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Portsmouth CITY COUNCIL

Title of meeting:	Resources Portfolio Decision meeting
Subject:	Portsmouth and South East Hampshire Coroners Update
Date of meeting:	12th October 2017
Report by:	Superintendent Registrar
Wards affected:	N/A

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1. Requested by:

1.1 Cabinet Member for Resources: Councillor Frank Jonas

2. Purpose

2.1 The purpose of this report is to update the Cabinet Member for Resources:

- on the service improvements undertaken to address the recommendations agreed in the Cabinet report of 21st January 2016.
- on further developments planned for the coroners service enabled by the relocation to the civic offices

3. Information Requested

An update on the recommendations listed in the January 2016 cabinet report is as follows:

3.1 Relocation of the Coroners Service

3.1.1 The Coroners Service successfully relocated from the Guildhall to the Mountbatten Suite of the Civic Offices on 1 February 2016. This relocation has provided a number of benefits for the public and improvement to service delivery such as:

- An improved environment for the bereaved attending inquests (as the public had had to wait in the public café area of the Guildhall which was not suitable for this purpose).
- We have been able to provided dedicated toilet facilities for the Coroner's Service which is essential during jury inquests

- The previous location caused concern regarding security of public access and also the storage of confidential material .These security issues have now been addressed due to the transfer of the service to their current location.

- Improved space and amenities for the media whilst reporting on inquests

- As hoped overall the new accommodation has provided a more welcoming and professional impression - a modern environment for a more responsive and user-friendly service to the public, at a deeply traumatic and emotional time in their lives.

3.2 Introduction of New technology

3.2.1 An additional benefit of the relocation has been the introduction of new technology installed in the Coroners Court with the joint aim of improving the service and reducing costs.

3.2.2 The new technology provides a secure video link which enables professional witnesses to give medical evidence via the link rather than attend the inquest. Witnesses often travel great distances with evidence that may take a matter of minutes to deliver. As a result there has been budgetary savings on transport and related costs of attendance.

3.2.3 Secondly, the link has allowed members of the public who may have previously been unable to attend court, for example those who live long distances away, to observe the Inquest procedure via the secure link and be involved in the process. The Coroner has already used this link for relatives and professional witnesses in Australia and India.

3.2.4 In addition to the secure video link, new recording equipment has been installed in the Coroners Court. As expected this has reduced the time spent preparing transcripts of Inquest proceedings, providing a more efficient service and reducing the time spent on administration. In addition amplification has been installed and we are anticipating the installation of a hearing loop system by the end of October.

3.3 Benchmarking and standards

3.3.1 The Portsmouth and South East Hampshire Coroner's area covers the areas of Portsmouth, Gosport, Fareham, Havant and East Hampshire Councils. The total population served exceeds 650,000.

3.3.2 The number of deaths reported to the Coroner is significant with over 3000 annually and despite the smallness of the area, its demographic makeup results in the Coroners workload exceeding many entire counties such as Berkshire or Worcestershire.

3.3.3 Following the transfer of the service from Hampshire County Council (HCC) to PCC management significant improvements in overall timeliness have been achieved.

The turnaround targets for non-Inquest cases are now exceeded virtually 100% of the time. The target for completion of Inquest cases within a year is being met with improvements year on year. This has been achieved against a background of 3412 deaths being reported during 2016 - the highest total ever for the area.

	2014	**2015**	**2016**
Deaths reported	2877	3216 (Increase of 11.78%)	3412 (Increase of 6.09%)
PM's performed	1142	1203 (Increase of 5.34%)	1140 (Decrease of 5.23%)
Inquests held	366	390 (Increase of 6.55%)	686 (Increase of 75.89%)
Number of Dols cases	23	158 (Increase of 586.95%)	339 (Increase of 114.55%)
Inquests opened	230	479 (Increase of 108.26%)	598 (Increase of 24.84%)
Inquests not completed in 12 months	7	12 (Decrease of 17.76%)	9 (Decrease of 18.8%)

3.3.4 An important factor in this significant improvement has been the positive impact on the Coroner's staff of support from PCC, a view that the Coroner shares. Everyone is working together to improve the quality of customer service and the target is for Portsmouth and the South East to be in the top quartile of the national statistical league on a consistent basis.

3.3.5 Although this success is notable, there remain challenges for the future. The requirement for the Coroner to hold an Inquest in every case where someone dies whilst subject to a Deprivation of Liberty Safeguarding Order (DOLS) has significantly added to the workload . That requirement has now been removed, however some residual cases may still have an impact on the service. This will reduce over the next few months as these inquests are concluded.

3.3.6 Inevitably certain cases will always take a long time to conclude, delays caused by late submission of evidence by pathologists and others can contribute to this issue. In some cases ongoing police investigations can have a major impact on the timeliness of the inquest. This problem is not unique to Portsmouth, it affects Coroners everywhere. As part of our ongoing efficiency plans, we have ceased to use the services of professionals who have failed to provide their evidence in a timely manner.

3.4 Joint supervision

3.4.1 The joint supervision has worked well and improvements have been seen such as electronic transfer of documents between the Coroner's Service and the Registration Service. This has reduced the time between issue and receipt of the necessary documentation between the two services, which benefits the public by allowing them to register the death in a more timely manner.

3.4.2 As the Coroner does not line manage staff, the Superintendent Registrar was introduced into the structure to support the service and help them in their operational management. There have been a number of benefits from this additional support ranging from improvements in communication between the services, standardising HR processes, embedding corporate processes. As the Superintendent Registrar cannot be on site on a daily basis we are currently in the process of recruiting a Team Leader at the Coroner's Service. This officer will oversee the day to day supervision of the staff and allocate the caseload. This post has been made feasible due to the loss of a full time administrator at a similar pay band. The Superintendent Registrar will remain responsible for budgetary management and overall strategy.

3.5 Further development and improvement in new technology

3.5.1 We have had to look closely at all the contracts transferred to PCC and have now been able to award the toxicology contract to a more efficient and cheaper supplier.

3.5.2 We have now successfully transferred all Coroners data from the IRIS system which was hosted by HCC - to the WPC system. The WPC system has provided the following benefits:

- Ability to produce more detailed statistical report (although as the data only starts in February 2017, the benefits for year on year comparative statistical analysis will not be as evident until further time has passed). However, the time it takes to run quarterly figures, figures for destruction of histology and figures for suicide and drugs death audits has been significantly reduced.

- Complete electronic files for non-inquest cases (which was not possible prior to WPC) this equates 1250 cases since the introduction of WPC, which are solely electronic records and would have previously had paper files. This means a reduction in paper and printing costs, reduced space requirements for archiving and time efficiencies.

- Auto-fill of forms and documents which are sent to stakeholders, reducing the time it takes to prepare such documents and the decrease in clerical errors.

- Audit abilities to track how many cases each officer has at any one time and at what status they are at (this is particularly helpful to assist if staff are unexpectedly off work).

- Live caseload data, so that officers do not have to rely on their own spreadsheets to track their work.

- Electronic tasks and notifications to alert officers of tasks that must be completed within specified critical time frames.

- The ability to log on remotely, so that the Coroner can still provide authorisation and advice when he is not in the office. This has already proved to be greatly beneficial.

- Reduction in photocopying, and also much easier to provide advanced disclosure to interested parties.

3.5.3 Now that the staff are familiar with the new system we are engaging with Queen Alexandra Hospital (QAH) regarding online reporting of deaths to the Coroner. This will hugely improve the speed and efficiency of the service, which will provide benefits to the public, PCC and the NHS Trust. Once this system is established, and we are confident that it is running efficientl, we will be extending this service to General Practitioners - again improving speed and efficiency.

3.5.4 QAH are now scanning post mortem results directly to the Coroner' Service, which again provides a more speedy and cost efficient service.

3.6 Ongoing challenges

3.6.1 **Transfer of Coroners Service to Portsmouth City Council**

The Coroner's staff were successfully TUPE'd from their respective organisations to PCC employment on 1st April 2015. Whilst the plan is to harmonise all staff under PCC terms and conditions, under TUPE regulations terms and conditions can only be changed if there is a specific reason (**E**conomical, **T**echnical or **O**rganisational) that would require a contractual amendment. We will be working with HR, the Coroner and the new Team Leader to see what changes are feasible.

3.7 Restructure of the Service

3.7.1 The initial actions outlined in the Cabinet report of the 6th November 2014 have been achieved and the service will continue to review service provision and service structure to better manage costs, improve service delivery and ensure that Portsmouth City Council and the public, are receiving the best value.

Portsmouth CITY COUNCIL

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Signed by:

Director of Culture & City Development

Appendices: **None**

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
Portsmouth and South East Hampshire Coroners Update	PCC website : Cabinet report 21st January 2016