



Inspection report

Service inspection of adult social care: **London Borough of Hounslow Council**

Focus of inspection:

Safeguarding adults

Increased choice and control for older people

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- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

Inspection of adult social care

London Borough of Hounslow Council

January 2010

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Acknowledgement

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Introduction

An inspection team from the Care Quality Commission visited Hounslow in January 2010 to find out how well the council was delivering social care.

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

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

Before visiting Hounslow, the inspection team reviewed a range of key documents supplied by the council and assessed other information about how the council was delivering and managing outcomes for people. This included, crucially, the council's own assessment of their overall performance. The team then refined the focus of the inspection to cover those areas where further evidence was required to ensure that there was a clear and accurate picture of how the council was performing. During their visit, the team met with people who used services and their carers, staff and managers from the council and representatives of other organisations.

This report is intended to be of interest to the general public, and in particular for people who use services in Hounslow. It will support the council and partner organisations in Hounslow in working together to improve people's lives and meet their needs.

Reading the report

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

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

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

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

Summary of how well Hounslow was performing

Supporting outcomes

The Care Quality Commission judges the performance of councils using the following four grades: 'performing poorly', 'performing adequately', 'performing well' and 'performing excellently'.

Safeguarding adults:

We concluded that Hounslow was performing poorly in safeguarding adults.

Increased choice and control for older people:

We concluded that Hounslow was performing well in supporting increased choice and control.

Capacity to improve

The Care Quality Commission rates a council's capacity to improve its performance using the following four grades: 'poor', 'uncertain', 'promising' and 'excellent'.

We concluded that the capacity to improve in Hounslow was promising.

What Hounslow was doing well to support outcomes

Safeguarding adults

The council:

- Provided a rolling programme of training and events that had ensured that issues relating to safeguarding vulnerable adults had a high profile.
- Had developed a risk assessment tool to identify safeguarding issues related to self-directed care.
- Took positive action to reduce crime and fear of crime in the borough, and the police had a high profile in promoting crime prevention initiatives.

Increased choice and control for older people

The council:

- Provided a good standard of assessment and care management to most older people and carers using services in Hounslow.
- Was effectively developing self-directed support and personalised care planning.
- Undertook assessments and reviews for older people in a timely way.
- Provided a range of services that promoted person-centred practice which were highly valued by older people and carers.
- Was developing the range of services to ensure increasing choice, promote independent living and provide varied levels of support.

Recommendations for improving outcomes in Hounslow

Safeguarding adults

The council and partners should:

- Update policy and procedures in safeguarding, and ensure that these are being implemented consistently across all teams and partner agencies
- Clarify the roles and responsibilities of practitioners and managers in undertaking safeguarding work.
- Ensure that a consistent level of good practice is achieved in case work, that secures good outcomes for vulnerable adults and effectively manages risk.
- Improve recording and monitoring of all aspects of safeguarding work.
- Promote the profile of vulnerable people and ensure that their needs are addressed corporately and in community safety strategies.
- Ensure people are offered and provided with advocacy as appropriate, particularly those without capacity to make decisions for themselves.

Increased choice and control for older people

The council should:

- Ensure that older people and carers have good access to information and services through a range of access routes.
- Ensure that responses to concerns raised or complaints made about adult social care are consistent and meet quality standards.
- Work with partners to improve outcomes and satisfaction for older people and their carers in relation to transport, wheelchair, and community mental health services, and address concerns raised around sheltered housing experience.

What Hounslow was doing well to ensure their capacity to improve

Providing leadership

The council:

- Gave a high priority to supporting positive outcomes for older people and carers in corporate plans, and conveyed a clear vision for the personalisation agenda.
- Had revitalised the commitment to drive change forward in the transformation of adult social care, and refreshed strategy, workstreams and structures to support change.
- Had well-established arrangements for consultation about '*Putting People First*', and effectively involved stakeholders in the vision and service developments.
- Had good processes for performance in recruitment and retention of staff.
- Had an effective performance management framework in place for the delivery of social care.

Commissioning and use of resources

The council:

- Had a good track record of financial management and use of resources, and had invested in posts to support both the transformation process and adult safeguarding.
- Used local information and a comprehensive Joint Strategic Needs Assessment (JSNA) to inform strategic planning.
- Effectively promoted compliance with quality standards in services for older people.
- Promoted outcome focused commissioning to support the transformation agenda.

Recommendations for improving capacity in Hounslow

Providing leadership

The council should:

- Improve the structure and functions of the safeguarding board and sub-groups to: ensure better attendance; establish a clearer understanding of responsibilities and roles across agencies and ensure that urgently needed improvements in safeguarding practice are achieved.
- Ensure that safeguarding training programmes are appropriately competency based and appropriate to the individual and the organisation, with effective monitoring in place to ensure take-up of training by all relevant staff and partners.
- Establish clear quality assurance systems for all aspects of safeguarding practice, wherever appropriate involving vulnerable adults who have experienced safeguarding processes in these systems.

Commissioning and use of resources

The council should:

- Develop clear and detailed joint commissioning and joint workforce development strategies, with delivery plans that set out the shape of service in the future and the use of resources, targets and timescales.

Context

Hounslow is the ninth largest borough in London, covering 22 square miles from Chiswick in the east to Bedfont in the west. The Thames runs through the borough for four miles along its northern bank, and there are large areas of public open spaces managed for nature conservation. Heathrow Airport employs around 11,500 residents directly. Several thousands more are employed within the airport supply chain, in industries such as retail, catering, freight, transport, logistics and security.

Hounslow is ranked 105th out of 354 local authorities in England in terms of average deprivation. A few parts of the borough are within the 10 per cent most deprived in England.

There has been a steady increase in the adult population of 172,300 in 2007. The population of older people is in line with comparator councils in terms of percentage. There has been a slight decrease in age groups 65-74, and 75-84 but an increase in the 85 and over age group (source ONS mid year estimates).

The 2001 census data shows that a higher percentage of the adult population are non white compared to comparator councils and national averages. The census reported 65 per cent of the population was white, 26 per cent was of Asian origin, 5 per cent was Black, and 4 per cent was Chinese and other minority ethnic groups. The council reports that an estimated 7,100 - 8,200 refugees live in Hounslow, over 3 per cent of the population. The refugee communities represented in the borough include people from Afghanistan, Albania, Bosnia, Kosovo, Iran, Iraq, Sri Lanka, Kenya, Somalia and Tanzania.

Following elections in May 2006, Hounslow no one political party is in overall control. Currently, the Conservative and Community groups have formed a partnership administration to run the authority. There is a leader of the council, an executive of 10 members including the leader, overview and scrutiny committees and five area committees.

In its 2008-09 Comprehensive Area Assessment, the Audit Commission judged the council to be 'improving well', moving up to the top four star rating due to high performance for adult social care and improvements to leisure and environmental services. In 2009, the Care Quality Commission assessed the council's adult social care function to be delivering excellent outcomes in all areas except for increased choice and control, economic well being, and maintaining dignity and respect, where it was performing well.

Key findings

Safeguarding

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

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

Promoting equality had a high profile in Hounslow, and increasing priority was being given to addressing issues relating to vulnerable adults in the areas of freedom from discrimination and community safety.

The council had Beacon status for promoting community cohesion. This was underpinned by well-established processes addressing racism and homophobia, and more recently disability discrimination in corporate policies, strategies, and work with partners, including addressing hate crime. The profile of vulnerable people was not high in current equalities strategies, although the work of forums addressing race and homophobic crime were being merged to form a hate crime forum. The new forum was to have an extended remit to include issues relating to vulnerable adults as well as people with a disability, with input from the Safeguarding Adults Team (SAT).

Equality impact assessments were routinely undertaken as required and when significant changes to policy or services were being proposed, and these included consideration of the impact on people due to age and disability. Assessments within the community services directorate had been carried out to a good standard. A corporate assessment of the equality impact of significant changes to customer access had identified potential for 'huge impact' on people with disabilities and vulnerable adults. The assessment gave insufficient consideration of how to effectively mitigate this impact and the actions proposed were inadequate to address the issues identified. A further impact assessment had been proposed, which would provide an opportunity to improve the situation.

The community safety partnership had a high public profile, through regular public consultations and a range of crime reduction schemes. Many older people that we spoke to told us that they had had information on securing their home. New co-ordinators appointed to Safer Neighbourhood teams promoted crime reduction. Initiatives to improve awareness for people with learning disabilities included a 'Keeping Safe and Healthy' fair, and Makaton training for police and community safety officers. The latest Community Safety Strategy included a section on safeguarding, however the impact of diverse disability or support needs on the incidence, reporting and prevention of crime was not systematically identified or evaluated. Public consultation events on community safety had been held in 2009

that had included input from a group of people who considered themselves as having a disability, learning difficulty or were a vulnerable adult. This was to inform future consultation including a questionnaire that more specifically addressed issues for vulnerable adults.

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

The SAT provided a rolling programme of training and events to a wide range of stakeholders, which was highly valued. Good work had been done in providing training for GPs and for elected members, and other agencies appreciated that training was tailored to meet their specific needs and role. In addition to this, an innovative team of Adult Abuse Awareness (AAA) volunteers undertook awareness raising activities to users and community forums. This included running stalls and providing information during Hounslow's annual Adult Abuse Awareness week, as well as leading information sessions to groups of residents or vulnerable people. Arrangements were also being made to develop safeguarding champions - identified members of staff from partner agencies and providers who would cascade training and promote awareness within their own organisations.

Safeguarding vulnerable adults had a high profile across most health and social care staff, most providers and partners. Large numbers of people had attended safeguarding training, and each service within the community care directorate maintained records of training, linked to staff appraisal. Attendance by external providers and partners was not routinely monitored centrally. Some key partners had not had basic awareness training, and some practitioners were undertaking safeguarding investigations without the relevant training. These issues needed addressing to promote consistency and ensure competency based training. The council planned to address this by developing a centralised collation and monitoring system.

The high levels of activity in awareness raising and training in procedures had not translated into good practice. There was a lack of effective quality assurance and management review systems to ensure that policies were complied with or that positive and safe outcomes were secured. We found systemic failings in compliance with policy, procedure, and best practice. In the sample of case files that we read, good outcomes for vulnerable people were not consistently achieved and at times vulnerable people were left at risk.

The process for initial alerts and referrals needed to be improved to promote clarity in processes and ensure that a timely response was made to secure people's safety. The safeguarding policy was that all alerts and referrals were to be made either directly to the SAT or notified to them by care management teams. There was not always a member of the SAT available to receive communications and so some referrals were not responded to within required timescales. Referral forms set out in the procedures were rarely used, with widespread practice being to make alerts by email which could be unread for some days, further undermining compliance with timescales. We saw some examples on case files of alerts being made to care management teams that were recorded but not responded to.

There were fundamental problems with recording that undermined good practice. Historically the SAT had kept separate paper records, although they had been logging records onto the electronic social care record (SWIFT) since September 2008 to promote availability to practitioners and managers in other teams. The quality of recording relating to safeguarding was generally poor, and the proper forms for recording the safeguarding process were rarely used. Notes of important discussions and meetings were frequently overly brief, although key decisions were recorded and followed through. They did not record the process of investigation, evidence or conclusions, clarify the decision-making process, or identify if the practitioners had consulted and agreed actions with the managers.

Failure to meet timescales for strategy meetings was common and some were excessively delayed with no action taken to protect the vulnerable adult in the interim. This had left some people at risk of further harm. We found some confusion over the purpose of strategy meetings, which were frequently used to review evidence from initial investigations rather than planning the investigation. This was further confused by strategy meetings sometimes being combined with care planning meetings.

The role of practitioners and agencies around the investigation process was unclear. Although the policy clearly defined which agency should take a lead role in investigating allegations of abuse, flow-charts and guidance notes emphasised that decisions were to be taken jointly between SAT and the care management teams. A culture had developed of over-reliance on members of the SAT to be involved in a high number of investigations even where there was a clear allocated case worker. As the SAT team also directly held safeguarding work relating to self-funders, out of borough placements and some complex cases, this led to difficulties in managing SAT workloads. The 'lead' for safeguarding was often interpreted to be limited to a co-ordinating role rather than undertaking active investigation, and the role of Chair of strategy meetings was often unclear. We found examples of providers inappropriately undertaking initial investigations including in matters of potentially serious abuse - in at least one case before the SAT or police had been notified - and there was no record that this had been challenged. At times it was unclear who was responsible for undertaking aspects of investigation work.

Partnership working with police had recently been strengthened through links made by the SAT. Practitioners and managers highlighted good working relationships with the police; we saw some examples of this on case files. However, there were also examples on case files of lack of or delayed notification of relevant incidents to the police. We were concerned that the police had not investigated one potentially serious safeguarding case because the people involved had learning disabilities and it was regarded as a 'social care issue'. There was no record that this had been challenged. We also saw one case where practitioners had not communicated with either the children and families social work team or the emergency duty team where it was appropriate to have done so.

We saw several examples of poor quality investigations and failure to assess risks, and action plans rarely detailed appropriate timescales or measurable outcomes. Families and people who use services were not always adequately engaged in strategy meetings or communicated with and there was a noticeable lack of use of

advocacy, or the Independent Mental Capacity Advocacy (IMCA) service for people lacking capacity.

We found a lack of effective management of the SAT, or of quality assurance to ensure good practice. Managers at all levels had been insufficiently challenging regarding the quality of practice and outcomes. Action was taken by the council at the time of the inspection as evidence about the quality of practice emerged, to reinforce compliance with procedures and improve basic response to safeguarding issues, and also the council had been planning to reorganise the service. However, significant cultural change was needed to bring about changes urgently needed and improve practice to ensure that vulnerable adults were appropriately protected. We understand that since the inspection the council has put in place more effective management and quality assurance arrangements.

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

People's dignity, privacy and preferences were generally promoted in the delivery of care services, but there were areas to be addressed in relation to safeguarding.

The council sought to assure itself that services it commissioned respected the dignity and preference of people who used them. There was a variety of measures to hear the views of people who used services, including use of Lay Visitors for older people's services. Contract monitoring included review of the quality of care and compliance with practice standards. Generally, satisfaction rates were high, particularly amongst older people. The council had taken action in areas where concerns had come to their attention about quality issues in provided services. One case indicated that relevant accidents and incidents of a serious nature had not been notified to the care manager. The council had recently taken action to improve incident reporting as a result.

Across the range of safeguarding cases that we saw, there was insufficient attention to the views or best interests of vulnerable adults, particularly those who were less able to represent themselves. A number of individual cases demonstrated very poor practice that undermined the dignity and well-being of people who use services. Issues included poor communication and lack of consideration of best interests or rights.

There was little consideration given to arranging advocacy, and in some cases people without capacity had not had representation in meetings from either family members or Independent Mental Capacity Advocates. The IMCA service had not been well used, with few general referrals and none relating to safeguarding issues. The service was planning to undertake awareness raising events to stimulate more referrals. The safeguarding policy did not give a high profile to the role of IMCA or detail when they should be involved, which was an area to be addressed. There was advocacy for people using mental health services through MIND, although the capacity of the single worker was stretched, as was the service provided by the Citizen's Advice Bureau. A service for people with learning disability, Speak Out, was generally well supported by the council however. A new advocacy service for all

client groups provided by Age Concern was due to be launched. This was a timely and much-needed development.

The safeguarding policy had not been updated to include reference to Deprivation of Liberty Safeguards (DoLS). However, DoLS guidance had been published and staff had been briefed and trained throughout 2009, with further training on DoLS and MCA programmed throughout 2010.

A multi-agency information sharing policy had been developed and we saw consent to information sharing forms on case files. Generally information was kept secure.

People who use services and their carers are respected by social workers in their individual preferences in maintaining their own living space to acceptable standards.

People's preferences in maintaining their own living space were generally respected.

The council performed well in carrying out timely provision of both minor and major adaptations in people's own homes. Local organisations provided valued help with home repairs and gardening, and the in-house Care and Repair team had recently secured additional grants and was expanding its capacity as well as its services, providing valuable support to people in their own homes. However, annual performance data showed that fewer people were getting access to equipment and adaptations, and the council was now performing below comparator groups in this area.

A range of sheltered and extra care housing was available. The council was addressing the development of these services as part of the Older People's Housing Strategy.

Where people were in registered accommodation, the council used monitoring and regulatory information to assure themselves of the quality of the environment. All residents had a single room. Inspection reports and star ratings of services published by the Care Quality Commission were referenced, including their measures of dignity and privacy. Hounslow policy was to not place people in services rated zero star or 'poor'. There were no zero star registered services in the borough, and Hounslow's in-house registered domiciliary and residential care services received good and excellent ratings by the Commission.

Increased choice and control

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

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

Most people using services were satisfied with information provided by Hounslow about social care, although some older people and carers not yet receiving services had some difficulties in getting information and advice. A good range of literature about assessment and access to social care was produced by Hounslow, widely distributed across locations open to the public. This was supplemented by information on a website that was well organised and easy to navigate. Regular articles on social care issues were featured in the free monthly council publication, Hounslow Matters, which was widely circulated including delivery to the majority of households in the borough.

People's experience of contact with the range of agencies that usually provided a sign-posting role, such as voluntary agencies and GPs, were very mixed. A soon to be launched information, advocacy and advice service provided by Age Concern was intended to ensure that older people and other service users could more easily access advice and information about the availability of services, including those that promote well-being such as activity, leisure and cultural services. This was a welcome development.

There had been a recent change to the Council telephone system to introduce options for callers to select the service they wanted. This was intended to increase choice and control but older people and carers told us that they found contacting the corporate centre for initial information was particularly challenging in both using the electronic systems and in finding the department or person that they wanted to speak to. The Access Team acted as a single point of contact for all social services, and provided an effective and responsive call screening and switchboard service which was highly regarded by people who used it. But awareness of the service was low, particularly among older people not yet receiving services. The team's contact number appeared on a range of leaflets and posters, but had not been well publicised in Hounslow Matters. The council recognised this and took action to ensure that the service provided by the team and their contact number would be featured more prominently in future publications.

Once in receipt of social care services, most people felt that they were given good quality information in a timely way. Most older people who responded to our questionnaire and who we met stated that they could always or usually contact social services. Several people reported good contact with individual care managers and that they were treated with courtesy and respect.

Support and advice for carers was particularly valued, provided by carer's workers, in

carers' meetings and long established information 'packs'. Some people felt that care management staff could be more pro-active in giving out information about the range of services available, such as taxi cards, and explaining financial issues and charges.

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

Most older people and carers were satisfied with the quality of their assessments and care planning. Increasing moves towards self-directed support was helping people to have more control over how their care was arranged. Some older people were benefiting from the flexible use of a direct payment.

Assessments of needs were carried out in a timely way by older people's teams. Regular reviews were carried out, were also undertaken on request, and care packages were increased in response to changing need. Most people who had direct contact with frontline staff felt involved in decisions about their care and generally had opportunities to make choices about the services they received. Practitioners were clear about how to provide personalised support to older people and carers, and positive consideration was given to addressing this. Generally, people's cultural needs were addressed, including promoting good communication and translation services, although there were a few instances where this had not been adequately addressed. Care needed to be taken to ensure accurate recording and clear processes for clarifying communication needs particularly where members of the family were involved in the care planning process.

A high number of carers' assessments and reviews were recorded, and there were some positive innovations to promote this, such as a 'Tell your GP you are a carer' campaign which led to increased referrals of carers for assessment. The council had an ethnic minority access and participation project (EMAPP), which promoted access to carers' assessments as well as engaging people from different communities in carers' forums and surgeries. A 'Caring with Confidence' service was available to support carers who were lesbian, gay, bisexual and transgender (LGBT), and the Hounslow's Gay Men's Project ran sessions offering information and advice to community groups including carers. However, greater attention needed to be paid to the needs of older people from LGBT communities in assessment and care management.

Self or supported assessment and outcome focus care planning had recently been implemented but this was still at early stages. A joint initiative with Hounslow and the Disability Living foundation, called AskSARA, provided residents with an on-line self-assessment tool for the self-prescription of independence equipment. A resident-led assessment and associated outcomes focused support plan had been piloted and recently introduced for use with new customers. A good range of literature and publicity for older people and carers explained this new approach.

Several stakeholders identified difficulties with the new resident-led assessment process. The forms were lengthy and further training was needed to help staff appropriately support older people and carers in its completion. Practitioners had to

continue to use previous assessment forms, to ensure quality and data capture while new IT was being identified to stop this duplication. The forms were not yet available in languages other than English, which created challenges in promoting choice, control and equality. Translation and interpretation services and information in other formats were however available to clients on request. The council recognised that it needed to continue work in evaluating and adapting processes in response to feedback about the resident-led assessment.

Care packages were largely put in place promptly after assessments. We found some examples of positive responses to meeting needs, and some older people had very high regard for their care manager. Practitioners had had training on outcomes focused care planning, and a newly developed support plan was being introduced alongside the resident-led assessment. The form was also quite long at 13 pages. Positively, it had specific sections for people to state their preferences in how their care was delivered.

The council promoted take up of direct payments, although take up amongst older people was lower than in comparator groups. A self-directed support team offered a service to people who were taking up direct payment and their role was extending to include support to people using personal budgets, which was being piloted by the council. Guidance had been produced for supporting users in managing or taking responsibility for accounting for finances and spend. Most people who were in receipt of direct payments were positive about how they promoted flexibility and choice in arranging their care. The council recognised that this needed to be supported by developing an independent brokerage service so that people would be enabled to access a wider range and choice of services. A pilot for external brokerage services was planned for March 2010.

Recognition of safeguarding issues intrinsic to the implementation of increased self-directed care was being addressed through development of a risk assessment tool. This was to be supported by a risk enablement panel that practitioners could refer to when dealing with risk or managing complex cases, although none had yet been convened.

People who use services and their carers benefit from a broad range of support services. These are able to meet most people's needs for independent living. Support services meet the needs of people from diverse communities and backgrounds.

A range of services were highly valued by older people and carers, which effectively supported independence, wellbeing and choice. A number of services providing low-level and preventative support, such as befriending, were available to people who were not eligible for social care services. The care and repair team had secured extra funding to extend their home maintenance service. A large team of volunteer health trainers had undertaken a programme of information and awareness raising sessions, and other council events promoted healthy lifestyles for the over 50s.

Older people were being helped to live more independently and remain in their own homes through good take-up of telecare, low waiting times for adaptations, and

above average levels of providing meals, community support and home care. Most people who responded to our questionnaire were able to identify positive aspects of care packages or services that had assisted their independence.

Carers benefited from support from dedicated carers workers; support groups were identified as an effective source of information and advice, and carers' training was available. Carers also valued the introduction of vouchers, which they could use flexibly to purchase care or services on an as-needed basis. The carers' emergency card was supported by good contingency planning that helped carers to feel assured that there would be a prompt response in an emergency. Hounslow also provided an Emergency Responder service to support the use of telecare, where staff responded to alarm calls if the carer was unavailable.

Older people that we spoke to raised issues of dissatisfaction around access to accessible transport and renewing Blue Badges, as well as significant delays and poor quality of service in the provision of wheelchairs. The Council was working with NHS Hounslow to modernise the wheelchair service and retender, to promote a more timely and personalised response. A number of older people and some other stakeholders also highlighted concerns about sheltered housing. Some people identified issues with criteria for residency and quality of support, which affected their own well-being and that of others. The council had undertaken a comprehensive review of Older Peoples' Housing Strategy, part of which included a review of sheltered housing. The council reported that no changes to services had been made, and that surveys of residents showed high levels of satisfaction. There would be value in further work being done with housing providers to establish an accurate understanding of the issues raised during the inspection, and how they could be best addressed.

Hospital discharge arrangements generally worked well, although some older people described poor planning that meant that they were unsupported on leaving hospital. Work was being done to address protocols around discharge planning and improve outcomes in this area, including improving communication between the hospital and housing. The council had also invested in a range of support for discharge including the rehabilitation team (ART), intermediate care and assessment flats. The hospital based social work team were well regarded and several older people and their carers reported getting a good service and access to support after having been in contact with them.

Day care, domiciliary care and residential services provided by the council were highly valued by older people and carers. We were impressed by the consistently high praise that older people had for the day care and newly developed resource centres we visited, and by the attention given by staff to promoting choice and person centred care. Some day services operated seven days a week in order to offer a flexible service to meet people's needs. The council was also taking action to enhance the range of services and provide varied levels of support, including commissioning new extra care housing, developing intermediate care services, and enhancing reablement services through reorganisation of the in-house domiciliary care service.

There were mixed experiences of the quality of service provided by external

domiciliary care and people were concerned about the limited choice of providers. The council had taken action to drive up the quality of care services and to promote the delivery of person-centred care. A further re-tendering process for domiciliary care was underway in partnership with the West London Alliance.

Work was being done to improve pathways to care, including across health and social care services for older people with mental health problems. Dedicated day services for people with dementia were highly valued and the memory clinic was open to people under 65 which helped early treatment and prevention. The Alzheimer's society provided support to people with dementia and their carers in the community, and a programme of training on dementia was available to staff to better support those living with an experience of this condition. The council had undertaken a gap analysis of dementia services, which was informing the development of a strategy to enhance the range of services and pathways into dementia care, including addressing the needs of people in the early stages of dementia. Responsibility for the direct provision of the joint older people's mental health team had recently been placed with West London Mental Health Trust. Assessments were not as timely as in community service teams for older people and some concerns were raised by carers of older people about the quality of response from community mental health teams. These issues were recognised by the council as areas to be worked on in partnership across the agencies.

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

Details of how to contact care managers or service providers were included in support plans but improvements were needed in processes for encouraging and responding to people reporting concerns.

There was a clear procedure for dealing with complaints that had been updated in 2009 to a 'Making Experiences Count' approach. Public information was produced and publicised in a variety of effective ways. Hounslow's older people's day services ran an annual complaints road show. Work had been done to improve the response to complaints made, especially in terms of timeliness of response. Numbers of recorded complaints had increased although this reflected the inclusion of complaints about external domiciliary care providers, which accounted for 60 per cent of the total complaints made. Only six per cent of complaints were not upheld, which reflected that people who did use the process were doing so appropriately.

Some older people and carers identified concerns about making complaints, and some reported that they had been discouraged from complaining. We saw examples of issues being raised with the council that were not responded to in a timely or appropriate way. Managers failed to ensure that action was taken to respond to these concerns or to secure the wellbeing of people using services. Whilst there was good quality of assessment and care management, responses to concerns or identified poor practice needed to be improved.

Capacity to improve

Leadership

People from all communities are engaged in planning with councillors and senior managers. Councillors and senior managers have a clear vision for social care. They lead people in transforming services to achieve better outcomes for people. They agree priorities with their partners, secure resources, and develop the capabilities of people in the workforce.

People from all communities engage with councillors and senior managers. Councillors and senior managers show that they have a clear vision for social care services.

Corporate plans and targets gave prominence to key policies and priorities for older people and vulnerable adults, with a high level of commitment from elected members. Within the community services directorate, effective action had been taken recently to drive implementation of the agenda to transform adult social care. However, the structures in place for safeguarding had not secured effective standard setting, monitoring or practice.

A high priority to supporting positive outcomes for older people and carers in Hounslow was evident in local area agreement targets, with long-standing commitment to the principles of promoting independence, wellbeing and choice. Initial action around the implementation of '*Putting People First*' focused on preparing for the transformation needed. While there were some key achievements, until recently little had been done to translate the vision into effective implementation plans across the range of areas that needed to be addressed. The commitment to change had been reinvigorated since the appointment of a new Director of Community Services, and Head of Transformation and Modernisation in 2009.

Positive recent action had been taken to ensure that systems and structures were in place to drive the personalisation agenda forward more effectively. Changes had been made in the senior management team and structure, and a review of '*Putting People First*' had led to a refresh of the strategy and action plans supporting it. Plans to progress the transformation agenda were coherent, with an impressive commitment to review local and national developments, to establish best practice and learn from the experience of others. A programme delivery group had produced a strategy and action plan, mapping progress and overseeing a number of workstreams. Priority was given to meeting requirements set out in key national milestones. Workstreams were now on track to meet targets for April 2010 in significant areas such as delivering self-directed care, providing information and advice, and consultation with stakeholders.

Leads in community services had been active in conveying a clear vision for the personalisation agenda across stakeholders, including a presentation to elected members in January 2010. Some innovative work had been done with GPs and faith communities, and generally there was a high level of awareness of and commitment

to the principles of '*Putting People First*' across all stakeholders.

High level corporate plans had targets for the protection of vulnerable adults, and the Executive Lead Member for adult social care was the dignity and safeguarding champion for the council. There was widespread awareness of safeguarding issues across most stakeholders, which was being supported by the recent development of safeguarding champions.

The Safeguarding Adults Board had not provided effective leadership in driving the vision for safeguarding across stakeholders. Good intentions around improving safeguarding practice and governance had been hampered by poor attendance from partner organisations and other corporate directorates. The sub-groups of the board needed to be strengthened to ensure that training and quality assurance were effectively addressed. Although there was a safeguarding business plan, its action plan did not reflect the strategic role it was intended to provide, and it needed to be more outcome focused. The senior management team in Community Services had recognised that leadership in this area needed to be strengthened, and had taken action in recent months to review the role of the board, sub-groups, membership and attendance. This was positive action but was too recent to have yet had the impact that the council intended in establishing a new vision for safeguarding.

People who use services and their carers are a part of the development of strategic planning through feedback about the services they use. Social care develops strategic planning with partners, focuses on priorities and is informed by analysis of population needs. Resource use is also planned strategically and delivers priorities over time.

Well-established arrangements for consultation with people who use services, carers and provider agencies were being strengthened to support their engagement in the development of '*Putting People First*'. Positive action had been taken to develop partnership working with health agencies and corporate partners. Efficient use of budgets and resources was a high priority. Clear plans needed to be developed to set out how the council would manage change within current resources.

Older people, representative organisations and providers were well engaged in service planning. Specific work had been undertaken to engage with faith communities through creating Heathlands health and wellbeing partnership in 2009. The older people's partnership board was well attended and had a track record of influencing service developments for older people. This had recently been changed to encompass planning for adults with disabilities. While this reflected the 'read-across' between the groups in health and social care agendas, some stakeholders were concerned that it made the agenda for the meetings too broad to ensure that all attendees could continue to participate as effectively. This would be an area for the council to monitor as work progresses. An older people's panel was also well established, whose remit was focused more on operational issues relating to access and equality for older people and their carers. This panel was well regarded as effective in promoting positive outcomes for people. Effective use was made of older people as volunteers in a range of projects at operational level and a community services engagement strategy was being developed. Carers were engaged in many

of the current forums and a specific carers' strategy group was being developed.

Elected members were well informed and understood the benefits and some of the potential risks associated with the development of the personalisation agenda, benefiting from regular communications from the community services directorate. Work to engage with corporate partners was less well developed and awareness of the implications of '*Putting People First*' varied considerably. The council was working to develop a coherent approach to social inclusion and promoting independence through a recently established corporate transformation board, which offered opportunities to identify and plan joint action across directorates including leisure, transport, housing and education. This was a timely development, which provided a forum for partnership working to address a number of areas for development identified by older people and carers.

The development of partnership arrangements with health agencies had historically been challenging but all agencies were working to strengthen relationships at both operational and strategic levels. Leads from community services had held meetings with primary care providers and undertaken work to clarify care pathways between agencies. Attendance at strategic planning forums across health and social care was good; this included the recently established corporate transformation board. The latter was in its early days and therefore its impact on operational change could not yet be determined.

Third sector providers benefited from positive relationships with community services and felt engaged in service planning and development. Hounslow was helping to prepare the sector for change linked to the transformation agenda through funding a voluntary sector co-ordinator and developing community and voluntary sector 'champions'. A recently established health and social care voluntary sector forum provided an effective channel for communication and providers had had one day training on '*Putting People First*'. A well-considered approach had been taken to developing Local Information Networks (LINKs) who had already been engaged in service planning and improvements.

The council managed budgets effectively, having achieved significant efficiency savings through a wide range of workstreams including modernisation of home care, remodelling in-house services and procurement savings. Maintaining a focus on efficiency savings was a high priority for the council, which created challenges in delivery of the transformation agenda. There was no planned uplift to voluntary sector providers and there was insufficient detail about how the council would deliver the transformation agenda within its own resources or, where appropriate, jointly with health. Funding had been secured to acquire a new IT system, which was to be crucial in streamlining processes and improving the overall reliability of information. This needed to be supported by a robust implementation plan with associated deployment of resources.

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

Processes for, and performance in, recruitment and retention of staff were good. Systems for management oversight of assessment and care management supported good practice but arrangements for oversight of safeguarding practice were in urgent need of improvement. Staff had been engaged in consultation about transformation of social care and some plans were in place regarding workforce development, but this needed to be strengthened.

Staff we met had manageable workloads, felt generally well-supported, and their morale was generally good. They had regular supervision and appraisal, and reported that they had good access to training on a wide range of issues relevant to their work. Evidence of audit and case discussion with team managers was seen on a number of care management case files, although consistency of recording of management decisions needed to be improved at an operational level. Human resource systems for the safe recruitment of staff and response to disciplinary matters were sound. Vacancy and staff turnover rates were low but there were some concerns about recent lack of recruitment to vacancies as they arose.

The council had invested in lead posts to support the transformation programme and development of financial systems to support it. The council was proud of the work that had been done to ensure that the resource allocation system was 'fit for purpose' and of the development of a web-based 'portal' that would be launched to promote people's access to information about social care. All of the programme workstreams now had a dedicated lead and regular team briefings were produced to keep staff up to date with developments. Staff had been engaged through an extensive training programme and '*Putting People First*' champions had been identified in staff teams.

Local service and team plans did not yet reflect new service priorities. The transformation leads were aware of the mixed views amongst practitioners regarding the success of initiatives to promote personalisation, particularly concerns about the impact on workload management due to incompatible IT systems. They were confident that this would be addressed through introduction of new technology in the near future. The council recognised that issues would be raised during the initial implementation phase of resident-led assessment and had put in place 'listening events' to ensure that they heard feedback and could respond with appropriate modifications. This would be critical to its success in both achieving a process that was fit for purpose and also supporting the change process by securing a strong 'buy-in' from stakeholders.

The senior management team had a clear vision for the future configuration of social care services and operational teams to support the transformation of services. There had been a number of workshops and presentations to staff and consultation with unions about some key changes. A newly established joint workforce forum across health and social care had been set up to discuss learning and development but little had been done across partners to jointly plan for workforce deployment or more integrated roles to support the modernisation programme. A clear workforce strategy, preferably jointly with health, was needed to clarify and underpin proposed reconfiguration.

Hounslow had invested in dedicated safeguarding co-ordinators, a Deprivation of Liberty (DOLS) worker and administrative support to the safeguarding team. One of the safeguarding co-ordinator posts had been vacant for some time, which had caused concern amongst a range of stakeholders about the capacity of the team. However, the lack of clarity about the role of safeguarding co-ordinators and continuing lack of effective management of their workload were more pressing issues. Positively, the council had already committed to developing a new Review and Protection manager post to oversee safeguarding and DOLS work, and the manager for the service was reviewing the role and structure of the team, including their workload. The funding for the vacant safeguarding post had been invested to enhance the specialist training function of the team, support the AAA volunteers, and support safeguarding Champions in order to build capacity and address some practice issues identified during the inspection. Hounslow PCT made a small annual contribution to safeguarding work, otherwise all cost implications were held by the community services directorate.

While extensive safeguarding training had been undertaken, monitoring of training uptake needed to be strengthened to ensure that all relevant staff and partners had appropriate levels of input. There was also a pressing need to review the quality of training and develop competency based standards, to ensure that issues around compliance and quality of practice were improved. This needed to ensure that practitioners and team managers had effective training about their roles and responsibilities.

A recent inspection, by the Care Quality Commission, of the West London Mental Health Trust had identified significant failings in responding to the wellbeing of patients in areas that had implications for its performance in safeguarding, although no major concerns had been raised about Hounslow services in the inspection report. Partnership working with the Trust had been strengthened since that inspection and over the last two years. Issues relating to safeguarding and serious untoward incidents had been on the agenda and discussed at each key partnership. Clearer links had been made with the safeguarding team, the Trust had an improved profile in safeguarding boards and sub-groups and there was good communication about action being taken to improve practice. Monitoring of improvements was strengthened by scrutiny from the Executive, who took a keen interest in ensuring that progress was sound and secure.

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

There was an effective performance management framework in place for the delivery of social care but arrangements for quality assurance of safeguarding were weak and ineffective.

There was competent and regular monitoring of the council's performance against national indicators. Monthly data reports and reporting to delivery boards and senior management team reinforced focus on performance which was generally and consistently high. Operational staff and managers were aware of performance

indicators for their teams and were performing well in these areas. Performance reports focused on national indicators without reflecting local delivery issues, however. The senior management team had been in discussion with the corporate performance management team to plan the capture of outcomes focused monitoring. Consideration was being given to this in the development of new IT systems.

The community services directorate had invested in a series of in-depth audits under the title of 'No Surprises', although one had not yet been undertaken for older people's services. The audit process included case tracking, review of policy, procedures, training and getting feedback from service users, and resulted in action planning with relevant team managers. The audit on safeguarding undertaken in 2008 had identified some key areas for improvement but was insufficiently critical about the quality of safeguarding practice or outcomes for vulnerable adults. Some progress had been made on the resulting action plan but progress had been hampered by changes of management that led to inconsistency of oversight and unclear responsibility for driving improvement.

Overall, processes for the quality assurance and performance management of safeguarding had not been robust or effective. Performance management of practice and outcomes needed to be formally monitored. Processes for monitoring compliance with practice expectations across the agencies had been particularly weak, although, more recently, the SAB was addressing these issues as part of its work programme. Safeguarding data was captured manually, and did not support adequate analysis of quality or activity. Limited data was presented in the annual report; its influence on service development and practice improvement needed to be made explicit. The Safeguarding Board and senior officers provided feedback on the report and as a result an Executive Summary was provided and a new format agreed for future reports. Urgent action was needed to secure consistent standards of practice and better quality of outcomes for vulnerable adults. There had been a lack of recognition of the failings in current recording and practice by all tiers of management prior to the inspection. Action was taken to promote administrative compliance with safeguarding forms following issues identified during the inspection in this area. Changes in senior management had been made to establish responsibility for best practice in safeguarding. Significantly improved leadership was needed to ensure that managers and leads had the skills and capacity to establish best practice and to identify and redress deficits in safeguarding.

Commissioning and use of resources

People who use services and their carers are able to commission the support they need. Commissioners engage with people who use services, carers, partners and service providers, and shape the market to improve outcomes and good value.

The views of people who use services, carers, local people, partners and service providers are listened to by commissioners. These views influence commissioning for better outcomes for people.

There were effective processes for capturing the views of stakeholders and examples of how this had influenced service planning and delivery. The strong commitment of stakeholders to the principles of *'Putting People First'* needed to be underpinned with clearer, more detailed plans on the reconfiguration of services and future commissioning.

Older people, representative organisations and providers reported positive experiences of their engagement with the council and felt that they had the opportunity to influence change through the range of forums available. We saw examples of how local intelligence and feedback had been used to inform service development and of consultation in specific reviews. A review of community based services had informed the recommissioning process to better address social inclusion and prevention agendas. Service users had been consulted in a review of service specifications for aftercare services. There were systems for gathering feedback about the quality of provided services through contract monitoring and accreditation schemes, as well as through use of Lay Visitors to help capture the views of people using the service. This helped to maintain a generally high standard of service delivery.

Provider agencies felt well engaged in discussions with the council about the personalisation agenda and effective work was being done to address issues of market development in preparation for this. There had clearly been a lot of work done to promote the principles of *'Putting People First'* and a lot of activity in a range of reviews and specific projects. However, there was insufficient information about how budgets, resources and commissioning activity would be managed over time to translate the overarching vision into a coherent reconfiguration of services. The joint commissioning strategy for 2007-10 needed to be updated to reflect the significantly changing care landscape and expectations of service providers within it, including how services would be diversified to meet future demand. Information on joint commissioning intentions 2009-11 was overly brief and non-specific. Consultation with stakeholders could not be fully effective or robust because better information on what the modernisation process would involve was required.

Commissioners understand local needs for social care. They lead change, investing resources fairly to achieve local priorities and working with partners to shape the local economy. Services achieve good value.

Commissioners had good quality information about the needs of older people, which was used in market management and contracting processes. Effective work to bring about coherent change in service configuration needed to be supported by more precise and transparent commissioning strategies and plans.

The Joint Strategic Needs Assessment was comprehensive and well linked to other strategies and local priorities. It had been undertaken with good local consultation, reflected the priorities in *'Our health, Our care, Our say'*, with a refreshed version produced in 2009. A needs gap analysis of dementia care was being undertaken to inform new joint strategy and service development with the mental health trust.

The structures for commissioning across health and social care are well developed and benefited from jointly funded posts in place since 2002 with joint commissioning and joint public health and involvement teams and a recently appointed joint Director of Public Health. Joint commissioning with health had been limited. In spite of the financial challenges faced by the PCT there was strong evidence of a shared commitment to the delivery of services and to managing financial pressures together. There had been a decision not to set up joint budgets but there was a pooled budget for ensuring discharge was not delayed and a number of services funded through contributions by both organisations in ring-fenced budgets. Social care budgets were increasingly being invested in early intervention and intermediate care as well as work on reablement and the new Transforming Community Equipment Services (TCES) project, to further promote the independence of older people and carers but this was being done across a range of separate reviews and commissioning projects. There was not yet a clear joint commissioning strategy across health and social care for how investment and resources would be shifted towards commissioning to meet the personalisation agenda. This was a key milestone in transforming adult social care.

Work was being done with providers to develop capacity in the market to encompass the changes needed in *'Putting People First'* and specific arrangements had been made to support smaller providers through the tendering process. This ensured equity in the process and also promoted a mixed market that was valued by people who use services. Providers were generally very positive about the processes for transformation although there were some concerns about the capacity of the market to deal with increasing numbers of people being directed to preventative and low level services. This was recognised by the council who had responded by establishing a range of approaches to work with the local voluntary sector to support them to respond to the transformation agenda. Changes in commissioning included redesign of in-house home care towards a reablement model, partnership work with Department of Health to deliver reablement and TCES and retendering of external domiciliary care. Procurement processes had been experienced by providers as complicated and council procurement tools were experienced as being insufficiently robust. This was recognised by the council who had already taken action to address issues around the complexity of European Union procurement processes and reported that this had become a role model for the West London Alliance.

A number of improvements had been made to support commissioning arrangements in assessment and care management. There had been positive changes to the continuing care panel to improve its efficiency. Staff across health and social care were benefiting from access to certificated training to develop skills in commissioning for personalisation. The council had invested in developing a resource allocation system and ensuring that it was fit for purpose. A risk enablement panel system had been established, to support care managers when implementing the new assessment and resource allocation system.

Provider agencies found that arrangements for contract monitoring were robust and helpful. A quality monitoring programme was in place, supporting routine contract and compliance monitoring. In-house services demonstrated commitment to quality targets through charter marks and achieving accreditation such as with RNIB. Lay visitors helped provide further quality assurance and positive work had been done on analysis of CRILL information. The council were changing contracting arrangements and developing outcome focused contracting to better support commissioning for personalisation.

Appendix A: summary of recommendations

Recommendations for improving performance in Hounslow

Safeguarding adults

The council and partners should:

1. Update policy and procedures in safeguarding and ensure that these are being implemented consistently across all teams and partner agencies. (Pages 11-14)
2. Clarify the roles and responsibilities of practitioners and managers in undertaking safeguarding work. (Pages 11-13)
3. Ensure that a consistent level of good practice is achieved in case work, that secures good outcomes for vulnerable adults and effectively manages risk. (Pages 11-13)
4. Improve recording and monitoring of safeguarding work. (Page 11)
5. Promote the profile of vulnerable people and ensure that their needs are addressed corporately and in community safety strategies. (Page 10 - 11)
6. Ensure people are offered and provided with advocacy as appropriate, particularly those without capacity to make decisions for themselves. (Page 13)

Increased choice and control for older people

The council should:

7. Ensure that older people and carers have good access to information and services through a range of access routes (Page 15).
8. Ensure that responses to concerns raised or complaints made about adult social care are consistent and meet quality standards. (Page 19)
9. Work with partners to improve outcomes and satisfaction for older people and their carers in relation to transport, wheelchair, and community mental health services, and address concerns raised around sheltered housing experience. (Page 18)

Providing leadership

The council should:

10. Improve the structure and functions of the safeguarding board and sub-groups to: ensure better attendance (Page 21); establish a clearer understanding of responsibilities and roles across agencies (Pages 21 & 23); and ensure that urgently needed improvements in safeguarding practice are achieved. (Page 23)
11. Ensure that safeguarding training programmes are appropriately competency based and appropriate to the individual and the organisation, with effective monitoring in place to ensure take-up of training by all relevant staff and partners. (Page 24)
12. Establish clear quality assurance systems for all aspects of safeguarding practice, wherever appropriate involving vulnerable adults who have experienced safeguarding processes in these systems. (Page 25)

Commissioning and use of resources

The council should:

13. Develop clearer and more detailed joint commissioning and joint workforce development strategies, with delivery plans that set out the shape of service in the future and the use of resources, targets and timescales. (Pages 26 & 27)

Appendix B: Methodology

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

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

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

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

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

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

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

We spent six days in Hounslow when we met with seven people whose case records we had read and inspected a further 14 case records. We also met with approximately 90 people who used services and carers in groups or individually, plus a further 60+ people, many of whom were older people using services or carers, in an open public forum we held. We sent questionnaires to 150 people who used services and 35 were returned. A further 15 people contacted us by phone or in writing.

We also met with

- Social care fieldworkers.
- Senior managers in the council, other statutory agencies and the third sector.
- Independent advocacy agencies and providers of social care services.
- Organisations which represent people who use services and/or carers.
- Councillors.

This report has been published after the council had the opportunity to correct any matters of factual accuracy and to comment on the rated inspection judgements.

Hounslow will now plan to improve services based on this report and its recommendations.

If you would like any further information about our methodology then please visit the [general service inspection page](#) on our website.

If you would like to see how we have inspected other councils then please visit the [service inspection reports](#) section of our website.