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.

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

BOARD OF DIRECTORS

KEVAN TAYLOR, CHIEF EXECUTIVE

LIZ LIGHTBOWN, CHIEF OPERATING OFFICER/CHIEF NURSE

SCC Cabinet

Executive Director
was Richard Webb, now Laraine Manley

Interim Director Care & Support
Moira Wilson

SHEFFIELD HEALTH & SOCIAL CARE NHS FT

CLINICAL DIRECTOR, TINA BALL

INTERIM HEAD OF SERVICE (HEALTH), ANITA WINTER (July 13 onwards)

SCC

Interim Head of Service Social Care
Jo Dakin-Goodall

Provider Services Senior Manager
Paul Brook

INTENSIVE SUPPORT SERVICE

Assistant Clinical Director
JOHN TOMLINSON

COMMUNITY LEARNING DISABILITY TEAM

Health Professions Manager
ANITA WINTER

SHSC PROVIDER SERVICES
Senior Manager Paul Brook (SCC, up to July 13)
Service Manager Julie Turner (SCC, up to Dec 13)

Assistant Service Director
ANDY BRAGG
(Jan 14 onwards)

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 City Council

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)