use of intelligence provided by them (b) CQC to review and improve continuity of Inspectors for improved multi agency working	NB RG	Apr 15 immediately	(b) The new DCC operational structure has been agreed for implementation from April 2015. This brings together safeguarding, contracts monitoring, Trading Standards and quality control under a single Head of Service and use of intelligence from Advocacy Contracts will be reviewed. (c) A new CQC Comprehensive Inspection methodology has been agreed from October 1st and requires contact with all agencies. More CQC Inspectors have been recruited and this will assist with continuity for Inspections and key meetings such as the CQMG

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8.	<u>*Commissioning local services for local citizens:*</u> The issue of *"local services for local citizens"* highlighted by the Winterbourne View enquiry is of direct relevance to learning from this case. The audit groups expressed a consistently strong view that the model of an institution placing large numbers of vulnerable people with complex needs in a single and geographically isolated location is fundamentally flawed. Although the location for the 10 people placed by Dorset County Council and the Commissioning Group could be described as "*local*", the fact of being in a geographically isolated (from local communities within Dorset) institution with such large numbers of other people with complex needs makes it an extremely difficult environment in which to deliver safe, person centred care and support. A related concern is that all of the residents at PC, including those placed from other parts of the country require local services, including the Community Learning Disability Team, primary health care, community nursing and	(a) All agencies' model of care reduces dependency and promotes person centred care and independence.	(a) A local model of care is developed which is based on reducing dependency and institutional care and promoting independence in a person centred way. (b) DCC will reconfigure the use of its Residential Care Homes for people with a learning disability with a view to supporting people in 'ordinary' community settings such as supported living, where possible. (c) All agencies will continue to review the use of institutional placements for service users with a learning	GG/AW GG GG	Immediately Immediately immediately	(a) Pathways to Independence has been agreed and is being implemented as the future model of service provision. This promotes person centred care, safety and independence for service users in community settings. (b) Two of DCC's Residential Care Homes for people with a learning disability have been de-commissioned and people placed successfully in community settings such as supported housing. The 3rd and final home is due to close in January 2015. (c) Person centred reviews are carried out routinely with a view to implementing the vision set out in Pathways to

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	hospital services. Similarly, as the chronology clearly demonstrates, PC residents also need (and are fully entitled to) significant levels of input from the police and other emergency services. This creates increased demands on local services and resources, which is likely to impact negatively on the level of provision available to local citizens.		disability			Independence.
9.	*Creative person centred commissioning:* There is no simple answer to the above question. However, one of the audit contributors provided an excellent example of what can be achieved, with input from a skilled care manager and creative person centred commissioning: *A previous resident of PC with challenging behaviours has moved to a community based setting, with an intensive support package. Since the move his individual needs have been more appropriately met, with the result that his behaviour is now significantly less challenging. The cost of the intensive support package is approximately £1500 per week less than his placement at PC. It is*	(a) All agencies have a clear vision about the commissioning and provision of person centred care services to people with a learning disability that reduces dependency and institutional care and promotes independence and this vision is articulated to all key stakeholders.	(a) Fully implement the Pathways to Independence Programme which includes more use of ordinary community options such as supported living in small cluster settings.	GG/AW	Immediately	(a) See 8 (a), (b) and (c) above. Pathways to Independence is being successfully rolled out with good initial feedback from service users and carers at the LD Partnership Board. People First Dorset have been reappointed to maintain and extend provider quality checks.

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	anticipated that his support needs may reduce as he becomes more settled in his new living environment. Other potential commissioning ideas put forward by audit group participants included: ▪ Small residential units of 4 to 6 people per unit, with a large majority of residents from the local community, including some crisis beds. ▪ Payments by results contracts which reward positive outcomes ▪ Requiring providers to have family / service user representation on management boards ▪ Ongoing quality checks by advocacy services / experts by experience.		(b) Implement the 4 stage pan Dorset model of support to people in crisis. (c) Ensure sufficient Safe Havens for people with a learning disability are available locally (d) Ensure Equality Impact Assessments (EqIA) are carried out where there is a new policy or procedure or significant change that relates to people with a learning disability. (e) Ensure continued use of	LD Pan Dorset JCB GG P.St.Q GG GG P.St.Q	Immediately Immediately Immediately immediately	(b) The 4 Stage model is agreed and is being implemented (c) DCC has identified 2 Safe Havens and is reviewing the need for more. (d) DCC has a formal process, linked to its policy and procedure for carrying out EqIA's and this is used routinely. (e) DCC commission People First Dorset to

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			independent advocacy services for people with a learning disability			provide advocacy services and carry out Quality Assurance Checks.
10.	*Unmet need for emergency placements:* The audit findings suggest that there is an unmet need for a small locally based service, which could provide short term emergency placements for people with learning disabilities and complex needs who are in crisis and unable to remain in their current accommodation. This would provide a period of respite and an opportunity for a person centred assessment of need, including consideration of the views of family members and informal carers. It would also reduce the frequency with which people are placed at services such as PC by "default", but subsequently stay as a long term resident, even when the service is unable to meet their assessed needs.	Independent Safe Havens for people in crisis is available	Expand one of the two existing Safe Havens. Create a third Safe Haven in Weymouth.	GG P.StQ	Immediately	Two Safe Havens are available for emergency use and one is being extended. A third is being commissioned for the Weymouth area.
11.	*Listening to / acting on concerns raised by advocacy services:* Independent advocacy services going into establishments such as PC and working directly with residents (in	(a) All agencies work more closely in partnership with advocacy	(a) (Advocacy services are commissioned so people with a learning disability and their carers can	GG P.StQ	Immediately	(a) DCC currently commission People First Dorset to provide advocacy services and carry out quality

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	groups or 1-1 contacts) should be a major factor in preventing harm and promoting a positive caring home environment. It is important that every care home resident has access an independent advocate, if they need and want one. It is even more important in an establishment such as PC, where most residents are living many miles away from relatives, and informal carers whilst a significant number do not have any contact from relatives. However, the ability of advocacy services to effectively promote a safe and caring environment depends very much on commissioners listening – and acting assertively – when these services raise the types of concerns outlined above.	services to support people with a learning disability and ensure they are safe and feel safe.	access them as necessary. (b) Care managers should ensure and evidence the use of independent advocacy services is considered as part of the statutory review (c) Concerns & complaints from advocacy services about safeguarding of people with learning disabilities should be considered by the monthly Intelligence Meetings. See 1 (a), (b) and (c) above.	 GG SW. VR. PS. JC	 Immediately immediately	assurance checks. (b) Care managers are currently required to consider the use of advocates for people with a learning disability as part of the Assessment, Care Planning and Review process. (c) Monthly intelligence sharing meetings will commence from 28th November 2014.
12.	<u>*Devolved management structures and accountability gaps*</u> The devolved management arrangements at PC were an important factor leading to poor quality management practices, for which there was a lack of clear accountability. This was ultimately the responsibility of PC's	Governance and management arrangements of providers are routinely scrutinised to ensure they are fit for purpose	(a) All agencies' Contract Monitoring Teams check management arrangements and governance as part of routine provider reviews and report any concerns	NB	Immediately	(a) Regular contract monitoring is in place and being implemented. Relevant outcomes will be shared with the monthly intelligence meetings from 28th November 2014.

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	Board of Directors who had made the decision to contract operational management to another company. However, it was also the responsibility of commissioners and contract managers to be aware of such management arrangements and the potential issues of accountability that may arise from them. When the new PC management team acknowledged that some residents' needs could not be properly met, this was a very positive sign that the service was now prioritising residents' safety and wellbeing, over income generation. However, it also raises the question of why this had not already been recognised and acted upon, by care managers, contract managers and commissioners.		to the monthly intelligence meeting and CQMG for action mentioned in 1 (a), (b) and (c) above. (b) All agencies' contracts teams to recommend to providers that a family carer is included as a member of their Management Board.		Jan 15	(b) To be included in all Contract Review Meetings and at the establishment of new Contracts.

ACTION PLAN GROUP (PCAPG)
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