Independent Adult Social Care Audits - Final Report

Southampton City Council

February 2019

National Development Team for Inclusion

About NDTi

NDTi is a not-for-profit organisation promoting equality for people who risk exclusion and need support to lead full lives. We make choice, control and opportunity for socially excluded people a reality in our communities. Our team works with government, local authorities, the NHS, voluntary and private sectors, user and family / carer led organisations to make change happen. We do this through supporting national policy development and working with local statutory and independent sector organisations to implement change.

We have a long track record of supporting individuals, teams and organisations through the design and delivery of a diverse range of development supports, training and facilitation programmes.

More information about the NDTi can be found on the website, alongside information about the extensive range of work that NDTi has been involved in developing and delivering over 20+ years. Current and previous clients include the Department for Education, Department of Health, Joseph Rowntree Foundation, the Winterbourne View Joint Improvement Team, NHS England, CQC, and Public Health England. Over the last three years, we have worked in almost every local authority area in England and many in other parts of the UK, particularly in Scotland, and we are proud of our reputation for high quality work.

Basis for this report

Southampton City Council (SCC) commissioned NDTi in November 2018 to undertake an independent audit of 80 case files of people with learning disabilities (LD) to provide assurance in relation to compliance with the Mental Capacity Act (MCA) 2005, the Deprivation of Liberty Safeguards (DoLS) 2009 and the Care Act (CA) 2014. The original specification was later amended by SCC to cover a cohort of 80 cases randomly selected across the whole of adult social care, not solely focussed on learning disability clients, to be split into 31 LD and 49 non-LD clients.

The primary aim was to obtain independent audits to inform the Council of their level of statutory compliance in specific areas of social care practice. The audit findings will be used to inform what, if any, actions are required to address areas of non-compliance, and any learning will support the wider aspects of the Council's quality assurance framework.

The main objectives of the audit were to provide:

- A set of tried and tested audit tools (to be agreed with the commissioners);
- Independent audits of the specified population;
- An audit report, to include findings and recommendations, which objective was subsequently amended to include an interim report on the LD case audits;
- Presentation to senior officers of the report, findings and recommendations, subsequently amended to include additional presentation of the interim report on LD cases as well.

The key themes to be explored via the audits were:

- Care Act compliance;
- MCA and DoLS compliance;
- Evidence of strength based / asset-based practice;
- Carers assessment and support;
- Service user involvement / person-centred practice;
- Use of Advocacy.

Process

NDTi associates Amanda Nally and Louise Close undertook an audit of 80 cases recorded on the PARIS system. Cases were selected by SCC and drawn from across adult teams in the City that were 'live' i.e. no more than three years old in terms of most recent interventions. The 31 LD cases were prioritised for audit and completed during January 2019 with an interim report provided: https://1drv.ms/w/s!AoFFt80VmaD5k0bKqEYGtUBcksmk The findings of this report will be presented to Kentish Road Independent Review Oversight Board on 19th March 2019. **It is recommended that the interim report is read ahead of this final report as the findings are consistent across the audits, with any exceptions to this being noted in this final report.**

All 80 case file audits were conducted using a tool jointly developed as part of this contract by NDTi and SCC which was based on a selection of audit tools readily available from other Local Authorities. This report highlights our general findings, key issues in relation to the themes with elements of interpretative observations about each and our recommendations based on these.

Audit tool

Generally speaking the audit tool was helpful in that it ensured that auditors covered the ground in all cases consistently and had a common format to capture issues. The drop-down menus worked well and the additional space for comment was extremely helpful in terms of explaining more fully the field selected where necessary. However, it was sometimes difficult to find evidence to answer all questions; in part

this was an issue related to the PARIS system and in part to differences in recording practice between individual practitioners. When using the tool it appeared that some of the questions were out of step with working through the system itself, for example auditing case notes and management oversight as part of section one made the process cumbersome and would have been better placed towards the end of the tool.

Also, in designing the tool, auditors were asked to include a specific question to identify permissions around linking carers and client records, however PARIS does not actually have an option for workers to record this anywhere. There is a "permission to share" form contained within PARIS which includes family and carers along with other professionals and organisations, and so this was scored instead – as good where this form was signed and uploaded, met but requires work if the form contained within PARIS had been completed but there was no evidence of a signature and inadequate if no form was present at all.

A large part of the challenge for auditors was that the "approved care pathway" (referral, assessment, plan, review) appeared from the records to not always be followed by practitioners. In part this was undoubtably because some people using SCC services, had had services for a very long time, hence the initial assessment phase was many years past and therefore outside the scope of audit timescales (more than three years old) and the introduction of the Care Act. However even in older cases there would sometimes be a plethora of "referrals" recorded, few of which actually were referrals, leading to much time being wasted seeking the linked assessment which did not actually exist. Additionally, there were many instances where it would appear that an assessment had been done but this had actually been recorded as a support plan, or where a review format had been used to record what was clearly an assessment.

Audit tool issues and observations:

- The audit tool is designed around scrutiny of specific *cases,* and these cases are often worked by several practitioners and teams over a period of time, which makes it difficult to draw conclusions about individual practitioner or team performance.
- The audit tool differentiates referral, assessment, support plan and review, but rarely are all four well represented on any one file; in practice, the customer journey only infrequently appears to mirror the ideal set out in the audit tool. In practice, auditors therefore sometimes found it helpful to "read across" between the different key stages and indeed case notes, making the whole process of auditing cumbersome and time consuming.
- The audit tool asks questions about the "carer"; in terms of the practice discovered through the audit there appears to be an assumption that someone is only a carer if they live with the person and provide personal care or similar. However for many of the cases reviewed, there is a family member who is very

involved and indeed in some cases is expressing difficulties in so being, but who seemingly because they do not live with the person and / or provide direct hands-on care has not been considered as a carer for the purposes of the Act requirement to offer assessment and support.

Compliance

The way referrals are recorded on PARIS make it difficult to see a flow and indeed often impossible to ascertain which among the many referrals recorded is in fact a referral triggering a new customer pathway to be followed. Each contact with the first point of contact team (FPOC) seems to be recorded as a referral and then instantly “closed”, when actually it may simply be the recording of a contact which has been passed on to an existing worker who already has the client allocated. Similarly for any out of hours contacts and safeguarding alerts, which appear as a new referral, often with limited or no information though occasionally there is an uploaded document, and then case is shown as closed. It is difficult to ascertain if this is a proportionate approach and if individuals have been appropriately signposted or simply “moved through the system”.

Where a referral does seem to be what is happening, the screening assessment format is rarely utilised in full and many times recording would seem to indicate that practice is simply to move people through to allocation. The screening assessment form includes a section entitled ‘alternatives NOT considered’ and this seems to simply be a list of alternatives that should be offered as an alternative to paid formal care, however, in practice it would seem that no one actually does anything with this list, so the file simply has this list with no explanation as to whether in fact information about any of these was discussed or passed on. Auditors query therefore if this is either being recorded wrongly or simply misunderstood by practitioners?

Within care plans where they are in place, almost invariably all paid support currently in place is listed under the "informal support" column rather than the "paid for from my personal budget" column. Auditors draw the conclusion from this that there is a lack of understanding that informal support does not mean that which is paid for, and that all paid support is technically from a person's personal budget, even where that budget is managed on their behalf by the council. It would appear that practitioners only consider support to be being “paid for from my personal budget” where a Direct Payment is in place, and there is rarely evidence of informal supports being explored or recorded, demonstrating a real lack of understanding of the purpose of the Care Act principles of choice, control and strengths based working.

A significant number of assessments and indeed reviews will detail under purpose “to assess to meet Care Act eligibility”. The detail that follows however is almost invariably purely deficit based as opposed to strengths based and therefore cannot

be said to be Care Act compliant, despite the fact that someone may be deemed eligible.

Examples:

75763 - 11/7/18 referral from hospital discharge team records "request a review within 6 weeks due to additional funding to facilitate discharge" Unable to find evidence that this review occurred so assume increased costs have continued.

24199 – Two referrals in 2018 for a review, but there is no evidence of review to date so assume this is still outstanding.

Practice: strength based practice/service user involvement/person centred practice

A recurring theme for auditors was: how much is something a recording issue and how much is it a practice issue? There were a small number of files audited which appear to demonstrate outstanding practice, although sadly this would relate to one aspect alone and not the whole case.

Examples:

42214 - Brilliant review & care plan – timely, well recorded in full on format. Couple of areas needing attention otherwise would have got outstanding.

6986 – really good assessment 2/18 but no plan to follow.

There were a significant number of cases where practice was deemed to be "met but requires improvement", and usually this would be where there is some evidence of compliant practice and / or thoroughness, but an overall lack of a person centred or strength based approach. Outcomes were found to be consistently lacking in both how they were recorded and defined, more often than not being a record of what services were already in place or had been planned, or simply being cumbersome cut and paste sentences from the Care Act eligibility criteria. There was a consistently clear lack of evidence to support any sense that the concept of outcomes focussed working is widely understood, with outcome statements often reading as a record of a decision to continue with a current service or put a service in place to rectify a risk situation and / or maintain someone's health or safety. It would not appear to be common practice to seek to explore and record with people aspirational or creative

outcomes beyond what could narrowly be defined as service based solutions to the presenting issues in the person's life.

Once outcomes have been recorded, the evidence would seem to suggest that common practice is default to paid for / service solutions to meet these rather than look to explore the individual's informal or community networks or indeed, to seek to build on their own strengths or potential.

Example:

The work, training, education or volunteering field is often left blank or has N/A in it or particularly prevalent for older people is the word "retired", suggesting an assumption that people simply have no aspirations in this area of their lives.

Very few cases demonstrated a clear focus on the person's strengths or network or on community assets. Social workers appeared to find it difficult to shift things in this direction and there was little evidence that they had local knowledge of technology, aids or adaptations or communities and the potential contribution of universal services. On occasions when informal or community supports are present, these would appear to have already been in place and / or were brought to the table by the individual themselves or their family and friends.

Practice issues and observations

- The characteristics and coverage of the record on file was very variable in terms of content, coverage and tone. Whole sections were often missing, and it appears to be acceptable practice to leave sections incomplete as these documents would often have a name and role of manager at the end, leading the auditors to assume this had been 'signed off'.
- "Case recording" practice is particularly inconsistent. Usually very sparse and often confined to uploaded forms or email correspondence copied and pasted into case notes. There were occasional management oversight case notes, sometimes recorded as supervision, but little sense of a record of reflective practice.
- Sometimes the record on file appeared to be too narrow, and the perspective exclusively that of the case holder: there was rarely any sense of a close working relationship with commissioners, families or other partners and it was rarely clear why a person was using service x rather than service y, making it difficult therefore to answer the specific question as to "whether the most cost effective" solution had been found.
- There are numerous references in a case record to "care and support plans" which were rarely found on the system; occasionally there was an uploaded

paper document by this name and in one or two cases there was a PARIS support plan format partially completed.

- Some case records are very slim indeed, with few completed forms, little case recording and minimal or vague outcomes, and it is not always clear that a light-touch is justified in these cases.

- Risk assessment appears generally poor – with overreliance on standard wording to describe risks and actions to address risk. The risk assessment format on PARIS is not user friendly, so that where they have been completed, they are invariably difficult to read as words are squashed into a tiny unreadable space, however more often these were simply blank despite risks being alluded to in narrative elsewhere within the assessment / care plan. Those risks which are recorded are invariably concerned with health and safety and demonstrate a primary desire to keep people safe, sometimes with little reference to whether this in fact may interfere with their desire to live their life their way.

- Reviews are frequently late, and sometimes appear not to be happening at all. There are instances of a future review date being proposed or referrals requesting reviews take place, which are often blank and seem to be literally used as a way to pass work through internal teams, and in many cases these have not then taken place.

- There is very little evidence of strengths-based practice with people with complex or high levels of need, regardless of age.

- In a small number of instances, cases appear to be "de facto closed" with the last significant action some years in the past. In some of these cases there is quite a lot of activity in terms of "referrals" and case notes, perhaps recording a client contact around money which seem to have been dealt with at face value rather than perhaps being used as an opportunity to re-engage with the individual and check that everything is going ok for them – i.e. to reassess or review.

- A combination of poor case recording and lack of review sometimes make it difficult to track progress or ascertain someone's story in order to judge if a proportionate approach has been taken. A particular issue is lack of continuity between assessment and review and between one review and the next, compounded by the regular lack of a care plan following assessment to identify outcomes that should be reviewed, whilst in other cases, the review which may have taken place one or more years after the initial assessment is substantially a cut and paste from an earlier assessment, demonstrating a potential lack of attention to detail and often resulting in errors.

- We saw evidence concerning management / organisational sign-off or agreement to a piece of work usually by way of a name and title at the end of a document or page. However this wasn't always the case and often just a name would be recorded so the auditors were unable to conclude if that was indeed

management sign off, particularly where worker and manager names were the same.

- It is unclear whether there is a consistent understanding between workers and teams as to the role and purpose of the case record, raising the question as to what training, guidance and supervision about purpose, content and style of recording are provided to staff.
- The issue of several workers involved in a case may well go beyond that of inconsistent recording, to the question of what it is that constitutes good practice / consistent support for the particular person. It is well known that people's needs and wishes are better met by consistency in terms of the professionals they interact with, and this is demonstrably not the case within SCC practice.
- Care and support plans are likely to be held by providers, but don't appear to be routinely uploaded onto PARIS despite the fact that these are clearly a critical document in terms of monitoring and reviewing practice. There is a section on PARIS for care plans but this seems to be a purely financial tool, and whilst there is a form within the assessment tab to use for a care or support plan this is rarely and inconsistently used. In only one case did we find the tab for Individual Budget review had actually been utilised.

Carers assessment and support

Carers assessments and support plans conducted by Southampton Carers utilise a standard / set format for both. Although where complete these are often very detailed there was little evidence of a strength based approach or of creative or alternative options to meet need being explored particularly widely. Direct Payment's, where given, were frequently for relatively standard items such as gym membership or relaxation sessions, and these often bore no relation to the outcomes or needs stated in the assessment. There is also a major issue in that these forms are often password protected, meaning they are likely to be inaccessible to individual workers. Carer centre assessments on the whole are of better quality and detail than the social work ones however considerable development is again needed in terms of understanding and recording outcomes.

Example:

The carer has no hobbies, feels tired all the time, misses her family and wants to get back to work at some point, but the DP is going to be used to go to the gym and get a massage, neither of which things appear in any of the narrative as things she wants to do, and neither of which would appear to be particularly useful in terms of assisting her to meet her stated outcomes.

Advocacy

There is very little evidence of consideration being given to the use of advocacy. In several cases this was noted as not required as parents or carers or even paid workers from a support provider were regarded as "speaking for" the person, all of which are of course helpful but not the same as the provision of an independent advocate to work with a vulnerable adult to ascertain and amplify their own view of their life. In far too many cases this field is simply left blank, even where the client is recorded as having communication or understanding issues.

PARIS and Recording

Auditors were made aware at the onset that the system is in the process of being replaced. PARIS clearly brings certain merits in terms of a common format across services; it is relatively easy to navigate and up to a point it is relatively easy to trace information. However, within these broad parameters, there is a good deal of variation in the way in which practitioners capture and record information which detracts instantly from its usefulness as a recording system. Consequently, a recurring theme for us was: how much is a particular concern a recording issue and how much a practice issue? We worried that sometimes an action may have in fact happened, but has either not been recorded at all, or was buried somewhere unusual on the system. Referral in PARIS terms is inconsistent with the referral / first point of contact questions on the audit tool so these quickly became N/A. It is clear that the PARIS referral forms are used internally to move work through the system, with forms often entirely blank and cases referred, allocated and closed within minutes, and the use of the screening assessment format in these instances is completely unnecessary.

Poor spelling, grammar and language is a consistent issue as is the use of 'cut and paste' in documents. There were numerous examples of perceived 'sloppy and lazy' practice particularly around the recording of demographic information, and also some inappropriate comments and personal messages appear within case notes such as 'did you have a nice holiday' or 'sorry I know you're overloaded' where the worker has simply copied an entire email onto the PARIS form.

Examples:

42214 – screening notes 3/9/18 state: "East duty dropped a clanger" "they (the person) has fallen through cracks"

42214 - 5/6/18 case note about a different unrelated person

Ticking 'white British' in one field seems to be assumed to explain all other fields, whereas it is of course possible to identify as white British ethnicity but have Italian nationality, Buddhist religion and east Asian cultural sensitivities.

A number of assessments had updates added into sections with that date of entry, however the original assessment date is maintained and therefore this is misleading when searching for the latest assessment. This will also be misrepresented on any performance data drawn from the system directly.

Auditors consistently found referrals, assessments, care plans and reviews in the wrong sections on PARIS named one thing only to emerge as another on reading. A significant amount of time was needed to locate and read through several to find one that actually was what it said it was in order to audit things correctly, and this difficulty and inefficient use of time will also apply to any SCC officer who is trying to ascertain quickly what the current situation is with a client. The issue about misleading performance data drawn down from the system also applies in this situation.

The audit tool steers us towards consideration of front line "practice", but less so towards the work of managers. Managers clearly do intervene or comment on practice occasionally, but as far as we can see from the files we audited, this appears rare and it's difficult to see any consistency in the sorts of situations where they do so. It is also open to question whether managers are scrutinising their workers recording practices sufficiently, as many of the issues we have uncovered during this audit would presumably be far less prevalent if so.

Our overall sense was that there is too much variability in what is recorded, and this makes the system potentially unhelpful and inefficient as a repository of information and record of practice. Auditors would like to emphasise that a new system will not eradicate this and there needs to be clarity and accountability from practitioners and management as to what constitutes good practice around recording; otherwise the new system will simply replicate the problems of the old.

PARIS and Recording Issues and observations

- Many blank forms were uploaded.
- Many incomplete forms were uploaded.
- Sometimes blank or incomplete forms relate to on-going work, but often they are historical. This makes the audit exercise and more importantly case oversight in daily practice more difficult than needs be.
- There was a good deal of duplicate information; similar information in different forms or in different places on the system. Again, this makes the audit exercise and daily oversight of practice more difficult.
- Our impression is that the PARIS system requires certain actions in a workflow to be completed before the next action can be initiated. Where the first action is incomplete and / or deemed superfluous, this has the perverse effect of inducing the leaving of blank or incomplete forms.

- Conversely, some important issues appear not to need to be addressed in order to move on to the next stage in the workflow.

Recommendations and suggested next steps

The findings of the audit do come with caveats, notably as a reflection of:

- A limited sample size.
- A methodology which makes it hard to distinguish recording issues from practice issues.
- The audits were purely desktop and therefore auditors were unable to include experiences from practitioners, family / carers and most importantly individuals whose cases have been audited.

With these important caveats then, the audit appears to point to issues relating to a number of different functions within the City Council, notably:

- Systems – PARIS and how it is used.
- Strengths based / person centred / outcomes focussed practice, the recording and oversight thereof.
- Community development – how practitioners come to know about and work with diverse communities, how they are enabled to draw on other SCC resources for this task.
- Process and accountability – minimum standards in case management, scrutiny and sign-off of care packages.
- Practitioner development and support, including supervision and accountability.

The recommendations and next steps which were documented in the interim report following the audits on LD cases have clear resonance now that the wider audit of all 80 cases has been completed, and given that the findings are consistent across all 80, it is recommended that the following key points for further development are considered to be relevant across the whole adult social care service.

1. Consideration should be given as to how the reports can be fully utilised to brief relevant staff groups across SCC as well as other stakeholders, including people who use SCC services and family carers, about the issues identified in the audit and to use these discussions as a foundation to develop co-produced solutions. Ideally this process would seem to present an opportunity for all to work together to co-produce a different culture of practice moving forward.

2. A review of internal learning and development needs is required, along with a targeted plan to develop understanding, skills and confidence of both practitioners and first line managers around:

- person centred, strengths-based approaches to assessment and care / support planning;
- understanding of personal budgets and the principles of choice and control which underpin these, as distinct from Direct Payments;
- working effectively with individuals, including the proper use of advocacy, family carers and with other professionals to take a holistic view of all resources available to people when planning to meet outcomes;
- effective person centred, outcomes focussed reviews;
- risk enablement and the promotion of choice and control;
- case management and proportionality, including expectations around making and recording case notes and decisions.

3. There is a need to examine the overall culture of social work practice in Southampton, with development time set aside for practitioners and managers to think through what it means to be truly strengths based and what the implications of moving to enable more choice and control, as directed by the Care Act, mean for them and for teams. This should include an exploration of how supervision currently works, and consideration of other quality monitoring and performance development mechanisms, such as developing a culture of peer support and challenge.

4. Working alongside commissioners both with and within communities to build a more thorough knowledge of the myriad resources available to people and to understand how these can be used to supplement and augment informal and paid support and how they are effectively accessed.

5. With all of the above some benchmarking of the current picture will be required, outcomes for improvement clearly defined and milestones along the way identified in order to measure and review progress.

Appendix 1

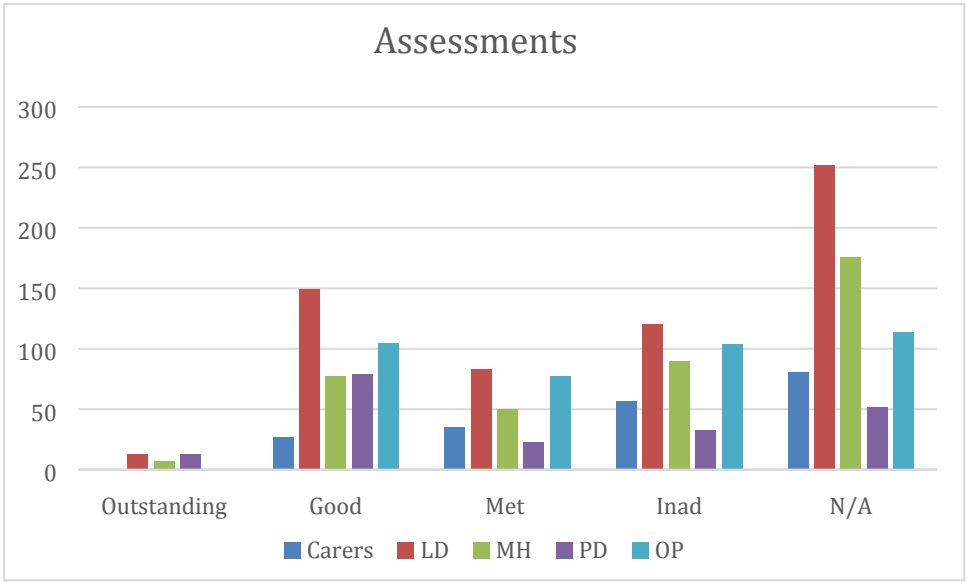
The audit tool comprised 7 sections with the following number of questions in each:

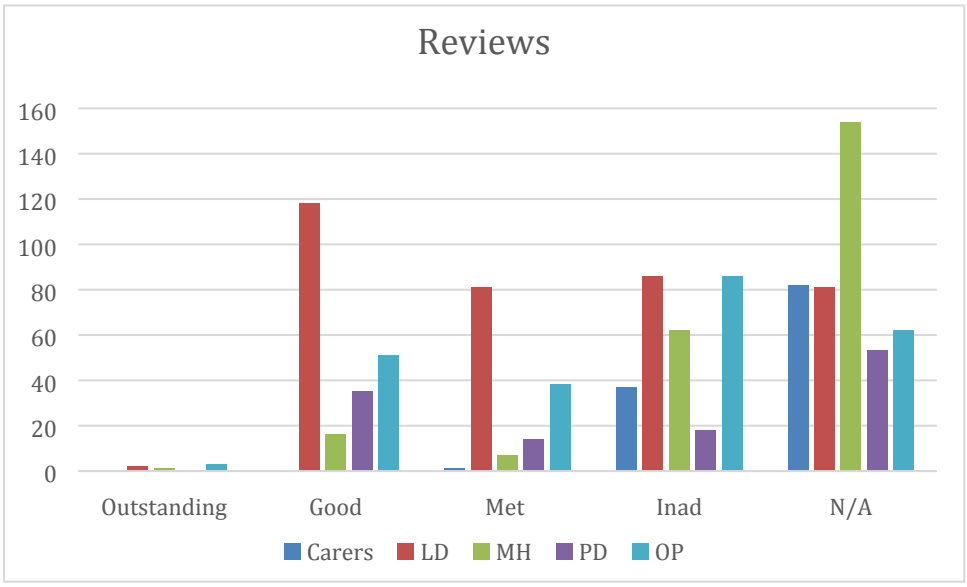
- Getting the basics right (12)
- Referral/First contact (6)
- Assessment (20)
- Care Planning (6)
- Reviews (12)
- Safeguarding (3)
- Carers (20)

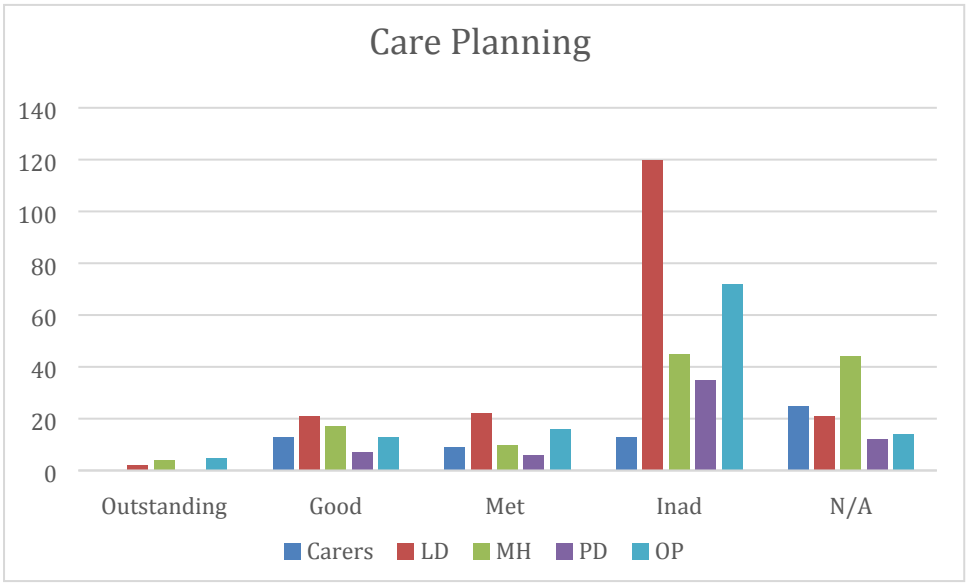
The criteria used to determine the audit outcomes:

Outstanding Standard (4)
▪ As 'Good' plus work that is:
▪ Structured, detailed information and analysis
▪ Knowledgeable attention and application of the law, guidance, policy and procedures
▪ Exemplary practice
Good Standard (3)
▪ Areas of evidence complete
▪ Focussed assimilation and evaluation of information
▪ Well-structured and clear case record
▪ Practice Instruction followed
▪ Proportionate and robust
▪ Person at the centre of all decisions
Standard met but requires work (2)
▪ Only partial evidence present
▪ Limited evaluation of information
▪ Sufficient recording to evidence Care Act and other legislative compliance
Inadequate Standard (1)
▪ Areas of evidence insufficient or incomplete
▪ Poorly organised record
▪ No evaluation of information
▪ Practice Instructions not followed
▪ Insufficient recording to evidence Care Act or other legislative compliance
Not Applicable N/A
Statement or section not Applicable

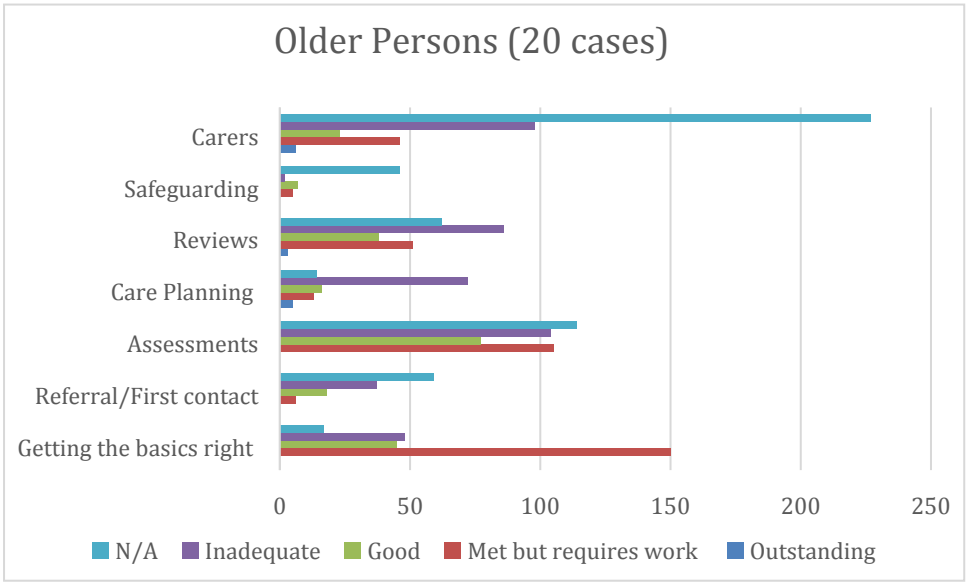
The following 3 graphs demonstrate each service area audit outcomes for Assessments (20 questions); care planning (6 questions); reviews (12 questions).
*Please take into consideration the different number of cases in each service e.g. LD has 31 cases x 20 questions in Assessment section = 620 whereas Mental Health has 10 cases x 20 = 200

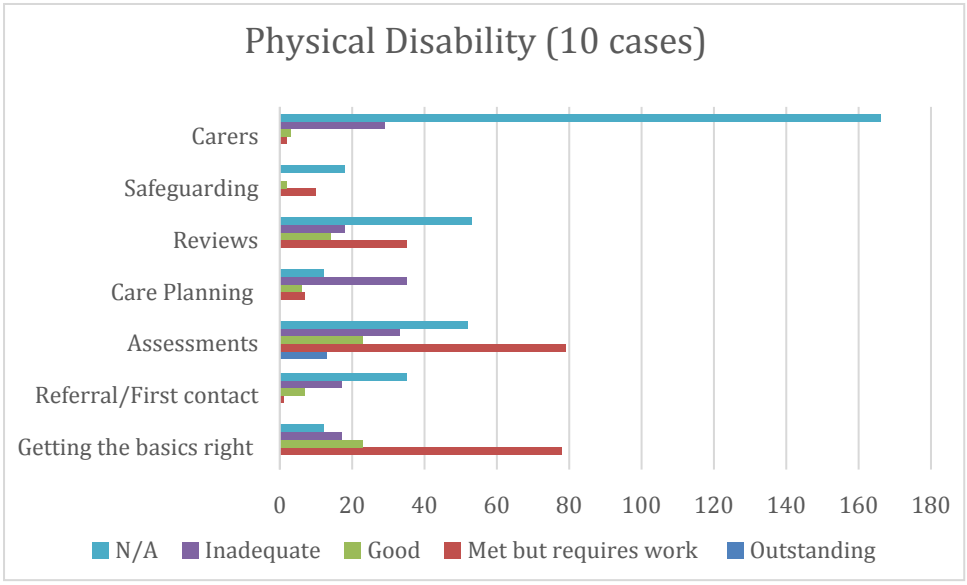

Assessments
300
250
200
150
100
50
0
Outstanding
Good
Met
Inad
N/A
Carers
LD
MH
PD
OP

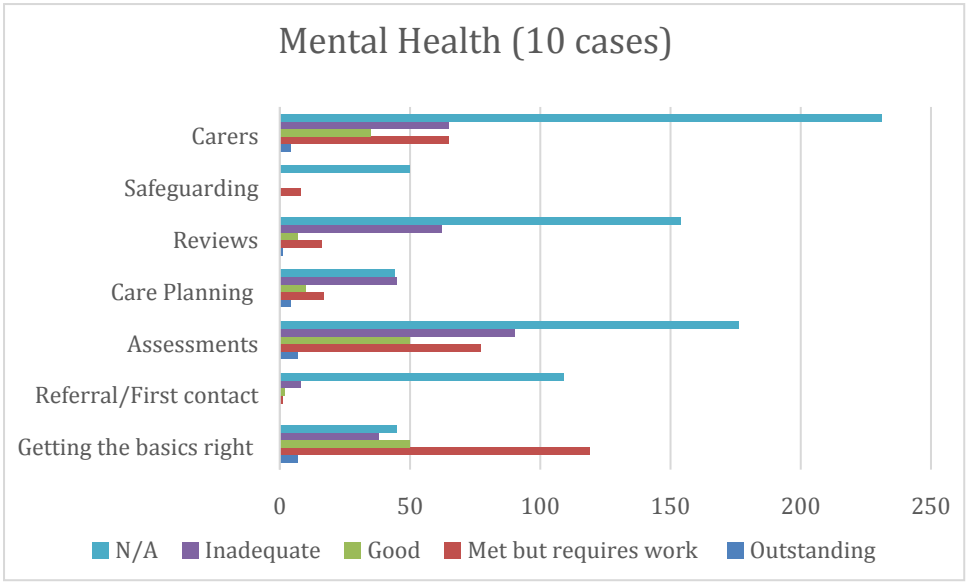

Reviews
160
140
120
100
80
60
40
20
0
Outstanding
Good
Met
Inad
N/A
Carers
LD
MH
PD
OP

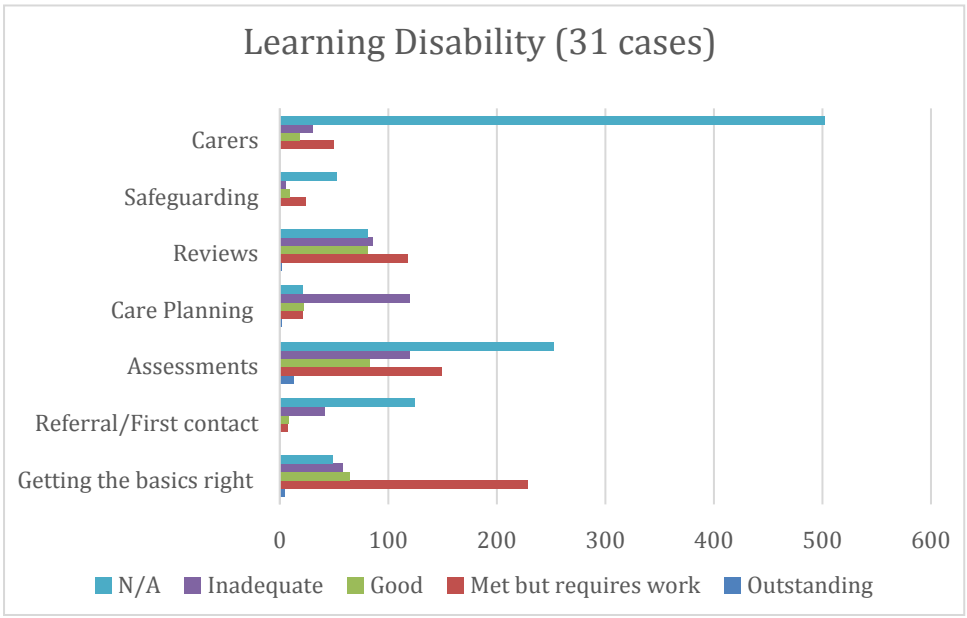

Care Planning
140
120
100
80
60
40
20
0
Outstanding
Good
Met
Inad
N/A
Carers
LD
MH
PD
OP

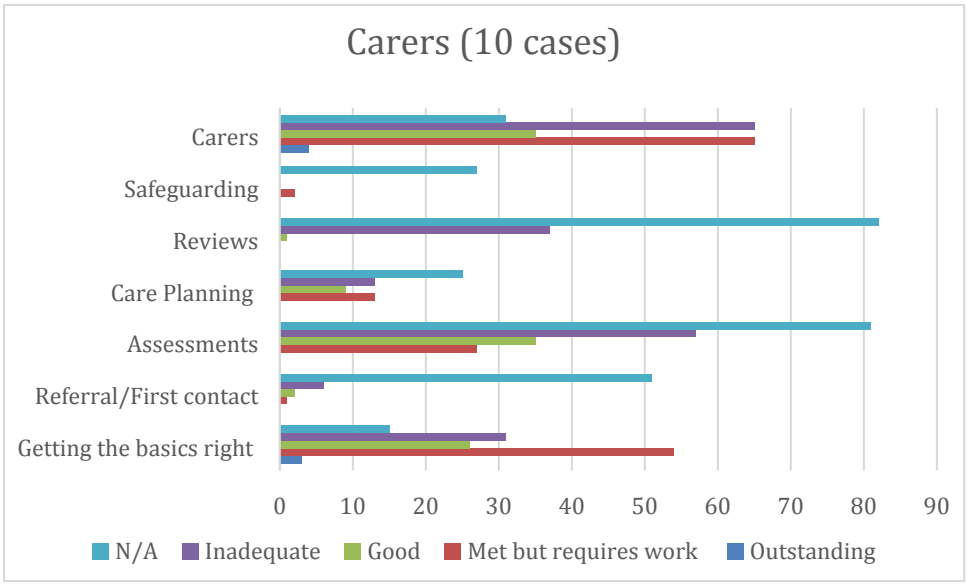
The following graphs show the audit outcomes for each service area individually against each of the 7 sections in the audit tool.






Mental Health (10 cases)
Carers
Safeguarding
Reviews
Care Planning
Assessments
Referral/First contact
Getting the basics right
0
50
100
150
200
250
N/A
Inadequate
Good
Met but requires work
Outstanding


Learning Disability (31 cases)
Carers
Safeguarding
Reviews
Care Planning
Assessments
Referral/First contact
Getting the basics right
0
100
200
300
400
500
600
N/A
Inadequate
Good
Met but requires work
Outstanding


Carers (10 cases)
Carers
Safeguarding
Reviews
Care Planning
Assessments
Referral/First contact
Getting the basics right
0
10
20
30
40
50
60
70
80
90
N/A
Inadequate
Good
Met but requires work
Outstanding