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 borough-based partnership was a joint board between NHS partners in the area and the local authority. The group provided challenge and coordination of shared local and national objectives. This included the joint funding of 4-year community grants supporting community connections, information and advice, mental health, respite, domestic violence advocacy, and infrastructure support. There was a clear understanding within the partnership that health and social care needed to be considered together within prevention to deliver the best outcomes for people.

Integrated neighbourhood teams were at an early stage had been set up to integrate services across community services, social care, primary care, acute hospital trusts, and voluntary and community sector organisations. Partners felt there was still more to do to get the right people from social care around the table to make these teams effective at a neighbourhood level. Leaders were also keen to see and build further improved strategic relationships with the Integrated Care System as it continued to develop.

There were several ways the partnership enabled speedier and safer hospital discharge and supported the avoidance of admissions. The local authority's new bridging service, developed with the hospital trust and Integrated Care Board, provided a 5-day service for people being discharged from hospital where risks were low and longer-term need was still being assessed. The local authority's 6-week reablement service supported people to increase their independence and reduce need for ongoing services. The care home in-reach liaison service, also in partnership with health services, worked with local care homes to support them to manage complexities where there was a risk of hospital admission, or where there was delayed transfer of care back to care homes. Both the bridging and care home in-reach liaison services were recent service offers at the time of our assessment.

The local authority was keen to develop and invest in an enhanced relationship with communities and community organisations within the borough through the 'your town, your voice' approach and in developing a joint vision for the 'seven towns'. The local authority was clear it would take time to fully understand the relationship people wanted with the local authority and to forge a true partnership. This aligned with work being done following the National Institute of Health Research funding that had recently been secured by the local authority. Leaders related how a community organisation leader had fed back that this work had significantly improved their expectations and view of the way the local authority was approaching partnership work.

The local authority's internal partnerships with children's services, particularly supporting transitions, worked well. Staff across children's and adults social work teams recognised and delivered a whole family ethos in their work.

Some staff felt that partnerships with housing services needed development, for example in working more collaboratively to find housing solutions for people with care needs. There were also good examples of how housing services completed joint visits with community organisations when needed to support with addressing complex needs. There were examples of good integrated working across housing and care commissioning, such as floating support services. The local authority and partners recognised rising numbers of people who were homeless within the borough and the impact this had on adult social care services. Housing shortages were recognised as a challenging factor and staff described a real difficulty in seeking permanent housing. The local authority in the Borough-based Partnership included targeted outreach work to support a reduction in homelessness and the Council Plan 2022-2026 indicated how care and support needs were considered within the local authority's housing considerations.

Some staff felt that engagement with the police could improve, though recognised that this mirrored the experiences of other local authorities across London. The relationship between frontline services and the police had changed since the implementation of the Right Care, Right Person agreement. Right Care, Right Person is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training, and experience to best meet their needs. Staff recognised the importance and appropriateness of this approach and were still responding to the change this necessitated on service delivery. This included having access to named police support and avenues to raise concerns with partners.

Arrangements to support effective partnership working

Section 75 agreements and delegated commissioning arrangements were in place with the Integrated Care Board. A section 75 arrangement 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.

Section 75 agreements had been used to support integrated working in some service areas. Where health and social care had subsequently reduced or stopped those formal funding arrangements, such as the section 75 agreement in learning disability and mental health services, strategic relationships with health had remained strong. In this instance, the Section 75 agreement had been replaced by a memorandum of understanding that outlined roles, responsibilities, and governance for the collocated teams. However, at an operational level, some staff described a blurred line now that the social care and health teams were no longer collocated and hybrid working. They felt they had less contact with health colleagues and that things took longer. Other staff felt they still had access to health information in a timely manner when needed and maintained positive relationships in the new ways of working.

The Better Care Fund was overseen through the Ealing Borough-based Partnership. This included representatives from across the Integrated Care Board, local authority, NHS trusts including mental health and community partners, and NHS primary care. The fund was focused on tackling population health and inequalities, developing integrated neighbourhood teams, and supporting identified challenges related to older people and complex needs. Challenges in implementing activities were well assessed. Some partners felt the resource allocation from the local authority did not always align with service demands, which resulted in pressure on staff and service provision, for example in the reablement and bridging service. The ICB had agreed to additional investment to the local authority to expand the bridging service and support social work oversight of the mental health step down pathway as a way to address growing discharge related pressures.

The out of hours emergency duty team had access to a range of agencies to support effective handover, including the police, health services, the crisis team, and hospitals, depending on the needs of individuals. There were arrangements that supported safe working with the police or fire service for joint visits if needed. The emergency duty team was able to work with the crisis assessment and treatment mental health teams over weekends and sometimes undertook joint visits. The out of hours team manager linked with urgent care partners to raise any issues regarding partnership working, which included a police liaison officer and clear escalation points if needed.

There was strong collaboration across the mental health teams, with staff being able to sit in on Mental Health Integrated Network Teams (MINT) assessments supporting a holistic approach to supporting patients in the community and hospital settings. However, some staff told us that there were funding decision challenges for people discharged from psychiatric hospitals across boroughs and partners. Some staff told us that patients were rarely discharged from this process and there was often push back when this was challenged. We heard examples where an individual had been waiting over two years to be removed from this process. Local authority leaders were clear that NHS funding arrangements in outer London impacted on their ability to effectively deliver services to meet the needs of people in the borough. They were working with the north-west London Integrated Care Board to address areas of step-down provision and unclear commissioning responsibilities.

The Advice and Referral Centre (ARC) described good working relationships with services in the community. They were able to access police information and support regarding risk. ARC staff had clear links to social prescribers to receive and share information to help people in the community. Partner organisations felt there were clear arrangements in place for referrals from and to the local authority's services, such as regarding carer's assessments and signposting to other services.

The occupational therapy team felt their role was misunderstood both internally and across partnerships. In some instances, they described 'scatter gun' referrals from partners across services to access support. One person described being left with no information about how to get support to use a walker when raising this with their GP and being unclear who was able to help. Different information systems sometimes meant that occupational therapists could not see when health teams were involved. Other instances were described, for example, where partner involvement had only come to light when staff from different organisations had started to work with the same person.

The Commissioning Alliance was a group of eight local authorities, facilitated by the West London Alliance and chaired by the Director of Adult Social Services (DASS) in Ealing. The group had a shared approach to quality and commissioning, working closely on several market management projects, including price and inflation management. This included a joint quality group to share market intelligence and jointly review quality issues. The group worked with Integrated Care Board commissioning teams regarding market sustainability and capacity. The local authority was enhancing its procurement processes to improve outcomes for people. For example, they were implementing a shared electronic procurement system to contract nursing and residential placements, and accommodation for people with a learning disability or mental health needs and a sub-regional dynamic purchasing system was being procured.

Providers told us they felt positively about having a named contact in the local authority, which facilitated relationship building and feedback. Others told us links to senior leaders were good, and innovation was seamless within the local authority's approach. Some community partners and provider organisations felt communication from the local authority needed to improve, for example, some organisations said that offered opportunities to attend team meetings to share their service had not been taken up; and some felt that they spent a lot of time chasing services for responses, which affected people's experiences of care and support. Some partner organisations told us some people with a dual diagnosis were not supported by good information sharing which meant they spent a lot of time going backwards and forwards between services and people had to tell their story multiple times.

Impact of partnership working

Staff shared several examples of where partnership working arrangements supported better outcomes for people who used services. This included working with partners including police, the fire service, hospital and crisis support, private and social landlords, physiotherapy and community services. Transitions staff, for example, described their partnership working with health and proactive, early referral processes as generating high success rates for health funding which resulted in a better experience of support for people.

Staff and leaders were proud that their approach to reablement and bridging had a positive effect on hospital discharge. Regular meetings took place to support discharge and placement allocations. There were concerns about available resource to continue the expansion of this effective work to ensure this was equitable across the borough. The monitoring of Better Care Fund activity indicated that most implemented actions were on track to achieve their targets, which included avoidable admissions, reduced falls, and increased discharge to the person's normal place of residence.

Leaders told us there was a well-established governance framework for strategic and operational working with partners. Hospital discharge data and Better Care Fund performance indicators were routinely monitored, and seasonal summit provided for reflective assessment of areas that were working well and areas for further joint working.

Working with voluntary and charity sector groups

The local authority was clear they relied on strengthening the community and voluntary sector to effectively deliver their connected communities, better lives vision. Their annual grant funding process had developed into a 4-year grant to reduce administrative burden and support sustainability. The local authority was committed to investing in the sector as a partnership through mental health and wider NHS services.

Some voluntary and community sector organisations felt the local authority worked well with them and recognised their role in the adult social care system in the borough. Staff across the organisation described their knowledge of the voluntary and charity sector in the borough and ways in which they worked effectively to provide support, including interpreters, advocacy, and carer's services. The local authority told us they recognised and valued the way in which the voluntary and community sector was able to support people's equity of experience and outcomes.

Some organisations felt the lack of inflationary uplift over recent years was affecting their ability to remain sustainable and retain staff. Some organisations felt this decision meant the voluntary and community sector would struggle to keep going over the coming years. For some organisations, they felt the local authority had been transparent with their tendering process and there were good and improving relationships with senior leaders, commissioners, and engagement staff. Others were unclear about funding decisions and questioned how impact of decisions had been considered, which suggested inconsistent communication. The local authority advised that an uplift has been built into the most recent grants process, and an appeals process for funding decisions was in place.

The local authority was refreshing its approach to co-production at the time of our assessment and supporting the ongoing development of more partnership boards. Some community organisations were not fully clear where they sat within this structure. Some partner organisations described limited strategic opportunities to engage with the local authority following the decommissioning of the local strategic partnership arrangements. They were unsure whether current arrangements had capacity to meet this need which affected relationships with local authority staff. Some described a feeling on long-standing neglect in terms of sufficient consultation and engagement. There were, however, encouraging ways in which local advocacy and community groups had been able to engage in the local authority's scrutiny processes and this appeared to be improving.