Ms Ollivere,
Birmingham and Solihull Coroner's Court,
Steelhouse Lane.
Birmingham
B4 6BJ

Dear Ms Ollivere,

I am writing in response to the Regulation 28 Order that was made in relation to the sad passing of Sylvia May Nash following a fall at the Orchards Nursing Home and the inquest which took place on the 25th of September 2023.

Sylvia was a P2 resident of Connaught House Care Home from the 31st of December 2022 until she left to go to The Orchards Nursing home on the 3rd of February 2023. Sadly Sylvia sustained a fractured neck of femur following a fall at The Orchards Nursing Home on the 11th of March and passed away at Heartlands Hospital on the 14th of April 2023. As the fall occurred some 6 weeks after Sylvia left Connaught House we were not invited to participate at the inquest and this led to some confusion being created apparently by the evidence given during the inquest.

Our care plans and risk assessments were clear that as Sylvia was at high risk of falls and subsequent injury. Sylvia required 1:1 supervision during the day and the use of our assistive technology at night and this was communicated consistently to the P2 team and the social work team who queried the need for 1:1 supervision with the Occupational Therapy team. I note with concern that the Social Worker claimed during the inquest that she was "not sure what the rationale for placing Sylvia on one to one care was" as this was always abundantly clear to all as confirmed by our care plans, risk assessments and correspondence with the social worker and wider physiotherapy and occupational therapy team.

We assessed that in order to keep Sylvia safe she required 1:1 supervision whilst awake and the use of our bed and door sensors along with acoustic monitoring at night. Sylvia was placed in our care for a period of assessment. We made it unambiguously clear that Sylvia required enhanced observations to meet her needs and prevent her from falling. A P2 placement is made in order to fully assess the care needs of an individual in a more appropriate setting than a Hospital ward with a view to ascertaining the most suitable placement for long term care. The responsibility for funding lies solely with the commissioners and it is extremely telling that we have not been paid a single penny for the 1:1 care that we provided for Sylvia during her stay with us.

The Regulation 28 Order suggests that Connaught House could make some changes to its procedures with respect to the cessation of 1:1 care and we strongly disagree with this conclusion. At no stage did Connaught House remove the 1:1 care for Sylvia and we kept this in place despite not being paid for this expensive provision. The P2 team are fully and solely responsible for the review of the care needs of any individual they place in a P2 bed and for the funding levels available to the new care setting they choose to send the resident to. Connaught House can only provide the information but are not in any position to dictate this decision in any way, shape or form. Similarly, The Orchards Nursing Home was responsible for assessing Sylvia's needs and for their decision that despite Sylvia being in receipt of 1:1 care at Connaught House they decided that they could meet her needs without 1:1 enhanced observations.

Whilst we have the power to control the delivery of care within Connaught House, unfortunately we do not have the ability to decide the funding levels or care delivered once a resident leaves our care

and it is extremely concerning that seemingly a misleading impression has been given to the Coroner in this regard. We shared our full notes, our assessment of needs, risk assessments and 1:1 paperwork with the Social Workers and The Orchards but unfortunately it appears that The Orchards did not carry out a face to face assessment.

The Orchards Nursing Home carried out a telephone assessment and were made fully aware of Sylvia's care needs and it is incumbent upon all providers of care to carry out a full assessment of needs before accepting the placement of a new resident. This assessment is specifically designed to ensure that the new home has sufficient information to adequately meet the care needs of any new resident. However, should the care home believe that the resident has more significant needs than they previously believed it is also their responsibility to increase the care provided in order to meet the needs of the resident. This may involve the provision of 1:1 observations which should be funded by either the ICB or the Council. Similarly, it is the duty of the commissioners to ensure that they meet the assessed care needs of the individuals whose care they fund. In this scenario the only agency that fully discharged its responsibility in respect to the care of Sylvia is Connaught House who provided the care at a loss whilst other agencies seemingly solely focussed on funding levels.

In response to the numbered matters of concern:

1. Connaught House did not remove 1:1 observations and indeed provided this care without being paid for its provision. Our decision making process for the provision of 1:1 care is absolutely clear and was followed by us at all times as evidenced by our continued provision of the enhanced care deemed necessary by our care plans and risk assessments. Our decision was that Sylvia required 1:1 care during the day and the use of assistive technology at night and this was effectively ignored by both the P2 team and The Orchards Care Home. I am unaware as to whether or not The Orchards Nursing Home is equipped with the same type of assistive technology but the P2 team and manager of The Orchards would/should be aware of this, and this information should have played an integral part in the decision making process.
2. I am unsure as to why the Council is suggesting that Connaught House, or indeed any other care home, has the power to decide the funding of care delivered by a different provider as it is clear from our experience that although we can decide that 1:1 care is necessary whilst a resident is in our care this doesn't mean that the Council agree to this level of funding or indeed pay the invoices. The decision making process is a multi-disciplinary process solely in the respect of the provision of information but the decision to fund enhanced care or to make a placement in another care setting lies solely with the Council. This has been the case for every single resident that has ever been placed in a P2 bed and I am astounded the Council have now suggested otherwise.
3. We fully understand the procedure for 1:1 funding and have followed it at all times. The Order refers to the removal of 1:1 supervision and I reiterate that we did not remove the 1:1 observations which remained in place whilst Sylvia was in our care. Despite being furnished with an abundance of information surrounding Sylvia's care, the funding authority and The Orchards Nursing Home decided that Sylvia did not require 1:1 observations. That responsibility and power rests with them and not with us. We desperately wish that we had the ability to demand funding levels for the residents in our care, or indeed the funding for those that leave our care, but sadly this is not the case. We can advise and demonstrate a need for funding but we cannot force the Council or ICB to agree to this funding. In that scenario we can only discharge our responsibilities to the best of our abilities and this is precisely what we did in relation to the care of Sylvia where we continued to provide and

fund the 1:1 observations without being paid for the extra care hours which we, and we alone, believed to be necessary. We did not remove 1:1 observations prior to transfer and provided ample evidence of our assessment that Sylvia required 1:1 care but this evidence was effectively ignored.

4. There is no issue with our communication or understanding of the need for 1:1 observations and this again was ably demonstrated by the care we delivered to Sylvia and the information we provided to the wider multi-disciplinary team. I would be extremely interested in the changes the Council have undertaken to adopt in light of this Regulation 28 Order as I believe the issue was not around our provision of information but rather whether there was an acceptance that this level of care was required or whether the Council could find an alternative placement that was cheaper. Connaught House did not decide that Sylvia needed to leave its care and nor did we decide that these 1:1 observations were not required. This decision was taken by others.

In conclusion I do believe the issue of commissioners refusing to continue to fund 1:1 observations is a huge issue for the care of our most vulnerable residents and sadly this is repeated across every area we operate care homes in. Indeed, in other areas, ICB Commissioners are now dictating that they will only fund 20 hours of 1:1 observations per day despite agreeing that the resident requires 24 hours of 1:1 observations and use the excuse that they will sleep at some point during the 24 hour period. This is quite simply unsafe and as an organisation we refuse to agree to this but other organisations will acquiesce as there is an imbalance of power between the commissioner and the provider.

I do not believe that it is within our power to make any changes to the way that funding is assessed or agreed by the Council or the ICB and we will continue to provide 1:1 care where we have assessed that it is required and continue to advocate for the residents in our care.

As I believe there is a wider issue surrounding the issue of removal of funding for 1:1 placements, I would welcome a further discussion with the Coroner and do believe that future deaths can be prevented. Unfortunately, during the inquest the Coroner was not furnished with the correct information regarding the process surrounding the funding or removal of 1:1 observations and as a result the Regulation 28 Order does not target the root of the problem. I would really appreciate the Regulation 28 Order needs to be reviewed as I feel it is unfair and not factual against Connaught House.

I also want to make you aware this still continues to happen from the local authority, only last week did a family come in to collect their relative from a P2 bed and we had not been informed by the social worker, when we rang the Social worker they advised they had asked the family to inform us, yet we are responsible for discharge paperwork, ordering medication etc. It is a clear failure on the ICB and Local authority, not Connaught House.

Yours sincerely,

Director of Operations.