London Borough of Hillingdon: local authority assessment

How we assess local authorities

Assessment published: 13 December 2024

About London Borough of Hillingdon

Demographics

Hillingdon is the second largest of London's 32 boroughs covering 42 square miles. Over half of this is countryside, interspersed with historic towns and villages. It shares borders with Hertfordshire, Buckinghamshire, Surrey, Hounslow, Ealing, and Harrow. The far south of Hillingdon is home to Heathrow Airport. Hayes, Yiewsley and West Drayton are more urban in nature.

The council footprint has an index of multiple deprivation score of 4, meaning it was slightly below midway between the most and least deprived. This overall score consists of some high-income and some high-deprivation areas. In 2019, 11.4% of the population of Hillingdon were income deprived.

Hillingdon has a population of 310,681. It currently has a greater proportion of children and young people at 23.36% (72,581) and people of working age 63.15% (196,203) as compared to the England averages of 20.82% and 60.57% respectively. The population is growing slightly, but most of the population growth is expected to be in adults over 65 predicted to increase from 13.49% (41,897) to 19.48 % (62,317) of the predicted population of 319,870 by 2041. Hillingdon is ethnically very diverse. 51.82% are from ethnic minority backgrounds including 33.32% of Asian or Asian British heritage.

Hillingdon is in the Northwest London Integrated Care System together with 7 other London boroughs. The local authority has a strong Place Based Partnership board (Hillingdon Health and Care Partnership) with other key stakeholders in Hillingdon. The London Borough of Hillingdon is a Conservative led council, with a 14% majority.

Financial facts

The Financial facts for **London Borough of Hillingdon** are:

- The local authority estimated that in 2022/23, its total budget would be £**430,659,000**. Its actual spend for that year was £**465,044,000**, which was **£34,385,000 more** than estimated.
- The local authority estimated that it would spend **£78,792,000** of its total budget on adult social care in 2022/23 Its actual spend was **£84,500,000** which is **£5,708,000 more** than estimated.
- In 2022/2023, **18%** of the budget was spent on adult social care (ASC).
- The local authority has raised the full adult social care precept for 2023/24, with a value of **2%** Please note that the amount raised through ASC precept varies from local authority to local authority.

- Approximately **3785** people were accessing long-term adult social care support, and approximately **820** people were accessing short-term adult social care support in 2022/23. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

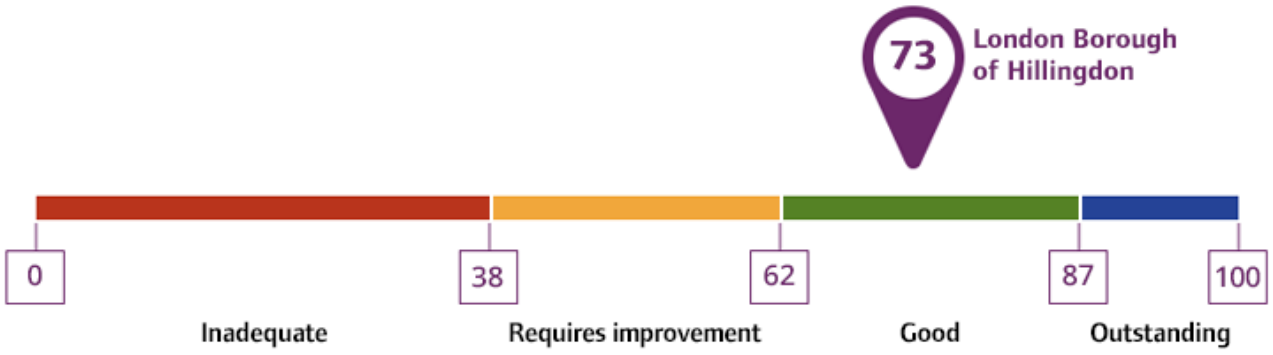
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

London Borough of Hillingdon

Good



Quality statement scores

Assessing needs

Score: 3

Supporting people to lead healthier lives
Score: 3

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 3

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 3

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

Most people could access the local authority's care and support services easily. They could make contact through multiple channels, including online and self-assessment options. According to national data, the proportion of people in Hillingdon who were satisfied with care and support they received was slightly lower than the English average, Fewer people paid privately to buy more care and support than the England average.

Most people did not have to wait for their Care Act Assessment, although people who needed specialist assessments from the learning disability or mental health teams were more likely to. Most reviews were completed on time. Carers reported more mixed experiences of accessing assessment and of understanding what sort of assessment they had had. Most people could access helpful information about care and support easily, but some found the increased online offer challenging. Difficulties using online sources of information was a barrier to access for some people.

There were no waits for occupational therapy (OT) assessments for equipment and adaptations. 90% of assessments were booked within 2 weeks, and where necessary these could be conducted more quickly. The provision of equipment after assessments could however be delayed, particularly if it was out of stock. Strategic management and oversight of the Occupational therapy service and equipment provision, and an arm's length relationship with the outsourced providers however, did not provide sufficient assurance that people would receive an efficient and effective service. The process for accessing equipment varied according to whether a person was already known to social care.

Most people had positive experiences of hospital discharge. We found it was timely, safe, and effective. Interventions such as reablement and short-term packages of care, resulted in a significantly better than average proportion of people being able to remain independent for longer when they returned home.

Transitions for people with care and support needs who were moving from childhood to adulthood were supported by a preparing for adulthood team. We heard of both positive and negative experiences. Transitions between local authority areas, and from self-funding to funded care were also managed safely.

Most people we spoke with who had care needs had a choice and were satisfied with the care and support they received. A much higher proportion of carers than average were able to access respite and short breaks, in an emergency, for less than a day and for longer periods.

There were no notable delays for packages of care or placement after an assessment of need. Whilst 75% of people across all primary support reasons were placed in borough, those with complex needs who needed residential, nursing care or supported living were more likely than others to be placed outside the borough boundary.

National data in the Adult Social Care Outcomes Framework (ASCOF Dec 2023) showed that the uptake of direct payments as a means of receiving support was lower than average for older adults and carers, adults aged between 18-64 and overall, but action taken by the local authority had increased the rate of uptake by 22% in the last 12 months. There was a good support service for people using direct payments, and the local authority had considered and addressed the barriers for people wanting to use them.

The local authority worked closely with the voluntary, community and social enterprise sector (VCSE) sector to provide an early intervention and prevention offer to support wellbeing in Hillingdon such as job clubs, and wellbeing support for people with a mental health condition.

Preventative services provided by the local authority and partners had a positive impact on well-being outcomes for people who might have care and support needs. Carers were very satisfied with the commissioned carers support organisation. Most carers felt safe, but the proportion was lower than the national average.

Where concerns were raised about people who may have experienced abuse or neglect, these were responded to without delay. Investigations might take longer for people who required advocacy to support them through this process. There were no waits for Deprivation of Liberty Safeguards (DoLS) applications for people in residential care waiting for assessment, and whilst there was a considerable wait for community based DoLS applications, the local authority had identified a team to progress these to be ready for the court process.

People in Hillingdon were given opportunities to be involved in developing strategies, and the way care and support were provided by the local authority. People were listened to, and their ideas shaped services.

Summary of strengths, areas for development and next steps

The London Borough of Hillingdon worked very closely with system partners across the area and had a clear focus on working together with others to achieve the best outcomes for people who lived there.

The local authority was committed to early intervention and prevention and there was a strategic and operational focus on reducing, delaying, and preventing needs for long-term care and support, which was effective. The formal strategy and commitment to this was documented in the Health and Wellbeing Strategy, to which the local authority was a signatory. This is also reflected in the Adult Social Care Plan 2024-27 and the Better Care Fund plan.

The local authority had a centralised contact point for all referrals, either from individuals or other professionals. Assessment teams were based either on specialism, such as a team of people with learning disabilities and autistic people, or mental health needs, or on locality.

The local authority was committed to tackling inequalities and was involved in a range of initiatives and action. At the time of our assessment, there was no data to demonstrate the impact of these efforts. There were still some areas where inequalities of access to information, support to participate or local provision were experienced by some people due to their specific care and support needs, or their ability to use online resources.

The local authority had a significant number of residential and nursing care home beds, but demand for these also came from people who paid for their own care, the NHS and other local authorities. This meant a relatively high proportion of placements, especially for people with complex needs had to be made outside the borough. There was limited availability of local supported living for people with learning disabilities, particularly for people requiring specialist provision, which contributed to out of area placements. The local authority has plans for some additional registered care capacity.

The local authority used data and engaged with the local community to understand its care and support needs. This included understanding of the diverse needs of different groups of people. They recognised they needed to do further work in this area, but had taken significant steps, particularly to ensure services for the LGBTQIA+ community were accessible and appropriate to meet their needs in a person-centred way.

The local authority had a robust commissioning team which actively engaged with providers to ensure a range of high-quality, diverse provisions were available to meet the community's needs. They worked with partners to ensure commissioning and contracting decisions were based on up to date, accurate information about performance. The local authority had a strong risk management framework for commissioning and care provision.

The London Borough of Hillingdon were valued by system partners for the way they worked together to achieve good results for people. Partners recognised the local authority worked hard at this. Integration and working together supported safe transitions for people between health and social care. The team working with young adults in transition had strong links with other teams, to ensure they planned at the appropriate time, in a person-centred way to prevent crises and ensure safe transitions.

The local authority had a clear understanding of the safeguarding risks and issues in the area. They worked with partners in respect of safeguarding to reduce risks and to prevent abuse and neglect from occurring. Specific issues included the increase of hoarding and the risk of suicides, for which protocols and strategies were in place. Audits had shown however that learning from SAR’s was not embedded in policy and practice.

The local authority had strong, visible leadership team with clear roles, responsibilities and accountabilities. Structures were in place to oversee governance, risk management, and accountability arrangements at all levels. These provided some visibility and assurance on delivery of Care Act duties. Some areas however lacked strategic oversight which resulted in inequitable outcomes for some people. Where shortfalls had been identified, for example in relation to occupational therapy assessment and the provision of equipment, performance data dashboards were being built to improve the line of sight on delivery.

The local authority did not currently have consistent data about performance over the last 12 months and this had been acknowledged by them as an area for development. A new approach to data, whilst still being implemented, was addressing this gap and further data collection and analysis was planned to improve governance and oversight.

Staff at Hillingdon were very proud to work there and felt valued and supported. The senior leadership team were visible, engaged and compassionate. The local authority sought feedback and coproduction with people who used services. Whilst this was an ongoing development, they were committed to co-production as a way of planning and working.

Theme 1: How London Borough of Hillingdon works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 3

Score: 3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

Many but not all people could access the care and support they needed easily. The local authority accepted referrals directly from individuals or from professionals on their behalf (with the documented consent of the individual). People could ring or email Hillingdon Social Care Direct (HSCD) to request support and there was an online system to complete a self-assessment. The local authority told us they were using "leading technology" for call triage and data collection. This included the ability to recognise existing service users to ensure those in need of support would be answered in a timely way. They said this helped them to manage demand effectively, identify early signs of vulnerability and provide timely support and intervention to individuals, thereby reducing the risk of escalating care needs. No data about the impact of this technology was available at the time of our assessment but has since been developed.

The local authority told us their phone system recognised if English was not a person's first language and diverted the call if a person needed extra support. We also heard that there were translation options on the website for people who wished to use them. Notwithstanding these measures, some partner organisations identified digital or telephone access only to the local authority was a barrier to some of the people they worked with, particularly those for whom English was not their first language, those with communication difficulties, or those who did not have easy access to the internet.

Some partner organisations also told us it was hard to make a referral and noted even they found the online form was difficult to use and limited their ability to explain a person's situations clearly. The local authority told us their phone system recognised if English was not a person's first language and diverted the call if a person needed extra support. We also heard that there were translation options on the website for people who wished to use them.

A duty manager triaged referrals to prioritise and signpost to the right team. HSCD staff are supported with information and advice from social workers in the team to gather sufficient information to aid appropriate triage. The case is progressed through the localities social work teams who complete the reablement or Care Act assessment.

Both reablement assessments, and Care Act assessments were explicitly strengths-based and person-centred. The local authority used an assessment model called 'Functional Analysis of Care Environment' (FACE) which was developed collaboratively with local authorities. The most senior leaders in the local authority had a clear understanding of the assessment process, which supported staff. Assessments considered the needs and preferences of the person with care and support needs, and any carer supporting them, reflecting their rights to choice. They built on their strengths and assets and reflected what they wanted to achieve. Staff were provided clear guidance to support practice.

Staff told us they offered individuals a choice about where their assessment took place. This could be in their homes, library services; the Civic Centre; or any other suitable location they chose. They could also be assessed through remote methods such as video or telephone calls if they preferred. Other factors such as communication needs, the presence of others during the assessment, safeguarding concerns, and the potential for substantial difficulty in participating were taken into consideration. Data from the Adult Social Care Survey (ASCS, Oct 2023) found 58.2% people in Hillingdon were satisfied with care and support they received as compared to the England average of 64.4%.

Not everyone we spoke with had a good understanding of the assessment process they had received but had received the support or information and advice they needed to achieve the outcomes that were important to them.

Most people's experiences of care and support ensured their human rights were respected and protected. We saw evidence people were involved throughout in decisions. Leaders at the local authority were committed to supporting people from diverse communities in Hillingdon. Staff were provided with equality, diversity and inclusion training to support them to work with all people, including those with protected characteristics under the Equality Act 2010 in a person-centred way. One person we spoke to however said they hadn't been asked about any support they needed to participate in the assessment.

Staff told us they kept up to date with people in other teams and knew who to contact about people's care and could do joint visits with other people involved in their care as well. Where there was a higher risk situation, they could discuss with their managers and partner health team managers. Staff felt partnership working was very good in Hillingdon.

There was clear evidence of pathways and processes which ensured people's support was planned and coordinated across different agencies and services. We heard from staff and partners about the very effective joint working between NHS and local authority staff which successfully managed assessments at the point of hospital discharge to ensure people were safe and had timely discharges.

The local authority had assessment teams who were competent to carry out assessments, including specialist assessments. They had good access to training and support, their practice was supervised, and audits were undertaken to ensure assessments were completed appropriately, and effectively.

Timeliness of assessments, care planning and reviews

We heard some negative feedback about the timeliness of assessments and responsiveness of the local authority. A partner organisation reported they had made referrals, they found the local authority slow to respond to referrals they had made, and people could wait weeks and sometimes months to be allocated. They also said they struggled to get a response when chasing this up, and when the person was allocated to a social worker, their case seemed to be closed quite quickly. One person we spoke to waited 2-3 months between initial contact and assessment and did not remember any contact from the local authority whilst they waited. Another partner organisation working with people with mental health needs also reflected long wait times for Care Act assessments.

The local authority had however recognised that some people had prolonged waits for assessment and had taken action to address the issue. At the time of our assessment there were 11 people waiting longer than 28 days. At the time of our assessment, the local authority had 42 cases requiring assessment and allocation across North and South locality teams, but all were within the 28-day assessment timeline and had been triaged.

Reviews were planned for six weeks after any service was initiated, and thereafter planned annually. According to the Adult Social Care Finance Report (ASCFR) / Short and Long-Term Support (SALT Dec 2023) 69.33% of people in Hillingdon in receipt of long-term support had planned or unplanned reviews which was better than the England Average of 57.14%. The local authority had recently cleared a backlog of overdue planned reviews and told us unscheduled reviews requiring allocation were being addressed. The oldest unscheduled review awaiting allocation was from January 2024. The allocated Duty team Manager and front-line workers proactively reviewed cases, triaged them, and prioritised them according to risk for allocation. This ensured urgent cases were identified and actioned immediately, prioritising those with the highest need for intervention.

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

The local authority told us no carers assessments were pending. Hillingdon Social Care Direct might signpost to the local carers organisation for a specific carers assessment, but if a cared for person is part of the referral conversation, the referral is passed to the adult social care team to complete under a joint assessment. They told us that in all cases, people are met with or offered a separate assessment, and the social worker will typically follow up separately. The local authority completed 853 carers assessments under the Care Act in the last 12 months, of which less than a third were sole carer assessments as compared to joint assessments with the person they cared for. Joint assessments can make it more difficult to articulate the separate needs of carers as distinct from the person with care needs. This is because the focus of the assessment is how best to support the person with care and support needs, whilst taking account of the impact on the carer and their wellbeing; and because if both are present it may be more difficult for the carer to speak freely about the impact of their caring role.

Information about obtaining an assessment was provided on the council website, through a consortium of organisations and various voluntary sector providers. However, carers told us that in their opinion, information about how to obtain an assessment was not readily available and was discovered either by word of mouth or the person seeking it out. All the carers we spoke to had however received what they called a carers assessment or knew where to get one, and subsequently received all the support they wanted or needed. The assessments had been completed by a variety of sources, including carers organisations. Carers had variable experiences of accessing assessment and support in their caring role, and not all were aware of the difference between a Care Act assessment from the local authority, as compared to an initial assessment from the local carers organisation. Carers organisations who provided support to carers, were able to refer onwards where they or the carer themselves identified a statutory Care Act assessment would provide additional support. This included support such as bed-based respite care, rather than the sitting service the Carers Association provided, or additional care and support in the home to reduce the burden on the unpaid carer.

Staff in the local authority told us they frequently identified carers during their assessments of service users. They subsequently conducted carers assessments as part of the Care Act assessment and provided information about support available. Where they identified young carers, they signposted them to a specialist service delivered by a partner organisation, which offered support through training and outreach initiatives.

The Survey of Adult Carers in England (SACE, June 2024) data showed carers in Hillingdon had relatively similar levels of access to encouragement and support at 28.57%, training at 7.41% and satisfaction with social services at 36.73% to the average figures for England. By contrast, fewer carers in Hillingdon felt they had control over their daily life at 16.07% as compared to 21.53% in England. Similarly fewer carers in Hillingdon 22.22% reported accessing a support group or someone to talk to in confidence as compared to 32.98% average in England. More significant variations were seen in the number of carers in Hillingdon experiencing financial difficulties because of caring at 57.14% as compared to the England average of 46.55%, and the number of carers not in paid employment because of caring responsibilities at 40% as compared to the England average of 26.70%. The local authority told us that 45% of carers were retired.

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

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The primary sources of this information were through HSCD, and the local authority's website, which had links to information about a range of services. Staff in the local authority also shared information with people during and following assessments. Partner organisations told us they had co-produced information with the local authority, for example about how to manage during the winter months or with the cost-of-living crisis but noted it was distributed on the local authority website which they felt was not easy to navigate. The local authority told us that they gathered feedback from people who used their information and advice team (HSCD) by way of a survey. Results from these surveys included that 100% reported that the service had made a positive difference and 100% reported the information given was clear and that they were listened to.

Eligibility decisions for care and support

The local authority's framework for eligibility for care and support was transparent, clear, and consistently applied. Decisions and outcomes were timely and transparent. They did not have a separate appeal process but reported only 1 complaint in the last 12 months related to an eligibility decision. In this case, the complaint was partially upheld and additional short-term services provided. According to the Adult Social Care Survey (ASCS Oct 2023) proportionately more people, 69.86%, in Hillingdon do not buy any additional care or support privately or pay more to 'top up' their care and support as compared to the England average of 64.63%.

Financial assessment and charging policy for care and support

The local authority had a framework for assessing and charging adults for care and support. There were occasions when it was not found to be clear, transparent, timely and consistently applied. They told us the Financial Assessment team had no waiting lists and assessments are typically completed within a time frame of 14 to 28 days. They noted however, more complex cases and the level of engagement with clients or their representatives may require additional time.

We were told that the local authority had received several complaints related to financial assessments and charging policies which were addressed through their standard complaints process, ensuring each case was thoroughly investigated and resolved. Two such complaints went to the Local Government and Social Care Ombudsman (LGSCO). Some complaints related to lack of clarity of information. In the example provided, where this was reviewed, the local authority had acknowledged that there were concerns about the clarity of information provided. Apologies were extended, and the complaint was addressed by ensuring better communication and support for the family. In a second example, the complaint related to fees incurred due to an unexpected delay in return home from short term care, following a review. The local authority took appropriate action to redress the situation.

Provision of independent advocacy

The local authority had a clear process to follow, guiding staff to when it would be appropriate to refer for independent advocacy support to help people participate fully in care assessments and care planning processes. They commission advocacy services through a single provider, to support people throughout the assessment and support planning stages.

The local authority said that use of the advocacy contract was overseen at a senior level, and that referrals were in line with the requirements of the Care Act. This contrasts with feedback from a partner organisation who told us they did not get as many referrals to support Care Act assessments as they thought they should, and sometimes referrals were instigated by care providers rather than social workers. They told us they felt the relationship with the local authority could be stronger. They also said they had challenges to deliver the level of support needed in a timely manner, and to have time once in place to complete assessments. Staff recognised that they had a good response from the service providing advocacy in the borough, but in some cases, there was a delay before an advocate was allocated. Staff also reported instances where delays in safeguarding investigations being completed were caused by delays of 4 weeks in providing a suitable advocate. They noted that this usually took 1-2 weeks. All these issues regarding advocacy provision impacted on some people's ability to speak up for themselves or engage fully in assessments. There were plans to retender the advocacy service in 2025.

Staff told us an individual's capacity was typically assessed during the assessment process. They may involve family members to assist the service user during this assessment if deemed appropriate. In cases where the service user lacked capacity and did not have family or friends to provide advocacy support, a referral was made to the advocacy service.

Where a person was placed by the local authority out of borough, they could not access Hillingdon's commissioned advocacy service. Staff reported difficulties and delays but would work in partnership with the host local authority to identify and access advocacy support for the individual, so the person was supported with appropriate advocacy before any decisions were made about their care. Staff told us monthly meetings were held with advocacy providers to discuss capacity and any case issues to address any capacity issues.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority, the Hillingdon Health and Care Partnership and the North West London Integrated Care Board (NWLICB) are jointly responsible for the Hillingdon Health and Wellbeing Strategy. This key document incorporates early intervention and prevention as a fundamental principle. The local authority did not have its own formalised strategy specifically focused on preventing, reducing, or delaying the need for care and support, but told us they were committed to delivering a range of initiatives aimed at achieving these outcomes. All staff and partners we spoke with had a clear understanding that early intervention was a significant part of the local authority's approach to delivering its duties under the Care Act.

The local authority said their focus was on addressing the root causes of care needs and promoting independence and well-being among residents, particularly older adults. They based their actions on proactive intervention and collaborative working across health and social care partners, people and the local community. Stakeholders offered a range of services, facilities, resources and other measures to promote independence, and to prevent, delay or reduce the need for care and support.

Voluntary sector organisations were commissioned by the local authority to deliver provisions such as job clubs, social activities and an early intervention service to adults 18+ promoting mental health and preventing worsening of mental health issues. Whilst the local authority told us they had provided a 12-month lead in time to the change, and support to develop business models, we heard the change from core grant funding to commissioned services, had had a disproportionate impact on smaller voluntary groups.

Health and social care agencies had a joined-up approach to people who relied heavily on services, including interventions and care packages to identify the most appropriate resources to intervene early and reduce crises. Hoarding was a particular issue in NW London. Partners in the Health and Wellbeing partnership were testing an approach, working together to address this, but had not yet captured any outcome data.

Assistive technology was being used to support people to remain independent. The local authority was piloting use of an aid which allowed them to understand a person's movements and subsequently provide proportionate, appropriate support which reduced risk but was not restrictive.

Partner organisations felt the local authority understood the challenges people in the community experienced, such as, housing and the double impact of cost of living and getting into debt. It was noted Hillingdon had some specific low-income areas. The local authority was aware of the lack of affordable housing and was explicitly seeking both to build and to buy additional housing stock, to address this.

We heard in recent years in Hillingdon, there had been a significant increase in the numbers of people, who had died by suicide. Partners in Hillingdon including the local authority, voluntary sector groups and transport providers were working together to seek to prevent this and to identify hotspots.

According to the Survey of Adult Carers in England, (June 2024) 80 % of carers found information and advice helpful which was slightly less than the England average of 85.22%. Only 12.5% of carers surveyed in Hillingdon reported being able to spend time doing things they value or enjoy. Whilst this is consistent with the England average, it is only 1 in 8 carers. However, carers spoke highly of the organisation commissioned by the local authority to support them, through whom they received help to complete difficult forms, provided benefits advice, information about local groups suitable to the carer's requirements, and direct support.

Data from the ASCS (October 2023) about adults with care and support needs, were mostly consistent with average results across England. For example, 62.41% people in Hillingdon who were surveyed, said help and support helped them to think and feel better about themselves, compared to the England average of 62.32%). 69.15% reported they spend their time doing things they value or enjoy which was comparable to the England average of 68.17%.

Public Health worked with organisations to support them in offering relevant opportunities to people to meet their individual needs and interests. Staff gave an example of how they met a person with early onset dementia who had worked for many years in a role they really enjoyed and was becoming depressed due to having to give this work up. The local authority worked with partners, provided training and advocated for them to become a volunteer in a similar role within the borough, which was still accessible to them. The person was able to volunteer for around 18 months and gave feedback during this time they felt valued and proud they could contribute to their local community.

The local authority had a significant extra care offer, where sheltered housing was provided with housing and personal care related support available on site. We heard there were only a few vacancies, but significant demand. There was a proactive approach by the local authority to reduce and delay demand for residential and nursing care home placements. Staff told us in the last 18 months there had been many success stories with people known to mental health teams, where they had supported discharges from Mental Health wards, and those struggling in the community moving on, into supported housing and extra care.

They were now introducing daytime support for people who did not live in extra care schemes within established services, so people could see what the schemes were like and consider them as a more independent alternative care option.

The local authority had taken steps to identify people with needs for care and support which were not being met. They had a Communities' Programme team who worked closely with the voluntary sector. A partner said they were very good at investing in facilities and green spaces, creating resources for communities, dementia cafes, language groups, and reaching into the heart of communities to find people. Leaders acknowledged they needed to do more but were using community places such as the sports centre, and running engagement events across the borough, to listen to people and provide information and advice. Where appropriate, people would be signposted to make a referral via Hillingdon Social Care Direct. Accelerated reform funding was being used for work to identify unpaid carers.

Provision and impact of intermediate care and reablement services

The local authority considered whether reablement approaches were appropriate before any long-term services were put in place. By screening at the front door for reablement, this reduced the number who went on to need longer term care. Reablement was provided as a partnership between a commissioned domiciliary care provider, and occupational therapists who provided the care plans. Local authority staff told us reablement programmes were based on an individual's personal goals but getting the therapy calls at the right time, and for long enough duration to work in an enabling way rather than doing for the person, was challenging. Reablement was also available to anyone on discharge from hospital who had the potential to be supported to improve their independence.

According to the ASCS (Oct 2023) 80.28% of people in Hillingdon who received short term support no longer required support as compared to an England average of 77.55% Impact of reablement was measured by whether the aim was achieved – but what this meant in practice could vary from one person to another and did not necessarily mean they did not continue to need care.

The local authority also worked with partners to offer intermediate care. They had 15 nursing care beds where there was in-reach from physiotherapists and other allied health professionals to help people to rehabilitate after hospitalisation.

The Adult Social Care Outcomes Framework – Short- and Long-Term Support (ASCOF)/SALT: (Dec 2023) found 1.86 % of people 65+ received reablement/rehabilitation services after discharge from hospital which was slightly lower than the England average of 2.91%. A senior NHS leader noted the local authority guaranteed all patients on the P1 pathway whose needs could be met by provision of support in their own home, would leave the hospital on the same day**.** This meant they could plan discharges for the day. They consequently had the lowest number of patients who did not meet the criteria to stay in hospital in NW London. The Bridging Care service was part of the P1 offer to people leaving hospital and gave 5 days support to facilitate same day discharge. This mitigated the immediate pressure on the wider domiciliary care market. Rehabilitation and reablement in Hillingdon was effective. ASCOF (SALT) data also showed 92.31% of people over 65 were still at home 91 days after discharge from hospital into reablement/ rehabilitation which was significantly more than the England average of 82.18%.

Access to equipment and home adaptations

People who needed assessment for and provision of aids, equipment and adaptations to their home, could access it. If a person was in hospital this would be dealt with by NHS staff who had access the same services as the local authority. if a person was not allocated to a social worker, Hillingdon Social Care Direct, were able to request a range of minor aids and equipment such as a raised toilet seat, and only make a referral for a full OT assessment if necessary. There was a difference of understanding between staff and the local authority about what happened if a person was already known to a social worker. Staff told us that in these cases, HSCD would pass the referral directly on to the social worker who would make a referral for an OT assessment for even minor aids, because they were not trained as Trusted Assessors for these. The local authority told us that all people could access minor aids and adaptations via HSCD.

Referrals were triaged by a senior OT who worked for the local authority and passed within 24 hours to external OT providers for progression. Part of the triage was to determine urgency. The most urgent cases were to be assessed within 2 days, high priority within 5 days and normal priority within 14 days. We heard the local authority and external providers worked together to expedite individual cases when necessary. The local authority also had access to the NHS rapid response (NHS team) for critically urgent assessments or interventions. More than 90% of assessments were booked within 2 weeks. The external provider had had a backlog with some referrals going beyond 14 days in February/March 2024 and took a pause for 1 week due to capacity, but reported they were performing normally now. Two service coordinators at the provider were trained as Trusted Assessors, which meant they could also order minor aids, to reduce waiting times for all.

Oversight of the end-to-end occupational therapy process, which involved different teams in different circumstances and an arm's length relationship with the outsourced providers, did not sufficiently ensure that people would receive an efficient and effective service. The process for accessing equipment varied according to whether a person was already known to social care and added a delay for some people. The local authority was unable to report median and maximum waiting times over the last 12 months but had noted this was an area for development. The local authority told us that assessments were quality checked and signed off by a senior OT employed by the local authority, and that cases were kept open until the equipment had been delivered, was meeting the persons needs and had been reviewed.

Referrals for Disabled Facility Grant applications for major home adaptations, were dealt with by a different local authority directorate.

Equipment was supplied by a provider commissioned at a regional level. Staff told us there were sometimes issues when an item was out stock, and the equipment provider did not keep either the local authority or the individual informed about this. They said there was an expectation that either the person themselves or a member of staff from the local authority would follow this up. The local authority told us in contrast that the equipment contract manager was kept informed of outstanding orders and would follow these up with the provider.

The individual would be without the necessary equipment, and it was unclear as to whose responsibility it was to ensure that they had safe and sufficient care in the interim.

We heard OT staff who worked for the local authority found it more difficult than previously to access training, for example about mental capacity, and the OT's used by the independent provider were responsible for their own continuing professional development. The local authority's contract with the provider placed responsibility on them to ensure personnel employed in connection with the contract were sufficiently qualified, competent, skilled, honest and experienced, and sufficiently instructed and supervised." The local authority told us the contract is monitored quarterly regarding agreed key performance indicators.

Provision of accessible information and advice

The local authority told us it provided information and advice and signposted people to the most appropriate resource at each touch point with services, from the front door to adult social care to the point a social worker is allocated. This included unpaid carers and people who fund or arrange their own care and support.

One way for people to access information and advice on their rights under the Care Act, and to meet their care and support needs was via the Local authority's Care and Support Directory. People, voluntary sector organisations and partners all noted the online nature of this resource was a barrier for some people. ASCS data (Oct 23) 65.68% of people who use services found it easy to find information about support which was consistent with the England average. Carers reported having more difficulty, and SACE (Jun 2024) showed 48.78% of carers in Hillingdon found it easy to access information and advice which was lower than the England average of 59.06%.

The local authority was aware of these concerns and was arranging an audit of the website to ensure it was as accessible as possible. They had committed to resolve all accessibility issues identified by the audit which were within their control. Nevertheless there was presently some inequitable access for people who were not able to use online sources of information.

Direct payments

Direct payments are money a local authority pays to people regularly (or someone acting on their behalf) so they can arrange their own support, instead of receiving social care services arranged by the local authority. The local authority had a lower uptake of direct payments than the England average of 26.22%. Data showed only 633 people, representing 13.65 % of total service users received direct payments. These were 19.83% of service users aged 18 - 64 compared to the England average of 38.06%, and 7.75% of service users aged 65 or over compared to the 14.80% average in England. ASCOF/SALT data (Dec 2023) shows 100% of carers who received a service, did so via a direct payment. Staff told us however they had had a 22% increase in direct payments in the last year. People reported it was hard to recruit personal assistants, so the local authority now gave them a list of providers of payroll services and recruitment support for Personal assistants which had helped.

Data from the local authority showed more people from ethnic minority groups used direct payments (360 out of 633), than white British people (270), with 3 people not disclosing their ethnicity. Just less than a third (190) of payments were ongoing personal budgets for carers, used to support them in their caring role. About one third each were used to employ personal assistants or to pay for agency care. The remainder was used for daycare.

There was a direct payment support service and people had ongoing access to information, advice and support. The local authority said ordinarily, a person would be able to use their direct payment to begin care within 4 days and most could within 2 weeks, although it could sometimes take longer.

People were signposted to use the Council's care and support directory but could purchase care from any provider. The local authority said they advised people who required personal care that they should use a CQC registered provider and consider their rating and most recent inspection report. We were also told the local authority had increased the direct payment rate for those who wanted to recruit personal assistants, rather than use a regulated domiciliary care company.

In the 12 months to March 2024, 60 people stopped using direct payments. All stopped because they were no longer eligible or suitable to the person. No-one was reported as moving from direct payments because they were unable to meet their needs through them.

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 had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions; there were equality objectives to reduce inequalities and to improve the experiences and outcomes for people who are more likely to have poor care.

The local authority understood its local population profile and demographics. They had introduced technology to gather data on referrals into Hillingdon Social Care Direct to capture whether the service was accessible to all. Leaders demonstrated both a commitment to address and an awareness of the inequalities across the borough. There were inequalities identified based on deprivation, which was linked to certain parts of the borough, and based on ethnicity and other protected characteristics.

Efforts by the local authority to support the principles were embedded in staff training, person centred ways of working and efforts to engage and co-produce with seldom heard groups. There was no written strategy, but a leader told us a workstream and delivery plan were being implemented. At the time of our assessment there was no data or reported outcomes to demonstrate the impact of initiatives and measures in reducing inequality. Nevertheless relationships were being built and engagement was improving.

Leaders told us during Covid efforts were made to reach out to seldom heard groups and over time this has resulted in trusted relationships with different communities. Community groups created during the pandemic were still active and were used as a gateway to engagement.

Senior leaders recognised hearing the voice of people/communities was an ongoing area for development across the local authority. They had co-production boards but acknowledged the need to widen participation, so they didn't just hear from the same people. Managers gave examples of how efforts to hear from wider communities were being addressed using ballot boxes to hear people's voices, and visits to schools to seek the experience of people with lived experience of care and support needs. Staff were going into the community and working with organisations and people who were supporting disadvantaged and marginalised people such as Muslim communities, Gypsy, Roma and Traveller communities and asylum seekers.

There was recognition some communities, for example the significant Somali community in Hayes, had strong religious and cultural beliefs which meant traditional ways of offering support and engagement were ineffective. The local authority and voluntary sector partners had reached into these communities, through people with the same languages and culture, to better understand and offer support which was accessible. We heard they had been invited to numerous celebrations, such as Eid celebrations alongside local authority members, police and other professionals as guests of groups. This promoted strong community links and good working relationships between community groups and professionals.

Staff told us they have sought and used information and guidance about how to make services equally accessible to people from the LGBTQIA+ community and liaised with another local authority who had developed expertise in this regard. Staff told us there were not enough services for the LGBTQIA+ community, but there was a project to set up access in the local library for advice and signposting services.

It was explicit in domiciliary care contracts providers should be able to meet the needs of any client for whom they were commissioned, in addition to valuing diversity and inclusion strategies. Providers were also asked about the languages their staff spoke, to ensure people were receiving care in their own language. Staff told us of the partnerships they worked with, such as language and interpretation services, MIND charity, and the Hillingdon for All hub which was a consortium early help and wellbeing organisation.

Staff were provided with training in equality and diversity, and there was a staff forum. Examples of cultural awareness training included Gypsy, Roma and Traveller communities, Hate Crime, LGBTQIA+ and Sexual Orientation, Neurodiversity and Learning Disability Awareness.

The local authority told us that 74% of people requiring accommodation-based services such as residential care or supported living, were able to remain in borough. People who needed care and support because of their learning disabilities were however more likely than others to be placed further away from people that they knew, due to a lack of local supported living. This created a risk of disconnection from people that were important to them, which might impact on their wellbeing, and other outcomes.

Inclusion and accessibility arrangements

The local authority had a translation and interpretation service. This was available in over 250 languages for telephone calls, face to face and online meetings, and translation of documentation. The service also had a subscription to a web-based tool which aided understanding and communication for people who find reading text difficult, and a library of easy read documents and could provide large print or braille versions if required. Use of this service was not fully embedded in all teams and a partner organisation told us information was not always being provided in accessible languages by the local authority.

The local authority maintained a spreadsheet listing the languages staff were fluent in, including British Sign Language, and Makaton.

Some people found the online nature of Hillingdon Social Care Direct, and sources of information such as the social care directory, inaccessible. This was because of communication barriers, such as not having English as a first language, or wider barriers to communication caused by their health and care needs. For some people this was simply because they did not have access to the internet. This created an avoidable inequity of experience.

During assessments staff used various tools tailored to the individual's communication preferences. They considered the persons preferences for different types of visuals. They considered where and how the assessment should take place to best support the person to feel safe and engage. They considered other factors such as the individual's engagement levels, preferred time, and medication schedule, which could impact their participation in assessments.

The local authority commissioned a report in 2020 “Making the Council more Autism Friendly” which led to numerous initiatives. An environment checklist was developed which was completed annually. This was used in front facing areas of the local authority and focussed specifically on how the environment might impact on the needs of autistic people.

Staff and leaders were mindful of, and working to address, any accessibility issues or limitations on services offered which might impact more on one group than another. They gave examples of providing additional written guidance to help older people use assistive technology and speaking to catering staff in care establishments about limited menus.

The local authority said that oversight of commissioning and use of the advocacy contract was managed, and that referrals were in line with the requirements of the Care Act. This contrasts with feedback from a partner organisation who felt not all staff had a robust understanding of when and how to use advocacy, which meant that people might not be offered it in a timely manner, to support them to speak up for themselves or engage fully in assessments. Staff also reported instances where delays in safeguarding investigations being completed were caused by delays of 4 weeks in providing a suitable advocate. They noted that this usually took 1-2 weeks. This was inequitable.

Public Health had sought to engage with people about health and wellbeing. Based on feedback about what would be the most accessible way to do so, they had set up a series of craft workshops in a venue known to be trusted by those they wanted to reach. This enabled them to build connections with the community and provided useful information.

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 had collected data about demographics, health conditions and mortality rates, and the impact of behaviour on health in their Joint Strategic Needs Assessment (JSNA). They also reported on the wider determinants of health and wellbeing, such as deprivation, employment and housing or homelessness.

Understanding of these contributing factors was evident in the initiatives the local authority put in place, either singly or more often in partnership with health and other partners, such as work to support people to access benefits, to cope in cold weather when experiencing fuel poverty, and to intervene in the housing market to increase the availability of affordable homes. The local authority demonstrated it understood these measures contributed to wellbeing, and to reduce, delay or prevent the need for care and support, for example in response to people with mental health needs.

Staff and partners in the voluntary, community and social enterprise sector VCSE told us they worked closely to identify and respond to the needs of community. Local authority staff told us they were forming much closer relationships by commissioning directly. They were co-producing a specification with the VCSE and had also talked to people at different events about what matters to them - being safe, independent, in control of their lives, and what their best life looked like. A provider also noted the local authority were very focused on local partnerships. They gave an example where the local authority had contacted them about available space for a café for one of their outreach partners, in the ground of their property. Due to the good working relationship between the provider and the local authority, the space was utilised for a café, providing a drop-in service, advice and support to individuals with mental health needs.

Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options which were safe, effective, affordable and high-quality to meet their care and support needs. There was no strategic commissioning function for adult social care. The corporate procurement team were responsible for identifying and understanding the impact of changes in the social care market, and for market shaping. There was no specific focus however on the market for people with more complex needs such as learning disabilities and communication and behavioural support need.

The local authority had a framework for domiciliary care. There were 2 lead providers, one each for the North and South areas of the borough, and 8 smaller contracts on a framework. Lead providers were expected to take 70% of referrals. We heard this had worked well to date, and there was a constructive relationship between partners which meant the provider could say no if they did not have capacity. We heard there were always conversations around numbers, and the local authority worked with them to understand capacity challenges.

Staff in the local authority felt it was better to have fewer providers as it was easier to manage contracts and assure quality. With closer relationships, they could reduce the risk of unexpected provider failure. They felt having a smaller framework also gave resilience, as those on the framework were more likely to be offered work more often.

Whilst the lead provider and smaller framework potentially limited choice, people could express a preference and if appropriate use direct payments to pay the agency of their choice. National data (ASCS Oct 2023) showed 67.74 % of people who used services in Hillingdon felt they had choice over services which was consistent with the England average of 69.81%.

Commissioners had moved from grant funding of the multiple organisations in the voluntary and community (VCS) sector to commissioning fewer, longer, large contracts. There were 10 larger VCS organisations commissioned. A VCS organisation told us however they were given a significant period to seek alternative funding, which they appreciated.

Staff understood flexibility needed to be built into longer contracts, so providers could respond as people's needs changed. They felt they had become more person-centred, and outcome focused in their commissioning approach.

Commissioning strategies were aligned with the strategic objectives of partner agencies, across the local area. The local authority commissioned a "Bridging Care" service to ensure patients who were medically fit for discharge, and only needed a simple home care package, could go home the same day.

The local authority considered specific services to meet the needs of unpaid carers. Local carers described the carers support service, commissioned by the local authority as "gold standard". This provided a sitting service and many other support services. Carers could access bed-based respite via a Care Act Assessment completed by the local authority. Carers in Hillingdon fared better than the average across England in terms of respite. SACE data (March 2024) showed 21.82% of carers surveyed in Hillingdon reported accessing support or services which allowed them to take a break from caring at short notice or in an emergency. This was almost twice the England average of 12.08% Similarly, 33.93 % of carers in Hillingdon accessed support or services to take a break from caring for >24hrs which was significantly better than the England average of 16.14%. Almost a third of carers (32.73%) said they had accessed support or services to take a break from caring for 1-24hrs. Whilst better than the England average, this was still at best 1 in 3 of carers who were able to access support as and when they needed it to take a break from caring, and the data also showed only 1 in 8 carers had time to do things they enjoyed.

The local authority commissioned a range of models of care to reflect the breadth of needs and preferences in the community in line with recognised best practice. They commissioned extensively in models which supported independence, and the least restrictive option for people – such as extra care and supported living. They were commissioning additional supported living accommodation, which was suitable for people with more complex needs, with staffing skilled in positive behavioural support.

Staff told us they were intending to increase their shared lives scheme where a person lives with a family in their own home and is cared for by them. Staff told us they currently had limited capacity in shared lives due to staffing.

Staff supported new and innovative approaches to care provision, where this led to better outcomes for people. The local authority was shown a flexible, homecare service provided in another borough to support people with mental health needs in the short term after they were discharged from hospital. Staff welcomed the information and commissioned it in Hillingdon. Feedback from frontline staff was that the model was working very well. We were also told of an example where a person with complex needs was supported to stay in their family home, with a package of support. This was jointly funded through health and direct payments. The local authority also worked with partners to make the most effective use of resources and facilitated connections between different stakeholders.

The local authority commissioned for outcomes with both the VSC sector, and for independent providers of domiciliary and residential care. The VSC sector were commissioned for outcomes such as connecting people, addressing fuel poverty and wellbeing. Providers told us case studies to understand outcomes formed part of the contract monitoring process. The reablement service was measured against the number of people who achieved their personal reablement goal.

Ensuring sufficient capacity in local services to meet demand

The local authority had the second highest number of care home beds in North-West London. There were 44 care homes in Hillingdon, 60 domiciliary care agencies and 50 supported living providers which is a high number compared to other local authorities. There was not always however sufficient care and support available to meet demand in borough. This was because of the numbers of people from inner London Boroughs placed in these homes due to lower unit costs, capacity was purchased by the integrated care board and the number of people who were self-funders. Most people could access the service they needed when and how but not always where they needed it.

Of the current 44 active homes 26 were residential and nursing care homes for older adults and 18 were working age residential care homes, focused on mental health needs or people with learning disabilities. The care home market was at 96% occupancy. The local authority's Market Sustainability Plan exercise identified demand for an additional 20 beds for nursing & nursing dementia. Staff told us they had a strategy for bed-based services and community services. There were no delays in securing domiciliary care packages. The local authority had invested in extra care provision, and there were 243 apartments to which the local authority had exclusive nomination rights. We were told there were no waiting lists for extra care, although we had also heard there was a lack of suitable supported living for people with more complex needs. Staff reported an extreme example where one person waited 5 years in a care home.

Based on the SACE data cited above, the capacity for unpaid carers to have access to replacement care for the person they cared for, in both planned and unplanned situations was better than in other places, but still only met the needs of a proportion of carers.

There were some gaps in the availability of residential care for people with more complex needs, such as dual diagnosis of learning disabilities and mental health needs in the borough. People with these needs, or with complex behavioural/communication needs resulting from dementia, were more likely to be placed out of borough. The local authority was aware of this issue and had plans for specialist care home capacity including dementia nursing care. They were also working on a proposal to develop a short-term provision to meet the accommodation-based needs of people with dementia.

The Market Position statement 2024-27 for the local authority specified there were no plans to increase the supply of supported living accommodation in self-contained flats, despite acknowledging an apparent mismatch between demand and supply. Between March 2023 and February 2024 51% of placements were made out of borough, some of which were based on supply rather than complexity of need or other requirement. The local authority told us updated data analysis shows that now only 26% of supported living placements for people with learning disabilities are being made out of borough. There was an expressed intention to collaborate with people who use services, their families, providers and NHS partners in 2025/26 to develop a supported housing strategy, in accordance with national requirements.

Staff told us there was reasonable capacity in the domiciliary care market, and there were no delays to hospital discharge for people who needed domiciliary care or reablement. Where a person needed a non-complex residential or nursing placement staff told us placements happened very quickly, and always placed people within the borough unless people actively wanted to move out of borough.

The local authority told us 418 people were currently placed in out of area placements, of which 111 had occurred since March 2023. Of these 164 were long term placements markedly further away than a neighbouring borough, and 41 were supported living placements for people aged 18-64 outside the London area. The local authority said for the majority, it was personal choice, for legal reasons or safety. There were occasions where urgent out of borough placements were needed to ensure people's care and support needs were met in a timely fashion. Being placed out of area when it wasn't personal choice, meant that people were further away from their families, friends and communities.

Staff told us they had a strong relationship with the Care Home Support Service which was managed by primary care and health partners. The local authority's quality assurance team met monthly with a care home matron which all care homes had access to. They helped avoid hospital admissions through a range of support to the care homes including falls prevention, hydration and nutrition.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of care and support services being commissioned for people, and supported improvements where needed. Staff told us the Quality Assurance team did in-person monitoring visits, shared intelligence with other local authorities and where appropriate liaised with the CQC. If the host authority of an out of borough home identified concerns, a Hillingdon social worker would attend to review people's needs.

Providers told us the monitoring and evaluation of services were conducted through the quality and monitoring service using both announced and unannounced visits and examining the people's journey. One provider told us the contracts and monitoring team referred to both qualitive and quantitative data, such as the achievement of outcomes for people, and how satisfied they were with their care as well as timekeeping and lengths of visits. This demonstrated that the local authority were concerned about the quality of care.

There was a provider risk panel which met monthly, and the local authority had recently invested in a risk scoring tool to support this. The panel considered any concerns arising from reviews, quality assurance visits, safeguarding, complaints or anything else. This would include intelligence from another local authority, or where a problematic pattern had been noted. These were discussed at the panel and recommendations made to the Care Governance board about the measures which should be taken regarding the provider.

Staff provided an example whereby they had worked with a provider under the concerns process, to uphold the standard of care required. The local authority sought improvements in their supported living service. The provider also ran a residential care home, but this was not implicated in the concerns. After a period of discussion and support from the local authority, the provider decided to leave the market completely in Hillingdon citing operational and financial pressures. The local authority brought the supported living service for 4 people under their control, so that care for those people was not disrupted.

The only other provider who handed back their contract in the last 12 months, was a homecare and outreach framework provider, who gave notice on cost / affordability grounds.

Other evidence of the operation of the local authority's robust approach to quality is seen in the following data. In the last 12 months, they had suspended new referrals to 4 providers on the Provider Concern list for a period. These included the Care Provider referred to above, 2 Supported Living Providers, and a Day Care service. There were also 7 care provisions within the borough footprint placed on a 'Do Not Place' embargo due to quality concerns and issues.

Staff told us they would not issue a contract to any provider rated less than good by CQC. If they were a new and not yet inspected provider, they would be prioritised for an assessment by the Quality Assurance team and intelligence would be gathered from other local authorities, who might be aware of them. Being as yet unrated would trigger more due diligence. Where a provider subsequently received a rating lower than good, this would trigger the local authority to work with the provider to support them to address concerns.

Care home ratings by CQC in Hillingdon were slightly better than the England average, with 82.14% of residential homes rated Good, 14.29% rated Requires Improvement and 3.57% are rated inadequate. 82.35% of nursing homes were rated Good, 17.65% were rated requires Improvement.

Ratings for supported living providers in Hillingdon were lower than the England average with 46.72% (compared to 63.79%) rated Good, 23.81% (compared to 10.24%) rated requires improvement, and 28.57% currently have no overall rating, which is higher than the England average.

58.57% of homecare providers in Hillingdon were rated Good, 10% were rated requires improvement and 31.43% currently have no overall rating. This is similar to the England averages.

Staff told us the quality assurance team would also go to services they did not directly contract with, and all providers were invited to the providers forum. The local authority invited speakers and offered training for providers. We were told the local authority worked with Skills for Care to facilitate a quarterly registered managers' network which was open to all providers in Hillingdon. Meetings were in person rather than held virtually, because they had feedback this was providers' preference, and they had good attendance.

Providers we heard from were very positive about the way in which the local authority worked with them. One provider said the local authority played a vital role in empowering them to deliver high quality services to meet the needs of vulnerable people. We also heard the local authority acted as a supportive intermediary with health and other partners on behalf of their contracted providers.

Ensuring local services are sustainable

The local authority collaborated with care providers to ensure the cost of care was transparent and fair. There was a framework rate for different provisions set by an external organisation, but only 20 care homes were on this framework and due to demand the local authority often paid significantly above these rates. The supplier relationship team worked with corporate procurement, safeguarding and quality assurance teams and had a quarterly two-way meeting with domiciliary care, residential and nursing homes, and supported living providers to share information and address issues or concerns.

The local authority recognised longer contracts of up to eight years, gave providers financial stability and allow for longer-term planning, which in turn helped secure better service quality for residents. To ensure contracts remain appropriate and effective, they built in scrutiny within this time and the opportunity to consider whether both parties wanted to continue. This was articulated in the local authority's Market Position Statement and was the default approach unless there was a good reason not to.

Staff told us they had worked with providers and analysts employed at a NWL regional level to look at care home fees. We heard providers put in requests for uplifts, which were considered under the uplift procedure. The local authority had discussions with them based on submitted business plans and individual need. Providers confirmed it was possible to have discussions and negotiations about rates, and there was room for negotiation, but it was usually about meeting an individual's needs, rather than generic uplifts. Providers acknowledged the local authority might not always agree to their requests, but listened, was responsive and supportive, and made and communicated decisions in a timely manner.

One provider told us 95% their invoices were paid within 5 working days, and disputes were responded to and dealt with in a timely way.

The local authority collaborated with the North-West London Alliance (NWLA) about providers who worked across the region. NWLA engaged with large private care home providers to talk about the costs process and Hillingdon used the information to inform their costings. Staff told us they felt it helped to know what other local authorities were paying.

Staff said they incorporated what providers said about their wages when they set the fees framework. The provider's annual contract monitoring review included consideration of the annual level of pay, and quality assurance monitoring looked at how staff were paid. Providers weren't contractually obliged to pay the London Living Wage, but the local authority expected them to pay the National Living Wage and for homecare providers to pay travel time between appointments. Providers confirmed this was their experience.

Staff said sponsorship licences had been a big issue in the provider concerns process and there had been several licence suspensions. When the local authority was notified about a suspension, they reviewed the service and talked to the provider about contingency plans in case the licence was not reinstated. They worked closely with other local authorities to support each other if a provider in their footprint was impacted. Most of the providers commissioned by the local authority were not involved, but across the wider domiciliary care market, there was 16% of international recruitment. The local authority collated data about all providers who were part of the scheme to conduct a risk assessment and had suggested they formally address this collectively at the wider NWLA. When a provider's licence was revoked the local authority helped workers to secure other employment if needed. Providers also reflected when they had been affected, the local authority had supported them to provide the information they needed for assurance, whilst being patient and understanding.

Providers told us the partnership approach the local authority took with them resulted in improved outcomes for individuals. They said they had demonstrated their commitment to supporting care businesses by streamlining communication channels, providing access to resources and information relevant to their industry, and offering guidance on best practices in care provision. They told us this continuity fostered effective partnership working and facilitated co-production and co-creation. While there was always room for improvement, the local authority consistently worked towards addressing areas of concern identified by the providers.

Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruption or provider failure. Providers were expected to have contingency plans, and the local authority was confident and could demonstrate most departures from the market were planned and managed, although occasionally individuals might be impacted by a short notice move. The local authority had a good understanding of current trading conditions and how providers were coping with them.

Staff understood the risks in the health and care sector market. They acknowledged competition from Heathrow meant providers had to pay more. The data about the adult social care workforce in Hillingdon showed mixed results compared to other places. According to the Adult Social Care Workforce Estimates (ASC-WE Oct 23), the sickness absence rate in Hillingdon was 4.11 days which was slightly better than the England average of 6.24 days, and the rate of turnover in adult social care (all jobs, all sectors) in Hillingdon was 0.15 which was significantly lower than the England average of 0.29. However, staff vacancy rates in Hillingdon were 14.89% - significantly higher than the England average of 9.74%.

Staff noted the workforce was ageing which meant people would potentially retire, leaving a shortfall. A new workforce strategy had just been published. They also recognised the age of care homes was an issue, for example being built to an earlier standard, so not all rooms had ensuite facilities. This was something individual providers needed to address but the local authority recognised it was a challenge in the medium and the long term for the market.

A provider told us the local authority had actively supported them by providing training opportunities for staff such as diabetes awareness, safeguarding adults, and a North -West London medication event through Skills for Care. The percentage of ASC staff with a care certificate in progress or partially completed, or completed in Hillingdon was 58.48% as compared to an England average of 49.65% which was tending towards a positive variation (ASC-WE, October 2023).

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 worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area.

Annual priorities were agreed jointly between the Hillingdon Health and Care Partnership members and the local authority. There was a lead for each strategic priority, a single process agreed, and all staff worked to agreed standards and as a team without being redeployed. The local authority was the strategic lead for discharge flow, and this was working effectively. It was noted the focus for current priorities was on the needs of the acute Trust, but the Health and Care Partnership board were planning to focus next on joining up early intervention and prevention.

Partners acknowledged the local authority was committed to working in partnership, so services worked seamlessly for people. They said they had shared information and learning with partners and collaborated for improvement. The local authority worked actively towards integrating care and support services with services provided by partner agencies.

The local authority worked with the local mental health Trust to develop a non-clinical, short stay service for people with mental health needs who were facing a crisis, to aid de-escalation and avoid an acute hospital admission. This was identified as part of the Adult Mental Health crisis pathway transformation programme.

A senior health leader told us their organisation had excellent relationships at all levels and across all parts of the local authority. They said they had worked with many local authorities, but this was the best relationship they had experienced, putting people at the centre of decision making and action.

The local authority had a voice and influence in the place-based partnership with 3 key leadership roles. A key health partner said Hillingdon had one of the better placed-based partnerships which was well aligned with health. The local authority had contributed estate resources to house community health facilities, including 3 super hubs, which offered a broad range of services.

There was a Partnership Board for People with Learning Disabilities. A local voluntary sector organisation was working with the local authority to set up an Expert by Experience group to consult on a new learning disability strategy. There was also an Autism Partnership Board, whose purpose was to enhance pathway transitions and ensure a more coordinated and consistent approach to assessment, care planning and ongoing support. There was an expert reference group of Autistic people who were supported by a voluntary sector organisation to contribute, support and participate in the Autism Partnership Board. The group had been involved in the development of the board, signing off the local authority's Autism Training and some activities from the Local authority's report on making the local authority more Autism friendly. The approaches for listening to the local community showed an approach that was flexible and responsive.

The local authority had integrated aspects of its care and support functions with partner agencies where this was best practice and when it shows evidence of improved outcomes for people for example in hospital discharge arrangements.

Arrangements to support effective partnership working

There was a clear and detailed partnership agreement between the local authority and North-West London Integrated Care Board (NWLICB) relating to the commissioning of health and social care services through Better Care Funding (BCF) under s75 of NHS Act 2006. 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 local authority used pooled budgets to jointly fund services with partners to achieve better outcomes. In Hillingdon the BCF resourced two 3-year contracts for 15 intermediate care beds (referred to locally as Step Down) for those requiring residential rehabilitation and reablement on discharge from hospital, reablement in the community and the short-term Bridging Care service. Bridging Care was available for the first 5 days, then reablement was offered for a maximum of 6 weeks. 80% of Bridging Care patients went on to reablement. Hillingdon were the first local authority in North-West London to introduce this service and NWLICB mandated it across all 8 local authorities in their footprint. Commissioning staff told us they were also managing personal health budgets, the health equivalent of direct payments, on behalf of the ICB under the BCF s75 as the local authority had the infrastructure and expertise to support people with this.

A senior health leader described the local authority as one of the better integrated boroughs in respect of how they worked. We heard the discharge hubs had been done in partnership with health, and the Integrated Neighbourhood teams and Primary Care Networks were an example of this. They also said there had been many years of developing joint working and this showed in hospital flow.

Staff told us governance of joined up commissioning arrangements came under the Health and Wellbeing Board, and the s75 agreement. Operational meetings managed delivery and were overseen by a BCF core officer group which included senior leaders such as the corporate director for Adult Social Care and the director for the Hillingdon Health and Care Partnership.

Impact of partnership working

A partner organisation told us they had co-produced the discharge-to-assess process with the local authority resulting in the Bridging Care service, which was now successfully implemented, resulting in better outcomes. The success of these processes was recognised by all stakeholders. The local authority had also recognised the importance of collaboration in achieving reablement goals, understanding these projects could not be accomplished in isolation.

Staff told us they could clearly see the collaborative opportunities within the borough to provide services to people and gave examples of the opportunities for people with a learning disability to be involved in their communities, which positively supported wellbeing.

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.

Working with voluntary and charity sector groups

A key strand of the partnership approach in Hillingdon was to engage with people through the voluntary sector.

One voluntary sector organisation was involved in a local authority project to set up an Expert by Experience group to consult on the new learning disability strategy. We also heard there was a strong working relationship between the local authority and the sector and they had a good knowledge of it.

One voluntary sector group noted there had been stronger links with professionals from the local authority, but those links were based on individuals and were not always continued if someone left. They said they were always invited to sit on boards and be part of groups, but they didn't always hear back how their feedback was used in practice. They told us they would receive grants or funding for specific pieces of work they have been asked to complete by the local authority.

We heard the local authority was looking to work more with the VCSE sector, were valuing what the sector was able to do and using them to increase activity for older people. It had been a piece of partnership work which had also strengthened relationships.

The local authority, together with NWL ICB, was using the Accelerated Reform Grant to fund a voluntary sector organisation in Hillingdon to identify unpaid carers. This was part of a co-ordinated approach across the whole of the NWL ICB footprint, involving 8 local authorities and their local carers organisations.

Theme 3: How London Borough of Hillingdon ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The local authority and other system partners prioritised safety. They understood the risks to people across their care journeys which were identified and managed proactively. They had mapped the pathways for transitions people experienced, and through standard operating procedures, detailed process maps and dedicated teams, built a robust framework for managing transitions effectively. They said through collaboration, best practice models, and a person-centred approach, they aimed to uphold the highest standards of care and support throughout the transition journey.

For example, staff told us although there were internal key performance indicators for discharging people from hospital in a timely manner, risk was a major consideration at every point of the discharge process. People would always be risk assessed to ensure their safety, informed by a multi-disciplinary team (MDT) which included both health and social care perspectives.

Where more than one organisation was involved in delivery, policies and processes about safety were jointly developed, and there were opportunities to share learning and drive improvement through partnership and governance boards. Some services were integrated, whilst others worked in close partnership in relation to transitions or joined up working.

It was clear information sharing protocols had been considered, and supported safe, secure and timely sharing of personal information in ways which protected people's rights and privacy.

Safety during transitions

Care and support was planned and organised with people, together with partners and communities in ways which improved their safety across their care journeys and ensured continuity in care. This included referrals, admissions and discharge, and where people were moving between services.

Transitions between children's and adults' services were managed by the Preparation for Adulthood team. This team worked with people from the age of 17 until 25 or earlier if they left education. At the point of leaving education, young adults would be transferred to the appropriate adult team for ongoing social care support. Staff told us there was good partnership working with education, health, police, housing and other agencies.

There was a legal framework for the transition process which started at 14. Children's services presented information to a multi-agency panel, according to identified needs and the age of the young person. The more complex a young person's needs, the earlier their circumstances would be brought before the panel for planning to start.

Children and young people with more complex needs, who were more at risk of being admitted to long term health care provision were considered monthly and would be rated according to risk and urgency.

Staff also cited examples where, due to a breakdown in family relationships or a crisis in a young person's health, they were brought at short notice to the panel, which met regularly, but could also be summoned ad hoc. There was a strong sense of partnership between different agencies and different teams within the local authority in the service of meeting the needs of young people. They communicated effectively and were responsive to each other. The hospital team, out of hours teams and housing worked with social care services and others to provide the most effective response in a timely manner.

A young person we spoke with was very positive about their experience of transition from children's to adult's services. They reported the assessment included the views of people who were important to them, at their request. The placement identified was nearer to valued family members, promoted independence, enabled attendance at college, and made the person happy. Family members had not however been offered a carers assessment and did not know what support was available as an unpaid carer.

There was an integrated discharge team at the centre of safe transitions which was constantly in contact with social care to ensure transitions from the acute hospital to the community were seamless.

Local authority staff attended a multi-agency meeting with health and care provider colleagues 7 days a week. All patients who were medically fit for discharge from the hospital, and in rehab beds were discussed, as well as more complex cases when needed. The local authority provided expertise and appropriate challenge in discharge planning for patients and was seen as a key component to MDT working in the discharge hub. The aim of these meetings was to ensure people were on the right pathway and to review where care processes were up to. There was a second meeting at the end of each day to review any cases which had not been progressed or faced unexpected barriers to discharge.

The Bridging Care service was effective in ensuring same day discharges for people who could go home to their previous address but had some additional care needs. This service was provided for up to 5 days post-discharge, to allow for longer term provision to be arranged.

Health staff said they also had good engagement from the local authority to support the flow from rehabilitation and intermediate care placements to longer term care arrangements.

One partner said there were clearly established processes to escalate delays or discharge queries. The local authority team was found to be responsive and to proactively engage with patients to support discharge as soon as safely possible. A senior health leader said every patient had an identified social worker, not just a team. They reflected the social workers were more rigorous than they had seen before. They said the social worker communicated with everyone and continued the conversation until all issues were resolved, never leaving an unresolved problem or an unhappy patient. Any impact on family members and unpaid carers of discharge plans would be incorporated into this discussion.

Staff told us in cases where interim support was required for a person with learning disabilities or autism, the appropriate response depended on how the need was identified. If a referral was received under the Discharge to Assess (D2A) process, typically accompanied by an occupational therapy report, efforts were made to adhere to the recommendations and implement services required. The social worker usually aimed to visit the resident as soon as possible.

A health partner said local authority staff had a problem-solving approach which enabled further collaboration and ongoing development of our services and processes. The team were open to challenge and would support and guide the discharge process. We heard the managers communicated regularly and were actively involved in supporting the Hillingdon Health Care Partnership. They also told us the local authority had been fully engaged with moving towards using a digital discharge patient tracker (OPTICA). It was hoped this would reduce duplication of work, removing waste of meetings, and streamline the communication related to patients' assessment, discharge planning and discharges in which ASC participation and engagement is key.

We also heard separately, of local authority involvement in a “Christmas Eve” initiative, to identify and address system blockages which delayed discharge. The local authority had facilitated a change in process, whereby if a social care assessment was completed, if it was safe and appropriate to do so, the outcome could be shared verbally, and next steps initiated whilst the documentation was written up. This reduced the time taken to get patients discharged which enabled people to return home or move to their next place of care sooner. The rigorousness of assessments and understanding of the person’s circumstances mitigated against unsafe discharges due to poor planning.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. The local authority told us when individuals moved to another local authority, their approach involved close collaboration with the relevant authorities. They noted their procedures facilitated seamless transitions and ensured individuals continued to receive the necessary care and support during the transfer process. This included bridging services to maintain continuity until the new host authority commenced provision.

Where an individual was no longer able to self-fund their care, the local authority’s procedures included provision to support them through transitions in care. This involved exploring alternative funding options, accessing community resources, or facilitating transitions to appropriate care settings while maintaining continuity of support.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions in the provision of care and support. They had a provider failure procedure and were able to evidence how this had been used to ensure the safety and continuation of care provision for residents. The local authority knew how it would respond to different scenarios; plans and information sharing arrangements were set up in advance with partner agencies and neighbouring authorities to minimise the risks to people's safety and wellbeing.

A senior leader in health advised there were never any disputes in Hillingdon as to who paid for care. The local authority moved the person then negotiated behind the scenes without impacting on the patient or flow. The local authority told us they had implemented measures to prevent financial disputes. In cases involving Continuing Health Care (CHC) funding, adult social care conducted assessments and made placements simultaneously, completing checklists and making decisions without prejudice to ensure safety and continuity of care. They held a weekly CHC panel where cases are presented and discussed, and in emergency situations, cases could be presented outside of the panel.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems, processes, practices to make sure people were protected from abuse and neglect. These included person-centred assessment and care planning with people, effective quality assurance and support of registered care providers, whether commissioned by the local authority or not, and robust safeguarding arrangements. Some partners however, said there could be more information around who to contact in the local authority when they have issues or wanted to support people, including for safeguarding.

The local authority had a Safeguarding Adults Board and worked with partners to deliver a co-ordinated approach to safeguarding adults in the area. In addition to the Board, there was a strong multi-agency safeguarding partnership, and the roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place so concerns could be raised quickly and investigated without delay. The Board had a clear business plan and produced an annual report.

The Safeguarding Adults Board Chair was from one of the organisations who were represented. This was a rotating position, with the expressed intention it increased commitment to the Board. This arrangement had been approved by the Department of Health and was found to be effective in practice. There was an independent scrutineer who reviewed how well the board was performing. The Safeguarding Board also undertook an audit to determine how well it was functioning. The Chair had received positive feedback the Board had an open and transparent culture.

National data from the ASCS (Oct 2023) showed people who used services in Hillingdon reported similar levels of safety to the England average. 68.79% of people who used services felt safe, and 88.30% of people who use services who said those services made them feel safe. National data relating to carers SACE (Jun 2024) was less positive, showing only 73.21% of carers who felt safe which was lower than the England average of 80.93%.

Staff in the local authority told us they were trained to level 3, which meant they were suitably skilled and supported to undertake safeguarding duties effectively. They received ongoing training, supervision and learning. The national ASC-WE data (Oct 2023) showed 30.79 % of independent or local authority staff had completed MCA DoLS training and 44.15% of independent or local authority staff had completed safeguarding adults training which were both similar to the England average.

Responding to local safeguarding risks and issues

The local authority had a clear understanding of the safeguarding risks and issues in the area. They told us they worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. Senior leaders said that meetings took place between the police, health partners and the local authority to discuss wider issues, which were fed down through organisations, allowing a proactive approach as information was shared earlier.

Staff had a good understanding of the prevalent risks in their local community and spoke of forced marriage, cuckooing, county lines as well as risks associated with hoarding and self-neglect. Staff told us the Safeguarding Board partnered with the NWLA, and resources such as 7-minute briefings, were shared. These briefings contained key information and knowledge derived from recent trends identified in the borough or from case reviews. Bespoke training sessions were occasionally organised, focusing on topics such as honour-based violence, forced marriage, and female genital mutilation (FGM). A partner organisation who was represented on the Safeguarding Partnership Board, supported the local authority in the preparation of a support document on hoarding.

The Safeguarding Adults Board had an infrastructure with representation from all key partners, to ensure lessons were learnt when people had experienced serious abuse or neglect and action was taken, to reduce future risks and drive best practice. There was a Safeguarding Adults Review (SAR) Panel, which looked at cases which had resulted in serious harm or death of a person with care and support needs. The 'Learning from Practice' task and finish group considered these, with the outcomes of a range of other reviews, research and any other significant information. This group reported to a quarterly Learning Development Forum which led on the planning, delivery and quality assurance of training and service development across the Hillingdon Safeguarding Partnership.

Following the 2 SARs in 2022/23, recommendations and action plans to improve practice were developed. These included mental capacity assessment in the context of self-neglect, the importance of professional curiosity, appropriate challenge when what is seen does not match what is said and avoiding "diagnostic overshadowing" whereby practitioners wrongly assume symptoms of physical illness are instead a symptom of mental illness or learning disability. Several resources were developed by the Safeguarding Board to support learning. An audit was used to assess what had supported learning most effectively, and whether practitioners had retained what they learned. The audit however concluded there was little assurance learning from recent SAR's had been embedded into policy, procedure or training among agencies including the local authority. The Safeguarding Adults Board had measures in their Business Plan for 2024-27 which sought to address this concern.

Responding to concerns and undertaking Section 42 enquiries

According to national data in the Safeguarding Adults Collection (SAC) (Sept 2023) 588 enquiries in Hillingdon met the Section 42 (s42) threshold over time (based on 2017-2022) but this average was based on annual figures from 245 in 2017 to 900 in 2020. Figures were significantly higher during the COVID 19 pandemic and have since dropped back to approximately 500 per year. In 2023- 24, 20.5% of 2810 referrals met the threshold for investigations under s42.

The local authority and other system partners were clear about what constituted s42 safeguarding concern and when s42 safeguarding enquiries under the Care Act were required, and this was applied consistently. There was a clear rationale and outcome from initial enquiries, including those which did not progress to a s42 enquiry. A s42 enquiry is the action taken by a local authority in response to a concern a person with care and support needs may be at risk of or experiencing abuse or neglect.

There were multiple channels through which members of the public or professionals could pass on information or raise safeguarding concerns. Some providers told us there had been issues raising safeguarding alerts, which noticeably improved when escalated to senior staff in the local authority. All safeguarding concerns or referrals were passed to the Multi Agency Safeguarding Hub (MASH) service.

The local authority said there were no safeguarding concerns awaiting initial review as all cases were allocated within 24 hours. The MASH service responded to all enquiries and completed initial enquiries within 24 to 72 hours to establish crucial facts of the concern. They used this to determine the level of safeguarding response required by the local authority or partner organisations. They reviewed whether there was a protection plan in place to keep people safe and reduce future risks, and whether it was adequate. If not, they would take action to ensure the person was safe pending any further investigations. A leader told us that any enquiries which took longer than 50 days were explored, and support provided where necessary to bring to a timely conclusion.

There was no waiting list for s42 enquiries. If a s42 enquiry was necessary, the case went to a MASH s42 officer for review and then to the correct locality or specialist team for the s42 investigation. If there were mental health concerns, a referral would also be made for relevant support. Managers from the MASH team signed off every decision which was made. The MASH team oversaw s42 enquiries, audited them before they were concluded and provided feedback to locality teams. There was a consistency of decision making, and quality assurance through management support, audits and formal supervision. The MASH team told us they tracked concerns and enquiries through monthly meetings, reviewing data outcomes as well as case notes and could view trends.

Safeguarding enquiries were not usually conducted by care providers in Hillingdon but were occasionally delegated to a hospital provider. The local authority retained responsibility for enquiries and the outcome for the person(s) concerned. All enquiries were quality assured by the MASH team, before they were concluded. At the end of each s42 enquiry, the person would receive a closure letter and every person at risk had a conversation with MASH team members. The local authority's information system provided an infrastructure which kept the process open and in the correct stages which could not be signed off until all steps were taken.

Some partners told us they didn't always get feedback following a safeguarding referral, but others noted they attended a safeguarding multi agency risk panel and there was inclusion from VCS organisations into these meetings. They said the relationship with safeguarding was good and they generally received feedback/outcomes from safeguarding referrals, although some noted they might have to chase these.

Deprivation of Liberty Safeguards (DoLS) are when people in care homes and hospitals are deprived of their liberty in a safe and correct way, to receive care and treatment. This is legally authorised under the Mental Capacity Act 2005 and is only done in the person's best interests and when there is no other way to look after them. The local authority provided data which showed they had no waiting lists for Deprivation of Liberty Safeguards for people in residential care. Once identified, cases are allocated for assessment within 5 to 7 working days and sooner where there is an urgent need to complete. Most people whose DoLS authorisations were ending were also reviewed and renewed in a timely manner.

By contrast the local authority had some delays in administering DoL for people living in the community, for example in supported living, where the degree of supervision and living arrangements amounted to a deprivation of liberty. By the end of February 2024 there had been an increase in the numbers of people requiring a Community DoL overall to 302. The local authority told us they have identified distinct workers to focus on Community DoL applications to improve the number being completed and reduce the backlog. Further solutions were being considered to fully resolve the challenges.

Making safeguarding personal

The Safeguarding Board took seriously the importance of Making Safeguarding Personal and undertook a yearlong project to seek the views of people who had been involved with safeguarding, as an adult or a child. As a result, they had produced a video webinar and briefings to educate professionals about what people said was important to experiencing safeguarding in a more personal way. These included good listening, tailoring communication, clarity about the process and relationship and rapport building. Some people were sharing this feedback to address poorer safeguarding experiences in recent years.

Staff told us they were committed to making safeguarding personal and prioritised implementing the least restrictive measures. They facilitated safeguarding meetings in places suitable to the person and where they felt safe, such as local libraries, and routinely asked for the individual to share their desired outcomes from the protection plan. Enquiries were carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. Once a referral was passed to a team for the s42 enquiry, they developed a strategy within five days, and created a plan for the enquiry officer to follow up on specific actions. They engaged with the adult at risk to obtain consent and progressed to a case conference if necessary. They adhered to established timeframes, with safeguarding processes aimed to be concluded within 50 days.

Most people had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they didn't feel safe, or they had concerns about the safety of other people. We spoke with one family who confirmed this. They were confident they would receive feedback from any safeguarding concern they raised.

People could participate in the safeguarding process as much as they wanted to, and people could get support from an advocate if they wished to do so. National data from the Safeguarding Adults Collection (SAC Sept 2023) showed 96.15% of individuals in Hillingdon who lacked capacity were supported by advocate, family or friend (SAC) which was significantly above the England average of 83.12%.

People were supported to understand their rights, including their human rights and those under the Mental Capacity Act 2005, and the Equality Act 2010, and they were supported to make choices which balanced risks with positive choice and control in their lives. Staff told us if a person lacked capacity, they used advocacy services and might also request an Independent Mental Capacity Advocate (IMCA), particularly if considering changes to a service user's accommodation. We heard staff had a good response from the service providing advocacy in the borough, but it could sometimes take a while for an advocate to be allocated to a case, particularly to access advocates for section 42 safeguarding investigations. This had an impact on the timeliness of completing investigations. Staff told us monthly meetings were held with advocacy providers to discuss capacity and understand any barriers to progression of a case.

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 relation to the delivery of Care Act duties, the local authority had structures in place which were overseen by the local authority Executive Portfolio Holder for Adult Social Care and Health, and the Health & Social Care scrutiny committee. The Corporate Director of Adult Social Care & Health reported directly to the Chief Executive, ensuring accountability and transparency in decision-making.

The Chief Executive Officer of the local authority had previously been the DASS. The current DASS had been at the local authority for some time and the 2 officers had a strong, effective and positive working relationship. We were told they shared a vision for adult social care, as articulated in the Adult Social Care and Health Plan 2024-27. Leaders at the local authority were confident the local authority members had an interest in, and were committed to, adult social care delivery, especially effective safeguarding. Other members of the leadership team reported excellent partnership working across the team. The team was stable, and there were clear roles, responsibilities and accountabilities. Leaders were visible, capable and compassionate.

The adult social care directorate was accountable to the Health and Scrutiny Committee, and to the Executive leadership group of the Hillingdon Health and Care Partnership, when necessary. The local authority's political and executive leaders were kept informed about the potential risks facing adult social care as reflected in the corporate risk register and considered in decisions across the wider council. Some members of the council reported the Scrutiny function was effective, although others felt that they were not provided enough information to provide constructive challenge.

The local authority told us the Chair, co-chair and Adult Social Care portfolio holder received information about ASC as members of the Scrutiny Committee. Members were briefed and given information about risks and challenge was presented at the committee to officers. This included updates on the quality and sustainability of services, for example at the Scrutiny Committee meeting which took place during our assessment, the Adult Social Care market position statement, and the Carers Strategy delivery were both reported on. This process is screened live on YouTube for resident engagement, has a public gallery and gives good information to elected members from both parties to enable good governance and decision making. The meeting where the Carers Strategy and Market Position statement were discussed, evidenced robust and detailed challenge to hold the local authority to account for its delivery of duties.

There was a detailed forward plan in place, which undertook major reviews, although some items, were presented, for scrutiny and challenge from all members of the committee in addition to the reviews and challenges of health and care services."

Strategic oversight and management of some services was not as effective as it might be, which impacted on people's experience. For example, although the local authority told us they had oversight of demand and future requirements, it was unclear what action was taken to address the lack of timely advocacy for some people who consequently experienced delays in safeguarding investigations. Similarly, people's experience of OT assessment and provision of equipment was variable. Some people had to wait longer than others purely because they were already known to social services, and therefore had to follow a different pathway.

The local authority told us that they had provided external practice supervision for some members of the OT team and that each person had a personal development plan where training needs were identified, and which were monitored monthly. Some staff told us that non-social work staff such as OT's had difficulty in accessing what they considered to be significant training, such as Mental capacity Act refreshers and the local authority may wish to explore this further to ensure that the arrangements were effective.

A risk register was maintained at a directorate level, with risks owned, actions planned within agreed timescales and reported on. For each risk, the impact and likelihood, and actions planned or taken were recorded. For example, equipment delays from the regional contracted provider were on the directorate risk register and were being addressed. The identified risks of minor delays of equipment were mitigated with oversight by the equipment contract manager and the OT Team Manager.

There were weekly Senior leadership team (SLT) meetings with clear governance where risk issues and mitigation were discussed. Contingency plans were in place for each service area and there were live dashboards of people's feedback of their experience of care and support, which were discussed at SLT.

Strategic planning

The local authority used information about risks, performance, inequalities and outcomes to inform some adult social strategies and plans and to allocate resources especially in relation to social work staff. They delivered, or had plans to deliver, many of the actions needed to improve care and support outcomes for people and local communities. For example, commissioning information showed a proportion of out of borough supported living placements were caused by demand exceeding supply in the area. Plans were in place to provide additional shared care settings, but not for more self-contained supported living options, which may be more suitable for people with more complex behavioural needs. However, there were further plans to recommission the contracted provision of supported living services in 2026. There had previously been delays in accessing advocacy by Hillingdon people from the commissioned provider, but usage had increased during 2024. The was senior level oversight of the demand and future requirements of the service to prepare for retendering in 2025.

The joint strategic needs assessment provided information, and the local authority had established a population health management team whose role was to focus on and address health inequalities within the borough. Staff told us they collaborated with external partners and adopted a systems approach to anticipate and address future health events, aiming to protect adult social care services in the long term. They recognised the importance of adopting a data-driven, insight-based approach to developing strategy, rather than relying solely on community feedback.

The local authority used data about current performance, although they recognised previous data collection had not captured some useful metrics, such as average waiting times over a year, rather than snapshots in time, and had committed to addressing this. Leaders told us they benchmarked their performance data with other neighbouring local authorities, as well as nationally published data. They also told us reviewing the local authority's own performance was a slow, manual process, but this has recently been transformed and was now much better supported by IT systems.

Evidence and data collected through work by the Safeguarding Adults Partnership identified rising trends in different safeguarding risks, such as domestic violence and self-neglect. Actions were identified such as increased training or practice support to improve care and support outcomes, although an audit had shown that previous learning from SARs had not yet been embedded or led to consistent changes in practice across all partners.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems. In every aspect of service delivery where agencies were working together, either as partners or in integrated teams, there was appropriate governance and protocols to ensure people's personal information was kept safe. This was not a barrier to different professionals working together to achieve safe, effective and personalised care and support. Staff told us about an information system which was owned and used by health staff but to which social care staff had access. Staff described this integration of systems as an improvement to their work. They said case notes were easier to access and it was more time efficient. Health leads noted social care staff could not yet add to these records which caused duplicate records and additional administration. There was a proposal to address this issue.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

Staff told us there was an inclusive and positive culture of continuous learning and improvement. Most local authority staff had ongoing access to learning and support, so Care Act duties were delivered safely and effectively. Some staff in specialist teams however reported more difficulty accessing training specific to their roles and felt their team function was less well understood by wider colleagues. This meant that some professionals had less support to maintain their professional competency, and less joined up working to support people from different perspectives. For people there were potentially lost opportunities to provide more tailored support which promoted and maintained independence. Staff also expressed that whilst they received a lot of practice information, they did not necessarily have the time to absorb it.

Many staff reported a significant focus on continuous professional development and opportunities to shadow other team, learn and progress. Leaders reported there was a panel for the assessed and supported year in employment (ASYE) for newly qualified social workers. The local authority also supported some people working in the voluntary sector as social workers. We heard the local authority had a culture of "growing their own" professionals through apprenticeships, although these were limited to social work roles. No such equivalents were offered for OT's or other roles. The local authority was developing a documented progression procedure to formalise the current approach based on capability and evidence of practice. Social work staff reported Hillingdon was a good place to work, and many had been employed there for several years, some despite long commutes.

There was a Principal Social Worker (PSW) in the senior leadership team, although this role was held by someone with a broad portfolio. The seniority of this role had enabled them to have strategic and leadership influence, and we heard of changes in the way Mental Capacity Act assessments were conducted because of their input. However, there were missed opportunities for this role to shape and lead strategic developments from a social model of disability perspective potentially due to the breadth of their role. Quality assurance of social work practice was managed by operational assistant directors, then reported to the PSW, which also reduced their ability to engage in a timely fashion to improve practice. The local authority advised they were reviewing where the PSW was situated in the management structure and the scope of their role, but it would be a lost opportunity if it were no longer part of the senior leadership team.

There was a lack of evidence of learning from audits, and how this linked to continuous improvement. The audit undertaken by the safeguarding board following 2 safeguarding adult reviews, found that learning had not been embedded.

The new technology employed in Hillingdon Social Care Direct has been used by the local authority to understand who is calling, for what reason, and whether the person they are calling about is already known to adult social care. They have used this information to develop a range of call scripts and pathways, maximising use of online services for professionals, contracted care agencies, and for straightforward applications. This enables staff to respond in a more timely manner to more complex or urgent enquiries.

The local authority worked collaboratively with people and partners to actively promote and support innovative and new ways of working which improved people's social care experiences and outcomes. For example, they worked with a local provider to develop a model of crisis support for people with mental health needs at risk of hospitalisation, as a short-term step-up response which avoided admissions, and enabled people to stay safe and as independent as possible. The local authority were also currently piloting an innovative assistive technology device intended to help identify the need for early intervention to support people living independently, by mapping their daily routines and patterns.

The local authority had used coproduction to inform and develop strategies and partnership boards, such as the Carers strategy, and the Learning Disability and Autism Partnership boards. The local authority recognised better engagement with the population to improve co production was still an area for improvement and this needed to become more embedded in services. Staff shared examples of using ballot boxes and going into schools to hear people's voices. Staff working with young people in transition had identified their voices were sometimes lost in the Youth Council, so were establishing an expert reference group to engage with.

The local authority, in partnership with a voluntary sector organisation led a strategic alliance which met quarterly to drive change for people living with dementia in Hillingdon. This alliance facilitated direct feedback from people with lived experience to a range of partners. For example, an individual shared how their experience of being told their diagnosis led to a two-year depression, which led the memory clinic to pledge to change how diagnoses were delivered to ensure people did not leave feeling hopeless. This piece of work was on-going. Leaders told us they were currently looking at how to gather feedback from individuals to tailor intervention/services better for better outcomes, to improve feedback loops and to improve their early intervention offer.

Staff and leaders engaged with external work, including research, and embedded evidence-based practice in the organisation. The local authority was working with Brunel University to understand people's journey through social care and were collaborating with a panel of people with lived experience. They intended this would inform future practice.

The DASS for Hillingdon was the Chair of the North-West London Board of Directors of Adult Social Services and felt this gave an opportunity to look outwards and share good practice. The Bridging Care service established in Hillingdon was mandated by the NWL ICB as good practice to be rolled out across all local authorities in their footprint, based on the impact it showed on patient flow.

The local authority had welcomed input from a provider about a successful scheme they were delivering for people with mental health needs in another borough and adopted the model in Hillingdon. They drew on external support to improve when necessary and had sought an independent audit of the functioning of their safeguarding board arrangements.

Learning from feedback

The local authority learned from people's feedback about their experiences of care and support, and feedback from staff and partners. This informed strategy, improvement activity and decision making at all levels.

Following an ombudsman complaint, the local authority updated their Localities Standard Operating Procedures (SOP) to emphasise assessment reports should be sent out to service users promptly for their input and comments. Staff showed an understanding of the importance of listening to people and shaping their response to meet individual needs.

Health leaders told us the local authority had listened and taken on board feedback from them around struggles for housing and provision for patients and had worked with the Trust to address the issue.

There were processes to ensure learning happened when things went wrong, and from examples of good practice. Leaders encouraged reflection and collective problem-solving. Supervision and team meetings were used to share learning from case work, complaints and compliments. There was a process to ensure learning from safeguarding work, and this was cascaded through the organisation via 7-minute briefings, and work to ensure changes to practice was embedded was in the Safeguarding Board Business Plan for 2024-27.

Data showed in the last 12 months, 9 complaints were made to the Local Government Social Care Ombudsman (LGSCO) about adult social care of which 89% were upheld. This was slightly above the expected number of complaints, and the uphold rate for an authority of this type, at 5 and 80% respectively. There was only 1 late remedy. The majority were resolved during the investigation process.