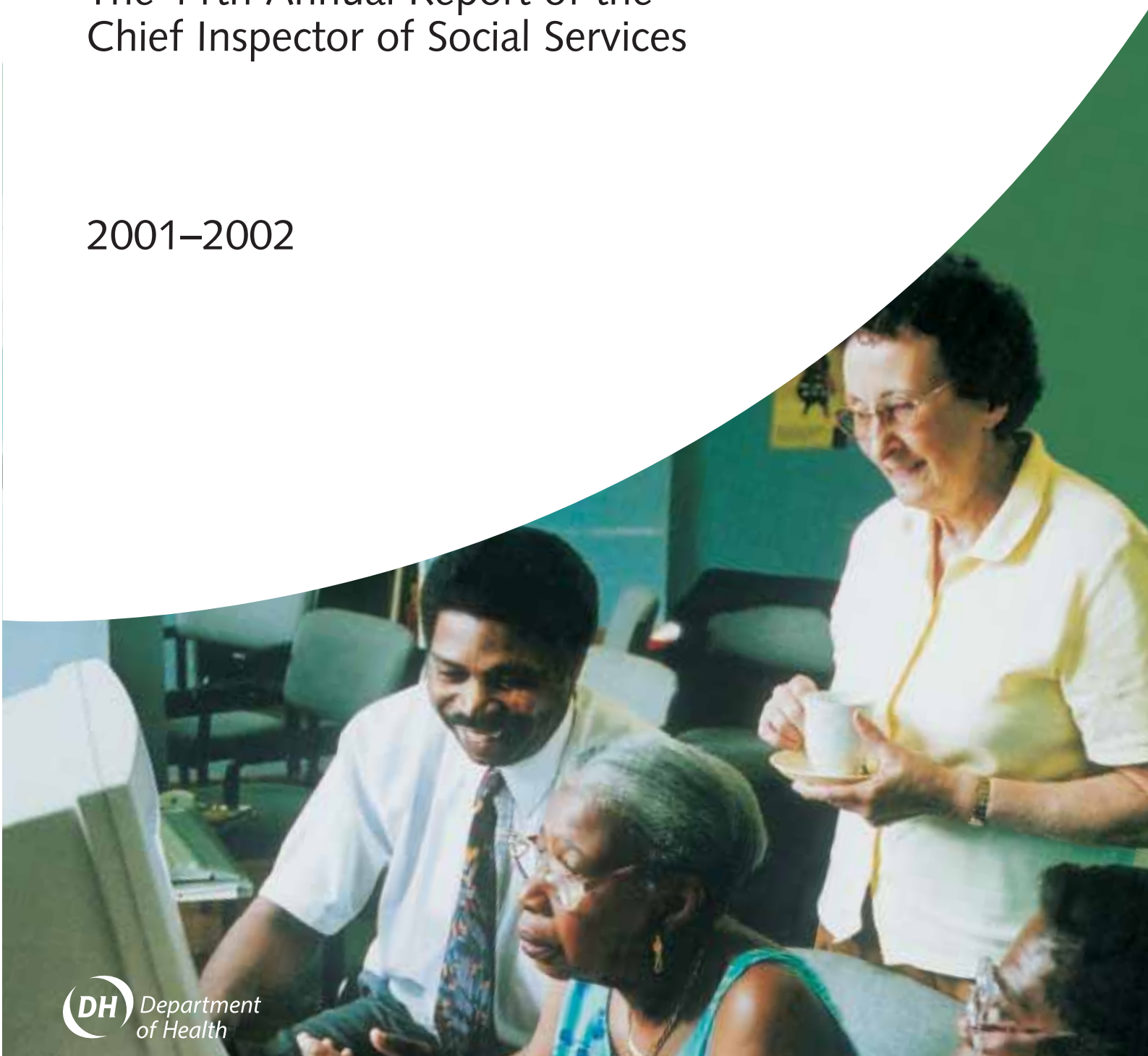
SSI Social Services Inspectorate

Modern Social Services

a commitment to reform

The 11th Annual Report of the
Chief Inspector of Social Services

2001–2002



DH Department of Health

Cover photograph.
With thanks to the Ackroyd Elder People's Support Project, a Voluntary Scheme that provides older people with information technology skills to help maintain their independence. The scheme is based in Forest Hill, SE London, e-mail: the.epp@tiscali.co.uk

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Social Services Inspectorate
Department of Health, Richmond House
79 Whitehall, London SW1A 2NS

Rt Hon Alan Milburn MP
Secretary of State for Health

Dear Secretary of State,

I am pleased to present my annual report for April 2001 to March 2002 *'Modern Social Services: A Commitment to Reform'*. In a year that culminated in the first performance ratings for local council social services, the report draws on that information and a range of inspection and performance review activity of the Social Services Inspectorate, to provide an assessment of performance across England. This year's report has a regional focus. It also provides information about the activities of SSI. In particular, the report notes that:

- Recruitment and retention of staff is a continuing problem across all sectors of social care;
- Budget pressures, particularly in children's services are evident in most councils. Councils need to reconsider how they commission children's services to get best value from the resources available;
- Councils are developing new services both for children and older people – these services need to move to the mainstream of activity if reform is to make a difference to all service user groups;
- The development of Direct Payment schemes is disappointing and further attention needs to be given to improving take-up;
- Relationships across health and social care, which have been disrupted by recent structural changes, are now being re-established locally;
- Capacity and investment in mental health services is a cause for concern; and that
- Councils have energetically tackled delayed transfers of care, but service capacity in older people's services needs to be improved for these gains to be sustainable.

Next year I hope that this annual report will be produced jointly with the National Care Standards Commission and the SSI/Audit Commission Joint Review Team in anticipation of the establishment of the new Commission for Social Care Inspection (CSCI).

Yours sincerely

Denise Platt CBE
Chief Inspector SSI

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Photograph. With thanks to the high support and independent living scheme, Barking and Dagenham Social Services.

Chapter 1

Chief Inspector's Introduction and Overview

1.1 In 1999, a Social Services Inspectorate (SSI) inspection team reported very poor services in Hackney council's children's services. Such was the level of poor performance that ministers issued directions to the council to observe their statutory duties. The council was placed on special measures. This year the council earned one star in the performance ratings and was thus able to come off them. And this year the same inspection team visited the council and was able to identify real and positive improvement in children's services.

1.2 It was a great pleasure to visit Hackney to thank the staff for their hard work and the effort they had put in to turning round their service. They knew what had made the difference: more confident management who were clear in what they expected of staff; shared values, which focused on doing the best for children; and procedures that supported the task, which were kept to. Issues were on the table for discussion not hidden, staff had been involved in thinking through structures and different ways of working. All were clear that the leadership of the Head of Children and Families Services had been a critical factor in the change. Staff were purposeful and talked about being able to do the job from the moment they arrived at work, not clearing yesterday's backlog. One woman who had worked in the department for 20 years described it as 'the best ever'. New workers I spoke to talked about friendly, helpful colleagues. People who had left the council had made a positive decision to return. The staff had no illusions that there was much still to do in the service, but they felt in control of their agenda, confident that they could do better, and were committed to the people of Hackney. They have put the basics in place to consolidate the progress which has been made.

1.3 Managerial capacity and development, particularly of front-line managers, is critically important to achieve improvement. Front-line staff will not put themselves or their professional expertise at risk in departments that are chaotically managed or lack proper supervision, or do not have systems which assist them to do their jobs competently.

1.4 The present Government is committed to reforming public services. Its vision of public services is one where the services are designed around the needs of the people who use them, rooted in the values of community. Services need to be designed to offer fair access to all and help to promote opportunities for all. In many services we are a long way from achieving this vision and the public is impatient for change.

1.5 To deliver the agenda and to transform and modernise the service we are asking the people who work in social services to work in new ways. More

often than not local councils do not exercise their statutory social services functions through a traditional social services department. Nearly two-thirds of councils have adopted new structures, which do not follow a traditional pattern. Directors of Social Services do not necessarily have responsibility for the totality of the social services function, many may also be responsible for housing, or for education, or for environmental health. Care Trusts – organisational arrangements, which bring together health and social care services into new structures – are being created.

1.6 We are asking social care workers to share power with the people who use the services, not always from the perspective of 'professional knows best', often working with people to assist them to purchase their own care through a Direct Payment. We are asking them to work in cross-disciplinary partnerships particularly with health service staff but also with education staff. We are asking them to work in new locations, often not in a council or a social services department, but in a general practice, a hospital, or in a school. Staff will often find themselves working in new teams – such as Care Trusts, or Youth Offender teams. And we are asking them to work outside the traditional limits of their roles, to share tasks with others and to avoid a rigid demarcation of tasks if this gets in the way of proper care.

1.7 The agenda for social services is to promote independence and life chances, to improve the protection of vulnerable people, and to raise the standards of social care. And there is evidence all round the country of improvements that are being made in local services. On my visits to departments I have seen many of these improvements first hand. Young people in care have new opportunities for further education, where new leaving care schemes are supporting them and giving them confidence. I have been accompanied and 'shadowed' by young people in care who have much to offer and are actively thinking about their future careers. Innovative new services have been created for older people providing intermediate care, community rehabilitation and intensive help at home. And it is very encouraging to hear people who rely on the service being so positive about the support they receive.

1.8 Councils now need to make the innovative and new schemes the normal experience for people seeking assistance. Much more flexibility needs to be built into the way that services respond to individual people's needs – departments need to encourage and support their staff to think laterally, when assessing people's needs, about what the solutions for them might be.

Views from a Carer

"I am in my ninetieth year, my son, is 54 years. He is epileptic and has learning difficulties. My biggest worry is fires. A fire has to be lit each day in my room to keep me warm and he has to light his fire also for warmth and hot water. I worry about his safety with fires and wish that the system could be changed to an oil fire central heating system whereby a switch could be flicked and we could have warmth and hot water. My son tries his best to clean fire grates and light my fire before he goes away each morning on his learning programme. Some mornings when he isn't 100%, he has to leave me with a cold house. I struggle then to pick up ashes, etc, and light the fire. I find it difficult to get up once I've knelt down. All of this could be avoided if central heating was in situ. I have been in touch with my social worker and have approached the warm care team, but no result as yet. This is my biggest worry and I am dreading the winter now. The price of coal and logs to keep us both warm is horrendous and I do wish that something could be done in this respect for us. I worry about my son's safety with a coal fire (when I'm deceased!) as he tends to build a large fire and sit over it, as the bungalow is pre-war and very cold. I always impress upon him to use fireguards, but he tends to forget and therefore leaves himself vulnerable. Can I say that I am coping otherwise to look after myself and my son at home and always have (and keeping us both out of institutions and nursing homes), and if I could be given this help for heavy work and the ease of heating and hot water, I'm sure I could cope a while longer."

Extract from an SSI questionnaire completed by a carer in a recent inspection.

1.9 The Government has identified four key principles, which underpin the reform programme. Firstly, a national framework of standards and full accountability for the delivery of high quality services. Secondly, devolution to the front line to encourage diversity and local creativity. Thirdly, flexibility around the needs of people who use services in how staff are deployed and in how services are organised, and finally choice for the people who use the services. Reform requires local leadership, clarity of purpose, confident managers and confident staff.

1.10 How might this approach apply to Hackney? Hackney's children's services certainly needed reform. It was the standards applied by the children's inspection that called them to account. Government took action to lever improvement. The senior management and councillors involved the people at the front-line in making the changes. The service has been redesigned with the needs of the users in mind, and partnerships with other agencies and partners offer choice and a variety of solutions. Managers in Hackney have been clear whose needs they are there to serve – those of the children and their families.

1.11 And if Hackney's children's services and other councils with similar problems can improve from a very low baseline of performance, then all councils can raise their game to reach the level of the best.

1.12 This report reviews the performance of local council social services from April 2001 until March 2002, and uses all the information available to the SSI – inspection evidence, performance information, self assessment reports from local councils, plan evaluations and in-year monitoring.

1.13 **Chapter 2** outlines some of the conclusions about performance, which arise from the exercise to assign star ratings. The chapter also examines conclusions arising from inspection evidence and monitoring information for services for children and adults, including the problems of delayed transfers of care. The chapter identifies some of the obstacles to better performance – including problems of recruitment and retention of staff across all sectors of care.

Chapter 3 reports on social services' performance in the regions.

Chapter 4 is the Annual Report for the SSI.

1.14 Government has now decided that in order to further the agenda of reform the SSI should become more independent of the Department of Health and part of a new Commission for Social Care Inspection (CSCI). A new healthcare Inspectorate will also be created – the Commission for Healthcare Audit and Inspection (CHAI). The health Inspectorate will combine the functions of the Commission for Health Improvement, the Audit Commission (in respect of health) and the National Care Standards Commission (in respect of health care).

1.15 It is hoped that legislation to create the new Inspectorates will be possible in the 2002–2003 parliamentary session.

The new Commission for Social Care Inspection (CSCI) will:

- be led by a Chief Inspector;
- be fully independent of the Department of Health;
- have a duty to work in partnership with the new Commission for Healthcare Audit and Inspection (CHAI);
- incorporate all the functions of SSI across performance and inspection;

- incorporate the social care regulatory and enforcement functions of the NCSC;

- incorporate the functions of the SSI/Audit Commission Joint Review Team.

1.16 Until the Commission can formally take on its responsibilities the SSI, the Joint Review team and the NCSC will work closely together in shadow form so that the benefits of the new Commission can be realised as quickly as possible. It is hoped that in 2003 a joint annual report will be produced.

Denise Platt CBE
Chief Inspector
Social Services Inspectorate
July 2002.

Photograph. With thanks to the Children's Panel members at Luton Social Services.

Chapter 2

Social Services Performance

"Reform in social services is as vital as in any other area of our public services. What is crystal clear from the latest performance tables is that there is excellence in our social services. But it is excellence that is spread too thinly. It is available only to some, when our ambition surely must be to make it available to all…

There is much to be proud of in the progress made in delivering better services for users and carers. But we have a long way to go to meet the public's expectations. We must work together to ensure there is a step change to provide services we can all be proud of."

Source: Alan Milburn MP, Secretary of State for Health. Social Services Conference, Harrogate. October 2001.

2.1 This has been the second full year of operation of the performance assessment system for personal social services which was introduced on 1 April 2000. The systematic assessment and judgement of councils' performance by SSI is now well established and based on:

- Performance Assessment Framework (PAF) Indicators and other national data;
- Evidence from SSI inspections and SSI/Audit Commission Joint Reviews;
- SSI performance monitoring of progress in achieving national objectives and targets, including spring and autumn position statements by councils; and
- Information from external auditors.

2.2 SSI undertakes an annual review of performance with each council. This is followed by a letter setting out strengths and areas for development in management including resource management and service delivery for both children and adults.

THE STAR RATINGS 2001–2002

2.3 The Secretary of State announced in his speech to the Annual Social Services Conference 2001 that, from May 2002, each council would receive a rating for their performance in social services. The performance information we now have for social services is extensive. But it can be difficult for the public, and councils, to have a view on how their council is doing over all and how they compare with other councils in delivering their social services.

2.4 The new star rating system brings together all the existing performance data used in the annual review meeting: SSI then formulates an assessment of each council's performance and assigns a performance rating. On 30 May 2002 SSI published the first ratings – there are separate judgements for children's and adult's services – but there is a single star rating for the overall social services' performance (www.doh.gov.uk/pssratings/starrating0102.htm).

2.5 This serves as a simple summary of performance that people who use services and members of the public can understand. In future people will know that a council with zero stars performs poorly, whilst one with three stars is among the best.

2.6 The star rating system is designed to help councils improve their services and to build in incentives for high performing councils, whilst providing help for those performing less well. Good performance is rewarded with the freedom to spend money in the ways that the council sees fit, rather than the ways set down by central government. For poorer performers, the system is a way of identifying and tackling poor performance. We know that clear and purposeful action linked to intensive monitoring works to improve performance. (See *Force For Change: Central Government intervention into failing local government services,* Audit Commission, March 2002). The new performance assessment arrangements will make it easier for SSI to identify and then deal with poor performance in specific councils.

2.7 In the allocation of the Performance Fund 2002–2003 councils with three stars will be able to spend the money on any part of their social services – they will also be inspected less. Next year they will be given similar freedoms over other grants which will be specifically targeted in other councils. Councils with lower ratings will agree a Performance Improvement Plan with SSI; their share of the Performance Fund will be targeted and closely monitored.

2.8 In December 2001, the Government announced in the *Local Government* White Paper that the performance assessment of a council's social services' functions undertaken by SSI will contribute, along with other service assessments and a new corporate assessment, to **Comprehensive Performance Assessment** of top tier councils. The approach to assessing overall performance using a range of evidence is similar to that which SSI has developed.

Messages from the star ratings

2.9 Performance ratings for all 150 councils with social services' responsibilities were published on 30 May 2002. A summary analysis of star ratings at national and regional level is provided in Table 2.1.

Table 2.1 Summary Analysis of Star Ratings

	Number of councils				% of councils			
	0	**1**	**2**	**3**	**0**	**1**	**2**	**3**
Northern & Yorkshire	1	8	10	2	5%	38%	48%	10%
Trent	1	5	7	1	7%	36%	50%	7%
North West	0	14	8	0	0%	64%	36%	0%
West Midlands	3	8	3	0	21%	57%	21%	0%
South East	1	13	6	0	5%	65%	30%	0%
East of England	0	5	5	0	0%	50%	50%	0%
London	3	21	5	4	9%	64%	15%	12%
South West	1	8	6	1	6%	50%	38%	6%
Inner London	0	7	3	3	0%	54%	23%	23%
Outer London	3	14	2	1	15%	70%	10%	5%
Metropolitan District	4	17	13	2	11%	47%	36%	6%
Shire County	1	17	15	2	3%	49%	43%	6%
Shire Unitary Authority	2	27	17	0	4%	59%	37%	0%
England	**10**	**82**	**50**	**8**	**7%**	**55%**	**33%**	**5%**

2.10 The overall distribution of the ratings across councils resulted in a small number of highly (eight) and poorly performing (ten) councils and a concentration of mid- to low-range performance. There are particular contrasts in performance in inner and outer London, with higher proportions of poor and good performance. In London overall, two-thirds of councils were awarded one star. Half of all three star councils are also in London. In the North West and East of England regions there are no zero or three star councils. None of the new Shire Unitary Authorities attained three stars.

Three star councils

2.11 The councils which are the best performers are: **Bexley, Cornwall, Kensington and Chelsea, Leicestershire, Newcastle upon Tyne, Sunderland, Wandsworth,** and **Westminster**. The performance of **Newcastle upon Tyne** is of note having been removed from special measures in April 2000.

2.12 These councils are those which have **focused on the front-line**, putting vulnerable children and adults first; and **getting the basics right**, finding ways of overcoming obstacles to performance by working in partnership and testing out different ways – many of them innovative – of delivering more responsive services.

Good Management Practice – 3 Star Councils

Newcastle upon Tyne introduced a new management information system and technology very impressively.

Key features:

- a clear lead from the Director of Social Services and his team;
- significant resources being made available by the council to achieve a step-change in the use of the new system;
- a practitioner-led implementation team;
- a significant increase in the level of training – both IT and management – up to and during implementation;
- back up from the implementation team; and
- the requirement for practitioners to input records directly was important to create ownership of the information.

Two star councils

2.13 The overall performance of **two star** councils paints an encouraging picture with current evidence showing an upward path of improvement and excellent performance in some councils – we hope a number of these councils will gain three stars next year.

2.14 Four councils in this category were previously subject to **special measures. Kingston upon Hull** and **Sefton** were both removed from special measures in March 2000 and are judged to have promising prospects across both children's and adults' services. **Barnsley** ceased to be subject to special measures just over a year ago and are judged to be serving most adults well with excellent prospects for improvement. Services for children had been of particular concern in **Cambridgeshire** until it was removed from special measures in September 2001: the council is now judged to be serving most children well with promising prospects for further improvement.

Good Practice in Service Delivery – 2 Star Councils

The community assessment rehabilitation and treatment scheme (CARATS) in **Rotherham** is preventing hospital admissions by providing intensive support at home from nursing and social care staff. There are intermediate care facilities as part of the service to provide rehabilitation and early transfer from hospital resulting in reduced delays in discharge. York University evaluated the service and considered that the equivalent of a hospital ward had been saved by the use of the service.

In **Kirklees** professional foster carers have been recruited to provide care for disabled children with complex health care needs, with adapted accommodation, specialist training and specialist health care support.

One star councils

2.15 Analysis of **one star** councils provides a more mixed picture, and many councils in this category could do better. For some councils performance is worrying; prospects for improvement are, at best, difficult to predict and are a cause for concern. SSI will pay particular attention to those councils identified as having 'uncertain' prospects.

2.16 For some councils, starting from a very low baseline of performance, a one star rating represents a significant achievement. **Hackney, Lambeth, Lancashire, Newham, Peterborough** and **Sheffield**, who were subject to special measures, achieved one star status. These councils are now removed from special measures. SSI will continue to monitor the sustainability of their progress using the monitoring arrangements for one star councils.

2.17 In agreeing the methodology for the ratings system, ministers decided that councils should achieve a requisite level of performance in 11 specified PAF indicators if the higher performance ratings were to be awarded. Five councils with a one star rating would have received two stars before key performance indicator thresholds were applied. Councils which might have achieved a higher rating, but did not because their threshold indicators did not show the required level of performance were **Bristol, Camden, Medway Towns, Milton Keynes** and **Tower Hamlets**.

Zero star councils

2.18 It is a matter of serious concern that, although comparatively small in number, ten councils have been rated as **zero stars**. These councils are now all subject to special measures. They are **Birmingham, Bromley, Coventry, East Sussex, Haringey, Merton, North East Lincolnshire, Swindon, Wakefield** and **Walsall**.

2.19 The star rating has helped to identify these councils as needing intensive support to improve their services, so that they can deliver a safe and good quality service to the people they serve. SSI has agreed a Performance Improvement Plan with each council – specific targets for improvement to be achieved by October 2002 have been identified. Four councils will receive the help of Performance Action Teams. The specification for the work of these teams has been developed jointly by SSI and the council concerned. The teams will not take over the management of a service; they are there to support managers and staff to make improvements.

2.20 We know, from experience, that councils can and do improve their services with focused support even when the services have deteriorated very significantly. But if councils cannot improve even with the assistance and support of a Performance Action Team, then, as a last resort, ministers will consider using the intervention powers set out in the Local Government Act 1999.

Overall performance

2.21 The underpinning judgements of the ratings give more detail. These show that, in **adults' services, 28%** of councils are serving **all or most** people well, **70%** of councils are serving **some** people well, and **2%** of councils are **not** serving people well. In **children's services 33%** of councils are serving **all or most** people well, **62%** of councils are serving **some** people well and **5%** of councils are **not** serving people well.

2.22 But, if we look at the prospects for improving on this performance, the star ratings show that **69%** of councils have good prospects (either 'promising' or 'excellent') for improvement. **Seventy-three per cent** of councils have good prospects for improving their children's services, and **66%** of councils have good prospects for improvement in their adult services. Even in one star councils more than half **(54%)** were judged to have good prospects. So there is considerable opportunity for councils to aim for a higher rating than the one they have gained this year by realising this potential and improving their services.

Action Needed

- *Ensure your Performance Improvement Plan addresses national targets and local priorities;*
- *Ensure you engage front-line staff and people who use the service in deciding how to improve your services;*
- *Aim High!*

SERVICES FOR ADULTS

2.23 Inspection and other evidence shows that, in adult services, councils have made progress in implementing the agenda for reform. There is evidence of good strategic partnership working with the NHS in planning, implementing policy frameworks and of encouraging initiatives and developments to promote independence with many illustrations of good practice identified. However, improvements in mainstream service delivery are slow to take effect and, in some areas, management of systems and resources is inadequate to ensure appropriate safeguards and assure quality.

2.24 The star ratings show that in **services for adults**:

- **28%** of councils are serving **all or most** people well;
- **70%** of councils are serving **some** people well;
- **2%** of councils are **not** serving people well.

2.25 And the prospects for improvement in **services for adults** show that:

- **10%** of councils have **excellent** prospects;
- **56%** of councils have **promising** prospects;
- **33%** of councils have **uncertain** prospects;
- **1%** of councils have **poor** prospects.

Promoting independence

2.26 The SSI Inspection overview report, *Improving Older People's Services* (www.doh.gov.uk/scg/improvingops.htm), published in October 2001 indicated that the majority of 21 councils inspected between October 1999 – November 2000 had created or expanded services delivering **prevention and rehabilitation**.

2.27 This progress was confirmed in the second tranche of inspections in 23 councils undertaken between May 2001 and March 2002. Inspectors identified a wide range of new and innovative services, including **intermediate care**, which had been established to promote independence. Many relatively inexpensive schemes were arranged in partnership with the voluntary sector or housing services and addressed the need for practical help. This was often highlighted by older people themselves as important. There were some very good local initiatives but no consistency was evident and, in many cases, there were **no arrangements to evaluate their impact**.

Good Practice Examples – Promoting independence

York has developed Domestic Support Services for older people on low incomes who need help with cleaning, shopping and pension collection. Age Concern and the Alzheimer's Society provided befriending schemes. Age Concern also ran a Hospital Aftercare Scheme to assist people with simple tasks for a few weeks after they were discharged from hospital.

In the **East Riding of Yorkshire** the Housing Services section provided a number of support schemes, including garden maintenance and safety testing of electric blankets.

Schemes in **Essex** included fall prevention projects, helplines, handyperson services and seated exercise projects. All projects were measured against key performance indicators.

2.28 However, the inspection findings indicated cause for concern about the low level of investment in services for older people. Tight eligibility criteria, low levels of preventive services and falling numbers of older people receiving home care support suggest that some older people were not getting the help they needed.

Domiciliary care services

2.29 Inspection evidence demonstrated **considerable variability in domiciliary care services**. When the service worked well it was the mainstay for many people who regarded staff not just as helpers but as friends. However, inspectors also found evidence of **poor quality services typified by high staff turnover, unreliability, unpunctuality, poor training and failure to stay for the allocated time** – a matter of particular concern to older people whether they were paying a charge for the service or not.

2.30 The inspections also found evidence of concern about the **quality of independent domiciliary care**, linked primarily to resources but also to shortfalls in the commissioning infrastructure. Some councils have not made the cultural shift from seeing themselves as providers to commissioners. Contracts with the independent sector were often based on cost alone with **inadequate regard to quality**. This meant that councils could not always be sure that older people receiving services were properly served and safeguarded.

Direct Payments

2.31 Whilst there is encouraging progress in the take up of **Direct Payments**, the numbers benefiting are still small. Take up had been expected to increase in response to the *Health & Social Care Act 2001*. SSI monitoring shows that, on 30 September 2001, there were **5,325 recipients of Direct Payments** across all client groups – older people, people with mental health problems, people with physical or learning disabilities or sensory impairment, representing **an increase of 41%** over the previous year. Under the provisions of the *Carers and Disabled Children Act 2000*, which was implemented on 1 April 2001, there were 90 parent carers and eight 16 and 17 year old disabled young people who received Direct Payments.

2.32 The inspection programme of older people's services reported that Direct Payments were not much used by older people apart from in 4 out of 23 councils. **SSI inspection of services for people with learning disabilities** in 2001 found that relatively few people with learning disabilities were receiving Direct Payments across all nine councils inspected although some councils were taking active steps to increase take-up. Inspectors found that councils employing **Direct Payments facilitators**, directly or through the voluntary sector, had a higher take up of Direct Payments than those relying on social workers alone.

Work

2.33 Last year SSI reported in *Making it Work: Inspection of Welfare to Work for disabled people* (www.doh.gov.uk/scg/makingitwork.htm) that many **disabled people** were not yet receiving the support they needed to gain, and hold on to, a regular job. The report, based on findings from inspection in eight councils in late 2000, suggested that that mainstream council services gave little emphasis to employment. Councils were not generally engaged with disabled people who were ready for employment and existing employment schemes paid little attention to people with physical disabilities or sensory impairment but only focused on people with learning disabilities or mental ill health.

2.34 Councils, in collaboration with key local partners, were required to produce **Welfare to Work Joint Investment Plans** for the first time in April 2001. SSI has evaluated the processes involved and identified that some progress has been made over the year. Three-quarters of councils rated partnership working with the **Employment Service and voluntary sector as 'good' or 'excellent'**.

Positive comments focused on the development of strong working relationships between agencies that have not traditionally worked together. However, many councils identified **difficulties in engaging with employers** to identify appropriate jobs.

Mental health

2.35 This year SSI inspected 19 councils to evaluate how far the policy commitment to **improve support for people with mental health problems** was being realised, see *Modernising Mental Health Services* (www.doh.gov.uk/ssi/modernisingmhs.htm). Planning in all councils was firmly focused and engaged with partners on implementation of the **Mental Health National Service Framework**. Much direct work with service users was highly valued by them. However, evidence suggests that there has been a significant time lag between policy formulation and local service development. Services generally started from a low baseline both in terms of quality and availability. Most councils were serving only some of their communities well but prospects for improvement were promising. There were **deficits in crisis intervention, supported accommodation, assertive outreach, and in developing capacity in the independent sector**. A lack of access to appropriate support outside traditional office hours was also a concern in most councils.

2.36 The Care Programme approach was integrated with care management in only a few services. Most fell short of arrangements specified in national guidance. The **nature and quality of risk assessment and management were a cause for concern** in many councils. There were, nonetheless, some examples of sound assessment and care planning and some very sensitive work in respect of equality issues. In the autumn nearly all councils reported to SSI that they saw the **Local Implementation Teams** as an effective organisational structure for delivering better mental health services and planned developments included those which were designed to address many of the shortfalls identified in the inspection.

Carers

2.37 Analysis of the performance indicators shows that, at 21%, the proportion of **carer assessments** in 2000–2001 is low. Inspection evidence confirms this but identifies different experiences in different user groups. For example, the inspection of services for **older people reported that the number of carers' assessments was disappointing** and inspectors found evidence of situations

that they felt merited a specific assessment for the carer. However, the inspection of services for **people with learning disabilities reported grounds for cautious optimism** in providing more support to carers. This inspection found some examples of good practice. Findings from SSI surveys suggested that carers were generally satisfied particularly if they had a named care manager or key worker to contact.

Implementing National Service Frameworks

2.38 Progress in delivering the national priority to improve consistency is mixed – with promising developments in strategic policy and joint planning not yet being translated into consistently good practice on the ground. The NHS Plan emphasised the role of **National Service Frameworks (NSFs)** as drivers in delivering the Modernisation Agenda by setting national standards and service models, putting in place strategies to support implementation and establishing performance milestones against progress within measurable timescales. NSFs published to date include: mental health; coronary heart disease; and older people; (www.doh.gov.uk/nsf.htm). The National Service Framework for Older People (NSFOP) sets out a comprehensive strategy to ensure fair, high quality, integrated health and social care services for older people.

2.39 The second tranche of inspections of social care services for older people demonstrated that social services had actively started to implement the NSF. Work on the NSF was a major multi-agency activity, carried out in co-operation with the NHS and other stakeholders including service users and carers. However, although policies have changed, the culture of social services was changing more slowly and in many places the systems to support the new policies and culture change more slowly still.

2.40 The inspection of mental health services reported that councils were engaged with local health communities and other key stakeholders in joint planning to deliver the NSF. However, the nature and level of that engagement varied and a **higher level of commitment was associated with greater levels of modernisation and overall performance**.

Eligibility criteria

2.41 The need for guidance on **eligibility criteria** for adult social care was identified in the 1998 White Paper. SSI inspections have continued to demonstrate continuing variability across and within councils which leads to considerable variation in access to adult social care. This in turn leads to unfairness. The practice of many councils to apply eligibility criteria for both assessment and particular services is confusing and unnecessary. Further unfairness is caused when councils apply **stricter or different eligibility criteria to certain groups of adults seeking help than others**.

2.42 Following extensive consultation, the department of health issued **Fair Access to Care Services** (www.doh.gov.uk/publications/pointh.html) guidance in May 2002. The guidance provides a **national framework** for councils to use when setting their eligibility criteria. At the heart of the guidance is the principle that councils should operate just one eligibility decision for all adults seeking social care support – namely, should people be helped or not.

2.43 Implementation of the guidance from April 2003 will promote access to care services that is based on evaluations of individuals' assessed needs and likely risks, including both immediate needs and those which are likely to worsen for the lack of timely help. Councils should keep assessment in proportion to individuals' needs using the general principles included in the guidance, and/or by reference to the most appropriate assessment framework such as the **single assessment process for older people**.

2.44 To reduce inconsistency in charging policy, the Department issued guidance for *Fairer Charges for Home Care and Other Non-Residential Services,* November 2001. Implementation will be in two phases, from 1 October 2002 and 1 April 2003.

Equality of access

2.45 This year SSI inspected six councils to determine how they were **managing the modernisation agenda for social care** – *Managing the Modernisation Agenda in Social Care* (www.doh.gov.uk/ssi/modservstrans.htm). This inspection identified that some councils were experiencing difficulty in establishing equal access to services for all of their citizens. It raised concerns that some councils did not appear to give adequate importance to meeting requirements of the **Disability Discrimination Act (DDA) 1995**. Inspection of services for people with learning disabilities found that many buildings were inaccessible.

2.46 The inspection of mental health services found serious deficiencies in common service-wide approaches to **diversity issues**. It signalled the problem that **culturally competent approaches developed by councils might not be replicated in the development of joint services**. There was some evidence of good quality specialist services for black and ethnic minority communities but many services needed to develop their understanding and response to these needs. The inspection of older people's services found good examples of individual services for black and ethnic minority communities which were usually providing lower level support. Intensive, flexible packages were less evident although there were signs that councils were making greater efforts to consult with local communities about changing needs.

2.47 By autumn 2001 more than half of all councils said they had agreed or implemented an action plan to implement the **Race Relations (Amendment) Act 2000**. Approximately two-thirds of councils reported that they had either reached agreement in principle or had action plans in place to adopt the **Commission for Race Equality standards**. Most councils reported positive action in responding to the **Human Rights Act 1998** with main issues under consideration being its implications for policy and practice in children's and mental health services plus access to information, equality strategies and handling of complaints.

User focused services

2.48 Evidence on the progress which councils are making to deliver **convenient user-focused services fitting individual needs** is mixed. The results from performance indicators and Best Value user surveys indicate that an average 84% of a sample of users got help quickly following initial assessment with the figure reaching over 90% for one-fifth of councils. Older people who responded to SSI surveys generally indicated they were satisfied with the services they received. The second tranche of inspections of older peoples' services found evidence that more people said they had a care plan and that they were told what was happening than in the Phase 1 programme. However, other performance indicators suggest that improvements are needed both in response to and review of need. Inspection evidence suggests that **review and follow up to take account of changing needs** are not consistently evident.

Views from Lay Assessors

"The area still needing further work by social services is keeping users and carers informed and learning from complaints. Also using users and carers in a meaningful way and not just including them as a way of paying lip service by including them in discussions in a 'token' way. Social Services need to realise that users and carers really have a valuable contribution to make to the way the service for them is run."

2.49 The inspection of services for people with learning disabilities found that in most of the nine councils inspected once a care package was set up it was not reviewed regularly. In a number of councils service users were identified who had been placed in expensive residential placements some distance from home, where a council organised review had not taken place for some years. Provider reviews tended to favour the status quo. Some councils had appointed reviewing officers specifically to deal with this issue.

2.50 The inspection of older people's services found a shortfall in monitoring and reviews. In a number of councils, cases were 'closed with services' – that is once the care package was established active engagement was withdrawn. If the situation changed the family or service user had to go back through the initial referral process – not at all a user-friendly system.

Action Needed

- *Innovative and pilot initiatives need to move to the mainstream of service activity.*
- *Councils need to ensure they are doing all they can to improve take up of Direct Payment schemes.*
- *Councils need to ensure coherence in their commissioning strategies across health and social care – paying proper attention to the need for preventative and rehabilitative services.*

SERVICES FOR CHILDREN

2.51 Evidence from inspection and review indicates improvements in children's services with examples of good practice in most areas of work. However, urgent attention is required in some areas to ensure that adequate safeguards for children are in place. Service choice remains problematic with high placement costs and persistent recruitment problems which inhibit the development of services.

2.52 The star ratings show that in **services for children**:

- **33%** of councils are serving **all or most** people well;
- **62%** of councils are serving **some** people well;
- **5%** of councils are **not** serving people well.

2.53 And the prospects for improvement in **services for children** show that:

- **10%** of councils have **excellent** prospects;
- **63%** of councils have **promising** prospects;
- **26%** of councils have **uncertain** prospects;
- **1%** of councils have **poor** prospects.

2.54 The third annual overview report of the **Quality Protects Programme** (2001–2002), indicated that the overall approach is now well understood, that the Management Action Plan itself is used more widely as a lever for local improvement, and that Quality Protects is leading to better services for children and families.

2.55 The national overview inspection report *Developing Quality to Protect Children* (www.doh.gov.uk/scg/developingquality.htm) reported on the first tranche of inspections of local council children's services over a 12-month period to July 2000. These inspections which took place in 31 councils showed that an encouraging start had been made to the Quality Protects programme. However, evidence of a striking variability in the quality of service provided by local councils was found. It was evident that, whilst service improvements were being planned and some new services provided, more needed to be done before improvements were to deliver lasting benefits to the welfare of children and their families.

2.56 This year, the second tranche **of inspections of children's services** in 32 councils straddled the commencement of the **Framework for the Assessment of Children in Need** (www.doh.gov.uk/scg/cin) introduced in April 2001. Many councils had a multi-agency steering group to implement the new framework and had involved other agencies in training.

2.57 However, only 13 of the 32 councils inspected were judged to be serving all or most people well. In the councils inspected an average 3% of cases of children on the child protection register were not allocated and an average 5% of looked after children were not allocated to a social worker. From a sample of case files, doubts were raised about arrangements to protect one in eight children. Inspectors took the view that the welfare of children was adequately safeguarded in only 21 out of 32 councils. A particular area of concern was staff recruitment which was insufficiently robust to ensure adequate safeguards.

2.58 A number of problems were identified at the point of **referral and initial response** to families. Councils were attempting to balance public accessibility with the need for service consistency and quality of response. Consistency appeared to be best achieved where there was an integrated review unit for both the reviews of child protection and looked after children, bringing together administrative functions, management information and reporting mechanisms for quality assurance into one place. Case file audit and various methods of getting service user feedback were relatively new areas of development of quality assurance in children and families services.

Placements

2.59 **Placement and service choice was problematic** with 22% of looked after children placed far away from their home. SSI estimates that an average 97 children per council are placed externally with half of them placed 20 miles or more away. This has implications for cost, efficiency and safety as well as making it more difficult to ensure that educational and health needs are met. Councils are developing different strategies to manage this problem. Many have set up multi-agency family support and specialist leaving care and after care services.

2.60 Findings from the inspection of **Foster Care Services** (www.doh.gov.uk/ssi/fosteringfuture.htm) in seven councils between July 2000 and March 2001 raise concern about the overall condition of foster care services and their ability to provide the range of care needed. In the absence of well developed **commissioning or contracting arrangements**, councils committed

to being the main providers of foster care services rather than working with independent sector providers face continued difficulty in securing a sufficient range of foster carers. Policies and procedures were generally in place to safeguard children in foster care but not applied consistently. Checks in two councils were considered inadequate and there were serious deficits in others with respect to the quality of supervision for carers, investigation of complaints against carers and the quality of statutory visits, care planning and reviews.

2.61 The Department of Health has now launched ***Choice Protects,*** **a review of placement and fostering services**. The aim of this review is to help councils commission and deliver effective services for their looked after children and young people.

2.62 The inspection of **services to privately fostered children** (www.doh.gov.uk/privatearrange.htm) between December 2000 and March 2001 was commissioned following debate in Parliament on the possible need for further regulation of these services. The exact number of privately fostered children remains uncertain. The inspection found that carers had **little knowledge of the need to notify social services** of private arrangements. For some children there is regular parental contact and written agreements that clarify roles and responsibilities and councils may have only a limited role to play. However, for many children where parental contact is infrequent or non-existent, the needs of the child and suitability of the foster carers should be at the heart of assessment, planning, support and protection arrangements. Some councils are not paying sufficient attention to their responsibilities to these children as arrangements to protect them are afforded lower priority. Jacqui Smith, Minister of State in the Department of Health, announced a review of the current arrangements for private foster care in January 2002. Recommendations will be made later in the year.

Adoption

2.63 Analysis of performance indicators showed that there was an increase in the proportion of looked after children adopted for the third successive year (from 4.7% in 1999–2000 to 5.2% in 2000–2001, representing an increase of some 300 children. The **Adoption and Children Bill** was introduced in October 2001 and will modernise the whole existing legal framework for domestic and inter-country adoption. An **Adoption Register for England and Wales** has been

established and **Norwood**, a Voluntary Adoption Agency, will run the Register. It will provide a national infrastructure for adoption services and is fully funded by the government. It will hold information on children waiting to be adopted and approved adoptive families from across England and Wales. The Register will tackle delays in finding suitable adoptive families for children from across the country where a local family cannot be found, or the child needs to move away from the area. **National Adoption Standards for England** have been published to ensure that children, prospective adopters, birth families and the general public understand what they can expect from the adoption service and so that all parties receive a fair and equal service wherever they live. Further information on adoption is available on the Department of Health's adoption website (www.doh.gov.uk/adoption).

Education of looked after children

2.64 Progress in **improving life chances** for young people looked after has been disappointing. Performance indicators show that the educational attainment of care leavers in 2000–2001 was very low. Thirty seven per cent of children achieved at least one GCSE grade A*-G compared with the target of 50%. Councils forecast a rise to 48% in 2001–2002. **Significant improvements are required** if the target of 75% is to be achieved for 2002–2003. On average only 69% of children looked after continuously for at least a year at 30 September 2001 had all necessary health checks; one in eight was absent from school for at least 25 days in the year. They were three times more likely to receive a final warning or caution or conviction than young people generally.

2.65 The second tranche of inspections of children's services reported that **links between education and social services were improving** with most councils now using unique pupil reference numbers to collect data on educational attainment and to track individuals. Some good practice examples and specific initiatives to address the under-performance in this area were identified. The inspection noted tensions in some councils between addressing the educational needs of looked after children and other priorities such as ensuring that the overall percentage of children gained five or more GCSEs.

Action Needed

- *Councils need to pay more attention to the development of proper commissioning strategies for children's services involving education, leisure and health services.*
- *Councils need to pay particular attention to their responsibilities to children that are privately fostered.*
- *Councils need to ensure that they and their partners continually review their safeguards for children to ensure that their arrangements are sound and robust.*

IMPROVING PARTNERSHIPS

Views from Lay Assessors

"One good feature that I have noticed over recent years is the way in which other agencies are beginning to talk to and relate with social services. In particular Health are finding more and more reasons why they should be working together. This has of course been given a strong push by Government drives in recent times but having started to talk, [they] have suddenly found that they are working towards the same end and are producing some good joint-funded initiatives of benefit to both."

2.66 In the spring 2001 Position Statement, councils reported to SSI that 518 initiatives to use **Health Act flexibilities** were in preparation. Ninety-five were reported to have been formally notified to the Department of Health. This widespread activity was encouraging and seemed to support a positive picture of strengthening partnerships but with difficulties apparent in progressing this even to the formal notification stage. By the autumn monitoring there was little progress to report. Twenty three point six per cent of councils had formally notified the Department of Health of their intention to use Health Act

flexibilities or had implemented their action plan for mental health services, and 24.2% for services for people with learning disabilities. For other service areas less than 10% of councils had reached this stage. Inspection evidence has shown that strategic partnership activity has been established across most adults' services but is, as yet, underdeveloped in children's services.

2.67 One of the main obstacles to progress identified by councils was reorganisation, especially in the NHS and including the establishment of Primary Care Groups and Primary Care Trusts. Other obstacles included financial and time constraints, internal organisational difficulties, and lack of joint eligibility criteria. **Some councils reported that partnership arrangements were already working well without the need to invoke Health Act flexibilities**.

2.68 Some of the best examples of good partnership working are in areas where considerable thought has been given to the most appropriate model for each care group.

Good Practice – Health Act Flexibilities

Sandwell has explored Care Trust status for Mental Health Services, Section 31 flexibilities for services for people with learning disabilities and joint arrangements between the council and three Primary Care Trusts for older people's services. The SSI Annual Performance Review letter said:

"Excellent partnerships with health which has ensured continued innovation and progress on delivering quality services to Sandwell services users, particularly in relation to Adults and Older People."

Barnsley was on special measures until March 2001 and achieved a two star performance rating in May 2002. The council has developed excellent partnership arrangements with Health and made use of Health Act flexibilities for all adult groups. Barnsley's Annual Review letter from SSI said:

"The close working partnership with the Health Authority and Trusts has resulted in considerable improvements on the interface indicators with an 18% reduction on the emergency admissions of older people and 41% fewer emergency psychiatric re-admissions. The numbers of delayed transfers of care remain some of the lowest in the Region. Despite limited financial resources the department achieved the national target for efficiency mostly due to the use of Health Act flexibilities."

2.69 The first four **Care Trusts** went live on 1 April 2002. These were in **Camden and Islington, Manchester, Northumberland** and **Bradford**. Care Trusts build on existing opportunities for joint working provided by the Health Act 1999. Ten sites are currently working to develop Care Trust proposals locally, of which five will be based on the NHS Trust model and five on a PCT model.

2.70 The inspection report, *Managing the Modernisation Agenda* (www.doh.gov.uk/ssi/modservstrans.htm) highlighted the added complexity in developing partnership arrangements, particularly for rural councils, when needing to work across district council and health boundaries. Overall, though, findings from this inspection suggested that **partnerships with health are stronger than with other council departments!**

2.71 The inspection of services for older people found that **joint working with housing was variable** – even where the two services were part of the same council. There were serious delays in several councils in arranging adaptations, attributed by social services to shortages of financial resources, shortages of trained staff, poor systems and processes with housing agencies, or a combination of these factors.

2.72 However, there were signs of increased co-operation over the **Supporting People** programme. The inspection found that relationships and working arrangements with **the independent sector** varied very much – from good relations and involvement in capacity-building initiatives to very poor. There was some reluctance to deal with providers as full partners despite publication of *Building Capacity and Partnership in Care* (www.doh.gov.uk/healthinequalities) midway through inspection. Similarly, although there were some councils which had developed **compacts with the voluntary sector**, local organisations did not feel sufficiently involved – either as advocates or service providers.

Views from Lay Assessors

"The recent drives in local government towards more corporate responsibility is also starting to find areas among education and housing where working together (and talking together) is producing benefits to the population in general, many costing no extra but stopping these areas from working in isolation and beginning to make them realise that what they do and decide has repercussions in other areas."

2.73 In children's services, inspectors reported that overall social services had good relationships with the Police. In the autumn position statements 95% of councils claimed to have achieved at least some level of integration of services for children with disabilities across health, social care, education and the voluntary sector. However, only 19% rated themselves as having good integration and only one council stated that services were fully integrated. Inspection findings indicated that partnership working with health particularly in **Child and Adolescent Mental Health Services (CAMHS)** needed development. The CAMHS service was generally perceived by social workers as an unresponsive service but was seen as most valuable where it provided quicker access to specialist services for looked after children. Inspectors found services for disabled children and work with young carers to be less well developed, lacking co-ordination and integration.

Action Needed

- *Ensure your council is making best use of the flexibilites of the Health Act 1999.*
- *Ensure your council properly involves housing and education services in strategies where their contribution is crucial to the outcome for the service user.*

THE NHS AND LOCAL COUNCILS – TACKLING PROBLEMS TOGETHER

"Social services are under real pressure and more investment still is needed. That is necessary not least to stabilise the care home market and to develop new rehabilitation, intermediate and home care services that can promote people's independence. Here the evidence is that putting in resources delivers results."

Source: Alan Milburn MP, Secretary of State for Health, March 2002.

Delayed transfers of care – building service capacity

2.74 The need to ensure that people receive **the right care at the right time in the right place** became a high profile issue during the year. Problems of sustaining capacity in the independent sector nursing, residential and domiciliary care market have been problematic in many areas. The issue of delayed transfers of care from the acute sector of the NHS has challenged social services, particularly because of the impact these delays have on other activity in the NHS.

2.75 Monitoring data in **September 2001** showed the total number of people occupying acute hospital beds as a result of delayed transfers of care in England was **6,215**.

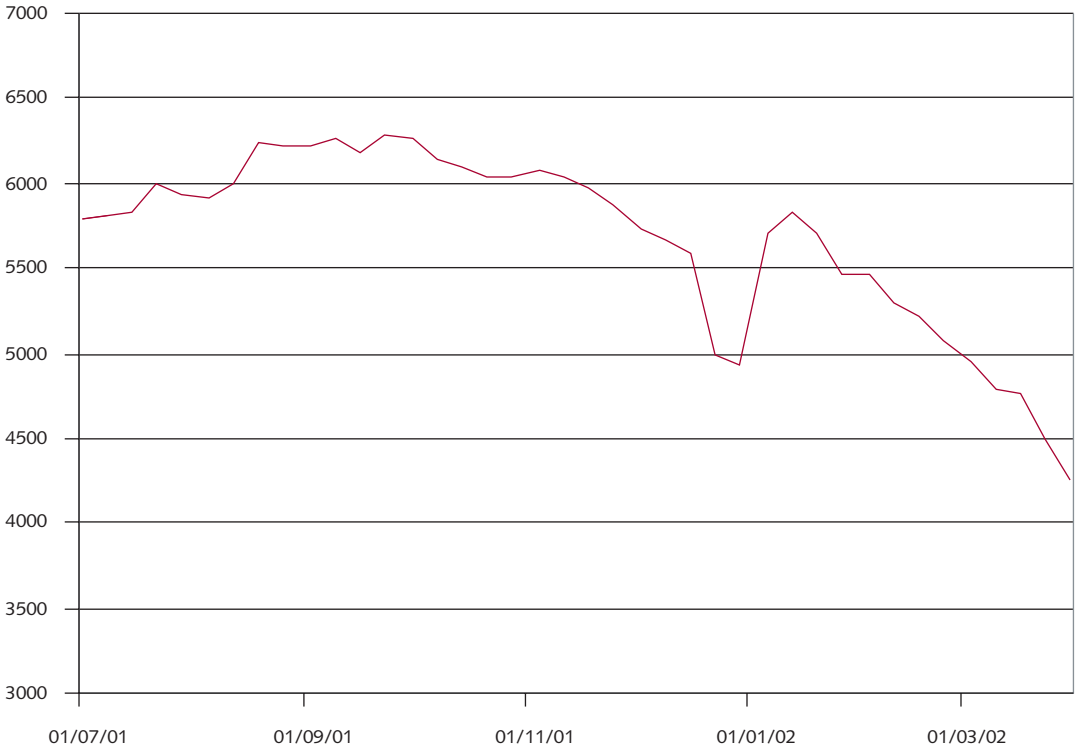
2.76 In October 2001 the Secretary of State announced a £300 million **Building Care Capacity Grant**. The Grant was to be payable over two years to councils responsible for social services. The aim was to help provide stability, incentives for local providers offering care to older people, and to contribute to the delivery of a new national target to reduce the number of delayed transfers in acute hospitals by 20% – or 1,000 – by 31 March 2002.

2.77 **Fifty-five** council localities were designated 'hot spots' – receiving enhanced grant – in acknowledgement of particular difficulties they faced. In response they were required to set more demanding targets in terms of reductions of delayed transfers. Forty-two of the 55 'hot spots' were in SSI's London, East of England, South East and South Western Regions. This indicates a concentration of difficulties in the South, well-charted in successive analyses of market conditions often characterised by reducing independent sector capacity, difficulty in recruiting and retaining staff, and high cost provision.

2.78 The announcement of the Building Care Capacity Grant was widely welcomed. It is a 'whole system' resource directed down the social services funding route. Councils had to agree with their NHS partners the proposed use of the new resource. Additional provision to enhance capacity was made to NHS partners.

2.79 Figure 2.1 shows how the allocation of the Grant – together with the requirement on localities to agree a local target to help support and deliver the national commitment to reduce delayed transfers by 1,000 – had an almost immediate impact. Through the autumn and winter, delayed transfers reduced steadily, with the only reversal characterising the New Year, following resumption of elective activity in hospitals and normal rises in referrals/admissions to hospital characterising the early months of the year.

Fig 2.1 **Monitoring data on number of NHS Acute Beds Occupied by People Whose Transfer is Delayed (England) From – 1 July 2001 – 31st March 2002**



2.80 The target of **a reduction by 1,000 in delayed transfers was comfortably reached** by 31 March 2002. Proportionate falls were highest in Central and Northern England, reflecting different market conditions from those prevailing in the South. Here capacity and affordability of independent sector provision were often constraints. Ninety per cent of localities broadly met their targets. Only six

'hot spot' localities missed their targets by an appreciable amount. Too often, delayed transfers are immediately associated with the actions or in-actions of social services departments. This oversimplifies the situation. There are many contributory causes, and the balance of reasons differs from place to place. Some are susceptible to direct action and short-term improvements through deployment of staff and extra finance. Others require different solutions.

2.81 The analysis set out in Table 2.2 highlights the differential progress made in-year in relation to the underpinning reasons for people's extended stay in acute hospital provision. It shows that, predictably, the **greatest proportionate improvement in numbers was on people waiting for public funding**. The reduction in the number of those cases accounted for almost half of the total reduction in delayed transfers in England. The reduction in the numbers of those awaiting non-acute NHS care, awaiting a residential and nursing home placement for which funding had been provided, and those patients and families exercising choice, preferring to wait for the home of their choice to become available, fell much more modestly. As a result they increased as a proportion of delayed transfers. Between them, these latter reasons for delayed transfers accounted, at the year end, for just over half the total number of delayed transfers.

Table 2.2 Percentage of Delayed Transfers by Specific Reason (England)

	September 2001 (baseline)	March 2002 (target)	
Awaiting completion of assessment	22%	24%	→
Awaiting public funding	22%	9%	↘
Awaiting further non-acute NHS care	12%	12%	→
Awaiting residential/nursing home placement	20%	25%	↗
Awaiting domiciliary care package	7%	8%	→
Patient/family choice	8%	11%	↗
Other	9%	10%	→

2.82 Experience this year confirms that allocation of extra resources has had an immediate impact on the number of delayed transfers. However, following the 'early wins' associated with the Building Care Capacity Grant, **agreement on local targets will be more difficult to sustain, given systemic weaknesses in markets in some parts of the country**.

2.83 More sustained progress is likely to be made where local agencies acknowledge **shared** responsibility for the issue of people improperly delayed in hospitals, and **work together** to devise solutions.

2.84 Commissioning activity for older people is still too often unsecured by **clear strategic intent across health and social care**. There is a continuing need to balance the provision of intensive home support with sensitive and accessible intermediate care and support for long-term care of a quality that meets contemporary needs.

2.85 There is continuing need for **significant social services managerial presence** in or close to major acute hospitals, to ensure rapid responses are made to quickly changing circumstances, and a clear shared resolve to address issues arising.

2.86 Many councils reported, alongside success in managing the reduction of delayed transfers, significant numbers of older people living at home similarly waiting for complex care packages. In the short term, it is possible that the focus on hospital patients may skew the direction of commissioning activity, leaving frail older people at home at some risk. Councils also need to give consideration **to the role of housing as part of the redesign of services**.

2.87 Councils performed very well in leading local partners to deliver significant reductions in delayed transfers of care in the months following declaration of the national target, and allocation of the Building Care Capacity Grant. The rate of reduction accelerated as the target date of 31 March approached. There is a risk, without continuing focus and resource allocation, that such progress will be unsustainable. This is particularly so in environments characterised by continuing provider shortages and increased activity and throughput levels in major acute hospitals.

2.88 The requirement for all localities to agree revised targets for 2002–2003 has been made clear. Such targets need to be realistic but challenging. Evidence suggests they are proving more difficult to negotiate with local systems than was the case in **2001–2002**. This tends to indicate that 'early wins' in 2001–2002 may not be readily replicable without fairly radical shifts in the ways in which statutory agencies support and shape the wider social care market. Work needs to take place to ensure **a balanced continuum of health and social care services** are in place to meet the varied and changing needs of a growing population of older people.

2.89 In December 2001 the Department of Health announced the establishment of a **Change Agent Team** to be led by Richard Humphries (Chief Executive of Herefordshire Health Authority and Director of Social Services for Herefordshire). The Team has been appointed to support the NHS and social services to resolve delayed discharge with practical management support, offering targeted intervention to specific areas with severe problems. Through this work, the Team will ensure that key aspects of the National Service Framework for Older People that may have an impact on delayed transfers of care, including the development of Care Trusts, are implemented locally. Change agents will also oversee implementation of £66 million capital programme for intermediate care, announced in March 2002.

Action Needed

- *Ensure your council and its partners have a strategy to implement the National Service Framework for Older People.*
- *Ensure you have an agreed capacity plan with your NHS partners to develop a proper range of services for older people.*
- *Ensure you have consistent and constructive working relationships with the independent sector.*

WHAT GETS IN THE WAY?

2.90 Last year SSI identified risks and barriers to progress that many councils were facing and which were inhibiting them from achieving policy objectives and service delivery targets. These were recruitment and retention of staff, finance and capacity issues, the planning overload, and organisational turbulence in the NHS. Many of these obstacles to performance remain the same. However, over the last year, following recognition by Government of the difficulties faced, there has been some investment and some promising signs of change. The challenge over the coming year will be how far short-term gains can be maintained over time and whether achievements made over the past year can become sustained improvements.

Workforce issues

In praise of social workers, the Prime Minister Tony Blair MP said:

"Social workers throughout this country perform challenging and vital work every day. Yet they are the unsung heroes of the public services – their compassion and care for others is rarely recognised publicly.

But it is their dedication to the profession that helps hundreds of thousands of individuals and families every year through difficult periods in their lives and I am delighted to have the opportunity to thank them for being a force for good in our country."

Source: Press statement for Reception in Public Recognition of Social Services hosted by the Prime Minister and Mrs Blair, 18 March 2002.

2.91 Improving the quality of the workforce and ensuring it is fit for purpose to meet modern standards and expectations is a priority over five years. It is estimated that over a million people work in the social services in England. Of these staff, 80% have no relevant professional qualifications. The largest group amongst professionally qualified staff is qualified social workers. About 65% of social care staff work in the private and voluntary sectors. The high proportion of care provided by the private and voluntary sectors is due to an increasing emphasis on local councils commissioning services rather than providing them directly.

2.92 Recruitment and retention of appropriate staff is the most critical issue that faces social care services in all sectors.

2.93 Vacancy rates and recruitment difficulties vary nationally (the most severe problems being in the South East and London) and locally. Social worker vacancies have been variously reported across the country and, according to inspection evidence in children's services, the use of agency staff occurred mainly – though not exclusively – in London and the South East. Evidence from the SSI in-year monitoring suggested that, while all groups of staff were affected at some level, the greatest recruitment and retention problems nationally were of **foster carers and field social workers**, with shortages of domiciliary care workers and Approved Social Workers also having an impact.

2.94 The image of the work, poor human resource management, low pay and poor career development and job prospects still remain the key factors which affect recruitment and retention rates.

Views from Lay Assessors

"I have great admiration for all social workers who I feel work under very difficult circumstances."

"…I have seen a lot of dedicated people such as frontline staff, support staff and carers being poorly rewarded for their efforts. It's a case of 'who cares in the community' – evidently they do!"

2.95 Whilst central government does not have responsibility for recruitment and retention of social care staff, as these are ultimately the responsibility of individual employers, it is taking a leading role in working with employers to tackle the problems. To this end the Secretary of State for Health launched a **£1.5 million social work recruitment campaign** on 19 October 2001.

2.96 In order to improve the quality of social work qualification training, a **new three-year degree level qualification** in social work is being introduced in England from September 2003. This is a unique opportunity to transform the status, image and position of social workers. The qualification will provide a sound foundation for the registration requirements for the General Social Care Council (GSCC).

2.97 A **£41 million grant** to support professional social work training over three years from 2001 is intended to provide opportunities for employers to improve human resource strategies and increase access to social work training.

2.98 In April 2001 a **new fund** was set up by the Department of Health to help with the implementation of the national training strategy produced by the Training Organisation for Social Care (TOPSS) with **£15 million** available **in 2002–2003**. The grant is intended to support 6,000 staff to undertake **induction training**, for 9,000 Registered Managers of Adult Care Homes to undertake the new **NVQ Level 4** Registered Managers award which is required for the National Minimum Standards of Care Homes, and for 11,500 staff to become **NVQ assessors**, **verifiers and mentors** providing the infrastructure for NVQ training on which to build in the coming years.

2.99 Investment in recruitment, education and training is welcome and SSI will be looking for evidence of the impact this investment is making over the next few years. However, SSI inspection and performance evidence suggests that investment alone may not deliver improvement unless employers **tackle fundamental human resource management issues**.

Views from Lay Assessors

"Overall SSDs are really trying to improve services. Budget restrictions and shortages of qualified staff make improvements a slow process. I really sympathise with SSDs with the difficulties they face in the future."

Finance and capacity

"What is more, social services – for too long the poor relation – are to enjoy big rises in investment as well. Six years ago spending on social services was falling. Today it is rising by over 3% in real terms. We know that more is needed. We have listened to what local government, private sector care homes and local health services have all had to say. So now, spending on social services will double to 6% a year over and above inflation for the next three years."

Alan Milburn MP, Secretary of State for Health, NHS Confederation Conference 24 April 2002.

2.100 Last year we reported that the mismatch of resource growth in health services and social care services was causing problems in partnership working. During the year local government reported that the majority of councils were projecting overspends in their social services budgets – especially in children's services. It is therefore very welcome that the Budget settlement for health and social care services announced in April 2002 gives an average 6% growth over the next three-year period to social services.

2.101 To complement **reform of the NHS**, the Government has stated its commitment to improving social care services, particularly care for older people and children, provided by councils. Details of social services resources, including Standard Spending Assessment (SSA) and Department of Health (DH) special grants, are yet to be announced. Table 2.3 sets out the new spending profile for the personal social services.

Table 2.3 Personal Social Services spending in England. Budget 2002 (Source: www.hm-treasury.gov.uk)

£billion	2002–2003	2003–2004	2004–2005	2005–2006	Average real growth
Previous plans	11.4	12.2			
New plans		12.5	13.4	14.6	6.0%

2.102 It is important however that this additional investment is seen to deliver services relevant to people's needs and that a step change in working with health and other partners is demonstrable. Councils will need to continue to seek value for money through **modernisation, service redesign and closer partnership working**.

Organisational turbulence

2.103 Organisational change in local health services has continued to create problems for continuity of joint working in health and social care despite the best efforts and commitment of both parties. New health bodies, with new management structures, have been created and new relationships need to develop alongside. However, the signs are very encouraging that the new Primary Care Trusts and local councils can improve their joint working focused on the needs of their local communities. The development of commissioning in Primary Care provides a unique opportunity for health and local government to work on local priorities in the context of a national framework. **Primary Care Trusts** are now the cornerstone of the NHS and will receive 75% of the NHS budget to shape, commission and provide services.

Action Needed

- *Ensure your council has a proper workforce strategy for the social care workforce developed with partners in health and the independent sector.*
- *Ensure your human resource policies support and encourage staff to develop their careers.*
- *Ensure your service strategies are supported by a proper financial strategy and that you can demonstrate the outcomes being achieved by increased investment.*

Photograph. With thanks to Salford Social Services foster carer's property adaptation scheme.

Chapter 3

Around the Regions

"I am grateful for social services, believe me; otherwise I would have to be taken care of in a hospital or home, this way I can stay in a bungalow."

"These people are second to none. They are first rate, caring people."

"Our family life has improved since social services involvement. The support given has enabled us to help ourselves. The future is looking rosy for a change. THANK YOU."

Source: comments from people who use social services. SSI surveys 2001–2002.

3.1 Until May 2002, the Social Services Inspectorate was organised into eight regions, which were coterminous with the NHS regions. Following the reorganisation of the NHS, and changes in local government performance arrangements, SSI has restructured to ensure coterminosity with the nine Government Offices for the Regions. The new SSI structure from May 2002 is set out in Appendix D; contact points are in Appendix B. The most significant change has been in the north and east where three areas – North East, Yorkshire and the Humber and East Midlands now replace Northern and Yorkshire, and Trent. The regional reports in this section relate to the arrangements prior to May 2002. Similarly the health links described are those which existed before 1 April 2002.

3.2 There is clearly considerable diversity within regions as well as across them. All areas have pockets of deprivation with some problems being tackled not just at council level but often at electoral ward level with the assistance of targeted government funding where indices of local deprivation have been identified. The regional reports illustrate common challenges such as dealing with the complexity and turbulence of change in the NHS, finance, capacity, and workforce matters. They also highlight some of the innovative approaches that councils are taking to tackle these issues. Some of the differences in performance achieved against key performance indicators across the regions are illustrated in Appendix J.

NORTHERN AND YORKSHIRE

Councils in this Region during 2001–2002

Metropolitan District Councils: Bradford, Calderdale, Gateshead, Kirklees, Leeds, Newcastle upon Tyne, North Tyneside, South Tyneside, Sunderland, Wakefield

Shire Counties: Cumbria, Durham, Northumberland, North Yorkshire

Shire Unitary Councils: Darlington, East Riding, Hartlepool, Kingston upon Hull, Middlesbrough, Redcar and Cleveland, Stockton-on-Tees, York

- **Regional Population:** 6.5 million
- **Health links:** 13 Health Authorities; 19 PCTs; 20/21 additional PCTs proposed for April 2002
- **Star Rating:** 3 star – 2 councils (10%); 2 stars – 10 councils (48%); 1 star – 8 councils (38%); 0 stars – 1 council (5%)

3.3 Performance assessment shows that councils in the region are performing well as a group, when compared to the national picture. **Twelve out of twenty-one (57%) councils in this region received a 2 or 3 star rating**. Almost half were judged to be serving most adults well with 18 councils demonstrating excellent or promising prospects for improvement. Councils in the region performed less well in children's services with only eight councils judged to be serving most people well. However, here too, evidence suggests that prospects for improvement are encouraging with 19 councils judged to have excellent or promising prospects.

3.4 The area spans a wide diversity of settlement and topography, ranging from heavily populated industrial areas to rural localities. The challenge of size and scale for social care managers varies substantially. Council size varies from Leeds with a population of 726,000 and an area of 212 square miles to Hartlepool with a population and size approximately a sixth of that; it includes North Yorkshire covering 3,200 square miles with a population of 574,000.

Issues for the Region to address

3.5 The **balancing of resources, needs and demands for social services** is the key challenge for all councils. About a third of councils anticipated a gap of more than 2% over budget between revised budgets on 30 September 2001 and predicted year-end outturn. For children's services the anticipated budget gap ranged from –2.7% to 11.9%, reflecting pressures widely described by managers in SSI annual reviews.

3.6 Establishing **effective performance management arrangements** has also been challenging. Councils in the Region need to ensure that there is better management information, improved data collection and reporting, reliable performance indicators and shared systems to support planning, performance management and practice with health and other council partners.

3.7 **Recruitment and retention of key staff** was widely reported to be a major pressure in delivering quality services to time. Particular difficulties were identified in finding foster carers, Approved Social Workers, field social workers, domiciliary care workers, and children's residential workers. High sickness levels were also reported: in 1999–2000 when 8.7% of working days were lost through sickness (England average 7.1%). The regional range was from 26.1% to 4.8%.

Good Practice

A regional initiative involving several councils led by **Gateshead**, to recruit carers from ethnic minority communities.

Sunderland won a National Health and Social Care Award in the 'improving the working lives of staff category'.

3.8 Further progress is needed in **services for looked after children** to improve their educational qualifications (Appendix J), to tackle absence from school and to attend to their health needs. The SSI development programme for this region will focus on these issues and on spreading good practice, particularly in the area of placement choice. There was considerable variation in the percentage of children who are looked after for more than four months who had a permanence plan (ranging from 2% to 100%) and a similarly wide variation in the percentage of children with a Personal Education Plan. There was also marked regional variation (range 30% to 87%) in the long-term placement stability of looked after children. Only six councils reported good integration of services for disabled children and this needs to be taken forward with the NHS and education partners. SSI will also continue to challenge the performance and delivery of services by councils to ethnic minority service users and to work with them to achieve improvements.

3.9 In **services for adults**, councils were more likely than other regions to rate Drug Action Team development as poor and progress in developing Health Act flexibilities was least marked in this area. Councils achieved the national average on all 35 Mental Health National Service Framework monitoring

indicators and were above average on eight. Areas where progress was slower included the development of Early Intervention Services, provision of ethnically sensitive services, services for women only, security of funding for services and the establishment of pooled budgets.

3.10 The regional challenge arising from **delayed transfers** of care of older people was less than in many areas further south but still required attention. Marked progress was made by the end of March 2002. Three councils received additional Building Care Capacity Grant and a further six council areas were allocated smaller amounts of contingency funding to support specific focused developments. Councils in the Region were more likely than the England average to admit **older people** to residential and nursing home care but less likely to help them at home. Regional variations in each category of care were wide. There were, however, clear signs of a substantial shift in the pattern of over reliance on institutional care and a proportionate increase in intensive home care provision (Appendix J). This may be related to a growing concern in a minority of councils about pressures on capacity in the residential and nursing sectors. However, the Region rated poorly on securing agreement with Health Authorities on investment in intermediate care.

What's going well?

3.11 **Partnerships for social care** are a complex challenge but progress has been made, with social services actively at the heart of addressing social exclusion. In the Region, neighbourhood renewal, Connexions, Sure Start and Children's Fund initiatives have active social services involvement and often-proactive leadership. Local Strategic Partnerships are being developed in every part of the region promoting 'joined-up' neighbourhood and district programmes. Most councils reported progress in discussions on Health Act Flexibilities, especially for services for people with learning disabilities and sensory impairment. Two councils moved services to Care Trust status on 1 April 2002: Northumberland for all adult services based on a Primary Care Trust and Bradford for mental health and learning disabilities services.

3.12 In **services for children** the *Quality Protects Management Action Plans* (MAPS) showed a general picture of progress to reduce the number of re-registrations on the Child Protection Register and duration on the Register. Overall councils performed better than the national average on the stability of placements and were less likely than elsewhere to place children out of their council area. The region had particularly high adoption rates and predicted a high increase.

Good Practice

In **Calderdale**, inspectors found a colourful and useful information pack had been produced for people expressing an interest in fostering or adopting a child. This information was supported by a video written, performed and produced by young people and their foster carers.

3.13 In **services for adults** good progress has been made to establish Local Implementation Teams for the National Service Framework for Older People with sub-groups working on early key milestones. Development activities have included intermediate care workshops, a Health Act Flexibilities master class, a regional conference on stroke services, and the setting up of an Older People's Mental Health Network. The development of a Regional Dementia Collaborative will support work on mental health and older people.

3.14 The Region had the lowest proportion of adults (18–64) with **learning disabilities** supported in residential accommodation and the highest proportion helped to live at home.

Good Practice

Hartlepool Multi-link scheme provides a single point of access to intermediate care services for older people, it won a Northern and Yorkshire Excellence Award in 2001.

Leeds Community and Mental Health Services NHS Trust won a Health and Social Care Award for the health category of 'improving the lives of people who are older' for its community-based, multi-disciplinary, intermediate care teams; this initiative was subsequently awarded Beacon status.

NORTH WEST

Councils in this Region during 2001–2002

Metropolitan District Councils: Bolton, Bury, Knowsley, Liverpool, Manchester, Oldham Rochdale, Salford, Sefton, St Helens, Stockport, Tameside, Trafford, Wigan, Wirral

Shire Counties: Cheshire, Lancashire

Shire Unitary Councils: Blackburn with Darwen, Blackpool, Halton, Warrington

- **Regional Population** 6.4 million
- **Health links** 17 Health Authorities; 15 PCTs; 12 new PCTs proposed for April 2002
- **Star rating** 3 stars – 0 councils; 2 stars – 8 councils (36%); 1 star – 14 councils (64%); 0 stars – 0 councils

3.15 Performance assessment resulted in no three or zero star ratings in this region. **Eight councils (36%) received a 2 star rating**. Out of 22 councils only seven were judged to be serving most adults well and eight to be serving most children well. Prospects for improvement were judged to be excellent or promising in 60% of services for adults and 69% of services for children. Particular attention in this region will need to be given to the 64% of 1 star rated councils; seven of these councils were judged to have uncertain prospects for improvement in both adult and children's services.

3.16 This is a very densely populated region. The region's population contains a higher than average proportion of children and young people and a lower proportion of people aged 75 years and over. This conceals wide variation, however. Blackburn with Darwen's population of people under 18 years of age and Sefton's population of people aged 65 years and over are both higher than the national average. Black and ethnic minority populations are very unevenly distributed across the region, with a concentration in the major cities and old cotton towns.

Issues for the Region to address

3.17 **Balancing the needs, demands and resources for social care** remains a key challenge for all councils in the North West. In 2000–2001, the net expenditure

on Personal Social Services for the region was £1,434.6 million. On average North West councils spent 10.3% above their SSA, an increase on the previous year of 1.8%.

3.18 In **services for children** the life chances of looked after children vary considerably. Attention to the health of looked after children needs to improve although there was significant variation between councils. Personal Education Plans were in place for 25% of looked after children. Improvements have been made to reduce the numbers of looked after children who are excluded from school, bringing regional performance in line with national averages. Performance in **adoption** improved but further work is needed. Six North West councils worked with the Adoption Task Force during the year. Services for **disabled children** showed significant variation in their integration with health and education and in their levels of service activity. This Region has seen a reduction in the percentage of children with a disability receiving a short-term break.

3.19 In **services for adults** the admission levels of supported residents aged 65 or over to residential/nursing home care were the highest nationally, although the level of supported admissions fell steadily over the past two years, and has shown the highest reduction in any region. Assessment, and the provision of services following assessment, to older people from black and ethnic minority communities is an area where performance needs to be improved. Integrated approaches to assessing need are being developed in the wake of the Single Assessment Process. The numbers of people receiving a statement of their needs was low in comparison to national performance.

What's going well?

3.20 Councils have continued to integrate social care services with health services and social services are also playing an important role in the modernisation of local councils and the development of community plans. Significant use has been made of Health Act Flexibilities with a particular focus on intermediate care, community equipment services and services for people with learning disabilities. The largest joint scheme was the development of a Care Trust for Mental Health Services in Manchester. Increasingly social services have been making joint appointments with PCTs to commission and deliver services jointly. Social Services are active partners in many corporate council initiatives including Health Action Zones and Neighbourhood Renewal.

3.21 Performance management developed during the year and, increasingly, IT systems are supporting effective **performance management**. Performance is being further enhanced by Local Public Service Agreements (LPSA) and social services targets feature strongly in them.

Good Practice

Bolton's Business Planning system links resources to agreed outcomes for divisions and service units in a comprehensive performance management system.

3.22 The Region has demonstrated comparatively strong performance in **child protection** services. High levels of child protection cases were reviewed compared to the national average (Appendix J) and there was a low level of re-registration to the Child Protection Register. The percentage of children on the Child Protection Register allocated to a key worker (98.9%) was amongst the highest in the country. Completion of reviews of looked after children done to time (95%) exceeded the national average (88%).

Good Practice

In **Salford**, the **Lifechancers Group**, including education, health, leisure and social services, is working to an action plan to improve outcomes for looked after children. Young people were fully involved in the project and the awareness raising campaign it was running.

3.23 Commissioning services for children has been developing well, with a particularly positive project for the joint commissioning of services for black and ethnic minority children which involves Warrington, St Helens, Knowsley, Halton, Cheshire and Sefton. Positive collaborative work across the Region has been undertaken by the Quality Protects Reference Group and the Children's Task Force (North West) with regional work in mental health services, services for children with a disability, acute services and children's participation – developing models for commissioning and sharing good practice.

3.24 Integration of mental health services has been a dominant issue in the Region this year. This has resulted in the establishment of a number of specialist mental health trusts offering new leadership to deliver more effective and consistent

mental health services. The development of assertive outreach teams, for example in Liverpool, is providing early evidence of positive outcomes for service users.

Good Practice

Halton, Knowsley, St Helens, Warrington and **Wigan** Councils in conjunction with an NHS Trust established an integrated Call/Knowledge Centre to improve public and staff access to information about services.

3.25 The numbers of **adults with a learning disability** supported at home in the Region was higher than the national average. A *Valuing People* Task Force has been established to support Local Partnership Boards to implement the White Paper. Councils in the Region supported more **people with physical disabilities** to live at home than the national average. Performance on the delivery of equipment was good with Cheshire, Knowsley and Oldham performing extremely well. Good progress was being made towards integrated Community Equipment Services. Welfare to Work joint investment plans were building on existing provision in terms of supported employment services which are particularly strong in Stockport and Oldham.

3.26 Significant work has been undertaken to implement the National Services Framework for **Older People** and in using the Building Care Capacity Grant. Eighteen out of 21 Councils, including three 'hot spot' councils, met or exceeded their targets to reduce delayed transfers of care. The North West Elderly Care Project, an ADSS/SSI annual survey of local market conditions, and Managing the Market Workshops have helped develop commissioning and market management strategies. The North West Task Force has supported intermediate care developments for older people. Councils in the Region were supporting more older people at home than the national average and were providing increased levels of intensive home care (Appendix J). Levels of carers' assessments and reviews of people receiving a service were positive in relation to the national picture.

Good Practice

Bury – Carers Breaks Direct Access Scheme – offering carers the opportunity to access services directly as and when they need them – won an award at the National Health and Social Care Awards 2001.

TRENT

Councils in this Region during 2001–2002

Metropolitan District Councils: Barnsley, Doncaster, Rotherham, Sheffield

Shire Counties: Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire

Shire Unitary Councils: Derby City, Leicester City, North East Lincolnshire, North Lincolnshire, Nottingham City, Rutland

- **Regional Population:** 5.2 million
- **Health links:** 11 Health Authorities; 27 PCTs; 10 new PCTs proposed for April 2002
- **Star rating:** 3 stars – 1 council (7%); 2 stars – 7 councils (50%); 1 star – 5 councils (36%); 0 stars – 1 council (7%)

3.27 Performance assessment resulted in **8 out of 14 (57%) councils in this region being awarded 2 or 3 stars**. Four councils were judged to be serving most adults well and six councils to be serving most children well. However, evidence suggested that prospects for improvement are encouraging in most councils with 11 judged to have excellent or promising prospects for improvement in services for adults and 12 in children's services. Of particular concern are a one star rated council judged to be serving only some people well across both services with uncertain prospects for improvement and the zero-rated council which remains subject to special measures. One council was judged to have made sufficient progress to be removed from special measures.

3.28 The geography of the Region is very diverse ranging from councils serving predominantly rural areas to those serving heavily industrial and post-industrial communities. The population of individual councils ranges from 750,000 in Nottinghamshire to less than 38,000 in Rutland. The majority of councils are well below the England average in the proportion of their population from ethnic minority communities. Derby City and Nottingham are above average and Leicester City is considerably above average. Individual council wards may also have a considerably higher figure than the average for the council as a whole.

Issues for the Region to address

3.29 Throughout the year Directors of Social Services have indicated that they have been under **considerable budgetary pressure**. All but two councils in Trent set an increased budget for 2001–2002, with an overall planned increase for the region of 3.5%. Most councils indicated in the SSI autumn 2001 monitoring that their forecast out-turn for the end of the year was no more than 2% above their revised budget at 30 September 2001. There were significant cost pressures in children's services, with seven of Trent's 14 councils predicting a forecast out-turn 3% or more above the revised budget for children's services.

3.30 The **recruitment and retention** of staff, particularly in children's services, has been an issue. Councils are developing innovative schemes such as traineeships and recruiting from abroad. Increases in looked after children as well as continuing recruitment difficulties of foster carers are having a significant impact on the ability of councils to match needs to available services. Increasing placement choice and attempts to reduce reliance on placements far away from the child's home are thus proving difficult. Despite this, placement stability has continued to improve and nearly all councils have met the national target. However, some councils have been experiencing difficulties in the long-term stability of placements.

3.31 Performance in **services for children** demonstrated many examples of good progress, but in some areas performance was slow to improve. Councils were beginning to see the benefits of inter-agency approaches through the implementation of the National Assessment Framework and Family Support/Children in Need strategies. Some councils were beginning to link together various initiatives such as Sure Start, Children's Fund and to a lesser extent Connexions into an overall strategy.

3.32 The Region as a whole showed high numbers of children reregistered on the child protection register, which is a matter of concern. Child Protection review performance (Appendix J) has been improving across the Region but the small number of councils whose pattern of performance is not consistent with the rest cause concern. Educational attainment for looked after children has remained very challenging particularly for urban councils and few councils have achieved the national target. (Appendix J). All councils are pursuing joint initiatives in social services and education services and several have included raising attainment as a Local Public Service Agreement target. Personal Education Plans showed signs of improving performance but from a low base.

3.33 Admission of people aged 65 and over into residential and nursing home care had slightly increased and the provision of intensive home care had decreased – both against national trend, (Appendix J). However, some councils were achieving reduced admission rates to residential and nursing home care.

3.34 Councils have been engaged in the partnership structures and processes to implement the **Mental Health** NSF. However, the uncertainty about the future configuration of Local Implementation Teams has been the cause of some frustration in the Region. Councils have demonstrated willingness to make use of the opportunity arising from organisational change and to develop robust commissioning strategies, with PCTs taking the lead commissioning role for mental health services. Areas of weakness have been in human resource strategies, strategic development, the development of integrated information systems, and full and consistent application of the Care Programme Approach (CPA). The Region has focused on improving practice in the CPA with resultant encouraging signs.

3.35 Work is underway to ensure that the social care dimension is appropriately and adequately included in planning for a regional mental health development centre in the East Midlands under the auspices of the National Institute for Mental Health.

What's going well?

3.36 **Adoption** performance was high in many councils and most councils were using the National Standards to develop services. The Adoption Register catch-up process has gone well. Good performance has been achieved in attending to the health of looked after children with a high percentage of children and young people having immunisations, and health and dental check ups. Implementation of the Leaving Care Act has been largely successful with some good examples of cross-council and voluntary sector partnerships.

3.37 All councils are exploring the use of **Health Act Flexibilities** and some are at an advanced stage in planning services for adults. Three councils have developed integrated health and social care services for people with mental health problems. Four councils have developed integrated learning disability services. There are currently no plans to establish Care Trusts in the area.

3.38 More people were receiving **Direct Payments**, with an increase of 39% for people with physical disabilities. In autumn 2001, a total of 624 people were in

receipt of such payments, 488 of whom were physically disabled. Four councils have increased the range of recipients to three or more service user groups. This is clearly an area where further improvement is needed, but with a firm foundation to build on.

Good Practice

Barnsley – good implementation and joint training of the national assessment framework for children as well as an effective system for auditing and monitoring case files.

North Lincolnshire has developed a clear policy and strategic direction for children's services, backed by a strong performance management culture. A strong multi-agency family support ethos has been developed, backed by robust assessment arrangements, a range of services, and a high degree of user involvement. This enables the Council to keep the looked after children population low, enabling a focus on quality and choice.

3.39 A Regional Board has steered the developments of the NSFOP and supported Local Implementation Teams. Conferences were held on Intermediate Care provision and Delayed Transfers of Care. The NSF 'czar' Professor Ian Philp has commented favourably on collaboration between health and social care and the innovative service provision in the Region. A recommendation has been made by the Board on an agreed single assessment system to be used across the Region.

3.40 The Region has been successful in managing delayed transfers of care in collaboration with health partners. A collaborative has been organised to increase partnership working and promote good practice. Considerable learning has taken place and successful projects on fast response and monitoring repeat prescriptions have been undertaken. Collaboration with housing and involvement of the independent sector has helped to achieve the targets.

Good Practice

The **Jackdaw** project in **Nottingham** provides intermediate care for older people with dementia and operates from a residential home with care assistants doing work with service users in their own homes and in day care.

3.41 All councils in this Region have established their **Learning Disability** Partnership Boards together with key partners and stakeholders. Most councils have reported an increase in the numbers of people with learning disability who are helped to live at home. Plans are at an advanced stage that will enable the closure of the Region's remaining long stay hospitals for people with learning disabilities by 2004. High numbers of people with **physical disabilities** were helped to live at home. Unit costs for residential and nursing care for adults with a physical or learning disability were low.

WEST MIDLANDS

Councils in this Region during 2001–2002

Metropolitan District Councils: Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall, Wolverhampton

Shire Counties: Shropshire, Staffordshire, Warwickshire, Worcestershire

Shire Unitary Councils: Herefordshire, Stoke-on-Trent, Telford and Wrekin

- **Regional Population:** 5.3 million
- **Health links:** 13 Health Authorities; 8 PCTs; 23/25 new PCTs proposed for April 2002
- **Star rating:** 3 stars – 0 councils; 2 stars – 3 councils (21%); 1 star – 8 councils (57%); 0 stars – 3 councils (21%)

3.42 Performance assessment of councils in the West Midlands resulted in no councils being awarded **3 stars and only three out of 14 (21%) councils receiving 2 stars**. In services for adults five councils were judged to be serving most people well. In children's services there were no councils that were judged to be serving most people well and three councils were judged not to be serving people well at all. There was some evidence of possible future improvement in services for adults in ten councils and in children's services in nine councils; 75% of both adults and children's services in 1 star councils were judged to have promising prospects. However, there was evidence of significant performance failure with poor and uncertain prospects for improvement, which will need to be tackled as a priority. Performance Action Teams will be working in three councils in this Region.

3.43 The West Midlands area covers a rich mix of large urban conurbations and rural communities. The Metropolitan District Councils and the four 'Black Country' boroughs form the second largest UK conurbation whilst the agricultural industry is evident in the rural counties. Birmingham has a population of over one million which is in extreme contrast to the county of Herefordshire which has a more widely spread population of 169,000. The age profile of the population mirrors very closely that of the UK as a whole. Black and ethnic minority communities form more than 10% of the population in four of the Metropolitan District Councils. People of Indian and Pakistani/Bangladeshi origin comprise respectively 3.6% and 3.2% of the resident population.

Issues for the Region to address

3.44 The expected difference between revised budgets at 30 September 2001 and forecast outturn for the end of the year ranged from –2% to 4% with six councils projecting expenditure to exceed budget by 2% or more. Increasing numbers of looked after children, the problems of finding them appropriate placements – especially in foster care – demands from acute hospitals to arrange the discharge of increased numbers of older people and difficulty in the independent sector social care market, were the main reasons behind the cost pressures in council budgets. The need to develop management information systems was bringing increased capital and revenue demands in many councils. New funding through neighbourhood renewal, Sure Start and the Children's Fund was important to sustain social services' input to promote social inclusion.

3.45 Most councils have more to do to improve service quality and to meet expected timescales in providing **children's services**. Councils need to increase the momentum of reform in these services, better exchange of good practice in the area is necessary. Councils need to look again at how the West Midlands Child Care Consortium can contribute to this. All councils need to pay attention to better performance management arrangements.

3.46 Improvement in maintaining the stability of children's placements was evident in nine councils but there was deterioration in the other five. Eleven councils have also reported deterioration in their performance in stability of long-term placements. While more than half of West Midlands councils completed more than 80% of reviews of looked after children within the required timescales, four achieved fewer than 70%. A marked variation occured in permanency planning arrangements, with only three councils having agreed permanency plans for more than half of the children they have looked after for more than four months. Eleven councils achieved good performance on the time children spent on the Child Protection Register. However, this performance is **not yet sufficiently consistent from year to year**.

3.47 In **learning disability** services all councils have established Partnership Boards. There has been a differential progress in setting up the sub-structure to work with the Boards and in the arrangements for effective participation by service users. Progress was similarly variable on the formation of quality assurance frameworks and Person-Centred Planning. The arrival of the Region's *Valuing People* Development Worker has been welcomed as a further spur to service change as well as the review of the configuration of health service provision for people with learning disabilities

3.48 The Region's services for **older people** are under pressure. Four health and social care communities experienced very high levels of older people being delayed in their discharge from acute hospitals. Four councils received additional Building Care Capacity Grant to assist. A further five councils received a smaller amount from funds held by the Health and Social Care Change Agent Team to support jointly agreed health and social care projects. The build up in delayed discharges in Birmingham in early summer 2001 attracted considerable media attention and prompted joint remedial work by the local health and social care community. The target set for improvement in West Midlands as a whole was achieved and significantly exceeded. This reflected well on partnership working and service developments which councils have put in place.

3.49 Seven councils showed improving performance in the provision of intensive home care although the West Midlands average was slightly below that for England. (Appendix J). Eight councils improved their performance in helping older people to live at home but in six there was evidence of some deterioration. The West Midlands average increased to a level just a little below the England average. In the autumn six of the 14 councils reported reducing availability of residential care.

What's going well?

3.50 Councils are using their social services experience to address the wider issues of social exclusion, and have sought active engagement with their health partners. Most councils have identified schemes using Health Act flexibilities, predominantly for mental health services and learning disability services. Identified barriers to progress in using the flexibilities include health services changes, difficulties in clarifying existing levels of investment, management capacity and time. Sandwell, Birmingham and Solihull declared early interest in exploring Care Trust status. The majority expect more and varied use of Health Act flexibilities to be the way forward.

3.51 West Midlands councils generally have some way to go before **services for children** are at acceptable levels although some councils have shown improvement. Five councils have shown improved performance in educating looked after children, and this has improved the West Midlands average (Appendix J). Eight councils achieved more than the 5% target level of adoptions during 2000–2001 with ten councils improving their performance. The West Midlands average figure was just ahead of the national average of 5.3%.

However, in eight councils waiting time increased for looked after children prior to adoption and figures were significantly higher in the West Midlands, compared with the national average, for children waiting more than one year for adoption.

Good Practice

Staffordshire – Creation of a comprehensive costed inter agency family support strategy involving up to five Sure Start programmes and family support teams working with Primary Care Trusts funded by the Children's Fund. A joint initiative with **NCH Action for Children** to provide a range of short breaks and support services for children with disabilities.

3.52 Social services are well engaged with health colleagues in taking forward developments in mental health services through Local Implementation Teams and under the auspices of the West Midlands Partnership for Mental Health. Further implementation of the Care Programme Approach, resolving workforce issues and better configuration of mental health services still need to be tackled.

Good Practice

Sandwell

- A user participation project supporting service user representatives on the Learning Disability Partnership Board and to contribute to service development initiatives.
- Production of a range of planning documents in an accessible format to support user participation.
- Work of the West Bromwich African Caribbean Community Centre which supplements existing day services for people with learning disabilities providing culturally-based music making, food preparation and discussion about heritage.
- Roshni – a service for Asian women with learning disabilities offering sporting, art and craft, and other community-based activities.

EAST OF ENGLAND

Councils in this Region during 2001–2002

Shire Counties: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk, Suffolk

Shire Unitary Councils: Luton, Peterborough, Southend-on-Sea, Thurrock

- **Regional Population:** 5.5 million
- **Health links:** 7 Health Authorities; 29 PCTs; 14 PCGs
- **Star rating:** 3 stars – 0 councils; 2 stars – 5 councils (50%); 1 star – 5 councils (50%); 0 stars – 0 councils

3.53 Performance assessment resulted in no council receiving either 3 stars or zero stars but **five out of ten (50%) received two stars**. Two councils were judged to be serving most people well with promising prospects for improvement. A further three were judged to be serving most children well. In the five 1 star councils, prospects for improvement were judged to be promising in services for adults in three councils and for children in four councils. In one council a 1 star rating meant that it ceased to be subject to special measures.

3.54 The area of the East of England is diverse, incorporating London commuter suburbs, towns, ports and seaside resorts, and extensive rural areas. Only two areas in the Region qualify for neighbourhood renewal funding, Great Yarmouth and Luton but, in common with other parts of the country, there are pockets of marked deprivation, and differences in health and longevity. The majority of councils in this Region have smaller black and ethnic minority populations than the average for England (5.01%), the smallest in Thurrock (1.89%). The exceptions are Luton (11.25%) and Peterborough (5.85%).

Issues for the Region to address

3.55 All councils in the Region experienced budget pressures and were finding it difficult to contain expenditure within budget. In the autumn, the expected out-turn was 2.2% over revised budgets.

3.56 Organisational arrangements, particularly with health, are complex. Councils in the Region are developing structural and organisational arrangements to achieve greater integration with health, education and housing. Two councils have

created new children and families departments combining children's social care services and education. Several councils have been contemplating similar arrangements. Two unitary councils provide integrated social care and housing services and most councils in the Region are developing locality arrangements to link social care services with PCTs. A number of councils have experienced difficulties in sharing and accessing information from health partners, and this was causing difficulty with partnership working.

3.57 There are three priorities for improving childcare services in the Region. These are commissioning children's placements, improving arrangements for undertaking serious case reviews, and implementation of the **Children's Assessment Framework**. Marked inconsistencies still exist in the implementation of the Framework across the region with variation in the target for initial assessment, core assessment and assessment leading to services. All councils are aiming to improve their performance.

3.58 The Region had a relatively low number of **older people** aged 65 and over who were admitted to residential or nursing home care and who were supported financially by councils (Appendix J). There was also evidence of comparatively low levels of support to people living at home. These factors raise questions about the eligibility criteria that have been agreed in the Region. Delayed transfers of care were particularly problematic in the Region with seven out of ten councils identified as 'hotspots'.

3.59 There were significantly more people with learning disabilities living in NHS long-stay hospitals in the East of England compared with the England average (57.3 compared with 15.4). However, the numbers of people with a **learning disability** supported at home were slightly above the national average.

What's going well?

3.60 Six out of ten councils have invested in new and improved **management information systems**, and a further two had agreement to invest in new systems in 2002. Hertfordshire had introduced IT systems that are capable of producing the information returns required by both the Department of Health and the Department for Education and Skills.

3.61 Although there is no full Care Trust as yet in the region there are good examples of **unified management of services for adults**. The use of pooled budgets, joint posts and teams, and partnership boards are some examples of this approach.

3.62 Considerable progress has been seen in the re-focusing of children's services. Councils that have invested in improved family support services were showing a continued reduction in the numbers of looked after children. Five councils have reported decreases of up to 9%. The percentage of children's reviews held on time increased in the last year and was consistent with the England average (Appendix J). Half of the councils in the Region have achieved 100% and the rest show improving performance.

3.63 All councils in the Region have produced and are using audit tools to **monitor the quality and outcome** of children's services. Regional work has been completed to collate these tools and to provide each council with a full set of audit documents. The aim has been to encourage systems that help team and unit managers to evaluate their own performance and which help track the progress of cases through planning stages.

3.64 The Region has achieved very good performance in the placement of children in **foster care or for adoption**. Councils in the Region have also been proactive in implementing the Adoption Register and built on good inter-council co-operation to share placement resources. The Adoption Taskforce has worked with Peterborough City Council and will be working with Southend-on-Sea and Cambridgeshire during 2002–2003.

3.65 Implementation of the **NSFOP** is progressing well with milestones being met appropriately. Areas of good practice are emerging around 'Falls' services and some excellent examples of this are evident within the PCTs in Cambridgeshire. Other good practice is evident in the development of intermediate care. The Building Capacity Grant totalled £9 million for the Region. Councils and their health partners undertook a number of initiatives that contributed to exceeding the regional target for delayed transfers. Improvements included:

- increase in independent sector fee levels;
- additional capacity in independent residential and nursing provision;
- wide range of operational interventions, for example extended cover for A & E, patient pathway case manager;
- additional hospital-based social workers;

- additional special equipment; and
- developments within intermediate care.

3.66 All seven Local Implementation Teams set up in line with the **Mental Health NSF** were able to demonstrate some progress in developing major new assertive outreach, crisis resolution and early intervention services. Progress was less marked in developing services for black and ethnic minority communities, management information, IT and workload development. Social care is managed within a single NHS Trust in four of the seven mental health systems and others are making determined progress towards integration.

3.67 Social services and their health partners have enthusiastically set about implementing the *Valuing People* White Paper in a partnership with people with **learning disabilities**, their carers and service providers from all sectors. All Partnership Boards are up and running, and service users and carers are actively participating.

3.68 Numbers of **Direct Payments** in the Region were above the national average and particularly good in relation to people with learning disabilities and physical disabilities.

Good Practice

Suffolk – Recruitment of social workers through a range of initiatives including through local diploma in social work courses, as well as from abroad. They anticipate only ten social work vacancies across the county by July 2002.

Luton – Has set up a children's panel, a formally constituted group of councillors and looked after children and left care young people. Their work has led to a number of policy changes and service improvements.

SOUTH WEST

Councils in this Region during 2001–2002

Shire Counties: Cornwall, Devon, Dorset, Gloucestershire, Isles of Scilly, Somerset, Wiltshire

Shire Unitary Councils: Bath and North East Somerset, Bournemouth, Bristol, North Somerset, Plymouth, Poole, South Gloucestershire, Swindon, Torbay

- **Regional Population:** 4.9 million
- **Health links:** 8 Health Authorities; 22 PCTs; 12/13 new PCTs proposed for April 2002
- **Star rating:** 3 stars – 1 council (6%); 2 stars – 6 councils (38%); 1 star – 8 councils (50%); 0 stars – 1 council (6%)

3.69 Performance assessment of councils in South West resulted in **seven out of 16 (44%) councils being awarded 2 or 3 stars**. Four councils were judged to be serving most adults well and six councils to be serving all or most children well. Prospects for improvement were encouraging overall – services for adults and for children were both judged to have excellent or promising prospects in eleven councils. However, particular attention will need to be given to four 1 star councils where prospects for improvement were judged to be uncertain as well as the zero-rated council where prospects for improvement are judged to be poor in services for adults and uncertain in services for children.

3.70 In the South West Region, more than 75% of land is in agricultural use and in some places rural isolation presents a significant challenge. There are lower than average numbers of children and young people in the population and a higher than average percentage of people over pensionable age. One point nine per cent of the population are from black and ethnic minority groups compared with the national average of 7.0%.

Issues for the Region to address

3.71 The **balancing of resources, needs and demands for social services** is the key challenge for all councils. In 2001–2002 actual expenditure over SSA was projected to be £70 million or 9.1%. The average cost of children's placements remained the lowest nationally, but rose by 28% during the year. The level of

supported admissions of adults to residential or nursing home care – at 4 per 10,000 population aged 18–64 – was the highest of any region, and placements for people with learning disability remained a source of significant budgetary pressure.

3.72 Concern to improve the **retention of staff** has generated a range of staff care initiatives. In Devon, for example, an analysis of staff absence and a concern about the numbers of staff suffering muscular/skeletal problems, has led to a scheme facilitating fast access to physiotherapy for assessment and treatment, promoting earlier return to work. Across the Region, there was a turnover of 25% in Directors of Social Services, in addition, many councils report reduced capacity to manage the increased load in the strategic planning of services.

3.73 Within **services for children**, Child and Adolescent Mental Health Services have suffered from under-development and under-investment, in the face of increasing levels of demand; and frequently lack of engagement by key agencies. Capacity to meet needs is restricted although there are some encouraging pockets of collaborative practice. Children from black and ethnic minority groups were over represented as looked after children (3.2%) and children in need (2.8%) compared to 2% nationally. A regional working group on improving the life chances of such children has been established.

3.74 In mental health services, the review undertaken in late 2001 showed that although the 11 Local Implementation Teams serving the Region have made progress in developing integrated commissioning and provision, progress against NSF targets has varied significantly, and some teams face considerable challenges. A regional Mental Health Development Service has been established in conjunction with the Sainsbury Centre.

3.75 Delayed transfers of care are a significant problem in the Region, in particular, seven councils were designated 'hotspots'. Additional Building Care Capacity Grant resulted in the number of delays being reduced by 28%. Comparatively, there is an over supply of residential beds in some places, but across the Region as a whole there is concern about declining capacity in residential and nursing home care. Although fees have increased, homes continue to close and in several areas providers will not accept the contract price. Gaps in the provision of residential and nursing home care for elderly people with mental health problems are particularly acute. However, the Region also recorded the lowest level of intensive home care (Appendix J) and the lowest rate of assessments of carers.

What's going well?

3.76 Increasingly robust approaches to **performance management** have been evident. Data capture and accuracy, however, still showed room for improvement, but there was a high level of awareness of service performance and good examples of efforts being made to involve front-line services to promote ownership of the information. Imaginative ideas for Local Public Service Agreements (LPSA) targets were also emerging.

3.77 The commitment to **evidence-based practice** is evident through the contribution of local councils to the Centre for Evidence Based Social Services (CEBSS), located at Exeter University.

Good Practice

Devon has used research into outcomes of intermediate care provision to estimate savings made on NHS hospital bed costs. They calculate that 1,346 individuals admitted into residential rehabilitation 'saved' on average 14 days hospital care per person – an accumulated saving of between £3.4 million and £5.3 million over a year.

3.78 All local councils in the Region were developing **integrated working with health partners** in ways that suit local circumstances. This is taking a variety of forms, including specific joint services – such as Somerset's singly managed learning disability community teams, and the creation of joint equipment stores. The Isles of Scilly and North Cornwall PCT are likely to establish joint management arrangements for the totality of the council's social services' functions in the near future. A number of the new shire unitary councils established departments that combine social services and housing functions and are just beginning to realise benefits from this relationship. 'Supporting People' has helped in this process. Wiltshire is moving to establish local Care Trusts.

3.79 Collaborative working at a strategic level is increasing in **children's services**. Councils have established a regional placement scheme – hosted by Gloucestershire – to facilitate the sharing of information about care placements, with the longer-term intention of developing greater choice for children. More than half of the councils were rated very good in securing stability of care. That 56% of long-term placements were stable represents the best performance

nationally (with East of England Region). At 11.43%, the Region has the lowest percentage of children placed in residential care. Seventy-eight per cent of looked after children were cared for in foster homes or adoptive placements – the highest level in any region. Half of the Region's councils were rated good or very good on the numbers of looked after children placed for adoption. Unlike other regions, South West Region had a 'surplus' of 90 adoptive homes, but there was a shortage of supply of appropriate placements for 10–13-year-old children.

Good Practice

South-West Adoption Consortium was launched in July 2001. Hosted by Somerset County Council, and a pilot area for the National Adoption register, it comprises 14 local councils, and three voluntary agencies – NCH Action for Children, Find a Family and the Catholic Children's Society. Its aim is to secure better and speedier placements, and by February 2002 over 43 children had been found new homes in 31 placements across the south-west.

3.80 Forty-two per cent of **care leavers** achieved at least one GCSE at grade A*–G or a GNVQ, and this – with West Midlands Region – was the best regional performance. At 9% the rate of school absence was the lowest of any region. Councils reported an improving picture of achieving the target for health checks and immunisations (69% to 80%) and there are specific clinical NHS posts dedicated to looked after children.

3.81 Six local councils are piloting **Care Direct** – a one-stop shop through which **older people** can obtain information about – and access to – social care, health, housing, and benefit services. Early indications are promising:

- in Bournemouth the service receives more than 1,000 contacts per month and provides more service for more people on an immediate basis;
- in Gloucestershire 95% of calls to the combined Care Direct/help service desk are resolved at first point of contact; and
- in Somerset – where the service is co-located with NHS Direct and the GP out-of-hours service – social care referrals for older people are progressively being routed via Care Direct.

Good Practice

The '**Task and Time**' Home Care scheme in **South Gloucestershire** aims to empower users of home care services by allowing them to determine how home care time is used.

3.82 Nearly two-thirds of councils were rated good or very good at supporting adults with a **learning disability** at home, thus making the South West the best performing region. South West Action on Learning Disability (SWALD) – is an initiative funded by councils in the Region with the aim of developing needs and evidence-based services and approaches.

SOUTH EAST

Councils in this Region during 2001–2002

Shire Counties: Buckinghamshire, East Sussex, Hampshire, Kent, Northamptonshire, Oxfordshire, Surrey, West Sussex

Shire Unitary Councils: Bracknell Forest, Brighton and Hove, Isle of Wight, Medway Towns, Milton Keynes, Portsmouth, Reading, Slough, Southampton, West Berkshire, Windsor and Maidenhead, Wokingham

- **Regional Population:** 8.7 million
- **Health links:** 12 Health Authorities; 24 PCTs; 38 PCGs
- **Star rating:** 3 stars – 0 councils; 2 stars – 6 councils (30%); 1 star – 13 councils (65%); 0 stars – 1 council (5%)

3.83 Performance assessment resulted in no councils being awarded **3 stars, six out of 20 (30%) earning 2 stars and one council rated zero stars**. Only one council was judged to be serving most people well in services for adults. One of the seven councils judged to be serving most people well in children's services was judged to be performing poorly in services for adults – serving no-one well with uncertain prospects – and this resulted in the council receiving a zero star rating and becoming subject to special measures. Prospects for improvement were judged to be excellent or promising in ten councils. However, in more than half of the 1 star councils, prospects for improvement in both services for adults and children were judged to be uncertain.

3.84 Within the Region are a wide variety of councils: rural and urban, large and small. Kent, one of the larger counties in Britain has a population of 1.3 million. At the other end of the spectrum Berkshire was separated into six Shire Unitary Councils which are relatively small. The newness of the shire unitary councils, and in some cases their size, has had an impact on service delivery as historical service models have prevailed. The Region is relatively affluent but with areas of deprivation in parts of the Kent coastline, Thanet, Brighton, Portsmouth, Southampton, Medway and the Isle of Wight. Overall the Region has earnings over the national average, with low unemployment, jobs mostly in the service sector, a highly qualified workforce, and small numbers of people from black and ethnic minority backgrounds.

Issues for the Region to address

3.85 **Balancing the needs, demands and resources for social care** remains the major challenge for councils in the Region. In autumn 2001, the Region was forecasting a 1% overspend on revised budgets, which was lower than the national average (1.6%), though the Region showed a larger in-year upward revision of budgets than the national average. The pressures arose from the demands and costs of services for people with a physical disability and children and families. Most councils reported significant overspending in children's services. Costs were high, especially for residential placements and the fees of Independent Fostering Agencies. Some areas are taking steps to tackle this by joining in consortia to specify and commission this type of care. There appear to be a high number of people with learning disabilities in parts of the Region as a result of resettlement programmes of large hospitals, and in some cases the historic usage of high cost placements. Across the Region, the budget projections varied from a 1.5% underspend to an 8.2% overspend across the totality of social services expenditure.

3.86 Core services for **children and families** were less well developed and performance to complete the reviews of children on the child protection register was lower than nationally. The regional picture disguises some real excellence in some councils and poor performance in others. Improvement in the placement of children close to home needs to happen more quickly than current performance indicates. Five councils had more than 20% of looked after children placed out of their area.

3.87 Almost all councils are experiencing **workforce** difficulties. The buoyancy of the economy and the high cost of living with competition from the retail sector does not attract people to seek care and administrative work in the public sector. Whilst there is a picture of a highly qualified population, many councils have high levels of vacancies especially in child care teams, in some cases up to 50%. Persistent use of agency staff can jeopardise performance through higher costs and discontinuity of support for children.

3.88 **Capacity and workforce difficulties are a major issue for the NHS** in the Region and this has had an impact on some health and social care economies. Four out of ten of the NHS poorly performing Trusts are in the South East.

3.89 The market and socio-economic factors in the region are reflected in the cost of the workforce and, for residential and nursing homes, the cost of land and property. The Region has experienced **rising costs** in service provision in the independent sector, home care is comparatively expensive, and the costs of

residential and nursing home care have risen during year. In the SSI autumn monitoring exercise, 80% of councils considered the supply of residential care homes was insufficient, and 90% of councils considered the supply of nursing home care was insufficient.

3.90 Across the Region there were generally low levels of supported admissions of older people to residential and nursing home care, this was frequently associated with low or modest levels of home care or intensive home care (Appendix J). The general picture was of **low council investment in the range of services for older people**. The proportion of social services budgets spent on older people was lower than the national average. People funding their own care form a substantial proportion of residents in residential and nursing homes in the Region. But in many councils, service thresholds are high.

Good Practice

Hampshire's Direct Payment scheme won a Health and Social Care Award in 2001.

3.91 Capacity in **older people's services** has been the dominant issue in the Region during 2001–2002. Nineteen of the 20 councils experienced high numbers of people delayed in hospital and were deemed to be 'hot spots'. Approximately £17 million of the Building Care Capacity Grant was allocated to this Region. A concerted effort by councils and health services between September 2001 and March 2002 reduced the numbers of people whose discharge was delayed by 25%. In 2002–2003 a similar target has to be met, and given the intransigence of the problems faced, achieving sustainable progress will be a critical challenge for the Region.

What's going well?

3.92 The Region increased the number of **people with learning disabilities** that were helped to live at home from 1.9 per 1,000 to 2.2 per 1,000, closer to the national average of 2.3. Councils reported a total of 551 people living in NHS long-stay hospitals, which was the second highest total by region. However, almost half of these people were expected to move on to more appropriate placements by the end of 2001–2002.

3.93 Performance on Direct Payments for **people with physical disabilities** was above the national average, but there was considerable variation within the Region in the number of people using Direct Payment schemes. Hampshire, Portsmouth and Southampton had high numbers of users, with the ex-Berkshire councils and the Isle of Wight having a low take-up.

LONDON

Councils in this Region during 2001–2002

Inner London Boroughs: Camden, City of London, Greenwich, Hackney, Hammersmith and Fulham, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth, Westminster

Outer London Boroughs: Barking and Dagenham, Barnet, Bexley, Brent, Bromley, Croydon, Ealing, Enfield, Haringey, Harrow, Havering, Hillingdon, Hounslow, Kingston upon Thames, Merton, Newham, Redbridge, Richmond, Sutton, Waltham Forest

- **Regional Population:** 7.4 million
- **Health links:** 14 Health Authorities; 18 PCTs; 35 PCGs
- **Star rating:** 3 stars – 4 councils (12%); 2 stars – 5 councils (15%); 1 star – 21 councils (64%); 0 stars – 3 councils (9%)

3.94 Performance assessment awarded **9 (27%) out of the 33 councils a rating of either 2 or 3 stars. Half of all councils in the country given a rating of 3 stars were in London**. Ten councils were judged to be serving all or most people well in their services for adults and ten councils to be serving all or most children well. Prospects for improvement were judged to be excellent or promising in services for adults in 17 councils and for children's services in 22 councils. However, it is a matter of concern that over half of 1 star councils have uncertain prospects for improvement in services for adults and that six of these councils also have uncertain prospects for improvement in children's services.

3.95 There are emerging differences in performance in inner and outer London. Six out of 13 councils **in inner London** were awarded 2 or 3 stars with the remainder (54%) awarded 1 star. Over half of these councils were judged to be serving most or all adults well and eleven were judged to have excellent or promising prospects of improvement across both services for adults and children. Two inner London councils were removed from special measures as a result of performance ratings.

3.96 **In outer London** councils the picture is quite different. Only three out of 20 councils in outer London were awarded 2 or 3 stars. 14 (70%) councils

were awarded 1 star. One council ceased to be subject to special measures but three outer London councils received a zero star rating; two of these were already subject to special measures and one became subject to special measures for the first time. Only three outer London councils were judged to be serving most adults well; prospects for improvement were judged to be uncertain in 75% of services for adults. The picture in children's services was only slightly better with five (25%) councils judged to be serving most people well and prospects for improvement judged to be uncertain or poor in 50% of outer London councils. One outer London council earned 3 stars.

3.97 London is a city of diversity and contrasts containing the three most deprived and two of the most prosperous areas in the country. The population tends to be concentrated in the 20 to 64 age band (63%) and the percentage of people aged over 65 (12%) is smaller than the national average. Twenty-nine per cent of the population of London is from black and ethnic minority groups compared to a national average of 9%. People from Indian communities form the largest non-white community in London, followed by Caribbean, African, Bangladeshi, Pakistani and Chinese communities. Every London council has at least one community of more than 2,000 people from one of the main black and ethnic minority groups included in the 1991 census. In addition, in the last five years London has attracted significant numbers of refugees and asylum seekers.

Issues for the Region to address

3.98 The **balancing of resources, needs and demands for social services** and consequent budget pressures are of concern for London councils which spent 34% more per head on social services than the England average. The cost of living, and accommodation in particular, remains high, which has an impact on the social care workforce. Recruitment and retention of staff continues to be a significant concern for many councils.

3.99 There continues to be a major **staffing shortfall** in the Region **and turnover of staff is high**. Action is being taken at all levels to tackle the problem. By March 2002, many councils had developed integrated workforce plans to address workforce planning, recruitment, retention, flexible working, training and development, and there are early signs of having a positive impact.

3.100 Despite much effort and some progress, the Region continues to face significant challenges to provide good **services for children** in need. The statutory inquiry into the death of Victoria Climbié has focused attention and further

raised the profile of child protection in the Capital. Councils are expecting that the Inquiry's recommendations will have a significant impact on the direction of future service delivery.

3.101 Placement choice for **looked after children** has continued to be a problem. London Region had high numbers of children placed some distance away from their home area. Efforts have been made to reduce the number, but it will remain a challenge for some time. It is therefore unsurprising that the Region had the highest costs for children's placement and foster care. However, the Region had a high level of placement stability and the highest proportion of young children placed in foster care.

3.102 London Region's performance in raising **the educational qualifications of looked after children was the poorest of all regions** (Appendix J). There were also low numbers of children with personal educational plans. For some councils achieving better educational outcomes has been affected by the high numbers of asylum-seeking children and, in some councils, the quality of schools. Pan Region approaches are required to address these issues and the Quality Protects Regional Development Workers are working with London councils to share the good practice. London Region is one of three regions whose performance to address the health needs of looked after children is poor. This is despite the Region having the highest number of clinical posts in the NHS dedicated to looked after children.

What's been going well?

3.103 Development of **integrated social care and health services** across a number of service areas has progressed. More councils and their health partners have begun to formalise their joint working by using the flexibilities of the Health Act 1999. Two London Directors of Social Services also hold the post of Chief Executive of their local Primary Care Trust.

3.104 Bexley Council and Bexley Primary Care Trust are part of the national group of Care Trust demonstrator sites. Their intention is to establish a Care Trust for older people and people with physical disabilities. Camden and Islington councils and their health partners established Camden and Islington Mental Health Care Trust on 1 April 2002. A number of other localities in London are exploring Care Trusts as one model to develop integrated services.

3.105 Increasingly, councils are **tackling their workforce problems** by working with their local communities to raise the profile of social care services as employment opportunities and are investing in access programmes to support these initiatives. The creation of the NHS Workforce Development Confederation for London gives scope for much closer working to tackle workforce issues across health and social care. London-wide action is being taken to address the top priorities to reduce the dependency on agency staff and to develop robust workforce planning systems and information.

3.106 Camden, Lewisham, Newham and Richmond all took part in **the pilot Local Public Service Agreement (LPSAs)** scheme in 2001. The uptake of LPSAs by London councils has been steady and a further five councils have agreements, with another five are expected to submit applications in early May 2002. Some councils have been imaginative in developing their local targets, such as the target to reduce the number of looked after children under the age of 10 in Southwark.

3.107 Councils and Primary Care Trusts are working in close partnership to implement **the National Service Framework for Older People**. The Region has seen substantial development of intermediate care services and has established an Intermediate Care Co-ordinators Network to promote further growth of rehabilitation, admission avoidance and community-based intermediate care. London councils had the highest levels of intensive home care services in the country (Appendix J). From the introduction of the Building Care Capacity Grant to the end of March 2002, delayed transfers of care in London fell by almost 30%.

Good Practice

Hackney won a Modernisation Award for the success of a Rapid Response Multi-Agency Team which provides support to enable older people to return home more quickly from hospital.

Hammersmith and Fulham made good use of Best Value and PFI to help older people to remain in their own home and to provide 24 hour care for those with the highest levels of dependency.

3.108 Progress has been made in implementing the **Mental Health NSF** across London. Overall the number of people with mental health problems helped to live at home is improving. However, improvement is needed in the development of integrated electronic records with health, and the provision of services for black and ethnic minority groups. There continue to be problems with acute in-patient services and recruitment of staff.

3.109 More attention has also been paid to services for **people with learning disabilities** during the year. An assessment of the joint investment plans for people with learning disabilities in the Region suggested good progress. However, while virtually all plans showed satisfactory or very close working relationships with users and carers, there is still room for improvement in the practice of involving them in the direction and design of change.

POSTSCRIPT

3.110 Reports from the regions highlight common themes and many examples of **collaborative working** – within councils, with health bodies and with other councils across regions to find solutions to common problems. These include:

- devising common approaches to the single assessment of the needs of older people;
- co-location of services and joint training;
- sharing good practice;
- joint commissioning of services for black and ethnic minority children;
- market management;
- intermediate care networks;
- workforce planning, recruitment and retention strategies;
- common approaches to the development of the Care Programme Approach;
- collaborative working to tackle delayed transfers of care; and
- inter-council co-operation and consortia to share placement resources.

1. **The SSI is a Government Inspectorate whose role is to evaluate the quality and performance of social services authorities in the practice and delivery of their statutory responsibilities for social services, and to assist councils in sustaining continuous improvement in their performance.**

2. **In all its activities of inspection, review and evaluation, the SSI aims to deliver a credible, authoritative and independent view of the performance, capacity and quality of social services as delivered by local councils. SSI uses this information to inform current, and future policy development.**

3. The Social Services Inspectorate (SSI) (England) was set up in 1985 as a professional division within the Department of Health. There are separate such Inspectorates in Wales, Scotland and Northern Ireland.

4. The Chief Inspector of the Social Services Inspectorate (England) is the principal professional social services adviser to Ministers and is responsible for the strategic development and management of the SSI. In July 2001 the current Chief Inspector took on responsibility for the Department of Health Directorate for Children, Older People and Social Care Services. This is a personal portfolio of responsibilities.

5. A Joint Steering Group oversees the work of the Inspectorate, agreeing and monitoring the inspection programme and reviewing, from time to time, the scope of future work – including performance activity. Chaired by the Chief Inspector and meeting twice yearly, membership comprises the Association of Directors of Social Services (ADSS), Local Government Association (LGA) and Lay Assessors. SSI meets regularly with the ADSS, the British Association of Social Workers and the Social Care Association but also consults more widely as needs arise.

6. SSI is committed to producing high quality work and has a code of practice that covers all staff and lay assessors. In line with the objectives set out in the *Modernising Government* White Paper, SSI continually reviews and assesses its work to identify areas where it needs to improve.

7. This section of the *Chief Inspector's Annual Report* reports on SSI's activities during the past year and highlights some of the achievements. It also sets out future plans and the direction of the Inspectorate in the coming year.

Photographs. (Top): The Social Care Workers Reception at No. 10. (Middle): With thanks to the Kingston Dementia Liaison Group, Kingston-upon-Thames, Health and Social Services. (Bottom): The SSI Management Team, July 2002.

Photograph. With thanks to the 'Inside Out' sculpture project, Hertfordshire Council's children, schools and families scheme.

Appendices

APPENDIX A

STATISTICAL INFORMATION ON PERSONAL SOCIAL SERVICES

DH Statistics Division is responsible for collecting annual returns on personal social services (PSS) from all councils in England. SSI has been working with Statistics Division to increase the use made of these data and the statistics derived from them. This appendix is arranged as follows:

- children's services;
- adults services;
- resources (finance and staffing);
- list of Performance Assessment Framework performance indicators (PAF PIs); and
- list of PSS statistical publications containing further information.

CHILDREN'S SERVICES

The Children Act 1989 sets out the legal framework under which children's services are provided. Considerable changes in practice followed the implementation of the Act in October 1991 and this limits the comparisons that can be made with the period before the Act.

Summary

Table 1.1 Children receiving Personal Social Services – a summary

numbers and percentages

	96-97	97-9 8	98–99	99–00	00–01
Children looked after by local authorities at 31 March	51,200	53,300	55,500	58,100	58,900
% aged under 10	40%	42%	43%	43%	42%
% in foster care	65%	66%	65%	65%	65%
% in children's homes & secure units	12%	12%	12%	12%	11%
% with 3 or more placements during year	20%	19%	19%	19%	16%
Registrations to child protection register during year	29,200	30,000	30,100	29,300	27,000
% whose reason was sexual abuse	21%	20%	19%	17%	16%
% that were re-registrations	18%	20%	15%	14%	14%
All adoptions during year [1]	5,200	4,800	4,400	4,800	4,900
adopted from care	1,900	2,100	2,200	2,700	3,100

[1] The number of adoptions is based on the date of court order

Key points are that:

- the number of children looked after by councils has been increasing. This is because, although the number of children starting to be looked after has decreased, the average duration of stay has increased;
- the number of children placed on the child protection register has been relatively stable;
- the percentage of children adopted from care of all adoptions in England has increased from 35% in 1996–1997 to 63% in 2000–2001.

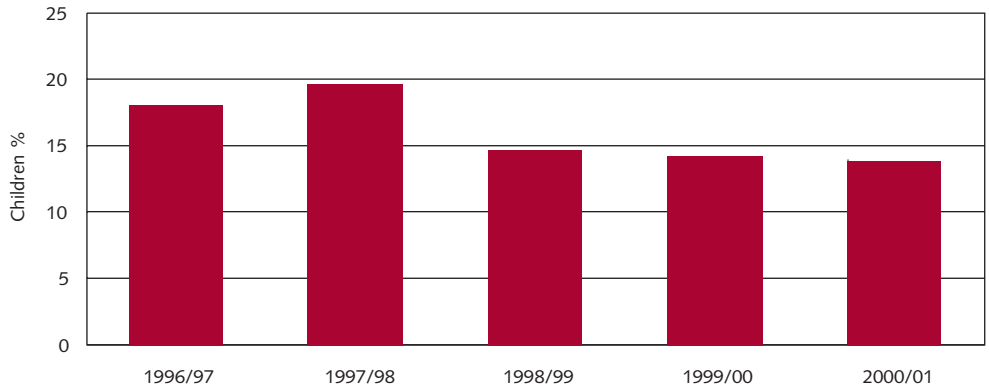
Performance

National Priorities and Strategic Objectives

- Progress has been made against the *National Priorities Guidance* targets set for children's services, but they have not all been met. Seventy nine per cent of councils met the target of 16% or less for the stability of placements for children looked after (PAF PI A1). However, the educational attainment of care leavers (PAF PI A2) is very low (37%) compared to the target for 2000–2001 of 50%. Significant improvements are required if the 2002–2003 target of 75% is to be achieved. Figure 1.1 shows that a further small fall has been seen in the national value for re-registrations on the child protection register (PAF PI A3). Although virtually all of the improvements from

1997–1998 to 1998–1999 were attributed to improvements in data quality, the figures for 1999–2000 and 2000–2001 suggest that the underlying long-term trend upwards in evidence from 1991–1992 has been reversed. The indicator has for the third year met the target level that was set for next year.

Fig 1.1 Re-registrations on the child protection register



Cost and Efficiency

- The proportion of children looked after in foster placements or placed for adoption has remained fairly stable (PAF PI B7 and PAF PI C22).

Effectiveness of service delivery and outcomes

- Most councils met their statutory inspection obligations. However, three councils failed to inspect all their children's homes (PAF PI C25).

- Review procedures for child protection cases improved but further improvement is required as only 25% of councils reviewed all their cases and one in eight reviews did not take place when they should. Nine councils reviewed less than two-thirds of cases (PAF PI C20).

- Duration on the child protection register (PAF PI C21) reduced, signifying improved performance. However 26% of councils had more than 15% of de-registrations relating to children who had been on the register continuously for two years or more.

- There was an increase in the proportion of looked after children adopted for the third successive year (from 4.7% in 1999–2000 to 5.2% in 2000–2001 (PAF PI C23), representing an increase of some 300 children).

- The average proportion of looked after children who had immunisations, health and dental checks up to date was 66% (PAF PI C19) and one in eight were absent from school for at least 25 days during the year (PAF PI C24). The proportion of looked after children who received a final warning/caution or conviction was three times the proportion for all children (PAF PI C18).

Quality of services for users and carers

- Long term stability of looked after children (PAF PI D35) showed little change and performance is still not acceptable for 57% of councils.

Fair access

- Eighteen per cent of councils have fewer children in need from black and ethnic minority groups than might be expected from their population make-up (PAF PI E45). This may mean that they are not reaching these communities in their areas.

Background information

Children and young people looked after by local authorities

Children can be looked after by local councils for a variety of reasons. Some families may be unable to care for their children because of illness or death. Other families may need some form of respite care, for example, in cases where a child is disabled.

Children who are at risk of abuse or neglect, or guilty of a criminal offence may also be looked after by the local authority. In some cases, children are accommodated under a voluntary agreement; in other cases children may be subject to a court order. The Act laid emphasis on partnership with parents and on the principle that, generally, court orders should only be made if they are in the best interest of the child.

Table 1.2 and figure 1.2 show the number of children in care, or looked after, in England at 31 March from 1991 to 2001. The long term decline in the number of looked after children came to an end in 1994, when the number being looked after at 31 March was 49,100. Since then there has been an increase of 20% to 58,900 as at 31 March 2001.

Children can be placed in a number of different settings, summarised in figure 1.2. The majority are placed with foster parents. In 1991 the proportion of all looked after children in foster placements was 58% and this rose steadily to 65% in 1995, since when it has remained fairly constant. In contrast, over the ten years since 1991 there has been

a marked decrease in both the proportion of children in homes, hostels, residential schools. At 31 March 1991, there were 11,400 looked after children in such placements (or 19% of all children), compared with 7,900 (or 13%) in 2001.

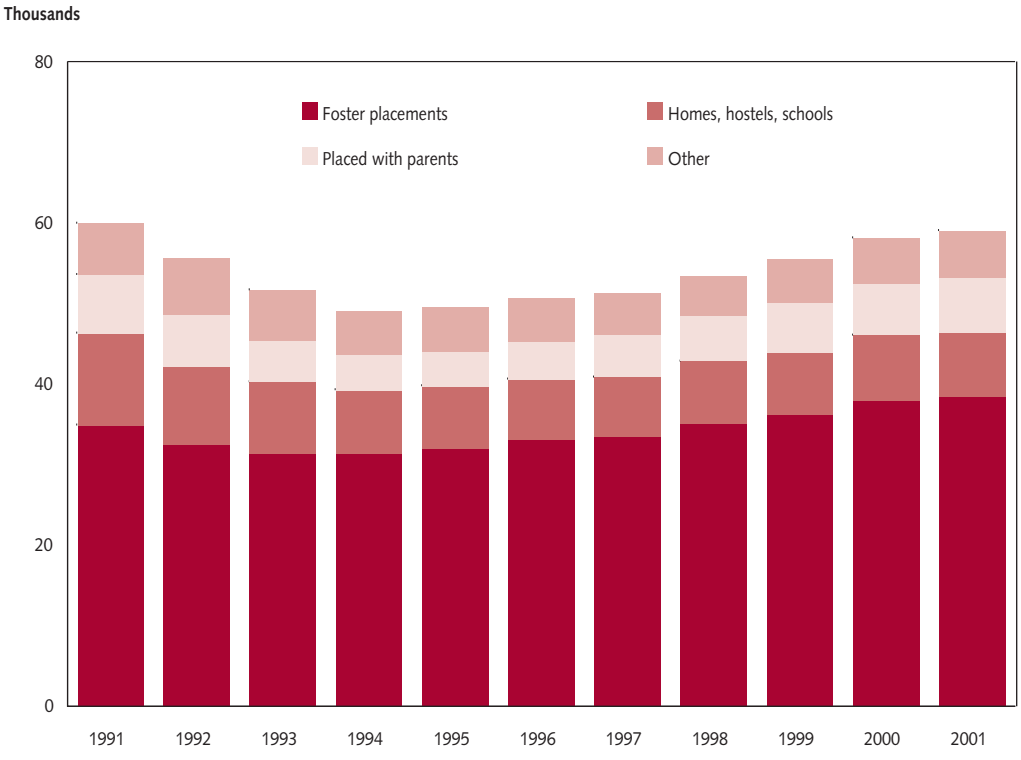
Table 1.2 Children in care/looked after by LAs by placement, England at 31 March 1991 to 2001

England — thousands of children

	All children [1]	Foster placements	Homes, hostels & residential schools [2]	Placement with parents	Other placements
1991	59.8	34.8	11.4	7.3	6.4
1992	55.5	32.4	9.7	6.4	7.0
1993	51.6	31.4	8.8	5.1	6.3
1994	49.1	31.3	7.9	4.4	5.5
1995	49.5	32.0	7.7	4.3	5.5
1996	49.1	33.1	7.4	4.7	5.4
1997	51.2	33.5	7.3	5.2	5.2
1998	53.3	35.0	7.8	5.7	4.9
1999	55.5	36.2	7.6	6.3	5.4
2000	58.1	37.9	8.1	6.5	5.6
2001	58.9	38.4	7.9	6.9	5.8

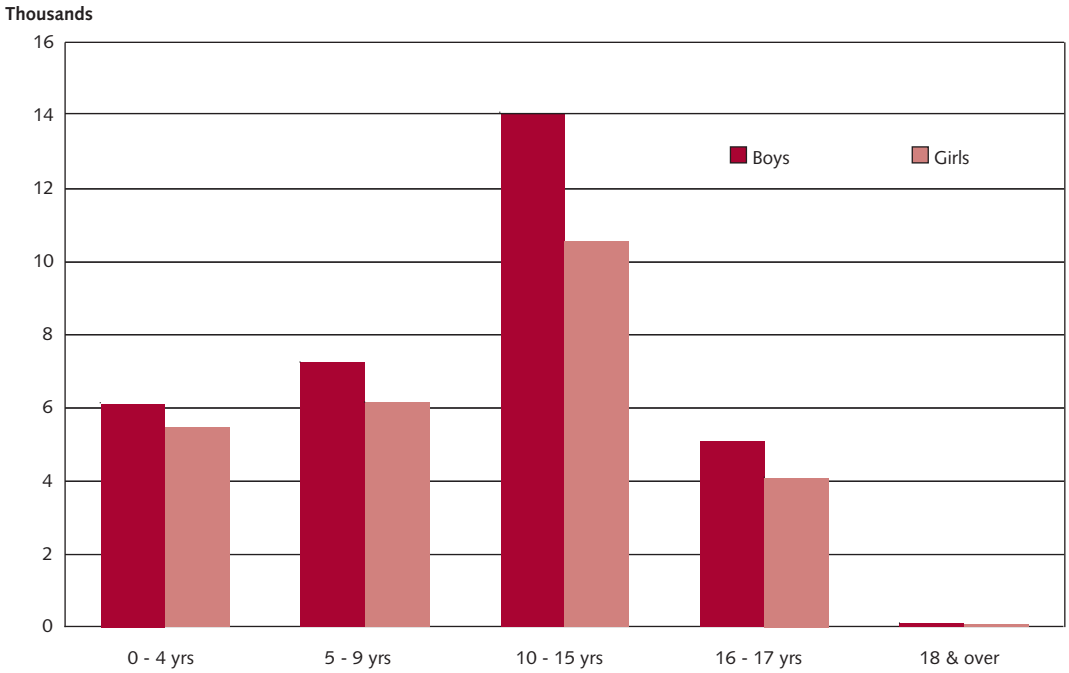
[1] Excludes agreed series of short term placements
[2] Includes community homes, voluntary homes and hostels and privately registered children's homes

Fig 1.2 Number of children looked after at 31 March 1991 to 2001, by placement



There are slightly more boys looked after than girls, and more than half of all looked after children are aged ten or over (Figure 1.3).

Fig 1.3 **Number of children looked after at 31 March 2001 by age and sex**



Duration of stay and stability

The length of time children remain looked after varies enormously from child to child. In some cases it is simply a matter of days, whilst at the other extreme a period of care can last many years. The average length of a period of care of children who ceased to be looked after during the year 2000–2001 was 711 days. The proportion of children who ceased in the year who were looked after for eight weeks or less was 32%, whilst 55% had been looked after for over six months.

The Department of Health is concerned about the frequent changes in placement that some looked after children experience during their period of care. To tackle this the Department established a national target for social services under the National Priorities Guidance (NPG) as follows:

- *Reduce to no more than 16% in all authorities, by 2001, the number of children looked after who have three or more placements in one year.*

A count of the number of different placements a child has had over a given period of time provides a rough measure of the stability of care that that child has experienced.

At 31 March 2001, 16.2% of looked after children had experienced three or more placements during the year (compared with 18.5% in 2000 and 19.0% in 1999 – see table 1.1).

Care leavers

Local authorities have a duty to 'advise, assist and befriend' young people who have ceased to be looked after at the age of 16 or over (*Children Act 1989*, Section 24). Increasing the support offered to care leavers, including steps to prevent the inappropriate discharge of young people at the age of 16 and 17 is one of the priority areas under the Department of Health's Quality Protects Programme. In addition two National Priorities Guidance targets have been established to improve the level of employment, training and education of care leavers.

Table 1.3 provides national figures for young people aged 16 and over who have ceased to be looked after in recent years. It is estimated that 6,800 young people left care in this age range during the 2000–2001 year; this figure has fallen steadily since 1994–1995. 36% of these young people were aged 16, a proportion that increased from 1994–1995 to 1998–1999, but has fallen in the subsequent two years with a corresponding increase in the number of children remaining in care until their 18th birthday.

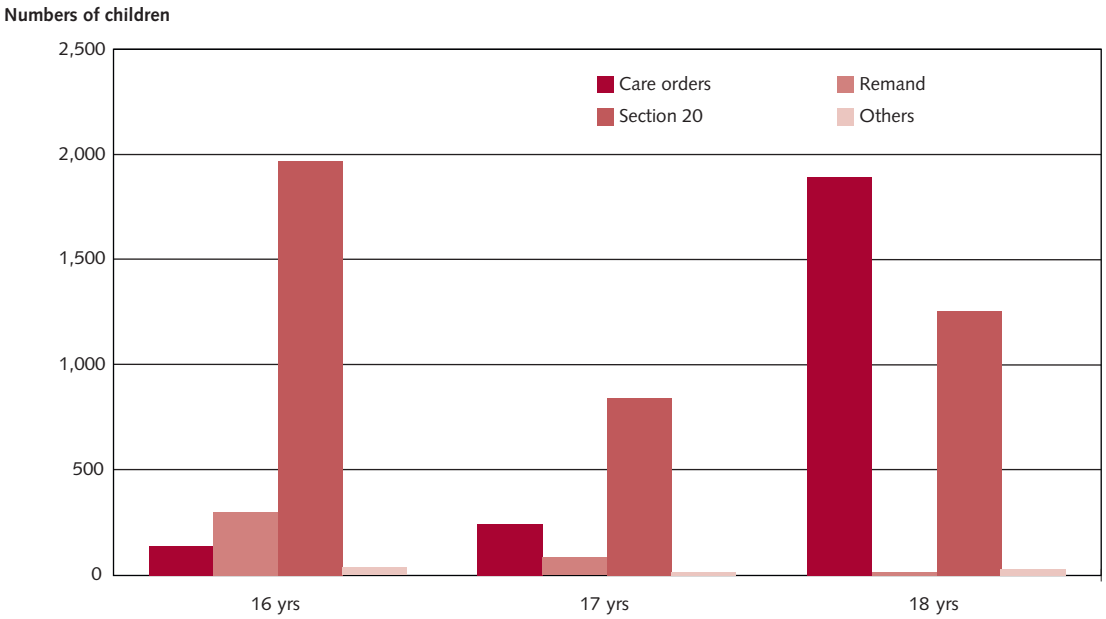
Table 1.3 Children aged 16 or over who ceased to be looked after during the years ending 31 March 1997 to 2001[1]

England

	numbers				
	1997	1998	1999	2000	2001
All Children [2]	**8,200**	**7,700**	**7,100**	**7,200**	**6,800**
Sex					
Boys	4,400	4,200	4,000	3,900	3,700
Girls	3,900	3,500	3,100	3,300	3,100
Age on ceasing					
16	3,400	3,500	3,300	2,900	2,400
17	1,500	1,400	1,400	1,300	1,200
18th birthday	3,300	2,800	2,300	2,900	3,100
Older than 18th birthday	100	130	70	60	80
Final placement					
Foster placement	3,700	3,600	3,300	3,200	3,100
Children's homes [3]	1,800	1,900	1,500	1,600	1,500
Living independently [4]	1,600	1,300	1,200	1,300	1,100
Placed with parents	440	480	430	450	480
Other	690	580	620	660	520

[1] Only the latest occasion on which a child ceased to be looked after in the year has been counted (see introducton)
[2] Figures for children looked after in this table exclude agreed series of short term placements
[3] Includes community homes, voluntary homes and private registered children's homes
[4] Includes living in lodgings, living independently, and in residential employment

Fig 1.4 Children aged 16 and over who ceased to be looked after during the year ending 31 March 2001 by legal status and age



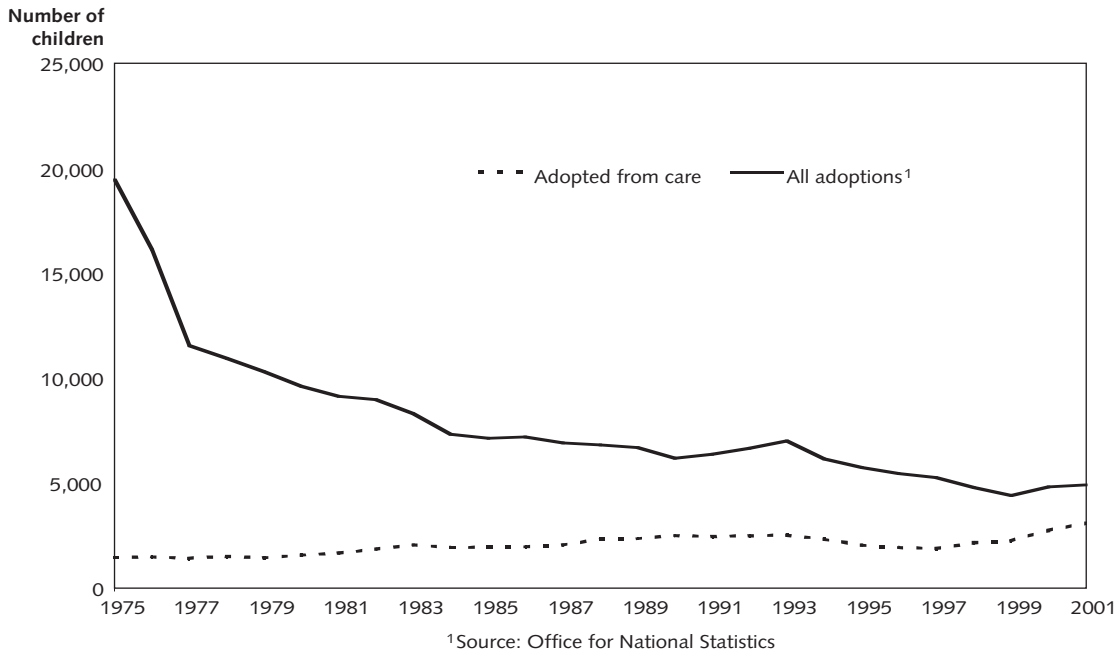
Adoptions

In recent years, just over half of all children adopted in England have been looked after prior to adoption, most of the remainder being adopted by step-parents or relatives.

As shown in figure 1.5 the number of children adopted *from care* has remained reasonably constant since 1974–1975, although there has been a marked increase in the past couple of years. The pattern for all adoptions is however quite different, with a significant decrease in the number of this period (although there has again been a small increase in the last two years). In 1974–1975, 19,400 children were adopted in England, compared with 4,900 in 2000–2001, a decrease of 75%. This decrease was most dramatic between the years 1973–1974 and 1976–1977, when the number of children adopted fell 46%. Since then there has been a more gradual decrease in the number of children adopted. It is important to note that the 'all adoption' figures include those children who were adopted from care. In 1974–1975, 18,000 children were adopted who had not been in care; this compares with 1,800 children in 2000–2001, a fall of 90%.

The average age of a child adopted *from care* has fallen from five years five months in 1996–1997 to four years two months in 2000–2001. Currently 61% of children adopted from care are aged under five. Only 4% of adoptions from care in 2000–2001 were children aged ten and over.

Fig 1.5 Children adopted from care and all adoptions, years ending 31 March 1975 to 2001, England



[1] Source: Office for National Statistics

Notes
[1] Figure for year ending 31 March 1992 is an estimate. The statistical collection for that period was disrupted by the implementation of the Children Act in October 1991.

Children and young people on child protection registers

Children and young people are placed on child protection registers if they are considered to be at risk of abuse and if they are currently the subject of an inter-agency plan to protect them. At 31 March 2001, 26,800 children and young people were on child protection registers, a decrease of 12% on a year earlier.

Table 1.4 shows the changing pattern of registrations, de-registrations and the number of children on the child protection registers in England since 1990. Prior to the implementation of the *Children Act 1989*, the number of children on registers was increasing steadily as registrations outnumbered de-registrations each year.

Following implementation of the Act, and re-examination of the registers in the light of new guidance, many children had their names removed from the registers and fewer new children have been placed on them. This resulted in de-registrations exceeding registrations for the first time in 1992 and a sharp fall in the numbers on registers in 1992 and 1993. Since then, numbers on the registers rose to 35,000 in March 1995 before falling to less than 30,300 in 2000.

Table 1.4 Registrations to and de-registrations from registers during the years ending 31 March 1991 to 2001, and the numbers on registers at 31 March each year

England numbers

	On the register	Registrations	De-registrations
1991	45,300	28,300	26,700
1992	38,600	24,500	31,300
1993	32,500	24,700	29,400
1994	34,900	28,500	26,200
1995	35,000	30,400	30,200
1996	32,400	28,300	30,500
1997	32,400	29,200	28,900
1998	31,600	30,000	30,200
1999	31,900	30,100	29,400
2000	30,300	29,300	30,500
2001	26,800	27,000	30,200

The sharp decrease in 2000–2001 is felt to be largely due to the majority of local councils excluding temporary registrations from their figures (children who are on the register in one council but located in another and are simultaneously on the register of both). 2000–2001 is the first year the Department of Health has requested that only the council with original responsibility for the child includes the child in their figures until the receiving council has decided whether the child should be registered by that council instead.

Figure 1.6 shows the distribution of children on child protection registers at 31 March 2001, according to the category of abuse. The risk of 'neglect' was the most commonly recorded category (39%), followed by risk of 'physical injury' (19%).

Fig 1.6 Percentages of children on child protection registers at 31 March 2001, by category of abuse under which recorded

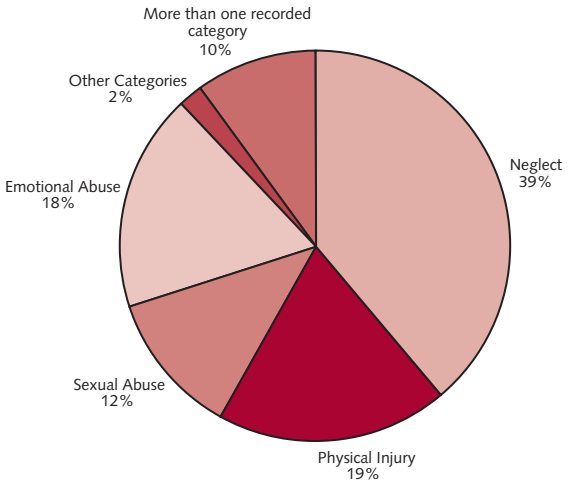
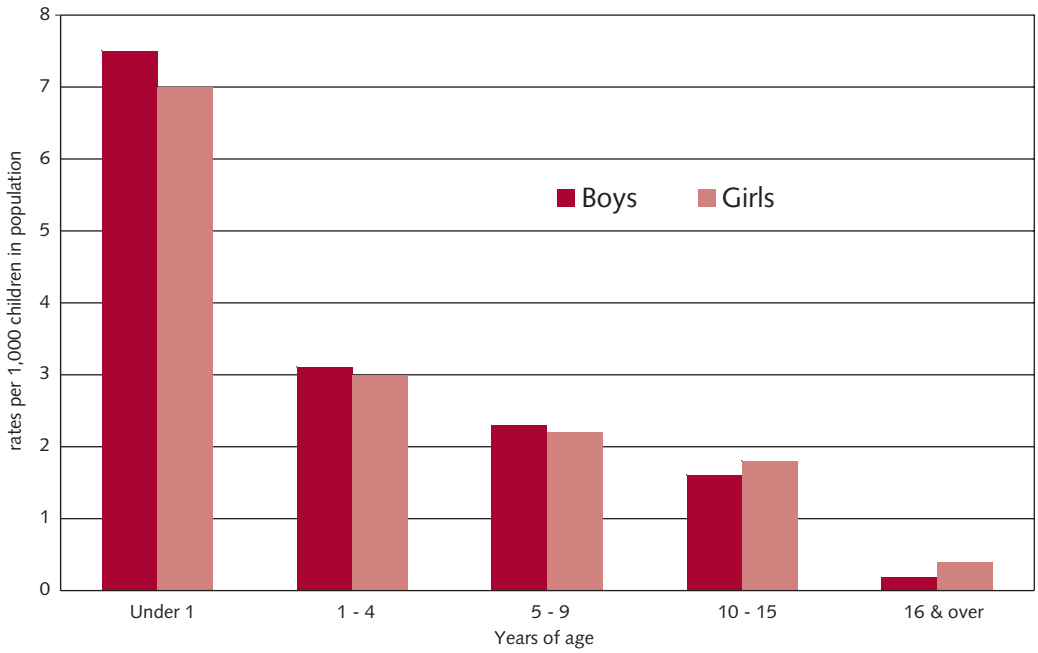


Figure 1.7 shows how the number of registrations during the year ending March 2001 compares with the number of children in the population, for different categories of age and gender. This is expressed as a rate per 1,000 children. Although there is little difference in the registration rates for boys and girls, the rate for children under one year old is more than twice the rate for children between one and four years old.

Fig 1.7 Registrations to child protection registers during the year ending 31 March 2001, by age and group and sex



SERVICES FOR ADULTS

Councils with social services responsibilities are responsible for the social care needs of older people and people with disabilities in their areas – for example by arranging the provision of residential care, day and domiciliary care services, including respite care. With the full implementation of the community care changes since 1 April 1993, these responsibilities have increased. In particular, councils are now responsible for assessing the needs of new applicants for public support for residential or nursing home care.

Key points are that:

- the largest group of adult users of social services is people aged 65 or over. Among younger adults other groups receiving services include people with learning disabilities, people with physical or sensory disabilities and people with mental health problems;
- the number of households receiving care in their own homes has fallen, though the proportion of these households receiving a large amount, or 'intensive' home care has increased;
- the number of people supported by councils in residential or nursing care has increased following the implementation of community care in 1993, when councils took over responsibility which had previously been shared with the Department for Social Security. In particular, councils had not previously been responsible for supporting people in nursing care. The number of people supported did however fall slightly in the year to March 2001.

Summary

Table 1.5 Adults receiving Personal Social Services – a summary

Shows people cared for either in their own homes or residential/nursing homes

rounded numbers, percentages and rates

	1995–1996	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001
All adults aged 18 or over						
Households receiving home care	513,600	491,100	479,100	447,200	424,000	397,800
of which, % receiving intensive home care [1]	21%	25%	28%	31%	34%	36%
People supported in residential care [2]	153,160	170,280	176,530	181,220	185,230	183,550
People supported in nursing care [2]	57,250	66,060	72,900	73,470	73,860	71,850
People aged 18-64						
with physical/sensory disabilities						
helped to live at home per 1000 pop [3]	..	2.2	2.3	2.0	..	..
helped to live at home per 1000 pop [4] new	..	..	..	3.5	3.7	3.7
supported in residential care [2]	6,660	7,180	5,910	5,910	6,220	6,060
supported in nursing care [2]	2,680	3,180	2,830	3,190	3,410	3,390
with mental health problems						
helped to live at home per 1000 pop [3]	..	1.2	1.2	1.2	..	..
helped to live at home per 1000 pop [4] new	..	..	..	1.7	2.2	2.6
supported in residential care [2]	6,520	6,840	7,910	8,700	8,840	9,180
supported in nursing care [2]	850	1,130	1,370	1,500	1,620	1,720
with learning disabilities						
helped to live at home per 1000 pop [3]	..	2.3	2.2	2.2	..	..
helped to live at home per 1000 pop [4] new	..	..	..	2.3	2.2	2.4
supported in residential care [2]	22,170	24,760	25,100	26,870	28,320	28,560
supported in nursing care [2]	640	690	930	930	1,010	990
in other groups						
supported in residential care [2]	1,700	2,150	2,340	1,960	1,750	1,670
supported in nursing care [2]	230	280	340	300	260	270
People aged 65 or over						
helped to live at home per 1000 pop [3]	..	83	81	71	..	..
helped to live at home per 1000 pop [4] new	..	..	..	82	85	83
supported in residential care	116,120	129,360	135,270	137,780	140,100	138,070
supported in nursing care	52,850	60,790	67,450	67,550	67,570	65,480

(1) Intensive is defined here as receiving more than 5 hours of home care and 6 or more visits during a survey week in September.
(2) Local authority supported residents at 31 March. Figures exclude those in unstaffed or other homes.
(3) Helped to live at home by means of home care, day care and meals services. This is an Audit Commission indicator. England figures based on unweighted average of authority figures.
(4) The basis for this indicator changes in 1999–2000. Helped to live at home by means of all community-based services. Figures are estimated.

Performance

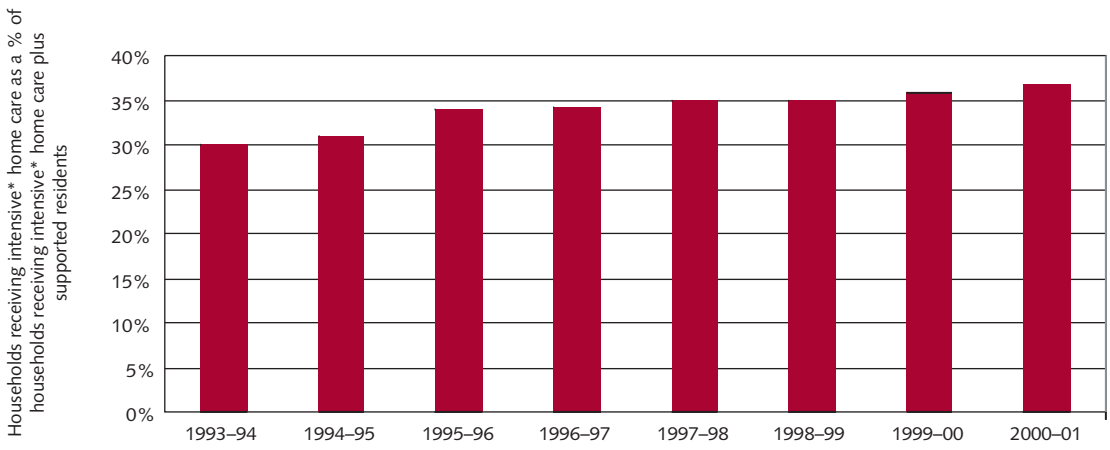
National Priorities and Strategic Objectives

- Performance at the interface, for which health and social care are jointly accountable, is improving. The targets for emergency admissions of older people (PAF PI A5) and delayed discharges (PAF PI D41 – in Quality) have both been met, and further progress is being made towards the target for emergency psychiatric re-admissions (PAF PI A6). Hospital admissions due to falls or hypothermia (PAF PI C33 – in Effectiveness) have reduced and are now back to 1998–1999 levels.

Cost and Efficiency

- The balance between care in home settings and in residential homes improved (PAF PI B11) although there is scope for further improvement. Figure 1.8 shows a variant of PAF PI B11 (with a different definition of intensive home care due to changes in the statistical collection). It shows an increase since 1993–1994, slower in recent years. This PI is closely related to the Best Value cost indicator PAF PI B12.

Fig 1.8 Intensive home care, percentage



* intensive is defined here as receiving more than 5 hours of home care and 6 or more visits during a survey week – ie a less intensive definition than that used in PAF PI B11 and other PIs

Effectiveness of service delivery and outcomes

- Most councils met their statutory inspection obligations. However, 14 councils failed to inspect all their adult residential care homes (PAF PI C34) (seven of them for the second year running).

- Progress appears to have been made in delivering services to promote the independence of adults and older people with an increase in households receiving intensive home care (PAF PI C28).

Quality of services for users and carers

- Despite improvements, only 90% of users are receiving items of equipment costing less than £1,000 within three weeks (PAF PI D38) and 81% are receiving a statement of their needs and how they will be met (PAF PI D39). Further improvements are needed if the top quartile targets of 95.57% and 90.85% respectively are to be met in 2004–2005.

- Almost one in ten single adults and older people are not allocated single rooms when they go into permanent residential and nursing care (PAF PI D37) and 13 councils reported that less than 80% of such people were allocated a single room.

- The proportion of clients receiving a review (PAF PI D40) and the proportion of carer assessments (PAF PI D42) was low, 42% and 21% respectively.

- A high proportion of users (84%) said that they got help quickly with the figure reaching over 90% for one fifth of councils (PAF PI D36).

Fair Access

- 110 per 1,000 older people were assessed in 2000–2001 (PAF PI E49) and 83 per 1,000 were helped to live at home at 31 March 2001 (PAF PI C32).

- Sixty eight per cent of assessments of adults and older people led to provision of service (PAF PI E50); the proportion was slightly lower for black and ethnic minority groups (PAF PI E48). The proportion of those assessed that were from ethnic minorities was slightly lower than in the population as a whole, but this relationship varied significantly across councils (PAF PI E47).

Background information

Residential care homes staffed homes

Excluding small homes, at 31 March 2001 there were 17,500 residential care homes, including dual registered homes, providing 324,900 residential care places. This represents a fall of 3.2% in the number of homes and 1.4% in the number of residential care places in the year, reflecting the downturn in the home care market. Over three-quarters of the places were intended for use by older people (including those with mental illness).

By March 2001, local authorities provided 16% of the total residential provision, compared to 25% in March 1994.

'Small' independent sector residential homes and nursing homes

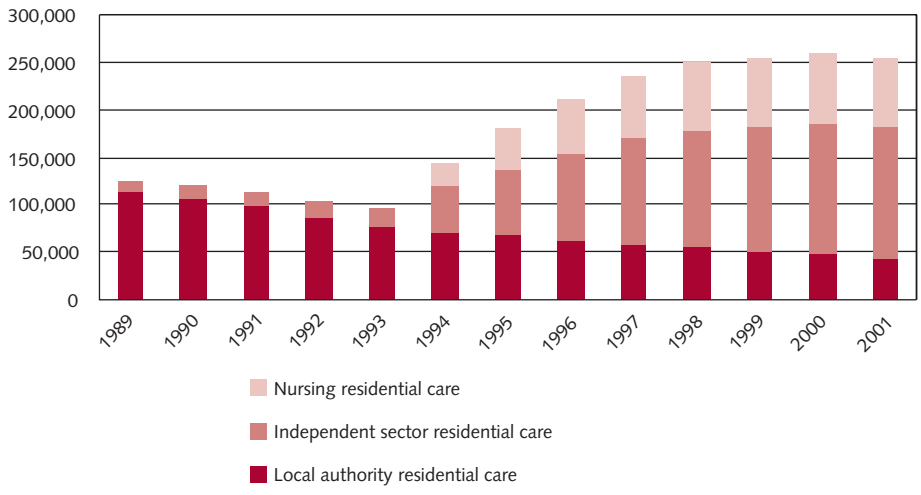
In addition to the homes mentioned above, at 31 March 2001 there were around 6,500 small homes (with less than four places) providing 16,300 residential care places. The number of small homes has remained fairly constant over the last five years.

There were 2,900 independent sector nursing homes accommodating 104,500 nursing care beds (excluding dual registered homes). The number of nursing care homes and beds respectively fell by 5% and 10% in the year.

Local authority supported residents

Over the period March 1988 to March 1993, the number of supported residents in residential care (excluding unstaffed and other homes) fell by 25% to 96,900 (see Figure 1.9). Since the change in funding arrangements in 1993, the number of supported residents in residential care has increased by 89% to 183,500. There was a 1% fall in the overall number of supported residents in residential care between March 2000 and March 2001. There has also been a change in the proportions of supported residents in local authority and independent sector homes, with the independent sector now accounting for around three quarters of residential care, compared with 10% in March 1988.

Fig 1.9 Local Authority supported residents by type of accommodation



Since 1 April 1993 local authorities have been able to support people in nursing home care. In March 2001, local authorities were supporting 71,800 residents in nursing homes, of whom 65,500 were aged 65 or over.

Analysis by client group

For residential homes and places, information on client groups is based on the primary purpose of the home rather than referring to the individuals within them. For example, where a home is registered primarily for older people, but also has places for say, younger physically/sensorily disabled adults, all the places will be counted for older people. For supported residents, the client group is now based upon the individual.

Older people and adults with physical or sensory disabilities (excluding small homes and homes for older mentally infirm people)

Between March 1991 and March 2001 the number of places in residential care homes for older people and people with physical or sensory disabilities decreased by 17% to 239,700.

At 31st March 2001 the majority of places (83%) were in independent residential care homes (ie voluntary, private or dual registered homes) and 17% were in local authority homes.

138,100 people aged 65 and over, and a further 6,100 adults aged under 65 with physical or sensory disabilities, were supported by local authorities in staffed residential care at 31 March 2001. The corresponding figures for supported residents in nursing care were 65,500 and 3,400 respectively.

People with mental health problems (excluding small homes)

Over the ten year period to March 2001, the number of places in staffed residential care homes for people with mental health problems (including older people) more than doubled to 37,800. At 31st March 2001, the vast majority of places (90%) were in independent staffed homes. Local authorities supported 9,200 people with mental health problems in residential care.

People with learning disabilities (excluding small homes)

Between March 1991 and March 2001 the number of places in staffed and registered care homes for people with learning disabilities increased by 23% to 43,600, but has slightly fallen in the year ending 31 March 2001.

At 31st March 2001, the independent sector was the largest provider for people with learning disabilities, covering 85% of all places. There were 28,600 local authority supported residents with learning disabilities in staffed residential care. Of these, 80% were in the independent sector.

Care in the community

Home help and home care services

Around 2.9 million contact hours of home help or home care were purchased or provided by local authorities during the survey week in 2001. Home help/home care contact hours have increased by 62% since 1993.

The number of hours provided by the independent sector increased by 11% from 2000 to 2001, compared with 14% between 1999 and 2000. Of all contact hours provided, 60% were provided by the independent sector in 2001, compared with 56% in 2000 and only 5% in 1993.

The number of households receiving services continues to fall (down 6% in 2001). However, the intensity of care has increased. Average contact hours per household are now around seven hours per household compared with six point three hours per household in 1999 and only three point five hours per household in 1993.

Other Community-based services

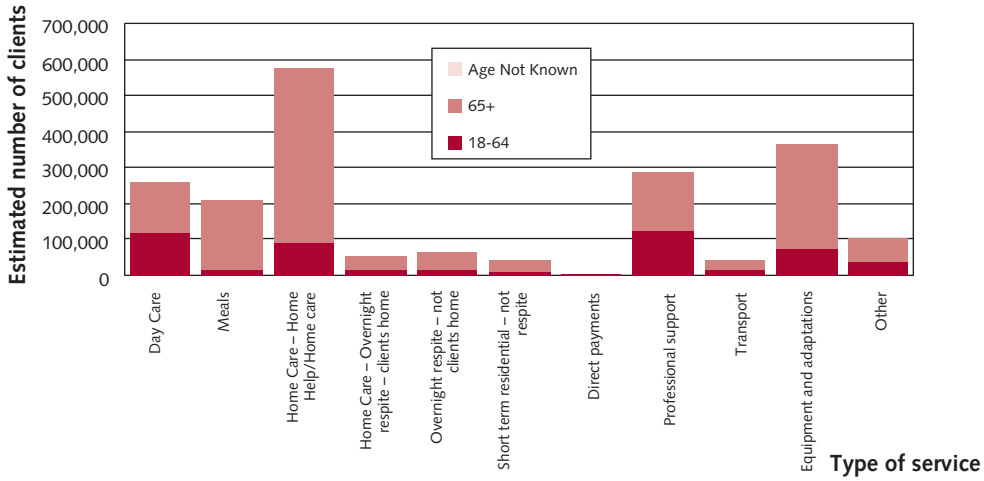
Further information on the provision of community-based services is contained within the publication *Community Care Statistics – Referrals, Assessments and Packages of Care for Adults (RAP).*

RAP aims to collect a coherent set of information on adult community care and is a client-based system. The RAP project has proceeded in dress rehearsal stages giving a chance for Local Authorities to set up their information systems and for definitions to be refined. The first year of full Rollout data (2000–2001) has just been published. Reports are available at www.doh.gov.uk/rap.htm

During the period, 1 April 2000 to 31 March 2001, community-based services (eg home care, day care and meals) were provided to 1.33 million clients. Clients may receive more than one type of service. An estimated 261,000 clients received day care and 212,00 clients received meals, during the period. There were 375,000 clients who received equipment and adaptations as a service. This differs from those clients who received equipment as a basic service, which generally includes small items of equipment and would be excluded from this figure. In addition 300,000 clients received professional support during the period (which includes any professional activity undertaken by the care manager, social worker or other professional staff such as Occupational Therapists, which is beyond the process of care management).

There was some variation in the type of service received by different age groups of clients. Almost three-quarters (72%) of community-based services were received by clients aged 65 and over (Figure 1.10).

Fig 1.10 Number of clients receiving community based services, by age



Resources

Finance

Local Government fund personal social services from resources raised locally and from funding distributed by Government, such as the Revenue Support Grant, National Non-Domestic Rates, and revenue grants. Distribution of funding is mainly by means of standard spending assessments (SSAs) which are intended to reflect the relative cost of providing comparable services in different authorities.

Table 1.6 provides details of actual and planned expenditure on PSS from 1996–1997 to 2001–2002. Between 1996–1997 and 2001–2002 local authorities' total budgets have increased by 40% in cash terms, and 23% in real terms.

Table 1.6 Personal Social Services Net Current Expenditure 1996–1997 to 2001–2002 (including revenue grants)

	1996–1997 Outturn	1997–1998 Outturn	1998–1999 Outturn	1999–2000 Outturn	2000–2001 Outturn	2001–2002 Budget
Cash *(£ million)*	7,943	8,454	9,059	10,050	10,696	11,048
Change over previous year % (*Cash*)	9	6	7	11	6	3
Change over previous year % *(Real Terms)*	5	3	4	8	5	1

The Government provides part of its funding of local authorities' services in the form of revenue grants. These are listed in table 1.7 below.

Table 1.7 Revenue Grants 2001–2002 and 2002–2003

	2001–2002 £m	2002–2003 £m
Promoting Independence Grant	296.000	155.000
Preserved Rights Grant	-	614.000
Residential Allowance Grant	-	93.000
Children's Services Grant	291.800	452.000
Building Care Capacity	100.000	200.000
Mental Health Grant	148.443	154.443
Carers Grant	70.000	85.000
Training Support Programme	47.500	57.500
Performance Fund	0.000	50.000
Deferred Payment Grant	15.000	30.000
AIDS Support Grant	16.500	16.500
Teenage Pregnancy Local Implementation Grant	0.000	16.000
Care Direct	2.000	10.000
Drug and Alcohol Misusers Grant	8.850	0
Young People's Substance Misuse Grant	4.500	4.500

Staffing

In the period 1996 to 2001, the number of whole-time equivalent staff employed directly by social services departments fell by 3% (table 1.8). There were significant reductions in the numbers of staff employed in residential provision for the elderly and in domiciliary services which reflects the reduction in direct local authority provision, caused by an

increasing emphasis on the commissioning of services from the private sector. There were around three thousand occupational therapists and assistants employed in social services departments in both 1996 and 2001 – these are included within the area office/field work services for children, adults and generic provision.

As they are dispersed in the various services shown in table 1.8, we have shown social work staff separately in a separate table 1.9. Most social work staff were in the area office/field work and day care sectors. The number of social work staff increased by 9% between 1996 and 2001 (table 1.9). The figures show an increase in social work provision for most groups over the period although there has been a fall in those working in generic settings.

Approximately one-third of all staff working in social services are employed directly by local authorities, the remainder are employed by either the private or the voluntary sector.

Table 1.8 Local Authority Personal Social Services staff, 30 September 1996 and 2001

England	Whole time equivalent, thousands	
	1996	2001
Area Office/Field Work staff:		
Domiciliary services staff	55	40
Services for children	18	21
Services for adults	11	14
Generic provison	6	4
Hospital and other health settings	4	3
Area directors/area managers	2	2
Specialist teams	6	10
Support services	14	14
Total area office staff	**116**	**108**
Residential care staff:		
Adults/elderly	52	39
Children	12	11
Specialist needs establishments/resource centres	4	4
Total residential care staff	**68**	**54**
Day care staff:		
Adults/elderly	21	21
Children	8	6
Generic	2	3
Total day care staff	**32**	**29**
Central/strategic/HQ staff	16	19
Other staff	2	1
Grand Total	**234**	**211**

Due to rounding, there may be a slight discrepancy between the sum of the constituent items and the totals shown

Table 1.9 Local Authority Personal Social Services social work staff, 30 September 1996 and 2001

England	Whole time equivalent, thousands	
	1996	2001
Children	13	15
Adults/Elderly	7	9
Generic	3	1
Health settings/Specialist teams	9	10
Day centres	1	1
Total	**32**	**35**
Of which Care Managers:	4	4

Due to rounding, there may be a slight discrepancy between the sum of the constituent items and the totals shown

LIST OF PERFORMANCE ASSESSMENT FRAMEWORK PERFORMANCE INDICATORS (PAF PIs)

PAF area	Indicator	Service area	Target and BV number
Natl. Priorities & Strat. Obj.	A1 Stability of placements of children looked after	Children	✓& BV49
	A2 Educational qualifications of children looked after [joint working]	Children	✓& BV50
	A3 Re-registrations on the Child Protection Register	Children	✓
	A4 Employment, education and training for care leavers [joint working]*	Children	✓& BV161
	A5 Emergency admissions of older people [interface]	Adults	✓
	A6 Emergency psychiatric re-admissions [interface]	Adults	✓
Cost and efficiency	B 7 Children looked after in foster placements or placed for adoption	Children	
	B 8 Cost of services for children looked after	Children	BV51 TQ
	B 9 Unit cost of children's residential care	Children	
	B10 Unit cost of foster care	Children	
	B11 Intensive home care as a proportion of intensive home and residential care	Adults	
	B12 Cost of intensive social care for adults and older people	Adults	BV52 TQ
	B13 Unit cost of residential and nursing care for older people	Adults	
	B14 Unit cost of residential and nursing care for adults with learning disabilities	Adults	
	B15 Unit cost of residential and nursing care for adults with mental illness	Adults	
	B16 Unit cost of residential and nursing care for adults with physical disabilities	Adults	
	B17 Unit cost of home care for adults and older people	Adults	

Effectiveness of service delivery and outcomes	C18 Final warnings and convictions of children looked after	Children	
	C19 Health of children looked after	Children	
	C20 Reviews of child protection cases	Children	
	C21 Duration on the child protection register	Children	
	C22 Young children looked after in foster placements or placed for adoption	Children	
	C23 Adoptions of children looked after	Children	
	C24 Children looked after absent from school [joint working]	Children	
	C25 Inspections of children's homes	Children	
	C26 Admissions of supported residents aged 65 or over to residential/nursing care	Adults	
	C27 Admissions of supported residents aged 18-64 to residential/nursing care	Adults	
	C28 Intensive home care	Adults	BV53
	C29 Adults with physical disabilities helped to live at home	Adults	
	C30 Adults with learning disabilities helped to live at home	Adults	
	C31 Adults with mental health problems helped to live at home	Adults	
	C32 Older people helped to live at home	Adults	BV54
	C33 Avoidable harm for older people (falls and hypothermia)	Adults	
	C34 Inspections of residential care for adults and older people	Adults	
Quality of services for users and carers	D35 Long term stability of children looked after	Children	
	D36 Users who said they got help quickly	Adults	BV57
	D37 Availability of single rooms	Adults	
	D38 Percentage of items of equipment and adaptations costing less than £1,000 delivered within 3 weeks	Adults	BV56 TQ
	D39 Percentage of people receiving a statement of their needs and how they will be met	Adults	BV58 TQ
	D40 Clients receiving a review	Adults	BV55
	D41 Delayed discharge [interface]	Adults	
	D42 Carer assessments	Adults	
	D43 Waiting time for care packages*	Adults	
Fair access	E44 Relative spend on family support	Children	BV61
	E45 Ethnicity of children in need	Children	
	E46 Users who said that matters relating to race, culture or religion were noted	Adults	BV60
	E47 Ethnicity of adults and older people receiving assessment	Adults	
	E48 Ethnicity of adults and older people receiving services following an assessment	Adults	
	E49 Assessments of older people per head of population	Adults	BV59
	E50 Assessments of adults and older people leading to provision of service	Adults	

Key: ✓=nationally set target, BV=Best Value indicator, BV TQ=Best Value indicator with top quartile target. *First data will be published October 2002

PERSONAL SOCIAL SERVICES STATISTICAL PUBLICATIONS

Most statistical bulletins are available on the Department of Health statistics website (www.doh.gov.uk/public/stats1.htm), where statistics can be downloaded in spreadsheet format. Also available are copies of many statistical returns together with guidance and details of developments in statistical collections.

Performance Indicators for Local Authority Social Services
(Contact: Keith Childs 020 7972 5736 e-mail: keith.childs@doh.gsi.gov.uk)

Social Services Performance Assessment Framework Indicators 2000–2001

The paper publication contains overviews for the indicators. Council-level detail is available on the internet (www.doh.gov.uk/paf/index.htm) and in the Key Indicators Graphical System (see below).

Key Indicator Graphical System – contains statistics on local authority social services, updated twice each year

Key statistics of social services for England in spreadsheet format

Services for Children
(Statistician: Annie Sorbie 020 7972 5573 e-mail: annie.sorbie@doh.gsi.gov.uk)

Children looked after by local authorities

Children and young people on child protection registers

Children accommodated in secure units, England and Wales

Children's homes

Children adopted from care, England

Educational qualifications of care leavers, England

Outcome indicators for looked after children

Children in Need, February 2000 (tel 020 7972 5593)

From 1998 responsibility for day care statistics has transferred to the Department for Education and Employment (Contact Stephen Cooke 01325 392765).

Services for Adults
(Statistician: Tracie Kilbey 020 7972 5582 e-mail: tracie.kilbey@doh.gsi.gov.uk)

Community Care Statistics: Day and Domiciliary Personal Social Services for Adults

Community Care Statistics: Residential Personal Social Services for Adults, England

Private hospitals, homes and clinics registered under Section 23 of the Registered Homes Act 1994, England

Referrals, Assessments and Packages of Care for Adults, England 2001 – Report of findings from the first year of the roll out of RAP

People registered as deaf or hard of hearing (triennial)

Registered blind and partially sighted people (triennial)

Registers of people with physical disabilities

Resources of Social Services Departments
(Contact: Keith Childs 020 7972 5736 e-mail: keith.childs@doh.gsi.gov.uk)

Personal social services expenditure and unit costs England

Staff of local authority social services departments England

APPENDIX B

CONTACT POINTS IN THE SOCIAL SERVICES INSPECTORATE AND SSI/AUDIT COMMISSION JOINT REVIEW TEAM

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Deputy Chief Inspector, Averil Nottage
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Head of SSI Quality Programme, Derek Gardiner
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79 Whitehall
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Head of Chief Inspector's Private Office, Simon Hiller
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Gateshead
Tyne & Wear NE8 2DU

Director of Methodology and Information, SSI – Paul Brearley
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Quarry House
Quarry Hill
Leeds LS2 7UE

and

5th Floor
Eileen House
80-94 Newington Causeway
London SE1 6EF

SSI/Audit Commission Joint Reviews
Review Director, John Bolton
33 Greycoat Street
London SW1P 2QF

APPENDIX C

SSI OFFICE BOUNDARIES

1 – North West

Blackburn
Blackpool
Bolton
Bury
Cheshire
Cumbria
Halton
Knowsley
Lancashire
Liverpool
Manchester
Oldham
Rochdale
Salford
Sefton
St. Helens
Stockport
Tameside
Trafford
Warrington
Wigan
Wirral

2 – North East

Darlington
Durham
Gateshead
Hartlepool
Middlesbrough
Newcastle upon Tyne
North Tyneside
Northumberland
Redcar & Cleveland
South Tyneside
Stockton-on-Tees
Sunderland

3 – Yorkshire and the Humber

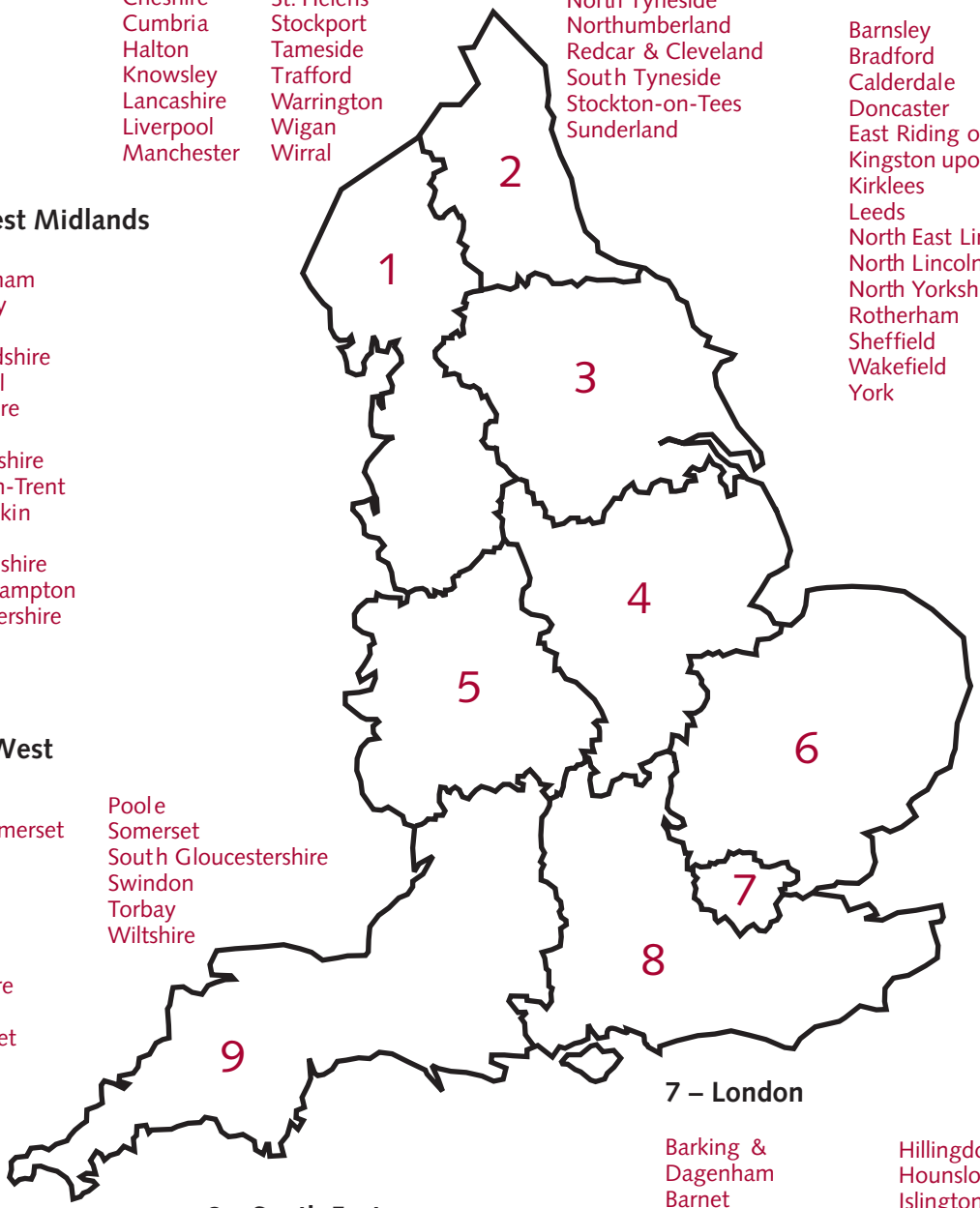
Barnsley
Bradford
Calderdale
Doncaster
East Riding of Yorkshire
Kingston upon Hull
Kirklees
Leeds
North East Lincolnshire
North Lincolnshire
North Yorkshire
Rotherham
Sheffield
Wakefield
York

4 – East Midlands

Derby
Derbyshire
Leicester
Leicestershire
Lincolnshire
Northamptonshire
Nottingham
Nottinghamshire
Rutland

5 – West Midlands

Birmingham
Coventry
Dudley
Herefordshire
Sandwell
Shropshire
Solihull
Staffordshire
Stoke-on-Trent
The Wrekin
Walsall
Warwickshire
Wolverhampton
Worcestershire



6 – East

Bedfordshire
Cambridgeshire
Essex
Hertfordshire
Luton
Norfolk
Peterborough
Suffolk
Southend on Sea
Thurrock

7 – London

Barking & Dagenham
Barnet
Bexley
Brent
Bromley
Camden
City of London
Croydon
Ealing
Enfield
Greenwich
Hackney
Hammersmith & Fulham
Haringey
Harrow
Havering
Hillingdon
Hounslow
Islington
Kensington & Chelsea
Kingston upon Thames
Lambeth
Lewisham
Merton
Newham
Redbridge
Richmond upon Thames
Southwark
Sutton
Tower Hamlets
Waltham Forest
Wandsworth
Westminster

8 – South East

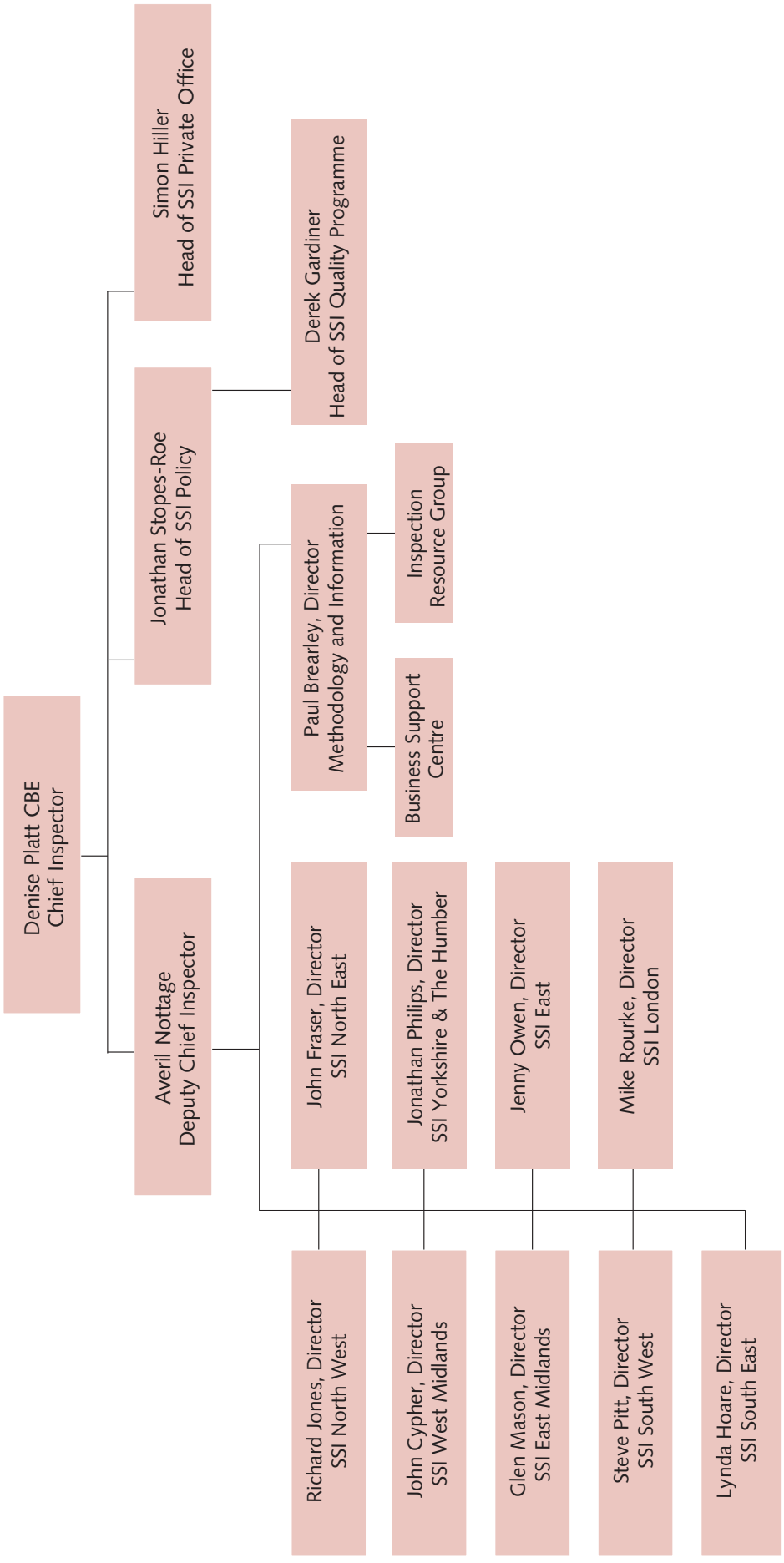
Bracknell Forrest
Brighton & Hove
Buckinghamshire
East Sussex
Hampshire
Isle of Wight
Kent
Medway Towns
Milton Keynes
Oxfordshire
Portsmouth
Reading
Slough
Southampton
Surrey
West Berkshire
West Sussex
Windsor & Maidenhead
Wokingham

9 – South West

Bath & North East Somerset
Bournemouth
Bristol
Cornwall
Devon
Dorset
Gloucestershire
Isles of Scilly
North Somerset
Plymouth
Poole
Somerset
South Gloucestershire
Swindon
Torbay
Wiltshire

APPENDIX D

SSI STRUCTURE CHART



APPENDIX E

LIST OF CHIEF INSPECTOR LETTERS AND SSI PUBLICATIONS 2001–2002

CI(2001)5

Health and social care planning 2001–2002

CI(2001)6

Developing quality to protect children – report of the inspection of local council children's services

CI(2001)7

Inspection of Best Value reviews in social services

CI(2001)8

Quality on the way – a report of an inspection of service quality improvements in social care

CI(2001)9

No Secrets – guidance on developing multi-agency policies and procedures to protect vulnerable adults from abuse

CI(2001)10

From Lip Service to Real Service – The report of the first phase of a project to assist councils with social services responsibilities to develop services for black older people

CI(2001)11

Safe enough? – a report of an inspection of health authority registration and inspection units

CI(2001)12

Modern social services a commitment to deliver: the 10th annual report of the Chief Inspector Social Services Inspectorate 2000–2001

CI(2001)13

The Social Services Inspectorate: who we are and what we do: 2001 edition

CI(2001)14

Children Act Report 2000

CI(2001)15

Private fostering awareness campaign

CI(2001)16

National standards for the provision of social care services in the high security hospitals

CI(2001)17

The Children Act now: messages from research

CI(2001)18

Improving older people's services: inspection of social care services for older people

CI(2001)19

Making it work: inspection of welfare to work for disabled people

CI(2001)20

Not Issued

CI(2001)21

Working together: Connexions and social services

CI(2001)22

First annual report of the adoption and permanence taskforce

CI(2002)1

Fostering for the future – SSI report of the inspection of foster care services

CI(2002)2

Getting the best from Best Value: sharing the experience of applying Best Value in social care

APPENDIX F

LIST OF LOCAL AUTHORITY CIRCULARS (LACs) 2001–2002

LAC(2001)14

Revisions to intercountry adoption procedures

LAC(2001)15

Children (Leaving Care) Act 2000: grant conditions for use of ring-fenced funds

LAC(2001)16

Care Standards Act 2000: transition arrangements for the creation of the National Care Standards Commission

LAC(2001)17

2001–2002: arrangements for whole system capacity planning: emergency, elective and social care

LAC(2001)18

Continuing care: NHS and local councils' responsibilities

LAC(2001)19

The Residential Accommodation (relevant premises, ordinary residence and exemptions): (amendment): (England): regulations 2001: Amendment to regulations governing circumstances in which councils can provide financial support to people with preserved rights

LAC(2001)20

Young people's substance misuse planning grant: 2001–2002

LAC(2001)21

Paving the way: the 'catch up' exercise for the Adoption Register

LAC(2001)22

National Adoption Standards for England

LAC(2001)23

Valuing people: a new strategy for learning disability for the 21st century: implementation

LAC(2001)24

Guidance to the foster placement (children) and adoption agencies amendment (England) regulations 2001: SI 2001/2992

LAC(2001)25

Charges for residential accommodation: CRAG amendment no 15: National Assistance Act: (residential accommodation) (disregarding of sources) (amendment) (England) regulations 2001: National Assistance Act (residential accommodation) (relevant contributions) (England) regulations 2001: determination under section 93 of the Local Government Act 2000 of the deferred payment grant for 2001–2002: National Assistance Act (residential accommodation) (additional payments) (England) regulations 2001 (and explanation of consequential amendment to the choice of accommodation directions 1992)

LAC(2001)26

Guidance on free nursing care in nursing homes

LAC(2001)27

Access to education for children and young people with medical needs

LAC(2001)28

The Quality Protects Programme: Transforming children's services 2002–2003

LAC(2001)29

Charges for residential accommodation: CRAG amendment no 16: National Assistance: (residential accommodation): (additional payments and assessment of resources): (amendment): (England): regulations 2001

LAC(2001)30

Care Standards Act 2000: (commencement no.9 (England) and transitional and savings (provisions) order 2001): guidance to local authority and health authority registration and inspection units on the transfer of registration for existing regulated providers to the National Care Standards Commission and other transitional processes

LAC(2001)31

Care Standards Act 2000 – guidance on continuing responsibilities of local authorities and health authorities following the transfer of registration and inspection to the National Care Standards Commission on 1 April 2002

LAC(2001)32

Fairer charging policies for home care and other non-residential social services – guidance for councils with social services responsibilities

LAC(2001)33

Adoption

LAC(2001)34

Guidance on Grant for Building Care Capacity, 2001–2002

LAC(2002)1

Guidance on the single assessment process for older people

LAC(2002)2

Implementing the Caldicott standard in social care: appointment of "Caldicott guardians"

LAC(2002)3

Mental health grant guidance 2002–2003

LAC(2002)4

Social services training support programme 2002–2003

LAC(2002)5

Adoption register catch up – next steps

LAC(2002)6

Not Issued

LAC(2002)7

Guidance to councils with social services responsibilities on the abolition of preserved rights

LAC(2002)8

Young People's substance misuse planning grant: 2002–2003

LAC(2002)9

Support grant for social services for people with HIV/AIDS: Financial Year 2002–2003: Supplementary credit approvals for HIV/AIDS capital expenditure: Financial year 2002–2003

LAC(2002)10

Teenage pregnancy local implementation grant 2002–2003

LAC(2002)11

Charges for residential accommodation: CRAG amendment no 17: National assistance (sums for personal requirements) (England) Regulations 2002: National assistance (assessment of resources) (amendment) (England) Regulations 2002: Deferred payments grant for 2002–2003: determination under section 93 of the Local Government Act 2000

LIST OF LOCAL AUTHORITY SOCIAL SERVICES LETTERS (LASSLs) 2001–2002

LASSL(2001)2

The children and family court advisory and support service (CAFCASS) and complaints about the functioning of child protection conferences

LASSL(2001)3

Consultation documents: [1]: The Care Homes Regulations 2001 and national minimum standards for younger adults in care homes and adult placements: [2]: Children's Homes Regulations 2001 and national minimum standards: [3]: National minimum standards for mainstream boarding schools, residential special schools and further education colleges accommodating children under 18

LASSL(2001)4

Consultation documents: [1]: The National Care Standards Commission: (Registration): Regulations 2001: [2]: Foster Care Services regulations and minimum standards: frequencies of inspection and regulatory fees

LASSL(2001)5

Consultation on: draft practice guidance to support the National Adoption Standards – England: draft standards and practice guidance: adopted adults and their birth siblings

LASSL(2001)6

Consultation document: The Care Standards Act 2000 (commencement no.[] (England) and transitional and savings provisions) order 2001

LASSL(2001)7

Consultation document: The disqualification for caring for children regulations 2002

LASSL(2001)8

Consultation document: nurses agencies regulations and national minimum standards

LASSL(2001)9

Local authority social services letter: Social services performance: the performance assessment framework indicators 2000–2001 and new performance ratings

LASSL(2001)10

Regulation of domiciliary care

LASSL(2001)11

Consultation on the implementation of the Adoption (Intercountry Aspects) Act 1999

LASSL(2001)12

Personal social services capital programme 2002–2003: annual capital guidelines

LASSL(2001)13

Personal social services (PSS) funding: 2002–2003

LASSL(2002)1

Children services (Quality Protects) grant: 2001–2002: special grant report no 89 and audit arrangements

LASSL(2002)2

Consultation document: children's rights director regulations

LASSL(2002)3

Care standards Act: regulations and national minimum standards for residential family centres consultation document

LASSL(2002)4

Guidance on accommodating children in need and their families

APPENDIX G

INSPECTION PROGRAMME – FIELDWORK COMPLETED IN 2001–2002

This list identifies the national inspection programme where fieldwork was completed in 2001–2002.

Inspection of Social Care Services for Older People.

Evaluation of Implementation of Services 2:

Barnsley
Bradford
Bromley
East Riding of Yorkshire
Essex
Hampshire
Kingston-upon-Thames
Knowsley
Lambeth
Lincolnshire
Manchester
Northamptonshire
Richmond-upon-Thames
Rotherham
Solihull
Southampton
Southwark
Staffordshire
Stockton-on-Tees
West Sussex
Wigan
Wirral
York

Adult Care. Evaluating Social Care/Mental Health Services:

Bedfordshire
Cornwall
Haringey
Hounslow
Leeds
Reading
Southend
Wiltshire

Children's Services 11: Evaluating the impact of Quality Protects:

Barnet
Cheshire
Derbyshire
Gateshead
Hartlepool
Luton
Portsmouth
Redbridge
Sefton
Sheffield
Torbay
West Berkshire

Children's Services 111: Evaluating the impact of Quality Protects:

Bexley
Birmingham
Bracknell Forest
Calderdale
Croydon
Doncaster
Enfield
Lancashire
Liverpool
Newham
Norfolk
North Tyneside
Oxfordshire
Plymouth
Rochdale
Salford
Sunderland
Telford & Wrekin
Westminster

Services for people with Learning Disability:

Bath and North East Somerset
Cumbria
Devon
Kingston-upon-Hull
Leicestershire
Sandwell
Sutton
Tower Hamlets

Management and use of Information:

Newcastle-upon-Tyne

Managing the reorganisation agenda in Social Care:

Bury
Camden
Isles of Scilly
Northumberland
Rochdale
Suffolk

Social Care Services for Disabled people:

Dorset

Inter-Agency inspection of Safeguards for Children:

Hammersmith & Fulham
Harrow
Kent
North Yorkshire
Nottingham
Shropshire
Stockport
Surrey

APPENDIX H

Fieldwork completed in 2001–2002 for Joint Reviews in English authorities

Bolton
Brighton and Hove
Buckinghamshire
Corporation of London
Darlington
Dorset
East Sussex
Gloucestershire
Greenwich
Halton
Havering
Islington
Middlesbrough
Milton Keynes
N. E. Lincolnshire
Redcar and Cleveland
Rutland
Slough
St Helens
Stoke
Swindon
Tameside
Thurrock
Trafford
Wakefield
Walsall
Waltham Forest
Warrington
Windsor & Maidenhead
Wirral

APPENDIX I

SIGNIFICANT SOCIAL CARE EVENTS 2001–2002

2001

April	124 new Primary Care Trusts established bringing the total number to 164
	National Care Standards Commission (NCSC) established
	Victoria Climbié Inquiry – terms of reference published
	Launch of the NHS Modernisation Agency and 'Shifting the Balance of Power' in the NHS
May	Norwood Ravenswood becomes preferred bidder for new Adoption Register
	Lynne Berry becomes Chief Executive of the General Social Care Council (GSCC)
June	General Election
	Jacqui Smith MP takes over from John Hutton MP as Minister of State for Health responsible for social care
	Information for Social Care – six demonstrator IT projects announced
	Putting Children First – Regulations and National Minimum Standards for Children's Homes issued for consultation
	Launch of national campaign to improve access to local mental health services – targeted at carers during Carers Week
July	New Learning Disability Grants Scheme to improve local citizen advocacy
	Health and Social Care Awards – Lifetime achievement award to Linda Couchman from the Link Resource Centre in Cheshire
	£20 million announced for computers for children in care
	National Institute for Mental Health announced
	Consultation launched of the *Guidance on Fair Access to Care Services*
	New teenage pregnancy advisors announced
	Jane Campbell confirmed as the first Chair of the new Social Care Institute for Excellence (SCIE)
	Professor Al Aynsley-Green Chair of Children's Task Force appointed National Director of Children's Health Care Services

August	Launch of Adoption Register and National Standards for Adoption Services
	Professor Ray Jones appointed as Chief Executive of the Social Care Institute for Excellence
	'Valuing People' guidance on services for people with learning disabilities issued
September	Ron Kerr, CBE, appointed as Chief Executive of National Care Standards Commission
	Implementation of the Children (Leaving Care) Act 2000 imposing stronger duties on local authorities to help care leavers until they are at least 21
	Rob Greig appointed new Director of the *'Valuing People'* Support Team
	Cambridgeshire County Council removed from special measures
October	Free NHS nursing care for people living in nursing homes introduced
	£300 million 'Cash for Change' initiative announced to help tackle 'bedblocking'
	SCIE 'open for business'
	Government launches first ever national recruitment campaign for social workers
	Publication of *Social Services Performance Assessment Framework Indicators 2000–2001*
	New 'Star Performance Ratings' announced for social services
	First reading and publication of the *Adoption and Children Bill*
November	Two social services Private Finance Initiative schemes for older people launched in Kent and Ealing
	Guidance on *Fairer Charging for Home Care* issued
	Mental Health in Prisons Expert Group announced
	Richard Humphries appointed Director of Health and Social Care Change Agent Team

December	Launch of new National Learning Disability Helpline TV personality – Louis Emerick – backs drive to improve adoption services at national conference on 'Delivering the Adoption Standards' New *National Standards and Regulations for Care Homes* issued

2002

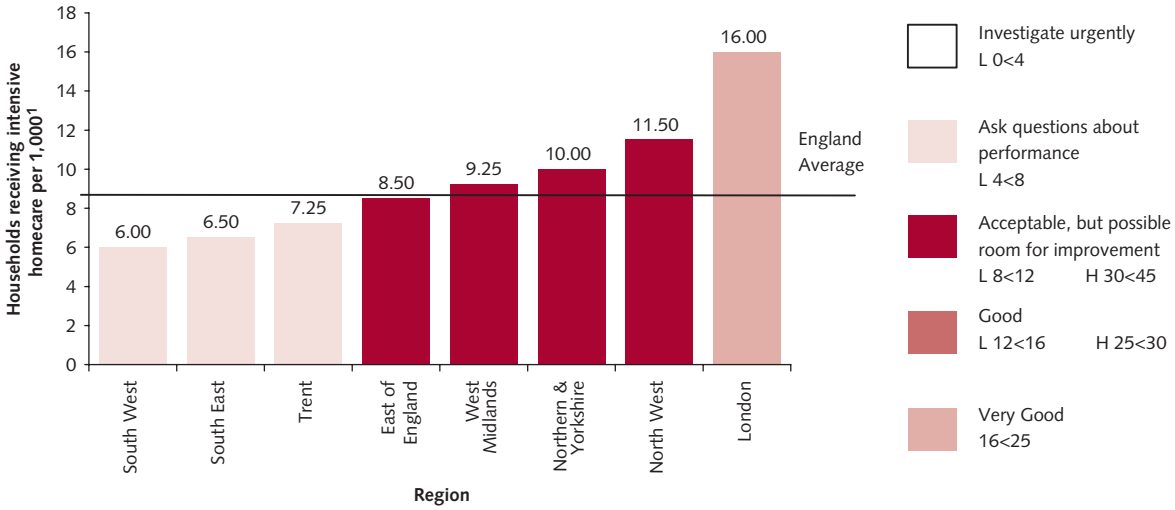
January	Draft *Codes of Conduct and Practice* issued by GSCC Roger Morgan appointed first national Children's Rights Director at the NCSC Guidance issued on *Single Assessment Process for older people*
February	Rodney Brooke CBE appointed as Chair of GSCC Government announces £300,000 for Childline £15 million granted to the Training Organisation for the Personal Social Services (TOPSS) for training and development of the social care workforce Wirral council removed from special measures
March	£66 million announced for intermediate care to help speed up transfers from hospital Reception in recognition of the value of social services hosted by the Prime Minister and Mrs Blair attended by frontline staff from England, Northern Ireland, Scotland and Wales Queen Elizabeth the Queen Mother died
April	First Care Trusts launched in Camden & Islington, Bradford, Northumberland and Manchester

APPENDIX J

Key Performance Indicators

These charts illustrate 4 of the 11 threshold indicators used in the determination of star ratings. They show regional variation.

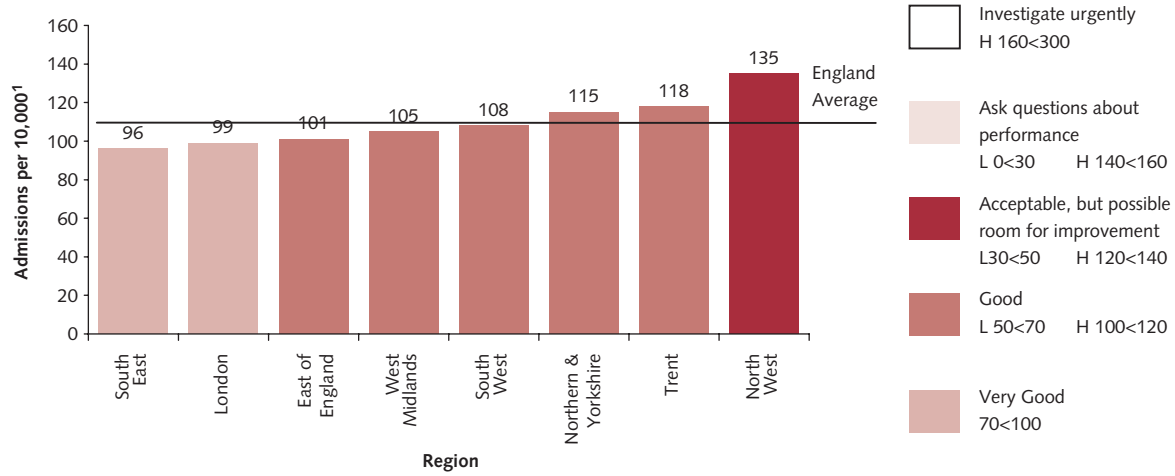
Fig 1 Intensive home care 2000–01 (PAF C28)



[1]Households receiving intensive homecare per 1,000 population aged 65 or over

Source: Key Indicator Graphical System

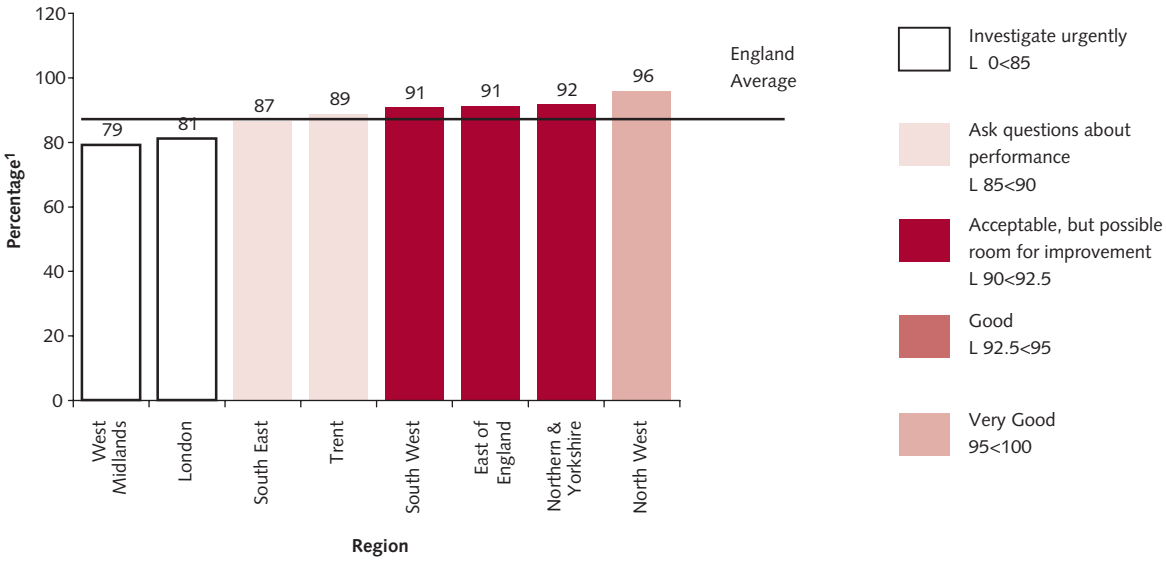
Fig 2 Admissions of supported residents aged 65 or over to residential/nursing care 2001–01 (PAF C26)



[1]Supported admissions of older people to permanent residential and nursing care per 10,000 population aged 65 or over

Source: Key Indicator Graphical System

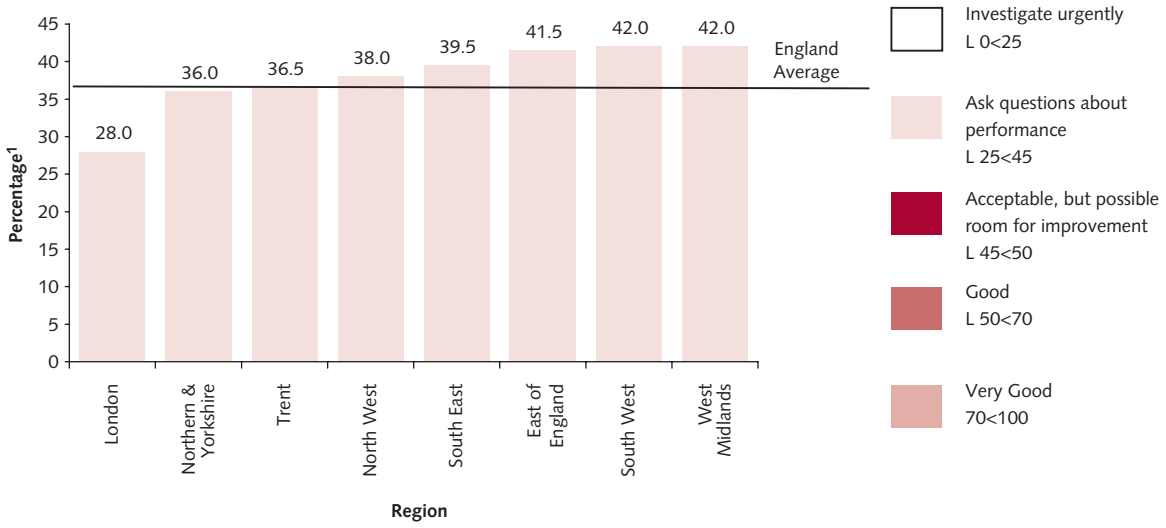
Fig 3 Reviews of child protection cases 2000–01 (PAF C20)



[1]Percentage of child protection cases which should have been reviewed during the year that were reviewed

Source: Key Indicator Graphical System

Fig 4 Educational qualifications of children looked after [joint working] 2000–01 (PAF A2)



[1]Percentage of young people leaving care aged 16 or over with at least 1GCSE at Grade A* - G or a GNVQ

Source: Key Indicator Graphical System

The Prime Minister, Tony Blair MP, meeting social worker Kyra Ayre from Barnsley Social Services at the No 10 Reception

Secretary of State for Health, Alan Milburn MP, and Sir Steve Redgrave present a Lifetime Achievement award to Linda Couchman from Cheshire Social Services

Minister of State for Health, Jacqui Smith MP and actor Louis Emerick at the launching of the National Adoption Standards

Pato Banton performing at the 2002 Quality Protects Conference

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