Bolton Council

Report to:	**CABINET**	
Date:	**11th March 2013**	
Report of:	**DIRECTOR OF CHILDREN'S AND ADULT SERVICES**	**Report No:**
Contact Officer:	**Bozena Allen, Interim Assistant Director (Adults)**	**Tele No:**
Report Title:	**Implementation of the Supported Housing Independent Review Recommendations – Final Report**	

Confidential / Non Confidential: *(delete as approp)*	(***Non-Confidential***) This report does **not** contain information which warrants its consideration in the absence of the press or members of the public
Recommendations:	The Cabinet is requested to note the progress made in delivering the recommendations from the Independent Review.
Decision:	

Signed:

Leader / Executive Member

Monitoring Officer

Date:

SUMMARY OF REPORT:

The report outlines the progress made to date in implementing the recommendations which were set out in the Independent Report into Supported Housing.

This is the final report to Members and focusses on the impact of the work carried out and the improved quality on the service being delivered.

The more detailed work has already been reported in previous reports to Cabinet and Executive Cabinet.

1.0 BACKGROUND INFORMATION

1.1 On 15th October 2012, an Independent Report into the abuse which occurred at one of the Council's Supported Living Units was presented to The Cabinet. The detail of the investigation and all the recommendations were accepted. A comprehensive programme of improvement work was put in place to be delivered over a 6 month period split into two phases:

- **Phase 1** October-January/February - ensuring systems, processes, structures, culture and management changes are made to the current service to ensure it is 'fit for purpose'.

- **Phase 2** December-March/April – development of a detailed vision for the service going forward both to ensure it is designed to meet a 21st century environment and to make a contribution to the Council's savings target for Adult Social Care.

2.0 THE PROGRAMME

2.1 The programme of improvement work consisted of 15 projects each of which aimed to address the recommendations in the Independent Report.

2.2 Management arrangements were put in place to ensure the plan was delivered to specification and within an agreed time line. These arrangements included:

- Corporate Oversight – Chief Executive and the Cabinet
- Informal Adult Briefings – Deputy Leader/Portfolio Holder Adults/Portfolio Holder Public Health, Director (Children and Adults), and Assistant Director (Adults)
- Strategic Programme Lead – Assistant Director (Adults)
- A Programme Manager to oversee the projects and ensure they stay to time and specification
- Lead Officers who will deliver the individual projects

2.2 Regular monitoring was established which included weekly verbal updates and monthly committee reports to the Executive Cabinet Member, weekly progress reports from Lead Officers with the Interim Assistant Director, written committee reports to Cabinet and reports to Scrutiny Committee. In addition regular updates have been held with the Trade Unions.

3.0 PROGRAMME ACCOUNT

3.1 The programme of work is now largely complete. A summary of the work carried out and the impact this has had is available in Appendix A. For more detail on how the recommendations have been addressed please see Cabinet/Executive Cabinet Reports from November 2012 – February 2013.

3.2 The recommendations have given the Council a real opportunity to review the practice, policies and procedures of the service. A significant amount of work has been carried out which has delved into all parts of this service.

3.2 The significance of the 'House H' report and the implications for the Council has meant that the pace of change and improvement to the Service has been fast but this

could not have been achieved without the full engagement of management, staff and Trade Unions.

3.3 The depth and scale of the recommendations meant that a whole system approach was essential to deliver real improvement. Staff have worked well across different departmental divisions in identifying dependencies and have worked together to resolve issues and achieve improvements to the service.

3.4 Managers of the service have expressed the feeling of empowerment and ownership which was previously absent. This has contributed to a significant shift in mind-set and culture of management and staff from being predominantly reactive to pro-active and positive.

3.5 Key changes and improvements made to the service include:

- Stronger and more visible leadership
- Implementation of a locality management structure
- A clear understanding of Safeguarding and the process for reporting
- Weekly house visits by managers
- Quality assurance visits
- Structured approaches to training and supervision
- Business intelligence reports and performance management
- Revised rotas which are efficient and based on the needs of the service user
- Revised and improved administrative systems and processes
- Improved communication
- Improved working relationships with the Trade Unions
- Locality based HR 'surgeries'
- Better inter-departmental working
- A more proactive and solution focussed management team

All of the above and other improvements have contributed to re-establishing a stronger management grip and creating a more confident workforce where ownership, accountability and responsibility have become the service mantra.

3.6 Throughout the programme staff have shown their continuing commitment to delivering a quality service to the individual service users. The changes in practice have reduced the levels of potential risk to service users by providing a greater focus on individual service user needs and better quality assurance.

3.7 A review of the service is now underway and proposals will be presented for consultation to meet part of the Department's savings targets.

4.0 FINANCIAL IMPLICATIONS

The review is contained within the financial envelope.

5.0 EQUALITY IMPACT ASSESSMENT (This needs to be attached to the report)

An initial / screening assessment has been undertaken and concludes that there will be no differential impact from this proposal, in respect of race, gender or disability.

6.0 HUMAN RESOURCE IMPLICATIONS

The interim revised working arrangements have involved on-going consultation with Trade Unions with support from HR.

Consultation with Trade Unions and staff will be on-going and will further consolidate the positive working relationship to move the Service forward within the framework set in the Action Plan.

7.0 RECOMMENDATIONS

1. The Cabinet is requested to note the report.

APPENDIX A

Programme Account

Recommendation	Account of work completed	Impact
1. Proactive and visible leadership of the service taking ownership of the issues and championing the improvement process	This recommendation has been fully implemented. Changes to the leadership and management of the service were made quickly with the appointment of an Interim Assistant Director responsible for delivering the recommendations and improving the service.	Senior management has become far more visible to the management team and the staff delivering the service which has reinforced accountability and established management grip. By holding weekly/bi monthly meetings with the management team this has improved communication and ensured that accountability and responsibility in the management team is strengthened. It has instilled confidence and empowered ASMs./SM/TL. A performance management culture now exists within the management team where issues are identified early and SMs and ASMs are held to account for their localities. There has been an overall shift in the culture- emphasising the expectation that the service user is always at the centre of the service. Staff continue to strive in delivering a quality service with greater transparency and accountability being evident .
2. A thorough appraisal of the quantum and quality of management and whether this can be brought to a uniformly high standard or whether other changes are necessary	This recommendation focussed on assessing the competencies of the management team and identifying areas of concern or risk where further training and support was required. The management team consists of the Team Leader, Service Managers and Assistant Service Managers but the work also included looking at the Administrative Team who are pivotal to the effective running of the service. It was identified early on in the project that not all staff were up to date with mandatory training including Safeguarding and	All staff have been brought up to the minimum standard in relation to their mandatory training, including: • **336** staff trained (including Bank staff) in refresher Safeguarding and Medication • **19** managers received refresher training for Supervision, Safeguarding and Finance Other priority training has been delivered to staff

	Medication. A series of refresher training events were put in place to ensure all staff had this basic level of training. A skills and competency audit was carried out with the entire management and admin team to assess what the gap was in relation to skill, knowledge and competency. The audit process consisted of a workshop with the management team where key roles and responsibilities were identified, observation work to understand the 'typical' day of an Assistant Service Manager and one-to-one support planning sessions with someone from outside the service. A further workshop was held with the management team to feedback findings and plan next steps. The audit also took into account feedback from the Quality Assurance visits. The Trades Unions were consulted throughout this process. The skills audit identified that there were skills gaps such as managing workload, assertiveness and IT. Much of the ASMs time was spent doing administrative work and that office systems and processes were time consuming and onerous. The audit found that there was a heavy reliance on the administrative team but that this team was under resourced and overwhelmed with the quantity of work.	where this is appropriate. All CRB checks are up to date (at the time of writing) Managers will be proactively using the Oracle Database to ensure staff's training is kept current and this will be monitored routinely at management meetings and through supervision. This will ensure staff have the relevant skills and knowledge to carry out their jobs effectively. Assessment of systems and processes was carried out to identify better ways of doing things. By improving the efficiency of office systems and processes, managers are freed up to focus more on service issues. As a result, the use of IT in the supported living homes may be piloted to improve communication with staff but also to improve the way information about service users is shared using the Carefirst care management system. Additional administrative support has temporarily been put in place under the supervision of the Head of Business Support. This has provided relief to the current Administrative Team whilst new arrangements are put in place or trialled. New and more effective ways of working have been introduced Some administrative tasks have been simplified and are now saving staff time enabling them to focus on other priority service issues. A Workforce Development Plan for 13/14 has been developed. The Plan includes the mandatory training that is required for all staff to ensure they have the skills and competencies.

3. A rebalancing of the relationship with the Trade Unions. Managers must be capable of managing the people who provide the service and need to be supported in this	This recommendation has been implemented. Bi-weekly meetings and monthly Joint Operational Group (JOG) meetings with the Director and Interim Assistant Director were put in place quickly and these have continued throughout the Programme.	The meetings with Trades Unions have proved to be positive and a new constructive working relationship has formed based on mutual respect where there is healthy challenge but not at the risk of not delivering a quality and safer service. These regular meetings will continue with the Director beyond the end of the Programme. Positive feedback from the Trades Unions continues to be received.
4. A model of the service that builds from the service user and the unit of the house upwards, with each service user having a holistic person centred plan with a granularity for deployment to be recorded in activity logs.	This recommendation has been implemented. Reviews have been completed for all 135 service users currently resident in the Supported Living Service. As an additional check, the last two reviews for each service user have been reviewed by the Director, the Interim Assistant Director and another Team Manager. An Admission Panel (includes the Director and Interim Assistant Director) has been established to ensure placements in the Service are appropriate and staff have the necessary skills and capacity to meet the assessed service user needs.	Following the reviews, it was identified that some service users' needs would be met more appropriately through offering a different type of service. This is being addressed. As a result of reviews, compatibility issues have been identified between service users in seven properties. An action plan is being drafted to ensure that these issues are addressed. The Admissions Panel has added rigour to the decision making process- approving and admitting individuals to the service ensuring no one is placed there inappropriately. Improved working relationship between Care Management and the Provider ensuring service user's needs continue to be met when they change.
5. Other roles and accountabilities need to be clarified and strengthened. It would be sensible to rethink the core role of the Assistant	The recommendation has been fully implemented. The remit was widened to include Service Manager and Team Leader and was included as part of the Skills Audit work (recommendation 2) Workshops took place with managers to clarify roles and	Managers now have a greater clarity regarding their responsibilities and accountability. Moving to a locality management structure has led to greater ownership, responsibility and accountability and strengthened management grip on the service. .

Service Manager (ASM)	responsibilities as well as identifying what support would be offered.	Enhanced business intelligence reports have given management greater oversight of the service and improved the decision making process. ASM 'champions' have been identified for aspects of work such as Systems and Processes, Carefirst, HR, Social Work and Quality Assurance. This has given ASMs a greater sense of ownership and, again, reinforces accountability and responsibility. As part of the budget efficiencies required a review of the service is underway which will result in greater clarity of all roles and responsibilities across the service.
6. Revised and active operating procedures and checklists are needed to demonstrate minimum high standards, together with clear escalation procedures where for whatever reasons they cannot be met.	This recommendation has been fully implemented. All relevant Policies and Procedures have been identified and made accessible on the Council's intranet site. Important policies such as Safeguarding and Medication have been made available in hard copy so that these are easily accessible by members of care staff in the homes. The following policies and/or procedures have been reviewed: • Challenging Behaviour and how to manage it • Supervision • Hand Hygiene • Confidentiality • Safeguarding • Shared Use of Equipment • Valuing Customer Feedback (Departmental complaints policy) • Whistleblowing (Corporate – see recommendation 11) In conjunction with the review of policy and procedure, a series	The profile of quality assurance has been raised as updated policies and procedures, including safeguarding, are now standard items in supervisions. Staff have been given the tools to carry out their job effectively with easy to follow, step-by-step guides leading to greater understanding of processes and expectations. . Safety and service quality are regularly checked and reported via weekly ASM and SM visits using a standard pro-forma. As a result, there is an increased confidence by management that risks will be identified earlier and acted upon. Both Care Management and the Provider are more aware of each other's processes and able to act proactively together to resolve any issues or respond to any concerns.

	of easy to use guidance notes have been produced for Supported Living staff which give them clear instructions and steps to follow. Examples of this include a flow chart and step by step guide to reporting a safeguarding concern; guidance on what Providers and Care Managers need to do in preparation for delivering effective reviews; and, guidance on clinical governance. Compliance with policies and procedures is monitored though the QA visits and the weekly ASM and SM house visits using the standard pro-forma. As issues are identified an improvement plan is developed and implemented. This is monitored by respective line managers. Closer working relationships have been built between the Provider and Care Management through monthly solution focussed meetings where issues and concerns are shared openly and constructively dealt with.	Effective feedback on progress has been provided between care management and providers leading to improved working together as partners.
7. Revised schedule for supervision and training, staff appraisal and development. This training must ensure that every member of staff has clear information on what is and what is not a safeguarding issue.	This recommendation has been implemented. The supervision policy has been reviewed and a standard format for supervisions put in place. Supervisions now include, as standard, discussions on the implementation of safeguarding and medication policy. A revised supervision frequency has been put in place with Service Managers, Assistant Service Managers and Care workers receiving supervision every 4/6 and 8 weeks respectively. Supervisions are booked across the service at least 6 weeks in advance. Planned and actual supervision is monitored as part of the Service Manager's and Team Leader's roles and responsibilities and followed up where there are issues.	Systematic and consistent supervision across the service has led to improved communication from management down to care staff. There is greater organisational grip because managers are meeting formally with their staff more frequently and following a standard format which is providing consistency and an evidence base which can be followed up where necessary. Management monitor who has received supervision and who have not and can therefore take necessary action. Scheduled supervision provides an additional quality check mechanism which is audited by management.

8. A new system of staff deployment led by management. This means a new (probably rolling) rota system apposite to the service model and which will be such that it provides real time information on staff deployment.	This recommendation has been implemented. Early in the Programme additional hours were offered to all permanent staff for a four month period. This is being extended to July following the transfer of ten properties to the Independent provider over the next few months. Interim rotas were implemented on 26th November 2012 and are currently being reviewed to take into account the budget efficiencies.	The offer of additional hours helped to fill the vacant hours and reduced the reliance on agency and bank staff. As a result this has led to a greater consistency and improved quality of service. Further changes to the rota will not be made until the transfer of homes to the Independent provider has been completed.
9. The person centred plans should be very explicit about the resources available for the care of each individual and what monies have been retained to run the service	This recommendation has been completed. Monthly meetings have been set up between the provider and care management to share issues and look to positively resolving them. Each house has an allocated number of hours to ensure service user's needs are being met. This was addressed through the updated reviews Financial arrangements are being reviewed between the Director/Team Leader and Finance lead. Letters have been sent to all staff from the Director clarifying expectations when working with Service Users and their finances. Further discussions and work is being undertaken to improve the processes to reduce any possibility of financial abuse.	Managers are fully aware what the expectations are around Person Centred Planning and there is now absolute clarity on the way resources are to be used for person centred plans. Person Centred Plans are now more individualised and tailored to suit service user needs. Improved standardisation of Person Centred Plans following the refresher training for managers. There is greater awareness amongst care staff of how service user finances should be managed.
10. Recognise the good practice that most staff undertake and celebrate what is good in the service.	This recommendation has been implemented. Staff have been kept up to date on progress made since the original report and have been given the opportunity to comment on and influence further changes where necessary.	Feedback from staff following the briefing sessions has been positive. Staff have expressed that there is improved communication between managers and themselves and are more aware of the overall direction of travel for the service

	Special lunchtime briefings were held on 19th December 2012 and 8th January 2013 providing staff feedback on progress, reminding them of their responsibilities but also recognising the significant amount of good work that is going on in the service. Recognition of staff achievement is now being routinely included in staff supervision.	Compliments from customers have increased and these are now routinely included in the monthly *Customer Voice* publication and shared at supervisions.
11. Change and re-launch the whistleblowing policy with an independent person able to receive concerns.	This recommendation has been implemented. The Council's Whistleblowing Policy has been reviewed and was approved by Cabinet on 14th January 2013. Concerns can now be raised through the Borough Solicitor in confidence. The policy was consulted upon with the Unions and staff. Following the publication of the report, Senior Management met with the 'whistleblowers' involved in the House 'H' case on a regular basis to hear and act on their concerns.	Staff now have a greater awareness of the revised whistleblowing policy and how to action it. Training for Senior Managers across the Council is planned for February 2013.
12. Ensure that such concerns when raised must be shared by the recipient of the whistle blower's concerns with the professional Social Worker who has responsibility for the Service User's wellbeing.	This recommendation has been implemented. The process for raising safeguarding concerns has been reviewed and reinforced with all respective staff. Training has taken place with Care Managers and with the Provider Management Team. Monthly meetings have been established between care management and the provider with safeguarding being a standing item on the agenda.	There is now a greater awareness and consistent use of the process. All those involved know what the process is and how to apply it. With the improved relationship between Care Managers and Providers, this has resulted in sharing and checking information early to reduce the risk of missing safeguarding alerts. Provider Managers feel more confident approaching Care Managers to share concerns if they are unsure about any concerns Communication and information sharing between care managers and the provider has been improved through these regular meetings.

13. As part of the re-launch of the whistleblowing policy and process, apologise to the whistle blowers of House H and thank them for what they did.	This recommendation has been completed. The Interim Assistant Director held a number of meetings with the 'whistleblowers'. As part of this process, the 'whistleblowers' were offered counselling and other support. The Interim Assistant Director has put in place open access sessions giving all staff an opportunity to share confidentially any issues or concerns they have regarding the service. This is held once a monthly ie the first Tuesday of the month . New 'buddying' arrangements are now in place for the whistleblowers who feel they need/ed additional support when attending training sessions.	Management have provided a significant level of managerial support to each of the individuals in line with their requests. Staff feel more confident to report issues or concerns because they feel that they will be listened to and supported. A number of staff have taken the opportunity to meet with the Interim Assistant Director on a confidential basis. All concerns and issues raised by them have been proactively addressed.
14. As the service does not wish to deter genuine whistle blowers, review the Council's position in respect of obtaining support for staff who are likely to face a traumatic time.	This recommendation has been implemented. The revised whistleblowing policy addresses this issue.	Raised awareness across the service regarding managerial responsibility towards these members of staff.
15. Develop a proportionate quality assurance system involving the local triangulation of relevant data and random unannounced inspections based upon the Care	This recommendation has been implemented. A 'level playing field' has been created with the in-house Provider now working to the same service specification used with the independent sector by the Contract Management Team. Monthly meetings with the Contract Management Team have been established who monitor progress against the improvement plan with.	There is a consistent application of standards and expectations across both Council and Independent Sector providers. As a result of the level of scrutiny a safer service is now being provided but there is no room for complacency. The profile of quality within the service has been significantly raised leading to an improved service

Quality Commission templates	Quality assurance visits have taken place and identified areas where improvement is required but also areas of good practice. An improvement plan is in place to ensure that the findings from the quality assurance visits are acted upon and changes made. Quality is checked regularly by SMs and ASMs who visit homes on a weekly basis using a standard pro-forma. This is monitored by the Team Leader, Service Managers and Interim Assistant Director. New business intelligence reports includes data which assist the management team to manage quality and identify any concerns early. A new locality management structure has been put in place with HR holding surgeries to assist in addressing any HR issues including sickness levels.	being delivered. There is greater accountability because ASMs are now responsible for quality in their houses and are held to account for this through the independent quality assurance visits, business intelligence reports and management .