Leonard Cheshire
Regus, The News Building, 3rd Floor, 3 London Bridge Street, London, SE1 9SG
[redacted]

9th October 2023

Dear Miss Crawford,

Re: Regulation 28 Report – Inquest into death of Linda Oldland concluded 3rd July 2023

The table below details the actions taken to ensure people living within a Leonard Cheshire facility are safe, following the sad death of Linda Oldland. I would also like to inform you of significant changes within the organisation over the last 12 – 18 months, which will have a beneficial impact on the safety of the people we support by further improving monitoring of quality and safety compliance:

- Executive team includes a new post of Executive Director of Quality and Clinical Care
- Restructure of Quality team with introduction of improved Quality Audit plan
- New Board of Trustees which includes Trustees with specific expertise in Quality and social care, and a new Chair of Board with extensive experience of the care sector. The new Chair has had a successful career as CEO and Chair in the Leisure and Hospitality sector. He is now chair for Ambitious about Autism, Nottinghamshire Trent University and St Christophers Hospice in South East London, as well as Leonard Cheshire. His focus is on the quality of services and financial sustainability in the charity sector.

Since the death of Linda, we have implemented several measures to reduce the risk and we have further changes planned as detailed in the following action plan.

Action	Impact	Expected Completion
Manager's daily walkaround	The service manager's now carry out a daily walkaround which is documented, following a standardised format. This ensures that they are visible, speak with staff and people being supported.	Completed
Daily 'flash' meeting	This is a 10-20 minute meeting held daily in the morning, chaired by the Service Manager/Deputy Manager or Nurse in Charge, its attended by key staff: Domestic, Maintenance, Activities, Nurses – at the meeting the daily activities are discussed along with any concerns regarding people using the service, changes in behaviour, signs of illness, external professionals visiting, GP contact	Completed
Weekly clinical governance meeting	These meetings are held with the clinical team, going into detail about clinical concerns within the service, any further support the people we support may need. Any visits from professionals and updates which have been carried out in the	Completed

	personal care plans or updates which may be needed.	
Sepsis training	We have implemented Sepsis training w/c 2/10/23 and all staff have a deadline of 30th Dec to complete.	30/12/23
Vital signs training	We have sourced further information which will be given to all clinical staff currently in post and to all clinical new starters	30/11/23
Review of our training	We are currently reviewing our training to ensure that we offer all necessary courses to meet the needs of people we support. Any courses we do not currently have, we either write them or source externally.	30/12/23
Reviewing Service Manager/Staff induction	In order to ensure that staff and service managers feel valued and we improve our retention, and in turn our people are supported by a consistent team of staff who know their needs.	30/12/23
Implementation of quality audit plan	Our quality team is changing and we are recruiting experienced quality and compliance specialists, they will follow an annual plan ensuring that each service is audited every 4 months, with the quality and operations teams working closely together to ensure that people we support are safe.	31/01/24
Implementation of electronic care plans	This would give the business clear oversight, enable managers to review incidents, illnesses and trend concerns. This is a huge project and we are currently reviewing systems to ensure that we source the best one to meet our needs.	30/03/25

In addition to the action plan above, we have a robust handover process which is an opportunity to discuss any concerns the nurses and carers have with people, which people have a Respect document in-situ and who does not want to be resuscitated. Hydon Hill specifically have implemented an additional system to identify discreetly who does not want to be resuscitated, this ensures that if a person is not in their bedroom but around the home in their wheelchair, staff can easily identify them, should they need to.

Yours sincerely

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Chief Executive, Leonard Cheshire