Bath and North East Somerset Council: local authority assessment

How we assess local authorities

Assessment published: 30 January 2025

About Bath and North East Somerset Council

Demographics

Bath and North-East Somerset (B&NES) is a unitary authority district in Somerset with two thirds of the area lying in 'green belt.' B&NES Council was created on 1 April 1996.Liberal Democrats currently hold B&NES and have been in place since 2019. B&NES currently has a population of approximately 196.000. B&NES has an Index of Multiple Deprivation score of 1 (with 10 being the highest and most deprived) and is rated 142 out of 152 local authorities (1st being most deprived). Nevertheless, there are significant gaps in education, employment and health outcomes for people.

The population is predominantly people of working age but there is a growing ageing population. The population of B&NES is projected to increase by 8% from 2018 to 2028, from 192,106 to 207,919. The 65+ population is projected to increase by 15% over the same period, the largest increase is projected to be in the 75-84 age range (33%), followed by the 85+ age group (20%). In 2030, it is projected there will be 3,670 older people (65+) with dementia in B&NES which is an increase of 36% since 2019. People living in B&NES are predominantly White (92.19%); Asian, Asian British, Asian Welsh (3.3%) and multiple or mixed race (2.72%).

The Integrated Care System (ICS) covers B&NES, Swindon and Wiltshire (BSW). When the ICB was formed B&NES integrated Care Alliance Group (ICA) became the strategic focus group for B&NES. Three localities have been set up to tackle inequalities across BSW, each represented by their own place-based ICA's.

B&NES have recently undergone a transition from commissioned services back to in-house and are currently going through a full transformation of adult social care and staff job roles. In 2017 Adult Social Work statutory functions and Learning Disability Day Services, alongside residential services were included in a contract with the HCRG Care Group until 31st March 2024. In October 2020, residential services were transferred back to B&NES and in October 2022 the Safeguarding Team was also transferred back to B&NES. The Learning Disabilities Day Services, Supported Living Day Services, Adult Social Work, Direct Payments Team, Shared Lives and Employment Inclusion Teams returned to B&NES in April 2024. The Community Health Services, including Reablement and the third sector contracts currently remain with the HCRG Care Group. The Out of Hours Emergency Duty contract sits with South Gloucestershire local authority.

Financial facts

The financial facts for **Bath and North East Somerset** are:

- The local authority estimated that it would spend **70,955,000** of its total budget on adult social care in 2022/2023. Its actual spend was **74,584,000**, which is **3,629,000** more than estimated.

- In 2022/2023, **30%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/2024, with a value of **2%**. Please note the amount raised through ASC precept varies from local authority to local authority.
- Approximately **2205** people were accessing long term adult social care support, and approximately **310** people were accessing short term adult social care support in 2022/2023. Local authorities spend money on a range of adult social care services, including supporting individuals. No 2 care packages are the same and vary significantly in their intensity, duration, and cost.

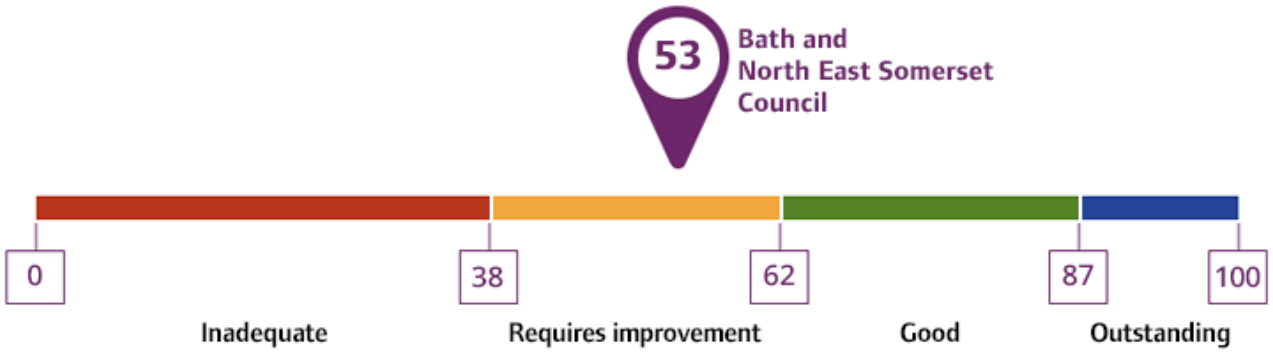
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Bath and North East Somerset Council

Requires improvement



Quality statement scores

Assessing needs
Score: 2

Supporting people to lead healthier lives
Score: 2

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 2

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 2

Safeguarding
Score: 2

Governance, management and sustainability
Score: 2

Learning, improvement and innovation
Score: 2

Summary of people's experiences

People's experiences of accessing adult social care in B&NES were mixed. Data to evidence whether people were able to access Care Act 2014 Assessments effectively via the first response team was limited. Staff told us people would contact the first response team and staff would ask questions in a strengths-based way to determine whether they required a Care Act assessment. If no assessment was required, staff would signpost and provide them with information about appropriate services in the community. Data provided for July 2024 showed only 2 people were referred to the teams for a Care Act assessment following contact with the first response team, data was not recorded for people who were signposted to other services. Most people who had accessed services told us they were able to do so easily. However, some people gave feedback that information was harder to find, especially if they were less familiar with digital platforms.

Feedback from people about the approach of staff was positive. People reported receiving assessments from kind, dedicated, and passionate staff who had a positive approach. Care Act assessments were completed in a strengths-based way, promoting independence and focusing on what people could do. Leaders told us they felt assessments were strengths based. However, leaders identified some improvements that were needed in support plans to ensure they were more creative, person centered and could flexibly meet people's needs.

Approximately 60% of people needing services were self-funders (this meant they would be funding the full cost of their care). Staff understood the need to provide a Care Act assessment and offer those funding their own care support to find services. The local authority charged an administration fee to support this, or people paying the full cost of their care could access services independently.

The experience of unpaid carers was mixed. We heard how people found it difficult to access advice and information regarding what support the local authority could give them. Unpaid carers assessments were not always carried out in a timely manner, and carers told us they were unclear about who carried out carers assessments and what support the Carers Centre provided. The Carers Centre confirmed they did not carry out carers assessments for adult unpaid carers but did carry out carers assessments for young carers. Some unpaid carers were unsure what benefits a carers assessment would have and how this would help to support them and their loved ones. Leaders identified the need to improve the carers offer and were looking at ways of how to improve this. One action taken to improve carers support was via the carers co-production group. Feedback from carers regarding the co-production group was positive.

People worked in co-production with the local authority to get people's voice and views heard. People told us this work was positive, and they felt listened to and respected and were looking forward to seeing how their input had improved practice and accessibility for people who use services and their carers.

Staff worked with partners to meet people’s needs holistically. We received positive feedback about voluntary services and heard examples of voluntary sector services supporting people with minimal care and support needs to return home quickly and effectively from hospital. People received support from staff who worked in a collaborative way. Leaders identified the need to continue to improve and embed collaborative working within teams.

Summary of strengths, areas for development and next steps

This assessment took place during a time of ongoing transformation. The local authority had recently brought their Care Act 2014 functions in-house and many policies, processes and governance procedures were being reviewed and embedded. Following the transfer back in-house, adult social care was also reviewing job roles and team structures. In addition, the whole council was going through a transformation with the vision "Being Our Best" which was intended to ensure every contact with the local authority was the best and improved each person's interaction with the local authority. Leaders and managers were also being introduced to an improved, more in-depth, version of their Power BI data system to support them with oversight and governance. The improved version had not yet been fully implemented at the time of our assessment however, leaders told us the original version was still being used by leaders and managers to support with oversight.

Feedback from staff regarding the technicalities of the transfer back in-house was positive. Staff told us the move went smoothly, and they felt well informed and prepared for the transfer. Staff told us the training offer has improved since moving back in house and that training was easily accessible, informative and relevant to their job roles. However, the overall council transformation, change in job profiles, and potential future structures of teams, were causing staff anxiety and staff did not feel the process was well communicated. Staff spoke positively about their managers and senior leaders and felt supported in supervision. However, staff told us they felt there needed to be more oversight and decision-making support in some teams.

Feedback from health partners was positive. We heard how health, adult social care, the HCRG group and the community and voluntary sector were working together in the Community Wellbeing Hub to prevent, reduce and delay people's care needs. Leaders identified a need for more collaborative working so people would only have to tell their story once more promotion of people's independence and to reduce the need for care and support. Health partners and leaders described positive working relationships and joint working to achieve shared aims. Health partners, leaders and staff understood the importance of the voluntary and community sector to meet their strategic aims around prevention. Feedback from the voluntary sector was positive. However, some organisations flagged issues around capacity and explained they had waiting lists due to the increase in referrals sent to them from the local authority.

National data showed the experiences of people living in B&NES were mainly positive or in line with national trends. Data showed people felt in control of their own lives and were satisfied with the care and support they received. National data showed the direct payment uptake was low.

Leaders had a good understanding of where they needed to improve. Where shortfalls were identified, plans were in place to address them though some plans and changes were yet to take place and embed. Changes had already been made to improve co-production, and leaders identified the need to continue to improve co-production and other ways to gain people's feedback on their experiences. The carers co- production was particularly positive, carers told us they felt listened to and respected. They were looking forward to seeing the changes and suggestions they made regarding the carer's strategy being put into practice.

Unpaid carers feedback was mixed, carers did not always know what support and advice was available to them and what impact a carers assessment could have. Some carers told us they had been in a caring role for some time before being offered a carers assessment. The local authority has identified the need to improve the carers offer.

There were gaps in knowledge of some leaders regarding the understanding of their diverse communities and seldom heard groups. We heard how adult social care, and public health had worked together to reach the boating and traveller community and how the Director of Adult Social Services (DASS) represented the local authority in the lesbian, gay, bisexual, transgender or queer (LGBTQ+) community group.

Data collected by the local authority did not support the identification of people whose voices are seldom heard. For example, it was not compulsory to add a person's religion or ethnicity to the recording system when creating a record at the front door, this meant there were potential inconsistencies in the monitoring of people from seldom heard groups and whether they had interacted with the local authority.

Waiting times for Care Act assessments and reviews varied from team to team. Some people waited longer than the adult social care targets set by the local authority. Staff told us staffing issues were having an impact on waiting lists for people awaiting an occupational therapy assessment, and the reviewing team had people who were waiting over a year for their annual review.

Leaders had positive and ambitious plans to improve adult social care in the future including improving performance, gaining people's voice, working collaboratively and improving governance, oversight and use of data to inform changes and improvements to practice. Leaders identified the gaps in governance and understood the importance of embedding changes in order to improve practice.

Theme 1: How Bath and North East Somerset 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

Feedback about access to Care Act assessments was mixed. The first response team was the first port of call for people who wished to contact B&NES. People may not always be able to easily access the local authority's care and support services. Staff told us people could contact them via telephone and online. However, lack of recording and staffing shortages could mean people were unable to access the local authority in a timely manner.

Data provided evidenced a lack of recording regarding people's requests for Care Act assessments and any signposting of services for people with non-eligible needs. Data showed only 2 people had been referred to teams from the first response team for a Care Act 2014 assessment in July 2024.There were no data records regarding how many people had contacted the first response team and had been given advice and information or signposted to a voluntary and community sector organisation. This meant the local authority could not monitor whether people had accessed advice, care and support before and whether signposting to community and voluntary organisations was meeting their needs.

Leaders told us approximately 60% of people needing services were self-funders (this meant they would be funding the full cost of their care). Staff understood the need to provide a Care Act assessment and offer support to find services for people funding their own care should they require this. The local authority charged an administration fee to support this, or people paying the full cost of their care could access services independently.

Following assessment, care packages over the financial delegation rate for managers agreement, or people with complex needs were presented at a practice forum. The practice forum reviewed assessments and records to audit quality and agree funding for high-cost care. Data reviewed showed 741 cases had been reviewed and audited in the practice forum since November 2023. Leaders told us this forum had improved quality of work and supported with the improvement of oversight. Staff told us the forum had improved their quality of work and enjoyed presenting their work and using the forum as a learning tool to improve their own practice. However, staff told us advice and guidance from leaders on the forum could be inconsistent. The local authority told us they also held legal surgeries for staff to attend to discuss complex cases and gain legal advice in relation to concerns such as safeguarding or mental health.

The overall approach to assessment focused on people's strengths and what was important to them. Staff talked about a strengths-based approach to assessments and their passion to put people first with a focus on what the person can achieve. One person told us, since a change in social worker they felt listened to and valued. The social worker had conducted a strengths-based assessment engaging with the person and their family to identify what the person was able to do and wished to achieve. People's experiences of care and support ensured their human rights were respected and protected, that they were involved throughout in decisions and their protected characteristics under the Equality Act 2010 were understood and incorporated in care planning.

Leaders told us strengths-based practice, the quality of Care Act 2014 assessments and staff's understanding of non-eligible care needs were areas they wanted to enhance and improve. A new interim Principal Social Worker (PSW) has been appointed to support this. Leaders also told us they felt assessments could be completed in a more person-centered way to ensure people's needs were met flexibly.

People usually received an assessment from specialist teams where they had complex needs, however staff told us some referral criteria could cause barriers to people accessing these teams. For example, staff told us contacts for people with a learning disability would be referred directly to the learning disability team. Most people who had received a Care Act assessment told us this had been completed in a timely manner and their needs had been met through effective care planning.

The mental health team had its own point of contact for people, which was separate from the local authority first response team. Referrals could be sent in from professionals, such as GPs, the Avon and Wiltshire Mental Health Partnership, or the community sector. These were then reviewed, triaged and sent to the appropriate mental health teams, such as the Recovery Team (Community Mental Health Team), or the Complex Intervention Team.

Staff told us the new training offer with the local authority had improved since returning as an in-house team and they felt supported to develop their skills where they wished to do so. Staff told us they received regular supervision and support from their team and managers. However, some staff did not feel they had received the correct training, support and guidance to work with people with more complex or specialist needs. Leaders told us improvements to learning had started to take effect for example, learning was focused on areas such as the Mental Capacity Act 2005 after staff had asked leaders for support with this.

Timeliness of assessments, care planning and reviews

Assessments were not always carried out in a timely manner to reduce risk and ensure people received care and support that met their needs. Data provided by the local authority showed some teams had waiting lists for people waiting to receive Care Act assessments, this included when people's needs changed, and they required a review and carers assessments. Staff told us some people had not received a review for over 2 years due to an increase in demand and workload.

Data provided by the local authority showed 128 people waiting for Care Act assessments with 109 waiting to be assessed by the locality teams, 15 people waiting for specialist teams such as the Autism Team and 4 waiting for assessment were unknown. The median waiting time for assessment was 28 days with the maximum wait 237 days.

There were 489 people waiting for a review. Data provided by the local authority showed a median wait of 166 days with a maximum wait of 465 days. The local authority told us they had an action plan in place to address outstanding reviews.

National data on Short and Long-term Support (SALT) showed 71.72% of people receiving long-term support had been reviewed (this included planned and unplanned reviews) this was a positive variation to the England average of 58.77%. Leaders have identified shortfalls in reviews and had plans in place to support and improve reviews. Data provided showed improvement plans in place had improved outcomes.

The local authority took a risk-based approach to reviews and staff and leaders acknowledged annual reviews did not always take place promptly. Planned reviews are where there has not been an identified change in need, but it would be considered good practice to carry out an initial review after 6-8 weeks of receiving care and support followed by an annual review, to check the support the person was receiving support that continued to meet their needs. One person told us they felt like they had to chase the local authority and request a review. Whilst another person told us their family member had received a timely review which resulted in increased support to enable them to go out in the community.

There were mixed responses on the timeliness of reviews, people told us that reviews of care and carers assessments were inconsistent and relied on the person, family or carer to contact the local authority to request a review of care needs/carer assessment. Some providers told us reviews of people's care were carried out in a timely manner, however, some providers told us they did not always feel included in the review.

Although data demonstrated that there were waiting lists, National data showed people's experiences were positive in this area and similar to the England average. In the Adult Social Care Survey (ASCS), 84.41% of people said they felt they had control over their daily lives, the national average in England was 77.62%. It showed 66.18% of people were satisfied with their care and support, the England average was 62.72%. The survey showed 48.92% of people reported to have as much social contact as they wanted, which was similar to the England average of 45.56%.

Staff told us they take ownership of their own caseload and monitor their own risk by occasionally contacting people on their caseload to assess risk or any decline or increase in care needs. Staff stated there was currently no official process for assessing risk, some staff told us they felt confident their managers had oversight of this whilst others were not sure of how risk was monitored. Teams such as the Autism Team, Reviewing Team and the Social Care Assessment team had waiting lists. Leaders told us that risk was monitored by a RAG rated system and team managers had oversight of this.

The Social Care Assessment Team supported people with hospital discharge including reablement pathways for further support, virtual ward pathways, community beds, and brain injury specialism pathways. There were waiting lists for most pathways. There was a Discharge to Assess (D2A) bedded unit that supported people with hospital discharge, but this was an interim service funded by the Integrated Care Board (ICB) in order to meet winter pressures and was closed as planned when pressures reduced. Following the closure this meant that people either waited for appropriate services to become available or could be placed in services that were not suitable for their needs due to the availability of beds. Staff told us this could also have an impact on people needing long term care and support in a residential setting as vacancies could be filled with people receiving reablement support. The local authority told us they had invested in Care Journey Coordinators whose role was to bridge the case management for people being discharged from hospital who were not eligible for reablement and required longer term statutory care in the community, this supported people to get home quicker under the "home is best" programme, people would then receive a Care Act assessment in their own home carried out by the Social Care Assessment Team.

The Local Authority had a dedicated Occupational Therapy (OT) team, there were also OTs within the reablement team. The team had unregistered staff called an OT aide to enable some low-level equipment to be installed to reduce need and risk. Whilst this reduced the possible impact delays for equipment could have on people, there were still long delays for a full OT assessment. This meant there could be a risk that people's needs could increase and opportunities to build their ability and independence could be missed. Staff told us people could be waiting up to 12 months for a full OT assessment depending on the person's needs. The local authority told us they had invested in 2 apprentice OTs to support the demand.

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

The feedback about unpaid carers assessments and reviews was mixed. Some people received carers assessments in a timely manner whilst others had been in their caring role for a significant amount of time before receiving a carers assessment. One carer told us, they did not receive a carers assessment despite requesting one and felt this had impacted significantly on their own wellbeing. Another carer told us that the local authority refused to carry out a carers assessment as they were not the main carer for their loved one but provided an extensive amount of support for them and their family, without this support the cared for person would require official support from the local authority.

There was confusion with unpaid carers around who conducted carers assessments and what support was available for them in the community. The local authority commissioned a service via the Carers Centre, however, some carers felt this was not flexible and did not always meet their needs. For example, some carers advised they were unable to attend groups arranged at the carers centre due to their caring role and would have liked a more drop-in style group to enable carers to get together when it was suitable for them and not when groups had been arranged. Unpaid carers told us they felt the lack of flexibility for carers could lead to carer breakdown. Other carers told us they enjoyed going to local carers groups and had met a lot of people who could empathise with their situation and understand the struggles of being a carer.

The Carers Centre completed carers assessments for young carers. However, adult carers assessments were completed by the separate adult social care teams. This caused confusion for some carers when trying to access advice and guidance and identifying who to contact when needed. Unpaid carers told us they found it challenging when needing advice and support for their loved one in an emergency and accessing emergency respite could be difficult. The local authority had identified the need to do more strategic planning around the unpaid carers offer.

The Survey of Adult Carers in England (SACE) data showed 45.59% of carers were satisfied with social services, this was tending towards a positive variation compared to the England average of 36.83%. Whilst this showed the local authority were delivering better outcomes than other local authorities it still meant that over 50% of carers were not satisfied.

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

Staff told us, people were given help, advice, and information about how to access services, facilities, and other agencies for help with non-eligible care and support needs. However, data held by the Local Authority for the first response team did not evidence the amount of people supported with information and advice and the outcomes of this. People were also supported to find advice and information through the Community Wellbeing Hub, outcomes provided by the local authority for the Community Wellbeing hub were positive.

If people received a Care Act assessment and the outcome was that the person had non eligible needs staff told us that they supported those people to access the correct information and right support before closing the case. Staff and partners told us that some of the voluntary and community organisations used to support people with non-eligible needs now had waiting lists due to an increase in demand.

Eligibility decisions for care and support

The local authority had a policy in place outlining the appeals process for eligibility decisions. The local authority website had guidance for people on how to complain regarding care or an eligibility outcome.

Financial assessment and charging policy for care and support

The local authority had a financial assessment and charging policy in place which was accessible to people, however, there was a current waiting list of 145 people waiting for a financial assessment to assess whether they need to contribute to the cost of their care. The median wait for people having a financial assessment was 42 days with the maximum wait 322. The local authority failed to meet their target of completing financial assessments within 28 days however, some delays were beyond their control for example if the persons finances were going through the court of protection. Staff told us they would support people with eligible needs to complete the initial referral form and send this to the finance team who would then complete a full financial assessment. In some cases, the care and support commenced before the financial assessment had been completed to ensure people's needs were being met effectively and reduce risk. The local authority had a system in place to calculate when a person's capital would be dropping below the self-funding threshold. The finance team would then notify the social worker and the person of that date.

Provision of independent advocacy

Access to advocacy was easily available to people who needed it. Staff told us it was more difficult to access advocacy for people placed out of area but was achievable, it just took more time to source an advocate than in the local area. An advocate can help a person express their needs and wishes, weigh up and make decisions about the options available to them. They can help people find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations. Partners told us appropriate referrals were made to advocacy organisations and carried out in a timely manner. There were currently no waiting lists for advocacy support.

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

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 collaborated with people, partners, and the local community to make available a range of services, facilities, resources, and other measures to promote independence, and to prevent, delay or reduce the need for care and support. The local authority worked with health, the HCRG group and voluntary organisations to create a Community Wellbeing Hub. The Community Wellbeing Hub was jointly funded by the Better Care Fund to create a multi-agency, single point of access for wellbeing services. It offered a range of advice services for people who needed help and support with employment, housing and social security benefits; community-based health and wellbeing services, physical and mental health needs; and access to essential supplies, such as food and medication. It was accessible to people via a phone call, text or email. People could contact the Community Wellbeing Hub themselves, and staff told us they would refer people to the hub for advice on voluntary sector services. The hub was created to respond to the Covid-19 pandemic and has continued to support people in the community to prevent, reduce and delay people's care and support needs. Data provided by the local authority showed an increase in partnership working over the past 18 months, increasing the number of partners involved with the Community Wellbeing Hub from 6 to 26. Data also showed an increase in referrals to the Community Wellbeing Hub in the same timeframe.

Feedback from unpaid carers was mixed about the resources available to them. We heard positive feedback regarding the information the carers centre could offer with 90.12% of unpaid carers in B&NES finding information and advice helpful, this was compared to the England average of 85.22%. However, support groups were not always accessible due to the unpaid carers caring responsibilities, and some felt support was not always flexible to meet their needs. Unpaid carers told us they found it difficult to access emergency respite when needed and found it difficult at times to contact their named worker for advice and support to prevent carer breakdown.

Prevention was a core component of the local authority's vision for the future. The local authority identified there were some improvements to be made and embedded to support people to lead healthier lives. Health partners felt their relationship and communication with adult social care had improved, and they had a shared vision for prevention. Key priorities in the area included smoking cessation due to 23% of the population smoking and continuing to work with sustainable communities. There was a joint health and wellbeing strategy and the local authority, alongside partners, focused on health inequalities. We heard how voluntary organisations worked with hospitals to safely discharge people with low level needs back home to promote independence.

A community support approach began with the First Response Team, the front door service to the local authority, with the aim of supporting people to connect with local services to reduce the need for care and support. However, there was a lack of data or recording from the first response team to evidence whether this was conducted effectively and how this impacted the outcomes for people.

Provision and impact of intermediate care and reablement services

There were clear and accessible pathways to short-term reablement and rehabilitation, however, should people require long-term support following reablement there were waiting lists for people to receive a Care Act assessment and long-term support, this meant people's needs could increase and independence lost due to delay in care and support.

The local authority used the 'home is best' model to hospital discharge and worked alongside providers to access intermediate care pathways. Whilst the reablement service appeared effective and stable, staff felt the hospital discharge process itself was not so strong. The Social Care Assessment Team worked collaboratively with health colleagues and attended regular multi-disciplinary team meetings to discuss people ready for discharge however, staff told us it was not as easy to work as collaboratively as they used to with the hospital team regarding patient discharge as they were no longer co-located. Staff told us they felt this impacted on the person's transition between services and could delay discharge. Health partners also told us they felt this had an impact and delayed people's discharge. The Integrated Care Board had recently de-commissioned their discharge to assess bedded unit, this unit was implemented to support with winter pressures and was decommissioned once risk and demand had reduced. Staff told us they were now using any home care provider and care home who had a vacancy to support with discharge and rehabilitation. Providers told us they did not always get a full picture of people's needs prior to discharge, this meant there was an increased risk of providers being unable to meet people's needs. The current interim care process was that people using this service would be placed where a care home had a vacancy, and the appropriate staff would visit the person in the care home for example, occupational therapist, physiotherapist and social worker. This meant people could be placed in care homes that did not fully meet their needs or promote their independence. The local authority also commissioned 6 'step up' beds allocated in extra care facilities to prevent hospital admission.

The Adult Social Care Outcomes Framework (ASCOF) data showed 88.57% of people 65+ were still at home 91 days after discharge from hospital into reablement or rehabilitation support, this was tending towards a positive variation from the England average of 83.70%.

Access to equipment and home adaptations

The local authority employed Occupational Therapists (OTs) and OT aides (unregistered staff) to assess people for equipment and adaptations to support people to remain as independent as possible. A clear pathway was in place for processing requests for assessments for equipment and adaptations. Requests for assessments were triaged by an OT duty team and prioritised, before being placed on a waiting list. A letter was sent to people advising them of options available whilst on the waiting list, and details of how to contact the team should their needs change. As part of the triage process minor pieces of equipment were assessed for and provided.

We were told that staff vacancies in the team had an impact on staff workloads and the waiting list, as well as the increase in referrals and increase in complexity. Staff told us there was a waiting list of approximately 12 months for an Occupational Therapy assessment dependent on the priority and need of the person. Data provided by the local authority showed a waiting list of 204 people waiting for an OT assessment with the median waiting time of 10 weeks and the maximum waiting time being 14 months. Where a person presented with less complex needs the case was assigned to an occupational therapy aide who would be able to schedule assessments in a shorter timeframe. The OT aide median wait was 14 weeks, with a maximum wait of 8 months. Following an assessment for a major adaptation and a Disabled Facility Grant (DFG) being approved, there were further waits of approximately 8 months before completion of work. Staff told us once equipment was prescribed the equipment was fitted in a timely manner.

Staff told us there was a lack of access to equipment to trial or demonstrate for people with a hearing or vision impairment, which meant that referrals were made to external organisations which led to delays for people.

There was a specific OT team within reablement whose sole focus was to visit and provide therapies to people in the community-based interim care beds, to return them to their optimum health and ability as quick as possible, this team prescribed and provided equipment in a timely manner, supporting people to gain their independence and build on skills already gained.

Plans were in place to improve the use of technology enabled care (TEC) to prevent, reduce and delay people's needs, however this was still in its infancy at the time of assessment.

Provision of accessible information and advice

The local authority provided information and advice to people in accessible formats but recognised the need to improve the accessibility of resources for example, for people for whom English was not their first language. Feedback about information was mainly positive with people telling us they knew how to contact the local authority should they need to. However, some unpaid carers told us they found it difficult to know who to contact for advice and guidance, we also heard the local authority's website could be difficult to navigate, particularly for older people who may face digital exclusion. Despite this feedback, the Adult Social Care Survey data showed 67.62% of people who used services found it easy to find information about support, this was similar to the England average of 67.12%. 69.05% of carers found it easy to access information this was a positive variation compared to the England average of 59.06%.

The local authority contracted a translator service however, staff told us, this was not always easily accessible and could delay information, advice, and assessments. Due to difficulties in getting an interpreter staff told us they would use a family member or friend to support the person which was not best practice.

The first response team did not complete home visits, this therefore limited people's opportunity to access information and guidance in a more accessible way. There were limited opportunities to provide information verbally to people who did not speak English. Leaders told us teams such as the Social Care Assessment team and the emergency duty team would make home visits in emergency situations.

Direct payments

Direct payment uptake was low, the local authority told us, this was an area where they recognised a need to improve. ASCOF data showed 21.8% of service users received direct payments this was tending to a negative variation compared to the England average of 26.22%. 28.61% of service users aged 18-64 received direct payments, England average of 38.06%. 11.43% of service users aged 65 and over received direct payments, England average of 14.80%.

Staff and leaders told us they felt the lack of uptake for direct payments was due to the large choice of commissioned services they had which meant people had choice without having to use a direct payment. Staff told us, they gave people the option of direct payment whilst conducting the Care Act assessment and supported people to complete the initial direct payment form, this was then passed on to the direct payments team to complete. Staff gave a positive example of dual funded care in which a person received a part commissioned and part direct payment service to support their individual care needs.

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 took steps to understand their population however, leaders and staff identified there were areas for improvement to fully understand the needs of the population. B&NES was an affluent area with pockets of deprivation. There was a risk of deprivation going unnoticed due to the rurality of some areas.

Health partners felt adult social care worked collaboratively regarding the awareness of inequalities within the community and were working to improve their knowledge of seldom heard and hard to reach people within the community. The local authority had recently held an event for the boater and travelling communities with health partners. Leaders and partners told us they felt this had a positive impact on the community by being visible and approachable in the community. Whilst there was an understanding of the needs of most of the local communities there were still some shortfalls in working with and identifying seldom heard voices. There were gaps in the knowledge of some staff and leaders with regards to Equality Diversity and Inclusion.

Data collected by the local authority did not currently record people's ethnicity, race, religion as a prerequisite when contacting the first response team, this meant the local authority had missed an opportunity to further identify seldom heard and hard to reach people and may impact on the local authorities understanding of the needs of the community when commissioning new services. Data provided from the local authority showed gaps in capturing data around people with protected characteristics, information was held on a computerised system, for ASC. However, this information was not mandatory for staff to complete during a person's first contact, so information was recorded inconsistently and meant it was hard to use the data to identify people and their needs. The local authority was aware of the need to make better use of data and plans were underway to improve this. Planned changes to data collection systems was intended to improve access to this type of data however, at the time of assessment the ability to interrogate data to determine a person's ethnicity, race or religion was limited. The local authority told us that the recording of information regarding a person's protected characteristics such as a person's ethnicity or gender were recorded once a person had progressed to a Care Act Assessment or care planning.

The local authority had an Equality, Diversity and Inclusion (EDI) lead in place to highlight the importance of EDI to staff and in the community.

The local authority had completed a Strategic Evidence Based Document to understand the health, care and support needs of the people in B&NES. The Strategic Evidence Based Document included work to look at populations and identify groups who were more likely to face poorer outcomes or inequalities such as homeless people, migrants, boater and traveller communities, people with a learning disability and unpaid carers.

Inclusion and accessibility arrangements

The local authority had taken steps to improve the accessibility of information for people and had identified the need to continue to provide more information in different formats to improve people's accessibility. The Community Wellbeing Hub was set up jointly with health, the HCRG group and the voluntary sector to improve people's accessibility to information, advice, and services. The local authority also provided advice and guidance via their Live Well B&NES website. We saw evidence of some documents, policies and procedures being available in other accessible formats such as large print, braille or an easy read format for people with a learning disability.

The local authority had a specialist hearing and vision team to support people with hearing and vision impairments and to ensure information and support was accessible. Staff told us the local authority was working on improving accessibility for people who communicate using British sign language to allow them to contact the council and gain the advice and guidance they needed. The hearing and vision team worked closely with voluntary organisations in the community and other social work teams within ASC to ensure people with a vision or hearing impairment had the support they needed. Staff told us, there was an increase in available technology. However, there was still a long way to go to embed the use of technology. We heard how 'what's app' was used by staff to talk via video call with people wanting advice and guidance but there were difficulties accessing and trialling higher tech offers.

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: 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.

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 used a variety of methods to understand the needs of the local community to commission the right services. Staff and leaders told us about work going on to improve the use of data to inform commissioning practice and to support the collection and analysis more effectively.

In April 2023 the local authority commissioned a service called Community Catalysts, their role was to develop and support micro enterprises to meet needs or demands of people in the community to support people to remain in their own home for as long as possible. Feedback provided by the local authority regarding this service was positive.

Information shared from commissioning, adult social care teams and village agents was used to identify the gaps and then look to bridge these gaps with the community catalyst scheme; examples included befriending and practical support services. Village agents worked in partnership in the Community Wellbeing Hub to provide free advice to people in the community about housing, finances and health, with a focus on supporting people in rural areas of the community. Village agents also provided talking café services for people to socialise and get information and advice.

The local authority had a large range of commissioned services available for people to support their needs in the community, this meant people did not have to wait very long for care and support to be in place. Data provided from the local authority confirmed people were supported to find care and support in a timely manner, home care had over 99% of care packages sourced within 72-hours, 68.6% of residential care homes were sourced within 72-hours and 91.2% of nursing homes were sourced within 72hrs.

Staff identified there was a gap in specialist learning disability provision, whilst they tried to always keep people in the area this was more difficult for more specialist services. There was evidence of commissioning being used to address gaps, for example, working with housing to create 2 new supported living developments, which consisted of 10 new flats across the 2 settings. The local authority told us they were continuing to work with housing to bridge that gap and to create more housing opportunities for people with a learning disability.

There was a Joint Strategic Evidence Based Document for Bath and North East Somerset which was shared with partners and used to set and focus on priorities for care and support in the future.

Demographic data showed a growing aging population, with an expected increase of 8% from 2018 to 2028. The 65+ population is projected to increase by 15% over the same period, the largest increase is projected to be in the 75-84 age range with an increase of 33%, followed by the 85+ age group with an increase of 20%. In 2030, it is projected there will be 3,670 older people (65+) with dementia in Bath and North East Somerset which is an increase of 36% since 2019.

Leaders felt able and ready to manage the market increase of aging people and had plans in place to support this. We heard about the planned implementation of a commissioning hub in which collaborative working would be key to understand the needs of the population using 3 key initiatives, start well (working in collaboration with special educational needs and public health), live well and age well. Leaders told us they used the Market Position Statement to inform commissioning plans to ensure commissioned services reflected the changes in need and market conditions. Commissioning arrangements in B&NES for a wide range of health and social care services were jointly managed and commissioned by the local authority and the integrated care board (ICB).

Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options that were safe, effective, affordable, and high-quality to meet their care and support needs. The local authority had a vast selection of commissioned home care services to choose from, staff told us they would receive a request for care and would send this request to all home care providers and await their response. Providers told us they felt at times the market was unfair and was commissioned on a 'first come first served basis'. Providers told us that the cost of care was also a key factor when choosing a provider. This meant people may not always receive care and support best suited to their individual needs. The local authority's brokerage process letter dated May 2023 which was sent to providers showed providers were given 1 hour to respond to the request and that care packages were initially awarded to providers based on their CQC rating and hourly cost.

Data from the Adult Social Care Survey showed 68.49% of people who used services felt they had a choice over services. This was in line with the England average of 70.28%.

The local authority identified a shortage in specialist learning disability services and specialist dementia services. Staff told us they were working with new care homes to ensure they were registered to support and care for people with dementia to meet this need. The local authority was also working with housing and had developed 2 new supported living settings with 10 flats to support people with learning disabilities. Commissioning strategies and market shaping activity supported this. Commissioning strategies aligned with strategic objectives of partner agencies for example, health, housing and public health. Partners told us that working in an integrated way with ASC enabled the team to be more creative when supporting people with personal budgets. There was a recognition of the housing challenges within mental health and work was taking place in improving the relationship with housing associations and enhancing their understanding of people's needs.

Unpaid carers told us there was not always appropriate provision in place regarding emergency care, the local authority had identified this as an area for improvement. The Survey of Adult Carers in England confirmed this with 9.32% of carers accessed support or services in B&NES which allowed them to take a break from their caring role for more than 24hrs this showed a negative variation compared to the England average of 16.14%. 8.47% of carers were able to access support or services allowing them to take a break from caring at short notice or in an emergency, this showed a negative variation compared to the England average of 12.08%. We heard how unpaid carers had worked with the local authority to improve their knowledge and understanding of unpaid carers needs and unpaid carers were looking forward to seeing their co-production work put into practice.

Ensuring sufficient capacity in local services to meet demand

The local authority told us service capacity in the area was mostly good, with sufficient service provision for older people with less complex needs. B&NES currently had 1162 care home beds for older people in the area. The local authority identified the market was predominantly privately funded with approximately 60% of the market being self-funders, 30% of beds funded by the council and 8% funded by health. Staff told us there was an increased pressure on services to support people being discharged from hospital to interim care beds. Staff told us there was no longer a separate provision for discharge to assess beds as this was an interim provision to meet winter pressures and was stopped once pressures reduced. Staff told us this meant people were being placed wherever there was a bed available to support with hospital discharge. Staff told us they felt this could have an impact on people waiting for long-term care in some care homes. The local authority told us alongside the interim care beds in care homes they had also joint funded interim care in people's own homes to support the local authority's home is best programme, allowing people to receive interim care and support in their own homes. In addition to the interim care beds the local authority had also jointly commissioned care journey coordinators to support people to return home whilst waiting for longer term support.

Staff told us there was a lack of specialist care provision, particularly for people with a learning disability and there was limited day care provision in the area. The local authority told us they had a wide range of day care services for people in B&NES delivered both in-house and through commissioned services. Support included work skills pathways to develop skills such as hospitality, horticulture and employment readiness and 4 dedicated day centres.

Some people were placed out of the area for specialist provision. One person told us they felt their family member being placed out of area had impacted on their ability to maintain family relationships and had impacted on their wellbeing. Data provided by the local authority told us that as of June 2024 39 people were placed out of area, 26 of those people chose to move out of area for reasons such as being closer to their family. 13 people were placed out of the area based on need. The local authority had identified a lack of care home facilities for people with more complex needs, plans were in place to open more care homes in B&NES with the aim that this would result in less people needing to be placed out of the area.

Data provided by the local authority showed a significant decrease in care packages being handed back, this was reduced from 23 in one month to 2. One care package was handed back due to an increase in the person's care needs and the other due to person's choice and they were self-funding their own care.

The local authority identified following conversations with the Parent Carer Forum that there was a lack of provision for young adults following transitions to adult social care in relation to their housing needs. Following this the local authority allocated 10 new flats for people using the service with complex needs across 2 supported living settings. Staff feedback about these services was positive and they told us they felt they needed more of this provision in the area as this had made such a positive impact to people, promoting independence and reducing people's dependance on care and support in a care home setting. The local authority told us they had a clear corporate and political vision to deliver effective housing solutions for people in the community and that adult social care was working closely with housing to identify possible housing support for people with care and support needs.

The local authority had worked with health partners to understand the local needs around hospital discharge and reducing hospital admissions. The 'home is best' hospital discharge model was developed with health partners and the commissioning of the reablement team and homecare services was designed to try and meet those rising demands. Staff told us whilst reablement in people's own homes worked effectively there was a backlog of people waiting for a full Care Act assessment for long term care.

Ensuring quality of local services

The local authority had arrangements in place to monitor the quality and impact of the care and support services commissioned for people and it supported improvements where needed however, providers told us improvements could be made regarding consistency and communication between the local authority and providers. The quality assurance policy in place clearly explained the support required for the monitoring of services including failing services. Staff told us they had a process in place to monitor and visit services to ensure they had the support and tools needed to improve their service. Where services required unavoidable closure, the local authority worked with providers and partners to ensure people received appropriate alternative care.

Provider feedback regarding quality assurance was mixed. Providers felt it often depended on which member of staff from the local authority they had supporting them and that advice and guidance from the local authority was inconsistent. Providers told us the change in the commissioning framework meant it was easier for providers to join the commissioning framework. Providers identified some services not yet rated by CQC and therefore the quality of services was not always clear. There were inconsistencies regarding quality assurance inspections for providers, one provider told us they had not been visited by the local authority in 4 years, and another told us their local authority inspections were carried out remotely but found these useful and supportive.

The local authority had recently restructured commissioning and quality assurance which was due to be launched in October 2024.The plan was to separate the commissioning and quality assurance teams to ensure a better focus on quality assurance of services in order to meet the local authorities' vision of "start well, live well, age well" Leaders told us their vision was to improve the availability and quality of support and services available to people across their life span.

The local provider market was good with 80.95% of nursing home services rated good, and 100% of supported living rated good. 66.67% of care homes rated good, and 72.23% of home care agencies rated good.

Ensuring local services are sustainable

The local authority had a large selection of providers on their framework which meant the provider market sustainability was strong however, providers felt at times this meant they did not have a chance to bid for the care as another agency had already been offered the care before they had chance to respond to the request.

The local authority had a market sustainability plan in place which included an assessment of the local care market identifying staff recruitment and retention as a large factor for care services. The staff vacancy rate in ASC in B&NES was 7.20%, which was similar to the England average of 8.06%. The local authority paid over the cost of care expectation to support the care market with staff recruitment and retention.

Staff and leaders told us the local authority had a policy and procedure in place for monitoring the risks of provider failure and monitoring the closure of services. This included the monitoring of financial stability, staffing and recruitment.

Providers told us the local authority did not have a formal provider forum in place to support providers and give them a chance to raise any concerns or share good practice with other providers. Leaders told us these were previously in place however, attendance was poor. The local authority identified this as an area that could be improved. Despite the lack of official provider forums most providers told us they felt the Director of Adult Social Services (DASS) was knowledgeable and approachable and would listen to providers concerns.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is coordinated, 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 had recently undergone a large transfer which brought commissioned ASC teams back in-house to the council. Following the transfer the local authority had continued to build relationships with partners to deliver shared objectives. The local authority identified that partnership and collaborative working was an area that they wanted to continue to develop to ensure the best possible outcomes for people.

Partners told us relationships had improved since the transfer and made communication between partners and the local authority more easily accessible. Leaders spoke positively about work with health partners, and explained how the Health and Wellbeing Board and the Safeguarding Partnership Boards were valuable for sharing information, escalating concerns, and identifying and responding to current themes.

Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated-Care-Strategy - 2023-2028 created a vision for the B&NES, Swindon and Wiltshire Integrated Care System in which they would listen and work effectively together to improve health and wellbeing and reduce inequalities. The vision would be delivered by prioritising the three identified objectives as follows, a focus on prevention and early intervention, fairer health and wellbeing outcomes, and excellent health and care services. Leaders and staff told us about the improvements made to the prevention and early intervention offer since the implementation of the Community Wellbeing Hub, which saw an increase in people asking for advice and support. Leaders told us the Community Wellbeing Hub was jointly funded with Public Health, the HCRG group and the voluntary sector using the Better Care Fund. The Community Wellbeing Hub originated during COVID-19 to ensure people still had access to advice and guidance in the community and continued due to its success.

Health partners told us how improved relationships with the local authority had helped them focus collaboratively on the improvement of health and wellbeing outcomes to reduce people's need in services. Leaders and partners identified there was still work to be done to improve and achieve their vision but were optimistic and passionate about achieving their goals.

Partnership working was embedded in some teams more than others. Staff told us how some partnership working had reduced for example, the Social Care Assessment Team were no longer based in the hospital and did not visit the wards when planning and supporting discharge, this meant their relationship with health teams was not as strong as it used to be and at times had impacted on a timely discharge. Leaders told us that the Social Care Assessment team were co-located with the First Response Team, the Health Access Team, Virtual Ward and Reablement at the Care Coordination Centre to support collaborative working. The Social Care Assessment team also attended regular meetings within local hospitals and supported with Care Act Assessments, support planning and reviews following discharge. Other staff gave positive examples and outcomes of collaborative working. For example, working with advocacy to conduct a Best Interests' decision under the Mental Capacity Act 2005 (MCA) and working with OTs and Physiotherapists to achieve people's optimum health and wellbeing.

Partnership working was used to understand and anticipate the health needs of the population. Leaders told us there were strong links between ASC, Public Health, and health partners. For example, public health collated data on local demographics to help shape future strategies for keeping people healthy, active and at home for a long as possible.

Mental Health partners told us working within an integrated model enabled the team to respond promptly to requests for care needs assessments, promoted better outcomes for people and assisted with reducing delays in hospital discharges.

Arrangements to support effective partnership working

The Community Wellbeing Hub was a partnership between the Council, public health, the HCRG Care Group and the third sector organisations. The purpose of the partnership was to link health and social care services with the third sector, collaborating to prevent, reduce and delay residents' need for statutory services. The partnership was governed through a partnership board, chaired by the local authority and attended by HCRG Care Group and third sector representatives.

The Community Wellbeing Hub was supported by an umbrella company called 3SG who was a community interest organisation, who were an active member of the Community Wellbeing Hub and supported the voluntary sector and charity groups across B&NES to have a voice. 3SG had three clear aims: to co-ordinate third sector support to meet the local authority's priorities, to support effective data gathering from the third sector regarding available services and activities, and to collaborate with the live well B&NES team to support signposting to the third sector. This partnership will continue to be reviewed to ensure the best use of resources to meet people's needs. The local authority told us they also had good relationships with drug and alcohol and suicide prevention services both of which had multi-agency strategies to support people living with drug and alcohol abuse or suicidal prevention.

The 2023/25 Better Care Fund plan focused on improving hospital discharges, reducing the pressure on urgent care and social care, supporting intermediate care, supporting housing adaptations, technology enabled care, transition from children's to adults' services and supporting unpaid carers.

Impact of partnership working

Partners worked together on strategies to improve health outcomes for example, the joint funding through the Better Care Fund of the Community Wellbeing Hub. Staff, partners, and leaders told us this service was working well however, there was limited data to show how this service had impacted and improved outcomes for people.

Health partners told us ASC leaders and staff were visible and available and felt able to approach them for professional advice and guidance. There was a structure and forum space for cross-sector discussions which worked well. Partners felt the local authority had an appreciation of other roles and partners within the wider system. This meant people who were already known to the local authority could be supported quickly and effectively without having to go through the whole assessment process again.

Mental health partners told us working within an integrated model enabled the team to respond promptly to requests for care needs assessments, promoted better outcomes for people and assisted with reducing delays in hospital discharges. Leaders told us the long established relationship with mental health partners worked well and provided good outcomes for people.

The 'home is best' programme which focused on people receiving the right care at the right time in the right place identified improvement in delayed discharge and the Community Wellbeing Hub, as positive outcomes for people because of partnership working, with a focus on assessing people once back to their optimum health and in the community.

Working with voluntary and charity sector groups

The local authority collaborated effectively with voluntary partners to achieve objectives however, we heard some voluntary partners felt the local authority needed to improve their communication and be more creative and open to listening to the voluntary partners ideas as some voluntary partners told us they did not feel their knowledge and experience was being effectively utilised when considering objectives. Staff told us voluntary partners played a vital role in supporting people in the community and identified how their support improved outcomes for people. For example, voluntary services supporting hospital discharge to prevent a delayed discharge and improve people's independence.

Theme 3: How Bath and North East Somerset 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: 2

2 - Evidence shows some shortfalls

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 its role in keeping people safe, however, systems were not fully embedded to allow full oversight and monitoring of risk. Leaders told us the introduction of a newer version of their Power BI Data monitoring system would help improve knowledge and oversight across adult social care. However, this system was not yet in full use. Leaders and staff told us knowledge of risk and the themes and trends relating to risk was often held by managers of individual teams however, this was inconsistent across teams. Staff told us there was very little oversight of this from a strategic level at this time. Leaders told us the practice forum and legal surgery supported staff with oversight of more complex cases and risks to people. The legal surgery was set up in March 2023 to support staff to have access to legal, mental health and safeguarding advice for complex cases. Leaders told us all cases which were presented to the legal surgery were audited to provide assurance.

Staff told us once cases were allocated it was their responsibility to monitor the risk of their caseload and they would discuss this in their supervision however, staff told us they were unsure what happened with this information after supervision. The local authority had recently recruited a PSW to support this oversight. However, this was a newly recruited role and therefore had not had time to embed any changes or oversight at the time of assessment. Staff and Leaders told us communication had improved since the PSW was in place. Staff were building trust and often went to the PSW for guidance, advice and support. This also helped bridge the gap between frontline staff and strategic leads.

Staff told us the limited access to other systems in integrated teams meant there was a risk of information getting lost and not being passed through the correct channels. For example, different health and local authority systems meant health could not always identify if someone was already known to ASC and what support was in place. OTs told us they were unable to access health systems, and this led to delays in assessments for people requiring equipment, which could result in people needing more care and support. Leaders told us they were aware of these concerns and were looking at ways to improve communication between systems.

Partnership working and joint policies and processes with health and voluntary and charity organisations enabled the local authority to share the responsibility for supporting people through their care journey. Partners told us risks were mitigated through joint working and early intervention, promoting independence and advocacy, this included strong links with the emergency duty team.

Safety during transitions

The local authority had arrangements in place to ensure safety during transitions and continuity of care provision. The local authority had recently undergone a transfer of staff in which ASC staff were brought back into the local authority from a commissioned service. Staff told us the physical transfer was smooth and that people using services were not impacted by the move as their workers remained the same throughout the process. However, some staff felt the process had meant they had increased workloads and changes to their job roles which had impacted on their wellbeing and ability to carry out their role effectively.

The process for hospital discharge had changed and staff told us they no longer visited the wards to support hospital discharge and felt this could have a negative impact on the discharge process, as people may be sent home without the correct support in place putting them at risk of further hospital admissions. Partners told us since the decommissioning of the D2A bedded unit from the ICB, hospital discharge had been more difficult, and people were being placed in settings that were not always appropriate because they had the space to facilitate a hospital discharge. This meant people could be placed in settings that were not able to appropriately meet their care needs. One provider told us how one person was discharged to a care home and later identified they were unable to meet that person's needs due to the complexity of their needs, putting that person at increased risk of harm due to not receiving appropriate care and support. The local authority told us of actions taken to improve and support hospital discharge using the "home is best" approach such as the interim care pathway available both in care homes and in people's own homes. The local authority also jointly commissioned care journey coordinators to support people to return home whilst waiting for a longer term care package.

The local authority had a clear process for transitions, however, current staffing levels meant there could be delays in supporting people transitioning from children to adult services. The local authority had recruited some new staff to work in transitions and was awaiting their start date at the time of our assessment. Feedback regarding transitions for young people transitioning to adult care was mixed. One person told us that referrals to the preparing for adulthood team were made in a timely manner and communication was good. Whilst some carers told us they felt the transition between adults and children's needed to improve and that communication between children's services, adult services, and education was poor at times and had resulted in one person missing out on opportunities to promote their independence. The transition from children to adult services started at around 17 years old although staff told us this could be sooner for more complex cases and maybe after the person turns 18 in some cases.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. This was demonstrated in the Community Risk Register. It included multi-agency information, procedures and actions to be taken to ensure an effective, timely response to any localised or major incident, which potentially could impact on people's safety.

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. A provider failure policy was in place to ensure quick and efficient provision of alternative care for people and their carers when needed. However, carers told us they found it difficult to access respite provision in an emergency to prevent carer breakdown.

Commissioning processes ensured access to services in a timely manner, however, access to specialist services was more limited. The local authority had identified there was a lack of local provision for young people moving into adult services. Leaders told us they continued to work collaboratively with commissioning and housing colleagues and ASC had supported and engaged in the development of the 10-year strategy with their housing association strategic partner to improve this provision in the future.

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

The local authority did not consistently have robust systems and processes in place to protect people from abuse and neglect. There was a process in place for receiving and processing safeguarding referrals and the managers provided oversight and decision making in relation to risk. Leaders told us staff had access to the duty chair if needed and cover arrangements for managers would be made if the manager was not available. However, staff told us there was not a clear process if the safeguarding managers were off work and staff would often self-allocate work with a lack of decision-making oversight. This increased the risk of people at high risk of abuse and harm being left at risk for a significant amount of time. Staff told us that they had a 4-day timescale to review safeguarding referrals however, due to demand this was no longer achievable. Leaders told us that staff used a RAG rating tool for safeguarding referrals to monitor risk and that data regarding safeguarding timescales was regularly monitored. Data provided by the local authority showed the expected timescale of 4 days for a safeguarding referral was not always achievable.

The local authority recognised safeguarding, the Mental Capacity Act (MCA) 2005 and Deprivation of liberty safeguards (DoLS) training for staff was an area they needed to improve. Despite this the Adult Social Care Survey data told us that 73.65% of people who used services felt safe, this was tending towards a positive variation compared to the England average of 69.69%, and 93.41% of people who used services said that those services had made them feel safe this was a positive variation compared to the England average of 87.12%. 79.66% of carers felt safe which was similar to the England average of 80.93%. Leaders and staff advised their access to training had improved since moving to the local authority and leaders told us how staff approached them for knowledge and advice.

Staff told us there were safeguarding themes emerging with an increase in domestic violence, self-neglect and cuckooing. Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation resulting in them losing control of their property. However, staff told us that there was a lack of focus on specialist concerns and staff did not feel knowledgeable enough to deal with such complex cases. Staff told us leaders had started to provide training around this and had received seminars on self-neglect to inform practice. The self-neglect policy was currently under review.

Feedback regarding outcomes of safeguarding concerns varied. Some providers told us communication following a safeguarding referral was poor. Partners told us they would not hear an outcome unless they chased safeguarding for an outcome and others told us communication was good, and they received outcomes in a timely manner. Staff confirmed whilst it was best practice to share the outcomes this was not always possible.

Responding to local safeguarding risks and issues

The way the local authority identified safeguarding risk was not consistent. Staff told us that quality assurance through audits had taken place in the past, however, this was not consistent, and staff did not know when the last audits took place and had not received any feedback from audits to improve practice. Records reviewed showed the last safeguarding quality assurance audit was carried out in May 2024, following the transfer. Leaders told us a second audit was due to be carried out at the time of the assessment. Audits were completed on cases that did and did not meet the threshold for a section 42 enquiry.

The safeguarding team managers monitored risk and RAG rated concerns, these concerns would then be passed on to one of the 6 safeguarding chairs who monitor allocation through a duty system which was then allocated to social workers. Staff told us whilst they understood risk and would escalate any risk to their manager there was not a clear process for recording risk. Staff told us if managers were off, the team would allocate work to themselves, this meant at times there was limited oversight and increased risk.

Between May 2022 and April 2024, the B&NES Community Safety and Safeguarding Partnership (BCSSP) received 6 cases for consideration of a Safeguarding Adults Review (SAR), 4 of which met the statutory criteria. As per the Safeguarding Adults Board SAR protocol, all organisations known to be involved with the individuals were notified. The cases were reviewed at the Practice Review Group and learning was identified for all cases, whether they met the threshold for SAR or not. Actions were identified to implement recommendations and learning. BCSSP identified areas of good practice in addition to identifying where improvements were needed in the future. One of the methods they used to implement learning from cases was the creation of 7-minute briefings, which provided key learning to aid practitioners' future practice. The BCSSP implemented an action plan to review the recommendations taken from the Practice Review Group, which included cases that required a Safeguarding Adults Review.

Responding to concerns and undertaking Section 42 enquiries

Some providers told us there was a lack of clarity regarding what constituted a safeguarding concern and when S42 safeguarding enquiries were required. The local authority told us advice and guidance for providers around what constituted a safeguarding was provided on their website and safeguarding portal and was accessible to all providers.

Providers told us they could wait around 6 months to hear whether a concern had progressed to a S42 enquiry. Partners also told us they often had to chase the safeguarding team for outcomes of concerns. Safeguarding Data Return provided by the local authority stated 973 S42 enquiries were received during 2023/24, all of which were immediately reviewed, risk rated and allocated to a Safeguarding Adult Manager, however, it did not evidence when these were allocated to workers to carry out the S42 enquiry. The local authority provided data following our onsite visit which showed just over half of the enquiry decisions were made and allocated within the local authorities' 4 days' timescale. Leaders told us enquiries were RAG rated and allocated based on risk. Staff told us vacancies in the team impacted on their ability to carry out their workload. Leaders told us recruitment across adult social care was ongoing.

Safeguarding Data Return provided by the local authority showed 1147 Deprivation of Liberty Safeguards (DoLS) applications were received during 2023/24. At the time of reviewing the information, 621 referrals were waiting, the longest wait was 2472 days, and the median wait was 307 days. All new referrals were triaged according to the Association of Directors of Adult Social Services prioritisation tool and all referrals awaiting allocation were monitored to ensure their priority status remained unchanged.

Making safeguarding personal

The local authority had identified a need to improve the recording of safeguarding with a focus on making safeguarding personal (MSP). Feedback from people involved in safeguarding was mixed, one person told us they felt respected and informed about the whole process and was given choice, whilst another person told us they had raised concerns and were unclear whether any action had been taken.

Staff told us advocacy support was readily available when needed to support people to have their voices heard. Partners told us they had good communication with the safeguarding team and were involved in assessments, reviews and kept up to date on outcomes of safeguarding enquiries.

Safeguarding adults' collection data told us that 88.37% of individuals lacking capacity were supported by an advocate, family, or friend this was in line with the England average of 83.12%.

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: 2

2 - Evidence shows some shortfalls

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

The local authority was going through a significant transformation which included the "Being our Best programme" which was council wide. More specifically to adult social care, the transfer of staff back in house meant some leadership structures were new and developing. Leaders had a good understanding of where the local authority needed to improve adult social care and had plans in place to improve them. Actions to improve governance such as the implementation of the newer enhanced Power BI data system had yet to be completed. Leaders told us how they anticipated the transfer and review of job profiles within teams would enable staff to work better across teams and have access to support, knowledge, and guidance to effectively carry out their roles. Staff told us communication regarding the transformation and review of job profiles was not openly transparent and this caused anxiety for staff who did not always feel safe and secure in their roles. Leaders and staff identified it would take time for new cultures, structures and processes to embed.

The local authority identified gaps in overall governance which were planned to be addressed after bringing statutory functions back in-house after several years of these being managed by an external commissioned company. Leaders told us they recognised the local authorities' oversight was limited when services were externally commissioned and had recognised that more work was needed to clearly define the standards of practice for example, better oversight and improved quality assurance. Leaders told us there was a clear focus on improvements, the local authority told us senior leaders have implemented a Quality Assurance Framework to support the monitoring and oversight of improvements. We found a strong strategic focus amongst senior leaders, with awareness and openness about where they needed to improve.

Despite staff telling us about their anxiety about the transfer, they also told us the leadership team was knowledgeable and approachable. Leaders told us they were taking steps to ensure they were visible to staff, by visiting teams and holding some lunch and learn sessions to improve knowledge and practice. The implementation of the PSW had helped improve communication between frontline staff and leaders. We saw examples of improvement such as the interim appointment of a PSW, prior to this the PSW role was vacant for 9 months which had negatively impacted on the quality and oversight of practice. Some improvements had been made since the appointment of a new PSW such as providing support to staff to understand the principles of the MCA 2005 and identifying gaps in eligibility following a Care Act assessment and quality of records and assessments.

Staff and leaders told us there was currently a lack of governance and oversight in relation to audits and the analysis of findings. Quality assurance within individual teams was informally carried out with staff discussing complex cases with each other and using each other's knowledge and experience to inform practice, rather than through structured arrangements. Plans were in place to improve overall governance, including an intention to carry out regular audits and further dip sampling of work to quality assure assessments, care plans and reviews. Leaders have also identified legal literacy and record keeping as areas for improvement. Some improvements have already been made, with the implementation of a practice forum in which staff took complex cases for decisions on care and funding. All cases that were presented at the practice forum were reviewed by a head of service or assistant director to improve consistency and oversight, this included any open safeguarding concerns relating to the person. Leaders told us they used this information to inform future learning and improvement. Since November 2023, 741 cases had been presented at the practice forum.

Staff told us identifying risk in relation to delivery of social care duties was mainly managed by the team managers and staff had little insight into how this was done. The oversight and management of risk was inconsistent and varied from team to team, for example, there was no mechanism for risk review in the manager's absence in some teams which could mean work may not be prioritised effectively and could result in harm to a person with care and support needs. The ways that waiting lists were managed was also inconsistent across teams. Performance data did not give a clear oversight of risk. However, there was a plan in place to introduce an improved Power BI data system that would support leaders with quality assurance and easier identification of risks. The Director of Adult Social Care (DASS) told us they had good working knowledge of risk, safeguarding and quality assurance and reported this monthly to the Chief Operating Officer. Leaders attended a newly introduced quality assurance board meeting to ensure strategic oversight of adult social care. Meeting minutes reviewed from 18 July 2024 showed data from brokerage, updates on extra housing, recruitment and finance however, these meetings were yet to be fully embedded in practice.

Strategic planning

The local authority had a clear 3-year strategy for adult social care which was being implemented through an ambitious transformation programme which was taking place at the time of the assessment. However, much of the transformation work was in the early stages and was yet to be fully implemented and embedded.

The local authority told us they were on a journey to developing a positive performance culture with ambitious plans for improvement. Leaders told us their priorities were focused on addressing service gaps and ensuring accountability in decision making. The adult social care strategy had 3 core commitments: to deliver a service focused on empowerment to deliver the support required; to recognise the value of communities, assets and resources available locally to support residents to be active and fulfilled, including the vital roles played by the Community Wellbeing Hub; and to focus on the delivery of quality provision to help people to progress and lead enjoyable and meaningful lives. The local authority described how they would be bold, ambitious, innovative and adaptable to support people to live the life they wanted to lead, as evidenced in their ASC vision and strategy.

Underpinning the strategy was the internal practice offer, which focused on having knowledgeable staff to provide effective support to people in a person-centered way. Leaders identified the need for further training and recruitment to ensure there were enough knowledgeable and experienced staff to carry out their social care duties effectively.

Information security

There were systems in place for the safe management of data. Teams told us how they followed the local authorities processes for safe handling and sharing of information. We also heard examples where information was shared between agencies such as out of hours duty shared with another local authority. There were plans and protocols in place to ensure information was shared and recorded securely.

Learning, improvement and innovation

Score: 2

2 - Evidence shows some shortfalls

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

The local authority was on a journey of transformation at the time of the assessment. Though the strategy was clear and was known by senior leaders, it was not fully embedded at operational levels. Staff told us the transfer back to 'in-house' provision had been positive and feedback from people with care and support needs, and their carers, had also supported this strategic change.

There was a training strategy and delivery programme which was monitored, evaluated and quality assured by a workforce steering group. Local authority staff had ongoing access to learning and support opportunities so that Care Act 2014 duties were delivered safely and effectively. However, data showed staff training levels for safeguarding and DoLs were low, and leaders identified the need to improve the uptake of training by frontline staff. Staff told us the training provision had improved since returning in-house and that they felt encouraged and able to take time to access appropriate training on offer.

There was support for continuous professional development and most staff reported a positive training package within the local authority. However, some staff reported limited opportunity for career progression and others from front-line teams experienced difficulty finding time to access training due to low staffing levels.

There was a handbook to support newly qualified social workers who were completing their assessed supported year in practice (ASYE); it set out the evidence needed to meet the requirements of the regulator for social workers. The staff we spoke with regarding ASYE told us their learning time was protected, they had time to complete the required study, and they had a protected caseload.

Approved Mental Health Professionals (AMHPs) were supported to maintain their professional registration; this was underpinned with guidance on how to ensure they were suitably skilled and trained to carry out their role.

The local authority had adopted an evidenced based approach to learning and development. Leaders had introduced 7-minute briefings, to share learning from safeguarding adults' reviews with staff. A recent example of this was a 7-minute briefing session on Korsakoff syndrome.

The Principal Social Worker (PSW) post was vacant for 9 months before the recently appointed PSW was recruited. The PSW had been in their role for 8 weeks at the time of the assessment, and in that time, they proactively identified several opportunities for improvement. For example, after collaborating with the adult social care teams, they recognised the need for enhanced training on the Mental Capacity Act (2005). As a result, additional support and training were implemented to strengthen understanding and practice.

The local authority had the opportunity to enhance collaboration with individuals and partners to further promote and support innovative approaches that improve people's social care experiences and outcomes. While not all system partners reported strong working relationships with the local authority, staff highlighted a valuable employment, and skills pod available to everyone aged 18 to 65 in the county. They expressed enthusiasm about how this initiative is positively impacting social care experiences and outcomes by focusing on prevention, reduction, and delay of the need for care and support services, demonstrating notable success.

Co-production was not yet fully embedded and senior leaders highlighted this as an area for improvement. The council's strategy highlighted a commitment to 'giving people a bigger say'. A co-production strategy was being developed, and a co-production group had been established. There was a co-production position statement which detailed several projects that had been identified for the year. We were told about a 'Let's Talk about co-production' programme and a co-production community of practice for social care staff. Furthermore, the local authority had engaged with 383 carers to co-develop a carers strategy as a test and learn project for developing and embedding the co-production process. Feedback from unpaid carers involved in the co-production of the carer's strategy was positive, unpaid carers told us how they felt listened to and respected as experts and were looking forward to the strategy being put into practice. However, some carers told us they were not aware of or had not been involved in any co-production work. The local authority's self-assessment detailed a plan for empowering staff to co-produce and co-design the adult social care offer for the population. However, staff were not familiar with what this was and what it meant.

The local authority shared learning, best practice and innovation with peers and system partners to influence and improve how care and support was provided. They worked as part of the local integrated care alliance to develop and innovate practice through shared learning, for example, through the use of a case study to highlight the need for more aligned working with other agencies. The need for improved practice in this area was highlighted by some adult social care teams who told us they did not understand the roles of other teams. Staff told us this meant that multidisciplinary working could be challenging at times, with an 'us and them' culture presented in some areas. Some staff said experience and knowledge was not always considered when allocating complex cases and this had impacted negatively on their confidence in supporting good outcomes for people with complex care and support needs.

The local authority participated in peer review, and they were involved with sector-led development activity. Staff and leaders engaged with external work, including research, and they embedded evidence-based practice into the organisation. For example, they invested in legal literacy training for staff to enable defensible and ethical decision making to reflect research and best practice guidance. The local authority told us in August 2024 they invested in a 2-year contract with Research in Practice for all Social Care staff. The local authority also told us about work being carried out with the Department of Health and Social Care and 4 other local authorities to look at ways to improve the Adult social care assessment.

Managers were using a business intelligence data platform to analyse data and manage waiting lists leaders told us a new and updated Power BI version was being implemented to improve oversight of waiting lists and risk, however this was not in place at the time of the assessment. There was a plan for all staff to use the new system, but it had not yet been rolled out as staff required training first.

Learning from feedback

The local authority gathered people's feedback about their experiences of care and support, and feedback from staff and partners. However, this was not consistently used to learn and improve services. Some feedback data had been used to inform strategy but processes to ensure that learning happened when things went wrong were not consistent or embedded in all teams. Processes for gaining feedback from people with care and support needs, or their carers, were not consistently followed. For example, staff told us the local authority had recently carried out a piece of work regarding hospital discharge and reablement to gain feedback from people who used the services, this was done by asking people to complete a questionnaire however, staff told us they were unclear whether any replies had been received and whether there had been any analysis of this feedback to improve practice. This meant the local authority had potentially missed an opportunity to share any learning from this to staff and to improve people's outcomes.

Feedback from people with care and support needs was positive with people saying assessments supported them the way they liked, and that staff were friendly and knowledgeable. Staff were proactive in gaining feedback from other professionals they worked with. We saw forms used to gather this feedback, which was positive.

There was a complaints process and complaint numbers for adult social care had been reduced. Seventeen complaints had been upheld in the previous year resulting in a 25% uphold rate. One complaint had been upheld by the local government and health service ombudsman. The local authority has produced and implemented an improvement plan in response to the report which set out key areas of development.

However, performance and quality assurance were not effectively embedded in the local authority culture. For example, highlights of learning from complaints, complaints data, and survey feedback were not well known by senior staff or leaders. Highlights were not consistently communicated to wider staff groups which hindered the learning being used to improve practice and achieve better outcomes for people. The local authority told us they had implemented a new Quality Assurance Framework to ensure robust progress monitoring and assurance reporting of identified areas for improvement however, this was yet to fully embed in practice.

Leaders encouraged reflection and collective problem-solving. Staff told us there were regular supervision arrangements and some staff reported team meetings where caseloads, outcomes of peer reviews and audits, compliments, and complaints were discussed.
