Shropshire Council: local authority assessment

How we assess local authorities

Assessment published: 28 February 2025

About Shropshire Council

Demographics

Shropshire Council is a Unitary Authority in the West Midlands with a population of 323,600 people (Census 2021). The area covered by Shropshire Council is mostly rural with 98% of the county classified as rural and 57% of the population living in rural settlements. This creates challenges of accessing transport networks in the rural areas. On the Index of Multiple Deprivation, Shropshire was ranked 101st out of 153 local authorities in England (with 1 being the most deprived), making it one of England's lesser deprived areas, however, there are pockets of deprivation and rural isolation within the county.

The population is 49.5% male and 50.5% female. Approximately 18% are aged 0-17 years, approximately 56% are aged 18-64 years and approximately 26% are over 65. There is expected to be a significant growth in numbers of residents aged 85 and over by 2030, to over 15,245, which is 4,422 more than reported at the time of the 2021 census.

The population of Shropshire is predominantly white, over 96% of the population is listed as white with under 4% Black Asian and Minority Ethnic groups.

Shropshire Council is located within the Shropshire, Telford & Wrekin Integrated Care System.

The council has been under Conservative majority control since 2005. The children and adults' directorates merged in October 2021 under the Executive Director of People who is also the Director of Adult Social Care.

Financial facts

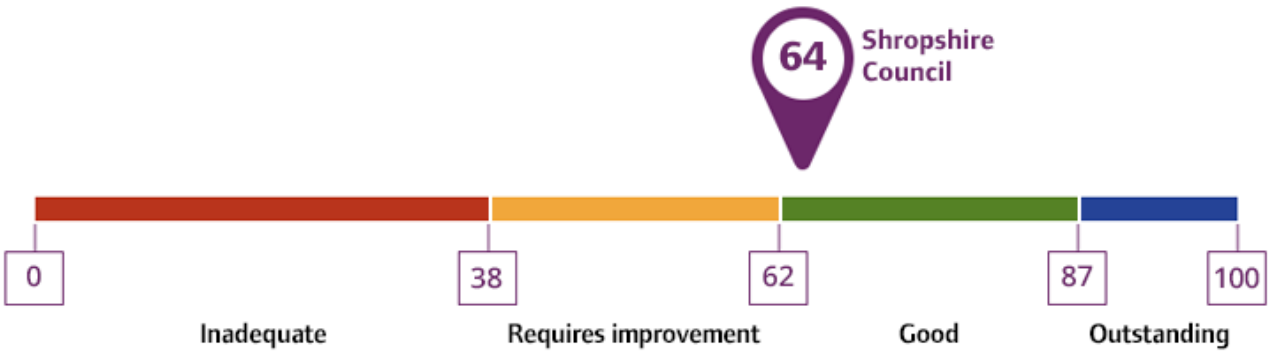
- The Local Authority estimated that in 2023/24, its total budget would be **£437,416,000**. Its actual spend for that year was **£492,157,000** which was **£54,741,000 more** than estimated.
- The Local Authority estimated that it would spend **£137,744,000** of its total budget on adult social care in 2023/24 Its actual spend was **£152,557,000**, which is **£14,813,000 more** than estimated.
- In 2023/2024, **31%** 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 **4595** people were accessing long-term Adult Social Care support, and approximately **1885** 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.

Overall summary

Local authority rating and score

Shropshire Council

Good



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes

Score: 2

Care provision, integration and continuity

Score: 3

Partnerships and communities

Score: 3

Safe pathways, systems and transitions

Score: 2

Safeguarding
Score: 3

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

Overall, we heard mostly positive feedback from people about their experiences of contact and support from the local authority and many people said their care and support had improved their independence.

On initial contact with the local authority, support was provided by the First Point of Contact Centre (FPOC) by way of information, advice or signposting to other organisations.

People's experiences of Care Act assessments was mixed. Some people told us the assessment had been person-centred, they had been listened to and they had regular contact with their social worker. Other people told us their assessment did not consider all the information that was important to them, and some people had to wait for an assessment. People said that social workers had kept in touch with them to monitor any changes in their circumstances whilst they were waiting.

Assistive technology was used to helped to prevent, reduce and delay the need for care and support and to support people to remain independent at home. We received mixed feedback from people in how effective this was for them. The local authority provided people with assistive technology only where it was assessed as being appropriate for individual needs and circumstances.

People had a positive experience when being discharged from hospital and good support was provided from reablement services. This had resulted in people remaining independent when they returned home.

For children moving into adult services, feedback about their experiences was mixed. We heard about positive outcomes with smooth transitions, but this was not the case for all.

Unpaid carers told us that support was available however, some told us the support on offer did not meet their needs. There was an All-age Carers strategy to improve the offer to unpaid carers and the local authority was taking action to identify and engage with more unpaid carers. There was a team specifically to support unpaid carers in addition to an online carer support service which provided a range of free online services including practical support and promoting wellbeing.

The local authority recognised the importance of co-production and there was an intention to get people involved and to involve more experts by experience on the Making it Real Board.

Summary of strengths, areas for development and next steps

At the time of our assessment the local authority was undertaking a transformation programme to drive its strategy to prevent, reduce or delay the development of care and support needs. This was set out in 'The Shropshire Plan'. There was a clear focus on supporting people to be as independent as possible and to continue to live in their own homes.

Assessment, care planning and review arrangements were not always timely and up to date. Waiting times varied for assessments to be undertaken across different teams, with significant waiting times for people with sensory needs and waiting times for older people and people with learning and/or physical disabilities who were supported by community teams. The local authority was taking action to address this, including creating a dedicated care review team and doing outreach work to assess people whilst they were accessing other community services.

There were no waiting times for assessments from the preparation for adulthood, mental health or hospital discharge teams. There was no waiting list for financial assessments, although the timeframes for completion of these assessments varied. A new online financial assessment was launched in April 2024.

There were shortfalls in the provision and accessibility of information and advice about care and support and the online information was not easily accessible for everyone. Work was underway to improve the website and the online directory of resources. There was also work underway with voluntary sector partners to address the risks of digital exclusion.

The local authority had a good understanding of the diverse needs and make up of the local population. Further needs assessments were being conducted in 18 geographical areas to give a more in-depth understanding of the issues affecting specific areas. For example, the rurality of some areas presented a specific challenge for the local authority to provide services there. There had been specific recruitment drives to increase home care capacity in rural areas and to reduce delays in service provision. The local authority was actively seeking to understand people's experiences and to identify gaps in service provision so that it could take appropriate steps to ensure people had equity of access to care and support across the area.

There was an established range of home care and care home provision, although care home provision was limited in some rural areas. Feedback from staff and partners indicated there was a need for more supported living, but we were not advised of people waiting for supported living placements due to a lack of capacity at the time of our assessment.

The local authority had strong relationships with health, public health, voluntary and community partners. They worked collaboratively to agree and align strategic priorities, plans and responsibilities for people in Shropshire. Recent work to improve understanding of respective roles and responsibilities had impacted positively on communication across the Integrated Care System and the Integrated Care Partnership.

There was a clear focus on promoting independence, and work to prevent, delay or reduce the need for care and support. This was detailed in the Shropshire Plan and the Prevention Matters Framework. There was a multi-disciplinary approach to the work, and examples of joint initiatives such as a healthy weight campaign and a suicide strategy.

There was a robust and effective reablement service with sufficient capacity to support timely discharges from hospital. The service was having a positive impact on enabling people to regain their Independence after leaving hospital.

There was a significant waiting period for access to occupational therapy, and this often led to delays in the provision of equipment and home adaptations. A review was underway to assess and resolve the problem. In the interim, the local authority was using a risk management approach to prioritise assessments of people with the greatest need.

There was a range of services and support available for unpaid carers, including support groups, a dedicated carer's worker in the hospital team and provision for respite care. The local authority had an 'All Age Carer Strategy', with an action plan to improve the offer to unpaid carers.

We received mixed feedback about people's experiences of moving between services, for example from children's to adult services. Some people had a lack of continuity in their care provision. The local authority was aware of these issues and steps were being taken to address them.

The local authority had a clear understanding of the safeguarding risks and issues in the area. Safeguarding enquiries were dealt with promptly and quality assurance arrangements were in place.

There was a strong emphasis on learning from safeguarding incidents, and partners highlighted the positive working relationship with safeguarding teams to keep people safe.

The local authority worked collaboratively with the voluntary sector. However, there was a recognition of the need to build on this and improve the engagement with sectors of the community who were seldom heard, and to draw on people's lived experiences in co-production activity. Work to develop a co-production strategy was in place but people and carers told us the changes and impact of co- production activity was not shared with them.

People told us they enjoyed working for Shropshire local authority and they felt valued and supported. They spoke about the many training and career development opportunities available to them and they said the local authority placed high emphasis on staff wellbeing.

One of the challenges with the rurality of Shropshire was attracting and maintaining a consistent workforce. There was a significant investment in recruitment and retention and a specific adult social care workforce strategy was being developed to support future sustainability and hard to recruit to roles across adult social care.

The local authority had clear and effective governance, management, and accountability arrangements. This provided oversight of the delivery of their Care Act duties. Improvements were needed in some areas such as reducing waiting lists for assessments, care reviews, DoLS applications and improving support for unpaid carers. Actions were in place to address these, and the local authority had implemented improvement plans.

Theme 1: How Shropshire Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

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

The First Point of Contact (FPOC) service was the initial entry point to the local authority for people requiring care and support.

People could contact the FPOC directly, and other organisations who provided health, wellbeing and preventative support could also refer people to the service. Contact was made by telephone, phone or email. There was not an option for people to complete a Care Act self-assessment online, however the local authority was exploring this as part of their digital transformation work. The FPOC provided initial information and advice or signposting people to other organisations. An appointment for a longer discussion or a Care Act assessment could be offered at a 'Let's Talk Local' session in a location near to them. The community teams staffed the 'Let's Talk Local' Hubs and also completed assessments in people's own homes. These teams worked with older people, people with a learning disability, people with a physical disability, autistic people and older people with mental health needs. There was also a specialist mental health team that completed assessments with people with mental health needs.

Assessment teams worked with people using a strength-based approach and to develop a person-centred package of care that supported people's independence. Feedback on assessments were mostly positive. This included evidence from a peer practice review which took place in May 2023 and had received 96% of good or outstanding feedback. National data showed 63.18% of people were satisfied with care and support provided by the local authority. This was similar to the England average of 62.72 % (Adult Social Care Survey 2023/2024 (ASCS).

Some people told us their assessments and care plans were person centred and included their aspirations and dreams. One person told us their care plan did not fully take account of their needs, and another person told us that the process of arranging suitable care provision for them had taken a long time and had been disjointed. We were given an example by a voluntary sector partner of two relatives with two different social workers who were living in separate care homes. The social workers had said they were unaware of the existence of the other relative until this was flagged by the voluntary sector representative. This lack of joined up working may have reduced the opportunity for their care home placements to be considered together.

We were told that people were given a choice of having an assessment over the phone or face to face. One person described the local authority support as 'exceptional' and said it could not have been better. Staff had listened and as result a bespoke package of care had been established.

Assessments included some information about people's individual hobbies, interests and social contract. However, we received feedback from one person that their assessment and support plan had not included support to reduce social isolation. The national data for Shropshire showed 43.38% people reported they had as much social contact as desired. This was similar to the England average of 45.56% (ASCS).

Care providers told us they undertook their own assessments further to the assessment provided by the by the local authority, to ensure they could meet people's needs. The local authority provided information about the pre-service agreement they had with providers which set out responsibilities and action, if individual needs were not being met by the level of support indicated in the support plan.

Timeliness of assessments, care planning and reviews

Assessment, care planning and review arrangements for community teams were not always timely and up to date. The local authority's data (submitted in March 2024) showed the median average wait for a Care Act assessment was 34 days. At the time of the assessment site visit the longest wait had reduced to 161 days from 195 days. The local authority had an action plan to improve performance of waiting times which had reduced from over 450 people to approximately 200 people waiting.

People's experiences of waiting times differed depending on which team they were allocated to. Local authority data (submitted in March 2024) told us there were 184 people on the waiting list for a sensory needs assessment. The median wait was 135 days, and the longest wait was 368 days. The local authority had an action plan in place to improve performance in this area and at the time of the assessment, the waiting list for a sensory needs assessment had reduced to 154. In order to manage the waiting list there was a RAG rating indicator to assess risk and prioritise with referrals being triaged and cross referenced by an administrator and duty officer on a weekly basis. A monthly team allocation meeting to review and scrutinise the waiting list was also in place.

Staff from the community teams told us there was good oversight of the waiting lists. When someone was first referred to the team they were triaged. Some people were offered appointments at a hub or were signposted from the duty system, for example for advocacy support. The waiting list was reviewed weekly, and allocations prioritised.

For people in hospital requiring an assessment, the assessment process commenced immediately when the local authority became aware of the referral, or the next day if a referral was received out of hours. The local authority told us there was routinely no waiting list for them to respond to the referral. There was no waiting list for Care Act assessments for people whose primary need was a mental health condition.

We received a mixed response from people and partners about the timeliness of reviews of people's needs, with some people having their care reviewed promptly in response to changes, and others waiting for a review. National data showed 45.37% of long-term support clients were reviewed (planned or unplanned), the England average was 58.77% (from the Adult Social Care Finance Report (ASCFR) / Short and Long-Term Support (SALT)).

We heard positive feedback from some partners who said that prompt care reviews were done in response to changes in circumstances, and new care support plans put in place. However, at the time of our assessment, some people were still experiencing significant delays. The local authority's own data (submitted in March 2024) showed 810 reviews were overdue and of these, 79% were overdue by less than 6 months. The median average overdue review was 181 days overdue and the longest was 335 days overdue. Overdue reviews were RAG rated and there were clear processes of prioritisation. More recent data provided by the local authority showed that at the time of the assessment site visit the overdue reviews had reduced to 701 and 73% of reviews had been completed.

The local authority was taking action to manage and reduce waiting times in the community teams for assessment, care planning and reviews. The aim was to assess people within 28 days by June 2024. At the time of our assessment this was up to 45 days.

A dedicated review team was being created to ensure the local authority met their increased target of 85% completion of care assessment reviews by 2025, from their target of 75% for 2024.

A triage and risk management system was in place to identify and respond to people presenting the greatest risks to their well-being first. Additionally, people received a fortnightly or monthly telephone call to monitor changes in circumstances and to offer support whilst they were waiting for assessment or review.

Partners told us they were involved in a pilot with the local authority to identify a change in need and to support capacity into the care market. complete reviews to help reduce the backlog. In their self-assessment the local authority stated the pilot was to identify over- prescription of care, and if successful they would move to a trusted assessor model.

Following an 'Innovation' week in October 2023, an action was to increase the focus on reducing waiting times for assessments. This resulted in a pilot in which social workers visited a community group and met people who were attending. On that day, social workers had contact with over 60 people, many of whom had been on the waiting list for assessment. This had a positive outcome for people and the local authority, enabling them to do face-to-face assessments of a high number of people in a short space of time. This intervention had a positive impact on people who had been waiting for an assessment.

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

National data showed that 38.00% of Shropshire carers were satisfied with social services. The England average was 36.83% Survey of Adult Carers in England (SACE).

At the time of our assessment, there were 1700 unpaid carers registered with the local authority, and this has subsequently increased to around 2100. However, the local authority was keen to identify and engage with more unpaid carers and action was underway to address this. There was an All-age Carers strategy to improve the offer to unpaid carers. The local authority's website contained specific information for unpaid carers, including how to request an assessment. Whilst an assessment could not be requested through an online portal, unpaid carers could enrol onto the Shropshire Carers Register website. The Carer Register was a mechanism for sharing important information quickly to support people in their role as an unpaid carer.

The local authority offered an online carer support service to provide a range of free online services. This shared local information about practical support, promoted wellbeing and it offered a five-part email course to support unpaid carers. A senior leader told us that unpaid carers appreciated the digital carers offer if they struggled to get to either of the 2 neighbourhood hubs, or the 5 carer support groups that were available. The online service enabled unpaid carers to communicate with each other, have local conversations with people and link in with national events. National data showed 23.81% of carers reported that they had as much social contact as desired, which is similar to the England average of 28.00% (Survey of Adult Carers in England (SACE)).

There was a team specifically to support unpaid carers; staff had good awareness of the needs of unpaid carers and provided them with information, advice and support. For example, by signposting them to social activities and making them aware of any welfare benefits they were entitled to such as Carers Allowance. National data showed that 42.86% of carers were accessing support groups or had someone to talk to in confidence. This was somewhat better than England average of 32.98% (SACE).

The local authority's carers service supported young carers. Young carers were reached through schools and colleges, where basic life skills courses were offered to them. Young carers were reached through schools and colleges, where they were offered basic life skills courses.

We received mixed feedback from unpaid carers about their assessments.The local authority's data showed 381 unpaid carers had received a new assessment since April 2023, with 129 young carer assessments completed in the last 12 months. At the time of this data, the local authority told us they had no waiting list for carers assessment. Feedback from unpaid carers about their experiences of assessment was mixed. Three of the people we spoke with gave negative feedback, including being unhappy with the length of time taken to do the assessment, feeling as though they had to battle to get an assessment, and one person having the assessment after the person they cared from no longer lived with them.

Some unpaid carers told us the support offered had not met their needs. Unpaid carers told us that the Carer's groups were not always suitable for them and some people told us they felt they had not received any support in their caring role.

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

People were given advice, and information about how to access services, facilities and other agencies for help with non-eligible care and support needs.

Staff working in First Point of Contact were confident about signposting people to other voluntary agencies (where appropriate) if they had non-eligible care needs. They gave an example of referring people to social prescribing as a preventative service. Social prescribing an approach that connects people to activities, groups, and services in their community to meet their practical, social and emotional needs that affect their health and wellbeing. They also offered people a call back service in 14 days, to see if they needed any further support.

The local authority had a dedicated worker who liaised with adult social care teams and advised them about referring people for support to meet their non-eligible care and support needs.

Eligibility decisions for care and support

The local authority had a framework for eligibility for care and support. Staff gave clear rationales for their decision making against the eligibility criteria.

Information was available to people on how to complain and appeal against decisions with the Ombudsman, setting out a one stage process. In the last 12 months, there were no complaints directly relating to eligibility decisions.

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. At the time of our assessment there was no waiting list for financial assessments although decisions and outcomes were not always timely. Leaders told us delays in completing assessments could be due to them waiting for further information from people.

The target period the local authority aimed to complete a financial assessment was 28 days. Local authority data taken on 23 February 2024 of completion times for the last 12 months, showed for non-residential financial assessments, the median was 3 days, the mean 10 days and maximum was 143 days. For residential financial assessments, the median was 7 days, the mean 32 days and maximum 252 days. We were advised by the local authority that this was a single outlier which had been caused by events beyond the control of the local authority.

Staff told us the online financial assessment was launched in April 2024. The online portal allowed a person to input their financial information securely and gave them an estimate of what their financial contribution would be. Further to this there was a detailed financial assessment process. The local authority had reviewed their financial assessment processes and introduced improvements where needed, based on any appeals and complaints.

Staff used preventative measures to avoid people getting into debt with their care charges. They called people after they received their first invoice to see if they had a direct debit in place and to ensure debts did not grow.

Provision of independent advocacy

The local authority contracted independent advocacy services to support people to have a voice and be involved in making decisions about their care provision.

Unpaid carers told us social workers assessed their relative's mental capacity to make decisions when required and best interest meetings were held when necessary. Social workers ensured independent advocates were in place when family were unable to advocate for the person. Staff told us the advocacy service who supported people with learning disabilities and autistic people were very good and the advocates were skilled. They gave us an example of how the service supported a parent who had learning disabilities. Feedback from this service confirmed the local authority had a good understanding of their advocacy responsibilities. They also told us they had positive working relationships with social workers.

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 worked with people, partners and the local community to promote independence, prevent, delay or reduce the need for care and support.

This was reflected in the 'Shropshire Plan' which was focussed on enabling people in Shropshire to live their best lives with 4 priorities of healthy people, healthy environment, healthy economy and healthy workforce. The lead member told us prevention activity was underpinned by the Prevention Matters Framework. The framework identified a multi-disciplinary approach and offered a wide range of preventative work-groups such as early intervention, housing support and social prescribing, to provide support and services to people in the community.

The local authority was actively engaged in the Health and Wellbeing Board and was working with partners in the voluntary sector on specific joint public health initiatives such as healthy weight campaigns and falls prevention. In addition to this, the local authority had worked with partners on the refreshed suicide strategy which was in the early phases.

The local authority 'Enable' service, was a work placement team working with Shropshire residents who have disabilities in any form, helping them into employment and to maintain their employment. Staff told us some colleagues had come through the Enable service and were now local authority adult social care employees. This had been a positive outcome for them. Enable referred people into a range of services, and signposts to health and fitness activities, including a Shrewsbury Town Football Club Foundation course called 'Make Sports Work', and monthly 'Walk and Talk' sessions. Social Prescribing and Healthy Lives Advisors also supported clients according to their personal needs. A partner organisation told us that this personalised support was beneficial rather than people being directed to lots of websites which may not be helpful to them.

The local authority had invested in upskilling workers at their 'front door' service (FPOC) to ensure they had the skills and knowledge to signpost people and refer them to the correct support. There were around 30 different organisations, including voluntary services where people could be referred to access support.

Assistive technology was used to helped to prevent, reduce and delay the need for care and support and to support people to remain independent at home. Staff were positive about assistive technology to make a positive difference for people and to reduce the need for formal home carer visits. The local authority provided people with assistive technology only where it was assessed as being appropriate for individual needs and circumstances. Feedback about assistive technology was mixed, with some people saying it was useful as a prompt and motivator, some staff finding it made a positive difference for people and reduced the need for formal home carer visits, whilst others said it could be overwhelming for some people such as people living with dementia. The local authority provided people with assistive technology only where it was assessed as being appropriate for individual needs and circumstances, and other support options were available.

Some people told us social workers had set priorities and goals to support them in crisis to improve their health and improve their independence. The national data showed that 59.72% of survey respondents living in Shropshire believed the help and support they received, helped them think and feel better about themselves. This was somewhat worse than the England average of 62.48% (ASCS).

Shropshire has a significantly high level of rurality, and leaders acknowledged that providing services for people to remain in their local communities is a challenge. However, there was a good understanding of rurality and the impact this can have on outcomes. There was a commitment to supporting rural communities and a clear plan on how this would be achieved, 'Rural Proofing for Health Toolkit'. Work was ongoing with the farming community to bring health checks and suicide prevention interventions to the community, and specific initiatives such as the use of Technology Enabled Care (TEC) and 'two carers in a car' scheme (2CiC) were targeting some of the specific care related challenges. There was also a successful bid for additional funding to work with rough sleepers across the rural county.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that enabled people to return to their optimal independence. Senior leaders told us they were proud of the Short-term Assessment and Reablement team (START) and 75% of people who went through this service did not need long term care. This is reflected in national data showed that 76.42% of people from Shropshire who had received short term support no longer requiring ongoing support. The England average was 77.55% (ASCS).

START provided a number of services, which included a rapid response and a bridging service. Rapid Response was a partnership between Shropshire Community Health Trust and the local authority, which provided a rapid assessment, treatment and care programme during a period of ill health. The purpose of the bridging service was to support people to be safely discharged from hospital whilst waiting for the previous care provider to restart their package of care.

Senior leaders said the local authority had made good progress with hospital discharge arrangements and more people were now being discharged, going home and not needing long term care because of the START service. Staff told us there had been an 89% increase in people being discharged with the reablement service over the last 2 years. National data showed that 3.36 % of survey respondents living in Shropshire aged over 65 received reablement/rehabilitation services after discharge from hospital. This was similar to the England average of 2.91% (The Adult Social Care Outcomes Framework (ASCOF)). National data showed 82.93% of people in Shropshire aged over 65 were still at home 91 days after discharge from hospital into reablement/rehab England average of 89.02% (ASCOF). This was similar to the England average. The local authority told us START also worked with voluntary organisations to expand the opportunity for community support for people. We were not informed of how people accessed the service nor any outcomes of the impact of this for them.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence and continue living in their own homes. The local authority identified the occupational therapy service as an area where improvement was needed in relation to the waiting lists. Occupational therapists were placed within the housing department in the place directorate. A full-service review was being undertaken at the time of our assessment to look at waiting lists and to bring the occupational therapy service under adult social care. In the interim, an action plan had been implemented, with staged targets that commenced from March 2024 to reduce demand and manage flow more efficiently.

A team of trusted assessors delivered occupational therapy services for people who had lower needs. They completed telephone assessments only and were able to prescribe equipment, minor adaptations and simple major adaptations such as straight stair lifts.

Adult social care staff said they had good working relationships with their occupational therapy colleagues. They used a shared care record, and this was an effective tool for risk-rating and sharing information on referrals and avoiding duplication. This process also helped them to assess risk and prioritise their waiting list, as they were able to see what other agencies or services were involved with the person.

Data provided by the local authority showed there were 431 people on the waiting list for an occupational therapy assessment, with a median wait time of 131 days. These were RAG rated and risk assessed. For the independent living service which was an in-house service providing advice, support, training, and guidance for preventative solutions there were currently 62 people on the waiting list. There was no waiting list for the community provider for equipment. In relation to assessment for people with sensory impairment in March 2024,184 people were on the waiting list with the longest wait being 368 days, of which 74 people were priority referrals (43 for vision and 31 hearing).

Staff told us that managing the waiting lists was challenging, and they had monthly allocation meetings to review it and maintain oversight. Improvement plans were having impact, and the local authority acknowledged that further work was needed to continue to reduce waiting times.

We received positive feedback from unpaid carers whose family members required adaptations to their home to support their caring role, they told us they had been provided with the relevant equipment. For example, walking sticks and frames, wheelchair, perching stools, and grab and handrails fitted. One person told us they had received some equipment to support them to move about safely in their property.

Provision of accessible information and advice

We received mixed feedback about how easy people, including unpaid carers, found it to access information and advice on their rights under the Care Act or the types of support that were available to them. National data showed 65.45% of survey respondents who use services in Shropshire found it easy to find information about support. The England average was 67.12% (ASCS). National data showed that 87.23% of carers found information and advice helpful, which was similar to the England average of 85.22%.

Partner organisations told us people approached them and told them that their biggest challenges were trying to get information via the telephone and the time it took for people to get through to the local authority. This caused frustration for people. However, the local authority provided information that for telephone calls to the First Point of Contact team, the average wait time for calls to be answered was 4 minutes and 2 seconds. Staff also told us there was a system in place to monitor how long people were waiting on the telephone and there was no concern about long waiting times. National data showed that 61.22% of carers responding to the survey and living in Shropshire found it easy to access information. The England average was 59.06% (SACE).

The local authority had a webpage, directory and Support Finder Brochure to support people with self-help. People were also be offered a 'let's talk' local session which was a face-to-face appointment in a hub if it was local to them. The local authority had a priority plan to improve their website and online directory of services and were addressing this through their digital transformation program. Staff confirmed they were involved in the development of the website to ensure information for adult social care would be in a more accessible format for people to access.

Voluntary and community partners told us much of the external consultation the local authority did was through an online medium. They were concerned about accessibility for all people to participate and the need to avoid digital exclusion. They spoke positively about the digital skills program, known as the 'Digital Inclusion Network,' which the local authority had set up to deliver to people through the voluntary sector. The network aimed to support and understand the barriers to digital inclusion.

The local authority website did not provide accessible information for people who communicated in non-English languages beyond the landing page of the website.

Carers groups were available for provision of information, advice and support. Some groups also contacted unpaid carers by phone to give them information.

Some unpaid carers told us they had been made aware of carers groups and spoke positively about the information received from these groups. However, not everyone was able to attend due for reasons such as employment and caring responsibilities. The local authority told us they had offered groups available at the weekend and in the evenings to make them inclusive. Some carers told us they had not received support or information.

Direct payments

The local authority had a clear direct payments policy on their website. Staff told us this has been co-produced with unpaid carers and the Direct Payment Board. The board met quarterly and was co-chaired by a person with personal experience of using direct payments. They provided a voice for people to feedback concerns to the local authority and co-produce solutions.

At the time of our assessment, there were 533 people in receipt of a direct payment. National data showed 20.83% of total service users received direct payments in Shropshire. The England average was 26.22% (ASCOF). The local authority had seen an increase in people receiving direct payments in 2023 and their target was to improve this to 25%. The local authority told us nationally, they had a higher-than-average number of people receiving an Individual Service Fund and this impacted on the proportion of people receiving direct payments.

Since March 2023 a total of 137 direct payments had ended, of which 36 were for unpaid carers. The local authority monitored trends where a direct payment had ended to see if there was improvements needs to the process. They told us the highest reason for ending a direct payment was due to an increase in a person's care needs, where the individual required a residential care or nursing care placement.

There was advice on the local authority website and a direct payments team to support people. The team also produced newsletters, gave support for people who employed personal assistants and offered drop-in sessions for people receiving direct payments.

Staff told us direct payments worked well in enabling continuity of care and support for children transitioning to adults' services, by allowing them to keep the same personal assistant. A partner organisation spoke positively about the local authority's management of direct payments, however they felt social workers needed to be more proactive in making people aware of direct payments as an option. National data showed 30.78% of service users in Shropshire aged 18 - 64 accessing long-term support, were receiving direct payments. The England average was 38.06%. Whilst 12.03% of service users aged 65 and over accessing long-term support, were receiving direct payments. The England average was 14.80% (ASCOF).

The finance team reviewed the direct payment in the first 3 months so they could identify any concerns in the management of the direct payment. Any concerns were then explored by the social work teams to be resolved at an early stage.

People told us about their experiences and outcomes in their use of direct payments. Examples included employing a personal assistant so they could undertake leisure activities they enjoyed. There was overall positive feedback regarding the use of direct payments to support unpaid carers with their own leisure time.

Staff told us that personal assistants were difficult to recruit in rural Shropshire. A digital personal assistant notice board was in use for personal assistants to upload their capacity, for people to advertise for a personal assistant and to help match people to a personal assistant for specific tasks. For example, to support a people with their household administrative tasks.

Data provided by the local authority said there was no waiting time for the direct payment to start after the individual budget had been agreed, care could start as soon as the support plan was authorised.

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 understood its local population profile and demographics. The county had a predominantly white population, with a significantly high level of rurality. The local authority used a number of measures to understand its changing population and it analysed equality data on social care users and used it to identify and reduce inequalities in people's care and support experiences and outcomes.

The Shropshire Inequalities Plan recognised that their current methods for identifying deprivation and health inequalities in rural areas needed improvement. The local authority worked with partner agencies, including health and the voluntary and community sector to understand the communities within the county, such as through the information they had commenced gathering from the Joint Strategic Needs Assessments (JSNA) to meet the specific needs for its localities. For example, the local authority used a fire and rescue building in an area as a community base as it was being under used.

The local authority recognised the impact the cost of travel had upon rural citizens and the inequalities of access to services. Staff told us that direct payments or a domiciliary care package could be increased due to a rise in travelling costs to remote areas and the local authority paid enhanced rated as required in rural areas where there were difficult to reach circumstances.

A Rural Proofing in Health and Care Task and Finish group set out key findings and recommendations to delivering and addressing inequalities in health and care to rural communities. Some recommendations accepted and being actioned by the local authority included undertaking an evaluation of the impact of digitalisation on vulnerable demographics.

Senior leaders told us there was consideration of all age intersectionality in relation to inequality, for example consideration of caring responsibility, mental wellbeing, dependency of drugs and alcohol, and age overlap resulting in disadvantages for people.

Public health had community outreach teams who supported the priorities of the Shropshire Plan and the Health and Wellbeing Board in improving health and reducing inequalities. The teams engaged with local communities to gain knowledge and insight into the needs of people within the communities.

The local authority had an Equality Objective action plan, which outlined actions to promote and foster good relationships between diverse communities, for example by using social media and face to face meetings to engage with groups that had protected characteristics. We received mixed feedback from people and partners about how well the local authority had engaged with people and groups where inequalities had been identified, to understand and address the specific risks and issues experienced by them.

There were a number of outreach programmes for example, the Ethnic Minority Outreach Programme was used to improve understanding about the barriers to health and well-being support and gaps in services. Specific work was also being undertaken with the Gypsy and Traveller community for those living in Shropshire and any people passing through. The local authority also had outreach staff working with the Bulgarian community to support their health and wellbeing needs and understand the barriers to access support.

Voluntary sector partners told us the police and mental health services relied heavily on leaders within the community to support their community for people who did not speak English. Partners wanted the local authority to also take more of a leading role to strengthen the local authority's relationships with these communities and understand the barriers to people's access to health and care services first-hand.

There was support in place for refugees in the area. A voluntary organisation told us they sat on a recruitment board to help the local authority recruit people to work with refugees and the local authority had a base in the organisation's hub to allow closer links with the local community. There was a refugee support scheme which was designed to help refugees to move into employment.

The local authority had an awareness of issues facing people who were LGBTQ+. They had partnered with a university to look at how they provided support for the LGBTQ+ community who were ageing and they had also signed up to the Safe Ageing No Discrimination (SAND) Covenant. SAND was a community organisation, whose goal was to improve the experiences and increase the expectations of LGBTQ+ people as they age in Shropshire, Telford & Wrekin. A voluntary partner said whilst the local authority was engaged in raising awareness of LGBTQ+ issues, they had not always taken the opportunity to embed LGBTQ+ and older people's issues into strategic partnership boards.

We also heard positive feedback from unpaid carers where social workers had worked in person-centred ways and considered the person's sensory needs, and made sure placements were suitable and adapted to meet their individual needs.

Senior leaders told us that whilst they could use data to identify any the themes and trends of complaints, their current data did not identify if there were any inequalities with particular groups of people, for example if people who had protected characteristics were not receiving certain types of services and why. They acknowledged this was a gap which needed to be addressed.

Senior leaders told us they did not have full representation on the Making it Real Board. The Making it Real Board was co-produced with people who had experience of accessing health, social care and housing services. A senior leader said the local authority had reached out to people to sit on this board, and they hoped the new co-production lead who would be in post from July 2024, would be able to improve this.

Within the local authority, the Shropshire Council Anti Racism Forum (SCARF) for staff had a corporate lead and 4 co-chairs from different ethnic groups. The group met regularly to discuss any issues in the locality. Staff told us they had regular training around equality, diversity and inclusion (EDI) and that data was recorded around the workforce's gender, sexuality and ethnic backgrounds.

Inclusion and accessibility arrangements

Appropriate inclusion and accessibility arrangements were not always in place for people to engage with the local authority in ways that worked for them. The local authority website needed updating to make it more accessible.

The local authority had written translations services and British Sign Language services for staff to use with people. Access to a visual interpreting and communication service which supported people who were deafblind, deaf and hard of hearing were also available.

We had mixed feedback from staff about access to interpreters and translation services. Staff told us inclusion and accessibility were not just about providing translation and interpreter services for people, but they should also be working to understand diverse communities. Some teams said interpreters and translation services was not always available in a timely manner. However other staff reported they had good support from the interpreting services and sign language services, and they were often able to offer support in less than a day when needed.

The local authority had face to face, telephone and interpreting services. There were also outreach teams who could provide support to access services in face-to-face settings for people who could not go online. The support could include assisting people to access social care and to call the FPOC service.

Whilst some paid carers who spoke languages other than English were sought for people needing care and support, this was not always possible for everyone who did not speak English as their first language The gypsy traveller service provided advice and support to people.

Partner organisations told us it was positive that the local authority was able to produce information in a ‘easy read’ format. Some teams used picture tools and communication aids to support people with a learning disability and autistic people. We were told an example of how people with hearing impairments achieved good outcomes for a safe discharge with support at home. This involved the input of interpreters and using a 'loop' hearing device.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect:

I have care and support that is 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 local people and stakeholders and used available data to understand the care and support needs of people and communities. This included people who were most likely to experience poor care and outcomes, people with protected characteristics, unpaid carers and people who fund or arrange their own care, now and in the future.

The local authority expanded their Joint Strategic Needs Assessments (JSNA) to include locality based JSNAs. They were in the process of undertaking an additional 18 neighbourhood JSNA's to get a more detailed understanding of the areas of need for care and support in each locality. JSNA is an ongoing process by which local authorities, integrated care boards and other public sector partners described the current and future health inequalities affecting people, the wellbeing needs of its local population, and its identified priorities for action. Senior leaders told us all the localities within Shropshire were very different and this approach would ensure all needs are being met. In Shropshire over 60% of people lived in small hamlets, villages and isolated rural locations. A challenge of this was the long waiting and travel times for transport and how it affected people attending health appointments, social and leisure activities. A senior leader told us they were learning more about the communities through the neighbourhood based JSNA approach. At the time of our assessment approximately 9 of the JSNAs had been completed and there was a written ambition to publish all 18 JSNAs by autumn 2024. Action plans were formed from the JSNAs which the local authority used to inform the 'Shropshire Plan' and the work of the Health and Wellbeing board. Improvement activity was underway and an example of an initiative that came from a neighbourhood based JSNA's was the development of a Community Health and Wellbeing Hub.

At times, people living in rural areas had to wait longer for their care than people living in urban areas. The local authority recognised this and worked with care providers and the voluntary and community sector to address this. For example, by looking at technology-enabled care and only accrediting new providers who evidenced they could supply care in the areas they were needed in. They were working with providers to redesign the domiciliary care market to ensure growth, flexibility and coverage and to increase the use of technology and digital solutions.

The local authority also extended their 'two carers in a car' scheme, which was a system that used 2 care staff to work overnight to visit and provide care and support. This arrangement allowed them to reach more rural areas. The feedback the local authority had received from people indicated that this had a positive impact on their well-being.

The local authority's Market Position Statement (2024-2027) had a strong emphasis on community-based commissioning within localities and recognised the strength and contribution of communities in prevention and early intervention for supporting people's wellbeing. This meant reducing the reliance for services to support people to remain independent at home.

Market shaping and commissioning to meet local needs

The local authority had a new commissioning structure in place comprising of 3 elements: start well, live well and age well. The objective of commissioning across the age groups was to improve pathways and provision for people moving between different parts of the system, for example from children to adult services. The local authority planned to look at a model of commissioning for aged 0-25 years in the future for further strengthen its pathway for care and support of young people.

The local authority worked with stakeholders and people in the community to ensure co-production and delivery of strategies, and they had several boards including the Making it Real, Learning Disability, Mental Health and Autism Partnership Boards who influenced strategy development. Providers told us they were not always directly involved in co-production, however the local authority worked with an organisation who represented care providers, and they met with this organisation regularly. Working with partners through the Joint Commissioning Delivery Board ensured the local authority's strategic objectives aligned with national and local agendas to drive their commissioning intentions. There was a priority focus on provision of domiciliary care services to support people to remain living in their homes for longer, as opposed to moving into residential care.

To understand people's views of care at home services, to drive up quality and to inform the wider transformation programme, the local authority undertook a survey of people who received care at home, care workers, and other stakeholders. The results were published in the Care at Home report, January 2024. Despite effort from the local authority, responses were limited with 70 individuals, 44 carers and 15 stakeholders taking the surveys, which is less than 1% of the populations of interest in this consultation. Despite the low response rate, the survey provided useful insight into people's experiences of care at home which the local authority is using in its transformation work, for example feedback on the importance of consistency and communication from care providers, increasing the ease of finding and arranging care, improving the quality of carer's training for frailty, dementia and mental health, and the impacts of rurality on the care sector.

The local authority had used the Market Sustainability funds to increase the hourly rates for domiciliary care by 12% and which had a positive impact on provision, for example 27% more people were supported at home in January to April 24, than between July and December 2023. The local authority told us the 12% increase also brought some providers back into the market and recruitment was improved through overseas sponsored workers. However, some care providers told us that more financial support was needed to cover travel costs.

There were mixed responses from providers regarding whether the local authority consulted with them effectively. Some providers said their feedback was ignored and felt the provider forums they attended were not collaborative. Others told us once the local authority had published their JSNA's and market position statement, they were then invited to webinars and remote meetings to share their thoughts on proposed changes, which they had welcomed.

A draft strategy for Independent Living and Specialist Accommodation 2023-2028, was currently out for consultation and it identified several priorities including addressing diverse housing need, delivering accessible and adaptable housing, providing specialist accommodation and preventing homelessness.

A partner organisation told us that Shropshire supported refugees but there was a gap in service provision, and some challenges in accessing provision such as housing. The organisation worked with the housing team to address this and secured housing for 400 refugees and supported them into employment.

The local authority had dedicated Commissioning Officer roles for Mental Health (all-age) and Autism (all-age) to ensure they had the right level of expertise to identify what was needed to overcome any gaps in the market and to maximise opportunities for joint working for complex needs.

The carers support team provided support to young carers and were developing a young carers group that would offer young carers activities such as cooking classes and basic life skills. There was a dedicated carer support worker in the hospital, who gave support and advice for new unpaid carers when they were leaving the hospital setting. An unpaid carer told us the support worker had been valuable for them.

Staff told us respite was available for people and unpaid carers and this included support during a crisis. The local authority block booked respite provision, and they spot purchased from this according to need. National data showed that in Shropshire, 14.29% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency. The England average was 12.08% (ASCS). 34/92% of carers accessing support or services allowed them to take a break from caring for 1-24hrs. The England average was 21.73% (ASCS).

Ensuring sufficient capacity in local services to meet demand

The local authority had 102 supported living properties and had identified a need to increase the number of providers with a focus on supporting people with more complex care and support needs. They were keen to develop more diverse models for supported accommodation, and they were working with the Housing Learning Innovation Network (LIN) to develop a needs assessment to inform future developments and models. Feedback from staff and partners indicated there was a need for more supported living, but we were not advised of people waiting for supported living placements due to a lack of capacity at the time of our assessment.

National data shows that in Shropshire, 87.77% of adults with a learning disability live in their own home or with their family, this is somewhat better than the England average of 80.42%, (SALT) October 2024.

Some staff said there were some gaps in services for people with a learning disability and autistic people, for example they said for people with more complex needs it could be difficult to find care due to the rurality of the area. However, they shared person centred examples of how they have supported people with more complex needs with 24-hour support in the community.

The local authority had a monthly accommodation forum for supported living to look at individuals needs and to match with other people where there were vacancies. Staff used the forum to assess whether a property and the people living there would be a good match for the person they were supporting.

There was some use of out-of-area placements. For people with more complex needs the local authority worked with commissioning and partners to explore bespoke services to facilitate people to come back to the county if appropriate. In total the local authority had 114 people placed out of area with 76% of these placements being made in neighbouring counties. Personal choice and geographical location were the most common reasons for an out-of-area placements, and the geography of Shropshire meant that some placements in neighbouring authorities could sometimes be closer to a person's home and their networks.People who were in out-of- area placements were continually monitored and 98% of out of county placements had been assessed or reviewed in last the 12 months.

The local authority struggled to get paid carers in rural areas due to the distances they had to drive. The local authority had specific recruitment drives in areas where they needed staff. A senior leader told us that by working with providers and community partners, the local authority had increased capacity for domiciliary care which reduced the need for residential care.

There was a commitment to develop models of support for people needing complex nursing care and people with dementia to enable them to remain living independently for longer.

Data provided by the local authority showed there were waiting times for services to start across residential, nursing, home care and supported living services. When formal services did not start immediately, interim care arrangements were made to keep people safe. Where care did not start within 3 months, the main reasons included people were admitted to hospital (20), care was declined (19), care was being sourced (18) and people were awaiting direct payments (16). This information was being used to direct improvement actions.

The local authority was also working with health colleagues to implement alternatives to admission to hospital by providing a 2-hour rapid response service in the community, and by implementing an integrated discharge team to support discharge from hospital with the right support within the community. The local authority told us they had seen a significant reduction in delays in hospital discharge as a result of this. The average discharge time in April 2023 was 2.02 days. The average discharge time once a person was ready to go was 1 day in April 2024, which included discharge times for people with complex needs.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed. The local authority told us the supported living market was a key area of focus that they needed to support and work with.

In spring of 2023, the local authority reviewed and identified risks in its provider quality monitoring and assurance processes. As a response, a draft Provider Quality Assurance Framework for commissioned care and support services was created. This outlined the local authority's approach to ensuring the quality of care and support services. Quality standards and expectations were clearly communicated and with the aim of building positive and supportive relationships across the range of agencies, care providers and people using services to foster a culture of continuous improvement.

The local authority used a risk dashboard which allowed partners to feed in data from many sources including CQC, monitoring of organisational quality concerns and financial stability to risk rate commissioned care providers. The Market Quality Assurance group maintained oversight of this and worked in partnership with other stakeholders including health partners.

CQC ratings of regulated providers, showed that at the time of our assessment, Shropshire had 6.58% outstanding, 67.11% good, 18.42% requires improvement and 2.63% inadequate residential services. The nursing homes had 81.58% rated as good 13.16% rated as requires improvement. Homecare had 9.76% outstanding services, 62.20% good, 9.76% requires improvement and 1.22% rated inadequate. Supported living was rated 7.69% outstanding, 53.85% good and 23.08% requires improvement.

Staff told us if a provider was identified as high risk or had received a CQC requires improvement or inadequate rating, there were a number of visits to the service along with an action plan set and the monitoring of improvement actions.

Data provided by the local authority showed that they had suspended commissioning with 5 providers in 2023 due to quality concerns. The common theme was high turnover of staff with poor management and leadership in place. A provider told us the local authority had been supportive and nurturing when they had come out of a period of suspension. This included the provider having 3 monthly meetings with the local authority to monitor progress and improvements.

Ensuring local services are sustainable

There were 200 active adult social care providers in Shropshire with 11 locations who deregistered in the last 12 months.

Whilst the local authority had arrangements to collaborate with care providers, including to ensure that the cost of care was transparent and fair, some providers felt the provider forums they attended did not always achieve this.

The local authority acknowledged that domiciliary care was the market area that presented the greatest risk to Shropshire in their ability to deliver statutory services. Providers were given a contract uplift of 12% to reflect increasing costs. The impact of this had been a reduction in waiting lists for domiciliary care and an increase in the number of providers. The local authority told us they would be prioritising Supported Living Providers uplifts for 2024/25 to mitigate instability within that market.

The local authority understood that different areas of the market required different uplift solutions and other areas received a 7% uplift on a 'cap an uplift' basis. Providers received the uplift if their rates were at or below their average rates at that point. This approach was designed to standardise fee rates and support a sustainable market.

The local authority told us they held quarterly forums with care providers. Providers we spoke with had attended a recent forum, but they were not aware of those in the previous year. Providers told us they were well supported with operational matters.

The local authority had a Joint Training Team which offered specialist training to care providers. Providers told us bespoke training was available for example, if a person using the service had specific moving and handling needs and equipment needs, the local authority would arrange this with an occupational therapist.

The local authority recognised that recruitment for its own workforce was challenging due to its geographical location. National data showed that there were 8.06% of adult social care job vacancies in Shropshire. The England average was 5.66% (Skills for Care Workforce Estimates).

To address workforce challenges, the local authority had developed a Workforce Strategy which identified the capacity, capability and diversity of the workforce and how it needed to operate to deliver outcomes for the residents of Shropshire. The workforce priorities were to attract, recruit and retain skilled workers and reduce reliance on agency and interim workforce in addition to developing apprenticeship and career pathways. Apprenticeships and social work student placements provided a positive way of attracting staff to social care that had helped to address recruitment issues.

The Adult Social Care Provider Failure and Service Interruption Policy set out how Shropshire would work with adult social care providers in the event of risks or issues that affected providers service delivery.

We were told that for care homes 2 contracts that were handed back in the last 12 months due to care home closures, with 2 homes closing in the last 12 months, due to quality and financial issues, and a provider changing their business. We were told that 1 supported living service had handed their contract back in the last 12 months which was supporting 31 people. The local authority negotiated and mitigated the risk for the people who had used this service to retain continuity in their care.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect:

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

The local authority commitment:

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority had strong relationships with health, voluntary and community partners. They worked collaboratively to agree and align strategic priorities, plans and responsibilities for people in Shropshire.

The local authority were active members of the Shropshire Integrated Place Partnership Board (SHIPP) which had representation from a range of stakeholders including the voluntary and community sector, senior leads from health providers (including primary care networks, community health and hospitals) and Healthwatch. The purpose of this board was to ensure the system level outcomes and priorities were agreed at the Integrated Care System (ICS) and implemented at place level.

Senior leaders told us there had been some difficulties and challenges with relationships within the ICS and ICB. They told us this was now an improving picture from their perspective which was described as more settled due to all partners having a better understanding of respective roles and responsibilities. Senior leaders told us they met with some NHS trust leaders monthly, to discuss and to continue to resolve any issues, and they described having a good working relationship at this level. An example of improved partnership working was the local authority having commenced sourcing domiciliary care packages on behalf of the ICB for fast-track assessed patients in May 2023. Initially referrals were accepted from the two acute hospitals within Shropshire and a short time later this was extended to the community hospitals.

The Shropshire, Telford and Wrekin Joint Forward Plan 2022-2028 was developed to outline how health and care systems will work together over the next 5 years. The plan was developed through engagement with the NHS, local authority, Midlands partnership and ambulance service, primary care services and community and voluntary sector. Three key elements of the plan were taking a person-centred approach, improving place-based delivery and provision of additional specialist hospital services.

The local authority and health partners worked in partnership to manage public health risks, such as infectious disease outbreaks, and linked in with the Community Trust. There were daily escalation meetings held between the local authority, the NHS Trust and the Community Trust which focussed on getting patients in the right environment. Other partners were included where necessary including mental health teams. Joint commissioning initiatives were developed which included falls and diabetes management. A recent joint project had been completed for the local authority to take a lead in providing community equipment which went live on 1st April 2024.

There was a good relationship with Public Health and there were several joint initiatives being undertaken. For example, through social prescribing at the First Point of Contact service and supporting people to access relevant services to delay or prevent their need to access health and social care services, while being on a waiting list for a care act assessment.

The Shropshire Neighbourhood Working was a group created to oversee the expansion of community-based services focusing on developing core teams for integrated neighbourhood working across local authority and health. Key priorities of the community-based services included a focus on self-care, integration, person centred care, and the voluntary and community sector to working with partners across the system. An integration 'test and learn' approach of Community and Family hubs had been trialled within the Shropshire County and the next step was the development of community and family hubs in other areas of Shropshire, as a result of positive outcomes from the trial. This would mean greater accessibility to services for more people.

The local authority worked in partnership to support rough sleepers and those at risk of rough sleeping with drug and alcohol dependence. This was through a multi-disciplinary team called Reset, who worked closely with homelessness teams and a voluntary sector provider to provided holistic support and improve outcomes for people.

Arrangements to support effective partnership working

When the local authority worked in partnerships with other agencies, there were arrangements for governance, accountability, monitoring, quality assurance and information sharing.

The local authority recognised that the Better Care Fund (BCF) was not utilised to its full potential as there was little formal integrated commissioning in place. For 2024/2025 there was a commitment from the local authority and ICB to focus on a number of pathways to drive forward the commissioning of integrated services. These included community equipment services, preventative services, falls services, neurodiversity pathways, alcohol services, independent market provision, carers services, dementia had discharge to assess with key focus on reablement. The BCF boards would be transitioned into joint commissioning boards and integrated commissioning forums. This governance would mean all partners were included and were active members. Place based joint commissioning would also be brought into this arrangement to support delivery within communities.

A voluntary partner told us the local authority and public health engaged well with them across numerous boards and forums and this allowed the organisation to have effective partnership working and informed the local authority of the specific needs for the people they supported.

There was a section 75 agreement for Shropshire and Telford and Wrekin councils and NHS Shropshire Telford and Wrekin ICB to commission, support and fund the provision of an Integrated Community Equipment Loan Service. A section 75 agreement is an agreement between local authorities and NHS bodies which can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partners. The aim of this was to improve the quality, cost effectiveness and efficiency of commissioning for the community equipment services and make more effective use of resources.

Staff told us they had good relationships with health colleagues and there was good multi-disciplinary working. They worked well with therapy services when supporting people with more complex needs and told us the local authority provided funding for more specialist assessments to ensure they understood people's needs. Staff described how since they had received continuing health care (CHC) training they felt more confident to challenge health colleagues about CHC assessments and outcomes, and discussions with partners were more open.

The local authority worked with the prison service. They supported with assessments if the person had a diagnosis of autism or attention deficit hyperactivity disorder (ADHD). They had also advised on what services might be available to the person on their release and worked with the probation service. Public health leaders told us the local authority was a key partner in the Health and Wellbeing board. Other partners involved in this board included voluntary sector partners and integrated care partners.

The local authority were active partners in a daily meeting which was run by the local police and attended by other stakeholders including the children's team, housing, the domestic abuse team, probation service and health colleagues. This was to ensure a joint approach with any safeguarding issues within Shropshire. The local authority also attended a monthly self-neglect and hoarding forum. This forum was attended by a wide range of partners including police, mental health teams, local food banks, housing, fire, and rescue.

A partner organisation told us there were systems in place for information sharing amongst partners and they attended information sharing meetings for domiciliary care and care homes with commissioners for those services.

Impact of partnership working

The local authority monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. This informed ongoing development and continuous improvement.

Senior leaders told us reaching funding agreements for continuing health care (CHC) continued to be a challenge, and a memorandum of understanding in relation to CHC was being established. They told us no one was ever without care whilst funding agreements were being reached. However, an unpaid carer told us they had experienced a lack of a joined-up approach and described times when professionals had not worked together in respect of funding decisions. In this example, the person told us they had been left without a placement, experienced a lack of support for their mental health and their access to community activities had been reduced due to funding dispute amongst professionals.

A co-production group described the local authority's system to implement changes as slow and difficult to navigate. An example was given about improving the council's website which had been ongoing for 12 months. They described a lack of urgency to make changes, address issues and said there was no feedback to understand if there was any progress or changes as a result of the work they were involved in.

Senior leaders said housing and adult social care were consulted on the independent living strategy. As a result, housing solutions were created, properties were bought including a care home, which was being reconfigured to be independent residences for homeless people, to create a blend of integrated living and supported living.

Some staff gave us examples of poor hospital discharges where people had been discharged without support as the NHS did not have an out of hours service for people who were fast tracked or received services funded by CHC. To address this, the local authority and the ICB agreed that the local authority could authorise increased funding in an emergency.

The local authority and health partners met on a weekly basis to discuss complex and long-term discharges. Since this partnership was formed, the average hospital stay decreased from days to 1-2 days. The local authority described how this improvement was due to better partnership working.

Working with voluntary and charity sector groups

The local authority worked collaboratively with voluntary and charity organisations to understand and meet local social care needs. They were open to critique and feedback and transparent in their approach to engaging with voluntary organisations.

The local authority worked with several voluntary sector organisations. Staff told us they signposted people to these groups where appropriate. Staff said there was no formal system to identify the voluntary sector services available, but they shared identified services with each other using a Microsoft Teams channel.

Overall, voluntary groups told us they worked well with the local authority who supported their services and understood the issues the voluntary sector faced. The local authority had frequent meetings with voluntary groups which were beneficial to them. However, the frequency of these were at times onerous and commitment heavy for the voluntary sector groups.

They said the local authority acknowledged the voluntary sector helped them to fulfil their statutory responsibilities. One group told us that the support from the local authority which resourced the administration for their group had been “tremendous.” They felt their organisation would struggle significantly without the support from the local authority. Another organisation said the local authority had been firm partners with them and had helped to facilitate their growth. They were invited to safeguarding meetings, strategic meetings, health and wellbeing meetings and sat on homeless forums.

One voluntary group told us there was a lack of communicated outcomes by the local authority following feedback and consultation during voluntary community sector forums. The group told us there had been no annual increases to funding over recent years and this had pushed organisations into deficit or closure as. They said financial stability was the biggest challenge to voluntary organisations, the loss of which had a negative impact on the community. The local authority told us they had increased the budget for community organisations including a 6% increase in 2024/2025 and also provided grant funding to voluntary organisations.

Theme 3: How Shropshire 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: 2

2 - Evidence shows some shortfalls

What people expect:

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

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

The local authority commitment:

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

Key findings for this quality statement

Safety management

There were systems in place to manage risks to people across their journeys, including referrals, admissions, discharge, and where people were moving between services. However, improvements were needed to ensure continuity across transitions from children to adult pathways.

Systems were in place for access to referral pathways and safeguarding teams during out of office hours and in emergency situations. The out of hours service was an all-age team, which provided mental health act assessments, adult safeguarding responses and child protection as their priority work. The service had suitably trained call handlers to identify the required action and to make the appropriate onward referral.

Safety during transitions

The local authority routinely commenced working with young people aged 16 to support them with the transitions to adult services. Adult social care social workers also attended education, health, and care plan reviews for young people. For mental health services for young people, transitions from children and adult's services started at 17 and the children's and adult's social worker completed the assessment together.

The local authority also worked with young people who did not meet the criteria for the preparing for adulthood team. This could be autistic people or people with a learning difficulty presenting with new needs and without special educational needs. The local authority began working with these young people from the age of 18.

We received mixed feedback from people about their experiences of moving between children and adult services. We were told about a smooth transition without any delays. The person had been contacted when they were 17 years old which enabled the social worker to develop a relationship with them and their family prior to the person becoming 18. Another example was a successful move to a new placement as the social worker had liaised with the provider to match the correct staff, so that the person had a choice of who they wanted to live with, and the environment had been adapted for their needs.

Information reviewed from the local authority showed that one person who has transitioning from children's to adult services, was allocated an adult social worker just prior to the person reaching 18 years of age. The person told us they felt this had a negative impact on them and their family in terms of care planning and continuity. The local authority confirmed their aim is to work with people from an earlier age but acknowledged this had not happened in this case.

A partner organisation told us they felt the local authority system was not joined up in terms of planning for a young person's future at the point of transition into adult services, or if they had a learning disability. They told us they were able to raise their concerns with the local authority through involvement in strategic forums and the Making it Real Board.

Staff gave positive examples of how they had supported young people to become more independent and supported another young person to move from the family home into supported living. This had a positive impact for the person, and they increased socialising with others.

Overall, the feedback from providers was positive on the role of the local authority supporting people when they needed to move between services. They told us there was a structured process for people moving from home or from one care home to another care home.

There were several pathways used for discharging people with support needs to care services, when leaving hospital. These included reablement, domiciliary care, short term placements and long-term placements. The local authority and health partners worked together in a multi-disciplinary approach to provide a 7-day hospital discharge model. There were daily meetings with health and social care staff to identify plans for discharge and to inform the transfer document used for sharing information on discharge from hospital. People discharged with support services were reviewed by a social work team.

There was a process for reporting problematic discharges to a joint 'discharge alliance group'. The alliance undertook deep dives into the issues to drive continuous improvement and work as a system in achieving positive outcomes for people. The local authority provided an example of how this had led to an improved discharge experience for an individual. Some people told us they had experienced a positive discharge from hospital and that the handover of care between the reablement service and a long-term care provider had worked well.

Some care providers reported a good relationship with the local authority, and they felt they could speak to them and come to decisions quickly. An example given was when an emergency care home placement was needed with specialist care and the person receiving the care had a swift and easy transition. However, in contrast to this we heard that communication was at times poor with social work teams.

Contingency planning

The local authority had contingency plans in place to ensure preparedness for interruptions in the provision of care and support. The provider failure risk report outlined all the appropriate support to be made available and identified risks in this event.

The draft Business Continuity Management Tactical Recovery Plan – Adult Services (October 2023), provided guidelines to help staff analyse the impact of the incident on their service, implement the appropriate solutions and ensure the continuity of service activities.

Staff working with providers told us they had a good contingency and emergency plans in place. An example was given in relation to areas that flood within the local authority. Conversations and plans had been put in place with the people using the service about how they would like to be evacuated. Care providers told us on one occasion due to flooding, a paid carer was unable to get to the person receiving care and the local authority assisted with this and ensured the person receiving care was supported.

Staff described contingency planning as a focus and being a critical part of the assessment process and the information about contingency plans was also kept at the top of the person's care records so it was easy for staff to access. However, people told us this was not always completed and person-centred information about what should happen in an emergency was sometimes missing.

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

The local authority and partners worked together in the Shropshire Safeguarding Community Partnership Board which led on children and adults safeguarding arrangements. Membership of the board was stable, with clear responsibilities, of the multi-agency partnership to protect people from abuse and neglect.

Subgroups provided the board with visibility and assurance of safeguarding adults duties, quality, and risks. For example, the Adult Statutory Case Review group reviewed considerations for Safeguarding Adult Reviews (SARs) then made a referral to the board for sign off and resource allocation. A SAR should promote learning and improvement to prevent future deaths or serious harm happening again. Work was being undertaken to strengthen the arrangements for responding to SARs.

There was guidance for staff on adult safeguarding processes which promoted partnership working in delivering safeguarding duties. In relation to organisational abuse concerns, the local authority followed the agreed regional safeguarding adults procedure (Framework for Responding to Organisational Failure or Abuse) adopted by 14 local authorities, in line with recommendations from the West Midlands.

Staff felt supported across teams to carry out their safeguarding duties. Senior leaders and staff told us professional curiosity was encouraged and there was a system for a safeguarding senior practitioner to review and make decisions. Staff told us the safeguarding team were active partners in a daily meeting called 'PITSTOP' which was held by the local police and attended by other stakeholders. This meeting was to discuss support for people who may not meet the criteria for statutory services with a focus on preventative outcomes. Partners and staff spoke positively about the knowledge and abilities of the safeguarding team.

The local authority provided training in safeguarding and mental capacity to partners to prevent or respond to risks occurring. A senior leader told us there was oversight in the local authority teams to ensure staff were trained appropriately.

Responding to local safeguarding risks and issues

There was understanding of safeguarding risks, with key issues and priorities identified around domestic abuse, self-neglect and tackling exploitation.

Over the last 12 months, domestic abuse was the highest and neglect was the second highest reason for safeguarding referrals in Shropshire. There was a good understanding around self-neglect with improvement work ongoing, for example a self-neglect screening tool was in the process of being developed. Senior leaders and partners told us self-neglect was a concern, the local authority had worked on recommendations through regular partnership forums and training which a senior leader told had been positive in the recent months.

Shropshire Safeguarding Community Partnership board brought together statutory adult and children's case reviews to co-ordinate multi-agency learning and actions. Under the Care Act 2014, Safeguarding Adults Boards (SABs) have statutory responsibility for Safeguarding Adult Reviews (SARs). We found there had been challenges in embedding learning and showing improvement, however, action had been taken by the local authority to reduce future risks and encourage best practice such as 3-minute learning briefings with staff. We found SARs recommendations had actions for example recognising unpaid carers, understanding mental capacity including executive functioning, and developing escalation processes. The board had commissioned an independent review of SARs over the past 3 years to support local understanding and risk management.

Staff told us they had open access to other partners such as the police to support timely information sharing and reduce the impact of risks to people. They described a verbal escalation process for safeguarding and deprivation of liberty safeguards with team managers and service managers which promoted a shared approach to presenting risks. This was available to them during office hours, during evenings and at weekends.

Responding to concerns and undertaking Section 42 enquiries

A Section 42 enquiry is a legal requirement under the Care Act for local authorities to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect in any setting.

There was a consistent referral and triage system to manage safeguarding referrals, including an out of normal working hours process for referrals. Safeguarding enquiries were allocated to the most appropriate worker based on the level of risk and complexity to respond and reduce any further risk or prevent other risks from developing.

Not all concerns were directed to the safeguarding team for a section 42 safeguarding enquiry, for example, some self-neglect concerns may be supported by the safeguarding team giving advice and guidance with longer-term support remaining with the community teams. Safeguarding enquiries were also delegated to providers for them to make enquiries if required. We were told about additional processes in place with different teams for concerns relating to financial matters. One senior leader told us safeguarding concerns were collated and monitored through management teams into senior leadership.

Quality concerns for known care providers were referred to the Quality and Contracts Team for enquiries to be made. The local authority had provider failure and service interruption policies in place for escalating and acting on care provider quality concerns to reduce any impact on people's physical and mental health, as well as their quality of life.

The local authority did not have a waiting list for individual safeguarding enquiries, as all enquires were allocated as ongoing work. The local authority had quality assurance arrangements for conducting Section 42 enquiries such as a safeguarding audit tool, departmental thematic audits, performance data and duty senior practitioner oversight. Staff and partners told us at the end of an enquiry if there was still risk, people had bespoke safeguarding plans which the board was made aware of, to reduce future risks for individual people.

The safeguarding team completed non statutory enquiries for the referrals which did not meet the section 42 threshold. Examples given for outcomes of non-statutory enquires included signposting people to domestic abuse support or carers pathways of support. Staff told us there were strong links between the safeguarding team and the first point of contact team to direct any safeguarding concerns.

Partners highlighted the positive working relationship with safeguarding teams through regular meetings and said there was a smooth referral process which worked well and provided links to other services and signposting. Care providers could contact the quality and contracts team for advice and to discuss any safeguarding concerns. However, we received mixed feedback from partners whether they were told outcomes of safeguarding enquiries when it was necessary for them to know to about it so they could ensure the ongoing safety of the person concerned. Some partners said there was no feedback or follow-up contact which could result in any learning from safeguarding enquiries being lost. However, others said staff were good at responding to any safeguarding concerns and would offer support and guidance to partners during investigations.

The local authority had a Deprivation of Liberty Safeguards (DoLS) team who carried out assessments with people in care homes and hospitals who were deprived of their liberty in a safe and correct way to receive care and treatment. The local authority told us they had a high rate of DoLS applications completed per 100,000 residents and the number of urgent applications had not changed over time.

Staff and partners said lower risk DoLS assessments could take 2-3 years to complete. Data provided by the local authority showed their median days wait was 57 days, and their maximum days wait was 1065. This presented a risk of people having their liberty unnecessarily restricted whilst waiting. To address the waiting lists, the local authority had an action plan which included use of agency workers to complete the assessments and a process for prioritising referrals against risk indicators. They were also reviewing their processes for staff to become best interest assessors and working with local hospitals to reduce some referrals made to the local authority.

Making safeguarding personal

Safeguarding enquiries were carried out sensitively, keeping the wishes and best interests of the people at the centre.

There was consideration of people's care and support experiences in the Shropshire Safeguarding Community Partnership Board, and we were told each meeting started with a lived experience case study which brought the discussions to life and supported better decision-making. There was a focus on monitoring data around peoples 'making safeguarding personal' experience. Whilst we did not see evidence of this data or monitoring, it was evident staff applied these principles when describing how they engaged with adults at risk to enhance involvement and improve quality of life, wellbeing and safety.

Information was provided to people to help them to understand safeguarding and what being safe meant to them. Staff and partners told us about Shropshire's 'My Enquiry & Safety Planning Cards' which were designed to support conversations between staff and the people they supported, along with their family, friends or advocates, to promote engagement in the safeguarding process and be supported to make choices and balance risks.

Staff and partners told us there were data standards and quality assurance arrangements to monitor advocacy referrals. This was for people who lacked mental capacity in relation to section 42 enquiries, to ensure people could get support from an advocate if they wished to do so. In Shropshire, national data showed that 83.33% of individuals lacking capacity were supported by an advocate, family, or friend, to facilitate the person's involvement in the safeguarding process. The England average was 83.38%.

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

In October 2021, Shropshire local authority merged the children, young people and adults directorate into a single People's Directorate. This was to streamline areas, align resources and improve outcomes for all age residents across Shropshire. The Directorate was led by the Executive Director for People, whose role included the Director for Adult Social Services (DASS) function.

There was a stable leadership team who were visible and promoted good communication in the directorate. A senior leader told us was an open invite to meet staff and have face to face direct conversations with them. They said this created an authentic communication route.

There were governance, management, and accountability arrangements at all levels within the local authority which provided visibility and assurance on the delivery of Care Act duties, quality and sustainability, and risks to delivery. A senior leader told us they, attended a range of meetings to provide them with oversight on service delivery. This included weekly directorate management meetings and specific focus sessions on areas such as performance and finance, meetings with the adult social care portfolio holder and meetings with the Chair of the Scrutiny Committee.

There were clear risk management and escalation arrangements, which included escalation internally and externally as required. Senior leaders told us the corporate risk register was reviewed at team manager, service manager level, and then was escalated to them for overall responsibility.

The local authority's political and executive leaders received good information from the local authority, and they were knowledgeable and well informed about performance and the potential risks facing adult social care. These were reflected in the corporate risk register and considered in decisions across the wider council. There was a good awareness and understanding of the joint strategic needs analysis and we were told how members had used data from it to support a campaign to reopen a community hospital.

Thematic audits were in place to monitor quality and review consistency of practice, for example in relation to care planning and mental capacity assessments. The Quality Improvement and Service Development Board selected case files for review against a prescribed set of quality indicators and resulting improvement actions and training needs were identified and reported to the senior management team for implementation.

Staff in one team told us they were was experiencing low morale due to difficulties providing a consistent and effective service and causing potential risks to people's well-being. Senior leaders were aware of this and following a review, they were making changes to some of the staffing structures to alleviate the difficulties. However, feedback from other teams was positive with staff saying they felt supported by managers.

Strategic planning

The local authority said the Shropshire Plan was the golden thread to delivering wellbeing, prevention, and early intervention as a strategic priorities for Shropshire. The Plan set a vision for people to live their best lives, with a strengths-based practice framework placing the individual at the centre of decisions.

There was a transformation programme for 2024/2025 underway to support the local authority to drive the strategic outcomes in the Shropshire Plan.

People and carers told us the local authority needed to improve its approach to co-production to ensure that local people and partners could fully contribute to developments. We were told that a co-production framework was being developed.

The local authority used a number of performance management measures and data to monitor and manage the use of resources, outcomes for people and to inform strategic planning decisions.

The local authority was working to identify opportunities to further improve the outcomes for people and staff, as well as looking at how to make greater use of technology and digital platforms, having an all-age commissioning approach and continuing to foster integration and partnership working.

A senior leader told us workforce was their biggest challenge but they were confident their vacancy rate was below national averages. There was a significant investment in recruitment and retention and a specific adult social care workforce strategy was being developed. The local authority advocated 'growing your own talent' and they had a graduate scheme to develop social workers. They were also looking at creating a key worker housing scheme for people who wanted to live and work in Shropshire. Additionally they had invested in increased fees rates for the care provider market to support their sustainability and ability to recruit to the sector.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems.

Staff followed GDPR processes and had to undertake mandatory training on this to use the computer system. Shropshire care providers had to follow the local authority's GDPR processes and were also given training on this.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment:

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

Key findings for this quality statement

Continuous learning, improvement and professional development

The local authority had a committed and passionate workforce. The local authority told us they were passionate about 'growing their own' and a second cohort of social workers supported by the local authority had just graduated with a 100% pass rate. Staff we spoke with felt valued, well supported and were very positive about working for Shropshire local authority. They said working conditions were very good which gave them a lot of flexibility to manage any caring responsibilities they had for children or relatives. They said their personal wellbeing was important to the local authority.

The local authority service had an award initiative which recognised the work of teams and individual staff. This was particularly valued because the awards were voted for by colleagues.

Local authority staff had ongoing access to learning and support, so they understood their roles and responsibilities to deliver the Care Act 2014 duties safely and effectively. Some teams told us they struggled to get specific training for specialist roles. Examples of recent training provided included continuing health care, women on the autistic spectrum and self-harm and trauma. Some training had been carried out by people with lived experience.

A programme called Getting Leadership Right had been designed to develop leadership skills and the behaviours required for a cohesive approach. We were told 350 people had completed the programme, and it had won the Best Learning and Development Award in the Public Services People Managers Association (PPMA) Excellence in People Management Awards 2024.

Teams told us they valued having access to peer support. They had regular 121 supervision with line managers time and space for reflective practice, wellbeing, and debriefing following difficult situations. Staff told us they received an effective induction and had regular direct observations of their practice as part of the supervision process.

The local authority worked collaboratively with people and partners to actively promote and support innovative ways of working that improved people's social care experiences and outcomes. Staff were given the autonomy to produce ideas and implement them to meet different demands.

There was a commitment to co-producing decisions and developments in respect of care and support provision and to involving people at all stages. Some work was already underway, and partners gave examples including working on an action plan with the Carers Support Team and developing the way they supported unpaid carers. This was considered by them to be a positive example of co-production as some ideas were generated jointly by unpaid carers and local authority staff.

There was a well-established 'Making it Real Board,' which was a formal mechanism to lead and progress coproduction activity in the area. The board was co-chaired by the member of Shropshire Council with responsibility for Health & Wellbeing, and by an Expert by Experience elected from the membership of the board. The board had drafted a co-production framework setting out what the local authority needed to do across individual operational and strategic levels to make co-production a reality. The local authority had recently appointed a co-production lead to deliver the actions within the framework.

It was positive to see the involvement of people in several coproduction groups. People who were currently involved in coproduction work said they would benefit from being able to meet and work with experts by experience from different boards so they could learn and support each other, and that it would be beneficial for them in their roles, if they were helped to increase their understanding of the working of the local authority and its structures so they knew who was responsible for what. To improve the involvement further, representatives from co-production groups told us they wanted more feedback provided to experts by experience about the outcomes of their feedback and contributions. They also said they would like to be involved earlier in decision making processes to ensure they were able to fully contribute and shape decisions. This was recognised by the local authority and there was an intention to get people involved at the design stage and to involve more experts by experience on the Making it Real Board.

The local authority participated in the Association of Directors of Adult Social Services (ADASS) peer review in March 2023, where they were assessed against the then proposed CQC assessment themes. Shropshire had also supported other local authorities as a critical friend, sharing learning and best practice across the region.

Senior leaders told us they were proud of specific initiatives that had improved people's outcomes, and which they described as innovative. For example, the 'Two carers in a car' scheme, which was designed to provide care during the night for people living in their own homes, who would otherwise have to move into residential care. Each contract required two paid carers who could travel to any household within a specified area to provide support between 10pm and 7am. Feedback from people who used this service was very positive. People told us it provided much reassurance, the night calls were incredibly helpful, and it was an excellent service. The local authority said this resulted in fewer people going into residential care because of their care needs.

Learning from feedback

The local authority gathered feedback in a range of ways and used it to inform and improve practice and service delivery. These included using Ombudsman reports, safeguarding adults reviews, thematic audits and complaints and compliments. A new Quality Improvement and Service Delivery Board was created to monitor progress against improvement actions. We did not see how the board worked in practice or the outcomes and impact.

Practice reviews were undertaken by peers. For example, the local Association of Directors of Adult Social Services (ADASS) had reviewed Shropshire's approach to strengths-based practice and learning disability provision within adult social care. As part of the review, case notes were evaluated, and reviewers sought feedback from people using the service. The review identified key strengths and areas of good practice for example ensuring good quality and clear Mental Capacity Act assessments with corresponding Best Interests decisions. It also made recommendations for practice improvement such as re-examining how risk was recorded and considering the development of a separate risk assessment. The local authority was using this to make improvements.

The Adult Services Feedback Report from October to December 2023 recorded 30 compliments and 28 complaints. The main themes related to arrangements for care at home, discharges from hospital, care needs assessments and placements in residential care. The report outlined clear outcomes, learning and actions to be taken where appropriate. The new Quality Improvement and Service Delivery Board evaluated progress of actions and improvements.

There were compliments received which related to Enable, START and day services. Some compliments provided were from other practitioners. Themes included the friendliness and approachability of staff who treated people with respect, and the level of care knowledge of staff, high standards and the way they supported people to regain independence.

Staff told us about an 'Innovation Week' which focused on what they could do differently and being empowered to find solutions to the challenges their teams were facing in terms of resources and meeting demand. Staff told the local authority their views on what was needed to do this, which included more training around health interface funding, Continuing Health Care and section 117.

Shropshire had 9 detailed investigations into complaints made about them by the Local Government and Social Care Ombudsman (LGSCO) in 2022/2023 and a higher than average uphold rate at 89%. The average uphold rate for a comparable local authority was 75.49%. The local authority also had a 100% LGSCO compliance rate which demonstrated they had been able to consistently make improvements where needed in response to the findings of the Ombudsman's investigations. Three service improvement recommendations were made by the LGSCO about assessment and care planning and 1 about direct payments in 22/23.

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