Derbyshire County Council: local authority assessment

How we assess local authorities

Assessment published: 16 August 2024

About Derbyshire County Council

Demographics

Derbyshire County Council is a large County Council with a population of 794,600 people. There are 8 District and Borough Councils across the county. The county is a mix of rural areas with centres of population in the towns across the county. The population had an Index of Multiple Deprivation score of 4 (1 is the least deprived 10 is the most deprived). The Eastern boundary of Derbyshire had greater levels of deprivation, as did those in rurally isolated areas who had additional challenges of rural transport networks.

Derbyshire had an above average population of over 65-year-olds, 22.33% compared to 18.31% nationally, and an ageing population. The population of over 90-year-olds, was projected to more than double, by 2043. Derbyshire's ethnic diversity was reported to be mainly White British, at 96.31% of the population.

Derbyshire County Council is located within Joined-Up-Care Derbyshire: The Integrated Care System with Derby City Council.

The local authority was Conservative led and had a stable leadership team, including the elected members and local authority staff.

Financial facts

The financial facts for **Derbyshire County Council** are:

- The local authority estimated that in 2022/23, its total budget would be **£1,058,965,000**. Its actual spend for that year was **£1,187,534,000**, which was **£128,569,000** more than estimated.
- The local authority estimated that it would spend **£283,795,000** of its total budget on adult social care in 2022/23. Its actual spend was **£330,009,000**, which is **£46,214,000** more than estimated.
- In 2022/2023, **28%** of the budget was spent on adult social care.
- The local authority has raised the full adult social care precept for 2023/24, with a value of **1%**. Please note that the amount raised through Adult Social Care precept varies from local authority to local authority.
- Approximately **12120** people were accessing long-term adult social care support, and approximately **3545** people were accessing short-term adult social care support in 2022/23. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

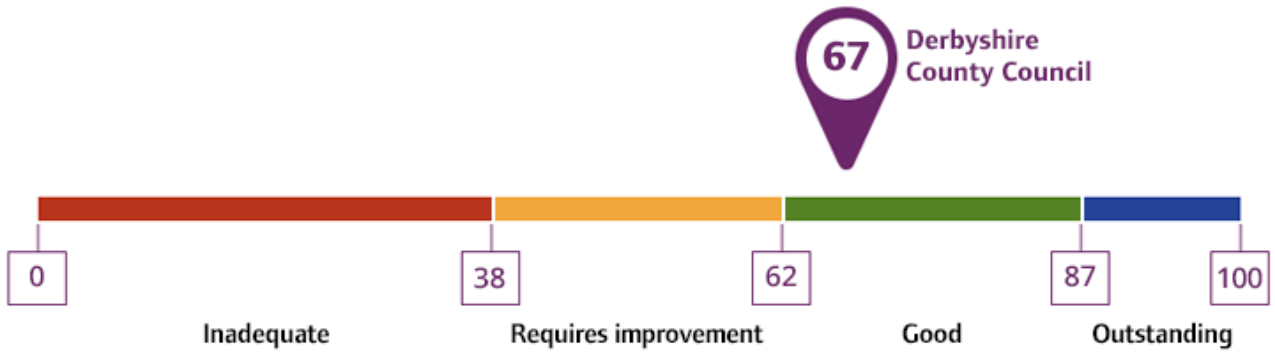
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Derbyshire County Council

Good



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 3

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 3

Partnerships and communities

Score: 3

Safe pathways, systems and transitions

Score: 3

Safeguarding

Score: 2

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People's experiences of their assessment, care and support in Derbyshire was mixed. We heard many examples of joined-up care, where people's needs were put first and staff described a commitment to supporting people. People in more rural and difficult to access places were less likely to get the full range of community services and homecare could be a challenge to organise. However, feedback from people showed staff demonstrated a strong level of creativity and purpose in keeping people well and at home for longer.

People felt supported and helped around hospital discharge, which was demonstrated in the data and in feedback we heard. The carers organisation, commissioned by the local authority, was valued and gained positive feedback, although the data told us fewer carers were able to live the lives they wished, than the national average. We also heard positive feedback about the transitions service from some people, however some carers described a lack of continuity between Childrens and Adults services. Some people also told us their care plans and reviews were not up to date, whilst others said their assessment and care needs were met.

We heard some accounts of care not being fully joined up and where services had been difficult to find. Greater clarity of advice about the cost of care, featured in feedback as did co-production and listening to people when designing services. People felt they had more control over their daily life and were satisfied with their care and support in Derbyshire than the national average.

Summary of strengths, areas for development and next steps

The local authority was part-way through significant transformation and changes were in-development. There had been changes in the operation of Adult Social Care functions, over the preceding six-months. As a result, some strategies and plans that would have provided a strategic framework to the directorate were postponed. Occupational therapy and reablement interventions were central to the local authority's transformation and were a focus of improving the outcomes of their short-term work. Significant team-structure changes had begun to operate at the front-line, and this had been achieved at pace. However, the new structure needed time to embed, and the short-term and preventative work needed to be 'tethered' or linked to a strategy, in order to allow a full evaluation of its effects and the sustainability of the new model.

The strategic vision of this work was evident from leaders and the messages around transformation were fully reflected by staff. The local authority was in a period of formal consultation on proposals to reduce the size of its in-house care services and to focus on providing short-term reablement services and long-term dementia services. This was consistent with their strength-based policy and came across as a 'mission' across the local authority. Leaders described the inherent challenges and the measures they had put in place to evaluate outcomes. The re-modelling of teams to work in an early-intervention and prevention focused way was demonstrating good outcomes in preventing, reducing and delaying people's needs for longer term care, alongside health partners. Although feedback from people and partners was mixed as to its effectiveness, for example with social worker availability.

Leaders described the levels of need and deprivation in different parts of the county. The local authority had noted, in advance of our assessment it had plans to understand its population, more fully in the future. Staff and leaders did not describe to us consistently how they worked with people with a range of care and support needs, or how they worked to remove barriers to care for seldom-heard groups.

There was a sense of 'permission' in staff teams, to do what was needed to keep people well. There were many examples of staff reducing duplication by sharing work with partners which are detailed throughout this report. Social work assessment waits in hospitals had been low, demonstrating a well-resourced and organised system. However significantly more people over 65 years of age returned to hospital or entered longer-term care settings following discharge, than the national average. Direct Payments were used in an innovative and enabling way to support care in a mixed geography, and when there were unique personal preferences. Short-term direct payments addressed issues where the speed of arranging a care package was a factor for people getting home or for those who lived in isolated settings.

A digital strategy was in-development and the local authority had just appointed a new digital director. We heard about plans to bring significant improvements to the Derbyshire shared-care record and other enabling systems to improve safe systems and respond to Safeguarding Adults Reviews. The communication of outcomes of safeguarding concerns to those who raised them could be improved.

Market shaping and commissioning was also part-way through transformation with a clear direction of travel. There was mixed feedback following the closure of traditional learning disability day services around maintenance of friendship groups, although a report to scrutiny from February 2024 demonstrated positive outcomes. A clear strategic direction of enabling a market to flourish through a reduction of in-house services was described. Co-production and involving people, was an area for development to design a service offer that meets people's needs.

The findings of this assessment broadly mirrored the local authority's self-assessment of its work (provided to the CQC ahead of the site visit). It was, therefore, self-aware with plans in place to address development areas.

Theme 1: How Derbyshire County Council 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

'Call Derbyshire', the main contact centre of the local authority, was the most frequently used route for people requiring adult social care assessment and advice. We also heard about access via an online form, but the call-centre was most prominently used and how people most often accessed the service. The 'person journey' process stated that a person contacted Call Derbyshire for 'advice information, simple equipment and signposting' and feedback from people was mixed, with some reports of long hold times and difficulties around getting support.

Teams were reorganised in January 2024, to promote short-term interventions and enable more effective use of longer-term care and support. We heard the front-line staff in Adult Care Assessment and Triage Team (ACATT), resolved 61% of enquiries, with the remaining 39% being sent to locality social work teams, occupational therapy or mental health teams, for further assessment. The person journey diagrams showed this later stage also took an early-intervention and strength-based approach, with cases being closed where this was appropriate, following advice and signposting. People with eligible needs were identified at this point in the process. However, feedback was mixed about how people were finding the new process, there were fewer named workers and some concerns were raised about consistency.

Front-line staff coordinated people's support and enabled low level intervention and wellbeing across different agencies and services. The Short-Term Assessment and Reablement Team (START) was deployed when a person requiring assessment was in hospital or at home, following referral. Their process document described how the choice and goals set by the person were incorporated, and the use of strength-based approaches. It also showed how people worked together with clear timescales with enablement, social workers and occupational therapists. There was a strength-based policy and staff consistently described using this approach in their assessment and reviews. There were mixed reports about how the new duty system worked, so far, in terms of being able to build on people's strengths and meet their needs.

Some people reported communication from social workers was positive, with their goals and wishes included in care planning. Others said their abilities and wishes were out of date, or not adequately considered in their care plans. Despite this, the percentage of people in the Adult Social Care Survey (ASCS) satisfied with their care and support was higher in Derbyshire (69.29%) than the national average (61.21%). Similarly, 80.02% of people felt they had control over their daily life with 77.21% being the national average. 44.84% of people had as much social contact as they would like, which was similar to the national average 44.38%.

Social work staff in localities managed differences in geography well and they triaged and enabled independence according to people's needs. The Community Connector service was used to help people find different opportunities in the community. People were encouraged to try new things and they reached into local resources and built relationships with families. The Better Lives review team worked with people who had long-standing support arrangements and used strengths-based approaches to review care plans.

Timeliness of assessments, care planning and reviews

The social work assessment waiting times in acute hospitals over the last 12 months were short, at one day or less. The Adult Social Care Finance Report (ASCFR) Short and Long-Term Support (SALT) data, showed 78.6% of long-term support clients had been reviewed, which was significantly higher than the national average of 57.14%. Staff said, because of the recent changes to team roles and the duty system, people waiting for assessments had been seen more quickly and overall waiting times had reduced. Review timescales were clearly set out in the policy, however feedback from people and from partners was mixed on whether these timescales were consistently met. One person told us they were able to be discharged from hospital and return home following the support they were given, whereas others said reviews were not regular.

The occupational therapy (OT) service had recently been redesigned and improved and was central to the local authority's revised front-line offer. They had established a principal occupational therapist role and three service managers, to address timeliness of assessments. They had developed a new coordinator post to reduce administrative work and to follow up on system partner recommendations and improve team communication and efficiency. The local authority had introduced a tool which enabled staff to develop a consistent approach to prioritisation and allocation, but it was too early to evaluate the full effectiveness of this approach.

Social workers told us workloads were generally high, but risk was managed effectively using a Red Amber Green (RAG) system, which was reviewed and re-prioritised regularly. The recently adopted practice framework was also being used to standardise the quality of assessments and waiting times. Some partners reported reviews and assessments were not easy to plan or request and levels of involvement with partners was dependent on the social worker. Out-of-hours social workers used short-term assessment plans (STAP), to arrange care quickly and senior managers effectively reviewed staffing levels, based on demand and complexity. There were no waits for Approved Mental Health Professional (AMHP) assessments and enabling mental health support.

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

Derbyshire carers association undertook carers assessments and provided support for unpaid carers with information and advice, emergency planning, helplines, training, calls and visits. Carers described Derbyshire Carers to us in positive terms, reporting an invaluable service. We heard examples of practical and financial support being arranged for carers. We heard they informed carers they were entitled to a review before the usual twelve-month period, if their circumstances changed and they were introducing a text-message service to prompt carers when they were due a review. There was a prioritisation system following referral and a target of 3 days for initial contact and the average wait for a carers assessment was 2.5 weeks. Front-line staff reported excellent working relationships. It was clear people were identified as carers and supported following an assessment in a person-centred way, distinct from the needs of the person they cared for. A pathway for direct payments to be set up for carers was clear and effectively used.

There was a young carers service pathway which offered 1:1 sessions, assessment and support with a care plan. They worked with schools or health staff and workers linked the young person to community groups in their own area. Due consideration was given to young carers who were in a transitions service and the offer included respite needs.

Data from the Survey of Adult Carers in England (SACE), showed more carers (42.92%) than the national average (32.37%) accessed support groups or someone to talk to in confidence. However other metrics showed similar or worse performance to the national average. For example, only 13.64% of carers felt they had control over their daily life compared to a national average of 22.1% and 26.36% of carers felt they had encouragement and support, with the national average being 31.47%.

Data showed only 8.76% of carers in Derbyshire accessed support or services allowing them to take a break from caring at short notice or in an emergency, compared to the national average of 10.76% (SACE). 11.52% of carers accessed support or services allowing them to take a break from caring for greater than 24hrs, with the national average of 13.56%. And 16.97% of carers accessed support (or services) that allowed them to take a break from caring for 1-24hrs, with a national average of 20.08%. Only 10.45% of carers said they were able to spend time doing things they enjoyed or valued with the national average being 16.22%.

It was clear the authority had a carers strategy and the carers organisation, funded by the local authority, was very well regarded with consistently positive feedback. There was also consistent feedback from carers there were not sufficient options or resources for them to access respite or breaks. Some staff worked flexibly to use periods of low demand to offer a sitting service for carers. Unpaid carers told us their lives were made better by the equipment provided from the equipment service.

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

The local authority's policy stated implementing strength-based support ensured effective information, advice and support was available to people (and their carers) who did not meet the eligibility threshold. There was information on its website about prevention services, an online information finder, a first-contact scheme, advice on benefits and other support, and information about how people could buy or find support. Equipment and advocacy services were featured online, along with information about transitioning from Childrens to Adults services.

Staff described how they offered alternatives to people when not eligible for funding. The brokerage service worked well with people who did not meet the criteria for local authority commissioned support, sourcing homecare for example. We heard from people how social workers had supported them around their wider needs, which had been beneficial to their long-term wellbeing.

Eligibility decisions for care and support

The local authority provided information about how they undertook Care Act assessments and their pathways for complaints and appeals. The authority performed slightly better (68.92%) than the national average (64.63%, ASCS), in the number of people that did not buy further 'top-up' care. A tiered-approval panel arrangement was in place to consider extra funding if there were concerns that the package of care did not fully meet the needs of the person. A financial review panel was introduced in October 2023, following learning from an ombudsman complaint and since then twelve referrals had been made to the panel.

Financial assessment and charging policy for care and support

There was a backlog in financial assessments which impacted payments to services. The median wait for financial assessments was 21 days, but the maximum wait was 388 days. The savings threshold for charging for social care was in the process of being reduced to the statutory minimum, in line with most other local authorities. We heard from people using services, that there had been confusion following its communication. The telecare service, providing people with someone to call for help if they suffered a fall or became otherwise unwell, had also recently become chargeable for some people. Feedback included that those at risk of falls, who might not have felt able to pay for this service, may be adversely affected. We heard consistently financial issues were a real concern for people. People said financial assessments were not always accurate, which had compounded anxiety around changes in charging arrangements. We also heard some families and carers didn't understand the reason for increases in charges, for example when a family member was moving into a nursing home.

The local authority had an Adult Social Care Digital Strategy in place (2022-2025). There was an online customer portal for financial and eligibility assessments. However, we heard the online financial calculator, which was designed to give people information about their level of contribution, was difficult for people with accessibility needs to use. We also heard about digital blackspots where certain rural areas did not have broadband and there were issues about digital exclusion.

Provision of independent advocacy

There had been a very recent change in advocacy provider, with a new provider starting its contract two weeks before our visit, which generated mixed feedback from people, staff and partners. Some staff told us they found it simple to access an advocate (someone who can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations) for a person, whereas others said it had been difficult in some cases. Advocacy and Healthwatch representatives were on the Integrated Care System and partnership boards and they provided effective representation in the system for the people they worked with.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The Adult Social Care Survey (ASCS) showed Derbyshire consistently performed above or at the same level as the national average on indicators relating to keeping people well and preventing further need for support. For example, 66.15% people, said help and support helped them to think and feel better about themselves compared to the national average of 62.32%. 70.26% of people reported they spent their time doing what they valued or enjoyed, with the national average at 68.17%. 93.75% of people who received short term support, no longer required support, far higher than the national average of 77.5%. Survey of Adult Carers in England data showed 86.9% of carers found information and advice helpful with the national average of 84.47%.

We heard consistently from front line staff about many different projects supporting people in the community, and these were effective in supporting people's wellbeing. Direct payments were used to meet assistive technology needs and to overcome geographical barriers to care, for example one person lived on a boat and another person lived across a large field. Geographical factors meant rural areas did not receive the same level of wellbeing work, however we saw specific mental health work being undertaken in rural areas.

The Public Health teams and the Adult Social Care teams had been combined as one directorate. Leaders articulated the benefits of this in terms of preventing, reducing and delaying people from needing high levels of support through better integrated working. The prevention strategy was recently delayed to incorporate work with partners. We heard feedback that the local authority had a sense of ambition about early-help and prevention. There was a consistent message from leaders within the local authority and Integrated Care Board (ICB) system about pride in their current partnership provision and how they wanted to do more together in the future. The Community Transformation Partnership (Living Well) was a multi-disciplinary community mental health team involving social care and health professionals alongside VCSE workers. It offered short-term care packages of up to 12 weeks, to people who did not meet the threshold for community mental health (CMHT) intervention.

Provision and impact of intermediate care and reablement services

Reablement staff in localities supported people to regain their independence. Partners worked together to better understand people with higher frailty scores and people with multiple conditions. The local authority provided step-up and step-down beds to support admission avoidance, discharge and system flow. Mental health enablement was also available, which avoided longer-term support.

Intermediate care was governed and funded through the Better Care Fund (BCF). A consultancy had been engaged by the local authority and health partners to evaluate an optimum use of intermediate care resources. The system worked effectively together through hospital discharge 'hubs' and followed the different discharge pathways, with the VCSE as equal partners. In periods of high demand, discharge pathways 1 (low need and low intervention including reablement at home) and 2 (reablement and intermediate care in bed-based provision), could be overstretched leading to longer-term care packages.

Significantly more people over 65 years of age were re-admitted to acute-care and long-term care in Derbyshire, than the national average (65% of people aged 65+ were still at home 91 days after discharge, compared to 82.18% nationally - Adult Social Care Outcomes Framework ASCOF). Leaders and partners recognised and described how the intermediate care system was being improved. Although work was underway, this was yet to be reflected in the data.

Access to equipment and home adaptations

Long-term home adaptations work had been successfully separated from short-term work. The Short-Term Assessment and Reablement Teams (START) and Adult Care Assessment and Triage Teams (ACATT) had reduced waiting lists through a 'Simple Service', which offered direct assessment without the need for a professional assessment. There was a 'waiting well' system which involved staff calling people who were waiting, to reassess their needs in case their situation became more urgent. The occupational therapy (OT) service during the day and the out-of-hours service, sourced equipment and provided moving and handling plans, reducing unnecessary care placements. People reported very high satisfaction with this service and told us the equipment provided made their lives better. The local authority exceeded its 95% target for the provision of equipment on time, at 99%.

Mediequip, the integrated community equipment service, worked well and utilised approval panels for specialist items, although market-availability of products could be an issue. This was a dual-funded contract between the local authority and the NHS through the Better Care Fund (BCF). We saw many examples of specialist teams using assistive technology to support people to maintain their independence and meet sensory needs, and examples of direct payments for assistive technology. A new technology contract for equipment and alarms supported people to remain in their own home and provided a risk-flag to services if there was a change in activity. There was often a very long wait for home adaptations. Minor adaptations, such as a level access shower, had an average wait of 9 months and major adaptations at 18 months.

Provision of accessible information and advice

In Derbyshire more people (67.73%) found it easy to source information about support than the national average (66.26%). 62.76% of carers found it easier to access information and advice, compared with 57.83% nationally (SACE). People and partners told us that increasingly information was only available online, which could be a barrier. We heard positive examples from people that they felt supported with advice and information. Other people said the range of support on offer to unpaid carers had not been fully explained.

Information was available about people's rights under the Care Act, including in easy-read format, braille and languages other than English. 'Care choices' was a 100-page digital guide with accessible information, in a recite-me compatible format. There was also a guide to adult social care containing the whole range of required information. The easy-read version of the equality and diversity policy also provided an explanation of fairness in the process and staff confirmed these were successfully used.

The local authority had funded a VCSE service for an information and advice roadshow, particularly in rural communities. Public health also provided funding for organisations to reach into farming communities to address the digital divide. Sensory services had provided low-level advocacy information and advice to communities. There were also Derbyshire Gypsy Liaison Group (DGLG) workers in relevant areas.

Direct payments

Data showed a very strong practise of using direct payments. There was a mean-average wait of 18 days and a median wait of 14 days for direct payments to begin. Significantly more people accessed direct payments in Derbyshire than the national average. 47.9% of service users aged 18-64 accessed long-term support (national average 38.06%) through a direct payment and 19.14% aged over 65 (national average 14.8%). The proportion of all service users using direct payments was 31.4%, above the national average of 26.22%. (ASCOF/SALT).

Staff reported very positive uses of direct payments within the whole range of service functions. People told us direct payments had enabled them to have care that helped them to live their lives. Examples included, people and carers using direct payments to go away for the weekend and for support with cleaning. Short-term direct payments had been used to bridge gaps during waits for long-term direct payments. There was an example of a short-term direct payment being used to support hospital discharge, before a care package could start. The Direct Payments team worked with social work staff, providing information and myth-busting, to encourage the use of direct payments. We heard from staff and people using direct payments about difficulties in recruiting personal assistants due to levels of pay and availability of the workforce.

Recent closures of in-house day service provision led to some feedback from staff and people using services, about care being organised differently. We heard some people found it difficult to maintain the friendships they had built and there was concern about the level of meaningful daily activities available. However, we heard one example of a friendship group being maintained through a joint Personal Assistant (PA) arrangement, enabling them to access football. Direct payments had been used to meet individuals' choice preferences, for example in mental health services when individuals had fluctuating needs or specific preferences about providers. Direct payments had been used to support care for people living on a boat, where their home was across a field or where it had been difficult to organise care sustainably through traditional measures. We heard positive stories from people and staff about direct payments enabling people to live the lives they wanted and remain in their own home for longer.

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

Leaders, staff and partners mainly described addressing equity in terms of service delivery and digital-equality for the rural population and the deaf community, with very little description about other groups that could be affected. Ethnic minority communities made up a very small proportion (<4%) of the population. Staff and leaders told us about eastern European communities and post-mining communities. Partners and leaders said they wanted to do more to reduce health inequalities and address barriers to care in the population. The Joint Strategic Needs Assessment (JSNA) captured this which fed into Integrated Care Board (ICB) and the Health and Wellbeing Strategy. There was a Black and Minority Ethnic (BME) partnership forum in place which provided engagement and feedback on policy and service developments.

The ICB was part of a pathfinder programme with National Health Service England (NHSE). The Director of Public Health was engaged in this project around health inequalities in terms of race. We heard the Black and Minority Ethnic (BME) local authority staff forum, worked with the health and social care sector and involved the carers organisation. Staff described working for an inclusive organisation where they felt accepted and able to be themselves and we heard about work-place networks such as the neurodiversity group. Staff asked people using services about protected characteristics which was introduced into conversations from the first point of call. The local authority had several over-50s groups in localities and it recognised the challenges and opportunities arising from a rising older population in the county. People attending these groups told us they felt listened to and involved.

The carers organisation offered a telephone befriending service for isolated carers in the rural population. We heard they intended to support more seldom-heard carers from ethnic minorities, Lesbian, Gay, Bisexual and Transgender (LGBT) carers and those caring for people with substance misuse issues. They did have a male carers support group.

Equality and diversity considerations were included in providers contracts and there was a quarterly monitoring tool providers completed, demonstrating how they supported people with cultural needs. Staff told us the equality impact assessment (EIA) process was actively used by managers across adult social care. We heard an example where colleagues across the local authority had used adult social care as a good example of an EIA.

Derbyshire local authority had not always communicated and coproduced with groups effectively and some seldom-heard groups reported the relationship with social workers could be improved. However, we saw efforts had been made to liaise with groups and direct payments had been used to support individual outcomes.

The local authority committed to adult care and health participation by people using services, or requiring care, in their strategy. It stated they would inform, consult, involve, co-produce and empower people. The inclusion strategy also described how the gap between the most and least deprived had widened, citing the Covid-19 pandemic as one reason for deepening inequalities. A workstream for each of the priorities had been established, however progress on this was not clear.

It was positive to see neuro-development hubs had been provided in the county to support autistic people.

Inclusion and accessibility arrangements

There was mixed feedback on inclusive accessibility arrangements. Some staff felt able to access interpreters and information in different formats, and other staff reported difficulties. Some people said speed of access to accessible information was an issue. Responses about access for people centred around rurality and we heard examples of individuals offering translation services themselves. Staff working with health colleagues described using them to source interpreters and we heard one example of a health professional being used as an interpreter, during a mental health act assessment. Some communication barriers had been difficult with people seeking asylum, in for example using international sign language.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

Through the Joint Strategic Needs Assessment (JSNA) the local authority demonstrated an understanding of diverse health and care needs with data showing a strong correlation between deprivation and health outcomes. It identified 20% of the population were experiencing deprivation. The JSNA also identified learning disabilities, dementia, autism and neurodiversity as areas to address for both children and adults. We saw evidence of action on this data with the roll out of Neurodiversity hubs. There was also a joint dementia strategy, and an integrated all-age autism strategy, which had been initiated following it. There was an impact assessment which recognised the link between housing and health outcomes with a collaborative agenda to tackle this issue with partners.

The JSNA had been used to shape services and staff described plans to do more with the information in terms of understanding the differences in their population. Data had been collected to inform models of care for example, there were gaps identified in the provision of nursing care home and dementia care home provision which was considered in the market position statement process.

Market shaping and commissioning to meet local needs

A significantly higher proportion of people (78.54%) than the national average (69.81%) felt they had choice over the services they used locally (ASCS). The market position statement made specific reference to identified groups in planning and shaping future services. This included new care and accommodation services, new crisis prevention and support services and clinically led care for those with complex needs. There was a collaborative approach towards a more community-based support offer for people with learning disabilities. A summit on 'building the right support' in terms of care and accommodation had been held. There was an all-adults housing accommodation and support strategy that focused on independent living and housing with support. The local authority was successfully working to their own targets of moving people with learning disabilities from more traditional settings such as care homes, into less restrictive settings such as supported housing.

There were significant levels of in-house provision of residential, domiciliary and day services. Leaders described a strategy to shape the market to improve the range of options for people. They explained how their move away from in-house long-term homecare had enabled a more sustainable independent sector market to develop. The local authority was in a period of formal consultation on proposals to re-design and re-size their in-house residential services to focus on short-term reablement services and long-term specialist dementia beds. This strategy was working in its early stages with services being used to support the discharge of people from hospital.

Staff from a variety of teams reiterated the transformation from in-house care provision to an enabling model of community support. We saw examples of commissioning practices enabling people and sectors, such as the homecare framework which increased the number of providers available to the local authority from 55 to 96. There was also flexibility in contracts around volunteer outcomes and service user outcomes. The commissioning team had a direct link to housing teams in districts to get appropriate housing to meet people's needs.

Partners and providers reported mixed levels of confidence in the local authority's plans for the future. There was some concern over funding stability, and risk around geography and capacity in the homecare market. There was a sense of detachment and a lack of involvement in market shaping, from some partners. However, an example was provided where the local authority had worked very positively to reshape a provider's services.

Ensuring sufficient capacity in local services to meet demand

The market position statement highlighted key pressures in the local authority for homecare, extra-care and nursing care provision particularly in the more rural parts of the county. It identified a challenge to develop and sustain care homes in specific areas, at affordable rates. New care homes had focused on areas where there was a strong self-funder market, with fees charged above those paid by the local authority.

The requirement for high staff-ratios had led to some providers informing the local authority that risks were too high to operate. Data showed admissions into residential care had decreased with an average occupancy of 85% and demand for homecare had increased at a rate higher than the pre-pandemic year of 2019. Senior leaders described plans to address this as part of transformation.

Recruitment and retention of skilled workers and a reliance on agency workers, was a challenge. People said homecare staff shortages had an impact on their daily life and their sense of choice and control. People in rural areas found it particularly difficult to access homecare and other facilities such as transport. We heard one example of the local authority supporting providers sponsoring overseas staff, but otherwise there was mixed feedback about support for providers around recruiting staff. Staff described some difficulty in finding care providers due to recruitment issues but said this may be improving. There was significant variation in different parts of the county with less choice for extra-care services for example. The senior leadership team had identified homecare as a priority and there was a new framework to facilitate prepaid rounds and block contracts.

Staff reported resourcefulness and creativity in meeting people's needs. There were good relationships between commissioning staff and staff in localities in arranging support for people in the community and in reporting gaps in provision. 'Team up', the locality partnerships where staff from health and care worked together, were described as being helpful in arranging care. The short-term service had daily huddles which helped colleagues to review who would offer support effectively. There was a focus to increase the provision of assistive technology for people to remain independent for longer.

It was challenging to access mental-health impatient beds out of hours, which increased out of area mental health placements. Mental health concerns had increased, including cases of self-neglect. Partners reported gaps in support for people with mental-health difficulties and younger people, especially those with communication needs. Positive feedback was given about supported-housing improvement projects and additional intensive housing support. There were plans to develop four supported living services and one residential care service in the county.

Leaders told us there was a sizeable nursing gap and people told us there were gaps in services for autistic people over the age of 25. We saw that people with complex needs were difficult to place. Leaders described an intention to provide specialist dementia beds and short-break services in-house. Out of area placements had risen over recent years with 334 people currently placed out of area. In the past 12 months there were 84 out of area placements. In 2023 there was an increase of 34%, mainly in older peoples' nursing and residential care placements.

The better lives residential review team had reviewed care packages for all people of working age in residential care and a new contract had been developed to promote quality and value for money. The specialist placement review team intended to complete assessments and support plans and review all out of area working age adults' placements, over the next 12 to 18 months.

Ensuring quality of local services

Data showed the CQC ratings of regulated providers in the local authority area, were generally slightly lower than the national averages. For example, there was 68.63% good-rated nursing care with the national average being 72.11% and 73.65% good-rated residential care with the national average being 75.95%. Good-rated supported living services was 42.42% with the national average being 63.95%. However, homecare was 67.16% good-rated with the national average at 59.21%.

Providers completed quarterly quality assurance returns and the local authority used annual checks, including around financial and information governance requirements, to check there were secure data-systems in place. Intelligence gathering meetings regularly occurred with partners to share information about services and provide assurance about placements and improvements. Feedback was positive around the support offered to providers, for example the local authority was proactive in supporting providers to improve and celebrated success. We heard positive examples of improvement support to providers following CQC inspections. For example, all care home providers had signed up to the local authority's terms and conditions and received appropriate support and monitoring, however this did not include those without local-authority residents living at the home.

The local authority gathered people's voice around experiences of services using different methods including complaints, compliments and social workers' concerns and we heard the 65 (years old) service stakeholder engagement team involved Experts by Experience (people with experience of services who provide insight to help service improvement). Specialist services were developed for people, following discharge from long stay hospital placements. The commissioning team used storyboards and person-centred tools to gather individuals' views on these services and quality questionnaires were used in frontline services to gather feedback.

The local authority provided each homecare agency with an electronic monitoring system at no cost, which had led the local authority to receive 87% of the care it commissioned, and significantly fewer missed calls. Medication administration and management support was written into contracts and followed up through quality monitoring. We heard the Integrated Care Board (ICB) usually led in this work in nursing homes, in partnership with the local authority. Two provider-forum summits were held last year to develop a deeper understanding around the social-care workforce and support joint working. We heard integrated working with the health service around care plans had improved.

Ensuring local services are sustainable

Leaders described the transformation plans clearly around maintaining a sustainable market and mitigating challenges around demand for care services. They described workforce as a major challenge and therefore there was a recent proposal with the Integrated Care Board, for a one-workforce approach across health and social care. Derbyshire performed better than average on staff vacancies with 9.14% of all adult social care job vacancies and a national average of 9.74% (Skills for Care). Sick days were slightly higher in Derbyshire (8.38) than the national average (6.24) (Skills for Care). We heard a social work apprenticeship programme was in place to help meet future workforce needs. Frontline staff consistently spoke about how they worked to manage staffing challenges, they reported pay affected retention, however some teams had very high retention rates with many staff working in the authority for many years. The overall staff turnover was 16%.

The people strategy's priorities involved attracting and retaining the best people, promoting diversity and inclusion, enabling a responsive workforce with a view to develop transformation, well-being and safety. The local authority recognised systemic challenges in its adult workforce strategy, it outlined key workforce priorities including skilled workers to reflect diverse communities and to meet registration regulation requirements.

The specialist accommodation and support strategy, demonstrated the care arrangements for people under 65 years of age living in specialist residential care homes, were under review to support people to live independently. The homecare scheduling team were also expanding to deliver emergency care-worker cover which aimed to replace the use of agency staff. Providers reported good relationships with colleagues in the contract team but there were some issues around accessing social workers. On one occasion when people had to move out of a care home due to a health and safety issue, it was managed well and supported by social workers.

Provider business continuity plans were checked by the local authority as part of their quality audit system. Payment of fees was sometimes not achieved on time, but we heard the local authority was responsive to any escalation of payment issues. Providers told us that in the information around fees there was a section about the living wage, travel time and sick pay. We heard there were assurance frameworks to ensure appropriate working conditions within domiciliary care services and they encouraged an enhanced rate of pay. Providers felt however, that the fees did not take into account the running of a business and the true cost of care. We saw modern slavery risks were built into procurement and monitoring arrangements.

There were 396 active providers in Derbyshire, with 23 non-active providers. In the past 12 months one nursing home and five residential homes had ceased contracts with the local authority and exited the market. Reasons given for these included financial viability, retirement and services feeling unable to meet regulatory requirements. Three supported living services, one specialist extra-care service and one community care provider handed contracts back to the local authority for sustainability reasons, withdrawing from the area and ceasing that type of provision. No homecare provider contracts had been handed back or left the market.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority shared joint work with the Integrated Care Board (ICB) to deliver local and national objectives. To provide a framework for alignment across the area, the chief-executives in Derbyshire, including the ICB, VCSE and local authority, met regularly to discuss and align their work around socio-economic regeneration. In terms of local objectives, they recently considered the adult social care fund.

Leaders said the future of social care included integrated teams and described an opportunity to invest in joint work to meet system challenges. They wanted to build on the work of some frontline staff, particularly in mental health, who had strong system relationships because they had experienced significant benefits from working together in the community. Leaders reported the voice of adult social care was heard in the ICB, but not as strongly as health partners.

Individuals and teams worked well together in the multi-disciplinary staff teams at locality level, and people told us their care was integrated. Locality partnerships reported into the Health and Well-being Board (HWB) as a mechanism for linking into different communities' needs. We heard the HWB included an elected member from each borough and district to ensure good working relationships. We heard staff used good partnership working locally to reduce hand-offs, improve efficiency and provide a better experience for people.

Proposed actions from recent ICB summits included commissioning step-up, step-down services and reviewing referral and tendering processes. The ICB neurodiversity working together report (March 23) gathered co-produced knowledge about how local services should be developed to meet local needs. The shared-care record had helped partnership working and there were plans to improve this system.

Occupational therapy approaches and joint working in delivery partnership arrangements reduced duplication across the system. OT's provided reciprocal training and used a trusted assessor approach, enabling joint working because community health OTs could complete major adaptation assessments. There had been a positive impact on waiting times, because activity had progressed as a result.

Arrangements to support effective partnership working

The local authority had a joint funding policy relating specifically to learning disabilities and autism. The policy highlighted a gap in existing funding pathways which had resulted in delays to decision making, and an impact on frontline services. The policy intended to bridge the gap and outlined the available joint funding options with health partners. The Team-up approach included 'Ageing Well' which acted as one-team across health and social care and saw people who were unable to leave home without support. The emphasis was on joining-up existing services and creating additional capacity. They provided people with care at home to avoid them going into hospital. There were urgent community response services, including a crisis response, and an enhanced health in care-homes programme, developing workforce skills including a digital IT project. An anticipatory care programme helped to identify and respond to the needs of people before their health and care needs deteriorated.

Living-well Derbyshire was the recently transformed integrated mental health support service. It had a single point of access and involved VCSE, adult social care and health staff and incorporated the voices of people with lived experience. Partners consistently described the co-location of adult social care with multidisciplinary teams and their integration, working well around hospital discharge. The Better Care Fund (BCF 2023 - 25) narrative plan, set out how the BCF was being used to support the integrated care strategy ambitions. The local authority attended the BCF programme board, which met monthly. Housing was represented on the BCF board and there was an established health and housing systems-group. However, some people told us that although place alliances worked well, adult social care workers were less visible than they were before.

Staff told us practitioner-led discussions worked well to share practise across teams. There was a sense of getting around barriers to secure the best outcome for people, including with the prison service. The transitions team worked with health partners and Derby City Council to review and align processes. The team described working with the police to support young adults with risky behaviours and worked with the Special Educational Needs and Disabilities (SEND) team, attending transition locality meetings.

Out of hours workers were co-located with health staff in discharge services at Royal Derby and Chesterfield Royal Hospitals, including at weekends. There was also a social-care resource for arranging discharges in Royal Derby Hospital. The contracts team worked with health staff and other partners such as the fire service and police. The deaf and sensory team described a positive relationship with health teams and using the British Sign Language (BSL) Act and the accessible information standard to advocate for service users. The Approved Mental Health Practitioner (AMHP) and hospital discharge teams included a housing officer, which supported work with housing associations and other housing resources.

Impact of partnership working

Team-ups were frequently used as a positive example of services working together. They started as a place initiative with partners such as primary care networks. They provided a multidisciplinary team assessment and response including General Practitioners, nurses, occupational therapists, care providers, social prescribers, care navigators, mental health support and others. Their evaluation data showed a positive effect in preventing avoidable hospital admissions. A system was available to access joint funding for people with learning disabilities and autistic people. This allowed care packages to be quickly agreed with good information sharing.

The deaf and sensory team described multi-agency working for people with complex needs and positive outcomes they had achieved as a result. This included examples of supporting people surviving domestic abuse and people in long-stay hospitals, to access independent living in the community. The Approved Mental Health Practitioner (AMHP) team described ways in which they used recordings of people's preferences, to prevent and avoid future need of the service. This included preferences around male or female doctors, caring for pets and feedback from experts by experience, following Mental Health Act (MHA) assessments. The single-handed care project had success working between agencies implementing a single carer approach.

Staff told us there were occasional inappropriate referrals for MHA assessments and as a result the AMHP service had provided education for partners. Strong partnership working was evident in the AMHP team including with police and with Community Mental Health Teams. Some staff described more could be done to support early intervention and prevention and sometimes joint working could lead to confusion about roles in MDTs.

Working with voluntary and charity sector groups

The Derbyshire VCSE sector alliance 'Moving Forward Together' event report, described development areas around commissioning, workforce and community engagement. Cross-sector commissioning workshops had been approved by the Integrated Care Board (ICB). The VCSE alliance intended to explore how to make the system more accessible, including by using workforce initiatives to encourage cross-sector secondments and volunteering opportunities. The local authority worked in partnership to provide a range of services and facilities, including a falls club and a range of equipment to support independence through the VCSE sector.

Staff and partners said the local authority worked collaboratively with VCSE organisations to understand and meet local social care needs. There was a memorandum of understanding (MoU) across the ICB and its voluntary sector leads, who met regularly, and they described a 'parity of power'. Similarly, the Derbyshire Gypsy Liaison Group (DGLG) gave examples where they effectively 'filled the gap' between adult social care and the Gypsy Roma Traveller community.

Frontline staff shared examples of support available from VCSE sector agencies around peer support and recovery. Partners agreed the local authority understood the pressures of the VCSE sector and fostered good relationships, including in commissioning and procurement. They felt the authority were open to discussion, planning and negotiation with them and dialogue around funding pressures had been undertaken. Leaders recognised the key role of the VCSE sector in adult social care and were working towards commissioning for outcomes. They said consideration of the role of the VCSE sector was forefront in their planning, in order prevent an adverse impact on preventative and well-being services in the area.

Theme 3: How Derbyshire County Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The transitions process map, demonstrated coordinated support across agencies, including when people moved between services. Derbyshire Safeguarding Adults Board (DSAB) provided learning resources, after collating data and other findings, to staff. Staff said the trauma-informed relationship-based practice model, used by the leaving-care team, was effectively used to support people transitioning into adult services. This model was used to develop safe and supportive relationships, between staff and young people who may have experienced developmental trauma. However, DSAB found communication needs were not always met and information was not always offered in different formats and better information sharing was noted as an action point.

Leaders said young people were identified and supported from the age of 14, with reviews every six months. Joint visits had been undertaken between the children and adults staff, to support positive transitions policy and practice. The adult transition survey results showed 61% of staff reported they were 'not very confident' around transitions processes. 87% of staff stated they required training and did not feel they were sufficiently informed about children's social care legislation. The local authority has subsequently told CQC that a transitions training offer has been developed.

There were established processes to support the hospital discharge team with safeguarding referrals. Partners said the adult social care discharge fund had been managed well and late discharges had improved against the previous year and delayed discharges had reduced.

Derbyshire Community Health Services (DCHS) and the local authority worked together to improve discharge pathways, particularly when a person had lower-level needs and included an urgent community response. The joint vision was consistently described as responsive assessment, short-term intervention and reablement, supporting people to remain at home in times of crisis and supporting timely discharge. The discharge assessment review team (DART) gained mostly positive feedback however there were some concerns raised with us from partners about the consistency of the level of support available to people leaving hospital, such as the gap between the VCSE aspect of the team's offer and those of statutory services.

Mental health discharge planning could be challenging, and there were mixed reports about access to shared records. Recently the deaf and sensory team had gained access to the shared-care record and found it very useful in their day-to-day work, giving examples of it enabling access to interpreter services when a person was in hospital. Other frontline staff reported positive use of the system and we heard it was in the process of being rolled out to more teams.

While Approved Mental Health Practitioners (AMHPs) had access to the shared care record they did not have access to the mental health trust's electronic records system, which they said would have helped them assess risk. Out of hours social workers received training on using the system which helped them to assess risk. We heard the numbers of AMHPs on shift overnight had increased from 2 to 4 following an increased need and they were co-located with the crisis teams in Chesterfield Royal and Royal Derby hospitals which supported good partnership working around safety.

Safety during transitions

We heard mixed feedback about people's experiences of transitions from Childrens to Adults services. One person told us the process had gone smoothly, where adult carers had shadowed children's carers to get to know the person, and provided a safe transition at 18, with community connections involved. Others described less continuity and a desire for more support. We heard each locality team held Childrens to Adults casework and staff capacity could be an issue in the delivery of transitions services. This led to people sometimes being assessed nearer the age of 18. We heard a clear commitment from staff to completing extended assessments, including where Childrens social workers needed to travel significant distances out of area.

The winter and spring period had been challenging for effective hospital discharge. Despite this, the use of the low-need discharge pathway (1) had experienced an improvement in its performance. We heard discharge pathways for people with greater needs (2 and 3) had been strained and sometimes overused, leading to some people being provided with higher levels of support than ideal for longer, because other services were at capacity. We heard from partners the authority paid providers for urgent increases in packages when necessary.

The local authority commissioned 'home from hospital', a VCSE service, through grants including the Better Care Fund (BCF), hospital discharge money and public health funding. It provided befriending, shopping and a handyman service. It supported admission-avoidance and was also referred into from the carers and dementia services. Hospital discharge teams in the area worked well, involving good joint working with social workers.

The Enhanced Support team worked well to prevent hospital admissions for people with learning disabilities and autistic people, and to discharge people from long stay hospitals. They also worked with some children at the aged of 14, but mainly by age 16, supporting transition to adult services. We heard the deaf and sensory team provided transitional support to children and received referrals from 14 or 15. This included transitions from the school for the deaf in Derby.

Mental health acute hospital discharges could be complicated by a shortage of supported housing services for homeless people. We heard however, of an example where a housing officer was routinely present in a mental-health hospital, to support housing on discharge. Neuro-development hubs had been implemented across Derby City and Derbyshire for children and young people who were neuro-diverse.

Community support beds were also used to support people being discharged from hospital, with daily flow meetings to look at occupancy levels and people who could be discharged. They worked with social workers and the reablement team for people to become as independent as possible and return home with a package of care, if required. There was an occupational therapist embedded in the discharge team to prevent overprescribed care on discharge, or care packages which were difficult to source, supporting safe transitions between settings.

The majority of feedback was positive from people about how their care was coordinated to support hospital discharge. The discharge process had not felt supportive enough for some patients with dementia, however, who may have required a higher level of support. We heard very positive feedback about the way short-term direct payments had been used to increase care availability on hospital discharge and following periods of reablement. Homecare packages, in place prior to admission to hospital, were held open for a person in order to support ease of discharge. Social workers, including out of hours, re-assessed needs following a hospital stay and liaised with the provider. If someone was admitted to hospital for over 72 hours their reablement intervention was also re-started on discharge.

Contingency planning

There was a 'managing provider failure' (and other disruptions) process document, showing how the local authority intended to maintain safe systems of care in the event of service interruption or provider failure, either in a planned way or in the event of an emergency. Leaders described a local resilience forum and an emergency planning service team, mutual-aid arrangements and emergency preparedness. We heard about community rapid response teams who stepped-in following a homecare breakdown. There was a mutual-aid arrangement in place for homecare with Staffordshire County Council and with Derby City council which had been used. There were also informal reciprocal arrangements across neighbouring local authorities around quality assurance and contracting and market arrangements.

The brokerage team supported contingency planning, direct payments and possible interruptions in the provision of care and support. The geography of Derbyshire presented challenges, as did winter weather, risking interruptions in provision. There were support contingencies in place which included the internal short-term reablement homecare team. We heard an example of care home closure where the local authority worked with the provider and sourced additional funds, to support the safe transfer of people using the service.

The out of hours social work team described working very well in crises, for example during times of flooding last year in Chesterfield. Staff volunteered to help during non-working time and service managers pre-empted demands and planned appropriately when there was knowledge in advance about disruptive events. The team gave examples of sourcing emergency respite, sourcing support following carer hospitalisation and around placement breakdowns and described good joint-working with the police. There was therefore demonstrable capacity for the local authority to respond to many unexpected and emergency situations.

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

People felt as safe in Derbyshire as the national average. 70.7% of people that used services in Derbyshire felt safe, compared to a national average of 69.69% and the percentage of people who said those services made them feel safe, was 89.35% compared to a national average of 87.12% (ASCS). 79.55% of carers felt safe compared to a national average of 80.51%.

We heard the Derbyshire safeguarding adults board (DSAB) met quarterly with the Derbyshire District Council's safeguarding leads group, which worked well with positive relationships between professionals. DSAB had three priorities: making safeguarding personal; prevention and quality assurance. The board had seven subgroups and working groups. Vulnerable adult risk management (VARM) was a process that managed risk for adults deemed to have capacity, but who were at risk of serious harm. There was both a VARM subgroup and a financial abuse working group. Subgroup membership was shared out across the partnership and provided accountability across the system. Engagement from the local authority with the board was good, there was a clear commitment and positive relationships from the local authority working with the DSAB. Although consideration of meeting jointly across Derby City and Derbyshire had not progressed longer-term, they did have a joint annual meeting, shared strategic plans and developed joint resources. A decision was made to revert to separate Board meetings at the beginning of 24/25 but with the first meeting of the year being held as a joint Board/ development session. The Joint Core Business sub-group meetings continued to take place quarterly. Leaders told us this was the most effective approach to allow City and County Board business to remain aligned, where possible, via the annual joint development session and joint quarterly meetings but also allowed sufficient time to cover separate business and apply local scrutiny and challenge at the three separate SAB meetings.

The skills for care workforce data estimated the percentage of local authority and independent sector staff who had completed mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training, was 39.31% with a national average of 37.48%. The percentage of staff who had completed safeguarding adults training was 51.75% with a national average of 48.81%. These compare favourably to the national average but remain a low number. Overall Safeguarding training was positive in Derbyshire, staff were passionate and creative in implementing local training and competency sessions within teams. However, some staff reported mental capacity training was not always available and at times the process was confusing. Safeguarding training could therefore be better coordinated and improved to provide staff with the appropriate level of training in areas such as mental capacity act training.

Responding to local safeguarding risks and issues

Staff had local ways of working and supported each other to respond to safeguarding risks. The need to protect people from self-neglect had been recognised as a significant challenge for professionals and as a result Derbyshire Safeguarding Adults Board (DSAB) had created a self-neglect toolkit. Transformation was clearly ongoing in Derbyshire, there were positive actions to improve information sharing and working with the police to make the VARM and safeguarding processes more explicit, improving the shared care record was also intended for development. Some animation work was created following a Safeguarding Adults Review (SAR) which was an effort to communicate learning in a new way. A specific subgroup focused on pulling out learning themes from SARs which was supporting staff to practise differently. However, it was too early to see what impact it had on adults at risk.

DSAB was well attended by partner agencies with good levels of buy-in and challenge. Demand for safeguarding was high, we were told there were many repeat referrals due to poor quality referrals and lack of knowledge from referrers. We were told action was underway with partners to aim to improve the quality of referrals, with local triage systems and staff speaking with referrers to support understanding. There had been a thematic learning action plan with action points around section 42 performance and learning required around mental capacity, best interests, Learning from Lives and Deaths (LeDeR) reports and from ombudsman complaints, and the safeguarding electronic form had recently been developed and was close to being launched.

Staff reported an increased focus on safeguarding and increased support around safeguarding over recent years. Safeguarding was a priority in frontline teams although there were different levels of confidence and consistency.

Responding to concerns and undertaking Section 42 enquiries

The proportion of safeguarding concerns meeting the threshold for a section 42 enquiry had remained stable over a three-year period, at around 40%. Safeguarding referrals had increased annually by around 15% to 20% and resources had not increased to meet demand. Over the preceding three months, data showed there had been 574 safeguarding referrals on average per month, with 191 becoming section 42 enquiries, which was a 33% conversion rate. The median wait time for safeguarding concerns for those on a waiting list, was 7 days and the maximum wait time was 34 days. A section 42 median waiting time (for allocation) was 4 days, with a maximum waiting time of 19 days. Improvements to processes meant safeguarding concerns were more consistently logged.

Deprivation of Liberty Safeguards (DoLS) applications received over the past 12 months had a median waiting time for allocation of 152 days and a maximum waiting time allocation of 364 days. Historic DoLS applications significantly exceed these waiting times and cause the median waiting time for all DoLS to be allocated, to 327 days. The risk of impacts from delays in completion of DoLS, was included on the adult social care risk register. There was a triage and Red, Amber, Green (RAG) rating system in place, to ensure risk was managed while waiting. There was a consistent county-wide approach to DoLS triage and all referrals were triaged via the duty system, led by qualified best interest assessors. In order to develop a future workforce, the local authority had sponsored 6 social workers to train as best interest assessors in 2023 to 2024 and a further 6 in 2024 to 2025.

There were mixed reports around safeguarding practises and reporting of outcomes, however. We heard the duty system meant accessing a social worker for enquiries, could be more time-consuming and difficult. The outcomes of safeguarding enquiries were not routinely received by providers, and they described ‘chasing’ outcomes. We heard reference to local approaches by local team practitioners which sometimes led to an inconsistent approach across the county.

Making safeguarding personal

The electronic system used for logging safeguarding alerts was recently updated, included mandatory questions around making safeguarding personal and when advocacy had been used to support people. Safeguarding Adults Collection (SAC) data showed only 14.38% of people who lacked capacity were supported by advocates, family or friends compared to a national average of 83.12% (2022-2023). This was supported by staff, we heard it was not always possible to secure independent advocacy in a timely manner, or sometimes at all for new referrals. More recent data from the local authority showed improved performance. This does not change the scores for this quality statement'.

Staff consistently referred to adults at risk with compassion and with reference to their personal views and wishes. They described significant recent improvements and describe the plans for incorporating feedback from adults with lived experience, carers and colleagues, to enhance performance outcomes and well-being.

The local authority stated 57% of people had been asked about their safeguarding outcomes in the year 23/24 which had been an improvement on the previous year. Making safeguarding personal had been prioritised for service improvement by the local authority.

Theme 4: Leadership

This theme includes these quality statements:

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

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

Governance, management and sustainability

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

The adult social care and health Social Work Prioritisation tool provided guidance on triage and decision making for unallocated work based on risk priorities. The tool was used to provide consistency across all prevention and personalisation teams, including occupational therapy. The adult social care and health Quality Assurance Strategy included work priorities from the Adult Social Care Strategy. A quality assurance board convened every six weeks, chaired by one of the departmental management team to drive and achieve priorities. They received updates and escalations from commissioning teams about contracts, external market quality monitoring and improvement, direct care teams, locality teams, quality assurance, stakeholder voice, safe services workstream, workforce, policy and complaints. The Adult Social Care Risk Register, recorded concerns and relevant actions, in order to reduce risks with monthly reviews and updates and included managing emergency situations and budget risks. Governance systems were therefore in place to effectively manage risk and provide accountability.

People and their advocates reported positive views of the senior leadership arrangements in the local authority. There had been senior leadership changes in recent months. The director of adult social care reporting to the DASS had recently retired, with an assistant director being promoted to the role on an interim basis. There were 5 assistant directors reporting to them, with some engaged on a short-term basis. We heard staff in the senior team had been in roles in the team for a significant amount of time, there were strong team bonds, a dedication to a joint vision and an 'energy' to achieve the strategy. We heard an external provider had been engaged to support the development of the team and there had been benefits from this in the team's culture and work. Leaders had regular briefing calls with around 3000 staff and used face to face visits and bulletins to communicate with staff. They described 'great pride' in building an open and honest culture with staff and visibility was important to them.

Staff described a significant amount of change had taken place recently which increased some pressures on them, including the increased requirements for occupational therapy (OT) resource. Significant recruitment activity remained on-going to fill posts in new teams to fulfil the planned changes. We were told locum cover was used to fill gaps in the interim period. Senior OTs reported excellent relationships with the principal social worker and described how operational and strategic planning was done together. We heard generally positive reports of team management and staff culture across teams and how OT improvements have benefited casework and waiting lists.

The elected lead-member was well briefed and there was a joined up strategic vision with the Managing Director, DASS, and the senior leadership team. Senior leaders described the assets within Derbyshire and consistently articulated a desire to focus on outcomes and cost efficiency in a compassionate way. There was a strong sense of pulling-together by senior leaders and partners with strong scrutiny and accountability in governance arrangements. Senior officers worked across political and geographical complexities in elected-member representation, to brief and involve members.

Strategic planning

There was a clear strategic aim to become a public health led organisation and significant steps towards this journey had been made. However, it was too early to understand the impact and sustainability of recent changes and plans, with further work needed to join peoples voice and front-line practice into strategic planning. The adult social care strategy launched in 2022, called 'Best Life Derbyshire', defined their ambitions and six priorities in an outcome focused way. Short term support; joining up support; co-production; supporting carers and the workforce; standards and value for money. Leaders described an 'incredible journey' of transformation, from being a substantial provider of in-house services, to one of community support and a stronger provider market, wishing to support people to live the life they wanted, with more independence.

We heard many examples where staff worked with permission, to test and try things out. There was a need to bring the strategic framework up to date to support this work. A prevention strategy remained under review at the time of our visit, having been set for publication in late 2023. Significant changes in frontline work around prevention, well-being and early intervention were underway which would benefit from tethering to strategy, so it becomes clearer how this work will be driven.

It was clear leaders intended to work with integrated partners in designing a joint, sustainable future around prevention, in consultation with the VCSE sector and incorporate better use of JSNA data around equity and health inequalities. The public health strategy was noted as being almost ready for publication. There was a clear intention to place more emphasis on consultation and co-production of strategies generally, and a more recent motivation to act as one-system strategically. Health-in-all policies had been successful, but further progress to become a data-driven public health led organisation was ongoing.

We heard positive examples of people's involvement in policy making, however more could be made of listening to people using services through Healthwatch and via other involvement and co-production mechanisms at a strategic level.

Information security

Leaders told us technology and digital transformation was an area for development. There had been at least five years of digital transformation, but some infrastructure remained traditional. The digital strategy for adult social care included themes around digitally enabled people, workforce, partnerships, foundations of systems and data.

The shared-care record could be improved and enhanced, however along with the discharge-to-assess workstream data, it provided staff with access to real-time information on a client's health and social care journey.

There was a secure desk policy which set out processes for accessing secure information when hot-desking. There was a corporate data protection policy providing a framework that ensured the local authority met its obligations under General Data Protection Regulations (GDPR) and the Data Protection Act. A corporate records management policy set out a framework for the retrieval management and disposal of records of information in paper and electronic formats.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

More adult social care staff in Derbyshire (59.61%) had a care certificate either in progress or completed than the national average (49.65%) (Skills for Care). Staff training and development was evident throughout our assessment. There was new tailored training for social workers and occupational therapists with specialised courses and an enhanced internal offer of training was in development. Senior leaders recognised the importance of valuing and supporting the social care workforce. There were plans for a joint-workforce strategic arrangement with the Integrated Care Board (ICB). Social workers had won national awards for their work.

The culture at the local authority was open and transparent and people felt able to speak up. Social workers were able to suggest improvements and were listened to, for example with the suggestion of short-term direct payments. Leaders identified the passion and commitment from the workforce and the delivery of strength-based support as an area of strength for the local authority. Opportunities for improvement were identified as collaborating on a greater use of collective resources and driving co-production forward.

The revised occupational therapy (OT) strategy incorporated working within multidisciplinary teams, strength-based approaches and supporting people in the community. There was an OT apprenticeship scheme, with rotation placements across health and social care. The revised OT structure provided opportunities for people to progress in their career and coaching was available through personal development reviews. There was also an 'inspiring leadership' course for managers. Practice weeks formed part of the local authority's quality assurance processes and feedback was shared with group managers, assistant directors and the quality assurance team. There was consistent reference to the Practice Standards Framework for social work and occupational therapy, throughout our assessment. This supported quality conversations and developing professional practice. It incorporated Think Local Act Personal's: I and we statements and was aligned to the Best Life Derbyshire strategy.

Staff worked in partnership across the seven districts. Training and development was available and monitored and a supervision app was recently adopted in order to ensure supervision was taking place consistently. Staff described peer-group discussions as supportive and helped them find creative solutions. We also heard about how rotas were used creatively to avoid de-skilling and ensure diversity of experience, for example in mental health act assessments and community treatment orders.

People's experiences on the effectiveness of their involvement in co-production was mixed. Work existed around co-production in a community of practice, to identify current services and gaps in delivery for autistic people and people with learning disabilities. This group had 145 members and had been involved in commissioning services by engaging experts by experience.

Leaders recognised the importance of co-production and noted it was an area requiring improvement. A co-production strategy was about to be implemented and they had recruited people with lived experience to help with the co-design. Some people told us there were groups and forums such as over-50 groups, which were useful and positive, however sometimes felt they ‘rubber-stamped’ existing plans. Other people said they felt listened to and there was change as a result of panels and groups. Staff also felt recognised, involved and respected in relation to their individual protected characteristics, and there were staff forums and support networks available to them.

Safeguarding practitioners had the autonomy to create and provide local team training in-house and continuous professional development sessions. Practitioners were also passionate about supporting the next generation of social workers, and there was an inclusive, positive culture of continuous learning and improvement. Frontline staff said that some relevant training had been offered, for example around hoarding, but gaps still remain in mental capacity act training. Social workers could also participate in communities of practice three to four times per year, where workers presented case studies for peer review. There was an annual occupational therapy development day and we saw reference to Skills for Care and Royal College webinars being promoted. We heard staff describe a joint learning culture and significant peer support. Out of hours, there were senior managers to support staff and good access to peer support.

In terms of training and support for commissioning staff, the majority of the team had completed or were nearing completion of a 'principles of commissioning for well-being' level 5 qualification (Skills for Care). New starters in the team were offered the training and all members of the commissioning team had completed the official transforming public procurement knowledge training. Several of the team had completed a diploma in contract management, and several officers had completed a foundation-level contract manager training and achieved accreditation. All commissioning managers had taken part in the 'inspiring leaders' managers training, and they were also encouraged to attend Association of Directors of Adult Social Services (ADASS) training and webinars on relevant subjects. This training meant the contract team understood what good practice should look like. Oliver McGowan training (training for and by people with a learning disability and autistic people) had also been rolled out and the local authority supported bespoke training for colleagues.

Learning from feedback

There were varied sources of feedback for the quality assurance framework including compliments and complaints; people who use care services; supervisions; safeguarding cases; adult social care team reviews; occupational therapy case reviews; AMHP approvals; Deprivation of Liberty Safeguards (DoLS) and best interest assessors; Practice weeks; quarterly contract monitoring of provider contracts and internal management reviews. Leaders described an open culture in terms of feedback and a desire to nurture an open dialogue from people receiving services and from carers and staff. Staff generally reported feeling listened to, and the authority was open to new ways of working. We saw evidence of the internal compliments, enquiries and complaints procedures being used and updated appropriately. We also saw health-check documents and action plans for social workers and occupational therapists.

The local authority had implemented an action plan based on the recommendations from the Local Government Social Care Ombudsman (LGSCO), particularly around complying with the MCA and around best-interests decision making. The LGSCO annual letter dated July ‘23, stated 26 investigations had been undertaken, with 81% upheld and based on 18 outcomes 100% of cases were satisfied with no late remedies, or risk flags.
