# ADDENDUM to MRS S REVIEW

**The following is added as requested by North Yorkshire County Council and agreed by Scarborough and Ryedale CCG as a point of clarity and factual accuracy.**

1. **Point 5.46 in the report reads as follows:**

Moreover, during the period under review, there was no evidence that the CHC team monitored the quality of Mrs S’s care in the Care Home. Recognising that the time period under review was a short one, the reviewer asked the CHC team when the most recent quality review had taken place. The team had apparently agreed with the Local Authority that any reported quality concerns would be taken via the Local Authority safeguarding route, ‘to ensure that a clear record is kept, and a thorough investigation takes place’. It therefore appeared that multi-agency safeguarding meetings were being used as a substitute for proactive, quality monitoring, to provide routine assurance about the quality of care and treatment commissioned.

## Whilst concerns were being reported through the Local Authority route it is not an accurate reflection that all concerns were taken via a safeguarding route; any quality concerns about the placement were reported back by the Local Authority to the CCG to be included in future care reviews.

It is important to stress this review was limited to the last four weeks of Mrs S’ life; the reasons for this are explained in section 1 of the review and this review should be read in the context of the wider independent review. Acknowledging the short time frame of the review Scarborough and Ryedale CCG accept this point as a valid reflection on what was deemed to be a lack of routine proactive quality monitoring by them during that period; it is however not a reflection of the whole of Mrs S’ case management.

1. **Points 5.62 states that:**

Within the Care Home chronology, there is no evidence of audits being carried out during the period under review, which is perhaps unsurprising due to its short duration. However, where there were concerns expressed by daughter 1 about her mother’s care, it would have been useful for the Care Home to have this type of information to examine and to use to frame a response to her. For example, audits of compliance with various care plans would have provided a focus for discussions concerning her dissatisfaction regarding their implementation. Either an audit would demonstrate full compliance with a care plan, or it would indicate improvement actions that could be put in place and shared with daughter 1. Instead the only clear route of escalation evidenced in the information submitted was to Local Authority led multi-agency meetings, which seemed not to take a focused, evidence-based response to her concerns about care and treatment.

## Whilst this point may relate to the clinical decisions that were made at various points, this

case was complicated and raised a number of practice and public interest issues. The meetings led by the local authority were not intended to be evidence-based, clinical decision-making meetings (those matters were for the relevant health professionals): they were put in place to bring together all parties, address perceived concerns, develop and implement a series of actions and try and find a constructive way forward that addressed the well-being of Mrs S.