Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans, and responsibilities for people in the area. Partners worked positively together, with many long-standing relationships, with a good understanding of the health and care needs of the area. Discussion around health services was high on the agenda at board level, including the health and wellbeing board and overview and scrutiny committee, showing a clear connection across strategic priorities. However, a focus on adult social care was at risk of being lost within the dominating health agenda linked to the implementation of the Integrated Care System across the region.

The local authority had an integrated mental health team with health services and much of this was long established. Partners worked together to work to joint strategic priorities. We received some feedback that guidance for the integrated mental health team didn't always align, and some managers were completing significant hours outside of their core working hours to keep on top of work. Operational arrangements had recently updated and changed based on feedback, ensuring there was effective management oversight and practice support for social workers.

People were informed through the local authority's website in plain language and using accessibility tools and videos, about ways in which integrated services were operating in the area.

Arrangements to support effective partnership working

The local authority was proud of their approach to integration. There were pooled arrangements in place to fund integrated strategic roles, allowing for system oversight. The health and wellbeing board maintained oversight of integrated work.

The Durham Mental Wellbeing Alliance was shared as a good example of a collaborative commissioned preventative service. Several provider organisations were contracted together to support improved mental health in the county. This Alliance joined up different services, including in the voluntary and charity sector, under one funding arrangement with a central access point. This was described by partner organisations as making a positive difference to the way organisations worked together and delivered the model of commissioning for mental health. It allowed for stability for organisations who were able to make joint strategic decisions with commissioners on an equal footing. This arrangement contributed to joined-up mental health services in the county. This meant fewer people had to tell their story to professionals more than once and had access to services at an earlier stage, reducing the complexity of mental health concerns.

The Better Care Fund in County Durham was used to support hospital discharge, wellbeing for life services, and crisis response services to support the avoidance of hospital admission. There was a clear assessment of the best use of the funding and early signs of improvement, for example in developing the new approach to reablement to avoid hospital admission.

Emergency out of hours staff had good access to support from partners, including the police, with no identified gaps in systems or processes. They were able to access intermediate care beds outside of hours. Where teams weren't fully integrated, such as hospital discharge teams and hospital social workers, daily meetings were in place that were well attended. Read only access to information systems was available to support service delivery. Access to this information meant that people's needs were met in a timelier way.

Most of the staff groups we spoke with identified strong relationships and supportive arrangements in place to support effective partnership working. Daily huddles took place in some services to support discussion around individuals. Twice weekly meetings took place to discuss delayed discharges from hospital. Joint visits were regularly undertaken. Staff identified how joint visits and multi-disciplinary meetings had supported them to better understand an individual's needs. Partners were regularly invited to local authority team meetings which improved staff knowledge about available services and processes to access them, which could be used to support assessments and care planning for individuals.

Staff identified that a lack of integrated information systems impacted on knowing people's needs and caused delays to their care. Some teams had read only access to systems, some used certain other systems and others had no access to partner information. We heard that some staff experienced 'battles' with health on a regular basis and that a focus on where funding was coming from was the priority, rather than the person's experience.

Impact of partnership working

People said they saw the impact of partnership working in the care and support they received. Staff teams across partnerships were responsive and worked together to promote independence, choice, and control. Staff across teams worked together to support each other and this was tangibly felt by people in receipt of services and their carers. We heard about regular multi-disciplinary team meetings and joint visits, focussed on what was working well, further reflections, and future planning.

Despite system pressures and rising complexity, leaders were proud of the way their aligned partnership approach had delivered consistent good performance on hospital discharge. Working in a partnership approach with care providers had delivered market sustainability, with clear impacts in minimal to no waiting times for people who required services, such as homecare or a residential placement. Performance was regularly monitored and challenged. The local authority was keen to explore new models of care with sector providers based on analysis of challenges they identified, such as a more preventative approach to reablement care. This aimed to reduce admission to hospital and prevent or reduce people's needs at an earlier stage.

Working with voluntary and charity sector groups

Most organisations we spoke to in the voluntary and charity sector felt they had good relationships with the local authority. There was a recognition that the sector had stepped in for crisis situations for individuals, supported hospital discharge, prevented readmission, and was integral to the offer in the county. Staff highlighted the importance of the sector in understanding the needs of communities and were relied on for their insight in consultation and needs analysis work. Voluntary organisations started the work with carers that was then taken forward with the local authority that resulted in the carers plan on a page. This highlighted key priorities for the community.

The importance of this sector wasn't always well supported by funding arrangements or other support opportunities. Some organisations felt the tendering process was difficult, especially for smaller organisations. Funding often had to be applied for every year or two, affecting the organisations' sustainability. Reporting requirements to the local authority were intensive for some voluntary and charity sector groups. Discussions were ongoing about ways that smaller organisations could be involved in larger contracts, but the outcome of these discussions was not understood by organisations in the sector. Those organisations within the Durham Mental Wellbeing Alliance had more clarity. They felt the local authority had made funding available, especially for innovative work, and more providers were on longer-term funding arrangements. There was a subgroup of the County Durham Together Partnership that was exploring this at the time of our assessment.

Integrated arrangements did not always work well for the voluntary and charity sector groups. For example, not all mental health teams across Durham communicated well and some sector members did not feel listened to and respected as an equal partner in someone's mental health issue and journey in the past. This extended to people's experiences. When workers changed there was little communication which was confusing and upsetting.

Voluntary and charity sector groups felt that the local authority was an advocate for the sector and celebrated their successes. Local authority staff and councillors developed and maintained relationships with organisations in the sector. Sometimes consultation was an afterthought, and organisations told us that they often felt decisions had already been made before they were consulted with. Co-production was not routine and to some felt tokenistic. The local authority had recognised this was an area of development for them.