Commission for Social Care Inspection

Champions for Social Care Improvement

inspection report

# INSPECTION OF SERVICES FOR OLDER PEOPLE

## Wirral

**February 2007**

## 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 social care services in England. CSCI combines inspection, review, performance and regulatory functions across the range of 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; and
- practise what we preach in our own organisation.

(*From 1 April 2007 the Office of the Children's Rights Director and responsibility for the regulation and inspection of children's care services transferred to Ofsted.)

## Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and is committed to making a real difference to the provision of healthcare and to promoting continuous improvement for the benefit of patients and the public. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and took over some responsibilities from other Commissions. It:

- replaced the Commission for Health Improvement (CHI), which ceased to exist on 31 March 2004
- took over functions relating to the independent healthcare previously carried out by the National Care Standards Commission, which also ceased to exist on 31 March 2004
- carries out the elements of the Audit Commission's work relating to the efficiency, effectiveness and economy of healthcare.

The Healthcare Commission has a statutory duty to assess the performance of healthcare organisations in the NHS and award annual ratings of performance, to coordinate inspections and reviews of healthcare organisations carried out by others, and register organisations providing healthcare in the independent sector on an annual basis.

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**Enquiries/Further copies may be obtained from:**

Vanessa Honeyghan
Commission For Social Care Inspection
6th Floor, Ladywood House
Stephenson Street
Birmingham
B2 4DH

**Telephone no:** 0121 600 5306

**Inspection team:**

Lead Inspector: Phil Green

Team Inspector: Laurie James

Health Care Commission: Sally Derbyshire

Expert by Experience: Terry Walsh

Administrator: Vanessa Honeyghan

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# Introduction and Background

The Commission for Social Care Inspection (CSCI) and the Healthcare Commission are independent organisations that assess the performance of social and health care services and promote improvement. Between January and March 2007 the two organisations carried out five joint inspections of services for older people, or people with physical or sensory impairment.

An inspection team from CSCI and the Healthcare Commission visited Wirral in February 2007 to find out how well the council and primary care trust (PCT) were meeting the needs of older people. The team consisted of three inspectors from CSCI, one from the Healthcare Commission, and an older person with experience of using services.

The scope of the inspection included:

- social care services for older people which were commissioned or provided by the council
- an assessment of the council and PCT's joint working and jointly provided services
- intermediate care services for older people which were commissioned or provided by the PCT

Before visiting Wirral, the inspection team reviewed a range of key documents supplied by the council and PCT, and assessed other information about the quality of services provided. They then refined the focus of the inspection to cover those areas where further evidence was required to reach robust judgements. During their visit, the team met with older people and their carers, councillors, staff and managers from the council and PCT, and representatives of other organisations.

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

# Summary and Recommendations

Wirral had made progress in improving services for older people. Their achievements included:

- a broad consensus existed on the way forward for services for older people in Wirral
- close and improving working relationships existed between health and adult social care management groups
- intermediate care services were helping people move from hospital care when they no longer required to be there
- established processes for consultation with and the involvement of older people in service development processes
- there was good data and understanding of local older people's demographic data across health and social care, as demonstrated in the joint commissioning strategy
- improvements had been secured in the quality of nursing/residential and block contracted home care
- contract monitoring was well developed
- an active voluntary sector was in place
- partnership work around older people's health improvement agendas was properly conceived, well-developed, and was leading to effective programmes of action
- arrangements for joint work on safeguarding vulnerable adults were well established
- advocacy services were supported by statutory agencies

However there was room for improvement in the following areas:

- the joint commissioning strategy had not been developed into a clear service development plan across agencies, and lacked PCT investment proposals
- strategic approaches to workforce planning were underdeveloped
- smaller voluntary agencies did not experience positive participation in service development activities

- full partnership planning between health and social care was underdeveloped, with no formal joint service arrangements other than for equipment services, relating to mainstream work with older people

- referral processes within adult social care had issues of efficiency and effectiveness that were being addressed as part of a structured project

- multi-disciplinary team work was underdeveloped, including at first line manager levels

- resource decision making panels tended to be single organisation focused

- the community mental health team for older people lacked professional social care involvement and a direct referral process adult social care

- the development of carers services had been interrupted and had, despite recent improvements, yet to make up lost ground

- the council's organisational framework for supporting Direct Payments had been deficient and required a sustained focus

- public information on local health and social care services was poorly developed

- it was widely acknowledged that there was a need to improve services to black and minority ethnic groups

Managers and staff in Wirral council and the PCT have demonstrated they have the capacity to improve, and this inspection has highlighted the following areas which will make a difference to the lives of older people:

- the strong commitment to jointly tackle the broader health and social care needs of the community

- the leaders of health and social care organisations had a strong commitment to work in partnership to improve services for older people

- both health and social care services had experience of managing significant change

## Recommendations

CSCI and the Healthcare Commission recommend that the council and PCT actively and promptly share the findings of this report with the public and partner organisations. In accordance with their aim to support local improvement of services for older people, CSCI and the Healthcare Commission recommend that the council and PCT should work together in partnership to implement these recommendations.

| Criteria | Recommendation | Action by |
|---|---|---|
| National priorities and strategic objectives | Develop a clearer whole system plan for the delivery of the joint commissioning strategy intentions | Council and PCT |
| | Ensure the incorporation of key PCT investment data and planned developments in the joint commissioning strategy | Council and PCT |
| | Review the basis on which progress in the implementation of the NSF for Older People is being managed, to ensure proper and consistent focus across all NSF standards | Council and PCT |
| Cost and efficiency | Re-consider the opportunities to work jointly within a framework of more formal partnership arrangements | Council and PCT |
| | Develop effective mechanisms to support/enable service review and business planning within the voluntary sector to enable agencies to be responsive to changing service user need | Council |
| Effectiveness of service delivery and outcomes for service users and carers | Pursue actions to improve effectiveness and efficiency in the delivery arrangements for Direct Payments, and ensure regular audits of these arrangements | Council |
| | Complete the review of the arrangements and responsibilities for providing effective and well-coordinated hospital discharge systems to provide for satisfactory and safe outcomes for service users | Council and PCT |
| | Improve multi-disciplinary team work at operational, first line management, and panel decision making levels, to ensure a whole system approach to the assessment of people's needs and subsequent service delivery | Council and PCT |
| | Ensure that the role of community matrons is widely understood, including by social care staff, ensuring the development of clear pathways for older people with long term conditions | PCT |
| | Develop staff knowledge of services available outside the statutory sector to improve outcomes to service users and carers by | Council and PCT |

| | | |
|---|---|---|
| | enabling more effective signposting for those with lower level needs | |
| | Sustain moves to develop a wider range of services for carers | Council and PCT |
| | Provide for more effective joint work with the community mental health team for older people | Council and PCT |
| Quality of services for users and carers | Develop clear, timetabled plans to improve referral, care management and review functions arising from the work with CSED; ensure that these processes fully engage with health service interfaces | Council and PCT |
| | Work with partners to improve public information on local social and health care services, and thus contribute to informed choice by service users and carers | Council and PCT |
| Fair access | Sustain the activities to improve work with people from black and minority ethnic groups | Council and PCT |
| | Review with advocacy organisations the effectiveness of current links with them, and expectations of them | Council and PCT |
| Capacity for improvement | Produce a workforce development strategy for the delivery of effective services across all sectors, in support of the joint commissioning strategy intentions | Council and PCT |
| | Ensure commitments in the PIMS performance reporting system are always accompanied by a clear set of actions designed to deliver these | Council |

# Context

The population of Wirral is 313,100 based on mid 2005 estimates, with 143,500 households according to council tax figures. The population is stabilising after a period of decline over the past 25 years. It is estimated that approximately 18 per cent of the population is over 65, with an increase of 4.6 per cent estimated between 2005 and 2010. Wirral has a small black and minority ethnic population; according to the 2001 census over 98 per cent of the population were classified as white and less than 7 per cent of residents were born outside of England.

The borough is an area of contrasts and diversity with rural areas, small towns, urban and industrialised areas in a 60 square mile peninsula. The areas around Birkenhead are characterised by relatively high levels of economic, social and environmental deprivation. According to the Indices of Multiple Deprivation 2004 Wirral is ranked 48$^{th}$ most deprived council out of 354 districts. Almost a quarter of the population lives in the most deprived areas. The areas further to the west are more rural with small satellite towns with higher levels of prosperity and longer life expectancy.

Wirral Metropolitan Borough Council commissions and provides social care services for older people. Wirral Primary Care Trust (PCT) commissions and provides health services for older people. The PCT was established in October 2006 from a merger of two previous PCTs.

# Key Findings

## 1. National Priorities and Strategic Objectives

### 1.1 Vision and strategies

Services for older people in Wirral had a clear direction in line with national policies; staff groups were aware of the major policy priorities. The Local Area Agreement (LAA) provided a broad and widely valued framework for service development, with a clear focus on improving outcomes for older people. A new LAA Programme Board was being introduced to support implementation of its programme. The Local Strategic Partnership (LSP) had the responsibility for overseeing the delivery of individual outcomes and targets in the LAA and bringing greater clarity to the range of development activities.

The LAA and LSP processes were seen by health and social care as a major vehicle for progressing their individual and joint agendas for the health and wellbeing of the community. This was supported by a positive strategy and action plan to promote the health of older people, which involved the active contribution of a range of agencies, council functions and health personnel. The LAA Programme Board had lately agreed to use the council's performance information management system (PIMS) to monitor the delivery of its programmes.

The joint commissioning strategy was the key document for providing vision and clear direction for meeting the health and social care needs of older people. It set service objectives that aimed to enable people to live independently and safely, to experience active ageing, with increased empowerment. There was no overarching plan for the implementation of the joint strategy, but a number of processes were in place to take forward particular elements. It was thus difficult to track how the whole strategy was being taken forward on a complete and managed basis.

Close connections between senior managers in the Department of Adult Social Services (DASS) and the Primary Care Trust (PCT) provided mechanisms for coordinating and progressing the delivery of common objectives. The Older People's Modernisation Team had been charged with overseeing the implementation of the National Service Framework (NSF), but this was not all progressing on a consistent and structured basis within a definite work programme; service users cited both positive engagement and disillusion with progress made in some key areas.

There were no workforce strategies in DASS or the PCT to ensure a sufficient staff, with training and skills to meet the diverse needs of older people in Wirral. Some data gathering had begun to take place as a preliminary to a workforce strategy, and a draft human resource policy had

been developed in DASS. The council's approach to workforce matters in social care had been informed by their active engagement with a regional network to support workforce development processes within social care. The PCT had national workforce policies that it was required to follow. There had been no effective joint work to address the human resource issues arising from the joint commissioning strategy.

### 1.2 Contribution of services users and carers to service development

There was strong evidence of a principled commitment to involve service users and carers in service development processes, and many services regularly surveyed the opinions of their users. The PCT had involved service users in health promotion training activity and the work of their PALS service. In DASS an involvement strategy was in place and being actively progressed with the support of a recent appointment dedicated to this area of activity, and by an involvement group.

Wirral Senior Citizen's Forum was a well-established group, and was being involved in work around the developing Older Person's Parliament. Forum members were positive about the engagement with statutory agencies, but retained some scepticism about service users' influence to move matters forward in a reasonable timeframe. They described some frustration about their experiences in some NSF linked groups where meetings were regularly cancelled.

A compact existed for work between statutory and voluntary agencies, which was to be reviewed. A strong Age Concern played an instrumental role in representing this sector and strove to keep other agencies informed of developments. However, in general, other smaller service providing voluntary agencies did not feel well connected to service planning or review processes, and experienced a lack of established links with these systems in the new PCT.

## 2. Cost and efficiency

### 2.1 Commissioning

The council and the two previous PCT Boards had approved a joint commissioning strategy, which was based upon a good analysis of the needs of the population, with positive use of public health data, and an understanding of modern service approaches. From these a broad set of commissioning intentions had been produced to guide future developments, within which there was a heavy council and social care focus and lead in implementation. There was very little detail of the balance of PCT current spend, or proposals for future investment, and

there was an acknowledged need to incorporate PCT commissioning activities within a 'refreshed' strategy to make it more convincingly joint.

Arrangements for partnership planning had not been well developed in the past, and the joint commissioning strategy had not been taken forward into comprehensive action planning. However a positive new development was for a new strategic partnership business planning process for 2007-08, which looked to use specific and measurable objectives including such key areas as improving whole systems commissioning, joint commissioning, intermediate care planning, a common assessment framework, and improved discharge planning.

## 2.2 Improving efficiency

The growing commitment to solid infrastructure support for partnership working between the council and health services had been noted in a number of recent external evaluations, as had the need to ensure greater clarity of responsibilities between partners. Partnership working between the PCT and adult social care was viewed as positive and improving. There were a number of joint appointments, but no formal partnership agreements existed for older people's services, and governance arrangements for joint work had not been formalised. The lack of formal partnership arrangements, requiring clear focus on the respective financial responsibilities of DASS and health partners had been an issue in the recent past, albeit arising predominantly from other service user groups.

DASS had sound and effective quality and performance monitoring processes with independent service providers. 'Market management reports' assembled useful data, but with the scope for more comments and conclusions. Financial incentives to providers to secure improved service quality had made an impact, and consolidation of the home-care market had been achieved. This evidenced a willingness to balance cost with quality issues, and to take action to address concerns about care standards. The commitment the council and its staff brought to these matters was sustained and very positive.

Full service reviews took place, but individual voluntary agencies were not reviewed in a way that allowed for the recognition of changing demands, and the increasing needs of their service users. Short-term funding and late confirmation of grants made effective business planning difficult for the voluntary sector. Regular meetings took place with independent service providers, but mostly focused on the council's contractual activities and did not facilitate wider discussion of a joint agenda that would enable market management and business planning across the whole system, including the council's in-house provision.

Good and inclusive work was being done to rationalise policy advice to staff across social services, resulting in the reduced number of more coherent 'pillar policies' to advise staff actions. This, when completed, should ensure more consistent operational practice in all fields of activity.

## 2.3 Resource and budget management

Budget control and information in the previous social services department had weaknesses identified and described in audit reports. A range of action had taken place to improve the processes within DASS, and in reporting to the council. The internal systems included care management budgets being held at team level with support from headquarters budget staff, the production of monthly budget data for all cost centres, deployment of finance staff to support sector managers understanding and control of budgets, and contributions to 'performance surgeries'.

Pressures on the DASS budget had led to the council providing substantial additional resources in the current financial year together with actions to strengthen budget control mechanisms. However a range of further actions had proved necessary to reduce a projected overspend where commitments had exceeded expectations. This was of concern, given the significantly increased investment in services. A number of reasons had been identified as contributing to this, including unexpected lengthier stays in residential care homes, pressures and success in dealing with delayed transfers of care and an unanticipated number of previous self- funding people now presenting for financial support. It was also suggested that the number of non-residential care packages had increased beyond expectations. The issue of projected overspend had a high local profile, which demanded, and was receiving, sustained attention.

DASS had a meaningful medium term financial plan. It provided clear linkages between future needs and investments, factoring in high level assumptions about the nature and number of older people likely to need services. It could not, however, take account of future changes to the pattern of care in the absence of detailed future plans for services. Financial systems in the PCT did not allow for discrete budget information on activity with older people.

# 3. Effectiveness of Service Delivery and Outcomes for Service Users and Carers

## 3.1 Promoting independence

There was a clear commitment to provide a range of services that promoted the independence and wellbeing of older people that extended to health promotion, developing additional extra care housing and improving access to leisure services. Joint commissioning intentions looked to improve support to people in their own homes and to focus on 'enabling' services. Partnerships with a range of providers were seen as fundamental to the realisation of these objectives.

An extensive and active voluntary sector, in part financed by the council, provided a range of services to supplement formal packages of care and for those of a lower level of eligibility. Age Concern was a major provider of support, advice and day activities in the borough. Knowledge of some of these wider voluntary sector services was, however, underdeveloped amongst statutory agencies, which restricted the capacity of staff to signpost appropriate individuals towards them.

The development of preventative services had been predominantly in the voluntary sector. The council funded the Promoting Older People's Independence Network (POPIN) service, which was universally approved of in the range of community based support activities that it provided. It focused on promoting the independence of older people who were not receiving community care services, and was able to offer a broad and flexible range of preventative approaches to help people who would not qualify for more intensive statutory services.

Care management staff within DASS were considering direct payments on a fairly routine basis, but delivery mechanisms had been uncertain. Use among older people had risen substantially, from a low baseline, over a short period, largely because of pragmatic decisions to use direct payments rather than change home carers when the council reduced the number of agencies with which it contracted. Numbers had dropped since the autumn and there was now a small waiting list. A contemporary policy and procedural framework for delivery of direct payments was not in place. There was a general concern that the hourly rate for paid for direct payments was at a level that the council had considered incompatible with quality in home care, thus requiring service users to supplement payments or be at risk of using lesser quality services.

Contract monitoring of the direct payments service, delivered by an external organisation, had proved inadequate over several years. It was through one of its 'performance surgeries' that the council concluded there were major organisational issues regarding the performance of the direct payments service. Large financial issues had arisen from the service's inception. Because they had not been dealt with over a long period the council had not been able to assure itself that value for money had been provided. Many users of direct payments had accumulated large balances, which were not being used. Appropriately the council was now making arrangements to seek to recover money from service users and had committed itself to an overhaul of current arrangements. Given the experience to date, there is a clear need for regular audits of the effectiveness of this service.

## 3.2 Range of services

There had been considerable success in reducing the number of delayed transfers of care from hospital facilitated by a range of 'step down' intermediate care schemes which had been introduced. The intermediate care system included nursing beds with an independent agency, residential

beds in council accommodation, an enablement discharge team of hospital occupational therapists and council home care staff, and a nursing service to support people in the community. A joint intermediate care coordinator's post and strategy group were in place. The people we met who had used intermediate care were positive about their experience and the services' own consumer feedback supports this.

The focus of both health and social care had been on developing services that enabled discharge, which had been a large and persistent issue locally. There had been less of an immediate focus in the preventative area.

There was a wide range of health care teams and different referral processes involved in hospital discharge and in arranging access to different parts of intermediate care or other community services. This was confusing to the outsider, and to some staff and managers. For example the 'Integrated Community Discharge Team' managed only the assessments and placement into intermediate care beds. All of the referral processes required staff to assess for particular services and then to return to the initiator of the referral to start again if the service user was unsuitable, subsequent to the initial assessment.

Despite the success in reducing delayed transfers of care, a high proportion of staff continued to consider that hospital discharge processes were as a whole inadequate. We heard examples of where the safe discharges of older people had not always been assured, but it was clear that, when cases were brought to the notice of the health managers, efforts were made to learn from the experience. There was some evidence that relevant agencies had differing approaches in this are, which demonstrated the need for greater clarity and simplified processes around the whole discharge planning system.

Multi-disciplinary teamwork was underdeveloped at operational and first line management levels, which militated against a whole systems approach to assessment and care management. There were no joint health and social care teams working with older people and services were to a great extent delivered on a single agency basis with varying levels of coordination. Whatever the organisational validity, the consequence of the withdrawal of social care staff from health settings and attachments to intermediate care services was that there was less direct multi-agency team work within social care and health services. First line managers from health and social care were not meeting on a structured and regular basis to ensure a whole system approach to service delivery. Community matrons had not yet made any significant impact on local joint working, and social care staff had limited understanding and experience of the role of community matrons.

The Community Mental Health Team for Older People was made up of exclusively health service professionals from the provider trust, with no set arrangements to ensure an effective social care perspective in the care of

older people with mental health needs. The team stood outside the social care referral systems experienced by other mental health teams and was thus inadequately linked with social service systems. At the same time, in general, older people's teams were reporting increasing demand from mentally frail older people, and increasing difficulties in meeting their needs. There was scope for more dedicated focus on ensuring whole system management, a need that was likely to increase in the future.

In house services performed well against National Minimum Standards. In many respects these services had evolved separately, but increasingly with knowledge of the broader strategic direction for services. Preferred status as providers had not yet helped to develop a clear vision consistent with the commissioning strategy. Their operation was not secured by any transparent service level agreements, reinforcing expectations. A Cabinet Report, approved in January 2007, set out the rationale for change to meet the needs of the developing market and to address the standards expected of people who use services. It had begun to chart a proposed three-year programme for the future of residential and home-care services; other areas such as the limited day care service had yet to be addressed. The likely shape of key services such as home care remained to be decided, but knowledge of the nature of possible change had caused some concern about the need for consultation to consider the full implications for other services. Some recent decisions to prioritise in-house home care meant somewhat arbitrary transfers from established providers at short notice. This impacted directly on users, some of whom had been distressed by this prospect. The Cabinet Report noted the need to take the proposals for in-house services out for wider consultation.

## 3.3 Supporting carers

Carers experienced a lack of public information to guide them on the availability of local services from health and social care.

*'Everything I've found out I've had to discover myself. There's no standard information on what's available'.*

Once they had become involved with staff the situation improved, but the lack of written information left them reliant upon the knowledge of individual members of staff, that at times was variable. Carers who were in contact with services reported that once within the system they generally learnt what was available and had good contact with care management staff. Service users and carers were generally positive about the quality of their contact with staff once links had been established.

*'My experience was mostly satisfactory and ……could not fault the care manager'.*

However, carers' experiences of service providers raised some concern about staff training on the importance of carers; one carer described her experience as:

*'I often feel like the woman that opens the door'.*

The Local Area Agreement addressed carers issues and a strategy for carers had been approved in January 2006. A detailed action plan was in place, but these had not yet delivered consistent gains. Services for carers suffered a set back some four years ago when the key commissioned agency went into liquidation. Services had yet to recover to the level that they had achieved previously. Major changes were only just taking place as a new carers' support programme was being commissioned with a new carers' support coordinator having just taken up post. Carers' assessments were on care managers' agendas, but it was less clear to carers what this led to. The number of carers' breaks provided was improving, but remained low relative to national indicators.

## 3.4 Safeguarding adults

A high level of managerial attention was given to adult safeguarding with the director of adult social services chairing the Adult Protection Committee and a senior PCT manager chairing the Monitoring and Development Sub Committee. Good quality assurance processes were in hand for the safeguarding processes. Safeguarding issues had a significant profile across DASS teams. The large majority of staff involved in community assessment and care management had received training in adult protection.

Multi-agency arrangements were well developed with dedicated posts from the council, the PCT and police, and effective partnerships between these agencies. Connections were in place to link with criminal justice and other public protection processes. The acknowledged need for better public awareness was being addressed in a new project with Age Concern funded from Comic Relief.

# 4. Quality of Services for Users and Carers

## 4.1 Referral, assessment, care planning and review

DASS had made a positive engagement with the Department of Health Care Service Efficiency Delivery (CSED) regional project to examine referral and care management processes. The project team was working on an inclusive basis with all levels of staff to develop ownership of an improved model of service, but this had yet to move to a confirmed action plan supported by councillors. We identified a number of areas where improvements in referral, assessment and care management were required. These are covered in the following paragraphs and include:

- the functioning of referral management systems through a central team and out to fieldwork teams
- communication links with people referred
- reviews
- resources taken up by the duty systems
- timely and effective signposting for inappropriate referrals for people with lower level needs.

The developments of these systems within DASS were separate from health systems, but characterised by regular communication with health service staff. There were clear and recognised needs to ensure that developments by DASS ensured effective links with the hospital's Single Point of Access. The structured project management exercise with CSED was soundly conceived and was identifying a wide range of substantial issues to be addressed that were consistent with many of our own findings.

Assessment and planning by care managers was generally systematic and carers generally felt involved in the assessment and care management process. The information from case records showed that within DASS there was a consistent use of the paperwork, assessments were usually at a depth consistent with need, and in many situations included input from health care professionals. However this was more of a combining of information, rather than a single process. The Single Assessment Process was not fully established across all services, and where used it was experienced by some as 'time costly'. Half of the health and social care staff that completed questionnaires believed that arrangements for obtaining multi-disciplinary assessments remained inadequate, and a high proportion felt that other services remained unresponsive to their referrals.

The effectiveness of the central team that provided a single point of contact for referrals to social services during normal working hours was being addressed by the CSED project. Referrals, when screened, were

forwarded to the local older people's teams, where staff reported a significant minority were inappropriate. Decisions to forward referrals that were subsequently found to be inappropriate could cause unnecessary delays in signposting people to a more appropriate service.

Each team had found it necessary to set up two duty systems; one for hospital based referrals and one for all others. This meant significant staff resources overall were focused on responding to referrals, and further complicated the effectiveness of referral systems. This was the more significant because, whilst national indicators for waiting periods in adult social care were good, waiting lists for allocation in local older people's teams sampled were persistent and varied particularly for non urgent cases. OT waiting periods had improved, but remained significant.

Following assessment, decisions about resources were often taken to panels, but practice within DASS was inconsistent, not widely understood and was generally on a single agency basis, which militated against a holistic approach. Referrals for continuing care went to a joint health and social care panel chaired by a senior officer from the PCT.

The proportion of reviews, which were completed annually, was relatively low and had not improved as planned, but a number of actions were taking place to improve practice. A pilot scheme was in place to improve the number and timeliness of reviews that held the prospect of improvement in these areas. There were mixed views about the overall efficacy of a the review process that had been introduced, with the expectation there would be more desk-top reviews held. Senior managers acknowledged a need to have a clearer set of expectations of reviewing officers, and options for the organisation of the review process, including the posibility of a centralised service, were being considered.

Fair Access to Care Services (FACS) criteria were now being applied systematically and past decisions were being re-considered, some by telephone and some by questioning service providers. Over half of the staff who completed questionnaires thought reviews inadequate or very poor, and some felt that they were focused on service reductions due to budget pressures. Budget issues were described as impacting upon care planning and review, particularly for some highly dependent older people; the use of 'transitional care' was being used for people awaiting complex care packages. These issues confirmed the need to develop improvement plans in this area and justified its inclusion in the CSED project.

Wirral council had a well-developed corporate approach to public access and information, but arrangements to display material varied between one-stop shops. Local information on health and adult social services was poor. The lack of public information had implications for facilitating informed choice and the efficiency of referral processes. DASS had responded to this matter and had very recently produced a number of new short leaflets, but had done so in-house and without consultation with key partners, service users and carers. These had been distributed electronically as a 'pilot' and

could be modified at a future point, but this did not seem consistent with ensuring initial accuracy of information and ease of understanding by involving service users and carers in the early stage of design. Well planned changes to improve the information on the council's website were at an advanced stage.

### 4.2 Quality assurance and complaints

Complaints processes were well established in the PCT and DASS and regular management reports were made in both organisations. There had been no tradition of joint work in this area, but a recent initiative had taken place to consider establishing joint approaches where this was justified.

There had been clear senior management commitment in DASS to promote a positive culture, which ensured complaints were to be viewed as learning opportunities. Renewed focus had been also placed on ensuring the capture and presentation of compliments received. Training in DASS had focused on managers, rather than front line staff, as key arbiters of practice. There was a clear focus on improvements to the responsiveness of the DASS complaints process, with positive notification and progress chasing systems in place.

Service user and carer awareness of complaints procedures was not assured, but plans existed to provide information as a standard part of a planned DASS referral information pack, to be shared with service users and carers at first point of contact.

Contracts monitoring staff played a valuable role in ensuring a consistent focus on quality with a mostly receptive group of external providers, but they had no such role with in-house services.

## 5. Fair Access

### 5.1 Valuing diversity and social inclusion

Both DASS and the PCT had produced equality and diversity strategies, which provided a clear framework for diversity. A draft policy on valuing diversity was under development in DASS. Half of the health and social care staff in our survey had participated in equalities training; this was a requirement for PCT staff. In health there had been a focus on staff development and the provision of information to staff.

The council assessed that it had met the requirements of level 1 in the equality standards for local government. It was systematically reviewing the wide range of policies and procedures in place, assuring these processes addressed valuing diversity, and underpinned all DASS activity.

### 5.2 Access to culturally appropriate services and advocacy

Improving links with minority groups was an acknowledged service development need and a priority in the joint commissioning strategy. DASS had recognised that engagement with people from black and minority ethnic groups needed to be strengthened. People from black and minority ethnic groups continued to experience services that were not responsive to cultural, language and personal care needs. There was a broad consensus that the use of a language telephone interpreting service was not fully effective in ensuring the subtleties of communication and dialect.

Wirral Ethnic Health Action Group and health care staff had produced, several years previously, information on working with people from different ethnic backgrounds, and this had been widely distributed within health care settings. However there was little obvious experience among people we met of improved responses and outcomes. There had been an equalities stakeholder event in January 2006 and the issues raised were being dealt with on a methodical basis in each council service. Despite this and two subsequent reports the people we met felt ill informed of what subsequent action had resulted from the event.

Wirral Advocacy and Involvement Services Partnership (WAISP) steering group had established meetings with senior DASS representation, and there was a separate advocates meeting. WAISP had arranged an away day for stakeholders in May 2006 and an ambitious action plan for 2006 to 2007 had been put in place to be managed by the WAISP Coordinator.

Advocacy services were established, but there were few effective links between them and operational staff from health or social care, and no clear policy about their routine involvement in significant assessment and case review meetings. Staff we met from these services did not consider existing liaison arrangements with the council to be fully effective, and given the high caseloads in some advocacy services, there was a need to consider the nature of work being undertaken and the extent to which this reflected service needs. Links between PALS and advocacy agencies appeared modest.

## 6. Capacity for Improvement

### 6.1 Achieving and sustaining progress

The council had demonstrated a solid improvement, as evidenced by external audits of its social care performance, from some years previously when social services were found to be failing. Managers were realistic that they were on a journey of continuous improvement with progress still to be made, and there was a clear commitment to a progressive development agenda. The new PCT had inherited performance ratings that were

generally positive. The need for sustaining and extending progress was identified in some external evaluations, a particular issue in the budget context of both organisations.

The direction for services could be clearly identified in the joint commissioning strategy, but this was not taken forward into an overall service planning process to ensure every element was progressed on a structured basis. However the influence of the strategy could be identified in particular service development work-streams and there was a connection between strategic objectives and the targets set in the performance information system (PIMS) in DASS. This was still a relatively new process with a number of declared commitments yet to have fully developed action points.

Staff confirmed that training and development opportunities were readily accessible and that these were linked to annual appraisals in both the PCT and DASS. There was evidence that independent and voluntary providers were involved in some key training events, in particular in relation to adult safeguarding. However some smaller voluntary organisations did not feel at all well connected to these activities.

## 6.2 Leadership, performance management and scrutiny

Capacity for service improvement was set against a background of strong budget pressures in the council and little potential for new investment by the PCT for other than the government's highest spending priorities. The council had demonstrated its commitment to adult social care services through a significant budget growth.

The role of Scrutiny was established for both council and health matters. Councillors had decided to replicate a 'Reference Group' process that had proved successful in children's services, to help provide a forum for the coordination of activities across all agencies that had a role in providing services for adults.

Staff from both the PCT and DASS were generally optimistic about future prospects; with clear leadership from senior managers and supportive political statements, they felt better informed about policy and development issues. Longstanding issues of policy and practice were being progressively tackled, some from a low base, and there was a palpable sense of growing cohesion and clarity around direction of travel for services. There was scope for greater dialogue with some sectors around this.

Within DASS there had been a developing use of performance information and clear expectations of specific managers to implement actions in relation to specific, mostly national, indicators. The use of PIMS and 'performance surgeries' brought a structured approach to performance activity within DASS and had made management staff more attuned to performance measurement. Team plans had been used to develop overall

performance frameworks within PIMS, but were not used as live documents to guide and inform the work of teams.

A sophisticated project plan was in hand to improve the ITC systems within DASS for both performance management and care practice. Current ITC systems in DASS older people's teams were universally recognised as inadequate and a programme to improve them was in hand. The trial of new IT equipment in one office had successfully demonstrated the benefits to both care managers and their managers, and in responsiveness to service users.

DASS older people's teams felt concern about the low level of their administrative support, which had implications for their efficiency, but also for written and telephone response to the public and other professionals. Processes in DASS to log staff movements against their planned programmes differed widely and were dependent upon ad hoc arrangements with managers and colleagues. The low level of administrative staff in team bases made this additionally difficult to monitor on a consistent basis, with clear implications for health and safety.

# Appendix 1: Criteria and Key Lines of Enquiry

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| **CRITERION 1: National Priorities and Strategic Objectives**<br>**The council works with partners to ensure that national priorities and objectives are delivered.** | |
| **1.1** | There is a coherent **vision and strategies for development of local services,** derived from analysis of local communities' diverse needs and implementation of national priorities, which are developed with key partners in relevant service areas. |
| **1.2** | Service users and carers from diverse groups within the community actively contribute to service development. |

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| **CRITERION 2: Cost and Efficiency**<br>**The council commissions and ensures delivery of services to clear standards of both quality and cost, and by the most effective, economic and efficient means available.** | |
| **2.1** | Commissioning is based on sound analysis of local population needs, including that of minority ethnic groups, results in a clear **strategy for resource allocation** which reflects improvement priorities and **balances cost and quality requirements** successfully. Scope for joint commissioning is actively explored. |
| **2.2** | There is a clear focus on **improved efficiency,** with joint financial arrangements used where this adds value. |
| **2.3** | The council demonstrates **probity** in managing resources. **Budget management** is effective and appropriately devolved to trained staff; accountability for budgets and expenditure in areas of shared and complementary responsibility is clear. |

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| **CRITERION 3: Effectiveness of Service Delivery and Outcomes for Service Users and Carers**<br>**Services promote independence, protect people from harm and support them to make the most of their capacity and potential and achieve the best possible outcomes.** | |
| **3.1** | The **independence of service users and carers is promoted** consistently to minimise the impact of any impairments, and to avoid family stress and breakdown. |

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| **3.2** | The **range of services** available is broad and varied to meet local needs, including those of diverse groups, offers choices to many and takes account of individual preferences. |
| **3.3** | There is a good range of services to **support and encourage all carers** in their caring role. |
| **3.4** | Service users are effectively **safeguarded against abuse**, neglect or poor treatment. |

**CRITERION 4: Quality of Services for Users and Carers**

**Service users, their families and other supporters, benefit from convenient and good quality services, which are responsive to individual needs and preferences.**

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| **4.1** | Service users and carers experience health and social care **referral, assessment, care planning, service delivery and review** processes which are convenient, timely and tailored to individual needs and preferences. |
| **4.2** | Key health and social care services have effective **quality assurance and complaints systems**, which promote consistent service quality across sectors and communities. |

**CRITERION 5: Fair Access**

**Service users, their families and supporters, have consistent and fair access to council services and those it provides in partnership.**

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| **5.1** | The range of services available reflects community needs, promotes equality, complies with relevant legislation and demonstrates that **diversity and social inclusion** are valued. |
| **5.2** | Access to services is **culturally appropriate, and inclusive**. Advocacy services are promoted and used appropriately. |

**CRITERION 6: Capacity for Improvement**

**The council has corporate arrangements, working partnerships and capacity in place to achieve consistent, sustainable and effective improvements in planning and service delivery.**

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| **6.1** | The council and key partners have made **sustained recent progress,** secured by relevant policies, plans, targets and risk assessments. |
| **6.2** | **Leadership, performance management and scrutiny** arrangements are effective: performance improvement can be clearly linked to management action. |

# Appendix 2: Standards for Better Health

The core standards relevant to these joint inspections are:

C6 Healthcare organisations cooperate with each other and social care to ensure that patients' individual needs are properly managed and met.

C7 Healthcare organisations a) apply the principles of sound clinical and corporate governance; b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources; c) undertake systematic risk assessment and risk management; d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources; e) challenge discrimination, promote equality and respect human rights; and f) meet the existing performance requirements set out in the annex.

C9 Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

C10 Healthcare organisations a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and b) require that all employed professionals abide by relevant published codes of professional practice.

C11 Healthcare organisations ensure that staff concerned with all aspects of the provision of health care a) are appropriately recruited, trained and qualified for the work they undertake; b) participate in mandatory training programmes; and c) participate in further professional and occupational development commensurate with their work throughout their working lives.

C13 Healthcare organisations have systems in place to ensure that a) staff treat patients, their relatives and carers with dignity and respect; b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and c) staff treat patient information confidentially, except where authorised by legislation to the contrary.

C14 Healthcare organisations have systems in place to ensure that patients, their relatives and carers a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services; b) are not discriminated against when complaints are made; and c) are assured that act appropriately on any

concerns and, where appropriate, make changes to ensure improvements in service delivery.

C15 Where food is provided, healthcare organisations have systems in place to ensure that a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

C16 Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

C18 Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

C22 Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by a) co-operating with each other and with local authorities and other organisations; b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

C23 Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

# Appendix 3: Methodology

This inspection was one of a number of joint inspections carried out by the Commission for Social Care Inspection and the Healthcare Commission in 2007. The aim of the inspections was to evaluate how well councils and primary care trusts (PCTs) met the needs of older people or people with physical or sensory impairment and their carers, with particular emphasis on improving outcomes. The experiences of service users and carers were a primary source of evidence for the inspections.

An inspection design team created the inspection methodology. The criteria and key lines of enquiry (see Appendix 1) were developed from CSCI's standards and criteria and reflect the core standards contained in *Standards for Better Health*.

The inspection team consisted of three inspectors from CSCI, a senior assessment manager from the Healthcare Commission and an older person with experience of using services. At the beginning of the inspection process, we asked the council and PCT to complete a self-assessment of their performance and to supply documentary evidence in support.

We sent questionnaires to 90 service users, 50 carers, and staff in the council and PCT who were involved in care management. The responses to the questionnaires were not sufficient to provide statistical information, but they added individual experiences to other evidence and helped us to identify areas for exploration during the fieldwork. We also wrote to other agencies for their views about the council and PCT.

Before the fieldwork, we reviewed all available evidence on the performance of the council and PCT. We then met managers from the council and PCT to tell them what we had found and to finalize plans for the fieldwork.

During the seven days of fieldwork, we met a wide range of people with knowledge of the services provided by the council and PCT, including:

- people who had experience of receiving services
- organisations which advocate or represent service users' and carers' interests
- council and PCT staff
- key staff in other health and council services
- key voluntary and private sector organisations.

## Contact information

**Commission for Social Care Inspection**
33 Greycoat Street
London SW1P 2QF
Helpline:
Telephone: 0845 015 0120  or 0191 233 3323
Textphone: 0845 015 2255 or 0191 233 3588
Email: enquiries@csci.gsi.gov.uk
www.csci.org.uk
Get monthly updates on news from CSCI – sign up to our email newsletter www.csci.org.uk