Jeesal Residential Care Services ltd
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Regulation 28: Response to report to prevent future deaths.

Jacqueline LAK
Senior for Norfolk,
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich
NR1 2DH

Date: 4th September 2021

Reference Ben Buster King / Inquest/Reg28/Response

Dear Jacqueline Lake,

I am writing to you in your response to the regulation 28 report.

Firstly, I would like to send my deepest condolences to the family relatives of Ben Buster King.
The staffing team at Cawston Park worked hard to provide the care and support to Ben in his time at the Hospital and we were deeply saddened by his tragic death.

I have requested from our Managing Director [redacted], to respond to the points within the regulation 28 report. His response is enclosed along with this letter.

We as the non- executive directors of the board, namely [redacted] and [redacted], have made further changes to the way our remaining care organisation operates.

These changes are as follows:

1. The board membership will be balanced between executive and non-executive directors.

2. The board will seek independent verification of operational management reports. This task will be carried out by a non-executive director.

3. The Board will commission independent staff and family surveys.

4. Since closing the Hospital service in May 2021, we have taken the decision that we will not run Hospital services in the future.

Your sincerely
[redacted]

Jeesal Care
"we provide, we support, we care"

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Following the tragic death of Ben King and the subsequent Inquest, the Coroner issued a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the coroners (Investigations) Regulations 2013. This letter is our response to that report. Each of the Coroner's 10 points are responded to in turn.

1. The management of Jeesal Residential Care Services (JRCS) is led by [redacted], who has over 40 years of experience in the Health and Social Care sector, holding a number of senior appointments including CEO/MD in the public, independent and charitable sector. He also has a clinical background and significant management training and experience in the sector. He is not a shareholder in any Jeesal Company or subsidiary, nor any other private company in the Health and Social care field. He is not a statutory Director of any company or subsidiary owned in whole or in part by the Directors named in the coroner's report.

   [redacted] do not have any day-to-day responsibilities for the activities of Jeesal Residential Care Services, this is delivered through an Operational Management Team (OMT) which reports to the MD. In addition, the organisation has a Governance Assurance Team (GAT) which also reports directly to the MD.

   [redacted] are Non-Executive Director of Jeesal Residential Care Services Board. The MD is currently seeking to strengthen the Board with the appointment of additional non-executive directors (NXD).

   JRCS is a community-based service for people with learning disability and or autism. our services are delivered in ordinary houses, sometimes adapted to meet the specific care needs of an individual. The services in the main are funded by the local authority and the residents have full access to the same community facilities as the rest of the local population.

2. CCTV is often used in hospital settings, though only in shared public areas. CCTV would be totally inappropriate in the residential homes that we manage. It could be considered an intrusion in the rights and liberties of residents, who consider the house as their home.

   Regular training, supervision of staff is key to good practice. In addition, internal and external inspection offer the opportunity to monitor that practice is both supportive and safe. Our residential services are overseen by a Service Governance Team (GAT), This team consists of a HR member, Training Manager, Head of Quality, Community Development Managers, Business Development Director and MD. They bring a wide

range of experience and expertise to the role. They carry out planned and un-planned reviews of each service and develop with the home manager action plans, which they also monitor progress against.

3. Each home has access to an external multidisciplinary team- Community Learning Disability Team. Where there is a need for dietary advice then a referral is made to the team. The referral is made on an individual basis and any treatment and support plan will be shared and explained to the staff and monitored by the GAT and the CLDT In addition, every resident is registered with a local GP practice and therefore has full access through this route to community, primary and secondary care and treatment services made up of local health service and social care professionals.

4. The training of staff in Residential Services is very different from that in a hospital setting. There is a two-week induction programme in a classroom setting with additional e-learning modules. the training department also offers support for the Care Certificate, which is a nationally recognised award that all staff are required to complete to work in the service.

5. The residential service does not employ Dieticians, please see my response at point 3. We access this service through the residents GP or a referral from a member of the joint NHS/ LA Community Learning Disability Team (CLDT). This is in recognition that all of our residents live in our homes in the community. Many of our homes are ordinary houses scattered around the county. The people who live in our homes are very different from hospital patients their support focus is on everyday living skills and community integration and participation.

6. The MD and members of the GAT have access to every resident's care file, we also have access to a whole range of information on each resident, all of which we can access remotely. The GAT carries out regular service reviews and unannounced inspections. Where there are deficiencies, the GAT will work with the Registered Manager to correct these deficiencies which may include report writing, care planning, risk assessments and healthy living plans. As an example, the GAT recently found inconsistencies in recording of information on Pandora, with some confusion as to record entries. This led to the establishment of a Pandora User Group, to work with homes to improve consistency of recording and content.

   We have also recently given access to the Pandora system to local authority professional staff so they can review the residents' files.

7. Because our primary focus is community participation, we do not employ a Sports instructor. We encourage, wherever possible, for our residents to access community facilities including local gyms, swimming pools and a wide range of community activities. Each service user has a written care plan, this is developed with the individual and takes account of his / her preferences, interests, lies and dislikes, it will also involve input from external professionals.

8. Each resident is registered with a GP practice, who carry out a yearly health MOT on our residents. This covers weight management. This intervention and any

recommendations from it are shared with the Manager and staff of the resident's home and incorporated into the resident's care plan. If required a referral is made to secondary health services or to the CLDT.

The CLDT have nurses who can advise and support on healthy lifestyles and will monitor progress. They are also have the expertise to support home staff in a whole number of general health and mental health issues and where necessary they can refer a resident to another member of the team. The CLDT also carry out regular out-patient appointments, led by a Consultant Psychiatrist and any interventions or onward referrals would be agreed and actioned from this appointment.

9. The Pandora system is still under development in Residential Services. We have recently strengthened and improved our systems, having taken learning from the issues at Cawston Park. This includes the creation of Pandora User Group. This group involves home staff to ensure that the Pandora Information System is accessible and useful to staff teams in the homes. However, we have to strike a balance between ensuring we capture essential information and not creating too much information. This is a task for the Pandora User Group.

10. Access by our staff for policies and procedure is via a different system called My Learning Cloud. Every member of staff when joining the organisation is given an account on My Learning Cloud to track their training, access Policies and Procedures and a range of staff focused activities. Another learning for us is the setting up of a Pandora user group, which is a recent development. This is a cross section of staff in the organisation to look at the further development of Pandora, how we ensure it is user friendly and what additional training is required by staff to ensure easy access to the system.

    We note the suggestion by the Dietician to have a paper-based system. We am resistant to this as this will undermine my ability and the ability of GAT and external colleagues to monitor remotely. I consider a two-system approach to be detrimental when trying to achieve a whole system approach to care and support. Unlike a hospital where the patients are in one place, our residential services are spread across the county and as such, while physical attendance at a home is important, so too is remote access. In addition, the Pandora system allows us to carry out statistical analysis and monitor trends.

11. The coroner is correct the investigation did not capture the concerns raised in the inquest. However, the investigation was halted due to the matter becoming a Police Investigation and as such common practice is any internal investigation is suspended to ensure it does not compromise the Police enquiry. I am satisfied that if we had been allowed to proceed all of the issues would have been identified by the investigating officers.

12. Our Head of Quality regularly reviews our SI and RCA procedures in the light of updated guidance. Where guidance changes then the Head of Quality will update our Policy and procedures in this area. The Service Governance Committee is required to ratify the changes and only then will the MD sign it off.

13. The residential homes have learned the lessons where applicable from the experiences of Cawston Park and from other investigations of a similar nature. The main area of lessons learnt was in the area of information sharing with professional colleagues. This still requires more work, and the MD meets regularly with Managers in NCC and the CLDT and takes forward personally any shortfalls in this area, referring them to the individual home manager to address or to the GAT to give support, guidance and support However, the delivery of services in the community are very different in their style and function as well as purpose. The majority of people in hospital are held under a section of the Mental Health Act and in some cases, they have additional Home Office restrictions upon them. This is not the case in residential services. In addition, a patient in a hospital is subject to management of their treatment by a Responsible Clinician, usually a Consultant Psychiatrist. This is not the case for the majority of people living in the community, nor should it be.

    However, with our external colleagues in Social Services we have being carrying out a review of each resident in our homes to ensure they are correctly placed, and the care package is appropriate to meet their needs. We have also ensured that residents in our homes are considered for a different service due to changing needs. We are working with our health and social services colleagues to seek ways of improving the care and support of our residents from external professionals and additional training for our staff. We meet weekly with our Social Services Colleagues and a rolling action plan is in place.

    Hospitals by their very nature are much more comprehensive in the way that care, and treatment is delivered, the majority of staff including the Multi-Disciplinary Team (MDT) are employed by the organisation that owns the hospital. However, the operational framework in the community is based on shared care with a range of organisations and professionals, this arrangement ensures that the necessary checks and balances are in place. The operational functioning of a hospital is alien to the workings of residential services and to the people we support.

    While lessons can be learned from any enquiry, it does not necessarily follow that sweeping changes should be made in residential services unless those changes emanated from a review of residential services elsewhere. In which case there would undoubtably be valuable lessons to learn. the people that are supported, the staff the management and the collaborative working in our services demonstrate that we are well ahead of the workings of a hospital setting. Hospital systems and processes are often not relevant to the way services are delivered for our residents.

[redacted]

Managing Director

Jeesal Residential Care Services.

1st September 2021