Inspection report

Service Inspection of adult social care: **Telford & Wrekin Council**

Focus of inspection:

Safeguarding adults

Increased choice and control for older people

Date of inspection: March 2010

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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

Telford & Wrekin Council

March 2010

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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 Telford & Wrekin in March 2010 to find out how well the council was delivering social care.

To do this, the inspection team looked at how well Telford & Wrekin was:

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

Before visiting Telford & Wrekin, 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 Telford & Wrekin. It will support the council and partner organisations in Telford & Wrekin 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 Telford & Wrekin 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 Telford & Wrekin was performing well in safeguarding adults.

Increased choice and control for older people:

We concluded that Telford & Wrekin was performing well in supporting older people.

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 Telford & Wrekin was promising.

What Telford & Wrekin was doing well to support outcomes

Safeguarding adults

The council:

- Provided a range of multi-agency community safety initiatives and services that supported citizens to stay safe in their own homes.
- Ensured that most people were safeguarded from abuse and harm.
- Increasingly effectively managed the Multi-agency Safeguarding Adults Board.
- Had raised the profile of adults safeguarding.
- Ensured that staff across the adult care sector had training regarding safeguarding.

Increased choice and control for older people

The council:

- Were effectively addressing the personalisation agenda and were aware that further developments were required.
- Produced good quality information about the range of support that was available.
- Had improved the availability and take up of direct payments.
- Provided timely assessments that involved people and put in place well structured care plans.
- Were increasing the range and choice of community based services.

Recommendations for improving outcomes in Telford & Wrekin

Safeguarding adults

The council and partners should:

- Further strengthen joint working across teams and agencies by more clearly specifying respective responsibilities.
- Ensure that risk thresholds for referral into the adult protection process are identified consistently.
- Implement better recording and information sharing.
- Ensure that managers routinely review practice and make clear, accountable decisions that are well recorded.
- Implement a more strategic approach to interagency safeguarding practice and use this to direct the work of the Adult Safeguarding Board and associated training.

Increased choice and control for older people

The council should:

- Ensure that assessments are holistic and result in care plans that are outcome focussed and meet people's aspirations as well as their basic care needs.
- Work with partners to implement standards for co-ordinating support for people discharged from hospital.
- Use advocacy services to empower older people to exercise choice.
- Increase the numbers of carers assessments undertaken and ensure that carers receive the support that they need.
- Strengthen the use of the intelligence derived from the complaints service to improve the service for older people.

What Telford & Wrekin was doing well to ensure their capacity to improve

Providing leadership

The council:

- Had an ambitious vision that identified corporate priorities for developing preventative and personalised services for older people.
- Had increasingly strong and settled leadership from senior managers and politicians and was effectively addressing the transformation of social care.
- Had well established and effective arrangements in place for consulting with people who used services and citizens.
- Had sound plans to develop the workforce to meet the challenge of providing more personalised support.
- Had used performance management information well to challenge some established services and develop more appropriate community based support.

Commissioning and use of resources

The council:

- Listened to the views of people who used services and amended service development plans in response to their views.
- Had sound financial plans and managed the budget well.
- Had used commissioning processes to develop some new and more community based services.
- Had well established joint commissioning arrangements with the Primary Care Trust.

Recommendations for improving capacity in Telford & Wrekin

Providing leadership

The council should:

- Ensure that training is effectively aligned to the need to make support more personalised.
- Ensure that business support and information technology systems support frontline staff more effectively.
- Communicate more effectively with staff and use team plans to set out new ways of working and local priorities.
- Use supervision more effectively to quality assure adult safeguarding practice and promote more ambitious practice in relation to older people's care plans.
- Ensure that Equality Impact Assessments are challenging and result in improved support for people from minority communities.

Commissioning and use of resources

The council should:

- Use commissioning processes to develop more choice in the way services and support can be provided.
- Establish an effective relationship with the breadth of providers in the voluntary sector.
- Agree with health partners respective investment in planned joint services and set out investment decisions clearly.

Context

Telford and Wrekin Council is a Local Authority in the West Midlands with a population of 168,100. The council has 27 Conservative, 17 Labour, six Independent/Liberal Democrats Group and four Telford and Wrekin People's Association (TAWPA) Councillors. Governance arrangements are constituted in a 'Cabinet and Leader' model. In order to give citizens a greater say in council affairs, a system of groups, forums and meetings have been developed where the community have opportunity to influence service planning, delivery and decision making, such as the Senior Citizens Forum.

Of the 152 upper tier councils across England, Telford & Wrekin has the 107th highest proportion of people aged 65 years and older. This population is projected to increase by 34 per cent over the next 10 years, a growth of 7,800 people. The age structure varies considerably across the wards within the Borough with the 65+ population ranging from eight per cent to 25 per cent of the total population. It is estimated just three per cent of the 65+ population are from a black or minority ethnic groups.

Telford & Wrekin was ranked 113th out of 354 local authorities in the 2007 Index of Multiple Deprivation. There is a large range of deprivation across Telford & Wrekin ranging from the top three per cent most deprived nationally to the top two per cent least deprived nationally. When considering the Income Deprivation Affecting Older People Index there are five areas within the Borough in the top 10 per cent most deprived nationally and a further 14 areas in the top 10-20 per cent most deprived.

In 2008-09 the Care Quality Commission assessment of adult social care judged the service to be performing excellently, and the Audit Commission's Comprehensive Area Assessment judged the council to be performing adequately.

Services for older adults are provided through the Adult Care and Support Priority Area, which is led by a team comprising of Corporate Director and two Heads of Service, one leading on Service Delivery and one leading on Commissioning, Transformation and Safeguarding. The Commissioning unit is a joint commissioning team, encompassing PCT and Social Care Commissioned Services.

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 who used services and their carers were free from discrimination and harassment. The development of improved safeguarding adults practice had been prioritised across the council in recent years. There was a range of corporate and departmental preventative initiatives including projects in relation to domestic violence and anti-social behaviour. The Multi-Agency Public Protection Arrangements and the Multi-agency Risk Assessment Conference processes worked well.

All council departments and partner agencies were aware of safeguarding issues and their role. There was an effective corporate safeguarding partnership board that worked well with the Adult Safeguarding Board. Council staff in leisure centres included designated persons with specialist training regarding hate crime and harassment. Departmental finance staff were increasingly involved in providing financial expertise in cases of suspected financial exploitation. There was a council wide Whistleblower policy in place.

Housing services included a sanctuary scheme and a ‘fast track’ for people leaving care to secure appropriate accommodation. The strategic approach regarding housing for the whole range of potentially vulnerable people needed to be stronger. Access to emergency accommodation for all vulnerable adults was not consistently good. High rates of homelessness for vulnerable young people had reduced significantly but a consistently positive contribution from housing services in safeguarding situations was yet to be achieved.

Good local standards had been set for community safety and community cohesion. Low level support services were available and these also undertook safety checks and referred onward to other services if required. Community Support Officers and neighbourhood police officers had a high and positive profile in the work of community groups and gave advice about how older people could stay safe. Up to date policies and incident data was available in relation to issues such as hate crime. A community safety booklet had been delivered to all households and the rate of crime had been reduced although fear of crime remained an issue.

Information for the public was widely available. Council leaflets were generally of a high standard and followed a set and structured format. Some access routes for referral and further support were fragmented. Some leaflets gave multiple telephone

numbers and required the citizen to know the service user group that they fell into to in order to be able to ask for help. Some obvious telephone numbers such as the Emergency Duty Team and Social Services were missing. The council website was not easy for citizens to navigate.

Outreach initiatives to engage with potentially vulnerable minority communities had been limited. Some leaflets did not include offers of help in other languages. Some partner agencies found specialist services hard to access and fragmented. Corporate groups to support council staff from the lesbian, gay and transgender community and black and ethnic minority communities had fallen into disuse.

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

Most people were effectively safeguarded from abuse, neglect and poor treatment. The profile of safeguarding had been raised, there were increasing numbers of alerts and initial responses to referrals were timely and consistent across the council. Interagency policies had been reviewed and updated in 2009 and some multi-disciplinary work was of a high standard. Effective action had been taken to address the low numbers of notifications of concerns relating to people who had mental health problems. Some of these interventions were of a high quality but there was room for improved consistency.

The specialist adult safeguarding team provided advice and guidance that was of a high quality and was valued by staff. Frontline practitioners had ready access to expert advice and support. The team had been strengthened in 2009 in recognition of the numbers of alerts increasing by 20 per cent per year. Public information was generally good but some agencies found it hard to know how to make a referral to the correct part of the council. The focus on adult social care staff as the lead agency had led to some situations in which other parts of the council and other agencies had relinquished all responsibility for cases at the time of referral.

The interagency procedures were thorough, clear and used by staff. The procedures were shared with Shropshire and this meant that key local partners and local agencies that covered both authorities had a consistent set of processes to use. The procedures focused primarily on the roles and responsibilities of adult social care staff. This meant that multi-disciplinary cooperation in investigations and the implementation of protection plans was variable. Historic and unrealistic timescales for intervention had been ratified in the 2009 procedural review and were routinely not met.

The response of the police had improved following capacity in the specialist unit being increased but was still variable. The responsibilities of respective adult care teams and other agencies were not clearly delineated and this led to some poor information sharing and confusion over case responsibility. The management of vulnerable young people transferring from children's to adults services was often sound. The departmental transitions procedure was based on processes that were appropriate for people with disabilities and needed to be extended to cover the breadth of vulnerabilities more effectively.

Overall practice was sound and there had been some excellent interventions to safeguard individuals. Strategy meetings and case conferences were held where appropriate and the partner agencies attended in most situations. Some risk threshold identification for referral into the adult protection process needed to improve. Some staff were unclear regarding information sharing responsibilities and the duty to engage the police in some cases. Some alerts had not been notified by providers in a timely way and some investigations had not been pursued because of well intentioned attempts to protect the interests of alleged perpetrators who also had their own vulnerabilities.

Recording was variable. Notes and records of formal meetings were routinely clear. Investigations were not always clearly set out, management of records and recording was often confused and at times key information was buried in other documents. Evidence of key decisions taken by managers was not always clear. A new investigation form had brought recent improvements to the clarity of that part of the process and had enabled the volume of alerts to be better managed by facilitating structured closure of the investigation phase at an early stage where appropriate. Protection plans were generally well set out and well structured. Implementation of some of those plans was less effective. Some plans had not been checked to ensure that specified actions by partner agencies had, in fact, been implemented.

Within the department, quality assurance processes were well established and included routine audits of selected case flies. Periodic 'learning outcomes' meetings had been used to reflect on specific cases and the lessons from practice had been used to improve procedures and processes. Elected members had undergone safeguarding training and played a part in some casework audits. This work should be further strengthened by aggregating data and sharing performance information more effectively.

The Vulnerable Adults Safeguarding Board provided increasingly effective leadership in Telford. The joint board with Shropshire was well established, governance arrangements were sound and high quality activity data was routinely collected and reported. Links with children's services were effective and the seniority, attendance and commitment of representatives from other agencies was improving. The effectiveness of the board in Telford had improved steadily from a period where the board had no settled chair, poor administrative support and consequently had limited impact on the work of staff. However, the leadership offered by the board in Telford suffered from the board having no safeguarding strategy in place. Elected members were not represented on the board. The future work programme of the board needed to be more structured and clear.

Interagency learning from serious cases and practice reviews had delivered important improvements regarding the management of medication and pressure sores but these developments had been fragmented and lacked coherence. The only sub groups in place were the recently formed training group which was yet to have any impact and a group that was drafting a strategy. There was no interagency safeguarding quality assurance group in Telford and Wrekin to take forward review and learning from experience on a structured basis.

Interagency training had been historically strong, remained freely available across the breadth of the social care sector and was valued by a wide range of staff and

stakeholders. High numbers of staff in all sectors had had training and there had been a substantial increase in the training that was available. Training was increasingly effective. Courses were more differentiated and focused better on staff in particular roles. Most adult social care staff who had been involved in key roles in investigations had had appropriate specialist training.

Training lacked strategic coherence and focus. Some staff were confused about policy document references to 'mandatory' training and rates of compliance with such requirements were poor in some situations. Training was insufficiently strategically directed and focused. There was no effective training strategy and priorities were confused. A new interagency strategy was vague and imprecise. Work to develop a structured link between roles and required competencies was at an early stage. Attendance at interagency training varied markedly between agencies. In some agencies only a handful of staff had attended. Some key staff had had no specialist training. Members of the specialist adult safeguarding team who chaired all strategy meetings and conferences had had training in chairing meetings as part of induction.

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

There was a range of measures in place that supported people's dignity, privacy and promoted personal preference. The interagency policy and procedure gave clear guidance to staff about how to manage confidential information. Public information was available on people's rights to privacy and confidentiality. Consent was required from people using services where disclosure of information was required.

Services provided were of a good standard and contracts specifications had been amended to strengthen references to dignity issues. People who used services were treated with respect and dignity. One person who used services told us,

"I am listened to. It feels like my views matter."

Where difficulties had been encountered in the quality of care provided, the council have worked effectively with Shropshire Partners in Care to raise standards. Agreed procedures to set minimum standards across all provider agencies in the borough had been brokered by the council. The council had worked with colleagues from health agencies to develop contract requirements on health providers to include specifications to contracts to ensure that services were appropriate for people with special needs.

Contract monitoring was generally robust but variably pursued in safeguarding situations. Some contracting issues that arose in safeguarding investigations had not been pursued effectively. In other situations adult safeguarding procedures has been invoked to address concerns that primarily related to contract compliance. Action to safeguard other service users and address situation of potential institutional abuse had improved during 2009 when staffing in the contracts section had been strengthened.

Some specialist advocacy services had been commissioned by the council and a high quality specialist advocacy service to support people in situations of domestic violence was well used and had led to a reduction in the number of allegations that had been retracted. Overall use of advocacy to empower vulnerable people who were the subject of abuse was poor. In many cases advocacy had not been used effectively to strengthen the voice of the service user and there were repeated situations in which advocacy might have been helpful but was not used.

Procedural guidance did not make clear the criteria for deploying independent advocacy and consequently utilisation of this service was rare and was not promoted by managers. In one case a person had been subjected to years of emotional abuse because their voice had not been heard. The use of Independent Mental Capacity Act advocates was variable.

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 had ensured that people and their family carers were provided with choice in the range and quality of services when selecting residential and domiciliary care.

Extensive training regarding dignity in care had been implemented on behalf of the council by Shropshire Partners in Care and contract monitoring had identified and addressed some situations in which dignity issues had not been properly considered.

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.

Some partners found that the council did not prioritise the dignity of people from minority communities effectively through the provision of culturally appropriate menus and luncheon clubs.

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 its partners were proactively addressing the personalisation agenda and were aware that further work was required to meet this challenge. Systems were in place to ensure that citizens, staff and partner agencies were involved in these developments.

Information about low level support was available and access points 'signposted' enquirers to non care managed support where appropriate. The Care Quality Commission survey for this inspection showed that people who used services and their carers were well informed about services. A specialist access team had been established in 2009 to strengthen accessibility of the full range of services and support. High quality information was available for carers including a carer's handbook and regular newsletter. Further work was needed to ensure that information was always available in other formats and languages. The means of accessing some services, including Direct Payments, was not easy. Information about services for older people with visual impairments was poor. The website was not user friendly, information was not available in other settings such as GP's surgeries and information about safeguarding was not easily available for carers.

The council had invested in extensive advocacy services provided by a range of organisations. Investment had increased and some advocacy was secured from specialist organisations for particular groups of older people. Some services provided useful support. However, many people who used services, carers and partners didn't know about what advocacy support was available.

An advocacy forum was in place but was ineffective. Staff were not clear about the criteria for deploying an advocate. This led to a situation in which the decision to allocate an advocate reflected the predilections of the worker rather than the requirements of the situation. A consequence of this was that, in some situations, decisions about the person using services had been made in accordance with the wishes of family carers rather than the individual.

Commissioning of advocacy services was imprecise and did not promote empowerment of people who used services. Some advocacy services offered basic personal assistance such as filling in forms or 'help with complaining' rather than helping individuals represent their views in major decision making forums. Plans were emerging for a more focused advocacy service based on an emerging user led organisation.

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

Progress had been made in making assessments more holistic and care plans more personalised. More needed to be done to ensure that practice was consistently inclusive, holistic and individual.

People who used services found it easy to get in touch with a social worker and some assessments were very comprehensive and personalised. One person who used services told us:

‘‘I have always had a good experience. I know who to contact and their phone number. They ring me back and fix an appointment.”

There were few delays in providing assessments and access to intermediate care and rehabilitation services was generally good. Some imaginative packages of care had been provided and Direct Payments was highly valued where support had been provided in this way.

Practice was highly variable. Some assessments were written in the third person despite the structure of the forms. Some assessments had failed to identify the individual’s aspirations and individual interests and had resulted in a ‘standard’ and inappropriate package of care. Individual preferences in some cases had not been identified, explored nor met.

Most family carers felt listened to, assessment and care management forms were generally completed and case notes were up-to-date. Carer’s needs were often not identified. Carers were not well informed of their right to an assessment. Commitments to increase the number of carer’s assessments to be completed had not been shared with carers. In practice, few carers assessments were undertaken, some were undertaken only after delay, some took place in the presence of the person using services and in some cases the assessment had not led to any additional support for the carer. One carer told us:

“Three hours support once a month would mean that I could join in community activities around where I live. It would make such a difference, but I have to be at home for when he gets back from Day Care. No one has discussed a sitting service with me.”

Assessments were available to people who funded their own care but practice was variable. Some carers of people in these circumstances had been given a list of homes by social workers and not offered further support. There was confusion regarding the entitlement of such older people to assessment, support and on going care management.

Multi-disciplinary assessments were variable. Some specialist services were hard to access. The community mental health team sometimes asked for a GP’s referral before responding. A single assessment process was well established but was almost exclusively completed by social care staff. The quality of experiences for people who used services and carers on discharge from hospital was good where they had been referred to the council prior to discharge.

There was no delay in transfers of care from hospital and an on site social work team and ancillary services provided in partnership with the voluntary sector provided an array of hospital based support. However, there was no interagency hospital discharge procedure in place to set out agreed minimum standards of practice for staff from each agency. The acute unit's procedure did not adequately address the need to identify particularly vulnerable people such as those taking their own discharge or homeless people. Responsibilities of hospital staff to notify the council in good time of people requiring assessment were unclear.

On occasions people who needed ongoing support following discharge were not referred to the council for assessment and outcomes in these instances was routinely less good than those who went through the discharge process. Consequently, some outcomes were unacceptably poor and some council staff were involved in retrieving such situations and providing emergency care on a regular basis. There was no effective interagency forum for raising and resolving concerns about such practice, identifying issues and training needs and taking joint agency action to ensure that such risk situations did not arise in the future.

Care planning was a structured process that effectively set out the care needs and disabilities of the person using services and detailed the services to be provided. Decreasing use was being made of residential provision and options for community based support were increasing. Nevertheless, many plans were unambitious and utilised well established traditional services such as block contracted Day Care.

Many people who used services had not had Direct Payments discussed with them as an option. In some situations care managers seemed unaware of the growing range of services in the community that would promote individual day opportunities. Assessors had not been challenged in supervision to consider more individualised options for people who used services.

Most cases did not receive ongoing care management when a service had been established. Reviews were increasingly regular but were often not challenging and rarely resulted in significant changes to the provided care.

Initiatives to promote access to service for hard to reach groups were limited. A sound 'choice and discrimination' policy had been established in response to particular concerns but this had not been integrated within the established assessment and care management procedures. The policy had had limited impact on ensuring that cultural diversity was respected in care planning.

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 council were developing services to enhance the range of support available to older people. There were some well established and effective intermediate care and rehabilitation services, accommodation options had improved and support for carers was available.

Traditional services were of a high quality, available in a timely way and were well regarded by people who used services and their carers. Newer services were being developed to deliver greater choice and variety in the types of care that was available. Waiting times for adaptations were short and the equipment service had been enhanced by the development of a telecare project. The Home Improvement Agency provided a range of low level support services including safety checks. An effective joint financial assessment and welfare benefits team worked in partnership with the Department of Work and Pensions and had secured increased benefits for older people.

The development of the range and choice of services was overseen by the Health and Wellbeing Board. The leadership provided by the board was sound but the strategy lacked specific targets to drive improvement. The falls prevention strategy was yet to be finalised and some established services, including the intermediate care service, had been identified as becoming less effective over time and were the subject of a joint health and social care review.

The use of Direct Payments had improved from a low baseline following a reconfiguration of the Direct Payments support team arrangements. The new support arrangements were strong and there was a specialist Direct Payments budget for both people from minority communities and for carers. The implementation of Direct Payments had had mixed success. Most users of Direct Payments were very satisfied with the flexibility of this form of support. Many older people had not been told about the option of Direct Payments and some assessments and care plan documentation simply missed out the section considering Direct Payments.

Information for carers did not include details of Direct Payments. Some potential Direct Payments packages of support had been frustrated by poor availability of Personal Assistants. Plans to develop training to increase the availability of suitably skilled Personal Assistants were yet to be realised. Some people utilising Direct Payments had not been able to use their care flexibly as their ‘allowance’ had been withdrawn when it was not fully utilised within a set period.

Significant extra care housing had been provided to increase the options for older people requiring support. Additional extra care housing was planned and due to become available in 2011. This development had contributed to more people being able to stay in their own home as their support needs increased. Specialist support services had been developed for older people, including dementia care services and a specialist stroke service. A user led organisation had been established and had worked well with local older people to identify priorities for service development which had included transport initiatives and the provision of training for taxi drivers regarding the needs of older people with disabilities.

A wide range of carers support was available. Carers were well represented on the older people’s partnership board and the Putting People First transformation of social care board. The views of carers had shaped the development of the rapid response service and had secured free travel on buses for carers when accompanying people who used services. The senior citizens forum had led the review of dementia services which had resulted in improved specialist services being commissioned in 2009. One carer told us:

"The Admiral nurse is a lifesaver. This support has been invaluable."

The strategic approach to carers work needed to be developed. The carer's strategy was a generalised vision statement that lacked specific investment commitments and failed to clearly specify the support that carers could expect. The carers inter agency strategy had no reference to support for especially vulnerable adults. The availability and quality of respite care, including emergency care and the consistency of availability of specialist dementia care, remained problematic.

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

Older people had good information about who to contact in the event of a service failure. The standard Emergency Duty Team support arrangements had been enhanced by a range of out-of-hours services. A generally well structured complaints service had failed to maximise the potential learning from difficulties that had been encountered by people who used services and their carers.

Good information was available in leaflets and other formats advising people how to raise concerns about the quality of services. Raising a complaint was made easy in a number of ways. There was a free-phone telephone line, a prepaid tear off slip and the complaints leaflet included an invitation to ask for the leaflet in other languages and formats. Efforts had been made to streamline the complaints service with partner agencies and a joint health and social care complaints service was planned to start in late 2010. The number of complaints had been falling and where appropriate, a 'learning outcomes' meeting had been used as a basis for examining particular service failures.

The experiences of people who used services and their carers of the implementation of the complaints process was highly variable. Some cases had been very well handled. Some people felt that service users were inhibited from complaining because of fear of negative consequences on their care plan and that some other complaints were not taken seriously.

More could be done to build on the sound Learning Outcome meeting process and promote the culture of a learning organisation. Monitoring of the intelligence revealed by the complaints process about the experiences of people who used services was insufficiently structured. One complaint had lapsed because the person using the service had died. The annual complaints report focused on investigation activity rather than lessons that could be learned. Analysis of service failures was weak. Few amendments had been made to general processes and procedures as a result of what had been learned from the experiences of particular people who used services.

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.

Leadership was strong. Elected members were well informed and senior managers were accessible to frontline staff. Leadership had been compromised by a significant period of managerial change and structural uncertainty. Clear political and managerial vision for the development of the service had yet to be effectively cascaded into detailed implementation plans that informed staff and stakeholders.

Service and corporate priorities focused on key challenges for the personalisation agenda including Local Area Agreement targets relating to personal budgets and sustainable community living. A new corporate structure was being introduced to promote cross service co-operation and the development of integrated, aligned and complimentary support arrangements. The new arrangements were well co-ordinated with the development of community based health services. Elected members had led events for staff and the public to promote the vision for the new processes and the development of a wider range of support services across the council.

Elected members gave sound leadership to the overall transformation of adult social care. The council had a track record of critically examining services in relation to quality and cost and had taken action to remodel the provision of service where necessary. Scrutiny had been used effectively to review a number of services including support for carers. The cabinet lead for adult social care met regularly with chief officers to review performance and had a lead role in publicising initiatives in relation to the transformation of social care. Elected members engagement in the development of personalised support for older people was less clear. There was limited understanding of the difficulties encountered in offering Direct Payments. The vision for how older people's services would be different in future was less well understood than for other adult service user groups.

A strategic approach to the development of older people's services had been determined in association with people who used services and their carers. Neither the strategy nor the significant achievements that had been secured had been disseminated widely. This led to some partner agencies and providers being unclear about their role in the future development of support. Within the department, a range of sound strategic business plans were in place. The vision and ambition of the service was evident but investment intentions and specific targets were less clear.

The service plan was process orientated and needed to set out improvements in outcomes that were to be achieved more clearly. A structured process of team plans had fallen into disuse during a period of managerial disruption. This meant that frontline staff and managers had insufficient guidance about performance expectations on their team.

A sound and effective transformation process, Putting People First, was underway within the department and three work streams were in place to progress specific issues. A project management approach had been adopted, finance and human resources issues were being addressed and a dedicated workforce remodelling officer had been appointed. Steady progress had been achieved in the first two years of the three year program. The council had met the ADASS milestones for implementation of the project. Staff and stakeholders had been informed of progress through newsletters and conferences.

The effectiveness of initiatives in relation to minority communities was mixed. A service level agreement was in place with the local race and equality partnership. An equality and diversity plan was in place and the progress of the action plan had been monitored. The policy lacked specific targets, focused on processes rather than specifying improved outcomes to be achieved and improvement had been variable. A range of approaches had been taken in relation to Equality Impact Assessments but impact on the services had been limited.

Initiatives to make services more accessible for older people from minority communities had been limited. Representation of older people from minority communities on the group developing the older person's strategy had been bounded. Generalised intentions to provide training for council staff in relation to people who were lesbian, gay, bisexual and transgender had not been realised.

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.

A well established and effective range of processes were in place for consultation with people who used services, carers and citizens. Some service users had not been asked about their views about the service.

Overall, people who used services and carers had been effectively engaged in considering new services. A senior citizens forum was well established, included representatives of health organisations and had identified issues for further examination. People who used services and carers were involved in the reference group for the Putting People First project and this had resulted in initiatives regarding increasing options for people to access transport more easily.

The older people's partnership board was well structured, had a track record of achievements when configured as the older person's local implementation team and were well supported by the Department. People who used services and carers had

been involved in the interview panel for new low level service providers and had influenced the service specification and charging/invoicing policy. A group led by people who used services and carers had investigated dementia services and produced a report that had formed the basis of enhanced specialist services.

Frontline staff did not collect the views of older people who used services and their carers and feed this into the decision-making and priority setting processes of the department. Some situations where people had been dissatisfied with services had not been addressed. Repeated requests for improved information services for older people with visual impairments had not led to change. The development of a Lay Assessors process to strengthen the impact of the views of people who used services and their carers on service development had drifted.

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

Workforce planning was well developed. There was a thorough plan which set out a clear vision of the future. The plan would benefit further from firmer targets. Workforce and training information was robust. Better business support systems would be needed to support increased choice for older people in the way that support was provided.

Significant recruitment and retention difficulties in older people's service had been addressed successfully. This period of staffing difficulty had led to high workloads in the assessment and care management teams which were yet to be fully addressed. There was no workload management scheme in place.

Personnel arrangements to address safeguarding issues were adequate. All new staff underwent basic adult protection awareness training and processes for ensuring that basic checks on newly appointed staff had been strengthened.

Performance management measures within the council were well developed and included periodic learning outcomes meetings to address particular practice difficulties. Routine supervision was undertaken but was not used to its full extent to promote improvement. Supervision was insufficiently challenging to ensure that both safeguarding and the personalisation practice were prioritised.

Training was generally strong but a more strategic approach was needed to ensure that the necessary skills were put in place to deliver personalised support. The Care Workforce Development Partnership was well established and effective in deploying training resources across the breadth of the social care community. Specialist training in relation to dementia was strong and there had been specific training initiatives regarding issues such as carer support. Shropshire Partners in Care worked closely with the council and had undertaken effective training initiatives where practice deficits had been identified.

Training needed to be more strategically driven. An extensive programme of training courses was good but insufficiently linked to the personalisation ambitions of the council. The training programme failed to set out a strategic plan for delivering new

skills that would deliver more personalised care. The vision for the future service was good but the action plan was vague, resources were not specified and there were no timescales for completion. There was room for improved joint training with health agencies to further streamline the delivery of health and social care.

The council had not prioritised investment in business support systems and the utilisation of technology for the management of information to support frontline staff. There was no Electronic Social Care Recording (ESCR) system and staff found the client database and manual recording processes difficult and time-consuming. Data accuracy was generally good and financial management systems were robust. Processes needed to improve to be able to deliver the financial support necessary for modern personalised support. The Putting People First transformation project had plans in place to address these deficits within 2010.

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

The council had an established and effective performance management framework in place. Key targets had been set within the Local Area Agreement and were reported in a quarterly 'Balanced Scorecard' performance indicator dataset. The performance culture was well embedded in the department. Performance improvement in the department had stood still in some areas in recent years because of protracted organisational disruption. Better use could have been made of performance information at team level if team plans with local targets had been in place.

Monthly and quarterly performance information was provided to a number of monitoring forums and action had been taken to address areas of poor performance. The department had met the targets that it had set for key improvements including carers support and increased use of self directed support. Elected members were well informed about most areas where performance was not adequate. Detailed data was available to the Vulnerable Adults Safeguarding Board. Elected members needed to be better informed about the challenges faced by council staff in keeping people safe.

A range of operational quality assurance processes had been introduced to promote quality outcomes for people who used services and their carers. Where a structured approach had been taken to setting and monitoring delivery of improved standards there had been good progress. Some business plans had been used to set out plans for focused improvements. The service standards unit set good standards for safeguarding, complaints and adult services.

A number of service user surveys had been pursued, a monitoring form had been introduced to gather information about victim's experiences of adult safeguarding interventions and a structured system of random case file audits had been introduced in 2009. More work was needed to make best use of information gathered in this way. Independent monitoring of case file audits by service review managers had yet to begin and intelligence had not been aggregated regarding the experiences of people under going safeguarding interventions.

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.

The council gave high priority to ensuring that people who used services were listened to and were fully involved in consultation and the process of service development. Commissioning and joint commissioning processes were well established but needed to engage more effectively with the voluntary sector.

Commissioning processes were well established. The needs assessment process was effective. The Joint Strategic Needs Assessment had been conducted in partnership with people who used services and had included in-depth consideration of key issues for older people. The needs assessment process had been used to shape new forms of support such as Extra Care housing, additional respite services and specialist support for older people with dementia. Pilot programmes had been pursued in relation to using an on line market place to support 'micro commissioning' in readiness for increased self directed support as part of the Putting People First project. Resources had been increasingly used to support low level and preventative services.

Some traditional services were in need of modernisation. There was widespread dissatisfaction with the Community Alarms Service. A review had been conducted but the reconfiguration of the service had been slow. Incentives had been used to secure some quality outcomes in some services but had been used less effectively to encourage providers to invest in and develop new services. The supply of support workers in the community to progress individualised day opportunities was poor.

Processes for contract specification and monitoring were broadly sound and had been strengthened further in 2009. New dignity and safeguarding clauses had been introduced, additional staff had been provided to strengthen the contracts section and attendance of contracts staff at safeguarding meetings had improved. Processes for ensuring that contracts staff were engaged in all safeguarding situations where there were wider concerns about the quality of provided care needed to improve.

Joint Commissioning arrangements were well developed. A specialist unit included co-located health and social care staff and had integrated management arrangements. A range of well established joint services were in place. A sound joint approach had been taken to deploy resources to support admission avoidance initiatives to address winter pressures. Commitments for future joint investments needed to be clearer. A shared vision for the development of community based Health and Social Care services was yet to be supported by specific financial commitments. Some Direct Payment packages had been threatened by the

withdrawal of health funding.

A range of forums were in place to work in partnership with the voluntary and independent sector. Partnership arrangements were variably effective. Some voluntary organisations did not feel valued or listened to. Some commissioning focused overly on activities to be completed rather than a requirement to deliver specific outcomes. There was little acknowledgement of the skills of the sector and insufficient delegation of authority within contracts to empower providers to act independently to swiftly respond to changing needs. Some providers thought that their place in the future plans of the council was unclear and found council processes to be bureaucratic and lacking ambition to promote new and innovative forms of support.

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.

Council commissioners were knowledgeable about local needs and worked well with most partners. Financial and budget management processes were well established but needed to be streamlined to support personalised practice more effectively.

The council had a well set out Medium Term Financial Plan which showed increased investment in older people's services to reflect demographic trends in the forthcoming year. Intentions to maintain investment to match rising demand was evident but remained subject to political approval at a later date. A significant capital programme had been deployed to extend choice for older people needing accommodation with care through the extra care housing programme. The council as a whole faced significant budget pressures and there were no plans for additional new services for older people above the demographic funding already committed.

Budget management processes were strong and the department routinely managed expenditure within budget. Budget decisions had been devolved to a range of managers and a joint agency funding panel and specialist financial support was provided. The council had effective processes in place to make payments to partner agencies from whom they commissioned services.

The council had prioritised securing value for money. The council made good use of a local benchmarking club and unit costs for traditional services were below those of the council's comparator group. All business plans had mini 'value for money' sections and in the best plans good use had been made of unit costs to identify where savings and quality improvements could be secured. Savings had been made in commissioning unit costs within the Supporting People team and the cost of Intermediate Care services had been decreased by a third without compromising quality. Planned efficiencies within the portfolio plan lacked the same detail of how these saving would be made that had been set out in other plans. It was unclear how the identified savings would be achieved and what impact they would have on the service.

Commissioning processes had been well used in the transformation of social care

project. The new access team was able to deploy local, low level support including community meals. Plans were in place to extend this to culturally sensitive services including small, local providers of community meals later in 2010. A Resource Allocation System pilot had been undertaken and plans were in place to implement a definitive system later in 2010. A range of extra care housing options had been secured and further facilities to extend choice in accommodation options were under development. Many providers were aware of initiatives to address identified gaps in services. More work was needed to ensure that the council was as helpful as possible to all providers who needed approvals and permissions to develop new types of support services.

Appendix A: summary of recommendations

Recommendations for improving performance in Telford & Wrekin

Safeguarding adults

The council and partners should:

1. Further strengthen joint working across teams and agencies by more clearly specifying respective responsibilities. (Page 11)
2. Ensure that risk thresholds for referral into the adult protection process are identified consistently. (Page 12)
3. Implement better recording and information sharing. (Page 12)
4. Ensure that managers routinely review practice and make clear, accountable decisions that are well recorded. (Page 12)
5. Implement a more strategic approach to interagency safeguarding practice and use this to direct the work of the Adult Safeguarding Board and associated training. (Page 12)

Increased choice and control for older people

The council should:

6. Ensure that assessments are holistic and result in care plans that are outcome focussed and meet people's aspirations as well as their basic care needs. (Page 16)
7. Work with partners to implement standards for co-ordinating support for people discharged from hospital. (Page 17)
8. Use advocacy services to empower older people to exercise choice. (Page 15)
9. Increase the numbers of carers assessments undertaken and ensure that carers receive the support that they need. (Page 18)
10. Strengthen the use of the intelligence derived from the complaints service to improve the service for older people. (Page 19)

Providing leadership

The council should:

11. Ensure that training is effectively aligned to the need to make support more personalised. (Page 22)
12. Ensure that business support and information technology systems support frontline staff more effectively. (Page 22)
13. Communicate more effectively with staff and use team plans to set out new ways of working and local priorities. (Page 21)
14. Use supervision more effectively to quality assure adult safeguarding practice and promote more ambitious practice in relation to older people's care plans. (Page 22)
15. Ensure that Equality Impact Assessments are challenging and result in improved support for people from minority communities. (Page 21)

Commissioning and use of resources

The council should:

16. Use commissioning processes to develop more choice in the way services and support can be provided. (Page 25)
17. Establish an effective relationship with the breadth of providers in the voluntary sector. (Page 26)
18. Agree with health partner's respective investment in planned joint services and set out investment decisions clearly. (Page 25)

Appendix B: Methodology

This inspection was one of a number service inspections carried out by the Care Quality Commission (CQC) in 2010.

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 Telford & Wrekin when we met with eight people whose case records we had read and inspected a further six case records. We also met with approximately 80 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 47 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.

Telford & Wrekin 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.