

Performance Inspection

City of Edinburgh Council 2008

Performance Inspection of Social Work Services

City of Edinburgh Council 2008

Acknowledgement

We wish to thank the City of Edinburgh Council's staff, stakeholders and service users for the warm welcome that they extended to us at all stages of this inspection. We are grateful to those who took the time to fill in and return our questionnaires. We would also like to thank the staff of Edinburgh who helped us to carry out the case file audit at the beginning of the inspection process. We found those we met during our fieldwork had prepared well for our visits and responded openly to our questions. Edinburgh's inspection co-ordinator and his colleagues deserve particular praise for their co-operation generally, but particularly for the Self Evaluation Questionnaire, and the remarkably efficient organisation of the complex timetable for the 146 inspection sessions over two weeks of fieldwork.

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Contents

Chapter 1	Summary, evaluations and recommendations	1
Chapter 2	Context	7
Chapter 3	Outcomes for people who use services	12
Chapter 4	Impact on people who use services and other stakeholders	19
Chapter 5	Delivery of key processes	30
Chapter 6	Management	47
Chapter 7	Leadership and direction	85
Chapter 8	Capacity for improvement	91
Appendix 1	SWIA performance inspection model (PIM)	93
Appendix 2	SWIA performance inspection methodology	94
Appendix 3	SWIA performance inspection process	95
Appendix 4.1	Department of children and families organisational chart	97
Appendix 4.2	Department of health and social care organisational chart	98

Social Work Inspection Agency

The Social Work Inspection Agency (SWIA) is undertaking performance inspections of all Scotland's council social work services. Each inspection focuses on the approach to continuous improvement of the council.

SWIA will monitor the implementation of the recommendations made in this report and will undertake a short follow-up inspection one year after the publication of the report.

SWIA uses a six-point scale in its inspection of council social work services. In this report the inspection team has provided an evaluation in relation to each of the 10 areas for evaluation of the performance inspection model (PIM), as set out in appendix 1.

The evaluation scale

Level	Definition	Description
Level 6	Excellent	Excellent or outstanding
Level 5	Very good	Major strengths
Level 4	Good	Important strengths with some areas for improvement
Level 3	Adequate	Strengths just outweigh weaknesses
Level 2	Weak	Important weaknesses
Level 1	Unsatisfactory	Major weaknesses

The report uses the following words to describe numbers and proportions when we quote findings from our surveys or from our file reading exercise:

almost all	90% or more
most	75% to 89%
majority	50% to 74%
less than half	35% to 49%
some	15% to 34%
a few	14% or less

The comments and evaluations made in this report are based on evidence that has been substantiated from a wide range of sources – that is they are triangulated.

We use quotations from people only where they illustrate widely held perceptions. They are not the views of just one person.

The full set of results for the City of Edinburgh from the file reading, and from the surveys of service users, carers and staff, is available on the SWIA website at www.swia.gov.uk. Corresponding results for the other authorities which have been inspected so far are also available.

Summary, evaluations and recommendations

Summary

The inspection found that Edinburgh was improving outcomes for some service users, but needed to improve outcomes particularly for people with learning disabilities, children in transition, and those receiving home care.

Most people who received services agreed they were of good quality, and more carers were being assessed in their own right. Edinburgh social work services worked well with the community they served, encouraging volunteering and striving to consult with stakeholders.

Staff enjoyed their work but morale in the departments of children and families, and health and social care was low. There were early signs that this position might be improving. Both departments performed well in attracting and supporting staff, and encouraging staff development.

Both departments faced challenges in delivering services appropriate to the needs of the people who used services. They needed to improve performance on reducing waiting lists in some areas, and in providing services more quickly. Some people who needed services were waiting considerable times for the service.

The development of integrated services is vital to the delivery of good care in children and families, and health and social care. Some progress, albeit slow, was being made and modernisation strategies were either in place or being developed in home care, learning disability services and mental health services.

There was a growing culture of quality assurance in both departments. Both departments had problems because of budget constraints and faced serious challenges to improve services in this climate. Recent changes in leadership in elected members and senior managers, coupled with support from the chief executive, gave cause for optimism that improvement identified could be taken forward.

Ratings for the 10 areas of evaluation

Area for evaluation	Rating
Outcomes for people who use social work services	Adequate
Impact on people who use social work services and other stakeholders	Adequate
Impact on staff	Adequate
Impact on the community	Good
Delivery of key processes	Weak
Policy and service development, planning and performance management	Good
Management and support of staff	Good
Resources and capacity building	Adequate
Leadership and direction	Good
Capacity for improvement	Good

Recommendations

Outcomes for people who use social work services

Recommendation 1

The service should continue to build on progress made to ensure that it provides the Scottish Children's Reporter Administration (SCRA) with reports within the required timescales.

Impact on the community

Recommendation 2

Health and social care should take action to ensure that service users are routinely invited to review meetings.

Delivery of key processes

Recommendation 3

Children and families services should ensure that clear and consistent arrangements for allocating and reviewing work, and for measuring and monitoring its workload, are in place, and that these systems operate effectively. It should ensure that all children who are looked after and accommodated have an allocated social worker.

Recommendation 4

Children and families should take steps to improve permanency planning for looked after and accommodated children.

Recommendation 5

Social work services should ensure its quality assurance arrangements for assessment and care management include action to ensure that all service users have a care plan which is reviewed at appropriate intervals, and that front-line workers and managers are aware of their professional responsibilities in assessment and care management.

Recommendation 6

Both departments should ensure that all applicable files, where issues about the protection of the service user have been identified, have an up-to-date risk assessment and risk management plan.

Recommendation 7

Health and social care should ensure that adult protection procedures are properly adhered to by all staff.

Recommendation 8

Both health and social care, and children and families services should ensure that systems are in place, understood by staff and fully operational, to pro-actively review the needs of people who they are not providing a service to due to resource constraints.

Policy and service development, planning and performance management

Recommendation 9

The council should fully embrace the personalisation agenda for people with a learning disability. As a matter of urgency, it should bring forward funded plans to address the housing and care needs of those waiting for services, including those in hospital. Carers should be appropriately supported while they are waiting. It should also ensure that a local strategy and commissioning plans are produced, to ensure that people with learning disabilities and their carers achieve greater integration in the community.

Recommendation 10

Children and families, and health and social care should work together to improve services for children in transition.

Management and support of staff

Recommendation 11

Children and families should draw together all the elements of its workforce strategy into a readily understood and comprehensive development plan.

Resources and capacity building

Recommendation 12

In order to facilitate forwarding planning and identify and plan for potential future cost pressures, the council should ensure that service plans, particularly children and families, are clearly linked to and fully supported by available resources as identified in detailed financial plans.

Recommendation 13

Departmental management and elected members should ensure that prompt action is taken to resolve significant budgetary overspends. This is particularly crucial where the council has virtually no reserves available to fund any such overspends. Planned savings should only be considered where they have a reasonable chance of being achieved.

Recommendation 14

The council should ensure that regular financial monitoring information is formally submitted to members in relation to services provided within partnership arrangements and that the appropriate officers also consider such data at their joint meetings.

Recommendation 15

Both departments should strengthen health and safety arrangements to ensure consistency and fitness for purpose in distinctive social work settings.

Recommendation 16

Senior managers in children and families should take early action to improve management information, so that managers at all levels receive regular performance reports and demonstrate the capacity to use these to drive up performance.

Recommendation 17

Both departments should develop their strategic commissioning of services. They should ensure that there are written, costed commissioning strategies which provide information about preferred models of care, unit costs of services and commissioning intentions. There should be more positive engagement with providers, and the findings of the recent review of contracting arrangements should be acted on at an early stage.

Context

Introduction

The inspection of the City of Edinburgh council's social work services took place between July and October 2007. Our inspection team consisted of Social Work Inspection Agency (SWIA) inspectors, an associate inspector, and a lay/carer inspector.

During the inspection, we read a wide selection of material about the council and the social work services it provided or commissioned. We analysed questionnaires received from staff, adults who use services, carers and stakeholders. Together with some staff from the council's social work services we read 150 case files. The team then spent a further 10 days in Edinburgh looking at services as part of a fieldwork exercise.

During fieldwork, we spoke to people who use services, their carers and people who were responsible for delivering or arranging services. We met with representatives from a range of organisations and groups as well as elected members and other stakeholders. We also visited places providing social work services and people's homes when they received services there. As a result, we collected an extensive range of evidence which informed the content, evaluation and recommendations contained in this report.

This report is not a detailed description of all the social work services in Edinburgh. It gives an overview and concentrates on the work being undertaken with people who need assistance and the areas where improvements are needed. It does not duplicate the inspection of services which are regulated by the Scottish Commission for the Regulation of Care (Care Commission) and Her Majesty's Inspectorate of Education (HMIE). In order to achieve this, the Care Commission and HMIE provided us with information about their inspection reports from Edinburgh.

Area profile

The City of Edinburgh has a population of 463,510, which is the second largest population of the 32 authorities, and covers 264 square kilometres¹. With a population density of 1758 per square kilometre, Edinburgh is the third most densely populated authority in Scotland. The population of Edinburgh has increased by 2.2% since 2000, while overall Scotland's population has increased by 0.04%¹.

From the 2004-based population projections, the population of Edinburgh is due to increase by 5.0% by 2014 and increase by 9.6% by 2024. The equivalent Scotland figures show an increase of 0.9% by 2014 and an increase of 0.8% by 2024².

1 Mid-2006 population estimates, General Register Office for Scotland

2 2004-based population projections for Scottish areas, General Register Office for Scotland

Chapter 2: Context

In Edinburgh, 67.8% of the population are of working age. This compares with a Scotland figure of 62.8%¹. The dominant employment sectors are retail, finance, and other service sectors including public administration, education and health³. The working age population of Edinburgh is due to increase by 6.2% by 2014 and increase by 11.6% by 2024. The equivalent Scotland figures show a decrease of 0.8% by 2014 and a decrease of 1.0% by 2024¹.

The claimant count unemployment rate in Edinburgh is 2.4% which compares with the Scottish average of 2.7%³.

The percentage of Edinburgh's population under the age of 16 is 15.2% which compares with Scotland's figure of 18.0%. Edinburgh's under 16 population is due to decrease by 3.9% by 2014 and increase by 3.4% by 2024. The equivalent Scotland figures show a decrease of 9.7% by 2014 and a decrease of 12.4% by 2024¹.

Seventeen per cent of the population are of pensionable age (the Scotland figure is 19.2%). Edinburgh's population of pensionable age is due to increase by 8.3% by 2014 and increase by 7.6% by 2024. The equivalent Scotland figures show an increase of 16.8% by 2014 and an increase of 19.3% by 2024. More specifically, Edinburgh's 75+ population is due to increase by 6.7% by 2014 and increase by 25.2% by 2024. The equivalent Scotland figures show an increase of 18.8% by 2014 and an increase of 53.3% by 2024¹.

Political representation

The City of Edinburgh is split into 17 wards and has a total of 58 elected members. The political representation consists of the following:

Scottish Liberal Democrat	17
Scottish Labour	15
Scottish National Party	12
Scottish Conservative	11
Scottish Green Party	3

Organisation of social work services

Social work services in Edinburgh are organised in two main service areas – health and social care, and children and families. The directors of these service areas report to the chief executive, and both departments draw on corporate council services in the areas of finance, human resources management, legal services and safety and risk.

³ Labour market statistics – local economic profiles, Scottish Government

The current structure of the children and families department was established in April 2007 (see appendix 4.1) with the director of children and families having responsibility for six service areas within the department:

- neighbourhood services;
- service development (social work);
- support for children and young people, and families;
- quality development;
- strategic planning; and
- infrastructure and support.

Approximately 7,307 staff are employed by the council in the children and families department with the largest group (49.3%) in teaching⁴.

The department of health and social care brings together the City of Edinburgh council's adult social care services and Lothian NHS board's City of Edinburgh community health partnership services, under one joint director and joint senior management team.

The director of health and social care is responsible for five service areas within the department:

- strategic planning and commissioning;
- social care performance;
- sector services;
- quality and standards; and
- community health partnerships.

In health and social care there are 4,120 staff employed in adult social care with the largest group (39%) working in the home care service⁵.

Appendix 4.1 and 4.2 contain diagrams of the structure of social work services.

4 Full-time equivalent staff in post as at 9 November 2006, Children & Families Service Plan 2007-10, City of Edinburgh Council

5 Health and Social Care Service Plan 2007-10, City of Edinburgh Council

Inspection methodology and process

The structure of the report is based on the SWIA performance inspection model, which asks six key questions:

- 1. What key outcomes have we achieved?*
- 2. What impact have we had on people who use our services and other stakeholders?*
- 3. How good is the delivery of our key processes?*
- 4. How good is our management?*
- 5. How good is our leadership?*
- 6. What is our capacity for improvement?*

The following chapters address each of these questions in turn.

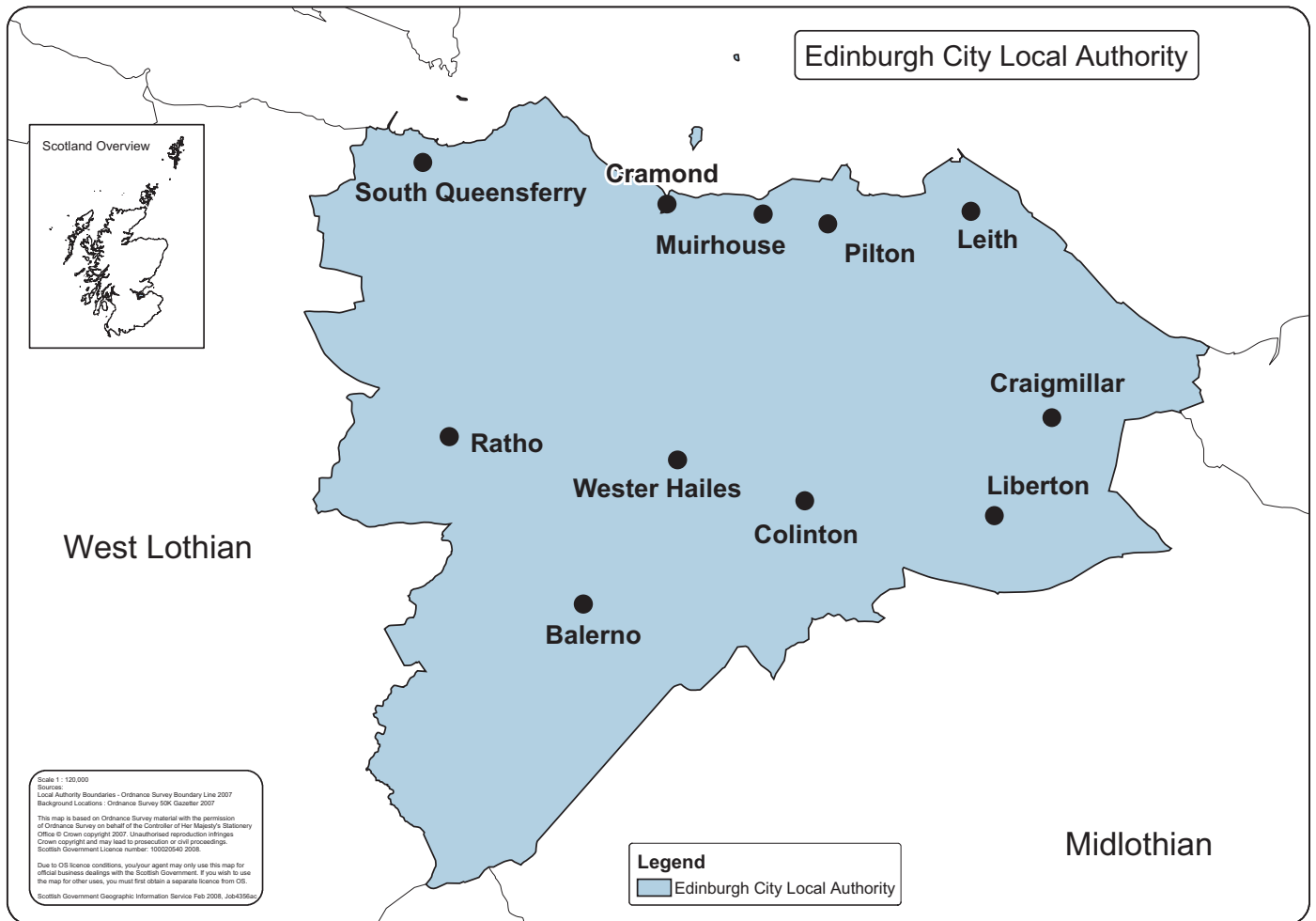
A more detailed description of the inspection methodology and the way in which we carried out our inspection are included in appendix 2.

Criminal justice services

The inspection of criminal justice services in the City of Edinburgh was carried out in 2005 as part of the inspection of Lothian and Borders criminal justice social work services.

A full report on the findings of this inspection is available from SWIA at www.swia.gov.uk

Fig. 1: Map of the City of Edinburgh



CHAPTER 3

Outcomes for people who use services

Social work services performed to an adequate standard in achieving positive outcomes with strengths just outweighing weaknesses.

We define outcomes as the direct benefits in people's lives from the services they receive. People who used the services were mainly positive about the difference these had made to their lives. Carers expressed more reservations.

The services had gathered a range of performance information which offered an indication of the likely outcomes for people who used their services. The health and social care department had more developed reporting systems than children and families. The information showed that there had been some improvement in the level of educational attainment for looked after children. There had also been improvement in meeting the targets for the delayed discharge programme.

The services needed to improve outcomes, particularly for people with learning disabilities, people who required care at home, overnight respite for older people, and children and young people with disabilities. They also needed to continue to improve their performance in submitting reports to the children's reporter on time. Data errors needed to be addressed in children and families to ensure that performance monitoring was as robust as possible.

Outcomes for adults, carers, children and families who use services

Measuring outcomes

In common with most local authorities Edinburgh's social work services had not yet routinely measured outcomes across all care groups. Nevertheless, they produced a reasonable amount of performance information which provided an indication of the likely outcomes for people who used their services. The two departments of health and social care, and children and families produced annual reports on performance and quarterly reports related to strategic priorities.

In chapters 5 and 6 we discuss what outcome information told us about how well services were working.

Views of people who use services and carers

In our surveys, the majority of service users stated that social work services had helped them feel safer and lead a more independent life. Just over half agreed that social work services helped them feel part of the community. This was among the lowest level of agreement in our inspections to date.

Most carers who responded to our survey agreed that social work services had improved the quality of life of those cared for. More than half of the carers who responded agreed that they had been helped to have time for family, work and other commitments.

File reading analysis

Overall, the findings of our analysis of case files were positive:

- there was evidence that social work services had achieved or were in the process of achieving the objectives set out in the care plan in most of the files;
- in the majority of the files there was evidence that the individual's circumstances had generally improved in the period under scrutiny; and
- in a quarter of the cases individuals had become more independent and in around a third of the cases more dependent on social work services. In most cases this seemed in keeping with their needs.

Looked after children

Edinburgh had 1,196 looked after children on 31 March 2006. This was equivalent to 13.8 per 1,000 of the population aged 0-18 while the figure for Scotland was 11.6 per 1,000. In common with other local authorities over the years 2001-06 there had been a steady increase in the number of looked after children per 1,000 population aged 0-17 years but the increase had been less in Edinburgh (13%) than the Scottish average (19%). Of the 1,196 children who were looked after in Edinburgh, 21% were under the age of five, which was higher than the Scottish average of 18%. Many of these young children had suffered the effects of parental substance misuse and Edinburgh had estimated that 40 newborn babies would be accommodated in the current financial year.

Of the children looked after as of March 2006, 89% were accommodated in community settings and 11% were in residential care. This compared favourably with Scotland as a whole. The percentage of Edinburgh children being accommodated within residential settings had increased from 9% in the previous year. There were 20 children on the waiting list of the accommodated children's review team (ACRT) at the time of the inspection.

Of the 715 children living away from home on 31 March 2006, 80% had been in their placement for one year or more, the Scottish average being 74%. Twenty-four per cent had been in three or more placements, while the Scottish average was 29%. Both of these numbers had increased, after decreasing the previous year.

Care Commission reports over the past two years indicated that young people's centres provided a good and improving quality of service for young people.

Educational attainment

In recent years Edinburgh has been focusing its attention on improving looked after children's educational attainment in the four secondary schools with the highest number of looked after children. Edinburgh had been improving educational attainment for looked after children, though from a low baseline.

Chapter 3: Outcomes for people who use services

In 2005-06, 58% of leavers looked after away from home obtained at least one qualification at Scottish Credit and Qualifications Framework (SCQF) level three or above (compared to a national average of 57%). This was an increase of 7 percentage points from the previous year's figures.

The picture was similar for leavers from care at home. In 2005-06, 46% obtained at least one qualification at SCQF level three or above. This was just above the national average figure of 45% and an increase of 7 percentage points from the previous year's figures. In the same year only 33% of all care leavers obtained qualifications in Maths and English at SCQF level three or above, in line with the Scottish average of 34% and an increase of 10 percentage points from the previous year.

Throughcare

Effective throughcare makes a difference to the prospects of young people leaving care. Edinburgh kept in touch with young people but could have done more to ensure that more had a pathway plan.

In 2005-06, 100% of care leavers were still in touch with social services, which was higher than the Scottish figure of 85%. However during the fieldwork there were 80 young people waiting for a service from the throughcare and after care team. For the same year, 90% of care leavers with known economic activity were in education, employment or training, which was significantly higher than Scotland's figure of 37%.

National figures showed that of the 123 care leavers in Edinburgh in 2005-06, 31% had a pathway plan and 93% had a pathway co-ordinator. The national figures were 52% and 60% respectively. While Edinburgh reported an improvement in the numbers of those receiving a pathway plan, they need to continue to improve on this.

Children with disabilities

In relative terms, Edinburgh performed well on indicators for provision of short breaks for children and young people with disabilities. It was ranked one out of 32 on the amount of daytime respite provided per 1000 of the population, although its performance was not good in relation to daytime respite not provided in day centres where it was ranked 27. Information obtained during the fieldwork revealed that there were 56 children on a waiting list for respite care at that time, and many had long waits for a service.

Scottish Children's Reporter Administration (SCRA)

Services should provide SCRA with timely assessments and reports on children and young people in need or at risk to themselves or other. In 2005-06, 39% of Edinburgh's reports to SCRA were submitted within the target timescale which was higher than the Scottish average of 36% and 4% higher than the previous year. In 2006-07 the number of reports submitted within the timescale was 27%, which was lower than the Scottish average figure of 34%. This issue was being addressed as part of the department's improvement plans.

Recommendation 1

Children and families services should continue to build on the progress made to ensure that it provides the Scottish Children's Reporter Administration (SCRA) with reports within the required timescales.

Youth justice

The youth justice team acknowledged that they were at an early stage in monitoring outcomes. Since 2003, Edinburgh had consistently been well below the national average in the number of children referred on offence grounds, as a percentage of the population aged 8-16. In 2006-07 the figure was 1.9%, while the Scottish figure was 2.9%. This suggests good joint working with other agencies, particularly the police.

The number of qualifying persistent young offenders referred in Edinburgh was 89 in 2003-04, 90 in 2005-06 and 103 in 2006-07. This represented an increase of 16% from the 2003-04 baseline, meaning that Edinburgh had not met the national target to reduce the number of persistent young offenders by 10% in 2006-07.

Child protection

The recently published HMle joint inspection report on services to protect children and young people in Edinburgh particularly highlighted the need to improve outcomes for older children and young people who were referred.

Edinburgh had a higher than average rate of child protection referrals. During the year 2006-07 there were 1018 child protection referrals which was equal to 14.5 per 1,000 population aged 0-15, while the figure for Scotland was 13.0. The high referral rate was seen as related to increased parental substance misuse, greater awareness by professionals and the public of the risks of harm to children, and a response to critical cases which had received wide publicity.

Edinburgh had 235 child protection registrations in 2006-07 which was equal to 3.3 per 1,000 population aged 0-15 years, while the rate for Scotland was 3.4 per 1,000 population aged 0-15. In 2006-07 Edinburgh had a higher than average number of de-registrations (253) equal to 3.6 per 1,000 of the population 0-15, while the rate for Scotland was 3.3.

Older people

During the period 2004-08 the projected rise in the population of Edinburgh of people aged 65+ was 16%. However during the period between March 2000 and March 2006 there was a 14.8% decrease in the number of registered care home places for older people in Edinburgh. This compared with an overall decrease of 2.8% for Scotland.

Chapter 3: Outcomes for people who use services

This decrease in Edinburgh was a reaction to the increase in property values and the social care market's pricing policy. Despite a slowdown in the rate of decrease of care places for this group, there had been a decrease of 2.2% care places in Edinburgh between March 2005 and March 2006, while for Scotland overall it was 0.6%. During this period there was also a loss of respite overnight stay beds for older people aged 65+. In 2005-06, Edinburgh was ranked 29 out of 31 authorities in its respite overnight provision for this group at a rate of 140.2 per 1,000 population aged 65+. The Scottish average figure was 307.5.

In relation to the provision of single rooms for long stay residents, the City of Edinburgh had been making steady progress and in 2005-06 provided 93% of residents with single rooms. The Scottish average was 97%.

The home care service in Edinburgh was ranked 18 out of 30 local authorities on the total hours of home care expressed as a rate per 1,000 population aged 65+ in 2005-06. It was also ranked 31 out of 31 on the number of home care clients receiving care in the evenings and overnight as a percentage of all clients. The figure was 12% in 2005-06. The ranking for the number of clients receiving care at the weekends as a percentage of all home care clients was 28 out of 31 local authorities with a figure of 37.3%. Although there had been efforts to increase the volume and flexibility of home care provision, which had resulted in some improved performance, Edinburgh still lagged behind almost all other local authorities in its volume of service and scope of provision.

In September 2006, of those receiving home care aged 65+, 60% received free personal care, less than the Scottish average of 71%.

Delayed discharges

The council and NHS Lothian exceeded its own target of a 27% annual reduction in delayed discharges by April 2006. Further reductions were achieved by the April 2007 census. The July 2007 census indicated that Edinburgh, in common with a number of other local authorities, had experienced a dip in reductions in the summer months. However there had been significant improvement in Edinburgh's performance in reducing the number of bed days lost to delayed discharges by 95%, from 33,350 days in October 2004 to 2159 at April 2007. This improvement had been significantly enhanced by the creation of specialist teams for hospital discharge.

Joint performance information and assessment framework

The Scottish Government receives reports from local authorities and the NHS about how effectively they are working in partnership to deliver aspects of community care. In response to the partners' 2006-07 Joint Performance Information and Assessment Framework (JPIAF), the Scottish Government assessed Edinburgh's overall performance as 'steady progress' towards meeting the indicator requirements. In respect of some indicators the evaluation focused solely on services for older people. The indicator in relation to the balance of care – the proportion of people who were receiving their long-term care at home as at 2005-06 was 22.5%, which showed improvement, but did not meet the local improvement target, and was well below the national average of 35.5%.

While Edinburgh was addressing the problems in relation to services for older people, it had some way to go to deliver a service which offered an appropriate balance of care and a home care service which responded to people's needs. We return to this later in the report.

People with learning disabilities

In 2006, Edinburgh had 1,838 adults with learning disabilities known to social work services, which was equal to 4.7 per 1,000 of the adult population. This was less than the Scottish figure of 5.5 per 1,000.

In 2006, only 1% of the adults with learning disabilities in Edinburgh were using the services of a local area co-ordinator, while the Scottish figure was 10%. However, in the same year 45% of adults with a learning disability had a personal life plan, which was significantly better than the Scottish figure of 29%.

Only 11% of adults with learning disabilities had employment opportunities, lower than the Scottish figure of 16%. However 21% of adults with learning disabilities were in further education. This was higher than the Scottish average of 18%.

Only 4% of adults with learning disabilities in Edinburgh had community short breaks, while the Scottish figure was 10%. Edinburgh did not perform well in supporting adults with learning disabilities to live in their own tenancies. In 2006, 18% of adults with learning disabilities lived in their own tenancy, which was lower than the Scottish figure of 28%. There were a large number of people waiting for suitable accommodation, many of whom had been waiting over a year. We return to this in chapter 6.

People with physical disabilities

The 2001 population census found that there were 15.5% of economically inactive people in Edinburgh who were permanently sick/disabled, as opposed to 21.3% for Scotland. Edinburgh estimated that there were approximately 30,000 of its residents who had a moderate or profound disability.

There were currently four day centres for people with physical disabilities in Edinburgh which offered 352 places. In 2006, there were 289 people with disabilities attending the centres. This translates into a rate of 0.9 per 1,000 population aged 16-64, which was higher than the Scottish average of 0.5 per 1,000 population aged 16-64. We considered the services for people with physical disabilities to be traditional, and in need of modernisation. We return to this later in the report.

In relation to the supply of equipment, Accounts Commission data indicated that in Edinburgh in both 2005-06 and 2006-07, 90% of clients had equipment delivered within 24 hours to prevent hospital or care home admission. Currently 96,000 people had equipment on loan from the Community Equipment Service which had developed a number of initiatives to speed up access to equipment, including self-assessment for accessing equipment. In 2006, 614 people were supplied with equipment this way. In addition, 365 people received a fast-track service as part of the rapid response team service.

People with mental health problems

Edinburgh had recently carried out an internal self-assessment of how its mental health officer (MHO) service delivered the national standards (September 2007). Of the 82 standards, 51 were fully met, 24 nearly met and two exceeded the standards. These were: service users and carers were given accessible information about their treatment and legislation; and that they were aware of how to contact their designated MHO. It failed to meet the required standard in five areas, including inviting feedback systematically from service users; contributing to the assessment of risk and vulnerability for people subject to statutory measures; and information on MHO referrals being routinely monitored. An action plan was in place to ensure that all standards were met in full.

People with alcohol and substance misuse problems

The health and social care teams were in the process of developing outcome measures for this group, which had a low profile in both departments, though addiction had a high priority in the council. Edinburgh social work services data on addictions was largely presented through the local alcohol and drugs action team and it was difficult to identify specific social work outcomes from this data. However, 70% of the 25-30 people per year referred to residential rehabilitation by the social work team were still drug free when followed up. The Drug Referral team had begun to follow up service users three months after the completion of their programme, and this was beginning to show signs of positive impact.

Direct payments

Direct payments and the independent living fund enable people to personally manage elements of their service. Edinburgh has a funding independence team. In 2006-07, 209 clients in Edinburgh were receiving direct payments, a 38% increase from 152 in 2006, while the national increase was 25%. This was equal to 4.5 per 10,000 of the population, which was the same as the national average. The total value of direct payments in 2006-07 was £3,652,200, averaging £21,300 per person, well above the average for Scotland, which was £17,400. The assessment system was being amended to include a mandatory field for direct payments, to ensure they were considered as a standard part of an assessment. The service matching unit had a procedure to check whether a person wanted a direct payment before they became involved. The difficulties in the direct payment system were affordability in the current financial climate and the fact that the highest rate paid was lower than the hourly cost of home care.

As of October 2007, there were 283 users of the independent living fund in Edinburgh. The total number of users was equal to 6.7 per 10,000 of the population, less than the Scottish average of 7.0.

Impact on people who use services and other stakeholders

In this chapter we look at three areas of evaluation:

- impact on people who use services;
- impact on staff; and
- impact on the community.

We define impact as the direct experience of people who use or deliver social work services, or benefit from them indirectly.

Impact on people who use services

Performance in this area was adequate, with strengths just outweighing weaknesses.

Most people who received services agreed that they were of good quality and almost all that they were treated with dignity and respect. Carer assessments were increasing from a low baseline, and direct payments and independent living fund were being taken forward. While the authority had taken steps to improve information about services, people who used services and carers did not always find it easy to access this information. Users of services were not always invited to review meetings. The most common concerns about services were inconsistencies in home care provision and the lack of access to short breaks/respite care.

Experience of adults, carers, children and families who use services

Finding out about services

Half of those who responded to our survey of people who used services agreed that they found it easy to get clear information about the range of services that might help them. This was one of the lowest figures in our performance inspections to date. Around one in three disagreed. There was a general view from a focus group of older people that they did not get enough information.

Less than half of the carers who responded to our survey agreed that it was easy to get information about services, while a similar percentage disagreed. A group of carers described information as 'patchy', relying too much on the web, which many families did not have access to. This view was endorsed by a group of social work managers.

Contact

We heard of few difficulties in callers being able to get through to Social Care Direct (SCD), the contact/call centre which was the main point of access for health and social care services. However some advocacy services said that service users could find it frustrating dealing with a telephone adviser rather than a case manager. The majority of both users of services and carers agreed that they received a good response from social work services during office hours. Just over half of service users and almost 40% of carers described a good response outwith office hours, and more carers were positive than negative in this response.

Most service users and the majority of carers who responded to our survey agreed that they received help at the time they needed it, and that services were reliable. Two surveys were undertaken by the council, a “Mystery Shopper” survey of SCD in 2006, which showed a marked improvement from the previous year, and a home care user satisfaction survey from July 2006 to July 2007 which had very positive result. For instance, 89% were satisfied with the help they received, and 90% said care workers did the things the user of services wanted done. However, 55% did not have anything in writing about what their care worker was supposed to do, and 33% said they were never or hardly ever told about changes in care.

In our surveys and focus groups of service users and carers, several problems were identified. These included: cancellations of home care without prior warning, not enough time being spent on care tasks and frequent changes of home carers, especially at weekends. Some service users and carers told us that they found it difficult to communicate their needs with some agency workers whose first language was not English.

Several comments from service users, carers and stakeholders, as well as some staff, made it clear that they saw the service as ‘budget’ or ‘target’ driven rather than centred on assessed needs. Staff in the social work services, and some stakeholders, were concerned that the recent tightening of eligibility criteria in health and social care would worsen this situation.

The home care service carried out bi-monthly surveys seeking service user views and the results indicated some very positive views held. Complaints about the home care service remained consistently low at approximately eight per month for a service to around 5000 people.

Quality and choice

Most of the service users who completed our survey agreed that there was a good range of social work services for them, and that they were given a choice about the type of service they received. Carers were less positive. Less than half of the carers who responded agreed that a good range of services was available to the person they were caring for and just over half thought that the person they cared for had been given choices about the services they received. These findings were similar to the views of carers in other authorities inspected.

The majority (66%) of service users in our survey agreed they had been fully involved in deciding what help or services they should receive and that they had been given a choice (54%) about the type of service they received. The majority (70%) of carers agreed they had been fully involved in deciding what help or services the person they cared for should receive. The majority (68%) also agreed that they had a say in how things were done, which was at the higher end of the findings of inspections to date.

The most common concern about services identified in our inspection was about respite care. The difficulty in accessing respite services and the traditional nature of these services were cited as problems by carers. One carer reported that the person she cared for had been on a waiting list for respite for three years. During the fieldwork, carers and parents expressed concerns about the scarcity of short breaks available for children under aged 16 and cessation of service or poor transitional arrangements post 15 years. These parents and carers had a clear view that their children had lesser priority than those children deemed at risk.

Residential support services for people with mental health problems included service users in all aspects of planning and delivery.

Good practice example

There were three council run residential supported accommodation services for people with mental health problems. These were awarded the Charter Mark in 2007. Areas of best practice included:

- the quality of information provided to residents and potential residents;
- the use of technology including internet access for residents;
- demonstrating that the organisation listened to residents; and
- actively involving residents in planning improvements for the services.

Most respondents to the service user's survey agreed that the services they received were of good quality, and almost all agreed that they were treated with dignity and respect. For instance, a group of young people who had left care described staff as '*accessible*' and reported that '*if you phoned you would be able to speak to someone*'. They felt able to express their views. Children and families had produced two books for children who were looked after – 'The Wee Book' for younger children, and 'The Big Book' for older children – giving them information about their rights and responsibilities, the children's hearing system and other relevant aspects of their care.

Keeping people who use services and their carers involved

The majority of the service users and carers who responded to our survey agreed that their social worker or care manager responded quickly to important changes in their situation. Just over half of service users agreed that there was a meeting at least once a year to discuss services they received, while slightly less than half of carers agreed.

The majority of the service user and carer respondents agreed that they had seen a written assessment of their needs. The majority of service users also agreed that they had been given a clear care plan to describe the services they would receive. A similar percentage of carers agreed that they had seen a care plan for those they were caring for.

There was evidence from our file reading that the services had shared key information with the service users or with their representative in most (83%) of the files. In 80% of the files there was evidence the views of the individual were taken into account at each key stage. We also found that the majority (70%) of service users were invited to attend decision making meetings or reviews. This was the lowest result in inspections to date with performance in health and social care at 61% being significantly poorer than children's services (85%).

Recommendation 2

Health and social care should take action to ensure that service users are routinely invited to review meetings.

Carers

Carers have a statutory entitlement to an assessment in their own right, and this assessment should look at the level of support required by a carer to continue in their caring role. A leading carer support agency welcomed progress recently in the numbers of carer assessments but pointed out that the baseline for the years since carers had been entitled to an assessment was low. Edinburgh social work services reported that 440 carer assessments were completed in 2006-07, an average of 36.7 per month. In the first two months of the 2007-08 reporting year, an average of 48.5 carer assessments were completed each month. Carers self assessments were introduced in 2007, and there were 62 such assessments in the first four months of their availability. A third of the carers who responded to our survey had had their needs assessed as a carer.

Impact on staff

We rated the performance of social work services in this area to be adequate – with strengths just outweighing weaknesses.

Most staff from both departments enjoyed their work. However, the morale of many staff in both departments was low. Staff, particularly those in health and social care, were concerned about the number of changes they had had to cope with over a short period and the lack of resources to help people who needed services.

There were concerns among staff that senior managers did not communicate well with them. Senior managers had taken steps to address this problem and there were signs that more recent approaches were beginning to have an impact. Managers and elected members needed to build on this quickly.

Motivation and satisfaction

We met many enthusiastic, professional and committed staff in our inspection. Most staff from both departments who responded to our survey agreed that they enjoyed their work and believed that they were making a real difference to the lives of people who used social work services. They were satisfied that they were helping people to lead as independent a life as possible and doing everything they could to keep people safe. The majority of staff also agreed that they received adequate training to fulfil the responsibilities of their job.

Despite feeling that they were doing a good job, many staff who responded were not positive about morale in their team. Over six in 10 of those in the department of health and social care and four in 10 staff working in the children and families department disagreed that morale in their team had been good for at least the last six months. The overall level of disagreement is one of the highest of the authorities inspected to date. Thirty-two per cent of health and social care, and 50% of children and families staff agreed that staff morale had been good for the last six months.

The findings of our survey were broadly similar to that of the authority's last internal survey carried out by MORI in autumn 2006. At that point 51% of children and families staff and just 32% of health and social care staff were satisfied with morale in their team, with 32% and 50% respectively expressing dissatisfaction.

Principal concerns among staff – particularly those working in health and social care – were the amount of changes they had had to cope with over a short period and their inability to provide people who used services with the resources they needed. Comments included: *'we need political support to value the service we offer'*, and *'managers lose sight of what it's like to face service users and tell them that there are no resources available'*.

In our survey, 42% of staff agreed that the quality of the service their team provided had improved in the last six months, while 30% disagreed.

Only 30% of staff agreed that their working conditions would improve in the next 12 months. Thirty-eight per cent disagreed – 43% in health and social care and 31% in children and families.

Only 26% of staff who responded to our survey (carried out shortly after local government elections) were of the view that elected members valued social work with a slightly higher percentage disagreeing that they did so. Edinburgh was one of only two authorities we had inspected to have received such an overall negative response.

The majority (62%) of staff felt valued by their managers. However, many staff (42% of health and social care and 31% of children and families staff) also disagreed that senior managers led change effectively, or communicated with them well (42% and 38% respectively). Only a minority of other authorities had received a similarly overall negative response to these questions.

During 2006 both departments had carried out internal reviews of their progress in meeting Investors in People (IiP) status. The findings reinforced the picture we found of a workforce committed to delivering a good service. An area of good practice highlighted by the review was the 'level of people commitment to the children and family service (highly motivated and focused staff)'.

As a result of the MORI poll and IiP reviews senior managers had put in place steps to improve staff confidence in them and to improve morale. These included:

- staff events;
- the introduction of newsletters and a staff magazine;
- the development of staff awards schemes; and
- 'good practice' presentations by staff at senior management meetings in children and families.

These steps had not had as much impact as managers had hoped for. Some groups of staff that we met remained disillusioned by management of the service. Comments included *'there's a gulf between frontline workers and managers'*, *'there's poor leadership from the top'* and *'we do good work in spite of, not because of, the department's policies and operation'*.

Some staff were nevertheless encouraged by more recent approaches adopted by managers which had increased both their accessibility and visibility. They welcomed the regular visits that senior managers had begun to make to offices and units, and the introduction by the chief social work officer (CSWO) of a weekly phone-in, though some children and families staff remained confused about the role of the CSWO, given her base in health and social care. This issue was being actively addressed by the CSWO through direct communication, briefing notes and visits to staff teams in both departments. A few middle managers we met described the atmosphere within the departments as more open.

Staff ownership of vision, policy and strategy

Responses to the MORI poll indicated that there was a good understanding among staff about their department's aims and objectives. Almost eight in 10 children and families staff and seven in 10 of those in health and social care agreed with this. A slightly higher percentage stated that they were committed to helping achieve these objectives.

While there was evidence of vision statements for the service, less than half of respondents in the SWIA survey agreed that there was a clear vision for their service. Nevertheless, the majority agreed that their service had a clear set of local targets and that they performed well against these. Most agreed that they were aware of the standards their team should follow.

Although both departments had circulated their departmental service plans to staff, many of those we spoke to or who responded to our survey commented that they did not feel involved in planning processes and did not always understand the rationale for many decisions. Comments included: *'staff consultation is very tokenistic,' 'we just get told what is happening'* and *'no-one taps into our knowledge about unmet need'*. Some city-wide teams commented about feeling 'detached' from the department.

A number of staff highlighted the anxiety caused by hearing for the first time about proposed changes to their service in statements made by elected members to the press. Some of those we spoke to valued the recent visits by the CSWO to offices and units to explain the authority's current financial situation and to outline the potential implications of this.

Dealing with the implications of the financial pressures while simultaneously moving through the process of reviewing pay and benefits would present senior managers and elected members with marked challenges. It is therefore all the more urgent that they build on the work they had begun in order to make sure that communication with staff was as robust as it could be.

Impact on the community

We considered performance in this area to be good, with important strengths and some areas for improvement.

Social work services demonstrated commitment to understanding the information and service needs of the communities they served. They were supporting volunteering and voluntary bodies to deliver culturally sensitive services. Volunteer services were making a positive difference but demand had outstripped supply for a long time. The creation of consumer involvement officer posts in both departments was a positive development.

Edinburgh strove to consult with communities and stakeholders through a variety of means. The involvement of stakeholders in the planning for services for older people was particularly positive. Where social work had undertaken consultation exercises on needs and services, some stakeholders felt that this had not translated into clear influence and change.

Community perception, understanding and involvement

Edinburgh is a prosperous city but has an unequal distribution of wealth, health and employment. Fifty-two thousand people were income-deprived in 2006. Thirty-seven thousand people were in touch with the welfare rights service in the same period and this resulted in successful applications of previously unclaimed benefits amounting to £7.3m, an increase of 13% from the previous year. The findings of a customer satisfaction survey were extremely positive.

Both health and social care and children and families services had up to date demographic profiles and both appeared to use this information in the planning of services. Health and social care had also incorporated these profiles into workforce planning. Each department had a Multi Equalities Action Plan with a programme of activity to reflect the priorities of equality groups in the planning and delivery of services. The council's equalities groups were said to have made a positive difference to raising awareness in their communities of interest about services available to those in need. They also had a role in encouraging job applications from the groups they represented.

Edinburgh social work services were funding and were involved in a very large number of stakeholder networks and consultation forums. They were perceived by stakeholders to be committed to the principle of meaningful engagement, but stakeholders also identified a gap between this principle and real influence on change. There were examples of good user and carer involvement in mental health and older people's services. However, examples were given of comprehensive stakeholder consultations where resulting recommendations were never implemented, or collective concerns about social work changes were perceived to have been ignored. Most advocacy representatives had more positive views that social work tried to include service users and carers as partners, and that there had been significant progress on the involvement of carers since the appointment of a dedicated officer.

Engaging existing service users, carers and the wider community in planning service provision for older people stood out as an example of good practice in health and social care.

Good practice example

'Live Well in Later Life' (the joint capacity plan for older people), together with the 'City for All Ages' strategy, and with the joint capacity planning for older people's services, developed a broad base of representation from existing service users, carers and organisations, as well as active involvement from the public. We saw good management of the different strands of involvement. There were strong links with community planning priorities. It was particularly positive that the equalities group for older people were leading consultation processes with the wider community and there were strong links with the ethnic minorities group on accommodating the need for some culturally discrete services. Information on the progress of the strategy and service options were available in a variety of formats in public places.

Social work services supported SAGE, the collective advocacy group for older people in care homes, to facilitate their involvement in planning a major development of care home provision in the city. Care home residents provided input to a training session for architects, contractors and construction staff involved in the building of the new care homes.

We did not find any other examples in either department where such a wide spectrum of stakeholders had informed and influenced the development of strategies and subsequent service maps. We felt that the model developed for older people could be employed to good effect with other service user groups.

The consumer involvement officers from the two departments had similar remits, with both officers developing strategies to engage with a range of stakeholders, including the wider public. It appeared that there was close collaboration between the two departments on developing a joint service user involvement strategy.

The council hoped that a neighbourhood model would lend itself to closer alignment between planning in public services and community planning processes. Voluntary sector bodies and community councils were both represented on the local co-ordinating groups. Social work service plans described providing training for the public to encourage their involvement in planning services for their communities. The neighbourhood model was still relatively new at the time of the inspection, but stakeholders were not positive about their experience of neighbourhood engagement to date. This experience was contrasted with a more positive one in relation to services for communities/housing. Social work services needed to be clearer about structures and processes connecting neighbourhoods to the central management of social work, before progressing public involvement further.

The national and local elections in May 2007 resulted in a change of administration in Edinburgh, with many of the members newly elected. Councillors told us that they intended to visit services, to spend time with staff, and to see for themselves the impact of cuts in services.

Impact on other stakeholders

Many of the comments from partners and stakeholders about social work services were focused on confusion about structural changes and perceived difficulties with the neighbourhood model. With the exception of views about the quality of care home provision, comments about social work services were generally positive. However, many concerns were expressed about inadequate access to services for a number of service user groups. Respite care, day care, foster care, resources for those in transition and for adults affected by disability were all raised as concerns. We return to this in chapter 6.

There were a number of information channels between social work services and the voluntary and private sectors about the range of services they each provided. Social work services supported the development and dissemination of such information, including partnership in the Compact, an agreement between statutory and voluntary sector bodies which sets out the principles on which to base the development of their relationship. It was helpful that the Compact web-site was being used as a means by which the council alerted the voluntary sector to significant changes in policy or services, and consulted them about draft strategies.

Children and families supported the Eke-out information resource. This supported the Edinburgh Network of Voluntary Services for Young People and Families. It provided information about voluntary sector bodies to other providers, including social work services, but more limited information about the nature of services was available to the public. It also published a newsletter which included news of changes or developments in the council.

Significant changes in policy and services in both social work departments sometimes resulted in multi-agency training or familiarisation events. Partner agencies (voluntary and independent sector) participated in multi-agency training programmes relating to adult and child protection. A comprehensive 0-3s framework had been produced by a multi-agency group. It had an extensive training programme involving voluntary and independent providers. Consideration should be given as to how independent sector participation could be more consistently achieved in planning training strategies.

Community capacity

Edinburgh was the first statutory authority in Scotland to apply for the Investors in Volunteering Award and social work is to be in the forefront of this. We saw excellent examples of good quality volunteering experiences linked to social work, such as the short breaks scheme for adults with learning disabilities. The volunteer strategy was written with voluntary sector colleagues and was very good.

There was a good rate of volunteer retention and 10% of volunteers subsequently went on to jobs in social work or social care. Five per cent of volunteers were from minority ethnic groups. This was seen as a positive bridge to communities where the acceptance of such help might otherwise have been problematic. There was also support for an agency to help people who had been long-term users of social work services to become volunteers.

Overall development of volunteering opportunities by social work services had been patchy, however, and had not kept pace with demand. There was a long waiting list for every service involving volunteers and further development required more investment in central support. We were told by voluntary agencies that it was not difficult to recruit volunteers in Edinburgh but they struggled to meet their need for training and on-going support. They were not given any additional funding or in-kind support by social work services to help with this. Some social work teams and services had tried to encourage local volunteering but expressed similar concerns that they received little on-going help to do so.

The success of existing volunteer services, together with the current strategy, provided strong foundations on which social work services could develop and support volunteering opportunities. Consideration should be given as to how to take things forward in tandem with voluntary sector colleagues.

Good practice example

'Moose in the Hoose' project

This project was set up to enable older people in care homes to develop computer skills. Working with Age Concern the volunteer co-ordinator was able to link pairs of volunteers to care homes for weekly sessions. Residents had been able to develop internet contact with relatives living abroad and to seek out websites of particular personal interest.

The recruitment of foster carers was more problematic. We were told that attracting foster carers in Edinburgh had been difficult for a long time. There was recognition that the policy of advertising for foster carers on local buses had produced a large number of initial enquiries which had not proceeded any further. In fact the number of successful applicants had fallen in the last year, and the consumer involvement officer had been asked to investigate whether information issues may have played a part in this. She had also instituted regular advertisements for foster carers in the free council newsletter.

There was an increasing trend of using private agencies to provide foster placements, often out of authority and always on a spot purchase basis. A working group had been formed to examine fees and allowances, which were lower than the national average. The group included foster carers. A senior manager told us that there had not been a strong foster carer lobby or support network in Edinburgh because groups had developed in localities rather than city-wide. This was changing and social work services were facilitating the emergence of a single group.

There were plans to increase the financial capacity to recruit and support more local foster carers. These plans were contingent to a degree on demand for out of authority residential placements diminishing. Some policy and practice did not systematically promote local provision. Family group conferencing was described by senior management as *'nowhere big enough for a city this size'* although we heard that a pilot was taking place in two teams where family group conferencing was always considered when children were at risk of being accommodated. Kinship carers were supported financially and involved in training. Training was also provided for foster carers on caring for vulnerable babies by staff from the Prepare project which worked with pregnant women with substance misuse problems.

CHAPTER 5

Delivery of key processes

Edinburgh's performance in the delivery of key processes was weak, having important weaknesses. Generally, we found that children and families had more need for improvement than health and social care in this area of the report.

There were generally good arrangements in place to help people make initial contact with social work services. These services faced considerable demand coupled with significant budget pressures. More coherent systems were in place to prioritise and allocate work in health and social care than children and families services.

We had concerns in both departments about the numbers of people waiting for assessment, or for the appropriate service after assessment, about the backlog of reviews, and the inability of services to respond to changes in people's need. Review processes in health and social care were not well embedded and large numbers of people were not being provided with services. In children and families there was a lack of clarity about the numbers of children unallocated or on waiting lists. Both departments needed to ensure that care plans for service users were in place and regularly reviewed. We had concerns about the differing levels of standards and practice in different neighbourhoods.

There was some strategic progress around adult protection, but work was still in progress in translating guidance into procedures and ensuring that staff would use these procedures. There were a number of weaknesses around child protection, including delays in case conferences being held. There were examples of good joint working, particularly between social work and housing services. Social work services had worked hard to achieve inclusion, equality and fairness in service delivery.

Access to services

Comprehensive information

We found a broad range of information available to the public on social work services. This was available in most offices we visited, although in some the information was limited. Information had been produced about a good number of individual services, for example care homes for older people and children and family centres. We found this was more comprehensive for health and social care services.

The council had produced an A-Z guide to all council services. Health and social care had produced a guide to adult services, but there was no equivalent for children and families services. Information was available on the council's website; for health and social care this included how the service could be contacted, what would then happen, and information about individual services. While there was some information on this site about children and families services, this was less developed. The council told us it was reviewing the content and format of its website. We thought the information about social work services for children and families in particular could be improved and we saw that the Integrated Social Work Improvement Plan contained actions to address this.

Referral and out-of-hours systems

Health and social care

The main point of access to health and social care services was Social Care Direct (SCD), established in April 2006. Managers told us it was the first contact/call centre specifically for community care services in Scotland and that it had been set up after a review of previous duty arrangements.

The aim of SCD was to deal with the large majority of referrals using specially trained telephone advisors supported by 'professional' staff (one social worker, one occupational therapist and one social work manager) on site. Almost half of calls were from the public. Eighty per cent of calls were being answered within 30 seconds. Managers said that this performance was a considerable improvement for the 11 local practice teams. SCD was able to deal with 60% of the calls and enquiries received, with the remaining 40% needing to be passed to the practice teams as referrals.

We heard mixed but generally positive views about SCD. Practice teams were generally satisfied with the quality of referrals they received. Some staff commented that they thought SCD was too focused on meeting targets, such as the turnover of calls, rather than taking time to listen to callers' concerns. Whilst we found some evidence that the role of SCD was not fully understood by services users and staff, we concluded that it provided an effective point of first contact for large numbers of the public seeking access to community care services. It had been nominated for a COSLA quality award.

It was clear that health and social care had considered whether a contact centre would work well for all service users. It decided, for example, that SCD would not act as the contact point for hospital social work services nor for homeless people who usually chose to use the city centre access point. It was also agreed that the specialist sensory impairment services would continue as the access point for people with a sensory impairment.

We heard different accounts of the 'standby' arrangements in the practice teams. Managers responsible for SCD said it had been recognised from the outset that practice teams would need to provide a small scale duty system for people preferring to visit a local office rather than phoning SCD. Some practice team staff had understood that the original intention had been for SCD to be the only access point. We found that sensible arrangements had been put in place which allowed members of the public to be seen in a local office where it was sensitive and practical to do so, but this had been done without undermining the whole rationale for the creation of SCD.

Whilst SCD did not act as a contact centre for children and families services, consideration had been given to how it would respond to children and families' referrals. For example, it took details of anonymous child protection referrals to avoid the risk of these 'being lost' by simply referring them on.

Good practice example

The operational and partnership planning which led to the redesign of access services and the setting up of the contact centre, Social Care Direct, demonstrated that an alternative way of providing the service would be more effective and efficient. The service had been kept under review and as a result further changes and developments had been made.

Children and families

Access to children and families services was primarily via the five neighbourhood areas. Each neighbourhood had one public access point provided from a practice team, with the exception of Edinburgh North, which, as the largest area, had two. The neighbourhood access systems were intended to develop in line with service standards which allowing scope to reflect local needs. We met a number of first line and middle managers during fieldwork who told us that systems for accessing services and the terminology used to describe them varied significantly across the city. However, they considered a greater degree of consistency was in the process of being achieved and that the SWIFT IT system was contributing to this.

Access to offices and units

The boundaries of the two departments were not co-terminous, with health and social care aligned with health boundaries and children and families services arranged in line with school neighbourhood boundaries. We saw few signs of operational problems arising from the different boundaries.

We visited a small number of offices. The arrangements put in place by the council meant there was a limited number of offices service users could access. For example, health and social care staff were located in 11 social work offices, children and families staff were located in eight local offices, but not all of these were designated as public access points. From what staff told us in focus groups and from what we saw, it appeared that the quality of accommodation available for public access was variable. We visited one local office in the South-east of the city. It was located in an industrial estate, was not easily accessible, and although not a public access point for health and social care, it was for children and families services.

Out-of-hours service

This service was provided by the emergency social work service (ESWS) which also covered two neighbouring local authorities. The majority (62%) of staff who responded agreed that there were effective links between the out-of-hours service and the wider social work service. This was comparable with other inspections to date.

The service provided was generic, with ESWS receiving over 50,000 calls per year. We visited the service and saw that it had effective systems in place to manage incoming work and had good working relationships with other agencies. It had an experienced staff team who said two of the service's biggest pressures were access to resources and home care. The council had no emergency foster carers who could be accessed out-of-hours (we say more about this later in this chapter) and the availability of mental health resources during evenings and weekends was also identified as problematic. Operational management of the home care service was the responsibility of staff within ESWS, both for in-house and purchased services. This responsibility was not helped by the home care IT system 'Open Road' not being linked to SWIFT. There were, however, plans for part of the out-of-hours responsibility to be transferred to Home Care Direct within some three months of our inspection.

Day to day planning and resource allocation

Both health and social care, and children and families services faced considerable challenges in meeting demand for social work services. This had intensified the focus given to day-to-day planning and resource allocation.

Prioritisation and allocation systems

Health and social care

In health and social care, SCD passed referrals to practice teams, which were screened daily by first line managers. They used the department's eligibility criteria which were based on the Department of Health's 'Fair Access to Community Care Services'. Referrals would be prioritised as either 'urgent' in which case the person should be seen and assessed within 24 hours, or as 'A' with a timescale of two weeks, or category 'B' with a timescale of four weeks. These timescales were not always met.

The eligibility criteria had recently been reviewed in response to the budget pressures, with tighter criteria introduced to target services at those in most need. It had been decided that a service would only be provided to people meeting the revised criteria of either 'critical' or of 'hospital discharge'. Effectively, all other categories of need, whether substantial, moderate or low, were not provided with a service or at the very least, the service would be delayed. They were sent standard letters in the director's name. Both managers and staff said they found this 'supportive'. However, some staff also commented that the letters were misleading as they could underestimate the length of time before a service would be provided. There were some arrangements to monitor this unmet demand and need which we discuss later in this chapter.

Practice teams consisted of response teams and care management teams, with the latter dealing with referrals where involvement was likely to be both long term and complex. A range of resource/sector panels were in place to manage the allocation of resources and access to services. Arrangements for the operation of the panels appeared to be generally consistent. At the time of our fieldwork, decisions to approve the use of resources – which had previously been delegated to practice team managers and sector panels – had been changed to require approval at higher levels by senior managers with a city wide remit.

A number of other arrangements were in place for allocating work and resources outwith practice teams. For example, duty and screening systems were in place across hospitals. Having ‘hospital discharge’ as a top priority meant this was prioritised, at least in terms of meeting delayed discharge targets. However, we considered the approach applied was not completely person centred. Referrals for discharge planning were marked as ‘pending’ and not allocated until the person was confirmed as medically fit for discharge. This meant discharge planning time could be lost, potentially resulting in an older person remaining in hospital longer than necessary. We also heard concerns from hospital based staff that when discharge care packages were stopped at the subsequent four week review as the ‘critical’ criteria was no longer met, this could be counter-productive, by undermining the rehabilitation process and increasing the risk of re-admission.

For both care home and home care services, dedicated service matching units (SMUs) had been established to identify the service provider, a task previously done by the assessing worker. The aim had been to reduce bureaucracy for frontline staff and for this remit to be concentrated in a small group of specially trained administrative staff. We refer further to the SMU for home care in chapter 6. Whilst we thought it had been a good idea to move the administrative responsibility away from front line staff, we had concerns about the commissioning framework within which the SMU operated. We visited the SMU where we were told that 30% of home care service users received services from more than one provider. This was partly because the in-house service had to be given the first opportunity to provide the service. If it was only able to provide part of the service, the remainder would be provided by another provider. We considered that the department should give far greater priority to ensuring the maximum possible service continuity for service users, by facilitating the provision of home care by a single provider.

Home Care Direct (HCD) had been established to manage the delivery of the home care service, after assessment, including the allocation of home care staff to service users. We heard mixed views about it. Comments that there were advantages with having the service co-located with Social Care Direct were offset by concerns the home care service had become fragmented.

Managers told us that whilst there was still some waiting time for assessment for equipment and adaptations, there was no significant subsequent waiting time for the service to be provided, with some 90% of minor adaptations, such as shower installations being completed within six weeks.

Children and families

Despite the large overspends in children and families against a high level of council funding, we were surprised to find prioritisation less dominated by budget considerations than was the case in health and social care. The implications of this are discussed later in the report. There was greater variation in the systems operated across the city. The service had identified a number of inconsistencies and was taking action to address them. Risk of harm and risk of becoming looked after and accommodated were important factors in the prioritisation of work.

Efforts were being made to use the neighbourhood model and a multi-agency approach both to help the early identification of children in need and also to agree the best way and agency to meet their needs. Within the neighbourhoods, duty teams played a key role in this process, but did so alongside a number of other mechanisms, namely pupil support groups, 'working together' teams and neighbourhood forums. At the time of our inspection for example, the South neighbourhood had some 250 children on its 'duty list'. This comprised of:

- recent referrals still being dealt with by the duty team which had not yet reached the appropriate point for allocation;
- referrals which could be concluded by the duty team;
- referrals which required to be allocated to a case manager, but where there was no available worker due to workload pressures;
- cases where the case manager role was being undertaken by another agency, such as Children 1st; and
- children who were allocated to social work staff, such as school based social workers, who were not on the SWIFT system and which were therefore recorded as unallocated.

Within the neighbourhood, operational managers came together at a fortnightly allocation meeting, but allocated urgent work in between. In addition, agencies came together at a monthly neighbourhood forum to share information about children for whom there were concerns and to make decisions about which agency would provide the intervention.

We heard that workload demands on children and families services were considerable and that there was unallocated work. However, when we asked the department to confirm the scale of this it was unable to do so. There was inconsistency amongst senior managers about what constituted an ‘unallocated case’ or how this was defined. We were concerned that this lack of clarity meant there was no consistent way of collating information about unallocated cases and that without this, efforts to review and re-prioritise unallocated work would be undermined. In addition to the cases we analysed in depth during file reading, we also looked at a sample of 72 unallocated cases (47 children and families and 25 health and social care). This revealed that children and families were unable to quantify how many unallocated cases it had, due to the use of different definitions and cases being wrongly coded. Also, only one of the 72 files contained evidence a review had taken place to examine any changing needs and priority. While there were systems in place to review cases, the above evidence raised serious concerns about both departments’ ability to safely manage unallocated work.

All child protection cases were allocated at the time of the inspection. The department told us that not all looked after and accommodated children had an allocated social worker, but it was unable to quantify this. We also had concerns about the volume and range of work being carried on a duty team basis.

Recommendation 3

Children and families services should ensure that clear and consistent arrangements for allocating and reviewing work, and for measuring and monitoring its workload, are in place, and that these systems operate effectively. It should ensure that all children who are looked after and accommodated have an allocated social worker.

There were a number of services unable to meet demand and which had waiting lists. Worryingly, these included some 40–50 children who required to be looked after and accommodated, but for whom no placement was immediately available. There were also children waiting for a service from the accommodated children’s review team (ACRT), and the throughcare and after care team.

Assessment and care management

Sound practice in assessment and care management is a key foundation to achieving good outcomes for users of social work services. In health and social care, single shared assessments (SSAs) based on the Carenap assessment framework were the standard assessment tool. In children and families services, the standard assessment framework was based on the Health Department framework. Children and families said this was under review with the aim of an integrated assessment framework (IAF) being introduced within 12 months of the inspection. Youth justice staff used the ASSET assessment model.

We found written guidance and procedures in place to cover case recording, assessment and case management, which were generally of good quality. The SWIFT system was the case recording tool for all practice teams, hospital teams, ESWS and some, but not all of the specialist teams. Plans were in place to extend SWIFT access. We heard some frustrations from staff about SWIFT. For example, whilst care plans were on SWIFT, assessments were not, but instead were found on e-Assess (an assessment recording system). However, at focus groups, both staff and managers said the introduction of SWIFT had contributed to a significant improvement in case recording and information sharing.

We read 91 adults' files and 59 children's files. The findings were broadly comparable with the file reading exercises undertaken in inspections of other authorities. We found that recording was continuous with no significant gaps in the majority (61%) of files. Recording was appropriate and in keeping with the needs of the person using services in 75% of files. However, there was a chronology of key events in only 10% of files which was one of the lowest results in inspections to date.

Assessment

We found there was an assessment in most (87%) of the files and that the timing of the assessment was in keeping with the needs of the service user in 85% of the files. The quality of the assessments was found to be good, very good or excellent in 54% of cases, which compared to an average of 64% in SWIA inspections of other authorities. The quality of the assessment was found to be adequate in 41% of files and to be weak in 3% of files. In health and social care an internal audit of assessment and care planning had been undertaken by council and health staff. This showed that most assessments had been completed on a single agency basis.

We heard from staff and managers that the use of single shared assessment was not fully embedded, with some health staff reluctant to complete SSAs or only doing so in part. Some managers from both departments and the independent sector raised concerns about the quality of assessments and about some being out of date. There were target timescales for the completion of assessments, but health and social care told us there were data quality problems in measuring performance in this area. However, according to JPIAF figures, the partnership's own targets for completion of assessments and the proportion of people waiting over 56 days for an assessment were not being met.

Chapter 5: Delivery of key processes

The most recent performance report for health and social care showed that in the three months since June 2007, more than half of all assessments were outside standard times in both response teams and care management teams, with performance particularly low in July 2007. Information about waiting lists for assessments was obscured because a large number of cases showed on the SWIFT system as having no assessment start date (in excess of 1,000 cases each month for the response teams and a further 400 or so for care management teams). Managers told us there were over 80 people in acute hospitals waiting to be assessed and that children with disabilities had to wait for over six months to have their needs assessed. The numbers of cases recorded as being on a waiting list was considerably smaller and fluctuated between around 500 for the response teams and under 200 for the care management teams. The numbers waiting for assessment was therefore considerable. Reports on waiting times were produced monthly for the Performance Management Group and for practice teams.

Children and families services said there was scope for improvement to meet the requirements of getting it right for every child (GIRFEC). A policy officer was being recruited to progress work on integrated assessment and co-ordinated care plans. We found progress in involving partner agencies in developing the integrated assessment framework had been slow, and we welcomed the new director's stated commitment to leading improvements in this area.

We met the children's reporter who commented on a lack of analysis and attention to identified risks in reports, as well as variety in their quality of across teams.

We visited the Prepare project. One objective of the project was to provide specialist and early assessment which was important given the often chaotic lifestyle of the service users involved.

Care planning

Care plans were present in the majority (59%) of files (64% of children and families and 56% of health and social care files) which was one of the lowest results in inspections to date. It is the responsibility of social workers to meet service standards and to be accountable for the quality of their work.

In 87% of the files with a care plan, the plan addressed the needs and risks identified in the assessment either mostly or completely. This was comparable with results in other inspections. This was also the case for contact with the service user, where the level of contact was in keeping with the requirements of the care plan in 77% of the files.

A care management programme was being piloted within health and social care which included social work and health staff shadowing each other. Feedback had identified that not all staff properly understood care management processes.

Children and families services had undertaken an audit of placements for accommodated children which identified a number of issues about permanency planning, including a large number of children waiting for adoptive or foster placements. It found care planning had been too slow in 10% of the cases. The service manager for family based care identified a need for sharper decision making around permanency planning and told us that the procedures had recently been re-written. We were concerned to hear that there was difficulty in getting accurate aggregated data about the needs of looked after and accommodated children and that 13% of scheduled permanency panels had had to be cancelled because social workers had not been able to gather evidence together on time.

Recommendation 4

Children and families should take steps to improve permanency planning for looked after and accommodated children.

Reviews

When file reading, we found the majority (73%) of files with a care plan contained evidence that it was being reviewed at regular intervals. Children's files performed better (82%) in respect of reviews than health and social care files (67%).

Health and social care

In health and social care there was a backlog of reviews in a number of areas. This included home care, where first line managers referred to the backlog as 'huge'. To address this backlog, the department had established a review team comprised of agency staff. Practice teams and some disability services were not undertaking all reviews within agreed timescales. There was also a high number of adults in out-of-area placements. Managers said there were not enough staff to allow these placements to be regularly reviewed. We also found a lack of capacity to respond to carry out reviews when a service user's needs had changed, resulting in the provision of inappropriate levels of service. We considered that health and social care should be more responsive to the changing needs of service users where these were brought to attention.

A short-term assessment review and resource team (STARRT) had responsibility for reviews of care home residents after the initial post placement review. Whilst the team was able to meet the review schedule for all new residents since it started, there was still a backlog. The team had concerns about its capacity to comply with the National Care Home contract's review requirements.

Children and families

Children and families services said all cases were regularly reviewed as part of supervision. With the exception of reviews of child protection cases, looked after and accommodated children and women involved with the Prepare project, we found little evidence of more formal reviews taking place within children's services.

An accommodated children review team (ACRT) undertook the 'independent' chairing of reviews of looked after and accommodated children. The department had reviewed the work of the team in 2006. It concluded that the independent chairing of reviews was generally of a high standard and that the team provided a good quality service to the children concerned. It also identified that some practice team social workers were unclear about the reviewing officer's role in care planning. The remit of the ACRT included addressing issues of concern about the care plan if identified and agreed within the review, and addressing issues of practice directly with social workers as required. We were unclear how effectively the ACRT ensured that concerns identified at a review were actively addressed before the next review.

In both departments we heard comments about actions agreed as part of assessments and reviews not being followed up. While regular supervision took place and systems were in place for regular file reading audits, in file reading we found evidence of worker supervision sessions in only 10% of the files, and of regular first line manager scrutiny in only 9% of the files. We also saw little evidence of case file audits having been done with any regularity within social work services. We were concerned, especially given the level of outstanding reviews and unallocated cases, that there was insufficient evidence of attention given to monitoring that actions agreed as part of care plans were being implemented.

Recommendation 5

Social work services should ensure its quality assurance arrangements for assessment and care management include action to ensure that all service users have a care plan which is reviewed at appropriate intervals, and that front-line workers and managers are aware of their professional responsibilities in assessment and care management.

Risk management and accountability

Inter-agency safeguarding procedures

Edinburgh had inter-agency procedures for the protection of children, and also inter-agency guidelines for adults at risk which were being developed into procedures. Both covered the Lothian area, were comprehensive, and available on the council's website as well as in paper form. Guidelines for agencies on protecting children living in families with problem substance misuse were well written and in place. Edinburgh was one of the local authorities participating in the national pilot child protection helpline. Most staff agreed they had clear guidelines to follow when dealing with risk to or from people who use services. Almost all staff agreed their team did everything possible to keep people safe. Fifty per cent of the stakeholders who responded to our survey agreed social work services met its responsibilities to keep adults and children safe.

In our file reading we read 31 files with issues about the protection of the service user. The majority (83%) had been dealt with according to procedures. Fifty-eight per cent of applicable files contained an up to date risk assessment, although less than half of these (45%) contained an up-to-date risk management plan. A risk management framework was currently being rolled out to ensure consistency of approach.

Recommendation 6

Both departments should ensure that all applicable files, where issues about the protection of the service user have been identified, have an up-to-date risk assessment and risk management plan.

Child protection

Services to protect children and young people had recently been the subject of a joint inspection led by HMle. The inspection report found some key strengths. These included the identification of concerns, assessment and information sharing on unborn babies and young children affected by parental substance misuse. However, it also found a larger number of points requiring action. Some children were found not be adequately protected, left at serious risk, with some who needed to be removed from their home left there because no safe place could be found. In its delivery of key processes, Edinburgh's performance was evaluated as 'good' for involving children and their families in key processes but it was evaluated as 'weak' for recognising and assessing risks and needs and also for the effectiveness of planning to meet needs. SWIA sought not to replicate the detail of the child protection inspection, but our inspection touched on child protection in a number of areas which merited comment.

The child protection committee and the services it represented were preparing an action plan in response to the HMle inspection. A quality assurance sub-committee, chaired by the CSWO had been set up to oversee its implementation.

Children and families services told us various risk assessment frameworks had been in place. We saw that further to a review of these, a new draft framework had been produced. We read the case file management guidelines which identified that child protection plans were often contained with case conference minutes, were not sufficiently detailed and that a separate child protection plan format was to be introduced.

In our file reading, we found that of 12 child protection cases, all of which had issues regarding protection of the child, only seven had an up to date risk assessment, and only five had a risk management plan on file.

We were told there had previously been children on the child protection register without an allocated social worker, but this was no longer the case. In our follow up sample of cases recorded as unallocated we saw 10 cases marked as child protection and 'awaiting allocation'. In fact we found all except one had been allocated, although three only very recently. We were also told by managers that the Amethyst team (a co-located police, social work and health child protection team) was receiving more referrals than it was able to respond to timeously.

We heard mixed views about the effectiveness of arrangements surrounding the Amethyst team. It co-ordinated inter agency discussions on all new referrals (IRDs). Whilst we heard there were few disagreements between Amethyst and practice teams about what action should be taken, there were some, including disagreements about the appropriate service that should be provided in response to referrals. We spoke to staff and managers in the agencies and heard that health staff could be by-passed in operational decision making, that social work resources for the team had never been sufficient and that the work of the team was police dominated. Senior managers told us that a police/social work review of Amethyst was to be held. Given some of the conflicting views, we thought an external review would be useful.

Social work staff in the team were in the process of assuming responsibility for chairing case conferences. This change, combined with an increase in the number of child protection referrals, had resulted in delays in some initial case conferences being held. This was being addressed as a matter of priority. As well as the team manager, the senior practitioner social workers chaired case conferences. The HMIe inspection found that independent chairs of case conferences (and looked after children reviews) 'did not have sufficient authority to challenge lack of progress of plans'. We agreed with this.

Adult protection

An adult protection committee had been established and had started to meet. The chief social worker officer was on the committee. We heard from a range of staff that considerable attention had been given to adult protection over the preceding years, which included the appointment of an adult protection officer. A SWIFT module for adult protection was about to be introduced at the time of the inspection. As stated in chapter 3, the council had assessed itself as not meeting national mental health standards in contributing to the assessment of risk and vulnerability for people subject to or requiring statutory intervention. However, an action plan was in place to address each issue.

Staff we met were not always following adult protection guidance or completing accompanying templates. They were aware of risk assessment tools in place in health and social care. Some service areas were using the Sainsbury mental health based risk assessment tool. We attended a vulnerable adult case conference where this was used. Staff present said it was a useful tool in describing risks, but less so in evaluating them. The Changing Lives Implementation Group, chaired by the CSWO, was leading on the development of a common risk assessment and management framework, to be used across both departments and supported by specialist tools as appropriate.

Managers and staff involved with the STARR team told us that having social workers linked to specific care homes gave them a good knowledge of individual residents and establishments and allowed them to identify adult protection concerns. Whilst we could see the value of this, some staff we met made little differentiation between concerns which would require to be dealt with under adult protection procedures, and others which should be dealt with by other arrangements, such as contract monitoring.

During file reading we read a number of files where professional meetings had taken place to discuss concerns, but where no clear conclusion had been reached about whether the service user was deemed to be an adult at risk. Health and social care was unable to tell us what proportion of professional meetings had led to adult protection case conferences. This caused us some concern as it is important that adult protection concerns do not become confused with wider adult welfare concerns.

Recommendation 7

Health and social care should ensure that adult protection procedures are properly adhered to by all staff.

Managing demand and unmet need

We commented earlier about the budget pressures facing the council, the operation of eligibility criteria in health and community care and the level of unallocated work within children and families services. All of this represented a significant risk which required to be carefully managed. Both departments needed to have robust systems in place to ensure that people with social care needs who were either not receiving a service or who did not have contact with an allocated care manager, were having their needs kept subject to review so that any significant change in these could be re-prioritised.

Both departments informed us that mechanisms had been put in place to manage the various waiting lists. Health and social care gave evidence that this involved reviews. These reviews were intended to ensure that people in the 'substantial' category were allocated a worker, had their needs reviewed on a monthly basis and that the worker was responsible for trying to access alternative means of support.

We found that there was good staff awareness of the revised eligibility criteria. However, we had concerns about review arrangements for people waiting for an assessment or not being provided with a service post assessment. Given that review timescales were not being met for all existing service users, we had reservations whether the needs of these people were subject to regular review and whether the departments had the capacity to do this in any event. Indeed, we saw that in some instances, the responsibility to contact the departments in the event of a significant change in circumstances was left entirely to service users. We were not satisfied that mechanisms were as well-embedded or as robust as the departments believed, as a means of managing risk.

Recommendation 8

Both health and social care, and children and families services should ensure that systems are in place, understood by staff and fully operational, to pro-actively review the needs of people who they are not providing a service to due to resource constraints.

Partnership with people who use services and their carers

In the self evaluation there was some acknowledgement that a lack of information about service changes was a source of complaint by service users and that communication about these changes needed to be improved. Social work services were already taking steps to improve this. However, we heard a number of concerns from users and carers. For example, we visited a day centre for older people where service users spoke positively about the service provided, but a number said their attendance had been reduced without discussion with them.

Edinburgh had a small specialist team for direct payments and we saw that it actively promoted them. Amongst steps taken to improve public information, the team had produced a new leaflet and had involved service users in its development. NHS Lothian told us in the stakeholder questionnaire that the council's efforts to promote direct payments should be recognised. We also heard how the short breaks team drew up personal profiles with service users and their carers and we saw a DVD drawn up by the team which made good use of service users' views.

We visited a number of family centres and were also impressed with how they made use of service users' views. For example, we met with staff at Greendykes child and family centre who told us how much they enjoyed building up open, honest, but supportive relationship with parents many of whom had substance misuse problems and were suspicious of social work.

Inclusion, equality and fairness in service delivery

We found both departments had given considerable attention to inclusion, equality and fairness in service delivery. Edinburgh's black and ethnic minority population was significantly above the national average. The manager of the emergency social work service told us the council was supporting a small number of unaccompanied refugee children and that there was a growing need to consider providing support, including financial support to people who had 'no access to public funds'.

We saw there was a range of services in place to support inclusion. In health and social care this included a multi-cultural family centre which provided support to black and ethnic minority families and migrant families from across the city. We found that consideration had been given to how to best meet the needs of people with mental health or substance misuse problems and other 'hard to reach' groups. A specialist care at home service (MECOPP) was in place for black and ethnic minority service users.

In children and families services we were told that all children who became looked after and accommodated were offered an opportunity to meet with a children's rights officer. We also met with staff who were involved with Viewpoint, a development which used a computer programme to support communication with looked after and accommodated children. The communications manager told us that a similar programme was being developed for young people with learning disabilities.

During fieldwork we heard numerous criticisms from both carers and staff about the quality of work around transitions for young people with disabilities. A specialist transitions team for children with disabilities had been established in October 2006.

We saw there was a good range of advocacy services available. This role was undertaken by 'Who Cares' and by children's rights officers in children services. A number of advocacy services operated within mental health and managers of older people's services told us that SAGE (senior action group Edinburgh) played an important role as a collective advocacy service for older people in care homes. Staff also spoke positively about the council's interpreting service as being easily accessible and able to meet demand.

In a number of inspections, issues had been raised about how the availability of services varied geographically across the local authority with comments made about 'a postcode lottery'. We heard very few concerns to this effect in Edinburgh. However, we were told by social work managers of different responses in each neighbourhood.

In our survey of service users, the majority (63%) agreed that social work services understood important matters about racial or cultural background.

Multi-disciplinary working

In the majority (69%) of the files we read we found evidence of multi-agency working with clearly stated roles and responsibilities. The majority of staff in our survey agreed their team had good working relations with the health, education and other social work services and also with the housing service. The levels of agreement were 83%, 74%, 83% and 58% respectively. We were also told about good joint working relationships and arrangements around adult protection.

During fieldwork, staff and managers we met were generally positive about multi-disciplinary working, although there were some exceptions. Whilst relationships with health colleagues were usually described as good, managers appeared to be clearer than staff about the added value of health and social care having come together in one department.

Although there was widespread recognition of the need for close links to be maintained between social work staff working in adults and children's services, operational staff said this was not happening. Staff and managers we met in children and families services said they had far more contact with criminal justice staff than with health and social care staff. Even within health and social care, the fact that the response and care management teams were not co-located was described as unhelpful.

Joint working with the police was almost always described as being very good and the police told us that attendance at case conferences had the same mandatory status for them as attendance at court. However, there was some tension around the work of the Amethyst team.

There were difficulties in resourcing multi-agency meetings and an expectation that it was always the social worker's responsibility, for example, to chair and minute child protection core group meetings.

We held a focus group with staff working in the throughcare and after care team. The team included a health worker who was on secondment to the team and who ran health improvement groups with young people as well as liaising with the looked after children nurses. Good joint working arrangements were in place with the voluntary sector in the form of Barnardo's and with the careers service. The team also worked closely with the council's young person's housing officer who participated in the group-work programme and had a weekly presence in the team. A second housing officer post and a network of support workers were also in place to support the work of the team.

We met with the head of housing and regeneration who said joint working with social work services was good. A senior manager from health and social care sat on the housing steering group. Also a member of staff from housing was seconded to the delayed discharge team as a means of addressing any housing needs as part of discharge planning. The youth justice team also included a housing link worker. Staff we met from both departments said they worked well with housing colleagues. We visited a neighbourhood office where social work staff were co-located with both housing staff and the police and were told this contributed to good multi-disciplinary working.

Good practice example

The involvement of housing staff in the throughcare and aftercare, the delayed discharge, and the youth justice teams was a good practice example of multi-disciplinary working between housing and social work services.

Management

This section of the report looks at three areas for evaluation:

- policy and service development, planning and performance management;
- management and support of staff; and
- resources and capacity building.

Policy and service development, planning and performance management

Overall performance in this area was good, having important strengths with some areas for improvement. Generally, we found health and social care to be stronger than children and families in this area of the report.

Policy review and development was well established and there was evidence of key policies and plans having been developed in recent years. Operational and partnership planning had been in place for some time. It was well advanced in a number of areas whilst others appeared to be making slow progress. There were mechanisms in place to involve stakeholders and measures were in place to canvas and consider their views.

The policy objective of the council and its key partners was to develop integrated services. We found that improvement was slow and this was still work in progress.

The range and quality of services was mixed. Whilst some service users and carers had access to a good range and quality of services, others did not, and the range and quality of services for people with a learning disability was a particular concern. A number of processes and procedures were in place to identify unmet need and lack of service provision.

Quality assurance and continuous improvement was beginning to develop at the time of this inspection, more so in health and social care than in children and families. It was too early to assess what impact these measures would have in service delivery and outcomes for service users and carers.

Policy review and development

In May 2007, the two departments embarked on a comprehensive joint review of all social work policies and procedures, recognising that many of the existing policies and procedures were out of date and did not reflect the new organisational arrangements for social work. The work was expected to take nine months. The evidence presented in the advance information for this area was predominantly from the health and social care department. This imbalance was reflected in our observations and interviews during fieldwork.

Children and families

The introduction to the Children and Families Service Plan 2007-10 was well written and informative. There was a very strong emphasis on integration but it did not make clear what this meant in practical terms. We did not feel that the integration of services was well reflected in the plan itself in a number of key areas. The plan contained no proposals to address the needs of children and young people affected by parental addiction. This was a particular concern given the prevalence of addiction in parts of the city. The needs of young carers were not addressed. The plan made reference to expanding integrated services for children with disabilities and a proposal to re-provision a respite unit with a new build facility. However, there was no reference to an integrated response by social work, health and education in key areas such as multi-agency assessments, children and young people with complex and severe disability, community based respite or shared care, or transition planning. The Integrated Children and Young People's Services Plan was a good example of a strategy in development.

In the children and families department the key management priority had been to jointly review the child protection procedures, in consultation with all stakeholders. New procedures had been implemented in June 2007. The department had also carried out reviews of policy areas such as adoption and permanence, kinship care, criteria for accommodation for children and young people, and a review of medication policy for children with a disability. The department recognised that there remained considerable work to be done to update and review all its children and families policies. They considered that the audit work carried out since May 2007 provided a secure base to build on. There were few references to policy review and development from staff in the children and families department and comments received suggested that this should be given greater emphasis. It was recognised that this had to be seen in the context of a new department which was seeking to move forward in an integrated manner. However, we considered there was a need to strengthen policy review and development in respect of social work services for children, particularly for children with disabilities and children affected by parental addiction.

Health and social care

Within health and social care we read a wide range of documents, most of which had been completed in the last two or three years, which demonstrated a recent policy review and strategy for service development in most of the care groups. These varied in quality and in the evidence of action plans for implementation. We met a number of staff who were engaged more or less full time in policy review and development. The joint programme managers in older people's services, mental health services and learning disability services carried significant levels of authority from the council for strategic planning, commissioning, procurement and driving the delivery of major change programmes.

Operational and partnership planning

There was considerable evidence of operational and partnership planning for a range of services between Edinburgh and its key partners in the development of social work services. Some of these had been in place for some time, such as partnership planning for older people's services, the community mental health teams and partnership working for children under five. Others were more recently conceived and arose from responses to particular policy directives from the Scottish Government such as integrated planning for children's services, or critical incidents such as planning for protection of vulnerable adults and child protection. The Children and Young People's Strategic Partnership, the Child Protection Committee and Youth Justice Strategy Group were good examples of partnership planning in children and families.

The Joint Capacity Plan for Older People was the most comprehensive of the operational and partnership planning processes. Although there had been delays in implementation of its key objectives, the first of the new care homes which formed part of the strategy was completed and beginning to take residents. In addition, a tender had been developed for the provision of extended and reshaped day services. The council was fully supported by its main partner, NHS Lothian and a number of other partners such as users, carers and the independent sector. The Joint Capacity Plan was led by the Chief Officers' Group, supported by the Strategy Development Group for Older People and through service development groups for older people and older people's equality forums across the city. The next stage of the plan, for 2008-18, was well advanced and in the process of going out for consultation with a DVD presentation and a colourful, easy to read leaflet under the corporate logo 'live well in later life'.

We also saw recent strategies for people with learning disabilities and for people with physical and complex disabilities which were developed in conjunction with NHS Lothian and the other three local authorities within the NHS Lothian area. These were completed and out for consultation. These concentrated largely on Lothian-wide specialist services. At the time of the inspection, both strategies were subject to consultation and implementation planning was scheduled for early 2008.

We were advised that the Partnership in Practice Agreements were the vehicle for the local implementation of the Lothian wide strategy for people with a learning disability. However, we were concerned that there was not an up to date strategy or service development plan for the vast majority of people with learning disability living in Edinburgh. The Partnership in Practice Agreement 2004-07 was still a draft document in 2007 and was neither ambitious nor innovative in its proposals. There were no details in the financial framework and there was no action plan to modernise services for this care group. We were advised that an initial draft Partnership in Practice Agreement would be submitted at the end of January 2008 but were not provided with evidence about the context of this document. We return to this care group later in this chapter.

There was a strategic action plan for dementia services although it needed to be refreshed. The service deserved particular credit for producing a separate strategy dealing with the mental health needs of older people.

Another example of operational and partnership planning in health and social care was the work of mental health management group, which had been in existence for some time prior to the creation of the department of health and social care and the reconfigured Community Health Partnership. The development of mental health services had been in partnership with NHS Lothian and other agencies. Although there had been significant problems in agreeing a sustainable business case for the replacement and reduction of the Royal Edinburgh Hospital, there had been improvements and service developments taking place in community mental health services. This included the redesign and development of a range of flexible and intensive accommodation with support services, the development of employment and unique specialist adult learning services, arts services, advocacy and the Edinburgh Crisis Centre.

We were told by senior managers and staff that the mental health strategic plan had not been implemented and was now being re-designed by the Joint Edinburgh Mental Health Implementation Group. Partners in Edinburgh need to continue to improve and invest in mental health services in Edinburgh.

There was a corporate Action on Alcohol and Drugs Strategy and the Health and Social Care Service Plan set out how social work services would contribute to the corporate strategy through restructuring the drug and alcohol services, developing community rehabilitation and developing services for people with alcohol related brain disease. Health and social care was actively developing an Edinburgh wide addictions strategy. Comment was made earlier on the omission of children and young people with parental addiction from the most recent service plan. However, at operational level this was given priority. A specialist children and families worker was employed by the drug referral team and all staff in the health and social care drugs team participated jointly with child protection staff in supporting families. Comments received from social work staff during the inspection suggested that the links between the corporate strategy and departmental plans could be strengthened. Further reference is made to addiction services later.

The draft Carers Strategic Action Plan was an important demonstration of partnership working with NHS Lothian, health and social care, children and families, services for communities, and carer organisations.

Involvement of stakeholders in planning and service development

Health and social care

We found that stakeholders were in general involved in planning and service developments and that there was a culture of inclusion and openness in planning and service development. In health and social care, for example, the Joint Capacity Plan for Older People had actively engaged with service users and carers in the design of the new care homes. In mental health services it was stated there had been a long history in Edinburgh of the involvement of service users in service planning.

The community care partnership steering group included representatives from the independent sector, service users and carers. This produced the Community Care Plan. Below this high level group there were strategic development groups for the full range of care groups, including carers, and these groups had involved stakeholders and service user and carer representatives. A consumer involvement officer had recently been appointed in health and social care department. The department had developed a related strategy and given training to managers to help them to consult with service users.

Carers and other stakeholders had been involved in the carers strategy development group. However, we were told that there were resource constraints on the involvement of carers. Two carers' development posts were unfilled and there was no budget to provide sitter services to assist carers to participate in planning and development events.

Children and families

Prior to the creation of the children and families department, there had been a long history within the council of the involvement of a number of departments, agencies, service users and carers in the development of the statutory 'children's plan'. The foundations laid here were built upon in establishing the Children and Young People's Strategic Partnership which had a very wide range of representation and included major stakeholders.

The children and families department had developed a neighbourhood approach to the delivery of services and these neighbourhoods were beginning to be active, but were at differing stages in engaging with key stakeholders, service users' and carers' representatives in planning and service development.

Children and families had a consumer involvement officer whose remit included developing service user feedback to service planning. To date the focus of the work had been on developing public information on child protection on behalf of the child protection committee but this was about to revert to the original remit for the post. A cross departmental group had just been established to develop a consumer involvement strategy for the joint improvement plan.

Developing integrated services

The social work service was reorganised in April 2006. Since this time the development of integrated services has been variable between and within each of these departments and during this inspection it was still very much 'work in progress.'

In health and social care the 11 social work areas had been reorganised and reduced to five to be coterminous with the five health sectors in Edinburgh. We read documents which described developing integrated services, but we saw little progress on implementation. However, there were plans to bring staff from health and social work together in the same locations in some of these sectors around general practices.

A report to the Joint Board of Governance for the health and social care department listed a number of such services which we found were fully integrated, such as the Intermediate Care Services of Crisis Care, Rapid Response and Community Rehabilitation Service, and the Community Equipment Service. Some of these joint services have been referred to in chapter 5. Others were joint teams with staff co-located and working together but not fully integrated, e.g. the community mental health teams.

Children and families

In children and families there had been efforts to integrate. Social care and education early years services were now managed under a single management system. We also visited the recently established Prepare service which was an integrated social work and health service to pregnant women with substance misuse problems. It had a single manager for both groups of professionals but was on temporary funding and had still to be evaluated. The school social workers were working closely with other educational support professionals with a team work approach but not in a single management structure.

We read a report for the Children's & Young People's Partnership on Local Co-ordinating Groups which described how these groups would fit into the wider planning and strategic framework from a locality base, linking into the meetings and planning cycle of the Children and Young People's Strategic Partnership. Since these groups were still in their infancy, it was difficult to evaluate their effectiveness and achievements.

Range and quality of services

There were examples of a good range of services for some people and some teams, particularly the specialist teams in both health and social care, and children and families, who were providing high quality and much appreciated services for those who were able to access them. However, we were concerned that for some care groups, particularly those with learning disabilities, services were insufficient to meet needs and traditional models of service predominated. The range and quality of services offered by the council needed to improve.

Health and social care

Best value reviews had been used in the past to examine specific aspects of social work services, but more recently both departments had moved to more focussed and shorter life efficiency and service reviews. In health and social care one such example was the review of day care services which identified unmet need among older people, but also a need for new and different types of day services for people with physical and learning disabilities. We also saw the information pack on the Social Care Budget 2007-10 which identified areas of unmet need and set out proposals as to how the department would attempt to address these shortfalls, should funding become available.

In health and social care we inspected the hospital discharge support services, which included Crisis Care, Rapid Response and STARRT. We also learned of an innovative scheme for people who had been assessed as requiring care home placements but who wished to try to return home. A three day trial discharge at home was offered, with 24 hour cover if required. If the person's return home could not be sustained, they could return to hospital, or an alternative care placement. We heard that 50% of those referred to the trial discharge scheme had successfully been supported in their own homes. Other aspects of the hospital discharge service provided time limited intensive support for four to six weeks following discharge and an integrated health and social care community rehabilitation service.

We found problems with the range and quality of services for people with a learning disability. While services were improving, there was over reliance on care home provision and day centres, and relatively low numbers of people supported in their own tenancies or in employment. There had been some diversification of day services and housing options. However, many people with a learning disability were still being supported in day centres which were traditional in nature and many were unable to access suitable supported housing. For several years, a group of around 12 people had been living inappropriately in interim hospital accommodation, following the closure of NHS continuing care beds. Approximately 160 people were waiting for supported accommodation, some of whom lived in other services unable to meet their needs (including the group in hospital). Most of the people on the waiting list had a high level of needs. Many were living with elderly carers, who did not appear to be well supported.

There were lengthy waiting lists for respite and short breaks and many people were unable to get a service. Despite the difficulties in accessing respite, the short breaks and opportunities team was an example of good practice in delivering a service to those who were able to access it.

Good practice example

The short breaks and opportunities team for planned respite, holidays and day opportunities for people with learning disabilities and older people was found to be a good and innovative team. It had a professionally produced DVD of the service presented by service users and carers which it used as a communication and recruitment tool. The team provided good quality and much needed services, tailored to each individual's needs but to a limited range of service users despite high demand for such services from care management staff.

We have referred elsewhere to the poor quality of services for young people in transition to adult services. The deficiencies in services for people with learning disabilities were acknowledged by the council, but as stated already, there was no plan or budget available to indicate that this situation might improve within an acceptable timeframe. Local area co-ordination was under developed although this was being addressed.

Recommendation 9

The council should fully embrace the personalisation agenda for people with a learning disability. As a matter of urgency, it should bring forward funded plans to address the housing and care needs of those waiting for services, including those in hospital. Carers should be appropriately supported while they are waiting. It should also ensure that local strategy and commissioning plans are produced, to ensure that people with a learning disability and their carers achieve greater integration in the community.

Senior managers in health and social care recognised that the mental health service needed to be modernised and that this would take time. While MHOs seem to deliver a good service, the deployment, management, and supervision of MHOs should be reviewed. Support to people with mental health problems at evenings and weekends was seen to be insufficient.

We have noted the relatively low profile of addiction in both departments. While health and social care services provided a drug referral and residential rehabilitation team, and a commissioning officer was in post, addiction services, particularly in relation to alcohol, needed to be modernised.

We found evidence that the practice of having two home care providers (in-house plus an external provider) was widespread. Managers at different levels in the organisation told us that the imperative was to ensure that the in house provider was utilised as much as possible. Examples were given to us of the in-house provider being introduced after an external provider was contracted to provide a service, for example, when additional care hours were required. We were advised by senior managers that the department did not have a policy to favour the in-house service but this was at a variance with the rest of the evidence we received. We noted that the practice of involving two providers would not apply to provision that was subject to the new framework agreement for core home care services. We comment elsewhere on the negative impact on service users of having services delivered by multiple service providers. Older people told us about a major gap in preventative home care services, which if available could have helped them have a better quality of life. The council acknowledged this in its self-evaluation, recognising the value of low tariff services which the department was unable to provide due to budgetary constraints.

Physical disability services were found to be provided largely in traditional day centres. A recently completed review proposed modernisation, with more support services and locally based resource and outreach centres. Services for people with a sensory impairment were commissioned from the independent sector. We were told by a group of service users that the range and quality of these services was good and the services were efficient and effective at meeting people's needs and providing ongoing support.

Children and families

We have already identified concerns about the number of children who were unallocated or who were waiting for services they had been assessed as needing.

In children and families we found the throughcare and after care team and the intensive family support team both provided good quality services, although the number of service users able to access these services was limited due to the size of the teams and lack of capacity for expansion. The throughcare and after care team had not expanded since it was established in 2002, despite a doubling in demand for the service.

Children and families had undertaken a review of residential services and, as a result, a new respite and outreach service was being established through the re-provisioning of two young people's centres. We also saw a report on an audit of placements for accommodated children completed in 2006 and this identified a number of children in the community awaiting foster placements.

The department provided or purchased a range of services for children with disabilities, including residential services, respite, evenings and weekend services, specialist schools, and breaks and opportunities. It acknowledged that there were budgetary constraints which currently limited services to a range of individuals. From the evidence we received, we were concerned about the level and range of services available to children with disabilities. This was a recurring theme throughout the inspection with strong adverse criticism by staff, service users and carers. It gave rise to 13% of all formal complaints about social work services for children and families. The lack of adequate provision did not end as these children became adults, as the absence of service provision continued during and after the transition period from children's to adult services. This was compounded by disputes and confusion between the two departments as to which was responsible for services at this particular stage in the young person's development. One staff member commented 'this area of service appears to be one where the division into two departments created particular difficulties for maintaining service continuity'. This gap in range and quality of service for this group was acknowledged by the council but there was no comprehensive plan to address these shortcomings.

Recommendation 10

Children and families, and health and social care should work together to improve services for children in transition.

Quality assurance and continuous improvement

In health and social care since its creation, there had been a strong emphasis on developing quality assurance and striving for continuous improvement across all its services, starting with social care services. In the former education service there had been a strong quality assurance culture. In the integrated department this culture had been developed through a quality assurance framework.

Health and social care

In health and social care, the performance management group was helpful to managers wishing to undertake quality assurance of the services provided by the department. This has been enhanced by the work on quality assurance developed by the quality assurance team. This team had developed and piloted a quality assurance review in three practice teams based on the SWIA performance inspection model. This was led by officers from the team, but involved self-evaluation by local teams and managers. This included an action plan for improvements in performance in all areas of service but particularly where weaknesses were identified. The first three reviews had been well received and had been given a high level of priority and engagement from the practice teams. The guidance and procedures were robust but easy to follow without being over demanding for busy frontline teams.

The Performance Management Group received the results of satisfaction surveys of home care services. Regular surveys of the in-house home care services commenced in April 2006 and were completed on the basis of 100 service users on a bi-monthly basis. Results overall had been consistently high. The surveys had recently been extended to people who receive services from the independent sector. The team had also undertaken a similar review in a care home for older people in 2005 and we were told that this had been well received, was an excellent learning experience and had led to real improvements. The team leader of SCD randomly sampled two or three calls each week from each of the advisers to evaluate how they dealt with calls.

Children and families

The quality assurance approach described above was based on the quality assurance framework developed and piloted in children and families which also used three out of the ten areas of the SWIA performance improvement model. The children and families quality assurance system included a Quality Framework, review procedures and self-evaluation booklet. Four pilot reviews were carried out, the methodology being reviewed and amended in the light of this experience. Six reviews of practice teams and several other social work teams and units had been completed. The absence of examination of performance data in key areas of service limited the comprehensiveness of the review process to some extent. The reviews to date had placed insufficient emphasis on the delivery of key processes, where there were major challenges of quality assurance. A 'support and challenge' approach was initiated by the Quality Improvement Team and implemented across all children and families services. As in health and social care, the teams had been keen to engage and take ownership of the process. There was also a manager responsible for quality assurance aspects of child protection and there was evidence of audit activity.

There was a recognition by the director of children and families that the approach to performance management for social work services needed to be rationalised and improved. She was committed to retaining the department's internal quality assurance system and acknowledged the need for this to be supported by better management information systems and a stronger emphasis on performance management.

Good practice example

In partnership with Standard Life, children and families department staged an annual achievement awards programme to celebrate excellence and recognise success, best practice and innovation in all aspects of children's services. This was in its second year for the new department and a number of entries were from children and families social work services such as a paediatric OT service and the throughcare and after care project. A similar awards scheme had just been introduced in the health and social care department and awards for 2007 had been presented.

We reviewed the complaints systems in both departments and found that the health and social care department responded to 100% of their complaints within the 28 day statutory time limit. Monthly monitoring reports were also produced and this information contributed to service planning processes. There was also evidence of improvement in home care as a result of learning from complaints. Children and families achieved a 90% response rate. We considered that children and families should aim to respond to all complaints within the statutory time period and the service plan target of 90% should be raised to 100% in line with the statutory requirement. Children and families had introduced complaints debriefings to inform service improvements. Overall we considered that there was scope to develop learning from complaints to improve further service improvement in both departments.

Management and support of staff

Performance in this area was good – having important strengths with some areas for improvement.

Both departments had made good progress in making sure that staff had the appropriate qualifications they needed to carry out their jobs. Children and families had taken great steps to reduce the vacancy rate in the department. Both departments had taken steps to build a workforce for the future. They had developed useful continuing professional development frameworks and had begun to develop more systematic ways of identifying the training needs of staff. Recruitment in children and families had improved. Induction programs were in place in both departments and the majority of staff received the appropriate level of supervision.

Both departments needed to develop more joint training opportunities with key partners. Children and families also needed to pull together all of the elements of its training strategy into a clearer workforce development plan.

Recruitment and retention

The council employed a much higher than average percentage of social work staff in children and families (in 2006, 12.0 per 1,000 – the highest in Scotland – against a national average of 6.8) and a slightly lower percentage in health and social care (6.1 per 1,000 compared to an average of 6.3).

From a vacancy rate of 34% in 2004 children and families had succeeded in reducing this to a rate of 5.1% in 2007, achieving this through improved advertising, salary increases and the introduction of six-monthly salary increments for social workers. This had relieved some workload pressures but in the short term had increased the demands on senior social workers and practice team managers who had to supervise high numbers of inexperienced social workers. There remained a shortfall in the number of senior social workers (7.5 vacancies). Staff commented that neighbouring authorities offered more competitive salaries for this grade of staff.

There were no vacancies within residential child care homes.

Good practice example

Edinburgh had a well-established recruitment and development centre. The centre offered a single point of entry for selection of residential childcare staff, issuing successful applicants with a six-month contract during which they were required to complete a competence portfolio. The centre had received a positive evaluation from Glasgow School of Social Work which had concluded that the approach had led to a raising of standards.

The department of health and social care reported historically low vacancy levels across the practice and hospital teams, though staff we spoke to highlighted marked delays in filling posts. It filled temporary posts elsewhere in the department through a locum bank (shared with children and families) or by using agency staff. There were particular difficulties in recruiting care home staff, and the new build care home had not been able to open fully because of insufficient staff despite recruitment drives.

Both departments had taken steps to build a workforce for the future. This had included funding 51 graduates over the period 2003-08 to complete the Diploma/Honours degree in social work, and planning for the end of the Government's fast-track scheme by developing a pilot distance learning project with Robert Gordon University. They had also piloted a programme – albeit with limited success – to provide assistant unit managers with the opportunity to gain the management qualifications they would need to take up posts of unit managers.

As a result of the council's financial crisis all requests to fill vacancies had more recently needed the approval of the relevant departmental director, although the director of children and families stated that frontline social work posts would receive automatic approval.

Although not connected to current recruitment restrictions, many staff we met, for instance in the youth justice and throughcare and after care teams, did not have contracts. Some had been employed by the authority for a year or more but had received only letters of appointment. Responsibility for these delays appeared to lie with the council's corporate human resources section.

Safer recruitment arrangements applied to all staff. The department of health and social care had identified a gap during the process of setting up its Social Care Direct service, finding that a number of staff recruited from the council's call centre did not have appropriate disclosure checks. The department had since addressed this issue.

Once employed, new staff in both departments received comprehensive induction programmes over their first three months in post. Both departments recognised the need to build on this by developing workplace-specific inductions.

The council offered the option of flexible and family-friendly working arrangements. The majority of staff who responded to our survey agreed that these were in place, and trade unions commented that they were not aware of either department placing any obstacles in the path of staff who applied for alternative working patterns.

For the period June 2006 to May 2007 average sickness rates for health and social care were 9.57% and those for children and families 7.78%. Unfortunately neither department had absence data prior to restructuring of social work services which would allow them to make useful comparisons.

In its SEQ the department of health and social care reported that it had taken a 'vigorous' approach to tackling high absence levels particularly in its home care workforce. This included regular performance reporting on absence targets and allocating dedicated human resources staff to assist home care co-ordinators in managing absences.

Managers reported that this had led to a reduction in absence levels to 8.49% (as at August 2007). Trade union representatives viewed the approach taken in relation to home care staff as over-vigorous and failing to pay sufficient attention to the welfare of staff. A positive example had been a pilot offering physiotherapy sessions to home care staff who were absent due to muscular skeletal problems.

Staff deployment and teamwork

Staff deployment

Both departments had taken steps to make best use of staff resources. Examples included:

- the development in health and social care of separate sector response and care management teams, the former undertaking short term assessments and the latter longer term work;
- the establishment in health and social care of the service matching unit, staffed by administrative staff who had taken over responsibility from professional staff for matching assessments for home care with local authority and external providers;
- a 2005 exercise in children and families to measure workloads in each practice team and to match staffing establishments to these; and
- the development of a workload management system for the sector teams.

There was more that both departments could do. For example, there remained a high number of unallocated childcare cases, including young people looked after at home and young people over the age of 16 who had recently been accommodated. The workload review that had taken place in 2005 may not have taken a comprehensive enough look at the workload of all practice, working together and city-wide teams to determine overall capacity of the children and families service and redistribute workload accordingly.

There was a workload management system within children and families services. The department told us that its aim was for social workers in children's services to have a caseload of 14 cases. However, we found the system was not being used in all teams, with comment made that it was too formulaic and took insufficient account of the large number of inexperienced staff. We noted the system included no means of weighting caseloads by taking account of the complexity of individual cases.

There was no workload management system in health and social care, where managers told us that they dealt with this as part of supervision. They received monthly reports with information about team and individual worker workloads which they could use as part of this process.

In our staff survey, 68% of staff agreed their workload was manageable within normal working hours, which was comparable with the findings with previous inspections. The level of agreement was higher amongst health and social care than childcare staff.

Staff we met also highlighted issues in relation to administrative staffing, commenting on the loss of economies of scale and imbalances in provision following restructuring of the former social work department. Forty-one per cent of those who responded to our survey disagreed that there was an adequate level of administrative support – which was at the higher end of the scale. There were plans to carry out a review of administrative services.

Managers acknowledged that the authority had fallen behind in developing a new pay and grading structure, a process that involved developing job profiles within ‘job families’. The authority planned to implement the new arrangements by July 2008 although discussions with the trade unions had yet to take place.

Staff supervision and teamwork

The majority of respondents to our survey or whom we met agreed that they received an adequate level of supervision. Exceptions included the home care service where there was a supervisor to staff ratio of 1:50. Senior managers in health and social care had acknowledged the issue and signalled their intention to address this through the working group on modernising the home care service. ‘Satellite’ MHOs in health and social care also highlighted difficulties in accessing professional supervision. A recent agreement had been put in place to offer them one-to-one mentoring from the central MHO team.

In order to ensure that the new children and families department retained a focus on professional supervision the service had established the post of service development manager. Responsibilities of the post included direct professional supervision of the small number of staff (five) who were line-managed by non-social work staff. There was no obvious link between the functions of this post and other processes for assuring the quality of services.

The majority of staff who responded to our survey agreed that their teams met regularly and that team meetings were normally purposeful and effective.

Development of staff

The department of health and social care had set itself a key task of ensuring that staff had appropriate qualifications to undertake their job and had proved successful in doing so. It had used government funding for developing skills in the workforce to deploy peripatetic SVQ assessors. By 2007, 53% of those working in care homes for older people and 71% of those working in residential care for other adults had appropriate qualifications and the majority of social care workers in the home care service had achieved SVQ level 2. Managers acknowledged that the process would slow down if funding ended in March 2008 at which point residential unit managers would resume the role of assessors.

Ninety-four per cent of staff in our survey agreed that they were aware of their responsibilities set out in the Code of Practice for social work service workers. Sixty-two per cent agreed that their employer was fulfilling its responsibilities under the Code of Practice for Employers, with 12% disagreeing.

Although there was a consensus among the majority of staff that they received adequate training opportunities, the department recognised that home care staff had more restricted opportunities for development and had commissioned Stevenson College to develop a 'practice licence' course for these staff.

Health and social care's workforce development team acknowledged that it had given less attention to providing continuing professional development (CPD) opportunities for qualified social workers but had recently begun requiring staff to forward copies of their personal development plans. Training managers stated that this was already beginning to help them identify training needs in a more systematic way. The department of children and families had carried out a training needs analysis during 2007, and this will be repeated bi-annually.

There had been delays in rolling out the council's personal review and development (PRD) process due to corporate amendments to the initial version of PRD issued last year. Training on the new version was underway in both departments and some teams had begun to use the process. PRD replaced the authority's staff appraisal system. Less than half of staff who responded to our survey had found the former system helpful.

The department of children and families gave similar priority to ensuring that staff had appropriate qualifications for their post. By 2007, 72.2% of child care workers held appropriate qualifications.

Child protection training and CPD were also priority areas. There was no ceiling, for example, on the number of qualified social workers who could apply to undertake the child protection course at Dundee University. Many newer staff had yet to undertake basic child protection training.

Both departments had developed useful CPD frameworks for qualified social work and occupational therapy staff. Children and families had also designated a member of staff in each team or unit to act as a CPD co-ordinator.

The departments advertised training opportunities primarily via e-mail. Staff who did not have access to computers – for example, those working in residential homes day care and home care services – stated that they did not always receive information. Staff in the council's emergency social work service also considered that they missed out on training opportunities.

There were only a few examples of joint or multi-disciplinary training. These included multi-agency child protection training and a recent pilot in case management training that had included district nursing staff. Both departments provided joint induction sessions.

The separate learning and development teams of the departments maintained strategic links through a workforce strategy group chaired by the CSWO. They maintained operational links on cross-cutting issues such as practice learning placements for student social workers and SVQ assessment (children and families use the assessment centre within health and social care for registration, standardisation and verification purposes).

There were some gaps in training provision, for instance in relation to substance misuse training for non-specialist staff.

Health and social care had set out its priorities for developing its workforce in a workforce development plan for 2007-08. Managers in children and families stated that their plans were contained in a number of documents including the service plan, CPD strategy and budget documents. There was no single document that clearly outlined the department's workforce development priorities, linked these to both corporate priorities and national strategies and that set out cost implications.

Recommendation 11

Children and families should draw together all the elements of its workforce strategy into a readily understood and comprehensive development plan.

Resources and capacity planning

We considered performance in this area to be adequate, with strengths just outweighing weaknesses.

The links between the operational service plans and the financial plans needed to be improved, particularly in regard to the children and families services. Corporate finance produced prompt, comprehensive budget management information. However, the children and families division struggled to take sufficient corrective action to reconcile the level of service provision with the available budgetary resources, particularly in a climate of rising demand for services. This resulted in significant overspends. Budgetary control was generally well managed in health and social care and budget holders appeared to be well trained. There were acknowledged weaknesses in budgetary control in children and families. Both departments had good working relationships with the appropriate finance staff.

In terms of Community Health Partnership arrangements, joint financial reporting required further development. More generally, partnership arrangements were found to be good, with a strong organisational commitment to engagement with partners, and a willingness to identify and address areas for improvement.

The management of resources was generally found to be good. The phased implementation of new information systems had been late to commence but was being well managed. There was room for improvement in health and safety and in administrative supports to front line staff. There were strengths in the development and use of management information systems in health and social care, while children and families were found to be weak in these areas. Whilst there were some strengths in commissioning, there were significant areas for improvement, particularly in the development of written commissioning plans, provider engagement and contracting.

Financial management

Financial plans

In recent years, the authority had set its social work services budget higher, on average, than the Grant Aided Expenditure (GAE) level. In 2006-07 the budget for social work services was 13% above GAE, in line with previous years. For social work services as a whole, outturn was slightly higher than budget in 2004-05 (£0.2m). In 2005-06, social work services were restructured and services for vulnerable children were included within the children and families department, with the remainder of the services being provided by the health and social care department. At 31 March 2006, the health and social care department's outturn was close to budget and the children and families department's outturn was 8.8% over budget (£4.7m), most of which related to services for vulnerable children.

Budgeted spend on children's services during the three years to 2006-07 averaged 27% of the social work budget, compared to the Scottish average of 23%. We were advised that this was due to greater priority being given to services for vulnerable children in recent years. Conversely, the percentage budgeted spend on older people was lower than the Scottish average over the same period, 43% against the national figure of 48%, although this had been converging.

In general, we found room for improvement in the way social work services linked financial plans and operational service plans. There were separate service plans covering the years 2007 to 2010 for the health and social care, and children and families departments. The health and social care service plan set out the key departmental priorities and the key service objectives for achieving these priorities. There were separate sections in the service plan which provided details of the health and social care revenue and capital budgets over the period of the plan and other relevant financial information. However, the 2007-08 cost pressures (see below) were an indication that the operational service plan was not adequately resourced by the 2007-08 budget, and therefore the council should consider strengthening the links between the service and financial plans.

Similarly, the Children and Families Service Plan 2007-10 set out the actions required to achieve the aims of the service. There was a financial framework section in the plan which provided details of the children and families capital investment programme over the period of the service plan. However, although the service plan contained examples of budget related aims, the revenue budget information within the plan was very limited. It provided brief details of the children and families 2006-07 revenue budget (which was not relevant to the period covered by the service plan). We did view a comprehensive children and families budget pack, but the links to the objectives in the service plan were not clear, as the purpose of the budget pack was to inform elected members during the budget setting process and was therefore produced prior to the approval of the final budget.

The director of finance informed us that the council was working with consultants to produce a 10 year financial plan. There were medium-term capital plans in place for general services and housing.

In 2006-07, the health and social care department exceeded its budget by £2.3m (1%), with the main areas of overspend relating to learning disabilities and services for older people. This was due, in part, to the council's decision not to reduce expenditure in those areas that would impact on delayed discharge figures. The children and families department exceeded its budget in 2006-07 by £9.5m (19%), £7.3m of this overspend relating to services for vulnerable children. The main areas of overspend were in residential staff costs, fostering and special carer fees, out of area school and secure unit placements, independent schools and section payments.

At the time of the inspection in 2007-08, both the health and social care department, and children and families department were continuing to face significant financial pressures.

Health and social care

The director of health and social care reported to the council on 20 September 2007 setting out measures to bring health and social care revenue expenditure for 2007-08 into line with budget. This report followed on from a report submitted to the council on 23 August 2007 which detailed the 2007-08 financial position of the council as at month 3 and identified that, in terms of the health and social care department:

Projected overspend (net of £4.9m of efficiency savings)*	£5.589m
Savings measures of £4.676m proposed of which approved -	£2.926m
Revised projected overspend	£2.663m

* - This overspend was due mainly to unbudgeted expenditure on purchased domiciliary care and higher than budgeted costs for free personal care.

The report submitted on 20 September 2007 by the director of health & social care identified that, at month four:

Projected overspend (net of £4.9m of efficiency savings) following management action subsequently approved by council	£1.810m
Further savings measures of £0.936m proposed of which approved -	£0.404m
Additional alternative savings measures approved by council *	£1.130m
Revised projected overspend	£0.276m

* - Included potential £1m dividend income from council companies and using members' allowances savings of £0.130m.

There was an appropriate system via the Performance Management Group and the Senior Management Team for monitoring the savings. Efficiency savings were reported to the council through regular performance and monitoring reports to the Council Management Team and the council itself.

Our review of the health and social care department's approach to the identification and monitoring of efficiencies noted a number of issues:

- We were informed that, of the original £4.9m efficiency savings included in the 2007-08 health and social care budget, some £0.9m might not be achievable.
- We were further advised that, with the exception of (a) deferred growth and (b) purchasing inflation, all savings would be recurring in the sense that the budget had been permanently reduced by these amounts.
- Efficiency savings were monitored and any issues were noted in budget monitoring reports considered by the council or the Finance and Resources Committee. Achievements against targets for the current year were included in the annual Budget Information Pack and were considered by Members as part of the annual budget planning process. We were further advised that, from October 2007, efficiency savings information were to be included in the bi-monthly scorecard, reviewed by the corporate management team and considered by the Health, Social Care & Housing Committee.

Children and families

The director of children and families reported to the council on 20 September 2007 setting out the measures proposed to bring revenue expenditure (which included education services) for 2007-08 into line with budget. This report followed on from a report submitted to the council on 23 August 2007 which detailed the 2007-08 financial position of the council as at month three. This report identified that the children and families department had a projected overspend of £3.969m (net of £5.802m of efficiency savings). This reflected almost £14m of cost pressures offset by identified savings measures of £10m, of which £3.641m were one-off savings for 2007-08 only. The main cost pressures within services for vulnerable children were staff costs, fostering services, out of area school and secure unit placements, independent schools and unachieved income budgets. The savings measures within services for vulnerable children included vacancy controls, freezing out of area placements and reducing commitments on out of area school and secure unit placements and independent school fees.

Furthermore, the report proposed a range of further potential measures totalling £3.387m to reduce the overspend in 2007-08 although some of these were one-off savings.

The same report identified that, at month four, the projected overspend had slightly reduced to £3.549m as a result of action taken by management. However, a decision by the council to postpone the estate rationalisation programme had impacted upon forecasted savings in property costs and the projected overspend had actually increased to £5.333m. The overspend reflected £15.855m of forecasted cost pressures offset by identified savings measures of £10.522m. The report also proposed a further range of measures to increase the total savings identified to £15.855m and balance the 2007-08 budget. We noted that £8.791m of the total savings identified were one-off and related to 2007-08 only. The council approved the action plan which detailed the measures to achieve a balanced budget. Our review of the department's approach to the identification and monitoring of efficiencies noted the following:

- We were unable to confirm whether or not the £5.802m efficiency savings included in the 2007-08 children and families budget would be achieved.
- There was no reporting mechanism to ensure that members received clear reports on the department's progress in achieving the anticipated efficiency savings.

We also noted that the director of finance submitted a further report to the council on 20 September 2007 which outlined the responsibilities placed upon elected members to approve the action necessary to address the difficult financial position. The report stressed that the council has a statutory requirement to set a balanced budget for each forthcoming financial year and outlined the impact of the 2007-08 financial pressures upon future years' budgets.

In summary, we found that, despite strong and clear reports produced by the director of finance, management in children and families and members had been slow to accept responsibility for the budgetary problems and take adequate, prompt action to resolve the difficulties. It appeared to us that there was a culture whereby children and families managers had an expectation that additional resources could be found from outside the service rather than by critically examining how the budget could potentially be balanced from within. Corporately, there was a recognition that health and social care managers were making every effort to balance the budget in difficult circumstances.

Furthermore, the problems appeared to be aggravated by 'efficiency savings' which both departments had considerable difficulty in achieving. It was also compounded by known commitments not being fully funded within the budget (e.g. care at home costs – £1m under-funded). As a significant proportion of the required savings were being resolved by one-off 2007-08 savings, social work services were due to face yet another very difficult budget setting period for 2008-09. Additionally, many of the planned 2007-08 savings were known by management to have a high risk factor and therefore unlikely to be achieved.

Recommendation 12

In order to facilitate forwarding planning and identify and plan for potential future cost pressures, the council should ensure that service plans, particularly children and families, are clearly linked to and fully supported by available resources as identified in detailed financial plans.

Recommendation 13

Departmental management and members should ensure that prompt action is taken to resolve significant budgetary overspends. This is particularly crucial where the council has virtually no reserves available to fund any such overspends. Planned savings should only be considered where they have a reasonable chance of being achieved.

Budgetary control

Within both health and social care and children and families, financial management and support was provided by the finance staff from the business support section. There were good working relationships between budget managers and the relevant finance staff. Overall, we found that in health and social care, budgetary control was well managed. We also found adequate financial skills both in quantity and quality.

There were acknowledged weaknesses in children and families. Remedial action had been agreed in order to instil a performance culture in budget managers, to complete an exercise to fully align budgets with cost centres and account codes so that budget monitoring reports were meaningful to managers, and to develop a workforce planning framework so that budgets could be matched to organisational structures. The director and the chief executive were aware of the need to strengthen financial skills within the department and a work programme had been approved which included further training for budget managers and inclusion of competent financial management in budget managers' objectives.

At the time of the inspection the council's internal audit function was reviewing the budgetary control procedures within the children and families department and reported to the council in November 2007. The findings identified failures in the financial management arrangements within the children and families budget which were exacerbated by the inability to track income as well as expenditure adequately.

We met with a group of budget managers from the two departments who told us that they had received financial management training as part of a general management training course and had also received financial ledger training. Additionally, they could request advice on budgetary control matters from an appropriate finance officer at any time. We noted that the action plan arising from the internal audit of children and families budget outturn variances included issuing revised guidance to budget holders.

The corporate management team regularly discussed revenue budget monitoring. Finance and budget control were discussed fortnightly at the Heads of Service meeting, which was chaired by the director and attended by all heads of service, along with the principal finance manager, children and families. We noted that there were regular detailed discussions on revenue budgets at health and social care senior management team meetings.

Finance officers generated monthly budget monitoring reports for budget managers who also received monthly detailed staff lists. Both monitoring reports and staff lists could be accessed electronically at any time and budget managers could 'drill-down' to individual transactions. Budget managers felt that the availability of IT systems and their ability to access these was extremely helpful.

Budget managers met regularly with finance staff to discuss budgetary matters and most said that they had been involved in the annual budget preparation process and were able to apply their local knowledge in identifying cost pressures and areas for savings.

In terms of financial performance reporting to elected members, the director of finance submitted regular budget monitoring reports at a corporate level to the executive of the council. The financial performance of individual service departments was included in these, and they also included the year-end forecast position. We noted that reports gave sufficient detail in terms of explanation of major variances and the actions required to address overspends. In addition, six monthly budget monitoring reports by the director of health and social care and the director of children and families were presented to the executive of the council during 2006-07, thus providing additional details to members.

Following the council election in May 2007, the council moved from a cabinet style structure to a committee structure. At the time of the inspection, the Health, Social Care and Housing Committee had met only once and had not considered any financial performance reports. However, health and social care financial performance reports for 2007-08 had been regularly presented to members at meetings of the council. Similarly, there had been only one meeting of the Education, Children and Families Committee during 2007-08 and no financial performance reports had been presented. However, financial performance reports for 2007-08 in relation to children and families had been regularly presented to members at meetings of the council.

The main forum for the management of joint working with NHS Lothian was the Edinburgh Community Health Partnership (CHP). The CHP was part of the health and social care department, which has a single management structure. In terms of financial monitoring of jointly provided services, finance officers told us that there had been no developments in this area and plans were in place to implement a revised reporting structure to address this. Therefore, at the time of the inspection no joint financial reports were produced and presented to elected members. We considered that financial monitoring information should be routinely submitted to members and senior managers in relation to services provided within partnership arrangements.

Due to the reduction in supporting people funding, the council had made deductions from commissioned services contract payments and budget managers had to manage service provision accordingly.

Recommendation 14

The council should ensure that regular financial monitoring information is formally submitted to members in relation to services provided within partnership arrangements and that the appropriate officers also consider such data at their joint meetings.

Capital expenditure/planning

The council approved a capital investment plan for the years 2007-10 and beyond.

A report to the executive of the council in August 2007 provided details of the capital outturn for 2006-07. The report noted that there was significant slippage, with children and families underspent by £17.9m and health and social care underspent by £12.3m. The slippage in the children and families capital programme related mainly to educational related projects. The slippage in the health and social care capital programme was almost entirely due to delays in the new care homes programme.

The slippage in the capital programme had continued into 2007-08 with significant underspends projected within children and families (£8.4m) and health and social care (£8.5m). The Corporate Asset Management Group monitored the progress of the capital investment programme on a monthly basis.

A report was submitted to the council in February 2006 updating members on the Joint Capacity Plan for Older People's Services. This report outlined that it would cost some £13.2m for the provision of three new care homes (£4.5m) and additional intensive community packages (£8.7m).

A significant proportion of the funding package to meet these costs was not guaranteed as it was based on anticipated savings being achieved in various areas and was considered to contain almost £3m of funding that was subject to financial risk. At the time of the inspection, we understood that at least £0.4m would not be achieved and it was unknown what other funding, if any, might not be realised. The council advised us that the funding gap for 2007-08 was largely being met by deferring the planned expansion of day care services to 2008-09.

The capital monitoring reports presented to members provided high level details for each department in total. The main reasons for slippage were also provided. Only year end reports appeared to provide data at individual project level.

Income

Managers told us that the council charged for all services wherever reasonable. Charges were regularly reviewed and the charging policy took into consideration COSLA guidance to councils on charging policies for social care.

Elected members role

Elected members are the ultimate corporate decision makers in local government and they should base their decisions on clear, complete and unambiguous reports.

We considered that the content of financial reports to members, although sufficiently detailed and with year-end projections where appropriate, could have been structured in clearer terms. This would allow members to more easily interrogate the data and ask informed questions.

We were satisfied with the quality and frequency of finance related reports to elected members. From discussions with elected members, the chief executive and directors, it was clear that elected members were generally supportive of social work services for vulnerable children. This had been reflected in successive budget setting exercises. There did not appear to have been a culture of elected members questioning whether children and families services were being delivered efficiently, or achieving best value. In health and social care, some additional resources had been allocated, for example, to develop some additional services for people with learning disabilities, although the pressure on social care budgets for adults remained severe. Nevertheless, in terms of the ongoing budgetary pressures, we were of the view that members had been slow to accept responsibility for the budgetary problems and take adequate, prompt action to resolve the difficulties. However, we were pleased to note that the director of finance had issued a clear report emphasising the responsibilities and statutory requirements of members in relation to the financial management of the council.

Resource management

Asset management plan (AMP)

An asset management plan gives clarity about balancing service needs and available capital resources. It informs a sound capital planning process linking service priorities and objectives.

The corporate asset management plan (AMP) 2006-09 was approved in January 2006 and covered all operational property, except council houses. At the time of the inspection, a 10 year AMP was being developed for older people's services, mental health services and learning disability services. The health and social care department had an asset management group chaired by the director of health and social care and comprised representatives from both the council and NHS Lothian.

The children and families AMP (originally produced in 2003) was monitored and updated annually, with a large scale review anticipated on a 5 year cycle. The children and families department had an asset planning section to oversee the strategic management of the buildings estate. A review of the entire children and families estate had taken place which proposed a rationalisation and development programme and was approved by the council in August 2007. However, on 15 September 2007, the council decided to revoke the decision made in August 2007. We understand that no further decision had been taken with regard to the children and families estate rationalisation programme.

Risk management

The council had approved a corporate risk management strategy in October 2005 and developed corporate and departmental risk registers. However, more work was required to ensure risk management was fully embedded across all departments. The health and social care department risk register was included as an appendix to the Health and Social Care Service Plan 2007-10. The register identified the top 10 risks facing the department (from a total of 30) and for each one there was a description of the risk and the controls in place to address it.

We were provided with a risk register for the children and families department which, for each risk, provided a description of the risk, the initial risk score and the mitigating controls to address the risk. The risk register was produced in June 2006, updated in October 2006, and was due to be further updated in November 2007. However no further update was provided to us as evidence of review and management of the risks identified.

Health and safety

A revised corporate occupational health and safety policy was approved by the executive of the council in August 2002 and had not been updated since then. This set out a requirement for heads of department to produce supplementary departmental occupational health and safety policies, and annual reports which summarised the health and safety performance of their departments. Although there was an occupational health and safety policy for health and social care (dated April 2005), no such policy existed for children and families. Compliance with the corporate policy on health and safety should be given priority.

No annual health and safety audits or reports had been produced by departments or by the council due to restructuring of the health and safety function into the corporate services department. Neither department appeared to have supplemented the corporate policies with service specific health and safety procedures. For example, the policy provided on lone working was the corporate policy and had not been customised for staff working in social work settings.

We were advised of some initiatives relevant to promoting health and safety. These included issuing community based practice teams in both departments with mobile phones. During staff focus groups, some health and social care residential workers felt that the service was not sufficiently responsive to health and social issues. The findings of our staff questionnaire revealed that just under a quarter (23%) of staff in health and social care did not feel well supported in situations of personal risk. This finding was surprising and suggested that there may be particular issues which the department should address. The comparable figure for children and families was 10%.

Overall, we considered that that health and safety should have a much higher profile in both departments, in terms of identifying risks, developing action plans to support staff, and promoting best practice.

Recommendation 15

Both departments should strengthen health and safety arrangements to ensure consistency and fitness for purpose in distinctive social work settings.

Information systems

A major programme to modernise social work information systems in health and social care, and children and families was underway. This was well behind many other councils, with the first phase of the Anite SWIFT system implemented as late as April 2006. We considered that the project was well managed and overseen by a project board, with representation from the two departments and the corporate e-Government division. Strong links had been established with operational interests through the secondment of operational staff to the project, for example to temporarily enhance the SWIFT training team. Financial modules, which would interface with the corporate finance system, were being phased in at the time of the inspection.

The council had a financial and technical impact assessment for the upgrading of SWIFT to enable implementation of a web-based home care module and further upgrading to allow implementation of the national eCare programme. In advance of the latter, single shared assessments were being managed using the e-Assess system for Carenap assessment information, while SWIFT held the assessment process data. The need to maintain two systems in the short term was an acknowledged irritant for front line staff. The upgrade costs featured in the department's 2008-11 budget submission.

Within children and families, a new pupil information system was in the process of being implemented. This would ultimately have the capacity to link with the SWIFT system when the technical infrastructure to support this was in place.

We heard that the implementation of SWIFT had involved a major step change for operational staff, as data entry on the previous client index system had received low priority. Operational staff and managers, including those working in the emergency social work service team, spoke positively about the benefits of the new system. However, there were significant data quality issues, both in terms of data required for operational purposes and also the quality of data used for management information. Whilst these were progressively being addressed, there was a need for managers to ensure that corrective action was taken as quickly as possible to address identified deficiencies. There were still some significant gaps in SWIFT coverage, in particular for stand alone projects and council operated residential, day services and home care. We also heard that there were issues in relation to information on externally purchased services being recorded on a number of different systems, however, at the time of the inspection, the departments were in the process of replacing these systems with the financial modules of SWIFT.

The findings of our staff survey suggested that there was scope to improve the use of information technology to assist staff in undertaking their day to day jobs. During the fieldwork, some staff and teams, including administrative support staff, reported insufficient access to personal computers, and restricted or no access to the council's email and intranet systems. This was felt to impact negatively on staff morale. We noted that the two departments were making significant progress in addressing these issues as part of the joint improvement plan.

Administrative support systems

We referred earlier in this chapter to the negative findings in the staff survey regarding the levels of administrative support available to front line staff.

During the fieldwork, we came across examples of poor administrative support for child protection case conferences. We considered that immediate action was needed to ensure a suitable level of administrative support for all high risk work with children and families. The director of children and families communicated a clear understanding of the importance of administrative support systems for front line services. She explained that administrative capacity issues had been raised with her by front line staff; these were being investigated and if necessary would be addressed. The chief executive was aware of her concerns about levels of administrative cover and was aware of emerging plans to address this.

In health and social care, particular concerns were raised about administrative support for mental health officers, where there were major, long standing issues which had been addressed with the recruitment of additional staff.

Management information systems

Edinburgh had adopted a corporate performance management system. Since April 2005, all departments had been expected to produce bi-monthly scorecards and these were reported to the corporate management team and relevant committees. The corporate expectation was that departments should be revising their performance scorecards in line with the 'priority actions for success' in the council's new Corporate Plan 2007-11.

The introduction of the SWIFT system had significantly improved the quality of management information, and in turn using information for management purposes provided an opportunity for checking and improving the data quality. However, operational managers had still to utilise the system's capacity to generate routine performance reports and we considered that planned extensions to the suite of routine performance reports should be accelerated.

Health and social care

In health and social care, management information systems covering a wide range of information were in place. In common with many other parts of Scotland, these reported service activity rather than outcomes. The service plan reported performance on statutory performance indicators, the departmental scorecard and a number of performance benchmarks which showed Edinburgh's performance compared to other cities and to Scotland. The current departmental scorecard consisted of 13 indicators drawn from a wider set used internally within the department. The information was succinctly presented, with explanations of short and long term trends, and action plans for each indicator which had a red rating. It was also published with a commentary on performance in the departmental newsletter.

In addition to the scorecard, health and social care produced a monthly performance report. This gave information on such areas as contacts, average caseloads, number of people waiting for assessment, number of carers assessments completed and various aspects of care at home, residential and respite services. They had also introduced a monthly audit of data input errors in order to address the serious concerns about gaps in information due to data input failure. Although the reports we saw were aggregated across the council, the same information was available to local practice and service teams. This development had been made possible by the introduction of SWIFT.

Internally, a wide range of management information reports were produced and this was co-ordinated through a regular performance management meeting chaired by the head of social care performance. There was scope to strengthen the challenge role of the performance management group, and to improve action planning and reporting.

There was scope for health and social care to improve its use of management information to provide an evidence base which would assist with its re-design and commissioning of community care services. Likewise, although elected members were provided with a high quality of information, we did not find much evidence that this influenced key decisions about the level of resources for health and social care, and the range and scale of services needed to meet community care needs.

Children and families

By contrast with health and social care, management information systems for children and families social work services appeared to be poorly developed. We did not find in the service plan or elsewhere routine information which enabled comparison of social work performance either with other cities or comparator authorities or with Scotland. The departmental scorecard was very limited in its coverage of social work related indicators. At different levels in the children and families, managers appeared to be unaware of key performance data and unaccustomed to using it operationally or strategically. However, we were encouraged that the director was giving high priority to identifying with key partner agencies a set of around 30 core outcome indicators which would be at the heart of future management information systems. This work was advancing well and we heard that the partners were close to concluding agreement on the indicators.

Recommendation 16

Senior managers in children and families should take early action to improve management information, so that managers at all levels receive regular performance reports and are required to demonstrate the capacity to use these to drive up performance.

Partnership arrangements

At the broadest strategic level, the framework for partnership working in Edinburgh was contained within the recently updated Corporate Plan covering 2007-11. This set out revised high level priorities. Further work was being undertaken to convert it into SMART objectives and action plans. New community plan objectives had been agreed by the Edinburgh Partnership in August 2007. The objectives were expressed in terms of four themes, and NHS Lothian had been given the lead on a short life task group charged with taking forward the theme of prevention and care, health improvement and social inclusion. It had not been made clear how this new task group would link to the community care partnership steering group which brought together representatives of the council, NHS Lothian and voluntary and private providers.

Partnership arrangements for health and social care

Edinburgh City Council and NHS Lothian had established a joint health and social care department, and had appointed a joint director who was accountable to the NHS Board and the City of Edinburgh Council. The joint department brought together under a single director the primary care and community health services provided through the Edinburgh Community Health Partnership (CHP) together with adult social care services. A joint board of governance had been established and met quarterly. In the main, partnership working and negotiations appeared to be led by chief officers rather than through the formal partnership structures. There was a history of some tensions between the council and the NHS Board at member level and there were occasions when this had been played out publicly. Nevertheless, at chief executive level within the two organisations there was positive engagement with a commitment to move forward positively which we heard should if anything speed up the pace of integrated working.

Partnership working for the main community care groups was structured around sub groups of the community care partnership steering group. There was particularly good partnership working around the vision for older people services and the strategy for carers, with strong engagement with older people and carers respectively.

A joint resourcing financial framework was included within the Extended Local Partnership Agreement (dated January 2005) but this was now out of date and required to be revised by the new combined health and social care department.

In terms of financial monitoring of jointly provided services, finance officers told us that there had been no developments in this area and that plans were in place to implement a revised reporting structure in the financial ledger to address this. At the time of the inspection, no joint financial reports had been produced and presented to elected members. Alignment of budgets was not yet well advanced and this inhibited joint financial reporting.

Comments received by inspectors during the fieldwork suggested that there was still a considerable amount to be done to achieve fully collaborative partnership working between the NHS and the council. There was evidence that at the top tier of management within the new department, the new joint arrangements had led to closer communication and to more effective collaboration on delayed discharges. However it had not led to greater integration of services or a move towards single management even where this had the potential to improve joint service delivery. We were advised by the director that there were no active plans to move in this direction, because of a perceived risk of service disruption. Some of the key players at head of service level and above expressed differing views about the reasons for lack of progress on joint/integrated service and we concluded that this area merited further attention.

Other key partnerships

Partnership working for children and families was organised around the Children and Young Persons Strategic Partnership and the Child Protection Committee. We heard that through both of these structures, partnership working was being refreshed to ensure that there was a greater focus on outcomes and related performance measures. Partnership working on child protection was led by Lothian and Borders Police. There was also strong partnership working on community safety.

Other partnership structures included the 'No Offence' youth justice partnership, and the drugs and alcohol team. The Edinburgh, Lothian and Borders Executive Group (ELBEG) oversaw strategy and direction for child protection, and the protection of vulnerable adults. This group had received very positive comment by HMIE in its recent report. Corporately the council had established a voluntary sector compact which focused on relationships between social care and voluntary sector partners. However, we received a significant number of adverse comments about social work services' capacity to work in full partnership with voluntary sector organisations. We return to this issue under service commissioning.

Protocols for sharing of information and assessments

Relevant protocols were in place for the sharing of information and assessments between all partners. These had contributed to some successful data sharing initiatives, including an online child protection register and the e-Assess application for single shared assessments. However, in Edinburgh, the partners had not yet progressed to joint electronic information stores to hold client data for adults or children and families services. We considered that it would be desirable for the council and its partners to increase profile and pace of development on electronic data sharing.

Other data sharing projects which were in progress included a shared database for delayed discharge, the Community Equipment Store Management system, with online catalogues, electronic ordering and improved equipment tracking (due to go live in March 2008); and a web based directory of children's services (on line directory by the end of March 2008)

Commissioning arrangements

A report to the council in November 2007 estimated that in 2006-07, the council spent £114 million on the purchase of social care and housing support services from external organisations. At the time of the inspection, expenditure on external community care services amounted to £88 million. Expenditure on external children and families social work services was approximately £28 million. Contracts for housing support services funded through Supporting People amounted to almost £5.3 million in 2006-07.

Service wide commissioning

In health and social care, there were an array of plans and strategies which could potentially inform service wide commissioning. These included the service plan, the draft Community Care Plan 2007-10, and joint strategies and plans covering the main care groups. We noted that these some of these required to be refreshed.

In health and social care, we particularly welcomed the emphasis placed on service commissioning in the older people's capacity plan and the inclusion of commissioning in the strategic action plan for carers. However, other plans and strategies did not routinely set out clear parameters for commissioning and redesign of services. It was therefore not always clear how or whether the service defined its strategic commissioning priorities, or made strategic judgements which would ensure it achieved best value through service wide commissioning. We recognised that the commissioning teams faced a challenging workload, and alongside work on older people and carers, we considered that commissioning personalised services for people with a learning disability should become a priority for the service.

The commissioning function for social work services in children and families had to be developed from a standing start following the re-organisation of social work services in 2005. At the time of the inspection, there were major capacity issues, and efforts were being directed at establishing reliable information about the nature and scale of commissioned services. The development of service wide strategies for the commissioning of services for children and families was likely to be a major challenge. The council was exploring several options for shared services at the moment with a view to identifying efficiencies. It had engaged KPMG Consultants to conduct an assessment of purchased social care and housing support services. The options were to be reported early in 2008. Children and families was therefore some considerable distance from having a clear and comprehensive set of service-wide commissioning plans which would set out the range of needs to be met and how best to secure quality and best value from existing and potential providers.

Contracting

Both departments had discrete teams, whose remit included contracting. In health and social care, for example, there was a contracts team. Commissioning was undertaken by planning and commissioning staff. A key element of this work was to ensure a programme of modernisation in the areas of procurement, contracting, monitoring and evaluation, as well as the maintenance of good links with providers. In addition, the services for communities department was responsible for the management of supporting people contracts.

A corporate review of the contract management arrangements for health and social care, children and families and housing support services had very recently been completed. This involved officers from the three relevant departments in consultation with a reference group which had representation from stakeholders from the voluntary and private sector. The outcome of the review was reported to the council in November 2007. The review focussed on areas for improvement. Key findings included:

- inconsistencies in contracting processes;
- the development of procurement risk and quality assessments (as part of compliance with EU regulations);
- the need to reach agreement with providers on administration and financing of contracts; and
- the development of a more open and transparent approach to payment of inflationary uplifts.

An action plan had been proposed which included taking a more consistent approach to monitoring and an initiative to assist providers by developing a four year plan for advertising social care and housing support contracts.

During the inspection, very positive comments were made to us by providers involved in supporting people contract negotiations with the services for communities department. By contrast, it appeared that relationships between the health and social care and children and families departments and their respective providers had been strained for some considerable time, largely because of the way financial negotiations and decisions had been handled. Generally, providers indicated to us that they were not optimistic about relationships improving, because of the difficult financial climate the departments were operating in. We considered that the review of contracting arrangements (described above) had been a very positive first step in engaging more positively with providers. The council had responded to providers' concerns by formulating jointly with providers the principle of a procurement risk assessment which offered a constructive way forward in relation the application of EU procurement regulations. The recognition of provider concerns in the review's findings and recommendations had the potential to provide a turning point which would lead to more positive relationships for the future. We considered that this should be a major focus of effort within the respective departments.

We were also hopeful that the review of contracting arrangements would lead health and social care to re-think its approach to purchasing voluntary and private social care services. We heard that inability to fund inflationary uplifts had been a major source of past tension, and the council had made available funding to address the issue relatively recently. We considered that the council needed to attach greater importance to creating a sustainable business environment which facilitated providers' capacity to deliver reliable, quality services. As mentioned in chapter 5, in its contracting and funding arrangements, the council should make every effort to be more responsive to the changing needs of service users where these were brought to its attention.

On a more positive note, there was evidence that staff responsible for commissioning and contracting held regular meetings with providers, and were aware and concerned about the difficult environment in which providers were operating. Contracts staff were sympathetic to the concerns expressed by many providers about the impact of EU procurement regulations, and were positive about finding practical ways forward on this front through the proposed procurement risk and quality assessments. Some providers spoke positively of staff designated as liaison officers whilst acknowledging that there was some variation at individual level. We also heard that progress had been made in working jointly with one provider to develop a stronger focus on outcomes in the specification of a service to support carers.

In health and social care, a recent major project was the development of a framework agreement with eight home care providers for the provision of core care at home services. This had been done on the basis of a quality assessment followed by an e-Auction, with online bidding for the lowest hourly rate for the service. Corporately within the council as well as within health and social care, this was viewed as a very positive initiative as it had generated a significant reduction in the hourly rates charged by preferred providers, whilst guaranteeing the quality of services. During the inspection we received some negative comments about the e-Auction process from providers. We also noted that two preferred providers had been suspended in the early days of the contract, because of service interruptions and failures. We considered that there was a need for the council to monitor the outcomes of the e-tendering process carefully to ensure that it was a suitable method for securing sustainable care services for vulnerable people.

It was intended to follow a similar process in 2008 to establish a framework agreement for specialist home care services and possibly housing support services. Some reservations that this was an appropriate approach were expressed to us by some council staff and by providers.

Health and social care had also recently tendered for the management of three new build care homes developed under the capacity plan for older people. This would commit the council to a seven year contract with an estimated value of £30 million for the first two homes. A fourth new build home was being operated by City of Edinburgh Council and was opening at the time of the inspection. The design of all four homes was for 60 bedded units, each with six units of 10 places. It was expected that the new care homes would deal with a wide range of needs, with an emphasis on complex needs. We were assured that this would be managed through careful risk assessments, and would be facilitated by the existence of smaller units within each of the homes. We consider that the mix of needs and challenging behaviour of older people placed in the new care homes should be carefully controlled and monitored.

Balance between commissioned services and in-house provision

Health and social care had a legacy of traditional home care, day and residential services and faced a formidable task to modernise and redesign these. We were advised that elected members had been reluctant to accept recommendations on outsourcing as part of budget savings exercises in the current year. We considered that further work was needed with stakeholders and staff to set out a vision for future services. Partnership working with external providers needed to focus on achieving personalised services which were demonstrably efficient and effective. We considered that as far as possible, the service should avoid taking a short term approach to savings in areas where it had already identified major shortfalls in service provision, as this would undermine its capacity to enter into new partnerships to secure the required volume and quality of housing and support services which were required.

A large volume of community care services were purchased externally and the Capacity Plan for Older People was a clear example of strategic commissioning across all sectors. We heard that the introduction of the home care framework agreement would result in a reduction of people with more than one provider.

In children and families, there were examples of partnership arrangements with voluntary sector providers to secure diversity of services alongside in-house provision. The service had also adopted a 'whole system' approach which incorporated local involvement in decisions on capacity and scoping service requirements, and disinvesting where providers were not meeting agreed standards. However, a more strategic approach was needed to the purchase of independent foster care and the use of out of area residential placements. The latter was the subject of a report to the council in March 2007, when the need to improve commissioning was identified.

We considered that both departments could improve the quality and best value of purchased services if a much more strategic approach were adopted, which set out:

- a framework of service objectives for each of the main groups;
- preferred models of care;
- quality standards;
- unit cost analysis; and
- provider expertise and options.

Where possible this should be done collaboratively with user and carer interests as well as provider representatives and other stakeholders.

Recommendation 17

Both departments should develop their strategic commissioning of services. They should ensure that there are written, costed commissioning strategies which provide information about preferred models of care, unit costs of services and commissioning intentions. There should be more positive engagement with providers, and the findings of the recent review of contracting arrangements should be acted on at an early stage.

Leadership and direction

We evaluated the leadership and direction of the social work services to be good, having important strengths with areas for improvement.

Over the previous two years, social work services in City of Edinburgh Council had experienced several important changes in leadership at senior officer level and in 2007 at political level. An organisational restructuring took place in 2005 which many staff did not support. As indicated in staff surveys, morale was low and perceptions of senior managers and elected members were not good but there were signs of confidence returning amongst middle managers and some staff perceived benefits in the current structures. Senior managers knew that communication within the services needed to improve, and had taken steps to do so.

Given the level of overspend in children and families, it was clear their previous leadership had lacked strong strategic focus in relation to the required reconfiguration of social work services. In health and social care some progress had been made in modernising the delivery of services over the previous two years, though further work was necessary to ensure the most efficient and personalised services were provided.

Senior politicians we met were knowledgeable and supportive of social work. The chief executive conveyed personal commitment to the services and a determination to see improvement, in an extremely difficult financial climate. Both directors were facing significant challenges in relation to budgets and service redesign. A major challenge in children and families would be to bring about a cultural change in staff attitudes at all levels to ensure a more effective and cost efficient approach. In health and social care, the service was poorly resourced in relative terms. In the current financial climate it was unable to deliver preventive services or to assist people with substantial levels of need. Both directors were clear about their plans to achieve change, though it would require full political backing to deliver them. On balance, because of this focus, we evaluated leadership as good

Context

The social work service in Edinburgh had experienced considerable change over the previous three years. Following a long period of operation within a generic social work organisational structure, the previous single department of social work was reorganised into a department of health and social care, in partnership with NHS Lothian, and children and families social work services was merged with education within a new department of children's services.

Within health and social care, the reorganisation had taken place in two stages, with the present structure being in place for nearly a year. Changes in key senior positions in both departments had occurred in 2007.

At political level there had also been important changes in leadership over the previous year. As well as a change of administration and an influx of new councillors, there had also been three different council leaders.

As has previously been stated, at the time of the inspection the council was in the middle of a serious financial crisis. There had also been a recent inspection of child protection which was critical of some aspects of the children and families social work service.

Vision, values and aims

Elected members we spoke to from across the political spectrum impressed us with their knowledge of social work and their support for its importance in improving citizens' lives. Most were concerned at the survey finding that staff did not feel valued by elected members, but did not express surprise, usually attributing this to the 'difficult' history over the past three years. There was overall consensus on the key challenges for services in Edinburgh. With some, there was perhaps a lack of realism about the need for radical service redesign in key areas to achieve better effectiveness and value for money.

The senior members in the administration were keen to be accessible to staff and to try to improve their perception of elected members. For example, the chair of children and families had met practice team leaders to discuss the child protection inspection report along with the director, and the chair of health and social care routinely attended induction courses for new staff.

In response to questions about how policy was formulated within the council, the leader of the council volunteered her view that she strongly supported evidence-based practice and the relevance of academic research to the development of policy. She considered that it had been largely officer-led in the past and she wished to change that. This was a view shared by the chair of health, housing and social care, who strongly disagreed with a view of members' roles as 'rubber-stamping' officers' recommendations. The chief executive expressed the view that he believed there was proper challenge and scrutiny from members in the previous council, both in terms of policy and service development and management of performance. It should also be noted that Audit Scotland praised officer-member working within the council in their Best Value Audit, published in 2007.

The chief executive expressed a strong commitment to partnership working, which was integral to the achievement of the vision for services for adults and children. He had also fully recognised the need for his senior team to operate in a corporate fashion when addressing key budgetary challenges. In his view, elected members had made an important commitment to child protection and children's services generally by the level of investment they had been prepared to commit to the service. Nevertheless, we were concerned that this investment had not been matched by significantly improved outcomes, and that this situation appeared not to have been challenged at the most senior officer and political level until recently. Both the chief executive and the leader of the council were clear that further overspend in children and families services must not occur.

The vision for each service was well articulated by the directors who were committed to defining action plans for what needed to be done, though at the time of the inspection activity was dominated by the need to bring spending back into line with allocated budgets.

The context of change for social work services had had an impact on staff morale and the perception of how strong the vision was for social work within the council. The very difficult financial climate was having an adverse effect on the confidence of staff and on external stakeholders. In response to our survey, staff and some stakeholders were not confident that there was a clearly articulated vision.

Senior members and the chief executive were aware of the 'corporate parenting' role of the council. A council report in March of this year had fully described the duties involved, and the CSWO had provided further briefings to members in September, as part of their induction.

Leadership of people

Staff surveys indicated not only low morale but a low level of confidence in senior managers. In meetings with staff, there was a more positive response, particularly from middle managers. One manager stated that things were 'beginning to get better after a long downward spiral'. Other comments included that the atmosphere was more open and that it now felt more like a 'learning organisation'. Some managers in health and social care were of the view that the joint senior management with health presented 'a real opportunity' to take forward joint working.

Some managers in health and social care also thought that the quality of the senior management team had improved and individuals were now much more visible. Both directors made strongly supportive comments about frontline staff commitment and dedication to public services. Nevertheless there continued to be low morale amongst this group.

The staff surveys were also critical of the quality of communication from senior managers, as referred to in an earlier chapter. Senior managers were aware of this and had tried different forms of communicating in an attempt to be more effective. For example, the directors set aside diary time each week to visit offices, homes and centres and to meet staff.

We attended the senior management teams of both departments, at which the agenda items were appropriately strategic in nature. At both meetings, the directors took the opportunity to set out firmly what needed to be done in the short and medium term.

Role of the chief social work officer

At the time of the division of the social work service, the council had found it difficult to resolve issues around the role of the chief social work officer. Eventually, the role was attached to a head of service post within the department of health and social care, but with professional leadership responsibilities across all social work services. This was not an easy arrangement to make work, and responses from some staff in the children and families department confirmed they perceived it as 'confusing' in practice, between line management and professional leadership. They clearly appreciated the higher profile given to social work by the CSWO, who had made visits to practice teams, but were not now sure 'who was steering the ship'.

There was evidence that the chief executive and senior staff had made considerable efforts to ensure that the role was given proper recognition and status. All were aware of the 'Changing Lives' agenda particularly in respect of professional leadership. The director of health and social care indicated that the head of service post was made intentionally 'light' on line management duties in order that attention could be devoted to professional leadership.

The chief executive expected all directors to consult with the CSWO on any reports or policy developments which might impact on the social work function. She was invited to attend the council management team for appropriate items, and also makes an annual report to the full council. She had also given briefings to councillors and been involved in induction of new elected members.

We had access to a recently agreed summary of reporting arrangements to the chief social work officer which helpfully set out the service areas in which she was expected to be consulted or involved in decision making. These included complaints, specified performance information, significant occurrences and case reviews, external scrutiny, safer recruitment and the specific requirements of the post in relation to secure accommodation, mental health and others according to statute.

Making this arrangement work across two departments required not only clarity of role but a willingness of senior colleagues to cooperate. We found both directors fully supportive of the need for professional leadership of social work, with a strong, shared commitment to overcome any difficulties that might arise.

Initially there had been tensions when the present CSWO had tried to exercise the role in relation to children and families social work, when it was reported that some managers had regarded her involvement as 'interference'. With new appointees in post, there appeared to be a more positive approach being taken to the role. Following the recent child protection inspection, the chief executive and the director of children and families intended to further extend the role of the CSWO in quality assurance of children and families' social work, including her attendance at senior management team meetings.

These were all positive moves, but we remained concerned that some staff, including managers in children's services, were unclear about future lines of management and accountability. It will be important that this is addressed to ensure that there is no scope for ambiguity.

Leadership of change and improvement

There had been extremely strong views expressed about the organisational changes which had been initiated in 2004. Many staff had disagreed with them and some still referred to the experience as being 'painful' and 'traumatic'. Though it was obvious this continued to account for some of the low morale, there was also acknowledgement by some staff that they saw changes for the better. Neither of the two directors nor the CSWO had been in post at the time of the division of the previous social work department.

Some practitioners expressed frustration that the new children and families department was too education dominated with little interest in the kind of work they did with children and young people. They believed it needed the director to get involved to give a positive example. Our observations of the senior management team suggested that concerns about the social work service to vulnerable children and families was in fact a central concern at this level of the organisation.

Senior elected members in the current administration were clear about their previous opposition to the current structure and were cautious in their views about how well it was now working. All acknowledged, however, that further immediate change would not be in the interests of the service or the public. Strong disappointment was expressed about the negative aspects of the child protection report, and how that might or might not be related to the integrated children's department.

Many senior officers and elected members we spoke to agreed that progress in changing and modernising some services had been slow and that Edinburgh was some way behind other councils in these developments. This was attributed to the disruption of the change process in the move to the separate departments, and, prior to that, to reluctance on the part of the then senior managers to move this agenda forward.

Progress in improving and developing services had been faster in health and social care services. The priorities in the last two years had been on creating the five sector services structure in alignment with GP practices, on the introduction of SWIFT, on the creation of Social Care Direct and the Service Matching Unit and on improving performance reporting and performance management. Many managers expressed support for the director in providing 'clear, strong leadership' in moving forward these issues. Trade union representatives were more cautious, particularly in relation to the future of in-house services. They were enthusiastic about the open approach of the new director of children and families.

We have previously commented that joint working was not as well advanced as we might have expected in a joint health and social care department. In this chapter of the report we reflect on how well the joint management arrangements for the director are working. The director had dual accountability to the chief executives of City of Edinburgh Council and NHS Lothian. His objectives were jointly agreed, he formally reported to both at least once a month, and his performance appraisal was jointly carried out. These arrangements appeared to work satisfactorily but there were intrinsic differences in the nature of the two organisations that had led to tensions at senior level, and could potentially impact on relations at other levels in the organisations if not carefully addressed. Several managers expressed their sympathy with the director in his task of having to 'face both ways' and how that had occasionally placed him in a difficult position. There was a danger of people close to the front line seeing the director as supporting either the health or social care 'camp'.

The two chief executives had already had full discussion about these issues, together with the council leader and the NHS board chair. Their intention was to jointly and formally set out a protocol which would cover agreed behaviours and approaches, binding upon senior staff of organisations, councillors and board members. It was hoped this would set an appropriate tone for constructive partnership working, which would reduce the scope for a ‘them and us’ culture developing.

Both directors faced significant challenges in managing their budgets, and with the redesign of services. As previously stated, work in some areas of health and social care such as learning disability services, and home care was not well advanced compared to other parts of Scotland. The service was short of examples of leading edge practice in health and social care, which if developed could provide a catalyst for change and improvement. We considered there were opportunities to move forward on this front, particularly in the second phase of the capacity plan for older people, and through a radical rethink of housing, care and employment opportunities for people with a learning disability. This was acknowledged by the director who already had plans to address this. Several reviews had taken place and some in house services needed to be substantially redesigned to be more ‘personalised’ as well as to ensure best value for the public pound. It is imperative that in the next financial year ways are found to ensure that people assessed as having ‘substantial’ needs have those needs met. The current situation, though driven by budgetary constraints, was unacceptable in terms of care and support of vulnerable people. A reduction in the shortfall below GAE in the funding of older people’s services – currently standing at approximately £6m – would assist with this.

The director of children and families faced a much greater problem, with a significant level of spend above GAE on children’s social work services. She has inherited a situation where spend was nearly three times the indicative level, with a very substantial overspend against a backcloth of generous resourcing by the council. There needs to be a much clearer understanding within that service of how this has occurred. She was unequivocal in her assertion of the need to contain current spending, and to reduce the usage of costly out of area placements. Although this was budget driven, it was clearly also in the interests of good quality care that a range of more local options was developed. This will require not only diversion of investment but a major shift in attitudes amongst some children and families’ staff and managers.

Further, significant areas to be improved in children and families services included consistency, speed of response and prioritisation. The director and the CSWO were agreed on the urgent need to address these weaknesses.

Capacity for improvement

Performance in this area was good.

SWIA's practice is to give priority in the evaluation of capacity for improvement on three key factors:

- improvement in achieving key outcomes and the experience of people using service;
- effective arrangements for assuring the quality of services; and
- effective leadership and management.

National and local performance indicators showed that social work services had made mixed progress in improving the lives of those who used services and those who cared for them. People who received services were generally happy with the services delivered to them, while carers were less positive.

Performance management was developing, with quality assurance and management information more advanced in health and social care services than in children and families services.

Senior managers and elected members accepted the need for improvement in services for looked after children, children in need of protection, children with disabilities, and in modernising many of the services for adults and older people. This offered a serious challenge to improve services in a time of budgetary constraint. They accepted the need to address low staff morale. They were already beginning to take steps to respond in both of these areas. Recent changes of elected members and senior staff gave cause for optimism that improvement would continue.

Improving outcomes

Edinburgh had gathered a range of performance information which offered indications of the likely outcomes for people who used services. While the two departments had shown improvement in some areas, including the educational attainment of looked after children, delayed discharges and waiting times in health and social care, they needed to improve outcomes, in particular for children with disabilities, people with learning disabilities, and people who required care at home. Children and families had begun to identify key priorities to improve performance information. Data errors needed to be addressed, particularly in children and families. Consistency of service across neighbourhoods needed to be improved.

Quality assurance arrangements

Edinburgh social work services were clear in their commitment to the importance of quality assurance, and were developing a quality assurance culture which was being embraced by staff. However, it was too early in the process to be clear about how successful this was in improving service delivery. Health and social care had a stronger emphasis on continuous improvement across its services and had some excellent initiatives, some of which had been recognised by national awards. Children and families recognised shortcomings in this area, which included better management information, and had plans to improve matters. A joint health and social care, and children and families integrated social work improvement plan was developed early in 2007, led by the chief social work officer and with the full support of the council.

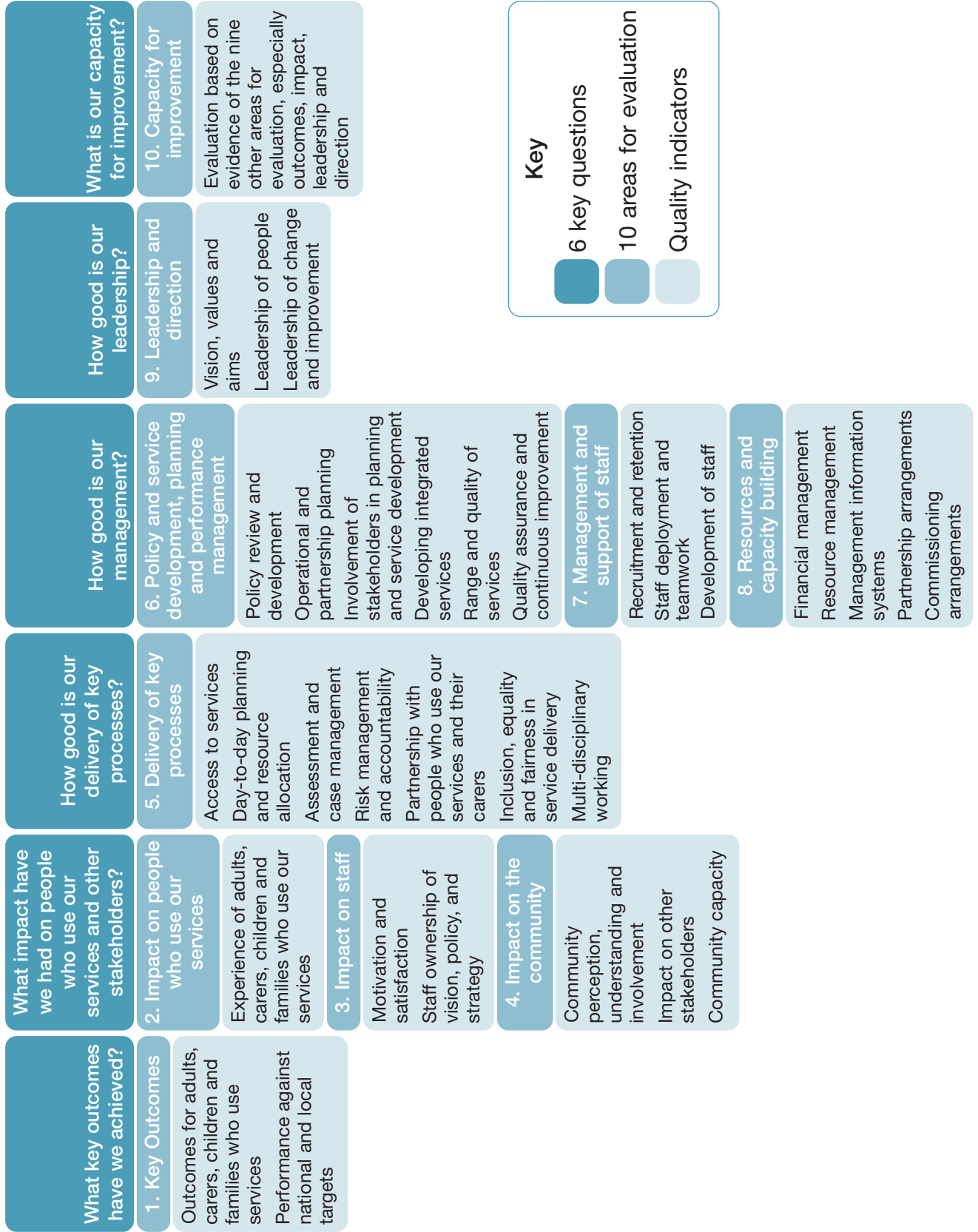
Leadership

Edinburgh social work services had undergone significant changes in leadership in the short time before our inspection, most notably in lead elected members, in senior management in children and families, and in professional leadership within social work. They had also faced major restructuring, which did not have universal support from elected members or officials. Some staff throughout both departments were still coming to terms with these changes, but there was evidence that some staff, particularly managers, were intent on taking these changes forward. Communication within social work services about these issues proved difficult. Low staff morale reflected these problems, and senior managers had instituted processes to improve matters, but with only partial success to date. The clarification of the role of the CSWO, particularly in relation to children and families staff, will be important.

The two directors faced serious challenges in modernising services in health and social care, and in re-designing children and families services, but both recognised the need for change and improvement in existing services. Some of the planning for these changes had already taken place at the time of our inspection and other services were being reviewed with a view to improving them.

We found senior politicians to be knowledgeable about social work services, aware of the difficulties social work faced, and committed to improving matters. Social work services had a strong identity within the council. The chief executive too recognised the need for continued change in social work and was committed to seeing it through. Recent senior management appointments offered a more optimistic view of the future. And both directors saw the necessity for service re-design, recognising the difficulties of this in a climate of budgetary restraint.

Performance Inspection Model (PIM)



Key

6 key questions

10 areas for evaluation

Quality indicators

APPENDIX 2

SWIA performance inspection methodology

The team conducted this inspection using SWIA's performance inspection model (PIM). Senior social work managers in the council were asked to consider the following six key questions and develop a self-evaluation of their performance. The same six key questions were used to structure the fieldwork in the council. This report reflects the PIM, with a chapter addressing each of these questions.

1. What key outcomes for people who use services have we achieved?

Here the inspection team gathered evidence on the actual difference that social work services have made, and are making, to the lives of individuals, families and communities. SWIA defines outcomes as the improvements in people's lives directly resulting from the social work services they receive.

2. What impact have we had on people who use our services and other stakeholders?

The inspection team looked at the direct experience and perceptions of the people who use social work services as well as those of employees and other stakeholders.

3. How good is the delivery of our key processes?

Here the inspection team looked at the day-to-day planning, management and delivery of services from initial contact with the person using the service through assessment and care planning.

4. How good is our management?

This involved examining managers' and staff's understanding and implementation of broad national and local strategic plans and objectives, their dissemination, monitoring and review of organisational strategy, along with performance management, integrated working, staffing and financial responsibilities.

5. How good is our leadership?

Here the inspection team looked at corporate vision, values and aims, the ability to work together across council departments, organisational culture and the leadership and management of change at all levels.

6. What is our capacity for improvement?

Here the inspection team brought together all the evidence and reached an overall evaluation about the capacity for improvement, taking into account both strengths and areas of weakness.

The inspection team reached evaluations based on the 10 areas for evaluation in the Performance Inspection Model. The full PIM is set out in appendix 1.

SWIA performance inspection process

The lead inspector for this performance inspection was Tom Leckie (0131 244 3795).

We began the inspection process by asking the City of Edinburgh Council's social work senior managers to complete a self-evaluation questionnaire about how well they were meeting the six key questions of the Performance Inspection Model (see appendix 1).

We also asked for a range of background information including strategic plans, policies, guidance, procedures, commissioning arrangements and information relating to performance, finance and quality assurance. We read the reports relating to the council from other regulatory bodies and inspectorates such as Audit Scotland, the Care Commission and Her Majesty's Inspectorate of Education (HMIE).

We sent out questionnaires to staff, and adults who use the council's social work services, carers, partners and stakeholders.

Groups	Sent	Returned	Response rate
People who use services	500	113	23%
Carers	500	93	19%
Staff	500	228	46%
Partners and stakeholders organisations	70	17	24%

Together with nine members of staff from the council's social work services, we spent four days reading a total of 150 case files from a cross section of care groups.

Fieldwork

We spent 10 days in Edinburgh examining aspects of both the services directly provided or services commissioned from the independent or voluntary sectors. We looked at services for children, young people and their families including youth justice; services to adults relating to physical disability, learning disability, mental health and substance misuse; and services to older people. We also examined strategic planning and support services. We did not inspect those aspects of services which are already regulated by the Care Commission.

We did not look at criminal justice services as the Social Work Inspection Agency had completed an inspection of criminal justice services in the council in 2005.

We examined services in a number of ways:

- meeting people who use social work services and their carers;
- interviewing staff at all levels of the organisation, both individually and by bringing them together in focus groups;
- meeting with elected members and with staff and managers from other parts of the council;
- meeting with partner organisations and voluntary organisations providing services;
- observing relevant meetings and visiting a range of services; and
- following up examples of good practice from case files which we had earlier read in the case file exercise.

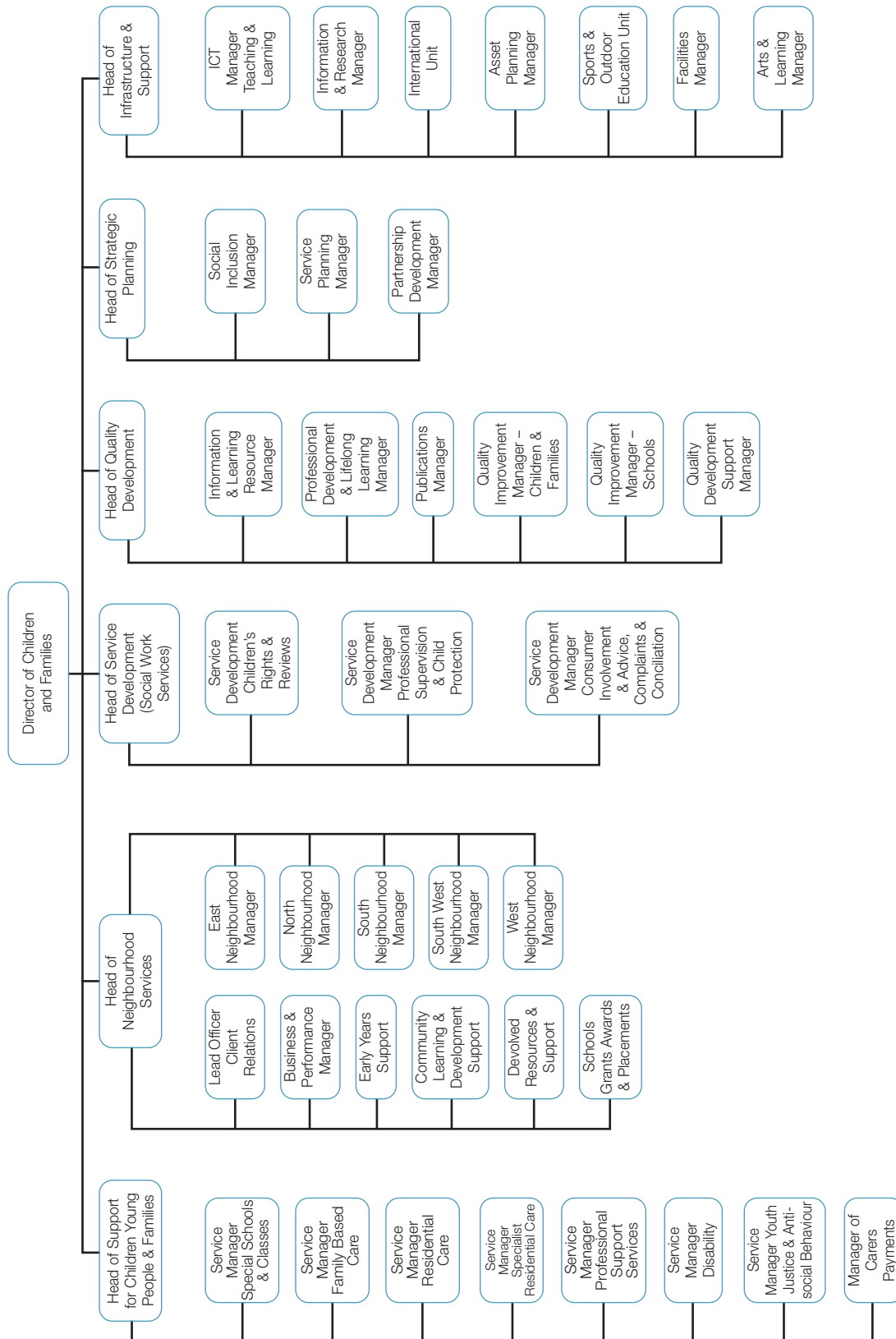
The table below sets out the number of sessions we undertook.

Inspection activity	Number undertaken
Visits to centres and offices	17
Meetings with people who use services	14
Meetings with carers	3
Meeting with front line staff, first line managers and middle managers	60
Meetings with senior social work managers, officials and elected members	14
Meetings with partner and provider organisations	13
Observation of meetings	14
Observed practice, case file and good practice follow up	12
Total sessions	146

After the inspection

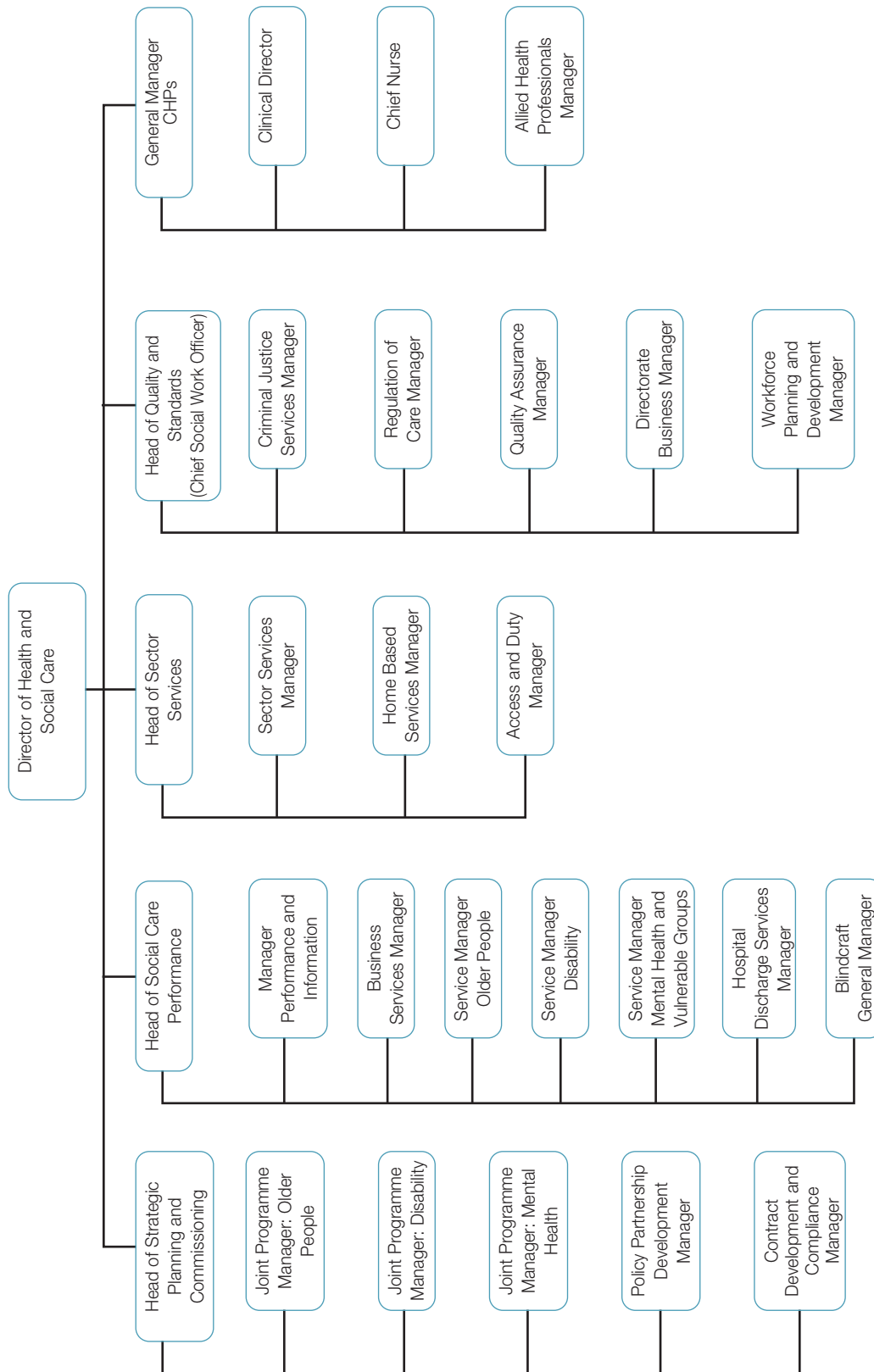
Following the inspection, the council will be asked to develop an action plan to take forward the recommendations in the performance inspection report. SWIA will monitor the improvements taking place over the next year and will undertake a follow-up inspection one year after the publication of the performance inspection report.

The City of Edinburgh Council – Department of children and families organisational structure



APPENDIX 4.2

The City of Edinburgh Council – Department of health and social care organisational structure



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