West Berkshire Council: local authority assessment

How we assess local authorities

Assessment published: 17 May 2023

About West Berkshire Council

Demographics

West Berkshire Council (WBC) is a unitary authority in the southeast of England. The population of 162,000 is largely rural, with centres of population in Newbury, Hungerford and Thatcham. The population is relatively affluent and healthy. West Berkshire has an index of multiple deprivation in the lowest category of 1. However, there are pockets of deprivation and large rural areas suffer from poor infrastructure.

The population is largely people aged between 18 and 64. However, the latest census data indicates the older adult population is growing rapidly. Since the previous census, the number of people aged 65 to 74 rose by 31.7%, the number of people aged 35 to 49 fell by around 11.2% and the number of people over 90 increased 23%. 92% of the population is white and the largest nonwhite ethnic group is Asian representing 4% of the population.

West Berkshire is located within the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICS) which is a large system. As a small authority it works closely with neighbouring authorities in Reading and Wokingham as part of the Berkshire West 'place'.

West Berkshire is a council in transition. In May 2023 the makeup of the council changed from a Conservative majority to a strong Liberal Democrat majority. The council was still in the process of updating and realigning strategies to the new administration. In addition, the role of Director of Adult Social Care was relatively new, having recently been separated from the previous dual director role for both adults and children's services.

Financial facts

- The Local Authority estimated that in 2022/23, its total budget would be **£263,597,000**. Its actual spend for that year was **£287,839,000**, which was **£24,252,000 more** than estimated.
- The Local Authority estimated that it would spend **£60,073,000** of its total budget on adult social care in 2022/23 Its actual spend was **£64,542,000**, which is **£4,469,000 more** than estimated.
- In 2022/2023, **22%** 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 Adult Social Care precept varies from Local Authority to Local Authority.
- Approximately **2,335** people were accessing long-term Adult Social Care support, and approximately **775** 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.

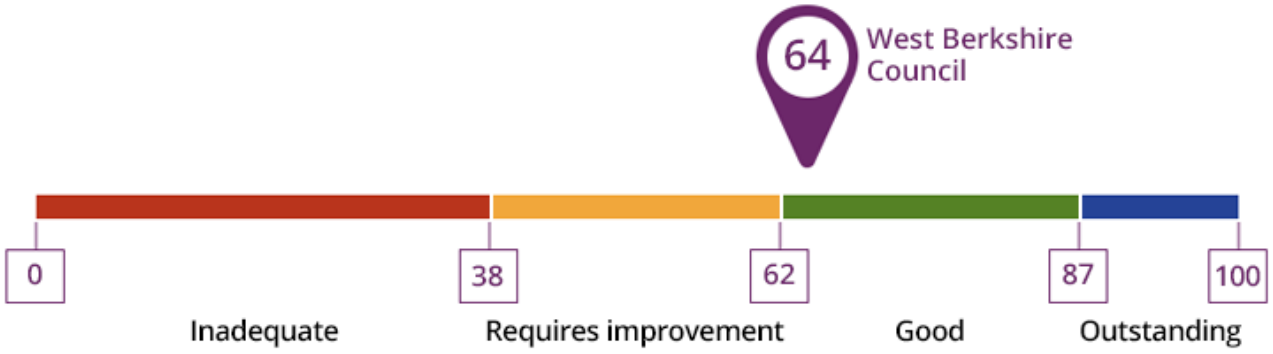
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

West Berkshire Council

Good



Quality statement scores

Assessing needs

Score: 3

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 2

Partnerships and communities
Score: 2

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 3

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People’s experiences of support from West Berkshire local authority were largely positive. People told us social workers were supportive, listened to them and developed care plans that met their needs. Teams were aware of different cultural, and diversity needs and accessed translation and interpreter services to provide support and care plans in people’s own language. There was a sensory team that could provide specialist support around sensory needs.

Access through the contact centre was good and people were put straight through to a locality team who could speak to them about their needs. There was online information and access to support, but people told us this was not always accessible and described the website as ‘clunky’. It was not easy to translate web pages and some people told us it was not accessible for autistic people.

Carers said support provided by the local authority was good, however we did have some feedback that initially accessing the support was not always clear. Some carers told us they had not originally identified themselves as carers and did not realise what support was available. The local authority was working to improve the identification of carers in the area.

West Berkshire is a largely rural and affluent area, however there are pockets of deprivation. We heard that people in isolated rural areas faced barriers to accessing support, particularly if they did not have access to computers and the internet, and there was more need for outreach with people from the local authority in the community, and use of more traditional communication for example through leaflets etc. The local authority was aware of the digital barriers to accessing care and was working to address this.

Summary of strengths, areas for development and next steps

West Berkshire is a local authority going through change, with recent changes in political leadership as well as the change of Director of Adult Social Services (DASS). The impact could be seen across the work of the local authority in meeting its Care Act 2014 duties. There was a strong positive, open learning culture within the local authority. Staff liked working for the local authority and described leaders as approachable and supportive. There were good systems in place to support learning and development of staff, including learning from feedback from people using services and when things went wrong. There was a culture within teams of understanding people's experiences and considering diversity and the needs of seldom heard and discriminated against groups. However there was work to do at a strategic level, including involving people and shaping the future of adult social care to meet all people's needs.

On the whole the national data for West Berkshire was positive or in line with national trends. There was positive feedback from carers on support from the local authority, there was more work to do to identify carers and make them aware of the support available to them. There was a relatively stable care market, and the quality of care was good. Models of care tended to be traditional including home care residential and nursing care and we did not see evidence of significant innovation in delivery. The local authority was aware of where they had gaps in services, and there was a desire to do more work to develop new models of services promoting independence. However, most of this work was reactive to pressures rather proactive market shaping. The current focus was on financial sustainability of the authority and addressing budget pressures. As the local authority begins to develop their strategies, consideration needs to be given to better understanding of the data, demographics and population need, particularly at community level to be more proactive to shape the care market to ensure sustainability over the next 5-10 years in line with demographic change that will also impact on budgetary pressures in the future.

There was also a need to have more focus on preventative work in West Berkshire. There were negative trends in the data for the number of people who have short term care that becomes long term. This indicated that where short term care was put in place, this was not supporting people's return to independence and was therefore resulting in long term care needs. In addition, there were high numbers compared to neighbouring authorities, of people of working age with long-term care needs. This was unusual in a relatively healthy and affluent area with low levels of deprivation. We found more work was needed to align strategies to focus on prevention and reduction in care needs which would address some of these concerns in the data. The local authority was aware there was work to do on strategies and this was part of the transition still ongoing to align with the new political leadership under the new DASS.

The local authority had identified they needed to develop their work with the voluntary sector as well as embed co-production across the authority. This was a view shared with us by partners and people. The local authority had produced an Equality, Diversity and Inclusion framework but the report itself noted there was a lack of clarity around the action and communication within the authority. Incorporating actions from the framework along with the development of co-production and work with the voluntary sector would support detailed understanding of community needs and inform the long-term strategy development and market shaping. This includes identifying, involving and meeting the needs of people who are at risk of experiencing poorer health and social care outcomes as a result of one or more protected characteristics and those people who are seldom heard.

There was a low number of people using direct payments, although within some teams such as when people were discharged from hospital and in the transitions team, there were examples of where they had been used positively to promote independence. We heard that the process was complex and cumbersome and was a barrier to supporting a personalised approach to meeting people's care needs that direct payments could otherwise facilitate. The local authority had been proactive in initiating a review with Association of Directors of Adult Social Services (ADASS) to understand how the use of direct payments could be improved across the authority to deliver better outcomes for people, promoting their independence.

Partners spoke positively about relationships with the local authority. West Berkshire was seen as a proactive partner. The safeguarding partnership across Berkshire West was a mature and effective partnership, and there was strong partnership working with health around hospital discharge. Other partnerships were in the early stages of development and further work was needed to embed these within governance and move towards a position to take forward joint strategies and commissioning to support the local authority in delivering their Care Act duties. One area that was particularly difficult for the local authority was Continuing Health Care Funding where the local authority consistently had a low number of positive decisions. The local authority was working with health partners and the Buckinghamshire, Oxfordshire, and Berkshire West (BOB) Integrated Care Board (ICS) to try to understand why this was the case to improve outcomes for people in the local authority. There was a clear desire to bring resolution in this area from both staff and leaders and frustration as there were elements of the work required outside of their control.

The work to develop strategies around market shaping, prevention, co production and the voluntary and community sector are a key priority to meet future needs and ensure the local authority can be proactive in the face of increasing changing demand. The issues relating to access to direct payments and continuing health care cause additional barriers to people in accessing personalised care and these need to be resolved. Partnerships need to be strengthened and developed to enable more joint approaches both with strategy and funding, to address these challenges learning from the integrated model of hospital discharge and effective joint working in safeguarding.

Theme 1: How West Berkshire Council works with people

This theme includes these quality statements:

- Assessing needs

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

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

Assessing needs

Score: 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 the local authority's care and support services was mixed. We heard there was good access through the contact centre from which people were transferred to the locality team according to the postcode of their GP. There was also an option to complete an online enquiry form. However, people and partner organisations told us the local authority website was not always accessible, which could be a barrier for people trying to access support online. Despite this, we received positive feedback from people about the social workers and the assessment process saying their views and wishes were sought and the assessment paperwork reflected their wishes.

There was a person-centred, strength-based approach embedded within all social work practice. In the Adult Social Care Survey (ASCS) 62% of people said they were satisfied with care and support which is similar to the England average. 80% of people felt they had control over their daily life which is slightly higher than the England average of 77%. People told us they were involved in their assessments, and their wishes and feelings were considered. The contact centre would refer people directly to locality teams who used a '3-conversation' model to understand people's care needs. This is a strength-based approach to assessment and care planning. It focuses on people's strengths and community assets and supports professionals to have 3 distinct conversations. This meant the initial conversation was with the locality team which reduced the need for people to have to retell their story.

People's experience of care and support ensured their human rights were respected and protected. They were involved throughout in decisions about their care. Front line teams described how the strength-based approach supported them to meet people's needs. It helped their understanding and incorporated consideration of protected characteristics or other areas of inequality in care planning and staff told us it worked particularly well for younger adults and people living with mental ill health. Teams had access to interpreter and translation services to support them when working with people for whom English was not their first language. They could give examples of where they had translated care plans into other languages. The work of the Sensory team was aligned with the front-line teams which enabled people with sensory needs to have information provided in alternative formats for example large print, or easy read.

Teams worked well across the local authority which ensured people's support was planned and coordinated across different agencies and services. This enabled frontline teams to access specialist support that people needed, for example, Approved Mental Health Professionals (AMHP) from the mental health team. This is a professional who assesses whether there are grounds to detain people with mental health needs. This is where people need urgent treatment for their mental health and are at risk of harm to themselves or others. Similarly, specialist sensory support was easy for teams to source from the Sensory needs team. There were strong working relationships with partners in health supporting pathways between services in hospital discharge. However, there was less coordinated working in the wider system with health and partners beyond hospital discharge.

Frontline teams, led by the Principal Social Worker had the training, knowledge and experience they needed to carry out assessments. The locality teams were generic teams dealing with assessments of people of all ages and needs. While we had some feedback that staff did not always have the specialist knowledge they needed, there were systems in place, supported by management, to develop staff skills enabling them to share expertise and use each other's strengths when allocating and managing caseloads. This was helping to develop knowledge and skills across the team. Teams worked with specialist workers where necessary, for example in relation to sensory needs or when carrying out assessments in the Gypsy, Roma and Traveller community.

Timeliness of assessments, care planning and reviews

Assessment and care planning arrangements were not always timely and up to date. According to the local authority's data, 4% of people who had requested care had to wait for their assessment, and a third of those had been waiting over 6 months. While these were relatively small numbers it did mean some people were waiting a long time for assessment. The local authority had made provision to ensure social workers in the locality team were able to provide basic equipment, as well as information and signposting if appropriate, reducing waits for equipment. However, if people's needs were more complex, they sometimes had to wait for assessments by an Occupational Therapist. In these instances, people were prioritised, and interim measures were put in place while people waited for a full assessment.

There were also waiting lists for people that needed a review due to changing needs, but numbers were small, less than 3% of people in receipt of long-term care. Just under a third of those waiting for an unplanned review were in residential, nursing or supported living placements. 60% of those waiting for an unplanned review did not wait more than 3 months.

There was a much bigger wait for people waiting for a planned review. This is where no change in need has been identified, but it is good practice to schedule reviews of needs on an annual basis. Between 30% and 35% of people receiving long term support were waiting for a planned review, 40% of these were people requiring physical support and 31% were people with a learning disability. National data on Short and Long-Term Support (SALT) showed that 74% of long-term support people had been reviewed (includes both planned and unplanned) and this was much higher than the England average of 55%.

There were arrangements in place for managing and reducing waiting times for assessment, care planning and reviews. Managers reviewed waiting lists and ensured that interim support was put in place to manage risks while people were waiting for assessment. There was a staff vacancy rate of 18% within teams which was placing additional pressure on teams in relation to waiting times. Locums were used where possible to fill vacancies.

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

The needs of unpaid carers were recognised as distinct from the person with care needs; assessments, support plans and reviews for unpaid carers were undertaken separately. Carers were identified early through initial assessments of people's needs. According to the local authority's own data, 89% of carers were assessed without having to wait. Of those that had to wait for assessment, a third waited less than 3 months, and a half less than 6 months. There was also an online self-assessment referral form that carers could access.

Some people found it difficult to access support as a carer including self-funders. This is reflected in the national data in the SACE that 19.66% of carers in West Berkshire were accessing support which is below the England average of 34%. This was confirmed by the carers we spoke with as part of our assessment, who told us they did not immediately identify themselves as a carer and did not always know what support was available. The local authority was aware carers had not always been identified in the past, so had put in place a system to identify whether carers were offered an assessment when the 'cared for' person was assessed. This included monitoring through the out of hours team and as well as for those people admitted to and discharged from hospital. The local authority held events and worked with partners to help raise awareness and identify carers. This work was continuing, and there was work around those groups that were less likely to be identified including children and young people and people from ethnic minority communities. To identify young carers, they had implemented an approach called, 'No wrong doors' with joint procedures between adult and children's services to support young carers and their families. This was based on the national template memorandum of understanding for best practice developed by the Carers Trust in partnership with Association of Directors of Adult Social Services (ADASS) and the Local Government Association. They were also working closely with isolated communities such as Ukrainian refugees to identify carers. The local authority was working with voluntary organisations to help with the identification and referral of carers to them. However voluntary organisations told us they did not always get feedback where they were making referrals and were unclear on the expected timescales. To support this work the local authority was in the early stages of working with partners in the BOB ICS through the Accelerator Reform Fund to improve identification of unpaid carers, develop a digital self-assessment and address waiting times for assessment.

Once an assessment was obtained, people told us the staff completing assessments were supportive and knowledgeable and they appreciated having someone to speak to about their caring role. The Survey of Adult Carers in England (SACE) data was positive about the support people received, the number of carers satisfied with social services was 46%, and 72% of carers felt involved or consulted as much as they wanted to be. Both are higher than the average for England which is 36% and 65% respectively.

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

People were given help, advice, and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The duty teams within the locality picked this up as part of the initial conversation through the 3-conversation model considering prevention and community solutions as first options to support people to achieve their goals. They funded a range of projects in the community through their voluntary prospectus, which was an agreement providing grant funding to the voluntary sector, to support people to achieve outcomes that would prevent, reduce or delay needs for care.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear and consistently applied. The criteria were easy to follow and shared with the public on the local authority website with clear process and timescales for complaints. The local authority did not have any appeals in the last year, however we also noted that while detail on the complaints process was accessible on the website the information about how to appeal was not. The data suggested that for most people the support provided by the local authority met their overall needs. From the Adult Social Care Survey (ASCS), 64% of people did not buy any additional care or support privately or pay more to top up their care and support. This indicates that the assessment met people's needs and was in line with the average for England.

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear, transparent and consistently applied. Decisions and outcomes were timely and transparent. There was no waiting time for financial assessments and frontline teams told us this did not impact on their assessment times.

Provision of independent advocacy

There was good knowledge within teams of the importance of advocacy to help people participate fully in care assessments and care planning. However, advocacy support was not always immediately available which meant people had to wait which resulted in delays to assessments. The advocacy provider had recently changed, and they were in the process of recruiting additional advocates which was anticipated would improve the availability of advocacy. An advocate can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations.

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority needed to do more proactive work with people, partners and the local community to make available a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support. While there were examples of individual projects there was not an overarching strategic approach to this work. In the ASCS data, 60% of people said the help and support helped them feel better about themselves which was in line with the England average and 69% of people reported they spent time doing things they value or enjoy which was slightly above the England average of 67%.

Examples of some of the projects the local authority was doing included, looking to put in place technology enabled care as a way of reducing long term care needs. There was currently a delay in implementation of this because of delays in the setup of the digital system. The local authority had plans in place to progress this, but timescales were not clear. The local authority told us they hoped the system would have impact for the future. The local authority was working with public health on several initiatives within their health and wellbeing strategy such as physical activity and health management, mental health and wellbeing, smoking cessation and falls prevention. They were developing work to look at the best locations in communities for delivery and had started using leisure centres for example. They had been working with the voluntary sector, through a voluntary sector outcomes-based prospectus to support delivery. In addition, they were working with partners through the Better Care Fund to set up preventative services including a social prescribing project across GP practices, supported by the voluntary sector and an urgent community response service to reduce admissions to hospital.

Overall, more work was needed to use the population data. Work had been done to create a digital resource from the Joint Strategic Needs Assessment to inform the Health and Wellbeing Strategy and address health inequalities. This approach focussed on the current situation but did not include a proactive approach to projecting into the future to understand trends over the next 5 or 10 years to prevent, reduce and delay care needs on this time scale. There was a lack of data beneath the general population data to help the local authority understand needs in smaller communities and particularly isolated groups and their current and long-term care needs that may be missed by the wider data. We heard from front line teams about their awareness of certain groups, such as recent migrant communities, and travellers but did not always see this reflected in data and this did not enable future demographic pressures of an aging population to be predicted and addressed.

We heard from partners in the voluntary sector who told us they had the knowledge and contact with some of the more isolated groups that could support the local authority in developing this work and understanding and meeting the needs of those seldom heard groups. At the time of our assessment this was not in place, although the local authority told us it was an area where they felt they could do more. This work could help them identify seldom heard groups and those at greatest risk of a decline in their independence and wellbeing.

There was specific consideration given to the support for unpaid carers. The local authority worked with voluntary organisations through the Reading and West Berkshire Carers Partnership to provide this support. The local authority had a carers section on their website, with a separate section for young carers to identify the support available. In a Survey of Adult Carers in England (SACE) of those carers that had accessed information and advice, 85% of carers said that they found the information and advice they received helpful. Partners confirmed the support the local authority gave to carers helped people to stay out of long-term care.

According to the ASCS data 64% of people who had received short term care no longer required support. This is much lower than the England average of 77% and the local authority needed to do more in the area of preventative services supporting people's independence. The local authority was aware of this and there were some good examples in specific areas. For porting people to return to independence. The local authority had identified that there was more work needed to reduce the number of people discharged to care homes, which was impacting on the number of people whose short-term care did not extend to longer term care. Pathways had changed in the month before the assessment and the local authority was hoping this would start to show impact later in the year. There was also further work needed across the population and particularly in areas of deprivation to gather data to identify people with needs for care and support that were not being met, and also to address the issue of a high number of people of working age requiring long term care. Despite there being a relatively affluent and healthy population in West Berkshire, the working age population had a high number of people with long term care needs; the 9th highest in the region out of 20.

There were some good examples of support that was effectively reducing the need for long term support. The Sensory team were able to give positive examples of the provision of equipment to support people's sensory needs which prevented, reduced, and delayed the need for care. For example, smoke alarms and doorbells adapted for deaf people in their homes. The Mental Health team were also able to give positive examples of where they had supported people to rebuild their lives and go on to live independently.

Provision and impact of intermediate care and reablement services

The reablement service focused on people's reablement goals. They carried out regular surveys to obtain feedback from people and received positive feedback. A local authority survey of people who had accessed reablement reported 77% of people said they felt more independent as a result of the service. The local authority monitored how much they saved financially by maximising people's independence and reducing care. The pathways for discharge from hospitals had recently been reviewed to focus reablement for those that would most benefit, which resulted in more positive outcomes for people on that pathway. There was a focus on setting reablement goals from day 1 to support people to return to independence. Care plans considered people's wellbeing and quality of life with meaningful activities. For people with no new health or care needs on discharge, pathway 0 could be used to support people with social needs through the voluntary sector. For example, supporting someone to continue to attend church, or making sure pets were also cared for. The National Adult Social Care Outcomes Framework data (ASCOF) found that 5% of people over 65 received reablement/ rehabilitation services after discharge from hospital and 89% of people over 65 were still at home 91 days after discharge from hospital into reablement or rehabilitation. Both were above the England average of 3% and 82% respectively.

Access to equipment and home adaptations

There was good access to equipment and minor home adaptations to help people maintain their independence and continue living in their own homes. There was no wait for equipment. Locality teams also had access, with appropriate training to provide basic equipment to increase independence. One person told us that while they had been worried about falls, the provision of basic equipment in their home such as handrails, a walker and lifeline which had enabled them to stay independent. Where people had more complex needs in a small number of cases there was a wait for an assessment by an Occupational Therapist. In 93% of these cases the wait was less than 3 months. The local authority had a strategy to address the waiting list and had an ambition to have an Occupational Therapist in a leadership role in each team, they were also looking to introduce a Principal Occupational Therapist role to have oversight in this area.

Provision of accessible information and advice

There was information and advice available for people on their rights under the Care Act 2014 and ways to meet their care and support needs, on the council website. This included information for unpaid carers and people who fund or arrange their own care and support. Information on the website was only accessible to people who had a computer which created a digital barrier to access. The local authority had a digital infrastructure group that was supporting digitally excluded communities such as older people, refugees, and the Gypsy, Roma and Traveller community. This group was working with a third sector organisation to improve accessibility. However, we also had feedback that the website itself was not always easy to access. For example, people told us the number of tabs on the website could present a barrier for people with autism and it was difficult to access the information in other formats or languages. People who fund their own care also told us it was difficult to find the information they needed. Despite this, in the ASCS survey 72% of people who use services said they find it easy to find information about support, which is higher than the England average of 63%. This data would not account for those people that had been unable to access services due to barriers. The ability of carers to access support was in line with England averages at 56% (SACE), however as noted above carers were positive about support once they had been able to access it.

Direct payments

The local authority had a low uptake of direct payments. Only 16% of people received direct payments which is low compared to the England average of 27%. There was also a backlog in the waiting time for reviews of direct payments. Frontline teams told us the process was over complicated to implement and difficult to use effectively to give people choice. Staff felt it was easier to use a commissioned service. This was because of the time required to complete referrals as well as the resource availability within the direct payments team that meant they could not always be immediately responsive to requests. This was compounded by the fact that local wages were high, so if someone wanted to employ their own personal assistant using a direct payment, this would be more expensive and fall outside of the indicative budget. We had some feedback from carers we spoke with that they were not aware of direct payments or where they received a direct payment, they did not feel it supported their independence effectively.

However, there were examples of direct payments being used well alongside reablement to support independence on discharge from hospital. The team gave a positive example of where direct payments had been used to support cultural needs. Direct payments were also used well in transition to support young people's independence.

The local authority was aware of the low uptake of direct payments and was undertaking a review with ADASS including the initial assessment, communication with people, the recruitment of personal assistance (PA's) and staffing levels in the team, to make improvements and give people better choice and control over their care.

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 worked with stakeholders and used data from the Joint Strategic Needs Assessment to understand current the care and support needs of people and communities. This included people who were most likely to experience poor care and outcomes, as a result of one or more protected characteristics, unpaid carers and people who fund or arrange their own care. The council had commissioned a group to develop an Equality, Diversity and Inclusion framework informed by the lived experiences of people. The report identified themes for the local authority to focus on, such as disability and accessibility, neurodiversity, rurality, socio-economic and age-related exclusion, digital exclusion for older people, Gypsy, Roma and Traveller communities and displaced individuals including refugees and asylum seekers. The report identified a lack of clarity on the action taken by the local authority in relation to addressing equality issues and said better communication in this area was required. The DASS also reflected that meeting the needs of people from diverse backgrounds was an area of challenge and while they had links with community groups, immigrant groups and other groups such as the autism partnership, it was an area where they could be doing more.

There was some work being undertaken within the local authority around equalities. For example, joint work with public health through the health and wellbeing strategy aimed at reducing inequalities, learning from the impact of the pandemic. There was a focus on specific groups to tackle inequalities such as healthy lifestyles for people with learning disabilities. The approach was encouraging closer working with the voluntary and community sector to engage with seldom heard and ethnically diverse groups including unpaid carers. There was a large Gypsy, Roma and Traveller community and a specialist worker was employed to support work in this area.

However, as noted in the Equality Diversity and Inclusion report it was not clear how the framework informed a more strategic approach to equity. The local authority did not always use opportunities to ensure they gathered data to help understand groups of people who might find it difficult to access services or those groups who needs were not being met. For example, data on complaints was broken down by team and by who was making the complaint (a carer or the person receiving care) but was not broken down by protected characteristics. Similarly, there was no breakdown of the number of people placed at distance out of area by protected characteristic, to understand if it was the needs of particular groups of people that were not being met within West Berkshire.

We had feedback that equality needed to be much more embedded in roles in the local authority with a 'soft' approach to communities and understanding cultural differences and barriers, including inter-generational difficulties. 95% of the population was white, with a small proportion of the population in other ethnic groups. When we spoke to staff, we heard about some of the smaller communities present in Berkshire including Gypsy, Roma and Travellers, migrant and refugee populations including Ukrainian, Polish and Afghan. Staff had local knowledge of their communities. This knowledge was used at an individual level in teams but there was no strategic approach to building on this knowledge and working with partners to understand population needs and now and in the future. Most work focussed on ethnicity and nationality. There was less focus on communities of interest for example considering the needs of LGBTQ+ population or how gender impacted needs in particular communities, other than at an individual level. Some teams identified concerns around particular groups, for example, both the Transitions team and the Mental Health trust identified higher numbers of autistic people within services, and particularly women in mental health services.

It was not clear how the local authority was meeting its Public Sector Equality Duty (Equality Act 2010) in the way it delivers its Care Act 2014 functions. As well as the lack of data, there was also a lack of a strategic approach to coproduction to inform and underpin strategies. This would support and drive an approach to gather data and identify groups of people whose needs are not being met by the local authority. This would help the local authority better understand and improve the experiences and outcomes for people who are more likely to have poor care.

Inclusion and accessibility arrangements

There were appropriate inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that work for them. However as already noted while there were some accessibility features on the website, we had feedback these were not always easy to use. There was a Sensory team that supported people around sensory needs. The work of this team was well integrated into other frontline teams. Staff also told us they could access interpreter and translation services including British Sign Language.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 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 worked with public health to create a digital tool from the Joint Strategic Needs analysis data to understand the demographic and other factors impacting on people's health and wellbeing in West Berkshire. This included people who were most likely to experience poor care and outcomes as a result of one or more protected characteristics. The data was used to inform the health and wellbeing strategy and the approach to prevent, reduce and delay needs for care, as well to inform the Adult Social Care Strategy. West Berkshire is a relatively healthy and prosperous place to live with an index of multiple deprivation of 1 which is the lowest score. However, the local authority noted within the largely affluent area, there are areas of deprivation and health inequalities. In particular, they noted a digital divide resulting in inequalities in access to opportunities, knowledge, services, and information. This particularly impacted older people over 75 and disabled adults. There was very little strategic assessment of need in relation to some of the seldom heard groups such as the migrant populations and ethnic minority groups as these were small populations below the level of analysis of the demographic data.

Market shaping and commissioning to meet local needs

People had access to a range of local support options in West Berkshire. The available services were safe, effective, and generally high-quality with CQC ratings above the regional average. In a survey of Adult Care in England 71% of people who use services felt they had choice over services. However, staff and leaders told us there were limited available spaces within residential care which meant people sometimes were placed out of the area. For most people this was still within their local area, just over the border in a neighbouring authority but 30% of those people placed outside the West Berkshire border had to travel further, particularly if they had complex needs. This represented 13% of the total number of people in nursing or residential placements. The local authority was also facing issues in relation to adverse outcomes in relation to decisions for Continuing Health Care funding that impacted people with more complex nursing needs.

The local authority was in the process of updating their market sustainability plan. While the local authority was aware of where there were gaps and pressures in services, market shaping by commissioning was responsive to demand, rather than proactively shaping the market to anticipate and manage future needs within budgets. The commissioning team sat outside of adult social care and therefore were responsible for commissioning across the local authority. While the commissioning team worked closely with adult social care in the provision of care, it was not apparent how they were taking a more strategic approach to deliver on the adult social care strategy.

There was little evidence of working with partner agencies to consider the data in relation to the population and needs for care now and in the future as a basis for actively shaping the care market. There was a recognition that there was a need for more services to support independence as numbers of people with complex needs wanting to stay in their own homes increased, but this was a response to current demand, rather than a proactive consideration of the data for a plan now and over the next 5 – 10 years. They were working to adapt the market for example, by working with providers to repurpose and adapt buildings in communities or change models of care to meet people needs. They had recently opened 3 new Extra Care services but recognised that there was a need for more as the population aged.

The local authority had considered provision for unpaid carers. They had worked with the carers partnership and voluntary organisations in producing their carers strategy. They had a focus on improving the identification of carers to enable them to access support and wanted to improve the availability of support to improve the health and wellbeing of carers as well as the provision of respite support to enable carers to take breaks. They provided voluntary sector grant funding for the provision of services for unpaid carers and a separate voluntary organisation had been identified to support young carers. However, the feedback from the voluntary organisations was that they didn't feel there was ongoing involvement and use of their experience to understand needs and develop services.

The local authority commissioned care based on outcomes rather than tasks. Contracts with providers focussed on person centred care, involvement of people in their care plans, and supporting social inclusion and wellbeing. However, these were largely delivered through traditional models of care such as care homes, nursing homes and home care. The local authority acknowledged a need to innovate and develop new models of care supporting independence and person-centred approaches such as Extra Care and more supported living.

Ensuring sufficient capacity in local services to meet demand

There was not always sufficient care and support available to meet demand. There were very few vacancies in residential care. There were not always suitable services available for people with a learning disability and autistic people, especially when people had complex and multiple needs such as physical disabilities requiring adapted environments. Similarly, there was a lack of services for people requiring complex dementia care. The demand for these types of services was increasing as people aged. This issue was compounded because the cost of care in West Berkshire was high. The local authority had a flexible approach to funding care placements which allowed them to be responsive to local market rates. Decisions about care placements were based on value for money, quality of care and people's choice. However, staff told us often cost was a driver and where people had complex needs this often resulted in out of area placements. People did not have to wait for services to start. Where there was not provision in West Berkshire there was close working with neighbouring authorities and people could be placed out of the local authority area, but close to the border and therefore close to home. For those with complex needs it was more likely the placement would be out of the area but also at a distance from their home. Of the 218 people placed outside the border of West Berkshire, 70% were local to the geographical boundary. There was a recognition along with public health that there was a need to integrate plans for housing and plans for social care investment, to improve provision within West Berkshire. However, progress was slow, with barriers because of the local costs of housing and poor relationships with planning. The local authority was starting to address this and building relationships with planning to plan for the future development of services. Further work was needed with partners to work toward joint commissioning, this included ongoing work with the integrated care board in relation to Continuing Health Care funding.

The local authority had worked effectively with the local care market to build the workforce in the home care sector, supporting with sponsorship, recruitment, and training. As a result, there were no longer delays for home care or in discharging people from hospital. Staff said there was good access to intermediate care beds for hospital discharge and if they weren't available there was an easy spot purchase system they could use.

Carers feedback indicated there was sufficient capacity for unpaid carers to have access to replacement care for the person they cared for in both planned and unplanned situations. In the survey of adult carers in England, 18% of carers reported accessing support or services allowing them to take a break from caring for more than 24 hours, which is slightly above the England average of 14%. We had feedback from organisations working with carers that carers told them the support was positive, and carers felt they could access support and respite when needed. Other support for unpaid carers included provision of information and support, social groups including a dementia café providing support for people caring for someone with dementia, respite breaks and help with transport for health appointments.

Ensuring quality of local services

The local authority had a care quality team placed within commissioning that monitored the quality and impact of care and support services being commissioned. Resources within this team meant they could not always be proactive in the way they monitored services across the local authority. However, West Berkshire had the second highest number of services rated good in the region with 88% of residential care and 73% of homecare rated good or outstanding. 62% of home care was rated good or outstanding and 69% of supported living services. 1% of nursing homes, 1.5% of care homes and less than 1% of home care and supported living services were rated inadequate. The local authority worked closely with partners in neighbouring local authorities in Berkshire West to share intelligence about any concerns relating to services. Services were requested to complete an annual self-assessment survey on the quality of care they provided, but most of the time this did not include an onsite review by the care quality team, unless there were specific concerns raised about a service. When concerns were identified, the local authority worked with providers to produce an action plan to bring about the necessary improvement, but again resources limited the amount of support it was possible to give to individual providers. In the past year the local authority had one service where they had used their 'place with caution' protocol due to poor care. This was a relatively new policy under which the local authority would place people in services rated requires improvement and was implemented to open the market to more affordable care. Staff told us this was used where they knew of improvement in a service since it was rated requires improvement. Prior to placing someone in such a service the protocol required them to assure themselves of the quality of care based on the work they had been doing with the service to improve.

Ensuring local services are sustainable

The local authority collaborated with care providers to ensure the cost of care was transparent and fair. There was a flexible approach to paying for care which allowed the local authority to adjust for the market rate. However, the high costs of care in West Berkshire did impact on the ability of the local authority to place people locally. Providers described their relationship with the local authority as collaborative. They were given opportunities to discuss issues and concerns and the local authority had supported with issues such as recruitment. They said the local authority was aware of the market and the barriers providers faced, and they felt the local authority had confidence in providers.

In the past year there was one embargo placed on a service that had now closed. The local authority had systems in place in case of provider failure and poor services. However, resources were limited to enable their own proactive monitoring to anticipate provider failure and service disruption, so they were reliant on intelligence from partner local authorities and provider self-assessment. Due to the resource levels in the team if there was a failing service this took away resources from the general monitoring of quality across all providers. However, the good quality of care across the authority meant that this was not a frequent event.

The local authority had an awareness of workforce pressures. They had recently supported providers in developing the homecare workforce to successfully meet demand, where there had been delays in being able to access care for people in their own home. However, there was less evidence of proactive work to foresee pressures in the market and develop a workforce to support future market shaping and new models of care.

Their contractual arrangements placed expectations on providers in relation to the training and development of staff. Providers were able to access training through the local authority. The local authority had an expectation of standards for working conditions including payment of the living wage, sick pay, and travel time for home care staff in provider services. They told us they advised providers through forums about their expectations and also include sources of support for safer recruitment practices and training etc. However, they told us they had limited capacity for proactive monitoring of the terms and conditions for carers employed by providers. Wherever they were made aware of concerns, they linked with relevant partners and colleagues such as Home Office, His Majesty's Revenue and Customs etc.

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 formed strong relationships with partners. Partners spoke highly of the Director of Adult Social Services. The local authority including elected members, the DASS and senior leaders worked with public health and neighbouring local authorities in Berkshire West on their health and wellbeing strategy.

Other partnerships were in the early stages of maturity and there was still work to do in relation to aligning plans and strategies for people in the area. For example, in relation to market shaping and commissioning. There was a feeling more work was needed on the relationships with the wider BOB integrated care system. There were concerns that West Berkshire was a small voice within a large system, not helped by changes of leadership in the wider system.

The local authority had worked in partnership with some voluntary organisations for example, in relation to autism and carers where there had been some coproduction work on strategies. The primary focus with the wider voluntary and community sector was in delivery of preventative services through grant funding rather than fully developed partnerships. Both voluntary organisations themselves and leaders within the local authority felt there was more that they could do in this area.

The local authority worked well with health in hospital discharge. Health partners described West Berkshire as responsive, quickly addressing issues and concerns to maintain flow from hospital. The local authority worked closely with health professionals operationally within the hospital to flag issues for example, any potential delays in discharge, or identification of unpaid carers who were admitted to hospital to ensure provision for the cared for person. They also reviewed trends within hospital discharge and had worked strategically with partners to change care pathways which had improved outcomes for people with reablement needs. As noted above pathways had recently changed and were currently working to reduce the number of people discharged to care homes to improve people's outcomes in relation to independence.

Arrangements to support effective partnership working

There was a West Berkshire locality integration board which was a subgroup of the West Berkshire Health and Wellbeing board. There were clear structures between the local authority and health to support the implementation of the Better Care Fund and to develop the integration of health and social care. This funded a range of interventions to prevent, reduce and delay the needs for care as well as supporting people's independence and rehabilitation. However, there was further work to do to develop structures across the ICS to support more joint commissioning and strategies, including around provision of mental health services. The positive strategic relationships, both within Berkshire West and in Health and Wellbeing Board arrangements, provided a basis to support positive future joint programmes and interventions. This was not at a developed stage of maturity, but the early work had been done toward this. There was close joint working on the front line between the mental health team in the local authority and the Mental Health Trust. A section 117 worker worked between the local authority and the Mental Health Trust, and there was a section 117 policy being created jointly with mental health partners through the ICB. This included how to support people who are no longer entitled to section 117 support but still have care and support needs. Section 117 places a duty on both health and the local authority to provide free aftercare services to a person on discharge from hospital after being detained under a treatment order of the Mental Health Act 1983. Safeguarding work between the mental health trust and the local authority was well developed and we saw evidence of mature relationships which delivered good practice in safeguarding vulnerable people.

Continuing Health Care (CHC) funding was an issue that we heard about at all levels from leaders to front line staff that was creating barriers, particularly for people with complex needs. Inconsistencies in decisions around CHC funding meant Berkshire West was an outlier with one of the lowest levels nationally of people found eligible. The DASS was proactive and working with system partners in the BOB Integrated Care Board, through an All-Age Continuing Health Care Programme to understand the factors causing the variation and identify areas for change. However, to date there had not been any impact, work was ongoing. There were concerns from the local authority the work was only a small part of a much wider transformation within a large ICS.

Impact of partnership working

The local authority was monitoring the impact of partnership working in place through the Better Care Fund. In other areas of partnership working such as hospital discharge, there were systems in place through governance to monitor effectiveness of the systems. This had resulted in changes to pathways and focus of resources which improved flow for discharge. However, measurement of impact beyond the BCF and hospital discharge was limited as there was still work to be done to develop impactful partnership working with fully integrated joint commissioning across health and care.

Working with voluntary and charity sector groups

The local authority worked with local voluntary and charity organisations and had recognised the sector as key partners in helping them to meet the rising demand for services and promoting the independence and wellbeing of people in the community. They provided funding focussed on outcomes around supporting people's mental health and wellbeing, building thriving and sustainable communities, and helping older people maintain a healthy independent life for as long as possible. There was a thriving voluntary sector in the local authority area, however we had feedback that communication was one way, with the local authority defining the scope of the prospectus when they could do more to engage and involve the sector in shaping plans and understanding local needs.

Theme 3: How West Berkshire Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions

- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

There was an awareness focussing on the safety of people in their care journeys from both frontline staff and senior leaders. The risks relating to people on waiting lists for assessment for example, was monitored by managers to ensure people were prioritised with the greatest risk. There were policies and processes in place to help manage risk so immediate provision could be made by social work teams while someone waited for assessments. Locality teams for example, were trained and able to put in place basic equipment in people's homes to support safety. There was a safeguarding specialist within the out of hours team to ensure that safeguarding issues were dealt with appropriately. The out of hours teams monitored trends in the issues arising such as emergency respite for unpaid carers. These issues were addressed both on a weekly basis for individual cases as well as the wider implications for learning and managing risk for the future.

Where services were delivered with partners, for example, in hospital discharge, there was a joint understanding about safety. Weekly meetings enabled operational staff to manage risks. Learning was shared at operational meetings to improve processes and drive improvement.

Safety during transitions

Teams worked closely with partners to manage risks for example, with discharge from hospital. When people were discharged from hospital, there was a trusted assessor model in place which enabled health staff to complete assessments for people leaving hospital in a timely way which were then shared with adult social care. A trusted assessor is someone who is trained to carry out assessments on behalf of the local authority. This was supported by daily meetings to discuss discharge. For people discharged from the mental health trust, AMHP's working in the local authority had access to health records to ensure they had access to the relevant information.

Transitions from children to adult services worked well. Data from children's services was used to predict workflow and adult social care started to work with young people from 16, attending meetings jointly with children's services. People told us the process worked well and they had felt supported to achieve their goals and maximise their independence.

If people were placed in services away from West Berkshire, their case would remain open to the local authority. However, they did not have named workers attached. The local authority was reliant on monitoring by the host local authority to share intelligence but did not actively seek this feedback for themselves. We heard of an example with a homecare agency closed and there had been timely liaison with the host local authority and people were quickly moved to a new service. For people with mental health needs there was closer monitoring. AMHP's worked closely with a specialist section 117 worker who carried out reviews including reviews for people out of area.

There was a potential risk around people who could no longer fund their own care. The high costs of care, particularly in the self-funder market, meant that people may have to move to a different care home, which was within the local authority fee rates once they could no longer fund their own care. Staff recognised that there was a need to forward plan where this might be the case to support safe transition if necessary.

Contingency planning

The local authority had in place contingency planning to ensure they were prepared for possible interruptions in the provision of care and support. The care market within West Berkshire was relatively stable and care was of good quality, this was not a high risk for the local authority. Resourcing in the care quality team, meant interruption to the provision of care and support put pressure on the team and impacted other monitoring activities. The local authority worked closely with neighbouring local authorities to support their resource in this area. We had some feedback from partners that sometimes the local authority was slow to respond in these situations and did not always move people from failing care homes in a timely manner. The local authority was currently revising their provider failure policy.

Safeguarding

Score: 3

3 - Evidence shows a good standard

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

There were effective systems, processes and practices to make sure people were protected from abuse and neglect. Managers carried out regular audits of safeguarding cases to ensure procedures were followed and this was reported to a corporate board. Safeguarding was embedded throughout front line teams with a specialist worker within the out of hours team and good internal relationships between safeguarding and other teams including the quality assurance and locality teams.

There were strong partnerships through the Safeguarding Adults Board working across the 3 local authorities in the place of Berkshire West. This ensured a co-ordinated approach to safeguarding adults in the area. Partners told us, there were close working relationships, and they were in close contact with each other, which avoided delays and resulted in better outcomes for people.

There was a strong multi-agency safeguarding partnership in place across Berkshire West, with clearly defined roles and responsibilities for responding to concerns. Information and learning were shared across all local authorities in the safeguarding board partnership. The board was well attended by partners including health, care providers and the voluntary sector and advocacy providers. The presence of the voluntary sector and advocacy providers was seen as essential to ensure the board heard peoples voice and there was a commitment to broaden the voluntary sector presence to include smaller local groups providing services at community level. The ASCS data reflected 91% of people who use services said those services had made them feel safe. This was above the England average of 85%. In the SACE 85% of carers said they felt safe which was above the England average of 80%.

Staff told us they had relevant training, support, and supervision to enable them to carry out their safeguarding duties effectively. There was a safeguarding learning and development group that supported training and ensured that training covered areas identified by Safeguarding Adult Reviews. The learning and development group monitored the effectiveness of training and impact on practice. Training was available in a range of formats in addition to formal training there were podcasts and webinars to increase accessibility.

Responding to local safeguarding risks and issues

The local authority worked closely with partners to reduce risks to prevent abuse and neglect from occurring. There was a well-established Safeguarding Adult Review (SAR) panel chaired by the ICB, covering the 3 authorities in Berkshire West. There had been no SARs within West Berkshire, however learning was taken from SARs in neighbouring authorities to reduce risks and prevent similar occurrences in West Berkshire. For example, there was a commitment to deepening understanding of the Mental Capacity Act 2005 and embedding learning beyond local authority staff. As well as responding to SARs the safeguarding board also carried out thematic based audits and had done an appreciative enquiry around self-neglect to understand strengths and areas for improvement.

Responding to concerns and undertaking Section 42 enquiries

Safeguarding teams worked proactively with providers. Providers told us, there was an open and supportive culture focussed on keeping people safe. There was a system in place to manage care quality issues that were raised but which did not meet the safeguarding section 42 threshold. This meant issues could be raised and dealt with, to prevent risk escalating and therefore preventing a safeguarding concern arising in the future.

When safeguarding enquiries were conducted by other agencies there were protocols in place. For example, the manager of the safeguarding team delegated some enquiries to health and had regular meetings with the health trust so they could give updates on their part of the enquiry and ensure oversight. There were clear standards and quality assurance in place for conducting Section 42 enquiries. A Section 42 enquiry is the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. There were no safeguarding concerns awaiting initial review. All decisions regarding concerns were made in 72 hours with enquiries starting on the day the concern was raised. Enquiries were then prioritised and picked up immediately in locality teams. Managers used a dashboard to monitor active Section 42 enquiries, following up any that had been open for more than 30 days.

Partners told us, there was good communication from safeguarding teams informing them of the outcomes of safeguarding enquiries. There was a waiting list in relation to Deprivation of Liberty Safeguards (DoLs) applications where some people had been waiting over a year. 250 out of 561 assessments in the year 2023/24 were still waiting for a decision. There were 22 applications that had been waiting over a year. DoLs is when people in care homes and hospitals are deprived of their liberty in a safe and correct way, to receive care and treatment. This is legally authorised under the Mental Capacity Act 2005 and is only done in the person's best interests and when there is no other way to look after them. The DoLs waiting list was managed using the ADASS risk-based system to prioritise cases. Safeguarding cases were prioritised, and the hospital discharge team said where they had urgent applications these had been dealt with immediately. There was an awareness through leadership in the local authority that the backlog created both a financial and reputational risk for the local authority. The DoLs team had fortnightly meetings with the legal team to discuss ongoing DoLs cases and to get guidance on priorities. Best interest assessors worked closely with care homes, and with support for families. As part of assessments, they could also pick up on any care quality concerns and look at adult social care records to understand if alternative less restrictive approaches had been tried.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively without delay, keeping the wishes and best interests of the person central. Making safeguarding personal was at the heart of the safeguarding processes. Frontline staff told us they wouldn't close a case if they had not got the person's voice but would mitigate risk whilst waiting. People were supported through the safeguarding process, and teams had a good understanding of ensuring people were supported in line with their human rights and the implementation of the Mental Capacity Act 2005 and Equality Act 2010. However, the team highlighted that there were sometimes delays caused by a lack of advocates. This was being addressed by the recruitment of more advocates so it was anticipated this would be resolved in the future.

Theme 4: Leadership

This theme includes these quality statements:

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

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

Governance, management and sustainability

Score: 3

3 – Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Governance, accountability and risk management

The local authority was going through a period of transition in leadership and governance. There had been a recent change in the political leadership of the council and the DASS was also relatively new in post having been appointed as Director of Adult Social Services 5 months prior to our assessment. Prior to that they had been in the interim post of Director of People which included Adults and Childrens services for 7 months. Governance and management systems were in place from the previous political leadership, ensuring oversight and scrutiny from members. Members understood their roles but were still in the process of learning the detail. Areas for improvement had been identified to increase accountability and scrutiny for Adult Social Care by merging scrutiny for adult social care with health. At the time of our assessment, scrutiny for adult social care was within scrutiny for all council business which meant it did not always get prioritised.

There were systems in place to provide assurance on the delivery of Care Act duties, including quality and risk and the experience and outcome for people using services. Management of performance and risks were embedded through front line teams. Managers were aware of where there were issues and concerns and monitored the work of frontline teams. There was a culture of gathering feedback from people using services to review and improve practice and ensure person centred approaches.

There was a stable leadership team, with clear roles, responsibilities, and accountabilities. Staff told us leaders, including the DASS, were visible, supportive, and approachable and worked with them to identify and resolve issues. There was a positive culture, staff told us it was a good local authority to work for. Staff reported having good support and supervision including consideration of their wellbeing.

There were systems in place to manage risk, safeguarding was embedded in all teams. There was a risk-based approach to managing waiting lists. The highest risk was prioritised for immediate action. Leadership worked closely with partners to manage risk across the system.

Strategic planning

Recent changes in the political leadership of the local authority meant some of the strategies had not yet been reviewed and aligned to the new leadership. However, partly because of the Covid-19 pandemic some of the goals and aspirations of previous strategies had not been met. For example, improving provision for people with complex needs and reducing the number of out of area placements which had been a goal in the market position statement. The context within which the local authority was operating meant that there was a relatively stable provider market, with high quality care. The local authority had trust in providers which meant the local authority was able to meet people's needs with existing provision. This meant there was less incentive for active market shaping. As needs were changing, more people with complex care needs and more people wanting to remain in their own homes, the growth in the number of older people, along with financial pressures meant there was an imperative need to have a more active approach to market shaping. There was an awareness of, and conversations about performance, inequalities, and risks for the future, but these had not yet been translated to strategy under the new leadership. There was a focus on dealing with financial matters. The local authority was aware there was more work to be done to develop proactive strategies based on the data including inequalities and future growth to shape the market and services within the available finances. More focus needed to be placed on measuring impact and savings of preventative work for example, which could improve outcomes for individuals as well as help reduce future costs of an aging population and address the high numbers of working aged people with long term care needs.

Information security

The local authority had systems in place to maintain the security availability, integrity and confidentiality of data, records, and data management systems. Electronic recording systems were in place with restricted access for those working with people using services. The local authority had a system in place to ensure security if physical records were printed, for example to give a person a copy of their care plan. Where documents were emailed, there was the additional requirement that a secure email system was used. If information was sent to third parties a secure portal was used. All staff were trained in the use of the secure systems.

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

Staff told us there was an inclusive and positive culture of continuous learning and improvement. Staff told us they had access to the training they needed and felt encouraged in a learning environment. The Principal Social Worker described a range of performance measures, monitored through audits to ensure staff carried out their role to ensure Care Act duties were delivered. Training was developed in response to areas for development identified in audits and staff practice was monitored to measure the effectiveness of the training in influencing practice. Front line teams described how they used learning from real cases to inform future practice at peer supervisions, through team meetings and learning events. For example, best interests' assessors reviewed themes within DoLs applications that were used at learning events with both internal and external stakeholders. Providers told us there was an open safeguarding culture of shared learning with a no blame approach.

The local authority needed to do more work in collaboration with people and partners to promote and support innovative and new ways of working to improve people's social care experience and outcomes. This work would support more active shaping of the market to meet people's needs. The local authority had good relationships with partners, but these were in early stages and needed to be further developed to develop joint approaches to solving issues within the market that meet the budget. There was ongoing work with the ICS on the review for CHC funding which to a large degree was outside of the control of the local authority. The low number of positive CHC funding requests was placing additional burden on the local authority, in relation to complex nursing and mental health needs which in turn impacted negatively on outcomes for people. This work needs to be expediated to reach conclusion for the local authority to ensure there was parity across the region.

The local authority acknowledged there was more work they could do in relation to their engagement with the voluntary and community sector in developing innovative responses to needs as well as in assisting in a wider understanding of needs and seldom heard groups across the area. Voluntary and community groups felt they had good relationships with the local authority on an individual basis but did not feel strategically involved or consulted in relation to areas of need, and gaps in resources. Development of the relationships with the Voluntary Sector would also support more co-production which was also an area the local authority had identified for further development and had recently adopted a new co production framework. There was some co-production through the autism partnership and the carers partnership had supported co-production of the carer's strategy, but these were isolated examples rather than an approach embedded across the local authority to inform learning and the development of strategy to meet the needs of people across the local authority.

There was a culture of sharing learning and best practice both with peers in the local authority as well as with system partners where relevant. For example, the hospital discharge team shared learning with partners to improve outcomes for people. Safeguarding shared learning outcomes across the system with health partners and providers to reduce risks to people and prevent escalation and safeguarding in the future. The local authority had drawn on external support to improve where necessary. For example, using ADASS tools to manage risk, and had invited an external review by ADASS to look at the situation in relation to low numbers of direct payments to better use direct payments to promote independence and improve outcomes for people. The Chief Executive held regular peer review meetings to gain perspective on strengths and areas for improvement.

There was not widespread innovation across the local authority, but there were some opportunities for innovation identified. For example, there was a new pilot project for single handed care which supported carers with moving and handling by using equipment instead of two carers. This reduced the need for 2 carer calls. Providers were positive about the pilot and the local authority had plans to roll out training for providers to expand beyond the pilot.

Learning from feedback

There was some learning from people's feedback about their experiences of care and support. Individual teams had a strong focus on learning from the feedback of people they supported. The local authority carried out surveys in relation to reablement, carers experience and feedback from autistic people to support with their autism strategy. The reablement survey showed people to be happy with reablement following the change in pathway 1 (the reablement pathway), along with an improvement in outcomes for people. The carers survey was carried out in 2022, and many issues such as access to services and respite availability reflected the pandemic experience. This data was used to inform the carers strategy.

There were processes in place to ensure learning happened when things went wrong. There was a strong learning and development group within the safeguarding board that supported learning from SAR's across Berkshire West. Learning from neighbouring authorities was used to improve practice in West Berkshire. There were no complaints upheld from the Local Government Social Care Ombudsman. Complaints to the local authority in the last year mainly focused on charging. The local authority took learning from these complaints to improve their process for managing complaints relating to invoicing and ensuring formal consultation before introducing changes to charging. Wider learning from complaints have been addressed through training for staff on clarity of communication and expectations with both people using services and partners.