Inspection report

Service inspection of adult social care: **London Borough of Bromley**

Focus of inspection:

Safeguarding adults
Increased choice and control for older people

Date of inspection: August 2009

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Inspection of adult social care

London Borough of Bromley

August 2009

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Acknowledgement

The inspectors would like to thank all the staff, people who use services, carers and everyone else who participated in the inspection.

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Introduction

An inspection team from the Care Quality Commission visited Bromley in August 2009 to find out how well the council was delivering social care.

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

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

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

Summary of how well Bromley 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 Bromley was performing adequately in safeguarding adults.

Increased choice and control for older people:

We concluded that Bromley was performing adequately 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 Bromley was promising.

What Bromley was doing well to support outcomes

Safeguarding adults

The council:

- Ensured that some people were effectively safeguarded from abuse and harm.
- Delivered increasingly effective multi-disciplinary support for vulnerable people.
- Provided a range of multi-agency community safety initiatives.
- Had raised the profile of adult safeguarding, developed extensive interagency procedures and strengthened practice supervision.
- Had critically examined and learned from examples of a range of practice.

Increased choice and control for older people

The council:

- Involved people in assessments and care planning and listened to their views.
- Had developed a sound brokerage project to support people who did not meet the eligibility criteria for care managed services.
- Promoted the independence of people who used services by providing a range of community and residential intermediate care services.
- Had begun to develop a wider choice of support services including additional extra care housing and specialist dementia services.
- Had developed specialist services for people with dementia.

Recommendations for improving outcomes in Bromley

Safeguarding adults

The council and partners should:

- Ensure that risk threshold identification, assessment and the implementation of protection plans are made more consistent.
- Strengthen joint performance management and compliance monitoring processes to ensure that staff from all agencies meet minimum practice standards.
- Minimise the risks faced by people who live in situations of ongoing vulnerability by providing appropriate protection and contingency plans.
- Utilise the available preventative services more effectively within protection plans.
- Ensure the full engagement and contribution of partner agencies to the work of the safeguarding adults board to deliver more challenging leadership.
- Improve the consistency of practice by staff from all agencies by ensuring that those undertaking key tasks have the necessary skills and competencies.

Increased choice and control for older people

The council and partners should:

- Improve information about the range of support that is available to give people who use services increased choice.
- Deliver more individualised packages of care through holistic and ambitious assessments and care planning.
- Ensure better outcomes for people leaving hospital by working more effectively with health partners.
- Empower people who use services by providing focused advocacy support for those who are vulnerable.
- Support carers more effectively by improving the profile of carer's assessments and services.
- Strengthen arrangements to ensure that Direct Payments and self-directed support options are proactively offered.

What Bromley was doing well to ensure their capacity to improve

Providing leadership

The council:

- Had a sound strategic vision for developing more personalised services.
- Used high level performance information well to monitor the effectiveness of a range of services.
- Had a training and development plan that was well funded and was beginning to address core competencies.
- Was improving the quality of local services through a joint approach to training with service providers in all sectors.
- Had worked well with housing partners to develop extra care housing and provide assistive technology.

Commissioning and use of resources

The council:

- Had well established consultation processes for involving people who use services and carers in service development.
- Had processes in place for liaising with the Independent sector.
- Had improved the quality of care provided by strengthening the staffing and processes within the contracting unit.
- Had a sound medium term financial strategy and had effectively managed its budget.

Recommendations for improving capacity in Bromley

Providing leadership

The council should:

- Improve the pace of change in transforming social care by setting out clear and monitorable implementation plans for developing new services.
- Work more effectively to utilise the skills and expertise of independent sector providers in developing new community based support arrangements.
- Evaluate the skills and training requirements for services that promote independence and choice, setting out plans to secure these skills in the workforce.
- Include performance information regarding the quality of outcomes for people in performance management data.
- Ensure that staff across all teams have manageable caseloads by establishing a consistent approach to workload management.

Commissioning and use of resources

The council should:

- Work more effectively with people who use services and carers to ensure that their views have an impact on the way services develop.
- Use commissioning and joint commissioning strategies to set out in detail what services will be developed.
- Disseminate commissioning strategies so that people who use services, partners and stakeholders will know what services will look like in the future.
- Continue to use incentives within commissioning to encourage the development of community based support arrangements to increase choice for people who use services.
- Prioritise the conclusion of reviews of mainstream services to improve the pace of change.
- Work with health partners to secure improved outcomes and efficiencies through developing streamlined and integrated services and support arrangements.

Context

Bromley is an outer London borough. At 58 square miles it is by far the geographically largest borough in London. There is an estimated population of 299,100. The proportion of residents from minority ethnic groups is 8.4 per cent with the largest non-British ethnic groups being Caribbean and Indian. Bromley has the highest proportion of people aged 85 years and over in London and by 2015 the council expects that the percentage of the population that are over 65 years to have increased by a further 11.3 per cent.

The deprivation index shows Bromley to be the 5th least deprived of the London Boroughs. There are significant pockets of disadvantage in five of the Borough's 22 wards (Penge & Cator, Mottingham and Chislehurst North, Cray Valley East, Cray Valley West, and Crystal Palace).

The Council has a political structure of a leader and executive cabinet. Health commissioning is organised through Bromley Primary Care Trust (PCT). The Adult Safeguarding Board for Bromley is chaired by the Director of Adult & Community Services, the revised inter-agency adult safeguarding procedures were agreed in January 2009.

In November 2007 the Audit Commission judged the Supporting People service as fair and with promising prospects for improvement. In 2008, the Audit Commission judged the council to be improving well and a recent update rated the Council's performance as 4 stars. In 2008, the Commission for Social Care Inspection rated Bromley's performance on the delivery of outcomes for adults as good with promising capacity for improvement, resulting in the award of two stars.

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 some good arrangements in place to ensure that people who used services were free from harassment and discrimination. Social care services were increasingly playing a part in a good range of projects and initiatives to improve community safety. Information about community safety initiatives was generally freely available and special campaigns such as 'Keeping Safe in Bromley' had raised awareness about support that was available for vulnerable people.

There was a well established community safety strategy and a Safer Bromley Strategic Partnership. Both the fear of and the rates of crime had fallen. There were a number of examples of where preventative services had made vulnerable people safer. More could be achieved by using these services in a wider range of situations.

Some special initiatives had been established to make preventative support available to hard to reach groups, such as travellers. However, some information about support that was available was not publicised or made available in other languages or formats.

The adult safeguarding policies and procedures were well focused on investigation of incidents of suspected abuse. There was a need to strengthen the relationship between these procedures and community safety initiatives. We saw casework where protection initiatives for people who did not meet the criteria for a full investigation had failed to secure preventative services which could have made people safer.

General prevention issues had a low profile within the Bromley Safeguarding Adults Board and the awareness of prevention issues and services was low in some partner services, within and outside the council. Some key interagency procedures did not prioritise the needs of vulnerable people for support. Some community safety plans had poor cross references to adult safeguarding arrangements. Work was underway to address this issue.

Processes were in place for undertaking appropriate checks on staff in provider services and support was available for people who had support in the form of Direct Payments to access such checks. A whistleblowers policy was in place and had

been used to highlight concerns. Special projects regarding domestic violence and an appointeeship service had made specialist support available at an early stage for some people who used services.

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

Some people were protected effectively. Revised and extensive interagency procedures were in place and alerts regarding specific incidents received a generally timely response. The numbers of alerts had increased and some clear and specific protection plans were in place. Awareness training was freely available to all social care staff and two consultant practitioners had been appointed to strengthen practice within Adult and Community Services.

Risk thresholds had been recognised and structured action plans had been developed where appropriate in some cases. Whilst some practice was good, we also saw evidence of inconsistency and, in a minority of cases, the recognition of risk thresholds had been poor and the implementation of structured action plans had not been undertaken where necessary. Some people who used services, including people who had needs that did not meet the council's eligibility criteria, had been left at avoidable risk because protection plans were not clearly set out. In some cases there had been confusion between teams about casework responsibility and other cases had not benefited from streamlined inter-team communication.

The increasing number of alerts had placed considerable pressure on frontline teams. Some investigations had had to be undertaken by managers and others had been pursued by duty officers over a number of days. Timescales were not always met for key events within the investigation, review dates were not always set and some reviews didn't take place. A high number of people who raised an alert had not been kept informed about the progress of investigations.

The safeguarding board was providing increasingly effective leadership for all agencies, had overseen some sound learning from reviewing difficult cases and had produced a sound annual report. The membership and governance arrangements for the board were a significant improvement on the preceding Adult Protection Committee. Four sub-groups had been established and were becoming increasingly effective although reports to the main board were irregular. Greater ownership of adult safeguarding procedures and practice had been secured across agencies. The strategic plans underpinning safeguarding interventions were mixed. The overall strategy was poor and dated but was supported by the current annual report which contained a sound action plan. The safeguarding board sub-groups had yet to become fully effective. Managers and staff within the department were not well aware of the work of the board. Some staff had presented cases to the board but other staff had no ready route to contribute intelligence about practice experience. The need to strengthen the political profile and leadership in the work of the board had been acknowledged by elected members.

Multi-disciplinary partnership working in practice was variable. The procedures laid specific and auditable responsibilities on social care staff but failed to make similar

demand for minimum response standards on other agencies. The quality of risk identification and sharing of information between agencies was inconsistent. The safeguarding board had no effective compliance or performance management arrangements in place to ensure that practitioners from all agencies met the expectations of the interagency policy. Direct access to support from the police through the public protection unit worked well but the quality of response was variable and in some cases poor.

Identification of thresholds for ongoing and cumulative risks was variable. Some situations of ongoing vulnerability received a less good response than those where there was a specific incident which could be investigated. We saw variable practice in relation to some preventative protection plans. More use could have been made of the range of preventative services within formal protection plans to minimise ongoing risks. In some cases people who used services and had capacity to make decisions were not considered to need a protection plan and remained vulnerable. Some situations of repeated risky behaviour of people with mental capacity had not been addressed for some years.

Basic awareness training and some specialist training had been made available to departmental and independent sector staff. Managers had acknowledged that training was insufficiently directed towards raising practice standards across all agencies. Progress was being made to give staff undertaking key roles in adult safeguarding work the skills to do the job. A system of six levels of training, including investigating officers and chairing strategy meetings, had been introduced. Monitoring of compliance with training expectations had been strengthened. Nevertheless, a proportion of current investigations and strategy meetings had been undertaken by staff that had not had specific training in these tasks. Managers had been insufficiently challenging regarding the quality of practice and this had led in some cases to visits not being made and protective action not being undertaken.

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

Most providers of registered social care services within the borough were good, some were adequate and a fewer number were excellent. The standard of care in NHS accommodation for people with learning disabilities had improved significantly following inspections by the Healthcare Commission. An increase in reporting serious issues had been achieved but further progress was required regarding issues such as standards of accommodation and training. A joint health and social care improvement process had been underway since 2007.

Policies required consent for disclosure of information and case files recorded confidentiality issues. Contracts had clauses regarding dignity and safety in the provision of care. Contract monitoring had led to the identification of unacceptable providers and appropriate action to suspend placements and instigate re-training had been implemented.

We were told of repeated issues regarding poor dignity and respect in service

provision and of carers needing to be forthright in making complaints to the department and advocating on behalf of people who used services. A carer of someone who received services said:

"You have to badger them all the time and do all the leg work…then they might respond".

We found little advocacy support available through the adult safeguarding processes. We found a lack of confidence in the Independent Mental Capacity Act service which was based outside the borough and information sharing was poor. Where advocacy was available, it was poorly specified and focused and had not been deployed in situations where it was needed to empower people who used services.

The involvement of elected members in maintaining quality of services was mixed. The Policy Development and Scrutiny committee had overseen effective action regarding concerns relating to one residential care provider but were not well informed about more wide ranging quality and dignity issues.

A range of initiatives were underway to strengthen quality and dignity in care and support. The council had used the serious case review process to identify arrangements that needed to be strengthened regarding support for people who posed a risk to themselves through self-neglect. A new and stronger protocol had been put in place.

A routine and periodic audit process to test the quality of adult safeguarding practice had been developed to supplement the longstanding case file audit process in adult care services. Information from this process had been fed back to the adult safeguarding practice group and to the executive of the safeguarding board but was yet to have its full impact.

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.

The council effectively used regulatory information provided by the Care Quality Commission and inspection reports to influence how they commissioned services from the independent sector within the borough and beyond. This practice ensured that people and their family carers were provided with choice in the range and quality of services when selecting residential and domiciliary care.

The council had a good understanding regarding the quality of provision it commissioned from regulated care providers. The council only commissioned services from residential care providers that offered single occupancy rooms to ensure that dignity and respect was maintained.

Increased choice and control for older people

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 had made some progress in addressing the personalisation agenda and were aware that further work was required to meet this challenge. A range of useful leaflets were available but many had no reference to them being available in other languages and formats. Bromley 'MyTime' produced a high quality website which offered a range of health related activities for older people. However, most leaflets referred to generalised services and aspirational commitments rather than specific standards. Several leaflets regarding universal services such as leisure facilities didn't mention older people and there was poor referencing to how services would be made accessible and safe for older people to use.

Most people who used services and carers who we surveyed and met considered that public information was not designed to encourage them to take up options. Choice in the type of support or how it was provided was not routinely offered by social workers during the assessment and care management process. Many people who used services and carers told us that Direct Payments had not been mentioned or had only been referred to as a difficult and complicated process. For some, the set up processes had been difficult, protracted and bureaucratic. However, the numbers of older people using Direct Payments had improved from a low baseline.

There was an effective single point of access to services through the Bromley Social Services Direct centre. People who used services and carers found it easy to get in touch with social workers initially but then often felt that social workers did not keep them informed about developments and proved harder to contact. A pilot self-assessment process was underway in partnership with a local voluntary organisation and a brokerage scheme had been set up to assist people who did not qualify for a community care assessment to secure support. People told us that they felt that they were swiftly excluded from the care system and left to fend for themselves.

The role of the informal carer was undervalued. Information for carers and about carers services was poorly presented. Many carers did not know about crucial services such as the carers emergency respite service. Some carers felt that they were expected to undertake key care management tasks such as identifying suitable placements without sufficient support. One family carer said:

"Bromley never consulted us, rarely communicated with us and were inefficient. I hate to think what would have happened if I wasn't there shouting for her".

The assessment and care management procedures were extensive and clear. However, practice did not always promote the development of choice. Further plans

to monitor the effectiveness of line management supervision of frontline practice were in the process of being implemented.

The procedures did not make clear the situations in which the choice and control of people who use services would be enhanced by the use of advocacy. Accordingly, poor use was made of the extensive advocacy services that were available. Citizens had little knowledge of the advocacy services, the agencies concerned were not clear about their role and specific specialist advocacy services had not been commissioned for very vulnerable groups such as people with dementia.

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

Older people were not consistently helped to shape their own support. Assessment and care planning was of variable quality and largely focused on people's physical needs and disabilities rather than their capabilities and aspirations. We saw few examples of ambitious and personalised care planning.

The assessment process was well established and included single assessment arrangements to dovetail multi-disciplinary assessments. Some specialist integrated health and social care teams had been established. Mainstream assessment teams were not integrated and we found examples of fragmented assessment and provision of health and social care. Many people who used services and carers had to undergo repeated assessments by staff from different agencies. Access to specialist assessments, including support from colleagues in housing services, was variable and, where they existed, inter-team protocols focused on the administrative transfer of case responsibility rather than delivering effective joint support in complex cases.

People who use services were routinely involved in assessments and had copies of relevant plans. However, staff shortages and an inability to cover vacancies and annual leave meant that there were delays in undertaking some assessments in both of the mainstream older people's teams. Assessments were not holistic and did not effectively identify the individual desires of people who use services and build on this to determine bespoke, individualised care plans.

Assessments were theoretically available for people who funded their own care but in practice proved hard to secure without significant pressure from families and informal carers. Those who had access to the brokerage project had a much better service.

The quality of outcomes for people who use services being discharged from hospital was unduly variable and often inadequate. The council had not negotiated a multi-agency Hospital Discharge Procedure setting out reciprocal responsibilities on staff from all agencies to ensure a minimum standard of care. We found deficiencies in the quality of some care plans. There were no performance management arrangements in place to secure minimum standards of care. There was no forum for staff from all agencies to take concerns about poor discharge planning so individual

problems could be resolved and so that all agencies could learn lessons to improve future practice. Local performance information showed a high degree of compliance with procedures by hospital social work staff where a patient was referred for a community care assessment.

There was a well established health and social care intermediate care project which provided high quality care for a significant number of people through an array of residential and community based options. One carer said:

"*The service was excellent. I hadn't thought that a return home to independent living would be possible. This support made it achievable".*

For those who did not meet the criteria for this service, the options were more limited.

Some carers were not routinely or effectively involved in the assessment and care management process. Carer's assessments had not been prioritised and the target for assessments was modest. Procedures were advisory and managers did not require staff to demonstrate that they had been implemented. Many carers did not have support services or information about support that was available. Access to respite care was not easy.

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.

Older people had access to a growing range and choice of services. A range of services including extensive intermediate care and rehabilitation services were well established and there were a growing number of universal support initiatives through local leisure and activity groups.

The brokerage project had piloted self-assessment, promoted holistic assessments and provided an ongoing 'care management' style support service for people who arranged their own care. This represented a model for the future development of self-directed, 'brokered' support arrangements. The Home Improvement Agency was making an important contribution to the range of support services available and some voluntary organisations had developed specialist services. Less use was being made of residential care, the equipment service was efficient and additional extra care facilities were planned for 2010. The joint health and social care intermediate care service delivered good results in helping people return to independent living following hospitalisation.

Nevertheless, there were some delays in securing appropriate placements in nursing respite care and specialist day care facilities. The in-house home care service had been restricted and the six directly provided older persons homes were the subject of a closure programme. There was a strategy for re-provision but this was not understood sufficiently well or consistently enough throughout the service. A few

people had waited longer than six months for a residential care placement of their choice. Use of alternative types of provision such as telecare was low.

The development and deployment of more modern services that could deliver individual support and care packages had been slow. The Direct Payments project had started with overly complex processes and had made slow progress. A recent recovery plan had been effective in revitalising the project and over 60 older people had subsequently secured a package. The department aimed to have one third of all people who use services taking advantage of Personal Budgets by 2011. The direct payment service was used often where the service user was dissatisfied with the traditional service and/or where the family could help administer the process.

Support packages focused on traditional services and made little use of individual support workers that were provided by some voluntary organisations. Some people who used services were offered a Day Care placement but were given no alternatives when they withdrew from the service because it was not meeting their preferences. Some people who use services had to accept help at times they would not have chosen. Many people who use services told us in our survey that they did not feel they were offered choice.

The development of services to meet the needs of people from black and minority communities had been slow. Direct Payments had not been used in a focused way to make support available in an acceptable way to hard to reach communities. Equality Impact Assessments had been ineffective in improving services and support arrangements.

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

Information about complaints and out of hours services was readily available but better use should be made of the learning from complaints to improve services. The council's emergency duty team was well publicised and had a direct contact telephone number. This service was complimented by out of hours health services. The availability of emergency cards for carers was good but there was no specialist out of hours support service that carers could contact for advice and guidance.

The complaints service had been revitalised, a new high quality leaflet had been produced and the numbers of complaints had increased. A high number of complaints were resolved at an early stage and some complaints had been well managed. Nevertheless, people who used services were sometimes reluctant to make complaints, did not feel that they were communicated with well about the progress of their complaint and were not always satisfied with the outcomes of investigations. Many complaints were not completed on time. We heard of repeated complaints regarding carers failing to stay for the specified time during a domiciliary care visit which had not been effectively resolved. In 2009, to address the relationship between adult safeguarding processes and the complaints process, a strengthened quality audit process was introduced.

The annual complaints report was up-to-date and detailed but failed to make good use of the intelligence received from complaints. The report was adequate but it was not used as an opportunity to provide intelligence to support improved outcomes for people or priorities such as safeguarding or personalisation.

A specialist team had improved performance on reviews but some providers told us that reviews didn't happen in a timely way and the council was not meeting its statutory responsibility on out of borough reviews. In one case, this had led to an adult safeguarding alert. We heard of difficulties in securing an urgent review of a care package when people's care needs changed.

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 a clear strategic vision for the development of personalised services and the service had well established systems in place for engaging with people who used services and their carers. The service had played an increasingly effective part in community safety initiatives and significant improvements in adult safeguarding processes had been achieved and others were underway. A range of initiatives had been undertaken to strengthen quality and dignity in care. The auditing of quality of practice was being strengthened.

The strategic vision of the service was not translated into effective implementation plans that gave clear leadership to staff, stakeholders and partners. Consultation and involvement processes were variably effective.

Progress on transforming social care had been slow. The initial transformation process had drifted. A new and sound, project management based, plan was at an early stage of development and was in the process of being implemented. Because of this inconsistent progress, managers and staff were unclear about what the service would look like in the future. There was low morale and considerable anxiety about impending changes.

An overarching strategic plan 'Supporting Independence in Bromley' set out the vision well and there was a broad implementation programme covering a three year period. Overall funding had been identified but the plan was insufficiently clear about specific resource commitments.

There was a range of strategic business plans at corporate and departmental level. The strengths of corporate plans had yet to be fully apparent in the transformation of adult social care. Departmental and transformation plans failed to set out effective action plans with clear targets, timescales and monitoring arrangements. The older person's strategic plan detailed the general vision for the service and progress on developing extra care housing was monitored quarterly. However, the associated delivery plan was in the process of being developed, did not clearly specify any resources and had vague and aspirational targets. The production of team plans for older people's services had been delayed because of a lack of management

capacity. Overall, the implementation of plans to deliver transformation was improving at the time of the inspection and we understood that team plans were in the processes of being devised.

Elected members had taken some difficult decisions regarding reshaping services and there was increasing understanding, leadership and commitment for the emerging transformation work. The Policy Development and Scrutiny Committee was less well informed than the portfolio holder about the transformation plans. A Programme Board was in place to lead the transformation process. Some issues, such as modernising Day Care were still in the process of being tackled and this had reduced the options for individualised support for people who used services. A further review of the role and structure of domiciliary care services was due to report in 2010.

The development of partnership arrangements with health agencies had been frustrated by structural changes and management changes. The department had an improving relationship with third sector and voluntary organisations. Some initiatives had drifted and some agencies did not feel engaged in service development at a sufficiently early stage. However, the profile of the third sector as an important partner had been raised by recent service development initiatives.

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.

Processes for engaging with people who use services and their carers were well established but inconsistently effective. The effectiveness of consultation in relation to particular service development initiatives such as extra care housing had been variable.

People who used services were well represented on the Older Persons Partnership Board and contributed to a well established annual conference to set priorities The experience of people who use services was beginning to be taken into account in quality assurance processes. An Expert by Experience programme was underway to involve people who use services in checking the quality of support that was provided. The Direct Payments support agency collected information about the views of people who used that form of support.

Ongoing consultation processes were less effective. Some partners thought that the Older Persons Partnership Board had not had an impact on the development of services. Lack of clarity about the direction of service development had hindered the contribution that people who used services and carers could make. Some carers did not feel their views had made a difference and identified a range of issues about poor quality of care that had been raised but had not been resolved. Many carers told us that consultation regarding the Carers strategy had not been widespread and there was no effective action plan for delivering improved support for carers.

Some important initiatives had been undertaken to help travellers and other hard to reach groups to contribute to service development initiatives. However, consultation with people who use services and carers in relation to the Equality Impact Assessments had resulted in little change.

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

Effective workforce development plans were not in place. The council had agreed a model for addressing skills gaps and informing the job redesign process. The shape of the new service was not yet clear and associated training plans lacked detail. There had been limited joint initiatives with health partners to plan for new integrated roles to develop more personalised forms of support.

The corporate workforce plan lacked specific targets and failed to prioritise the development of new skills to deliver more personalised services. The plan made only general reference to the early stages of developing the social care workforce to meet the challenges of transforming social care. Senior managers acknowledged that the transformation project had yet to scope job redesign and skills development requirements and had no active workforce planning stream of work.

A three year training and development strategy was in place with committed year on year funding. Training was informed by an annual learning and development process, was available to independent sector providers and had included courses relating to the Mental Capacity Act. In general, training was valued by departmental and external staff. However, the training strategy was vague and aspirational, future developments amounted to a list of training courses rather than a strategic analysis of the social care workforce and skills base that was needed.

Joint workforce plans with health partners were underdeveloped. One specialist team had piloted the development of a joint health and social care post and there were outline plans to merge the occupational therapy and care management role in the future. Plans to pilot closer integrated working in teams providing support for older people with mental health problems had been in place for some time.

High turnover and vacancies within the care management teams had led to workload management problems and delays in assessments and reviews. Workload management processes differed between the two older people's teams and were not clear to staff. Recruitment had been difficult and a period of staff turnover had contributed to the pressure on the teams already suffering a lack of clarity about the direction of the service.

Staff received supervision regularly although the notes of casework discussion were not copied onto casework files. The role of the consultant practioner was valued as a source of expert support in safeguarding work but there was also confusion in some cases about line management responsibilities where there were parallel safeguarding and care management streams of work. Processes for periodically auditing the quality of casework and providing feedback had been delayed because

of a key staff vacancy.

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 well established corporate and departmental performance management arrangements. The performance business plan was a clear, detailed and auditable document which set the framework for regular quarterly datasets. However, this information focused too much on quantitative data relating to national performance indicators. Information about the quality of adult safeguarding social care practice had only recently been started to be collected and did not include the quality of interagency practice.

Specific standards were set regarding quantitative issues such as timescales for assessments and performance was reported regularly. However, the interpretation of data was limited and awareness across elected members, staff and partners of areas of good and weak performance was mixed. Information on the quality of the experiences of people who use services was collected for traditional, directly provided services and generally showed good levels of satisfaction. Awareness regarding the importance of securing dignity in service provision was high. However, some performance information was distributed to first line managers irregularly and local quality standards had only recently been set for key services such as intermediate care.

Elected members had a high personal profile in quality assurance processes including visiting directly provided and independent sector services. Performance reporting processes for members were sound. However, awareness of key strengths and areas for development in older people's services was limited. People who used services told us of a range of poor experiences, including the reliability of transport and carers rushing their duties during home visits. Concerns regarding a limited focus on promoting independence skills by mainstream services after intermediate care services had ceased, had been acknowledged by managers and a assessment and rehabilitation service was due to start later in 2009. An overriding deficit was the lack of individualised options for the way that support was to be provided.

Workload pressures on supervisors and first line managers within care management teams led to spasmodic implementation of quality assurance processes. Some supervision was insufficiently challenging and lacked focus on quality assurance. Key areas where improvement was needed such as carers' assessments and the use of Direct Payments had not been subject to sufficiently effective performance improvement initiatives. Quality assurance processes within the interagency field were underdeveloped. Key processes such as hospital discharge arrangements had no compliance monitoring arrangements. While the safeguarding board had undertaken good work in reviewing and learning lessons from a range of difficult cases, there were no joint processes for checking on the practice of staff from agencies who had agreed the joint procedure. The quality assurance sub-group was yet to become effective.

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 a range of mechanisms in place to ensure that the views of people who used services influenced commissioning practice and better outcomes for people. These had been variably effective.

The views of people using services were collected in a variety of ways to inform commissioning and contracts work. There was an annual 'dignity day', effective consultation regarding extra care housing and a portfolio planning day. Provider services undertook regular surveys of people who used services. The older person's forum collated the views of people who used services and their carers.

The experiences of people who used services and carers of consultation was mixed. The processes for engagement were more consistently effective than the impact of the views of people who used services on development of new forms of support. Some people told us that consultation about existing services was stronger than involving people who used services and their carers in consideration of new types of outreach and community support arrangements.

Many people felt that they had had an opportunity to comment, but some consultees felt that their views had not had an impact. An innovation had been the adoption of a 'Select Committee' approach to considering service development. This model included an independent chair. This process had led to the development of the brokerage service and was felt to be more inclusive and effective at ensuring that the contribution of people who used services and their carers had an impact on the planned developments.

There were well established liaison forums with the independent sector that had been used for developing some specific initiatives which reflected the views of people who used services. The strategic accommodation review was inclusive and led to increased extra care housing. The contracts for this service had included some elements suggested by people who use services and carers. The older person's partnership board included a range of stakeholders, including people who used services and carers. However, the lack of clear older person's commissioning and a joint commissioning strategy left some people who used services and partner organisations in difficulties about how to contribute to the debate about the development of services.

The service generally made good use of service user feedback from surveys and

information produced by the Care Quality Commission regarding safeguarding issues. Some consultation discussions were too general to be useful and many seemed to involve repeated consideration of the overall vision for the service. Issues regarding service quality remained unaddressed despite repeated representations by some people who used services and their carers particularly those outside the regulated sector.

Contract monitoring was generally sound but information about the views and opinions of people who use services was not collated and used to inform future commissioning intentions. Contracts had been strengthened regarding safeguarding and diversity clauses.

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.

Council commissioners had an increasingly effective understanding of the needs of older people. This was leading to more effective market management and contracting processes to deliver a wider range of services and support options. Shaping the market to reflect the priorities of a more personalised service had been hampered by a lack of precise and transparent commissioning priorities and developments had lacked coherence.

The Joint Strategic Needs Analysis (JSNA) had identified priorities regarding developing services for some geographical areas and hard to reach communities and some premiums had been paid to ensure that services were available to these groups. Stakeholder groups had been established for providers. However, some providers had not felt that they had an opportunity to contribute to the JSNA and others were not clear about how the priorities of that exercise were to be translated into development plans for new services and support arrangements.

Decommissioning arrangements were underway regarding directly provided older person's homes but the plans for reproviding four new homes had fallen through and there was some confusion about what was going to be made available. Extra care provision was available and increasing. A successful brokerage scheme had been developed with the third sector. However, some transformation of other mainstream services such as day care and domiciliary care had been the subject of protracted consultation and delay.

Some independent provider services did not feel valued. A range of services provided through the voluntary sector were increasingly becoming subject to year on year funding and new tendering arrangements which were largely perceived as focusing on cost rather than developing quality and an increased range of services. Providers had not been engaged in discussions about a wider range of services and support arrangements. The pace of improvement had been slowed by budget constraints and lack of effective leadership in relation to the early days of the transformation project. There was a need to set out the plans and milestones for growth in self directed support services more clearly. Work remained at a very early

stage on this issue.

The contracting function had been revitalised and restructured in 2008 and was increasingly effective. More stable staffing and improved processes had led to a better relationship being developed with providers. However, the full impact of the improved contracting service had yet to be realised. The team were not fully involved in the transformation of social care project and plans for self-directed support were at an early stage of development.

Financial processes in the council and the department were generally sound. There was a four year medium term financial plan in place and budget management had been good for several years. Investment in older people's services had been stable and the proportion of the budget deployed on residential and nursing home care had reduced. The service was in the process of making more flexible some long term contracts for traditional services but the relative spend on Direct Payments remained low.

Efficiencies had been delivered through increasing the range of preventative services. However, there was confusion amongst a range of stakeholders about the future investment plans for the service and planned efficiency savings were not set out in detail.

There was no joint commissioning plan for older people's services and arrangements for increasingly streamlining health and social care support were unclear. Efficiencies that had been, or might be, achieved through bringing services together under joint management were unclear.

Appendix A: summary of recommendations

Recommendations for improving performance in London Borough of Bromley

Safeguarding adults

The council and partners should:

1. Ensure that risk threshold identification, assessment and the implementation of protection plans is made more consistent. (page 11)
2. Strengthen joint performance management and compliance monitoring processes to ensure that staff from all agencies meet minimum practice standards. (page 11)
3. Minimise the risks faced by people who live in situations of ongoing vulnerability by providing appropriate protection and contingency plans. (page 11)
4. Utilise the available preventative services more effectively within protection plans. (page 12)
5. Ensure the full engagement and contribution of partner agencies to the work of the safeguarding adults board to deliver more challenging leadership. (page 11)
6. Improve the consistency of practice by staff from all agencies by ensuring that those undertaking key tasks have the necessary skills and competencies. (page 12)

Increased control and choice for older people

The council should:

7. Improve information about the range of support that is available to give people who use services increased choice. (page 14)
8. Deliver more individualised packages of care through holistic and ambitious assessments and care planning. (page 15)
9. Ensure better outcomes for people leaving hospital by working more effectively with health partners. (page 15)
10. Empower people who use services by providing focused advocacy support for those who are vulnerable. (page 15)
11. Support carers more effectively by improving the profile of carer's assessments and services. (page 16)
12. Strengthen arrangements to ensure that Direct Payments and self-directed support options are proactively offered. (page 17)

Providing leadership

The council should:

13. Improve the pace of change in transforming social care by setting out clear and monitorable implementation plans for developing new services. (page 19)
14. Work more effectively to utilise the skills and expertise of independent sector providers in developing new community based support arrangements. (page 23)
15. Evaluate the skills and training requirements for services that promote independence and choice, setting out plans to secure these skills in the workforce. (page 21)
16. Include performance information regarding the quality of outcomes for people in performance management data. (page 2)
17. Ensure that staff across all teams have manageable caseloads by establishing a consistent approach to workload management. (page 21)

Commissioning and use of resources

The council should:

18. Work more effectively with people who use services and carers by ensuring that their views have an impact on the way services develop. (page 23)
19. Use commissioning and joint commissioning strategies to set out in detail what services will be developed. (page 23)
20. Disseminate commissioning strategies so that people who use services, partners and stakeholders will know what services will look like in the future. (page 19)
21. Continue to use incentives within commissioning to encourage the development of community based support arrangements to increase choice for people who use services. (page 24)
22. Prioritise the conclusion of reviews of mainstream services to improve the pace of change. (page 20)
23. Work with health partners to secure improved outcomes and efficiencies through developing streamlined and integrated services and support arrangements. (page 25)

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 London Borough of Bromley when we met with seven people whose case records we had read and inspected a further nine 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.

London Borough of Bromley 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.