



# Inspection report

## Service inspection of adult social care: **Southampton City Council**

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**Focus of inspection:**

Safeguarding adults  
Increased choice and control for older people

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**Date of inspection:** July 2009

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The Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities, private companies or voluntary organisations, we make sure that people get better care. We do this by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

# Inspection of adult social care

## Southampton City Council

July 2009

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# Contents

<b>Introduction</b>	<b>3</b>
<b>Summary of how well Southampton was performing</b>	<b>4</b>
What Southampton was doing well to support outcomes	5
Recommendations for improving outcomes in Southampton	5
What Southampton was doing well to ensure its capacity to improve	6
Recommendations for improving capacity in Southampton	7
<b>Context</b>	<b>8</b>
<b>Key findings:</b>	<b>9</b>
Safeguarding adults	9
Increased choice and control for older people	14
Capacity to improve	19
<b>Appendix A: Summary of recommendations (referenced)</b>	<b>26</b>
<b>Appendix B: Methodology</b>	<b>28</b>

## Introduction

An inspection team from the Care Quality Commission visited Southampton City Council in July 2009 to find out how well the council was delivering social care.

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

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

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

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

## Summary of how well Southampton was performing

### **Supporting outcomes**

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

### **Safeguarding adults:**

We concluded that Southampton was performing adequately in safeguarding adults.

### **Increased choice and control for older people:**

We concluded that Southampton was performing adequately in supporting increased choice and control for older people.

### **Capacity to improve**

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

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

## What Southampton was doing well to support outcomes

### Safeguarding adults

The council:

- Increased the profile and awareness of safeguarding across adult social care.
- Ensured an increased commitment to improving the safeguarding of vulnerable adults across partner agencies.
- Committed and redirected additional resources to safeguarding.
- Ensured a comprehensive set of policies and procedures were in place to support staff in the management of safeguarding cases.
- Implemented improvements to the management oversight of case work.

### Increased choice and control for older people

The council:

- Ensured there was a focus on promoting the wellbeing and independence of older people through self directed support.
- Developed a comprehensive and wide range of public information for older people and their carers.
- Ensured that a range of services were in place that supported older people to remain in their own homes.
- Assist voluntary sector organisations and volunteers to provide more support to older people in their own communities.
- Ensured that relationships between older people and their care managers and social workers were positive and that older people were treated with dignity and respect.

## Recommendations for improving outcomes in Southampton

### Safeguarding adults

The council and partners should:

- Improve the quality of case recording of safeguarding activity.
- Improve the monitoring and evaluation of the outcomes of safeguarding actions.

- Improve the arrangements for safeguarding training.
- Ensure that preventative approaches to safeguarding are better promoted to the public and people whose work brings them into contact with vulnerable people.
- Ensure that the Adult Safeguarding Board can confirm that safeguarding arrangements were keeping people safe.

## **Increased choice and control for older people**

The council should:

- Ensure public information is systematically made available to people.
- Improve case recording to ensure that it captures the views and personal preferences of people who use services and their carers that are key to the delivery of person centred care.
- Ensure that the needs of carers are recognised and met.
- Improve the experience for older people when they make contact with the council.
- Ensure that the changes to the charging policy and the provision of domiciliary care improve the quality of services.

## **What Southampton was doing well to ensure their capacity to improve**

### **Providing leadership**

The council:

- Had a clear vision for the future of adult social care that reflected a strong commitment to working in partnership with health, the voluntary sector and independent providers.
- Increased the priority given to safeguarding vulnerable adults in adult social care and provided more resources to ensure people's safety.
- Had strong financial planning and budget management in place.
- Ensured that all staff were aware of how their work contributed to the improvement of outcomes for older people and their carers.

## **Commissioning and use of resources**

The council:

- Had a strong process in place for identifying and responding to local needs.
- Taken actions to increase the value for money of some of the council's own services.
- Provided a range of low level services that were improving the well-being of older people and their carers.
- Provided with health partners, a good range of supported housing for older people.

## **Recommendations for improving capacity in Southampton**

### **Providing leadership**

The council should:

- Ensure there are sufficient staff resources at both senior and operational level to deliver current and future changes.
- Ensure that safeguarding is more widely promoted across the council and community.
- Complete the work to decide how the council intends to lead adult social care in the future as planned.
- Develop more detailed, multi agency plans that will show how the transformation of social care will be achieved within timescales.
- Ensure action is taken to better promote the current and future work of adult social care with the public.

### **Commissioning and use of resources**

The council should:

- Develop plans that show how the council will respond to and fund the needs of older people and their carers in the future.
- Ensure any future changes to the provision of services or charging arrangements are subject to rigorous risk management processes.
- Develop stronger ways in which it monitors and reports on how well the services it buys are serving older people and their carers.
- Continue to work with the new providers of home care services to improve the quality and reliability of these services.

## Context

Southampton has a population of approximately 227,000 residents. Southampton City Council is ranked the 96th most deprived out of the 354 local authorities in England. In the 2004 index of multiple deprivations Woolston, Bevois and Bargate wards are the most health deprived wards in Southampton. The most significant employment sectors in Southampton are distribution, tourism, business and finance and related activities. The port makes a significant contribution to the economy of the area. At 2.4 per cent the unemployment rate is higher than the average for the south east but below the national average.

The majority of the population is White British, with 10.7 per cent of the population coming from non-white minority ethnic groups. Of the adult population 16 per cent (30,689) of the adult population is aged 65 years and over, 2.6 per cent (4,978) of the population is aged 85 years and over.

The Conservative group has an overall majority on the council and forms the city's Council administration after being a hung council since the previous election in 2008. The city council's services are delivered through five directorates each led by a strategic director. The Communities Health and Care Division is responsible for adult social care. The council's Fair Access to Care Services (FACS) criteria includes people who fall within substantial and critical levels of need. The council achieved level 4 of the local government Equality Standard.

The council was rated as a '3 star' council and was judged to be improving well in its direction of travel report by the Audit Commission in 2008-09. Southampton City Primary Care Trust (PCT) services the borough. In 2008 the Healthcare Commission judged the PCT to be 'good' for the quality of services and 'fair' on the use of resources. The Commission for Social Care Inspection rated the council as a '3 star' council. It assessed its performance as good overall in its delivery of outcomes with excellent capacity to improve.

## Key findings

### Safeguarding

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

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

The council had adequate arrangements in place to ensure that people who use services and their carers were free from discrimination and harassment when they used services. Community safety work had not been used to inform the development of preventative approaches to safeguarding. This work could be better supported if high level links between the community safety and safeguarding partnerships were more effective. The profile of safeguarding was low in the community safety plan and related strategies. There were some examples where social care had contributed to the improvement of community safety but there were further opportunities for this work to benefit the wider community.

The council's established community safety partnership had been successful over the last year in developing a number of community safety schemes to improve people's safety. Most people we met during the inspection reported feeling safe in their communities and were aware of how to report any concerns about their personal safety to a close relative, professional person or the police. There was a reduction in the number of people who were repeated victims of crime. The work targeted at hate crime had resulted in an increase in the reporting of incidents. To support this work there was a network of staff who were designated as hate crime and harassment monitors in place across the community with nine monitors identified within adult social care. These monitors were responsible for raising the profile of hate crime and harassment in their areas of work.

The needs of vulnerable groups in the community required greater focus to ensure they were being considered in the work of community safety. The council, in partnership with the voluntary sector, had undertaken some targeted work with people with learning and physical disabilities to raise the awareness of how to report incidents of discrimination or harassment. This work could be targeted more widely at communities whose populations were at particular risk. The Thornhill project had contributed to the improvement of community cohesion and there was a commitment to build on this and sustain the improvements achieved. Other communities could benefit from this work also.

There was more work to do to ensure that discrimination and harassment was embedded within the work of adult social care. We found only limited examples

where issues of diversity had been taken into account during assessments. Only a small proportion of staff within adult social care had accessed training in hate crime and harassment and the uptake of inclusion training in adult social was low. Equality impact assessments informed service changes.

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

Some people were effectively safeguarded against abuse, neglect and poor treatment. The council had demonstrated its commitment to securing people's safety by gradually increasing the priority and resources given to safeguarding.

There was multi agency commitment to safeguarding that was being co-ordinated through the Adult Safeguarding Board. The board had more work to do to ensure that it was being informed by reliable information on the effectiveness of safeguarding arrangements including the quality of frontline practice and outcomes. The sub group structure of the board did not fully support on going improvement activity. This should be reviewed to ensure that the identified priorities would be achieved, with multi agency ownership of this work where appropriate. The recent creation of the Citizens Forum as a means of engaging people who use services and carers in the work of the board was worthy of note.

The Safeguarding Annual Report 2008/09 was nearing completion. The report was used to inform partners of progress made over the last year and the planned improvements. It could be used more effectively to assure the board of the effectiveness and quality of current arrangements. The report lacked detailed analysis of safeguarding that could inform future improvement work. The report would also benefit from more qualitative information on outcomes for people.

Public awareness of safeguarding was limited. The council had developed a range of public leaflets but these were not always available in care and non-care settings such as libraries, leisure centres or GP surgeries. People we met during the inspection were unfamiliar with the term safeguarding and not had seen any public information on the subject.

Responses to safeguarding referrals were prompt and effective in securing people's immediate safety. Awareness of safeguarding amongst staff in adult social care and partners was high. This had resulted in a considerable increase in the number of referrals over the last year. During 2008/09, 610 individual safeguarding referrals were made. The numbers being referred had increased compared to the previous year. As safeguarding referrals were given high priority the increased level of activity had impacted on staff's ability to respond to non-safeguarding issues in a timely way.

Care management processes did secure people's safety and were supported by a comprehensive set of safeguarding policies and procedures.

A person who had experience of safeguarding procedures stated:

*"I feel safer now, I could not find fault in how they helped me."*

A carer reported:

*“The social worker was a lifeline, an absolute god send.”*

Recording of safeguarding activity did not always reflect the depth and breadth of the work undertaken. Standard of recordings were generally low and did not meet the council’s expectations. In particular, the recording of risk was poor which was of concern when procedures were risk based.

The council had recently introduced new tools to support staff in safeguarding work. This had included a new process for recording on the councils IT system, templates for protection planning and recording strategy meetings. These new tools had created increased recording requirements for staff. The impact of these requirements on staff time had not been assessed before their implementation. Staff were overwhelmed by the expectations this had placed upon them and it had impacted on their ability to complete other work in a timely way. The council were committed to monitoring the effectiveness of the new tools.

Multi agency contributions to investigations were variable. The co-ordination of multi agency activity did not always ensure that the full range of interventions was considered in the management of safeguarding situations. This was particularly evident in some of the complex cases we saw that would have benefited from greater inter-agency co-ordination. Police contributions to safeguarding work were reported as variable. Plans were in place for work between social care and police to be enhanced by the secondment of staff between the two agencies.

We found that the council could not assure itself that safeguarding practice secured peoples safety. Systematic quality assurance and performance management processes had only just been introduced. An external audit of practice had recently been undertaken that had identified five central recommendations for improvement, some of which had been implemented. The council had recently introduced quality assurance procedures that should improve management oversight of safeguarding work. A new safeguarding data set had been identified and was in the process of being implemented.

The council responded robustly to ensure people’s safety in cases in large organisational settings. Following some serious safeguarding incidents in a small number of regulated services the Safeguarding in Provider Services Team (SIPS) had been created. They worked closely with regulated services, commissioners and partner agencies to improve the quality of services and ensure the on-going safety of people who use these services.

Current arrangements for the provision of safeguarding training were in need of improvement. The provision of training over the last year for staff internal and external to the council was significantly below the level of similar authorities. There was no training strategy in place that would inform a more structured approach to ensuring staff were competent in fulfilling the specialist safeguarding roles and responsibilities. Staff valued the safeguarding awareness and investigator training that was available but felt that more regular access to refresher training was needed.

It was unclear what role the training subgroup of the safeguarding board had in the improvement and commissioning of training. A senior practitioner forum was in place but had not been used effectively to share best practice.

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

The council had some mechanisms in place that supported people's dignity, privacy and promoted people's preferences. Personal preferences were not always identified in assessments. In particular the identification of lifestyle choices was frequently not completed. Therefore personal preferences did not often feature in care and support plans. Care plans we saw as part of the inspection were not routinely signed off by the service users or carers. There was more work to do to ensure oversight of care plans was systematically monitored and reported on.

In November 2008 the council had undertaken a routine survey of people who use domiciliary care services. This survey had reported positively that care workers did the things that people wanted them to do and that people were happy with the way that they were treated by domiciliary care workers. However, some people we met during the inspection reported not being treated with respect and dignity by a small number of homecare agencies and by some staff who were directly providing homecare. The council was actively working with these agencies to ensure that people were treated appropriately at all times. There was a plan in place to move to outcome focused contracts that would ensure greater focus would be given to the monitoring of privacy and dignity.

All people we met during the inspection reported being treated with dignity and respect by care managers and social workers. People who used services established positive working relationships with these staff. A service user reported:

*"The staff were patient, respected my wishes and explained everything to me."*

There was some confusion about the use of mental capacity assessments in relation to safeguarding. When a lack of capacity was identified Independent Mental Capacity Advocate's (IMCA) were not routinely used. The profile and take-up of the IMCA service was low. The council commissioned a range of advocacy support. We found some cases where advocacy had not been considered or accessed when it may have been appropriate.

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

Adult social care was promoting people's choice to remain living in their own home. We saw good examples of how people had been supported by packages of care to maintain their lifestyle. Telecare featured in many care arrangements to secure people's safety. The provision of low level services such as the handyman and

gardening services assisted people to maintain their standards of living.

The council did not provide any public information on the quality of services they commissioned. They relied on regulatory information and inspection reports to inform people about the quality of services. Information from contract monitoring could be used more effectively to gain a better understanding of the experience of people who use services who were dependent on others for their safety and wellbeing. The council needed to ensure that people had greater access to information about services when selecting residential and domiciliary care services. Eighty five per cent of placements made by Southampton council in care homes are accommodated in single rooms.

## **Increased choice and control**

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

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

Older people were not systematically provided with information that would allow them to consider the range of service options available. Supply of information by social workers and care managers was inconsistent. This undermined the value of the range of public information available and effectively limited choice for people. People we met during the inspection had access to very little information. In particular the carers pack was comprehensive but awareness of this pack and information on services to support carers was limited.

The range of public information was broad, leaflets were found to be easy to understand and clearly set out. Availability of information in both care settings and non-care settings was limited. There were more opportunities in buildings such as housing offices, libraries and the civic centre to have a variety of up to date information alongside contact details that people could easily access. Staff in all settings were found to be helpful and willing to help with finding relevant information. Options to access information in other formats and media were not always made clear on leaflets or brochures. One service user reported:

*"I have a problem at finding phone numbers as I am partially sighted."*

The council's website was a source of useful information with many opportunities for people to email or telephone the council. There were helpful links to other relevant websites as well. Overall, there was a wealth of information on maintaining well-being in later life. Some people reported that they did not have access to computers and therefore the council should not rely too heavily on its website as the main source of public information. A higher profile could be given on the website to information for people from black and minority ethnic communities.

Initial contact and signposting arrangements were not systematic or efficient. On first contact only minimal information was taken from callers. No immediate signposting work was undertaken. Details were emailed to the adult social care contact team who had to assess the needs and priorities of the call from, what was often, very limited information. As a result of this people often experienced delays in receiving a call back. The Initial Contact Team had recently introduced a new monitoring system that involved sending out customer satisfaction surveys but only limited analysis had been obtained from this process. It was not yet being used to improve the experiences of the people. The council needed to review the current system to improve the timeliness and quality of response from adult social care.

A service user stated:

*"If I have a problem it's sorted eventually. It might take a couple weeks but it's done."*

The council had recently made changes to the way they charge people for services. People we met during the inspection felt that this process had not been well communicated to people who use services and their carers. Many people reported that they had little or no warning of these changes. One carer reported:

*"The letter came out of the blue, it was very abrupt."*

Alongside this the council had also reduced, from nineteen to five, the number of domiciliary care agencies it commissions services from. People reported that this change had also been poorly communicated to them.

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

Older people and their carers were not always helped to shape their own care and support. We found gaps in case records that were critical to the delivery of person centred care and support. Written assessments were very basic and did not always capture the views or preferences of service users and their carers. There was no systematic recording of whether direct payments or personal budgets had been discussed with service users. Care planning was not sufficiently outcome focused or holistic. Reviews were normally completed as planned, including reviews of direct payment arrangements. The single assessment process was not embedded in care management processes and often resulted in service users and carers repeating their stories to a range of health and social care practitioners. The exception to this was the intermediate care teams who used an electronic single assessment forms. There were plans in place to improve the quality of record keeping.

The council were aware of the need to reduce the time taken to complete assessments. However, over the last year there had been no improvement. There were significant waiting lists across all locality teams, the contact team and access to occupational therapy assessments. All teams were under significant pressure in managing caseloads mainly due to the increase in safeguarding alerts and increased vacancy levels. How the council intended to address this matter was not fully clear.

The council was committed to supporting self directed support for older people. Progress had been delayed mainly due to the cautious approach taken by the council to financial risk. Targets had been identified for the take-up of personal and individual budgets. Progress on the implementation of supported self assessments for older people was limited.

The council had established brokerage arrangements with one broker employed by the council and three brokers commissioned through the voluntary sector. Over the last year the council had increased the number of new direct payments for older people, which is in line with similar authorities. A proportion of the increase was as a

result of the re-provision of domiciliary care arrangements.

Advocacy and interpreting support was not always proactively offered to people who required additional assistance to make their needs known. Additional communication support was provided in some cases to support older people with sight or hearing loss.

The intermediate care service had provided a more person centred approach to its work that had resulted in improved outcomes for people. This had resulted in 92 per cent of service users reporting improved or maintained independence levels between October and December 2008. Brownhill Intermediate Care Centre offered a good joint service to support people on discharge from hospital and helped to maximise people's skills and confidence. There was more work to do to ensure that all hospital discharge arrangements were well planned and safe. Some older people had been discharged inappropriately mainly due to discharge being arranged by hospital staff rather than going through the social work or hospital discharge team.

There was a lack of focus on carers within care management processes. A range of services were in place to support carers but their value was not fully realised as insufficient attention was given to the needs of carers. Case files we saw lacked recognition of carer's contribution to existing care arrangements or identification of and response to their own needs. We found no examples of completed carer's assessments on the case files we read. The number of carers assessments completed over the last twelve months was below the national expected level. The council needed to review the resources available to complete carer's assessments as resources were limited.

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

A broad range of services were in place that supported older people to maintain their independence in their own homes. There was effective use of telecare, and supported housing options. The rapid response team was able to provide prompt support to avoid admission or facilitate hospital discharges. A service user reported:

*"Input and support from various staff has encouraged me, it has helped my self-confidence and enabled me to remain independent."*

When the council had reduced the number of home care services it had been hoped that this would provide more locally based, high quality care. We found that this process had been traumatic for many older people. Some had little or no notice of the change. We found that the public felt that choice had reduced as a result of this change and that the quality of service had deteriorated. The council needed to ensure that it monitored the use and effectiveness of homecare visits of short duration. It was questionable how visits of 15 minutes could provide a high quality personalised service to older people. A service user stated:

*“They don’t always come in the evening at times arranged, they are always too early.”*

Another service user reported:

*“Sometimes I don’t know who is going to walk through the door, I have had a lot of different carers.”*

Choice was further perceived to have been eroded as a result to the change to the charging policy in April 2009, as new charges no longer brought the same level of service prior to the change. The council had undertaken a review on all older people where this was the case. Despite the council working hard to ensure people had understood these changes, people we met remained concerned and confused about the change.

There were plans in place to improve the council and partner’s response to the people with long term needs and people who require complex care with the creation of an integrated team that would be better able to respond to their needs.

There were some gaps in services for older people with mental health problems; in particular there was no specialised home care provision for people with dementia and at times access to residential care respite could be difficult. There were plans in place to increase the provision of specialised residential care.

Older people with lower level needs were supported by a growing range of preventative services, many of which were provided by the voluntary sector. Many of these were helping to ensure older people maintained their health and well being by participating in community based activities. Volunteers were increasingly being used to support these activities. Day services for older people were mainly building-based. The council had plans in place to modernise these services when the current contract arrangements finish in 2010.

There were few specialised services for older people from black and minority ethnic communities. Older people from minority communities were integrated into mainstream provision. We found some good examples where the needs of people from diverse communities had been met and positive outcomes achieved.

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

The majority of older people we met knew how to contact their own care manager or social worker and had contact details for the specific services they used. However, older people we met had not been routinely advised of how to contact social services outside of normal office hours or how to make a complaint about the services they used. Many older people had had to make contact with new homecare providers to register a concern or complaint about the service they were receiving. Whilst some issues were resolved through this route, some people reported that at times the

response given by some agencies was not respectful or appropriate.

Overall complaints received by the council were dealt with in a timely way. An annual report on complaints had been published. The number of complaints received by the council over the last year had risen significantly, mainly in response to the changes to homecare provision and charging policy. The council had identified learning points from these, in particular about poor communications and lack of support. Some improvement actions have been identified in response.

Out of hours social work provision was provided via the home treatment team. Awareness of this was low amongst both people who use services and staff. It is imperative that the council makes its out of hours arrangements clear to all staff so they can inform people appropriately.

Once known, older peoples changing needs were not always responded to appropriately. We found examples where delays had been experienced. In one example there had been an escalation of the service users and carers needs as a direct result of a delay. The quality and outcomes from reviews of individual needs required closer scrutiny.

## Capacity to improve

### Leadership

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

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

The vision for the future of adult social care was clear. It reflected a strong commitment to working together with health partners to deliver joint strategic objectives and captured the transformation of adult social care agenda. The council's corporate plan had a focus on improving the quality of life for senior citizens. Wider support for this was seen in the Health and Well-being Strategic Plan 2009-2012. This strategy had been well informed by the views of older people.

There was a growing awareness of the council's vision across the community. We found that some stakeholders were less clear about the implications of the vision for them. There were further opportunities for this vision to be communicated to the public and other stakeholders. Senior managers and other leaders could take a more active role in preparing the community for future change.

An interim Director of Adult Social Services was in place. The council, in partnership with Southampton City Primary Care Trust (PCT), was in the process of reviewing its arrangements for the leadership of adult social care, taking into account the increasing amount of integration of health and social care services. There was a clear commitment to the timely completion of this work.

The council had initially responded well to the transformation of adult social care. Over the last year the council had focused its activity on ensuring that a robust infrastructure was in place and therefore overall progress had slowed. A stronger, more structured approach had recently been taken to the project management of this work. It was envisaged that the pace could now be accelerated. Acceleration of the pace of change would be improved with more corporate support. The council also needed to ensure that staff resources dedicated to this work was sufficient. Capacity of senior managers was already stretched and the demands of the identified work streams were likely to create additional pressure.

Safeguarding adults had been accorded high priority within adult social care yet this profile was not reflected across the council. There were further opportunities to promote and secure the safety of people across the work of the wider council. In recognition of this there were plans in place to deliver awareness training to all

council staff through seminars or e-learning. Adult safeguarding was not clearly supported within the corporate plan or the safer city partnership plan. The Adult Safeguarding Board had secured senior representation from most partners and had been successful in raising awareness of safeguarding across partner agencies.

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

The council had a range of mechanisms in place that ensured people who use services and their carers contribute to the development of strategic plans. Whilst this had been reflected in a number of council plans and strategies many people we met held the view that the council did not sufficiently engage or listen to older people. In the main this was as a result of the public's perception of how the changes made to the charging policy and the provision of domiciliary care had been implemented by the council. The council had much work to do to change this perception and address the real scepticism felt by some staff, partners and the wider community about their ability to effectively manage future change.

The Later Years Partnership was an effective partnership group that was corporately led. It focused on influencing, developing and involving people to secure change for older people. It had been successful in tackling exclusion, improving access to services and engaging with older people in Southampton. Current projects the group were leading included influencing the PCT commissioning vision, assessing the impact of the recession on older people, dementia, employment and enterprise.

The Later Years Partnership also supported the work of the Senior's Council. This group was a key engagement and consultation group and had been engaged in commenting on the housing strategy and one member had been included on the panel that awarded the domiciliary care contract. The council had recognised the further potential of this group and had recently appointed a development worker to support them in their work. The Senior's Council had created a statement on ageism and developed standards for dignity in care which had been accepted by the council however the Seniors Council were unaware of this.

Carers were contributing to service development via a Carers Strategy Network Group and were also represented on other groups. Carers were involved in the transformation work through the Putting People First Citizen Leadership Group that had carer representatives on it.

Financial planning and management were strong. Sound budget management had resulted in the achievement of some cost efficiencies. There was evidence of a shift in resource allocation from traditional patterns of care to more personalised approaches. There were further opportunities to align service and financial planning in order to support the delivery of key targets in a more planned way.

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

The capacity of the social care workforce was struggling to manage and deliver service improvement for older people. All frontline social care teams working with older people had high and increasing workloads. The breadth of responsibilities held by senior practitioners and team managers was wide. In some cases this was impacting on their ability to provide sufficient oversight to case work. There had been a significant increase in staff turnover over the last 12 months that was now above that of similar authorities. There had also been an increase in the vacancy rate that was also higher than similar authorities. There was potential to generate additional capacity by taking a more proportionate approach to the amount of paperwork frontline staff were required to complete and more efficient use of IT systems that would support staff more in their work.

Workforce planning and development strategies needed further work to support the delivery of consistent and high standards of practice across the whole health and social care system. There was a clear commitment to the further development of integrated teams to meet the needs of older people. Where integrated teams were already in place they were delivering improved outcomes for people, in particular the older people's mental health team.

The network of 'Putting People First Champions' made up of social work staff, had been valuable in helping to engage staff in the transformation agenda. Over the last two years all staff had received briefings and training on transformation. There was still more work to do to embed this work further for staff within adult social care and across the wider council.

Over recent years the council had increasingly committed resources to safeguarding. The creation of the SIPS team had been formed from the redeployment of existing resources. The council had considerable work to do to ensure that there was sufficient staff capacity and skills to meet the demands of the safeguarding agenda.

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

The council's performance management system had a good record in setting and achieving most targets. Business planning processes were embedded across social care teams with a good read-across between the corporate improvement plan and targets in team plans. This process was supported by regular reporting on performance to teams and managers and had resulted in improving some outcomes for older people. The council and its health partners were implementing a programme of improvement activity to reduce delayed transfers of care of older people from hospital.

Performance management and quality assurance arrangements for safeguarding were under-developed with the result that senior managers and the Adult

Safeguarding Board could not be assured that practice was effective. Some new systems for assuring consistently good safeguarding practice and appropriate case recording had recently been developed but they had not yet provided evidence of improved outcomes. The new data set to inform performance reporting had also recently been developed but would benefit from an alignment with more qualitative information.

The council had shown commitment to focus more on outcomes for people and this was reflected in the move to outcome focused contracts. It was planned that all adult social care contracts would be transferred to the new outcome focused contracts by 2012. The council was in the process of developing a data set that would reliably monitor and report on these outcomes.

## **Commissioning and use of resources**

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

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

The council had demonstrated its commitment to involving local people in the planning, commissioning and review of services. The council could do more to promote wider representation that reflects the diversity of the community. There was also greater potential to ensure people who use services are more involved in shaping services, particularly in relation to safeguarding.

The development of the Health and Well-being Strategic Plan had been informed by a range of consultation events. The council had also used opportunities presented by the development of the 60 Plus project to listen to what lower level services older people would value.

The city's LINKs network was still developing its role fully but had secured a wide representation from the community. The Thornhill project was an example of where the community had been involved in making decisions about how local health resources should be allocated. There were plans in place to extend this approach to widen community involvement further.

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

The Joint Strategic Assessment provided a comprehensive picture of local needs and trends. It was a sound framework to target support to key individuals and populations and was in the process of being refreshed.

There was no medium term joint commissioning strategy that would drive forward the personalisation of services for people. The current Adult Joint Commissioning Strategy 2009-2010 was being used to assure a steady state whilst the council defined how the transformation agenda would translate into a robust, shared commissioning strategy fit for the future. The lack of a medium term joint commissioning plan had not prevented services from being jointly commissioned. We found some episodic examples where joint commissioning had successfully improved outcomes for older people, such as Rose Brook Court and Brownhill. The council and PCT had developed a strategic vision for the future of services for people with dementia. However resources to support the implementation of this vision had

not yet been agreed.

The council had sound corporate strategic resource management in place. Nevertheless this had not yet been translated into how resources would be used in the future to support the delivery of the transformation agenda. The current joint adult commissioning plan lacked detail of how resources would be allocated to support its delivery.

The council's approach to strategic review of services was robust and demonstrated a commitment to value for money and improving outcomes for people. There had been some decisive action taken by the council in relation to closure of two of its residential care homes, the agreement to remodel its own homecare service to a more short term, reablement approach and the changes to domiciliary care provision. The council's decision to change the arrangements for domiciliary care had been taken to achieve greater value for money. In particular this had supported the implementation of a strengthened contract that was outcome focused and would allow for more effective monitoring of outcomes for people. It was envisaged that the change would also allow for more flexible models of care that will be required with personalisation.

As a result of the change to the charging policy people reported that there had been an increased use of top-up payments. Some older people were reliant on their families to assist them in meeting fee levels. Other people had chosen to reduce the amount of care they received because of the fee levels. The council had undertaken a review of all people who had changed their packages of care.

The decision making processes related to the management of risks associated with the change to domiciliary care arrangements had been flawed. The change had created considerable levels of disruption and anxiety for older people. The quality of care delivered by some of the chosen providers had been unacceptable. The council had worked rigorously with these providers to ensure that the delivery of these services was improved. We found that whilst some people had experienced improved arrangements over the last two months, there continued to be concerns over the quality and reliability of some of these services. There had been a need to involve the SIPS team with two of the agencies to ensure that people's on going safety was improved and close monitoring had continued.

Contract monitoring was fragmented. There was a combination of processes in place depending on whether services had a spot or block contract. There was a small staff resource allocated to monitoring block contracts and care managers were inappropriately relied upon to monitor spot contract arrangements. Plans were in place for further resources to be allocated to contract monitoring. The new outcome focused contracts that were being introduced offered a good opportunity to embed improved outcomes into the contracting process. The council needed to ensure that it developed a robust and effective system for contract monitoring that was appropriately resourced, worked in partnership with providers to improve the service and informed future commissioning intentions.

Little proactive work had been undertaken with providers whose performance was in need of improvement. There were a number of providers whose contract was currently under suspension or under caution. There had been a rigorous response by the council when services were assessed as not being able to ensure people's safety through the SIPS team. Action plans were then drawn up with providers. These were monitored closely to ensure that improvements were made to secure improved safety for people who used the services. More proactive work with providers would reduce the workload of the SIPS team.

## Appendix A: summary of recommendations

### Recommendations for improving performance in Southampton

#### Safeguarding adults

The council and partners should:

1. Improve the quality of case recording of safeguarding activity. (page 12)
2. Improve the monitoring and evaluation of the outcomes of safeguarding actions. (pages 11 and 12)
3. Improve the arrangements for safeguarding training. (page 12)
4. Ensure that preventative approaches to safeguarding are better promoted to the public and people whose work brings them into contact with vulnerable people. (page 10)
5. Ensure that the Adult Safeguarding Board can confirm that safeguarding arrangements were keeping people safe. (page 11)

#### Increased choice and control for older people

The council should:

6. Ensure public information was systematically made available to people. (page 15)
7. Improve case recording to ensure the delivery of person centred care. (page 16)
8. Ensure the needs of carers are recognised and met. (page 17)
9. Improve the experience for older people when they make contact with the council. (page 15)
10. Ensure that the changes to the charging policy and the provision of domiciliary care improve the quality of services. (pages 17 and 18)

#### Providing leadership

The council should:

11. Ensure there are sufficient staff resources at both senior and operational level to deliver current and future changes. (pages 12, 16, 20 and 21)
12. Ensure the work to decide how the council intends to lead adult social care in the future be completed as planned. (page 20)

13. Develop more detailed, multi agency plans that will show how the transformation of social care will be achieved within timescales. (pages 23 and 24)
14. Ensure action is taken to better promote the current and future work of adult social care with the public. (pages 16 and 19)
15. Ensure that safeguarding is more widely promoted across the council and the community. (page 20)

### **Commissioning and use of resources**

The council should:

16. Develop plans that show how the council will respond to and fund the needs of older people and their carers in the future. (page 24)
17. Ensure any future changes to the provision of services or charging arrangements are subject to rigorous risk management processes. (page 27)  
Develop stronger ways to monitor and reports on how well the services it buys are serving older people and their carers. (page 24)
18. Continue to work the new providers of home care services to improve the quality and reliability of these services. (page 24)

## Appendix B: Methodology

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

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

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

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

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

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

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

We spent six days in Southampton when we met with seven people whose case records we had read and inspected a further twelve case records. We also met with approximately 50 people who used services and carers in groups and in an open public forum we held. We sent questionnaires to 150 people who used services and 38 were returned.

We also met with

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

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

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

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

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