Report to Healthier Communities & Adult Social Care Scrutiny & Policy Development Committee

27th January 2016

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Subject: Quality care provision for adults with a learning disability in Sheffield: improvements and next steps

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Type of item:

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	**X**
Other	

1.0 Background

1.1 In mid 2013, following changes in management arrangements, concerns began to be raised about quality of care within residential, short break and day services for adults with learning disabilities provided by Sheffield Health and Social Care NHS Foundation Trust (SHSC) and Sheffield City Council (SCC). Both organisations carried out extensive investigations that resulted in detailed improvement plans.

1.2 Sheffield's NHS Clinical Commissioning Group (CCG) were advised about this work and additionally commissioned an external review to ensure no stone was left unturned in the improvement of services.

1.3 While acknowledging the progress that had been made when evidence

was gathered in April 2015, the external review quite rightly concluded that both organisations had further to go in developing quality and consistency across learning disability services. This scrutiny has helped both SCC and SHSC to further accelerate improvements in the time since the review was carried out.

1.4 This report seeks to update Scrutiny on the progress of improvement actions. Safe systems are now in place across services for adults with a learning disability run by both the City Council and SHSC NHS Foundation Trust, supporting physical, emotional and financial well-being of the people served. There are a limited number of further actions to complete from original plans but the most significant issues have been fully addressed and overall both services have moved a long way since concerns were first raised in 2013-14. Both SCC and SHSC have also strengthened oversight arrangements so that services for people with a learning disability maintain a high profile, a high degree of support and also appropriate performance management.

1.5 However the CCG, SCC and SHSC recognise the need to go much further than just guaranteeing safety for people who use services. It is essential that people of all ages who live in Sheffield with a learning disability are afforded the same opportunities and the same sense of worth as the wider population. Many people with a learning disability make a huge contribution to their families, their communities and also the local economy. Therefore it is essential that organisations do more to work alongside them and their family carers to value this contribution, co-design their support and give them the choice and control they deserve. This report also highlights how this much more ambitious work is progressing.

2.0 The Scrutiny Committee is being asked to:

2.1 Consider the improvements that SCC and SHSC have made in the residential, short-break and day services that they run for people with a learning disability, note the arrangements in place to ensure good standards are sustained and consider any further oversight that Scrutiny wishes to exercise.

2.2 Note wider programmes to support improved outcomes being developed by SCC, SHSC and the CCG that recognise the huge contribution people living with a learning disability can and do make to Sheffield life.

3.0 Summary of Sheffield City Council improvements and next steps

3.1 SCC divided its improvement plans into two key themes, (a) Quality and Safeguarding and (b) Finance and Management. This has ensured a clear focus and enabled clear accountability for manageable tasks. These documents accompany this report as Background Papers A(1) and A(2).

3.2 The Quality and Safeguarding workstream has resulted in measurable improvements that can be summarised as follows:

- A hugely improved focus on safeguarding, with updated information

for clients, carers and professionals, training for staff tailored to their individual roles, specialist support to assist with key issues and management oversight to ensure ongoing compliance

- Improvements to the physical standards of premises
- Regular monitoring, recording and rectification of health and safety issues
- Improvement of recording in relation to clients' individual records including Support Plans and regular audit of standards
- Greater emphasis on explicitly taking into account the needs of clients and family carers, in partnership with social workers
- Greater communication and supervision within the service, for example via regular team meetings and one to one sessions between managers and staff
- Greater emphasis upon understanding the individual needs of clients and placing them at the centre of decision-making around their needs (for example all clients now have a communication passport, and service documents are made available in appropriate formats)
- Improved choice of activities with a range of options guided by client feedback
- Improved awareness of physical health needs and links with NHS professionals to ensure the right follow up
- Overall approach to staff standards

3.3 However, although considerable progress has been made as above there is more the service recognises it needs to do to build on improvements:

- Further work on improving communication and engagement at all levels which will be supported by Inclusion North
- Greater emphasis upon use of advocacy for people who cannot speak up for themselves and do not have others to represent their best interests
- Further work developing Support Plans that are fully client-centred in partnership with SCC social workers
- Work with SCC commissioners to develop a range of day and short break opportunities that properly reflect current preferences, have greater benefits for clients and family carers and increase opportunities to develop skills, confidence and well-being. Further developing the Council's Sharing Lives service is absolutely key to this

3.4 The Finance and Management workstream has also achieved a number of necessary improvements:

- New guidance, procedures and controls for staff handling clients' money, consistent across all services
- Tighter managerial controls for both storage of clients' money and usage of petty cash
- A single approach for recording of financial transactions and receipts
- Client charges now handled by the Social Care Accounts Service
- Consistent monitoring and recording of clients' use of services so that access to support is equitable and charging is accurate

- Regular audits of financial transactions and money-handling processes
- Regular supervisions and appraisals with arrangements for monitoring the frequency and quality of these
- Improved recording of sickness absence and management follow-through to better support staff and enable return to work
- Improvements to organisation of training opportunities, linking with staff requirements identified at supervisions and appraisals

3.5 Again, further improvements are currently being implemented to financial and management controls over and above those listed in 3.4:
- Making arrangements for the Council to manage appointeeships for clients who do not have other arrangements for managing their money.

3.6 The above process improvements and performance measures will only work if they are supported by consistent and focused leadership.
- There has been wholesale renewal of Sheffield City Council's senior management team since 2013-14, with new appointments being made at Service Manager, Head of Service and Director level. The previous interim Director and Head of Service arrangements came to an end in the autumn of 2015, with permanent appointments now in place to bring stability, support and accountability to management arrangements
- The Cabinet Member for Adult Care and Health formally reviews progress on Learning Disability Provider Services each quarter, ensuring that further improvements are made and there is no sign of standards slipping back

3.7 Senior officers and Members recognise that they need to be more visible and accessible than in the past, both to ensure standards remain where they should be and also to better support clients, carers and front-line staff through being in touch with day to day realities. A number of actions are now in place to enable this:
- Regular visits to establishments from Service Managers, Head of Service and Directors
- In depth "In Your Shoes" sessions where senior officers spend a full working day supporting clients under the supervision of front line staff, for example the day worked Stradbroke Road Day Centre by the Director of Adult Services in October 2015
- The volunteering of Member "champions" to be attached to Learning Disability establishments and provide extra oversight and support

3.8 The above measures will continue to sustainably improve the safety and quality of SCC provider services. However it is important to have a wider vision for the development of support for Sheffield's adults with a learning disability that fully reflects their individual diversity and ambitions. To this end, Council Cabinet agreed a three year Commissioning Strategy in December 2014. This strategy (see Background Paper B) sets out the following objectives which are all currently being implemented:

- Services will actively promote people's wellbeing, helping them have a good life and be as independent, healthy and well as possible
- Local support services will be more diverse so all people with a learning disability in Sheffield, whatever their age, background, or level of need, will have more choice in their support
- Social inclusion will be promoted throughout everything we do. More people with learning disabilities will be doing more within their community. Support will build on resources in the community, tackle barriers to social inclusion and reduce dependence on social care services alone. We will have stimulated creative and innovative ways to make this happen
- More people with learning disabilities will be in paid work and volunteering opportunities, working alongside the rest of the community
- There will be major improvements in the support for family carers, improving the support available to carers in their own right, and making life better for people with learning disabilities who live in the family home
- There will be major improvements in local accommodation and support for people who live away from their families. Housing will be high quality and the support will promote people's independence and wellbeing and will offer dignity and privacy
- Fewer people with a learning disability will live out of the city, and people who need and want to return will have been helped to do so
- Sheffield will have moved away from traditional or institutional forms of support and will focus on support which is personalised, flexible and meets people's individual needs
- Services will help people work together and pool their personal funds so they can share their support and sustain meaningful and rewarding relationships
- There will be more coordinated information about services and support across all relevant agencies
- The transition for young people with a learning disability to adulthood will be positive
- There will be strong partnerships between the Communities Portfolio, Children, Young People and Families Portfolio, Place Portfolio and NHS partners to make sure support is joined up.
- All services will provide best value for Sheffield people.
- People will say they have been fully included and involved in the planning and implementation of changes

3.9 The most important objective on the list of bullet points in 3.8 is the final one, the need to fully involve Sheffield's learning disabled population and well as their families and other supporters. The improvement plans for Learning Disability Provider Services have already been shared with clients and carers with feedback sought and acted upon. However, involvement must be seen as a two way street. It is not enough for the Council to inform people of their plans: clients and carers must be empowered to actively determine priorities and hold the Council to account for seeing them through. To help enable this, Service

Improvement Forums (SIF) have been set up for key client groups. For example, there is a SIF for people with a learning disability and a further SIF for family carers. Each of these has a chair and vice chair from the client group, and a majority of clients / carers as compared to professionals at each meeting. Not everybody is able or inclined to attend meetings so the SIF is underpinned by a wider network of clients and carers who are able to make their views known and influence agendas.

3.10 SCC has recognised that working accountably to people with a learning disability and their family carers, both at individual and strategic levels, is the strongest guarantee that service standards remain high. The Service Improvement Forums provide a strong foundation for this, but more work is required to continue to make connections and build further trust.

4.0 Summary of Sheffield Health and Social Care NHS Foundation Trust improvements and next steps

Between July 2013 and April 2014 SHSC undertook a Review of Culture & Practice across all the Adult Social Care Learning Disability Registered Care & Supported Living homes. The purpose was to review the: Leadership and Management; Working Practices; Culture; Experience of Residents, Tenants and their Families and the Quality of Care provided. The Executive Summary Report and Trust Board Response to the Review of Culture & Practice accompany this report as Background Papers C (1) & (2) respectively.

All issues and concerns that arose during the Review were regularly and routinely reported into the Executive Directors Group (EDG) (weekly) and the Board of Directors (monthly). Importantly they were routinely shared with the Directorate Senior Management Team (SMT) to ensure immediate action was taken as required, to ensure safer / higher quality care was delivered during and after the Review itself.

Following the Review, progress reports on recommendations and actions were regularly reported into the Directorate SMT, EDG and Board ensuring effective governance with clear lines of responsibility and accountability from frontline services to the Board of Directors. In May 2015 a new substantive Clinical Director was appointed. In December 2015 the Board of Directors received and approved the new SHSC Learning Disability Governance Framework & Quality Improvement Programme, copies of which accompany this report as Background Papers D (1), (2) and (3).

The aforementioned regular EDG/Board reports on SHSC's findings, actions and progress were also shared with the Sheffield CCG's Governing Body and SCC Executives and Directors.

4.1 Key Organisational Learning in SHSC from the Review:

To ensure a culture where dishonesty, abuse and indifference are not present or tolerated, ever, requires constant vigilance and attention, at all

levels of the organisation, from the individual to the Board and vice versa. It requires strong clinical leadership and performance management and an effective system of governance. At every level of an organisation there is a need to know what is going on and how well or not care is being delivered. The need for individual personal responsibility and to hold to account at each level is paramount.

To ensure we routinely and consistently put Service Users and their Families / Carers first and genuinely at the heart of all we do, enabling their voices to be consistently heard and acted upon.

For each member of staff to recognise and understand that upholding the rights and ensuring the safety of service users is their responsibility and is our core business. We want to consistently provide services that we ourselves would be happy to receive.

Leaders and managers must be competent and capable, always acting as role models demonstrating in their behaviour and professional relations the values we espouse as a Trust. In turn we wish all our staff to experience being well managed and well led, to be supported and treated with respect, to be appreciated and recognised for their contribution to providing high quality care. In such a work environment, the ethos of service is well articulated, understood and lived, the purpose of the team is clear, the team is appropriately staffed and high standards of conduct are realised, effective individual and team work exists and high standards of care can be delivered to all of those we are here to serve.

Establishing a clear sense of shared purpose and belonging to the wider organisation, understanding each person's role within it and the difference each person makes, is key.

4.2 The Review of Culture & Practice has resulted in measurable improvements across SHSC's Adult Social Care Learning Disability Service that can be summarised as follows:

4.2.1 Putting the Service User's Voice at the heart of what we do:

Understanding the experience of service users, their family, carers and front line staff is a powerful means through which to learn about the quality of current services, we believe engagement is essential to drive change and the service has implemented the following programme of development:

- Cloverleaf Advocacy: engaged to ensure that service uses are given access to independent support and advocacy through the two financial investigation processes and at other times of key decision making

- Service user and family carer engagement: Sheffield MENCAP Sharing Caring Project commissioned to understand and support to improve the experience of service users and their family carers when accessing the following service areas:

- Respite Care Service
- Supported Living Service: Mansfield View, Stradbroke Road & Beighton Road
- Community Learning Disabilities Team (CLDT)
- Intensive Support Service (community and inpatient area).

Julia Thorpe, from the Challenging Behaviour Foundation (CBF) will mentor and advise SCP throughout their work with the Intensive Support Service.

- Initial findings are highlighting areas that can be improved upon such as the development of accessible information on admission, and sharing and building on good practice; working with services to develop improvement strategies; changes to systems and processes for routine engagement; working with services to develop a range of tools to support them to routinely engage and improving current systems for communicating

- Microsystems: Series of workshops held with service users to look at methods of obtaining in-depth feedback via focus groups. Service users have also attended the Microsystems meetings and are keen to be involved in this quality improvement work

- Carers: 6-weekly Carers Clinics (held jointly with SCC). The Carers Clinics offer family carers the opportunity to discuss any concerns, worries or frustrations they might have about the health, care and support of the person with learning disabilities and /or autism they support with senior managers from SHSC and SCC Learning Disability Service and have led to many situations being resolved before turning into a crisis

- Experts By Experience: The Directorate is working in partnership with Inclusion North to ensure experts by experience are a central focus in the delivery of the Transforming Care Agenda, Care and Treatment Reviews

- Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DOLS): A review of SHSC MCA/Deprivation of Liberty lead roles, responsibilities and reporting structures has taken place. New Steering Group and Practice Development Group established with Terms of Reference and Work Plans developed as a result. Key priority areas of work have been to ensure MCA/DOLs awareness and training for all Trust staff and a review of Trust Policy and Procedures. A programme of practice development sessions (open to SCC colleagues) has received positive feedback. Practice changes evidence that capacity assessments and best interests' decision are taking place. However this will be a focus of continued development

4.2.2 Strengthening and Improving Management and Leadership

Senior Management Structure

- The Directorate has undergone a review of its management structure with new substantive senior management appointments being made to Clinical Director, (external appointment, experienced and dynamic), Service Director and Assistant Service Director. Recruitment to other senior clinical leadership roles is underway

Delivering Effective Governance / Practice

- A new Governance and Quality Improvement Framework has been designed and implemented to support a culture of outstanding quality at every level of the Directorate. Although in its early stages, this framework will enable the Directorate to deliver well-led, safe, responsive, effective and caring services to the people supported. Changes to the way in which information is obtained, collated, analysed and reviewed is already being used to identify early signs of problems, as well as identifying examples of excellent practice that others can learn from. Some examples of areas of progression are detailed as follows:

    - Increased prominence of safeguarding, investigation and trend identification within the Directorate
    - Monitoring of CQC Inspection outcomes and resulting action plans. Mansfield View receiving a rating of 'Good' from its most recent inspection
    - Review and analysis of incidents which has resulted in a targeted 'falls' training programme
    - Operational Protocol review and development across the Directorate
    - Performance and productivity improvements that has ensured referrals to the Community Learning Disabilities Team are responded to efficiently and waiting lists are kept to a minimum
    - Staffing capacity and capability monitoring which provides an overview of the utilisation of resources, identifying and responding to areas where shortfalls exist or areas of increased use of flexible staff etc.
    - Performance management systems established which enable: monitoring of delivery of supervisions and Performance and Development Reviews, their frequency and sampling of quality. Achievement of training and development against the mandatory framework
    - Established an annual programme of Audits e.g. Detailed Risk Assessment Measure
    - Established programme to National Institute of Clinical Excellence Guidance and its application into practice
    - Senior Manager unannounced quality monitoring visits to Provider Service areas, in and out of hours. A format for systematically recording these visits and actions is being devised
    - As part of the reconfiguration of the Provider Services, a review of the use of waking nights has been undertaken and actions have

been taken in some areas to remove waking nights and implement a system of internal rotation. A programme to support Nurse Rotation is now in development

- In 2014 the Learning Disabilities Directorate participated in the NHS Benchmarking Network LD Provider Project. Participation in the project has enabled the Directorate to benchmark itself across a wider range of metrics across the health community, the outcomes of which have informed the Directorate Quality Improvement Plan.

Service Meetings

- Monthly Service Meetings have been established to provide networking opportunities for staff across the Directorate and to provide a platform to support a culture of collaborative working and service development. This forum is used to share learning and best practice through interactive practice development topics. For example on the 12th May 2015 a staff consultation event was hosted to discuss the government green paper, “No Voice Unheard, No Right Ignored – a consultation for people with learning disabilities, autism and mental health conditions”

Organisational Development

- The Directorate has begun to establish a programme of organisational development which has initially focussed on supporting leaders through a time of significant change, empowering them to develop their own skills through for example accessing courses such as ‘Crucial Conversations’.

- In addition, the Directorate has commissioned support from NHS Elect and Diversity Matters, external consultancy to support the delivery of a programme of development days targeted to first line managers and above for all service areas. These service specific development days provide teams with an overview of national direction and examples of innovative practice. Vision, direction, culture and quality were key themes through which the Directorate has developed a deeper understanding of how it functions and its needs in relation to on-going transformation.

Residents Financial Services (RFS) - management of money and personal property

- External audit by KPMG (review of the Trust’s arrangements for managing monies belonging to service users) commissioned in 2014 in response to the emergence of fraud. Recommendations made and action plan implemented across the Trust.
- Revised RFS guidance, procedures and controls for staff handling service user monies and the management and disposal of service user property implemented and consistently applied across all service areas. Guidance includes safe storage, recording and receipt management.
- Staff subsistence practices ceased and new guidance implemented across all areas. Practice is audited within monthly monitoring

processes.

- All staff trained in RFS and Counter Fraud procedures which includes completion of the 'Fraud in the NHS Counter Fraud Competency Mapping Workbook'.
- Criminal investigations:
    - Wensley Street Residential Care Home investigation led to the dismissal of Deputy Manager who received a 2-year custodial sentence for the theft of service user monies.
    - Mansfield View Supported Living Locality investigation led to the suspension of two members of the management team. Case remains 'live' with a 3-week Crown Court hearing scheduled for May 2016.
    - Monthly audits of service user monies undertaken by:
    - RFS team who sample purple books from individual services in order to allow an independent reconciliation to vouchers issued.
    - Independent checks of individuals expenditure records undertaken by the Assistant Service Director and Business Support Manager documented and reported back to the Trust Audit committee.
    - 360 Internal Audit RFS Follow-up completed in February 2015.

4.2.3 Raising the Value & Esteem of Learning Disabilities Across the Trust / Culture

- Learning Disabilities has been a prominent focus at EDG and Board level with the Clinical and Service Directors attending to present regular verbal and written updates. Two key Board sessions were as follows:

    - March 2014 - The Board's role in developing the culture in the Learning Disability Service Board Development Session
    - May 2014: Presentations on:
        - Confidential Inquiry into the premature deaths of People with Learning Disabilities: Findings and recommendations from Trust Stock take
        - Winterbourne View Review, Concordat and Actions Up-date Briefing
        - Directorate Updates on the Respite Care Service, Green Light Toolkit and Practice and Culture Review Confidential Up-date
        - Sessions have been held with Trust Service and Clinical Directors to share the outcomes and lessons learned from the Culture and Practice Review

4.2.4 Care and Support Planning

- Audits of Care and Support Plans have been undertaken across all provider service areas with supplementary on-going visits being made to carry out observations of support in practice. This work has resulted in changes being made to the way in which individuals care and support is delivered, monitored and reviewed. The Directorate recognises that there is still further work required to ensure that individuals and their family/carers are fully engaged in this process and that the structure and content of care and support plans are much

more accessible to the individual

- Community Learning Disabilities Team Input (CLDT): A programme of work to review and update the CLDT Care Pathway has taken place which has resulted in improvements being made to individual and team productivity and performance, changing the way in which referrals are received and responded to. The CLDT now have a more focussed ‘enabling’ role in working with social care providers

4.2.5 Audit

- A series of audits have taken place which have improved the quality of service delivery internally to the Directorate and some have had wider implications for other LD Provision across the city, two examples are noted as follows:

    - DNAR Audit: Tool implemented across Directorate the findings shared with Safeguarding and Sheffield Teaching Hospitals Foundation Trust (STHFT).
    - Dysphagia Audit: City wide audit implementation following the death of a service user and attendance at Coroners Court. Audit is to determine which service users are in receipt of a modified diet and if this is recorded appropriately within the care/support plan. A sample format of how we provide guidelines and a list of danger signals which would trigger a referral if the person does not currently have guidelines in place has been developed. This audit is schedule for completion in 2016 but is already identifying individuals who require Speech and Language Therapy input for individuals who require support around eating and swallowing

4.2.6 Medicines Management:

- PRN Medication Audit completed and findings shared with Medication Committee. On-going review of medication and action plans implemented in response.
- Prescribing Observatory for Mental Health (POMH–UK) The Learning Disability Directorate has been identified as a national leader in best practice according to the latest POMH-UK audit of anti-psychotic prescribing (POMH-9c). POMH-UK aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice.

4.2.7 Staff Development to Support a Change of Culture and Practice

- The development of staff across the directorate has been crucial in moving service forward and has been supported by a number of key training delivery programmes:
    - 2-Day Care and Compassion Training Programme: delivered February to March 2014 to 350 staff. Covered National and Local context for LD Services, Social Role Valorisation; Person Centredness, Professional Behaviours/Codes of Conduct, MCA,

- DOLs, Restraints, Best Interests, Care and Support Planning and the 6 C's
- Positive Behavioural Support Programme: The Directorate has commissioned a programme of training from the British Institute of Learning Disabilities (BILD). The aims being to support the culture and practice of Positive Behavioural Support within the Directorate. To date 54 staff attended 'basic awareness' or 'intermediate' courses and a cohort of ten passed a three day 'coaches training course'
- Clinical and Management Supervision: Targeted to first line managers and above. This training will enable managers to effectively supervise their staff ensuring clarity of responsibility, accountability and support the quality of service delivery

4.2.8 Human Resources Management (HR):

- With the significant changes that have taken place over the past 2 years the Directorate has seen an increase in sickness absence levels and the application of HR Processes. The Directorate has therefore, increased HR advisor capacity to work alongside managers to support:
  - Improved recording, monitoring and review of sickness absence procedures
  - Develop skills and knowledge and support managers in the application of HR Procedures such as capability and disciplinary investigation

4.3 The Board of Directors of SHSC wishes to work collaboratively with Service users and their families, the CCG and SCC, and other agencies to create a coherent vision, strategy and community for all people with a learning disability supporting individuals to lead fulfilling, happy and meaningful lives in Sheffield and its surrounding areas. Detail of the Trust Board's position is covered in the accompanying Background Paper C (2)

5.0 Further improvements via robust partnership arrangements

5.1 The integrated service that oversaw Learning Disability provision on behalf of both SHSC and SCC had moved away from the vision and values of both organisations, resulting in the failings set out by both internal and external reviews. Sections 3.0 and 4.0 describe how SCC and SHSC have each been ensuring improvement with their respective staff groups through systematically addressing previously identified concerns and through developing broader engagement and ambition alongside Sheffield's adults with a learning disability and their family carers.

5.2 Both organisations have also continued to work in partnership, both at case level and via strategic forums. Firstly the Safeguarding Adults Executive Board has provided strong leadership. The Board and the wider partnership are attended by both SCC and SHSC. Safeguarding Adults in Sheffield is led by an independent chair, and pulls together leads from

across the spectrum including key NHS organisations, the police, housing and adult social care. There is also a strong connection to service user voice. The Safeguarding Adults Board has remained appraised of both SCC and SHSC work to ensure improvements and has provided a critical friend role in relation to these. The Board has also championed improved standards and greater inclusion of people with a learning disability more generally. For example, the recent independent review into unexplained deaths at Southern Healthcare Foundation Trust will be debated by the Safeguarding Adults Executive Board in the next session, with a view to understanding key points of learning for both health and social care organisations in Sheffield.

5.3 Secondly SHSC and SCC work closely together in integrated care workstreams under the joint leadership of the CCG and Council commissioners. The focus of current integration activity is around the person not the organisation. In other words, energy is directed at considering new ways of working that put clients and family carers at the centre (for example only being asked once for key pieces of information, having clearer arrangements to help them co-ordinate their care, providing better information about opportunities in their local neighbourhood). Previous attempts to integrate organisations providing care in other parts of the country have failed because they have prematurely focused on new structures and governance without first resolving key issues of delivery for the people they are intended to serve. The intention in Sheffield is to get the foundations right before building the house.

5.4 Therefore, SHSC and SCC are jointly working within various aspects of the "People Keeping Well", "Active Support and Recovery" and "Ongoing Care" workstreams that make up the current Integrated Commissioning Programme. Alongside other NHS and community organisations, both are committed to form following function in relation to new ways of working that better support adults with learning disabilities in line with their wishes.

Background Papers:

A. Progress on SCC improvement plans, December 2015:
- (1) Part 1 Quality, Safety and Safeguarding
- (2) Part 2 Financial and Management Controls

B. Sheffield City Council Learning Disability Commissioning Strategy 2014-17

C. SHSC Review of Culture & Practice:
- (1) Executive Summary Report, July 2014
- (2) Trust Board Response December 2014

D. Progress on SHSC Action / Improvement Plans:
- (1) Final Action Plan, August 2015
- (2) LD Governance Framework, December 2015
- (3) Quality Improvement Plan, December 2015

Action Plan – Quality and Safeguarding

Findings	Agreed Recommendations	Action taken
The standard of the premises varied from site to site. The quality of some buildings was better than others. Warminster Road was highlighted as needing urgent improvement.	A review of all Sheffield City Council day service and supported living buildings should be carried out. The future use of these premises should be decided by the Learning Disabilities Commissioning Team as part of a wider review of LD services.	• All sites have been assessed and action plans put in place to address any issues. Checks will be carried out regularly. • Improvements have been made and repairs carried out. Some buildings have been closed and services transferred to more suitable buildings. • Warminster Road was closed and a range of improvements were made. • An electronic action log for the whole service will be held and monitored by the Quality and Governance team. • The LD Commissioning Strategy was agreed at Cabinet in December 2014 and commissioning plans are now being developed. Consultation on these plans will be carried out.
The Learning Disabilities Service and its staff did not pay sufficient care and attention to premises.	Senior management should consider whether disciplinary action is required.	• Investigations were carried out and are now complete. Actions have been taken to address individual performance concerns in line with the Council's Human Resources procedures.
There was an inconsistent approach to managing health and safety, including fire safety. Regular checks were not carried out.	Management should put new procedures in place across the service and ensure that regular monitoring is carried out.	• A range of new procedures have been put in place across the service. • Monthly monitoring is now carried out to ensure staff carry out the correct checks. • Any issues are discussed with staff during supervision sessions. • Monthly health and safety meetings are held and any actions are recorded and followed up with relevant managers. • An electronic action log is held and managed by the Quality and Governance team.
Several known health and safety issues had not been dealt with.	There should be action to deal with the outstanding issues. Senior management should consider whether disciplinary action is required for the staff responsible.	• A plan was put in place to ensure the issues were dealt with. Many were dealt with straight away but some complex issues are being completed as part of wider work highlighted in other areas of this document. • Regular monitoring of actions plans is now taking place. • Investigations were carried out and are now complete. Actions have been taken to address individual performance concerns in line with the Council's Human Resources procedures.
Issues were raised by the Chief Fire Officer regarding Grimesthorpe Road, Malinda Street and Ecclesfield Support Unit (ESU).	Immediate action is required to ensure sites meet relevant safety standards.	• A wide range of improvements were carried out to improve safety and to ensure standards were met. • The Service now meets the relevant fire testing requirements at ESU. • The recommended works at Grimesthorpe Road are being completed by SCC property services and the registered social landlord. • The service at Malinda Street is now provided by another organisation.

There were inconsistent approaches to maintenance, cleaning and decoration.	A review of current arrangements should be carried out	• Staff now have a daily schedule of tasks which includes cleaning and maintenance. • Regular checks are now carried out by managers.
The quality of record- keeping varied and was sometimes poor. .	The purpose and function of each record should be reviewed and understood by staff and managers. Training should be given to staff where needed. Records should be reviewed regularly and be up to date and accurate.	• Current documentation has been thoroughly reviewed and a range of changes made. New documents have been created where needed. • Consultation with staff has been carried out and their feedback helped to improve the quality of documentation. Staff were given support to understand the new documents. • Operational managers carry out a regular audit of service user files to ensure they are up to date and accurate.
The quality of support plans was poor, lacking in information and appeared not to be used in day services. Basic information was inaccurate.	A review of what is required for good quality support planning is needed as soon as possible. Current support plans should be updated with a clear focus on the service user.	• A new support plan based on research of good practice across learning disabilities services was implemented in December 2014. The support plans are now more person focused. • Managers are now clear where responsibility for the completion of support plans lie. The approach will be applied consistently across the service. • Current support plans have been reviewed and transferred to the new format. • Staff have been recruited specifically to carry out this work.
Care plans did not fully take account of people's needs as assessed by Assessment and Care Management (A&CM).	Services provided in supported living and day services should link better to A&CM. There should be a person focused care plan in place for all service users which includes all of their care requirements. Staff should have access to A&CM support plans and be included in the annual review process. Reviews should be carried out at an agreed frequency depending on the needs of the service user. Every service user should have a thorough review that focuses on creativity and positive outcomes. Service users and families should be involved and supported by advocacy services if required. Service users' communication needs should be taken into account and appropriate tools used.	• Service managers now ensure closer working with A&CM so that assessed needs are reflected in the service user's care plan. • The new care plan ensures that information is shared with other services and external organisations, who also have the opportunity to input into care plans. • A&CM are working with professionals from Sheffield Health and Social Care Trust to ensure health- related needs are fully taken account of. • The Service now tracks and records the progress of reviews to prevent delays occurring. • Work is underway to ensure all plans are reviewed in line with the recommendations. Service users and families are now more involved in the process. • There is a new communication passport to help assessors better understand service user's needs.

The Service restructure led to confusion about who should carry out reviews.	service user Management should decide which staff should carry out reviews.	• An investigation into how the situation occurred was carried out and is now complete. • A new staffing structure has been put in place with clearer roles and responsibilities. Staff are aware of their roles and this is monitored through supervision sessions. • Front line managers now carry out the reviews using the new format as outlined above.
There is no evidence of the involvement of advocacy services.	Advocacy services should be in place and used where appropriate.	• Advocacy services are now available and will be used during reviews process if required.
It was not clear what difference (outcomes) care plans had for day service users.	The way the day services operate should be reviewed. There should be a focus on support that provides goals and opportunities.	• The Learning Disabilities Commissioning Team is developing a new approach to day time opportunities. • There is now more choice of activity at Ecclesfield Support Unit and some other day services.
Staff did not put enough importance on good communication with service users.	Good communication should be a key part of all elements of the service including planning, staffing and delivery. A new way if sharing information and supporting staff should be put in place.	• Clearer communication across the Service has been put in place. • Regular meetings are now held with staff and information shared. • Team meetings are held more frequently and managers set the agenda to pick up key issues. • Service user documentation has been made available in appropriate formats. • A new approach to communication with service users is being developed with the Learning Disabilities Commissioning Team. • Investigations into how management put in place previous communication procedures has taken place.
Staff and managers were not always aware of good practice relating to communication methods.	Best practice guidance such as the Royal College of Speech and Language Therapists' five good communication standards should be in place and referred to as standard. Managers should know and understand policy and guidance documents. Training on good communication methods should be provided to staff. A&CM and the Service should work together to improve communication methods for those service users at increased risk of displaying challenging behaviour.	• The recommended best practice guidance is being used to develop a new approach to communication. This is being led by the Quality and Governance team. • Inclusion North are supporting the Service to improve communication and engagement across all areas. This includes training for staff. • Communication needs are now part of the A&CM assessment and reviews. Staff refer for Speech & Language Therapy and psychology assessments where appropriate.

A lack of attention to good communication methods was affecting decision making, choice and control.	A review of the communication needs for all service users across the Service should be carried out. Following this, new communication methods should be put in place. A plan to incorporate choice and decision making for every service user should be put in place. Services should be developed in a way that promotes positive social interaction and communication.	• Every service user now has a communication passport. The new care plan supports this approach. • Work to develop new communication methods is ongoing and the Service aims to review and improve the new approaches. Inclusion North are supporting the Service to improve methods of communication.
Appropriate accessible forms of communication were not in place and there was little evidence of personalised communication techniques.	A review of the communication needs of each service user should be undertaken and recorded in care plans. Communication passports should be developed for every service user. Tools such as distress and pain identifiers should be in place for any service user who needs them.	• Further work is required on communication tools and methods. • Inclusion North are supporting the Service to improve methods of communication. • The new care plan and risk assessment identifies pain management and how this links to medication management
Safety, safeguarding and complaints information were not displayed in accessible formats.	Hospital passports and other communication tools must have the same information as communication passports.	• The introduction of the new care plan is helping with this.
	Communication plans must be monitored for quality and completion at regular periods.	• Managers now carry out monthly checks.
	Accessible safety, safeguarding and complaints information should be developed.	• These documents have been produced in accessible formats and distributed throughout the Service.
	Monitoring and review of communication plans must be carried out rigorously and on time.	• A user friendly document has been produced for all service users. • Monitoring and review is part of the support plan.
	Service users must be able to understand this information. Staff should receive training in good communication techniques.	• A user friendly health and safety guide has been produced and distributed. • Inclusion North are supporting the Service to improve methods of communication. Following an audit of Speech & Language Therapy needs, assessments will be checked to ensure service user needs and up to date information is on file.

Intensive interaction was only in place for some people in some places and for some of the time. Most service users were unlikely to be able to access information relevant to them.	Every service user must have a communication assessment and plan in place that meets their needs. A review of the quality of the one to one support provided should be undertaken to ensure it meets the needs of service users. All general communication must be available in accessible formats.	• A&CM is changing support planning and the panel's decision making. This includes ensuring activities on the support plan are meaningful and appropriate. • The Learning Disabilities Commissioning Strategy calls for different approaches to ensure providers offer access to personalised, meaningful activities that enrich people's lives.
Many of the one to one activities were centred around very similar sorts of activities.	More thought should be given to the needs of service users as part of the wider review and response to the Council's duties under the Deprivation of Liberty Safeguards.	• Deprivation of liberty assessments are taking place as part of a council wide approach. • Extra staff have been brought in to carry out overdue reviews which will identify any deprivation of liberty issues.
One to one supported activities were mainly going shopping, going out for lunches, going to local parks or museums and attending hydrotherapy sessions. There was limited attention to meaningful activities taking place within people's own homes.	The Service should ensure that the time people spend in their own homes is as stimulating and meaningful as the service user wants and needs. Day services currently provided that are not based in a building should be reviewed as part of an overall model for future day opportunities.	• The new care plan has ensured that managers address this need and clearly describe how the recommendation will be met when the one to one support is provided. • Day services are being reviewed as part of a longer term plan. • Care plans aim to identify opportunities for meaningful activities in people's homes.
Some people were unable to leave their homes without one to one support and relied on staff.	A new model for future services should be urgently decided based on national policy and good practice guidance. Plans should be put in place to ensure that current service users' needs are re-assessed alongside service users and their families.	• The Learning Disabilities commissioning plans will identify a new approach and standard for day time activities, and encourage more good quality support providers. • Care plans now aim to be more focused on service users' needs and carried out alongside the needs of relatives.
Building based day services at Ecclesfield Support Unit were found to be out dated.	ESU should be closed. Alternative, meaningful day opportunities should be planned, based on people's assessments. Family members should be involved in the re-assessments.	• The quality, safety and appropriateness of the services provided at ESU have been reviewed and there is a programme of work in place to improve services and ensure care plans are reviewed to make sure they include good outcomes for people.
There was no evidence of planning or development for the Service. Many staff did not have regular supervision.	Staff supervisions and performance reviews must be carried out as required.	• Supervisions are now carried out regularly and this is checked. • This has got much better and staff are getting used to the new approach.
Fire safety checks were not being carried out.	Fire safety checks should be carried out as required and monitored by managers.	See 'Health and safety' for actions taken.

Staff did not think enough about safeguarding. There was confusion between confidentiality and secrecy. .	Safeguarding must become everybody's responsibility. Experienced managers working in the Service, Safeguarding and Commissioning should help make staff aware of safeguarding. There must be guidance to help staff understand confidentiality and what information should be shared and recorded.	• A new team is now leading on safeguarding in the Service. • The Service is developing a new way to deal with safeguarding issues and make sure they are followed up. • There is now better recording and monitoring of safeguarding cases. • Safeguarding is now talked about in all meetings and supervisions. • There is good information and posters about safeguarding in the Service.
	There should be more effort to let staff know about safeguarding issues. Managers should check to see if the same kind of safeguarding issues are coming up.	• Safeguarding is now talked about in all meetings and supervisions. Safeguarding training sets out what staff need to know. • Managers now check all safeguarding issues every month. Actions plans are developed where required. When there is a safeguarding investigation, action plans are written and these say what lessons have been learned. The Quality and Governance Team will look for safeguarding patterns or trends.
Communication and record keeping was inconsistent.	Senior managers must ensure normal safeguarding policies and practice are kept to.	• Managers within the Service have been supported to fully understand safeguarding. All safeguarding issues are raised in the correct way.
The Service wanted to deal with safeguarding issues itself ("in house").	Best practice advice contained in this action log must be followed. Abuse must be prevented before it happens. There must be clear roles and responsibilities. The new safeguarding procedures should be jointly reviewed by the Safeguarding team and Provider Services after six months to ensure they are good enough.	• An investigation into past safeguarding issues and practice was carried out and has now ended. • A review of safeguarding practice in the Service was completed in June 2015. • The Quality & Governance team now manage all safeguarding alerts, investigations and lessons learned across the provider service. This will help the Service know how to deal with issues better and more consistently. • Staff have received safeguarding training relevant to their role.
There was inconsistent understanding of safeguarding issues. Staff were not always clear on their roles and responsibilities.	There must be guidance to help staff understand their roles and responsibilities. Staff should receive training. There should be a review of how investigations are carried out.	• Staff have received safeguarding training as required by the Care Act. • All safeguarding cases that require further investigation have been jointly led with colleagues in Assessment & Care Management. • The new care plan assesses the risk that people face.

The Service was not checking enough if people were at risk.	Every service user should have easy access to information to support them to avoid abuse or report it if it happens. The Service must make it straightforward for service users, family and friends to report concerns or abuse How service users access advocates should reviewed and improved. This is particularly important for those at increased risk due to communication needs or limited family involvement. A system to ensure good joint working must be put in place.	• A new user friendly document that meets these requirements has been shared with staff and service users. • Monthly reviews now require staff and managers to have contact with service users families. Concerns can be discussed easily. • Safeguarding is a standard agenda item on supervisions to allow staff to raise concerns. Supervision sessions are carried out regularly. • The A&CM reviews identify clients with additional advocacy needs. More advocates are now available. • A review of safeguarding across learning disability services has taken place and the Service is putting the new system in place.
There was a lack of joined up working with other parts of the service. The outcome of safeguarding alerts and investigations was not always clear.		• All Serious Incidents are now routinely monitored and actions taken as appropriate. • More effective staffing levels, supervision, team meetings and other measures are helping with this – see above.
It was not clear if recommendations following an investigation into "institutional abuse" had been carried out.	Senior managers must review the findings and recommendations of the investigation and ensure that all necessary actions have been taken.	• Health action plans are looked at with the new care plan and discussed with service users and families. • The Service has checked who required a health action plan. • The Service has used health assessments to help produce the health action plans.
There was no evidence that people are supported or encouraged to have an annual health check. Only a few service users had a Hospital Passport in place	Discussions should take place with health colleagues to determine how many users have had health checks Health Action Plans should be explained, encouraged and supported. Specific plans should be in place to assess the health needs of each service user. Hospital passports must be in place for all service users.	• As described above the same approach has been taken for hospital passports.
There was little evidence of pain and distress tools being used.	Easily available tools should be used. Staff should receive training to use them. These tools should be monitored to ensure they are being used properly to support people.	• The new care plan and risk assessment includes pain management. This encourages managers to consider how pain may show itself and how they can support the service user to communicate their pain. Pain assessment tools are used.

There was an example of a long delay in physiotherapy assessments.	A review should be carried out to make sure physiotherapy and other health needs assessments are up to date. Where physiotherapy or other therapy is used, a system to monitor its effectiveness should be put in place. Health services should be involved in this.	• The care plan review has highlighted service users who required physiotherapy. Referrals have been made where needed.
Feeding and swallowing plans were not always easily accessible.	Feeding and swallowing records should be made easily accessible and always available.	• The care plan and risk assessment introduced ensures a more detailed and thorough approach in this area – see above. • All eating and swallowing plans have been reviewed using the old format and all plans are being transferred onto the new documentation. • The Service and Sheffield Health & Social Care Trust have agreed that they will jointly carry out an audit across all services to check the number of people being assessed with eating and swallowing needs, the date of Speech and Language Therapy assessments and how medication is accessed and managed.
The Service was not checking enough for signs of depression or dementia.	Training should be delivered so that staff have an understanding of the issues of depression and dementia in people with learning disabilities. Staff should work closely with health colleagues to develop tools to help identify issues and refer on appropriately.	• Staff will receive training on mental health and dementia during 2015 / 2016. • Good practice information regarding dementia has been made available to all staff and team meetings regularly focus on this topic.
There were a significant number of errors and lack of up to date information in medication records. There was an inconsistent approach to record keeping including receipt, dispensing and stock control. A further review found that medication errors had not been alerted to safeguarding.	Records should be accurate, consistent and up to date. All information should be kept in service users' files. A new system should be put in place to ensure records are accurate and consistent. Different ways of checking medication records should be trialled. The style of record keeping used by pharmacists is recommended. The risk caused by medication errors should be understood by all staff.	• A review of the medication documentation was carried out and a new range of documents is now in place. • The Service now links in with the Council's medication steering group ensuring best practice is adopted and implemented in line with other services. • Medication errors are reported and recorded. The Quality and Governance team will work out why errors happen to help make sure the process is improved. • The current medication policy is being reviewed.

Service reviews were overdue. The Service review carried out for Warminster Road found standards to have been met. Two months later the Interim Head of Service found the premises to be so unsafe that they were immediately closed.	Service reviews should be carried out in every service area. Senior management should review the reasons for the difference between the two assessments.	• An investigation into why service reviews were not carried out has taken place. • Following a period of major changes, service reviews were arranged in every area from April 2015. • Service plans are now complete for all parts of the service. • An investigation into this issue was carried out and has now ended.
There was a lack of structure, systems, processes and consistency across services. There was evidence of standard practice not being carried out properly.	Recommendations made elsewhere in this report should be carried out and any further gaps dealt with.	• Much work has been undertaken to ensure that systems are consistent across the Service. New ways of working have been put in place consistently across all service areas. • The Service now has the same approach citywide and not locality based as it once was. Managers are working together in all areas to ensure there is consistent management.
There was concern about the changed arrangements for managing staff rotas.	The arrangements should be reviewed to ensure they work for staff and the Service.	• Work has been carried out to examine the current rota system to ensure it is working to benefit staff and the Service.
The two locality Area Managers were not working together and there was no evidence that this was being addressed.	Discussions should take place with the Deputy Head of Service, the Area Managers and relevant staff to understand this issue.	• An investigation was carried out and finished. • The Service now operates citywide and not in areas (localities) so the risk of inconsistent approaches is reduced.
Staff morale was low, particularly in day services. There was evidence that staff and managers were aware of poor practice but that nothing was being done to address this.	A clear plan should be put in place and shared with staff as soon as possible. The views and feelings of demoralised and demotivated staff should be listened to.	• Service planning days have taken place involving staff. Staff feel included in decision making. • Changes have been communicated to staff through regular meetings. Attendance at meetings is monitored and staff can give feedback. Minutes of the meetings are available and accessible to all staff. • Regular supervision sessions are scheduled with all staff.
Ligature risk was highlighted as an issue.	The Service should ensure that a risk assessment and policy is put in place. Attention should be given to ligature risk. Advice should be sought from Sheffield Health and Social Care Trust.	• The Council developed a risk assessment and this was put in place in April 2015. All risks identified are recorded and actions are being undertaken to address them.
Choking risk was not identified in care plans.	See above. A review of care plans should be carried out to ensure any risk is identified and dealt with.	• A review of the care plans was carried out. The new care plan identifies risk.

There were no First Aid plans in care plans.	This is good practice that should be adopted.	• A generic First Aid risk assessment is now in place. • Service user issues, e.g. allergies to plasters, are in the risk assessment and hospital passports.
There was no protocol in place for the administration of PRN.	The Service needs to ensure that protocols are in place for PRN administration indicating why the medication is prescribed, and the symptoms for which the medication should be given.	• The new care plan has a section that covers this.
There was no record of discussions with service users about medication, why it was used and its side effects.	This point has been challenged as social care staff are not clinically trained to describe medication prescribed.	
There was no protocol in place for controlled drugs.	There were no recommendations.	• There are now clear protocols in place for the management of controlled drugs. These are in the medication policy, shared with staff through annual training and monitored through monthly medication audits.
Medication MAR sheets were A4 loose documents.	Sheets should be stored securely.	• All MAR sheets issued by a pharmacist are loose documents. To ensure the safe storage, all MAR sheets based at Warminster Road are now stored in a file for the residents. The file remains with the medication cabinet locked in a secure room. • In supported living it is stored with the medication.
Some staffs medication training was out of date.	All staff must be trained each year.	• There is a rolling programme of training dates for the year. • Staff will also receive a direct observation of their practice that includes medication administration.
The medication policy was being poorly followed. It seemed unlikely that the policy would become standard practice in the Service.	The current policy should be reviewed.	• The policy review was carried out. The Service is about to ask the medication steering board to approve a new policy. • Following approval, the Service will ensure that all managers and staff understand the new policy. The implementation will be carefully managed through workshop sessions and the policy will form the basis of annual training.

Action Plan – Finance and Management

Findings	Agreed Recommendations	Action taken
Guidance on handling client's money had not been fully circulated to staff. Some guidance had been circulated but it had been written by the Service and not properly authorised by Sheffield City Council.	Guidance should be reviewed and updated by managers and brought into line with Council policies. Better controls should be put in place to protect clients and staff. New policies should be approved through the correct Council channels.	• Current guidelines were reviewed by senior officers at a workshop in February 2015. Work continued throughout 2015 to make sure the policies were appropriate for LD Provider Services. • A review of current practice was carried out and the findings used to improve the policies. • The new procedures have been introduced and are being regularly reviewed.
The cost of staff meals during outings were met from client funds.	The approved practice of funding staff meals from client's monies should be stopped immediately. If a client requests to go out for lunch/dinner, the staff member should pay for their food.	• The recommendation is being followed. It is a matter for the service to determine meal arrangements (including funding issues) for staff while they are at work.
The policy "Holiday guidelines and Procedures Providers Services" was out of date and led to the Service incurring inappropriate costs.	The policy should be reviewed.	• The policy was reviewed and updated. There is now clearer guidance on what is classed as appropriate expenses.
Controls for the management of clients' monies were not consistent across the Service. This made it difficult to know if any misuse had occurred.	Staff should have refresher training, which should include the new policy. Procedures for handling client's money should be reviewed regularly.	• The new policy was introduced between April and May 2015, and staff have received relevant training. • The new policy is being reviewed regularly to ensure it is being implemented properly. • Daily financial balance and transaction checks are being carried out by managers.

The current appointeeship contract did not meet the needs of the service or clients. The appointeeship service did not audit the personal money and financial records of their clients. Letters from that detailed the amounts of personal monies despatched were not retained at all sites The Social Care Accounts Service (SCAS) operates an in-house Appointee Service for people in residential accommodation. The Service to expand this to other clients.	There should be a review to find out what is required from an appointeeship service. A new contract should be written and providers invited to apply to provide the service. . The new contract should ensure that money is delivered directly to the client or that they are able to collect it at a time to suit them. Future appointeeship services should be required to check the personal money and financial records of their clients. All checks should be documented and evidence kept on file. Letters sent from the appointee service to clients with personal money payments should be kept in the client's finance file for future reference. There should be a decision about whether to provide this service in-house through SCAS.	• The Social Care Accounts Service (SCAS) is currently transferring clients from Citizenship First into the Executor Services Team. The recommendations made relating to Citizenship First will be met by the Executor Services team. • A pre-paid card system is being considered to remove the need to handle cash.
Cash deliveries to a client's home were not witnessed by two members of staff. This exposed the client and staff member to some level of risk. The recording of money transactions was not consistent across the service. Often only one signature was present for entries and withdrawals. The way receipts were recorded across the service was inconsistent. Some receipts were incomplete or missing.	All cash deliveries should be witnessed and recorded by two members of staff. Management need to review how clients are able to access their money. Thorough controls need to be in place to reduce the opportunity to use money inappropriately. Independent checking should also be carried out. Management should review the current process and ensure that a new system for handling and properly recording receipts is put in place and used across all sites.	• Deliveries were/are witnessed by two staff when possible, however staff availability means this is not always possible. However, money is usually delivered by a manager. • The process was reviewed at a workshop in February 2015 and a review carried out by internal audit. • A review of the Business Support team and its role was carried out. Some changes have been made relating to how transactions are recorded and checked. A single approach and standard paperwork for transactions and receipts is now used.

Some clients had their money delivered to Ecclesfield Support Unit. Operational managers held the money and then gave it to clients. The way additional funds were requested from the appointeeship service was not consistent across the service.	The practice should be stopped immediately. Citizenship First should be instructed to deliver money directly to clients at home on a specific day. A member of staff should be available to sign for the payment. The safe keeping of money should stop immediately. All requests to change payments should be recorded in the client's file and authorised by a manager.	• Safe-keeping' of money has now ended. • Staff from the Council's Contracts team met with the appointeeship service to identify the affected clients. • The changes to payments are now being recorded correctly. Requests for change are now done by email request so there is a clear evidence trail.
Council staff and other support workers had access to the bank cards and the PIN of clients who needed help to make cash withdrawals from a bank.	If a client is in charge of their own finances, staff access to their bank card and PIN details should be restricted. In line with the Managing Clients Monies policy, Care and Support staff can support clients to access their money but they should not be relied upon to take control of a bank card and PIN. An appointeeship service should be used where the client cannot manage their finances.	• A review was carried out and affected clients identified. The majority of cards were found to be 'pre-loaded' rather than bank cards. • Transactions are recorded and matched to the amount withdrawn. • Clients with bank cards are being supported to access their money in ways that do not involve staff.
The frequency and quality of account audits by management was inconsistent and poorly recorded.	Management should ensure that the audit of account sheets are carried out each month and issues raised with relevant members of staff. Management should carry out a fraud risk assessment and take action to prevent any financial losses.	• A new process has been put in place and regular checks are carried out.
A number of housekeeping contributions had been deducted from appointee cash payments before being recorded in clients' account sheets. This resulted in incomplete records. Funds were not always held securely and safes could be accessed by several people. Safe audits were not carried out regularly and the code had not been changed in several years. The amount withdrawn from	The Service should ensure that the total value of the appointee payment is recorded in the client's account sheet before any deductions are made. All funds should be held securely and only chosen staff should have access. Management should ensure that override keys are kept securely. Safe audits should take place every three months at ESU in line with the Council's Use of Worksite instructions. The safe code to be changed every three months as part of the regular check. The Service should ensure that principles	• This recommendation is now in place and is being checked regularly by operational managers. • Balance checks are carried out at the start of each shift and for each transaction to address any errors when calculating deductions. • Safes have been installed where needed. Staffing levels at some sites is likely to mean that all on duty staff will need access to safes. However management will ensure the number of staff with access is kept to a minimum and on a need to know basis. • The safe checks are carried out by a Business Support Manager k.

housekeeping funds did not always match that being spent. These errors appeared to be the result of calculation / mathematical errors.	contained in “Recording transactions and accessing client finances” policy are maintained for recording housekeeping deductions.	
The process for documenting the contents of the ESU safe was too complicated and relied on too many documents.	The way the safe contents are recorded should be reviewed.	• A new process has been put in place.
Contributions of between £12.20 and £19.72 per night were paid by some clients. There were no controls in place to differentiate between contribution paying and non-paying clients. Contributions were paid directly to the unit. Keeping records and receipts was inconsistent.	A way of easily identifying the two different client groups should be put in place. A record of those required to pay should be shared with Social Care Accounts Service (SCAS) The collection of cash contributions should be stopped. SCAS should deal directly with clients who are required to pay a contribution.	• The Service no longer receives contributions. This is now sorted between Assessment & Care Management and SCAS.
Three clients wrongly paid contributions to Warminster Road as the Support Plan Sign off Record was not clear enough.	A review of every client attending Warminster Road should be carried out to confirm if respite care is included in their support plan. A statement of payments made should be produced and the clients should be informed that they had overpaid. Clients should be asked to identify any other payments made that are not on the statements and evidence such as receipts should be recorded.	• The statements have been produced and sent to clients. • Review Complete and action taken.
There was no way to know if clients were using the correct number of respite days that they were entitled to.	The number of respite days used by each client should be recorded and compared to the number in their Support Plan Sign off Record.	• The Service met with Social Care Accounts Service (SCAS) and Assessment and Care Management (A&CM) to agree a way to monitor respite days. They agreed that stays will now be booked through A&CM and not directly with the Learning Disability Provider Service.
The Warminster Road Respite Unit petty cash float was being used a lot to buy groceries. This is not allowed by the Council’s financial regulations.	Management should review how food is purchased for Warminster Road. Different ways of purchasing food such as online shopping and pre-paid debit cards should be looked at. Purchases should be delivered directly to the unit at agreed times so that staff are available to check what has been delivered.	• The float has been reduced to £500. • Food is still bought through petty cash but the Service is trying to find suitable providers. However, this is proving difficult given the small quantities involved.

Withdrawals of petty cash from the respite unit were not signed by two staff and some receipts were missing.	Payments from petty cash should be signed by the staff member who is responsible for the float and Authorising Manager. Receipts should be kept for each payment including a valid VAT receipt where appropriate.	• The Service is aiming to ensure that nothing should be spent without a receipt for the right amount. • Throughout the week only authorised managers give out money. At weekends a small amount is left in a secure place.
Clients staying at the unit could choose to manage their money themselves or allow staff to record the amount they had and spent. It was not clear which option they had chosen.	The care plan of each client guest at the Warminster Road Respite Unit should be clear which option is being used. Where staff are monitoring the money, records should be kept up to date and all receipts kept.	• The new care plan has a finance section which notes which option is being used.
Some small room safes were not secure.	A review of the facilities in each room should be carried out.	• The office safe has been made secure for those clients who do not look after their own finances. Room storage security is being improved and safes secured.
The business plan for Green Cake Café (GCC) was out of date and did not show how it could be it could make enough money to run itself.	The GCC business plan should be updated to include all costs and income, any risks that could affect its long term future and ideas on how to make the business sustainable. Once complete a decision on the café's future is needed and management will need to decide about the costs of future support.	• Work on the business plan is on-going.
Yearly appraisals were not being carried out consistently across the service. One to one meetings were not carried out regularly.	Formal annual appraisals should be carried out as required by the Council. Appraisals should be kept in staff files. One to one meetings should be held regularly and records kept in files.	• Managers have received training on how to carry out appraisal and regular monitoring checks are carried out. • One to one meetings are scheduled regularly and managers check to make sure they are being held. • Documents are kept in staff files.
Formal training plans for staff were not in place. Individual development plans were not found in staff files.	A training and development plan should be written for each area of the service.	• A review of what training is needed has been created and this is being used to plan training sessions. • Regular training meetings are held. • The Learning and Development Co-ordinators now have a clearer understanding of their role.
A number of training courses were cancelled and were not always rearranged quickly.	Cancelled training sessions should be re arranged quickly.	• Learning and Development Co-ordinators now manage training sessions. Training is monitored by Management.
The way staff sickness was recorded and monitored needed improvement.	Management should ensure that the staff who record employee sickness are fully aware of the guidelines. Records should be reviewed regularly to ensure they are accurate.	• Regular sessions were held with staff from the Council's Human Resources team. • Staff are now recording sickness properly. Area managers check records each month to ensure they are accurate.
Some members of staff were paid significantly more than they were contracted for during 2012/13.	A review into the use of zero hour contracts and agency should be carried out.	• Work is being carried out to ensure there is a fair allocation of work. • Human Resources are working with the Service to ensure a new process is put in place.

Sheffield City Council

Commissioning Strategy for services for people with a learning disability and their families

2015 - 2018

Foreword

I am pleased to introduce you to our Learning Disabilities Commissioning Strategy.

We want to make a positive difference to the lives of people with a learning disability and their families in Sheffield. This strategy describes the changes and improvements we plan to make to care and support services in Sheffield. These changes are based on what people have told us, what we know about the needs of local people with a learning disability and their families, the challenges we face, and the opportunities we have identified to help make things better.

Between September and November 2014 we consulted on our draft strategy. We engaged with people with learning disabilities, their families, carers, care professionals and other stakeholders to help shape our ideas. The feedback has been taken into account in this final version of the strategy, which was approved by the Council's Cabinet in December 2014.

Now we have produced this final strategy, we will develop detailed commissioning plans for specific changes and consult on them. For example, where the commissioning plans recommend changes to specific services, we will consult with users of those services on these changes. We want change across the whole system, and for people of all ages with a learning disability. We will develop these plans with our partners across the Council and in the NHS, including working together with the Children Young People and Families Portfolio.

Cllr Mary Lea

Cabinet Member for Health, Care and Independent Living

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1. Introduction

The needs of people with a learning disability are changing and becoming more diverse. People have higher expectations of an independent life in their community, and want more control over their lives with good quality support built around their individual needs.

At the same time we face significant challenges. Some local services are out of date, expensive, and need to change if we are to meet people's expectations for the future. Other services, including some housing options, are poor quality and need improving. In the past some people have had to leave Sheffield to access the services they need. We need to make sure this no longer happens, that all support is provided locally and that people who live away from Sheffield can return if that is what they want.

The Council faces severe financial pressures. People are anxious about the impact this might have on their own care and support: there is a need to make sure services provide the best value so people can get the most from the available resources. We need a more diverse range of good quality care and support services to meet people's highly individual needs and ensure real choice. We also need culture and practice to change so that support builds on individual, family and community resources and reduces people's dependency on social care services as the only form of support. And we need strong partnerships to make sure the 'whole system' helps people with a learning disability and their families stay independent, healthy and well, and fully included in community life.

This Commissioning Strategy responds to these challenges. It builds on work already in place to improve learning disability services in Sheffield, and proposes significant changes in the way services will be commissioned and provided in the future.

2. Vision

Our vision is that in four years' time:

- All services will provide high quality care and support to people with a learning disability and their families.
- Services will actively promote people's wellbeing, helping them have a good life and be as independent, healthy and well as possible.
- Local support services will be more diverse so all people with a learning disability in Sheffield, whatever their age, background, or level of need, will have more choice in their support.
- Social inclusion will be promoted throughout everything we do. More people with learning disabilities will be doing more within their community. Support will build on resources in the community, tackle barriers to social inclusion and reduce dependence on social care services alone. We will have stimulated creative and innovative ways to make this happen.
- More people with learning disabilities will be in paid work and volunteering opportunities, working alongside the rest of the community.
- There will be major improvements in the support for family carers, improving the support available to carers in their own right, and making life better for people with learning disabilities who live in the family home.
- There will be major improvements in local accommodation and support for people who live away from their families. Housing will be high quality and the support will promote people's independence and wellbeing and will offer dignity and privacy.
- Fewer people with a learning disability will live out of the city, and people who need and want to return will have been helped to do so.
- Sheffield will have moved away from traditional or institutional forms of support and will focus on support which is personalised, flexible and meets people's individual needs.
- Services will help people work together and pool their personal funds so they can share their support and sustain meaningful and rewarding relationships.
- There will be more coordinated information about services and support across all relevant agencies
- The transition for young people with a learning disability to adulthood will be positive
- There will be strong partnerships between the Communities Portfolio, Children, Young People and Families Portfolio, Place Portfolio and NHS partners to make sure support is joined up.
- All services will provide best value for Sheffield people.
- In four years' time people will say they have been fully included and involved in the planning and implementation of changes.

To achieve this vision, some services will need to change. We understand that changes can create anxiety and we will be respectful of this. We will engage with people with learning disabilities, their families and carers throughout the development of plans and make sure their needs continue to be at the forefront of all that we do. We will make sure changes are implemented sensitively and allow people enough time to make successful transitions to new arrangements.

3. The Scope and Context

3.1 Local people with a learning disability and their families

Over 1,550 adults with a learning disability aged 18-64 currently receive adult social care arranged by the Council. People with a learning disability have a wide range of needs, with a range of backgrounds and live within all of our increasingly diverse communities. They include people with lower level needs for support and people with significant additional needs - including people with dementia, physical disabilities, sensory impairments, mental health problems, profound and multiple intellectual disabilities, autism or behaviours that services find challenging. They also include people who need short term support to help them regain their independence, people needing social care for the first time and people receiving longer term ongoing health, housing and social care services. Approximately 40% of all people with a learning disability receiving adult social care live with their family and approximately 60% live away from their family.

This all means local community-based services must be as diverse and flexible as possible, and develop in ways that reflect people's increasingly varied and changing needs.

3.2 Local services for people with a learning disability

This strategy is about the care and support services that can be purchased or provided to meet the needs of adults with a learning disability and their families. The majority of services are currently provided by a range of Independent Sector organisations (voluntary sector, private sector, social enterprises and self-employed people e.g. personal assistants). Services are also provided directly by the Council and by Sheffield Health and Social Care Trust. Some people have 'packages' of a number of different services provided by one or more of these. This strategy covers services in all these sectors. The gross budget for these services is approximately £44 million per year. More information on this is given in Section 6.

It includes a number of services that may be purchased by the Clinical Commissioning Group, including people eligible for NHS Continuing Healthcare. There are strong links with the Council's Regeneration and Development Services in the development of our local housing offer, and strong links with the Children, Young People and Families Portfolio, including the Employment and Skills Service.

Adult social care provided or funded by the Council includes:

- Support for family carers, including short breaks services
- Home support services
- Support for people in the community such as support for day time opportunities, volunteering and employment
- Accommodation and support services such as supported living, residential and nursing care
- Adult Placement Shared Lives services, such as befriending, day support, short breaks services and long term placements
- Direct Payments for people or families who want to make their own arrangements for support. This can include paying for support from personal assistants
- Help for people to manage their Direct Payments – such as money management services
- Advocacy support

The strategy also prioritises development of local services so that people do not need to leave Sheffield to access the support they require. This will help people who live out of the

city to return to Sheffield if that is what they want to do with access to the appropriate levels and types of services.

There have been many changes to services for people with a learning disability and their families over recent years, and other changes to learning disability services are taking place now. All of these changes aim to contribute to the overall vision.

3.3 A whole system approach

The strategy does not include everything that has an impact on adult social care for people with a learning disability. Other key developments, including our implementation of the requirements of the Care Act 2014, the Children and Families Act (2014) and our Integrated Commissioning Programme will have significant impact on wider Learning Disabilities services. For instance, it does not include the development of social work practice or our plans to integrate commissioning for all customers of health and social care.

All organisations and agencies are committed to working in partnership as we develop and implement specific plans over the next three years. This will include joint or integrated commissioning plans with Children's services, housing and HNS partners where this will benefit local people with a learning disability and their families.

4. What Local People Want From Services

4.1 Engaging with people with a learning disability and their families

This strategy is based on detailed consultation with people with a learning disability, their families and other stakeholders. Details of how we carried out the consultation and the detailed feedback are presented in a separate report.

4.2 Key messages for our Commissioning Strategy

The consultation greatly added value to the draft strategy and enriched the evidence base. Feedback was broadly supportive of the direction set out in the strategy. However, additional issues were raised, and there was a need to change the emphasis in places. The feedback has been fully taken into account in this final strategy.

- **Coordination** – the strategy needs be joined up with Assessment and Care Management, Children's services, Health, Housing, and other partners.
- **Support to carers/families** – there should not be an assumption that people with learning disabilities will remain living in the family home, and there must be planning ahead and support to prevent carer breakdown.
- **Support to live in your own home** – there was broad support for Supported Living and tenancy support models.
- **Support for community involvement** – there was broad support for this aspiration but specific support for people with learning disabilities is needed to help them take advantage of community opportunities and to support social needs, and there needs to be more to do in the evening and at weekends. There are also a number of barriers, including transport, costs, people's perceptions of safety, and lack of information on opportunities in the community.
- **Doing things together** – there was a strong theme on the importance of people with a learning disability being supported to take part in communal activities, and that many people enjoy and appreciate friendships and shared experiences. People also said they would benefit from support to pool their personal funds so they can benefit from doing things together, and share their support so the available funding can go further.
- **The impact of reductions in available funding** – there were concerns that there will be insufficient resources for people to access more community activities (e.g. if they need support from Personal Assistants to do this).
- **More choice in short breaks services** – people with learning disabilities and their families need more choice and information about good quality affordable short breaks. People whose behaviours services find challenging need better choices of building-based short breaks services.
- **Quality assurance** – people need assurance that all services in all sectors of the market are of high quality.
- **People need time to adjust to new arrangements** – when things change, people need time and support to adjust to new support arrangements. This should not be under-estimated when implementing changes.
- **Barriers to paid work** – many people talked about wanting paid and unpaid work but there are mixed views, and the impact it might have on people's benefits is seen as a major obstacle.
- **Broad spectrum of need** – it is important to recognise the wide and increasing diversity of need of people with learning disabilities, including people with complex and multiple disabilities and behaviours viewed as challenging.
- **Building-based services** – whilst people support the aspiration for more flexible community based services, many people, in particular people with complex needs,

benefit from services based around buildings with the right environments and the right specialist support

- **Advocacy** – people said there is a need to make sure our plans for the future include plans for advocacy services.

5. The policy context

This strategy has been developed in line with local and national policies, with a focus on providing high quality care that promotes independence, social inclusion, choice, and provides best value. A summary of the relevant policies is provided below.

The Care Act 2014 reinforces national policy for adults with a learning disability, including the core principles in Valuing People (2001), and Valuing People Now (2008): rights, independence, choice and social inclusion. The Act consolidates existing law, and introduces a number of new duties on local authorities. It emphasises the requirement for services to actively promote improvements in people's wellbeing through the care and support they provide at all stages, from the provision of information and advice to reviewing a care and support plan. It brings new entitlements for carers. It reaffirms the principles of personalisation, legislating for Personal Budgets and requiring local authorities to promote Direct Payments.

Assessments should build on individual, family and community strengths, support access to universal services and aim to prevent, delay or reduce people's dependency on services. The Act brings a duty to stimulate a diverse market of continuously improving, high-quality services, including a range of different service provider organisations to ensure genuine choice. Councils must commission a diverse range of services that provide best value for local people. Transitions for young people with a learning disability into adulthood must be effective. The duty of co-operation will help drive our partnership working.

The 'Winterbourne Concordat' and 'Winterbourne View – time for change' will underpin this strategy. Stronger local community-based services will build on the Concordat's five good practice indicators: co-production, community building, a capabilities based approach, integrated services and personalisation. The requirements for strong joint approaches including pooled budgets, integrated commissioning and genuine partnerships with people with a learning disability and their families, and a 'whole life-course' approach will further strengthen our partnership working.

The Health and Wellbeing Board and joint Health and Wellbeing Strategy strengthen whole system working to improve health and wellbeing, tackle inequalities, make sure people get the right support in the right place at the right time, and ensure best value. Implementation of the Commissioning Strategy will also be aligned with implementation of Sheffield's plan for integrated commissioning of health and social care for people of all ages, which sets out four main areas for integrated working: keeping people well in the community, intermediate care, community equipment, and long term high support.

The Care Act, along with the Children and Families Act 2014 has specific implications for effective progression to adulthood and reinforce our commitment to a 'life-course' approach to supporting people with a learning disability and their families. The new Children's Act also replaces Special Educational Needs statements with a new 'birth to 25' Education, Health and Care Plan, improving cooperation between Councils and the NHS and requiring Councils to publish a 'local offer' of support. It is essential the local 'birth to 25 offer' is aligned with the service offer for all adults with a learning disability.

6. The Social and Economic Context

6.1 Demographic change

The number of adults with a learning disability is increasing and their needs are becoming more complex.

It is good news that more children with major disabilities are surviving into adulthood and more disabled adults are living into older age. However the overall gap in life expectancy between people with a learning disability and the rest of the population has not reduced.

The number of adults (20+) recorded by Sheffield Case Register increased from 1,950 to 2,671 over the ten years between 2003 and 2013 - approximately 4% per year. This is significantly higher than the trends given in the national 'Projecting Adult Needs and Service Information' resource, which estimates increases around 0.5% a year. There is no evidence of specific demographic pressures in Sheffield that might explain the difference: further work is needed to understand the national projections, and the balance between actual population change, and increased identification by local services.

The increase in numbers is principally due to a rise in the number of younger people with a learning disability, in particular children with more severe and complex needs, and children with autism. (Over 50% of 10–20 year olds known to the Case Register have a diagnosis of autism). Our plans therefore need to make sure local services deliver good quality skilled support for people with an increasingly diverse range of needs, both in family and community settings and in accommodation with support away from the family. This requires a joint approach with NHS partners.

The proportion of adults with a learning disability from black and minority ethnic communities (BME) is around the same for as the White British population in ages between 20 and 50, and lower in over 50s. There is evidence of increased prevalence of people with the most complex disabilities within BME communities.

There is also a 'bulge' in the number of people aged 35 to 50. Many of these people are living with family carers, most in older age. As their family carers age, there will be an increase in demand for accommodation with support away from the family. Supporting families to plan in advance for the future living arrangements of their disabled sons and daughters provides significant reassurance, and helps develop plans that optimise people's future independence and social inclusion.

6.2 Change in demand for services

Over the nine years from 2005 to 2014 the number of adults with a learning disability receiving care and support increased by 35% from 1,136 to 1,531 – again around 4% per year. The proportion of adults with a learning disability supported by the Council per head of the overall population increased from below the England average until 2011/12, to above the average from 2012/13. As with the demographic information, further work is needed to understand the balance between the impact of population increases, and the impact of other factors.

- The biggest area of increase was in younger people. Approximately 60% of the increase in numbers was in young people under 25.
- However 16% of 'new starters' were people who had been living with older family carers, and another 14% were due to breakdown in carers' circumstances.
- Approximately 60% of people live away from family, with either community based support, or in supported living, residential and nursing care settings. If current practice and demand stay as they are, we estimate there would be an increase of

around 200 people living in accommodation with support by 2020.

Our understanding of needs and demand informs our priorities.

- The need to make sure services develop to meet the changing needs and expectations of younger adults with a learning disability, at the same time as meeting the changing needs of an ageing population.
- The need for a more diverse and flexible range of local services to meet the increasingly diverse needs of local people.
- The need to make sure family carers have the right support to care for their disabled relatives at home if that is what they want to do.
- The need to improve the quality and achieve best value in accommodation with support for people living away from their families.

6.3 Budget, spend and best value

The total cost of services for adults with a learning disability is £65m. This includes assessment and care management services and other direct costs. Of this, approximately £44 million per year (gross) is currently invested on direct care provision for people with a learning disability.

The Council has faced several years of austerity as a result of Government cuts to its budget, rising prices, and increases in demand for services. Nevertheless, Sheffield's investment in services for people with a learning disability has increased year on year over the last five years. The budget for 2014/15 is around £3.5 million more than 2013/14. Given the Council's financial challenges, this is an unsustainable position.

In comparison with other authorities, the latest available published 'Personal Social Services Expenditure' information (PSSEX1, 2012/13) shows Sheffield's spend per head on adults with a learning disability has moved from below the national, regional and core cities averages in 2008/09 and 2009/10 to above all these averages in 2012/13.

According to the latest benchmarking information, the average cost of residential care in Sheffield for people with learning disabilities is in the highest quartile in England[1]. The average cost of nursing care for people with learning disabilities in Sheffield is also higher than in almost any other area. Costs for home support and day services for people with a learning disability are broadly in line with the England averages.

This Commissioning Strategy must be delivered in the context of reducing Council budgets, and we expect any future changes to help us meet our financial challenges. It is important to make sure all services are delivered in an effective and efficient way, and of high quality. The detailed commissioning plans will make sure all services are good quality and affordable. This will also allow us to make accurate financial forecasts and ensure a sustainable range of provision.

[1] http://www.hscic.gov.uk/catalogue/PUB13085 PSSEX1 Indicator 2.9

7. What Needs to Change

7.1 Social inclusion

We need a major shift in culture and practice towards promoting people's social inclusion, and reducing people's reliance on institutionalised forms of care as their only form of support.

In the consultation there was broad support for the aspiration to increase people's social inclusion and for more people to be supported to access everyday community opportunities. However many respondents said specific support is needed to help people take advantage of community opportunities and to support social needs, and there need to be better evening and weekend opportunities. People also cited a number of barriers, including transport, costs, people's perceptions of safety, and lack of information on opportunities in the community.

We need to highlight key issues and examples of good practice in promoting social inclusion, strengthen the evidence base and generate new innovative approaches. This will include working with Children's Services, Public Health and the CCG to develop 'whole system' approaches.

Alongside this we need culture and practice in Sheffield to change so it is based on high expectations of people's capabilities and their ability to develop new skills (whether they live with, or away from their families), and recognises that unnecessary dependence on services is 'disabling'. This will require major improvements in the quality of community-based services, including robust, preventative and proactive care.

This will involve innovative new approaches including the rapidly developing assistive technologies. It will include building on Sheffield's strengths as a friendly city to make sure the wider community and universal services are welcoming and accessible to local people with a learning disability. The Special Olympics, to be held in Sheffield in 2017, provides a unique opportunity to draw together partners from all sectors in the city to meet this aspiration.

The implementation of the vision for reducing unnecessary dependency and increasing people's social requires active input from Public Health. We will identify options for Public Health to play a lead role in improving people's wellbeing and social inclusion, and in tackling the inequalities people and their families face in many aspects of their lives.

7.2 Improving employment and volunteering opportunities

A key indicator of social and economic inclusion is the proportion of people with a learning disability in paid employment. This is a key priority for local people. In the consultation the terms 'employment', 'work', 'volunteering' or 'jobs' came second only to the general term 'support' and well ahead of the next most repeated terms. Of the survey respondents, 67% agreed with the aim for more people with a learning disability to have the support to do paid or unpaid work if they want to.

However Sheffield's performance has been consistently lower than other areas at under 4% compared with around 6% for the UK, Yorkshire and Humber and similar Local Authority comparator group averages.

Support to access paid employment is provided by the Council's in house Employment Service and Independent Sector providers. However, providers had concerns about inadequate employment support in Sheffield, including a perception that Government schemes and services (e.g. Jobcentre Plus) were not known about and did not benefit people

with learning disabilities. Some people felt day services still operated a 'teaching' model rather than promoting empowerment, and that there was a need for better co-ordination between Jobcentre Plus and learning disability services.

Welfare benefits issues were also seen as a significant barrier to employment, and the desire to retain non-work benefits had a practical impact on people’s appetite for paid work.

Many respondents also wanted improved access to wider community based volunteering activities, especially outdoor opportunities e.g. gardening projects and working with animals.

Improving employment support is a clear priority: there is a need to review our overall approach and clarify responsibilities. This will include working with the city’s Employment and Skills service, the Public Health team and our NHS colleagues to ensure a co-ordinated approach to employers and employment support providers.

7.3 Support for family carers

Support for people living with their families and to family carers is a high priority. ‘Valuing People’ and ‘Valuing People Now’ both placed a strong emphasis on families’ vital contribution to the lives of people with learning disabilities, often providing most of the support they need, and being crucial in ensuring that people with learning disabilities can live in the community. The Care Act gives us further opportunities to change and improve the support available to family carers.

The consultation provided wide ranging feedback from family carers. Many agreed with the emphasis on making sure families have access to high quality support to help them continue caring at home, if that is what they want to do.

Families need reliable and timely information and advice, and reliable communication and support from Assessment and Care Management services. Peer support between families is important. Many family carers value short breaks services, but there was mixed feedback about the quality of the available choices. There is a need for short breaks services to meet the increasingly diverse range and backgrounds of people with a learning disability, and to provide a positive experience for younger people. There is interest in flexible alternatives to building based short breaks services but a clear message that for some people, especially those with more complex needs, building based short breaks services are a positive option.

However, many family carers also stressed there should not be an assumption that they should continue to care at home, and that for disabled relatives to move on and live away from their families is often a positive or necessary option.

In particular, families need the reassurance that comes with being supported to plan ahead for the future. Families also need the assurance that there is flexible and responsive support if they are in crisis, to provide the time and resources needed to resolve problems and help them remain together.

7.4 Making sure people can get what they want from Direct Payments

The number of people with a learning disability and their families accessing Direct Payments more than doubled from 367 at the start of 2010/11 to 901 by the end of 2013/14. The principal uses of Direct Payments are for personal assistants, day time opportunities and supported living services. An increasing number of families (including families of children and young people with a learning disability) now also use Direct Payments for flexible alternatives to building based day and short breaks services.

However feedback suggests that whilst Direct Payments are popular, there is a lack of the right kinds of support for people to purchase, and a lack of reliable information about local

services and opportunities. There is also a need for people to be assured about the quality of support provided by personal assistants. Some people are concerned about the administrative burden of managing Direct Payments.

It is a priority to stimulate diverse, innovative support, based on the feedback from people with a learning disability, their families and support planners, to make sure the right services are available for people using Direct Payments, and that people have comprehensive up to date information about services and opportunities available in the city.

7.5 Moving away from traditional 'blocks' of service

We continue to have significant reliance on 'block' arrangements for services in particular for day time opportunities, supported living, short breaks services and residential and nursing care. This includes the arrangements for the Council's 'in-house' services.

These arrangements are not in line with our vision. They mean our investment is tied up in 'pre-purchased' support. This can be expensive, limit choice and reduce the ability of services to adapt to people's changing needs and expectations. We also need to respond to the Care Act's requirements for local authorities to ensure a diverse market of services. The Care Act also makes clear that Direct Payments should not be used to purchase local authority in-house services other than in exceptional or 'one off' circumstances.

We need to reduce our reliance on current block arrangements, and make sure the social care market provides a wider range of services that provide best value and can be accessed through Direct Payments. This will mean specifying the outcomes people want from services, stimulating innovation and development, and having frameworks in place that make sure alternatives to traditional blocks of service provide quality and best value. If people don't want, or are unable to manage a Direct Payment, the Council will arrange services directly using these frameworks, based on people's person centred support plans and Personal Budgets.

7.6 Doing things together: pooling personal funds.

It is clear from the consultation feedback that people want opportunities to make and sustain personal relationships, and value communal activities. People also want to get the most out of their available resources. Many said that one way to achieve this was to pool their personal funds, including their Direct Payments, to purchase shared support if they do not require 'one to one' support to take part in group activities.

As we move away from traditional 'block' arrangements, which often provide shared support, it is a priority to make sure people have both the opportunity and support to pool their personal funding, including their Direct Payments, so they can share their activities and support, and make their personal budgets go further.

7.7 Moving away from traditional or institutional forms of care

Whilst we have many examples of excellent services in Sheffield we also have an over-reliance on some traditional or institutional models of care, where support is arranged around the guidelines or principles of the service, rather than individual need. This is the case in many service areas, both building based and community-based, including some residential and nursing care, supported living, short breaks services and day time opportunities. This is not in line with our vision, and does not meet the changing expectations of local people with a learning disability and their families. This can be seen in the lower uptake by young people with a learning disability of more 'traditional' types of service.

We need to reduce our reliance on traditional or institutional models of care and make sure

all people with a learning disability have access to community-based services that promote independence, wellbeing and social inclusion. An important part of this is to reduce our reliance on residential care, increase the level of supported living and improve the outcomes it delivers. Our new supported living framework sets new, higher standards for supported living based on clear outcomes: enhanced quality of life, health and wellbeing, maximising independence from paid services, a positive experience of support, and staying safe. It is now a priority to build on this and stimulate new, innovative alternatives to more traditional day services and short breaks services.

There was support in the consultation for proposals to increase the level of Adult Placement Shared Lives (APSL). This service is registered by the Care Quality Commission, and trains, approves and supports APSL carers to provide long term care and short breaks in the approved carers' own homes and in the community. It is similar to the fostering model in children's services and is seen by many as an attractive alternative to traditional forms of care. Some Asian family carers saw potential in APSL and were keen to learn more.

However, some people felt it was difficult to match people to approved APSL carers, and arrangements can take a long time to set up. There were questions as to how well APSL could meet the needs of people with complex needs. Some family carers had concerns that APSL arrangements could break down or come to an end when the approved APSL carers themselves became too old to carry on. These issues will be taken into account in the plans to increase the capacity of the APSL service.

7.8 Building based services

There was a clear theme in the consultation around the need for building based services. Many family carers do not want building based support for young people, wanting instead flexible support that meets different aspirations, often arranged through Direct Payments and personal assistants.

Nevertheless there was also a clear message in the consultation that many people, in particular people with more complex needs and behaviours viewed as challenging, benefit from building based services. Many people said building based services provide the specialist physical environments, the specialist support, the reliability and the safety needed by people with more complex needs. There was also a view that it is unrealistic to expect people to be 'perpetual tourists' spending their days going from one community activity to the next. People also considered that building based services provided the opportunity to maintain friendships and personal relationships.

Some family carers also said the current range of building based services did not provide the right environments for their disabled relatives. If such services were the only option, this was a significant barrier. This was particularly clear in the feedback from Asian carers.

As we develop more community-based services, it is a priority to have a clear vision for building based environments that sets out the outcomes good building based services will help deliver. We will need to review the current capital assets in use in line with the vision and take opportunities to improve their effectiveness.

7.9 Improving people's housing and accommodation

Whilst we have much good quality housing for people with a learning disability living in supported living settings, we also have examples of poor quality accommodation that does not meet people's needs. It can be difficult for some people with specific housing needs to access the right accommodation. In some cases this can lead to people needing to leave Sheffield to access the accommodation they need. Some types of accommodation, particularly more institutional models, are now less popular and have vacancies that are

hard to fill, making them unsustainable in the long term.

In the consultation, the need for the right choice of accommodation was highlighted by people with learning disabilities, carers and providers. Respondents also stressed the importance of making sure accommodation was well matched to people's needs and that care should be taken to make sure people living in shared accommodation are able to live well together.

In the consultation it was clear that the accommodation in the city should reflect the increasingly diverse range of people's needs and expectations. People with more complex needs, including people with autism, may require housing that is specifically designed for their unique individual needs.

There was broad support for supported living as a model of choice. There was support for housing network and other tenancy support models. People felt there was a need for more supported living for people with lower level eligible needs. However there was also interest in people with a learning disability being able to access other forms of accommodation with support if it best met their needs – for instance nursing care for people with dementia, or Extra Care Housing.

We need to expand the range of good quality local accommodation and decommission less popular accommodation. We need to build on the lessons set out in 'Winterbourne View – time for change' and take advantage of the recommendations and opportunities in the report. Accommodation services in Sheffield must meet the whole range of people's needs so people do not need to leave Sheffield to access the housing they require. This should help minimise the risk of breakdown in people's support arrangements, reduce the need for hospital placements and help people move on swiftly from hospital to community-based services. We need to improve the way we manage accommodation to make sure people can access the housing options that best meet their needs at the time they need it. We also need to improve the coordination of housing, support and benefits to make sure supported living works smoothly for people.

7.10 Advocacy

Advocacy in its broad sense plays a key role in ensuring people's rights - in decision making processes and in their wider social and economic inclusion. The Care Act sets out specific responsibilities for local authorities to arrange independent advocates to facilitate people's involvement in their assessment, care planning and review, where they have substantial difficulty in this, and where there is no-one appropriate available to support them and represent their views. In a period of change we need a strong emphasis on advocacy to support people to make choices and engage in planning and managing change.

In the consultation people stressed the importance of advocacy, and said there needs to be a clear vision and plan for making sure the right advocacy support is available when people need it. We need to review our investment in advocacy as part of our implementation of this strategy.

8. What we propose to do

8.1 Improved social inclusion

Aim: In all our developments we want to help improve wellbeing through major improvements to the social inclusion of people with a learning disability in community life in Sheffield. We want community and universal services to be as inclusive as possible, and play a major part in promoting people's independence, safety and wellbeing.

How will we achieve this?

- We want to talk to people, their families and the wider community about what this means and how we can help make big improvements.
- We will look at what already works well in Sheffield and what opportunities we can build on for the future.
- We will also look at other places where they have done this successfully, to learn what works well and help shape our more detailed plans.
- We will work with the organisers of the Special Olympics and other partners to make sure the games and city life are fully inclusive of Sheffield people with a learning disability.

What will this mean for people with a learning disability and their families?

- The wider community and public places will be more welcoming, accessible and safe for people with a learning disability and their families.
- People will have more opportunities to spend their time doing things alongside the rest of the community in Sheffield.
- As a result, some people will need less 'service' based support.
- The Special Olympics will provide a lasting legacy of Sheffield as a city that is friendly and inclusive of disabled people.

8.2 Better access to paid employment and volunteering

Aim: We want more people with a learning disability to have paid employment in Sheffield and for the number of people doing so to be as good if not better than similar cities. We also want to improve access to volunteering activities which give people a real opportunity to contribute to the community and help move them closer to paid employment.

How will we achieve this?

- We will review the effectiveness and value for money of our current employment support services, including the Council's in-house services, and develop options for the future. We will do this in partnership with people with a learning disability, the city's Employment and Skills service, Public Health, NHS colleagues, the voluntary sector and the city's employers.
- We will work with colleagues to develop specific proposals for employment support and will consult on these to make sure they reflect what people want and evidence of what works best.
- We will work with others to make sure information and advice about pathways to employment is accessible and up to date.
- We will promote, with the organisers, opportunities for employment and volunteering for people with a learning disability when Sheffield hosts the Special Olympics in 2017.

What will this mean for people with a learning disability and their families?

- People with a learning disability will be engaged in developing our more detailed proposals.
- More people with a learning disability will be in paid employment if that is what they want.
- Some support services will be re-designed based on evidence about what works best.
- People will have good information and advice so they can make informed choices about accessing employment.
- Some services may need to change. People with a learning disability and their families will be involved in developing detailed proposals before any plans for change are finalised, and will be closely involved in any changes that happen.

8.3 Better support for family carers

Aim: We propose to make major changes and improvements to the support available to family carers, so that people are able to live well in the family home and have a good life in their communities, if this is what they would like to do. We want to make our investment in carer support more effective. This will include timely information and advice, emotional and practical support, and short breaks away from the family home.

How will we achieve this?

- We will continue to engage with family carers and carer support services to better understand what family carers want.
- Using this feedback, we will review the effectiveness of the carer support services we fund. Our current carers' contract ends in November 2015 and we will propose changes to the new contract which better provide what family carers say they want.

What will this mean for people with a learning disability and their families?

- Family carers will be better supported as carers in their own right.
- Carer support services will be re-designed based on the feedback from family carers.
- There will be changes to carers' support services from November 2015.

8.4 More choice in day time opportunities

Aim: We want to widen the current offer so there is much more choice in day time opportunities. We want to improve opportunities for people with learning disabilities to engage in social and learning activities which are purposeful, leading to people increasing their access to their wider community. People have told us they want better opportunities to make friends, build social networks and enjoy social activities.

We want community-based day time opportunities that support all people with a learning disability including people with the most complex needs and behaviours viewed as challenging. We want to move away from block arrangements where appropriate, so that more services can be as personalised and flexible as possible and so our money is not tied up with 'pre-purchased' services. As we do this we want to stimulate innovation and flexibility. Alongside this we want a positive vision for good quality building based services. We want day time opportunities to offer best value so that people can get the most out of their Personal Budgets. As part of this we want to support people to do things together by helping them pool their personal funds to arrange innovative activities with shared support.

How will we achieve this?

- We will engage with people with a learning disability and their families to better understand how people want to spend their days, and generate new ideas about how this might be achieved.
- We will work alongside children's services to stimulate innovation and choice in local services by encouraging new ideas. This might include investing in an innovation fund for new day time opportunities.
- We will review the effectiveness and value of the day time opportunities we commission, and develop options for the future.
- We will make sure the improvements are accessible to all people with a learning disability, including those with the most complex needs or behaviours viewed as challenging.
- We will develop a vision for good quality building based services.
- As we develop specific proposals for day time opportunities we will consult on these to make sure they reflect what people want.

What will this mean for people with a learning disability and their families?

- People with learning disabilities will have more choice about how to spend their days and have varied experiences, which meet their needs and aspirations and enrich their lives.
- Some services will be re-designed based on the changing needs of people with learning disabilities.
- There will still be building based services for people to meet and socialise. These will be fit for purpose, and there will be more opportunities for people to spend their time out and about in their community.
- Some services will need to change. New developments will be stimulated. People with a learning disability and their families will be engaged in developing detailed proposals before any plans for change are finalised, and will be closely involved in any changes that happen.

8.5 More choice in short breaks services

Aim: We want to widen the current offer so there is much more choice in short breaks services. This will include different opportunities for a short break, such as activity based breaks or 'sitting' services. We recognise the need to retain some building based services especially for people with complex needs. People have told us they want short breaks services to offer meaningful activities including opportunities to make friends, build social networks and enjoy social activities.

We want short breaks to work better for all people, including people with very complex needs or people whose behaviours services find challenging. We also want short breaks to offer best value so that people can get the most out of their personal funds. We also want reliable services for families who find themselves in crisis situations, such as providing short term intensive support to allow the time and space for crises to be resolved so families can continue caring, if that is what they want to do.

How will we achieve this?

- We will engage with people with a learning disability and their families to develop a vision for good quality building based short breaks services and generate new ideas.
- In partnership with the Clinical Commissioning Group, we will review all short breaks services we commission, develop clear plans for the future, stimulate innovation and real choice, and make sure all services are of the highest quality and offer best value.

- We will make sure people have good information about what short breaks services are available.

What will this mean for people with a learning disability and their families?

- People with a learning disability will be able to have more varied experiences whilst having a short break, which meet their needs and aspirations and enrich their lives.
- People will have a better choice of good quality short breaks to help family carers care for their disabled relatives at home and prevent family breakdown.
- Building based short breaks services will be high quality and offer enjoyable and purposeful experiences.
- Short breaks services will provide best value, so people will be able to get the most from their Personal Budgets.
- Some services may need to change. People with a learning disability and their families will be engaged in developing detailed proposals before any plans for change are finalised, and will be closely involved in any changes that happen.

8.6 Increasing Adult Placement Shared Lives

Aim: Many people with learning disabilities and their families have support from approved carers registered with the Adult Placement Shared Lives (APSL) service. This includes befriending, day time opportunities, short breaks services and long term placements as an alternative to supported living or residential care. Adult Placement Shared Lives also offers good value for money. We want more people to benefit from Adult Placement Shared Lives.

How will we achieve this?

- We will increase the number of families registered with Adult Placement Shared Lives who provide befriending, day time opportunities and short breaks.
- We will double the number of families registered with Adult Placement Shared Lives who provide long term Shared Lives support.
- We will make these opportunities more accessible, including to people with complex needs and people whose behaviours services find challenging.

What will this mean for people with a learning disability and their families?

- More people with learning disabilities and their families will be able to have support from families registered with Adult Placement Shared Lives.
- As Adult Placement Shared Lives services offer good value for money, people will be able to get more from the available resources.

8.7 A new accommodation commissioning plan for people with a learning disability

Aim: We want to expand the amount and range of good quality accessible community-based accommodation and support that meets the wide range of people's needs.

We want accommodation to enhance wellbeing and reduce social isolation by combining privacy with access to shared space, shared activities and, where people choose, shared care arrangements. We want to set and enforce quality standards. We want good processes to identify people's needs and help them access the right options.

We want to make sure people do not need to leave Sheffield to access the accommodation they need, and help people who live away from Sheffield to return if that is what they want to do. This will include making sure good quality local community-based accommodation services help prevent breakdowns in people' s support, and help people move on from hospital placements as soon as they are ready. And we want services to provide the best

value for local people.

How will we achieve this?

- We will implement a new Learning Disabilities Accommodation Commissioning Plan. This will be developed with Children, Young People and Families, Housing and NHS partners. It will set out our vision for accommodation and support, and how we will improve the range, quality and accessibility of housing options available.
- We will stimulate new accommodation through external grants and by supporting private sector investment.
- We will set clear quality standards for accommodation and will make sure these are maintained.
- We will improve the way we manage accommodation and support.
- We may decommission housing that no longer meets people's needs.

What will this mean for people with a learning disability?

- People with a learning disability will have more choice of good quality accommodation and support.
- People will have better access to the housing options they need at the times they need it.
- Accommodation services will facilitate swift, safe discharge from inpatient settings back into the community.
- Accommodation and support will provide best value for money so we are able to support the growing number of people who will need it in the future.
- People will be engaged in developing more detailed proposals before the Commissioning Plan is finalised.

8.8 Improving accommodation and support for people with lower level needs.

Aim: There is insufficient accommodation and support for people with a learning disability who are eligible for adult social care support, but who have lower level needs. This means some people live in settings that are not geared to helping them maximise their wellbeing and achieve their full potential. We want to improve range, choice and achieve best value in accommodation and support for people with a learning disability with lower level eligible needs.

How will we achieve this?

- We will stimulate new housing options to increase the choice and availability of housing for people with a learning disability with lower level eligible needs.
- We will work through the Homes and Communities Agency bidding process to develop new build accommodation, and work with Council Housing and Registered Private Providers of Social Housing to develop new housing networks and other supported accommodation opportunities.
- We will work with people with a learning disability and support providers to develop high quality, innovative, personalised and flexible forms of community-based accommodation services that deliver best value.

What will this mean for people with a learning disability?

- People with a learning disability with lower level eligible needs will have better choices of good quality accommodation and support. This may include new housing networks where a group of people have their own homes within a short distance of one another, so they have companionship and support from a coordinator. People

will also have access to new build supported housing developments.

- Accommodation and support services will provide best value so people can get the most out of the available resources.

8.9 Implementing the new supported living framework

Aim: We want more people who live away from their families to be able to live in supported living settings. We want supported living to be high quality, reduce people's dependency and increase their social inclusion. We want supported living services to provide best value for local people. We want to reduce our reliance on block arrangements for supported living.

How will we achieve this?

- We will implement the new supported living framework for all supported living services in the city. This change is already taking place.
- We will proceed with de-registration of 'block funded' residential care homes to change them to supported living services. When we do this we will tender for the supported living service against the new supported living framework. This change is already taking place and is ongoing.
- We will continue to use the 'Deciding together' protocol so people can continue to work together and pool their personal funds to choose supported living providers, if that is what they want to do.
- We will review the Council's 'in-house' supported living services, and develop options for the future.
- We will improve the way supported living services can be accessed by individuals or groups of people.

What will this mean for people with a learning disability?

- More people will have the benefits of supported living - more control over their daily lives, their own tenancy, access to benefits, and a greater say in their support.
- More people will have services that are geared towards helping them become more independent and take an active part in their local community.
- Supported living services will provide best value so people can get the most out of the available resources.
- Some people's services may need to change. People will have the chance to comment on detailed proposals before any plans for change are finalised, and will be closely involved in any changes that happen.

8.10 Achieving best value in higher cost accommodation and support services

Aim: We want all accommodation and support services to provide best value for local people. This means making sure services are good quality, help people achieve the outcomes they need, whilst also being good value for local people.

How will we achieve this?

- We will review high cost Independent Sector residential care and supported living services funded by the Council and/or through Continuing Healthcare.
- Where necessary we will take action to improve quality and achieve best value.

What will this mean for people with a learning disability?

- People's accommodation and support will be good quality, meet their needs and

help them achieve their goals.

- People's accommodation and support will provide best value so people can get the most out of the available resources.

8.11 Quality

Aim: People expect services to reflect their unique individual needs and be delivered to consistent high standards, regardless of who commissions them i.e. the person with their own personal funds or the Council. The people best placed to challenge are those people who use services, their family carers and their advocates. We want to make sure quality is at the heart of all developments in this strategy.

How will we achieve this?

- We will work closely with people with a learning disability, their families and advocates to make sure their outcomes and aspirations are being met by service providers.
- We will maximise the opportunities to improve quality and capacity in community-based services and build the skills of the local workforce, as set out in 'Winterbourne View – time for change.'
- We will have in place a range of quality assurance measures at the heart of which is feedback from people who use services on their experiences to make sure provision is safe and sustainable.
- We will make sure all service providers, regardless of who commissions the services, work closely with people who use services and family carers to continuously improve their services, and provide flexibility and innovation.

What will this mean for people with a learning disability and their families?

- All local services will meet the needs and aspirations of people with a learning disability and their families and promote their independence, safety and wellbeing.
- Local services will provide high quality community-based support to all people with a learning disability, including people with the most complex needs and behaviours viewed as challenging.

9. Engaging with people throughout the changes

9.1 Working together on future changes

This Commissioning Strategy sets out the need for considerable change and development across Learning Disabilities services in Sheffield. Following the consultation there will be further work to consider the feedback and develop detailed options for changes to specific services. In doing this, we will work in genuine partnership with people with a learning disability and their families in drawing up commissioning plans, in implementing the plans, in making sure services meet our high quality standards, and in scrutinising and holding us to account. Where we propose changes to specific services we will have further detailed engagement and consultation with all the people whose lives will be affected by specific plans to make sure these plans are right.

9.2 Integrated working and partnership

We will work together with a range of partners, including our partners on Sheffield's Health and Wellbeing Board and wider 'universal services' to ensure a whole system approach. This will include

- Children, Young People and Families Portfolio
- Public Health
- Regeneration and Development Services
- Housing and Neighbourhood Services
- The Clinical Commissioning Group (including the Continuing Healthcare assessment teams)
- CCG funded clinical support teams.

In particular we will align our plans with Sheffield's plan for integrated commissioning of health and social care for people of all ages. We will work closely with Children, Young People and Families to make sure the 'local offer' of services to children and adults with a learning disability and their families is consistent, and based on what local people want.

9.3 Advocacy

In working with people with a learning disability throughout the changes we will make sure their needs for advocacy are fully reflected in the Council's overall approach to advocacy and the requirements set out in the Care Act. We will also make sure there are effective arrangements in place at times of specific change so that people are fully involved in planning and implementation of change.

Sheffield Health and Social Care
NHS Foundation Trust

C1 - Executive Summary Report – July 14

Confidential

Learning Disability Provider Services Review of Culture and Practice

Executive Summary Report

2 July 2014

The Learning Disability Service

1. Brief Service Overview

The Learning Disability Service within Sheffield was jointly managed by Sheffield City Council (SCC) and Sheffield Health and Social Care NHS Foundation Trust (SHSC). The service provides care for people across a spectrum of need, ranging from supporting people with mild learning difficulties to those with very complex physical and profound intellectual difficulties/needs. The service was led by a full time Service Director / Head of Service and a part time Clinical Director who had joint responsibility for the whole service.

Currently, the Learning Disability Service for which SHSC has responsibility comprises (see Appendix A):

1. The Intensive Support Service (ISS), based at Firshill Rise, which is an in-patient and assertive community based service for people with more acute and complex health needs who require assessment, treatment and intensive support,
2. A multi-professional Community Learning Disability Team (CLDT), based at Love Street, which provides a city-wide service supporting people living in their own homes with their health & social care needs, and
3. Provider Services, (staffed by SHSC employees) and includes: Buckwood View Nursing Home, a number of Registered Care Homes and Supported Living Units; Respite (health care) provided at Longley Meadows and Respite (social care) provided at Warminster Road (see Appendix B).

The Local Authority has responsibility for: Assessment and Care Management and Care Purchasing; all Social Work personnel; and the City Council Provider Services (SCC staffed) including Supported Living Units, Respite (social care) and Day Services.

In Sheffield people with learning disabilities live in a wide range of settings. Some individuals live completely independently, some require a few hours of support each day and others who have a greater need live in supported housing, care or residential settings. A number of individuals require specialist in-patient assessment and treatment provided by the Intensive Support Service.

Registered and supported living services within SHSC are provided at thirteen locations across the city, ranging from individual houses to residences housed together on one site and provide support to people living in their own homes, from a few hours a week up to twenty four hours a day.

Many of these services and interventions offered are determined and assessed according to eligible needs and described by the commissioned specifications. The individuals who live within supported living units and registered care homes, in addition to their learning difficulty have a variety of needs for physical, mental health and social care/support to enable them to live as fulfilled a life as possible in their local communities. Respite services offer both short-term and emergency respite, together with planned or a rolling-programme of respite.

The Trust has a number of different partnership arrangements with Housing Associations and the Local Authority to directly manage and run the nursing home, the registered care homes, supported living units, and the health and social care respite facilities. The partnership arrangements determine (via the commissioning specifications/intentions) the funding received for managing the units in terms of both human resources (staffing) and physical resources (environments).

2. Introduction: the Review of Culture and Practice

In July 2013 Sheffield Health and Social Care NHS Foundation Trust's (SHSC's) Executive Directors' Group (EDG) commissioned a review into the culture and practice at one supported living unit (Unit 1) and one registered care home (Unit 2). (See Appendix C - removed).

The review was commissioned at both units following:

1. An Executive and Director led analysis of key governance indicators, including:
   - five service user related serious incidents/safeguarding concerns (alleged assaults)
   - the slow handling and delayed response to effectively managing service user safety incidents by relevant managers
   - high sickness absence rates
   - a number of staff versus staff complaints and on-going Human Resource grievances/suspensions and disciplinary procedures.
   - concerns regarding culture of care identified in a safeguarding investigation report.

2. Identification of some staff working excessive hours and routine nights (rather than internal rotation).

3. Visits to the sites by Executive Directors, which reinforced the concerns identified through analysis of the governance data.

The Terms of Reference for the review are attached at Appendix D.

The review sought to obtain a thorough understanding of the culture and practice within the two units and the impact this had upon the quality of care delivered and the experience of service users living in the units. Early indication at one unit (Unit 1) suggested potential financial irregularities and following this all registered care homes and supported living units were subject to a financial audit by the Review Team and supporting staff.

Following receipt of the Review Team's interim report by EDG in October 2013, EDG extended the review of culture and practice to all learning disability registered care homes and supported living units in order to: gain a better understanding of the standards of care being delivered across all social care settings; and to ensure in due course a confident level of assurance about improvements in the quality of care being provided.

3. The Review Team

The Review Team comprised:

1. Tony Flatley, Associate Director of Nursing – Review Lead
2. John Tomlinson, Assistant Clinical Director, Learning Disabilities (July to December 2013)
3. Tania Baxter, Head of Integrated Governance
4. Ishrt Raouf, Admin Support to the Review Team
5. Additional SHSC Reviewers commissioned for specific work:
   - Erne Bradley, Investigating Officer (Community Directorate)
   - Helen Grant, Community Nurse Clinical Lead
   - Debbie Albrow, Community Nurse
   - Jude Francis, Community Nurse
   - Ruth McFall, Community Nurse
   - Louise Barber, Administrative Officer
   - Diane Snape, Residents Financial Services Manager
   - Robert Purseglove, Local Counter Fraud Specialist Manager
   - Julia Shepherd, Nurse Consultant

- Sharon Brookes, Speech and Language Therapist, Clinical Lead
- Anita Winter, Interim Head of Service (Health) Learning Disabilities
- Zara Clarke, Clinical Psychologist

6. External reviewer - Kevin Clifford, Chief Nurse, Sheffield Clinical Commissioning Group attended fortnightly Review Team meetings to obtain independent assurance on the thoroughness of the Review and provide regular feedback on progress to the CCG.

7. An external peer reviewer from Humber NHS Foundation Trust was identified to provide objective feedback on the process/methodology and outcomes of the Review. Due to sickness absence the individual identified was unable to fulfil this role.

The Review Team worked closely with the Learning Disability Senior Directorate Management Team (DMT) to ensure that all areas of concern / issues requiring action were reported to the Head of Service and Clinical Director, in order that matters could be addressed and acted upon as soon as they were identified. This enabled early recognition of issues and the ability to plan and progress improvements during the Review, rather than waiting for the outcome of the review before acting. Throughout the Review, regular updates have been provided to both EDG (weekly, fortnightly and then monthly) and the Trust's Board of Directors (monthly).

4. Methodology

The Review of Culture and Practice has drawn upon a variety of methods for data collection, gathering information and analysis. Over thirty formal interviews of unit managers, deputies, team leaders, support staff, carers and clinicians were carried out by the Review Team. Interviews with senior managers, including executives, senior clinical staff and individuals working into Provider Service units, also took place.

Additional methods of data collection and information about care included:

- Observation of activity / practice.
- Attendance at Advocacy Groups.
- Observation / attendance at Tenants' Meetings
- Informal conversations with service users
- Interviews with advocacy / family
- Reviewing care records and documentation of service users
- Unit/management records

- Individual staff personnel and supervision records
- Team records
- Human resources data
- Governance Framework data
- Finance data
- Incident and safeguarding reporting data / information / records
- Information and intelligence from other relevant external parties.

The initial stages of the Review saw the collation and review of a number of existing reports including Performance Reviews, Housing Association monitoring visits and Care Quality Commission reports, and contracting audits and inspection reports. In addition, a review of other relevant documentation took place including supervision and appraisal (Personal Development Review) records, flexible staffing usage, financial records, including personal monies and housekeeping, disciplinary, complaints and incidents data and care plans.

5. Review Key Findings

5.1 Management and Leadership

5.1.1 Finance

Financial audits were undertaken, initially commencing with one supported living unit (Unit 1) sampling five tenants' personal monies, together with housekeeping monies. The findings from this initial audit suggested that significant misappropriation of finances had taken place. The financial audit was therefore widened across all SHSC managed provider services, which suggested further significant misappropriation of finances had taken place at another location (Unit 3). Both cases of theft identified at Units 1 & 3 were referred to the local Counter Fraud Specialist and the Police for further independent investigation. One member of staff (Unit 3) was subsequently found guilty of theft and is serving a two year custodial sentence. The second case, involving two staff members, is currently being investigated through the criminal justice system. There was no evidence of financial irregularities found at any other unit.

The financial audits also identified a number of weaknesses in the operational systems of the accounting procedures for both housekeeping and personal monies across most locations.

A mixed picture of processes emerged: in general poor practice was found in the recording and handling of monies, there were errors and discrepancies found in the recording of purchases, receipts were missing, calculation errors had been made and monitoring of the practices was weak. However one supported living unit (Unit 4) was identified as having developed extremely efficient finance systems that allowed little room for error or exploitation and an area of good practice was also identified at one registered care home (Unit 5) where an audit of an individual housekeeping budget had been undertaken by a team leader.

Financial management systems within provider services varied from location to location, and even within similar services. In some cases differences were imposed by the relevant housing associations, but in most areas, units had adopted different mechanisms for the day-to-day management of monies. The Review Team found that financial systems ought to have been far more consistent, including the checking of vouchers, rectification of identified errors, storing and archiving receipts and records and monitoring and audit.

Key Actions Taken

- Sixteen training sessions for support workers and three sessions for managers on the management of residents' finances have been carried out by the Manager of Resident Financial Services (RFS), with a further session for managers and admin staff scheduled.
- The RFS procedures have been reviewed and improvements made, which are in operation across provider services, with a further review planned to ensure planned improvements are maintained.
- A regular independent audit programme has been established by the Assistant Service Director and recent audits have shown improvements in financial procedures management.
- EDG commissioned an external review of Resident Financial Services (RFS) and the handling of patient monies both within learning disabilities and across all Trust services. This review has been undertaken and completed by KPMG the recommendations have been received, reviewed and accepted by the EDG and the Board. The Director of Finance has lead responsibility for overseeing implementation / monitoring of all the required actions. The report will be shared with Housing Associations, the Local Authority and the CCG to ensure that the wider system can benefit from the lessons learned.

5.1.2 Food / Subsistence and the Management of Property

The financial audit identified irregularities in the application of staff subsistence procedures, particularly within one supported living location (Unit 6).

This triggered a specific investigation, commissioned by the Directorate Management Team, into staff subsistence within the homes and whilst supporting service users on planned outings.

The investigation found numerous inconsistencies in the application of the Trust's Subsistence Policy and other related policies and a number of managers gave inconsistent answers relating to what the claimable allowances for staff subsistence were. Managers identified that some staff were consuming service users' food by taking meals with the service users, this was at a financial cost to the service user as the service users paid for the food (and this was without the service users knowledge or explicit consent) and some managers failed to recognise this as an issue as it had historically been permissible as a therapeutic activity.

One location in particular (Unit 6) was deemed, by the review team, to have taken advantage of staff subsistence. The investigation identified that this practice appeared to have been known by the Provider Services Senior Manager (SCC Employee). Staff contributions towards tea / coffee had been introduced prior to the Review of Culture and Practice commencing, within supported living which the review team noted was a positive step.

The review of culture and practice identified an absence of consistent approach with regards to the protection of service user personal belongings and property across the units. One registered care unit's (Unit 8) inventory procedures were deemed by the Review Team as being good practice and involved the booking in and out of service user purchases, for example clothes. One supported living unit (Unit 1) appeared to have a number of instances where service user property was unaccounted for and had disappeared.

Key Actions Taken

- The Directorate Management Team commissioned a full investigation into subsistence across all provider services, led by an independent investigating officer, Erne Bradley.
- All payments of staff subs, where staff were expecting payment in the course of carrying out their normal daily duties have been stopped.
- The local protocol on staff accessing service user funds (RFS procedures) has been revised and reissued with a robust process for exceptions being in place.

- A regular independent audit programme has been established by the Assistant Service Director and recent audits have shown improvements in this area.
- Sheffield City Council was informed by the Head of the SHSC Review Team regarding the Provider Services Senior Manager.
- An investigation into the alleged misappropriation of service user personal belongings has been actioned.

5.1.3 Governance

With the exception of the recently appointed Assistant Service Director, (February 2014) and the Clinical Director, (June 2012) the joint LD Senior Management structure between SCC and SHSC has been in place for a number of years. In the Review Team's opinion there was evidence that the approach of the Senior Management Team in its governance of the service was to get on and deal with issues and did not always appropriately escalate issues to SHSC Executive Directors. Some matters went unreported centrally (safeguarding alerts, incidents of falls, etc.) so that, whilst matters were being investigated, information about this was only held within the directorate.

A preference for allowing local tailoring and application of policies and procedures has resulted in inconsistencies in interpretation and application of policies, oriented in some cases towards benefit and ease for staff. The devolved culture has meant that such developments in practice have been unchallenged by senior managers.

At an individual unit level, performance was assessed on an annual basis, through a service devised performance review system. This consisted of unit managers presenting their performance report to a joint health and social care (SHSC and Sheffield City Council) management board. The review team found that there was a lack of senior management input into the monitoring of actual practice across the services, with an over reliance on accepting the local managers' views without additional checks and scrutiny or any objective triangulation of what was being reported.

There were evident weaknesses in managerial control across a range of areas including:

- Staffing levels / use of flexible staffing / shift systems
- Vacancies
- HR procedures
- Staff training, supervision and appraisal rates

- Clinical governance indicators e.g. safeguarding, incidents, serious incidents
- Care planning, including use of medication.
- Budget and cost improvement plans

Data was insufficiently analysed, appropriately questioned and understood by the directorate senior managers.

Key Actions Taken

- A health services governance group has been established which pulls together representation from all provider services with a revision to the clinical governance reporting structure. The aim is to support greater transparency and understanding of actual practice and drive quality improvements , together with seeking the views of service users, their carers/families/advocates and 'experts by experience' as to the quality of care provided.
- Robust audits, reviews and more stringent monitoring are undertaken both within teams and independently to ensure that evidence is tested enabling quality assurance to be provided.
- A strengthened annual governance review process has been established within the Directorate using a multi-disciplinary inspection team including experts by experience and specialist experts.
- The Trust Board held a Board Development Session with the Learning Disability Directors focussed on board level governance and organisational learning.
- CEO, Chief Nurse and Review Team Lead met with the City Council CEO to inform of emerging findings, concerns and discuss future strategic direction.

5.2 Working Practices

5.2.1 Staff Management and Leadership

Each registered care home / supported living unit is led by a unit manager supported in some units by a deputy manager and/or team leaders or team coordinators. Day-to-day care provision is provided by support workers. Unit managers have varying backgrounds with some being qualified nurses and others having social care/support worker backgrounds. Where nursing care is provided, as defined by the Care Quality Commission, units are managed by a qualified nurse(s).

Due to the absence of some unit managers, e.g. long-term sickness, disciplinary investigation, etc, a number of managers had been moved to cover additional or alternative units.

The Review of Culture and Practice found that a large amount of time is spent dealing with staff issues and ensuring units were suitably staffed. In some instances this was the manager, in a number of units organising staffing rotas had been delegated to one or two individual team leaders. E-rostering duties were also often limited to one individual per team, due to the perceived expertise required.

A number of staff interviewed at one supported living location (Unit 1) advised that rotas were often changed without their knowledge; some described turning up to work planned shifts to be turned away. There was also a perception of favouritism towards some staff commonly requested to do additional shifts.

Unit managers and their team leaders/team coordinators in all locations identified having some difficult staff, with some managers feeling better equipped than others to deal with the challenges this brought about. Strong staff cliques had formed in a number of units, which some managers felt unwilling to challenge directly, preferring to keep staff on board. A few managers described some Trust HR policies as unhelpful in challenging difficult staffing issues. The Review Team found evidence of a small number of managers who appeared to struggle to effectively deal with operational staffing issues. A few managers felt additional pressures caused by the absence of team leaders / co-ordinators, especially when particular tasks/subject areas were delegated to the individual leaders.

The Review Team found an assumption of union involvement in management / staff interactions. In some units (1, 2 and 7) the assumption was that conversations about service user safety incidents, safeguarding concerns, allegations of abuse or complaints could not be raised with staff unless there was union representation and if union representation was not available, then the conversation had to be delayed. In the Review Team's opinion this undermined managers' ability to effectively manage their staff and on occasions compromised service user safety and standards of care.

5.2.2 Supervision, Appraisal and Training

All staff interviewed confirmed that they did receive supervision, but many could not recall when the last one had occurred. Staff who had recently had a change in management commented on the strengthened push to carry out regular supervision. A small number of staff, including managers themselves, had not had any supervision in the last six months. A number of staff, particularly within supported living locations, questioned the usefulness of their supervisions. The manager responsible for SHSC staffed provider services (SCC Employee) upon interview stated that the majority of locations were not compliant with the Trust's Supervision Policy, in terms of the frequency of formal one-to-one supervision (minimum requirement once every six weeks).

Likewise, Performance Development Reviews (PDRs) had either been recently carried out, due to a renewed emphasis to complete them, or there was a lengthy time lag from the previous one. Again, the quality of the PDRs was questioned by staff in a small number of units.

Many staff described that they had received a lot of training; some believed that the Trust did too much training. When the types and frequency of training was discussed in detail, it became apparent that there was a gap in staff attending certain mandatory training, such as safeguarding, and Mental Capacity Act awareness among staff was limited across all units. Staff members who had been in post a number of years recalled doing online training when the Mental Capacity Act was brought in. However, the absence of follow up training for existing and new staff was evident.

Key Actions Taken

- The LDS Senior Management Team has been strengthened through the appointment of a new Assistant Service Director (replacing the former SCC employee) with responsibility for all provider service locations (health).
- The Learning Disabilities Directorate is currently being supported by the Service and Clinical Directors from the Specialist Directorate in order to strengthen the senior operational management and peer support to the Interim Head of Service (Health) and the Clinical Director.
- The values based recruitment of team leaders/coordinators to vacant posts is ongoing.

- Regular supervision of all staff is now being undertaken and monitored through line management structures.
- PDRs for all staff are being undertaken in line with the Trust's mandate for all PDRs to be completed within quarter one of each year.
- Shift systems have been introduced for Unit Managers, Deputies and Team Leaders/Team Coordinators to ensure extended support, management and leadership is available for staff and service users.
- A three shift system (early/late and nights) and internal rotation for support workers has been operationalised, eliminating all permanent night shifts. This is currently being rolled out across all provider service locations.
- The Trust's approach to staff supervision is being reviewed as part of the organisation's response to the Francis Inquiry.
- The DMT are organising increased technical / knowledge based training for provider services staff in the Mental Capacity Act and Safeguarding.
- Deprivation of Liberty Safeguards (DoLs) applications have been submitted to the Local Authority where deemed necessary.

5.3 Quality of Care

Service user experience was generally reported as being positive by the small number of advocates, family members and service users spoken to.

The majority of staff interviewed said that they would be happy for their nearest and dearest to be cared for within provider services. A smaller number of staff qualified their answers as being dependent upon the particular staff on duty. Most staff believed that they and their colleagues cared deeply for the individuals within their services.

The Review Team established that all staff felt empowered to inform their managers if they saw practice that was not of an adequate standard, but fewer staff felt empowered enough to challenge colleagues directly.

Staff and managers alike identified that a number of individuals had worked with the same service users in the same location for a very long time. One consequence of this longevity could be staff becoming less sensitive to offering service user choice in their day to day living, for example what to wear, respect for their likes and dislikes and their wishes, with staff members assuming to know the service users preferences and in effect making choices for them.

An initial small sample of service user care plans were reviewed at one supported living unit (Unit 1) as part of the review of culture and practice. This raised several concerns regarding the quality, consistency, accuracy and timeliness of the care plans. The Directorate therefore commissioned a full review of care plans across all provider service locations; this was carried out by lead health clinicians from the Community Learning Disability Team using a recognised audit tool. The findings from the individual units were fed back to the relevant managers with action plans requested to address shortfalls in quality. A further review/re-audit of care plans is due to commence in October 2014.

It was evident from the care plan audits that there were inconsistencies in their completion, accuracy and involvement of service users and their carers with them. Some care plans identified individual health needs, including physical health, others did not. Activities described in individual care plans did not always happen and staff interviewed put this down to being short staffed or due to a lack of transport

The care plan audit identified some positive practice in record keeping in certain instances, for example clear risk assessments and management plans and identification of personal care needs such as diet, mobility, medication and continence issues. However, overall the audit revealed that if care plans were more person centred, with clearer goals and evaluation they would be a more useful tool in driving actual practice.

5.3.1 Staffing

Staffing ratios differed across the numerous locations from 2:1 in some supported living locations to 5:1 in some registered care locations, yet the complexities of the needs of the individual service users were relatively comparable.

Historical funding levels from the numerous commissioners, together with individual funding packages, were identified as a reason for this disparity. Staff and managers found these differences to be inequitable and unhelpful for increasing staff morale, however the review team found little evidence to suggest effective action was taken to address this.

Staff were unanimous in describing never having enough time for activities with the service users. The majority of staff believed their responsibilities in respect of domestic duties, eg cooking, cleaning etc, detracted valuable caring time away from individuals. Others described the potential for encouraging service users to assist, wherever possible, in domestic duties as a way of further promoting their independence.

The review team acknowledge the balance required between supporting all service users individually and organising staffing to enable this to happen. However the review team believe that over time some practice has become institutional in nature and has developed more around the convenience of staff and practicalities of staffing, rather than meeting individual service users' needs. An example is a mobile hairdresser coming to a registered care unit (Unit 2). This may have been appropriate for some service users but not for all. Consequently some service users, who may have benefited from visiting the hairdressers of their choice, remained in the home and missed an opportunity for contact within their local community. It was also evident where food shopping was done solely by staff for the entire care unit (i.e. several houses) rather than individuals being supported by staff to do their own shopping if they wished.

Some staff and managers described feeling isolated and detached from the rest of the Trust, and also within their own directorate. Upon exploration, this was explained as being due to the geographical spread of the units, the dual management arrangements with the Trust and the Council and a lack of visibility of the very senior managers / directors responsible and accountable for the joint service.

Key Actions Taken

- Sixteen, two day Care and Compassion training sessions have been delivered to all support workers across the provider services, together with separate sessions for unit managers. The training was developed in-house in collaboration with the Trust Organisation Development (OD) Team as a values-based approach to understanding how values, attitudes and beliefs affect behaviour and to support and enable a more considered, compassionate, and person-centred approach to individuals with a learning disability in receipt of care.
- An external company 'Diversity Matters' were commissioned by the OD Team and Learning Disability Service and undertook a facilitated workshop with learning disability provider service managers and leaders on: systemic dynamics, cultural aspects of services / care, belief systems, patterns underlying practices and structural issues.
- The DMT has been strengthened through the appointment of an Assistant Service Director (SHSC employee) with overall responsibility for provider service locations.
- A quantitative and qualitative audit of all care plans across provider service locations has been carried out.

- All care plans are being improved to address the gaps around person centred care highlighted and a regular programme of care plan audits has been developed with the next re-audit scheduled for October 2014.
- In conjunction with the care plan audits, Community Learning Disability Team health care professionals observed practices in (Unit 1) of the care homes/supported living units, to determine if what was recorded in care plans was reflected in practice (and vice versa).
- Incident reporting and management training has been delivered to all staff at one supported living location (Unit 1) in both individual and group settings.
- Shift systems have been introduced for Unit Managers, Deputies and Team Leaders/ Team Coordinators to ensure effective 24/7 care and support, management and leadership of staff and service users.

6. Conclusion

6.1 Moving forward – developing a culture of continuous quality improvement

The culture and practice review team concluded that considerable and ongoing effort will be needed to develop a culture of continuous quality improvement in the provider services for people with learning disabilities. Critical to ensuring this is the need to strengthen the service user voice within the service and the organisation as a whole. Processes such as the complaints system are not readily available to many of the people who are supported by these services. A considerable number of people have no active family involvement. Hearing the voice of people with learning disabilities and ensuring services are person centred is not a passive process.

The service has over time become marginalised from and the rest of the Trust. Contributory factors were the shared accountability arrangements with the local authority and consequently a Directorate leadership that was not strongly oriented towards the Trust, the model of provision, the geographical spread and the priority given to issues that tend to draw senior managers' attention – new developments, financial pressures and externally assessed performance measures.

There has been an over-reliance on the development of local practices, and insufficient attention to ensuring that the practice across the service is at the standard of the very best. There is ample opportunity within this service to raise standards by applying the best practice across all services, and ensuring that practices continue to be developed in this way.

The management of quality and performance within these services has relied heavily on trusting local managers and self reporting on standards. Visits, including by the CQC have not identified some of the issues found to be of concern to the Review Team.

Performance management processes that actually involve going and seeing how the care actually is are being developed.

There is a significant challenge facing the leaders of this service. There is an uncertain future that will raise anxieties for service users, their families and staff. Expectations of an engaging style of leadership need to be made clear and supported. Support to staff, in the form of supervision, encouragement, acknowledgement and feedback are essential to developing and maintaining high quality services. There is a challenge to be addressed in the nature of the relationship with Trade Unions, so that there is a clear and felt shared commitment to supporting staff and protecting their rights in service of providing high quality services.

It is not a one off exercise. Constant vigilance and commitment is required to ensure that the voice of people with learning disabilities is heard and staff providing long term care are supported and lead in a way that maintains motivation and aspiration. The review team would like to acknowledge that change has already begun and has seen evidence of a commitment to change at all levels within the Trust.

Key Recommendations

As outlined throughout the report, the issues and concerns arising during the review of culture and practice were regularly & routinely reported and shared with the DMT to enable the DMT to take immediate action as required, to ensure safer / higher quality care was being delivered. These are described as 'key actions' within the report. In addition a number of key recommendations are made:

Board and Executive Level

1. The Directorate, EDG and Board find new and improved ways to hear and effectively respond to the voice of service users, their families and carers.

2. EDG review the Directorate's Senior Leadership

3. EDG and Board address the Trusts role in the distance experienced by the directorate ensuring the new directorate leadership is fully absorbed into the Trust leadership.

4. The Board and its members utilise learning from the review of culture and practice to influence and determine the current and future strategic direction for the commissioning and provision of Learning Disability Services for the residents of Sheffield.

5. Ensure Board's on-going focus on people with profound learning difficulties.

6. EDG ensure there is organisation-wide shared learning of the review of culture & practice across SHSC.

7. The Human Resources Directorate and Executive Directors Group consider the Trust's current management development training provision for middle and senior managers in the LD Service and trust wide.

8. All Board members, Executives and Directors review their respective services and responsibilities in the light of the findings of this report.

Directorate Level

1. The DMT ensure all care plans are subject to a review within the next six months and a regular cycle of maintenance and monitoring is established.

2. The DMT to develop robust systems for the purchase/management and disposal of service user property, ensuring regular audits are built into the system, in conjunction with relevant partners where appropriate, eg Housing Association.

3. The DMT develop effective protocols in relation to the purchase/management and disposal of service user property and personal belongings within provider services to protect service users and staff from risks associated with misappropriation of property.

4. Staff rotation across the units to be considered by the directorate as a way of spreading good practice as well as tackling strong, static staff groups.

5. The DMT work with the Human Resources Directorate & EDG to contribute to the development & delivery of a management development programme for middle and senior managers in the LD Service

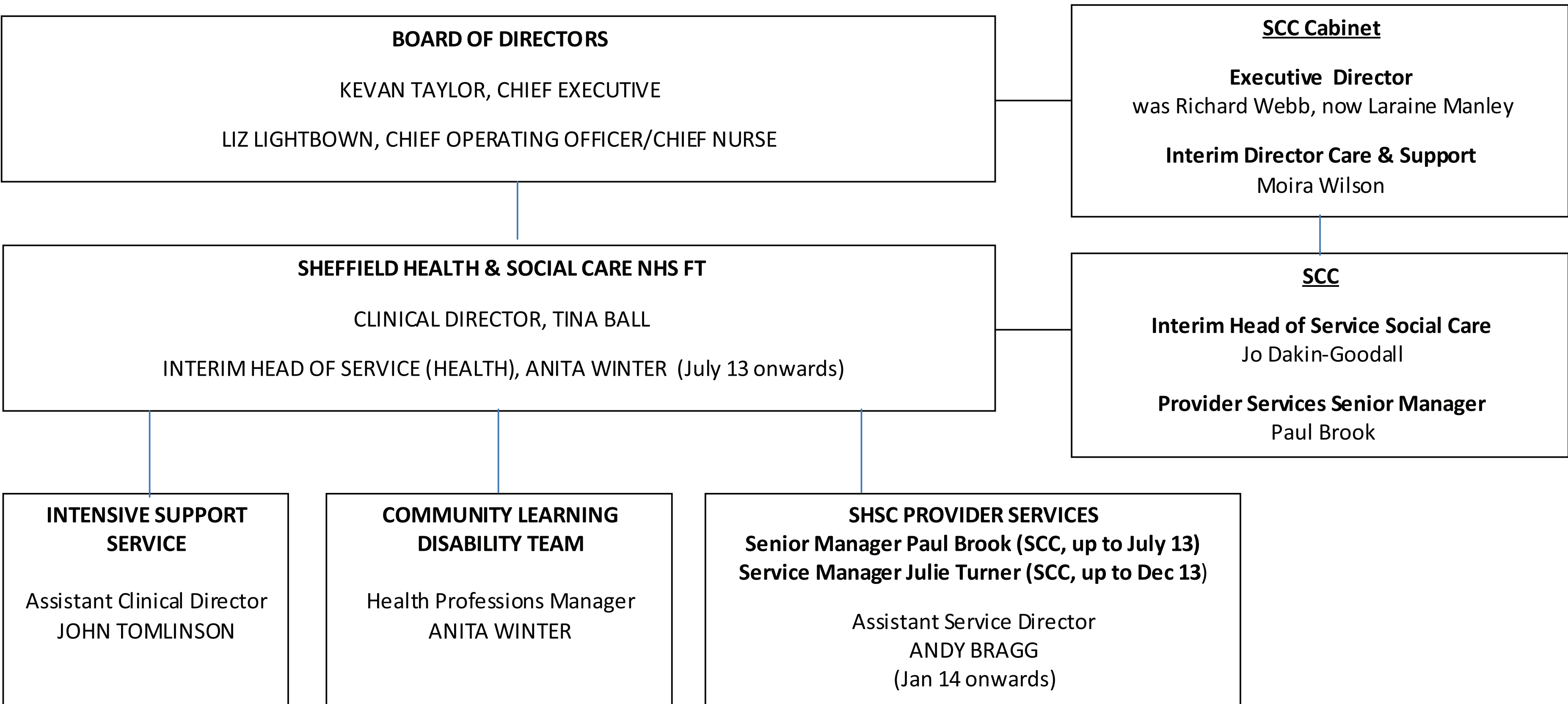
6. The DMT to work with the Education and Training Department and subject specialists to increase the technical/knowledge base of provider services staff in the Mental Capacity Act and Safeguarding.

Sheffield Health and Social Care NHS Foundation Trust

Appendix A
Structure Chart as at July 13

LEARNING DISABILITY SERVICE
Sheffield Health and Social Care NHS FT and Sheffield City Council

INTERIM GOVERNANCE and LINE MANGEMENT REPORTING – FRONT LINE SERVICES TO ACCOUNTABLE OFFICER AT BOARD / CABINET



Appendix B

Provider Service Locations

Supported Living Locations	In association/ partnership with	CQC Registration
Mansfield View	Guinness	SHSC
144 and 146 Wensley Street	SYHA	SHSC
29-31 Angleton Avenue	Places for People	SHSC
51 Viking Lea Drive	Places for People	SHSC
8 Melrose Road	Sheffield Homes	SHSC
Burngreave Block	Sheffield Homes	SHSC
102 Beighton Road	SYHA	SHSC
104 Beighton Road	SYHA	SHSC
131 Stradbrook Road	SYHA	SHSC
50 Daresbury Road	SYHA	SHSC
68 Berners Road	SYHA	SHSC
22, 32 and 34 Stevens Close	SYHA	SHSC
71, 73-73a Scott Road	SYHA	SHSC

Registered Care Locations	In association/ partnership with	CQC Registration
Cottam Road	SYHA	SYHA
142 Wensley Street	SYHA	SYHA
Handsworth (63 and 65 St Joseph Road and 101, 103, 105 and 107 Hall Road)	Guinness	Guinness
Buckwood View	Guinness	Guinness
458a East Bank Road	SYHA	SYHA
136 and 136a Warminster Road	SCC	SHSC
100 Beighton Road	SYHA	SYHA

Key

SYHA = South Yorkshire Housing Association
Guinness = Guinness Partnership Ltd
SCC = Sheffield City Council

Appendix C

The Appendix giving detailed information on individual Units has been removed.

Appendix D

Sheffield Health and Social Care NHS
NHS Foundation Trust

TERMS OF REFERENCE
Review of Culture and Practice

Initial Review of Mansfield View and Cottam Road,
Extended to incorporate all SHSC Staffed Provider Services

Introduction

A Service Review has been commissioned by SHSC's Executive Directors Group in order to obtain an overview and thorough understanding of the culture and practices that impact upon the tenants and the quality of care they experience at all of the SHSC staffed Provider Services (see list below).

There are currently a number of serious incident and safeguarding investigations, disciplinaries and an inquest which all require some form of investigative report/conclusion for either the individuals raising these, or the organisations commissioning/regulating these services. Some of the aforementioned investigations have resulted in Police interest and as such have delayed internal processes. There have been sufficient levels of concern highlighted within these investigations to warrant a full Service Review within provider services. Despite the complex nature of the discreet number of investigations, and their subsequent reporting requirements, this Service Review will consider a wide range of issues and concerns that have been raised through all of the above.

Housing Association	Supported	Registered
South Yorkshire Housing		
Cottam Road		R
71, 73-73a Scott Road	S	
142 Wensley Street		R
144 and 146 Wensley Street	S	
50 Daresbury Road	S	
68 Berners Road	S	
458a East Bank Road		R
131 Stradbrook Road	S	
100 Beighton Road		R
102 Beighton Road	S	
104 Beighton Road	S	
22, 32 and 34 Steven Close	S	
Sheffield Homes		
8 Melrose Road	S	
Burngreave Block	S	
Places for People		
29-31 Angleton Avenue	S	
51 Viking Lea Drive	S	

Housing Association	Supported	Registered
Guinness Partnership		
101, 103, 105 and 107 Hall Road		R
63 and 65 St Joseph Road		R
Guinness Northern Counties		
Buckwood View		R
Rented from Sheffield City Council		
136 and 136a Warminster Road		R
Rented from Guinness Partnership		
Mansfield View	S	

Serious concerns have arisen during the initial review of Mansfield View and Cottam Road and as a consequence, EDG has decided that ALL SHSC staffed Provider Services will be subject to a Review of Culture and Practice.

The Review of Culture and Practice Team will consist of:

1. Tony Flatley, Associate Director of Nursing – Review Lead
2. John Tomlinson, Assistant Clinical Director, Learning Disabilities
3. Tania Baxter, Head of Integrated Governance
4. Peer Reviewer - TBC
5. External Members to join the SHSC Review Team - to be identified and confirmed by Dean Wilson.

To Review:

The leadership and management; working practices; culture and practice at all SHSC staffed Provider Services; to understand the experience of tenants, whether the service meets their needs and expectations & the expectations of families/friends; and the overall the quality of the care provided.

1. Management and Leadership

To Review the management and leadership at directorate, service, team and individual level, looking at governance and performance, systems and processes, effective deployment of accountability and reporting frameworks, human resource and financial management and the application of relevant policies, including localised working policies/procedures.

2. Working Practices

To Review individual and team practices and performance including: roles and responsibilities; staffing levels; skill mix; sickness absence; training and development; record keeping; supervision; appraisal; incidents and safeguarding; use of flexible staffing; possible intimidation / bullying by LDS staff of other LDS staff; staff experience of working in the service; and staff support. Particular focus will be made in respect of team working, team culture and staff contribution to safety and quality improvement.

3. Culture

To Review internal and external interpersonal / inter professional relations and dynamics to better understand underlying values & beliefs, attitudes & behaviours at an individual, team and directorate level.

This will include both eliciting the views of and understanding the relations with commissioners, trade unions, regulators, external providers and other external agencies as deemed appropriate, in order to get a sense of the 'prevailing culture' of how things get done / work / operate in the service.

4. Experience of Tenants and their Families

To Review the experience of tenants and their perceptions as to whether the services provided are meeting their needs as well as identifying whether the expectations of families/friends are being met.

5. Quality of Care

To Review the overall quality of care received across the services (safety, effectiveness, experience, inclusion & equality).

Methodology

The service Review will draw upon a variety of methods for data collection, gathering information and opinion. These will include:

- Interviews / discussions with individuals, groups and significant parties
- Observation of activity
- Reviewing records and documentation of tenants, individual staff & teams.
- Human resources data.
- Finance data.
- Incident & safeguarding reporting & management of.
- Information and intelligence from other relevant external parties.

Outcomes and Reporting

The findings from this service Review will be incorporated into a comprehensive written report which will be submitted to the Executive Directors' Group.

The report will provide conclusions on the issues raised and make suggested recommendations for consideration & approval by the Executive Directors' Group.

Distribution of the report will be agreed through the Executive Directors' Group (EDG).

Given the complexities involved in this Service Review, it is anticipated that an initial report will be reported to EDG by the end of December 2013 (initially set for September 2013).

Should any further issue(s) of concern come to light during the course of this Review, other procedures, including HR procedures, may be initiated.

Liz Lightbown Chief Operating Officer /Chief Nurse
Tony Flatley, Associate Director of Nursing
John Tomlinson, Assistant Clinical Director, Learning Disabilities
Tania Baxter, Head of Integrated Governance

16 October 2013 (Original ToR dated 24 July 2013)

Sheffield Health and Social Care NHS
NHS Foundation Trust

C2 - Trust Board Response - Dec 14

Trust Board Response to the Review of Culture and Practice LDS Provider Services

Rosie McHugh
Director of Organisation Development/Board Secretary
November 2014

On behalf of
The Board of Directors, Sheffield Health and Social Care Trust

Background

On 27th July 2013 Sheffield Health and Social Care NHS Foundation Trust's Executive Directors Group commissioned a review into culture and practice at one supported living unit and one registered care home within the Learning Disability provider services. The terms of reference are attached at Appendix 1. The Trust's Directors commissioned the review when concerns were raised following a range of serious incidents, safeguarding investigations, disciplinary investigations and a specific inquest. In October 2013 the Executive Directors Group extended the review of culture and practice to all eight SHSC learning disability registered care homes and supported living units in order to gain a better understanding of the standards of care across all social care settings and to ensure in due course a confident level of assurance about improvements in the quality of care being provided. The Trust Board and its commissioners and regulators were kept informed throughout the review.

The Board received the Confidential report into the Review of Culture and Practice LDS Provider Services at its meeting on 7th May 2014 and accepted in full the recommendations. The Board had a number of concerns about the quality and style of the report.

In the overall summary paragraphs statements, the report highlighted that the review had discovered a range of practice within the services:

> *"It is the authors' opinions that the DMT should be commended for the numerous issues they have identified, addressed and continue to address. It is also important to recognise that this review could be seen to overemphasise many of its negative findings. However, it should be recognised that the Review Team interviewed and observed many highly skilled, committed and compassionate staff. Many of the managers and support staff endeavour to provide a high standard of care and are committed to improving the quality of life of their service users…"*
>
> *"Many teams and services were able, through effective leadership to maintain high standards of care. However, many teams were not able to maintain standards to an acceptable level. However, although difficult to elicit, the experience of service users was generally reported as being good".*
>
> *"At its best the philosophy of care and the dedication of the staff group was commendable. Despite the aforementioned concerns, many staff and teams were able to provide excellent care. Despite limited resources, limited skills and knowledge, limited access to expertise many teams were able to provide acceptable levels of care"*

However, those summary statements were not supported by the detail within the report. A section within the report highlighted the limitations of the methodology as follows:

> *"This review consists of significant subjective interpretation of data from interviews. Triangulation occurred when comparison with other data, from other methods of collection, occurred. Although validity may be viewed as questionable rigour is drawn from the examination of data from these further methods of data collection. Conclusions drawn from the data may also be questionable with regard to reliability. Much of the interpretation has been derived from the interviews with significant personnel and although opinion should be seen as valid, it is important to recognise the limitations of such methodology.*
>
> *However, it is the firm belief of the review team that the findings within this section reflect a true and accurate view of the Service, at the point of review"*

The Board did not find an adequate explanation for the subjectivity and lack of rigour within the report. Many words were in bold typeface and presented as quotes, without attribution. A number of the key statements presented this way were in fact the views of the author, for example: "entitled or distorted care", "dysfunctional teams", "false entitlement", "pathologically powerful cliques".

The Board was also concerned about the lack of specifics and detail, without which it would not be possible to adequately be assured about improvements. For example the terms “a number of”, “many”, “some” and “often” were used over 200 times in the report.

It was confirmed to the Board that the primary concerns regarding standards of care were at the two areas that were the original subjects of the culture and practice review: Mansfield View Locality and Cottam Road Residential Care Home. The Board requested that a summary report be written in a more objective style that made it much clearer what specific practices had been discovered where. This was received by the Trust Board at its meeting on 2nd July 2014 and the recommendations were accepted in full. The Board also received at that meeting the report on the Review of Patients’ Monies commissioned from and produced by KPMG. The Board accepted those recommendations in full and established a project team to deliver the action plan.

Following discussions with Sheffield Clinical Commissioning Group, the Board agreed that a formal Trust Board response was required that specified the Board’s consideration of the findings from the reviews and included an integrated action plan. In reaching its conclusions and approving this report, the Board has been informed by the remaining inquiry team member, evidence from other audit reports and data, CQC inspection reports and findings and visits by Board members to the services.

Implementing Improvement and sharing learning

The Board accepts the need for improvements in culture and practice across the service, and all recommendations from the reviews were accepted and form the basis of the Trust’s action plan. The Trust did not wait until the production of the review report before taking action. Action was taken from the outset and throughout the period of review to address issues raised by the review team and this is described in detail in the action plan.

There were many factors highlighted in the report that presented risks to the quality of care, and the greater the number of unmitigated risks the higher the likelihood of an impact on quality. As the report states, the combination of factors allowed a culture in which poor practice developed in some areas. Given that concerns regarding culture and practice have been significant in two localities and partially noted in others, the Board accepts that governance needs to be strengthened in a number of areas within the service and the Trust.

In order to adequately identify the organisational learning from the culture and practice review, the Board needs to be assured that in future the full range of risks to quality are identified and assessed, adequate controls are put in place and robust assurance of those controls is obtained. The risks identified in the review are set out in the following categories:

- Risks from a lack of shared purpose and values
- Risks associated with care
- Risks associated with staffing
- Risks associated with structure and assurance

This structure will inform the development of the Board’s assurance framework.

The Board is committed to transparency and therefore all specific concerns mentioned in the review report are noted and addressed within this structure. Where the Board has deemed it necessary, additional actions to those recommended in the reviews are identified and have been included in the action plan.

1. Developing shared purpose and values

In the Board's view, the provision of services for people with learning disabilities in the city is lacking a compelling and coherent vision and strategy that all agencies support. The residential and supported living services have, for a number of years, been anticipating change which is now underway as Sheffield City Council leads a process of deregistration. All the services exist within a challenging financial environment. Alignment around a compelling shared purpose at all levels (team, Trust and city) is essential to ensuring high quality provision. The Trust Board therefore welcomes the opportunity to co-host with Sheffield Clinical Commissioning Group and Sheffield City Council a city-wide summit for services for people with learning disabilities in Sheffield.

The residential and supported living services had been managed by officers from Sheffield City Council for a number of years as part of the Joint Learning Disability Service. The report states that Learning Disability services are peripheral to the work of the Trust, that learning disability is seen as less important at senior levels and that Recovery has less meaning in Learning Disability. The Board strongly refutes those statements.

Supporting and working towards meeting the needs of people with learning disabilities is an integral part of the Trust's work. The Trust has begun work on a needs led service, looking at access issues relating to all age and all populations, and has been working on the Sheffield Education Exchange (Recovery College). Both of these developments have the involvement of the Learning Disability Clinical Director. The Physical Health Strategy launched by the Trust has been informed by work in the Learning Disability Service around the Confidential Inquiry into the Preventable Deaths of People with Learning Disability. The former Clinical Director worked on the Greenlight Toolkit with her counterparts across all of the Trust, scoping work and gaps around access. The Deputy Medical Director is leading the implementation of the action plan. Clinical Leads within the Community Learning Disability Team (CLDT) have held workshops with provider service staff, service users and family carers to inform the development of the care pathway processes for CLDT. This information has helped shape the services. The Board has recently received several reports on Learning Disability services. For example, in May 2014, there was a focus Board development session at which there were detailed presentations, action plans and discussion on Winterbourne Concordat, CIPOLD, Greenlight Toolkit and respite care.

The service was decoupled in July 2013 and the Board believes that, under its direct management, the learning disability services can be transformed both in terms of the quality of services delivered in the transitional period and in establishing a new model for the future provision of Supported Living for people with complex needs. Co-production with service users and a fully lived life are central principles to service delivery. The underlying principles of recovery, including aspiration, enablement, choice, hope are equally important to services for people with a learning disability and operate alongside other service philosophies, aimed at addressing social inclusion through a social model of disability. The Board accepts that the services under review need to be radically different to meet the future needs of people with learning disabilities in Sheffield, and that the phrase "home not hospital" referred to in the report is not an adequate description of a future service philosophy.

2. Improving care and welfare

2.1 Finances

As part of the culture and practice review, financial audits were undertaken at and the findings suggested that significant misappropriation of finances had taken place at two locations. Both cases of theft were referred to the local Counter Fraud Specialist and the Police for further independent investigation. One member of staff was subsequently found guilty of theft and is serving a two year custodial sentence. The second case, involving two members of staff, is currently being investigated through the criminal justice system. There was no evidence of financial irregularities found at any other unit.

The Executive Directors Group commissioned an external review of Residents Financial Services and the handling of patients' monies both within Learning Disabilities and across all Trust services. This review was undertaken and completed by KPMG and the recommendations were received, reviewed and accepted by the Trust Board in full on 2nd July 2014.

The culture and practice review report also highlighted that subsistence policy was being inadequately applied and that some staff incorrectly believed such practice was an entitlement and that the practice was sanctioned by managers.

The Directorate Management team commissioned an investigation into staff subsistence procedures. Although historically permissible as a therapeutic activity, it is considered to be unacceptable unless appropriately authorised. Robust approval processes at cross service level have been established.

2.2 Mental Capacity Act

The report states that it was unclear that best interest was being followed, that there were restrictions taking place without appropriate considerations (such as restricting access to certain areas within a house or to activities), decisions should have been constantly reviewed were not and this was not seen as a care deficit. It was also not always evident that Alternatives to Restraint Policy was followed.

The Board recognises that there was a gap in leadership and training in relation to the Mental Capacity Act, which has now been addressed. This gap, and the subsequent lack of training for staff that was addressed in the Care and Compassion training, contributed to a lack of robustness in ensuring people's rights under the Act.

Over the last month, the Mental Capacity Act Steering Group Terms of Reference and Strategy has been refreshed and a new Practice Development Group has been established to promote best practice. A systematic audit of records within the residential/supported living services has taken place and reporting and monitoring arrangements are in place. The MCA/DOLS priority work plan for 2014/15 has been produced.

2.3 Medication

Concerns were raised regarding the proper handling, management and administration of medications.

An audit of PRN Medication was carried out across all provider service areas in February 2014. The aim of the audit was to measure compliance to the PRN medication standards across learning disability accommodation based service areas. A specific focus being on the use of PRN medication in response to pain and/or behaviours that challenge services. The PRN medication standards measured were as follows:

- Non medication based interventions being considered
- Assessing and documenting capacity
- A plan to measure outcomes using objective measures
- If the person lacks capacity has a prescriber considered the capacity bill or the mental health act
- Behaviour being assessed
- Evidence of interdisciplinary involvement
- Target behaviour being identified

2.4 Choice and respect

The report states that "certain teams had eroded to allow practices and values to emerge that could be described as institutional, misguided and distorted". The specific practices that were described were :

> *Overemphasis on task completion of domestic duties taking precedence over individual care*
> *Shopping collectively rather than individually*
> *Bed before night staff on duty*

The report explains that although choice was recognised by staff it became limited where there was time pressure/ capacity shortfalls. The Board accepts that there is a balance between supporting everyone individually and organising staff for this to happen and believes more creative approaches could be tried. Where staffing levels have a significant impact on the ability to provide person centred care, this needs to be reported through the Trust's incident process.

The report contains quotes from staff commenting on the lack of respect demonstrated by other staff:

You know when there's a problem when staff don't knock before entering – it says so much
Jeremy Kyle show blasting on three televisions – at least two residents don't watch TV
Watch DVDs to pass the time
Treat homes as if their own
Spending time getting ready for a night out after work
It's as if they forget why we're here – you wonder what else is going on

All support workers attended the two day care and compassion training earlier this year, which included discussion of values. Furthermore, the Trust has recently undertaken work to set out the expectations of behaviour of all staff in relation to its values. This work will support managers to develop an engaged team culture with a clear focus on meeting the needs of people who use services.

Forgetting why we're here is a lack of engagement in the real purpose of the work. The Trust has committed to developing coaching capability in microsystems quality improvement methodology and the Board believes this approach is appropriate to supported living services. We will ensure that this approach is made available to the provider services, so that staff are engaged in improving the way they work for the benefit of service users – rather than an approach which is reliant only on staff challenging each other / informing managers.

2.5 Meaningful activity

The report states that there is "evidence that care plans relating to social activities not carried out". Also mentioned are "the dearth of meaningful activities, lack of physical activity, boredom and social activities not always provided".

Care plans have been reviewed by the Service Director to reflect and ensure activities take place. In some areas staffing levels have been increased to meet this priority. The Directorate will give further consideration about monitoring this in future, as it is a key indicator of service quality.

2.6 Care records

Considerable concerns were expressed about care planning in the review report, including quality, implementation and updating. It states "in many areas care plans were seemingly devalued". In response to this, the Directorate commissioned a full review of care plans across all provider service locations. This was carried out by lead health clinicians from the CLDT using a recognised audit tool. The concerns highlighted in the Review were confirmed by the audit. Care plans will be a more useful tool in supporting practice if they are more person centred and with clearer goals and evaluation. The audit also identified some positive practice in record keeping, clear risk assessments and management plans, identification of personal care needs including diet, mobility, medication and continence issues. The findings from the audits were fed back to relevant managers with action plans requested to address shortfalls in quality.

The Directorate are now revamping the whole support planning framework across the directorate. The development of care plans is a priority across all Trust services, to ensure they are oriented towards a recovery approach and are actually enabling and supporting care rather than being seen as an additional and separate task. Learning Disabilities staff are members of this cross Trust working group.

2.6 Health needs

The report suggests that there has been an emphasis on *"home not hospital"* which explains any shortfalls in identifying physical health needs. The Board finds this to be at odds with the reports conclusion that health needs are seen as a priority by staff and they are aware that they play a role. The report also goes on to say that a high level of skill and knowledge is required and asserts that many staff fall short of this knowledge. It is also asserted that many health risks have gone unaddressed and many clinicians expressed concern that they were unsure if staff could identify emerging health problems.

One example was given of a plan to meet an individual's swallowing needs not being followed. A review of the individuals needs was undertaken, expectations of staff were communicated and the Board has received confirmation that the plan is being fully implemented. The comprehensive review and audit of care plans by members of the Community Learning Disability Team ensured that all health needs have been identified and plans are in place.

The report questions the role of the CLDT in the care of people within residential services. There is a suggestion that the CLDT should have a more assertive role in the care of people living at and supported within the residential services. The report states that the teams function at a distance and do not feel it is their responsibility to ensure clinical recommendations are carried out and suggests that care co-ordination roles should be considered. However, CLDTs are commissioned to provide a city wide service not a bespoke service to our in-house services. The Clinical leads within the CLDTs have been given information on how to report any provider in the city where there are concerns about delivery of service in relation to the CLDT interventions, including our own provision. Any concerns in relation to Trust services will also be raised through the Directorate governance arrangements.

The review report describes details of a number of specific health risks that people with learning disabilities are vulnerable to and also notes that the Directorate physical health plan will focus on training, systems for referral and incorporating guidance into care plans. This is in line with the Trust and city's strategy to address the gap in life expectancy for people with a learning disability.

2.8 Placements that do not meet needs

The report stated that staffing levels have no rationale and that there is a lack of standardisation of staffing levels. Whilst the standardisation comment may indicate a lack of understanding of the ways in which the services are commissioned, there is an important issue that needs to be raised in the appropriate forum. Whilst historical funding levels and individual funding packages have been offered as explanations for this disparity, if the levels are inadequate then there are risks to the quality of care that can be delivered. High work demands will impact negatively on staff morale.

At the beginning of the review into culture and practice, staffing levels were raised in a number of localities. All packages are now assessed under eligible need and commissioners determine staffing levels. Where managers are of the view that needs cannot be met within the service, this will in future be entered onto the Directorate risk register. Dependent upon the numbers of people involved and the scale of the risk to individuals' quality of care, it may need to be escalated onto the Board level register in future.

3. Developing leadership and supporting staff

3.1 Management capacity

A number of issues were raised in the report relating to management capacity and focus. It was noted that the senior manager had, at some point in the past moved to more strategic issues. The Board recognises that there are significant demands on the capacity of the Directorate leadership team and with the scale of the transformation agenda this will continue for the foreseeable future. This will be added to the Directorate risk register and the Chief Executive will ensure that an adequate management structure is in place.

The report stated that there is a shortfall in managerial capacity, with managers managing more than one unit. There are three areas where managers are covering two units, and the deputy and team leader infrastructure has been enhanced to provide additional capacity. The report suggested that there were problems with role design and delegation and the Assistant Service Director will ensure that managerial responsibilities are appropriately delegated during periods of absence.

3.2 Management capability

The Board agrees that the quality of team functioning is linked to the quality of management and staffing governance is critical if quality is to be assured.

The report states that inconsistent and weak management was evident in a small number of units although it does not go on to specify which ones. Managers at the two units of most significant concerns were replaced at or around the commencement of the review, Cottam Road (June 2013) and Mansfield View (October 2013).

The report states that team managers were not aware of local practices although no detail is provided on this. It is the Board's view that the task of the leader is to ensure the delivery of a quality service by enabling and supporting staff. Managers must engage with tenants and staff if they are to assure themselves of the quality of care for which they have ultimate responsibility. A leadership development group has been established within the Directorate with support from the Organisational Development team. In addition to a programme to develop engaging leadership for team managers, a programme for team leaders focussing on supervision and care planning will also be delivered.

Given that the quality of managers is so critically linked to the quality of care, the Workforce and OD Committee will request an annual report on the experience of managers in the Trust, to ensure that leaders of large staff teams are adequately supported and equipped for the role.

3.3 Staffing capacity

The report states that flexi staff are excessive in a number of areas. The Board is aware that this will primarily be permanent staff working additional hours and a plan is in place to reduce the numbers of staff working excessive hours within the Trust, which is being closely monitored by the Workforce and OD committee. The report identified other risks to staffing capacity including vacancies held to save money, temporary contracts due to service change and high sickness levels. The risks to quality as a result of deregistration is on the Board's risk profile and the Board needs further assurance of the adequacy of controls in relation to staffing levels, including escalation levels. This will be addressed under the Trust wide work on staffing capacity and capability.

3.4 Staff skills and development

The report acknowledges that there are a wide range of staff training interventions available to staff including a10 day induction programme, a competency booklet and health training, but then goes on to suggest that the impact of this training was limited and cascade training had limited impact on practice. Whilst no evidence was provided for this assertion, the Directorate has delivered two days care and compassion training for all support workers, which included values and Mental Capacity Act updates, which was evaluated by course attendees as relevant to their roles.

The Board accepts that the presence of training plans varied across the service and that there are weaknesses in mandatory training compliance. An action plan is in place to address the mandatory training weaknesses across the Trust. In addition, each area within these services now has its own register of training attended and scheduled.

The need identified in the report for communication and health assessment skills will form part of the Directorate's training plan for 2015/16.

3.5 Staff Engagement

Team dynamics and climate

The report states that managers are overly embroiled in staffing issues and that management of staffing issues takes an inordinate amount of time. The report also states that HR practice left managers unable to act and individual personnel issues were left unresolved. The HR data suggests that managers in these services are taking action in relation to disciplinary matters. Managers have confirmed in a joint workshop with Human Resources Directorate managers that it is managing capability and performance that is the challenge. HR clinics have been established to discuss with managers complex cases and HR are working directly alongside managers to support and resolve sickness management issues. In addition, the Trust has invested in the delivery of crucial conversations training for all managers in this aspect of the role, which many find difficult. All managers of these services will attend that training.

The report states that "some managers are bullies, some managers have favourites" and "many staff felt threatened and had become defensive in their dealings with managers. and also that "power with strong staff groups where there was institutionalised behaviour " and "powerful cliques that management couldn't challenge and bullied staff.

The report states that there were a number of examples of unhelpful approaches to dealing with conflict, and staff versus staff complaints was a trigger for the culture and practice review. This included inability to resolve conflict without union, staff making unreasonable demands, using complaints procedures to solve personal disagreements or problems, an expectation of union involvement in some routine management interactions and using sickness as an influencing strategy.

Human resources data on complaints and grievances does not correlate with this description of the culture, nor does an analysis of the staff attitude survey data, in which the ratings for the Disabilities directorate are generally higher than for the rest of the Trust. However, a culture of bullying is a serious concern to the Trust Board and, given the degree of change and uncertainty currently being faced by the staff group, a staff climate diagnostic will be undertaken. The Board believes that enhancing the focus on staff experience and engagement in this service could lead to benefits for both staff and service users. Putting energy into developing a more engaged, supported and motivated workforce could reduce the hours and focus on resolving staffing problems.

Staff health and wellbeing

The report stated that and that managers are not able to follow sickness policy due to workload and that many teams have exceptionally high sickness levels and that sickness shows worrying trends. Following the Board's concerns regarding sickness absence, a strategy focussed on health promotion and prevention was agreed by Board in July 2014. This included establishing a case management approach to sickness absence and investment in the HR team will enable this to go ahead as an evaluated pilot from January 2015. The sickness absence levels across these services vary, with some under 2% and some over 15%. The teams with high sickness levels will be prioritised for the Trust's healthy teams process, which is being overseen by the Workforce Committee. Information from the staff climate survey identified above will also inform this work.

Supervision

The report stated a number of different things regarding supervision. It noted that some managers were confident, supervision was implemented with rigour and these managers recognised the value of supervision and could provide records, and also that there was an absence of clear processes for staff support with appraisal and supervision limited in value and application which was seen by some as not a priority or constituted passing conversations. It concluded that the quality of supervision was difficult to ascertain but it can be assumed that many staff received weak or no supervision.

It is the Board's view that supervision is an essential process for supporting and developing staff and thereby maintaining high quality services. A review of supervision, commissioned by the Board, shows similar challenges to delivering high quality supervision in the other 24 hour staffed services, and among the nursing and support worker workforces in particular. The Trust is currently developing with the university a training course in supervision for nursing staff, which will be adapted to meet the needs of non-nursing staff in residential and supported living services. The Workforce Committee has also recently requested that supervision rates are monitored as a key workforce performance indicator in future.

4. Strengthening governance through structure and assurance

4.1 Isolation

Isolation of services is a risk. Given that the Learning Disability services are geographically spread, conscious efforts need to be made to create a sense of connection and to ensure standards are maintained and developed. The Board is pleased that mechanisms have been put in place for the cross service development of practice and policy issues and is keen that the peer review takes place across Directorate boundaries and involves service users and families. Following the recent development of Board members in quality improvement methods, we will set out the Trust's expectation that all service managers should visit a site of good practice in order to learn and bring back best practice. The Board agrees with the report's recommendation to establish student placements within services and that having students provides additional opportunities to reflect on the quality of practice.

Managers of the residential services have reported that there has been a significant increase in the visibility of the Directorate senior leaders within these services.

4.2 Structure

The Board rejects the statement that it was "misaligned or disconnected". In the Board's view, this fails to acknowledge the existence of the joint learning disabilities structure that was agreed by all parties in Sheffield as the best model to meet the needs of people with a learning disability. The partnership approach reflected the Care rust ethos and was nationally recognised as good practice. The Board does not accept that it was an intention to keep the service "at arms length".

What is clear from the culture and practice review and the KPMG review is that complex management arrangements (partnerships for example) do increase risks in terms of governance. The KPMG report states that "the accountability framework led to a blurring of responsibilities and a lack of accountability within the service". In relation to financial management, responsibilities between the service, Residents Financial Services and the Housing Associations were not sufficiently clear.

The Trust will ensure that in its partnerships the governance arrangements are robust. The report highlights, for example, the poor quality of some of the environments. Clear operational arrangements are in place for managers to escalate concerns about the environment should they not be addressed. The Quality and Assurance Committee will review the governance arrangements of the Trust's partnerships by the end of March 2015.

4.3 Service user and carer voice

The review concluded that "Although difficult to elicit, the experience of service users was generally reported as being good".

The Board was disappointed that there was not a greater input from service users and their families to the culture and practice review. The report argues that there is little formal engagement with carers, friends and families. The Board is aware of many instances of service engagement with carers and family members. For example, during the period of the review there was active involvement with the families of tenants at Wensley Street and the Care Quality Commission reports have included evidence of conversations with engaged family members.

But we can do more. The Board believes there is considerable scope for increasing service user involvement, not only in their own care but in delivery of training, interviewing staff

and participating in service review processes. There are additional challenges to understanding the needs of people with learning disabilities and a Service User and Family Carer Engagement Strategy has been developed, which Sheffield Mencap has been commissioned to deliver. We will explore with carers whether a support group would be helpful to enable them to raise concerns if they have them. We will also communicate with family members the ways in which they can raise their concerns. In order to address the isolation of services and provide an added check and balance to our services, the Board supports the recommendation that every service user has a family member, friend, or advocate involved in their care.

The Executive Directors Group has recently agreed to work with the CCG and other health partners to develop improved public engagement with people with learning disabilities in the city as a whole.

4.4 Raising concerns

In the report it states that there is some evidence to suggest that staff failed to report knowledge of unacceptable practice and turned a blind eye in relation to personal belongings going missing, timesheets and eating clients' food. In addition it is claimed that staff, including senior managers, were not surprised and knew of examples of this. However it later says that staff felt empowered to inform managers of practice but not to challenge colleagues. The Board is aware of a number of incidents where staff have reported concerns; several of the triggers for the culture and practice review were incidents reported by staff. The Board will ensure that advice to staff on the raising of concerns is reissued via the Chief Executives letter, is clarified on the intranet and is set out clearly in the Trust's induction process.

4.5 Assurance

The report states that there was disregard of regulatory bodies. At one locality, a weakness in addressing mandatory training had not been addressed by the time the CQC revisited the service. The manager of that service has been replaced and this incident does not, in the Board's view, constitute the disregard described in the report. The Board finds no evidence for this comment in relation to these services as a whole.

The report also states that there was reporting of facts and figures only and a lack of triangulation. The structure and nature of the annual performance review contains considerable amounts of information that is not simply facts and figures (over 20 pages). Many of the Trust's performance indicators do not apply to these services – such as waiting times, DNA rates, 7 day follow up etc. Rather than there being too much reliance on data as the report suggest, the Board is of the view that there is an absence of quality indicators for these services at Board level and that needs to be reviewed. The challenge from the KPMG review is that the annual performance review did not have sufficient depth and was not comprehensive enough as it did not challenge for example financial management. The Board accepts that there were weaknesses in the team governance arrangements, most significantly that managers did not go and see for themselves and check things out – they took it on trust. This is the difference between assurance and reassurance and this lesson will be shared across the organisation and checked out via the Directorate level performance management processes. A similar lesson emerged from the KPMG report with a need for increased challenge in addition to support.

It is also important to note that the culture and practice review was initiated because Executive Directors were paying attention to data. A range of data was considered and taken together it highlighted that something was not right. Culture and practice are most likely to vary at the level of the team and the Board's investment in a performance information system to provide team level data will enable the Trust to identify difficulties earlier in future.

The Trust's quality audit programme for next year needs to be informed by the weaknesses identified in this report.

4.6 Risk Management

A robust risk management process, that took into account the vulnerability of the service user group and the evidence from national inquiries into failures of care may have identified some of the concerns that were discovered through this process at a much earlier date, particularly in relation to patients' monies. Following discussion of the KPMG findings at the Audit and Assurance Committee, the Trust has recently commissioned an internal audit into its risk management processes.

5. Conclusion – moving forward

The culture of a service is created from a number of interacting processes and systems and therefore it follows that in order to bring about culture change, action is required on a number of fronts at the same time. The Board is satisfied that the review into culture and practice of the learning disability services sought to understand all the contributory factors to the culture. Whilst the poorest examples of culture and practice were primarily focussed in two locations, the fact that that could arise highlighted risks in the Trust's governance arrangements. Therefore, the Board has committed to a comprehensive action plan to address a wide range of systems and processes that support and enable high quality care. Lessons will be shared with all Directorates to ensure that governance is strengthened across the Trust.

As acknowledged in the report, the commitment to change and improvement began as soon as the investigation team started its work. Directorate and locality managers have been working hard to address the concerns for over a year. Progress to date is set out in the attached action plan and progress against the plan will be rigorously monitored by the Quality Assurance Committee on a six monthly basis. The Board is also pleased that the Care Quality Commission has found progress in areas previously identified as of concern. Board members have visited services and been assured that improvements have been made.

Finally, the Board welcomes the joint external review that will be commissioned by Sheffield City Council and Sheffield Clinical Commissioning Group and will contribute to ensuring that the services provided to people with a learning disability in Sheffield are services we can all be proud of.

Rosie McHugh
Director of Organisation Development/Board Secretary
26th November 2014

On behalf of
The Board of Directors, Sheffield Health and Social Care Trust

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D1 Final Action Plan - Aug 15

Culture and Practice Review - Final Action Plan Up-dated As At July 2015

A review of adult social care accommodation services managed and delivered by the Learning Disabilities Directorate of SHSC

Index	Rec. No.	Findings	Recommendation	Actions Taken	RAG Progress Score
4	1	There is limited formal involvement with carers, friend and families. There appears to be no apparent formal structures involving carers. There is some evidence that carers feel unable to express concern and incidents have occurred where carers have not felt able to challenge formally. Not all clients have access to formal advocacy. Many clients have no family or carer contact. Given the vulnerability of clients, often isolated from families, many staff believed that greater emphasis should be given to supporting formal advocacy across the service. A number of staff expressed a desire to see carers and advocates contributing to formal oversight of the service. They stressed the value of bringing advocates and carers into governance processes as well as providing individual support for clients.	The Directorate, EDG and Board find new and improved ways to hear and effectively respond to the voice of service users, their families and carers.	Sheffield Mencap's Sharing Caring Project has been commissioned to undertake a focussed piece of work around Service User and Family Carer Engagement. Terms of Reference agreed. The first phase commenced July 2014 and focused on understanding current practice across LD Provider services by scoping current engagement. The Second phase is working to an agreed action plan for the following areas: - Respite Care Services (Longley Meadows and Warminster Road - Mansfield View 24hr Supported Living Service - Intensive Support Service (bed base) - Community Learning Disability Teams Service User and Family Carer Steering Group established and meets on a bi-monthly basis Workstream action plans and minutes of meetings available Update Paper to QAC scheduled for July 2015	
	2	This category refers to a number of dysfunctional aspects found to present in a number of teams across the provider services. As highlighted in the category "Home not Hospital", it was evident that the quality of team functioning was significantly influenced by the quality of management and leadership. It would appear that where staff teams had "drifted" into more institutionalised behaviours, power to influence the culture of care, was seen to have shifted toward "strong" staff groups.	EDG review the Directorate's Senior Leadership	The Senior Management Team has been strengthened through the appointment of a new Assistant Service Director (replacing the former SCC employee) with responsibility for all provider service locations (health). Recruitment to the substantive Clinical Director post has been completed and the new Clinical Director commenced in post on 1st May 2015 Assistant Clinical Director JT retired. Restructuring of clinical leadership within ISS/CLDT scheduled for final sign off by Senior Management Team.	

Index	Rec. No.	Findings	Recommendation	Actions Taken	RAG Progress Score
6	3	The categories identified within this review strongly indicate that there is evidence of “detachment” and “distance” at all levels within the organisation. This “distance” can be viewed as a “core” element to the overriding culture of the service, and the service set within the boundaries of the trust. It can be seen as present in many formal activities, processes and relations within the organisation and indeed beyond the confines of the Trust. In some respects the Learning Disability Service is perceived by many as peripheral to the work of the Trust. That mental health is the core work of the Trust. That even at a very senior level the issues relating to learning disabilities are “less important”. Strategic objectives, such as developing Recovery within the Trust, had less meaning to staff within the Learning Disability Service.	EDG and Board address the Trusts role in the distance experienced by the directorate ensuring the new directorate leadership is fully absorbed into the Trust leadership.	Culture and Practice updates previously reported weekly to EDG, and the Board session held on 7th May 2014 Board focused on LD. Services have regular visits from Council of Governors, NEDs, senior Trust managers and more recently SCC Contacts Monitoring Team. Clinical Director and Service Director have regular 1-1s with executive team. The Directorate is working with commissioners as a wider organisation - not just at directorate level, to make decisions about our role in future service provision.	
7	4	The categories identified within this review strongly indicate that there is evidence of “detachment” and “distance” at all levels within the organisation. This “distance” can be viewed as a “core” element to the overriding culture of the service, and the service set within the boundaries of the trust. It can be seen as present in many formal activities, processes and relations within the organisation and indeed beyond the confines of the Trust. In some respects the Learning Disability Service is perceived by many as peripheral to the work of the Trust. That mental health is the core work of the Trust. That even at a very senior level the issues relating to learning disabilities are “less important”. Strategic objectives, such as developing Recovery within the Trust, had less meaning to staff within the Learning Disability Service.	The Board and its members utilise learning from the review of culture and practice to influence and determine the current and future strategic direction for the commissioning and provision of Learning Disability Services for the residents of Sheffield.	Board Development Session held on 6 May 2014 looked at the role of Board in developing the culture in the Learning Disability Service. Board reflected on the lessons for the Board emerging from the Review of Culture and Practice in Learning Disabilities and agreed a number of steps, as described in the Summary Report presented to 2 April 2014 Board. Risk to the quality of care in the provider service has been added to the Risk Register. Meeting held on 13 July 2015 with SCC Lead Commissioners, EDG members and Service and Clinical Director to discuss strategic direction of the Directorate.	
8	5	Speech and language therapists provide recommendations for care which are implemented by staff. However, on occasion it was identified that these plans we not fully implemented and there was little or no follow up. The reliance lay with staff to implement and re-refer when required.	Ensure Board’s on-going focus on people with profound learning difficulties.	Paper to Board in May 2014 summarising the findings and recommendations of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities. It reports the results of a Trust stock-take which was agreed following discussions of the Confidential Inquiry findings at Operational Directors Group. The stock-take has included all the clinical directorates and the Clover Group. It reports on existing activity and future plans and made recommendations for Trust action. Audit undertaken of Feeding and Swallowing Guidance by SALT for individuals that we support in accommodation services. This followed a death in service and Coroner lessons learned. This audit is now being rolled out to LD Service Providers across the city. This will provide us with public health information and a fully city-wide audit on feeding and swallowing practice.	

Index	Rec. No.	Findings	Recommendation	Actions Taken	RAG Progress Score
9	6	In some respects the Learning Disability Service is perceived by many as peripheral to the work of the Trust. That mental health is the core work of the Trust. That even at a very senior level the issues relating to learning disabilities are "less important". Strategic objectives, such as developing Recovery within the Trust, had less meaning to staff within the Learning Disability Service.	EDG ensure there is organisation-wide shared learning of the review of culture & practice across SHSC.	Board Development Session held on 6 May 2014 looked at the role of Board in developing the culture in the Learning Disability Service. Board reflected on the lessons learned and agreed a number of steps, as described in the Summary Report presented to 2 April 2014 Board. Risk to the quality of care in the provider service has been added to the Risk Register. Workshop held to share lessons leaned with lead clinicians and managers. Assistant Clinical Director held lessons learned feedback sessions with all provider services areas during 2014. Lessons learned from Culture and Practice shared with Service Directors in January 2015. Learning from the Coroners Hearing on the death by choking shared across the directorate and wider trust. Work on the Green Light Toolkit is being led by Rachel Warner.	
10	7	The inconsistencies highlighted within this report show how differences in management competencies and leadership skills are in someway responsible for the findings contained within it. Allowing 'local interpretation' to occur in regards to policies and procedures has further added to the inconsistencies of the implementation of numerous practices.	The Human Resources Directorate and Executive Directors Group consider the Trust's current management development training provision for middle and senior managers in the LD Service and trust wide.	External contractor (Diversity Matters) commissioned to: * Enhance the review of culture and practice (7 days facilitated to-date) * Facilitate a reflective process with key leaders to better understand the systemic dynamics that have affected the Learning Disability Service. * Focus will be on cultural aspects, including belief systems and patterns underlying the practices, as well as considering larger structural issues. * Outcomes will be to consider and agree required interventions, workforce development and cultural/ belief system change that may be needed. All managers are accessing training on Crucial Conversations The LD Directorate has funded a programme of Supervision Training which has been opened up to the wider Trust HR clinics are held with managers to discuss issues of staff performance/sickness	
11	8	In some respects the Learning Disability Service is perceived by many as peripheral to the work of the Trust. That mental health is the core work of the Trust. That even at a very senior level the issues relating to learning disabilities are "less important". Strategic objectives, such as developing Recovery within the Trust, had less meaning to staff within the Learning Disability Service.	All Board members, Executives and Directors review their respective services and responsibilities in the light of the findings of this report.	Board Development Session held on 6 May 2014 looked at the role of Board in developing the culture in the Learning Disability Service. Board reflected on the lessons learned and agreed a number of steps, as described in the Summary Report presented to 2 April 2014 Board. Board Development Sessions / sharing of lessons learned with other directorates scheduled for September 2014.	

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12	1	It many areas care plans were seemingly devalued. Important aspects of planned care had not been properly implemented. Social activities, identified were not provided, health plans not always followed. Some staff were not fully aware of the content of plans and did not see their contribution to the documentation as important. The content of plans was less than relevant for some clients. Many had not been reviewed within the identified time scales. The process of reviewing specific recommendations from experts within the community teams had not been followed through. Clinicians recognised that not all recommendations were implemented and there was no systematised method of formal review to ensure implementation. Although staff could identify plans to promote health relating to identified individuals, these aspects of care were not always included in the documented plan of care. Some teams showed evidence that clients had been involved in the development of their plans but in many cases there was little evidence to suggest client or carer involvement.	The DMT ensure all care plans are subject to a review within the next six months and a regular cycle of maintenance and monitoring is established.	An audit of care/support plans was carried out across the LD Provider Service commencing November 2013 and concluded in March 2014. This included examining the processes relating to MCA and DOLS. Findings from the audit were fed back directly to individual Registered and Locality Managers at the time of the audit. The Care/Support Plan Audit Report collated by Jim Chapman, Clinical Audit Manager is complete. The overall findings from this report was been fedback to managers and clinicians across the Learning Disabilities Service In April 2014. January 2014 Service Meeting focussed on "What makes a good Care and Support Plan". * A review of the current Care/Support Plan format is now complete. Reviews of Care/Support Plans now being progressed in each service area and being monitored by Assistant Service Director within Team Manager supervision. Each area progressing their individual action plans. In conjunction with the care plan audits, Community Learning Disability Team health care professionals observed practices in (Unit 1) of the care homes/supported living units, to determine if what was recorded in care plans was reflected in practice (and vice versa). Health needs were also audited by the clinical lead for community nurses. Incident reporting and management training has been delivered to all staff at one supported living location (Unit 1) in both individual and group settings. A number of audits have been carried out across LD Provider Services and are detailed as follows: - Dysphagia Audit - PRN Audit - DNACPR - Deprivation of Liberty Audit All areas are now following the Trust Policy for the review of care plans Community Nurses commissioned to undertake review of care plans within the Respite Care Service - scheduled for completion July 2015.	

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13	2	Within this environment developed a sense of "false entitlement" amongst certain staff. This manifested itself in a number of ways. In the absence of policy, some staff and some teams believed themselves to be "entitled" to remuneration or "subsistence" payments. In some areas this led, over time, to tenants/ service users' funding staff meals in clients' accommodation. This practice varied in its application and some areas staff were expected to make a small contribution. A number of interviewees expressed concern that they had been required to make this contribution and perceived it as a "pay cut". The collection of this "food payment" was not monitored, audited or managed. On escorted social activity trips away from the accommodation some staff believed it "reasonable" that the client should "cover any expenses".	The DMT to develop robust systems for the purchase/management and disposal of service user property, ensuring regular audits are built into the system, in conjunction with relevant partners where appropriate, e.g. Housing Association.	Review of local protocols undertaken on the retention and disposal of service user property. New guidance is in place. An Audit of the application of Residents Financial Services (RFS) Procedures was concluded in November 2013. Financial irregularities were identified in two areas (Wensley Street and Mansfield View). The Learning Disabilities Management Team met with Registered and Locality Managers to feedback (both verbally and in writing) the outcome of the audit and have put measures in place to ensure no further irregularities will take place. There is no evidence of financial abuse/ mismanagement in relation to housekeeping arrangements in other areas of Provider Services. Verbal and written feedback has also been provided to respective Housing Associations. Guidelines for Supported Living Managers and Registered Care Managers receiving money via RFS Voucher System reviewed and amended to address irregularities in November 2013. Guidelines were issued to all Locality Managers with agreement to review following a 3-month period. Guidelines reviewed June 2014. Three RFS and Counter Fraud Training Sessions were held during June/July 2014 to which 37 managers attended. One RFS and Counter Fraud Training Session was held for business support staff in July 2014. RFS training provided to all Support Workers in May 2014 and repeated for new starters in December 2014. A Fraud in the NHS Competency Mapping Workbook has been developed with colleagues from Training and Development in the Sheffield City Council. Workbooks rolled out to service areas since September 2014. All staff within the directorate have completed this. EDG commissioned an external review of Resident financial Services (RFS) and the handling of patient monies both within Learning Disabilities and across all Trust services. This review has been undertaken and completed by KPMG. The recommendations have been received, reviewed and accepted by the EDG and the Board. The Director of Finance has lead responsibility for overseeing implementation/monitoring of all the required actions. The report will be shared with Housing Associations, the Local Authority and the CCG to ensure that the wider system can benefit from the lessons learned. Trust-wide register of people suspected of fraud not yet set up. Rolling programme of audit has been in place since 2014. Progress evident - no untoward issues identified.	
14	3	Within this environment developed a sense of "false entitlement" amongst certain staff. This manifested itself in a number of ways. In the absence of policy, some staff and some teams believed themselves to be "entitled" to remuneration or "subsistence" payments. In some areas this led, over time, to tenants/ service users' funding staff meals in clients' accommodation. This practice varied in its application and some areas staff were expected to make a small contribution. A number of interviewees expressed concern that they had been required to make this contribution and perceived it as a "pay cut". The collection of this "food payment" was not monitored, audited or managed. On escorted social activity trips away from the accommodation some staff believed it "reasonable" that the client should "cover any expenses".	The DMT develop effective protocols in relation to the purchase/management and disposal of service user property and personal belongings within provider services to protect service users and staff from risks associated with misappropriation of property.	The Learning Disabilities Service commissioned a full investigation into subsistence across all provider services, led by an independent investigating officer, Erne Bradley. All payments of staff subs, where staff were expecting payment in the course of carrying out their normal daily duties have been stopped. The local protocol on staff accessing service user funds (RFS procedures) has been revised and reissued with a robust process for exceptions being in place. Training has been provided to all staff within provider services, led by RFS, and is being repeated approximately every six months A regular independent audit programme has been established by the Assistant Service Director and recent audits have shown improvements in this area. An investigation into the alleged misappropriation of service user personal belongings was actioned and addressed. Protocol on the Management and Disposal of Service User Property implemented 2014.	

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15	4	A number of historical staffing practices, with little or no value, had rarely been challenged. These included the absence of staff rotation within units and across the service and the acceptance of permanent night staff. The Review Team saw little value of these practices continuing and believed that a proper process of staff rotation would improve the quality of care, standardising practice and staff development.	Staff rotation across the units to be considered by the directorate as a way of spreading good practice as well as tackling strong, static staff groups.	Some significant rotation taking place within service areas. However, opportunities for rotation across the service have been postponed due to the de-registration process and the need to factor in matching of support workers and service users based on service user preference, staff knowledge and skills, and service user and staff interests Implementing internal rotation in 24hr/three shift system at all services except Mansfield View Locality 1, where we are currently in consultation process. Everywhere else now rotating staff.	
16	5	The inconsistencies highlighted within this report show how differences in management competencies and leadership skills are in someway responsible for the findings contained within it. Allowing 'local interpretation' to occur in regards to policies and procedures has further added to the inconsistencies of the implementation of numerous practices.	The DMT work with the Human Resources Directorate & EDG to contribute to the development & delivery of a management development programme for middle and senior managers in the LD Service	External contractor (Diversity Matters) commissioned to: * Enhance the review of culture and practice. * Facilitate a reflective process with key leaders to better understand the systemic dynamics that have affected the Learning Disability Service. * Focus will be on cultural aspects, including belief systems and patterns underlying the practices, as well as considering larger structural issues. * Outcomes will be to consider and agree required interventions, workforce development and cultural/ belief system change that may be needed. Action plan developed to address issues identified with Diversity Matters. To up skill local managers within provider services, the Service Director enlisted HR Advisor support to run HR clinics for managers experiencing particular issues with staff capability.	
17	6	The safeguarding process varied in its implementation across the service. A significant factor was that teams had two lines of communication when raising a "safeguarding alert". The trust Safeguarding Office did not receive regular records of alerts raised as they would commonly be passed on to the local Authority Safeguarding Office. The consequence of this practice was that the trust was limited in its ability to accurately report on, provide analysis, and act on safeguarding issues. The Review Team was not able to receive an accurate report on alerts raised, meetings and outcomes. Staff were generally aware of their responsibilities with regard to Safeguarding. However there was evidence that some staff failed to "connect" the poor application of the Mental Capacity Act with the application of safeguarding procedures.	The DMT to work with the Education and Training Department and subject specialists to increase the technical/knowledge base of provider services staff in the Mental Capacity Act and Safeguarding.	A MCA/DoLs practice development group was been set up with its own Terms of Reference and plan of action. These are posted on the Trust Intranet. MCA training has taken place over September - December 2014 and will continue. The Trust-wide MCA Steering Group has a priority work plan. MCA Mandatory Training Plan agreed with ETD. Training task and finish group set up to agree the contents of delivery of stage 2&3 training. Completed MCA self-assessment audit for CCG in May 2015. Local Trust-wide audit also completed. Work underway to upgrade Insight forms for MCA	

Index	Rec. No.	Findings	Recommendation	Actions Taken	RAG Progress Score
18	Specific Rec. 1	The application of Residents Financial Services (RFS) Procedures identified financial irregularities in two service areas. Overall the application of the RFS systems in place differed from area to area across both Registered Care Homes and Supported Living Localities. In summary: • Records were often untidy with careless mistakes being made. • Attempts to rectify errors were often inappropriate; e.g. altering digits or using tippex. • In many areas, there were no checks for the recipient of monies to know the amount they received was the amount ordered. • In the two areas where financial irregularities had occurred, the main responsibility for ordering monies had been given to one or two individuals. • There were examples of good practice, i.e. the audit report at East Bank Road and the systems in place at the Burngreave locality. • Money books were often signed as correct by local management teams, when they were, in fact incorrect.	Consideration will need to be given to the findings of the KPMG audit.	An Audit of the application of Residents Financial Services (RFS) Procedures was concluded in November 2013. Financial irregularities were identified in two areas (Wensley Street and Mansfield View). Criminal proceedings at Wensley Street resulted in a criminal conviction with a custodial sentence of 2 years. Criminal investigation remains on-going at Mansfield View. Both cases have been dealt within within safeguarding procedures. Full communications plans in place to ensure family carers kept up-to-date on progress of investigations and outcomes. CloverLeaf Advocacy Services commissioned to support service users in both areas during the criminal investigation process. The Learning Disabilities Management Team met with Registered and Locality Managers to feedback (both verbally and in writing) the outcome of the audit and have put measures in place to ensure no further irregularities will take place. There is no evidence of financial abuse/ mismanagement in relation to housekeeping arrangements in other areas of Provider Services. Verbal and written feedback has also been provided to respective Housing Associations. Guidelines for Supported Living Managers receiving money via RFS Voucher System reviewed and amended to address irregularities in November 2013. Guidelines were issued to all Locality Managers with agreement to review following a 3-month period. Guidelines reviewed June 2014. Guidelines for Registered Care Managers receiving money via RFS Voucher System reviewed and amended in response to financial irregularities identified in October 2013. Guidelines were issues to all Registered Care managers with agreement to review following a 3-month period. Guidelines were reviewed September 2014. Three RFS and Counter Fraud Training Sessions were held during June/July 2014 to which 37 managers attended. One RFS and Counter Fraud Training Session was held for business support staff in July 2014. EDG commissioned an external review of Resident financial Services (RFS) and the handling of patient monies both within Learning Disabilities and across all Trust services. This review has been undertaken and completed by KPMG. The recommendations have been received, reviewed and accepted by the EDG and the Board. The Director of Finance has lead responsibility for overseeing implementation/monitoring of all the required actions. The report will be shared with Housing Associations, the Local Authority and the CCG to ensure that the wider system can benefit from the lessons learned. Training for new starters in 2015 is being planned to take place within year. A Fraud in the NHS Competency Mapping Workbook has been developed with colleagues from Training and Development in the Sheffield City Council. Workbooks will be rolled out to service areas during September 2014	
19	Specific Rec. 2	The application of Residents Financial Services (RFS) Procedures identified financial irregularities in two service areas. Overall the application of the RFS systems in place differed from area to area across both Registered Care Homes and Supported Living Localities. In summary: • Records were often untidy with careless mistakes being made. • Attempts to rectify errors were often inappropriate; e.g. altering digits or using tippex. • In many areas, there were no checks for the recipient of monies to know the amount they received was the amount ordered. • In the two areas where financial irregularities had occurred, the main responsibility for ordering monies had been given to one or two individuals. • There were examples of good practice, i.e. the audit report at East Bank Road and the systems in place at the Burngreave locality. • Money books were often signed as correct by local management teams, when they were, in fact incorrect.	Internal and External audit of all similar services, relating to finance, to be completed on a regular basis and reported to the Board.	Re-audits across LD Provider Services continued throughout 2014/15. These audits are being undertaken by the Assistant Service Director and Business Support Manager . Outcomes of each Audit are recorded and shared with respective stakeholders and through the LD Governance Structure.	

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20	Specific Rec. 3	Within this environment developed a sense of "false entitlement" amongst certain staff. This manifested itself in a number of ways. In the absence of policy, some staff and some teams believed themselves to be "entitled" to remuneration or "subsistence" payments. In some areas this led, over time, to tenants/ service users' funding staff meals in clients' accommodation. This practice varied in its application and some areas staff were expected to make a small contribution. A number of interviewees expressed concern that they had been required to make this contribution and perceived it as a "pay cut". The collection of this "food payment" was not monitored, audited or managed. On escorted social activity trips away from the accommodation some staff believed it "reasonable" that the client should "cover any expenses".	Subsistence policy to be reviewed in the light of report. Formal processes to be implemented ensure compliance.	Local guidance on staff accessing service user monies for their own purposes e.g. to fund food/beverages has been reviewed and new guidance implemented. The Learning Disabilities Service monitor this as part of the monthly audits described above The local Governance meeting has been reviewed to encourage wider outside engagement and external support for management The finance audit will be extended to Buckwood View, Respite and ISS. Audits to continue monthly through forthcoming years	
21	Specific Rec. 5	The Review Team found that there appeared to be weak governance systems in place, and an over reliance of these systems indicated the possibility of a lack of awareness of actual performance and functioning.	Implement developmental plan to ensure that governance systems are robust and supported	The management team have embarked upon a clear developmental plan to ensure that governance systems are robust with provider services and that these are supported at every level. Governance reports across the Trust have been Reviewed to test the functionality of these within learning disabilities. Following the changes within the management team, a learning disability health services governance group has been established which pulls together representation from provider services for the first time. This enables learning, best practice and problem solving to be shared across the service. A robust Physical Health Plan is being developed across the directorate. This will focus on training and practice development. It ensures that systems are implemented for appropriate referral, care planning and monitoring of client's physical health needs. On-going quality improvement Physical health group remains an outstanding issue. This will be considered as part of the refreshed governance framework	
22	Specific Rec. 6	An apparent absence of robust systems across services suggests limited managerial control over governance, including finance, staff management and staff practices.	Peer Review to be implemented across services to ensure independent challenge of the information	Service Meeting held on 8 July 2014 looked at developing peer what aspects of our work is reviewed by peers and could/should be reviewed by peers. Guidance from session being developed into a 'Peer Review Terms of Reference' Investigations now routinely undertaken by Managers from other provider and clinical services to ensure increased objectivity and transparency in response to incidents and complaints To be considered in refreshed governance framework	
23	Spec-ific Rec. 7	The inconsistencies highlighted within this report show how differences in management competencies and leadership skills are in some way responsible for the findings contained within it. Allowing 'local interpretation' to occur in regards to policies and procedures has further added to the inconsistencies of the implementation of numerous practices.	Increased senior management capacity. Further Review of Management responsibilities is required.	The Senior Management Team has been strengthened through the appointment of a new Assistant Service Director (replacing the former SCC employee) with responsibility for all provider service locations (health). The Learning Disabilities Directorate is currently being supported by the Service and Clinical Directors from the Specialist Directorate in order to strengthen the senior operational management and peer support to the Interim Head of Service (Health) and the Clinical Director. Job Descriptions for Service and Clinical Director reviewed to include responsibilities around financial auditing. Shift systems have been introduced for Deputies and Team leaders/Locality Co-ordinators to ensure effective 24/7 care and support to service users, management and leadership of staff. No longer being supported by specialist directorate management team - moved to more substantive arrangements.	

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24	Specific Rec. 8	The Review found that a number of teams have staff that report feeling unsupported and isolated from the rest of the organisation. Some staff teams appear to have developed local practices independent of the wider service. These practices, that are at times paternalistic and institutional, were often unchallenged by management. In certain areas there was an absence of clear processes for staff support and development, with supervision and appraisals limited in their application and value. Staff identified a lack of training, in particular in relation to values and attitudes.	The service to develop methods in the selection process that identify positive attitudes applicants	LD Provider Services have worked with HR to pilot and use assessment centres in support worker recruitment, and with successful outcomes. Now the norm to consider values during recruitment in provider services. This assessment centre approach has been adopted by other parts of the organisation such as flexi-staffing. Building on the success of assessment centres in recruitment, LD provider services to support recruitment of support workers to Flexible Workforce to ensure equal attention to positive attitudes within that sub-group of staff	
25	Specific Rec. 9	Given the complex nature of the many issues facing many clients, the Review Team was concerned with the level of skills and knowledge possessed by the staff group. Systems to ensure access to expertise were heavily reliant on individual staff possessing the awareness to "signpost" or "refer" individuals to the appropriate expert. Teams had been targeted with basic training to allow them to monitor certain specific issues, particularly health related issues. However, to address the complexity of these issues, the Review Team believed that a more proactive approach by associated experts was essential. Given the emphasis on maintaining environments and completing "domestic" tasks, many risks may have gone on unaddressed. Many staff believed that units/ homes and services should allow greater access to students from all disciplines. This is known to have a positive impact of skill and knowledge of staff group and provides a further oversight of staff behaviours and client experience.	Service reviews the potential value of a reintroduction of "essence of care" benchmarking process to support quality delivery	No action has yet taken place in regard to this recommendation.	
26	Specific Rec. 10	Given the complex nature of the many issues facing many clients, the Review Team was concerned with the level of skills and knowledge possessed by the staff group. Systems to ensure access to expertise were heavily reliant on individual staff possessing the awareness to "signpost" or "refer" individuals to the appropriate expert. Teams had been targeted with basic training to allow them to monitor certain specific issues, particularly health related issues. However, to address the complexity of these issues, the Review Team believed that a more proactive approach by associated experts was essential. Given the emphasis on maintaining environments and completing "domestic" tasks, many risks may have gone on unaddressed. Many staff believed that units/ homes and services should allow greater access to students from all disciplines. This is known to have a positive impact of skill and knowledge of staff group and provides a further oversight of staff behaviours and client experience.	Service to develop formal competency framework aligned with team and individual objectives. Formally included in Supervision and PDR practice	Learning Disabilities Service has been involved in the supervision stock take recently undertaken by SHSC. An audit of supervision compliance across the service has been completed. A programme of improvement has been put in place. Regular supervision of all staff is now being undertaken and monitored through line management structures. Managers and Co-ordinators have been nominated to undertake supervision training in 2015 Audit of PDRs across the Learning Disabilities Service and Trust undertaken. PDRs for all staff are now being undertaken in line with the Trust's mandate for all PDRs to be completed within quarter one of each year. Discussions underway with Corporate Services to look at expanding Mental Health Awareness Training to include Learning Disability Awareness Training. Introduced competency framework The Directorate has commissioned a programme of Supervision Training for all managers and clinicians. This programme of learning has been opened up to the wider Trust.	
27	Specific Rec. 11	Vacancy rates were high in a number of teams and managers complained that, on occasion, they were unable to recruit to these vacancies	Implement the "Capacity and Capability" requirements, as set out in the National Quality Board report (Nov 2013).	Whilst the implementation of the 'Capacity and Capability' requirements have not taken place. A review of establishments for each area has taken place. All vacant posts at Team Leader/Coordinator level and below are recruited to as a matter of course. Commitment to filling vacancies and effective recruitment despite losing services	

Index	Rec. No.	Findings	Recommendation	Actions Taken	RAG Progress Score
28	Specific Rec. 12	Given the complex nature of the many issues facing many clients, the Review Team was concerned with the level of skills and knowledge possessed by the staff group. Systems to ensure access to expertise were heavily reliant on individual staff possessing the awareness to "signpost" or "refer" individuals to the appropriate expert.	Review skills and knowledge essential for all staff roles, to ensure ability to identify, refer and respond to common, yet complex health issues.	A review of job descriptions is shortly to commence across supported living areas. Training and information available to staff in respect of identifying health needs and appropriate referral is being developed within Physical Health Group and published A number of learning programmes have been commissioned for delivery across the directorate these include: - Epilepsy - Positive Behaviour Support - Autism - Sensory Impairment	
29	Specific Rec. 13	Vacancy rates were high in a number of teams and managers complained that, on occasion, they were unable to recruit to these vacancies	Adopt a reliable, validated tool to identify and agree funded establishments across the service. This would then be linked with a transparent risk analysis of the key issues impacting upon quality and	No validated tool has been identified. Funded establishments in residential care were reviewed and agreed with commissioning Housing Associations. Review of assessed need / funding and hours of support provided currently being undertaken within Supported Living Services A review of funded hours of support for each individual in Supported Living Services in nearing completion.	
30	Specific Rec. 14	Vacancy rates were high in a number of teams and managers complained that, on occasion, they were unable to recruit to these vacancies	All teams should recruit to vacancies where impact on quality is evident.	A review of establishments for each area has taken place. All vacant posts at Team Leader/Coordinator level and below are recruited to as a matter of course. A review of the use of "flexi staff" has taken place across the Learning Disabilities Service and Trust. Accurate monitoring and reporting of issues leading to the use of "flexi" staff has also currently being undertaken. Local governance reports contain action plans to address both the "over-use" of such staff and the causes of such "over-use". A "Flexible Staffing Working Group" and a "sickness and Absence" working Group are currently reviewing such practices across the trust and will be reporting shortly. No longer looking to accelerate recruitment process. New strategy is to recruit in batches via assessment centres	
31	Specific Rec. 16	Most managers reported that one of their biggest concerns was ensuring that they had sufficient staff to cover all shifts, whilst ensuring sickness absence was being managed appropriately. A number of team leader/coordinator absences presented some managers with added pressures. In some units, team managers were absent, meaning that other unit managers were managing two units, or that deputy managers were moved to manage other locations.	The "Sickness and Absence" Policy should be strictly and rigorously adhered to, monitored and reported upon within the Directorate governance processes.	All Registered and Locality Managers are working with HR to manage sickness issues within their respective areas. This includes progression through capability of disciplinary procedures. Team Leader / Coordinator absences addressed to ensure capacity with teams to manage sickness. HR reporting on sickness absence management within Directorate Governance meetings to ensure oversight. Reduced use of temporary contracts to maximise job security for staff. HR providing additional assistance in case managing complex capability cases Work commenced with HR more routinely to consider wider strategies to reduce sickness in problematic areas. Trust-wide work to improve employee wellbeing, occupational health and sickness rates has commenced.	
32	Specific Rec. 17	A number of historical staffing practices, with little or no value, had rarely been challenged. These included the absence of staff rotation within units and across the service and the acceptance of permanent night staff. The Review Team saw little value of these practices continuing and believed that a proper process of staff rotation would improve the quality of care, standardising practice and staff development.	All permanent night staff posts should be removed.	Review of current practice across LD Provider Services has been undertaken. All services except Mansfield View now only have permanent day or night staff on recommendation from Occupational Health or through Flexible Working requests and in these areas the majority of staff on any one shift are working across 24 hour period. Only remaining service with permanent night team is Mansfield View and all staff have been notice of move to internal rotation with 1:1 meetings currently taking place Continue with current move to internal rotation at Mansfield View. Once completed reaudit across services to ensure OH recommendations and flexible working requests are manageable and do not allow return to separate day and night teams	

Index	Rec. No.	Findings	Recommendation	Actions Taken	RAG Progress Score
33	Specific Rec. 19	Given the complex nature of the many issues facing many clients, the Review Team was concerned with the level of skills and knowledge possessed by the staff group. Systems to ensure access to expertise were heavily reliant on individual staff possessing the awareness to "signpost" or "refer" individuals to the appropriate expert.	Redevelop areas/ units/ homes to allow for increased access as learning environments for students of all disciplines	The Learning Disabilities Directorate is developing protocols that ensure appropriate increased access by other disciplines. Clinical staff from Community Learning Disability Teams now providing and supporting audits of care e.g. care/support plans, PRN use, management of dysphagia, service user activities. Access to clinical experts also much improved through multi-disciplinary response to referrals and reduced waiting times Pilot work is underway at Mansfield View Locality with focussed clinical input, community mapping, assessment and access to assistive technology. Continued monitoring of referral rates from provider services and concerns raised by visiting clinicians	
34	Specific Rec. 20	There is limited formal involvement with carers, friend and families. There appears to be no apparent formal structures involving carers. There is some evidence that carers feel unable to express concern and incidents have occurred where carers have not felt able to challenge formally. Not all clients have access to formal advocacy. Many clients have no family or carer contact. Given the vulnerability of clients, often isolated from families, many staff believed that greater emphasis should be given to supporting formal advocacy across the service. A number of staff expressed a desire to see carers and advocates contributing to formal oversight of the service. They stressed the value of bringing advocates and carers into governance processes as well as providing individual support for clients.	Increase advocacy across the service ensuring that no client is without an active carer/ family member or an advocate	Residential care settings currently have access to Cloverleaf Advocacy support as part of the deregistration process. Information about available advocacy and IMCA support in city has been shared across all areas.	
35	Specific Rec. 21	The Review Team acknowledged that a philosophy of care that emphasises the individual and choice is commendable. However it is believed that the pursuit of such goals leaves a number of concerns. In certain circumstances where there is: weak management, poor leadership, a lack of oversight, and a lack of robust governance, there is significant concern as to the quality of care. Where these circumstances are combined with: "isolated teams, isolated staff", poor supervision, an isolated, vulnerable client group with complex needs, the concern as to the quality of care is considerable.	Ensure governance structures within teams includes representatives drawn from advocates, carers, families and service users.	A directorate Governance Group has been established which pulls together representation from all provider services with a revision to the clinical governance reporting structure. The aim is to support greater transparency and understanding of actual practice and drive quality improvements , together with seeking the views of service users, their carers/families/advocates and 'experts by experience' as to the quality of care provided. New Service Review format piloted for Longley Meadows Respite Care Service which incorporated service user and family carer representation. Further work to be carried out on how best to engage service users in a meaningful way at team level. Cloverleaf Advocacy Service is engaged with all tenants across the 5 Registered Care Homes as part of the de-registration process. Expectations regarding team governance are now incorporated with the Governance Framework	

Culture and Practice Review - Supporting Information

Summary of some of the supporting information available

No	Document
1	Audit Report of the application of Residents Financial Services (RFS) Procedures
2	Rolling Audit Programm Summary (supported by Audit Reports by area)
3	Guidelines for Supported Living Managers receiving money via RFS Voucher System
4	Guidelines for Registered Care Managers receiving money via RFS Voucher System
5	RFS Fraud and Counter Fraud Training Sessions and Evaluation data
6	KPMG Report - Review of Residents Monies
7	Fraud in the NHS Competency Mapping Workbook
8	Care and Support Plan Audit
9	Care and Support Plan Audit - Observations by house
10	PRN Audit
11	Dysphagia Audit
12	DNACPR Audit
13	DNACPR Audit Terms of Reference (city Wdie)
14	Deprivation of Liberty Audit
15	PDR Audit
16	Supervision Audit
17	Service User Engagement Terms of Reference

KPMG Review of Residents' Monies

No	Priority	Recommendation	Timescale	Stakeholder	Actions	Supplementary Actions Taken	RAG Rating Progress Score	Tania comments and evidence	Evidence	Cross referencing
1		Embed the proposed Team Governance Model throughout the Trust to support improved outcomes for service users and demonstrate compliance against CQC standards	Sep-14	Director of Planning and Performance	• Directorate Service Review process in place this year. This will provide for periodical reviews of performance in respect of quality, safety, effectiveness and financial performance.	**January 2015 update**		*Anita - service review?	*Agenda for Service Reviews July 2014	
					• Revised Team Governance processes and arrangements will be in place for September onwards. These arrangements will provide for consistent approach to reviewing standards of care provided by teams, with effective escalation of issues and concerns and a focus on assurance and quality improvement.	Revised governance arrangements to ensure effective reporting from team, SMT and to the QAC were reviewed and approved by EDG and QAC in September. These are now being implemented from January 2015 onwards.				
					• A review of the Risk Register processes will be completed with revised arrangements in place for September. The new arrangements will provide for a more informed focus on key risks within services, consideration of shared and Trust wide risks across all services, and the effectiveness escalation of issues and concerns.	Team level risk registers have been reviewed and completed as of the end of September. Directorate level and Corporate risk registers have been updated accordingly.				Main Action Plan Row 7
						The Safeguard system has been upgraded to introduce an options for e-based management of the risk registers. The review of the risk register process will be completed and a supporting development plan in place by the end of March. (Originally this was planned for Oct/ Nov, but re-adjusted in light of the introduction of the new reporting stsyem).				

No.	Recommendation	Date	Lead	Actions	Progress	Evidence
					A review of the Trust's Performance Framework is being undertaken that will confirm the on-going arrangements for Performance monitoring and Services Reviews for the 2015-16 year. This should be completed by February 2015.	
						local protocols (Andy has sent)
					Full implementation of recommendation expected end March 2015.	Cross-ref protocols Row 13 Cross-ref audits Row 19
2	Review the Trust's organisational culture at all levels to identify development needs and opportunities. This should lead to a re-emphasis of the importance of accountability throughout the organisation and the provision of robust challenge where standards fall below those expected e.g. In relation to the management of residents' monies	Sep-14	Director of Organisational Development		**January 2015 update**	Rotation not taking place
						Cross-ref to Row 10
				• Each Corporate Directorate has been asked to identify priorities for action following the Culture & Practice Review.	Achieved. Final Board response including actions to be taken across organisation approved by Board in December 2014	MCA/DOLS practice group T.O.R evidence put in
						Cross-ref Row 13 for all evidence
					Leadership development group established. Work commenced in December 2014 to set expectations. All managers and team leaders trained on their responsibilities in the RFS operational guidance. Audits involving peers/managers showing compliance.	Cross ref to Row
						Cross-ref Row 13 for evidence on local guidance
				• Leadership development in the Directorate will include setting out expectations of managers and team leaders by the Directorate leadership team.	In progress - peer review guidance in draft and shared at directorate service meeting in 2014. Peer reviews to commence March 2015.	*new governance reporting structures, trust-wide
					Achieved. Training has been running from July 2014 and a further 9 sessions booked to July 2015	
					Achieved. 8th January 2015 session held with Executive Director of Nursing, Director of OD/Board Secretary and ODG members to share the lessons.	* Staff briefing on Mansfield View emphasising accountability

No.	RAG	Action	Date	Lead	Actions	Update	RAG	Ref
					• Performance Management processes in the Directorate will include an element of peer review • Challenging conversations training will be made available to all staff in leadership positions in the Trust. • We will share the lessons from the culture and practice review more widely with other Directorates - this will include identifying risks that arise from service user vulnerability - check whether we do this at ODG or separately.			AP 22
3		The Audit & Assurance Committee to provide greater levels of challenge to auditors and executives to improve its overall effectiveness.	Sep-14	Executive Director of Finance	• Board workshop facilitated by Beachcrofts under consideration by Chair. • Consider peer review of Audit Committee by external Audit Chair. • Review Attendance at AAC. • Establish Training Needs.	**January 2015 update** Board workshop facilitated by Beachcrofts scheduled for 24th February 2015. 360 Assurance facilitating peer relationships with Audit Committee Chairs. SHSC Audit and Assurance Committee to agree terms of reference for such relationships. SHSC Audit and Assurance Committee to consider and agree following workshop, peer review Review of Board Assurance Framework undertaken and considered by Board 5/11/14 and Audit Committee 21/1/15		

Cross ref to Row 24	
Cross-ref Rows 21, 35 for LD gov meeting ToR and mins Cross-ref SU engagement with Row 4 Cloverleaf cross-ref Row 34	

					• Review BAF			
4		Update the job description of the Head of Service to include clear responsibility for reviewing and ensuring there are sound financial governance arrangements operating within individual units in relation to residents' monies.	Sep-14	Director of Operations	Job description for Interim Head of LD Service amended to include clear statement regarding this responsibility.	Complete		
5		The relevant Registered Manager together with the Head of Service should undertake regular independent checks of residents' financial records (purple books and receipts). These independent checks should be documented and recorded.	Sep-14	Head of Learning Disability Service	• An Audit of the application of RFS Procedures was concluded in November 2013. Verbal and written feedback given at time of audit to respective Registered/Locality Managers and Housing Associations. • A schedule of re-audits across LD Provider Services has been established for the period 2014/15. These audits will be undertaken by the Assistant Service Director, Business Support Manager and the Quality Assurance Officer, SYHA. Outcomes of each Audit will be documented and shared through the LD Governance Structure.	A schedule of Audits across LD In-patient areas (ISS and Respite Care) is in development.		
6		The RFS team should request that a sample of purple books from individual units are provided on a monthly basis in order to allow RFS staff to undertake an independent reconciliation to vouchers issued.	Sep-14	Residents Financial Services Manager	• Purple books have been requested to be submitted by 30 June 2014, to cover the months of March and April 2014 for selected residents throughout LD including housekeeping and personal monies. RFS will then check monies requested via RFS has been entered into the purple books.	Initial audit completed and findings shared with Service Manager/Unit Managers. Plans to repeat on a rolling programme.		

Sheffield City Council

Sheffield Health and Social Care NHS Foundation Trust NHS

D2 - LD Governance Framework – Dec 15

SHSC Learning Disability Directorate Governance Framework

A NHS Framework Ensuring High Quality Outcomes for Adults with Learning Disabilities.

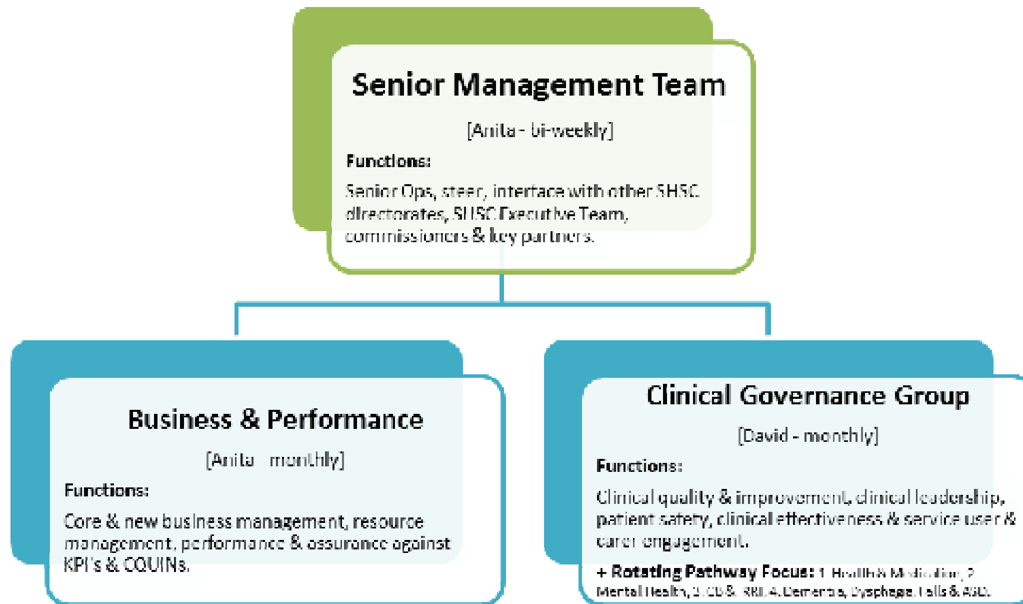
Well-led, safe, responsive, caring & effective.

Dr David Newman: Clinical Director - LD
Anita Winter: Service Director - LD
Andy Bragg: Assistant Service Director – LD
Tania Tailor: Business Planning Partner

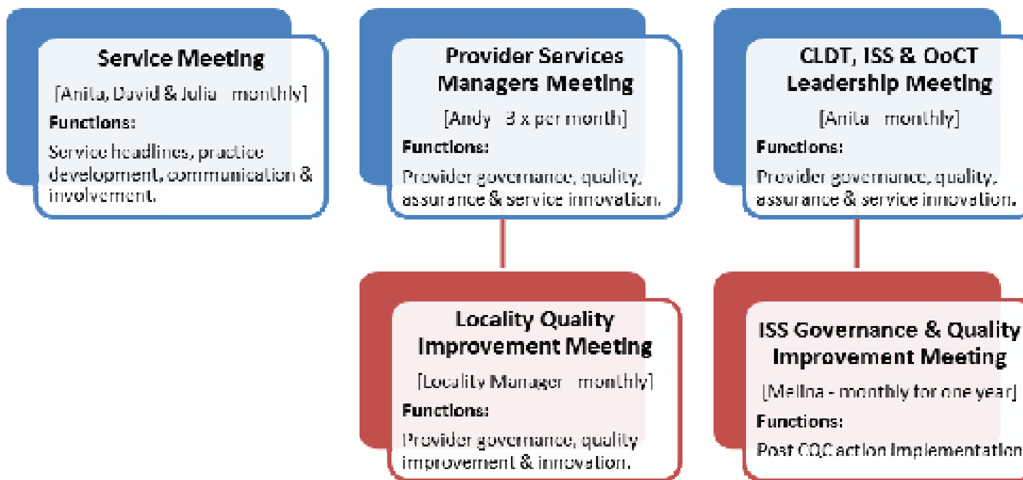
Date: 28th September 2015

Learning Disability Directorate – Governance Framework

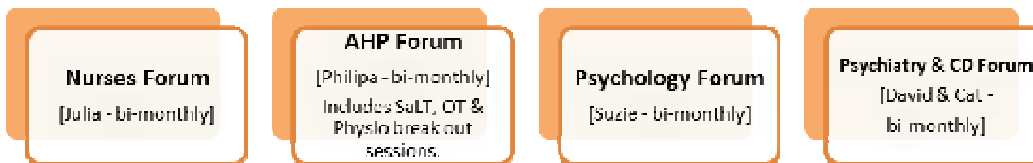
Directorate Level (Receives & Reports to Trust level)



Service & Team Level



Professional Level



Individual Level

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4. Responsibility & Accountability 5
5. How Are Quality Goals & Standards Set And Agreed? 6
6. How Will Managers and Clinical Leaders Improve Quality? 7
7. How Do We Monitor Our Progress? 8
8. Conclusion & Forward Vision 9

1. Introduction

This framework is designed to support a culture of outstanding quality. It will help us to deliver well-led, safe, responsive, effective and caring services to the people we support. It will help us to know if there are any early signs of problems, as well as identifying examples of excellent practice that others can learn from.

The evidence log of agendas, papers, presentations and minutes is stored on datastore in the following location: ..\LD Governance. It is available for appropriate scrutiny and assurance by the SHSC Executive team.

2. What Is Governance?

Governance is a term that brings together many familiar concepts such as 'quality assurance', 'service performance', 'service improvements', 'continuous quality improvement', 'quality and service monitoring' etc.

It is sometimes defined as:

"making sure that we are doing the right things, in the right way, to the right quality at the right times"

Good governance brings together information about what we are doing with the resources we have got. It ensures that are making the best use of our resources for the benefit of the service users we serve.

3. Quality Is Everyone's Business

We believe it is essential that the responsibility for governance is seen as everyone's business. Opportunities for quality, care and innovation can come from all places within an organisation. Sometimes top down leadership is necessary in order to steer a service in the right direction. However, the experience of service users and front line staff is an equally if not more powerful means through which to learn about quality and drive change.

With this in mind we have set out a governance framework for the Learning Disabilities Directorate that is implemented across number of levels. These include:

- Directorate level
- Service & Team level
- Professional groupings level
- Individual practitioner level

This governance framework means that the directorate can supply quality assurance to higher levels within the trust such as the board as well as outside stakeholders (commissioners, CQC & the general public).

This framework will apply across the whole of the Learning Disabilities Directorate. It will cover diverse teams including residential care homes, supported living schemes, inpatient areas, respite care services, community teams, out of city teams etc.

Intelligence supplied by central corporate departments such as Finance, Human Resources, Incidents, Safeguarding, Complaints, Compliments and CQC inspection reports are all made available to help us monitor our quality performance.

4. Responsibility & Accountability

Directorate Level

The Service Director (Anita Winter) and Clinical Director (Dr David Newman) are ultimately accountable for the quality of service provision within the LD Directorate. The Assistant Service Director (Andy Bragg) provides focused operational management to our provider service. Together these three individuals form the Senior Management Team, responsible for ensuring that resources and capacity are coupled with the knowledge and capability to deliver high quality services.

The Service Director role has a strong emphasis on 'operational quality' and the Clinical Director role has a strong emphasis on 'clinical quality'. The distinction between these two realms of focus is illustrated in the different agendas of the three directorate level meetings:

- Senior Management Team: Chair – Anita Winter
- Business & Performance: Chair – Anita Winter
- Clinical Governance: Chair – Dr David Newman

Service & Team Level

The responsibility for ensuring quality standards are being met within each service rests with the team service manager/team leader for that area. Within the LD Directorate the following service managers are accountable for their areas:

Clinical Services

- ISS (Inpatient) Melina Simmonite (Nurse Manager)
- ISS (Community) Julia Shepherd (Nurse Consultant)
- Out of City Team Lucy Harrison
- CLDT Anita Winter
- Older Carers Team Anita Winter
- LD Case Register Anita Winter

Provider Services

- Beighton Rd Karen Johnson
- Wensley St Mandy Mason
- Buckwood View Diane Staniforth
- Burngreave Dev Patricia Wright
- Mansfield View Mandy Johnson
- Steven Close Karen Johnson
- Respite services Wendy Hastings Quainoo

Support Services

- Business Support Louise Barber

Professional Level

The responsibility for ensuring quality standards are met within each professional group lies with the most senior professional within that group. Within the LD Directorate the following clinicians are accountable for the quality of our health care professionals:

AHP: Philipa Allen (SaLT), Lucy Harrison (OT) & Kate Scott (Physio)
Medical: Dr Catriona Murray – Lead Consultant Psychiatrist
Nursing: Julia Shepherd – Nurse Consultant
Psychology: Dr David Newman – Consultant Clinical Psychologist

Dev Workers: Supported via relevant service level management structure.

Individual Level

Finally there is a responsibility for ensuring quality standards are being met by each individual employee. Attending to continuing professional development, seeking support and taking ownership and responsibility for raising concerns about practice are integral to all our roles. Every member of staff should have a job plan that details when and where they are delivering their input to ensure effective use of their expertise and resource.

5. How Are Quality Goals & Standards Set And Agreed?

Our quality framework is driven by a range of national and local sources. These include Department of Health strategy and guidance, NICE guidance, professional bodies, regulator frameworks set by CQC & Monitor. Ultimately we are accountable to our local customers in the form of service users, carers, commissioners and partner organisations.

Quality Goal Setting

For the remainder of 2015 our quality focus will be driven by the learning and recommendations from the 'Culture & Practice Review' and the CQC action plan.

In 2016 we will proactively set our Quality Improvement Goals and these will be refreshed at the start of every financial year. They will be focused, 'must do' priorities based upon our awareness of quality issues and opportunities. As well as external influences, our goals will be influenced by the experience of our service users and staff. This includes:

- Learning from serious incidents, compliments and complaints
- Service user and carer feedback
- Innovation and 'bottom up' ideas from staff within our services

Each goal will be SMART[1], an acronym that stands for:

- *Specific* – target a specific area for improvement.
- *Measurable* – quantify or at least suggest an indicator of progress.
- *Assignable* – specify who will do it.
- *Realistic* – state what results can realistically be achieved, given available resources.
- *Time-related* – specify when the result(s) can be achieved.

6. How Will Managers and Clinical Leaders Improve Quality?

Staff in management and leadership positions have an exciting opportunity to take responsibility for and make a difference to quality. It is a great privilege to be entrusted to a position where you can develop the workforce and make a real difference in the lives of service users. Initiatives that support quality also support workplace well-being and job satisfaction for all concerned.

There are a number of key responsibilities that will help ensure continuous quality improvement. The most important of these is to 'lead by example'. Positive modeling and nurturing a proactive culture within the service can achieve this. Positive modeling includes:

- Setting direction by being clear about what, why and how we deliver high quality care.
- Being clear about the fundamental standards of care and what quality 'looks like and feels like' in practice.
- Supporting and developing your staff by encouraging positive change and celebrating success.
- Supporting processes to ensure these standards are achieved by measuring and evaluating progress and looking for improved delivery based on findings.
- Working in partnership across the 'triangle of care' – bringing together service user, carer & service provider ideas.
- Developing a learning culture (rather than a blame culture) so that incidents and near misses are used to improve care and safety going forwards.
- Holding people to account when their performance or conduct falls below agreed acceptable standards.

[1] Doran, G. T. (1981). "There's a S.M.A.R.T. way to write management's goals and objectives". *Management Review* (AMA FORUM) **70** (11): 35–36.

Microsystems – Your Toolkit for Quality

SHSC is committed to continuous quality improvement and has invested in supporting its leaders and managers to successfully engage in positive change. Part of this investment includes being an active member of the Microsystems Coaching Academy at Sheffield Teaching Hospitals. This approach states that the quality of care in a big organisation such as SHSC can be no better than the services generated by the small systems it is composed of. A wide range of people influence quality. It is not just about the work of the multidisciplinary team. It is also about the crucial input of Development Workers and supporting staff (e.g., clerical, ancillary & domestics). We are 'all in this together' alongside our service users, their advocates and families/carers.

You can read more about the microsystem approach here: http://www.sheffieldmca.org.uk/

7. How Do We Monitor Our Progress?

Quality is a moveable feast. What was considered good or acceptable in the past or even one year ago may no longer reach the bar. With this in mind we will be monitoring and supporting team managers and professional leads across the year to focus on quality improvement. Each manager/lead will be responsible for reporting once a quarter on their team's performance against the key Quality Improvement Goals. This reporting will take place during the LD Clinical Governance Meeting.

Reporting

The Quality Improvement Goals will be measured using a reporting framework. It is important that all SHSC staff are where practicable involved and engaged in this process. The team alongside their Team Manager/Lead will rate the outcome of their performance against the agreed measure with a colour coding. This highlights how the team/service is performing against their Quality Improvement Goals:

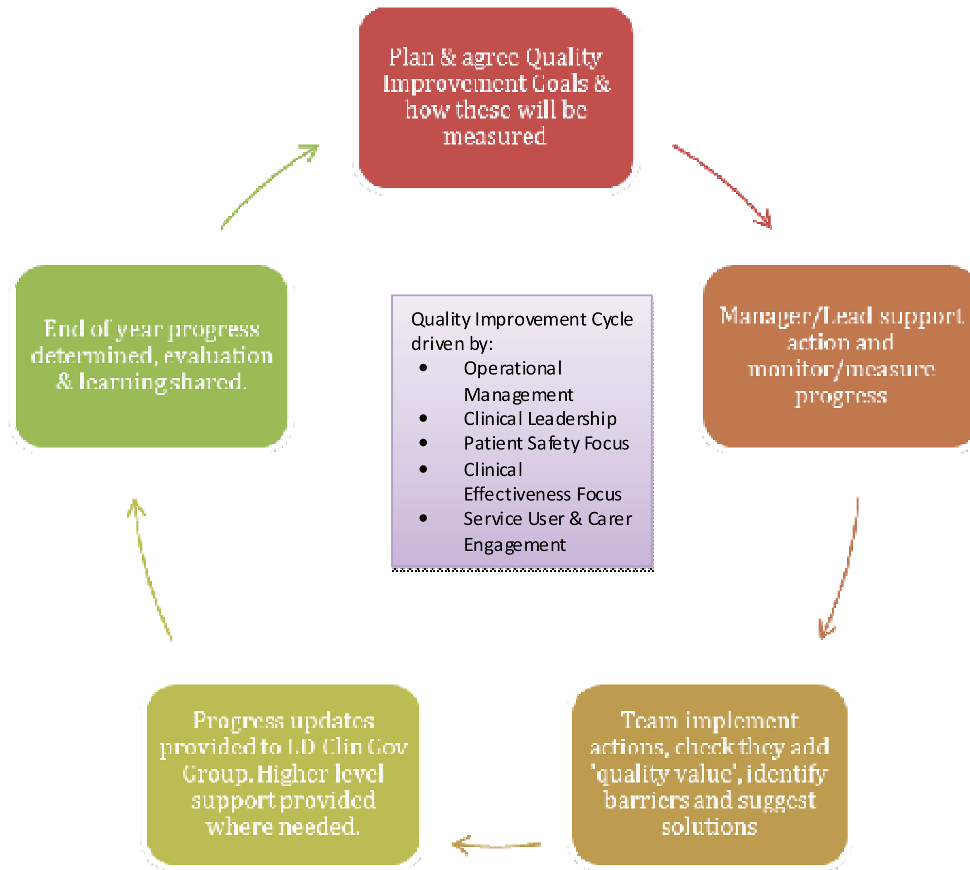
Blue	*there is evidence that the standard is fully embedded in practice*
Green	*standard is complete and in place*
Amber	*standard is partially met and progress is ongoing*
Red	*standard is not met or there are barriers to progress*

Evidence for the achievement of the quality goals and standards may come from a variety of sources (eg, CQC reports, service user feedback and forums, local audits, care plan reviews, service evaluations etc). Teams will identify and provide the evidence they consider relevant.

Action plans will be agreed for any Amber and Red standards and the relevant Service Manager/Lead will decide if the progress against quality goals needs to be escalated to the Senior Management Team or reported to the Risk Register.

At the end of the year our progress against Quality Improvement Goals will be reported to the LD Clinical Governance Meeting. It is good practice to ensure that the outcomes of performance reviews are reported to service users. Service Managers should ensure that teams have a process by which this will be done.

This process will support a proactive cycle of continuous quality improvement:



8. Conclusion & Forward Vision

Quality governance is a robust system that defines, checks and learns about quality. It supports a well-led and resilient culture that is open to positive improvements. It provides assurance at all levels from the 'ward to the board'. This governance framework is driven by a desire to offer the best provision to our service users. The microsystems approach means the ideas and contributions of all staff and service users are integral to what we do and how we do it. By placing the person at the centre of everything we do, we all have a real opportunity to develop high quality services that deliver safe & effective care and use our resources in an optimal manner.

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Sheffield Health and Social Care
NHS Foundation Trust

NHS

Sheffield City Council

D3 Quality Improvement Plan – Dec 15

Our Governance & Quality Improvement Plan

Learning Disabilities Directorate
23rd Nov 2015

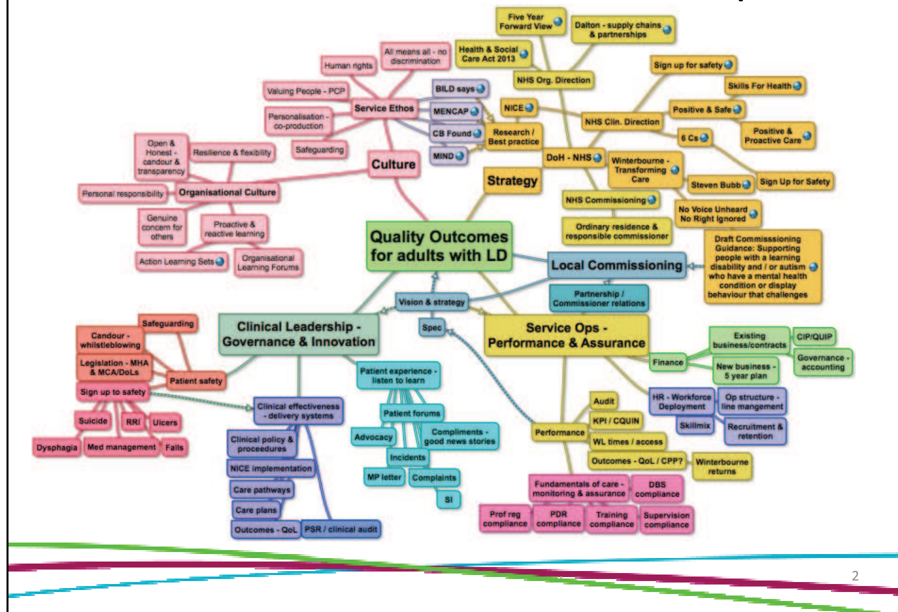
Dr David Newman - Clinical Director
Anita Winter - Service Director

0114 2263055 | 07980934511

david.newman@shsc.nhs.uk

Sheffield Health and Social Care NHS FT
Fulwood House, Old Fulwood Road, Sheffield, S10 3TH

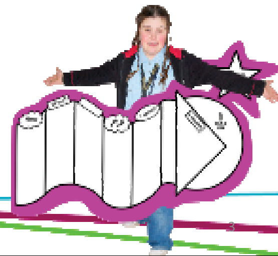
The LD Governance Mind-Map!



2

9 Quality Outcomes for People with Learning Disabilities

1. My care is planned, proactive and coordinated.
2. I have choice and control over how my health and care needs are met.
3. I live in the community with support from and for my family and paid carers.
4. I have a choice about where I live and who I live with.



9 Quality Outcomes for People with Learning Disabilities

5. I have a fulfilling and purposeful everyday life.
6. I get good care from mainstream NHS services.
7. I can access specialist health and social care support in the community.
8. I am supported to stay out of trouble.
9. If I need assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to.

Our Objectives – 2015 - 2020

Build on the Trust values

Transform services & deliver outcomes

Rebuild trust, reputation & brand

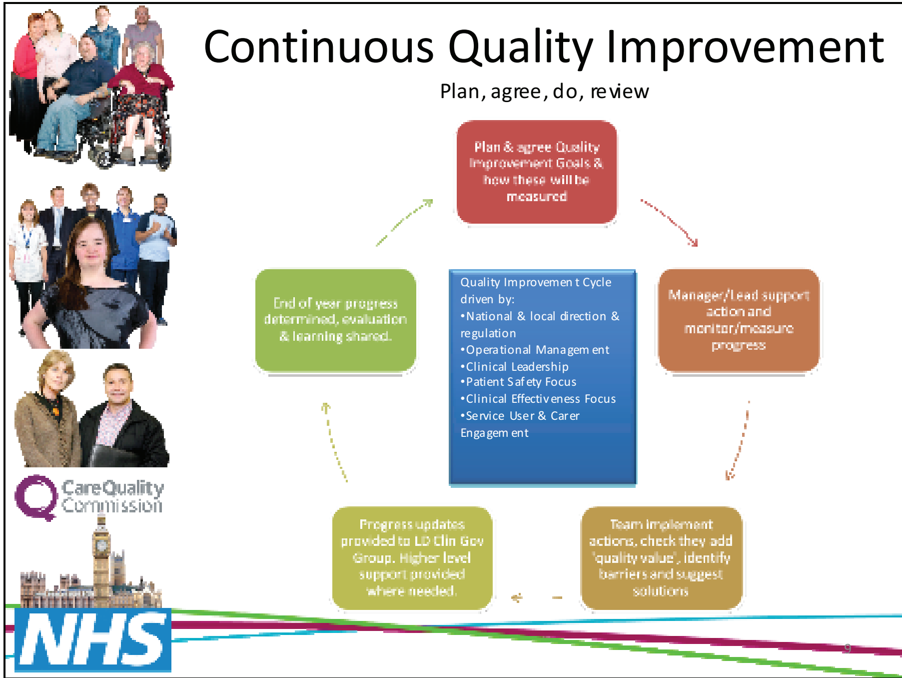
A New Governance Framework

The Learning Disabilities Directorate has redesigned its governance framework. The new framework helps us, *"make sure that we are doing the right things, in the right way, to the right quality at the right times"*

- *Well-led*
- *Safe*
- *Responsive*
- *Caring*
- *Effective*

Quality is
everyone's business
Governance refers to the processes and relations by which an organisation is controlled and directed.
Governance structures identify the distribution of rights, responsibilities & accountabilities among different participants in the organisation.
Directorate Level – Reporting to Board Level
Senior Management Team
[Anita - bi-weekly]
Functions:
Senior Ops, steer, interface with other SHSC directorates, SHSC Executive Team, commissioners & key partners.
Business & Performance
[Anita - monthly]
Functions:
Core & new business management, resource management, performance & assurance against KPI's & CQUINs.
Clinical Governance Group
[David - monthly]
Functions:
Clinical quality & improvement, clinical leadership, patient safety, clinical effectiveness & service user & carer engagement.
+ Rotating Pathway Focus:
Service & Team Level
Service Meeting
[Anita, David & Julia - monthly]
Functions:
Service headlines, practice development, communication & involvement.
Provider Services Managers Meeting
[Andy - 3 x per month]
Functions:
Provider governance, quality, assurance & service innovation.
ISS, CLDT & OoCT Leadership Meeting
[Anita - monthly]
Functions:
Provider governance, quality, assurance & service innovation.
Locality Quality Improvement Meeting
[Locality Manager - monthly]
Functions:
Provider governance, quality improvement & innovation.
ISS Governance & Quality Improvement Meeting
[Melina - monthly for one year]
Functions:
Post CQC action implementation
Professional Level
Nurses Forum
[Julia - bi-monthly]
AHP Forum
[Philipa - bi-monthly]
Includes SaLT, OT & Physio break out sessions.
Psychology Forum
[Suzie - bi-monthly]
Psychiatry & CD Forum
[David & Cat - bi-monthly]
Individual Level
Clinical Supervision
Operational Supervision
PDR & Job Plans
CPD
Professional Validation

Clinical & Managerial Leadership
everyone has a role to play….
Clinical Quality Goals
Business & Performance Goals
Patient safety
- We aim to get it right first time - every time
- We safeguard the vulnerable
- We learn from our mistakes
- We reduce our errors
Clinical effectiveness
- We are evidenced based & NICE compliant
- We are outcome focussed
- We make a difference to people's 'Quality of Life'
Patient & carer engagement
- We listen to learn
- We have experts by experience
- We seek feedback and make time to reflect upon it
Our staff
- We develop our workforce
- We manage our capacity & capability to respond to need
- We recruit & retain only the best staff
Finance
- We are clear with our contracts with commissioners
- We develop and deliver cost improvement plans, delivering efficiencies
- We generate new business
Performance
- We have low waiting times
- We focus on meaningful activity
- We achieve our KPIs & CQUINS
8

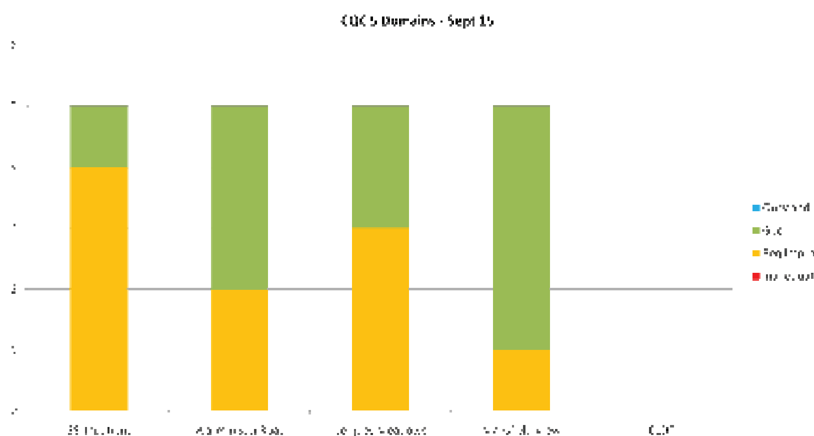

Continuous Quality Improvement
Plan, agree, do, review
Plan & agree Quality Improvement Goals & how these will be measured
Manager/Lead support action and monitor/measure progress
Team implement actions, check they add 'quality value', identify barriers and suggest solutions
Progress updates provided to LD Clin Gov Group. Higher level support provided where needed.
End of year progress determined, evaluation & learning shared.
Quality Improvement Cycle driven by:
•National & local direction & regulation
•Operational Management
•Clinical Leadership
•Patient Safety Focus
•Clinical Effectiveness Focus
•Service User & Carer Engagement
Care Quality Commission
NHS

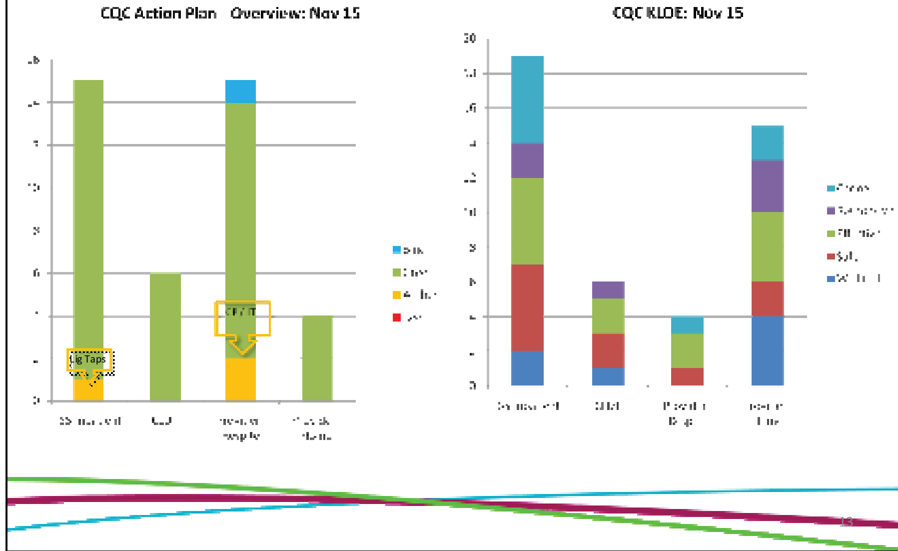
Celebrating Success
Waiting List Summary - Number on List
Start of Project
on List

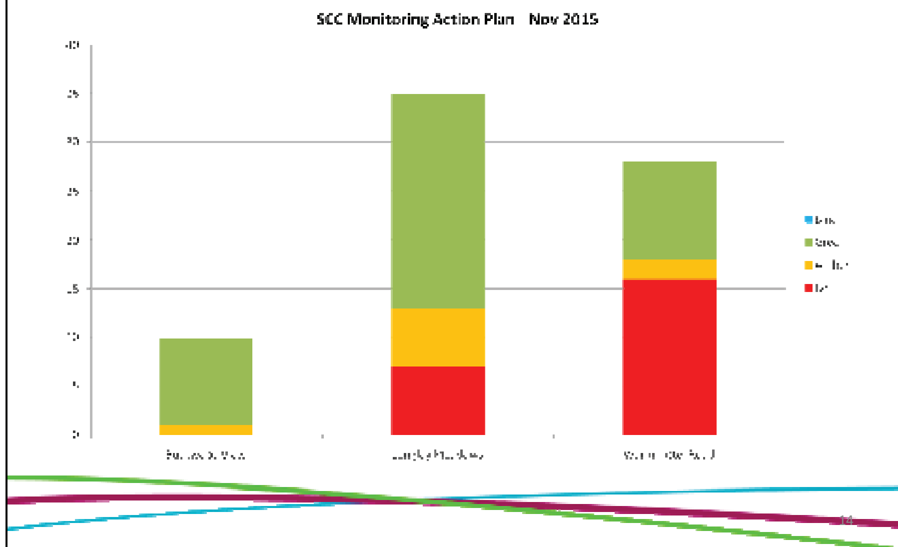
Quality – Our Current Position 2015/16

Achievements	Areas of Improvement	Lessons Learnt
• CLDT/ISS Community - 67% reduction in waiting times • POMH-9c best in country results • CQC 'Good' rating - supported living and residential care service areas	• New governance framework implemented • Service user and engagement plan (MENCAP) • On-going pathway work across CLDT & ISS • Reducing lengths of stay and delayed transfers of care at ISS	• Culture & practice – the rights and safety of service users is at the core of what we do • City-wide dysphagia awareness work • Capability & conduct – the need to hold to account

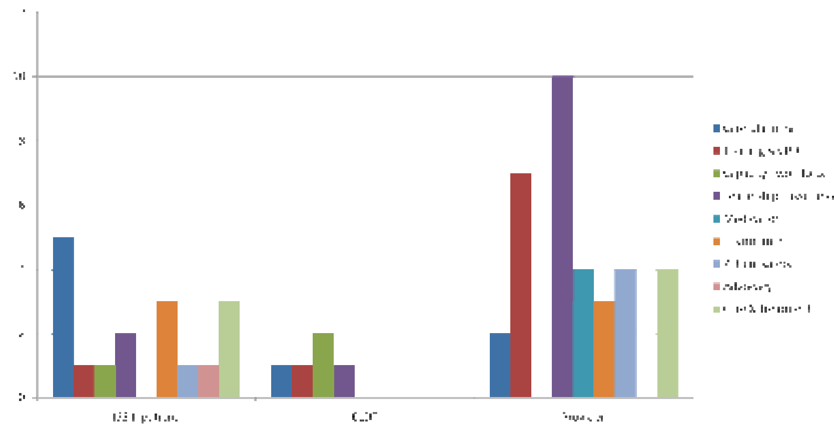
How Are We Performing? CQC




Using CQC Trackers To Monitor Progress
CQC Action Plan Overview: Nov 15
CQC KLOE: Nov 15

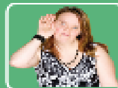

Using SCC Monitoring Action Plan
SCC Monitoring Action Plan Nov 2015

Learning From Compliance Feedback



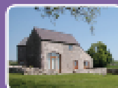
How will the LD Directorate Deliver the Trust's Corporate Objectives - 2016/17

Continually improving quality: implementation of new governance framework – well-led, safe, responsive, caring & effective. Engaging the workforce



Listen to learn - Feedback and lessons learned from service user and family carer engagement plan (MENCAP), CQC, Culture & Practice & Commissioner Scrutiny

Taking a lead role in transforming care via Positive Behaviour Support, Care & Treatment Reviews, Out of City Team returns & Reducing Restrictive Intervention (ARTS)



Ambition & innovation - new service developments with 7 Hills

16-17 Draft Quality Goals

Well led

Quality Goal	Methodology	Outcome
Strategic alignment with commissioning vision for Sheffield (Transforming Care & Competitive Provider Market)	•Agreed service spec •Aligned & meaningful CQUIN & KPIs	•Delivering agreed outcomes ↑QoL & Physical Health ↑CTR ↑Out of City returns ↓Challenging behaviour & restriction ↓DTC
Improved directorate operational and clinical leadership	•Recruitment of key operational and professional posts •Review of roles and responsibilities in line with service priorities and clinical pathways	•Operational framework delivers to spec •Improved workforce development •Improved performance management •Reduced sickness •Sustained PDR levels
Supervision in place to support capable, reflective, resilient and compassionate workforce	•All areas made aware of trust policy & access to training •Clinical supervision structure complete •Audit of frequency & quality of supervision audit	•Culture of clinical supervision embedded into clinical practice, including person centred values, positive behaviour support & safeguarding •Baseline supervision data

16-17 Draft Quality Goals

Safe

Quality Goal	Methodology	Outcome
To embed learning from Culture & Practice (2015) by proactively reducing safeguarding concerns	•Monitoring of SIs & safeguarding referrals •SI and safeguarding lessons learnt embedded into the governance framework as evidenced in minutes	•Reduction in SI & adverse healthcare incidents (medication management incidents) compared to previous year •100% combined safeguarding training compliance
Reduced restrictive interventions	•Implementation of improved service model supporting positive & proactive behavioural support & home support •PBS training rolled out	•Reduction in ISS-ATU bed days •Reduction in ISS-ATU length of stay •Reduction in Delayed Transfer of Care days
Evidence that staff actively and routinely assess & support care taking appropriate action to ensure patients safety	•Routine environmental risk assessments in place •Pathways developed to access clinical leads in relation to falls & dysphagia	•Reduction in avoidable falls •Dysphagia awareness audit illustrates increased capability across health and social system

16-17 Draft Quality Goals

Responsive

Quality Goal	Methodology	Outcome
Maintain CLDT & ISS-Community **productivity** & access to services	• On-going 'meridian' analysis & management tool • Performance monitoring	↑ Access to services ↓ Reduced waiting time
Improve **productivity** within ISS inpatient & OoCT	• On-going 'meridian' analysis & management tool • Performance monitoring	↑ Out of city returns ↑ Care & Treatment Reviews ↓ Reduced length of stay
Transformation of respite services into "Short Breaks for Extraordinary People"	• NHS Elect consultancy • Partnership working • Change management • Ambition & perseverance	• Longley Meadows is closed • Service users are given options to access multi-location experiences of their choosing

16-17 Draft Quality Goals

Caring

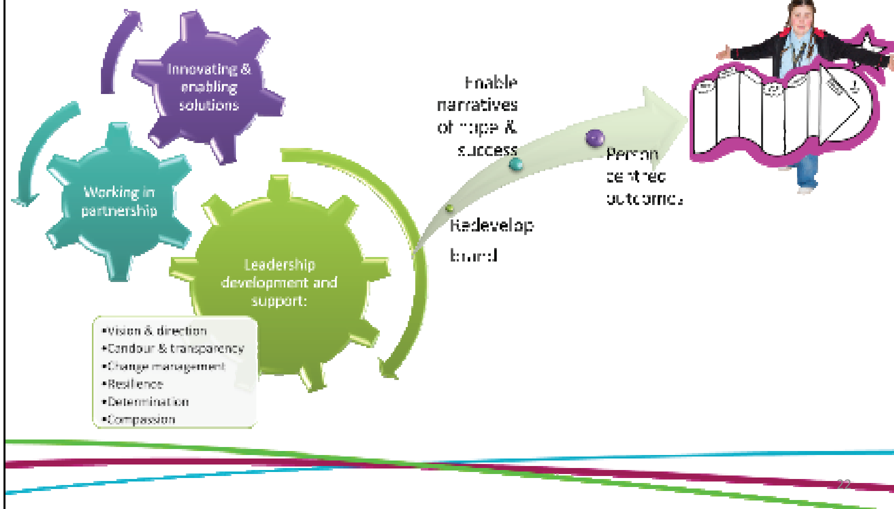
Quality Marker	Methodology	Outcome
Accessible information about services and care. Co-production occurs in care-planning.	• Increased use of photosymbols • Audit of accessible service information and care plans including My Care, Positive & Proactive Support Plan, WRAP	• Proactive use of accessible information across the directorate including service info & website • Accessible LD Quality Account
Evidence that **consent** procedures are in place and that records detail how best interest decisions are taken	• Audit undertaken • MCA external training • Active use of IMCA/IMHA • Review of CTR feedback	• Audit results & action planning • Training compliance figures • Improved CQC feedback • Improved CTR feedback
Evidence that staff collate positive & negative **feedback** from service users and carers and use this information to improve delivery of care	• Routine schedule of accessible questionnaires in place	• Increase in service user feedback • "You Said We Did" poster

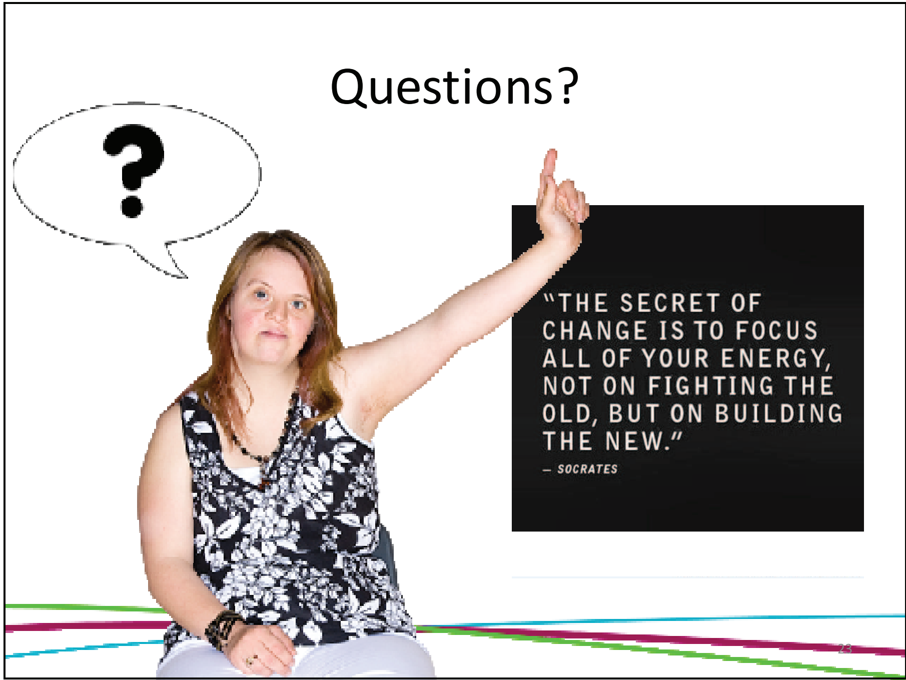
16-17 Draft Quality Goals

Effective

Quality Goal	Methodology	Outcome
Routine service user & service level **outcome measures** employed across services	•Agree core data set per for each service •Audit dataset	•Each service area can demonstrate global outcome •Practice based evidence used to support discharge or transfer across service thresholds
Clinical practice is influenced by **NICE**/national guidelines and can be evidenced by audit of records	•Directorate database of core & relevant NICE guidance linked to service pathways	•Increased awareness and profile of NICE in pathway delivery. •Increased work streams looking at achieving pathways & NICE implementation.
Evidence of adherence to good practice with regards to **medicines management** & side effect & physical health monitoring	•Consultant Psychiatrist & Consultant Nurse attend medication management & support/maintain practice development •Local medication audits	• LD side effect monitoring standards maintained •Maintenance of 2015 POMH-9c results

Governance & Proactive Quality Improvement Will Transform Care




Questions?
?
"THE SECRET OF CHANGE IS TO FOCUS ALL OF YOUR ENERGY, NOT ON FIGHTING THE OLD, BUT ON BUILDING THE NEW."
— SOCRATES

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