

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Rosanna Gardens
Centre ID:	OSV-0001711
Centre county:	Wicklow
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Limited
Provider Nominee:	John Hannigan
Lead inspector:	Karina O'Sullivan
Support inspector(s):	Michael Keating
Type of inspection	Unannounced
Number of residents on the date of inspection:	13
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 23 February 2016 09:30 To: 23 February 2016 18:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the fifth inspection by the Health Information and Quality Authority (hereafter called HIQA) of this designated centre operated by Sunbeam House Services Limited (hereafter called the provider) which is a company registered as a charity. It is governed by a Board of Directors with the CEO (Chief executive officer) nominated to act on behalf of the provider.

The purpose of this inspection was to follow up on the previous four inspections which found varying degrees of non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013, the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 (hereafter called the regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the standards).

Inspectors also wanted to monitor improvements and seek clarity in relation to the action plan submitted as part of the previous inspection conducted on 19 May 2015.

Unsolicited information had also been received identifying concerns in relation to the overall management of the organization and the designated centre. This information related to the care provided, provisions of food and issues pertaining to an external investigation. The external investigation was conducted on behalf of the provider as a result of an allegation of abuse involving one resident. Inspectors found on the day of inspection residents had access to food; however, inspectors were concerned with the management of the designated centre and the lack of progress in relation to the

implementation of the recommendations following the external investigation.

This designated centre comprised of three houses all located on the same grounds, and was home to 13 residents.

As part of this unannounced inspection inspectors met management, residents, and staff members. Inspectors observed practice, spoke with staff, residents, the person in charge and the senior service manager. Inspectors viewed elements of personal care plans, assessments, health plans, medical records, accident and incident records. Audits, medication management documentation, meeting minutes, staff supervision, training information, policies and procedures and risk management protocols were also viewed by inspectors.

The long term issue of the inappropriate mix of residents was not being addressed despite plans been submitted to HIQA on 2 December 2015. Inspectors were informed by the person in charge and staff members the plan submitted to HIQA in December 2015 was no longer being implemented due to funding issues. The providers representative also confirmed this plan had been replaced in November 2015.

At this inspection, inspectors found very little improvements had been made across the four outcomes inspected. The management of the designated centre at times negatively impacted on the quality of residents lives from an emotional, physical and psychological perspective. Inspectors found evidence to suggest the governance and management structure of the designated centre was not implementing the improvements required. This resulted in some residents living in an unsuitable environment due to the impact of some behaviours on other residents. These issues had been identified by the organization itself through internal audits and reports. HIQA had also consistently identified this issue through previous inspections.

The outcomes relating to health and safety and risk management, safeguarding and safety and governance and management were all found to be in major non-compliant with workforce found to be moderately non-compliant with the regulations.

This inspection was discussed at feedback with the person in charge and the senior service manager. On the day of inspection the provider nominee was not available to meet with inspectors. Therefore inspectors went to the organizations head office to meet with and provide feedback to his representative.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

This inspection focused upon specific components of this outcome. Overall inspectors were not satisfied the health and safety of residents, visitors and staff were promoted within this designated centre. Measures had not been put in place to prevent incidences from reoccurring pertaining to self harm and aggression. Inspectors were not able to see evidence of review of incidences to bring about learning in order to mitigate the risk of future occurrences.

From speaking with the person in charge and reviewing documentation inspectors determined there was a system in place to monitor accidents, incidents and near misses in the designated centre. However, incidents based on self harm and aggression and violence relating to residents were not managed appropriately. Repeated incidences were being recorded and no means of mitigating the risk to fellow residents was evident to inspectors. For example, residents living within specific units (houses) could access other parts of the centre freely with no consideration given to the impact this had on all residents living in designated centre.

Incidents of aggression were recorded as physical peer to peer assaults. There were also regular incidences of residents being subjected to naming calling and verbal insults. This occurred by peers entering their homes without permission. Staff described this as an ongoing issue. Inspectors viewed copies of accident and incident forms provided to them, which also confirmed this issue.

The person in charge informed inspectors accidents and incidents were reviewed within the organizations head office. However, the person in charge stated these reviews were not made available to the person in charge. The providers representative confirmed they were reviewed and audited. Copies of these reviews were provided to inspectors subsequent to the inspection. However, while these were provided, clear actions to mitigate risks were not identified. For example, incidents between residents were reviewed and signed off by senior management with review comments referring to awaiting available resources. There was no evidence of learning from the review of

incidents. Inspectors were not satisfied interim measures were in place or considered to adequately mitigate risk to residents.

Inspectors viewed a sample of resident's assessments pertaining to risks such as unexpected absence. These were found to contain sufficient information for the risks identified. Information incorporating the identification and management of the risks including control measures in place within the designated centre was also specified.

Inspectors also viewed documentation pertaining to safety for residents this information was documented within resident's "My safety plan". These documents outlined safety considerations for residents within their home and while out in the wider community. This information was present in a person-centred format.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

This inspection focused upon specific components of this outcome. Inspectors found the safety and safeguarding of residents, visitors and staff were promoted within this designated centre.

Inspectors viewed behavioural support plans and noted clear guidance for staff in the identification of triggers to behaviours and de-escalation techniques. However, inspectors were concerned in relation to the lack of clarity among the person in charge and staff members in relation to relevant interventions. For example, within one behaviour support plan the requirement to use C.P.I. (crisis prevention interventions) techniques as a last resort was evident, this was reviewed on 7 February 2016.

Inspectors discussed this with staff, the person in charge identified no C.P.I. techniques were being used within the designated centre. However, other staff members identified C.P.I. techniques were required at times and referred to a specific occasion which had occurred during the previous six months. This was also documented within a resident's file.

Inspectors were also concerned in relation to the procedure around administering p.r.n. (a medicine only taken as required) medication. The protocol in place for one resident and was contradicted by staff when inspectors queried the duration of time prior to administering the medication. Inspectors highlighted this could lead to confusion among staff members resulting in the administration of medication incorrectly.

Inspectors viewed several incidences of documented behaviours displayed by residents these related to residents threatening each other. Inspectors viewed several incidences where the behaviours displayed from some residents impacted upon other residents lives leading to distress for residents.

Inspectors were concerned this form of behaviour was displayed on a regular basis. For example, one resident had over 44 incidents documented in the past three months. Staff were attempting to manage the situation within the resources available. However, the incidences were still ongoing on the day of inspection. Inspectors over heard incidences on the day of inspection with screaming and banging of doors and windows evident.

Inspectors were also not satisfied in relation to the appropriate management of staffing within one house in the designated centre. Some staff refused to work with individuals due to fear of allegations from residents. Inspectors viewed the policy document in relation to allegations and safeguarding this document stated "unfortunately, people working in services such as SHS need to be aware of the possibility of an allegation being made against them as an occupational hazard" the document described "protecting the staff member from further opportunistic allegations". Inspectors were not satisfied that this was an appropriate response to protect residents and staff.

Inspectors were concerned with the lack of clarity and progress in relation to areas of concern highlighted following an external investigation in 2015. For example, one recommendation stated "there is an immediate need for the organisation to examine and audit the culture factors which appear to be influencing practice and service delivery in the designated centre". The action devised by the provider on 27 October 2015 identified a staff member was "looking into where to get a sample of an audit tool". Inspectors were not satisfied this was a timely response to an recommendation identified as immediate. The senior service manager and the person in charge later identified they intended to speak with an external person providing training in April 2016 and seek guidance in relation to this. Another recommendation stated "serious consideration should also be given to providing accessible format information on safeguarding vulnerable adults to all service recipients in an organised manner which ensures this information is accessible, available and discussed between service recipients and relevant staff members/key workers". This was to be completed by 10 December 2015 on the day of inspection the person in charge informed inspectors this was not completed yet and other members of staff were not aware of this being completed.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

This inspection focused upon specific components of this outcome. Inspectors were not satisfied with the governance and management within this designated centre. An annual review had taken place as identified in the previous inspection significant areas of concerns came to the attention of inspectors during the inspection.

As part of this inspection, inspectors requested an update on the information submitted to HIQA by the provider on 2 December 2015. This consisted of three residents acquiring alternative accommodation. Residents stated they were looking forward to moving to another house. One resident stated "HIQA stopped us from moving", one inspector was shown a video by another resident identifying the same message. Inspectors asked for clarity around this area as HIQA was not made aware of any changes to the plan submitted to HIQA in December 2015 outlining the relocation of some residents. Inspectors were informed the plan submitted to HIQA was not in operation since November 2015. However, a second group of four residents were met with and plans had been devised to relocate to a different area. Residents visited the proposed home and identified bedrooms and purchased items. Residents were looking forward to the move and this was evident from both residents who met with inspectors on the day of inspection.

A meeting was held with staff on 30 November 2015 and inspectors received minutes of this meeting titled special staff meeting to discuss downsizing update. During this meeting one of the senior service managers identified the house no longer existed for the residents to move to. Front line staff identified the proposed house had been identified a year ago and since then work had been ongoing in relation to residents visiting the house. During this meeting staff also identified concerns in relation to the current mix of residents.

Inspectors viewed an internal audit conducted on 16 November 2015 where staff identified "the client mix is unsuitable to maintain a safe environment. This has been acknowledged and documented in previous audits. The physical environment does support safe care. The client mix however, means that some residents are kept apart and isolated". Staff had also raised these issues at monthly staff meetings. Another resident identified "they were bullied by other residents". Inspectors were not satisfied

with the actions arising from the internal audit which did not specify any action to improve this situation for residents.

Inspectors also followed up on recommendations outlined from the external investigation which took place in 2015. Inspectors were concerned with the lack of clarity and progress in relation to areas highlighted for example "serious consideration should be give to reviewing the current local governance, line management and reporting structure and systems within the designated centre with a view to redeveloping and reconfiguring the current structure where necessary. The action specified for this recommendation identified a "review of the local governance will be discussed with staff on Monday the 30 November 2015". However, inspectors received a copy of this meeting where local governance and management was not identified as an agenda item.

Judgment:
Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
This inspection focused upon specific components of this outcome. Overall inspectors found there were not appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services within the designated centre.

The assessed needs of residents were not met as one resident was assessed as requiring to one-to-one staffing support and this was not always provided. This was a consistent finding from previous inspections. The provider acknowledged in a previous action plan that one-to-one staffing could not be provided as required due to staffing issues. This remained the case.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Limited
Centre ID:	OSV-0001711
Date of Inspection:	23 February 2016
Date of response:	09 June 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The management and ongoing review of risk to residents from other residents within the designated centre was not effectively managed in order to mitigate to risk to other residents.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

To address the number and re occurring incidents pertaining to self harm and aggression two Community Support Staff will be recruited. One Community support staff will be allocated to the resident who has the highest number of incidents. The second Community support staff will work with the current staff to address the needs of all other clients.

Extra staff will reduce client access to others house without invite.

The recruitment of more staff will address the nature and number of incidents.

Timescale for recruitment October 31st 2016

Incident review – the number of incidents is currently reviewed quarterly by PIC and Senior Service Manager. Where there is an increase or trend in incidents this will be reviewed and referred to The Social Work Team.

Within the residence the following supports have been put in place:

Positive Behaviour Supports with reactive strategies have been identified and updated. Next review to identify what has been effective and working well is on July 26th 2016. A detailed social plan and daily activity plan is currently in place and reviewed with the Self Directed Living Team and Location Staff Team. Four meetings have been held since January 2016. A review of this process is scheduled for 27th July 2016 with Social Worker, Psychiatry Services, Sensory/behavioural support and representation from the Quality Team. Resident has more family contact and regularly visits home. Sensory Therapist has been engaged and a programme of supports has been identified around skills training and managing triggers for behaviour and in addition to environmental adaptations to support sensory needs.

A process to look at a workshop for residents entitled 'building bridges' is under development. The aim is to assist residents to overcome barriers to communication and facilitate positive relationships.

Proposed Timescale: 31/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The person in charge did not have access to the review of accidents and accidents within the designated centre. Therefore the measures in place to control and identify risks and learn from incidents in order to mitigate them was not evident within the designated centre.

2. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

Incident review – the number of incidents is currently reviewed quarterly by PIC and Senior Service Manager. Where there is an increase or trend in incidents this will be reviewed and referred to The Social Work Team.

The recruitment of more staff will address the nature and number of incidents.

Proposed Timescale: 31/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The procedure for administering p.r.n. medication to alter behaviour was not clear within the designated centre.

3. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

PRN Protocol in relation to one resident identifies the positive interventions required if the resident is becoming stressed. If positive intervention do not show signs of working at an early stage then the PRN protocol identifies the use of psychotropic medication within a twenty minute period or sooner if these interventions are ineffective and resident stress is escalating.

The procedure for administering PRN medication has now been updated to reflect the above plan.

Proposed Timescale: 02/06/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The use of restrictive practices was not clearly outlined within the designated centre.

4. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:

Personal Profile for one resident has been updated on 22/04/2016 regarding the use of a restrictive practice. CPI was discussed at team meeting on 29/04/2016 and will continue to be an agenda at team meetings from July 2016.

Proposed Timescale: 02/06/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inadequate measures were taken to identify and alleviate the cause of resident's behaviour as residents were subject to verbal and physical assaults from other residents on an ongoing basis.

5. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:

To address the number and re occurring incidents pertaining to self harm and aggression two Community Support Staff will be recruited. One Community support staff will be allocated to the resident who has the highest number of incidents. The second Community support staff will work with the current staff to address the needs of all other clients.

Extra staff will reduce client access to others house without invite.

The Plan for one resident has been updated on 22/04/2016 regarding the use of a restrictive practice- CPI technique and the possible need for PRN psychotropic medication.

CPI was discussed at team meeting on 29/04/2016 and will continue to be an agenda at team meetings from July 2016.

Incident review – the number of incidents is currently reviewed quarterly by PIC and Senior Service Manager. Where there is an increase or trend in incidents this will be reviewed and referred to The Social Work Team.

Proposed Timescale: 31/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The potential risk of allegations involving staff members was not appropriately managed nor was the policy document sufficient in guiding staff practice.

6. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:

New staff will receive training in Protection and Safeguarding and existing staff will receive refresher training if required by December 31st 2016.

Re potential risk of allegations to staff:

A local guideline will be developed in terms of staff guidance in relation to any allegations made against staff and this will be reflected in the Protection of Vulnerable Adults Policy.

Proposed Timescale: 30/09/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The service provided to residents within the designated centre was not safe, consistent or appropriate to the residents residing within the designated centre.

7. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

To address the number and re occurring incidents pertaining to self harm and aggression two Community Support Staff will be recruited. One Community support staff will be allocated to the resident who has the highest number of incidents. The second Community support staff will work with the current staff to address the needs of all other clients.

Extra staff will reduce client access to other houses without invite.

Proposed Timescale: 31/10/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staff were concerned about the quality and safety of care provided to residents within the designated centre.

8. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:

To address the number and re occurring incidents pertaining to self harm and aggression two Community Support Staff will be recruited. One Community support staff will be allocated to the resident who has the highest number of incidents. The second Community support staff will work with the current staff to address the needs of all other clients. Extra staff will reduce client access to other houses without invite.

Proposed Timescale: 31/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Arrangements were not in place to meet the assessed needs of some residents.

9. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

Two Community Support workers have been recruited to residence in order to skill mix. Completed 01/07/2016
To address the number and re occurring incidents pertaining to self harm and aggression two more Community Support Staff will be recruited. One Community support staff will be allocated to the resident who has the highest number of incidents. The second Community support staff will work with the current staff to address the needs of all other clients.

Proposed Timescale: 31/10/2016