Inspection report

Service inspection of adult social care:
Sefton Metropolitan Borough Council

Focus of inspection:

Safeguarding adults
Improved quality of life for older people
Increased choice and control for older people

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- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

Inspection of adult social care

Sefton Metropolitan Borough Council

December 2009

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Acknowledgement
The inspectors would like to thank all the staff, service users, carers and everyone else who participated in the inspection.

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Introduction

An inspection team from the Care Quality Commission visited Sefton in December 2009 to find out how well the council was delivering social care.

To do this, the inspection team looked at how well Sefton was:

- Safeguarding adults whose circumstances made them vulnerable.
- Improving quality of life for older people.
- Increasing choice and control for older people.

Before visiting Sefton, 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 people who used services 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 Sefton. It will support the council and partner organisations in Sefton in working together to improve people's lives and meet their needs.

Reading the report

The next few pages summarise our findings from the inspection. They set out what we found the council was doing well and areas for development where we make recommendations for improvements.

We then provide a page of general information about the council area under 'Context'.

The rest of the report describes our more detailed key findings looking at each area in turn. Each section starts with a shaded box in which we set out the national performance outcome which the council should aim to achieve. Below that and on succeeding pages are several 'performance characteristics'. These are set out in bold type and are the more detailed achievements the council should aim to meet. Under each of these we report our findings on how well the council was meeting them.

We set out detailed recommendations, again separately in Appendix A linking these for ease of reference to the numbered pages of the report which have prompted each recommendation. We finish by summarising our inspection activities in Appendix B.

Summary of how well Sefton was performing

Supporting outcomes

The Care Quality Commission judges the performance of councils using the following four grades: 'performing poorly', 'performing adequately', 'performing well' and 'performing excellently'.

Safeguarding adults:

We concluded that Sefton was performing well in safeguarding adults.

Improved quality of life for older people:

We concluded that Sefton was performing excellently in supporting improved quality of life.

Increased choice and control for older people:

We concluded that Sefton was performing well in supporting increased choice and control.

Capacity to improve

The Care Quality Commission rates a council's capacity to improve its performance using the following four grades: 'poor', 'uncertain', 'promising' and 'excellent'.

We concluded that the capacity to improve in Sefton was promising.

What Sefton was doing well to support outcomes

Safeguarding adults

The council:

- Ensured that most people were effectively protected from abuse and harm and had co-ordinated the production of a revised interagency framework for intervention.
- Provided a range of community based multi-agency initiatives that supported people in remaining safely in the community.
- Had raised the profile of adult safeguarding and provided an increasingly effective and diverse range of training.
- Had implemented initiatives to identify and meet the safety needs of some hard to reach groups.

Improved quality of life for older people

The council:

- Was working effectively with partners to improve the provision of a wider range of preventative services.
- Had involved people who used services and their carers in the development of preventative services.
- Had improved the accessibility of universal services for older people including those with complex needs.
- Worked well with health agencies to provide intermediate care and rehabilitation services and provided an array of carers support.

Increased choice and control for older people

The council:

- Were making services more personalised, promoting care in the community and had strengthened out of hours support.
- Produced good quality information about services and had streamlined points of access.
- Had improved performance in the use of Direct Payments markedly and had introduced a dedicated direct payments scheme for carers.
- Had involved people in their assessments and were beginning to reflect individual aspirations in care plans.

Recommendations for improving outcomes in Sefton

Safeguarding adults

The council and partners should:

- Improve the practice in relation to identification of ongoing risks and the implementation of protection plans.
- Strengthen recording and ensure that managers' decisions are clear.
- Develop the Adult Safeguarding Executive Board, clarify interagency commitments, and implement a system of cross-agency performance management.
- Develop differentiated training opportunities for key staff from all agencies and ensure attendance.
- Make the role of the adult safeguarding co-ordinator more focused on quality assuring practice.

Improved quality of life for older people

The council should:

- Improve the availability of individualised and independence-promoting support in the community including Day Opportunities and Extra Care accommodation.
- Progress the planned production of a carers' strategy. Ensure that there is an implementation plan that clearly sets out the levels and types of support.

Increased choice and control for older people

The council should:

- Ensure that care planning increasingly reflects the individual aspirations of service users as well as meeting their physical care needs.
- Ensure that information about services and support that is produced is properly distributed and made available to the public.
- Use advocacy in a more focused and precise way to ensure that the views of people who use services are heard and responded to more effectively.
- Work with partners to improve the consistency of outcomes for people who use services and their carers at the time of discharge from hospital.
- Use the intelligence gathered through the complaints process more effectively to fine-tune and improve overall service provision and processes.

What Sefton was doing well to ensure their capacity to improve

Providing leadership

The council:

- Had a sound strategic vision of a range of safe and secure personalised forms of support.
- Had strong managerial leadership.
- Had plans for the transformation of social care that were sound and project managed.
- Had well established performance management arrangements.

Commissioning and use of resources

The council:

- Had sound commissioning processes.
- Had a good understanding of the needs of the community.
- Had effectively managed its budget.
- Had involved people who use services and service users in service development initiatives.

Recommendations for improving capacity in Sefton

Providing leadership

The council should:

- Ensure that workforce development and training plans have clear improvement targets that are able to be monitored.
- Clarify the strategic priorities for older people's services and share the detail of these plans with staff and stakeholders.
- Strengthen the implementation processes associated with the Equalities Strategy.
- Ensure that Equality Impact Assessments are used consistently to improve services for hard to reach groups.

Commissioning and use of resources

The council should:

- Strengthen directorate and partnership strategic developments through publishing detailed commissioning and joint commissioning strategies for older people.
- Use commissioning incentives to improve the pace of development of a wider range of community based, flexible support services and accommodation options.
- Use a value for money approach more effectively to challenge established services.

Context

Sefton Metropolitan Borough Council is a Local Authority in the North West of England with a population of 275,200. The council has 28 Liberal Democrat, 21 Labour and 17 Conservative Councillors. Governance arrangements are constituted in a 'Cabinet and Leader' model. In order to give citizens a greater say in council affairs, seven Area Committees are in operation. The council has held beacon status in 2005/6 for 'supporting carers', 2007/8 for 'delivering cleaner air' and 2008/9 for 'improving accessibility'.

Of 150 councils in England, Sefton has the 13th highest proportion of people aged 65 years and older. This was 20 per cent compared to the national average of 16 per cent. This population is estimated to increase by 10,000 over the next 10 years. Just 2.8 per cent of the population are from a black or minority ethnic group. The age profile differs significantly across the wards in the borough.

Sefton was ranked 83rd out of 354 authorities in its index of deprivation. Deprivation in Sefton is characterised by pockets of both severe deprivation and affluence as evidenced by its rank of local concentration of 46th out of 354 authorities. Tackling health inequalities is a major priority for the council and its health partners.

In 2008-09 the Audit Commission's Comprehensive Area Assessment of the council as a whole and the Care Quality Commission assessment of adult social care both judged the council to be performing well.

Services for older adults are provided through the health and social care directorate, which is led by a team comprising of strategic director, head of adult services, head of central services and an assistant director.

Key findings

Safeguarding

People who use services and their carers are free from discrimination or harassment in their living environments and neighbourhoods. People who use services and their carers are safeguarded from all forms of abuse. Personal care maintains their human rights, preserving dignity and respect, helps them to be comfortable in their environment, and supports family and social life.

People who use services and their carers are free from discrimination or harassment when they use services. Social care contributes to the improvement of community safety.

The council had effective systems in place to ensure that citizens and people who used services were free from harassment and discrimination. There was a wide range of low level support and services which included all parts of the council and key partners such as community policing. Some strategic policies needed clearer identification of vulnerable groups and how their needs were to be met.

The Sefton Safer and Stronger Community Partnership Board was well established and provided sound leadership within the council and across partner agencies. A range of high quality specialist leaflets were available but we were told by some people that they were not aware of the extent of services that were available. Overall rates of crime and specific incidents of race and culture, domestic violence and anti-social behaviour incidents, had fallen.

The wide range of services to help keep people safer in their homes included strong sexual and domestic violence services, a dedicated hate crime unit and a specialist vulnerable victims' advocacy service. There was widespread information available about homophobic crime for all citizens, people who used services and carers. Interagency preventative work had been strengthened through the use of the Multi Agency Risk Assessment Conference (MARAC) system for sharing information and assessing risks at an early stage.

The council and partners had made good use of the Joint Strategic Needs Assessment (JSNA) and areas of particular vulnerability had been identified. These had been reflected in the Partnership Board's over-arching priority to develop community safety initiatives and had been well set out within the crime and disorder plan and Local Area Agreement (LAA) targets. Specific support had been given to the newly identified vulnerable group of international workers who were at some risk of exploitation.

The council had taken steps to promote community cohesion and provide support for minority communities. There was a revised Community Cohesion strategy in place together with a sound 'balanced scorecard' performance monitoring process. There was a good understanding of the varying needs of the diverse community and outreach projects to engage with hard to reach groups had been undertaken. Two specialist workers had been appointed to meet the needs of people from minority

communities, a corporate travellers group co-ordinated a range of initiatives and free legal advice was available for people seeking asylum. Housing partners had developed a network of neighbourhood community workers and there was a strong sense of community.

People are safeguarded from abuse, neglect and self-harm.

Most people were effectively safeguarded from abuse, neglect and poor treatment. The awareness of safeguarding issues had been raised and the numbers of alerts had risen sharply. Most practice was sound and some interventions were good. Further development was needed in relation to the consistency of risk threshold identification, performance management and multi-disciplinary working. The adult safeguarding executive board needed to provide improved leadership.

The adult safeguarding executive board had been reconfigured in 2009 under new chairing arrangements and the membership had been increased. However, the terms of reference remained weak, governance arrangements were poor and attendance and recording of decisions was poor. There was no tradition of the board overseeing multi-agency project work through a range of focused sub groups and staff and many stakeholders were not aware of the work of the board or how to contribute intelligence and issues to the board. The annual safeguarding report failed to set out clearly the progress that had been made in the previous year and the action plan was weak.

An 'Adult Safeguarding Interagency Framework' offered advice regarding multi-disciplinary practice had been re-issued in 2009 and was valued by staff. However, lead staff within social care had no council safeguarding procedures to guide their practice and there was some confusion about whether the framework constituted procedural guidance or was simply 'best practice' advice. Some staff were uncertain about timescales to be followed. Some targets set out within the framework were confusing and increased uncertainty had been caused by publication of 'stretch' targets to try and improve the responsiveness of the service.

Safeguarding alerts received a timely response, people were protected and initial investigations were frequently satisfactory or good. Risks faced by people who funded their own care had been addressed. People who lived in placements outside the borough were protected where necessary and staff in Supporting People teams had referred risky situations appropriately. Specialist legal advice was readily available to investigating officers. Preventative services were utilised well in some protection plans.

Some longer-term risks were less well addressed. In some cases the presenting problem was dealt with but underlying and ongoing vulnerabilities remained unaddressed. Protection plans were not always clear or well monitored. Recording was frequently unclear and a multiplicity of differing forms was used. Reviews did not always happen within the required timescale.

There was poor use of independent advocacy services to empower people who were vulnerable and subject to safeguarding procedures. The adult safeguarding co-ordinator role was valued by staff and partner agencies but lacked focus and the

range of duties was too great.

The response and contribution from other agencies to alerts was variable. Where this worked well, good outcomes were secured. There was an effective single point of access for contacting the police and in some situations the police chaired strategy meetings. We saw some good examples of a wide range of agencies working in partnership to deliver high quality care. In other situations, key agencies either did not respond or were unclear of their role. On occasions some partners were reluctant to acknowledge risks as safeguarding issues. There was no overall transitions protocol in place to manage the movement of children into adult services.

Quality assurance processes had improved when the co-ordination of safeguarding performance information had been integrated with wider performance management functions in 2008. Standards of performance had improved but remained mixed. All investigations were carried out by appropriately skilled and trained staff. Meetings to share good practice and standardise managerial and operational performance were in place and highly valued by some staff. There was a well-established process for sharing contracting information. A clear audit trail on manager decisions at critical points in safeguarding interventions was not always evident and in some cases it was unclear within the case record if and when an investigation had ceased.

The adult safeguarding executive board had only one, recently formed, sub-group and had no performance management arrangements in place for monitoring and ensuring that practice of staff from all agencies met minimum standards in supervision for considering safeguarding issues. A sound serious case review process had not been used and an alternative casework review process had not delivered improvement.

The strategic approach to training had been strengthened in 2009 when the learning and development section took responsibility for co-ordinating directorate and interagency training. Awareness raising and alerter training was freely available to staff and partners across the social care network. Take-up by partner agency staff was variable. More specific skills training was being developed but some sessions had been of variable quality. Clear competencies were set out for key roles within the directorate and for most partner agencies. Performance management of compliance with expectations for staff from other agencies to attend appropriate training and thus secure minimum competencies was underdeveloped. More clear and binding agreements across partner agencies for minimum compliance with declared standards were required.

People who use services and carers find that personal care respects their dignity, privacy and personal preferences.

There were a range of measures in place that supported people's dignity and privacy. A Dignity in Care project management group had been formed and reported to the Chief Executive. Dignity policies and champions were in place in the Directorate and partner agencies. The interagency safeguarding framework set out how private information should be handled and public information was available about people's rights to confidentiality.

Overall progress in promoting dignity was monitored regularly by the Health and Social Care improvement Group.

Contracts with providers included safeguarding and dignity clauses and contract monitoring was generally strong. However, specific information about compliance of providers with dignity clauses was not collected. Deprivation of Liberty (DOLs) referrals had started to be received from social care agencies. The dignity in care action plan needed to be more precise and ambitious in specifying improved outcomes to be achieved. Many targets were process orientated and had vague benefits. Initiatives to promote dignity for other adult social care groups had been pursued. Less progress had been achieved in securing dignity for older people.

Advocacy arrangements were mixed. The directorate had invested significant sums in advocacy and specific projects, such as the vulnerable victims advocacy service and specialist advocacy support for people who had suffered domestic violence. These were of high quality and were well used. When necessary, Independent Mental Capacity Act advocates were available, six best interest assessors were in post and the Local Implementation Network (LINk) monitored this process well.

Procedural guidance on the deployment of other forms of advocacy was, however, imprecise and the use of advocacy was consequently poorly focused and less effective than it could have been. It was unclear why some people had an advocate and others didn't. In some cases clear indications of the need for advocacy were not addressed and in other situations advocacy was used to deliver basic social care support. The way that advocacy was used in safeguarding situations was not monitored.

Sound processes were in place to monitor the experiences of people who used services who had been involved in safeguarding situations. Consultation had led to a number of service improvements including strengthening of information that was available about preventative support and the development of the MARAC scheme.

People who use services and their carers are respected by social workers in their individual preferences in maintaining their own living space to acceptable standards.

The council effectively used regulatory information provided by the CQC and inspection reports to influence how they commissioned services from the independent sector. This practice ensured that people and their family carers were provided with choice in the range of services when selecting residential and domiciliary care. Residential and domiciliary care services were generally of a high standard and the range of services within the borough meant that people could routinely secure local provision.

The council had a good understanding regarding the quality of provision it commissioned from regulated care providers. The council only commissioned services from residential care providers that offered single occupancy rooms to ensure that dignity and respect was maintained.

Improved quality of life

People who use services and their carers enjoy the best possible quality of life. Support is given at an early stage, and helps people to stay independent. Families are supported so that children do not have to take on inappropriate caring roles. Carers are able to balance caring with a life of their own. People feel safe when they are supported at home, in care homes, and in the neighbourhood. They are able to have a social life and to use leisure, learning and other local services.

People who use services and carers get advice and support at an early stage. Support services take account of the needs of individuals, carers and families. This helps to prevent loss of independence and isolation, and maintains their quality of life.

Both the directorate and the council as a whole had single points of access, which offered good initial advice and facilitated redirection to non-care managed services where appropriate. A wide range of voluntary organisations provided an array of preventative services and were well supported by a council-funded CVS co-ordination service. There was a well-established database and catalogue of preventative services.

Information about services was not always accessible, but signposting to other services had been assisted by a 'No Wrong Door' policy which ensured that the first point of access to council services undertook to broker a response or facilitate a response from the appropriate service. People found it easy to get in touch with the council. One person commented,

"*'The ring back system works well….I wasn't forgotten."*

The council had prioritised early intervention and prevention through the JSNA process and had established clear LAA targets for improvement. An 'early intervention' network had been established in 2009 and a new preventative strategy gave a clear vision for improvement. However, the action plan was at a very early stage and more specific targets – including for social care initiatives with hard to reach groups – were needed.

A well-established rehabilitation and intermediate care service had delivered sound results for some years but had been under review for some time. This process had drifted but the current joint plans were well scoped to deliver a service that was increasingly integrated with developing community-based health services. The equipment service was highly valued and provided a speedy response. A number of preventative services had been improved in 2009 including the provision of faster disabled facility grants and a reconfiguration of the joint health and social care falls service.

People who use services and their carers are able to have a social life and to use mainstream local services. Local service providers, including transport, healthcare, leisure, shops and colleges, adapt services to make them easier to use.

The council worked effectively with partners to address accessibility issues in the borough. Access to universal service was good and improving. Some people found key services such as NHS walk-in centres to be poorly located but amendments had been made to bus services and timetables to ease access to a range of services. Neighbourhood wardens and park rangers were in post to help people feel safer, a special card had been produced to help people with visual impairment use public transport and community matrons worked with council staff in community support projects.

Partner agencies had included quality of life issues within their assessment processes and had facilitated access to services in the council. Council services were increasingly made available to older people in an accessible form. Several thousand older people were involved in an active lifestyles project and physical activity was promoted through free swimming for over 60's and the council had match-funded initiatives for intermediate physical activity. Older people had good opportunities to directly access leisure services.

Services to address social isolation had been developed in association with voluntary organisations. Increasing numbers of older people had been helped to live at home and the use of residential care had reduced. Extra Care housing options had been slow to develop but the planned provision was well scoped and included a consideration of the role of the planned units in the life of the local community. Most developments were yet to be delivered and more work was needed to offer a wider range of accommodation choices.

People who have complex, intensive, or specialised support needs and their carers are supported. They have a choice in how and where they are supported.

The LAA had prioritised meeting the needs of older people with complex needs and there was an improving range of services. Specialist residential placements were available within the borough and the directorate had developed an end-of-life support service in partnership with the Primary Care Trust. An 'expert patient' scheme involved a number of people who used services in working with people with complex needs, helping them manage their care and to establish the kind of services that they valued. Services for older people with mental health and learning disability needs had been developed and there were two specialist co-located, though not jointly managed, health and social care teams for people who were elderly mentally infirm.

Carers' support was highly developed and largely very effective. There was a well-established carers' register and a guide for new carers' had been produced and distributed through GP surgeries. This had led to an increase in registrations within the first year. The carers' strategy needed to be updated and uptake of key services

such as the carers' emergency card scheme had not been monitored effectively. A carers' Direct Payment scheme had been developed in response to consultation with carers about the kind of support that they valued.

The older people's partnership board had not been effective for some years but had an increasing understanding of the needs of older people with a range of support needs. The board had played a part in identifying issues that mattered to Older People. One example was the development of the role of the Direct Payments support organisation to enable people with complex needs to receive support through that scheme.

Some partner agencies were less well aware of the range of support for people with complex needs. Pressure for a speedy residential care solution to be considered in a number of hospital discharge situations had threatened the quality of the outcome for the person using the service. Arrangements were not in place for the key relevant agencies to examine such difficult cases, agree an improvement plan and ensure that better standards were applied in the future.

Increased choice and control

People who use services and their carers are supported in exercising control of personal support. People can choose from a wide range of local support.

All local people who need services and carers are helped to take control of their support. Advice and information helps them think through support options, risks, costs and funding.

The council and partners had achieved steady progress in making services and support more personalised and were part way through a three-year project plan. Systems were in place to involve a range of people who used services, partner organisations and other stakeholders in the development of services and support.

High quality information about services and support had been produced and there was an attractive and effective corporate template for leaflets. The website was accessible, library staff were often proactive in helping people find out information and there was a useful 'find my nearest' search function which helped people access information about local sources of support. There was a single point of access for directorate services and customer services staff were well trained. The majority of leaflets carried details in a range of minority languages about how information could be made available in different formats

We found people who used services to be generally well informed about services and support. The council undertook its own 'mystery shopper' quality assurance checks about the quality of information. Where people were not aware of services this was often because the leaflets and publicity material had not been displayed effectively. There was no system for checking the effective dissemination and distribution of information. Some information leaflets remained in their packaging in local offices and information points.

The directorate had invested heavily in advocacy but had failed to specify the service to be delivered clearly or set eligibility criteria for the use of the service to ensure that the people in most need of independent support received this help. Some staff viewed advocacy as a low level service which could provide simple and practical advice and support as an alternative to a care managed package of help. Performance information was not collected about the extent to which people that used services and their carers were being empowered to exercise increased choice through the help offered by advocacy services.

People who use services and their carers are helped to assess their needs and plan personalised support.

The directorate delivered a broadly effective assessment and care management service in partnership with colleagues from health agencies. Increasing attention was being given to the inclusivity of assessments and the personalisation of care plans.

Practice remained variable. Opportunities for effective multidisciplinary work and ambitious care planning were missed and some hospital discharge arrangements were unacceptably poor.

A successful pilot programme of assisted assessments was being developed and take-up of service was high. We were told of some assessments that were inclusive and respectful of the views of individuals and their carers. One carer said,

"Direct Payments have been brilliant."

On occasions, assistive technology had been used to ensure that people with communication difficulties could make their views known. Other assessments were more bounded, focused on the physical needs of the service user and failed to consider the use of Direct Payments. Some assessments had taken more than 28 days to complete but performance in relation to timeliness of assessments and the availability of social workers was generally good and improving.

The quality of care planning was mixed. Many plans were thorough and detailed. A very high proportion of care managers had undertaken person centred-planning training and awareness of the principles of personalisation was high. On occasions practitioners had worked hard to promote the views of the person using the service in the face of opposition from others involved. The panel system for allocation of resources worked well, was not unduly time-consuming or bureaucratic and acted as a quality check to ensure that the breadth of the views of the individual had been considered.

The majority of care plans were traditional and unambitious. Where individual assessed needs had been identified, such as depression or social isolation, many care plans either recommended standard solutions such as Day Care or ignored the issue entirely. On occasions, specific preferences regarding how the care should be provided or activities that would be valued were not met.

Carer's support was good for those who were known to the service. Carers' assessments were undertaken and support needs identified. Carers felt valued as partners in providing care but needed better quality information about what support was available.

Multidisciplinary work was promoted by two specialist teams for older people with mental health problems which had co-located health and social care staff. Other social care teams had less ready access to specialist and multidisciplinary assessments and practice reflected the quality of local relationships. The Single Assessment Process was well established but access to specialist assessments was variable. Access to resources from the health panel was difficult at times.

Particularly variable outcomes for service users were evident in respect of the quality of discharge arrangements from hospital. Some people who used services had experienced rushed discharges which had involved poor co-operation between health and social care professionals. Other patients had been discharged without an appropriate referral having been made to the council. Directorate staff were under considerable pressure to maintain good performance regarding the speed of transfers of care. However, there was no health and social care hospital discharge

procedure in place which committed staff from all agencies to delivering minimum quality outcomes for people returning to the community. One carer told us,

"I didn't know what was going on. I was just expected to cope."

There was no structured interagency management process in place for resolving operational difficulties and learning lessons to improve future practice. Some staff had had to resort to raising interagency practice concerns through the departmental complaints procedure to try and ensure that partner agency responses met minimum standards.

People who use services and their carers benefit from a broad range of support services. These are able to meet most people's needs for independent living. Support services meet the needs of people from diverse communities and backgrounds.

The breadth and choice of services and support were increasing. The overall health of citizens was being improved through a range of healthy living and exercise options and people who needed additional support had ready access to rehabilitation and intermediate care services. Some traditional services such as Day Care had not been properly reviewed and this meant that some people did not have access to a real choice of individualised day opportunities. Increased accommodation options were planned but had not yet become available.

The directorate had a sound track record in promoting independence; use of residential care was decreasing and community-based options were increasing. The joint equipment service with health partners delivered prompt support and there had been good use of assistive technology. The intermediate care service had been the subject of external evaluation and had been shown to be effective in reducing long-term dependency on care-managed services. Best use of specialist services was sometimes compromised by lack of easy access to ongoing support which led to some rehabilitation services becoming blocked.

The use of Direct Payments packages of care to increase the flexibility of support for people who used services had risen markedly in 2008, to a level of performance that was above the council's comparator group. Some Direct Payments packages were imaginative and provided high quality and bespoke packages of support. Others were inhibited by the lack of modern services such as community-based support and outreach workers to deliver individual packages of flexible care. This meant that some self-directed support arrangements simply provided traditional support for physical care needs. Opportunities to address individual aspirations and ambitions of some people who used services were lost. The availability of flexible and community-based accommodation options and community-based support in partnership with the Supporting People service was limited but was improving following an adverse inspection in 2007.

Most people who used services were satisfied with the quality and reliability of the service. Access to respite care services had been difficult for some people who used

services and carers. The availability and appropriateness of their service had improved in 2008 when respite support within the home of the person using the service was provided.

Carers' support was well developed and included a range of options including respite vouchers. Some services had not been well used in recent years and the strategic approach to development of carers' services was weak. There was no carers' strategy in place and we were told that the application of some carers' support processes was bureaucratic and cumbersome. The recent development of alternative forms of carers' support had included a highly valued carers Direct Payment scheme. The engagement of carers in designing the planned revised carers' strategy was good.

People who use services and their carers can contact service providers when they need to. Complaints are well managed.

There was a growing range of out-of-hours support for older people. Progress had been made on increasing the frequency with which packages of support were reviewed and a new policy had been established. The complaints service worked well in individual situations but the directorate had failed to make best use of complaints information as a basis for improving the service as a whole.

The established emergency duty team (EDT) had been supplemented over recent years by an improved range of support for people who used services and carers. There was a 24-hour palliative care service provided in partnership with health agencies and the need for emergency intervention had lessened because of the growing array of out-of-hours care.

The use of reviews to improve the appropriateness of individual packages of support required further improvement. The numbers of reviews of older people had improved in 2008 and there was a new review strategy which focused upon outcomes. The strategy stood apart from the basic care management procedures and there was confusion about the status of the guidance. Review numbers remained relatively low and some reviews were led by the agency providing the care and were limited to a consideration of the provided service – even where an assessor was involved. Some files showed reviews where sections had been repeated without amendment from year to year, the continued appropriateness of the care provided was not effectively challenged and many reviews concluded with a recommendation of no amendment.

Information about how to complain was freely available, including offers for the information to be translated into other languages, and was of high quality. People who use services and their carers were clearly advised of their entitlements regarding the assessment and closely associated processes. The complaints service had joined with health partners in providing an integrated and streamlined service in 2009. Some wider information documents about what support people who used services and their carers could expect were insufficiently clear to empower people to use the complaints procedure to secure the level of service that they were entitled to expect. The numbers of complaints was low and stable. Lessons from the

experiences of individuals had not been learned to ensure that overall performance improved. Staff and elected members were not well informed about these issues.

Capacity to improve

Leadership

People from all communities are engaged in planning with councillors and senior managers. Councillors and senior managers have a clear vision for social care. They lead people in transforming services to achieve better outcomes for people. They agree priorities with their partners, secure resources, and develop the capabilities of people in the workforce.

People from all communities engage with councillors and senior managers. Councillors and senior managers show that they have a clear vision for social care services.

The council had a clear vision for improving services and plans were underway to deliver the necessary changes. Directorate initiatives were broadly supported by other council departments and there was a sound transformation plan and project management approach in place. The transformation process was supported by external management resources. The eight work streams of the transformation project were making progress, performance information was regularly produced and specific key issues such as strengthening the transitions workforce and processes were being addressed. People who used services, carers, voluntary sector groups and minority communities had been engaged and carers were supported in contributing to the transformation process.

There was a well-established and stable senior management team in place. The Senior Management Team led the performance management of the transformation project and there were good links to corporate leadership and elected members. There had been improvement in some key services and senior managers and elected members had undertaken leadership roles in relation to championing both the needs of especially vulnerable adults and the cause of dignity in care. The directorate was confident of meeting the target of all new packages of support being offered through self-directed care by April 2010.

Elected members and corporate leaders had access on a quarterly and monthly basis to information about safeguarding and the transformation process. The understanding of elected members about the quality of safeguarding practice and the pace of implementation of individual budgets was limited. Key strengths and areas to be addressed were unclear. Scrutiny committee had not been involved in challenging the effectiveness of both transformation and safeguarding vulnerable adults initiatives.

There was a well-established business planning process in place. A sound template for an array of plans was consistently used but performance was mixed. An older persons strategy had yet to be finalised and confusion about the status of the draft document inhibited its effectiveness as a driver for change and improvement. The service plan for older people lacked a specific and targeted action plan and the otherwise sound Transformation Plan had no specific references to any anticipated

improved outcomes for older people. Team plans were in place but the quality was highly variable.

At the time of the service inspection the directorate was about to be restructured. Communication initiatives with staff had taken place regarding the changes but these had focused too much on the overall strategic vision for the service. Some staff were uncertain about the future and increased clarity about what the changes would mean for different parts of the service was needed. The progress of improvement had been fitful for some years in the directorate. Notable improvements had been achieved but in other areas, such as promoting individualised day opportunities and accommodation options, progress had been slow. A number of recent independent inspections had highlighted weaknesses. The directorate invariably responded well by addressing the shortcoming identified but this had meant that some important improvements were secured only after external intervention.

The directorate prioritised making services available to people from minority groups. The diversity strategy was strong but did not have a robust action plan and the use of Equality Impact Assessments to improve service to hard-to-reach groups was variable. Information about the type and source of contacts that were made through the customer service centre was not collected and data regarding contact with hard-to-reach groups other than minority communities was limited. The directorate employed a high proportion of people from minority groups.

People who use services and their carers are a part of the development of strategic planning through feedback about the services they use. Social care develops strategic planning with partners, focuses on priorities and is informed by analysis of population needs. Resource use is also planned strategically and delivers priorities over time.

People who used services and their carers had a good range of opportunities to contribute to service development initiatives. A number of developments had been prioritised because of feedback about the kind of support provided. The council as a whole had developed a sound public engagement policy which set out the approach to be used in consultation arrangements.

There were a wide range of consultation forums including a well-established older people's partnership board. People who used services and carers were involved in the scrutiny committee and the Health and Social Care Forum. An expert stakeholder group had recently been formed. Consultation events had identified services that needed to be changed. The Direct Payments brokerage support service had been restructured to deliver a wider range of support initiatives and a 'caring with confidence' training module had been introduced for family carers because of feedback from carers.

Initiatives to engage with hard-to-reach groups and people who used mental health services had been less successful overall. Consultation within the Supporting People service had led to the development of some services for people who are transgender.

Some established forums had needed to be reviewed and refreshed. The older people's partnership board had drifted and lacked leadership and impact. Training and support for members had been inadequate. A new priority and focus for the board on the whole of the older people's community concerns and reinvigorated leadership in 2009 was beginning to produce results.

The social care workforce has capacity, skills and commitment to deliver improved outcomes, and works successfully with key partners.

Workforce development initiatives across the whole of the social care sector had been pursued and significant progress achieved. A range of training opportunities were available to all social care staff. Workforce plans were underdeveloped and there was limited job redesign and development to support the transformation of social care.

Processes to support the work of the directorate were generally well developed. The directorate had secured the Investors In People award in 2006. The relationship with the independent sector and the availability of training opportunities for provider partners were sound. Within the directorate there was low staff turnover, few vacancies and no reliance on agency staff. A revised absence management policy had reduced short and long-term sick leave and staff with disabilities were well supported. Supervision had been prioritised, included some challenges regarding the quality of work and was valued by staff.

Training opportunities were generally available and included courses on person-centred planning and dignity in care. Staff had an opportunity to influence training priorities through a quarterly forum and this had led to some specific specialist training such as dementia care being provided. The workforce development grant had been used effectively to develop training opportunities across the social care sector. Within the directorate, a management development programme was available to all staff with managerial responsibilities.

The strategic direction of workforce development was unclear. The council's workforce strategy was only a draft document. The directorate's human resources manager had been on secondment and some staff were uncertain about cover arrangements. The workforce plan for the directorate was a sound description of the service but failed to set out specific priorities and targets for reshaping the workforce to meet the challenges of personalised support. There were no joint workforce development plans with health agencies. Staff were unclear about the future shape of workforce arrangements. Plans were in place to strengthen the strategic approach to workforce management in early 2010.

Learning and Development arrangements were set out in an up-to-date plan but we were told of some uncertainty surrounding the future of the dedicated unit within the directorate. The strategy for learning and development was a sound vision document but addressed only vague and general aspirations. Clearer quantative targets and performance information needed to be included. Planning for joint health and social care training was under-developed.

A regional model had recently been adopted to strengthen further the breadth of training opportunities across the social care workforce.

Performance management sets clear targets for delivering priorities. Progress is monitored systematically and accurately. Innovation and initiative are encouraged and risks are managed.

The directorate had effective performance management arrangements in place. The performance management framework produced monthly reports and datasets regarding national Performance Indicators and local LAA priorities for elected members, senior managers and frontline staff. Processes for monitoring both the quality of frontline assessment and care management and of provided services were sound.

Quality assurance of provided services was undertaken through a number of quarterly customer satisfaction surveys with major providers. The quality of regulated services was high and the directorate made use of Care Quality Commission (CQC) information in maintaining standards. Supervision arrangements were sound, performance managed and supported by specialist training for managers regarding the management of poor performance.

Limited progress had been made in involving people who use services and carers in quality assurance arrangements. Processes for involving people who use services in mystery shopping exercises that were underway for other adult service user groups were yet to be started in relation to older people's services. Key issues that concerned people who used services and their carers such as the quality of hospital discharge had not been prioritised within the performance framework.

Opportunities had been lost to set out increasingly specific quality standards for key services. Standards within the long-term care charter Better Care, Higher Standards were vague and un-monitorable. A promised case file audit system focused unduly on process issues and had yet to be started. Partner agencies were unclear about the progress that the directorate were making in relation to Individual Budgets, Advocacy and the development of a brokerage service.

Commissioning and use of resources

People who use services and their carers are able to commission the support they need. Commissioners engage with people who use services, carers, partners and service providers, and shape the market to improve outcomes and good value.

The views of people who use services, carers, local people, partners and service providers are listened to by commissioners. These views influence commissioning for better outcomes for people.

Traditional commissioning arrangements within the directorate were well established and of a generally high standard. Progress in developing new processes to support individual commissioning of personalised packages of care had been steady. Essential processes built upon established systems and were due to become operational in April 2010. The council had prioritised the involvement of people who used services and their carers in shaping new arrangements and types of support.

The directorate had a good understanding of the needs of the community and the JSNA had been used well to identify priority areas for improvement. Some commissioning incentives had been used to manage the market and deliver a stable set of provided services. The relationship with the independent sector was good and regular forums were in place. Contract monitoring was undertaken regularly and action had been taken to raise standards in relation to quality of care issues where these had been identified.

Key partners were aware of the vision for the future but did not have a clear picture of how the new types of services would be delivered, what the new service would look like or what investment the council were prepared to make in encouraging the development of new forms of support. The absence of a commissioning plan for older people led to confusion. A sound draft Market Facilitation Plan was yet to become active and lacked sufficient detail to reassure providers of their role in the new service.

The commissioning unit had focused upon procurement of traditional services. Additional clarity about investment intentions and the use of incentives to encourage the development of a wider range of new community based outreach support services was required. The pace of delivery of new forms of commissioning arrangements to support individual budgets needed to be maintained to meet the locally determined 2010 deadline. Stronger systems for collecting and using the experiences of frontline staff in setting commissioning priorities were required.

Some successful joint commissioning initiatives had been secured in partnership with the PCT but there was no coherent approach set out in a formal joint commissioning strategy. Some partnership work had drifted and joint initiatives had been fragmented and limited. Plans to use the PCT's 'Transforming Community Services' plan as a vehicle for a co-ordinated approach to developing a wider range of community based services were well scoped but yet to have an impact. New joint management arrangements for commissioning processes, focused leadership from both the

council as a whole and the PCT and co-location of the PCT and the directorate headquarters indicated that further developments should be possible.

People who used services had been involved in the Joint Strategic Needs Analysis process. People engaged in consultation events felt supported in this role, had access to training and valued the feedback on concerns that they had raised through the ready availability of detailed minutes of meetings.

Commissioners understand local needs for social care. They lead change, investing resources fairly to achieve local priorities and working with partners to shape the local economy. Services achieve good value.

Resources were used well to address strategic priorities. The JSNA had identified key issues across social care and budget deployment had been adjusted to reflect these priorities. This had led to increased community-based options and less use of residential and nursing home care.

Corporate and directorate financial planning and budget monitoring was well established. Investment in older people's services had been maintained in recent years and elected members had made a commitment to increases for the next three years that reflected demographic growth and inflation. There was some uncertainty about projected spend levels at the time of the inspection. The council as a whole faced a budget deficit of c. £11m in 2010/11 and the budget for the directorate for 2010 had yet to be determined. Financial planning forecasts had been made and additional investment in adult safeguarding training was beginning to deliver improvements.

Budget monitoring was sound and budget holders had access to timely financial information and support. The directorate had remained within budget consistently year on year. Associated financial processes such as charging information and financial assessment service provided a streamlined service which had maximised the income for people who used services and their carers.

The council as a whole delivered value for money and made good use of benchmarking exercises. Within the directorate performance was more mixed. Many unit costs for existing and traditional services were relatively low and efficiencies had been secured through strengthening contracts and externalising some services. Directorate plans regarding reshaping services to secure additional value or more appropriate forms of support at a similar cost were weaker. A detailed breakdown of how an understanding of unit costs and management action had led to savings and extra value for people who used services was not clear. Some managers were not able to give examples of where traditional services had been subjected to rigorous internal challenge and the value delivered properly evaluated.

Joint commissioning had developed in an unplanned way and reflected a range of particular and unco-ordinated initiatives. There was a need to formalise health and social care partnership processes and share transparent investment plans with partners and stakeholders. Joint rehabilitation and intermediate care services were under review and work was at an early stage.

Some modern and empowering support arrangements were under-developed. Advocacy was not specified or used well and brokerage support for individual packages of care was limited to a Direct Payments support service. Preparation work to put in place business systems to support more individualised forms of care had been undertaken in the first two years of the three-year transformation of social care project. Planned systems built upon well-established existing processes. This had left the transformation project team with significant systems such as IT support and a Resource Allocation System to be delivered by April 2010. This was a challenging deadline.

Appendix A: summary of recommendations

Recommendations for improving performance in Sefton

Safeguarding adults

The council and partners should:

1. Improve the practice in relation to identification of ongoing risks and the implementation of protection plans. (Page 11)
2. Strengthen recording and ensure that managers' decisions are clear. (Page 11)
3. Develop the Adult Safeguarding Executive Board, clarify interagency commitments, and implement a system of cross-agency performance management. (Page 11)
4. Develop differentiated training opportunities for key staff from all agencies and ensure attendance. (Page 12)
5. Make the role of the adult safeguarding co-ordinator more focused on quality assuring practice. (Page 12)

Improved quality of life for older people

The council should:

6. Improve the availability of individualised and independence-promoting support in the community including Day Opportunities and Extra Care accommodation. (Page 15)
7. Progress the planned production of a carers' strategy. Ensure that there is an implementation plan that clearly sets out the levels and types of support. (Page 15)

Increased choice and control for older people

The council should:

8. Ensure that care planning increasingly reflects the individual aspirations of service users as well as meeting their physical care needs. (Page 18)
9. Ensure that information about services and support that is produced is properly distributed and made available to the public. (Page 17)
10. Use advocacy in a more focused and precise way to ensure that the views of people who use services are heard and responded to more effectively. (Page 17)
11. Work with partners to improve the consistency of outcomes for people who use services and their carers at the time of discharge from hospital. (Page 18)
12. Use the intelligence gathered through the complaints process more effectively to fine-tune and improve overall service provision and processes. (Page 20)

Providing leadership

The council should:

13. Ensure that workforce development and training plans had clear improvement targets that were able to be monitored. (Page 24)
14. Clarify the strategic priorities for older people's services and share the detail of these plans with staff and stakeholders. (Page 23)
15. Strengthen the implementation processes associated with the Equalities Strategy. (Page 23)
16. Ensure that Equality Impact Assessments are used consistently to improve services for hard to reach groups. (Page 23)

Commissioning and use of resources

The council should:

17. Strengthen directorate and partnership strategic developments through publishing detailed commissioning and joint commissioning strategies for older people. (Page 26)
18. Use commissioning incentives to improve the pace of development of a wider range of community based, flexible support services and accommodation options. (Page 26)
19. Use a value for money approach more effectively to challenge established services. (Page 27)

Appendix B: Methodology

This inspection was one of a number service inspections carried out by the Care Quality Commission (CQC) in 2009.

The assessment framework for the inspection was the commission's outcomes framework for adult social care which is set out in full on our website. The specific areas of the framework used in this inspection are set out in the Key Findings section of this report.

The inspection had an emphasis on improving outcomes for people. The views and experiences of adults who needed social care services and their carers were at the core of this inspection.

The inspection team consisted of two inspectors and an 'expert by experience'. The expert by experience is a member of the public who has had experience of using adult social care services.

We asked the council to provide an assessment of its performance on the areas we intended to inspect before the start of fieldwork. They also provided us with evidence not already sent to us as part of their annual performance assessment.

We reviewed this evidence with evidence from partner agencies, our postal survey of people who used services and elsewhere. We then drew provisional conclusions from this early evidence and fed these back to the council.

We advertised the inspection and asked the local LINks (Local Involvement Network) to help publicise the inspection among people who used services.

We spent six days in Sefton when we met with eight people whose case records we had read and inspected a further eight case records. We also met with approximately 30 people who used services and carers in groups and in an open public forum we held. We sent questionnaires to 150 people who used services and 35 were returned.

We also met with

- Social care fieldworkers
- Senior managers in the council, other statutory agencies and the third sector
- Independent advocacy agencies and providers of social care services
- Organisations which represent people who use services and/or carers
- Councillors.

This report has been published after the council had the opportunity to correct any matters of factual accuracy and to comment on the rated inspection judgements.

Sefton will now plan to improve services based on this report and its recommendations.

If you would like any further information about our methodology then please visit the general service inspection page on our website.

If you would like to see how we have inspected other councils then please visit the service inspection reports section of our website.