CORNWALL AND ISLES OF SCILLY
SAFEGUARDING ADULTS BOARD

SERIOUS CASE REVIEW

OVERVIEW REPORT OF THE JOHN DANIEL DAY CENTRE

January 2015
## INDEX

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Facts of the case</td>
<td>6</td>
</tr>
<tr>
<td>Key features, findings and recommendations</td>
<td>11</td>
</tr>
<tr>
<td>Conclusion</td>
<td>30</td>
</tr>
<tr>
<td>Appendix 1: Terms of reference</td>
<td>32</td>
</tr>
<tr>
<td>Appendix 2: Extract, Single Issue panel</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 3: Management structure -2011</td>
<td>48</td>
</tr>
<tr>
<td>Appendix 4: Main references</td>
<td>49</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 This document is intended to provide an overview of the deliberations and recommendations of the Serious Case Review panel instigated by Cornwall and Isles of Scilly Safeguarding Adults Board (SAB) relating to a day care facility in Cornwall called the John Daniel Centre (JDC).

1.2 A Serious Case Review (SCR) is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of adults at risk in the future. Where there have already been changes for improvement achieved during the course of the SCR, this is reflected.

1.3 This overview report brings together, and draws conclusions from, the information and analysis contained in the Individual Management Reports (IMRs) from the relevant organisations and all other information that has informed the SCR.

2. Individual Management Reviews (IMR’s)

2.1 A key part of the SCR process is the input from all organisations via their IMRs. An IMR is a detailed document which each organisation produces following a set template. This document aids the organisation to set out its involvement in the matters which are the subject of this SCR and encourages reflection on practice and asks the organisation to set out what learning, if any it has identified.

2.2 The SCR panel wishes to thank all IMR authors who were asked to produce wider ranging information from their organisations than would normally be the case to meet the requirements of the Terms of Reference for this particular SCR. All IMRs apart from one required some further clarification and this was provided with full cooperation. Each IMR produced a list of recommendations and where appropriate these are outlined later in this report.

2.3 These were received into the SCR from the following organisations:-

- Devon and Cornwall Police
- Peninsula Community Health
- NHS Cornwall Isles of Scilly (successor organisation-NHS Kernow)
- Cornwall Partnership NHS Foundation Trust (CFT)
- Cornwall Council:-
  - Human Resources and Organisational Development
  - Community and Support Services
  - Safeguarding Adults Unit
  - Contracts and Service Improvement Team
2.4 A significant amount of documentation was submitted into the SCR throughout the process as well as interviews being held with relevant personnel. These include professionals of varying grades of seniority who worked at JDC before and after this SCR was commissioned as well as historic and current staff at a senior management and corporate level.

2.5 A number of families and people who use the service have also inputted into this SCR and the SCR panel are very grateful to all that have contributed.

2.6 Three members of the SCR panel also visited JDC on two separate occasions on behalf of the SCR panel.

3. The circumstances that led to a Serious Case Review being undertaken in this case.

3.1 Many SCRs emanate from the death of a vulnerable individual but the circumstances that led to this SCR arose from multiple serious concerns raised by a whistle blower and others as to alleged substandard care at the day care facility in question. These concerns came to light in November 2011. These concerns ranged from alleged incidents of physical and wilful neglect, to incidents of humiliation, ostracising, favouritism, inappropriate communication, rough handling and also a deliberate exposure to a service user to an item of which he was known to be phobic. There were also allegations around the service being run for the staff at the day centre rather than being person centred toward those using the day centre.

3.2 Under current law a whistle blower is entitled to confidentiality and as such the SCR cannot name or seek to identify in any way the whistle blower who initiated a number of these allegations.

3.3 A safeguarding alert was also raised around alleged institutional abuse and/or wilful neglect. This was of sufficient concern that the SAB considered that it would be in the public interest to commission a SCR and that the criteria for holding such an SCR were met. This was also in the context that there had been historic and similar concerns about JDC in 2006 and also around another day care facility called Morley Tamblyn Lodge (MTL) in 2007/8. The concerns in November 2011 for JDC led to the Head of Service suspending thirteen members of staff at JDC and appointing an interim manager to take over management of JDC. The Head of Service also soon afterward appointed an independent investigator to work with the interim manager and look at systems and standards at JDC to assist on any required service improvements, and to have the fullest picture for the management of suspended staff.

3.4 The SAB commissioned this SCR in line with the criteria in Cornwall and Isles of Scilly Serious Case Review policy (September 2011) which relies upon the original guidance around vulnerable adults “No Secrets” (March 2000) which states:-

“when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults, a Serious Case Review should be undertaken”
3.5 The specific criteria state that when there is potentially serious abuse in an institution or when multiple abusers are involved, while the process is the same, these SCRs are likely to be more complex, on a larger scale and may require more time. This has been the case in terms of complexity and scale of this SCR and for legitimate reasons it has taken a considerable time to complete.

3.6 The SAB also gave weight to the fact that they can consider commissioning an SCR into any incident(s) or case(s) involving vulnerable adult(s) where it is believed to be in the public interest to conduct such a SCR.

3.7 Therefore while at the time of commissioning the SCR, despite an on-going internal investigation underway by an independent investigator, the SAB considered the commissioning of a SCR appropriate in all the circumstances. This was also in the context that the police had commenced an investigation to look at possible criminal culpability of those staff suspended given the nature of the concerns.

4. Terms of Reference and Methodology

4.1 The specific Terms of Reference for this SCR are at Appendix 1 and references at Appendix 4.

4.2 While various methodologies were being looked at nationally for SCRs concerning adults at risk at the time of the commissioning of this SCR, this development work had yet to be fully scoped or developed and therefore the standard process using IMRs was used for this SCR. The process followed the conventional approach as set out in Cornwall and Isles of Scilly Safeguarding Adults Serious Case Review Policy and this report is largely structured in accordance with the overview report template contained in that policy.

4.3 The complexity of an SCR based on concerns of an institutional nature or possible multiple abusers/victims, and with wide ranging terms of reference that emanate out of that, should not be underestimated. This SCR has required an extensive approach to capture learning over key functions of the relevant organisations. The capture of this learning has been multi-agency but as the service provided at JDC is commissioned and provided by the Council, there is a certain focus on that agency given its major role in the day centre and operational running.

5. Process timetable of the SCR

5.1 This SCR has taken some time to conclude due to several factors including the complexity; the extent of review that has been required to fulfil the terms of reference and the need to ensure that the police investigation and later the criminal proceedings were not compromised. That is not to say that the agencies involved in this review have waited until the report’s conclusion or publication to make some
improvement, this has occurred to some extent already as indicated in this report though there remains work to be done to develop and sustain further change.

6. Facts of this Individual Case

6.1 JDC is a day centre facility for adults with learning disability in Penzance. JDC was officially opened in 1983. There are three similar day centres. All are commissioned (purchased) by the Council but what is being purchased as such is the provision of a service also run and owned by the Council so both the purchasing and provision lies under one organisation. This is different from when the Council may purchase services externally, for example from a voluntary sector organisation. In that case the Council would be the commissioner (purchaser) but there would be a separation between the Council and the provider of the service (the voluntary or independent sector). In both cases there is a duty for commissioners to check that the service they have agreed can be provided is safe and provides good quality care.

6.2 From an operational services perspective JDC is managed as part of the Community and Support service which was part of Adult Care and Support but is now Education, Health and Social Care. At the salient time, the service was provided to 100 adults with a learning disability and some with complex needs. Some also lacked mental capacity. Many attended part time and the average daily intake was 60. As described by a number of families whose disabled relatives use JDC, and have done so for many years, JDC has become a valuable resource and meets demand in a relatively isolated location being toward the far end of the peninsula. Families describe the service at the beginning as being well run and a number referred to a deputy manager who is described as managing the service with a formal management style but also with compassion and kindness. The staffing over the decades has had a very low turnover rate with many of the staff coming into JDC on initiatives such as Youth Training Schemes as carers and then staying in employment at JDC for many years and in some cases decades. The local nature and demographic of the workforce at JDC mean that some staff were related, in personal relationships and many staff knew each other as friends and socially as well as being colleagues and living and working in the same community.

6.3 There was continuity of frontline management, though the highly regarded deputy manager left in the mid 1990s. Families report that after she left the management of JDC gradually slipped and was described by some staff and families as being less formal and more casual in nature. However, there was always an element of “give and take” to support families and most staff are described as being kind, personable and approachable. Almost from its inception JDC is described as being “out on its own”. Staff and families suggest this is partly due to location but also that there was very few new staff coming in with fresh perspectives. It was essentially seen as a self-managing centre not really attracting the attention of more senior personnel. This does appear to be borne out by a dearth of historic papers.
around JDC in terms of senior management appraisal, commissioning audits or governance checks.

6.4 There have been attempts to modernise the service and an executive report in March 2009 was supported as a valid proposal by the Executive at the Council but this was then halted by a Single Issue Panel deliberation in 2010, after concerns were expressed around the proposals. This resulted in an alternative plan for development and this was being actively progressed throughout 2011 via restructuring around management lines and staffing primarily. Senior management were still seeking to address issues around the service needing to become more person centred, better at involving community groups and optimising new opportunities to strengthen leadership and frontline management. This included the JDC but the restructure was across all day services. An extract from the single panel deliberation and their recommendations are at Appendix 2.

6.5 On 25 November 2011, concerns were expressed regarding the treatment of adults with learning disabilities at JDC subject to this review. Allegations were received by a member of council staff via a whistle blower. Under whistle blowing legislation the identity of a whistle blower is protected and the information being received must be taken seriously and acted upon under sound governance. Human Resources (HR) at the Council became involved. On 29 November, the information was reviewed by senior managers in HR and senior management in commissioning. The outcome was thirteen immediate suspensions of staff from JDC on 30 November 2012. Two further suspensions followed. Five of those suspended were later arrested and released on bail.

6.6 It should be explained that suspension is a neutral act in employment terms. Where concerns are raised that mean safety is an issue, an employer will need to consider suspension though in many cases if staff can be redeployed away from direct contact with those who use the service that is often acceptable. Suspension is the last resort but it depends on the seriousness of the specific facts of each case and the gravity of concern.

6.7 The sequence of events from allegations being made by the whistle blower and then to suspension and an internal investigation did not follow the correct procedure and contravened the Council’s own policy for managing serious concerns around staff. The police became aware of staff suspensions through the media and the safeguarding concerns were not raised as a priority. The police involvement into staff conduct was therefore delayed and safeguarding was informed later.

6.8 The gist of the concerns involved allegations of wilful neglect; an unsafe environment; lack of effective care planning and care delivery resulting in poor and
unsafe service delivery; lack of sound management and supervision; disrespectful communications towards those who use the service; poor or no choices offered for activities and running the service to suit staff. Senior management did raise a safeguarding alert when informed of these allegations but not immediately as is should be the case. There was also some delay in informing the police. In the meantime, staff were deployed to JDC from other in house services to maintain the service as well as agency staff. It should be noted that many of the staff to whom the allegations relate consider the allegations to have been made maliciously, and it is fair to say, find it very hard to accept that there were any problems at JDC whatsoever. There are a few that are more reflective but overall a number genuinely believe that there has been some sort of senior management conspiracy at play.

6.9 The state of the buildings and environment at JDC shocked the interim management staff going in. There was damage to the internal and external aspect of the building, the windows looking into the office were boarded up so no one could see into the office. The building was in a state of disrepair, toilets were broken, there was dried faeces on one of the toilet walls, and old, used incontinence pads piled in a corner in one toilet area. Storage was an obvious problem with supplies piled up in various places and in some cases precariously placed on high shelves. The kitchen was dirty and unhygienic and some way off being fit for purpose on health and safety grounds. Some of the furnishings in the communal areas were stained and worn and the whole day centre was reported to be darkly lit and in serious need of maintenance and decoration. The interim manager immediately took up the task of improving the environment though with very little resource and senior management support. Progress improving the environment was slow and the SCR panel did suggest a short closure to deal with the state of the building, repairs required and furnishings.

6.10 The large hall at JDC was being used as a main holding area where many people who use the service would congregate and sit around. This hall and the corridor could become very congested as up to 80 people who use the service a day would be at JDC. It was clear that some areas and spaces at JDC were not being used at all and were bare. The pottery area was working but did not seem to have been used in recent times. There is a garden at JDC that is accessible but this needed some attention.

6.11 Some people who use the service and families were understandably very upset by the sudden change in staff as the permanent staff were very familiar to them and their families. The stress of this uncertainty and change was supported by psychologists and other professionals who were brought in to support given the sudden influx of new staff and the distress this caused.
6.12 Service improvement visits were made, an action plan agreed and a number of GOLD meetings held, (this is a meeting with police, operational staff, safeguarding leads and social workers.) The social work team became involved in reviewing people who use the service and an independent investigator was appointed on 9th December 2012 to conduct a full internal investigation at JDC. Health staff supported the assessment of individual service users regarding their mental capacity to take part in police interviews and on-going internal and external communications were managed at a corporate level. As the service is not regulated by the CQC as a day service there were no external reporting requirements.

6.13 The first safeguarding adults strategy meeting was on 2 December 2011. The SAU Independent Chair who had some involvement with safeguarding issues arising from another day service MTL in 2008 became involved and quickly recognised the similarities of concerns with that alert and the current one with JDC. In recognising there were systemic issues, the SAU Independent Chair stated that at both day centres:-

a) The staff had become insular and institutionalised because they had a group of people who use the service and their families reliant on the services provided with a core staff group with no external scrutiny.
b) People who use the service care plans did not carefully consider individual needs and how they could be met and there was a lack of input from relevant others, like health professionals to assist meeting communication and behavioural issues;
c) Care plans were driven by service provision offered not needs.
d) People who use the service lacked choices and were not afforded proper respect.
e) There was a lack of independent scrutiny of the day care services and more specifically there were no external inspections of services or evidence of rigorous audit of services.

6.14 The SAU Independent Chair communicated with the senior managers with responsibility for adult services after the strategy meeting on 2 February 2012 and requested that a check be made on all other day centres in the County. The SAU Independent Chair was trying to get agreement for an additional action point to this effect but could not secure the assurances of immediate checks being made. This led the SAU Independent Chair to escalate matters to the Adult Care and Support Head of Commissioning, Performance Improvement and the Chair of the SAB. The Chair of the SAB escalated the matter to the Director of Adult Care and Support and the Assistant Chief Executive of the Council. One of the outcomes of that escalation was this SCR. At the case conference on 1 May 2012, an action was added that all council commissioned day services be reviewed to ensure that current safeguards are sufficiently robust to protect adults at risk from abuse. The SAU Independent
Chair requested to be kept informed of progress. A multi-faceted improvement programme was proposed to commence in July 2012. This resulted in numerous improvement plans that have continued throughout the period of the SCR. Safeguarding processes for JDC were concluded on 05 November 2013.

6.15 The interim manager brought in after the whistle blowing allegations moved from the JDC on 7 May 2013 to take up another post and JDC is now run by an experienced manager who is not part of the old staff grouping.

6.16 Some works have been done to deal with building maintenance and improve the environment at JDC. The challenge is delivering a modern service from an old building in which the design works against a modern service delivery. However, in terms of health and safety there have been significant improvements as seen by SCR panel members who visited JDC later on in the SCR process and were able to compare from the first visit some time before.

6.17 The police did charge three members of staff in relation to events at the JDC but the criminal proceedings were halted after a decision was made that the evidence would not be sufficient to meet the criminal burden of proof. This decision was apparently made after consideration of the JDC internal report. The remit of that report was to investigate and look at collective and individual capability of each member of staff in the context of reviewing what objective data there was around the standards being delivered at JDC, and how that was being delivered. This internal investigation would then inform any disciplinary considerations or actions. This was conducted by a senior manager with extensive safeguarding experience.

6.18 The summary of the JDC internal report indicated problems with staff performance and standards at JDC and this was shared with the SCR panel. This demonstrated pre November 2011, a long established and largely self-managing workforce. The view was that staff were poorly trained in modern approaches of care for those with learning disability and were operating an out dated model of delivery and operated in an insular manner. The internal report questioned senior management input and control. Management at JDC was found to be operating heavily on informal parameters which required professional development and improved governance across a number of domains. The service was considered to be operating around staff requirements rather than the people who use the services. An example of this were staff taking leave at the same time leaving the centre low on staff to care for those at the centre. The safeguarding assessment in 2011 was not disputed and JDC had not developed minimum standards nor effectively improved the skills of the workforce.
6.19 It is fair to state that some of the original staff at JDC who have inputted into this SCR do not accept there were any problems whatsoever at JDC in 2006 or 2011. A number state that documentary evidence has been destroyed to discredit the original JDC staff team. During the SCR there is no evidence that there has been any destruction of relevant documents although there was a theft at Old County Hall of the medication documents which had shown medicines management irregularities in 2006. In terms of understanding the paperwork around risk assessments in 2011 it is accepted that some of these were retained in a computer with passwords only the original staff knew. Therefore conceivably it could appear that those care and risk assessments had not been done or recorded when indeed they had but were only stored electronically. This needs however to be seen in the light of some original staff saying that some of their colleagues were not competent in inputting data and using the computer and so the system of recording and accessing care information then does appear to have lacked uniformity and been rather disparate.

7. KEY FEATURES OF THIS SCR

7.1. There are several key features in this SCR and it is from these that the findings and recommendations emanate, as well as from the IMRs and other inquiries. The key features are:-

- Previous safeguarding concerns
- Modernising day care services
- Frontline and senior staff accountability
- Partnership working
- Commissioning governance and risk
- Lack of national regulation

8. PREVIOUS SAFEGUARDING CONCERNS

8.1 JDC had been subject to safeguarding concerns before the allegations emerged in 2011. The first clear indication of any recorded safeguarding concerns within the day centre was in 2006 when a distressed parent raised concerns about care standards and these were investigated. At that point an interim manager was placed by a senior manager into JDC.

8.2 The issues then related to poor care planning and risk assessment of those using the service; poor medicines management; inadequate knowledge of up to date
policies and processes; informal management and supervision of staff; inadequate adherence to health and safety and a seemingly embedded staff culture where JDC was being run for the staff and not those who were attending. Serious concerns were also expressed around the state of the environment such as it was noted to be dirty, repairs left undone and the view was had JDC been regulated at the time the service would have very likely faced closure or enforcement action.

8.3 Some of the documentation around this time and the associated investigation was not available to the SCR panel as some of the evidence pertaining to it has been lost and some evidential information apparently lost in a theft of the building where some of the information was kept. However, the findings of that investigation are accepted as it has been possible to speak to those who oversaw that investigation and the core documents which remain. The main action from the concerns raised was to have more formal reviews of care at JDC and proactive senior management in relation to supervision at JDC.

8.4 However, it is clear from this SCR that while these actions were a reasonable and considered aspiration, this was not achieved. It is reported this was largely because of resource issues and this meant that essentially JDC went back to being self-regulating. This was a lost opportunity to build in systems of care standard reviews, formal staff performance reviews and support staff more fully in their development needs, as well as embedding some core care standards.

8.5 Around the same time the Safeguarding Adults Unit (SAU) was set up at the Council, following an investigation into the abuse of adults with learning disabilities at a county hospital which subsequently closed but safeguarding alerts did not appear to feature in the 2006 investigation. The SAU is still in existence now with its functions to support the safeguarding adults partnership; provide quality assurance mechanisms and provide appropriate challenge.

8.6 The next time that JDC featured for safeguarding albeit indirectly was in 2007/2008. Concerns were raised around another day centre, MTL and the SAU were involved including both its Independent Chairs at the time. Consideration of this matter spanned October 2007 to June 2008. The safeguarding process at this time found the service at MTL to be unsafe around health and safety and care planning and did not meet the required standards. The cause of these problems was considered to be cultural and systemic. The SAU Independent Chair requested in November 2007 that a planned accreditation process be brought forward to assess the working of the day centre against national standards of care.

8.7 The safeguarding co-ordinator then opened this up more widely by asking the senior commissioning lead at the time “with regard to day services for people with
learning disabilities commissioning by adult social care and partner agencies, what processes are in place to monitor and review that these services are safe”. The response in March 2008, sought to reassure the safeguarding process that the involvement of “Supporting People in Accreditation” would provide more rigor to quality assurance and a plan to improve commissioning was detailed.

8.8 The “Supporting People” initiative was an assessment of adult services that the Council made against the National Quality Assessment Framework (QAF). This was produced by the Office of the Deputy Prime Minister to regulate housing related support services. The QAF had core standards in areas such as Health and Safety, needs and support planning, risk assessment, safeguarding, complaints, and equality and diversity. There was an initial self assessment following a site visit to evidence policy and procedure followed in practice which was then triangulated via consultation with staff, service users and stakeholders. It provided a criteria to assess minimum standards.

8.9 In June 2008, when MTL was reviewed by the SAU Independent Chair there was a case conference and it was noted that systemic weaknesses still needed to be improved. There were also concerns that communication needs of people who use the service were not being addressed. By September 2008 progress under the Supporting People action plan remained slow and taking too long to progress. However, in October 2008, it was considered that improvement plans were now gaining real momentum but that the learning at MTL needed to be passed to other day centres in the County. This would require audit and proactive delivery.

8.10 Cases were allocated to social workers and reassessments and reviews were carried out at MTL into 2009. It was identified that the national drive was away from institutional day care. Those managing the safeguarding alert and its impact sought to take an assertive stance to work toward provision of alternative day care and community provision.

8.11 MTL was different to JDC in that it did not have a longstanding core team of people who had worked there for many years. The turnover at MTL was great and this in itself caused problems with continuity of care, service development and relationship building with people who use the service and outside partnership agencies.

8.12 The SAU Independent Chair followed due process and appropriately concluded the safeguarding alerts but did so relying upon the Head of Service who assured improvements had been identified and achieved at MTL and wider.
9. FINDINGS –PREVIOUS SAFEGUARDING CONCERNS

9.1 In both 2006 and 2008, clear plans and actions were in place under safeguarding process. The concerns in 2006 and 2008 were found to be valid but in each case there was a loss of momentum to maintain audit activity and senior management scrutiny. Both these periods represent serious lost opportunities to develop staff, the service and raise standards. This was also compounded by difficulties in bringing to fruition an overarching change programme to modernise the service in line with national initiatives.

9.2 The follow up of both these alerts in terms of what was required for frontline service improvement was not fully achieved. The commissioning and provider functions were somewhat at conflict.

9.3. This SCR finds that the governance system at that time in terms of securing improvements arising out of both safeguarding concerns was weak. The auditing and monitoring activity in 2006 and 2008 did not deliver the requisite improvement for people who use the service. It was not for the SAU Independent Chair to follow this process after the safeguarding matters were appropriately brought to a close.

In January 2013 further concerns were raised about the day service at MTL around similar issues found to be an issue in 2008.

10 RECOMMENDATIONS-PREVIOUS SAFEGUARDING CONCERNS

10.1 The SCR panel accepts the recommendations of the SAU IMR as set out below:-

10.2. That the Adult Care and Support Commissioning Performance and Improvement service make immediate arrangements for an independent multi-disciplinary team to immediately inspect Adult Care and Support day care centres for adults with learning disabilities. This inspection to identify where good and poor practice exists and take urgent steps to ensure the safety of all people who use the service. Despite internal audit activity, the SCR panel has not seen any firm assurance of this having yet been completed.

10.3 That the relationship between the commissioning and provision of services be reviewed and that systems are put in place to ensure there is independent scrutiny built into a monitoring and review cycle to support the safeguarding process and wider governance.
10.4 That Adult Care and Support revisit the 19 recommendations of the Commission for Social Care (Learning Disabilities Service Inspection Report 2007) and provide the Safeguarding Adults Board with evidence that they have been actioned and embedded into practice.

10.5 That in house services are commissioned using methods of co-production that produce an outcomes focussed framework that is clearly published, monitored and reviewed internally as other services which are external.

11. MODERNISING DAY CARE SERVICES

11.1 Running parallel to the safeguarding considerations in 2008 at MTL but unrelated was a consultation process undertaken in the winter of 2007/2008 to look at modernising day and other services. A change manager was appointed in 2008 to work with others to help plan for the future of day services and consider how best to ensure the service was modernised and progressive in delivery. It was not clear what reference points the change manager was working towards.

11.2 However on an objective analysis the service was seen as requiring modernisation and proposals were submitted in an executive report in March 2009 after some consultation. It was noted that learning disability day services in Cornwall had remained unchanged for some considerable time. Much of the configured service had been established in the 1980s when the underpinning ethos was to segregate people and training in large day centres. This meant that in many situations people had been travelling long distances to outdated buildings and were not always having the opportunity for meaningful activity that was local and integrated into the life of the community. The planned changes were designed to move away from reliance upon isolated and large day centres. The proposals were in line with the Department of Health’s “Valuing People Now” (2009), and there was a national drive to change the mode to delivery toward this ethos by seeking to enhance the lives of those with learning disability.

11.3 The proposed development plan as it related to the JDC was not to close the day centre as some staff and families of some of those who use the service seem to believe. This SCR has looked at this issue closely and carefully within the broad terms of reference for this SCR and has not seen anything to suggest that JDC was earmarked for closure and yet in this SCR some previous staff who worked at the centre during this time and some families maintain that there was an agenda to eventually close JDC. Other day services were earmarked to be closed and indeed dates given for the timescales for this be achieved. The plan was that JDC would
undergo a fairly radical transition so that it would become a full community resource and centre and bring learning disability services into the community. This was very much in keeping with research and evidenced based thinking at that time. These changes were to result in a management restructure to reflect the new nature of the service and also ensure positive outcomes. There was also to be an extensive skills development programme for all staff to ensure new enhanced minimum skill level for those staff working in support of those with learning disability.

11.4 These proposals were approved by the Council’s Executive but then challenged by families, staff and lobby groups and this led to a Single Issue Panel to deliberate upon the proposals for modernisation. The relevant recommendations are at Appendix 2. While lengthy, these extracts merit being included in detail in this report as they demonstrate the complexity of seeking to modernise day services within national strategy; the high level of anxiety from families and staff around any change to the service and very importantly the voice of the community and voluntary bodies who also inputted on the deliberation around day centres for learning disability.

12. FINDINGS-MODERNISING DAY SERVICES

12.1 Families who have inputted into this SCR report that at the time of the Single Issue Panel the dominant fear was of a closure of JDC as well as other day centres and that the view of many was that any change at JDC was a precursor to eventually losing the service for financial savings. That view prevailed. There was a high level of distrust between those seeking to facilitate the development plan and stakeholders. This SCR finds that the development plan as proposed was a genuine attempt to improve the service for the better and that people who use the service would have had their best interests met in modern service meeting national expectations and best practice.

12.2 Unfortunately the transition plan across the service to ensure there was adequate provision while services evolved was unclear. The key message of service improvement to benefit people who use the service was not adequately explained or delivered to families and relevant other stakeholders. They were left with many unanswered questions around the very practical impacts of the changes from a day by day perspective despite dedicated information events. Families and other stakeholders should have been involved in developing the plans rather than being informed of them in what was essentially an expedited consultation. Families, staff and other stakeholders were left not knowing any of the detail they needed to know. The message that dominated was that the changes were purely cost driven. There was also a distinct lack of strategy in how this service user group of people who use
the service would require great sensitivity and major additional support to deal with any transition. The SCR is not suggesting that all would have been happy with change but in terms of collaboration to design services within a national context, and then win trust, hearts and minds of people who use the service and their families for the transition work required, the way the development plan was conveyed was unsuccessful.

12.3 There was a lack of sophisticated lines of communication and the decision to outsource worked against collaborative working with partner agencies, people who use the service and families. There needed to be a clear transition plan for change at a pace that was tolerable for the most sensitive and complex person who uses the service.

12.4 On reflection now, and while inputting into this SCR some families appreciate that the proposals to use JDC with a wider remit and more linked into the community would in fact have been an improvement and that the plans to provide enhanced skills training for frontline staff and managers with minimum skill standards to improve staff skills could only benefit their relatives at JDC at that time. However, they report that the sound and positive proposals to modernise the service at JDC got lost in the focus in resisting any of the day centres being closed and a resource being lost. Many therefore resisted any change in its totality.

12.5 During and following the Single Issue Panel process plans to modernise and redesign the service stalled and in fact initiating any change was very difficult. Development work did eventually commence around a staff restructuring exercise which ran from March 2011 to November 2011. An alternative delivery plan was produced post the Single Issue Panel recommendations. The work around enhancing staff skills and setting minimum standards around this did not happen effectively as the Single Issue Panel recommendations diluted much of the development proposals and drew the senior lead into rethinking the whole plan. This was unfortunate as while the Single Issue Panel made key and valid points around people who use the service, engagement and the need for improved professional assessment of needs, the momentum to increase skill sets of frontline staff which included JDC were lost.

12.6 Also while not suggesting that the Single Issue Panel meant for this to occur, the sense from both the Director of Adult Care and Head of Service was that after that deliberation, modernising the service was going to be difficult. In certain parts the Single Issue Panel stated they agreed with the ethos of the development and greater integration of people who use the service into the community but gave very prescriptive recommendations. Staff and families read this to mean that it would never be legitimate to close services or change the operational delivery model. That
was very unfortunate as the ethos of the developmental proposals were anchored in sound thinking around the care of those with learning disability in accordance with national thinking at the time and the associated professionalism and skilling up of the workforce at JDC and other remaining centres was a positive development. There was a valid recognition that there was a need to improve the nature and quality of the service across and including JDC.

12.7 While it is a legitimate criticism that the pace of change and people who use the service consultation could have been managed more effectively the fact that the original development plan could not be achieved, albeit with some adjustment represents a major lost opportunity to have brought the service structure and ethos in a modern delivery model. The Director of Adult Care and Head of Service then embarked on a programme of trying to introduce new ways of working with a more community based approach via a restructure but at a time when the relationship with staff at JDC and senior management was very poor.

12.8 When speaking to those who use the service for the SCR this was limited to those who wanted to speak as the panel members are strangers and also some service users clearly lack mental capacity and have higher needs and are particularly vulnerable. Some said that historically they would get very bored at JDC, sitting in the big hall and the main structure was around meals. Some said they found the noise and so many people together at the same time quite hard to cope with. They also said some staff they did not like and were scared of them as they would shout and tease and that also some of the others were very kind. Some said that when they needed help with hygiene staff were not always around and they had accidents and that made them feel ashamed and they would stay in one place until home time. Some said that they have lots of ideas of how they would like to spend their time but that they have to do as they are told and that it is not easy to say no or for their ideas to be heard. Some said they would never complain and would not know how to do this exactly. They would not stop coming though as a number had real awareness that their families needed some time without them. Many felt they were a burden to their families and to staff. These insights were very striking and this review found that there is very little said, written or conveyed in any other way about what those service users actually think or want. One service user reported that in over a decade this SCR was the first time that he had ever been asked what he thought or wanted. He said this in a matter of fact way and despite many of those who use the service having loving and caring families. In the course of modernisation there must be inherent in the care being given for users of the service to input on a daily and longer term basis on how the service should be run and what this should include. This is basic care around dignity, communication skills, respect and engagement with those whose needs should be central. This would go a long way to empower those that use the service and make them feel valued as they should be. The tragedy in speaking to the selection of those who use the service and in some cases their families was that there is virtually no insight that there are other models of care that are far superior to the model used at JDC. The same could be said of some of the longstanding staff that inputted into the review also.
13. RECOMMENDATIONS- MODERNISING DAY SERVICES

13.1 Planning and delivery of service redesign and development should be at a pace that people who use the service can tolerate and take into account the need for people who use the service to be part of the development plans, rather than these be presented as a finalised plan. Therefore the stakeholders need to be involved at inception and evolution points and stakeholders must also understand the very real budgetary pressures on all services. This transparency would go some way to rebuild trust and relationships.

13.2 To all intents and purposes the service at JDC still requires modernisation. The SAB and all stakeholders are recommended to assimilate and use as a primary design template the document produced by the Social Care Institute of Excellence which was first produced in 2007 and remains good on the core principles today. This document and guidance is “Community Based day Activities and supports for People with Learning Disabilities - how we can help people to ‘have a good day’.” (SCIE guide 16). The core principles are that a “good day” is when people:-

- Are doing things that have a purpose and are meaningful for them
- Doing things in ordinary places, that most members of the community would be doing
- Doing things that are uniquely right for them, with support that meets their individual and specific requirements
- Meeting local people, developing friendships and connections and building a sense of belonging

13.3 Adult services should abide with the following extract of the checklist for community developments as set out in the above guide:-

- The support and service network being developed should include individualised provision for people with higher support needs so that they can access ordinary opportunities
- Avoid using segregated, special buildings run by the learning disability service
- Have supported employment provision that targets young people in transition
- Have a target of four more people to secure paid jobs
- Develop more social firms and helping more people into self employment
• Provide whole life support away from people’s homes that is person centred
• Modernise day services to be operating in places where people are alongside members of the public
• Set up activities that involve members of the public alongside people with learning disability
• Support those with learning disability to contribute positively to the local community

13.4 The Panel recommends a move away from a limited, static and less structured provision as the JDC follows but to move towards a community based model with skilled staff to support wide range of activities to bring the best quality of life possible to the individual and encourage independence and confidence so that each person can learn and develop and lead as ordinary life as possible.

13.5 Mechanisms must be put in place immediately that empowers the voice of those using the service. Modernisation must be achieved with skilled carers who can overcome the fear of change and any communication difficulties.

13.6 There may also be a place for peer review with centres coming together under one management to bring consistency and a check and balance.

13.7 If there is to be one manager per centre it is recommended that there be a rotation of managers

14. FRONTLINE AND SENIOR ACCOUNTABILITY

14.1 A major feature of this SCR has been the perspectives and perceptions of the frontline staff and culture at JDC and staff performance management and standards. On one hand there is a strong body of opinion that see the previous staff grouping as insular, operating in closed shop culture with informal management, operating outside the boundaries of a professional and modern service. On the other hand some previous staff (including those that managed the staff at JDC for a considerable number of years) state that JDC was run for the people who use the service and in a progressive and professional manner. As indicated earlier on this report the staff grouping pre suspension in 2011 was very much a group with very few new staff over decades and most knew each other socially as well as being colleagues. This extended to some of the families who use JDC. When suspensions were made some families knew a number of the suspended staff on a social level as well as carers of their relatives. The location of JDC and the demographic does work
against JDC in that recruitment will always be from a relatively small pool of communities.

14.2 Families and people who use the service are split in their views of the historic management of JDC. Some know the staff suspended personally and have felt there has been a great injustice against them and that they did not have concerns. While others much prefer the current management system which is more formalised and consider that care planning and what is on offer for their relatives has actually been improved. Most however, consider the way that the suspensions took place and the gap it left at JDC in terms of a large number of unfamiliar staff coming in was ill considered and did not appreciate the impact this would have upon people who use the service who had worked with some of the original staff for a considerable number of years and in some cases decades.

14.3 This SCR in looking at staff culture considered supervision and senior management support. Any frontline workforce should be supported by clear strategic direction from senior managers and corporate leads who are accountable for ensuring good standards of care, but also the HR function should be such that there is a culture of strong operational management embedded in robust frontline management. This should be in accordance with and aligned with employment law, staff workforce development, equality and diversity, health and safety and formal performance management processes. In the best organisations this HR function is proactive. What is apparent from this SCR in the time period agreed in the terms of reference is that the operating model for the HR function was reactive and also in 2006, poorly resourced.

15. FINDINGS- FRONTLINE AND SENIOR ACCOUNTABILITY

15.1 On a look back exercise for the HR IMR for this SCR it is noted that there have been a significant number of employee relation issues emanating from JDC including several suspensions. During the past 12 years there have also been significant occasions where health and safety concerns were raised. Training of staff did not always mean adherence to formal management processes or standards of care. On an objective appraisal JDC was a poorer performing centre. There were management failings at JDC over an extended period of time. While the management team at JDC were accountable for the running of the centre and staff performance there was also responsibility lying with senior managers and HR have to manage this. The HR system pre 2010 was much less sophisticated than now and performance and trend analysis was simply not being proactively managed. There was also a blurring of roles and accountability between the Head of Service and Director of Adult Care and at times the Head of Service took on too much.

21
responsibility which did work against the Director being much more proactive in approach and gripping the difficulties in the service effectively. The dynamic was not a helpful one as the lack of boundaries and formality between the two roles meant that the corporate governance required to support the managers dealing with the service post November was not in place and it was certainly disparate pre 2011. This left middle managers without proper and appropriate supervision so the frontline was able to drift and operate in a way that was unchallenged and became entrenched over many years. One such middle manager who had knowledge of the 2006 issues at JDC and then came back to assist after November 2011 advised the SCR that the service had not changed in that time and none of the learning from 2006 was embedded or frontline staff held accountable by any level of higher management let alone accountability at a director and therefore corporate level. The management structure as at 2011 is at Appendix 3.

15.2 In 2009, the seven former county, borough and district councils merged and the new council began a significant period of transformational change. A new head of HR was appointed in 2009 and a new service model increased the strategic capacity particularly in the area of organisational development and change and learning and development. These changes did bring positive and tangible improvements to the HR function. In 2011 when allegations were made by a whistle blower these were considered by HR and senior management immediately and action taken. Where the system was less effective, was around the interface between involving the police and safeguarding and that is explored more later in this report. It was also clearly a serious challenge for HR and the Head of Service to deal with staff who were not subject to criminal charges but still needed to be investigated around capability but with a sense of proportionality. This was partially addressed by the report of the internal investigator who looked at these matters outside the remit of this SCR. The summary of that investigation echoed the HR IMR in terms of a poorly performing day centre but one in which frontline staff were very underdeveloped from a training perspective and in fact lacked knowledge of current best practice in the field of learning disabilities. The staff grouping represented a wide range of abilities and training records for the historic period are disparate and poorly kept.

15.3 No particular focus was put upon JDC as part of the restructuring process in 2011, nor was it ever suggested that JDC would be one of the day centres to close but in the six meetings held with staff from September 2011, senior managers were struck how staff at JDC remained vehemently against any change and that were rigid in their views that the service did not require change internally or indeed in nature. Families supported this stance though some of those who have inputted in to this SCR now say that they can now understand that JDC did require changes and were fearful to say anything negative at that time though they knew the service was far from perfect.

15.4 Families report that they were told by staff that if they did not support their opposition JDC would close later on with nothing in its place for their relatives. They
also had genuine concerns for their relatives who relied upon carers they knew though it was accepted that those carers may not be highly qualified. When problems arose the families took this to the JDC manager rather than raise safeguarding alerts. Families were not well versed in how to do that and would defer to the manager. It should also be noted that most of those who use the service are transported in and home again as adults. Therefore relatives report they had limited opportunities to observe staff/people who use the service interacting or the environment in which their relatives were being cared for. Those who use the service are vulnerable and not all would be able to report anything untoward.

15.5 Some of the previous staff contributing to this SCR having reflected on past events stated that they were not really aware of other ways in which a day centre could operate. While they did have some basic training they do appreciate now that JDC was being managed in what many would call within unprofessional parameters but that this was how it had always been and the team was very protective of maintaining that status quo. During a meeting in 2010 to discuss the changes there was a core of staff from JDC that stood out in that they behaved unprofessionally throughout the meeting, continuously speaking over the presenters and seeking to disrupt the meeting. The trade union representative was shocked by the behaviour and commented the presenters needed “a bullet proof vest”.

15.6 Two families also describe care concerns during 2010. When questioned why they didn’t raise this as a safeguarding alert or challenge this they say they felt the manager was kind in other ways and they did not want to rock the boat for their relative attending. They also say that after the Single Issue Panel deliberations they did not wish to bring attention upon JDC for fear of that being used as a reason to close or change the centre.

15.7 As it was after the Single Issue Panel deliberations and recommendations had the effect of staff believing that going forward no day service could ever be closed and effectively that the panel had endorsed the current care delivery model. When the development plan was revised to an alternative and less contentious plan as indicated above, senior management still faced major difficulty in engaging staff at JDC for a restructure which was to at least address some of the skills issues identified. Despite this senior staff did produce alternative plans to develop JDC which triggered a restructure of staff and it was toward the end of that process that the whistle blower made allegations in November 2011.

15.8 The incoming interim manager who came in to assist was faced with a large gap in the workforce. Thirteen staff had been suspended in all and also around five others of the permanent staff took sick leave. Experienced staff were drafted in from other services and an agency although it was quite a task to bring this mixed group together to maintain the service. The interim manager showed immense energy and commitment to make positive changes at JDC in the face of some staff being hostile, as well as having to manage distressed people who use the service and families. By the time she left to hand over to others on 7 May 2013, there were real improvements.
15.9 When a number of the SCR panel visited the centre they reported back in March 2013 that having seen the environment before this was much improved and also having spoken to people who use the service and carers there was clear evidence of activity taking place and of increasing links with the wider community. However they did see that there were divisions between agency staff and original staff members. There was also anxiety around original staff returning to work but the whole atmosphere of the centre was much improved. HR processes were in train at this time which is outside the remit of this SCR. One of the SCR panel members also raised the fact that the Service Improvement plan said that care planning issues were still being worked through and formal supervision for staff embedded. At every SCR panel meeting assurance was sought around the other day services but audit there has been slow and this has been actively discussed with the Chair of the SAB and the corporate team.

15.10 At an event to which all stakeholders were invited on 7 November 2013, there was acknowledgement that the service had improved in the face of major concerns over recent months and years. The suspension of placements that had occurred following the allegations were formally lifted on 6 August 2013, nearly two years after the index allegations. It was confirmed then that there had been significant and continuing improvements in all aspects of care at JDC. This SCR would not disagree with that view though there will need to be continuous and committed management at local and senior level to embed the cultural shift. The original staff grouping were largely scattered by then with only a number of the original staff now working at JDC with a new but experienced manager.

16. RECOMMENDATIONS – FRONTLINE AND SENIOR ACCOUNTABILITY

16.1 The SCR panel accepts the recommendation of the HR IMR and in many respects the issues that this SCR has considered, are from a HR perspective already in progress. Much of the recommendations are about reinforcing the good people management practices that are expected to be implemented across all services. The recommendations are:-

16.2 To establish productive working arrangements between the Head of Service team and the frontline local management teams. These arrangements should be built on a strong bond of trust, respect and confidence.

16.3 That the senior management team identify service direction and development and set out explicit standards of care expected to be delivered and to be appraised formally. They must also ensure there is stronger governance of performance. This has not yet been fully achieved and is explored further in relation to commissioning risk and governance.

16.4 It is essential that there are strong and competent managers leading the staff group at JDC, aspiring to being held up as a centre of excellence. Senior leads need to ensure that the focus of the management team has the interests
of its customers at the forefront of every idea, process, decision that takes place at JDC and this needs to be embedded within the behaviours and values of the workforce.

16.5 The whole staff group need to accept that JDC now has a serious reputational issue, which needs to be addressed, owned and delivered by each and every employee that works at the day centre.

16.6 A robust bespoke performance monitoring system needs to be established to ensure the senior management team are able to identify whether improvements are being delivered with strong and clear accountability lines for delivery on this quality indicator.

16.7 The HR IMR quickly identified that good management information was not readily accessible/available. It is therefore recommended that a review of key HR performance indicators are identified. This could include:-

- An in depth diagnostic of Learning and Development training for staff at JDC.
- A review of resourcing decisions to identify any deficiencies within the established safer recruitment practices.
- Identification of management practices in relation to monitoring and managing sickness absence (referrals/welfare visits/return to work and capability management activity).
17. PARTNERSHIP WORKING

17.1 The importance of partnership and multi-agency working for this service group cannot be underestimated.

17.2 The police IMR did not identify any learning from the concerns expressed around JDC outside the remit of the criminal case. NHS Cornwall and the Isles of Scilly identified the need for training to staff around human rights. Peninsula Community Health IMR had no notable learning points.

17.3 Professionals from several agencies were going into JDC but not often. Given this was a day service GP’s were not involved as any part of a multidisciplinary team at JDC. Social workers worked with senior management in 2006 and 2011 to improve the assessment of needs and risk that each individual person who uses the service required. There was key worker arrangements for staff to be linked to individual people who use the service. The care planning in place was largely single agency and it is reported that some of this documentation was held on computer and only some staff could access as it was password protected. This did however mean that other agencies, professional staff and interim/ agency staff would not be able to access this important information easily. Previous staff explain that some staff were not confident or comfortable using the computer for care planning so there was no uniform system to care plan, what to include or how to store.

17.4 Some of the people who use the service were also receiving health funding under continuing healthcare but assessor nurses had very little need to go in to JDC and there were no reported concerns from those professionals. Also the police occasionally used JDC to hold police surgeries (in a discrete area of the centre). The IMR’s do not refer to any concerns expressed while JDC was used by others.

17.5 The partner agency that had the most involvement was the local mental health trust which also provided Learning Disability services. In 2011 they had 25 users with complex needs and learning disability open to their professionals. This did not include the five victims of alleged wilful neglect. There were more alleged victims but the police had to consider their rationale very carefully around this and evidential thresholds. Also there was some consideration in some cases that the safeguarding process would be the most appropriate way to proceed.
18 RECOMMENDATION- PARTNERSHIP WORKING

18.1 The SCR panel accepts the recommendations of the CFT IMR:-

18.2 Joint working - CFT and JDC to formulate agreed expectations and standards for sharing information and working collaboratively.

18.3 CFT Learning Disability Service and Adult Care and Support to identify sources of advocacy for JDC people who use the service ensuring it is available or offered to all people who use the service.

18.4 Learning from MTL Safeguarding in 2007-8 to be shared with CFT Learning Disability managers and staff.

18.5 CFT learning disability staff to offer to be involved in JDC Induction training.

18.6 If CFT continue to offer some education to JDC, a formal arrangement and protected time commitment be agreed.

18.7 The review would also add that CFT training leads may be best placed to support JDC staff and managers understand the legal framework of the Mental Capacity Act in that some of those using the service lack or have questionable mental capacity. This group represents particular vulnerability and it should be identified and understood who has, or lacks mental capacity.

19. COMMISSIONING GOVERNANCE AND RISK

19.1 The need for senior scrutiny is appropriate for all commissioned services and is the check and balance for sound governance, particularly important where there is the same organisation commissioning as well as providing the service. How else can the commissioning side know that what is being providing is fit for purpose? This does not happen by osmosis and requires systems and processes to gain that assurance. Therefore it is fair to say that as well as missing the opportunity to further professionalise the staff at JDC, as a result of concerns in 2006, the informal style of management within JDC was matched by the informal senior scrutiny which lacked continuity and drive. After four months, interim management was pulled out in 2006 and the status quo at JDC was re-established.

20 FINDINGS-COMMISSIONING GOVERNANCE AND RISK

20.1 Where the same organisation is commissioning and delivering a service in house the commissioning function must be governed in such a way to act as a quasi-regulator to obtain valid assurance that the service being provided is safe. This
should be owned at Head of Service level but also a wider and defined risk matrix to be reported direct to the Director of Adult Care and in cases of evidenced institutional concerns to the executive leadership team. In this way those leading commissioning can be assured that it can identify failing or weak providers and work with those services to either secure long term and sustainable standards or close the service as unsafe. This should all be underpinned by strong and formal contract management.

20.2 The physical state of the buildings and furnishings at JDC remained unchecked for many years. When the interim manager went in the whole building needed a deep clean, and considerable work to make it safe and in accordance with health and safety legislation. The boards blocking sight into the office were taken down and the lighting issues addressed and requests for repairs submitted. This was done while trying to maintain service delivery and in truth JDC would have benefited from a short closure so that this work could have been done more quickly and extensively. The kitchen also required serious attention to bring it up to health and safety standard.

20.3 As a commissioner this level of underinvestment, lack of senior management inspection and failure to grip health and safety issues should not be permitted to occur again. A visit by SCR panel members in August 2012 indicated very clearly the major challenge in improving the environment and in fact triggered the SCR panel suggesting the Director of Adult Care that a closure to deal with the poor environment was highly desirable. That was not to criticise the efforts of the interim manager or staff at that time but the physical improvements could only be superficial at that stage.

20.4 Commissioning governance was also weak around ensuring proper assessment, care planning and risk assessments. There are differing accounts on whether all service users has these completed for and with them and where this information was stored but the reality is that the overwhelming evidence is that as the commissioners the Council did not have the requisite profile care data to inform service needs or formally quality benchmark its own in house service. Care planning and assessment has improved after a great deal of work by staff on the ground but the sense is that there is still a level of informality in the relationship between the function of the Council as a commissioner and provider and that lack of check and balance can only work against quality, governance and against the best interest of the people who use the service, their families and other stakeholders. The Director of Adult Care during the salient time was conflicted having responsibility across both functions. The contractual environment around contracting this service on formal grounds was non-existent but there are evidenced improvements to that during the course of this SCR. There is however still some way to go on this aspect.
21. RECOMMENDATIONS- COMMISSIONING GOVERNANCE AND RISK

21.1 The Executive Board should formally health check the status of commissioning governance and risk to now be able to meet legal and national expectations.

21.2 Any weakness/adverse events around this function need to be recorded on a risk register and the ownership and accountability stay anchored in the Executive.

21.3 A positive reporting culture is required to report adverse events or serious incidents at JDC. The framework for this needs to be revisited and revised.

21.3 Development needs for commissioning staff at all levels needs to be addressed to produce a highly skilled team delivering this function with clear expectations on quality.

21.4 Core quality standards for day services need further development and embedding. It is suggested these mirror the quality and judgement standards that the CQC expect as these are sound judgment standards as reviewed in the “Learning Disability Services Inspection Programme-National Overview” June 2012. This can then provide a firm framework against which services can be appraised.

21.5 The Commissioners need to formulate a policy on dealing with poor or failing providers including in house services. This needs to include a contingency and continuity plan should a service need to be closed for an interim period or otherwise.

21.6 The Council’s “Wellbeing, Early Intervention and Prevention Commissioning Strategy 2012-2015” touches on some of these themes but does not elaborate upon how the strategy will be achieved in all areas relevant to the policing and assurance for day services.

22. LACK OF NATIONAL REGULATION

22.1 Many learning disabled services in other care settings are regulated by the national health regulator, the Care Quality Commission with appropriate registration requirements and quality assurance standards against which the service and setting is judged and graded. The regulatory framework for other services means that in those settings LD people who use the service are afforded an additional layer of protection and indeed a commissioner and/or provider would be obliged to declare...
evidenced compliance with standards of care across a number of care domains. There is also a process of enforcement action ranging from temporary suspension to a closure notice. However, under the current regime day centres such as JDC fall outside inspected services. At the time of this SCR the inspection regime toward adult social care is be refreshed and enhanced as set out in “a Fresh Start for the Regulation and Inspection of Adult Social Care” 2013.

23. FINDINGS - LACK OF NATIONAL REGULATION

23.2 It is likely that JDC would have been deemed unfit to remain open in 2006 and in 2011. The state of the buildings alone in 2011 would have indicated to the regulator an environment which at that time was not fit for purpose or meeting health and safety regulation, even without any consideration of staff performance and safeguarding. As far as can be ascertained the health and safety executive were not involved at JDC and the fact that there was not a serious incident involving a person who uses the service, staff member or visitor to JDC sustaining injury.

23.3 The Director of Adult Care declined to temporarily close the service and yet had this been a service regulated by the Care Quality Commission (CQC) it would have undoubtedly had its registration and service suspended and probably a warning notice given which could have resulted in a closure.

24. RECOMMENDATIONS- LACK OF NATIONAL REGULATION

24.1 The SCR panel accept and adopts the second recommendation as stated in the IMR from the independent author for the SAU which states:-

24.2 That the Safeguarding Adults Board make a submission to the Department of Health and the National Learning Disabilities Champion that an Independent Regulator is necessary to protect adults with learning disabilities within day care services, citing this review. The most appropriate regulator for this service would be the Care Quality Commission.

25. CONCLUSION

This SCR has demonstrated how a lack of governance infrastructure at multiple levels can allow a service to exist unchanged, underdeveloped and largely with a
workforce that simply did not have the skills, insight or incentive to deliver a progressive service over some decades. This was compounded by missed opportunities to embed learning from previously identified concerns. The service at JDC has been very limited with little scope to change lives for the better or indeed truly permit those who use the service a voice. At the heart of this has been the lack of check and balance between the commissioning and provider functions of the Council which remain under one organisation. It is hoped unanimously by the review panel in this SCR that this report acts finally as the catalyst for change and that this is met with commitment, energy and imperative.
APPENDIX 1

Terms of Reference

Introduction

The Cornwall and Isles of Scilly SAB Serious Case Review (SCR) Guidance has been considered and this SCR is sought under the criteria contained therein. While there has not been a death of a vulnerable adult there is sufficient multi-agency concern to merit a SCR in the face of alleged multiple abusers and it is considered in the public interest to proceed. The Safeguarding Adults Board, SAB, has established guidance for conducting serious case reviews and this also offers a clear route for multi agency learning from experience.

Purpose

Embodied in the terms of reference for the SCR is the overarching purpose which is as follows:-

- To establish whether there are lessons to be learnt from the circumstances of the case about the way in which relevant professionals and agencies have or are working together to safeguard vulnerable adults
- To inform inter agency and multi-agency practices as they relate to safeguarding vulnerable adults
- To develop best practice by the learning which will emanate out of the SCR
- Identify lessons clearly in the overview report on a single and multi-agency basis and define expectations as to changes required to improve outcomes and in what timescale.

The SCR panel will be led by a Chair who will be supported by expert advice from a legal advisor from Cornwall Council, a learning difficulties specialist from NHS Cornwall and the Isles of Scilly and a SAB representative form the Learning Disabilities Partnership Board.

It is anticipated that all participants and panel members attend each panel meeting. Given the complexity and broad nature of this SCR it is anticipated that the panel meetings will exceed the two panel meetings that the SCR guidance indicates would be the norm.

Timescale

The SCR guidance states that the work should be completed within 6 months of the SCR being formally commissioned and Terms of Reference agreed. However, it is acknowledged that where an SCR relates to serious institutional abuse or where
multiple abusers re involved then such reviews are likely to be more complex and may require more time.

There is also an on-going criminal investigation that must not be prejudiced by the SCR process.

**Specific terms of reference.**

- The SCR sets out to obtain an independent, fair, and objective appraisal of all relevant facts and factors pertaining to the management of the John Daniel Centre (JDC) from a multi-agency, commissioning and provider perspective, in the face of current allegations of abuse and neglect.
- The SCR will be conducted in the spirit of openness and fair play that avoids hindsight bias, and any bias toward any one agency or individual involved.
- The SCR will look at contextual data such as previous safeguarding or management concerns around JDC and the inter agency response to this.
- Contextual and historic data for the SCR will span from 1st January 2006 to the current date (May 2012)
- The SCR will include a commissioning risk profile of the JDC over this period of time incorporating a consideration of governance toward delivery quality and standards of care in as far as can be ascertained given the passage of time.
- Specific consideration will be given to events and outcomes arising from the Morley Tamblyn Lodge safeguarding case of 2007-8 and whether learning has been embedded.
- HR processes will also be considered from January 2006 to May 2012, as to the performance management of staff at JDC; implementation of previous recommendations and the effectiveness of the whistle blowing policy.
- The SCR will objectively analyse both single and multi-agency input into outcomes and safeguarding of vulnerable adults at JDC and highlight areas for improvement and also areas of good practice.
- Once the investigatory stage of the SCR is concluded the overview writer will produce an overview report for the SAB and an executive summary to be considered for publication.
- Where appropriate, service users, relatives and families will input into the SCR subject to any sensitivities toward the mental capacity of service users and the on-going criminal investigation.
APPENDIX 2

10.4 Cornwall County Council – Extract from Report of the Day Services for Adults with Learning Disability Single Issue Panel

Recommendation 1:

Through its consultation and engagement with users of the service, carers, staff and other witnesses the panel believes that day centres play a key role in the health and well-being of people with learning disabilities in Cornwall.

When meeting with people who use the service, many stated that they wanted day centres to stay open, and expressed concerns about what they would do without day centres. Panel Members met with carers at informal meetings across the county and the majority of people greatly valued the services provided by the centres. However some carers did express concern at the gradual reduction in activities undertaken by some centres, as felt that the centres were being closed via the back door.

In the Carers Survey, one of the top five responses for what carers thought was ‘very important’ in relation to the person they look after was ‘Structured Day Service’, and when asked ‘What would you like in the future?’ – A number of respondents referred to day centres being kept open, and in response to the question ‘What elements of the service do you feel needs to be kept’ responses included ‘all of it’ and ‘continuity of service’.

In the day centre staff survey – 95.5% of respondents felt that day centres will still be needed in the future. And when speaking to day centre managers they expressed the view that a structured day service model with a permanent base is needed to maintain friendships, options and choices.

The panel also heard evidence from Exeter and District Mencap Society of the experiences in Exeter when those day services were modernised. It was explained that when the modernisation plans were initially discussed people were assured of improved services and more choice. It was stated that this did not materialise, instead it was felt that many opportunities had been lost, the system was very fragmented, and now the modernisation had happened, it was considered that it would be very difficult to change things. The panel were advised that Exeter were now looking at forming a social enterprise.

The panel received and reviewed written evidence from an author who had written papers for ‘Professional Social Work’ on day centre modernisation. It was argued ‘that the resources centre of the future did not have to carry with it the burdens of the past such as insufficient number of suitable staff necessary to encourage and support community integration or the restrictions imposed by bureaucracy. The two way flow concept and the centres of excellence concept still had much to offer and buildings were still a vital component for development until reliably validated research could come up with more appropriate strategies.’
Written evidence by the Learning Disability Coalition – a 15 member organisation alongside an advisory group made up of leading academics, MPs and Peers and others with expertise in social care and finance – was also reviewed by the panel. In relation to this evidence the panel noted that families and people with learning disabilities wanted fulfilling lives and to take part in employment, leisure activities, further education and continuing education through life and day services. However, it was noted that the report said that these activities were all being reduced or cut, transport provision was often not available and people spoke of having great problems in doing the things they wanted to do. The report ‘Tell it like it is’ also confirmed that people with a learning disability are a hugely diverse population. One solution will not suit all and a person centred approach, backed by sufficient funding could make a huge difference too many thousands of lives.

10.5 Recommendation 2:

The panel received a lot of feedback from stakeholders who believe that dedicated bases for day services are very important, the issue of a dedicated base was one of the top 5 responses in the Carers Survey in relation to what respondents thought was ‘very important’, day centre staff also cited this as one of their top 5 responses as being ‘very important’.

Representatives from Cornwall People First attended a formal panel meeting and supplied written evidence to the panel, one of the common threads they identified through the people they have spoken to is that bases are important to people. Through their informal meetings with users of the service, carers and staff the importance of a dedicated base was frequently raised. Staff explained that dedicated bases are needed with suitable facilities such as a kitchen, resting facilities, adequate storage, relevant equipment, accessible and are needed as a back-up facility should external activities get cancelled for whatever reason. The Newquay Project that currently operates without a permanent base, explained the difficulties they experience with nowhere to store equipment, how its limits the flexibility of activities that can be offered to people who use the service, and causes an additional workload for staff who support the service.

People also told panel members that by having dedicated bases with suitable facilities the needs of those people with complex needs can be more easily met.

10.6 Recommendation 3:

The panel reviewed evidence from “Valuing People Now” that states that if day services base their minimum standards on the needs of people with a complex needs, the service will be the right service for everyone. The panel fully supports this principle.

Another of the common threads identified by Cornwall People First through the people they have spoken to is that people want to be sure that people with complex needs will be looked after.

The panel heard and received written evidence around a pilot project in Cornwall of the 9 centres in the county working specifically with advocate groups on how to
pursue targets within Valuing People Now. The written information on the consultation meetings held in the Spring of 2009 stated that ‘throughout the county there was a consistent voice in support of more life opportunities for people with complex support needs, a group of people who are seen to be the most overlooked at this point in time.’

Through their informal meetings with carers the needs of people with complex needs were raised, carers commented that there is a need for activities need to be delivered at an appropriate level and suitable for all those present, people stated that they believe that day centres can provide this opportunity, and that centres should in future provide options for people with complex needs.

Staff explained to panel members that activities provided in the wider community would not meet the needs of people with complex needs, as they are aimed at a higher level to meet the needs of the wider community, and people staffing this activities would not have the time or skills to meet the needs of those with more complex needs. Staff felt that community engagement can be supported to happen within the centre environment, enabling those with more complex needs to be offered opportunities to be included.

In their recent presentation to the panel the Directorate of Adult Care and Support stated that the service will provide support to people with complex support requirements in a way that does not separate them from other people, and the panel welcomes this.

10.7 Recommendation 4:

Through engagement with key stakeholders and evidence provided the panel has identified a number of basic operating principles that it recommends. The panel recognises that the key to the level of services received by an individual is their assessed need and this should be the key determining factor in terms of the level received by an individual

(a) As stated above the panel, through evidence gathered, believes that dedicated bases are crucial.

(b) & (c) Through the carer’s survey, the panel found that for the majority of those that responded ‘the person they cared for’ attends the day centre for 5 days, in addition many carers stated that day services provide structure, routine and regularity. Through the informal meetings carers told panel members how day centres provided them with a break/respite which enabled them to cope, this is backed up by the statement from East Cornwall Mencap which states that 5 days care is essential for many family carers and the day centres have been the major security for many families’. Therefore the panel believes that day services should be available and base their minimum standards on 0900-1600hrs 5 days a week, unless there is clear proof that this is not required by service users. The panel is not proposing that everyone attends all day 5 days a week, but that people should have the option of purchasing this.
The panel has received mixed feedback on the issue of evening/weekend opening, in the users survey 77.4% of respondents stated they would not like to go to the day centre one evening or day over the weekend instead of the day they normally go, and in the carers survey and the day centre staff survey one of the top 5 responses for what respondents thought was ‘very unimportant’ in relation to the person they look after was ‘flexible opening times’.

However in the comments section of the surveys, there were comments relating to the need for extended opening hours. In addition at one of the meetings with carers all the carers present agreed that a mixture of days, evening and weekends would be ideal, whereas at another the parents/carers present felt that weekdays was the best time for the service to run, they did not feel a need for evening or weekend activities as they felt it could impinge on the service offered during the week.

Within the written statement from East Cornwall Mencap it stated that ‘day means waking hours not just 09.30am to 15.30pm Monday to Friday. It includes evenings and weekends.’

(d) Through the informal meetings, the staff fed back to panel members that they felt the current level of activities and person centred approaches were not fully appreciated within the current centres. Staff stated that person centre-plans need to be live and continually updated, in the staff survey in response to the question ‘What changes would you like to see in the future?’ many respondents stated listening to and involving service users, giving people who use the service more choice.

In written information supplied regarding a consultation in 2009 it states that ‘most people demanded a continued support to develop better Care Assessments but especially to encourage more person centred planning for everyone.’

Therefore the panel would like to see more person centred planning in the future delivery of the service, this is reiterated within the proposals recently presented to the panel by officers which state that ‘person centred working needs to improve to make sure that we do not have a ‘one size fits all’ service.

(e) Through the surveys and through meetings with staff, carers and people who use the service the importance of trained, familiar staff has been frequently mentioned. This is discussed in more detail in the ‘Staffing Arrangements’ section below.

10.8 Recommendation 5

One of the proposed principles put forward by the Directorate of Adult Care and Support is for ‘gradual and evolutionary change’ the panel supports the principle of the need for change, however it is the extent of the original proposals that the panel has concerns about.
• The panel would want to see that any changes made were realistic, viable and sustainable; based on the assessed needs of people that use the service and driven by both the users and their carers. The basic framework upon which to build a structured and progressive service already exists.

• The panel would not want to see any changes that led to a reduction in the current levels of service. People who use services and their carers deserve nothing less than service support that is appropriate, secure, stable and structured.

• The panel would not want to see the service fragmented.

• The panel broadly supports the long term future vision briefly presented by the new community access manager, of day centres with an extended role which builds on existing resources and offers expanded services. These could include social workers, welfare advice, and support for carers. This would enable people who choose to access smaller bases or services within the community to do so but provide a safety net when these changed or ceased to meet the needs of the person attending.

At their meetings with carers, staff and people who use the service the panel heard how upset and distressed people were when dates for the closure of some day centres were announced. However, when talking to stakeholders and when reviewing the comments from the surveys panel members identified that there is a lot of frustration and uncertainty associated with the day centre modernisation plans, and people would like to know and fully understand what it being proposed and when.

Therefore the panel believes that future changes should be clearly communicated to all stakeholders in advance.

10.9 Recommendation 6

The panel has received feedback from a variety of sources that day services provide people with the opportunity to create and maintain friendship groups, people who use the service stated in the survey that one of the top 5 things they like to do at day centres is ‘socialising with friends’, and in the day centre staff survey ‘friendship groups’ were one of top 5 responses for what respondents thought were very important in relation to the people they provide a service for.

At the meetings with carers across the county, many people spoke about the value of day centres in facilitating friendships for people with disabilities, and one of the concerns carers had about the closing of day centres was the breaking up of social networks.

In addition the panel heard evidence stating how day centres provide good circles of support with many users and advocates wanting them to stay open, as it was a social benefit to many of the users to meet people and participate in activities as a group.
In the written information supplied by Cornwall People First they stated that the people they have spoken with have said that people want to keep the friendships they have built up over the years.

The panel is therefore pleased that the latest proposals from the Directorate of Adult Care and Support state that the service will ‘support people to keep their friendships as well as develop new friendships’. However the directorate has stated that they key factor in terms of the level of service received by an individual is their assessed need and that maintaining and forming friendships will not be an element of everyone’s care plan, and that some support offered in this area will be through informal services that can be developed in partnership with other agencies.

1. Core Principles
The panel recommends the continuation of day centres and believes they play an essential role in the health and well-being of people with learning disabilities in Cornwall. It calls upon the Cabinet to recognise this within the in-house service or in any future commissioning of services.

The panel recognises that services may change over time, but is concerned about the extent of the changes that were originally proposed.

If a decision is taken to commission day services the panel would like reassurance that its recommendations are taken forward within any commissioning arrangements.

2. Core Principles
The Panel recommends that a core principal of day services is the need for a dedicated building based service. This is crucial to the delivery of the service and offers a bridge to the wider community. This need was underestimated in the original proposals for the modernisation of day services.

Centres should be large enough to accommodate the needs of people with learning disabilities, including people with complex needs, with satellite hubs in communities as required. The panel was pleased that the Directorate of Adult Care and Support has recognised the need for specialist facilities in a range of buildings in their latest proposals.

3. Core Principles
The panel recommends that any service provision should base its minimum standard on the needs of people with complex needs, and that this must be an integrated service. The panel would not want to see a stand-alone service for people with complex needs that could isolate people who use the service. Those that wish to be able to use satellite services can still do so. One important consideration overlooked in the original proposal was the need for people to have a choice to attend the most suitable and appropriate service to meet their assessed needs.

4. Core Principles
The Panel recommends that basic operating principles are adopted for the service and should include:

• Dedicated building bases.
• Centres should as a minimum standard operate from 0900-1600hrs unless there is clear proof that this is not required by service users. The panel does not intend that everyone attends from 0900-1600hrs, but for those people that do want a full day they should have the option of purchasing one.

• Centres should as a minimum standard operate 5 days a week – unless there is clear proof that this is not required by service users. Again the Panel is not proposing that everyone attends for 5 days a week, but if they would like to they should have the option of purchasing this.

• Centres should operate in a person centred way. Economies of scale would need to be applied in relation to location of the bases.

• Trained familiar staff working across bases

5. Core Principles
In principle the panel supports the process of gradual and evolutionary change subject to the detailed comments contained within the report.

6. Core Principles
The panel supports the directorate view, as presented at the panel meeting in October 2010, that the service should support people to keep their friendships as well as help them to develop new friendships

10.10 Recommendation 7

Panel Members reviewed the ‘Property and Financial Issues Report’ and ‘Cost Feasibility Report’ provided by the Councils Finance Department and Property Services at one of their formal meetings. The panel believe that further clarity is required in relation the costing’s provided, and would like to see more detailed, fully costed business plans developed.

The panel is pleased that the Directorate of Adult Care and Support has recognised the need for ‘clear business plans for the development of the service’ in the future proposed principles outlined at the panel meeting in October.

In particular the panel recommends that these business plans contain detailed and accurate information on full costing, including the cost of staffing, refurbishment costs, the buildings involved and facilities required and clear identification of the people that will be using the centres/bases.

10.11 Recommendation 8

In recent proposals put to the Panel from the Directorate of Adult Care and Support, there are proposals to ‘work with partners to develop a solution through partnership, social enterprise, community interest companies.’
The panel has discussed this and at this stage feels it does not have enough information or knowledge on this issue and therefore recommends that further information on the Social Enterprise and Community Interest Companies is brought to the Health and Adults Overview and Scrutiny Committee via the business plans mentioned in recommendation number 7.

The panel has received verbal clarification from the Directorate explaining that the proposals are around local community groups being formed around the service, not about the service becoming a Community Interest Company.

10.12 Recommendation 10

The panel has received mixed views on using the centre as a community resource, some carers saw it as a positive, using the centre as a hub for community needs, others were more cautious stating that in principle this sounds like a good idea but were concerned about the impact on people who use the service. When talking to one group of carers, they all expressed concern about the centre being used by the general public. They felt that the service users were all very vulnerable, and that whilst the public at large were generally very accepting, there was always the fear of bullying, abuse, name calling and worse.

However this same group of carers unanimously felt that the Centre should be used as a community centre for all people with a learning disability, including those people who are at present receiving no support. The carers also felt that professionals such as learning disability social workers, care managers etc. should also be based at the Centre.

When visiting day centres, panel members saw and heard of good examples of mutually beneficial relationships and commercial use, for example the use of the kitchens at Murdock and Trevithick for the café, and the pottery workshop at John Daniel Centre. The panel is therefore supportive of such relationships where it brings people into day centres, but is less supportive of proposals to operate the centres from, for example, library spaces, one stop shops etc.

In the Cornwall People First report to the Single Issue Panel, it states that people they have spoken with have said that they want to be part of their local community; they want the same chances to access local services and leisure opportunities as everybody else.

The panel broadly supports the brief outline of a future vision presented by the new community access manager, of day centres with an extended role which builds on existing resources and offers expanded services. These could include social workers, welfare advice, and support for carers this would enable people who choose to access smaller bases or services within the community to do so but provide a safety net when these changed or ceased to meet the needs of the person attending.
10.13 Recommendation 11

The panel has received mixed feedback on the Locality Forums. At their panel meeting in May panel members received evidence from officers on the Locality Partnership Forums. Members were informed that Locality Partnership Forums were established bringing together representatives from a wide range of people including Adult Care and Support staff, advocacy services, users, carers and community members. They met quarterly with an aim to shape services locally and reflect need and priorities. They were restructured but the effectiveness of them remained an issue with a lack of consistency throughout the county. The forums were still ongoing with over 160 members. The panel also received a copy of the Locality Partnership Forums Terms of Reference.

However, some carers told panel members that they felt people’s views were not truly being reflected at the forums, that certain people took over meetings, and one person felt they hadn’t been able to get on the forum because their views didn’t match other people’s views. Carers also expressed concerns around the lack of reporting structure for locality forums and confusion around the aims and objectives of the group.

Information to the panel was brought on work undertaken to assess the capacity of self-advocates within each of the nine day centre sites to contribute to the Locality Forums, with the aim of getting more self-advocates actively involved in the forums.

The panel therefore recommends there is a review of locality forums to cover its aims, objectives and membership. The panel also believes that people who use the service and carers need to be actively involved in the forums.

10.14 Recommendation 12

As part of its terms of reference the panel wanted to examine consultation and engagement with users, carers, advocates and other relevant stakeholders, and therefore received evidence from representatives from the Learning Disability Partnership Board (LDPB) at their panel meeting in June, and received a written submission from the co-chair of the LDPB.

The panel received information on the LDPB’s governance arrangements, its role, how it is structured and how it engages with users, carers and other stakeholders. The Panel were told that the LDPB accepted that more work needs to be done to engage with carers and enable greater representation of their views.

This view is backed up by the results from the survey where 75.7% of carers who responded stated they had not been contacted by the LDPB for their views, and 82.1% of respondents stated they had not contacted the LDPB to put forward their views. In addition panel members spoke to carers about the LDPB, some of whom expressed concerns including that the LDPB did not act on their behalf, carers stated that people who purported to represent carers were not doing so. Carers also expressed the view that people who sat on the LDPB should be elected and unpaid.
Similar concerns were expressed in the written statement supplied by East Cornwall Mencap Society, in particular that people with learning disabilities and family carers should be elected to LDPBs by their peers, whom they feel would then make it a truly consultative body.

As a result of this the Panel recommends there is a review of the LDPB, its membership, role and engagement strategy with carers and people who use the service.

10.15 Recommendation 13

The panel received similar feedback in relation to the Carers Partnership Board, in the Carers survey – 77.8% of respondents stated they had not been contacted by the Carers Partnership Board for their views, and 83.6% of respondents had not contacted the Carers Partnership Board to put forward their views.

The panel heard evidence from the Commissioning and Partnerships Officer – Carers at a formal panel meeting. The officer advised that the membership of the Carers Partnership Board was under review, as it was important to have a balance of carers and professionals and that more carers were being sought to sit on the Board.

As a result of this feedback the panel considers that the Carers Partnership Board should put in place an engagement strategy with relevant carers to ensure their views are represented.

The panel therefore agrees that day services /centres should play their part in preventative services or a wider group of people with learning disabilities in Cornwall.

10.16 Recommendation

The panel has spoken to many carers and other stakeholders who have expressed concern over the consultation undertaken by the Directorate of Adult Care and Support prior to the original proposals being taken to the Executive in March 2009.

In the carers survey, 66.1% of respondents felt that had not been consulted on the modernisation of day services, and 78.3% of respondents stated they did not know what the proposals were to replace day services.

At informal meetings carers told panel members that they felt they had not been consulted by the council on day centre proposals, they did not feel valued or listened to, feeling that comments they had made had been disregarded. Carers expressed frustration and disillusionment with the process to date.

The panel heard evidence that as part of a pilot project in Cornwall the 9 centres in the county were working specifically with advocate groups on how to pursue targets within Valuing People Now. The feedback from carers and users was that they did not feel listened to as they were rarely asked to participate in decisions which would affect their future.
The written evidence from East Cornwall Mencap Society also illustrated the lack of confidence their organisation had in consultation process, in particular the lack of a full, honest and meaningful consultation with all service users of every ability and their carers/families/advocates/deputies.

At one of their formal panel meetings, Members received evidence from the Directorate of Adult Care and Support on the consultation process previously undertaken by the Directorate, including a formal consultation process undertaken in the winter of 2007/2008. It was stated that this consultation was widely advertised and 18 events were held with users and carers and another 6 for special schools and colleges. Officers used the Consultation and Participation Framework and Good Practice Guide to inform the process, the panel; were informed that consistent comments and issues were raised across the county. The panel were then advised that a Change Manager was appointed in 2008 who initiated a series of meetings designed to help develop the plan for the future of day services, the outcome of these meetings formed the basis of the Health and Adults Social Care Overview and Scrutiny Committee report of January 2009 and the Executive report of March 2009.

Legal advice given at the time, and confirmed again at the meeting, was that the consultation had been succinct and sufficient to meet legal requirements. There was not a specific requirement to have a 12 week consultation as consultation should always be tailored to the need at the time. If a change was made to policy, there would need to be a further consultation and this would have to be looked at in detail.

At this meeting members had asked for a copy of Cornwall Councils present consultation policy. It was noted that at present, Cornwall Council did not have a policy, but that the Cornwall Strategic Partnership, of which the council was a key partner, had an Engagement Strategy and accompanying guidance. Members were advised that this was not in place at the time when a consultation on the Day Centre modernisation proposals was undertaken. A ‘Consultation and Participation Framework and Good Practice Guide’ was in place.

Members feel that a Cornwall Council Consultation Policy would be useful and recommend that Cornwall Council consider implementing a Consultation Policy.

10.17 Recommendation 19

The panel were informed that one of the challenges faced by carers is finding the right people with the relevant knowledge and training to provide an acceptable level of service to the people who they care for. A clear message that came through the results of the surveys was the importance of trained, familiar staff. In the Carers Survey of the top 5 responses for what respondents thought was ‘very important’ in relation to the person they look after was (1) Trained staff and (2) Familiarity of staff, this was echoed in the Day Centre Staff survey where again these two issues were within the top 5 responses for what respondents thought was ‘very important’ in relation to the people they provide a service for.
Information supplied by Cornwall People First stated that one of the common themes arising from the people they have spoken with is that people trust the staff that they have come to know and who know them.

When speaking to carers and staff similar issues arose. Day Centre Managers stated that the people who use services need familiarity and trust with the people who care for them. Carers spoke of the importance of reliability and experienced knowledgeable staff. Some also expressed concern about the costs of using agency staff. Day Centre managers stated that whilst they recognise that there is a continuity issue when using agency staff, managers felt that day centres would not function without agency staff. In the Carers Survey and Day Centre Staff survey the issues of staff shortages was mentioned by some respondents as something that 'you dislike about day services' and something that 'is not working well'.

As a result of this feedback the Panel believes that familiar and trained staff are very important to the delivery of the service. The panel recommends therefore, that in the delivery of day services:

1 There are familiar staff.

The use of agency staff is reduced to ensure consistency and quality of care.

There is adequate staffing to work across bases ensuring cover for sickness and holidays.

That staff need to be supported through improved training

Staffing Arrangements
The panel supports the recommendation that mutually agreed flexible working arrangements for all staff are employed.

10.18 Recommendation 20

Through their work the panel has identified issues with assessments, in the Day Centre Staff survey 42.5% of respondents stated that the people they support do not have FACE assessments and 35% of respondents did not know if the people they support have FACE Assessments, in the comments section of this survey respondents also expressed concern about the assessments. In addition when speaking to day centre staff, staff members expressed concern about inaccuracies and discrepancies associated with FACE assessments, and people’s needs not being correctly identified through assessments.

In evidence supplied by East Cornwall Mencap, a letter from the national Mencap organisation was included. This stated that ‘Mencap believes the assessment process as the key to the success of care and support. A failure to properly assess an individual can be costly for both the local authority and the individual. Mencap calls on the assessment process to be open, transparent and honest from all participants.’
At panel meetings in May and June, following a request by the panel, Members received data and other information on needs assessments. Having reviewed this information Members believe that it is difficult to plan a service without a consistent approach to needs assessment and reliable data on the process, and therefore recommends that further work is undertaken on this area.

10.19 Recommendation 25

The issue of safeguarding was raised in the assessing staff questionnaire and through engagement with managers and staff in the day centres. 100% of the assessing staff that responded felt that day centres played a role in safeguarding vulnerable adults.

Day Centre Managers stated that parent/carers need to know that their loved ones are safe. Outside activities need double risk assessments and parents/carers need to be involved in these assessments.

When panel members attended a Cornwall People First Forum meeting the worker supporting the group spoke about the importance of going to a place where people are going to be safe, with people that can give medication, and suitable changing facilities. Another worker spoke of how day centres provide a back-up for people who live on their own.

At one of the meetings with carers, parents/carers stated that safety and familiarity are paramount; one carer stated that care in the community was felt fraught with difficulties; they felt the element of safeguarding would be lost and under the duty of care loved ones should not be put at risk. Carers stated that centres were a trusted place not only for service users but for their parents/carers, where they know staff are trained to spot signs of abuse/neglect; carers were concerned that this vital element would be lost.

In the statement supplied by East Cornwall Mencap they state that ‘the centres role in protecting and detecting abuse must be acknowledged and encouraged.’ The panel therefore feels that day centres play an essential role in the safeguarding of vulnerable adults and felt that this must be recognised and robustly supported.

10.20 Recommendation 26

Having undertaken a comprehensive review on Day Services for Adults with Learning Disabilities in Cornwall on behalf of the Health and Adults Overview and Scrutiny Committee, the panel believes that it is important to continue to monitor the issues and recommendations of this report and therefore recommends that 6-monthly updates on progress are brought to the Health and Adults Overview and Scrutiny Committee.
10.21 Recommendation 27

Throughout the review panel members have talked to people who use the service, their carers and families, staff and other stakeholders, many expressed their frustration at not being kept informed of progress in relation to the modernisation of day services.

The panel recommends that the Directorate of Adult Care and Support contacts carers, people who use service, staff, and other key stakeholders to inform them of the findings of the SIP and show how the service will be developed in the future.

**Monitoring and Feedback**
The panel recommends that 6-monthly updates on all of its recommendations are brought back to the Health and Adults OSC.

**Monitoring and Feedback**
The panel recommends the Directorate of Adult Care and Support contacts carers, people who use the service, staff, and other key stakeholders to inform them of the findings of the SIP and how the service will be carried forward in the future.
Day Service Structure – 2011

1. Director of Adult Services
2. Head of Service
3. Senior Manager - Community & Support Services
4. Day Centre Manager
5. Deputy Centre Manager
6. Senior Day Centre Officer
7. Day Centre Officer
8. Care Assistant
APPENDIX 4

Main References


11. Social Care Institute of Excellence (2007) Community-based day activities and supports for people with learning disabilities –How we can help people to have a “good day”


