D1 Final Action Plan - Aug 15

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

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

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

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

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9	6	In some respects the Learning Disability Service is perceived by many as peripheral to the work of the Trust. That mental health is the core work of the Trust. That even at a very senior level the issues relating to learning disabilities are “less important”. Strategic objectives, such as developing Recovery within the Trust, had less meaning to staff within the Learning Disability Service.	EDG ensure there is organisation-wide shared learning of the review of culture & practice across SHSC.	Board Development Session held on 6 May 2014 looked at the role of Board in developing the culture in the Learning Disability Service. Board reflected on the lessons learned and agreed a number of steps, as described in the Summary Report presented to 2 April 2014 Board. Risk to the quality of care in the provider service has been added to the Risk Register. Workshop held to share lessons leaned with lead clinicians and managers. Assistant Clinical Director held lessons learned feedback sessions with all provider services areas during 2014. Lessons learned from Culture and Practice shared with Service Directors in January 2015. Learning from the Coroners Hearing on the death by choking shared across the directorate and wider trust. Work on the Green Light Toolkit is being led by Rachel Warner.	
10	7	The inconsistencies highlighted within this report show how differences in management competencies and leadership skills are in someway responsible for the findings contained within it. Allowing ‘local interpretation’ to occur in regards to policies and procedures has further added to the inconsistencies of the implementation of numerous practices.	The Human Resources Directorate and Executive Directors Group consider the Trust’s current management development training provision for middle and senior managers in the LD Service and trust wide.	External contractor (Diversity Matters) commissioned to: * Enhance the review of culture and practice (7 days facilitated to-date) * Facilitate a reflective process with key leaders to better understand the systemic dynamics that have affected the Learning Disability Service. * Focus will be on cultural aspects, including belief systems and patterns underlying the practices, as well as considering larger structural issues. * Outcomes will be to consider and agree required interventions, workforce development and cultural/ belief system change that may be needed. All managers are accessing training on Crucial Conversations The LD Directorate has funded a programme of Supervision Training which has been opened up to the wider Trust HR clinics are held with managers to discuss issues of staff performance/sickness	
11	8	In some respects the Learning Disability Service is perceived by many as peripheral to the work of the Trust. That mental health is the core work of the Trust. That even at a very senior level the issues relating to learning disabilities are “less important”. Strategic objectives, such as developing Recovery within the Trust, had less meaning to staff within the Learning Disability Service.	All Board members, Executives and Directors review their respective services and responsibilities in the light of the findings of this report.	Board Development Session held on 6 May 2014 looked at the role of Board in developing the culture in the Learning Disability Service. Board reflected on the lessons learned and agreed a number of steps, as described in the Summary Report presented to 2 April 2014 Board. Board Development Sessions / sharing of lessons learned with other directorates scheduled for September 2014.	

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

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

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

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

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

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

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

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

Culture and Practice Review - Supporting Information

Summary of some of the supporting information available

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

KPMG Review of Residents' Monies

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

						A review of the Trust's Performance Framework is being undertaken that will confirm the on-going arrangements for Performance monitoring and Services Reviews for the 2015-16 year. This should be completed by February 2015. Full implementation of recommendation expected end March 2015.				
2		Review the Trust's organisational culture at all levels to identify development needs and opportunities. This should lead to a re-emphasis of the importance of accountability throughout the organisation and the provision of robust challenge where standards fall below those expected e.g. In relation to the management of residents' monies	Sep-14	Director of Organisational Development	• Each Corporate Directorate has been asked to identify priorities for action following the Culture & Practice Review. • Leadership development in the Directorate will include setting out expectations of managers and team leaders by the Directorate leadership team.	**January 2015 update** Achieved. Final Board response including actions to be taken across organisation approved by Board in December 2014 Leadership development group established. Work commenced in December 2014 to set expectations. All managers and team leaders trained on their responsibilities in the RFS operational guidance. Audits involving peers/managers showing compliance. In progress - peer review guidance in draft and shared at directorate service meeting in 2014. Peer reviews to commence March 2015. Achieved. Training has been running from July 2014 and a further 9 sessions booked to July 2015 Achieved. 8th January 2015 session held with Executive Director of Nursing, Director of OD/Board Secretary and ODG members to share the lessons.				

local protocols (Andy has sent)	
Cross-ref protocols Row 13 Cross-ref audits Row 19	
Rotation not taking place	
Cross-ref to Row 10	
MCA/DOLS practice group T.O.R evidence put in	
Cross-ref Row 13 for all evidence	
Cross ref to Row	
Cross-ref Row 13 for evidence on local guidance	
*new governance reporting structures, trust-wide	
* Staff briefing on Mansfield View emphasising accountability	

					• Performance Management processes in the Directorate will include an element of peer review • Challenging conversations training will be made available to all staff in leadership positions in the Trust. • We will share the lessons from the culture and practice review more widely with other Directorates - this will include identifying risks that arise from service user vulnerability - check whether we do this at ODG or separately.			AP 22	Cross ref to Row 24 Cross-ref Rows 21, 35 for LD gov meeting ToR and mins Cross-ref SU engagement with Row 4 Cloverleaf cross-ref Row 34
3		The Audit & Assurance Committee to provide greater levels of challenge to auditors and executives to improve its overall effectiveness.	Sep-14	Executive Director of Finance	• Board workshop facilitated by Beachcrofts under consideration by Chair. • Consider peer review of Audit Committee by external Audit Chair. • Review Attendance at AAC. • Establish Training Needs.	**January 2015 update** Board workshop facilitated by Beachcrofts scheduled for 24th February 2015. 360 Assurance facilitating peer relationships with Audit Committee Chairs. SHSC Audit and Assurance Committee to agree terms of reference for such relationships. SHSC Audit and Assurance Committee to consider and agree following workshop, peer review Review of Board Assurance Framework undertaken and considered by Board 5/11/14 and Audit Committee 21/1/15			

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