Care Quality Commission

Local authority assessments

Local authorities are a central component of care systems – their work affects the way people experience health and care services by ensuring that people are able to live their best lives as independently as possible while ensuring that their equality and human rights are respected and preserved.

As well as inspecting health and social care services, we have a role in assessing how local authorities meet their duties under Part 1 of the Care Act (2014). This is a newer responsibility, which we began in 2022.

In 2023, we reported on the under-provision in some types of specialist care, such as services for autistic people, specialist dementia care, and in the availability of beds in care homes with nursing. Last year's report also focused on issues around people's flow through the local health and care system – and what system partners could do together to improve flow.

Among other areas of concern at the outset of our assessment programme, we wanted to know about prevention and reablement models and home first policies, including using technology to help people to remain independent. We also wanted to find out whether particular groups of people were facing inequalities and what providers and systems are doing to address that.

From the early stages of our work with local authorities, the information in this report is largely based on 5 pilot assessments and the first 9 of our formal published reports.

We carried out our first 3 formal site visits in February and March 2024 – these first reports were published in May 2024. By October 2024, there were 58 assessments underway and 9 published.

Access to care

Local authorities have different ways to enable people to find information and access services and support, and there were varying degrees of success in making services accessible.

There are phone and internet services, but waiting to get through on the phone is a common issue and for some people digital access is a barrier.

We found that carers often struggled to access support. All the local authorities we have assessed had work to do in identifying carers and raising awareness that they are entitled to an assessment and services to support them in their caring role. We found that this was more acute for people in ethnic minority groups who would not see themselves as carers.

Access issues in general included:

- people who self-fund their care struggling to access support
- gaps in language or cultural needs to get information
- specific barriers for people in rural areas, such as poor infrastructure and lack of digital access.

Care pathways for autistic people and pathways for young people transitioning to adult services were not always clear – this made it harder to access support and we found this at several local authorities.

Nevertheless, we have seen some solutions to access issues, including:

- local authority-run ‘conversation cafes’ in the community in Harrow, where people, including unpaid carers, can access services
- voluntary organisation champions who reach diverse communities
- providing information in the community – at GP surgeries and in libraries, and ensuring it is available in a range of accessible formats and languages.

A small number of local authorities had waiting lists for all areas of their work, including assessments and reviews, and some had waiting lists for a limited number of their services. For example, one had waiting lists for reviews in relation to the Care Act assessments for people with mental health needs, while another had a list that showed a review of placements to enable people to leave a care home and return to their own home – these were people who were temporarily placed in care homes for a recovery period. Nearly all local authorities identified waits for occupational therapy services.

All the local authorities we assessed have more work to do to understand and identify groups whose voices are seldom heard, especially beyond the demographic data available in a census. Some local teams had knowledge of these groups, or the local authorities were working with voluntary organisations to develop this work. There is also a challenge for local authorities to see where there is intersectionality, for example where there may be groups within groups, such as autistic people or people with disabilities within a larger ethnic minority group – and to understand how this intersectionality may affect someone’s ability to access services and experience positive outcomes.

Where support is not available under the Care Act, local authorities are providing information about non-eligible support needs. One local authority had a roaming roadshow to share information.

There are gaps in care for people with more complex needs, including some working-age adults, people with a learning disability and autistic people, people with mental health issues, and older people with needs associated with dementia.

Local authority websites are generally a good source of information about accessing services, but some people have accessibility issues. Accessibility of websites and a lack of clear information about care or support pathways was found to be a barrier for some people. In several assessments, digital exclusion was cited as a barrier, especially for people with a learning disability, autistic people and people who do not speak English as their first language.

In West Berkshire there was a digital infrastructure group supporting some communities, including older people, refugees, and the Gypsy, Roma and Traveller community, but in general we found that greater flexibility and a variety of approaches was needed to engage people from all communities.

Carers

Unpaid carers continue to struggle to access the support they need, and this was more pronounced in local authority areas where there were staff vacancies or difficulties with recruitment. Carers also say information is not always presented in accessible ways. We have found:

- Access to services was affected by awareness – some carers did not identify as carers, which affected their ability to access services or even understand that they could access services.
- A lack of flexible and responsive respite is affecting carers, especially their ability to work, rest and have choice and control in their lives.
- Access to services was poorer in rural areas.
- All local authorities were working to better identify carers but problems are more pronounced in some seldom heard groups – in some Black and ethnic minority cultures the caring role is more embedded and some people do not see themselves as carers, running greater risks of crises if the carer becomes unwell or unable to continue their role.

- Lack of digital access affected access to services, especially if this was supposed to be a solution to rural isolation.

Poor communication and hospital readmission

One full-time carer explained the variety of problems he experienced around communication after his wife was discharged from hospital – and how she ended up back in hospital with a urine infection. This man is a full-time carer for his wife, who has multiple sclerosis. He organises all his wife’s appointments and care needs, with support from care workers twice a day.

After a successful operation in hospital, it was the hospital handover and aftercare that was disappointing. He said the “communication is very, very poor on discharge”. There was no hospital handover that detailed the care his wife had received, or information shared about new medications she was given, or what catheter bags were needed. He said he had explained to the hospital that he needed to understand what had been done, especially because his wife was unable to tell him. He added that he often had to re-tell his wife’s story to healthcare professionals, explaining about his wife’s capabilities and incapabilities.

A problem, he added, is that “communications between departments is poor and information is not passed on”.

The carer noticed things were not right with his wife’s urine when she got home after the operation. In a call to a GP, he says he wasn’t listened to and he felt “dismissed”. Two days later, his wife was taken by ambulance to hospital for a urine infection, where she had to stay for a fortnight.

(Interview with a member of the public)

One local authority was in the early stages of working with partners in the ICS through the Accelerating Reform Fund to improve how unpaid carers are identified. It wanted to develop digital self-assessment and address waiting times for a carer's assessment. The Better Care Fund had been used to set up preventative services, including a social prescribing project and an urgent community response service to reduce admissions to hospital.

Waiting for services

Most local authorities said they had gaps in services for people whose needs are more complex to meet, particularly nursing needs or complex mental health needs, as well services for autistic people and people with a learning disability.

The gaps resulted in widespread examples of people being placed out of their local area – some in a nearby area, but others a long way from home. A common finding was that people with more complex needs, including autistic people and people with complex mental health needs, were more likely to be placed out of area. Some local authorities acknowledged that long-term work was needed to shape the market and resolve this problem. Among the ways this is affecting people, we found:

- Some people were on waiting lists for occupational therapy for so long that cases were closed because their needs had changed so much.
- Younger people with complex needs were admitted to adult services.
- People with sensory problems, for example with hearing or vision, were placed out of their area or in inappropriate care settings.
- The lack of services for working-age adults with complex needs affected young people who needed to transition to adult services; extra appropriate provision for working-age adults was needed to promote independence, such as supported living.

Where solutions have been found to some access problems, they often involve collaboration – for example, with housing organisations and the voluntary sector, and particularly for those groups experiencing most inequality. Local knowledge was used to identify gaps in provision and work with those at most risk of being unheard.

There are some examples of pooled budgets leading to better support for people with a learning disability and mental health needs, but this has not always worked. We also saw that where there was good joined-up working, people were less likely to need to repeat their story, which helped to build good relationships with the support staff.

Where there was a strong focus on preventative services, this helped people to lead more independent lives. These worked well in partnership with public health initiatives, focused on obesity and smoking cessation, as well as improving mobility and physical and mental health. They also worked well where people could access advice and guidance at the relevant facilities, such as libraries or leisure centres.

Addressing inequalities

Local authorities are taking steps to address known inequalities and understand the demographics of their local populations. Some had identified groups that were at risk of, or who were experiencing inequality. This looked different for each local authority and there were different groups of people identified who might experience inequality. Examples included people in ethnic minority groups, neurodiverse people, Gypsy, Roma and Traveller communities, as well as displaced people including refugees and asylum seekers.

The actions local authorities took to understand or address inequalities were not always clear, particularly where there were small minority groups within the wider population.

At one local authority, equality and diversity leads worked in partnership with voluntary organisations to get a shared understanding of the inequalities facing groups whose voices are seldom heard. There were mixed views about the effectiveness of these relationships.

For too many local authorities, the main focus in tackling inequality was around race, culture and ethnicity as single issues, rather than considering how different protected characteristics might affect people in combination – also called 'intersectionality'. Or, in predominantly affluent areas with a mostly white ethnic population, the focus was on urban/rural inequalities and deprivation. There was limited intersectionality analysis.

We did not see many examples of local authorities engaging with the LGBTQ+ community, particularly where it intersects with other protected equality characteristics, for example the needs of older LGBTQ+ people in the community, or LGBTQ+ people who have a learning disability. Some local authorities were aware there were potential barriers to engaging, and they were trying to connect with relevant groups to address these.

For example, in Birmingham, there was a dedicated senior manager to co-ordinate equality, diversity, and inclusion work. It used data and intelligence to consider people's different protected equality characteristics and to inform its approach. Commissioning was delegated to community groups to develop community assets for under-represented groups, and neighbourhood networking schemes were tasked to identify gaps in services, working with local groups to submit bids to fill these gaps.

Autistic people said they found it difficult to use the usual channels, such as websites, to engage with local authorities – services could be inaccessible, and it was hard for them to engage in co-production. This is a challenge for multiple local authorities. Among others potentially excluded were older people and people with sensory needs.

There were also shortfalls in other aspects of some local authorities' understanding of the intersection of protected equality characteristics – for example, some faith groups raised this in relation to gender and their access to services.

In areas with a higher proportion of people from ethnic minority backgrounds, there was evidence of more culturally-specific service provision. In Harrow and in Birmingham there was considerable work around meeting cultural needs.

However, feedback shows that the market is generally not well developed to meet culturally-specific provision, particularly in residential or nursing care. In Harrow, the local authority's market sustainability and improvement plan demonstrated that it was aware of capacity gaps in the market. There were also challenges in brokering culturally-specific provision at an affordable price. Providers had told the local authority they had issues providing services that meet the ethnic, cultural, and greater needs of people living with dementia. There were plans to use co-production with faith and voluntary groups to address gaps in provision.

Engagement with the voluntary sector was mixed and constraint on resources could be a factor. Where engagement with the voluntary sector was linked to strong governance processes, including co-production and participation in partnership boards, this was more effective and supported the local authority in understanding local communities – this resulted in targeted commissioning to meet needs.

However, even where these relationships were effective, local authorities did not always have sufficient resources to commission the necessary services. Also, a lack of strong links with the voluntary sector led to patchy coverage because local authorities did not have the knowledge or intelligence about local community needs.

The cultural competency of staff – including social workers and commissioners – was vital to ensure service commissioning that also supported people from ethnic minority groups. And access to interpreters was important to help provide equal access to care.

Inequality affects carers too – often they do not identify as carers at all and so they do not access support or get assessed for support. This was particularly the case for unpaid carers from ethnic minority groups.

There was recognition that some people in rural communities might experience inequality. One local authority revised its commissioning to address delays for homecare in rural areas. It worked with a small number of providers who were able to subcontract with other providers and there was a joined-up approach between public health, local authorities and health partners in looking at housing, and understanding the effect of poor housing on people's wellbeing.

Local authorities are trying to improve their understanding of local inequalities. There was good partnership working with public health in one local authority that was trying to predict future demographic changes and how its strategies might need to adapt. Frontline staff had a good understanding of their communities and the groups at risk of inequality. There was learning from reviews and a focus on involving people with lived experience in co-production work, which provided extra opportunity to identify groups who may be at risk of inequalities.

In 2024, we published a report on tackling inequalities through the regulation of services and organisations, which considered the enablers and challenges to tackling inequalities.

Improving safety by working collaboratively

Across our local authority assessments, we have heard how safety can be improved where local systems work collaboratively, bringing together health services, housing and probation services, and voluntary, community and social enterprise.

Shared data and information improved safety because it was made available across services and care pathways. For example, some local authorities were working in partnership with mental health trusts, and the IT helped to improve safety for people moving between hospitals and the community. This also helped young people moving from child to adult services, and it was part of improvement in safety for younger people building skills to support their independence.

These local authorities also described good joined-up working that resulted in better outcomes and more trusting relationships with people who need services, and that this supported their safety. We also saw examples where several local authorities were working well with statutory and other partners for better safety. This work was most effective where there was a strong safeguarding adults board, working closely with partners and where there were clearly-defined roles, governance and audit processes.

Safety was also bolstered through other collaborative work. Several local authorities are using information portals for different professionals, which helps to speed up people's triage by providing prompts for the right information.

One had implemented a trusted assessor system with some regulated providers carrying out assessments for people waiting to be discharged from hospital. It also had a community connectors scheme with partner organisations, leading to improved pathways for hospital discharge.

Most local authorities have integrated hospital discharge teams and there is sometimes integration in other areas, such as in mental health. In Hertfordshire, there was a jointly-funded director of health integration in the local authority leadership team – this was helping to develop partnership working.

We have also seen evidence of joint commissioning of services and partnership arrangements, including information sharing protocols and contingency planning to ensure safe pathways for people moving between hospital and home.

Other positive safety activities noted from our assessments included:

- Planning to safely manage people receiving self-funded care when their savings are diminished, if their housing/support is unaffordable through local authority funding.
- Ensuring people are safe to return home from hospital with a reablement package, which worked best with integrated teams involving hospital staff and adult social care services.

- Closer working across local authority teams,ensuring there are no communication barriers that can stop people getting the care they need.
- Collaboration across agencies, including the police and the fire service, to identify any risks or concerns for people's safety.

Improving quality

Where there are concerns about quality, local authorities have cited pressures on staffing as a concern and the cause of complaints. They say staffing issues are also a contributing factor where they have waiting lists.

Although they have quality monitoring teams, they say the resources available in teams affects how proactively they monitor quality in providers. Some local authorities said they relied more on CQC data and inspections to tell them about quality, rather than gathering their own intelligence.

However, they said they did share intelligence with health sector partners to identify where there may be quality issues. Looking to improve on quality, some said that the voluntary sector could help in terms of monitoring the quality of services and supporting them to understand people's experience within services – as well as supporting them to better understand people's needs.

A concern among some local authorities is for people who are placed 'out of county', or away from their home area. Most had gaps in relation to provision for people with complex needs – and these were people more likely to be out of their own county. When this happened, they usually relied on another local authority to monitor quality and inform them of any concerns.

Local authorities knew that good care was more likely where there were positive relationships, with partners taking a joint approach to quality assurance. Where resources were depleted, a reactive approach was more likely. But we saw quality monitoring processes that included a proactive approach to independent audits and annual reviews. Quality monitoring, including care package reviews, was usually integrated with the commissioning team.

We have found an awareness among local authorities of the areas that need to be developed and improved, as well as embedded cultures of continuous improvement. Similarly, we found positive and supportive relationships with providers, and they celebrated successes.

We also see strong relationships between some providers and the local authorities – often through forums, including co-production with providers and collaboration in market shaping and developing new models of care such as supported living and extra care. For example, one extra care service currently being developed is intended to reduce out-of-area placements; it involves 2 neighbouring local authorities that had worked on a supported living accreditation scheme, which should promote a consistent level of service quality.

Where local authorities were aware of good care, there were strong internal relationships between commissioners and social workers, and clear guidance and processes to manage risk when people were placed out of county.

Culture and leadership

Local authorities recognised the importance of good culture and leadership. This was borne out by some examples where there were clear cultures of openness, and the people felt ‘listened to’ and involved in co-producing strategies.

We have seen some clear leadership structures and cultures with an increasing focus on performance – and there was self-awareness where some senior leaders acknowledged that they were not as effective as they wanted to be.

In one local authority, we saw a culture of working openly with partners; there was an awareness of risk from senior leaders and councillors, with systems in place to monitor and manage this.

We have found leadership in local authorities to be open and transparent, and generally staff were positive about their leaders, telling us about opportunities for professional development and training.

Many local authorities are going through a process of transformation to increase the focus on preventing, reducing and delaying the need for care and support – this includes cultural change, structural change and changes in approach to balance allocation of resources against increasing needs and demand for support. There is a common theme of increasing numbers of people with complex needs (learning disabilities, mental health illness in working age, as well as complex dementia, mental health, or frailty among older people).

Some local authorities were clearly focused on addressing the future needs of their populations and the associated delivery risks. Others were more focused on delivering support to respond to current needs. The local authorities that performed best had:

- a clear strategic vision alongside a clear delivery plan to meet current and future needs
- embedded processes to gather people's experience to inform strategy and support delivery, particularly where there was a recognition in governance that flexible or creative approaches were needed to provide person-centred support, especially for those population groups whose voices were seldom heard.

Local authorities are moving towards a more performance and data-driven culture and they are at different stages in developing their approach to achieving this. This shift requires establishing a combination of appropriate and robust systems to support performance measurement and monitoring, quality assurance and learning from when things have gone wrong, and embedding collective problem solving. There is a correlation between strong governance and authorities that have a multi-disciplinary leadership team.

The nature of relationships and the development of governance with voluntary, charity and faith sector organisations (VCF) was varied. Some authorities had a relationship based on grant giving to enable VCF organisations to focus on delivering specific outcomes for people. Others had more strongly developed and mature relationships with the VCF sector, including formal involvement in partnership boards and in the commissioning of services, such as carers support services, social prescribing activity, hospital discharge pathways, and helping to shape the local market to meet people's needs.

Workforce collaboration

Workforce recruitment and retention is a major issue for local authorities, as well as in the NHS, as described earlier in this report. This can have an impact on people's access to services across local care systems and the quality of the services.

Some local authorities were working with providers to support the adult social care workforce and using this approach to develop skills in the local workforce to address gaps in provision, particularly for the needs of older people and those with advanced dementia, or working-age adults with a learning disability, autistic people, and people with mental health needs. Local authorities were aware that they needed to be proactive and forward-looking to develop their workforce and the market.

We have seen how some are also working in partnership with regulated providers to address some workforce challenges – including processes for staff training through apprenticeships.

In one area, the local authority had increased capacity in its homecare market to ensure there were no delays for homecare or hospital discharges – this was attributed to effective work between the local authority and the care market to increase the homecare workforce, supported by sponsorship and training. There was also a local authority that held service provider forums to help develop a better understanding of the social care workforce and joint working across sectors – as well as discussions with an ICB about a 'one workforce' approach.

In North Lincolnshire, the local authority has been developing a campaign to address workforce challenges through their Proud to Care initiative. This was set up to raise the profile of care sector roles and highlight career progression opportunities within the sector, as well as support recruitment and retention of the social care workforce by developing various initiatives, such as funded childcare, providing electric bikes and scooters under their 'wheels to work scheme' and a subsidised gym membership. They also used this initiative to develop skills in the workforce to meet people's more complex needs. This work was just starting to have an impact and staff gave examples of people enabled to stay in their own homes with care at home support.

During our assessments we found some common recruitment issues:

- Competition across sectors meant adult social care providers often found it difficult to recruit, especially those near major local employers.
- Smaller local authorities found staff might leave and commute to neighbouring authorities, sometimes for better pay or development opportunities.
- Use of agency or locum staff was common as local authorities tried to maintain stable workforces, but it was hard to recruit to occupational therapy positions, which was affecting waiting lists and people's ability to maintain independence.

It was acknowledged that recruitment in rural areas was always a challenge, and this continued to affect the ability to provide services. Some local authorities were working with providers and visa schemes to support recruitment from overseas, while others reported a significant amount of recruitment through an immigration sponsor scheme.