Care Quality Commission

County Durham: local authority assessment

How we assess local authorities

Assessment published: 16 August 2024

About County Durham

Demographics

Durham County Council is a large, predominantly rural county primarily, with over 528,000 residents. It is the largest geographical authority in the North-East covering 862 square miles. Since 2009 Durham County Council has been a unitary council. County Durham has an index of multiple deprivation score of 7 (with 10 being the highest and most deprived). 50% of the residents live in the 30% most deprived wards nationally.

The population is 48.9% male, and 51.1% female. Approximately 20% are aged 0-17 years, approximately 60% are aged 18-64 and 19% are aged over 65. It's expected that the proportion of people aged over 65 will increase by 25% by 2043.

Comparatively, Durham is not a particularly ethnically diverse county. 96.82% of County Durham residents are White with 94.75% White British. 1.5% of people are Asian or Asian British, 0.95% of people are from a Mixed or Multiple background, and 0.33% are from a Black, Black British, Caribbean or African 0.33% background.

Durham County Council is part of North-East and North Cumbria Integrated Care Board. County Durham is one of 14 local authorities in the integrated care board area.

Durham County Council historically has been run by Labour party. Following the 2021 elections, control of the council moved to a Conservative, Liberal Democrat, Independent and Green Alliance.

Financial facts

The financial facts for County Durham are:

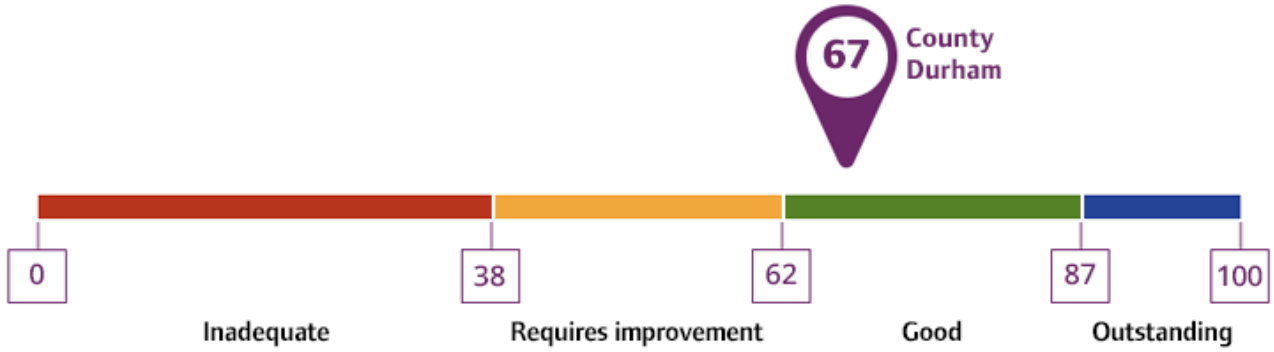
- The local authority estimated that in 2022/23, its total budget would be £829,402,000. Its actual spend for that year was £925,466,000, which was £96,064,000 more than estimated.
- The local authority estimated that it would spend £160,490,000 of its total budget on adult social care in 2022/23. Its actual spend for that year was £161,777,000, which was £1,287,000 more than estimated.
- In 2022/23, 17% of the budget was spent on adult social care.
- The local authority has raised the full ASC precept for 2023/24, with a value of 2%. Please note that the amount raised through adult social care precept varies from local authority to local authority.
- Approximately 9435 people were accessing long-term ASC support, and approximately 2240 people were accessing short-term adult social care support in 2022/23. Local Authorities spend money on a range of adult social care services, including individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

County Durham
Good



Quality statement scores

Assessing needs
Score: 2

Supporting people to lead healthier lives
Score: 3

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 3

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 2

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

Overall, we had positive feedback from people about their experiences of contact with and receiving support from the local authority. There were a variety of ways in which information about the services available could be accessed, including talking directly with someone in the Social Care Direct team. Durham Locate allowed people to explore services that could meet their needs in their communities. Staff used the same resource to signpost people.

People told us that they felt listened to and that their assessments and care plans reflected their needs, wishes, and aspirations. Front line staff teams had a good understanding of the area and there were several examples of innovative and considerate ways they worked with communities with different needs. Not all communities who were at risk of poorer outcomes were well understood or provided for, however.

People had access to interpreters and translation services where needed. There was a specialised sensory team who supported people with sensory needs.

Carers who had continuity of social workers often described having a better experience. Some described it as a battle to get help whereas others found staff to be helpful. Some carers chose to provide care themselves because they did not think that the care and support required was provided by the local authority. Some carers were not always clear that they had had an assessment but felt that they knew where to go to get help if they needed it. Carers didn't always feel their future needs were considered, and some felt they did not have enough time to focus on their own health and wellbeing. Most carers felt the local authority communicated well and included them in the assessment and support planning.

Summary of strengths, areas for development and next steps

Staff were proud of the work they did and in working for the local authority. Staff demonstrated a person-centered approach in assessing needs and developing care plans. Most of the staff we spoke with felt supported through supervision and appraisals and by a visible and interested management and senior leadership team. Staff had opportunities to develop and complete training or required learning, though some staff indicated pressure on caseloads did limit their ability to do this. Some teams had vacancies which impacted on caseloads.

Teams worked well together, including across partnerships. The local authority had progressed significantly on its integration journey with health services and there were operational and strategic relationships that delivered this in a way that improved services for people.

The local authority had a clear focus on performance and completed timely assessments of need. They had made significant progress in reducing their waiting list for Deprivation of Liberty Safeguards (DoLS) from approximately 2000 in 2022 to at the time of our visit being close to managing new applications as they arrived. Targeted work to improve the timeliness of section 42 safeguarding enquiries and annual reviews was ongoing and proving effective.

There was some disconnect between teams about safeguarding practice. Staff couldn't be confident that everyone across the county understood and made safeguarding personal. The Adult Protection Team were seen as a specialist resource able to provide quality advice and support. We were not assured that everyone in the county received the same quality of safeguarding support. We heard about quality assurance regarding safeguarding at a very strategic level and were assured that significant issues were identified and understood. There was not a clear process that all staff understood for monitoring the quality of section 42 enquiries that were completed by all partner organisations. Local authorities have a duty to maintain oversight of section 42 safeguarding enquiries, whether they lead the process themselves or whether another agency does. Not all staff could articulate the lessons learned from Safeguarding Adults Reviews outside of individual practice feedback to inform their future practice.

There was a vibrant and sustainable market of provision in County Durham and teams had done significant work to support the market. This included the Care Academy, which worked in innovative ways to improve recruitment, retention, and skills in the care market in the county. There were no waiting lists for homecare, residential care, or nursing care. Commissioning was felt to be responsive to needs identified from locality teams. We heard from providers that they felt listened to and that the local authority was responsive and open to feedback. Over 85% of CQC regulated care provision in the county was rated as good or outstanding as per our data in June 2024. There were contingency plans covering care home closure and de-commissioning, and partnerships with the adult protection team in escalating concerns where joint visits were required to ensure safety and quality.

Issues were identified by providers and frontline teams regarding specific areas of care where people required additional equipment and staffing, for example, providing ongoing care and support for people with bariatric care needs. Teams were aware of issues and some solutions were in place. There were challenges in sourcing flexible respite services for people with a learning disability, and single person accommodation for people with mental health needs and people with a learning disability. There were issues with people being assessed for a mental health crisis bed.

Data in relation to people's differing identity characteristics was limited because this was not well recorded. More robust data would support the improved understanding of barriers to accessing services or to outcomes experienced for people. There were some examples of work that had been effective in supporting communities within the county – such as the Gypsy, Roma, and Traveller community. These pieces of work felt isolated and a focused strategy around equity of experience and outcomes would help realise the potential of this work and set out an ambition for the county. Culturally competent care could not always be commissioned. Specific needs for older people who were part of the Lesbian, Gay, Bi-sexual, Transgender (LGBT+) community, for example, were not always considered in the way services were commissioned across the area. There was limited curiosity on the part of the local authority in understanding the ways the different parts of people's identity combined to affect their experiences and outcomes.

Adult social care did not appear to have a strong focus in scrutiny arrangements which were more health dominated. There were significant changes in the region in the development of the North-East and North Cumbria Integrated Care Board which required attention but minimised opportunities to focus on adult social care. People had limited opportunities to be involved in governance and co-production in County Durham. This created a feeling of a divide between council services and how the public were involved in them. The local authority had recognised this and had plans in place to improve this.

Theme 1: How County Durham works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

People could access care and support services in several ways in County Durham through Social Care Direct, either on an online assessment form, over the phone, or via text message. The Durham Locate website provided information for people to find other services that could meet their needs. The County Durham local authority website provided information about eligibility, including for unpaid carers. Some organisations told us that some information from the local authority was difficult to navigate.

Social Care Direct included social workers and occupational therapists, alongside assistants, apprentices, and qualified managers. The team received all referrals and enquiries and were able to effectively triage and allocate each one. They used the 'Three Conversations' approach when responding to initial requests for support. This approach used open and inquisitive questions to support a collaborative understanding of people's need. Social Care Direct supported some people to access community services before they needed a care assessment. Social Care Direct told us that they had no waiting lists for triage at the time of our assessment.

People gave us positive feedback about the way the local authority completed assessments and care planning. Staff throughout frontline teams described and demonstrated a person-centered approach in assessing need and developing care and support plans. Assessments involved people in the process and their human rights were considered. Health, care, wellbeing, and communication needs were assessed and reviewed. Individual's wishes and aspirations were included in their assessments, re-assessments, care plans, and reviews. National data showed 63.17% of people were satisfied with the care and support they received, which was in line with 61.21% as the England average (Adult Social Care Survey, published October 2023). Several people identified how social workers, the person, and their carers had worked together to develop care plans. This involved social workers focussing on the individual's wishes and aspirations, alongside supporting them to maintain their independence, choice, and control. National data highlighted people's experience of control in their daily life was in line with the England average: 79.31% of people felt they had control over their daily life, in comparison to the England average of 77.21% (Adult Social Care Survey, published October 2023).

The local authority told us about open forums, practice toolkits, and resources that focused on topics around people's protected characteristics. Staff were encouraged to disseminate their learning with colleagues who were unable to attend. However, we did not see much reflection of how an individuals' care assessments, plans or reviews understood their protected characteristics. Where appropriate, whole family assessments took place to ensure carers needs were identified and referrals for carers assessments were made.

Assessments for adult social care in the community and any subsequent care and support plans included people's medicines support needs. Funding was provided by the local authority to support the implementation of Electronic Medication Administration Records (EMAR) for homecare providers and older people's care homes. The local authority's quality band assessment tool routinely assessed that staff were well trained in administering medication, had the relevant competency assessments, and appropriate policies and procedures were in place.

Sometimes, carers found their experience depended on the social worker allocated and those who had continuity of social workers often described a better experience. Some described a battle to get help, however, most found staff to be helpful, ensuring they and the people they cared for got the care and support they needed. Some carers provided care themselves because they did not feel the care and support required could be provided by the local authority.

A trusted assessor approach was in place in Durham to support the effective and timely assessment of people's needs within care settings. This is where staff received additional training to enable them to carry out assessments. Frontline teams told us this had a positive impact on hospital discharge. Nurses, however, who were also trusted assessors, were reluctant to identify nursing needs on patients' records at discharge as they felt this information meant it would take longer for brokerage services to find suitable services to meet those needs. People then had their continuing healthcare assessment when in reablement provision and therefore were having another assessment in a relatively short period of time. The local authority told us that there was a 1% readmission rate from care homes to hospital following hospital discharge which they felt was positive and assured them that the placements were appropriate.

The local authority aimed to support people to live within the local area wherever possible, but out of area reviews were robustly managed where needed. Social workers and the review team members would travel to complete reviews in person.

Timeliness of assessments, care planning and reviews

The local authority had a clear focus on delivering timely assessments and reviews. The local authority defined their waiting lists as where people were awaiting the allocation of a named social worker. Waiting lists for an allocated social worker to complete care assessments, occupational therapy, and equipment assessments were in single figures at the time of our assessment. The local authority told us that the median time to complete care act assessments between June 2023 and May 2024 was 14 days, which was within their 28-day target. This meant that most people who used services were quickly given a named contact following a request for support. Their relevant assessment was completed within a short period of time.

Performance was monitored throughout the organisation and managers and leaders felt able to challenge timeliness of assessments where they had concerns. Frontline staff and leaders told us that rising complexity of needs was affecting the timeliness of completion of care assessments.

Staff were confident working in a strengths-based approach to complete reviews. People described reviews as exploring current and future needs. Social Care Direct as the front door to accessing services completed timely triage and assessment, often within the same day. The team effectively applied a risk rating to triage and contacted people to manage expectations around the completion of assessments, referrals, or the provision of equipment.

Staff also identified increasing numbers of referrals to services and complexity of people's needs as challenges that affected the timeliness of assessments, reviews, and care planning. Some staff felt they did not have enough time to fully understand and plan for the complexity of people's needs, especially when they were in crisis. Staff communicated well with people, for example in relation to any delays. Staff said that they had access to advice from specialists and were able to escalate concerns as required to managers. Senior leaders had an open door and met regularly to hear about concerns from staff. They were aware of the rising complexity of needs of people and challenges faced by frontline staff and were exploring how this impacted timeliness of assessments.

Staff told us there were often delays for health assessments, including psychology, mental health, and autism. Staff were able to access partner information systems, which supported the completion of thorough assessments. Using different information systems in different partner services sometimes created delays. Staff escalated concerns to managers when relevant to manage risks. Senior leaders were confident they understood risks and effective systems in place to manage these. Partner organisations told us that it was not always clear to people what services they could access while they waited, for example when awaiting autism assessments from health services. While awaiting a medical diagnosis, a person may still have eligible care and support needs, which the local authority should meet in these circumstances.

People received a mixed experience of reviews. Some people told us they received timely reviews, whereas others had to request them. Data provided by the local authority in June 2024 indicated that nearly 2000 people had not received a care review in the preceding 12 months. The median wait time, over this 12-month timescale, was improving, however. This was reflected in national data that 40.13% of people receiving long term support received a review (planned and or unplanned) in comparison to 57.14% as the England average (Short and Long-Term Support, published December 2023). The local authority had dedicated review teams who were clear on targets to improve waiting lists and processes had been changed to support the completion of reviews. The local authority had taken further action, due to start after our assessment, to complete overdue reviews from internal resource and an external agency, aiming to clear outstanding reviews by March 2025. Some good practice was reported from the mental health teams that a 'keeping in touch' approach was in place to support people on waiting lists.

The local authority's guidance indicated all care plans should be completed within 28 days and should be reviewed within 6 weeks of the start date of provision. The local authority did not assess the timeliness of care planning at the time of our assessment. Home care packages were monitored for any delays in start date, with only one person so far in 2024 waiting for at least one day. We were advised that there were no waiting lists for other types of care provision, however data relating to this was not available at the time of our assessment.

Assessment and care planning for unpaid carers, child's carers and child carers

Staff were clear when to refer carers to Durham County Carers Support, commissioned by the local authority, to provide informal assessments and support carers' needs. If a carer required a statutory assessment, this was referred into the local authority for completion. At the time of our assessment there was only one carer on the local authority's waiting list for a statutory carers' assessment. Durham County Carers Support and the local authority felt this arrangement reduced perceived stigma of assessment for carers and supported the prevention of escalation of needs through appropriate and proportionate assessment. Most carers we spoke with were unaware whether they had received a formal carers assessment but generally people could find the information they needed to get support. Further work had identified and reached 48,000 carers in need of low-level support and alternative ways and times to contact support services around their needs.

Durham County Carers Support provided a range of services including one to one support and advice, counselling, parent carer support, and training. Significantly fewer carers in County Durham, according to national data, experienced financial difficulties because of caring at 25%, compared to the England average of 42.81% (Survey of Adult Carers in England, published June 2022). The same survey also indicated significantly more carers felt they had control over their daily life (34.38%) compared to the rest of England (22.1%).

Feedback from older carers was that they were more reluctant to ask for help as they did not necessarily see themselves as carers. The local authority told us that most of the referrals to their carers' service were for older people and most attendees at their carer support groups were older people. Because of this, the local authority did not prioritise additional work with this group of carers. However, the local authority told us their 'keeping in touch' project aimed to proactively reach out to individual carers who had not had any contact with the local authority.

Several carers who were aware of support groups and forums but didn't access them because they didn't meet their circumstances. Some carers were unaware of support groups and forums. This was reflected in national data where 16.77% of carers were accessing a support group or someone to talk to in confidence in County Durham, which was much lower than the England average of 32.37% (Survey of Adult Carers, published June 2022).

Carers generally had a good experience of working with the local authority and Durham County Carers and they felt listened to. This was reflected in national data, which indicated 40.93% of carers were satisfied with social services, which was higher than the 36.27% England average (Survey of Adult Carers in England, published June 2022). 71.64% of carers felt involved or consulted as much as they wanted to be in discussions, which was better than the 64.95% England average (Survey of Adult Carers in England, published June 2022). Some carers had plans in place that meant they were able to take care of their own wellbeing. However, some of the carers we spoke with told us that short breaks, for example, were not always offered. Most of the carers we spoke with said their future needs had not been considered and that services were not always proactive in these discussions.

Young carers support and assessment was commissioned to Family Action by the local authority. This included young carers assessments, whole family support, and peer support. The Navigations Team completed carer reviews when a young person reached 18. Family Action took a whole family approach to assessments and worked with families for up to 6 months. Awareness campaigns to hear the voice of unpaid carers who were seldom heard, such as the Traveller communities, were highlighted. The organisation told us that there were 12-13 week waiting lists for young carers assessments, which were risk managed and high risks were supported quickly. Young carers were on the agenda of partners across the system in County Durham.

Carers worked with the local authority to develop the carers 'plan on a page' to reflect their priorities including to further support ethnically minoritised carers, carers with sensory support needs, and to improve the availability of respite care and advocacy.

Help for people to meet their non-eligible care and support needs

Services in County Durham supported people to understand services where they may not have had eligible care and support needs. The area's Social Care Direct team acted as the first point of call for contacts to the service had a good knowledge of services in the community. They were able to support individuals to find local services and organisations to provide support to people with non-eligible needs. Frontline teams had a good knowledge of community resources. Staff advised people with non-eligible care and support needs about their options and people were given information about providers outside of the local authority's framework to support their decision making. People with no recourse to public funds were supported by community organisations, and the local authority had directed resources to support individuals in this group.

Eligibility decisions for care and support

The local authority's framework for eligibility decisions was made available on their website. This clearly explained how eligibility criteria should be applied. National data showed that 66.51% of people in County Durham did not buy any additional care or support privately or paid more to 'top up' their care and support, which is roughly in line with the England average of 64.63% (Adult Social Care Survey, published October 2023).

The local authority did not have a formal process in place for appeals about Care Act eligibility decisions. They used local resolution to resolve disagreements related to the outcomes of assessments, managed within the operational management structure. Where resolution was not achieved, people who used services and carers were advised to make a formal complaint through the local authority's complaints procedure. Information from the local authority indicated that there was only one complaint made to them in the 12 months preceding our assessment about an eligibility decision, which was not upheld. Information about how to complain was easy to find on the council website. Clear timescales for response and how to raise complaints through the Local Government and Social Care Ombudsman were available.

Financial assessment and charging policy for care and support

The local authority's guidance to staff outlined clear processes around financial assessment. Information was made available to people during their assessment about charging, including information about specific types of care and support. People could provide their information via a secure online portal or via telephone assessment. The formal charging policy was available on the council's website. Some staff told us they were not always able to give clear information to people who paid for their own care and support about what their financial contributions would be. Staff told us that financial assessments took a long time and affected the timeliness of assessments. While this did not prevent services from being provided, it did cause anxiety and risked incurring debts for people in waiting to understand their financial contributions. The local authority told us that they commissioned brokerage services that had assisted people who paid for their own care and support to understand costs.

Weekly joint decision meetings were in place with partners across social care, commissioning, finance, and NHS services to discuss funding arrangements. Development work was ongoing at the time of our assessment to streamline the local authority's funding panel process. Staff had access to training about the new process.

Data provided by the local authority at the time of our assessment indicated that 82 individuals were on their financial assessment waiting list. The financial charging policy was the primary reason for complaints for the local authority over recent years. There were 23 complaints over the previous 12 months related to the outcomes of financial assessments. Themes from complaints around financial assessments were back-dated charging dates and the amount of disability related expenditure included in calculations. Eight appeals were upheld and 4 were ongoing at the time of our assessment. The local authority made improvements to their financial charging fact sheets and processes, and these were made available to individuals to support them to understand the charging policy. Internal audit services were used to assure financial activity.

There had been a gap when reporting financial assessment waiting lists and completion timelines linked to the deployment of the new case management system. An action plan was in place to resolve the issue.

Provision of independent advocacy

The local authority commissioned a partner to provide independent advocacy services. This covered all of aspects of advocacy services. An advocate can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations. Information about advocacy services was available on County Durham's Locate directory and provided in leaflets. Feedback from people who used advocacy services, including staff, indicated that advocates were seen as core members of the team around the individual. Advocates were active throughout capacity and care act assessments to support individuals to participate fully in the assessment and care planning processes.

At the time of our assessment, the provider was unable to take on any non-statutory advocacy work as they were at full capacity with statutory work. There were no waiting lists for care act advocacy or mental capacity advocacy at the time of our assessment. However, there were 5 to 6 month waiting lists for Relevant Person's Representatives to support Deprivation of Liberty Safeguards (DoLS) applications. Requests for advocacy were triaged, with urgent cases allocated on the same day, and light touch contact made regularly with people on their waiting lists.

Processes for accessing advocacy in the local authority had been reviewed over the last 12 months and that practice and recording had improved. The local authority recognised that there had been challenges with the initial contract and the advocacy organisation was affected by inherited waiting lists and recruitment challenges. Practice and commissioning teams worked together to review the contract following the recognition that there had not been enough capacity for advocacy services in the county. Though staff recruitment had taken place at the advocacy agency, supported by the local authority, waiting lists were still seen as a problem.

The Principal Social Worker supported frontline staff to understand the role of advocates and to more effectively identify when someone had been offered an advocate, when family and friends could be appropriate advocates, and when they had been used. These improvements were being implemented at the time of our assessment. This work focussed on how frontline staff understood, enabled, and recorded advocacy involvement. It was not clear whether there was sufficient capacity within the advocacy contract to meet the needs of the population or how this was being improved.

The referral process was described by staff as easy to use, either over the phone or online. Some staff told us that they needed to make multiple referrals for a person who required different advocacy services, even though the person would have the same advocate working with them. This made the process complicated and time-consuming. Advocates started work quickly once referrals were accepted.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

The local authority commissioned preventative services, ranging from information and advice, peer group support, carer breaks, and worked with community groups to deliver services locally. Services were available and sensitive to people's differing needs, such as carers and people with dementia.

Public Health initiatives were in place that focused on key challenges and priorities identified through the Joint Strategic Needs Assessment (JSNA) and health and wellbeing board. There was a clear link between the identified challenges of the area and the services available. These priorities and actions were well understood, and impact was monitored through the health and wellbeing board.

The Social Care Direct service was able to effectively direct people to a range of preventative services in the community that catered to people's early and more specialist needs. Staff across teams used Durham Locate which provided information about the services available across the county and knew about services in their communities. As a response to mental health needs in the county, the Durham Mental Wellbeing Alliance implemented a single point of access for referrals, so people did not have to repeat their story. The arrangements were in place to support earlier prevention. Most carers we spoke with said the support they have received from the local authority had helped them with their own mental wellbeing. They were signposted to appropriate services for their needs. National data indicated that 88.13% of carers found information and advice helpful, which was slightly better than the 84.47% England average (Survey of Adult Carers in England, published June 2022). However, several carers indicated they were aware of support, but they did not have enough time to attend support groups or felt that the support available did not suit their needs.

The local authority had recognised the increasing need and a gap in services to support people who hoarded and implemented the Breakthrough service. This was a practical, multi-agency service, with roots in trauma informed practice, which was still developing at the time of our assessment but was seen as having positive impact for people. There was a focus on exploring further on how services could better support people to remain independent in their own homes for longer.

While the public health strategic plan was clear, we did not see a comparable version for adult social care. We did not see how adult social care preventative activity was monitored, impact measured, or gaps identified. Activity within the local authority's register of services that prevent, reduce and delay need tended to focus on formal intervention and intermediate care and reablement, with fewer activities that delivered earlier prevention outside of public health. For example, some staff identified that there was a gap in earlier prevention services for older people and were unclear what was being done to resolve it.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver reablement and intermediate care services that supported people following a stay in hospital and to recover at home. The local authority recognised that there had been capacity issues and funding challenges that had affected their approach, and they were exploring the delivery of a new model at the time of our assessment. The local authority recognised that their offer focussed on supporting hospital discharge and missed opportunities to prevent, reduce, and delay the need for acute intervention. There was a recognised commitment within the local authority to innovate and improve in this area, taking a more preventative, therapy-led approach.

Three hospital discharge teams operated in the county, linked to each of the main acute hospitals and connected to the community hospitals. People were able to be discharged from hospital within 24 hours of being medically fit for discharge and the receipt of a referral. There were no waiting lists for hospital discharges at the time of our assessment. Homecare or care home beds were sourced quickly, and there were no delays to hospital discharge linked to lack of capacity in commissioned services.

The Transfer of Care Hub (TOCH) focussed on a person's needs to support speedier hospital discharge. This was a multi-disciplinary approach between the local authority and hospital teams, alongside housing and substance misuse teams where relevant. This was done in a person-centred way. For example, staff described support to an individual who was hoarding, and who would not allow therapists to enter their home. The TOCH worked with the individual and arranged to put support in place, funded by the local authority, to ensure the individual's priorities, alongside supporting their reablement and safety in their home.

Options were available to people as part of their reablement journey that reflected people's differing needs, including intermediate care beds, 'time to think' assessment beds with a maximum stay of 3 weeks, and short-term domiciliary intervention and reablement services for up to 6 weeks, and 'time to heal' beds for a maximum of 12 weeks. This linked into community rehabilitation services through Occupational Therapists and Physiotherapists as needed. Clear criteria were in place to ensure people received the right level of support. County Durham was in line with the England average for successful reablement with 84.27% of people aged 65 and over still at home 91 days after discharge from hospital into reablement or rehabilitation services, compared to the England average of 82.18% (Short and Long Term Support, published December 2023). However, national data indicated that 70.86% of people who received short term support no longer required further support, which was not as good as the 77.55% England average (Adult Social Care Outcomes Framework, published December 2023). The local authority had recognised that their reablement approach could be more preventative and they were exploring changes to their approach, particularly to increase capacity in their community reablement service, to improve this.

Access to equipment and home adaptations

People could access a range of equipment and home adaptations to maintain their independence and continue living in their own homes. People were supported by knowledgeable and conscientious staff across teams, integrated arrangements, and partnerships, via assessments of their needs and a responsive provision of equipment.

Occupational Therapists were integrated into teams and worked across social work and NHS teams. An equipment advisor worked within the county, providing independent information and advice for people who needed to purchase or hire equipment or make adaptations. An 'Independent Living House' was available for people to try equipment or technology before going through the process of buying or hiring this.

The local authority told us that they had very small waiting lists (less than 10) for the allocation of an Occupational Therapist to complete assessments. They told us that all assessments should be completed within 28 days and the median completion time for June 2023 to May 2024 was 26 days. Where waiting lists did arise, the local authority communicated well with people and used the risk threshold tool to allocate and triage effectively.

The local authority told us that 95% of their equipment was delivered on time, within a day or a week, for example equipment to support mobility like a Zimmer frame. Major installation of equipment, such as stairlifts, were in place within approximately 2 months. This was predominantly due to manufacturing time rather than delays in the local authority. Home adaptation such as accessible showers could take up to 6 months. New contracts to speed up people's waiting times for equipment and adaptations were ongoing at the time of our assessment. The Disabilities Facilities Grant was well utilised in the area to support home adaptations. There were delays in major home adaptations, when design and contractors were required and this was a lengthier process, due to availability of contractors within the wider market.

An online converted house was available to support staff to learn and understand equipment and adaptations available. This was mandatory learning for staff. Staff also told us that the local authority had an online portal to support people to check on the progress of their equipment provision enabling them to get updates independently.

Bariatric equipment was identified as a challenge by some local authority teams. This included how quickly equipment could be manufactured. There were close relationships with commissioning teams about challenges around contracts, sourcing appropriate suppliers, and managing best value for money so that issues could be addressed as quickly as possible.

The sensory team within the local authority worked with people with sight and/or hearing loss. They worked with wider teams, and were included in joint visits with social workers, housing colleagues, and home care agencies where packages of care were in place. The team advised and sourced equipment, and supported safety in the home and community. Examples were provided of the way the team effectively used equipment and technology to support people whose first language was not English or British Sign Language (BSL) to read braille.

Provision of accessible information and advice

People could access information and advice on their rights under the Care Act and ways to meet their care and support needs. In County Durham 70.64% of people who use services found it easy to find information about support, which was better than the England average of 66.26% (Adult Social Care Survey, published October 2023). This included unpaid carers where 67.68% of carers found it easy to access information and advice, which was better than the England average of 57.83% (Survey of Adult Carers in England, published June 2022). This was primarily through the local authority's Durham Locate website, or through their online policies and procedures portal, which had some accessibility features included. Social Care Direct was available over the phone to support people with information and advice and to find resources in the community to meet their needs. Some information was available in leaflets and through community-based locations such as libraries.

Specific needs were met through commissioned services. For example, a partner organisation was commissioned to provide information, advice and guidance services for people who are deaf, deafened, or deafblind. Another organisation provided information and advice to people with dementia and their carers and had specialist provision included for people with early onset dementia, people in the prison system, and veterans.

Some partners told us a lot of the local authority information was online, which disadvantaged people in rural areas who did not have access to robust internet connections. We received mixed feedback from partner organisations about how easy Durham's information was to navigate. Frontline staff told us they provided information in accessible formats. We heard examples of where information had been provided in over 30 different languages to support people seeking asylum and refugees.

Direct payments

There was a low uptake of direct payments in the local authority area as 15.02% of people who used services received direct payments. This was significantly lower than the England average of 26.22% (Adult Social Care Outcomes Framework, published October 2023). The local authority was aware of this, and several staff told us that there had been a drive to increase take up of direct payments. Teams had direct payments champions and training was provided to staff to understand and promote the use of direct payments.

The internal direct payments team offered support to people who accessed direct payments or their representatives. There was clear and robust local guidance on how to set up, support and audit direct payments. Support included facilitating recruitment of Personal Assistants. Individuals could access a service that worked alongside the council to support people with payroll services or to manage accounts. Personal Assistants were advertised on Durham Locate and with support through the local authority's commissioned recruitment tool. Personal Assistants were able to access support through the Care Academy.

Data from the local authority showed that 79 people who had ongoing care and support needs stopped receiving a direct payment in the 12 months preceding our assessment. Their analysis showed that people's needs changed, and they did not feel able to manage their direct payment, and often requested a commissioned service, or people moved into long term care. It was not clear if further analysis had taken place around other potential contributing factors, such as age, primary care reason, or what area of the county people lived in.

Transitions to direct payments were described as smooth and enabled independence, choice, and control. For example, one family where an individual had been supported to move into supported living. The person's parents were then employed as personal assistants through a direct payment, allowing the individual to settle into their new accommodation, while maintaining continuity of care. The local authority told us that they were exploring projects to support young people transitioning to adult services and people with a learning disability to use direct payments to support independent travel.

We heard from frontline staff that the availability of Personal Assistants was seen as a barrier to accessing direct payments. If an individual needed several Personal Assistants, recruiting could be a challenge and it could take time to get arrangements in place.

Information the local authority had about why the take up of direct payments was low, was anecdotal. Some staff felt that the strength of the domiciliary care market reduced people's need to explore alternatives that could be supported by direct payments. Others reflected that direct payments were complicated, people didn't want the stress, or they didn't have capacity to consider them at the time they were offered due to it being a difficult time, for example, as part of discharge from hospital. The local authority's commissioning intentions, for example through their market position statement, did not indicate how they intended to support the development of services that would help people to take up and use their direct payments.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority was aware of challenges for people in accessing and experiencing services based on their large geography, areas of deprivation, and transitory and settled populations (such as students and full-time residents). The local authority worked with partner agencies, including health and the voluntary and community sector, to understand the communities within the county, such as through the Joint Strategic Needs Assessment and Assets (JSNAA) and the accompanying 'deep dives'. Staff recognised that there were significant inequalities in their rural and coastal communities, which was affecting healthy life expectancy. Some staff described a postcode lottery, that commissioned and voluntary and community services were more available on the East coast and less so in other places. Transport was often described as a challenge, though some improvements to support accessibility were available. Public health initiatives could see where they were reaching people from areas of deprivation. There were some examples of where the local authority had responded to information that indicated people were not experiencing the same quality of outcomes. For example, the implementation of the Enable service, which had been successfully supporting increasing number of people with a learning disability into employment. The Health Squad was a locality-based approach working in partnership with health and voluntary and community sector agencies to deliver support. This approach reduced barriers in access to services for people who traditionally would not have come forward for support, including people experiencing homelessness and substance misuse.

Other characteristics of people's experiences were not always used to understand themes and trends on a deeper level to target work with communities. There was limited understanding or focus on communities of interest and where people's identity characteristics intersected. For example, we heard that older people who were also LGBT+ did not have their needs met, especially those in more rural areas.

In County Durham 96% of the population was white, with a small proportion of the population in other ethnic groups. Staff told us about some of the communities within the county, highlighting their local knowledge, such as about the Travelling and settled Gypsy and Roma communities. Staff also told us that it would be unlikely that the local authority could source culturally competent care specifically from the care market in the county. There was no strategic approach that built on this work and linked it into future planning. Speaking with staff who were closely linked to work with communities at risk of poor outcomes, indicated a clear understanding of the need of the local authority to recognise the changing demographic of people accessing services and respond. Leaders expressed confidence that their frontline services, based in their communities, understood those communities, and used a person-centred approach to understand and meet their needs. The local authority told us about some instances, such as for domestic abuse services and mental health services, where steps had been taken to commission specialist services in response to cultural needs. Training was available around equality, diversity, and inclusion, and there was specific local training, for example to support the Gypsy, Roma, and Traveller communities, which supported staff's knowledge and understanding.

The local authority had some regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. It utilised equality impact assessments when considering significant changes to services. There was a lack of data collected systemically across all services and analysis made which affected the local authority's ability to understand and improve the outcomes for people who are more likely to have poor care. The local authority recognised it had further work to do on co-production and work was recognised as improving in the area. A strategy that connected equity of experience and co-production across governance systems would benefit the local authority to better understand people's experiences.

Inclusion and accessibility arrangements

One partner we spoke with was pleased the local authority had retained phone lines and customer services points to facilitate appropriate access for people who found the website difficult to navigate or who were unable to access it. Organisations told us that information was regularly provided in languages other than English. The local authority was aware and responsive to these issues. The interpreter service was available out of hours to support people flexibly.

Outreach services were in place through public health to support people who traditionally wouldn't have come forward for support. This included integrated services people who were homeless or had substance misuse issues for example. This changed over time to support other communities who were reluctant or unable to travel to services and was more accessible.

Social workers supporting people with hearing impairment were qualified to level 2 and 3 in British Sign Language (BSL) or BSL was their first language. An interpreter service was in place, including the use of Signlive, at all County Durham access points. Frontline staff teams told us that there was a shortage of BSL interpreters in the region and this was affecting some people's experience, especially for health appointments or for people in the criminal justice system. The sensory team used creative solutions, such as apps and websites, to communicate with people during appointments where this proved difficult.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

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 the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders using available data to understand local needs for care and support. County Durham expanded their Joint Strategic Needs Assessment to include assets (JSNAA). This meant they were able to see their assessments of needs within the context of the strengths of their communities. Communities were seen as integral stakeholders to understanding specific needs. For example, the ageing well workstream of the health and wellbeing board expanded their work to people aged 50 and over to take a more preventative approach, with more focus on veterans, carers, and dementia. This activity tended to focus on public health than specifically for people using adult care services. Services used the information available to understand potential future needs for services.

The local authority made information available from their JSNAA through Durham Insight. This was an online tool that provided information through infographics to support people in the county to use and understand the key challenges identified. For example, life expectancy and healthy life expectancy was identified as significantly lower in County Durham than England for men and women, and more so in deprived areas of the county. The data was used to inform the health and wellbeing strategy and the approach to prevent, reduce, and delay need. Data was regularly updated and used to understand impact and performance in relation to long term public health intervention. Some information about communities who were more likely to experience poorer outcomes was identified, such as for deprived areas. This recognition did influence how services were designed and delivered, for example, where locality services were based in order to have most impact for people in the county. There was limited information that identified how people's protected characteristics affected their experiences, though the local authority did identify some instances, such as domestic abuse, learning disability and mental health services in which this had taken place. However, this was not reflected in a specific focus on how people's experiences were fully considered into outlined commissioning intentions, such as in the Market Position Statement.

The local authority worked with another organisation and linked this work with Durham County Carers Support. They had identified 48,000 carers in the county who required low level support and had developed a service to understand and deliver support. There were regular events in which carers were able to feedback and shape future care provision.

Commissioning teams maintained good relationships with frontline staff who felt they were able to feed into gaps in services and where there were local needs that the care market may be able to fill. Staff were not always sure how resolutions to gaps in services were progressing. Staff were not sure they would be able to source culturally competent care and that provision was fully able to meet people's cultural needs.

Market shaping and commissioning to meet local needs

People had access to a range of local support options across the county including for nursing, residential, supported living, extra care, and day opportunities. National data indicated that 67.48% of people felt they had choice over the services they used. This was in line with the England average of 69.81% (Adult Social Care Survey, published October 2023).

The local authority worked with health to jointly commission services for adults, children, and young people. The local authority's Market Position Statement and Market Sustainability Plan highlighted joint priorities and approaches. This included being a key contributor to the development of the draft housing strategy principles and market position statement to ensure local alignment. For example, the local authority was able to demonstrate that their coordinated approach had supported people to remain at home with appropriate care and support in place. This had increased the age when people were being admitted to residential care due to this approach. This integrated approach also enabled services to plan for young people's transition to adult services, supporting continuity and reducing families' anxiety about transition. Services were able to view capacity, quality, and sustainability across a broad range of factors.

Where gaps were noted, commissioning strategies were developed. Staff predominantly liaised with providers and frontline services and used data to understand issues. People who used services were generally only involved in service changes at the point of contract reviews and were not actively involved in many early discussions about new provision. People had limited involvement in helping the local authority understand and shape the care market. Survey results from people who moved into care or nursing homes were collected and used to support developments. The local authority had recognised they needed to develop their approach to co-production, for example of the monitoring of quality and design of new or alternative provision. There were plans in place to further involve people with commissioning activity.

Commissioning strategies and market shaping activity supported prevention and delaying people's need for care and support. They focused on developing recognised good practice and supporting the market to deliver person-centred care as a standard for the county. Commissioning approaches were integrated and maintained a focus on the objectives of partner agencies.

The local authority commissioned homecare mainly through their framework arrangements, as a shortlist of preferred providers. Spot purchasing from providers who were not on the framework was available. This approach supported people's choice and control regarding their preferred provider or to support their needs.

There were delays in mental health service provision linked to mixed diagnosis of people or provider breakdown whey they felt they could no longer meet people's needs. Commissioners were working together with a local health trust to source placements. There was a recognition that hospital environments were not effectively able to support people but a lack of providers willing to work with this group of people was affecting people's experiences. People had less choice about their placement or were unable to live as independently as they wanted with appropriate care and support. The local authority recognised that their commissioning approach prioritised filling vacancies within existing provision and choice was supported where possible. The local authority was expanding their range of single person and dispersed properties at the time of our assessment.

The JSNAA had identified mental health and suicide as a significant challenge in County Durham. Approximately 1 in 5 people in County Durham have poor mental health and the suicide rate for people aged over 10 is significantly higher than the region and England averages. In response, the local authority developed the Durham Mental Wellbeing Alliance as a collective of voluntary, community and faith sector agencies and providers. They recognised issues regarding mental health and suicide and collaborated with commissioners to bring in a different way of commissioning that responded quickly to changing need, including through low need mental health and wellbeing in a preventative approach.

Developments were ongoing regarding supported living services, where gaps had been identified related to the availability of single person accommodation for people with mental health needs or people with a learning disability. There was an ongoing shift from shared housing to smaller bungalows or flats that supported this area in line with people's preferences. Commissioning staff were exploring social rehabilitation models within this provision and identified that they had creativity within the design approach and budget arrangements to make this work for the future.

There was specific consideration for the provision of services to meet the needs of unpaid carers. Durham County Carers Support was commissioned to provide support services for carers in the county. National data indicated that 13.6% of carers were accessing support or services allowing them to take a break from caring at short notice or in an emergency, which was higher than the England average of 10.76% (Survey of Adult Carers in England, published June 2022). The same data indicated that 20.51% of carers were able to take a break from caring for more than 24 hours, which was better than the 13.56% England average. Carers, partner agencies, and frontline staff told us this was still an area that should grow, specifically where carers were supporting people with learning disabilities.

The local authority was aware of challenges related to bariatric care and had worked with providers to increase available beds and equipment. This was ongoing work, as equipment and adaptations were in place but not all providers felt care plans reflected the additional care workers required to support bariatric patients and it could be hard to ensure they were paid for this.

Ensuring sufficient capacity in local services to meet demand

Information provided by County Durham indicated that they had no waiting lists for homecare provision or care homes. People had no delays in hospital discharge due to capacity issues within the market. There was sufficient capacity for intermediate care beds, which were effectively spread across the county to ensure people were able to remain local.

Staff groups and organisations told us that there was not sufficient respite provision in the county. This included bed-based provision and short term generally and specifically for people with a learning disability, partly linked to the temporary closure of internal provision for refurbishment. Access to mental health crisis beds and more general mental health provision was a key area staff felt needed more provision. Staff felt there was also a gap in provision of community services for older people and people with a learning disability. The local authority told us that they were developing future service delivery based on these issues.

There was minimal need for people to use services or support in places outside of their local area. When support was being accessed from outside of the area, this was predominantly due to personal choice or to be close to family. The local authority placed 38 people in the last 12 months outside of the area. Reviews for people placed outside of the area were robustly managed. Six monthly assurance updates were provided to Durham Safeguarding Adults Board concerning people with learning disabilities in out of area placements. All out of area placements had been reviewed. For those who were assessed as potentially having their needs met in County Durham, each person's circumstances were monitored through a Provisions Development Group which met monthly. Plans were at various stages of development to identify opportunities in County Durham to meet individual needs.

The local authority's joint commissioning arrangements were well established and integrated providing a county wide view of provision. Staff within commissioning carried out quality assurance and contract monitoring as part of their roles. The integrated commissioning structure had sufficient oversight of services across the county. There were sometimes challenges for voluntary, community and faith sector organisations who may be funded by other parts of the organisation or through arrangements outside of the integrated commissioning function with conflicting or challenging monitoring requirements. Organisations reflected that alignment here would support them to deliver services to people in the county. The local authority was aware of this and looking at ways to improve it through the County Durham Together Partnership working group.

Ensuring quality of local services

The local authority had clear arrangements in place to monitor the quality of commissioned care and support services. Commissioning teams had oversight of quality and used a quality band assessment tool that was developed and adapted by the county council to the different provider sectors. The tool provides a robust and detailed scoring benchmark across 16 areas including nutrition, environment, medication, and risk. A threshold for further support was applied. According to our information on regulated services, 86% of care providers in the county are good or outstanding.

The practice improvement team worked closely with commissioners to identify patterns in safeguarding contacts and enquiries and support quality and practice improvement. There were links between safeguarding practice and overall quality improvement for a provider. The quality band assessment tool used by commissioning staff also covered safeguarding. Practice improvement staff were involved following an incident or pattern of incidents.

Internal teams communicated well regarding suspended providers. At the time of our assessment, 16 providers had been at one of the stages within the local authority's executive strategy process that identified concerns around providers. In total 5 had been suspended throughout the year, with only 1 active at the time of our assessment. Themes included medication errors, safeguarding concerns, staff culture and environment. The local authority had a robust process in place to work with providers to improve. Managers and leaders recognised how changes in quality within the care sector could quickly affect other parts of the system and were well sighted on information.

The local authority had established a Supporting the Provider Market (STPM) team to collaborate with partners and providers to further improve quality of services and support market stability and sustainability. The STPM team supported social care providers with recruitment, retention, training, and development through the County Durham Care Academy and assisting providers with digital developments and opportunities and service improvement, including funding for technology initiatives, for example.

Ensuring local services are sustainable

The local authority used the Market Sustainability and Improvement Fund to increase fee rates to social care providers and to increase the adult social care workforce. As the fund was not available for the integrated care and hospital funded provision, the local authority recognised a potential risk that the fee uplifts to part of the market only would destabilise system provision. Temporary workforce payments were released ahead of expected demand in the run up to winter 2023 to mitigate any market destabilisation. Fee rate uplifts were applied for all domiciliary care agencies commissioned through the integrated commissioning team to support continued operation and rurality payments were available to maintain the market.

The local authority proactively engaged with providers on their cost of care exercise to understand pressures and main areas of concern. For example, recognising a significant factor was increasing costs for building-based services, the Council agreed a revised model, in partnership with provider representatives to reflect these factors. This created a targeted and market specific approach to support providers to meet the challenges of rising costs. A similar approach was seen in homecare services. This enhanced uplift was seen as having significant impact on market stability.

The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping with them. Staff maintained good relationships with providers and provider forums were in place, tailored to the type of services commissioned, to support open discussion. Providers told us they felt listened to and the local authority was transparent.

Information from the local authority indicated at the time of our assessment that 7 providers were either decommissioned or handed back contracts over the previous 12-month period, affecting around 80 people, across nursing, residential care, day care for older people and people with a learning disability or mental health needs, supported living and home care. Predominantly reasons for closure were financial viability and leaseholder changes, but recruitment of nursing staff was also a factor. In this case, the residential care home side of the provider remained open, and the local authority worked with the provider to reassess each residents needs to ensure appropriate provision. There was a good understanding of the factors that cause provider failure, as evidenced by market sustainability plans and the cost of care exercises. Providers and commissioners described good working relationships, alongside the quality band assessment tool that allowed them to manage and share any risks.

Recruitment and retention of staff within the local authority was seen as a key concern for partner organisations and they did not feel they knew about any actions and further developments in relation to this. The local authority recognised workforce risks, particularly in meeting increasing demands for services within existing budgets. The strategy set out induction, learning and apprenticeships as mitigating factors. Many of the staff we spoke to had worked at the local authority for a long time and retention was generally seen as good. It was seen as positive that the mental health team had been fully staffed when this had previously been a challenge.

The recruitment of Personal Assistants was described as challenging and a possibly contributing factor to the low take-up of Direct Payments in the area. We were unaware of any plans that supported the increase of the number of Personal Assistants in the area and they were not included in the existing local authority workforce development strategy. The local authority told us they planned to include Personal Assistants in their Commissioning Workforce Development Strategy that was in development at the time of our assessment.

The local authority used its quality band assessment to ensure care sector staff were working in safe environments and with appropriate working conditions. An inflationary uplift to the local authority's hourly rate was provided to domiciliary care providers to ensure a minimum pay rate above the national living wage and to support retention and recruitment. A requirement to pay staff travel time was not covered in their quality band assessment tool and the local authority chose not to monitor this in any other way. Local authorities have a duty under the Care Act 2014 to foster a workforce whose members are able to ensure the delivery of high-quality services (because, for example, they have relevant skills and appropriate working conditions). The local authority felt that their contractual terms were sufficient to ensure this was the case.

The local authority had developed the Care Academy as a local solution to challenges with recruitment in the sector. This included the development and delivery of training courses from entry level through to management qualifications. The service recognised gaps in terms of care workers being unable to drive, that affected provision in more rural areas of the county. The Care Academy supported individuals to complete their driving tests and reduce the impact of this issue across the county and ensure more people in rural areas were supported. The local authority told us that the work through their Care Academy was instrumental in removing any waiting lists for homecare and that the Care Academy had supported the recruitment of over 100 care workers in the county in the last 2 years. This is reflected in improving national data, where 56.03% of sector staff had completed or were in progress of completing the care certificate, which was better than the England average of 49.65% (Skills for Care, published October 2023). The area had a lower job vacancy rate in the sector of 8.4% compared to the 9.74% England average (Skills for Care, published October 2023). The local authority felt the Care Academy was integral to the quality and sustainability of the care market which was an important factor in people's experience of care and support in the county.

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.

Theme 3: How County Durham ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

The local authority understood the risks to people across their care journeys. They worked with health partners to ensure people were safe during transitions. Regular meetings took place, both operationally and strategically, to understand and respond to any risks. The local authority and partnerships had recognised where demand on hospital admission was increasing for people aged over 65. They were exploring how their reablement could be adapted to support reduction in hospital admission for this group. The Better Care Fund was used to support this work.

Work was ongoing to support people who were presenting as homeless in the county. There was a perceived increase in complexity of need, including care and support needs and substance misuse. Pathways existed but staff were not sure these were sufficient. The local authority was mindful of the challenges and had dedicated social workers supporting the homelessness team to identify substance misuse issues and support people into accommodation. Services were focused on safety and preventing future needs.

Senior staff and practice development teams reviewed areas for improvement in social work pathways and processes. Specific work took place to improve recording of information to support safety management, including in the importance of current mental capacity assessments and best interest decision making.

Staff took risk positive approaches with people who used services. Risk assessment and contingency planning in conjunction with people who used services ensured a personalised approach that was mindful and supportive of people's lives, priorities, and needs. People indicated supportive transitions from hospital to their communities.

Safety during transitions

The local authority did not have one transition pathway, but each team outlined within their own practice frameworks how transitions were managed. Where a person's care and support needs were stable, their case management transferred to the relevant annual review team. Where a person's needs became primarily health-related, funding and case management would transfer to the Integrated Care Board. Transfers generally involved manager to manager discussions, the option for pre-transfer multi-disciplinary team meetings, joint visits which would include advocates where relevant, and a planned period of co-working if needed. This happened before the case management recording system transfer was completed. People told us that transitions to new staff or teams was well communicated, their wishes and feelings were well considered, continuity of care was maintained, and handovers were robust.

All referrals for local authority adult care services were managed through the Social Care Direct team, which created a robust audit trail and allowed oversight of service activity. This made pathways clear.

The Navigations team supported young people to move from children to adults' services. On average they started working with young people around 15 years old, but were aiming to do this earlier, in line with recognised good practice. This had improved in recent years from starting this work when the young person was 17 or 18. The Transitions Forum, introduced in 2023 highlighted early transition referrals and was having an impact on reducing the referral age, further supporting robust and smooth transitions. People we spoke to had a good experience of young people's transition services. Young people were able to share their wishes and views at multi-disciplinary meetings, supported by staff who respected and included them. Direct payments were being used to provide more personalised services and were seen as helpful in supporting transitions by providing flexibility.

There wasn't anyone in specialist learning disability beds in the county at the time of our assessment. Colleagues at a local health trust described the investment in social accommodation that was responsive to needs in the county through Transforming Care. This supported effective discharge at the earliest opportunity. There were some identified challenges in ensuring there was sufficient accommodation that supported the complex needs of people who were discharged from learning disability specialist beds. The local authority was developing models to support this.

Very few people who were a usual resident of the local authority area were placed out of the county, with the majority of those placed within the region. There was a robust process for agreeing out of county placements. Social Workers or the review teams completed reviews for people placed out of county in person. Commissioning teams reviewed monitoring visit reports and contracts with host local authorities before agreeing out of county placements. They maintained relationships with teams in host authorities to be informed of any concerns arising in provision.

Contingency planning

Plans were in place across adult care services, including for frontline services and the integrated commissioning service, to support business continuity in the case of interruptions to provision of care and support, including for staff, ICT, cyber incidents, and utilities disruptions. Plans had recently been reviewed.

Care home closure and provider de-commissioning protocols were in place which had been used within the 12 months preceding our assessment. Executive Strategy Meetings were utilised to manage serious concerns about provider quality or safeguarding, in conjunction with the practice improvement team.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

All staff had access to and used the safeguarding risk threshold tool developed through the Safeguarding Adults Board. This supported staff to understand safeguarding risks and how concerns would be dealt with. There was clarity on what constituted a section 42 enquiry, and this was applied consistently and supported by 'risk factor' training. A Section 42 enquiry is a legal requirement under the Care Act 2014 for local authorities to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. Approximately 2 in 5 safeguarding concerns raised with the local authority between April 2022 and March 2023 became section 42 enquiries. Some staff told us that they thought the risk factor tool worked well but needed further development, for example to support people with concerns about hoarding. Self-neglect and hoarding were recognised as growing areas of need within the county. The local authority was working with the Safeguarding Adults Board to develop the tool further to account for this at the time of our assessment.

National data showed that people felt safe. 91.15% of people who used services said those services made them feel safe, which was better than the 85.63% England average (Adult Social Care Survey, published October 2023). 89.24% of carers felt safe, which was significantly better than the 80.51% England average (Survey of Adult Carers in England, published June 2022).

Guidance for internal local authority services was clear, in terms of both individual safeguarding concerns and concerns about organisations. The recording information system used by the local authority supported this process and allowed for follow up on progress as needed. Concerns linked to providers were able to be supported through the Practice Improvement Team. These establishment concerns included significant level of concerns about a provider, where several concerns had been identified over time, and the risk to people using the service. This team connected with commissioning staff to support quality improvement and provided a robust response to potential organisational abuse situations.

Some staff described a two-tier system, where some people received a high standard of safeguarding enquiry, and others didn't due to the range of staff skills and experience. Not all staff were confident in each other's skills to complete safeguarding enquiries. This applied across the sector. National data indicated that skills were in line with England averages. Skills for Care estimated 40.34% of staff within the area completed Mental Capacity Act Deprivation of Liberty Safeguards training, and 55.98% of this group completed safeguarding adults training (information published October 2023). Staff felt they had access to appropriate reflective supervision and support.

Relationships between partners were a strength of the area. This was seen at strategic levels and operationally. For example, police met with safeguarding and commissioning every 3 months to share intelligence, themes, and any practice issues. Quality assurance boards linked into the Care Academy to support training development and delivery. The local authority worked with the Safeguarding Adults Board and partners to deliver a co-ordinated approach to safeguarding adults in the area. Some staff did identify that shared access to systems would help to improve people's experience of safeguarding.

Responding to local safeguarding risks and issues

The local authority worked well with the Safeguarding Adults Board. There was clear strategic alignment and prioritisation of significant safeguarding activity for the county at an executive level. Chief Officers of partnership organisations met regularly to share information, aiming to ensure learning was shared across organisations in the system. The Safeguarding Adults Board maintained a clear focus on actions and outcomes following serious incidents.

There was a clear understanding of the safeguarding risks and issues in the area. The local authority was part of the Chief Officer safeguarding group including the Chief of Police, Integrated Care Board representatives, representatives from health trusts, and the children and young people's director. The group was an opportunity for Chief Officers to have challenging conversations about issues such as how changes to ‘right care, right person’ would be implemented. This reduced risks and improved people’s experience of crisis responses.

The local authority area recognised rising numbers of people affected by self-neglect and hoarding in both safeguarding enquiries and Safeguarding Adults Reviews. There was partnership across different activities to ensure a robust set of actions to reduce this identified need. The Breakthrough service was developed to support people who were hoarding. A working group was set up to respond to a Safeguarding Adult Review involving an individual’s death linked to their home environment. An analysis of the use of advocacy for mental capacity linked to self-neglect took place to ensure this was being used appropriately. Resources developed through the Safeguarding Adults Partnership were shared with staff around mental capacity to support their practice. Lessons were learned when people had experienced serious abuse or neglect and action was taken to reduce future risks and drive best practice.

Leaders described a learning culture, with summits to review the actions and learning from recent Safeguarding Adults Reviews. 'Toxic Cultures' training had been identified as a local priority and a training course had been developed attended by staff across local authority, independent and voluntary and charity sector organisations. Frontline staff could not always describe learning from serious incidents or Safeguarding Adults Reviews, outside of where they had been specifically involved in an enquiry or investigation.

Responding to concerns and undertaking Section 42 enquiries

The Social Care Direct team initially triaged all safeguarding contacts and assigned them to relevant teams. This resulted in minimal waiting times for initial reviews or awaiting allocation to staff. Data quality was monitored well through their case management system which had an impact on timeliness of completion of section 42 enquiries. We heard from senior leaders that safeguarding enquiries were not always dealt with in a timely way following allocation and these had 'stacked up'. Audit activity had identified this issue and better recording and practice had improved this situation.

Some staff and organisations felt the safeguarding concerns system needed to improve as it was difficult to raise concerns for some. Some delays at Social Care Direct had been noted, though progress had been made at the time of our assessment to improve this. Some staff told us that there were delays especially when awaiting support or information from the police. Relevant agencies were not always informed of the outcomes of safeguarding enquiries. The local authority was working on improving this with people who use services. Training was available to staff across the local authority and partner agencies to support them to raise concerns effectively.

In local authority cases, the appropriate team was allocated. Sufficiently complex concerns were managed through the Adult Protection Team. These allocations accounted for approximately 10% of all enquiries between April 2022 and March 2023. This team were approached by people working in the sector regularly for advice. We heard examples of complex safeguarding issues that required careful and diligent management to reach resolutions that were person-centred and positive for the individual concerned. The team often had to describe their roles because Adult Protection was not always a well understood or modern term to describe their function. Feedback from some staff was that this team felt stretched, and this had caused delays and backlogs.

Timeliness of completion of section 42 enquiries was improving in the local authority following targeted work. The local authority's data indicated that approximately 90% of enquiries were completed within their 91-day timescale in April and May 2024, compared to 77% between April 2022 and March 2023. Recording practices and appropriate completion of mental capacity assessments had contributed to this improvement. This was led by the Principal Social Worker in conjunction with appropriate managers. National data indicated that the number of safeguarding concerns and subsequent section 42 enquiries was higher between April 2022 and March 2023 than in the previous 2 years, which could impact on how busy it felt to staff. Many staff we spoke to recognised increasing complexity of needs at the point of contact.

When safeguarding enquiries were conducted by another agency, for example a care or health provider, it was not clear how the local authority assured the robustness or quality of planning or outcomes for the person involved in line with their Care Act duties. The Practice Improvement Team were able to support care providers, though did not support enquiries about individuals. For internal local authority teams, operational managers signed off all enquiries. However, mechanisms that enabled the local authority to decide on the actions to be taken and by whom were not evident on enquiries completed by all partner agencies. A process was in place when safeguarding enquiries involved other local authorities or where an individual's care and support was funded through certain joint health arrangements.

Completion of Deprivation of Liberty Safeguards (DoLS) was improving. Data provided by the local authority indicated that they had greatly reduced their DoLS waiting list over the previous 18 months. They said that they were now very close to achieving their monthly completion target. The local authority was defining how they maintained this at the time of our assessment.

Making safeguarding personal

Staff gave examples of when safeguarding enquiries were carried out sensitively and focused on the wishes and best interest of a person. Some staff told us that making safeguarding personal wasn't something they were sure everyone in the sector or all internal teams understood and could apply to enquiries for individuals.

Advocates were not always referred to and involved at the right time with safeguarding concerns, with some instances of referrals taking place after the enquiry was concluded. This aligns with national data where 32.64% of individuals lacking capacity were supported by an advocate, family, or a friend, which was much lower than the England average of 83.12% (Safeguarding Adults Collection, published September 2023). This was a feature of recent Safeguarding Adult Reviews. The local authority was aware and further training, including on recording advocacy, was ongoing. They had also recognised capacity issues in their advocacy contract and were working to resolve this.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

There was a culture of performance within the local authority where clear data and people's experiences were used to understand the local authority's delivery of Care Act duties. The local authority had worked over the last year to adapt their data reports to ensure performance was easy to track for councillors, including the lead member, shadow lead member, and chair of the overview and scrutiny committee. This allowed for timely challenge and monitoring.

There were links between the local authority's internal and political governance systems and the Durham County Care Partnership Executive. This included system senior leaders from the health trusts and Integrated Care Board, representatives from the voluntary and community sector, Healthwatch, the Durham University. The group focussed on system management and finance pressures and improving outcomes for people in the county.

The Principal Social Worker (PSW) had regular meetings with the Director of Adult Social Services (DASS). They were part of the oversight and assurance group and quality assurance board as well as with regional work. This ensured there was visibility and assurance from and on practice. However, strategic managers for the appropriate operational area oversaw fitness to practice issues in the local authority, supported by the Human Resources. We heard that the PSW was not involved in this. The role and responsibilities for adult principal social worker guidance from the Department of Health and Social Care (published July 2019), indicates that PSWs are responsible for advising the DASS on fitness to practice issues when they occur. There was a risk that these were not overseen in a way in line with recommended good practice.

There was a stable adult social care leadership team with clear roles, responsibilities, and accountabilities. Staff felt that leaders were visible, capable, and compassionate. The DASS had an open-door approach. Staff were able to influence the focus on practice development sessions through their suggestions. Social work forums, staff roadshows, and heads of service events were all described as ways staff felt supported. Staff felt able to raise concerns and understood where to go to get help.

The local authority's political and executive leaders were well briefed about many of the potential risks facing adult social care. Councillors felt they were provided with the information they needed to effectively understand their portfolio or function. Councillors from both the administration and opposition supported and believed in officers and were keen ambassadors for people. Adult social care did not appear to have a strong focus in scrutiny. Health issues were dominating overview and scrutiny committee and the health and wellbeing board. The significant change for the Integrated Care System and any concerns that this would destabilise any existing integration arrangements in County Durham contributed to this issue.

There was some reflection that there was limited involvement of people who use services in the governance systems that managed adult social care activity. The Health and Wellbeing Board meetings, for example, had previously rotated around community venues but had settled in County Hall in recent years. This was seen as a potential barrier to people's involvement and a limitation of the governance system in understanding the communities of County Durham.

Risks were reflected in the corporate risk register and considered in decisions across the wider council. This had been a recent shift for adult and health services, who had been seen as very stable and consistent in terms of budget. Senior leaders were keen that the council was not complacent about adult and health service performance and leaders were aware of the risks to the service and people's experiences and outcomes. Partners told us that the local authority was proactive and robust in their self-assessment and assurance processes, for example through challenge clinics.

Strategic planning

The local authority used information about risks, performance, some inequalities information, and outcomes to work with partners to develop the Joint Health and Wellbeing Strategy. This provided a focus on the key challenges highlighted in their Joint Strategic Needs Assessment and Assets (JSNAA) through to priority actions that were well monitored and tracked. These impacted on the experiences of people who used health and social care services and formed the backbone of very early preventative work within the county. Deep dives into the needs assessments were explored with people and organisations in the community. Action plans were co-designed with these groups, for example in the way the Ageing Well workstream began considering ageing from age 50, rather than 65.

Strategies, such as the workforce strategy, market shaping and sustainability planning, and technology enabled care (TEC) strategy were driven by data and insight and were increasingly including people through co-production. For example, we heard about the virtual carers project, which aimed to provide information, advice, and guidance to carers in a virtual arena, which was accessible at any time for carers. In these pieces of work, we saw clear analysis to support the allocation of resources and actions that were progressing. Partners and providers reflected that the local authority took a proactive approach to managing risks, for example in its internal and care market workforce, to reduce the impact.

There was not an overarching strategy that focussed on the needs of people who use adult social care services in County Durham. Many of the initiatives and areas of good practice, such as the work with the local authority's prison population, or in supporting first time entrants to the county, felt compartmentalised. An overarching strategy may have supported the activity of the directorate to feel cohesive, ambitious, and focused.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records, and data management systems. This included training for staff, and updated training where issues were identified, such as in recording Mental Capacity Act assessments. Easier access to mental health partner systems was recognised as something that would improve people's outcomes and reduce risk of missing information in either source system.

Some personal information was shared across social care services and the NHS, primarily through NHS numbers to maintain data safety. Privacy notices in line with the General Data Protection Regulations (GDPR) were available on the local authority's website for each of the services within social care and health. General principles were summarised on the website in plain language to support people to understand them. People were informed of their information rights. Contractual arrangements supported information security. The local authority was a partner in a recording system with the Integrated Care System called the Great North Care Record which some staff teams had access to and used regularly.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

There was a positive culture of continuous learning and improvement in the local authority. Staff had ongoing access to learning and support so that Care Act duties were delivered safely and effectively. Learning and development were shared across the sector through strong infrastructure arrangements such as the Supporting the Provider Market Team and Care Academy. The local authority was improving its response to hoarding as a challenging issue in the area through the development of the Breakthrough service.

Staff received appropriate training and support to be able to carry out assessments in line with their job roles and in most cases had time to keep up to date with training. Some specialist training was identified and delivered to support staff groups who needed it, such as for substance misuse, autism, and hoarding in the mental health teams. The local authority's review of their reablement service, for example, found a minimal specialist training offer. Plans were in place to develop the reablement service to improve this.

Staff felt there was support for continuous professional development, though some found high caseloads made this hard to complete and there was not always protected time to do training. Some staff were unaware that specific Care Act training was available from the local authority to support continuing professional development.

In some instances, we received mixed feedback from staff on different staff groups' training or knowledge level. Not all staff were confident that there was a consistency of quality of mental capacity assessments across the area, for example, in staff's understanding of executive functioning. Not all staff in locality teams understood the level of experience or knowledge within the Social Care Direct team and expressed concerns that this created variation in how assessments were progressed. Frontline staff told us that the new hub model had helped to improve low morale for some staff. There was some disconnect between teams about understanding each other's roles, skills, and experience which may have been linked to structural changes. Staff felt more focused reviews of teams and communication across the service would help this.

There were opportunities for reflective supervision and peer support, and most staff felt supported by their line managers, specialists, and teams. Focused practice development groups were held monthly on identified areas of improvement needed, such as the Mental Capacity Act 2005 and Deprivations of Liberty Safeguards (DoLS). Partner organisations were connected into team meetings to share their services and improve people's experiences.

The local authority recognised co-production was an area of development for them. There was an increasing focus on this work and the local authority had developed a 'rainbow of coproduction' toolkit which had been used effectively in several projects, for example, with carers to develop the carers 'plan on a page'. Carers were part of focus groups with the local authority and wider partners, including health and the voluntary and community sector, to ensure focus on their priorities, such as increased support to carers from minority ethnic backgrounds and those with sensory support needs, as well as increased availability of respite care and advocacy services.

Pilot schemes were ongoing around digital innovation. This included touch screen surveys and the Independent Living House which had all increased and improved people's independence and outcomes. Staff were excited about these opportunities and saw the possibilities for improved outcomes for people who used services when expanded across the service.

The local authority was well connected into regional work in the North-East region, including through the North-East Association of Directors of Adult Social Services (ADASS) group and the regional Directors of Public Health group as well as into the North-West and North Yorkshire. The local authority was involved in sector led improvement, with a key focus on the region's approach to international recruitment and supporting the care market. There was work ongoing with Durham University regarding research and connectivity across the system. There was a push to work with the university with the service on the doorstep in the county, rather than more broadly across the region. A recent marketplace on their research and projects from the university took place and staff were encouraged to support and learn.

Learning from feedback

The local authority learned from people's feedback about their experiences of care and support and made improvements. They worked with carers to recognise where services could improve or in coproduction with communities to redesign their Durham Locate service, which was ongoing at the time of our assessment.

The local authority was open to feedback from staff about what was working and what needed to improve. Staff felt managers and senior leaders were open, visible, and responsive. The Principal Social Worker and practice development team disseminated information and learning from audits. Not all teams knew about themes from complaints or general learning and how this was connected to people's feedback, which made some learning isolated.

The local authority had a robust response to complaints. Local authority data showed that there were 118 complaints received between February 2023 and January 2024. A slight increase in complaints had been noted over recent years but the proportion upheld was declining. A complaints officer for the service reviewed each complaint response to identify actions and learning. Examples of this included internal process improvements regarding Direct Debit instruction or advice to Registered Managers about the importance of wearing identification to support people's safety. National data from the Local Government and Social Care Ombudsman (LGSCO) indicated that the local authority had a higher than average uphold rate and number of detailed investigations in 2022 than for other local authorities of its type. The local authority's own data suggested that this had improved in 2023. The local authority clearly recognised its role to investigate and remedy fault where necessary. Responses to the LGSCO were timely and compliant.

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