CareQuality Commission

Inspection report

Service inspection of adult social care: **Stockton-on-Tees Borough Council**

Focus of inspection:

Safeguarding adults
Increased choice and control for older people

Date of inspection: July 2010

Date of publication: October 2010

About the Care Quality Commission

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

Stockton-on-Tees Borough Council

July 2010

Service Inspection Team

Lead Inspector: Laura Middleton

Team Inspector: Sue Talbot

Expert by Experience: Walter Park

Project Assistant: Balwinder Jeer

This report is available to download from our website on www.cqc.org.uk

Please contact us if you would like a summary of this report in other formats or languages. Phone our helpline on 03000 616161 or Email: enquiries@cqc.org.uk

Acknowledgement

The inspectors would like to thank all the staff, service users, carers and everyone else who participated in the inspection.

Contents

Introduction 3

Summary of how well Stockton-on-Tees was performing 4

What Stockton-on-Tees was doing well to support outcomes 5

Recommendations for improving outcomes in Stockton-on-Tees 6

What Stockton-on-Tees was doing well to ensure its capacity to improve 7

Recommendations for improving capacity in Stockton-on-Tees 8

Context 9

Key findings:

Safeguarding adults 10

Increased choice and control 13

Capacity to improve 18

Appendix A: Summary of recommendations (referenced) 24

Appendix B: Methodology 26

Introduction

An inspection team from the Care Quality Commission visited Stockton-on-Tees in July 2010 to find out how well the council was delivering social care.

To do this, the inspection team looked at how well Stockton-on-Tees was:

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

Before visiting Stockton-on-Tees, 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 Stockton-on-Tees. It will support the council and partner organisations in Stockton-on-Tees in working together to improve people's lives and meet their needs.

Reading the report

The next few pages summarise our findings from the inspection. They set out what we found the council was doing well and areas for development where we make recommendations for improvements.

We then provide a page of general information about the council area under 'Context'.

The rest of the report describes our more detailed key findings looking at each area in turn. Each section starts with a shaded box in which we set out the national performance outcome which the council should aim to achieve. Below that and on succeeding pages are several 'performance characteristics'. These are set out in bold type and are the more detailed achievements the council should aim to meet. Under each of these we report our findings on how well the council was meeting them.

We set out detailed recommendations, again separately in Appendix A linking these for ease of reference to the numbered pages of the report which have prompted each recommendation. We finish by summarising our inspection activities in Appendix B.

Summary of how well Stockton-on-Tees 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 Stockton-on-Tees was performing well in safeguarding adults.

Increased choice and control for older people:

We concluded that Stockton-on-Tees was performing well in supporting increased choice and control.

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 Stockton-on-Tees was promising.

What Stockton-on-Tees was doing well to support outcomes

Safeguarding adults

- There was a clear priority on improving community safety, with strong multi-agency working relationships through the Community Safety Partnership (CSP).
- In most cases we saw appropriate actions were taken to make people safe.
- Poor providers were challenged and concerns followed up through the contracting and compliance process to improve services.
- People's care respected their privacy and dignity. People's wishes were respected when they did not want information shared with other parties.
- Senior managers gave a high priority to safeguarding adults' work.

Increased choice and control for older people

- There was an improving focus on providing information to the public.
- Most users and carers were very satisfied with services they received. There were clear priorities at the front line about promoting choice and control.
- There were strong relationships with other statutory agencies and the quality of care management was effective in joint working.
- The Independent Living Centre (ILC) helped to promote peoples choice. Telecare was well used to support security and safety.
- The complaints we saw were generally well managed and used to learn lessons to improve the quality of services.

Recommendations for improving outcomes in Stockton-on-Tees

Safeguarding adults

The council and partners should:

- Improve the quality of case recording to ensure consistent high standards across the partnership.
- Ensure that actions agreed at strategy meetings and subsequent reviews are explained, recorded and followed through.
- Improve access to advocacy for both alleged victims and vulnerable perpetrators. This should include ensuring that the duty to consider the use of Independent Mental Capacity Advocates (IMCA) is consistently exercised and the reasons for decisions are recorded.

Increased choice and control for older people

The council should:

- Ensure that assessments, including the new assessment tools, fully reflect people's interests and history.
- Tighten up on the process for reviewing care packages to ensure outcomes are consistently clearly explained and recorded.
- Ensure consistent standards in written responses following complaints so that outcomes are always clear and ensure that information on how to complain is easily accessible.

What Stockton-on-Tees was doing well to ensure their capacity to improve

Providing leadership

The council:

- The Council engaged well with older people and made improvements as a result.
- Elected members had key roles as champions for older people and dignity in care.
- Work undertaken by the Council's Overview and Scrutiny Committees had evaluated and secured better services.
- The Council worked well with strategic partners to plan future services. At the front line key services were integrated well with health partners.
- There was a good level of qualified and experienced staff with high retention rate and few vacancies.

Commissioning and use of resources

The council:

- The Council made excellent use of customer surveys to monitor the quality of its services.
- Poor providers were challenged and concerns followed up through the contracting and compliance process.
- There was good joint commissioning with statutory partners based on Joint Strategic Needs Assessment (JSNA), which was regularly refreshed.
- There was good management of budgets with effective controls in place. Panels were working well and Continuing Health Care was carefully considered.
- Performance clinics were in place, with national indicators and local targets to support improvement.

Recommendations for improving capacity in Stockton-on-Tees

Providing leadership

The council and its partners should:

- Further develop the First Contact team to ensure staff are kept up-to-date and better integrated with other parts of the department.
- Strengthen the leadership of safeguarding to ensure clearer and more consistent approaches to its management and quality assurance.
- Ensure the Local Safeguarding Vulnerable Adults (LSVA) Committee is supported by robust performance and management information.
- Increase the safeguarding training for the independent sector.

Commissioning and use of resources

The council should:

- Improve their engagement with the community and voluntary sector in shaping the market to increase the range of options available.
- Ensure implementation of plans to address the overprovision of care homes and develop more extra care housing or supported living schemes to provide people with an alternative. More extra care housing, or supported living schemes to provide people with an alternative.
- Strengthen the role of the Local Involvement Network (LINk) to further develop its role as a watchdog and assist in its future role in Health Watch.
- Ensure the First Contact Team is consistent about how it records and monitors its activity to comply with organisational policies and procedures.

Context

Stockton-on-Tees is a unitary authority in the north east with a population of 191,500 people. The population is increasing. The total population is projected to rise by 11% by 2021, with a significant increase in older people of 41% in the same period. Almost 5% of the population are from minority ethnic backgrounds, which is lower than the national average of 9.1%.

The area is one of social and economic contrast with prosperous neighbourhoods alongside wards with high levels of deprivation.

The council is administered on a Cabinet model, with joint power sharing between Labour and Conservatives. At the time of the inspection there were 22 Labour, 13 Conservatives and 21 others representing three main parties and three independent associations. At the time of the inspection, there was a local consultation in process on whether people wanted an elected mayor.

Partnership working is a key feature, both with other Teesside authorities and with health partners.

Services for adults are delivered through the department of Children, Education and Social Care led by a corporate director. Commissioning for older people is managed with NHS Stockton-on-Tees, through joint posts in commissioning and strategy development.

Safeguarding is overseen by both the Stockton-on-Tees Local Safeguarding Vulnerable Adults Committee (established over 6 years ago) and the Teeswide Safeguarding Board (established in 2009). Teeswide Safeguarding Board.

The Care Quality Commission assessed the councils adult social care services in November 2009 as performing well.

Key findings

Safeguarding

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

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

There was a clear emphasis on tackling harassment and improving community safety. This was brought together in a Community Safety plan, which prioritised incidents of discrimination. There had been a marked reduction in reported crime in Stockton-on-Tees in the last five years. There was a recognised need to improve the understanding of hate crime, including encouraging of reporting from the black and minority ethnic community. Some work had been done to prevent people from being bullied but it was recognised that this could be extended.

The Council had a strong working relationship with the police Vulnerable Persons Unit, which worked across Stockton-on-Tees and Hartlepool. The Police had a strong focus on tackling financial exploitation. This was well supported by the Council's Estates team, which managed a large number of appointee-ships. The Fire Brigade also had a vulnerable persons' project identifying risk through fire home safety visits and providing advocacy to reduce that risk.

The Doorstoppers Project was put in place to help reduce doorstep crime and updates were regularly promoted in the Stockton News. Some people we met were concerned about cold calling which seemed be specifically targeted at vulnerable people who lacked capacity. They were unsure how best to report this. Many older people were concerned about antisocial behaviour and the lack of safe night time activities.

Telecare was widely used with a range of equipment to provide early warnings and security for relatives and carers. Back up support was good in addition to the emergency response provided. However, not everyone we met was clear about how to use and test their alarm systems.

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

Priority was given to making people safe. In most cases we looked at there was timely, sensitive and good multi-disciplinary working. For example a referral by a neighbour about possible intimidation and financial abuse resulted in prompt attendance and a support package. This meant a person was enabled to remain in his own home. This case involved the police, drug action team and the older person's social worker. Another case demonstrated good sensitivity to the needs of deaf people within care homes.

Information leaflets were produced but needed higher prominence. We found none in GP surgeries, the library or Citizen's Advice Bureau (CAB). Some were produced in easy read or accessible formats for people with sensory loss or learning disabilities.

Work coming into the safeguarding system needed to be better managed. There was still work to do to ensure everyone had a clear understanding of what constitutes a safeguarding alert. A new system of working had been introduced recently with some screening at team level, with encouraging early results in diverting some work.

Some situations within care settings could have been more effectively risk managed within establishments to make better use of resources. We saw multiple alerts around the same vulnerable perpetrator where there was no intent to cause harm. This included both people with learning disability and people suffering from dementia.

We found some gaps in recording, such as in running records and review documentation. Better awareness of previous referrals would have meant that some repeat incidents might have been prevented. Where we saw records which linked with children's safeguarding we found much stronger recording standards on the children's files.

Key decisions were not always explained and in one case a decision was reversed without the reason being recorded on either occasion. This was a situation where someone who was not considered suitable to be an appropriate adult was acting in that role a few months later.

Actions from strategy meetings were not consistently followed up. In one case a woman with learning disabilities was left at risk despite a decision at the strategy meeting to separate her from the perpetrator. There was no explanation on file to explain why the recommendation from the strategy meeting had not been carried out.

There was still work to do to ensure that people at the centre of safeguarding investigations were appropriately involved and supported. This included a need to strengthen work with advocates. There was variable access to representation and support for both alleged victims and vulnerable perpetrators. Some workers did not refer to advocacy at all, while in other cases referrals had been late. The need to involve advocates early rather than wait for crisis was not always recognised. The use of Independent Mental Capacity Advocates was low. It was not clear from files whether or not the caseworker had exercised the duty to consider IMCA. This applied both for victims and vulnerable perpetrators. We saw one case where IMCA

was used, and the work was of a high standard.

There were strong links between adult safeguarding and contract monitoring, with positive action taken to learn from incidents and improve safety and care standards. The Council were implementing Deprivation of Liberty safeguards, with basic training being rolled out. Some people were still struggling with the complexities but senior staff leading the process demonstrated good understanding.

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

In most cases we found that people's personal care respected their privacy and dignity. In the one case we saw where this was breached actions were taken to advise staff on appropriate behaviour.

Most people told us that adult services respected their wishes whether to remain independent or seek other options. Students and trainee social workers came in for particular praise as being willing to go over points and clarify them.

We found that care managers respected people's wishes during safeguarding incidents. This included the sharing of information. For example we saw a number of cases where alleged victims asked that information was not shared. In another case a sensible decision was taken not to inform a victim without capacity that she was part of a safeguarding procedure.

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.

We saw a number of cases where care managers advised people about their options, enabling them to make best choices about their lifestyle. We heard good reports about the adaptations service. One person commented:

"*I was taken through all the available options and was even asked what colour flooring I would like in my shower.*"

Care managers we met were enthusiastic about their work and put individuals' preferences as a high priority. This needed to be followed through in ensuring people's case records, histories and care plans more fully reflect these priorities.

Increased choice and control

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

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

The Council and partners were giving a high priority to personalisation and most care managers were ensuring that people had choices and were able to take some control of how their needs were met. Most people who answered our questionnaire were positive about the services from their social worker, care manager or occupational therapist. One person wrote:

"The same person has dealt with me over the past years. Always pleasant and takes into consideration what I can cope with and what I need. I am always involved in decisions about my care."

Another person said:

"The service we require is allowed to be dictated by ourselves after consultation with social services."

Advice and information to support choice were available on the web site and in leaflets. There was a good quarterly newspaper, the Stockton News distributed to all households.

However some people told us work was needed to improve the information in terms of readability, which was sometimes hard to understand and not readily available. LINks also suggested information to promote services and options could be made easier to understand. We understand the Council have a readers' group to address this.

Initial referrals to the Council were through a First Contact team, covering children and adults. We found the staff were person centred and helpful and user feedback was positive.

The team would have been more effective by being regularly included in updates and training. More efficient practices, such as inputting work into computer records the same day, would improve the experience for users. For example, the same referral was taken from a GP one day and a relative the next. It would have been better if it had it been possible to tell the second caller that their doctor had already rang and his referral acted on.

There was a lack of robustness in recording and monitoring of the team's activity. The number of calls signposted were not counted, which may have resource issues. Someone reporting a domestic abuse risk was asked to ring back to speak to

another member of staff who knew the case. In this case the lack of recording could have had serious implications should the caller not try again.

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

Care management services were delivered through Integrated Service Area teams (ISAs), which provided sound interdisciplinary assessment. There was also a good older persons' mental health service. We saw some innovative preventative work in supporting people with dementia and their carers. There was an improving focus on supporting carers in their role, for example by promoting information and offering short breaks through direct payments, but carers reported much more could be done about meeting their own needs.

In most cases we read we found good assessment and planning. People were encouraged to express their preferences through newly developed personal needs questionnaires and the carer's self-assessments. We saw instances of people with very complex needs who were supported at home in accordance with their wishes. This included good work across teams and involvement of family members. It was good to see correspondence in large print where appropriate. One person told us:

"What is good is they always seem to have an answer – every time I ring a department I have had immediate help. Also, a great understanding and empathy is shown."

However, there was a need to tighten up on reviews of care packages. The formats required development to ensure a better focus on outcomes. In one case a package was reduced inappropriately when an older person failed to understand the practical implications of reducing carer time to save money on carers with whom she was dissatisfied. This reduction had been made without a home visit or reference to the family. The care plan was not revised following the reduction, meaning essential tasks were left undone. The dissatisfaction with the carers was neither addressed nor recorded.

Personalised services could be improved by better focus on individuals' histories and preferences. For example, we met one person who had become isolated from family, especially a sister in a neighbouring borough, as neither was able to travel without assistance. The care manager was unaware either that her client was lonely or that she would like to see her sister.

Good use was made of Telecare, from which over 6,000 people received some measure of support. Over 300 people were linked to a mobile warden system. A plan to introduce a Telehealth service across Hartlepool and Stockton-on-Tees, was in the early stages of development.

The community occupational therapy service was well regarded and took referrals electronically from the First Contact team. People we spoke to commented very favourably and appreciated the suggestions and ideas to improve their

independence. However, there were some concerns about poor workmanship by people fitting adaptations, which may need better monitoring. Waiting times had increased from last year for both minor and major adaptations, suggesting a need to remain vigilant.

Community matrons were working effectively with teams to prevent unnecessary hospital admission and to enable people to have more control in managing their conditions at home.

Hospital discharge was generally well managed in cases we saw, although LINks expressed concerns about paucity of information for people about what help may be available. Rosedale Residential Rehabilitation Care Home provided effective support, although there was a recognised need to expand intermediate care at home. The hospital discharge liaison team were effective and there was an improving focus on identifying and supporting carers. However, there remained a need to enhance the capacity of community services to continue to enable to be discharged people to be discharged in a timely manner. There was also a need to expand "step-up" options to address the relatively high number of emergency admissions.

The Council were committed to direct payments which were on the increase, although still lower than the national average. People we spoke to were generally happy, although some of the paperwork was found to be arduous. While numbers were still low, the Council were committed to introducing Personal Budgets and it is now policy to offer these as an option to new referrals and when care packages are reviewed.

There was good recognition and provision of support to 'self-funders' who did not meet the Council's criteria. In one case this meant the provision of information to a terminally ill man, enabling him to make his own care arrangements for end of life.

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.

People had access to the Independent Living Centre where aids and adaptations could be demonstrated and tried out. Telecare services were well developed across the borough, with Carecall backup enabling people to remain more safely in their own homes.

There was a recognised over provision of care homes in the borough, with a high level of vacancies, and a recognised need to increase the levels of accessible and supported housing. Admissions to care homes were high. Two more extra care schemes were planned for the next two years. The housing scheme we visited was of a high quality and well regarded by its tenants. Another gap was in specialised supported housing for older people with mental health needs.

The Council commissioned its domiciliary care from independent providers and the council's in house service. A number of people told us about problems of quality, reliability and too many changes of care worker. The contracts team kept these under review.

Providers had a good grasp of the new personalisation agenda and were responsive to becoming more involved. There had been an expansion in support for people at the end of life. There were positive developments to improve support for people with dementia and their carers, such as information packs and cognitive stimulation groups.

The local voluntary sector required further development to help widen the range of options for support. For example, more isolated older people could be helped to participate in community activities, attend places of worship or stay in touch with friends and family.

Services for carers themselves could be broadened. There needed to be more creative options around the use of direct payments for carers and additional support for those who worked and could not easily access existing support groups. The George Hardwick centre was widely commended as providing innovative support.

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

Most people were highly satisfied with the quality of support and the ease of communication with the Council and appreciated having named workers where these were available. One person wrote to us:

"In the early days the social services were excellent but obviously due to their workload personal contact has now decreased. However, I understand that they are only a phone call away. I have met the person I need to contact so I can put a face to her."

Another person said:

"I have the phone number of my social worker and get good results with any problems that crop up."

LINks reported that people were concerned about the lack of a clear route to complain about social care services, which suggested a need to better promote the complaints procedure. In the last twelve months there were 33 complaints received concerning older people, which was a significant decrease on the year before. The completed complaints we read were well managed and the responses appropriate. There were lessons for the organisation which were taken account of.

However, some response letters to complainants could have been clearer. It was not always easy to determine from the letter whether the complaint was upheld or not, what actions would be taken or how these would be monitored. Customer services'

offer to quality assure letters was not always taken up.

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.

There was strong leadership from the chief executive and the corporate director, to support high quality adult social care and the emerging personalisation agenda. Elected members across the Labour - Conservatives power sharing coalition had worked well in support of social care and were hopeful of maintaining the joint commitment despite expected significant budgetary cuts.

Elected members demonstrated a strong focus on adult safeguarding issues and two of them were members of the Stockton-on-Tees Local Safeguarding Vulnerable Adults Committee, Cabinet Member for Adult Services and Health and Chairperson of the Health Select Committee and Dignity Champion. Elected members undertook safeguarding training.

There were member champions for older people, carers and dignity in care although their role and impact was not widely understood by people we met.

The Overview and Scrutiny committees were effective. Members gave detailed attention to key policy issues through the Efficiency and Improvement Transformation process (EIT). The review of adult operational services recommended a clear need to shift towards more community based delivery.

The Council engaged well with local people, for example through the annual event 'Are you being served?' This was in its eighth year and had a good response from the community. Sadly, a 250 person cap on numbers has been imposed this year because of limited space at the venue. The over 50's forum was another route for engagement, although at 40 people numbers were low for a council of this size and may need strengthening.

The Council's engagement would be strengthened by closer working with agencies in the community voluntary sector, who would welcome increased involvement and a greater transparency from the council about its plans. In particular, this would include an improved understanding by the sector about what the council's plans around personalisation might mean for them.

The arrangements for overseeing safeguarding were undergoing transition at the time of the inspection with a Teeswide safeguarding board put in place in 2008 in addition to the existing local committees, whose remit was changing. This was intended to provide a strategic overview and some consistency across the four boroughs. The new arrangements were not yet fully effective, with some committee members unclear about the respective roles of the Board and Committee.

Paperwork was thought onerous with too high a number of tabled papers for effective scrutiny. Better use might be made of executive summaries and a distinction between items requiring decisions and those for information only. There was a need to streamline the regional and local work and clarify the accountabilities of each committee. The current chair of the Adult Safeguarding Board was in place for the past 3 years.

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.

There was excellent engagement with statutory partners to deliver the adult social care agenda and safeguarding work. One health partner described the relationship as "*collaborative, challenging and respectful*". Wellbeing, older peoples and carers' strategies were in place and up-to-date, driving a range of work programmes. Safeguarding governance needed strengthening. There was a need to improve the levels of data collection, interrogation, analysis and reporting around safeguarding so that both the local safeguarding committee and Teeswide Board could better exercise their responsibilities. Better information would enable resources such as staff and training to be more effectively deployed.

The local annual report was weak, lacked key data and a detailed analysis. This meant, for example, that despite a huge rise in referral rates there was a lack of intelligence about sources and/or cross referencing with level of appropriateness, which would have better enabled the issue to be addressed at source. There was a need to improve consistency in what was considered appropriately dealt with through the safeguarding process.

There had yet to be any formal analysis of IMCA usage either in Stockton-on-Tees or at a Teeswide level. A new business manager, funded by the four councils had been appointed to work to the Teeswide Board, to take a strategic lead which included improving data collection and analysis.

New arrangements meant that subgroups would report to the Teeswide Board and these were not yet working effectively. A safeguarding training sub group had not met for some time despite a huge need to address training in the independent sector. More positively, there was a Being Safe sub group of the Learning Disability partnership board which was working to expand awareness of risks and to promote self-protection skills to address risk for disabled people.

Resources in terms of staff time in safeguarding could be better managed. Some cases could have been more effectively managed through care management or by thorough risk management within day centres and care homes. For example in one incident where a person with learning disabilities threw a chair indiscriminately, safeguarding files were opened on all people present, resulting in duplicated work and distorted data on numbers of vulnerable perpetrators. A better focus was needed on managing individuals who lack capacity but may present unintended risks to others.

Although there was clear intention to introduce Personal Budgets, development was still at a relatively early stage with significant resource challenges meaning that progress had been slow.

There was a measure of uncertainty about future joint arrangements with health following the publication during the inspection of the government white paper "Equity and Excellence Liberating the NHS". However, health partners we met were confident that services would continue to be delivered and that they would work with the council to ensure smooth transition to GP consortia commissioning.

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

The Council had a high level of qualified and experienced staff with high retention rates. Front line workers were positive, professional and enthusiastic in their approach and had adopted integrated working to the benefit of users. Effective caseload and care management arrangements were in place. There was good professional supervision across the integrated teams to ensure that peoples' professional skills were up-to-date. There was effective joint working with sensory impairment specialist staff to promote people's independence and confidence.

Access to training was good across all teams with the exception of the First Contact team. Managers described the team as disempowered by being "out of the loop". There was a recognised need to ensure that this team was brought up-to-date with its knowledge both about local resources and procedural changes.

Resources in safeguarding were stretched with the need to take control of the significant rise in alerts and how these were dealt with. This was currently being addressed by new referral procedures and by the temporary appointment of an additional chair and seconding two team managers on a part time basis. The police were also stretched by the rise in alerts. However, these problems needed addressing earlier in the process.

There was recognised need to improve the quality of both chairing and minute taking of safeguarding meetings. Training in this area was proposed but had not yet been fully implemented.

Within the Council and statutory partners there was a well regarded training programme. However, in the independent sector the Council estimated that only 53%

of the workforce had received safeguarding training and the aim to increase this to 55% in 2010-2011 appeared modest, especially as it was not tied to information about turnover of staff.

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

The Council had a strong ethos of customer care, meaning that learning from customer feedback played a central role. LINks was only one year old but developing into a useful feedback forum. There was a recognised need to widen its scope to become more representative of the diverse community.

The Council set clear targets based on national indicators and local improvement targets. Performance clinics were in place to address drift. There was good budgetary management with controls in place to ensure that the Council remained within budget. There were recognised challenges ahead but Council members demonstrated a commitment to social care. The panels worked well to ensure appropriate allocation of resources.

Performance management required further development to support identification and reporting of outcomes from support planning and review work. The Council were currently working on ways to best capture information about outcomes by using some support plans but were not yet in a position to measure or monitor on a significant scale.

Incident reporting to contracts staff was well embedded across the sector and ensured a strong link between individual experience and contract compliance. We saw evidence of appropriate action taken to address poor provider performance and keep people safe. Contracts staff were working with providers to improve their internal quality assurance controls.

Performance management for safeguarding needed more attention. The internal audit systems had not picked up on some of the recording and practice issues identified in the inspection.

The Council made good use of learning from complaints to make improvements within services affected and address any wider implications. Actions agreed were reported to, and reviewed by, the management team.

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 made excellent use of customer surveys to address quality of services. There was evidence that changes had been made in a range of commissioned services in a response to feedback. For example, the Home Improvement Agency was commissioned in response to issues identified through consultation. A recent initiative, in response to concerns about the safety of mobility scooters, was to put in place a mini-assessment clinic at the Independent Living Centre.

LINks was beginning to demonstrate its potential to make an impact upon commissioning decisions. A review from LINks fed into the MIND review of services for Gypsies and Travellers.

Concerns of older people about intimidation by traders had been taken into account in the Doorstoppers initiative designed to deter cold callers. This project has also generated volunteering opportunities with people trained to deliver information to residents.

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.

Joint Strategic plans were based on a Joint Strategic Needs Assessment which was regularly refreshed. There was a recognised need to tackle the over provision of care homes and move the balance of provision toward more supported and extra care housing, which was being addressed. However, this remained a challenge as Stockton-on-Tees is an attractive area for the care home business given the availability of building land.

Although a small organisation, Catalyst played a positive role in supporting the work of the voluntary sector. There were some gaps in effective commissioning from the voluntary sector. There was still some confusion about services procured by grants, service level agreements and open tendering. The provision of feedback to the voluntary sector was variable about their potential to contribute and the quality of their services.

Commissioning and contracts staff were working to get a better understanding of the

needs of local people, raise the quality of local services and strengthen a preventative approach. They had identified the need for more work with carers.

There were strong partnerships between service providers and Stockton-on-Tees Council in service development. There is a good focus on raising the quality of care in local services based on customer surveys. We found that providers had a good understanding of the new personalisation agenda and were responsive to it. There was an expansion of support for end of life care and people with dementia.

Information Communication Technology (ICT) was a recognised area for development and project plans were in place to promote the more efficient collection, collation and management of data. There was a need to progress more effective and management of information between health and social care.

Appendix A: summary of recommendations

Recommendations for improving performance in Stockton-on-Tees

Safeguarding adults

The council and partners should:

1. Improve the quality of case recording to ensure consistent high standards across the partnership. (page 11)
2. Ensure that actions agreed at strategy meetings and subsequent reviews are explained, recorded and followed through. (page 11)
3. Improve access to advocacy for both alleged victims and vulnerable perpetrators. This should include ensuring that the duty to consider the use of IMCA is consistently exercised and the reasons for decisions are recorded. (page 11)

Increased choice & control for older people

The council should:

4. Ensure that assessments, including the new assessment tools fully reflect people's interests and history. (page 14)
5. Tighten up on the process for reviewing care packages to ensure outcomes are consistently clearly explained and recorded. (page 14)
6. Ensure consistent standards in written responses following complaints so that outcomes are always clear and ensure that information on how to complain is easily accessible. (page 16)

Providing leadership

The council and its partners should:

7. Further develop the First Contact team to ensure staff are kept up-to-date and better integrated with other parts of the department. (page 19)
8. Strengthen the leadership of safeguarding to ensure clearer and more consistent approaches to its management and quality assurance. (pages 11, 17 and18)
9. Ensure the Local Vulnerable Adults Safeguarding Committee is supported by robust performance and management information. (page 18)
10. Increase the safeguarding training for the independent sector. (page 19)

Commissioning and use of resources

The council should:

11. Improve their engagement with the community and voluntary sector in shaping the market to increase the range of options available. (page 16)
12. Ensure implementation of plans to address the overprovision of care homes and develop more extra care housing, or supported living schemes to provide people with an alternative. (pages 15 and 21)
13. Strengthen the role of the Local Involvement Network to further develop its role as a watch dog and assist in its future role in Health Watch. (page 21)
14. Ensure the First Contact Team is consistent about how it records and monitors its activity to comply with organisational policies and procedures. (page 13)

Appendix B: Methodology

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

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

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

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

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

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

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

We spent six days in Stockton-on-Tees when we met with 8 people whose case records we had read and their carers and inspected a further 10 case records and 7 complaints files. We also met with approximately 90 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 53 were returned.

We also met with

- First Contact staff
- 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.

Stockton-on-Tees 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.