Royal Borough of Windsor & Maidenhead: local authority assessment

How we assess local authorities

Assessment published: 8 November 2024

About Royal Borough of Windsor & Maidenhead

Demographics

The Royal Borough of Windsor & Maidenhead is a Unitary Authority in the southeast of England. The population of 155,000 is spread across the Borough which includes the towns of Windsor, Maidenhead, Ascot, and Eton. On the Index of Multiple Deprivation decile, the Royal Borough of Windsor & Maidenhead was ranked 152nd out of 153 local authorities in England, making it the second least deprived local authority in the country. There is a 6.1 year gap in life expectancy for boys born in the least and most deprived areas of the Royal Borough of Windsor & Maidenhead.

The population is predominantly people of working age but there is a growing aging population. Between the 2011 and 2021 census, the number of people aged 50 to 64 years rose by 2.3% and there were gradual increases of between 0% and 2% of people aged 65 to 74, 75 to 84 and 85+. The growth in the population of people aged 50 to 64 years means the local authority can expect their population of adults aged over 65 to increase over the next 10 years. Overall, the population in the Royal Borough of Windsor & Maidenhead grew by 6% over the decade.

The local authority sits within the Frimley Integrated Care System (ICS), which covers 5 local authority areas. There are no acute hospitals within the Royal Borough of Windsor & Maidenhead, but the local authority works with Frimley Integrated Care Board, Frimley Health Foundation Trust, the Royal Berkshire Hospital and Berkshire Healthcare NHS Foundation Trust in areas such as hospital discharge and prevention.

The Royal Borough of Windsor & Maidenhead is a local authority in transition. In May 2023 the makeup of the council changed from a Conservative majority to a Liberal Democrat majority. The Royal Borough of Windsor & Maidenhead, with Wokingham Council, jointly owned a local authority trading company which carried out Care Act 2014 functions on behalf of the local authority since 2017. At the time of our assessment, the local authority was in the process of bringing all the functions that delivered on their Care Act 2014 duties back in-house as part of a wider transformation.

Financial facts

The Financial facts for **the Royal Borough of Windsor & Maidenhead** are:

- The local authority estimated that in 2022/23, its total budget would be **£180,496,000**. Its actual spend for that year was **£201,166,000** which was **£20,670,000** more than estimated.
- The local authority estimated that it would spend **£41,596.000** of its total budget on adult social care in 2022/23 Its actual spend was **£48,862,000**, which is **£7,266,000** more than estimated.

- In 2022/2023, **24%** 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 **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.
- Approximately **1725** people were accessing long-term adult social care support, and approximately **340** 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.

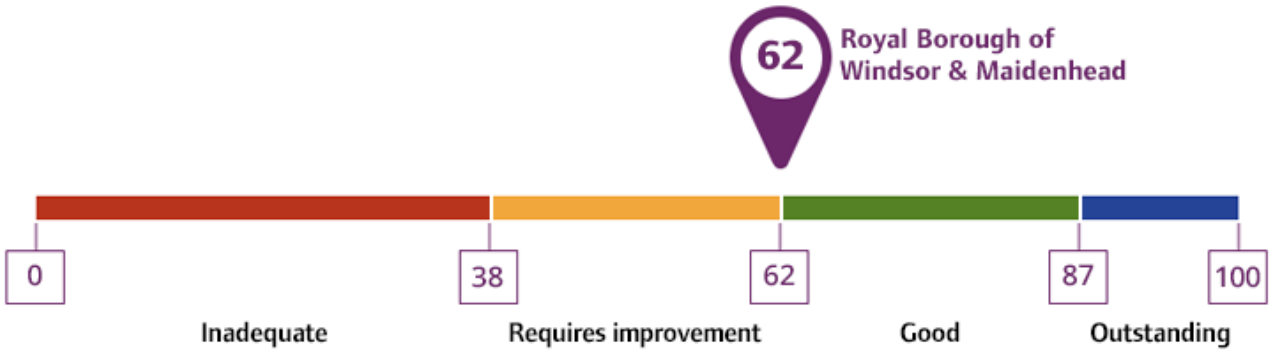
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Royal Borough of Windsor & Maidenhead

Requires improvement



Quality statement scores

Assessing needs
Score: 3

Supporting people to lead healthier lives
Score: 3

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 2

Partnerships and communities
Score: 2

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 2

Governance, management and sustainability
Score: 2

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People's experiences of accessing adult social care in the Royal Borough of Windsor & Maidenhead were positive. National data supplied by the Adult Social Care Survey (ASCS) showed 68.83% of people were satisfied with their care and support. This was above the national average of 61.21%. Additional data provided by the local authority, but as yet unpublished, suggested further improvements had been made in this area in 2024. Staff conducted assessments which focused on people's strengths and abilities. The feedback about the approach of staff and their competence was positive and this was reflected in compliments the local authority received. People received assessments and support from kind, dedicated and compassionate staff.

There was a front door team who had a good understanding of what was available to people with either eligible or non-eligible needs. We heard examples of how staff often worked with people at an early stage, before they developed eligible needs, to delay or avoid the need for more intrusive or restrictive interventions in the future. However, we heard feedback that young carers did not always receive a timely assessment and national data showed access to advocacy was limited. We also heard feedback that at times information was harder to find, particularly for older people who may face digital exclusion. These were areas where the local authority told us they had plans to improve. However, people who contacted the local authority often received a call or a home visit which reduced the impact of the gap in the information and advice offer.

The experiences of unpaid carers were mostly positive, but we did hear feedback that access to information and advice was not always consistent. Unpaid carers received their own assessment and we saw examples of care planning to meet their eligible needs. Unpaid carers spoke positively about the support available to them from the voluntary sector. Unpaid carers received an assessment in a timely way, but we did hear there was sometimes difficulty finding information related to the support available to them and some difficulty accessing assessments for young carers.

Staff worked closely with partners to meet people's needs holistically. We received feedback about the voluntary services on offer to people and saw examples of positive joint working between health partners and the local authority to meet people's needs. People received support from staff who worked closely with health partners, both at hospital discharge and at the front door team who received initial contact, to ensure the right support was available to people at the right time. Recent work to improve hospital discharge pathways through the 'Home First' model had brought about improvements to the time it took for people to be discharged from hospital; national data showed the reablement people received was achieving good outcomes and avoiding readmission to hospital.

Summary of strengths, areas for development and next steps

This assessment took place during a time of significant transformation. The local authority was bringing their Care Act 2014 functions in-house and many processes were currently being reviewed or were recently updated. As well as having recently introduced new teams, the local authority was about to introduce new IT systems and change their strengths-based model of assessment to a 'Patchwork' model which was intended to better enable staff to assess people's needs around their strengths and assets. The relationships with health partners were also going through a period of transformation, with recent changes to the structures of the safeguarding partnership board, and the health and wellbeing board.

Despite significant transformation being underway, feedback from staff about the support they received during change was positive. Staff felt proud of the work the local authority did, and we heard multiple examples of positive, person-centred, practice being used to ensure people achieved good outcomes. Staff told us the transformation would improve the way they work, particularly around having better access to data, being more collaborative across teams and seeing improved consistency and oversight of performance. Staff were overcoming most of the challenges presented to them by the current systems, but recognised the transformation would lead to more sustainable processes and approaches.

The feedback from health partners was positive; despite change at the local authority and within the local health structures, we heard about positive working relationships focused on ensuring people were kept healthy and their care needs were met. The local authority and health partners had achieved particularly good outcomes on shared priorities around hospital discharge, but joint strategic work in areas such as public health and safeguarding were at an earlier stage in their development.

National data showed the experiences of people living in the Royal Borough of Windsor & Maidenhead were positive or in line with national trends. Data showed the local authority performed particularly well in how safe people felt, with 80.77% of people who used services stating they felt safe (ASCS) which was significantly above the national average of 69.69%. However, data also showed direct payment uptake was low, with Adult Social Care Outcomes Framework (ASCOF) showing 12.08% of people using direct payments to access services, significantly lower than the national average of 26.22%. Additional data provided by the local authority, but as yet unpublished, suggested improvements had been made in this area in 2024. Data provided by the Safeguarding Adults Collection (SAC) showed 58.33% of people lacking capacity were supported by an advocate, family, or friend. This was below the national average of 83.12%.

Leaders had a good understanding of where they needed to improve and where we identified shortfalls, there were already plans underway to address them. Actions taken recently were clearly tethered to the overarching transformation strategy, but some changes had yet to take place or to fully embed. Changes had already been made to improve approaches to safeguarding and update the information and advice offer. Changes to areas such as co-production and commissioning had started but were at an earlier stage, whilst new IT systems to bring about improvements in the use of data had yet to be implemented.

Data was used by the local authority to measure the impact of improvements and measure the impact on people's experiences, but the use of data was limited by the current systems. We heard from staff and leaders that sometimes data was time consuming to collate and the ability to compare and interrogate data was limited. However, where data was available the local authority was able to use it to demonstrate the positive impact of recent changes. For example, the introduction of the new safeguarding hub had reduced waiting time for decisions about safeguarding concerns and staff described improved consistency in decision-making in this area.

Waiting times for Care Act 2014 assessments had also been reduced, but there was a wait of up to six months for occupational therapy assessments. Staff and leaders had a good understanding of risks within waiting lists, and we heard how initial triage led to interim care provision arrangements being put in place ahead of full assessments. Unpaid carers received timely assessments most of the time, but data showed there was a slightly longer wait time for young carers assessments. The local authority recognised their current systems made data difficult to collate which meant it wasn't always easy to monitor waiting lists. However, the processes in place meant all cases were being regularly checked and risk assessed. This area of improvement was a strategic priority; the local authority's plans to introduce new systems were driven by the need to improve their oversight of data.

There had been recent changes to public health, and we saw examples of improved use of data to understand the health needs of the population, with data being used to keep people healthy and anticipate future need. Data had been used to set some strategic priorities, particularly around commissioning and hospital discharge pathways. Health partners and staff described positive working relationships and joint working to achieve shared aims. We heard about a strong and thriving voluntary sector but did hear some feedback on how it could sometimes be difficult to contact the local authority or work with them strategically. The public health team were considering new ways of co-productive working in specific cases. For example, they were working with the Primary Care Networks to shape Tier 2 weight management services alongside the practices and their users.

Staff and leaders had a good understanding of diverse communities across the Borough, and they knew who their seldom heard groups were. We saw examples of particularly positive outcomes being achieved for some groups which had drawn interest from other local authorities, but strategic work to positively impact other groups had not yet shown its full value. Whilst some of the strategic work was at an early stage, we saw how creative approaches had been taken in setting up groups or undertaking work with individuals to meet their needs in a way which was considerate of their preferences and any protected characteristics. Whilst some work was achieving good outcomes, planned actions such as updating the autism strategy, or improving commissioning for people with a learning disability, had not yet been fully realised.

We heard positive feedback about leaders, and staff understood the strategic direction and vision of senior leaders. The local authority had an ambition to introduce a performance culture, and we saw examples of how understanding and reporting of performance had improved over the last year. The local authority had planned for the new IT systems with a view to improve their ability to collate and monitor data; this part of the transformation had not happened yet, so there were areas where access to data was limited, but interim arrangements reduced the impact on service and strategic planning.

Theme 1: How Royal Borough of Windsor & Maidenhead 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: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

Feedback about access to Care Act 2014 assessments was mostly positive; people said they received timely assessments and had their needs met through effective care planning. Staff and people described how the front door team provided a single point of access to assessment, and provided early interventions such as signposting, information, and advice.

The approach to assessment focused on people's strengths and what was important to them. Staff and leaders talked about taking a personalised approach to assessments and this was reflected in feedback from people. There was a strengths-based approach to assessments which focused on people's abilities and their existing support. The approach reflected people's right to choose, built on their strengths, reflected what they wanted to achieve, and how they wished to live their lives. The assessments were then used to develop personalised care plans.

Examples seen showed people's human rights were respected and protected, they were involved in decisions, and their protected characteristics under the Equality Act 2010, such as in relation to their religious or cultural needs were understood and incorporated into care planning. However, there were sometimes barriers to accessing advocacy services which had the potential for decisions being made without peoples' voices being heard.

National data showed people's experiences were positive in this area. In the Adult Social Care Survey (ASCS) 87.5% of people said they felt they had control over their daily lives, which is significantly higher than the national average in England of 77.21% and was consistent with feedback we received. Staff articulated good social work practice to us and shared examples which demonstrated a commitment to personalised assessments and care planning, with a focus on people's strengths and their human rights. We heard examples of people being supported to achieve outcomes in different areas of their lives, such as maintaining important family relationships, being more active in their community, or gaining employment.

Leaders told us strengths-based practice was an area they wanted to enhance and build upon. Plans were underway to adopt a new model of strengths-based practice known as the 'Patchwork' model. This is a model where people's strengths and assets are assessed as a variety of small complete sections, which come together to represent a holistic picture of people's lives. Staff and leaders talked about how they were building upon their current approach so simplify the tools available to staff, so it would enable them to gain a better understanding of a person's family and support networks, to ensure care plans were proportionate and promoted people's strengths and independence.

There was a clear pathway people followed from assessment through to review. We heard how the front door team would carry out assessments and put care packages or equipment in place where necessary, before carrying out a six-week review and transferring cases to the community teams.

Assessments and care planning considered people's health needs, including how and when they administered their medicines. Assessments we saw were strengths-based and looked at people's ability to self-administer medicines and the level of support they required where they were not able to self-administer. Care plans recorded this clearly so commissioned services had clear information about what people needed. The local authority also told us about work they did through commissioning to ensure providers had robust medicines training in place for their staff, as well as how the local authority worked with the Integrated Care Board medicines optimisation team to share any themes and learning.

Where necessary, staff worked jointly with health colleagues to identify and meet people's needs. The front door team worked with the local access point (LAP) which was a jointly commissioned function where health partners and local authority staff worked together to support people in a way which prevented needs from developing and avoided or delayed hospital admissions. We heard positive feedback about the work of this team, with staff describing how they took a multidisciplinary approach by discussing cases and carrying out home visits or assessments jointly.

People usually received an assessment from specialist teams where they had complex needs, but we heard some referral criteria could cause barriers to these teams. The community teams received cases from the front door team after care and support had been put in place and reviewed after six weeks; the community teams then oversaw ongoing reviews and responded to changes in need. Where people had needs because of a learning disability there was a community team for people with a learning disability (CTPLD) and for people with needs related to mental health conditions or autism there was an integrated community mental health team (CMHT) where local authority staff worked alongside staff from Berkshire Healthcare NHS Foundation Trust.

We heard how the CTPLD and the CMHT teams provided a specialist assessment from staff who had a good understanding of their specialisms in learning disability, autism, and mental health. Feedback about the training on offer for staff to understand their specialisms was positive. However, there had been instances where people did not have a formal diagnosis, which meant they did not fit the referral criteria for the CTPLD. This had led to uncertainty about how a person's needs could be met in situations where there was no formal diagnosis but a presenting need consistent with a learning disability or autism. There were very few examples where this had happened and when it did, staff worked together to find the right team for the person. This ability of staff to problem solve reduced the risk that people could fall through gaps or receive assessments from staff without the right skills and expertise.

The local authority ensured staff training was up to date, and staff gave positive feedback about the support they received to develop their skills. We heard examples of learning being focused on particular areas staff had raised, such as recent training in how to support people with no recourse to public funds, in response to increases in assessments of people who could be undocumented or from a refugee community.

Timeliness of assessments, care planning and reviews

People did not often have to wait for an assessment, but where they did the local authority took steps to meet urgent needs. Assessments and care planning for social care were timely but there were waits for assessments for occupational therapy (OT). There were no significant waiting lists for social care across the front door team and the community teams, and leaders had a good understanding of their waiting lists and the risk-reduction processes. Staff and leaders frequently reviewed waiting lists and we heard how initial interventions, such as smaller-scale equipment provision, signposting to alternative services, or interim packages of care, were used to mitigate risks to people whilst they waited for a full OT assessment.

The local authority employed OTs across its community teams and at hospital discharge. The local authority used occupational therapy assistants and trusted assessors which enabled some equipment to be installed more quickly to reduce need and risk. Whilst this reduced the potential impact assessment delays would have on people, it still meant people could wait up to 6 months for a full assessment of their OT needs so there could be a risk of some needs not being identified and met promptly. This heightened the risk that people's needs could increase in that time and opportunities to build their independence could be missed. Local authority data showed 180 people were on the waiting list for OT assessment with an average wait of 39.8 days. However, 2.2% of people had waited over six months.

People did not always receive a timely annual review of their care and support needs. The local authority took a risk-based approach to reviews and staff and leaders acknowledged planned reviews did not always take place promptly. Planned reviews are where there has not been a change in need, but it would be considered good practice to carry out an initial review after 6 weeks followed by an annual review, to check the support the person is receiving is continuing to meet their needs. The local authority had data on reviews but this data combined planned 6 week reviews and annual reviews. We heard from staff and leaders that it was annual reviews where people could wait longer if there had not been any changes in need or risks, we heard that 6-week reviews usually took place in a timely way.

Local authority data showed that 156 older people or people with a physical disability had a planned review which was overdue and for people with a learning disability there were 26 planned reviews outstanding. In mental health there were 11 planned reviews overdue across both working age and older adults and there were no planned reviews outstanding for people with sensory needs and autistic people.

Leaders regularly risk assessed waiting lists to identify and respond to urgent need. Staff and leaders had a good understanding of which cases were awaiting reviews and we heard how reviews were prioritised where there was increased risk or changing need. However, teams and leaders acknowledged this meant people with no change in need, such as those in settled residential care placements, did not receive a timely annual review. Staff told us they would usually carry out a review sooner for people placed out of county. Local authority data showed that for people placed outside of the county, there was an average wait of 75 days for a review, compared to 84 days for people placed within the county. These average wait times for planned reviews included both annual and 6-week reviews.

National data on Short and Long-Term Support (SALT) showed 70% of people receiving long-term support had been reviewed (includes both planned and unplanned reviews) and this was higher than the England average of 55%. This showed that the local authority was performing better in relation to other local authorities.

Leaders had identified delays to reviews as a risk and had commissioned an external company to support them with these reviews. Whilst this would address the issue in the short term, there would be more work to do to ensure reviews always took place in a timely way in the future.

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

Unpaid carers received a separate assessment to the person with care needs and staff understood how the needs of unpaid carers were distinct from the person they cared for. Data showed waiting lists for carers assessments for adult unpaid carers were very low and carers did not have to wait for an assessment, which was consistent with the feedback we received from people and unpaid carers.

The feedback about carers assessment and reviews for unpaid carers was mixed. We heard carers were routinely assessed, and support was built around their needs. However, we also heard information and advice was not always easy to find prior to assessment, which in turn would impact on the local authority's ability to identify unpaid carers in a proactive way. There had been recent work to develop and publish directories which would provide clear information on what was available to unpaid carers, but this feedback showed this was not yet having the anticipated impact. The local authority had identified a need to do more strategic planning around services for unpaid carers. Plans were in place to use joint funding with health partners to introduce a new role, to map the resources available to unpaid carers at an early stage, and to identify and address any gaps in provision. The Survey of Adult Carers in England (SACE) data showed 32.26% unpaid carers in Royal Borough of Windsor & Maidenhead said they were able to spend time doing things they enjoyed, which was higher than the national average in England of 15.97%.

Care was planned holistically around unpaid carers' lives and support plans included replacement care for their loved ones. We heard examples of how care planning was used to enable unpaid carers to pursue leisure activities, practice their faith, and sustain important family roles. We heard positive feedback about the support put in place for unpaid carers, but we did hear feedback planned reviews were not always holistic. There were extended waiting times for planned reviews which the local authority were aware of. Staff and leaders described processes for identifying and assessing unpaid carers in a strength-based way, with assessments considering the needs of the whole family. SACE data showed 48.48% of unpaid carers said they were satisfied with social services, which was above the national average in England of 36.83%.

We received feedback that young carers were not always identified proactively and it could sometimes be difficult to access a young carers assessment. The local authority commissioned an organisation, to carry out young carers assessments. Staff and leaders described processes for identifying young carers and offering support, but feedback from voluntary groups showed this could be more proactive. The local authority recognised a need to do more in this area, particularly around raising awareness of young carers. Data showed the average waiting time for assessment for young carers was 12 weeks after referral. Managers monitored waiting lists, and we heard how staff would put interim support in place, such as replacement care or direct payments, to reduce risk and alleviate the impact the caring role was having on the young person. We also saw that the local authority risk rated young carers cases to prioritise cases where the young carer was primary carer for the person. However, there was a difference in experience of wait times for assessment for young carers compared to adult unpaid carers when it came to accessing assessments.

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

People were able to access information and advice, as well as early support to meet non-eligible care needs. The local authority and partners had recently carried out a series of 'World Café' events. These engagement events took place across the Borough and were used to hear the views of residents to understand what was important to them; the events identified loneliness and isolation as a priority. The local authority identified a need to improve the information and advice provided by the front door team, which had been implemented. We also saw multiple examples of joint health and social care funding being used to set up clubs and activity groups for people of different ages, needs, cultures, or faiths, to provide people with opportunities to reduce isolation and loneliness.

The front door team frequently received referrals from people without eligible care needs. Staff described how they often carried out a home visit even where the person was not likely to have eligible needs because it provided an opportunity to signpost and identify early input which could prevent or delay needs developing. Staff also described how they often worked remotely across the Borough, such as from health centres or GP practices, to be on hand to provide information and advice to people about how to access an assessment, or to signpost to voluntary and community resources where people did not have eligible needs.

There were community health and wellbeing events held in local libraries and community centres, such as a recent 'Men Matter' session which provided support and advice to men about mental health and wellbeing. There was a jointly funded social prescribing team and a community connections service supporting people with mental health issues as well as support in areas such as loneliness or drug and alcohol misuse. Local authority data showed the social prescribing service had over 2,000 referrals in the first three quarters of 2023/2024 with 98% of new referrals contacted and a person-centred plan started within 7 days. There were satisfaction survey measures available of over 95%. We also heard positive feedback about community groups as well as services provided, such as leisure support for unpaid carers without eligible needs.

These proactive approaches mitigated some feedback we heard that information and advice for people without eligible care needs was not always easy to find. We saw a lot of recent work had taken place in this area, and the local authority told us it was aware this was an area to develop further as part of their transformation.

Eligibility decisions for care and support

The local authority had a policy in place outlining how to accept and process appeals about eligibility decisions. There had been no appeals against an eligibility decision in the last 12 months. The local authority website had guidance for people on how to complain, but it did not detail people's rights to appeal eligibility decisions after a Care Act assessment. The Local Government and Social Care Ombudsman (LGSCO) website did not show any eligibility appeals were referred to the LGSCO in the previous 12 months.

Financial assessment and charging policy for care and support

The local authority had a financial assessment and charging policy which was accessible to people, but they recognised a need to improve how quickly people were invoiced for charges. Local authority data showed 80% of new referrals were completed within the target of 20 working days. However, the local authority told us their target to invoice people within 30 days was not always met, which could impact on people's ability to plan their finances around care charges. Despite the local authority highlighting this to us, we did not receive any negative feedback about financial assessment and charging.

The local authority told us appeals against charging decisions were often submitted as complaints; this meant they did not have accurate data about the number of appeals made following financial assessments. However, senior leaders had used complaints to identify and address themes from complaints. For example, where there had been issues with the information and advice provided by staff the local authority had implemented training to address this. Teams told us training in this area was useful and assisted them in providing the right information to people about financial assessments and charging.

Provision of independent advocacy

Access to advocacy was sometimes limited. An advocate can help a person express their needs and wishes, weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations.

Safeguarding Adults Collection data showed 58.33% of people who lacked mental capacity were supported by advocates, family, or friends. This was significantly lower than the national average in England of 83.12% and shows that people who lacked mental capacity to make particular decisions faced a risk of not having their voices heard in decision-making that affected their lives.

Staff feedback on use of advocacy was mixed. We heard where people faced increased risks because of their care needs or circumstances, then staff could usually access advocates. However, staff and leaders said the budget for advocacy was limited which could create barriers to accessing an advocate in cases where the levels of risk were not as high. Local authority data showed there was a waiting list of 17 people for non-urgent referrals and no waiting list for urgent referrals. However, the local authority's use of advocates was significantly lower than national averages which could indicate more work was required to ensure staff were always making referrals where necessary. Reduced use of advocacy meant people could be subject to decisions in which their voice was not heard, and their rights not upheld. The local authority was aware of this and commenced a new contract for advocacy in July 2024. Leaders told us about recent plans to improve understanding of advocacy amongst staff and they had implemented training in the Mental Capacity Act 2005 and the use of independent mental capacity advocates because they had identified a training need in this area. It will take time for the impact of these changes to demonstrate improved access to advocacy for people who lacked the mental capacity to make particular decisions.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority worked with people, partners and the local community to develop a range of resources to prevent or reduce future need. Feedback from unpaid carers about the resources available to them was positive and we heard positive feedback about a variety of different types of support people had received from voluntary sector partners. However, some of the improvements made in this area were recent and would require time to embed and demonstrate their value.

Prevention was a core component of the local authority's 'Council Vision' document; recent changes to Public Health structures meant the function was no longer shared with neighbouring Boroughs. Staff and leaders told us this had enabled a more local focus, but meant some initiatives were at an early stage.

The local authority had improved its use of data, and we saw evidence of work with health partners to share information in areas such as smoking cessation, suicide, and drug and alcohol services. There was a Joint Health and Wellbeing Strategy and the local authority, alongside partners, used a 'Wellbeing Circles' approach to identify early support needs. The use of Wellbeing Circles is an approach where care and support can be built around the person; it was used in the Borough to link support to people from the local authority, health partners, the voluntary sector and faith groups. It was intended to make available a range of services, facilities, and resources to promote independence, and to prevent, delay or reduce the need for care and support.

The community support approach was implemented through the front door team with the aim of 'quickly connecting people to local services'. The project was recently evaluated by a university and found it had a positive impact on partners and people, by creating a network of services and ensuring all involved had a good understanding of what was available within the community so people could be linked to the right service to meet their needs. This had led to a 'no wrong door' ethos for people approaching the local authority for support or advice, and we heard positive feedback from people, partners and staff who felt able and equipped to link people up with appropriate community resources in a timely way.

The local authority employed staff who led work with communities to understand the voluntary sector offer and address any gaps in provision. We heard about recent work to develop strategic partnerships with the community and voluntary sector which had led to the development of community directories which listed services across the Borough and helped identify any gaps. We were told this work had also led to improvements in shared databases, which allowed better information sharing between statutory and voluntary partners.

The local authority had carried out a series of 'world café' events and workshops with health partners. Joint funding was used to engage with the community across the Borough to understand their needs and to develop their prevention offer. The events had informed improvements to information and advice provided at the front door and led to the creation of co-production groups. The work to make changes identified during the workshops was at an early stage and more time was required for the potential impacts to evolve and demonstrate their value.

We heard mixed feedback from voluntary partners about engagement with the local authority. Whilst we heard positive feedback of good joint working in some operational areas, other partners described difficulty in engaging with the local authority at a strategic level. Staff and leaders recognised the Borough had a strong and thriving voluntary sector, but strategic work to plan early interventions had not fully progressed. The local authority had recognised a need to improve its strategic planning for the support of unpaid carers, and to develop the approach to coproduction with the community and voluntary sector. This view was echoed by partners. At the time of this assessment, workshops were underway to better understand community needs, and to build upon the work completed so far.

People's feedback about the resources available for early intervention was positive and the local authority had identified the need to develop its strategic planning in this area to further improve the offer. This was reflected in national survey data. In the ASCS data, 67.31% of people said the help and support helped them feel better about themselves which was trending slightly higher than the England average of 62.32%. ASCS also said 97.12% of people reported they spent time doing things they value or enjoy which was significantly higher than the England average of 67.00%.

Provision and impact of intermediate care and reablement services

There were clear and accessible pathways to short-term reablement and rehabilitation services. The local authority had introduced a 'Home First' model alongside Frimley ICS to enhance the reablement offer by working alongside a specially trained homecare provider to improve capacity and access to intermediate care pathways. Staff and health partners spoke positively about joint-working when it came to hospital discharge and reablement.

Staff took a strengths-based approach to assessment at hospital discharge and worked across disciplines to triage referrals and ensure people received short-term care where required. Data showed this approach was producing particularly good outcomes; in the ASCOF data, 8.96% of people aged over 65 received reablement or rehabilitation services after discharge from hospital, which is significantly higher than the national average in England of 2.91%. SALT data also showed 94.12% of people 65 or over were still living at home 91 days after discharge from hospital into reablement which was higher than the national average in England of 82.18%.

Reablement services were available in a timely way and ICS data showed there had been improvements to the time taken for people to be discharged from hospital. Data showed the average time to discharge from hospital was reduced from 42 to 13 days following the introduction of the Home First model. In ASCS data 97.54% of people who have received short term support said they no longer required ongoing support, which was significantly higher than the national average in England of 77.55%.

Access to equipment and home adaptations

The local authority employed OTs alongside staff who were trusted assessors; these were staff who were not qualified OTs but were trained to assess people for equipment and minor adaptations. The OTs sat within the front door team, so they could provide input at an early stage. The waiting list for OTs meant people could wait up to 6 months for a full assessment, but in all these cases the person underwent a triage and initial assessment to identify any early interventions and equipment. This reduced risk and meant some people's needs could be met earlier if they required smaller interventions or adaptations, such as grab rails or raised toilet seats which could be requested by trusted assessors. However, people requiring a more thorough OT assessment for larger adaptations or to access a Disabled Facilities Grant (DFG) waited longer.

Equipment was installed in a timely way after people had been assessed. The local authority commissioned an equipment provider, and they shared performance data which the local authority monitored. Performance data for equipment delivery showed 97% of 'same day' deliveries arrived in time. Only 93% of 3 day and 88% of 5 day deliveries were delivered in time, below the expected targets of 98% for each of these types. Despite this data, people, staff, and partners did not raise any issue with the timeliness of access to equipment.

Provision of accessible information and advice

The local authority provided information and advice to people in accessible formats but recognised the need to improve the accessibility of written resources for people for whom English was not their first language. Feedback about information was mostly positive but we heard that the local authority's website could be hard to access or navigate, particularly for older people who may face digital exclusion. However, ASCS data showed 86.79% of people who use services found it easy to find information about support. This was significantly higher than the national average in England of 66.26%.

The local authority contracted a translator service and staff told us this was easy to use and quick to access. The front door team often spoke with and visited people who needed information and advice in person, giving an opportunity to make information accessible to people who did not speak English. This approach, which often involved a home visit to people who may not have eligible care needs, mitigated some of the potential impact of the gaps in accessible information because staff were able to take time signposting and explaining services to them in person. The local authority employed a staff member whose role was to look at how they engaged with people from ethnic minority backgrounds, including the accessibility of information and advice.

The local authority commissioned an organisation to look at the accessibility of its publications and we saw documentation was often available in easy read and larger print. Teams also told us how some colleagues had been trained in British Sign Language (BSL), which meant these staff in the front door team could visit people who used BSL to provide information in an accessible way.

The local authority had recognised the need to further improve the accessibility of its written information, and there were plans to update the information and advice offer as part of its transformation work.

Direct payments

Direct payment uptake within the Borough was low and the local authority told us this was an area where they recognised a need to improve. ASCOF data showed 12.08% of people in receipt of services used direct payments which is significantly lower than the national average for England of 26.22%.

Leaders and teams told us direct payments could be hard to set up, some staff lacked understanding of how they could be used, and there were barriers to people using them effectively to meet their care and support needs. The local authority told us they had identified barriers such as a lack of staff awareness of the direct payments process and how to follow the processes to set them up. The local authority had appointed to a new post to drive increased awareness of direct payments and had plans to recruit to another post supporting people using services working with personal assistants.

We heard about other barriers to direct payment uptake, for example when using the direct payment to purchase homecare, staff told us people may have to top up their direct payment budget if the hourly rate being charged was more than the local authority's contracted rate with the homecare provider. This often happened where providers charged an increased rate in the evenings or weekends which was not the same rate as the local authority contracted rates.

Staff and leaders also told us providers were expected to apply the same standard rates of care for people using direct payments as they would charge the council. This was monitored by commissioning and quality assurance teams. However, staff told us this discrepancy in rates for direct payments happened and created a financial disincentive to people accessing direct payments and further work was needed to improve the uptake.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority took steps to understand their population. We heard examples from voluntary groups about how the local authority met people's cultural needs as well as the needs of people where English was not their first language. We heard about groups being set up as well as the 'World Café' events being targeted so they took place in areas where they could reach minority populations and seldom heard groups. Staff and leaders told us about how they would continue this approach through co-production and outreach events now the World Café events had concluded. The World Café events led to the creation of specialist groups such as a carers support group for ethnic minority unpaid carers of people living with dementia. Many of the examples seen were recent but there were long-standing initiatives such as 'WAM [Windsor and Maidenhead] Get Involved' and 'RBWM Together', which were initiatives bringing together community, voluntary and faith groups across the Borough.

Leaders and teams demonstrated a good understanding of the demographics in the Borough and current challenges, we heard examples of work undertaken to meet the needs of local Gypsy, Roma and Traveller populations and a growing refugee population. We heard examples of staff working to meet the cultural needs of people through care planning, such as a person supported to attend an important cultural event through creative social work practice and commissioning.

There had been recent work to be more proactive in meeting the needs of minority communities and seldom heard groups, but whilst we heard about longer-established work that had achieved positive outcomes, some of this strategic work was in its infancy. We heard positive examples and feedback about the work they did, including the way they highlighted issues and reported into senior leadership. The local authority used joint funding to meet the needs of diverse or seldom heard groups and had set up an Innovation Fund with partners which had been used to support various groups such as a forum for women from black and minority ethnic communities, cookery groups for asylum seekers and digital champions across the Borough to support older people at risk of digital exclusion. These groups showed the local authority was working with partners to find ways of meeting the need of intersectional groups, such as particular faith or ethnic groups where people belonged to specialist groups with specific needs. However, the local authority was aware of gaps, such as we heard there was a limited offer for people from the lesbian, gay, bisexual, transgender or queer (LGBTQ) community. We heard positive examples of staff working with people to overcome stigma, but also heard that there were sometimes limited options for people who identified as LGBTQ, including intersectional groups such as offers for older people or autistic people who identified as LGBTQ.

The local authority's ability to use data to understand the experiences of people who used their services was limited, which impacted on the local authority's ability to evidence how well they met their public sector equality duty. The local authority was aware of the need to make better use of data and plans were underway to improve this. We heard from staff and leaders that waiting list data was difficult to interrogate by groups and saw during assessment that this information was time consuming to collate. This meant the local authority could not easily review data to identify if waiting times were different for people from different groups or communities. The potential impact of this was mitigated by staff practice, we heard how staff were proactive in contacting people who were waiting to triage cases and manage risk by putting initial interventions in place. This reduced the risk of people facing discrimination around how timely their assessments were, but the local authority's ability to use their data to understand people's experiences to inform their strategy was limited.

The local authority had already identified this as an area to improve and the planned changes to IT systems was intended to improve access to this type of data, but at the time of our assessment the ability to interrogate data in areas such as waiting lists, safeguarding and complaints to identify potential impacts on certain groups had not yet improved. Where data was available, improvements had not yet been implemented to address disparity. For example, there were differences in process and approach for adult unpaid carers and young carers, with data showing young carers waited longer for assessment. The local authority recognised a need to raise awareness with staff about young carers but the impact of the work had not yet been seen.

The local authority had carried out a Joint Strategic Needs Analysis (JSNA) to understand the health, care and support needs of people in the Borough and across Berkshire East. The JSNA included work to look at populations and identify groups who are likelier to face poorer outcomes or inequalities such as homeless people, migrants, the Gypsy, Roma and Traveller communities, sex workers, people with a learning disability and unpaid carers.

The JSNA identified vulnerable migrants as one group who could be at risk of achieving poorer outcomes because of barriers in access to health services or housing, as well as low pay and risks such as trafficking. Staff and leaders described recent work to train staff in how to support vulnerable migrants, as well as working alongside the Home Office to meet the needs of the migrant and refugee populations. Whilst feedback showed this was meeting the needs of these groups, we saw limited evidence of strategic work in this area. The world café events and recent improvements in use of public health data, had laid the groundwork for an improved strategic approach, but much of this work was at an early stage at the time of this assessment.

The local authority recognised a need to improve in this area. We heard from staff and leaders how the world café events were the start of a project to better understand communities. Whilst this demonstrated the work underway was already informing strategy in some areas, we found areas where this had not yet been developed. For example, the Autism strategy was out of date and there were plans to publish a new one once a leader had been recruited to a role to oversee it. The inequalities project detailed above showed work was underway in identifying different demographic groups, but this had not yet evolved into strategic approaches to meeting the needs of those people, in areas such as service provision or prevention. The work that had already taken place had demonstrated good outcomes, such as the work with unpaid carers of people living with dementia from black and ethnic minorities. We heard how the local authority's approach had attracted interest from other local authorities who wanted to learn from the Royal Borough of Windsor and Maidenhead. However, this strategic work would require more time to achieve what the local authority had set out to.

The local authority was working with health partners to share data about demographics and meet need. For example, there was joint work underway to plan services for people from local deprived communities who had needs related to addiction and mental health conditions. The local authority employed staff who led on working with community groups and we heard mostly positive feedback about this work from voluntary and health partners, but some partners said it could be difficult to work with the local authority strategically. The local authority was working with housing partners where the inequalities project identified risks for people with a learning disability and autistic people when it came to security of tenure, this had led to work to develop new specialist accommodation in the Borough.

The local authority had started the next phase of delivering on these priorities by using joint funding to bring together partners and communities to further understand what was available in the community and enhance co-production to develop services to meet the needs of minority and seldom heard groups. For example, RBWM Together had supported community projects reducing the risks of social isolation for parents and carers, including advice and support around mental health. Leaders also told us about future plans to use data more creatively in public health, as well as considering the use of citizens assemblies to directly involve representatives of local communities in decisions about health and social care services.

Inclusion and accessibility arrangements

The local authority took steps to ensure information was available in an accessible format to people, but the local authority recognised a need to provide more information in different languages for people for whom English was not a first language. Staff told us they had access to translator services, and we saw evidence of information being published in accessible formats, such as large print or easy read for people with a learning disability. Staff said they had access to British Sign Language (BSL) training, and we saw staff could access services to communicate with people with sensory needs on visits or through follow up information provided to them.

The front door team frequently carried out visits where information and advice could be provided, and these visits presented opportunities to use translator services to ensure people who did not speak English as a first language were kept informed.

Whilst this approach mitigated some of the risks of people being unable to receive accessible information, the local authority had not yet fully ensured information and advice was consistently available to people in inclusive and accessible formats.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority used a variety of methods to understand the needs of the local community to commission the right services. In some areas there was tangible evidence of commissioning practices having a positive impact but in other areas strategies were either under development or had not yet been fully embedded. Staff and leaders told us about work going on to improve the use of data to inform commissioning practice, and we heard about initiatives starting to have a positive impact. The previous year the local authority and health partners used the Better Care Fund to run 'world café' events in every area of the Borough. The local authority employed staff who took the lead on understanding the local community, from the perspective of strategic planning and commissioning, as well as staff whose role was to reach and speak up for seldom heard groups.

There was evidence of commissioning being used to address gaps, but leaders acknowledged a need to do more with data. We heard about how public health data was being used to understand health risks to inform what the local authority would need to commission in the future. Staff and leaders told us there were new IT systems being commissioned to support changes in assessment approaches and to provide more effective methods of data collection and analysis.

There was a Joint Strategic Needs Assessment (JSNA) for Berkshire East which was published online and used data across a patch of 6 local authorities known as 'Berkshire East'. The local authority had also carried out a People and Place JSNA, with a focus on the Borough. These JSNAs showed data was being shared with partners and was used to set priorities for care and support, including how to strengthen transparency and accountability.

The People and Place JSNA highlighted loneliness and isolation was an area to develop a response to mitigate risks; this was also an area of focus arising from the World Café events. This had led to the development of a working group to work on tackling loneliness in the Borough. Staff and leaders were aware of this priority and described effective work in the community to provide information and advice, as well as visibility of the local authority's offer. The local authority also commissioned small projects to respond to this need, such as a cookery group developed with local authority funds which started as a group to encourage healthy eating but evolved into a social group that became highly valued by the local community who used it. Whilst the examples provided showed the local authority was meeting identified needs, the overarching strategic approach was still in an early stage. Many of the working groups had only recently been set up, and further time would be required for this to develop and become embedded in practice.

In other areas, the local authority recognised a need to improve but had not yet achieved their ambitions. The local authority's adult social care strategy identified a need for a focused strategy for commissioning services for people with a learning disability and autistic people; work had started but the strategy was not expected to be published until the end of 2024. The local authority had also commenced plans to increase provision of supported living to meet an identified need for secure housing for people with a learning disability, who staff told us were either placed out of borough or in unsuitable housing. This project was underway, with plans to create new provision later in 2024. This showed the area was identified as a strategic priority but at the point of this assessment it had not yet been fully realised. Staff and leaders described recent difficulties finding the right provision for working-age adults with complex care needs, including dementia. The local authority had also identified this as a gap but had not yet implemented a strategy to address it.

Demographic data showed a growing aging population, with an expected increase in people aged between 65 and 80. Staff and leaders told us about plans to address this, we heard about development of new extra care provision which was underway as well as work with the provider market through a market management planning process. Staff told us there was sufficient capacity in the older people's care market in the borough, but staff were working with providers to ensure the right care was available for this anticipated increase in need.

Market shaping and commissioning to meet local needs

The local authority's market shaping plans had recently been reviewed. The Market Positioning Statement (2024-27) identified further work to shape the local provider market, but the full impacts of this work had not yet been realised in areas such as direct payments and complex care for working age adults. There was a market shaping plan which identified several actions in response to areas identified to improve outcomes for people. The plans were underway at the time of this assessment, but many were at an earlier stage and not yet fully implemented. They included a plan to develop a commissioning strategy for people with a learning disability, develop an adult social care workforce strategy, and to improve uptake of direct payments. We heard from staff and leaders these projects were progressing but had not yet had time to impact on the local market and meet local people's needs.

Staff and leaders told us the local authority had a number of initiatives in place to shape the wider market. The local authority collected data through partnership working and engaged with the local community through events and via staff employed to engage communities to inform strategic commissioning. For example, staff identified the need for live-in care was increasing in the Borough and new care provision was being considered for the local aging population. However, staff also said they felt there was less planning in areas such as prevention services and complex needs provision.

The local authority showed awareness of housing inequalities and understood the barriers for housing provision for adults with care and support needs in their local communities. For example, they had identified there was an insufficient supply of social rented housing for all of those who need it. The local authority commissioned a housing needs assessment for people with learning disabilities. The assessment concluded there was a need for 16 units by 2025 and further requirement of 33 by 2030 and there were projects underway to meet this need.

The local authority was also aware of a need to develop more community provision, alongside health and voluntary partners, to address risks associated with loneliness and isolation identified as a priority through the world café programme. Whilst extensive work had been undertaken to understand this risk and the current provision in the Borough, there had been limited time for actions taken to have the impact the local authority intended by the time of this assessment.

The local authority told us they had an excess of provision for older people with less complex needs. The local authority commissioned 22% of this type of provision to meet demand within the Borough. Staff and leaders told us the number of care home beds available was higher than the demand for these beds. Therefore, there was a higher than expected number of placements into the Borough from neighbouring local authorities as well as a high number of people moving into the Borough to receive care privately.

There were challenges presented by a strong provider market, where people had moved into the Borough who funded their care privately. This resulted in challenges for the local authority in relation to inappropriate placements. There was a strong private care market in the Borough because higher numbers of people who funded their own care lived there relative to other Boroughs in England. Staff and leaders told us how this presented challenges as people could often be privately placed inappropriately in care homes and when their capital fell below the financial threshold for local authority funding these placements often costed more than the local authority's budget for the type of provision, or people's assessed needs did not demonstrate they required residential care.

The local authority had identified that instances of this had quadrupled in the previous 12 months and were actively working with providers to address this as part of their contract arrangements. Staff and leaders told us about work to engage the provider market to identify at an earlier stage when people's capital made them eligible for local authority funded provision, so teams could carry out an assessment and plan care in a timely way whilst reducing the risk of transfers of service provision.

Feedback about unpaid carers provision was mixed, we heard there was provision available but opportunities for unpaid carers to influence commissioning were limited. National data provided by SACE showed 60.61% of carers felt involved or consulted as much as they wanted to be in discussions. This was below the national average of 66.56%. SACE data also showed only 38.89% of carers felt it was easy to access information and advice, which was significantly below the national average of 59.06%. Senior leaders told us they were working with other local authorities across the ICS to review the support available for unpaid carers. We heard from partners how a strong voluntary sector meant there was an offer for unpaid carers but the local authority's role in shaping that had previously been limited.

Staff and leaders told us about local support options for unpaid carers, including residential respite, personalised carers breaks and access to leisure activities. Social prescribers and dementia care advisors also supported unpaid carers to access learning and gathered feedback on people's outcomes and the impact of service provisions. However, we heard feedback from unpaid carers who felt opportunities to influence service development was limited despite local voluntary organisations being particularly good at signposting them to the right services.

Ensuring sufficient capacity in local services to meet demand

The local authority told us service capacity in the area was mostly good, with data showing there was sufficient provision and choice for older people with less complex needs. In a survey of Adult Care in England 65% of people who use services felt they had choice over services, this was slightly lower than the average in England of 69.81%. The local authority was aware of gaps in provision for people of working age with a learning disability or long-term conditions, including more complex health needs, and there were projects underway to address these areas through work to develop new supported living accommodation and plans to increase shared lives provision.

People were sometimes placed outside of the Borough, but these placements were often within the county of Berkshire. The local authority monitored data on placements which showed in the last 12 months, 5 people had been placed outside of the Borough to receive specialist care for physical and/or learning disabilities and long-term conditions. Data showed all other out of Borough placements had been due to individual choice and the data showed for residential and nursing care for older people there had been no out of county placements that were not due to individual choice in the last 12 months.

The local authority had worked with health partners to understand local needs around hospital discharge and reducing hospital admissions. The 'Home First' hospital discharge model was developed with health partners and there was joint commissioning of reablement and homecare services designed to meet rising demands. Adult Social Care Outcomes Framework data (ASCOF) showed 94.12% of people aged 65+ avoided readmission to hospital within 91 days for people discharged from hospital with reablement, which was significantly higher than the England average of 82.18%. Health data also showed improvements to discharge waiting times.

Ensuring quality of local services

The local authority had systems and processes in place to monitor and ensure the quality of the providers they worked with. The were systems to identify and respond to concerns, such as safeguarding issues, concerns with compliance or service quality. The local provider market showed good quality, with 84% of care home providers rated as good or outstanding following assessments by the Care Quality Commission (CQC). The local authority had a clear policy about not placing people in services that had not achieved at least a good CQC rating, including that providers could not join their commissioning framework without being rated good. We heard from staff how they were able to routinely achieve this due to sufficient choice of commissioned and non-commissioned care in the Borough.

There were robust checks in place for homecare providers both before they were commissioned by the local authority and on an ongoing basis. We heard how rates were designed to ensure travel time was paid for between care calls and agreed as part of contacts with providers. Before contracting with a provider, commissioners carried out intelligence gathering to check quality or follow up on any intelligence of concern the local authority might receive. Staff also told us about effective communication between teams if there were concerns or intelligence to share before agreeing placements. We heard examples where concerns shared with the local authority had led to a swift visit from the quality assurance team and saw how they worked with providers to produce action plans in response to quality concerns. There were systems to share information with partners about quality of provision for people placed out of area and staff told us they would conduct reviews in person for anyone in an out of area placement.

Feedback from providers told us the local authority undertook regular quality checks, and we heard there was a supportive approach from the local authority, allowing providers to feel comfortable raising queries. We also heard positive feedback from health partners about sharing of information, prompt sharing of concerns, and local authority responsiveness to issues raised about care quality; this was a shared strategic priority, and we heard how there was effective sharing of information between partners to monitor quality and respond promptly to any concerns.

Ensuring local services are sustainable

The local authority had a plan to overcome challenges and ensure the provider market was sustainable. Commissioners assessed all new providers and their assessment included the sustainability of staff recruitment, including training, pay, conditions and providers approaches to recruiting staff from overseas.

The local authority had put a sustainability plan in place which included an assessment of the current financial sustainability of local care markets and how the local authority currently commissioned them. The plan identified current and expected challenges in areas such as workforce and contracts. The plan detailed how the local authority would use fair cost of care funding to ensure social care jobs were attractive and could be recruited to. The plan described how providers already mostly offered above living wage rates to their staff because of the challenges of recruiting in the local area, and the local authority recognised a need to increase provider fees to sustain this. Providers spoke positively about working with the local authority around contracts and rates and staff told us how this was a key component of their commissioning and tendering processes.

Staff and leaders told us the local authority had a proactive strategy for monitoring the risks of provider failure in the Borough. This included a support framework, monitoring of financial stability, joint working on overseas recruitment, and contractual agreements on staff terms and conditions. Provider forums offered further support through peer review, training and the sharing of good practice. There were processes in place to understand provider's plans in the event of fires and floods to ensure continuity of care, which were monitored by commissioning and care quality teams as they worked with providers.

Partnerships and communities

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority had strong supportive relationships with partners which had been strengthened by recent changes to local health structures and the local authority's transformation programme. The local authority worked with health partners on shared strategic aims, and we heard from staff and leaders there were positive working relationships including space for professional challenge. Feedback from partners was positive and we saw multiple instances of the local authority and partners sharing information or data on shared priorities in areas such as hospital discharge and admission avoidance. There was also strong co-working in areas such as public health, housing and safeguarding. Some of this work had been recently implemented and in the early stages of maturity and more time was needed to realise the full impact.

Staff described positive working relationships at the frontline, with frequent joined up approaches to assessment and care planning. Leaders spoke positively about work with health partners, including recent changes to the structure and format of the Health and Wellbeing Boards and the Safeguarding Partnership Board. Partners, staff, and leaders all described how these forums were valuable for sharing information, escalating concerns, and responding to current themes.

Partnership working had achieved good outcomes in hospital discharge and avoiding hospital admissions. The Home First model for hospital discharge was jointly commissioned with health partners and we heard positive feedback from staff, leaders, and partners about how they had collaborated in developing the model. Partners shared data to measure the impact of models of support and the latest data showed a reduction in the time taken to discharge people from hospital safely; data showed the average time had reduced from an average 42 days to an average of 13 days. The local access point (LAP) was a joint-agency function where health partners and local authority staff worked together to support people in a way which prevented needs from developing and avoided hospital admission. Staff described how they valued the input of health colleagues and the collaborative nature of the relationship, which often meant people's needs were met holistically through joint interventions. For example, we heard from staff how they would often undertake joint visits with health colleagues which meant people received packages of care or equipment alongside physiotherapy.

The local authority worked with Berkshire Healthcare Foundation Trust (BHFT) to deliver mental health services across two integrated teams and we heard about positive partnership working and shared strategic ambitions. Staff told us about positive working relationships with health colleagues with clear lines of accountability and responsibility. We heard how the use of separate systems could be a challenge which was an area the local authority told us they were working with BHFT on implementing new shared systems. We also heard they had identified a need to improve early intervention and work was underway to review the current model with BHFT and we heard from partners about recent work to improve information and advice for younger adults living with dementia.

Partnership working was used to understand and anticipate the health needs of the population. Staff and leaders told us there were strong links between adult social care, public health, and health partners. For example, public health teams were collating data on local demographics to help shape future strategies for keeping people healthy, active and at home for as long as possible. Current programmes were focusing on healthy weights and substance misuse, which were areas seen as linked to people's experiences and changes in lifestyle during the COVID pandemic.

The local authority and partners had used Better Care Funds to set up an Innovation Fund, which was an initiative to provide seed funding to kick start creative ideas in the voluntary and community sector. We saw many examples of programmes designed to achieve health outcomes for people or meet the needs of specialist groups, ethnic minorities, and faith groups. Examples seen included a group to enhance the social lives of people with a learning disability and autistic people, a frazzled café designed for people to de-stress and ease loneliness and isolation, walking cricket and a cycling scheme for people who used a local mosque.

Arrangements to support effective partnership working

The local authority and health partners used partnership boards to maintain a shared focus on strategic aims across the Borough; recent changes meant that some of these forums were in an early stage of maturity. The local authority told us the 'Connected Leaders' and 'Place Committee' forums were key to ensuring continuity of strategic focus, and we heard from health partners how shared priorities were sustained during the ongoing period of change and transformation at the local authority.

We heard positive feedback about the effectiveness of shared forums from staff, leaders, and partners, but some of the work was recent and needed time to evolve. For example, we heard how the Safeguarding Partnership Board was responding to themes and trends identified in the safeguarding annual report, such as domestic violence and self-neglect. Working groups had led to the development of toolkits to support staff and partners but some of these had not yet had time to embed and improve outcomes for people receiving support.

There were effective partnership arrangements which overcame challenges related to funding. We heard how there could sometimes be challenges when it came to Continuing Healthcare (CHC) funding. Staff and leaders told us the joint ownership of this funding could lead to delays in approval but also described a positive relationship with health colleagues, where professional challenge was encouraged. Leaders described how it was important to meet the needs of the person first and agree the right funding stream later. Providers told us there was good partnership working but did say that at times there could be delays to payment where people's care was jointly funded, such as care provided jointly by health and social care under section 117 of the Mental Health Act 1983.

Impact of partnership working

The local authority and health partners worked together to achieve strategic ambitions through use of joint funding. The Hospital Discharge Fund had been used to fund the Home First Model for hospital discharge and the local access point, both of which showed value through their impacts on hospital discharge, availability of care provision and information and advice. There were systems in place to monitor the use of shared funding and ensure it was focused on areas of shared priority. There was a Better Care Fund commissioning board to oversee use of the funds and we heard how funding was being planned to achieve shared priorities in areas such as unpaid carers.

Partners worked together on strategies to improve health outcomes across the Borough. There had been a Creating Healthier Communities strategy which included public and voluntary partners across the Integrated Care System. The programme had been used to inform the development of a new hospital, step-down service provision, virtual wards, and the development of a large remote monitoring model for avoiding hospital admission.

The local authority worked alongside health and community partners in delivering the world café events which had been used to inform strategy, with plans for this to evolve through RBWM Together, which was an initiative to encourage people to come together, share information and ideas as well as for more formal co-production to take place. Staff and leaders told us how RBWM Together will be used to maintain partnership working and co-production to deliver on shared strategic objectives. RBWM Together also signposted people to services and provide details on how to access support in the areas identified at the world café events, like the cost of living, weight loss and mental wellbeing. There were a variety of small jointly funded initiatives that these strategies had led to, such as 'Blokes Losing Timbers' which was a weight loss group for men and a yoga group for over-70s.

We also heard how feedback from events around loneliness and cost of living had enabled partners to identify shared priorities and work was underway to develop community provision to address these areas of focus. We saw examples of joint funding being used to target these areas, such as where funding had been provided to the voluntary sector to develop comedy groups for young adults to improve confidence, groups for people with a learning disability to socialise and several activity groups set up for people with specific needs relating to their religion or ethnicity.

Working with voluntary and charity sector groups

The local authority worked effectively with voluntary and community partners to achieve shared objectives. We heard from staff, leaders, and partners that the voluntary sector was a crucial source of support for people and unpaid carers. The local authority had employed staff who worked directly with voluntary, faith and community groups to identify shared objectives and meet need. However, we heard from voluntary partners it could sometimes be a challenge to access local authority funding. The local authority recognised a need to do more to harness the potential of a strong voluntary sector. Some recent work had yet to develop and mature.

Theme 3: How Royal Borough of Windsor and Maidenhead ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The local authority understood it's role and responsibility in keeping people safe. Staff and leaders had access to case management systems which provided overview and scrutiny of risk. However, these current systems lacked a joined-up, fluid process for sharing information. For example, senior leaders told us knowledge of themes and trends relating to risk was often held by managers of individual teams and there was no overarching system for collating information without approaching teams and requesting submission of this data.

Many of the data systems used by the local authority were not accessible to all staff or leaders. This led to delays in reporting themes and trends and meant proactive risk management strategies were not always implemented in a timely manner. For example, systems used by mental health teams and transition teams could not be accessed by most community-based teams.

Senior leaders had recognised the limitations of the current case management systems and had implemented temporary arrangements to mitigate the impact of the monitoring processes whilst a new case system was sourced. Staff and leaders told us there were clear processes for monitoring referrals and assessments, including reactive risk management of waiting lists by clinical leads to support those at higher risk in a timely manner. A new case management system had been purchased and was at implementation stage during this assessment. Feedback from partners showed the interim arrangements were effective, and leaders demonstrated they had an oversight of safety in the system, but the new systems will make data easier to find and quicker to interrogate.

Partnership working and joint policies and processes with health, voluntary and charity organisations enabled the local authority to share the responsibility for supporting people through their care journey whilst enabling a more proactive risk management approach to people's needs. Partners told us risks were mitigated through joint working around early intervention, promoting independence and advocacy; this included strong links with emergency duty teams across the local ICB. We heard how safety was a key focus of partnerships, through the Health and Wellbeing Boards and Safeguarding Partnership Board. We heard about how safe pathways was a topic often focused on, such as readmission to hospital or health partners collaborating with the local authority to develop toolkits around self-neglect.

Safety during transitions

The local authority worked closely with partners to ensure peoples' care journeys were safe and to promote continuity of care provision. We saw evidence of safe arrangements for hospital discharge. The local authority had introduced a Home First model and discharge team, based at the hospital, who worked jointly with health professionals to provide holistic short-term support at the person's home for up to 2 weeks; at the end of the 2 weeks people requiring ongoing support would be transferred to a suitable community care provider.

Staff and partners told us there were multiple hospital discharge pathways to ensure peoples' needs were met in the most effective way. For example, discharges to long-term care services such as care homes were supported differently to Home First discharges and involved community assessment teams as well as care providers, and occupational therapy and sensory teams.

Leaders told us quality assurance processes and processes for the secure sharing of peoples' information with partners had a significant positive impact on reducing waiting lists and had improved proactive planning for increased service demands, reducing the risk of unsafe discharges. For discharges from mental health hospital, we heard how staff worked with health partners to plan care and there was an integrated approach to ensuring a smooth and safe pathway from hospital. We heard about joint working and effective communication and planning where people were discharged with jointly-funded packages of care where applicable.

Transitions from child to adult services were led by children's services, with staff from adult services as well as multidisciplinary teams from health and community services incorporated into the teams. Staff told us this approach allowed a more flexible transition between services for young people, with transitions taking place at the end of education provision rather than at 18 years old. However, leaders recognised this created uncertainty for people close to the younger person and made preplanned transitions more difficult to predict and resource for adult teams.

Leaders told us they were reviewing the transitions process to improve safety and outcomes for young people following feedback from people receiving care and support. For example, staff told us they were looking at ways to make the transition process more inclusive for young people and their families, to promote independence and improve support networks around the person going through transition.

People told us transitions between child and adult services were planned, set at the pace of the person receiving support, and reviewed regularly. Those assessed as no longer requiring formal support were signposted to community services and information to enable them to live independently. People we spoke to told us they had named key workers during transitions which made them feel safe and encouraged inclusive processes. Staff described working with young carers when preparing them for adulthood, we heard how young carers were involved in assessments and there was a young carers champion within the team to support assessment and care planning around their needs. However, there was not a consistent pathway for staff to follow when young carers transition to adulthood, which showed further work would be required in this area.

We saw systems were in place to monitor and support people using services which were located away from their local area. These services were only used if they were in the best interest of the person, for example due to personal choice or because specialist support was required. Leaders told us they were reviewing the service provision locally to encourage more options for people who wished to remain in services locally. For example, new supported living services and shared lives options had been approved to support people with a learning disability and people with mental health needs.

The local authority had a process in place for people who were in privately funded care placements where their capital has fallen below the threshold for local authority funding. There was a process staff followed and we heard how staff used a risk tool to consider best options for the person, based on their needs and any risks, to ensure this pathway was a safe one.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support.

We saw joint quality assurance processes across the local authority and ICS which enabled senior leaders to monitor for provider failure and intervene with support and guidance in a timely manner where appropriate. Commissioning processes ensured a variety of options were available through a mix of block contract and spot purchasing offers. These processes included decommissioning arrangements and safe transfers to new service providers.

Programmes such as the Winter Care Fund, which were jointly funded with health partners, allowed the local authority to consult with the local community and to plan resources for future demand. For example, the local authority was currently working with providers to improve capacity and skills of the local workforce to support for people with complex dementia needs and reduce the need for out of Borough placements.

Staff and leaders told us there was a robust civil contingency plan in place to allow staff, working with partner agencies, to respond effectively to different scenarios. For example, during flooding in January 2024 several vulnerable people had to be found temporary accommodation. The local authority's pre-planning and clear lines of joint responsibility allowed staff to quickly coordinate placements and reduce the risk to people living in flooded areas.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

The local authority had effective systems and processes to protect people from abuse and neglect. The local authority had set up a safeguarding hub to deal with all referrals and concerns and decide about whether to proceed to an enquiry. Cases would then be allocated to the community and front door teams to undertake enquiries.

The safeguarding hub had been set up in response to issues identified in a local authority analysis of safeguarding referrals. The analysis identified delays in processing referrals, inconsistencies in what was progressed as a safeguarding and extended time taken to complete enquiries. Staff and leaders spoke positively about the impact the safeguarding hub had on practice and data showed it was effective in improving performance and consistency. Staff also shared there were pressures in areas such as mental health, where they received a higher number of referrals. The local authority had systems to monitor and audit safeguarding systems, and there were leaders who were accountable for processes and practices.

The local authority recognised safeguarding training for staff was an area they needed to improve. Leaders and staff described improved access to safeguarding training more recently but that difficulty recruiting and retaining staff will have impacted on training data. We heard how the local authority was working on their training offer as part of the transformation. The ongoing impact of training will take time to embed and demonstrate value, but we did hear about ongoing training and learning from safeguarding that was disseminated to staff in response to themes, as well as more formal training for staff.

There was a multi-agency safeguarding partnership board in place, but this iteration of the board had only been set up recently. The complex make-up of the Berkshire geography and the ICS had presented challenges in governance and transparency, and the structure of the partnership board had changed to address this. We heard how the terms of reference and makeup of the boards were agreed recently and the partnership board had published a safeguarding partnership board strategy in April 2024. There were strategic priorities in areas such as domestic violence, early intervention, sexual abuse, and governance. Task and finish groups had been set up in areas such as self-neglect, early intervention, and adult exploitation. We heard how this had led to new tools and systems being implemented, such as the development of a self-neglect toolkit for staff. These groups were still at an early stage and would take time to become fully embedded and influence practice across the partnership. Despite this being new, we heard positive feedback from partners and staff who told us the good joint working around in place prior to the new makeup of the board and been strengthened by the changes.

There were systems in place to provide external scrutiny to the safeguarding partnership board. The partnership board was co-chaired by the Director of Adult Social Services and the Director of Children's Services. The local authority had identified the need for scrutiny in the absence of an independent chair so had commissioned an organisation to provide quality assurance and scrutiny of the board and their work. Staff and leaders spoke positively about this, and we heard from leaders there were plans to recruit to a role to provide governance support to the board to provide better access to data and information for the scrutiny company.

The local authority told us they were particularly proud of the Adult Social Care Survey (ASCS) safeguarding data which showed 92.13% of people who use services said those services had made them feel safe. This was significantly higher than the England average of 87.12%. In the SACE 80.65% of carers said they felt safe which was in line with the England average of 80.93%.

Responding to local safeguarding risks and issues

There had not been any recent safeguarding adult reviews (SARs), but partners, staff and leaders described how learning was shared from SARs in neighbouring local authority areas and integrated care systems (ICSs). We saw examples of learning being shared in areas such as bed rails, restraint, and self-neglect, where there had been learning or themes identified. Staff and leaders told us learning from safeguarding enquiries which did not meet the threshold for SARs were shared with staff to improve operational practice. These 'learning briefs' were signed off by senior leaders before being shared with staff through staff forums and reflective supervisions. Learning was also shared from external partners including other local authorities, health partners, and related forums.

Partners described how the partnership board was a good forum for sharing learning and best practice on themes which had come up locally and regionally. We saw evidence of work with health partners around ambulance referrals for safeguarding in response to high volumes of concerns. Staff told us about work undertaken to educate partners on safeguarding, and a process to conduct welfare checks where a referral was made that did not meet the threshold for safeguarding enquiries but could mean a person required support to keep themselves safe.

The local authority recognised a need to be proactive in identifying and disseminating learning from SARs and had introduced a rapid review process. This was a newly structured, multi-agency decision-making process, for deciding when a case had reached the threshold for a SAR. Staff and leaders told us the rapid review process was set up to provide a more structured, clearer joint working process with partner agencies & to give health partners a clear information governance process. This had improved information sharing and supported clear decision making when reviewing SAR thresholds.

The partnership board looked at data and themes across the patch and monitored for any risks for particular groups or minority communities. Staff and leaders told us about emerging themes from seldom heard groups included forced marriages, incidents of financial abuse, and self-neglect risks for people living with mental health issues and autistic people. The safeguarding partnership board were working with partners to raise awareness and provide toolkits for providers and other agencies to use when identifying concerns.

Responding to concerns and undertaking Section 42 enquiries

Staff and teams worked effectively with providers and partners to keep people safe and there had been recent improvements to performance following introduction of the safeguarding hub. However, local authority data showed performance was not yet where they wanted it to be.

The safeguarding hub provided a central point for all safeguarding referrals. The team reviewed referrals and spoke to the public, providers, and partners to gather information and decide whether to proceed to an enquiry under section 42 of the Care Act 2014. Section 42 relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect.

The local authority took immediate action where necessary to refer to other agencies, such as the police, or to put measures in place to ensure people were kept safe. Providers spoke positively about the safeguarding hub, saying they always had a prompt response and were able to receive feedback or advice in response to concerns raised. Staff and leaders said the hub provided consistency in section 42 decisions and data showed they had reduced the time taken to allocate safeguarding.

Section 42 enquiries were allocated to the community teams if the person was already known to them. The waiting lists for allocations were minimal, with data showing there was usually only 1 or 2 cases awaiting allocation at any given time. Staff said waiting lists for safeguarding case allocation were lower than they had been previously but did say at times there could be delays in allocating cases to the community teams. Staff told us the introduction of the safeguarding hub had helped with caseloads, as well as allocation and consistency in decision-making.

Local authority data showed 69% of enquiries were completed within the local authority's expected timescales in July to December 2023 after the hub was set up, compared to 45.9% in the period January to June 2023 under the previous system. This data and staff feedback about waiting lists showed an improvement but also demonstrated further work will be required to embed the new system and improve safeguarding performance further.

Staff and leaders told us safeguarding processes were quality assured through audits of practice and reviews of enquiries every two months. Managers of individual teams were responsible for authorising case outcomes before going to senior leaders for scrutiny and oversight. Learning from enquiries, including themes and trends were then shared with staff via learning focus newsletters, training, and workshops.

The local authority had identified a need to improve waiting times for review of deprivation of liberty safeguards (DoLS) applications. Staff told us there were 397 cases awaiting allocation at the time of the assessment, which was a reduction from up to 800 cases. Staff and leaders described how they prioritised cases so they were triaged, and urgent cases could be assessed quickly.

The local authority told us staff retention was impacting on DoLS waiting lists and all the best interest assessors who reviewed these applications were recruited by an external company. Staff and leaders said the plans to move Care Act functions in-house were intended to improve recruitment and retention of staff, which would improve waiting lists, as well as to improve consistency and oversight around DoLS. We heard from staff, providers and partners about effective communication and support for providers around DoLS.

Making safeguarding personal

The local authority had identified a need to be more proactive and structured in seeking feedback from people to implement 'making safeguarding personal' (MSP). They had introduced systems to routinely ask the person raising the concern about what was important to them, but shortfalls in staffing of Best Interest Assessors and some limitations on the use of advocacy meant there was a risk people would not always be properly informed about their human rights and their rights under the Mental Capacity Act 2005.

There were sometimes barriers to accessing advocacy. The availability of advocacy support could be limited, and staff described how it was prioritised for higher-risk cases. This meant there was a risk people may not have their voices heard in cases which were not deemed to be higher-risk because they did not have the same access to advocacy services.

Theme 4: Leadership

This theme includes these quality statements:

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

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

Governance, management and sustainability

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

The local authority were going through a significant transformation which meant leadership structures were new and developing. The governance and accountability during transition was strong, leaders had a good understanding of where the local authority needed to improve and the plans in place to bring about improvements were robust. We heard from staff and leaders how they anticipated that the transformation would enable them to work better across teams, such as with children's services, housing or finance. However, it will take time for new structures and processes to embed. Staff described strong leadership and we heard from leaders how they remained accountable to staff and people who used their services. However, at the time of this assessment many leaders were in interim roles and some of the actions to improve governance, such as implementing new IT systems, had not yet completed.

The local authority had identified gaps in overall governance which were planned to be addressed by bringing statutory functions in-house after six years of these being managed by a local authority trading company. At the time of this assessment there were interim senior leadership team arrangements in place to mitigate the impact of the change and ensure governance arrangements were in place whilst the transition was in progress. We found a strong strategic focus amongst senior leaders, with awareness and openness about where they needed to improve. There was a Transformation Plan and a Transformation Board in place to provide guidance and oversight of the extensive change which was taking place.

Staff consistently spoke positively about the senior leadership team and demonstrated an awareness of the strategic direction of the local authority. Staff told us transitions had been handled well and gave positive feedback on the approach taken by senior leaders. We saw senior leaders took steps to ensure they were visible to staff, by holding regular all staff calls and meetings with small groups of staff, as well as regular local authority events where staff could meet and talk to leaders and share ideas or feedback. Senior leaders also told us they had taken practical steps to provide forums for staff to share ideas or concerns, as well as being physically present in the office and working alongside staff. The Chief Executive Officer (CEO) and the Director of Adult Social Services (DASS) had been in post for just over a year and staff told us they felt able to speak directly to them, as well as using local authority systems and process to have their voices heard.

There had been a change in political administration at the local authority in May 2023 and this had seen new leads and committee chairs take office around the same time as the new CEO and DASS came into post. Despite it requiring time for these relationships to embed and for the new administration to develop their scrutiny functions, we saw evidence of decisions and strategy being effectively scrutinised by members, and we heard how leaders and staff had supported this by working with members and responding to issues. We heard about a positive professional relationship with healthy challenge.

The local authority told us they were on a journey towards developing a positive performance culture. We saw evidence of increased monitoring of quality and data, but some of the actions had not yet taken place. The local authority had already recognised limitations to their use of data caused by their case management system. The DASS had introduced regular performance meetings in which data relating to Care Act duties was used to understand performance in areas such as safeguarding, waiting times and commissioning. We observed staff and leaders had a good understanding of where to focus, such as responding to waiting lists for safeguarding by introducing the safeguarding hub or plans to improve around DoLS. However, we also saw that some data was difficult to collate and leaders were keen to address this through new IT systems. Despite the limitations of the current system, at the time of assessment senior leaders had a good understanding of performance and we heard from staff how this filtered through to teams who also understood their own performance and expectations.

Staff and leaders told us monthly quality assurance audit meetings were in place to enable staff to discuss complex cases, reflect on good practice and facilitate shared ownership of decisions. These sessions were led by senior staff and were designed to encourage creativity, transparency, and openness. However, we also heard the data used was mostly quantitative rather than qualitative, which created barriers to effective discussion in areas such as outcomes and strengths-based work.

Health partners described clear lines of accountability and escalation processes. For example, they described positive work around winter pressures meetings where leaders worked closely with them and overcame challenges by being accountable and working proactively with leaders across the integrated care system.

Strategic planning

The local authority had a clear strategy which was being implemented through the ambitious transformation programme taking place at the time of this assessment. However, much of the transformation had not been implemented yet and the local authority was having to carefully prioritise where it focused resources.

The adult social care strategy ran from 2023 to 2026. It described the local authority's aims to produce positive outcomes for people, promote people's independence, integration with partners, digital innovation, and efficient management of resources. The strategy's delivery plan spanned 6 core objectives and included changes to systems, models of assessment, and structures, to improve outcomes and focus on better performance management through access to improved data and analysis.

The local authority was introducing new technology to support their strengths-based approach to Care Act 2014 assessment and unpaid carers assessment. We heard examples of good social work practice, and a learning culture. The Principal Social Worker and Principal Occupational Therapist roles were used to inform strategic direction. Whilst these roles had been involved in setting the interim strategy, they did not sit alongside directors at a senior level within the organisational structures.

Information security

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

Leaders and partners told us how they had agreements in place to ensure data was shared safely and all parties were clear about what was being shared and its intended use.

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

The local authority was undertaking a significant transformation which was informed by learning. Leaders had a good understanding of where the local authority needed to improve and there were plans to improve in areas where we identified shortfalls. The local authority had started to improve its approach to co-production and we saw examples of people's feedback being used to inform strategic priorities. Staff and leaders could clearly articulate what the local authority did well as well as an honest appraisal of where they needed to improve. Wherever shortfalls had been identified there were clear actions, tethered to the strategy, which were intended to bring about improvements.

The strategic priorities had also been set by learning in areas such as safeguarding, staffing and performance. Leaders were able to use data to measure the impact of the transformation and could attribute improvements in performance to the strategy, such as improvements to waiting lists or safeguarding timescales being driven by work to set up new teams. Leaders could clearly articulate how actions in the delivery plan for the strategy were directly linked to learning and improvement. For example, the introduction of the safeguarding hub was informed by performance data about waiting lists but also feedback and learning about consistency of decision-making. Staff and leaders could describe how the introduction of the hub was already having a positive impact on performance and consistency. Staff had a good understanding of their own performance and were able to cite data and describe learning and outcomes from recent themes and trends, such as financial assessment training which was introduced following work to understand timescales for claiming charges back and learning from feedback from people using services.

The local authority used co-production to seek the views of people with lived experiences. However, feedback about co-production was mixed, whilst we did hear about people being involved in strategic planning in areas such as support for people with a learning disability, other areas such as co-production to develop services for older people were at an early stage. Voluntary partners gave mixed feedback about the extent to which they were able to inform and influence strategy in this area.

We heard that opportunities had been limited but there was a sentiment expressed that engagement was improving in recent months. The local authority and partners launched RBWM Together which was an initiative to encourage people to come together, share information and ideas as well as for more formal co-production to take place. This was at an early stage at the point of assessment so the full impact may not have come across in feedback.

The local authority carried out surveys to seek feedback from people using services. There was a system to request feedback from people and unpaid carers through an annual survey. The majority of feedback showed people were satisfied with the local authority's approach and support. The last survey was completed in January 2023 and was sent to a random selection of adults who had contact with adult social services over the previous 12 months. The survey had a 31.1% response rate and showed 46% were 'very satisfied'. We also saw data from people with a learning disability who were surveyed with 85% saying they were very happy with the way staff treated them.

We heard from leaders how these survey results were reported through the local authority's governance processes, but they also said there were plans to improve in this area and to seek ongoing feedback from people. Staff and leaders said they anticipated the new IT system would provide more opportunity to gather and collate feedback and information about outcomes.

Staff had access to training. We met multiple staff who had undertaken professional qualifications to develop professionally and feedback about this was consistently positive. There was structured training for staff but also training in response to specific learning or issues, such as recent training in financial assessments after it was identified as a theme. Staff could access apprenticeships as well as be supported to undertake a professional qualification.

Learning from feedback

The local authority used learning from complaints to improve practice. In the 12 months up to December 2023, the local authority had received 21 complaints. Of these, 24% were upheld, 33% were partially upheld and 60% were not upheld. Feedback was also used to inform the local authority about what they were doing well. In the same period the local authority had received 20 compliments. The compliments cited positive feedback such as the professionalism, kindness and helpfulness of staff who worked with them or support offered to people during difficult circumstances. One member of staff working with autistic people had received 4 compliments about their practice and approach.

In the same 12 months up to December 2023 there were 5 complaints referred to the Local Government and Social Care Ombudsman and 1 of these complaints was upheld. Complaints were analysed and the themes were presented to leaders, with learning shared from all complaints regardless of their outcome. We saw how these were used to inform changes to areas such as charging, information and advice, and provider quality.

The 'world café' programme created opportunities for those attending the events to provide feedback to influence changes to service provision. We heard how the programme led to improvements in information and advice services as a response to people's feedback, as well as using feedback to inform priorities for community funding. The programme had evolved into workshops to gather more detailed comments in priority areas which showed feedback was being used and gathered in a structured way to inform strategic priorities.

However, we heard from voluntary partners that it could sometimes be difficult to engage with the local authority. This was also an area of strategic focus, with recent work to introduce more co-production at the local authority. The feedback we received showed co-production was not yet fully informing strategy, which the local authority recognised.

Staff feedback was used to inform the transformation programme. The local authority had identified challenges in recruiting and retaining staff and used staff feedback about pay and conditions to inform the decision to bring the Care Act functions back in-house to enable the local authority to offer staff parity of terms and conditions with other local authorities and to allow more direct control of financial decisions. Leaders demonstrated a strong value base when it came to listening and responding to staff, they described how they found staff input and feedback important and took steps to frequently meet with staff to provide opportunities to share feedback or learning.