Appendix 1

Commission for Social Care Inspection

Making Social Care Better for People

Service Inspection Report

INDEPENDENCE, WELLBEING AND CHOICE

Leeds City Council

July / August 2008

Safeguarding Adults

Delivering Personalised Services

Delivering Preventative Services

COMMISSION FOR SOCIAL CARE INSPECTION

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

Our Vision and Values

The Commission for Social Care Inspection aims to:

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

INSPECTION OF INDEPENDENCE, WELLBEING AND CHOICE

Leeds City Council

July / August 2008

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INTRODUCTION AND BACKGROUND

An inspection team from the CSCI visited Leeds in July/August 2008 to find out how well the council was safeguarding adults whose circumstances made them vulnerable.

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

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

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

SUMMARY

Safeguarding Adults

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

Adult safeguarding arrangements in Leeds were inadequate and did not satisfactorily protect vulnerable people. Alerts were responded to speedily, but practice failed to identify risks, procedures were weak and poorly implemented and multi-disciplinary cooperation was deficient. Investigations were inconsistent, strategy meetings sporadic and protection plans ineffective. Operational staff and managers did not have a clear understanding of the circumstances in which to intervene or the processes to follow in providing protection.

The skills of staff from all agencies were variable. Effective focus on awareness raising regarding risk issues had increased the numbers of alerts but this had put pressure on ill equipped staff to cope with the increased workload. Neither the department nor the Adult Safeguarding Board had determined a set of basic competencies to be required for particular staff undertaking specific responsibilities. There were extensive training opportunities, but a lack of a competency framework to underpin training activity led to a confused and inconsistent set of initiatives. A multi-agency training strategy had been agreed but was unfunded and yet to be implemented.

A well developed range of preventative services had been used episodically in protection plans. The adult care service and partners had not prioritised protection planning in relation to anticipated risks or the provision of contingency plans for people living in situations of ongoing vulnerability. Risk situations had not been identified and workers had not understood safeguarding in the context of eligibility and risk and had failed to offer appropriate services. Arrangements for frontline staff from the council and partner agencies to identify potential risk situations and ‘fast track’ vulnerable people to appropriate support were insufficiently detailed.

Quality assurance procedures were absent. First line managers and managers who reviewed specific cases had not identified clear risks. Effective management oversight and assurance of minimum standards of practice, in casework, was missing. The community of health and social care agencies had failed to promote an approach of challenging their own practice, there was no serious case review process in place and learning from national issues had not taken place. A recent audit of practice had been insufficiently rigorous and had led to an action plan that lacked appropriate urgency. Managers and elected members did not have access to adequate performance data about the quantity or quality of practice, to have confidence that minimum standards were being achieved. Some agencies had decided not to use the inter-agency procedures without detection or challenge.

The Adult Safeguarding Board had been weak and ineffective for some years. A well scoped recovery plan was in its very early stages and was yet to have meaningful impact. The board met regularly and membership had been enhanced. However, the board had made few decisions and had not given adequate leadership. The weaknesses had been identified and the Executive Director had secured the support of chief officers from partner agencies to oversee the improvement of the board.

Delivering Personalised Services

We concluded that **delivery of personalised services in Leeds was adequate.**

Assessment and care management arrangements were well established and often delivered sound and timely packages of care. The degree of identification of individual needs in the assessment process and personalisation of care plans was, however, highly variable.

Information about services was generally good and contact arrangements for new and existing services users worked well. Signposting arrangements to ensure that people who did not meet the criteria for care managed services were directed towards appropriate support organisations were in place and some assessments had been undertaken in relation to people who could fund their own care.

Casework was generally well structured and recording was up-to-date. However files were often disorganised and evidence of multi-disciplinary contributions to assessments was frequently missing. The single assessment process was well established but the use of the process by staff from other agencies was variable. Most mainstream teams were neither jointly managed nor co-located and the degree of inter-agency cooperation in the assessment process often reflected the local management arrangements. Hospital discharge practice was unacceptably variable and inadequately managed. The hospital discharge procedure was unduly focused on speed of discharge and people who use services experienced multiple difficulties at the time of leaving hospital. Implementation of the procedure was not performance managed by staff from any agency. Partners had not agreed any joint system for resolving disputes about the quality of experiences of people using services and learning lessons to improve practice.

Performance management of assessment and care planning was unstructured. It was overly reliant on a supervision policy that was implemented fitfully and for which there were no compliance monitoring arrangements. Management oversight had not challenged practice which included the rigorous implementation of eligibility criteria within the available budget which, on occasions, failed to realise the capabilities and ambitions of people who use services and their carers. Direct Payments, although an improving area of performance, was not routinely offered to people as a way of increasing control and choice in their care plan. Advocacy services were available but had not been used to empower people to express their views or promote their own plans in relation to how care was provided.

Poor performance on reviewing the changing needs of people who use services had been addressed and a dedicated review team had secured improvements in the quantity of reviews completed. However, the quality of reviews was variable; departmental commitments to important quality standards were not achieved in practice and the review process was not effective in identifying situations in which emerging risks and vulnerabilities were evident.

The range of services had improved, the quality of commissioned services was generally high and community services were developing. Admissions to nursing homes had decreased and there was increased use of independently provided home care. However, there was a corporate and departmental acknowledgement of the need for improved out-of-hours services and there were significant quality concerns regarding the availability and reliability of some specific services. Large parts of some services remained directly provided and unmodernised. However, key services, such as day care, had well scoped plans for development and investment in a new commissioning unit and had delivered an improved range of services, including extra care housing and additional respite care.

Delivering Preventative Services

We concluded that **delivery of preventative services in Leeds was good.**

The council and partners had agreed a sound prevention strategy and had prioritised the development of preventative services. A range of community based services had been developed in partnership with people who use services and carers and this had effectively built community capacity. Projects included a widespread availability of neighbourhood networks and a range of projects focusing on developing social inclusion opportunities and targeting key deprivation issues such as fuel poverty.

A significant and effective two year Partnership for Older People Project (POPP) had been implemented, telecare opportunities had been developed and there had been good partnership work with Supporting People services. Some projects had focused on support for older people with mental health problems and there had been significant success in reducing admissions to both hospitals and nursing home care.

Partnership working with health agencies had been successful and a falls reduction programme had led to reduced attendance at accident and emergency departments. The sustainability of especially funded projects had been broadly agreed. Good use had been made of the Supporting People budget but financial commitments from health were yet to be specified. A number of projects had focused specifically on the needs of people from black and ethnic minority communities. Needs analysis and focusing resources had been sound. Carers' services were developing, and a range of information about what was available had been developed, however this had not been disseminated effectively.

Capacity to Improve

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

Overall leadership arrangements were improving but were yet to effectively build the systems and processes required to address some of the deficits identified within this report. Periodic sound leadership had been evident in relation to the development of particular projects such as preventative services and a well established business planning process had been enhanced in recent years by the development of a formal transformation process. However, in the past, core business processes including strategic partnership and leadership had been under prioritised. The new management team had a good understanding of the historic deficits in service provision and long-term business process shortfalls. Clear plans which built on improving corporate and inter-agency partnership arrangements were in place.

Business planning processes were in place but insufficiently specific and detailed to be effective drivers of change. Many important improvements had been undertaken as special projects outside this process. Increased cohesion had become evident since the formation of the Transformation Board in 2007. Elected members had given increasingly sound leadership and had supported important changes that were being implemented in relation to modernising services and business processes such as the charging policy.

Current strategic partnerships were strong, the new corporate strategic management arrangements had improved partnership working in the council and good 'vision' was given through the Local Area Agreement which prioritised both personalisation of services and adult safeguarding. However, the cascade of these high level aspirations into specific and monitorable targets for improvement was compromised by weaknesses in business systems for implementing change.

Some partnerships with health agencies had been weak for some years and had been exacerbated by organisational restructuring in the council and the Primary Care Trusts. Well established health promotion, public health and specialist joint care management teams had been supplemented by the relatively new Joint Strategic Commissioning Board and more trusting and widespread partnership relationships were being established. A history of agencies acting in a fragmented and sometimes uncoordinated way was changing slowly but the need for greater sustained and formal joint commitments was evident.

Leadership and governance arrangements in relation to adult safeguarding were unacceptably weak. Elected members did not have access to sufficiently detailed and accurate information about the performance of the service and the degree of practice failings that had been identified in the 2007 audit had not been effectively communicated. Within the health and social care community a culture of self scrutiny had not been established and poor practice had been tolerated.

Key business processes remained weak. The department had a limited history of commissioning high quality services and the departmental approach to cost, quality and value for money was inconsistent. Savings had been made in services that had been reconfigured but quality improvements were less evident. There was no commissioning plan in place for older people's services and there were no systems in place to use the experiences of frontline staff to inform future commissioning. The commissioning plans that were available were fragmented and yet to be funded. Nevertheless, the investment that had been made in the new commissioning unit had delivered important results. The involvement of people who use services and carers in service development had improved, contracting and contract monitoring was stronger and adult safeguarding clauses within contracts were sound. Quality had become a more prominent feature in contracting but managers were aware that further progress was required.

Workforce planning was poor. Annual plans were traditional and the plan for 2008/09 was only in draft form, bounded in ambition and the scope of the plan was insufficiently developed to support and enable the identified priorities for transforming services.

Processes for performance managing basic levels of performance in assessment and care management teams were ineffective, managers were not empowered to challenge poor practice and training plans were fragmented and lacked coherence.

Performance management systems regarding national performance indicators were well developed at a corporate and a departmental level. These were not complimented by similarly effective processes focusing on quality assurance of frontline practice and the experiences of people using services. Performance information for local managers to improve the service was poor but there were impressive plans in place to improve these systems. The complaints service was sound, had used information to learn lessons from practice failings and could be built upon to strengthen the service user focus of the quality assurance processes within the department.

Budget management had improved strongly since the significant financial overspend in 2005 and was effective in controlling costs. However, budgets were not effectively devolved to managers to allow flexible allocation of resources within clear guidelines and priorities and a 'cost' rather than 'quality' focused culture had evolved in practice.

RECOMMENDATIONS

Outcome theme	Recommendation
Safeguarding adults	• The council should urgently ensure that concerns are investigated, strategy meetings held and protection plans devised and implemented where necessary. • The council should strengthen frontline quality assurance arrangements to ensure that minimum standards of practice and recording are implemented routinely in responding to adult safeguarding alerts. • The council and its partners should agree and implement improved procedures, ensuring that these: o set out specific and monitorable expectations on staff from all agencies; and o implement a system of compliance monitoring processes that ensure consistent practice. • The council and partners should progress the emerging multi-agency training strategy and link this development with an agreed set of minimum competencies for specific roles within the adult safeguarding process. • The council should ensure that staff are alert to potential risk factors where people live in situations of ongoing vulnerability and that appropriate contingency plans are put in place. • The Adult Safeguarding Board should: o prioritise the development of the quality assurance sub-group; and o agree an adult safeguarding serious case review process and mechanisms for sharing performance issues and learning with partner agencies. • The Adult Safeguarding Board should strengthen its leadership role and processes for informing and reporting practice issues to elected members.
Delivering Personalised Services	• The council should ensure more inclusive and individualised assessments. • The council should promote more ambitious, outcome focused care planning. • The council should ensure that departmental standards in relation to the timeliness and the quality of regular reviews are met. • The council should ensure that opportunities to promote individualised care plans utilising Direct Payments are always seized. • The council should build on the wide availability of advocacy services by specifying and focusing the circumstances in which it should be used to empower people who use services.

Outcome theme	Recommendation
	• The council should extend the range and choice of services by reconfiguring and modernising traditional, buildings based services. • The council and partners should strengthen hospital discharge procedures by: o focusing on the quality of people's experience; o setting out clear reciprocal responsibilities, with procedures in place for ensuring compliance with those standards; and o agreeing a process for resolving and learning from concerns about the quality of multi-disciplinary work.
Delivering Preventative Services	• The council should improve the availability of information about the range of carer's services. • The council and partners should improve the use by staff of the wide range of preventative services in preventative support packages for particularly vulnerable people in the community.
Leadership and Commissioning	• The council and partners should agree a set of joint funding priorities and set out clear service development plans with associated joint management arrangements and joint funding commitments. • The council should set out a clear commissioning plan for older people's services including re-commissioning arrangements for existing services where appropriate. • The council should implement a system to ensure compliance with the expectations of the supervision policy. • The council should make the established business planning process more effective by cascading general intentions in strategic vision documents into more effective action and team plans. • The council should publish a workforce development plan that reflects the reshaped services and sets out how retraining and job redesign processes are to be utilised to deliver the skills needed for the reconfigured services. • The council and partners should strengthen governance arrangements so that elected members and relevant chief officers in partner organisations have a clear understanding of the performance of adult safeguarding arrangements.

CONTEXT

Leeds is a city located in the Yorkshire and Humberside region of England and is the second largest metropolitan council. Leeds has a population of approximately 750,249 (source: ONS 2006 mid year estimates). Over 14 per cent of the population are older people. Over the next three years, the city's population of older people will increase by an estimated 2,690 people overall, from 109,910 to 112,600 (source ONS subnational projections 2006-2031).

The 2001 census indicates that black and minority ethnic population is approximately 8.2 per cent. The percentage of older people that come from black and minority ethnic communities is 2.82 per cent.

The council works closely with the co-terminus Primary Care Trust (PCT), and with the voluntary sector, in the commissioning of services. Provision of social services for the adult population sits within the council's Adult Social Care Directorate. The Directorate incorporates responsibility for social care services for older people, learning disabled people and physically and sensory impaired people and people with mental health concerns. The Director of Adult Social Services is responsible for the Adult Social Care Directorate.

In the December 2007 Comprehensive Performance Assessment update, the council was judged by the Audit Commission to be a four star council, with a Direction of Travel judgment of "Improving Well" and a score of three out of four for adult social care services. In December 2007, social care services were judged by CSCI to be two star, with adult services being assessed as delivering good outcomes, with promising capacity to improve.

KEY FINDINGS

1. Safeguarding Adults

1.1 Safeguarding against poor treatment

Arrangements for protecting vulnerable adults in Leeds were poorly set out and inconsistently implemented. Practice was unduly variable, some risk situations were not effectively addressed and implementation of the procedures was of an unacceptable standard. Some good interventions were pursued in the course of ongoing casework and immediate action to respond to alerts was evident, even where these involved people who use services and were in placements outside the city. However, some staff were reluctant to implement adult protection procedures because of uncertainty about what would be involved. Awareness of risk thresholds was poor amongst operational staff and some people who use services were left in a variety of risk situations without help. A number of case files sampled had to be revisited by the council for reallocation and proper action to be taken.

Operational staff and managers made repeated decisions which sought to minimise the evident risks and to justify non intervention. There was a belief that if police investigations could not be justified, then no intervention was warranted. There was confusion amongst practitioners and managers about whether people who use services had to give 'permission' before protective action could be embarked upon. There was similar confusion regarding the impact that mental 'capacity' had on risk assessment; some staff believed that those people judged to have 'capacity' could not, therefore, be considered to be at risk.

Investigations were recorded in case notes, on separate sheets of paper or in e-mail exchanges. Manager's decisions were not clear; some cases were closed when risks remained evident. Strategy meetings were not routinely held. Some records of meetings were of poor quality. Protection plans, where in place, had poor content and were confusingly presented. Notes did not explicitly set out the risk assessment process and actions did not specify responsibilities, timescales and implementation arrangements. There was no system for ensuring that actions had taken place. A requirement within the procedure for three monthly reviews of protection plans was widely ignored.

Policies and procedures were widely available in hard copy and on the department's intranet. Individual members of staff and managers, on occasions, delivered sound results for some people who use services. The inter-agency procedures were six years old and were not fit for purpose. There were no forms or templates for recording alerts, investigations or recording progress of implementation of protection plans. Recording was consequently confused and repeatedly inaccurate. Management oversight of practice and key management decisions were weak. Recording errors and, more worryingly, deficits in frontline practice and risk management, had been approved by reviewing managers.

Multi-disciplinary cooperation was poor overall and on occasions, non-existent. Within the council, partners such as housing managers did not acknowledge the need for priority to be given to the most vulnerable people. There was no effective protocol for coordinating the involvement of various departments and no 'fast track' through key services such as the homeless unit for people in risk situations. Operational staff found other agencies keen to report incidents but then often reluctant to remain engaged. There was no process in place for raising concerns about poor practice by other agencies. Referral routes to secure the help of other agencies were confused and inadequate. Difficulties and delays were evident in securing timely and effective support from the police and from health agencies. Information was not shared effectively and evidence was not collected.

The hospital discharge procedure did not mention adult safeguarding and gave overriding priority to speed of discharge. Some partner agencies bypassed the adult safeguarding procedures altogether. Managers in the adult social care service had not been aware of this practice.

Increased training regarding adult protection awareness had led to an impressive increase in 'alerts', but some agencies reported indiscriminate referrals, confusion about where to direct a request for partner agency cooperation and some referrals being directed to the wrong place.

Inconsistency in practice had been identified by managers in 2007 and the inter-agency adult safeguarding unit had been strengthened and was valued by staff from all agencies. The unit was increasingly seen as an important source of advice and guidance.

The department had funded a range of established specialist adult safeguarding advocacy services, including one focusing on elder abuse, and significant Independent Mental Capacity Advocacy (IMCA) training had been undertaken. However, advocacy was rarely used in practice and opportunities to empower particularly vulnerable people in this way had been missed.

1.2 Making sure that staff and managers know what to do

Both the department and the adult safeguarding partnership provided extensive training opportunities but there was no strategic cohesion to the initiatives. There was a lack of clarity about skills required to undertake specific adult protection roles and multi-disciplinary training was under developed and poorly implemented.

Staff found training helpful and skilled but confusing. Significant investment in awareness training had led to a marked improvement in the number of alerts made by partner agencies. However, there was inconsistent take up of training and there was confusion about whether certain training was a requirement or not. There was no strategic approach to developing key skills regarding the assessment of vulnerable people and the identification of 'risk thresholds', implementing investigations or chairing strategy meetings and setting up protection

plans. Training for safeguarding adults enquiry coordinators was discretionary.

There was no competency framework to ensure that staff undertaking key roles would perform to a minimum level of proficiency. Adult protection procedures were vague in relation to the required competencies for key departmental and partner agency staff to undertake specific roles. However, adult protection awareness training had been prioritised within the adult social care business plan and training had been strengthened by the development of a training officer role.

Workforce development arrangements made no mention of adult safeguarding training and development needs beyond a sound requirement for new staff to have training as part of their induction process. Despite the plan having no effective or specific targets, an introduction to adult protection issues was generally well delivered to probationary staff. Weaknesses identified by the Audit Commission regarding training for staff from the Supporting People service had been well addressed.

The adult safeguarding partnership did not prioritise the creation of sub-groups to progress improvement work until 2007. The best established sub-group focused on training and this group had scoped an improvement plan in relation to multi-disciplinary adult safeguarding training. The plan was sound and the training needs of staff from all agencies had been well analysed. However, the plan was unfunded, implementation arrangements were unclear and the multi-disciplinary training in place was poorly developed and ineffective.

Take up of training opportunities from other agencies was muddled and highly variable. Corporate staff in important frontline services had had little training. Some staff found the IMCA training lacking in focus on the application of skills in practice. The emergency response team staff had had awareness raising training and had been Criminal Records Bureau (CRB) checked. However, other key groups such as joint care management teams, contact centre staff and staff in the homeless unit and telecare services, had had few training opportunities. Managers were not able to readily identify which members of staff had had what type of training.

Significant efforts had been made to cascade skills and awareness training to independent sector providers. Over 90 per cent of staff had had some training and there was an effective adult protection employee development unit in place. However, the department's knowledge of the level of skill amongst these staff was minimal; neither the department nor the Adult Safeguarding Board had specified a minimum competency framework for staff in these units.

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

A well developed range of preventative services had not been used in a formal, structured and consistent way to support and monitor

contingency plans to keep vulnerable people safe. Guidance for the utilisation of these services in these situations was less good than overall access procedures for general preventative services. Some risk management processes that had been set in the context of ongoing casework were not sufficiently prioritised or documented. This minimised their effectiveness in safeguarding adults.

A broad range of preventative services had been developed and elected members gave sound leadership to prioritising developing preventative services. CRB checks were offered for people appointing their own personal assistants and increased training regarding complaints had led to higher numbers of people using services knowing how to raise concerns about their care. However, there was no strategic approach to early risk identification and contingency planning. Some managers were concerned that frontline staff only identified existing people who use services as qualifying for risk assessments and preventative packages of care. Random cases we saw showed risk factors that had been missed. Where protocols had been established, they focused on sharing information rather than structuring coordinated interventions. The contact centre did not have clear processes for routing risk situations through for a priority response and did not 'own' potential risk situations. In one case, where a caller asked for help with an adult threatening suicide, the response given simply advised that this issue should be referred by the caller to the relevant GP.

Information about support services was mixed. The website had good sections in other languages; however, adult safeguarding information was not made available to minority groups in leaflet form in languages they could understand and the complaints leaflet failed to refer to protection or vulnerability issues.

Some assessments for self funding people had been completed but the number was low. Some managers identified particular services where the importance of offering expert help and assessment to people who could fund their own care was poorly developed. In some situations, assessors and managers were quick to withdraw care management when people proved hard to engage.

The adult protection procedures gave little priority to the need to anticipate potential risks and institute formal preventative protection planning and few situations were evident where underlying risks for vulnerable people had been identified and structured contingency plans set up in practice. Important services that could have helped make people living in situations of ongoing risk less vulnerable were not used effectively in protection plans.

Awareness of the full range of support services such as neighbourhood networks, community safety initiatives and community policing services were not well known to frontline staff. Telecare was not focused on the very vulnerable. In some cases a strict interpretation of Fair Access to Care Services criteria had been used to justify non intervention despite evident risk factors. No alternative preventative services were engaged to provide support. Conversely, some providers of preventative services felt

that where they had been involved in increasingly risky situations, they were left with undue responsibility and did not have swift access to reassessment and support if the situation deteriorated.

There was little use of established services to monitor and maintain a safe environment for people who lived in vulnerable situations. Some cases were closed when evident risk factors, such as a person with special needs moving into independent accommodation, indicated that there should be a contingency plan where particular risks could be monitored for a period.

The issue of quality assuring service providers for non care managed services had been addressed and some processes, for major partners that were funded by the department, had been put in place. Within the Supporting People services there were strong processes in place which included clauses regarding protection of vulnerable adults within the service provider contracts.

Opportunities were missed at the point of reviews to identify changed circumstances and increased vulnerability in service user's situations. The role of reviewing officer in strengthening the processes for identifying risky situations was unclear.

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

Quality assurance processes in the department and in the Adult Safeguarding Board were under developed and inadequate. Inter-agency procedures set out four 'standards' but there were no compliance monitoring processes in place to ensure that these expectations were actually met in practice. Performance information on frontline practice was not reported in sufficient detail on a regular basis to help managers and elected members understand the quality of the service for people who use services and carers.

A range of weaknesses in practice and process had been identified in an internal review of the service in 2007 and an action plan documented a number of important improvements to be addressed. However, the document lacked focus and detail and, while constituting a structured work programme for generalised improvement, was not an effective or sufficiently urgent driver for change to improve practice.

The Adult Safeguarding Board had no compliance monitoring process or serious case review process. There was a new quality assurance sub-group that had met once but the outcomes from this group were yet to have an impact. Oversight of performance standards was particularly poor in joint care management teams and some teams had developed their own checklists of standards. There was confusion and tension about managerial responsibility for some cases between casework team managers and nominated safeguarding adults enquiry coordinators.

There had been sound work on a joint whistleblowers campaign and the board had identified a number of cases where practice had been poor.

However, the board had decided, on reflection, not to pursue further investigation of these situations to learn lessons for the future. The learning disabilities strategy did not reflect the national learning that had emanated from the Cornwall enquiry.

Performance and quality assurance data was poor. There was no system of checking the quality of casework practice or learning lessons from mistakes. Teams did not have any performance targets regarding quantity or quality of interventions. Sound plans were, however, in place to introduce a structured system of random case file audits and use the forthcoming Electronic Social Care Record process to strengthen performance information and institute a 'bring forward' review notification process in late 2008.

There was confusion about the minimum qualifications required by staff to undertake adult protection responsibilities. The service had not determined minimum skills required to deliver a quality assured level of practice. A significant minority of investigations had been conducted by staff who had not undertaken the expected training. Generalised assurances that these staff were competent to undertake the investigations were inconsistently evidenced. The raft of practice deficits we identified related both to staff who had, and had not, had additional training.

1.5 Making sure that POVA arrangements are robust and work well

The Adult Safeguarding Board had failed to provide effective leadership for a number of years and an urgent need for radical improvement had been identified by managers. A broadly satisfactory recovery plan had been devised but had yet to have an impact.

The board was well established and met on a regular basis. The profile of adult safeguarding had been raised and agreement to improving multi-agency training arrangements had been secured. Health representation on the board was sound and there were well scoped plans to strengthen the involvement of the police at an operational and strategic level. The board had developed improved links with the Children's Safeguarding Board including the new chair being a member of both boards. However, the board had not set a clear direction for partner agencies to deliver and improve adult safeguarding arrangements. The procedures had been the subject of a number of reviews and attempts at improvement over several years and partner agencies had resorted to developing their own processes.

The minutes of meetings were vague, imprecise and ineffective. Some agencies considered the board to be ineffective and consequently attendance and commitment had faded. Some members of the board were critical of its past performance, finding it unfocussed and characterised by drift. We also heard of a lack of any process for raising concerns about the failure of partner agencies to meet their responsibilities under the agreed inter-agency protocol.

Partnership work at a strategic leadership level was missing. Links with key community safety services were under developed and representation of partner agencies on the board had been unsatisfactory. Seniority of attendees had improved in late 2007 but on occasions the status of those attending meetings was insufficient to inform the debate and make agency commitments. The Executive Director had brought together chief officers from key partner agencies to oversee improvements in the safeguarding board function. The recovery package had delivered some important improvements including the group being renamed, an agreement in principle to establish a serious cases review process and an expanded membership. A multi-agency training plan was under discussion and good progress had been achieved regarding IMCA awareness, although a practice guide had yet to be developed.

Major improvements to the functioning of the board remained outstanding. Plans to revise the terms of reference of the board and improve appropriate attendance at the board had yet to be completed. The plans were sound but yet to have an impact and lacked precise targets and timescales. Membership remained deficient, additional sub-groups had yet to be established and the revised procedures were still under discussion. A policy and procedures sub-group had been established to revise the 2002 inter-agency protocol, with plans for the new arrangements coming into force in late 2008.

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

A sound range of confidentiality processes were in place although some lapses were evident in practice. Case records were often confused and on occasions, chaotic. Consent forms for data recording were inconsistently completed and there was no separation of adult safeguarding information from other data on file. A number of case files had gone missing without explanation.

Confidentiality procedures were well set out and a large number of staff had attended relevant training. Dignity in care projects had prioritised confidentiality. In practice, however, there was confusion about sharing information regarding risk and protection issues; some staff were reticent to share information because of concerns about potential breaches of confidentiality.

2. Delivering Personalised Services

2.1 Access to assessment and care management

Processes for access and receiving referrals were sound and delays in processing assessments had improved in 2007. Eligibility criteria were clear and were routinely used in assessments. The contact centre and one stop shops worked well and delivered timely and accurate information to

social care teams. However, advocacy services to support vulnerable people in accessing services were not used by the contact centre.

People who use services and carers found it easy to contact a social worker and most people received a quick assessment. However, some people had received a speedy initial response to a request for an assessment only then to be asked to wait for some time for a full assessment to take place. Some users of specialist sensory impairment services had to undergo a specialist and a general social care assessment to access the full range of services and there were significant delays in providing social care occupational therapy assessments. Signposting of people who did not qualify for care managed services or an assessment towards support services generally worked well. However, some community support organisations were overwhelmed by 'diverted' demand.

There were a range of high quality leaflets and information systems, a care homes directory was available and a website dedicated to services for older people was well used. Information was generally available in other formats but the single assessment leaflet had no strapline indicating that the information was available in other languages. Interpreters were easily available.

Some older people had difficulty knowing the full range of services that were available. One carer was impressed by the supported living service that was provided for her relative, but the service had not been offered until the carer asked if it was possible. Information on services for older people with mental health problems was particularly scarce.

The procedures made a clear commitment to assessments being available to people who could fund their own care. However, the potential demand from this source was not known.

2.2 Assessments and care planning

Assessments were completed on time and routinely involved people who use services and carers. The department had sought the views of people who use services and carers and there were high satisfaction levels with their involvement in assessments and being treated with respect. However, most assessments failed to identify individual aspirations and capacities. Opportunities to meet individual choices and promote independence were sometimes missed through unambitious and overly risk-averse practice.

Case files were generally up-to-date though not often with clear chronologies or evidence of structured management oversight of practice. Specialist, inter-team protocols were in place for intermediate care and Supporting People services. The quality of multi-disciplinary work was, at times, adequate but on occasions poor. Older people and carers told us of having to repeat the same information to separate agencies.

The single assessment process (SAP) was well established, there were service user leaflets, easy care forms and some electronic summaries

were available across agencies. Some voluntary organisations had been engaged and empowered in delivering the assessments and although mainstream assessment teams were not jointly provided or co-located, a number of joint health and social care teams were in place. However, the SAP toolkit had not been updated since 2004 and was inconsistently implemented. Some staff felt that only social care staff completed the process.

The SAP guidance and documentation was a sound best practice guide but was not implemented as an effective set of required quality assured procedures. Reference to cultural needs was limited to noting the facts, rather than identifying how the assessment might understand the specific preferences and wishes of the person. There was no mention of multi-disciplinary training, no arrangements for monitoring compliance across the agencies and only staff in a minority of teams could deploy the resources of other agencies.

Hospital discharge procedures were ineffective in ensuring consistently high quality outcomes for people who use services and carers. Practice was highly variable. The procedure was written as a single agency acute unit guide and had a dominant focus on fast discharges. It had been successful in securing low numbers of social care related delays. However, the processes did not ensure the quality of outcomes for people at the time of discharge. Although the policy stated an intent that residential and nursing home placements direct from hospital would only be an exception, in practice, almost half of all such admissions came from hospital discharges. Some discharges from particular hospitals had led to high levels of admission to residential care and unsatisfactory post hospital discharge support plans. Arrangements for ensuring effective hospital discharges with hospitals in neighbouring boroughs, used by Leeds residents, were poor.

There was no multi-agency process for examining difficult discharges and learning lessons to improve practice; monitoring by the Performance Board focused entirely on the speed of discharges. Many referrals from hospitals staff requested specific services such as ‘needs 24 hour care’ rather than requesting an assessment of needs.

Agencies had not agreed any minimum standard for securing specialist assessments. Health contributions were missing on a high proportion of files and staff reported a high degree of variability in eliciting specialist assessments. The quality of response often reflected local relationships rather than inter-agency commitments to minimum standards. Single assessment procedures made no mention of adult safeguarding processes.

The clarity and effectiveness of quality assurance processes in assessment and care management were poor and a predominantly ‘cost management’ process. On occasions, managers had reviewed practice and added copies of notes of supervision discussions to case files. However, the degree of ‘challenge’ at this casework stage in the assessment processes to drive forward inclusive practice and an

individualised assessment was poor. This had led to the resource allocation panel being used as a compensatory quality assurance process.

The implementation of carer's assessments was episodic but improving. Many carers were unaware of the breadth of carer's support available; leaflets had not been distributed effectively and case notes frequently failed to record carer's support related discussions.

Adult social care had invested heavily in advocacy services and minimum standards had been specified. However, the services were not well focused and use was fragmented. Some services were overwhelmed by demand and there were gaps in specialist provision. There was no procedural requirement that advocacy should be used in certain circumstances or for particular people where the vulnerability issues were high and the need for service user empowerment was a priority.

Care management forms were fully completed, specification of services to be provided was satisfactory and the cost of services was clear. Instances of good practice were spread throughout the service user groups and there were some sound interventions to support people who had had a stroke. However, some cases had short periods of intervention followed by long periods of support being provided with no ongoing care management.

Care planning was structured and care plans were routinely shared with users and carers but the approach did not prioritise personalisation. Practice was traditional, bounded and there was a tendency to provide standardised packages of support. Managers had identified that there was a need to encourage more creative care planning. In practice, implementation of eligibility criteria had controlled costs but had not always contributed to the delivery of packages that realised the capabilities and ambitions of people who use services and their carers.

Although a high proportion of staff had undertaken outcome focused care management training, the resource allocation panel that approved funding of packages of care and placements often had to act as a quality assurance process to challenge unambitious care planning. Neither frontline practice nor management oversight routinely demonstrated a culture of promoting individualised care plans. Care plans focused on physical tasks rather than social stimulation and holistic wellbeing.

Although, older people and carers reported high levels of satisfaction with the traditional service provided, they had been offered largely standard packages of care. Direct Payments had not always been clearly discussed. The resource allocation panel system created a barrier between the care manager and the department and some staff felt that it was a hurdle to be negotiated rather than a helpful enabler of service user focused care management. Social isolation and loneliness were routinely not considered priorities.

Performance on the quantity and quality of reviews had been poor. Managers had acknowledged that improvements were needed and had created a dedicated review team. Specific service standards had been

established, including all reviews taking place 'face to face' and ensuring that all nursing home reviews took place at least annually. Frequency of reviews had improved significantly and the specialist team of reviewing officers led holistic reviews in a number of cases. In other situations, however, reviews were essentially limited to a provider led 'stock takes' of the effectiveness of the provided service. People who funded their own care did not regularly receive a review and some reviews, including some for vulnerable people, were carried out without involving the carer or notifying them of the outcome of the review. Outcomes often resulted in little change.

2.3 Availability of out-of-hours services

The council had recognised the need to strengthen out-of-hours support and a corporate business process re-engineering project was underway, but yet to report. The contact centre was only available during office hours but there were funded proposals to develop the contact centre service in evenings and weekends. The emergency duty service provided out-of-hours support and had access to sessional workers to undertake priority support. The service had access to the client database system and was used to monitor known risk situations. Notification of these cases was given to social work staff but the frailty of the IT system meant that at times this had to be undertaken by fax rather than e-mail. There were a number of emerging out-of-hours support projects which had developed in an incremental way but some staff found the access and availability of these services unclear.

Some wellbeing initiatives such as exercise and health advice classes and some day care units were available in the evenings and the out-of-hours rapid response and mental health crisis support service were available outside office hours. However, specific support services for carers ate weekends and in the evenings were under developed. Telecare was available citywide, had been used effectively to support over two thousand people who use services and was supplanted by a much smaller service to people who could not nominate informal carers to be available in emergency situations.

2.4 Range of services

A range of initiatives were underway to promote independence and increasing success was being achieved. Direct Payments had been neglected for some years but a reinvigorated policy had delivered impressive results in 2007 and there were ambitious plans to deliver increased self directed support in 2009-10.

Good progress had been achieved in promoting the independence of people and developing speedy and accessible community services. The waiting time for major and minor adaptations had reduced and a Transformation Board coordinated initiatives with the PCT and with people who use services and carers to promote further service development. The average length of stay in hospital had been reduced and information about the range and availability of services had improved.

Uptake of Direct Payments had been slow but there were a growing number of impressive packages in place which engaged with support workers to deliver specific activities that were valued by older people. Where this happened, the quality was good. Local audits suggested that a high percentage of casework discussions included the consideration of this form of support. However, we found that assessors often failed to enthusiastically promote the Direct Payment option, some packages that were created were little different from traditional care and opportunities to use Direct Payments to promote individualised support to realise the aspirations of older people and carers were missed.

Awareness of Direct Payments amongst older people and carers was low and some carers had asked for Direct Payments but had no response. Initiatives to improve the use of Direct Payments had included new and impressive guidance regarding the process within the assessment and care management procedures. A programme management board, including people who use services and carers, was driving the increased use of Direct Payments. A fourfold increase in take up in older people's services had been achieved between 2006-07 and 2007-08 and take up by this group was now in line with comparator groups.

Information about Direct Payments was available in a wide variety of formats including DVD and there had been a number of awareness raising events that had been led by people who use services. Overall financial spend had shifted towards self directed care and the department had made an ongoing commitment to the In Control project.

Intermediate care services had developed and were being used increasingly effectively, especially to support hospital discharge. However, the service was under provided and follow-on care failed to continue to promote independence. Home care services were often provided at times to suit the provider, rather than the person using the service. One carer said,

'They say the latest they can come to help her get to bed is 6.00 p.m. – there is no choice about it.'

Carer's services had improved. Support was good where a carer's needs had been identified, prioritised and addressed and they were 'in the system'. The take up of carer's services by carers from black and minority communities had been prioritised in 2007-08, but take up remained low; only 52 carer's breaks were provided for this group in 2007. Overall, carer's support needs were not always identified, awareness amongst carers of the full range of carer's services was poor and some carers had simply been offered a regular newsletter and contact numbers. Few formal carer's support plans had been established and recorded.

The overall quality of care was mixed but improving. A focus on dignity in care had delivered a higher profile for quality issues, gave a sound lead to improved practice and contributed to the development of audit tools to evaluate the quality of provided and commissioned services. However, a number of services had not been reprovided and remained of variable

quality and reliability. However, performance had improved regarding services being available within four weeks and there were no longstanding delays.

Commissioned services were generally deemed to be of a high quality by CSCI regulatory services. There were more robust quality assurance systems in place for commissioned and provided care than for assessment and care management services. Nevertheless we were told that some people who use services had no choice of provider, some still had to use shared rooms, some people had packages that were so rushed as to preclude conversation and social stimulation and some had care packages where more than one agency provided the care despite the preference of the person using the service. Concerns about the quality of home care services were paramount. Some older people felt they were not respected as individuals and had been allocated pet names without their permission. Some specialist services were inflexible. Contracts were increasingly written in a way that allowed care to be provided in a way that reflected the changing needs of people who use services but, in practice, provider organisations were not empowered to provide variable care.

The council had prioritised users and carer's surveys and people who use services reported high levels of satisfaction. People who use services had been recruited to be a part of the evaluation of the quality of services and key services, such as the meals and equipment service, secured excellent ratings. The survey of people who use services for this service inspection showed high levels of satisfaction with the services provided.

Interpreting and translation services were available and a number of initiatives had been pursued to extend services to people from minority groups. There was an impressive falls development programme that prioritised black and minority group elders. Two equality impact assessments had been completed but neither had an action plan that constituted an effective driver for improvement. The complaints leaflet was not inclusive; the leaflet was available in other languages but there was no strapline on the widely available English version indicating that information could be accessed in other languages or formats. There was limited specialist home care service for people from black and minority communities and take up of telecare from hard to reach groups was poor.

Some specialist health services were hard to access in parts of the city and in short supply. Boundaries between health and social care tasks had not been satisfactorily negotiated. There were continued disputes regarding agency responsibilities for certain tasks. High cost, in-house directly provided services had been scrutinised regarding quality, cost and 'value for money' but re-commissioning better value provision had yet to be delivered. Directly provided home care service had yet to be established within the same quality and cost arrangements as the independent sector.

2.5 Promoting independence and choice

The range and choice of community based services was improving from a low baseline of a spread of traditional and building based resources. Service transformation was ambitious but at an early stage for some services. The quality and geographic availability of some services remained problematic.

The department had prioritised dignity in care and the provision of choice since 2006 and had secured cost and quality improvements by re-shaping some of the large array of directly provided services. People who use services reported that traditional services provided good quality of care overall. Partners reported an increasing range of services, including some specialist day care provision for older people with mental health problems in parts of the city and increasing extra care housing and respite services, some of which included facilities for carers. There had been improved access to Direct Payments support and an established agency to undertake support had been revised and improved in 2007. There were few long delays in the provision of services. However, some directly provided services had yet to be modernised and there was a lack of specialist respite care.

Admissions to nursing home care had reduced and increasing use of home care had been achieved. An adult placement scheme was available and some additional extra care provision was planned, with specialist skills in intermediate care and dementia care. A specialist scheme encouraged the take up of services by hard to reach groups.

A review of directly provided buildings based day care was ongoing and at an early stage; none of these services had yet been reprovided. There were delays in securing home care in some parts of the city and there were widespread reliability and quality concerns regarding home care. There was limited choice for some home care users and some services had a deficit of staff with specialist skills, such as coping with dementia.

Advocacy services were not routinely used to promote independence. Specialist services for people from hard to reach groups were under developed and there was no specialist advocacy service for people with dementia. Advocacy was not used to empower people who use services who were involved in the complex Disabled Facilities Grant appeals process or the convoluted bidding process for housing allocations.

3. Delivering preventative services

Preventative services had been given high priority and the council had achieved a range of important improvements. A sound preventative strategy, Older Better, was in place and the department was working well with health colleagues on a range of initiatives to tackle health inequalities. A programme of developing local services to meet needs which did not qualify for care managed services had been pursued in

partnership with users and carers, in a manner which prioritised building and developing community capacity.

Assessment and care management procedures contained good guidance on the range of, and access processes for, preventative services, including Supporting People projects. The 'infostore' older person's website, provided high quality information to people who use services and carers and was well used. Signposting from departmental and corporate access points for those who were appropriate to use these services, was good.

A range of neighbourhood networks had been developed in partnership with the community and voluntary organisations. These were well used, providing social stimulation opportunities and support. Some social enterprise services had been successfully developed to provide low level care such as domestic work and gardening. The gateway projects provided fuel poverty support and access to social activities and support services. However, information about services for carers was poorly disseminated. Some services, such as carer's passes, were not widely known of and GPs and other health staff did not always direct people with lower level needs to the appropriate services.

A significant two year Partnership for Older People Project (POPP) had been completed and had developed services for older people with mental health needs. This had involved sound joint projects with Supporting People services and telecare. Important outcomes had been achieved, including reducing hospital admissions.

Examples of the outcomes from successful health partnerships included the development of telemedicine, rapid response, community support and resource centres in 2007. A falls prevention programme had led to a reduction in attendances at accident and emergency. There had been significant savings in health care costs. The sustainability of the POPPs had been well evaluated; some projects were yet to be proved effective but the majority had been deemed a success and were to be absorbed into the mainstream or the Supporting People budgets.

A range of projects, including falls prevention which prioritised Asian elders, had focused on people from black and minority communities. Projects in relation to women's groups and older people in sheltered accommodation had prioritised wellbeing, basic health care of feet and eyes, and exercise and healthy lifestyle issues. Permanent admissions to nursing home care had reduced and the financial burden on the care management budget had been eased by the development of early intervention and preventative services.

4. Capacity to improve

4.1 Leadership

Overall leadership had been weak for some years but had improved from a low baseline in recent years. Current leadership had recognised deficits and made a sound start in implementing a performance management culture, strengthening processes to deliver improvement and sustain performance in the future and ambitious plans had been agreed. Effective leadership had been demonstrated in the prioritisation and businesslike development of preventative services. The management team had a good understanding of shortfall in business processes, such as workforce development, which needed to be addressed. However, the extent and urgency of adult safeguarding problems had not been identified and overall leadership processes and cascade of a performance and service user orientated culture remained inadequate.

Strategic plans were broadly effective as 'vision' statements. The strategic plan and Local Area Agreement (LAA) were well set out and had been developed in effective partnerships. The breadth of 'sign-up' to overall goals had been enabled by the director having a wider strategic responsibility in the council and with partner agencies. The LAA had included specific priorities in relation to personalisation and adult safeguarding.

Many strategic plans lacked effective action plan/implementation processes and managers acknowledged that high level aspirations were yet to cascade effectively into team level priorities. Improved performance regarding national performance indicators had been achieved at the cost of under developed locally determined quality indicators. Incomplete understanding of the nature of the deficits had led to some strategic priorities being poorly specified. The adult safeguarding priority in the LAA was limited to an aspiration to strengthen training and a range of citizens had been excluded from efforts to improve adult protection arrangements through the priority referring only to people who received directly provided or commissioned care.

The council had a history of directly providing a significant proportion of its social care services. Over the last few years it had focused upon improving its national performance indicators and had prioritised controlling costs. During the last five years Adult Social Care had been through a very significant period of change in its leadership. Over this period it had been led by four different directors. These factors limited the pace of improvement, however progress had been enabled and hastened by the appointment of the current director and the reconfiguration of the management team.

Business planning was well established and had been further strengthened in 2007 with the establishment of the Transformation Board. Service improvement plans were in place and used a set template

which prioritised health and wellbeing, personalisation and inclusion and efficiency and effectiveness as strategic priorities. However, staff were not engaged in the business planning process, there was a limited culture of using the plans to drive change and action plans lacked detail.

More recent plans, such as the adult social care business plan supplement was a strong summation and analysis of challenges and achievements in relation to adult safeguarding and personalisation. There were good links to the prevention and Supporting People strategies. The equalities and diversity plan was up-to-date and included a comprehensive analysis of demography and needs. The department had achieved level three of the equality standards for local government and had plans in place to deliver level five by 2010. However, as with other plans, the action plan did not reflect the quality of the policy document.

Some managers had unacceptable levels of autonomy to determine policy for units that they managed and other managers found management support lacking when they tried to confront inadequate standards of practice by frontline staff. Processes for setting out minimum requirements and monitoring and enforcing compliance were largely absent. Service improvement plans were insufficiently detailed about their performance priorities for the forthcoming year.

The council had prioritised and invested in a range of effective preventative services and a preventative strategy was in place and well understood by staff and partners. Where there were specific targets, such as public transport passes, then progress had been impressive. However, the action plan was insufficiently specific; targets were general and descriptive.

The Partnership for Older People Project had been utilised as an effective vehicle for developing workforce redesign processes to reshape the skills of some staff to meet the requirements of new services. However, there had been no workforce development work with health partners to address joint working issues such as the implementation of SAP or the hospital discharge procedure.

Increased management capacity at directorate level was beginning to have an impact and there was a sound understanding of the progress that had been achieved and issues to be addressed. Strategic messages were communicated effectively within the department and the move towards a better focused quality assured and managed service was widely welcomed by managers. However, the burden of trying to deliver such ambitious and challenging service transformation had heightened and exposed tensions in resources and capacity at a middle management level.

Elected members gave sound leadership and a scrutiny review of dignity had raised the profile effectively. There was a good understanding of the improvement agenda. Performance information and governance in relation the adult safeguarding issues was, in contrast, under developed and inadequate. Scrutiny by elected members had had an impact where it had been deployed but it had yet to consider adult safeguarding

arrangements. Elected members undertook a range of 'visits' to directly provided services but were not aware of any system of independent scrutiny of the quality of care and personalised services in the residential care homes. Members were well informed about the systematic quality assurance system regarding national indicators but had less information about local quality standards and performance against local improvement targets.

Partnership work with health organisations had been hindered by the restructuring of the five PCTs into one and further progress in extending the current, partial integrated operational level arrangements and joint commissioning processes was required. Sound progress and relationships had been established in 2007 and the continuing health care agreement was streamlined and well configured.

Leadership in adult safeguarding remained weak. Some important improvements had been secured but practice deficits had not been accorded sufficient seriousness and actions had yet to deliver required improvements. The full extent of the failings of frontline practice and management arrangements had not been understood. A sound analysis of needs and a shared vision for adult safeguarding across partner agencies had not been determined and arrangements for ensuring effective multi-disciplinary partnership work had not improved significantly. A culture of all agencies jointly critically scrutinising practice had not been secured. Elected members had no involvement in the Adult Safeguarding Board, received limited routine information regarding the quality of practice and were insufficiently aware of the serious deficits in practice.

Workforce development was fragmented, under developed and lacked strategic cohesion. Frontline quality assurance processes were inconsistent. Workforce initiatives had delivered important savings in relation to use of agency staff and overtime. Some training and development initiatives had been identified in service development plans and the department had a good understanding of the makeup of the workforce. Minority groups were represented proportionately within the workforce. There was a clear supervision and staff appraisal policy in place and internal audit had been used effectively to independently review some aspects of current practice.

Extensive training opportunities were available, including training in regard to prevention services. There were opportunities for management training and a structured system of NVQ training was in place. However, training intentions focused on courses rather than skills or outcomes and strategy documents had poor action planning processes. Teams did not aggregate training needs and service development plans had poor quality training needs analysis.

There was a well established and valued process of staff surveys and staff were more effectively involved in recent initiatives such as budget workshops. A project management approach had been implemented to address key issues and some successes had been achieved in relation to improved budget management, improved performance indicators and

some re-provisioning and externalising of traditional services such as home care. However, a range of business process issues, including workforce planning and quality assurance, were yet to be addressed.

In practice, supervision was poor. Supervision and annual performance appraisal policies were inconsistently implemented. Senior managers lacked awareness of the quality of the process in practice, with no systems in place to check the compliance of staff and managers with the departmental policy. No standard format for supervision records of sessions or content was used. Staff were unclear about supervision practice and expectations and managers had not had training in how to supervise. Some mandatory annual appraisals hadn't been completed. Assumptions of adequate implementation of procedures were common. A system of spot case file audits in adult safeguarding was planned for later in 2008.

The complaints service was strong and represented an important part of the performance management process. The process was effective and established and had used information from complaints about service deficits to drive improvement. The unit had developed training initiatives with independent providers to prioritise and value complaints. However, the protocol for jointly handling complaints with health colleagues was ineffective and integration was limited to an administrative coordination of separate processes. There was a need to improve performance in relation to undertaking complaints within timescales and ensuring that hard to reach groups were aware of how to complain. Case files did not show that referrals had been made to the complaints officer or record any subsequent actions.

High level performance management arrangements were set within a well established and thorough corporate performance management framework. There were good links to the priorities set out by the Local Strategic Partnership and within the LAA. There were good plans in place to involve volunteers in monitoring dignity issues and plans for appointing dignity 'watchdogs'. The new director had prioritised benchmarking and self challenge and this was beginning to have an impact on strengthening performance.

Performance information was poor but was improving fast and very well scoped plans were in place for implementing a new electronic records process later in 2008. However, information was often incomplete, for example all placements were not recorded on the system. Performance information was particularly poor regarding adult safeguarding information but was improving. Data could increasingly be disaggregated by teams and the development plans for the Electronic Social Care Record was well dovetailed with the emerging revised inter-agency adult protection procedures.

4.2 Commissioning and use of resources

Commissioning was improving but was not yet fully effective in delivering consistently modern, high quality and value for money services. Good progress had been achieved since the commissioning unit was established

in 2006 and further strengthened in 2008. The unit was having an increasingly positive impact on the transformation of some services. Use of the independent sector was increasing, with a developing range of services such as extra care. However, there were a range of unaddressed issues including capacity and quality difficulties. Despite some specific projects, specialist services for black and minority ethnic community remained under developed.

The department had identified the excess of direct provision of traditional building based services as a significant inhibitor in the development of the range and choice of services and begun to implement a successful recovery plan. Contract design and contract monitoring had been strengthened, included strong clauses in relation to dignity in care, adult safeguarding and diversity. Increasing use was being made of incentives within commissioning arrangements to develop specific types of services and, importantly, to encourage providers to develop services in particular geographical areas. A sound medium term financial plan was in place and the service was investing significant funds into older people's services. Spend increasingly reflected strategic priorities and investment was directed towards increased community based services.

Commissioning intentions were, however, unclear. The joint strategic needs analysis had yet to be completed. Staff and people who use services were not clear about the shape and type of services to be developed in the future. There was no commissioning plan for older people's services and plans to publish a 'commissioning prospectus' were at an early stage. The redevelopment of day care services and the outreach and community support services had been agreed in principle but was yet to be delivered. The speed of improvement had been compromised by capacity problems in the commissioning unit. There were regular provider forums in place and fees paid were more generous than some neighbouring authorities. Nevertheless, partnership work in service development was limited. Some stakeholders found that the tendering processes caused delays and some initiatives were progressed so slowly that they were never delivered.

The relationship with the independent and voluntary sectors providers was strong. The development of voluntary organisations work had been inhibited by the lack of long term funding and organisational security. Increasing use was being made of three year funding arrangements and organisations were optimistic about the future. The relationship with individual voluntary organisations was sound but a clear map of the sector capacity had yet to be determined.

Contract monitoring was in place and interventions had been made to suspend services where quality concerns had been raised. Where quality issues had been identified, work had been undertaken with providers and in some cases service standards had been improved and commissioning had been reinstated. Managers acknowledged that the capacity was not yet in place to undertake contract monitoring with full effect and quality assurance initiatives were still dominated by issues identified by CSCI regulatory inspections.

Information was collected from social enterprise services to inform commissioning but arrangements to use the frontline experience of assessors, to inform commissioning were poorly set out. Staff did not feel they had had an impact on the way services developed or that gaps in services were properly recognised. There was no form for alerting commissioning about service gaps or adult safeguarding issues. Enforcement action was taken where concerns came to light but in some cases no notification to the contracts section was made by assessors undertaking adult protection investigations and consequently other people who used services were left at risk.

Budget management and financial planning had been significantly improved since 2005 when spending was out of control. However, Gershon savings had been achieved and significant savings had been demonstrated, including savings for partner agencies, through the implementation of the Partnership for Older People Project. Parts of services had been improved but some high cost services such as small residential care units remained un-modernised. Sound benchmarking exercises had been implemented in 2007 but costs were remained high. For example, the in-house home care service did not have differentiated specialist and highly skilled staff to meet the wide variety of older peoples needs.

Costs were controlled centrally. Budgets were not effectively devolved to managers to allow flexible and responsive allocation of resources within clear guidelines and priorities. The resource allocation panel was effective in controlling expenditure but was not seen as enabling and encouraging in respect of promoting high quality and imaginative care packages. Small adjustments and minor increases in expenditure required reapplication to the panel.

Some general policies required review to ensure that resources were increasingly shifted towards services that promoted independence and personal choice. Charges were traditionally low and the policy was not underpinned by a coherent understanding of costs, quality and 'value for money' issues. Elected members had agreed a major consultation exercise regarding possible changes.

The involvement of people using services in service planning had improved significantly, there was an increasing range of initiatives underway and their views were beginning to have an impact. The Older People's Modernisation team within the Commissioning and Strategic Partnership Board was well established and some older people and carers were involved in annual service quality questionnaires. People who use services had been engaged in developing Direct Payments and equipment service, and were strongly represented on the Self Directed Care Transformation Board that oversaw the whole reshaping of services. The self directed support reference group and related events had been led by people who use services. Initiatives had been undertaken to engage with hard to reach groups such as travellers.

The Joint Strategic Commissioning Board was in the early stages of development and the understanding of some health professionals of the

vision for older people's services was limited. Where there had been developments, they had been pursued in different ways and at different paces in areas of the city, leading to highly variable specialist services including therapies and intermediate care. There were few formal, jointly funded projects which involved transfers of resources, rather than simply better aligned services. These focused on prevention rather than mainstream services. The development of community matrons had been positive and there were some joint teams.

Improved strategic management and cooperative relationships within council services and with key partners were now in place. The older person's strategic partnership had wide membership and was chaired jointly across both health and social care organisations. Joint appointments had been made and funded with the PCT and strategic partnerships with housing had led to a successful Department of Health bid regarding extra care housing. The Local Strategic Partnership was strong and oversaw the work of the Health and Well Being Board. The Director of Adult Social Services had responsibility for the 'health and well being' work stream and health agencies were better engaged in the transformation of traditional local government services including driving forward Direct Payments, community support pilots and the equipment services.

Corporate partnerships were improving and the council had secured Beacon status for strategic partnership work in 2007. A range of managers were confident that adult social care was now seen as a corporate responsibility and optimistic about improving partnership and joint commissioning arrangements. Housing services had been missed out of planning for some years and operational partnerships difficulties reflected this dislocation. Important initiatives had been made to develop relationships including a forum for senior managers to intervene where operational difficulties had been identified, a range of development workshops and improved links with housing provider organisations. However, there was no inter-departmental protocol for streamlining housing and social care interventions for vulnerable people.

APPENDIX 1 INSPECTION THEMES AND DESCRIPTORS

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

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

INSPECTION THEME 4 People Have Access to Preventative Services	
4.1	The independence of all people who use services and carers is promoted consistently within all services. Well targeted initiatives in a wide range of areas: • meet people's care needs (appropriate to culture, religion, sexual orientation, gender and age); • minimise the impact of any disabilities; and • enable people to live their lives in the way they choose.
4.2	There is a successful focus on early prevention, which can be demonstrated to be reducing need for higher-level support in almost all relevant instances.
4.3	Where the council commissions services which do not require a formal assessment all people have easy access to these services, which meet their cultural and other needs.
4.4	Where the council commissions services which do not require a formal assessment the council and all people who use these services are satisfied with the care and support on offer and the council can evidence good outcomes from these services.
4.5	Care managers refer on to relevant non-care managed services all people who need them.
4.6	There is universal access to initial assessments of social care needs regardless of whether a person intends to self-fund, or whether they are eligible for council services.

Leadership	
8.1	Highly competent, ambitious and determined **leadership skills** of senior officers in the council champion the needs of all people who use adult social care and their carers, to ensure that [the selected themes[1]]. Senior officers make sure there is **effective staff contribution**, both within the organisation and across partnerships, to planning and delivery of key priorities and to meeting suitably ambitious outcomes in the selected themes.
8.2	**Plans** to ensure the delivery of the selected themes **are comprehensive** and linked strategically and address key developmental areas. They identify **national and local priorities** for the selected themes[2]. Realistic **targets** are being set and are being met. Local area agreements reflect identified key areas for improvement. Coordinated working arrangements across the council and with external partnerships are reflected in **strategic planning** to ensure delivery of the selected themes. There is evidence that this working has resulted in improvements in the selected themes.
8.3	There are the **people, skills and capability** in place at all levels to deliver **service priorities** and to maintain high **quality services** to ensure the good outcomes in the selected themes.
8.4	**Performance Management, quality assurance**, and scrutiny arrangements are in place and effective to ensure that good outcomes in the selected themes: performance improvement can be demonstrably linked to management action.

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

[1] People are safeguarded / people receive personalised services / people have access to preventative services.
[2] Safeguarding Adults / Delivering personalised services / Prevention

APPENDIX 2 METHODOLOGY

This inspection was one of a number inspections carried out by the Commission for Social Care Inspection (CSCI) in 2007-08 under the Independence, Wellbeing and Choice agenda[3]. The aim of this inspection was to evaluate how well adults were safeguarded by Leeds City Council and how well Leeds City Council were meeting the needs of older people in relation to delivering personalised and preventative services.

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

An inspection design team created the inspection methodology. The Themes and Descriptors (see Appendix 1) were developed from the CSCI's Outcomes and Descriptors[4].

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

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

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

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

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