Inspection report

Service inspection of adult social care:
Darlington Borough Council

Focus of inspection:

Safeguarding adults
Improved quality of life for older people

Date of inspection: August 2009

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- 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

Darlington Borough Council

August 2009

Service Inspection Team

Lead Inspector:	Laura Middleton
Team Inspector:	Laurie James
Expert by Experience:	Lilias Gillies
Supported by:	Help the Aged
Project Assistant:	Balwinder Jeer

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Acknowledgement

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

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Introduction

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

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

- Safeguarding adults whose circumstances made them vulnerable.
- Quality of life in respect of services and outcomes for older people.

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

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

Improved quality of life for older people:

We concluded that Darlington was performing well in supporting improved quality of life.

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 Darlington was promising.

What Darlington was doing well to support outcomes

Safeguarding adults

The council:

- Worked in partnership to help reduce crime and improve community safety.
- Maintained clear ways to report concerns and responded swiftly.
- Had team managers who acted as safeguarding leads and worked pragmatically and well together to address safeguarding issues as they arose.

Improved quality of life for older people

The council:

- Had made the centre of Darlington attractive, accessible and pedestrianised.
- Provided social care services which users reported very favourably on.
- Had put a structured, inclusive review process in place.
- Operated some good specialised services for older people.
- Had a range of dedicated social and health based programmes to encourage fitness and well-being.

Recommendations for improving outcomes in Darlington

Safeguarding adults

The council and partners should:

- Develop more robust quality oversight to ensure consistent professional standards of work are achieved.
- Extend training to a wider range of people, including those outside the social care and health sectors working regularly with vulnerable adults.
- Give particular focus to understanding issues and improving safeguarding for people with learning disability, both as potential victims and perpetrators.
- Improve standards of record keeping to ensure they are an accurate representation of events, actions, decisions, monitoring and formal determination of the outcomes.
- Work with the police to ensure referrals to them are timely and appropriate, to improve the ability of the police to respond effectively.

Improved quality of life for older people

The council should:

- Consult further with older people about ways to make them feel safer.
- Work with partners to improve peoples' independent mobility including better wheelchair provision and better public transport.
- Improve the dissemination of information to people at the time they need it. This should include consulting with those older people and carers who prefer to access information on the Web.
- Develop assessments and services for carers in their own right.
- Increase the use of self-directed care, including direct payments, to provide more individual and innovative solutions for both older people and carers.

What Darlington was doing well to ensure their capacity to improve

Providing leadership

The council:

- Had maintained political stability for a number of years, in a small authority which had managed within its budget.
- Had some key plans in place.
- Had established sound operational oversight of older people's services, with a wide range of quality mechanisms in place so that senior staff understood what was happening at the front line.

Commissioning and use of resources

The council:

- Engaged well with older people and carers in developing and assessing the quality of its services.
- Had worked jointly with the PCT on improving contracts around domiciliary care to reflect both their interests.
- Had worked jointly with the PCT to use three year contracts with third sector providers.
- Undertook regular contract monitoring with a clear focus quality.

Recommendations for improving capacity in Darlington

Providing leadership

The council should:

- Be more realistic about its achievements and develop wider, more national benchmarking of its progress.
- Ensure that the Darlington Safeguarding Adults Board has senior commitment from all key agencies and that a clear programme of work is established.
- Strengthen quality management around safeguarding so that staff across agencies have a better understanding of what works well and what needs to be improved.
- Ensure that council leaders take a stronger line on modernisation to increase the pace of change.
- Develop and act on more local performance targets, which reflect local priorities.

Commissioning and use of resources

The council should:

- Improve joint working, among statutory commissioners around respective budget, workforce development and resource commitments.
- Improve the efficiency of the equipment service from a service user perspective.
- Develop a more streamlined structure for consulting with the independent sector.
- Ensure that all front line teams have plans, which feed the developmental agenda.
- Improve the quality of IT systems and support, enabling electronic communication between agencies.

Context

Darlington is a small unitary authority in the North East with a population of 100,600. It was a Labour controlled the council. Governance arrangements were centred in a Cabinet and Leader model.

The black and minority ethnic profile of the borough was lower than the national average. Only 3.5 per cent of the population were from black or minority ethnic communities, compared with 9.1 per cent nationally with only 0.6 per cent of those over 65.

Darlington is a popular destination for gypsies and travellers, with two large permanent sites and a changing population. It is also close to a large army training camp and is a popular destination for off-duty recreation, necessitating close working with senior army personnel.

Darlington was ranked 90th most deprived out of 354 authorities in its indices of deprivation.

The council was judged by the Audit Commission to be performing well and improving strongly in 2008. In November 2008, adult social care services for Darlington were judged by CSCI to be '3 stars', delivering good outcomes with excellent capacity to improve.

Services for older adults were provided through the Community Services Directorate, which is led by the director of community services. An assistant director led services for adult social care and health. This post was vacant at the time of the inspection, the work being covered by the director of housing. Two heads of service, one covering operations and one transformation reported to the Assistant director, together with three new joint commissioning managers who will also report to the head of joint commissioning in Durham PCT.

Safeguarding was part of the transformation service within the council. It was overseen by a multi agency safeguarding adult's partnership board chaired by the Director of Community Services.

The PCT configuration had been subject to considerable change in the recent past. At the time of the inspection, although Darlington retained a separate PCT, its commissioning function was managed by Durham PCT.

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 worked in partnership to help reduce crime and improve community safety. The Community Safety team planned to work with older people to develop neighbourhood community safety initiatives, based on a 'you said, we did' model.

Darlington's Anti-Social Behaviour team and the Police patrolled the borough on mountain bikes and on foot as well as in police vehicles, to focus on known anti-social behaviour hotspots in a bid to crack down on anti-social behaviour throughout the Borough and in an attempt to educate young people about their effect on others' enjoyment. Most people we met were positive about these initiatives, although some older people reported concerns.

There were clear ways for people to report safeguarding concerns. Most external agencies we spoke to reported that the safeguarding process worked well from their perspective and that staff had been helpful and well informed.

The Darlington Safeguarding Adults Board had recently agreed inter agency policies and procedures for Darlington, adapted from elsewhere, although some adopted proformas still carried the logos originating in other localities. Some staff from advocacy organisations told us there was still some confusion about what was Durham policy and what was Darlington's.

The council had produced useful public information, although some leaflets on public display still had 'draft' printed on them. There were plans to develop accessible safeguarding leaflets, and to improve the information for direct payment users. Information was posted on the Website, although people we spoke to found it tricky to navigate.

Supervision was in place but standards of good practice were not well established.

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

Team managers acted as safeguarding leads and worked pragmatically and well together to address safeguarding issues as they arose. They usually responded promptly and appropriately to make people safe once concerns were reported. However, while immediate problems were dealt with there was sometimes insufficient follow up to ensure problems did not recur. People in vulnerable circumstances were not always carefully tracked to ensure support was in place. Such follow up was sometimes needed from other departments or organisations outside the council, but required oversight.

Standards we saw were variable, and more robust quality oversight was needed to ensure consistent professional standards of work and that council policies were adhered to. A better understanding of how to balance individual rights with the duty to protect was needed. It was of particular concern that shortfalls we saw had not been picked up as part of the safeguarding case audit or other process.

We saw proper steps taken with one provider where there were several repeat concerns of abuse of residents. The council, PCT and partners invoked local policy to convene 'Executive Meetings' to ensure continuing and high-level focus on concerns arising. This meant that all residents' welfare was better secured. In this work, links with CQC were maintained. There was scope to clarify respective understandings of council and CQC roles in such circumstances.

There was a well regarded training programme in place. Training needed to be extended to a wider range of people. We were concerned that many people outside health and social care were either not aware of training available or had not systematically accessed it. We found a range of people had not yet had appropriate training. Although training had been made available around the Mental Capacity Act, a workable understanding of how this related to safeguarding had yet to fully develop.

Better attention was needed to proper records. Information and records of incidents of abuse were not carefully enough managed or monitored. We found the quality of safeguarding recording was variable, and sometimes very poor. Documents were often incomplete, unattributed and/or undated. Key information was sometimes missing. For example records failed to note one person's heroin addiction.

We found there was sometimes a lack of formal determination about outcomes on file. This may mean that key staff know less about overall referral trends, activities and outcomes than they should.

There was a failure to record decisions about involving the independent mental capacity act advocacy service (IMCA), a consideration both in safeguarding and non safeguarding records. A failure to consider the use of IMCA where it may benefit a user or perpetrator in safeguarding cases may have meant that the Council was acting unlawfully.

Recording and communication across agencies and sharing of information between some teams within the Council was in need of improvement, and could be streamlined by improving consistency of recording. The outcomes of safeguarding

incidents were not monitored and reviewed through the Darlington Adults Safeguarding Board.

We found that the police were appropriately involved in most cases we read. The dedicated Vulnerability Unit within Durham police was a valued resource and working relationships were good. However, we read one case where contaminated evidence and late reporting had prevented police investigation.

We had mixed reports on the police response from users and carers who had reported concerns, suggesting a need for the Darlington Adults Safeguarding Board to monitor referrals and responses.

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

People told us they were included in decision making:

"People give their opinion on how things are with my husband, but we always have the final say".

The council had an effective sensory impairment service, and positive attention was being paid to the communication needs of Deaf people around safeguarding. Deaf people could contact the safeguarding team directly by text on a dedicated mobile telephone number. This probably contributed to the recent increase in safeguarding referrals involving hearing-impaired people.

In cases where an IMCA was involved we saw some good practice. However, wider use should be made of IMCAs and other skilled advocacy specific to the needs of people within the safeguarding process. We found some lack of understanding among both staff and managers about how and when IMCAs should be involved. There was sometimes reluctance for the IMCA service to accept someone who had relatives. There was a need to clarify and reinforce the IMCA role in those families where there may be conflicts of interest.

Safeguarding for people with learning disability needed additional focus. We found poor quality working practices, delayed response and failure to follow up within the learning disability service. People with a learning disability were not well enough engaged in the process, and their wishes unrepresented in written records. There was some lack of understanding around capacity as it affected the need to protect people with learning disability. More account needed to be taken of the needs of people with learning disability who may be perpetrators.

Some learning disability providers were not well engaged with the safeguarding agenda leaving some people at greater risk. Case recording was often poor. Safeguarding referrals were dealt with on a minimal basis, and wider case recording was sometimes episodic, with big gaps. We understand work was underway to set more explicit recording standards within the service.

Improved quality of life

People who use services and their carers enjoy the best possible quality of life. Support is given at an early stage, and helps people to stay independent. Families are supported so that children do not have to take on inappropriate caring roles. Carers are able to balance caring with a life of their own. People feel safe when they are supported at home, in care homes, and in the neighbourhood. They are able to have a social life and to use leisure, learning and other local services.

People who use services and carers get advice and support at an early stage. Support services take account of the needs of individuals, carers and families. This helps to prevent loss of independence and isolation, and maintains their quality of life.

Older people who needed support were helped quickly, once referrals were received.

The staff at the Access and Contact centre were well organised, professional and knowledgeable. Ring back was used when a contact assessment was required, and this was a same day service.

One person told us that:

"*A telephone call usually to the duty officer and I can obtain advice or a promise that another officer will contact me".*

We found most front line workers knowledgeable about their own and other services in the area. The quality of external professional referrals varied, sometimes wasting time and suggesting some training needs.

Assistance provided was appropriate and had helped restore confidence, enabling people to do things for themselves as far as possible. Some people told us they would have liked to hear more about electric and computerised aids and devices (assistive technology). Assessments were well focussed and full, and help provided was reviewed on a regular basis.

Older people's case records were well kept. Care plan and review documentation was supplied to service users. Some care plans would have benefited from a wider focus on peoples interests rather than simply being a checklist of tasks for care providers.

Carers' assessments were overwhelmingly done jointly with those of the person being cared for. We found less than 2 per cent of carer's assessments were stand alone. There was a need to develop carers' assessments and services in their own right.

Public information was well written and developed in conjunction with readers' groups. However, many people told us that getting straightforward initial information

about how to access services and what was available was the hardest part. This included being given too much to take in at once, such as on hospital discharge. People we spoke to found it difficult to find their way around the website which mirrored our own experience. Some older people suggested the council could offer some courses in how to make best use of computers.

There was an acknowledged shortfall in the use of advocacy for older people but active promotion of a newly commissioned service had resulted in a recent rise in the number of self-referrals.

People who use services and their carers are able to have a social life and to use mainstream local services. Local service providers, including transport, healthcare, leisure, shops and colleges, adapt services to make them easier to use.

Darlington town centre was pedestrianised and accessible with the bus terminal in the central market square. The council had helped fund a range of accessible information services near or around the market square such as CVS, Age Concern and the Darlington Action on Disability. Some provided significant services on behalf of the council and all were well regarded as helpful.

There was a large range of fitness and health based programmes, many of which also had social benefits. The falls clinic was cited frequently as providing good social contacts as well as health advice. Activities included a well publicised and well attended outdoor tea dance managed by the voluntary sector and held in the market square. Age Concern ran a 'Fit as a Fiddle' scheme. The Dolphin swimming baths and fitness centre, also in the market square, provided some free and low cost activities for older and disabled people. The Live Darlington programme was well publicised and gave some carers free access to leisure facilities. Contracts for care homes required exercise and social activities programmes.

There was good support to enable people to stay at home and access mainstream facilities. One older person commented:

"I have been very satisfied with my care workers, I find them helpful and they give information quite happily."

There was good use of extra care housing, assistive technology and occupational therapy. Darlington runs four extra care housing schemes. The one we visited was new build, with large rooms. Staff were enthusiastic staff and there was an active residents committee and usually full attendance at residents' meetings. Services were provided by an in house team, which residents trusted.

Some older people told us they did not feel safe in the town at night and that this limited their opportunities to participate, for example in going to the Civic Centre theatre. One person wrote:

"I never go out alone. I do not know who to contact for help."

There was a need to consult with older people about ways to make them feel safer and enable wider use of the town centre at night. A few people also told us about harassment at home by young people which they were reluctant to report.

Some people's quality of life was severely restricted by lack of independent mobility, both inside and outside their homes, and long waits were reported for appointments at the wheelchair clinic. One person wrote:

"*Not being able to have a motorised wheelchair for independent use and the lack of a social life of any sort."*

One woman had a kitchen adapted through the OT service but was unable to move into it without a carer, as she lacked a wheelchair she could propel herself. We also met a stroke victim who was unable to get about independently as the wheelchair he was given was unsuitable for self propulsion. These situations represented a lack of effective joint working with the health provider.

Poor public transport was widely cited as a hindrance to people engaging in social and shopping activities and in getting to hospitals. This had deteriorated with the recent monopoly by one bus company, and the dropping of less profitable routes, despite significant investment by the council to offset the problems by subsidising some routes.

People who have complex, intensive, or specialised support needs and their carers are supported. They have a choice in how and where they are supported.

"Social services have been excellent. The fact that there have been 3 different care workers in 10 months has been a cause of slight concern."

Older people and their carers reported favourably about the help they received. People received prompt and appropriate responses. Assessment documentation was generally sound. Detail was sometimes lost when assessments were translated into care plans, which typically concentrated on social care tasks at the expense of a wider holistic approach. Assistance provided was designed to maintain or restore independence, and restore confidence. Social work staff had a sound appreciation of many information sources and services. This knowledge about local opportunities could have been better used by some staff in making greater use of community services, rather than using day care.

There was a structured review process in place which was inclusive of older people and worked well, Key interests were included. Better links might be made with the overview assessment structure and notation to ensure there is a continued focus on meeting holistic needs.

There were some good specialised services. The older people's mental health team

was a large integrated service although hindered by some lack of resources and discrepant access to IT, which compromised potential for joint work across disciplines. The council's largely residential intermediate care service was positive and purposeful. Services for older people with visual, hearing and dual sensory impairments were impressive for a town of Darlington's size although there was still an acknowledged shortfall in resources.

Development of a new short-term enablement service, funded by Supporting People resources to help to older people in temporary need of housing-related support was well-conceived, although its links with wider Intermediate care services needed clarification.

There was a range of dedicated social facilities and efforts were made to encourage and facilitate participation in mainstream activities.

"I have been helped to be independent by my determination coupled with the advice and help I have been given."

We visited a high quality specialised day service run by MIND, although its usefulness was restricted by limited transport. MIND had made effective use of the church hall facility with imaginative decoration and activities. There was a well regarded carers group attached, which was described by one person as "real life saver". Social facilities for people with sensory impairments were varied. Hospital discharge for older people was effectively managed through the discharge management team who are based at the Darlington Memorial hospital, although its dependency for referrals from ward staff meant some patients were missed.

There was an acknowledged need to improve the quality of life for older people in care homes, end of life services, and for people in nursing homes.

One person told us:

"I have had very little help in the independence category, although the care home does an adequate caring job my social life is nil. I sit hours each day on my own."

The current use of direct payments for older people was modest and largely used to solve problems with independent providers, suggesting a more robust approach to some care providers is needed. There is a need not only to increase the use of direct payments, but also to provide more individual and innovative solutions for both older people and carers in their own right.

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 had been political stability for a number of years, in a small authority which had managed within its budget. There was a commitment to thin down management and move resources to the front line. There was political sign up to innovation and more choice, although the transformation agenda was still at an early stage.

At the time of the inspection there was a significant leadership gap created by the vacancy of the assistant director for adult social care and health. This was being addressed on a holding basis by the director of housing overseeing the role while discussions were held with the PCT about possible reconfiguration. Some work had slowed as a result. We understand that this temporary position has been made permanent since the inspection enabling clear decisions to be made on ways forward.

The Council were behind the pace in a range of areas of service development. We found some dated ideas around carers' assessments, direct payments, individual budgets, community equipment and using mainstream facilities. A stronger line on modernisation was needed to challenge some orthodox thinking. This was now emerging.

We found a tendency to compare performance with other councils in the north east, which limited horizons. In line with the status of a three star council, there was a need to develop a broader, more national outlook with a better focus on sites of excellence.

The older people's partnership board was struggling to be more effective. It had not been meeting regularly and there was a lack of clarity about its role and accountability although it had some success with a small project to improve energy efficiency. It had a very low profile and played little role in monitoring delivery of the older people's strategy. We understood that the recently appointed Joint Commissioner would be developing a work stream to improve this position. The Board had also arranged dedicated time shortly to review its remit and accountabilities.

The Darlington Safeguarding Adults Board had secured senior commitment from

most key agencies and was moving to establish a clear programme of work. We found some lack of clarity among board members about its priorities, and about its relationship with other scrutiny and management functions.

At the time of the inspection the Darlington Safeguarding Adults Board was producing a three year strategic plan for safeguarding (2009-2012) and had decided not to produce a separate annual report. This strategic plan was still in draft form at the time of the inspection and lacked a well developed action plan. Data collection and its analysis were in need of refinement to ensure the Board was well equipped to deliver its multi-agency remit.

We found a lack of trend analysis or cross-referencing to make better sense of data. Lessons were not routinely drawn up from reviews of cases, nor was there a clear forward plan. A better understanding and explanation was needed about key issues which were suggested by the data, but had not been interrogated. Such as referral source, numbers of substantiated cases and numbers of prosecutions. The focus on carers in safeguarding data needed to be strengthened.

A serious case review had been commissioned by the Darlington Safeguarding Adults Board in late 2008 following a death of a client from a neighbouring authority in a care home. This had resulted in a number of recommended actions for partner agencies. Some of these had been completed and a review of progress was nearing completion at the time of our inspection. Key shortfalls were within the health community around training and GP engagement.

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.

Darlington council engaged well with older people around service development and quality. This was largely through the Growing Old and Living in Darlington (GOLD) organisation, which was well established and jointly funded. GOLD itself had a draft plan to widen its scope to involve harder to reach groups.

Some key plans were in place and signed off, such as the community strategy, older people's strategy, carers' strategy and the older people's mental health strategy. Business planning was developing in these areas, although the approach was uneven and there was scope to learn from the better action plans and monitoring systems, such as the Carers' Strategy Steering group. Others were still in draft such as the Commissioning for Citizenship and the safeguarding team plan.

Joint planning with the PCT was underdeveloped. Some plans seemed unrealistic and were not being achieved. We found ambitious joint planning around the integration of adult social care and health, which had made little progress since being drawn up.

There were recognised areas of duplication with health care services. Intermediate care still ran as two separate health and social care services. This was despite frontline staff's efforts to align approaches and longstanding commitments to integrate provision.

Discussions had taken place recently to make progress on re-ablement, with a 'framing half day' held during the time of the inspection, but this lacked high level representation and had yet to result in any firm plans. The new enablement service's links with adult social care were capable of being developed. Its assessment and review procedures might be closely aligned and its operation enhanced by incorporation within a wider intermediate care service.

A framing day to develop a single point of access for social care and health had been held in February 2009, without evidence of progress since. In July 2009, Northgate Kendric Ash consultancy agency had been brought in to address some of these issues, as well as escalating spend and to deliver efficiency savings. The work was still in its preliminary stages at the time of the inspection. It was too early to judge its effectiveness and PCT sign up was unclear.

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

Council staff had access to good training and development opportunities and were kept briefed by transformation staff about future developments. Staff had appreciated this engagement and were positive about early work in this field. Supervision was regular, appraisal considered helpful and turnover relatively low. Sickness levels were an issue and were being addressed.

Workload pressures were commonly cited. There may be value in considering the balance of workloads across social care personnel in respective social care teams. Staff would have appreciated more time for reflective practice, which would help improve the quality of work.

There were what a senior manager described as "pockets of work" around integration, to make best use of workforce in social care. However, the Council and PCT did not have a joint workforce strategy despite recognised areas of duplication and inefficiency.

The council had recognised the insufficiency of resources to address the safeguarding agenda. This had resulted in considerable recent activity, including a new safeguarding team; adoption of procedures around safeguarding and serious case reviews. While yet to be fully embedded, the new procedures were widely welcomed by partners as bringing greater clarity to the system.

The new safeguarding team had yet to establish itself, its work plans or priorities for the forthcoming year. We were not confident the team would deliver the range of expectations placed on it. Senior staff are aware of the need to ensure capacity and capability if the team is to provide the necessary leadership and quality oversight.

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

Operational oversight of older people's services was sound, with a wide range of quality mechanisms in place so that senior staff understood what was happening at the front line. These included regular meetings with service managers, social care forums where services are health based, case file audits and quarterly briefing with the portfolio holder.

Council policy requires that problems with home care providers are shared with contracts staff. However, we found some case files which were not compliant with this and did not record such problems.

There was a tendency for the Council to overstate some of its achievements. Where this occurred it gave an unrealistic picture of what needed to be done. We found some claims by the Council about levels of performance which it could not robustly substantiate. For example, the policy intent around single assessment had not been delivered in practice. Although yet to start, some activities of the new safeguarding team were presented as already embedded, such as the monthly meetings with the MCA adviser and close working with children's services.

We found the council well sighted on national performance indicators but there could have been a better focus on more local issues. For example, performance on quantifiable targets in the carers' strategy was mixed. Elected members were unaware of any local performance targets. For example, a local PI might measure the time between referral for OT service and face-to-face contact. We understand a set of local indicators around the housing and OT services is being drawn up to improve performance around adaptations. This practice could be broadened to other areas arising from consultations with older people about what makes a real difference to them.

Quality management around safeguarding was weak. Beyond supervision, we found no robust systematic evaluation of the quality of work or a system of review to drive improvement. Council managers' own evaluations of the quality of safeguarding were largely uncritical and suggested a need for a stronger approach. Conclusions shared with us that the quality of work in safeguarding was variously "excellent," "outstanding" and "amazing" were not supported by evidence we saw.

There was no regular review system in place with and by team managers of safeguarding issues. In the absence of any formal system, there was some pragmatic work between some council team managers to review quality of work or learn lessons, which should be formalised, extended and key messages disseminated.

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 engaged well with older people and carers in developing and assessing the quality of its services. There was a good focus on development needs around carers, and a range of new initiatives had been identified.

Joint working needed improvement. There had been considerable change in both Durham and Darlington PCT governance and respective responsibilities in the past few years creating a degree of frustration about inability to secure agreements and resources to move forward. There was a need for a better understanding among statutory commissioners about respective budgets and resource commitments. We found some reciprocal doubts and mistrust about fairness which may hinder progress.

Medium term workforce planning with the PCT was absent. We found parallel development of services and some inefficient use of scarce skills. There was a need to move towards a single intermediate care service across health, housing and social care. Current operational delivery was hindered by a continuing health and social care divide. This has adverse consequences for some people, as well as being poor use of resources. For example, people have been placed in expensive nursing home provision, as district nurses have not been able on occasions to use vacancies in adult social care provision.

The council had recognised that a more streamlined structure for working with the independent sector was needed. The Independent Sector Provider Group (ISPG) had become dominated by the interests of care home providers. This had been a longstanding issue, in which original inclusive ambition had not been mirrored in ISPG operations. Plans to develop more sector-specific work streams had been agreed and were just being implemented.

We saw a mixed picture in how well teams planned their work, suggesting a need to ensure that all front line teams have plans in place which feed the developmental agenda.

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.

A joint strategic needs assessment had been produced, with a comprehensive information base which could be built upon to underpin commissioning intents, although it had yet to make much impact. It was intended that data from an updated JSNA would inform the community strategy when it is revised in 2011. Joint commissioning intent was unclear.

The Council and PCT have worked jointly on revised contracts around domiciliary care to reflect both their interests. This was the subject of a recent tender exercise. The council has moved to extensive use of three year contracts with third sector providers, and there is regular contract monitoring in place.

The efficiency of the equipment service could be improved from a service user perspective. While performance on the national indicator for delivery of equipment was good, this did not include fitting or instructions about use. The Council could explore the use of trusted assessors to streamline the service. There were some anomalies which could be addressed to improve outcomes for older people, such as the inability of some health partners to access equipment. Work responding to the national transforming community equipment initiative, designed to give greater consumer choice, was in its very early stages.

Contract monitoring has a clear focus on aspects of quality, made very explicit with regulated providers, and reported on systematically.

We found a number of instances where working practices were inefficient and time consuming as a result of poor IT configuration, access provisions or support. In some teams, effectiveness was compromised by dual IT systems, without shared access.

Appendix A: summary of recommendations

Recommendations for improving performance in Darlington

Safeguarding adults

The council and partners should:

1. Develop more robust quality oversight to ensure consistent professional standards of work are achieved. (Page 11)
2. Extend training to a wider range of people, including those outside the social care and health sectors working regularly with vulnerable adults. (Page 11)
3. Give particular focus to understanding issues and improving safeguarding for people with learning disability, both as potential victims and perpetrators. (Page 12)
4. Improve standards of record keeping to ensure they are an accurate representation of events, actions, decisions, monitoring and formal determination of the outcomes. (Page 11)
5. Work with the police to ensure referrals to them are timely and appropriate, to improve the ability of the police to respond effectively. (Page 11)

Improved quality of life for older people

The council should:

6. Consult further with older people about ways to make them feel safer. (Page 15)
7. Work with partners to improve peoples' independent mobility including better wheelchair provision and better public transport. (Page 15)
8. Improve the dissemination of information to people at the time they need it. (Page 13)
9. Develop assessments and services for carers in their own right. (Page 13)
10. Increase the use of self directed care, including direct payments to provide more individual and innovative solutions for both older people and carers. (Page 16)

Providing leadership

The council should:

11. Be more realistic about its achievements and develop wider, more national benchmarking of its progress. (Page 18)
12. Ensure that the Darlington Safeguarding Adults Board has senior commitment from all key agencies and that a clear programme of work is established. (Page 18)
13. Strengthen quality management around safeguarding so that staff across agencies have a better understanding of what works well and what needs to be improved. (Page 20)
14. Ensure that council leaders take a stronger line on modernisation to increase the pace of change. (Page 17)
15. Develop and act on more local performance targets, which reflect local priorities. (Page 20)

Commissioning and use of resources

The council should:

16. Improve joint working, among statutory commissioners around respective budget, workforce development and resource commitments. (Page 21)
17. Improve the efficiency of the equipment service from a service user perspective. (Page 22)
18. Develop a more streamlined structure for consulting with the Independent sector. (Page 21)
19. Ensure that all front line teams have plans which feed the developmental agenda. (Page 21)
20. Improve the quality of IT systems and support, enabling electronic communication between agencies. (Page 22)

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 5 days in Darlington Borough Council when we met with 8 people whose case records we had read and inspected a further 12 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 25 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.

Darlington Borough Council 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.