Commission for Social Care Inspection
CSCI
Making Social Care Better for People

Service Inspection Report

INDEPENDENCE, WELLBEING AND CHOICE

London Borough of Richmond upon Thames

January 2008

COMMISSION FOR SOCIAL CARE INSPECTION

The Commission for Social Care Inspection (CSCI) was set up in April 2004. Its main purpose is to provide a clear, independent assessment of the state of adult social care services in England. CSCI combines inspection, review, performance and regulatory functions across the range of adult social care services in the public and independent sectors.

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The Commission for Social Care Inspection aims to:

- put the people who use social care first
- improve services and stamp out bad practice;
- be an expert voice on social care;
- practise what we preach in our own organisation;

INSPECTION OF INDEPENDENCE, WELLBEING AND CHOICE

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INTRODUCTION AND BACKGROUND

An inspection team from the CSCI visited the London Borough of Richmond upon Thames in January 2008 to find out how well the council was safeguarding adults whose circumstances made them vulnerable.

The inspection team also looked at how well Richmond was delivering personalised services. To do this the team focused on services for older people.

Before visiting Richmond, the inspection team reviewed a range of key documents supplied by the council and assessed other information about how the council was delivering and managing outcomes for people. This included crucially the council's own assessment of their overall performance. The team then refined the focus of the inspection to cover those areas where further evidence was required to ensure that there was a clear and accurate picture of how the council was performing. During their visit, the team met with older people and their carers, staff and managers from the council and representatives of other organisations.

This report is intended to be of interest to the general public, and in particular for people who use services in Richmond. It will support the council and partner organisations in Richmond in working together to improve the lives of people and meet their needs.

SUMMARY

Safeguarding Adults

The Commission rates council performance using four grades. These are; poor, adequate, good and excellent. We concluded that Richmond's safeguarding of adults was **adequate.**

The implementation of adult safeguarding arrangements in Richmond was insufficiently rigorous. The department had identified a range of procedural weaknesses in late 2007 and taken action to tighten up administrative processes. However, the responses to concerns were not consistently well organised, did not follow departmental and inter-agency policies and were poorly monitored by managers.

Response times were generally good and there was a growing range of preventative and support services in the community for vulnerable people. However, the co-operation of other agencies in pursuing timely interventions was generally poor and the inter-agency procedures had not been rigorously administered.

There was an unmanaged approach to training, with a lack of clarity about minimum skills required to undertake specific roles. There were no quality assurance processes in place regarding the training that was available and no process to ensure that all relevant staff had undertaken the expected specialist training. There had been very little inter-agency training. Recent investment in, and more thoughtful development of, differentiated training opportunities were sound but were yet to have an impact on the service.

Management oversight of the quality of casework and compliance with basic risk management requirements was insufficient. There was no system of spot practice audit and in some situations investigations took place without any written management agreement. Some managers assumed that staff were completing the necessary processes without checking.

The Adult Safeguarding Board was under-developed and gave ineffective leadership to all agencies. There was a lack of sub-groups to promote learning; no serious case review process and developmental 'work streams' had been ineffective. The strategic leadership on adult safeguarding within the department had failed to prioritise the issue and some management information had been inaccurate and inhibited improvement of practice.

Delivering Personalised Services

We concluded that delivery of personalised services for older people in Richmond was **good.**

Users and carers found it easy to get in touch with departmental staff and overall satisfaction levels in relation to information, accessibility of services and the quality of service provided was good. The Richmond Direct contact centre

had improved the responsiveness of the service and there had been significant improvements in both joint health and social care services and in the availability of out-of-hours support.

Services increasingly promoted the independence of people who used services and carers. The range and choice of services had developed well. Direct Payments had been positively developed and there was an emerging and increasing use of self directed support. However, significant quality issues regarding domiciliary care compromised the growing range, choice and effectiveness of services and some Direct Payment packages had failed to secure the individual care elements that were important to service users and carers.

Assessment and care management systems were well established and delivered good results overall. However, both the assessment and the care management services were insufficiently holistic and personalised.

The aspirations, and individual potential, of people who used services were not always identified and the focus was often on the physical care needs and disabilities of the person. Advocacy was not used in a focused way to engage and empower service users. Where more particular 'wellbeing' needs had been identified, the assessment did not always lead to individualised, person-centred and 'bespoke' care plans. Most care plans did not specify overall objectives and were primarily service led.

The single assessment process was well-embedded and joint agency assessment worked well. Access to assessments and services was easy and timely; there were minimal delays. Access to some specialist assessments was less good and the quality of the hospital discharge experience for people who used services and carers did not match the success that had been achieved in relation to the speed of discharge. There was no effective inter-agency system for improving discharge practice in the light of experience.

Capacity to Improve

The Commission rates council capacity to improve its performance using four grades. These are; poor, uncertain, promising, and excellent. We concluded that capacity to improve in Richmond was **promising.**

Senior managers and elected members set out a strong vision for the future of adult services and had put in place largely sound business processes to deliver improvement. However, similarly impressive systems had not been secured in respect of adult safeguarding arrangements.

The vision for older people's services was emerging. Good needs assessment work had been undertaken but this had not yet resulted in a clear and coherent commissioning strategy for older people's services. Nevertheless there was a good relationship with providers and commissioning arrangements were sound. Contract setting had been recognised to be a weakness and had been the subject of an improvement plan. Contract monitoring had been strengthened.

There was a well-established business planning process that was complemented by good performance management and performance information systems in

respect of national indicators. Team plans, however, failed to cascade departmental objectives into local improvement targets. Workforce initiatives had been effective and had addressed issues of diversity purposefully. Budget management, processes for the allocation of resources and financial monitoring arrangements were strong.

Frontline quality assurance processes were mixed. Management and monitoring of commissioned services was strong but quality assurance of assessment and care management processes and adult safeguarding practice was markedly less effective. A sound supervision policy secured frequency of sessions but the quality of supervision was neither high nor well monitored.

Partnership arrangements were generally well developed and there was an extensive range of individual and rolling consultation events that had helped people who used services and carers shape emerging services. However, the department had failed to utilise complaints information to drive improvement. The service had recovered from unacceptable performance in respect of timescales for responses to complaints but intelligence gathered from complaints continued to be undervalued and had not been aggregated and analysed to inform more general policy improvements.

Overall governance arrangements were strong. Members were well informed about issues and performance and had set a firm strategic agenda for managers. However, adult safeguarding had had a low priority within the department and the council as a whole. Managers had recognised procedural deficits in late 2007 and brought about effective changes. However, the impact of poor quality assurance processes upon professional practice had been understated. Governance and reporting arrangements for safeguarding were weak; elected members had received limited, and on occasions, overly optimistic information regarding the effectiveness of the service.

RECOMMENDATIONS

Outcome theme	Recommendation
Safeguarding adults	• The council and its partners should implement robust performance management and quality assurance arrangements so that: - compliance with procedures is ensured; - minimum standards of practice and management are assured; and - performance is improved. • The council and partners should devise and implement a robust, skills based, specialist training programme for staff from all agencies involved in safeguarding procedures. • The Safeguarding Adults Board should strengthen its leadership role to ensure the proper level of engagement of partner organizations so that safeguarding activity is supported by all agencies. • The Adult Safeguarding Board should strengthen the specific commitments of partner agencies within the inter-agency adult safeguarding procedures and implement a structured system of compliance monitoring to ensure minimum standards of performance.
Delivering personalised services	• The council and its partners should ensure person-centred planning is at the heart of assessment and care management processes and delivers more individualised and independence promoting packages. • The council should ensure that people who use services and carers are more consistently engaged as partners in determining individual goals within the assessment and care management process. • The council and its partners should ensure that hospital discharge difficulties are aggregated and analysed to inform improved performance management of inter-agency practice. • The council should work jointly with its partners to effectively promote and support the use of focused advocacy services. • The council should improve intervention processes to ensure minimum standards in commissioned domiciliary care services.

Outcome theme	Recommendation
Leadership, commissioning and resources	• The council and partners should articulate their vision for older people's services in an older person's commissioning plan with detailed associated procurement arrangements. • The council should implement robust care management quality assurance processes, including strengthening systems for ensuring the quality of supervision. • The council should build on good standards of performance and service delivery by ensuring team plans detail specific targets. • The council should ensure that the intelligence about service failures and limitations is aggregated and analysed and contributes to service development. • The council should strengthen governance arrangements so that elected members have a clear understanding of the performance of adult safeguarding arrangements.

CONTEXT

Richmond is the fifth smallest of the 33 London boroughs, with a population of approx 180,000 (Source: ONS Mid Year Estimates 2006). About 13 per cent of the population is of pensionable age, and within this there is the fourth largest proportionate population aged 85 and over in London.

The black and minority ethnic population is approx nine per cent (Source: Census 2001). Over the next three years, the borough's older population will increase by an estimated 500 people overall, from 22,600 to 23,300, but will stay virtually the same as a proportion of the total adult population. Most significantly, the 85 and over population is expected to remain constant at around 3,600.

The council is co-terminus with a single PCT with which it works closely, along with a vibrant voluntary sector, in the commissioning of services. Provision of social services for the adult population sits within the council's new Adult and Community Services Directorate. This becomes fully operational (on a rolling basis) within the first months of 2008, and has evolved from the previous Adults Social Services and Housing Directorate.

The new Directorate incorporates responsibility for corporate policy, planning, and community engagement, linking these functions at both directorate and council level. This structure has been designed to 'mirror' PCT arrangements as far as possible. The Council has no housing stock, all of which was out-sourced in 2000. The Director of Adult and Community Services holds the Director of Adult Social Services role.

The Adult Safeguarding Board is chaired by the Assistant Director, Care Services Commissioning. The inter-agency adult protection investigation procedures, developed in 2005, have recently been updated and the proposed revisions are currently going through a consultation/approval process.

In the December 2007 Comprehensive Performance Assessment update, the council was judged by the Audit Commission to be a three star council, with a Direction of Travel judgment of "improving well" and a score of three out of four for adult social care services. In December 2007, social care services were judged by CSCI to be three star, with adult services being assessed as good in relation to delivering outcomes and having excellent capacity for improvement.

KEY FINDINGS

1. Safeguarding Adults

1.1 Safeguarding against poor treatment

The implementation of adult safeguarding responsibilities in Richmond Council was insufficiently rigorous. On occasions, minimum standards of intervention for vulnerable adults were not secured. There were some effective responses and interventions by frontline staff and initial responses were generally prompt. However, interventions were inconsistent and did not conform to departmental expectations.

We considered that the implementation of joint procedures and movement towards formal strategy meetings was unstructured. Procedural and professional omissions and limitations were sometimes viewed by managers as 'administrative' problems rather than considering how these issues may compromise outcomes.

Some investigations were poorly structured and inconsistently recorded. We saw case records where there had been a range of failures to implement the department's own standards. Where strategy meetings had taken place, there was variable performance. Some records of strategy meetings were detailed and focused but a significant number were not. These omissions and failures to comply with expected standards had led to suboptimal outcomes for some service users and had potentially left some people who used services at increased risk. Other agencies were not consistently kept informed of decisions and protection arrangements. Communication with other professionals was an area of consistent and particular weakness. Provider agencies spoke of difficulties in identifying where to report incidents and an inconsistent approach to the implementation of procedures amongst departmental staff.

The inter-agency procedures set out standards but failed to implement any monitoring or performance compliance processes to ensure that these standards were met. This was detrimental to good practice. As limitations in practice emerged, managers had recognised the weaknesses in the documentation and withdrawn implementation of the new processes to allow the learning from the service inspection to be incorporated. The revised procedures presented as a 'best practice guide' rather than a set of specific commitments, agreed as a set of minimum standards to be achieved by all agencies. The requirement to review the effective implementation of protection plans was advisory only.

Partnership working was variable. Within the Mental Health Trust there was some good joint work, with community psychiatric nurses leading on some investigations. However, there was a view from some people we met and heard from that partner agencies considered adult safeguarding as almost entirely a social care issue. Joint inter-agency procedures did not specify clear roles and minimum commitments for other agencies in relation to co-operating in investigations and protection plans. Provider

units did not always 'alert' appropriately. Clauses regarding adult safeguarding in contracts were vague and inconsistently implemented by provider units.

There was variable awareness of adult safety issues in partner agencies, including voluntary organisations that were significant providers of care. The participation of housing in investigations and protection plans was highly variable. Some good practice was balanced by episodes of poor communication and unresponsive joint working arrangements. There was confusion around the role of the police. There were delays in criminal investigations and uncertainty about the status of an emerging joint police/Local Authority protocol.

The profile of adult safeguarding had been low within the council and partner agencies. Strategy documents, departmental and council publications made little reference to the need to focus on protecting particularly vulnerable people. Leadership on this issue had been weak within the council and within the wider health and social care community. Nevertheless, senior managers had identified a range of 'severe procedural concerns' during 2007 and had urgently implemented improved processes that were beginning to have an impact on practice. Awareness of adult safeguarding issues had been raised amongst departmental staff and 'alerts' were increasing.

1.2 Making sure that staff and managers know what to do

Adult safeguarding training arrangements were weak. Too few staff were clear about their basic responsibilities under departmental and inter-agency procedures. An urgent improvement programme had been implemented for specialist training in 2007 and was beginning to make an impact. However, there was a poor strategic approach to specialist training and considerable confusion about whether the training was mandatory or not.

Training was available for staff that wanted it. Spend on specialist training had been tripled and a range of differentiated courses established in 2007. However, a managed and focused approach to developing expertise had not been established. Minimum specialist skills training had not been matched to a set of required competencies for staff undertaking key roles. Priority staff, such as those undergoing their probationary period, had to wait for a course. Not all investigations were undertaken by staff who had had the 'mandatory' specialist training and a high proportion of strategy meetings were chaired by staff who had not undertaken specific training in that role.

There was no adult safeguarding training strategy, the Adult Safeguarding Board did not give an effective lead to inter-agency training and the programme was delivered by, and curtailed by the availability of, volunteer departmental staff. There was no quality assurance process in place for either the trainers or the training itself and training records were disorganised and sometimes contradictory. No specialist training in recognising and responding to adult protection issues had been given to front line staff in the contact centre.

Training was made available to partner agencies, but was unfocussed and limited. Primary Care Trust (PCT) staff had access to their own NHS training but in 2007, only five members of staff from the PCT had learnt about their key partners role through being a part of the department's training. There were no joint health and social care training events and the police had not participated in departmental training. Independent sector colleagues had a mixed view of the availability and quality of training. Some statutory and voluntary sector partner agencies had not had any training from the department and there was a confused picture regarding training for staff from housing services.

1.3 Making sure that there are services to help prevent abuse and neglect

Extensive preventative and support services were available from a range of sources in the community. However, the deployment of these services as part of formal protection plans to monitor and manage situations of ongoing risk and improve outcomes for service users and carers, had yet to be fully realised. Careline provided a monitoring service and the cultural services department of the council had a number of outreach projects that made contact with people who might be living in situations of some ongoing vulnerability. A number of well-developed initiatives were underway including the safer neighbourhoods scheme and mental health outreach teams which supported vulnerable people in their own homes. Assessment and care management services were routinely offered to people who could fund their own care, enabling placements in exceptional circumstances for people who could not manage their own affairs.

Effective initiatives had been taken regarding hard to reach groups such as making contact with travellers and managing community tensions. Adult safeguarding information was extensive and widely available. A high quality leaflet had been produced and included an invitation in the primary local languages to have a copy provided in different languages or formats. A new personal/sexual relationships policy for people with learning disabilities had been drafted and was intended to be developed for other client groups in 2008. Partnership work had been undertaken with Richmond Mencap to provide training on sexuality and bullying. However, there were no initiatives to meet the needs of people with a range of sexual preferences.

Council initiatives had been developed to address domestic violence and a recent project had included the development of a Multi Agency Risk Assessment Conference (MARAC) process, which could identify risk situations at an early stage and co-ordinate an inter-agency support, monitoring and risk management process. There were several examples of well-established financial systems that had been deployed in helping social work staff to manage complex and detailed situations of potential or actual financial abuse. Strengthening transition arrangements had been successful in both streamlining transfer of cases to adult services and in identifying low-level needs that may not qualify for a formal care

package but which nevertheless needed contingency management of the risks for the young adult concerned.

Case files we read identified few situations in which preventative services were transparently deployed to address and manage situations of vulnerability within formal protection plans. Some services were unclear about their potential role in monitoring and supporting risk issues.

There was no formal adult protection risk management protocol for Careline staff and the community safety partnership was only just setting up a vulnerable persons sub-group to structure a response to the needs of people with learning disabilities and with sensory impairment. The partnership also had a low awareness of the vulnerability of people receiving support, rather than a care managed service, via the Supporting People team and many people receiving such support had no care plan or individual worker. Protection plans and care planning did not consistently identify risk, set out contingency plans and ascribe formal responsibilities to relevant agencies engaged with the person who used services.

1.4 Making sure that quality assurance processes are in place and working effectively

Quality assurance processes in relation to adult safeguarding were weak and required extensive improvements. Improved tracking and business processes had delivered a more managed system but were yet to be fully complimented by consistent professional management oversight and supervision.

Senior managers had identified serious weaknesses in systems to ensure effective minimum standards in investigations and associated activity in 2007. It was acknowledged that recording of incidents and activity, together with a poor database of information, had contributed to inadequate interventions with vulnerable groups. Extensive and impressive systems and processes for checking events and timescales had been implemented utilising the new management information system Framework in late 2007.

There were plans in place to develop these systems further but these were only draft and monitoring and reporting arrangements continued to be limited. A senior manager had undertaken responsibility for adult safeguarding but a key deficit had been the absence of a dedicated lead officer for this service. This weakness had been identified in a report in early 2006 but plans had only recently been put into place to fill this post.

Sound arrangements were in place to offer Criminal Records Bureau checks to people accessing Direct Payments. Managers had recognised that some protection clauses in contracts were weak and a stronger focus on monitoring clauses within contracts relating to Adult Safeguarding had been prioritised. A dedicated administrator had been appointed from early 2008 to check that all recording and events had been completed and to support strategy meeting minute taking.

However, many improvements were process orientated and initiatives to ensure that proper professional supervision and management oversight of casework was implemented were less clear than arrangements to strengthen administrative processes. There was no routine pattern of scrutinising and critically evaluating casework practice and managers were not fully aware of the range and nature of deficits in practice. Frontline staff had not had the support of a systematic and structured process of guidance, monitoring and control. We saw cases where managers had not scrutinised professional practice on an ongoing basis and had not ensured that minimum standards had been achieved. An initial audit of cases undertaken by the department in 2007 had identified a range of procedural and administrative concerns. There was an action plan to implement a rolling programme of spot audit of the quality of investigations during 2008.

The Adult Safeguarding Board had not been used as a vehicle for driving up the performance of the health and social care community as a whole. The board did not effectively promote the quality of the service by challenging inter-agency practice. Many of the improvements underway focused on departmental staff and utilised Framework as a vehicle for change rather than prioritising effective implementation of inter-agency procedures. The revision of the inter-agency procedures had not adequately required other agencies to set out, and performance manage, minimum standards for their contribution to joint interventions. There were no associated systems such as routine random casework audit to monitor compliance. Where providers led investigations, there was no requirement for written reports of those investigations to be submitted to managers or the subsequent strategy meeting.

1.5 Making sure that POVA arrangements are robust and work well

The Adult Safeguarding Board was insufficiently developed to give good strategic leadership to the work of local agencies. The priority for adult safeguarding and the work of the board had been low. Corporate plans, including the Local Area Agreement and the Best Value Performance Plan, made no mention of protecting vulnerable adults. The purpose of the board was not clear and the board did not operate at a strategic level. The board focused on protection of vulnerable adults processes rather than engaging with the wider remit of addressing adult safeguarding issues. In the absence of a case review sub-group or process, the group discussed individual cases but came to few conclusions. The board acted more like a special interest group of likeminded professionals than as an inter-agency strategic lead forum.

The board was well established and met every two months. Attendance at the partnership was generally good and there were well-developed links between board representatives and other relevant groups such as Multi Agency Public protection Arrangements (MAPPA), MARAC, the community safety partnership board and the domestic violence forum. The board included representatives of workforce development.

A desktop review by the University of Sheffield in 2005-06 had judged the work of the board to be of a high standard, but no cases had been examined at that time. An internal audit in 2006-07 conducted by Directorate managers had identified a number of failings in process and outcome, but there was no detailed action plan for improvement.

The Adult Safeguarding Board did not have a clear understanding of its role in providing leadership and co-ordination for local agencies. The board had attempted to improve inter-agency processes through a review and refresh of the inter-agency adult safeguarding procedures. However, the board had failed to ensure that the necessary detail was included regarding specifying minimum standards and associated compliance monitoring processes. The health and social care community therefore had no robust performance information upon which to base their confidence in the smooth working of inter-agency partnership working.

The Adult Safeguarding Board annual report was a detailed document, which analysed data well. However, the report failed to take the opportunity to set out targets and demonstrate strategic leadership regarding areas for improvement. The board had not agreed a serious case review process. There was confusion about what inter-agency protocols had, and had not, been established. The referral protocol for working jointly with the police lacked clarity and would be hard to monitor. Some members of the board thought it had been approved, others disagreed.

The emergency duty team had not been effectively engaged in adult safeguarding development work. The team had not contributed to the development of the revised inter-agency adult safeguarding procedures.

1.6 Making sure that people's privacy and confidentiality are respected

Confidentiality and privacy arrangements were generally sound but there were some lapses in practice. Framework offered the facility of restricted access to sensitive information and case files showed that consent to share information was routinely sought and all staff signed confidentiality agreements.

However, management oversight of casework practice had not identified and rectified lapses of confidentiality, within learning disability services and some provider organisations, regarding case file recording, e-mails and strategy meeting minutes.

2. Delivering Personalised Services

2.1 Access to Assessment and Care Management

Referral and initial response arrangements were generally sound and user focused. The department provided a good range of information, there was an impressive resource/service directory and leaflets were produced to a high standard and readily available. The website was easy to access and had 13 ‘fact sheets’ which were helpful.

Access had been improved in recent years. Local duty teams had been supplemented by a council wide contact centre in 2006 and this had been further enhanced with a senior social worker attached to the service in 2007. The provision of speedy advice and assistance was good. Service users had access to direct telephone numbers when they had an allocated social worker. Response times for all contacts had been improved in 2006 by the introduction of the contact centre and effective systems to monitor performance. People who used services and carers reported that access to services was smooth and most respondents to the user survey indicated that they found it easy to get in touch with a social worker.

There were minimal delays in providing an assessment. Contact centre and health staff undertook the early stages of the assessment process and assessed for simple pieces of equipment. Monitoring of local waiting times for assessment was effective and included local targets and performance data with clearly understandable performance information provided for frontline managers. A previously high waiting list for sensory impairment assessments had been well managed and eliminated.

The respondents to our user survey expressed high levels of satisfaction with the availability of information. There were a number of impressive outreach initiatives underway to engage with people who use services and carers, including an annual ‘carer’s day’. Assessment services were made available to people who could fund their own care. Eligibility criteria were clearly set out, included ‘moderate’ need and were addressed in assessments on case files. Staff found the processes and forms in Framework client information and database system to be helpful. However, case files we read showed that some people who used services had been subject to repeated assessment against eligibility criteria – sometimes by different staff within the multidisciplinary team and sometimes with differing outcomes.

Access to reassessments was well addressed in terms of process and the procedures required service users and carers to be advised about how to re-refer for help. However, we found examples of re-establishing contact being less easy in practice. Some providers felt that seeking a re-assessment when people's needs had escalated was harder than eliciting a first response and a number of people who used services had been pleased with the initial response but had then found that their case had been ‘de-allocated’ or transferred to another worker/team without the user or carer being informed.

We found that knowledge of the contact centre as a central and easily accessed resource for people who use services and other people, was low. The council's access and information strategy made little mention of prioritising the process of making information available to members of the black and minority ethnic communities. However, take up of services overall by service users from black and minority communities was above average, including utilisation of Direct Payments. Some council buildings remained inaccessible to people with physical disabilities.

2.2 Assessments and Care Planning

Multidisciplinary assessment arrangements were good but some assessments were insufficiently person-centred. Multidisciplinary assessment arrangements were well developed. There was a range of co-located integrated health and social care teams and staff from health agencies could commission social care services without asking for a separate social care assessment. The single assessment process was well embedded and the majority of respondents to our survey indicted that they felt involved in the assessment process.

Partnership work in assessments was generally good. The availability of specialist assessments and joint work with other disciplines was generally sound although access to some specialist assessments was difficult; carers viewed dementia assessment and services as less expert and effective. Nevertheless, people who used services and carers could directly access specialist sensory impairment teams where this was appropriate. Provider agencies reported increasingly sophisticated and detailed assessments being undertaken by social care staff and were pleased to be increasingly involved in joint assessments at an early stage of the process.

However, the quality of some assessments was variable. At times the focus was entirely upon the physical disabilities of the person. People's capacity for improvement and their aspirations to achieve personal goals was not well set out in assessments. Some managers acknowledged that this had led to the ambitions of the department as a whole to promote individualised approach to assessment, had yet to cascade consistently into frontline practice.

Hospital discharge arrangements had been addressed through a number of joint documents including a reimbursement policy. Delayed transfers of care performance had slipped a little but remained comparatively good. Social care staff worked closely with discharge champions and co-ordinators within a number of hospitals. However, people's experience of the hospital discharge process was highly variable. A significant number felt rushed and/or pressurised. Communication at the time of hospital discharge was sometimes poor. Social care staff reported variable quality of compliance by hospital staff in relation to agreed protocols. Progress on securing overall inter-agency 'learning' from mistakes and improving processes was slow. The arrangements for dealing with difficult discharges worked well on a case-by-case basis, but service users' experience was not aggregated and reported regularly. Accordingly,

opportunities to hold staff from all agencies to account for poor performance and to learn more general lessons from individual experiences were lost.

Advocacy services were not used effectively and had not been fully used to empower the most vulnerable people within the assessment process. The service often represented a befriending approach rather than truly engaging with and empowering people who use services to determine the nature and extent of their care. The service was not used by assessors in a focused and purposeful way to ensure that those who were most isolated, or facing the most significant decisions, had the benefit of independent support.

Care planning was well developed and implemented in a structured and businesslike way. Care plans were thorough and gave a detailed account of the physical dependency needs of the service user and listed the services to be provided to meet those needs diligently. However, care plans were often generic and infrequently set out services to match individual's aspirations or potential. Some 'outcomes' sections of forms had been ignored by care managers and overseeing managers, while others made generalised statements about aspirations that would be applicable to anyone. Managers had acknowledged that care plans did not adequately specify individualised plans to meet the aspirations of people who used services. An outcome focused care planning initiative had been suspended when the decision had been taken to move to self-directed support.

Some opportunities to craft bespoke arrangements to meet individualised 'wellbeing' needs (where they had been identified at assessment) were missed. While some Direct Payments programmes were impressive, others were little different from the preceding provided packages. We heard that imaginative plans including initiatives like swimming did occur but these were the exception rather than the rule.

Reviews happened regularly, were led by assessors and involved other professionals where necessary. There were a number of dedicated reviewing officers and a sound system for identifying reviews that needed to be undertaken. Reviews generally involved a good re-assessment of the care provided.

The charging policy was generous and the financial assessment process was well dovetailed with income maximisation and welfare benefits checks. This was often undertaken in partnership with specialist voluntary organisations.

2.3 Availability of out-of-hours Services

The development of out-of-hours social care support and advice services was underway in relation to many parts of the service. However, some users and carers told us that they did not always feel supported. The emergency duty team was a lead part of a four-borough process and had good communication with the rest of the department. The team had access to both departmental and health databases and also had it's own

mailbox so that care managers could alert the team to any particularly dangerous or unstable situations. The phone number of the team was available to the general public. There were a number of health led out-of-hours services including the intermediate care team and GP and district nursing out-of-hours services, which were valued by service users and carers.

Social care out-of-hours services included an effective Careline monitoring/telecare response service and some commissioned and directly provided services, such as day care, offered a weekend service. The Careline team also had the capacity to make an instant response through utilising either home care agencies to carry out emergency visits and their own Careline support worker to undertake physical checks.

Social care assessment and support was less available. The contact centre only offered traditional 'office hours' availability and there was no carers support telephone/counselling evening service. Some people who used services and carers, although generally satisfied with the speed and extent of support offered, felt very alone and vulnerable during these hours. One carer commented:

> *'If there is anything available to carers out of hours, it is a closely guarded secret...I feel all alone in the evening...that is when the problems are likely to happen and that is when everywhere is closed.'*

2.4 Range of Services

The department had been reviewing and modernising services for some time. Increased choice and diversity of services available had been developed. Services were generally of a satisfactory quality but major problems related to the consistency and quality of domiciliary care services.

Services had been reviewed and refocused and there was a good range of varied day care and day opportunities available, including centre-based activities to meet a range of levels of need. The day care service and cultural services department provided a range of social inclusion activities as part of the council's approach to community support for older people. Cultural services had been involved with the disabilities partnership board and an effective income maximisation scheme had been put in place.

Many services were under review in the context of the move towards self-directed support. Choice for people who use services was increasing. Partner agencies reported a growing range of opportunities and a significant majority of respondents to our survey reported a good choice of services.

There were few waits for services and quality assurance processes for services were markedly better than those for assessment and care management and adult safeguarding processes. A number of postal satisfaction surveys were in place and respondents to our user survey indicated overall satisfaction with the quality of services.

An effective brokerage scheme was in place and performance on delivering equipment had been satisfactory for some years. A need for further extra care housing to meet a continuum of housing support needs had been identified by the council, funding had been secured but the impact of this development would not be felt until 2009.

The development of joint services with health colleagues had been prioritised. There was a well-established intermediate care service managed by the PCT and the role of community matron had been developed as a part of the integrated locality based teams. However, the intermediate care service had restricted eligibility criteria, which excluded predominantly social care service users who also had health care needs and would have benefited from the service.

People who use services and carers identified poor access to some specialist services and highlighted a range of concerns around the quality of domiciliary care. We were told of repeated examples of service failure and poor standards, such as different carers appearing without notice, poor timekeeping, and carers who decided the time of day that they would visit to provide care. We found that complaints about domiciliary care had not always been satisfactorily resolved.

A further gap related to care of people with dementia, where the lack of especially skilled domiciliary care staff and poor availability of 'in borough' residential care placements was identified as a significant weakness. The council had an accessible residential respite service but there was no adult placement scheme. The home sitting service was over-subscribed and the council had recognised the need to improve management of the waiting list.

Partner agencies highlighted limitations in meeting the cultural needs of people from minority communities. No support had been given to providers to meet the language needs of residents, except on an emergency basis.

2.5 Promoting Independence and Choice

Very good progress had been made on promoting Direct Payments, developing a range of non-care managed support opportunities and moving towards self directed care. However, some developments had yet to satisfactorily demonstrate improved outcomes for service users.

The quality of Direct Payments arrangements was generally good. Some excellent practice was observed and locally sourced information about peoples' views of the quality of the service was generally good. A high proportion of the care budget was devoted to these services and some pre-existing packages we saw had been re-designed utilising Direct Payments. However, in one case this was done irrespective of the appropriateness for the service user and some plans that had been amended to utilise Direct Payments were still insufficiently focused on the individual aspirations of the person.

The council had a strong track record of achieving low rates of admission to residential and nursing home care and had developed an impressive range of non-care managed, often voluntary organisation led, services. A good number of older people and their carers used Direct Payments, support arrangements for service users were sound and a significant take up of Direct Payments had been achieved from members of minority ethnic groups.

Plans to move towards self directed care were well formed and supported by robust business processes. Voluntary groups provided a range of easy access preventative and social inclusion opportunities alongside cultural and adult education services. However, there was a lower take up amongst older people of education opportunities, than for other adult service user groups. Direct Payment packages were enabled by a positive Personal Assistant finding service provided by the Independent Living Advisory Service, although some people who used services and carers were not aware of this facility.

Carers' services were driven by a new carers strategy and included a well-respected carers centre and a carers break scheme. The Supporting People programme dovetailed well with the work of the department. Health and social care services were generally well-developed and offered increased choice. A range of effective joint initiatives with health were underway, including intermediate care, falls work, a sound equipment service and an emerging telecare programme.

Service users expressed high levels of satisfaction with equipment provision and the delivered a high number of adaptations. One service user commended the speedy delivery of equipment:

> *' I was stunned and delighted that it arrived so quickly – such a boost to my morale.'*

However, there were some delays in provision of disabled facilities grants and waiting times for major adaptations was high.

3. Capacity to Improve

3.1 Leadership

There was a strong vision for the department that was well communicated to staff. Management arrangements were generally sound but leadership and governance arrangements for adult safeguarding were inadequate.

The department had performed well over a number of years and staff morale was high. Elected members gave sound leadership and were well informed about most of the work of the department. The overview and scrutiny committee played an effective role in service development and review.

Business planning arrangements were generally well developed but required more precise and specific action plans. Well established business planning processes set out, and cascaded, the key vision of the department. Some equalities and diversity plans were clear and some processes were in place to deliver improvements. The directorate equalities board was confident of achieving level three of the local government equalities standards in 2008. The Director of Adult Social Services met regularly with corporate and departmental representatives of staff groups from minority communities. Lower level business plans were in place for the integrated teams and performance on national performance indicators was monitored at a team level. However, team plans were virtually identical, with targets that were difficult to monitor.

Workforce information in relation to diversity issues was impressive and the department employed a higher proportion of staff from minority communities than the proportion in the community as a whole – albeit at predominantly low staff grades. Three Equality Impact Assessments had been undertaken. The one relating to accessibility of services had been pursued to level two, where impressive and specific improvements had been secured. Assessments that had not progressed to stage two had delivered limited results.

There was a well-developed quality assurance and performance information system in place. Clear local targets supplemented national performance indicators. This well managed approach had delivered overall good performance in relation to national indicators. Performance information was reported in a clear and concise way, with good analyses, on a quarterly basis to senior management forums and to elected members. Workforce planning was well developed and the supervision strategy was well set out. However, lack of management oversight and rigour in the quality of casework supervision, had weakened quality assurance in relation to frontline staff. Senior managers acknowledged that sound quality assurance processes were not in place for safeguarding adults work or for assessment and care management teams.

There were a number of new, improved processes within Framework for managers to oversee, agree and approve expenditure on casework. Staff files were well structured and generally up-to-date. However, the quality of some supervision notes and locally held training records were poor.

Workforce challenges had been well addressed and improvements in staff turnover and vacancies had been secured. A clear and impressive supervision and annual performance appraisal system had been set out and was generally well addressed in relation to the regularity of supervision sessions.

Adult Safeguarding information was provided about the number of investigations, but not the quality of intervention. Adult safeguarding cases were not prioritised for consideration and agreeing action to be taken within supervision sessions. Although the system had become electronic in 2007, some management information about adult safeguarding investigation was inaccurate. Information had not been checked or analysed and opportunities to improve protection arrangements had been missed. Adult safeguarding had been ascribed insufficient priority in the department and in the council as a whole. Important strategic documents failed to refer to the issue and there was a lack of strong professional leadership in the department for this issue. Communication with elected members about the developing challenges in relation to safely maintaining vulnerable people in the community had been insufficient.

Governance arrangements for safeguarding were weak. The portfolio holder was briefed on serious case issues but accountable elected members were less well informed. Performance deficits in relation to adult protection were interpreted as being primarily around administrative and procedural processes. The impact, and potential impact, of these limitations on the quality of service users' experience was under-reported.

The complaints service was in place and produced an annual report. All formal stage 2 complaints were investigated by external independent complaints investigators to a high standard and this role included a remit to act as advocate for the complainant. Complainants and relevant staff had copies of the final determination. The speed of response to complaints had improved, from a low baseline during 2007. However, the department did not effectively use the complaints service to systematically and routinely evaluate performance and learn from specific difficulties.

3.2 Commissioning and Use of Resources

Departmental commissioning arrangements were in place, had been underpinned by effective needs analyses and were sound. However, the developmental and analytical work that had been undertaken in relation to older people's services had yet to be formalised into an overarching commissioning strategy. The monitoring of contracts had been an acknowledged weakness.

Sound and early work had been achieved to develop a joint strategic needs analysis and service development objectives for older people's services were identified in a range of documents. Plans were in place to secure a 'vision' document, agreed with health partners, by October 2008, and this was to be followed by a series of more detailed 'procurement plans' which would incorporate precise details of investments and disinvestments. However, none of the needs analyses documents underpinning service development referred to adult safeguarding issues and consistent, formal involvement of all agencies in proactive protection plans regarding vulnerable adults had yet to be realised.

Good budget management over the years had been complimented by a well-established medium term financial plan that effectively linked strategic objectives with available resources. Projections were good and there was increased expenditure on older people's services planned.

The relationship with providers was good. There were well-established forums. Contract monitoring focused largely on activity rather than outcomes, but was increasingly robust and the voluntary sector was thriving and positive. However, good monitoring was let down by unclear procedures relating to intervention in service delivery and contract monitoring was let down by some poorly specified contracts. Senior managers acknowledged that adult safeguarding and diversity clauses within existing contracts were vague. Some services, such as transport and mental health services were not monitored.

Some improvements had been implemented in 2007. Enhanced monitoring of current contracts, including benchmarking and audits of provider files, had been introduced as a short-term measure to address safeguarding issues. Recent contracts with the voluntary sector had improved clauses regarding diversity. Care managers had a form they could complete if they were aware of service failures and providers were challenged about their performance. However, there was less confidence that quality improvements necessarily resulted.

The department had a good record of budget monitoring and delivering efficiencies. Ongoing budget management processes were generally sound. Budget allocation was swift and focused. The department had been in budget for five out of the last six years. The financial management guidance and training was good and there were clear delegation guidelines and thresholds. There were two resource allocation panels including one which focused on continuing health care, was run jointly with health colleagues and included people who used services and carers representatives. The panels worked well. Emergency allocations could be made outside panel and all parties were speedily informed of panel decisions. Increased investment planned for 2008 included improved resources for older people's services, £65k increased expenditure on adult safeguarding arrangement and a significant increase in expenditure on adult safeguarding training.

Improved IT systems had provided further improvements to a largely sound finance and budget management system. Framework had delivered

integrated activity and finance information and continued value for money improvements had been achieved. Gershon efficiency targets had been met and the council also had it's own local efficiency goals. The unit cost of home care was low but there were quality concerns regarding outcomes for users of this service.

Arrangements to include people who use services and carers in service development processes were in place, both on an ongoing basis and in relation to modernisation processes. All reprovision processes included an element of user/carer consultation and some service redesign had been influenced by these discussions. Periodic strategy consultation events had secured good carer representation. However, there was a lack of overall cohesion in the consultation arrangements. Some staff and carers felt that the involvement of people who used services and carers in older people's services was less well developed than for other adult groups. Some older people's carers told us that they had not felt well engaged with the development of the carers strategy and felt that their experience and expert knowledge of the needs of service users had not been valued.

People who use services and carers had not been involved in developing adult safeguarding arrangements. There had been discussion of these issues at boards and forums where user representatives were in attendance but there were no examples of their views having influenced policy or services.

The department had well developed partnership arrangements with the independent sector, health agencies and with other parts of the council. In addition to a number of formal joint agreements, the department had a range of services aligned with health partners. Corporate partnerships were strong. The service had a good relationship with cultural and leisure services and with adult education institutions. There was a quarterly independent sector provider's forum that was chaired by a senior manager and addressed service development issues such as building nursing home capacity and the accreditation process for self directed care workers. The forum had identified and agreed the need for additional protection of vulnerable adults training for independent sector provider staff.

The voluntary sector was heavily and appropriately involved in developing non care managed support opportunities and believed the department was involving partners appropriately in developing a good continuum of services. Some parts of the voluntary sector felt that partnership arrangements had yet to settle completely, there were concerns at the impact of budget pressures on partnerships and at the time taken in some decision-making processes.

APPENDIX 1 INSPECTION THEMES AND DESCRIPTORS

INSPECTION THEME 1 (Core Theme) People Are Safeguarded	
1.1	Adults who are vulnerable are safeguarded against abuse.
1.2	Workers are competent in identifying situations where adults who are at risk may be abused and know how to respond to any concerns. The council makes sure that all managers are aware of how to manage safeguarding issues.
1.3	Workers are aware of and routinely use a range of preventative support services and this has led to an increase in the reporting of incidents of abuse. There is satisfactory closure in all cases.
1.4	Robust quality assurance processes are in place and working effectively.
1.5	Adult Protection Committees, or similar arrangements, are in place; they work effectively and accord to POVA requirements.
1.6	People who use social care services are assured of privacy and confidentiality through the consistent application of appropriate policies and procedures.

INSPECTION THEME 3 People Receive Personalised Services	
3.1	All referral, assessment, care planning and review processes are undertaken with respect for the person and in a timely manner.
3.2	People with urgent social care support needs outside normal working hours are appropriately supported.
3.3	All people who use services and their carers: • need to 'tell their story' only once in having their social care needs assessed; • have care plans that include clear accounts of planned outcomes; • know how to access any records kept about them; and • have been offered advocacy services.
3.4	The range of services is broad and is able to offer choices and meet preferences in all circumstances.
3.5	All people who use services are aware of the availability of self-directed services and are encouraged to take up these services; they are able to continue to live in the environment of their choice.
3.6	There is universal access to initial assessments of social care needs regardless of whether a person intends to self-fund, or whether they are eligible for council services.
3.7	All people are clearly assigned to a team or manager for assessment, care planning, and service delivery.
3.8	Care planning and service delivery are holistic and effectively identify and meet individual needs.

Leadership	
8.1	Highly competent, ambitious and determined **leadership skills** of senior officers in the council champion the needs of all people who use adult social care and their carers, to ensure that people are safeguarded/receive personalised services. Senior officers make sure there is **effective staff contribution**, both within the organisation and across partnerships, to planning and delivery of key priorities and to meeting suitably ambitious outcomes in the selected themes.
8.2	**Plans** to ensure the delivery of the selected themes **are comprehensive** and linked strategically and address key developmental areas. They identify **national and local priorities** for the selected themes[1]. Realistic **targets** are being set and are being met. Co-ordinated working arrangements across the council and with external partnerships are reflected in **strategic planning** to ensure delivery of the selected themes. There is evidence that this working has resulted in improvements in the selected themes.
8.3	There are the **people, skills and capability** in place at all levels to deliver **service priorities** and to maintain high **quality services** to ensure the good outcomes in the selected themes.
8.4	**Performance Management, quality assurance**, and scrutiny arrangements are in place and effective to ensure that good outcomes in the selected themes: performance improvement can be demonstrably linked to management action.

Commissioning and Use of Resources	
9.1	The council, working jointly with relevant partners, has a detailed **analysis of need** for the selected themes with comprehensive gap analysis and **strategic commissioning plan** that links investment to activity over time. Expenditure on relevant services reflects national and local priorities and is fairly allocated to meet the needs.
9.2	The council secures services relating to the selected themes at a **justifiable cost**, having identified the range of options available and made comparisons in terms of quality and cost with other areas and nationally. There are robust **financial management planning and reporting systems** in the services delivering the selected themes.
9.3	The council makes sure that all people who use services, carers groups and staff groups relevant to the selected themes are integral to the commissioning process through **consultation, design and evaluation of service provision**. There is evidence that the council has information about costs in relation to quality and these are used in strategic and service planning and in commissioning to improve the economy, efficiency and effectiveness of the selected themes.
9.4	The council has a clear **understanding of the local social care market** relating to the selected themes and there are innovative measures taken jointly with providers to meet the needs of both publicly funded and self-funded individuals. Optimum use is made of **joint commissioning and partnership working** to improve the economy, efficiency and effectiveness of the selected themes. Informed choices are made about the balance of cost and quality in commissioning and de-commissioning services.

[1] Safeguarding Adults / Delivering personalised services

This inspection was one of a number inspections carried out by the Commission for Social Care Inspection (CSCI) in 2007 under the Independence, Wellbeing and Choice agenda[2]. The aim of this inspection was to evaluate how well adults were safeguarded by Richmond and how well Richmond were meeting the needs of older people in relation to:

delivering personalised services.

The inspection had a particular emphasis on improving outcomes for people. The views and experiences of adults in need of community social care services were at the core of this inspection.

An inspection design team created the inspection methodology. The Themes and Descriptors (see Appendix 1) were developed from the CSCI's Outcomes and Descriptors[3].

The inspection team consisted of two inspectors from CSCI and an 'expert by experience'. At the beginning of the inspection process, we invited the council to provide evidence, supplementary to that provided in their annual self-assessment survey, related to the focus of the inspection. Before the fieldwork, we reviewed all available evidence on the performance of the council.

We sent questionnaires to 150 older people who use services. The results from these questionnaires helped us to identify areas for exploration during the fieldwork. We also wrote to other agencies for their views about the council in relation to the focus of the inspection.

The fieldwork consisted of six days 'on site' in the council community. During the fieldwork, we met a wide range of people with knowledge and experience of the services provided and commissioned by the council, including:

- people who had experience of receiving services;
- organisations which advocate or represent people who use services and carers' interests;
- council staff; and
- key staff in other parts of the council and partner organisations.

[2] Department of Health 'Independence, well-being and choice' (2005) and subsequent White Paper 'Our health, our care, our say' (2006).
[3] CSCI 'Outcomes Framework for Performance Assessment of Adult Social Care' 2006-07