Wiltshire Council: local authority assessment

How we assess local authorities

Assessment published: 29 January 2025

About Wiltshire Council

Demographics

Wiltshire Council is a large unitary authority with a population of around 510,430 people. There has been an 8.4% rise in the population over the last 10 years. The local authority is made up of mostly rural areas. The population has an Index of Multiple Deprivation score of 2 (1 is the least deprived, 10 is the most deprived) meaning it is one of the least deprived local authorities in England. There are some areas of deprivation within Wiltshire, most prominently in Trowbridge, Chippenham, Melksham and Salisbury.

Around half of Wiltshire Council's communities live in towns and villages with fewer than 5000 residents, and a quarter live in villages with fewer than 1000 residents. Wiltshire has the largest military settlement nationally. Of 28,835 households, at least 1 person has previously served in the Armed Forces, equating to 13.4% of all households.

The population is mostly white British. People from ethnic minority groups comprise less than 6.6% of the Wiltshire population, predominantly people of Moroccan and Polish heritage and a smaller community of people with Gypsy, Romany, Traveller and Boater heritage. 'Boater' is a term for people who live in boats, which is used in Wiltshire to describe this community.

Wiltshire has a larger population aged 65 and over, than the England average (18.61%) and smaller population than the England average aged 18-64 (60.57%) and under 18 (20.82%).

Wiltshire is part of the NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (known as BSW Together). There are 13 Primary Care Networks, and 46 GP surgeries located in Wiltshire. It is bordered by six counties.

Wiltshire Council has remained politically stable with consistent governance by the Conservative Party since 2000.

Financial facts

The local authority estimated that in 2023/24, its total budget would be **£791,878,000**. Its actual spend for that year was **£705,443,000** which was **£86,435,000** less than estimated.

The local authority estimated that it would spend **£234,189,000** of its total budget on adult social care in 2023/24. Its actual spend was **£176,563,000**, which is **£57,626,000** less than estimated.

In 2023/2024, **25.03%** of the budget was spent on adult social care.

The local authority has raised the full adult social care precept for 2023/24, with a value of **2%**. Please note that the amount raised through ASC precept varies from local authority to local authority.

Around **6345** people were accessing long-term adult social care support, and about **650** 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.

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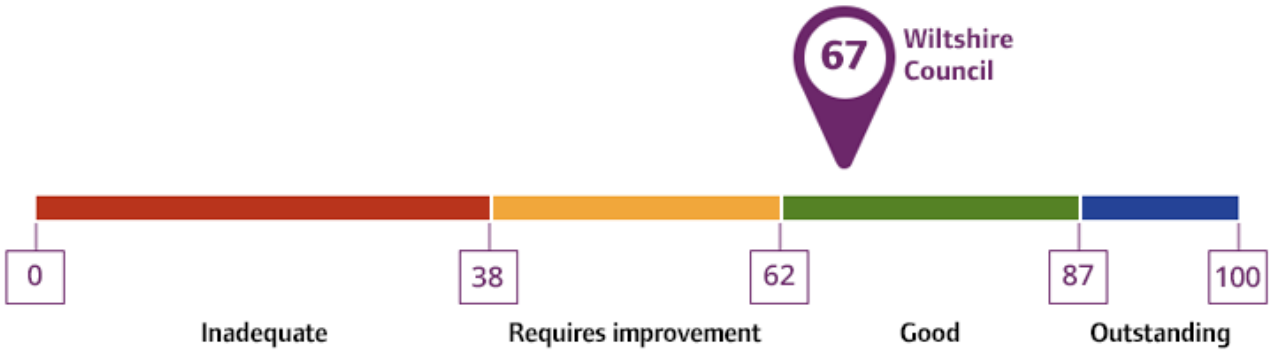
Overall summary

Local authority rating and score

Wiltshire Council

Good



Quality statement scores

Assessing needs
Score: 2

Supporting people to lead healthier lives
Score: 3

Equity in experience and outcomes
Score: 3

Care provision, integration and continuity
Score: 3

Partnerships and communities
Score: 2

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 2

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

There was mixed feedback about adult social care and services in Wiltshire. People told us the local authority had an improving culture of 'doing with' people, rather than 'doing to', so people felt involved in decisions about their care and support needs. Strength and asset-based approaches were being embedded in both staff practice and processes, with the aim of improving people's experiences and focusing on their wellbeing. These were ongoing developments to enhance choice, and support people to take risks when planning and agreeing care. People consistently told us the quality of the care services they received was good in Wiltshire.

People had access to approaches and options to prevent, reduce and delay their need for care and support. Feedback was consistently positive about reablement and enablement services to prevent, reduce or delay people's needs for care and support. However, there were gaps in mental health services when a person did not meet the threshold for support under the Care Act.

There was excellent feedback about staff skills and attitudes people told us staff went above and beyond when working alongside people with care and support and their carers in Wiltshire. However, there was mixed feedback in relation to processes, such as waiting times, ways to contact staff post initial contact, accessible information and financial assessment processes. For example, one person told us they had waited more than 2 months for an assessment and were still waiting at the time of our CQC assessment, they needed assistance to leave the house and join support groups that had been offered to them but had no way to access this. Another person told us they had specialist advice in a way that worked for them, this had focused on what they could achieve and improved their independence. The local authority was acting on feedback and complaints to improve experiences for people, for example to improve the accessibility of contacting staff and reducing waiting times. There were people awaiting assessment and authorisation of deprivation of liberty applications, the wait for this specialist assessment was being managed based on presenting risks. People were referred to advocacy services when they needed it. Young people and their carers told us their experience of transitions from children to adult services was improving.

The local authority sought to listen to people who were most likely to experience inequalities in their experiences or outcomes. There were gaps in engagement between some groups of people and the local authority, such as people from smaller ethnic minority groups and people with a visual impairment. The local authority recognised the gaps and was committed to improve the way it listened to these groups. The local authority funded Healthwatch to independently hear the views of local people. There were many ways people could be involved in co-production or share feedback, including forums, councils and Wiltshires own 'Pioneers' and 'Innovators' programme. The local authority funded organisations to work with people in different ways, for example, to hear their voices including through art and music. People with care and support needs gave examples of how they shaped and improved services and strategy.

Feedback from unpaid carers was mostly positive. Carers told us they felt supported, and they were aware of opportunities to be involved in co-production projects. Carers used direct payments to support them in their role to care.

Summary of strengths, areas for development and next steps

There was good leadership at Wiltshire Council and an 'always improving' ethos. The local authority demonstrated its corporate message, 'Our Identity and One Council' and how this fed into its 'living well' and 'whole life' strategies. These were supported by organisational structures, for example housing services were embedded in the adult social care directorate, and the commissioning directorate had an all-age approach. There were strong internal links between adult and children's social care. Children's services in Wiltshire were rated 'outstanding' in 2023 by Ofsted. The adult social care directorate was keen to keen to take the learning from children's services and apply it in adult social care.

The transformation of adult social care programme (TASC) aligned with identified areas of development and provided assurance there was the necessary support to facilitate this work. There was a focus on providing the right care in the right place and developing a skilled workforce. Elected members were visible and involved in performance and outcomes groups and boards, enabling them to have direct discussions with teams and leaders.

The local authority had reduced waiting lists to assess peoples care and support needs using a 'waiting well' approach. This provided people with information or access to local services whilst waiting for an assessment of need. Staff risk assessed people waiting for an assessment and prioritised those most in need. Ongoing plans and monitoring evidenced waiting lists were reducing and improvements continued to develop. Senior leaders utilised resources realistically such as budgets and staffing with targets for longer term actions to be effective and sustainable.

Promoting people's independence was part of everyday practice when people first contacted the local authority. There were arrangements to prevent, delay or reduce needs for care and support to improve population health, and reduced the demand on health and social care services. For example, the adult social care Prevention and Wellbeing team reduced the volume of referrals coming to the 'front door' through preventative work. Wiltshire had a well-established therapy-led reablement service that was meeting the needs of the local community. This community approach avoided people unnecessarily being admitted into care homes or hospitals. There was also specialist enablement offers for people with learning disabilities, autistic people and people with mental health needs. There were notably some gaps in resources for veterans experiencing a mental health crisis. There were arrangements for interpreter services, and staff training to understand cultural diversity and engage with people appropriately.

There was market shaping and commissioning to meet local needs. The self-funding population in Wiltshire was a competitor in the care provider market due to the large number of people who paid privately for their care. People in Wiltshire had access to high quality support and there were no known overall concerns around provider capacity to meet demand. There was quality monitoring of local services. However, managing risk could sometimes take priority over people's choice, this meant peoples voices and desired outcomes were not always at the forefront when commissioning suspensions happened. The local authority worked with other local authorities to support out of area placements. There was an accommodation strategy to identify priorities for market development including specialist dementia care.

The local authority was working to involve smaller voluntary sector services and support the wider workforce through stronger partnerships. Strategic relationships with care providers and health and integrated care system leaders continued to evolve to improve working together. However, working relationships with partners were not always positive, there was a need for improved communication, transparent sharing of data and analysis and strengthening of shared principles. For example, hospital discharge services were under review and there were differing perspectives across the local authority and partners on how transformation could improve system working and positively impact peoples' outcomes. Partners told us the local authority was passionate about improving people's outcomes and prevention was high on their agenda. There were good foundations in place with partners to further develop relationships.

Staff and senior leaders were committed to safeguarding people with care and support needs. There were consistent ways of working to respond to initial safeguarding concerns. We had mixed feedback from staff and partners in relation to section 42 enquiries to share recommendations and learning which as a result would reduce risks to people. Senior leaders acknowledged areas for improvement in the safeguarding vulnerable people's partnership and had appointed an independent scrutineer to hold the partnership to account. There was improvement work ongoing around deprivation of liberty safeguard wait lists including those in the community, and the risks this had on people, unpaid carers and partners.

Workforce was an area the local authority was proud of. Internal recruitment and retention strategies had been successful in enabling the right mix of skills and numbers of staff to deliver care act responsibilities. Staff were supported to be confident and evidence-based practitioners. The local authority sought feedback and learning from people and partners, this fed into strategy, and shaped operational practice. Transformation work was supporting improvements around people's choice and embed strengths-based approaches, such as growing direct payments, independent living and technology-enabled care offers. This aligned with the adult social care vision, 'We all deserve to live our lives our way'.

The local authority knew themselves well. Internal workforce, leadership, governance, and performance management was strong. The Director of Adult Social Services (DASS) had been in position for 18 months, the Principal Social Worker for 7 months and the Chief Executive Officer (CEO) was appointed in July 2024., Both the CEO and DASS had worked in Wiltshire Council for over 10 years and there was stability in the political support for over 24 years. The developments in leadership roles were seen as a positive to adapt to change and focus on innovation.

Theme 1: How Wiltshire Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

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

The local authority had a multidisciplinary advice and contact team which supported people to access care and support services, this included connecting them to voluntary and health services in their own communities. When a person needed an assessment, they were directed to preventative services while they waited. Calls to the local authority were monitored and internal audits ensured the quality and timeliness of calls to ensure people could contact the local authority easily and be directed to the right team or service. People also had access to online and self-assessment options as an alternative.

There was mixed feedback and findings from people and unpaid carers about the quality of assessments and care planning that took place. We heard some assessments took place over the phone, and some people felt it was a 'tick box' exercise. In contrast, we heard about excellent communication skills and multidisciplinary working by some staff. Care records indicated a holistic and co-productive approach to keeping the persons voice at the centre of assessments.

There was found to be a lack of genuine choice in how to meet the range of needs and reasonable preferences of people who needed care and support services. People, staff and partners told us there was no or little choice for people to take direct payments or to choose their own care provider. The local authority controlled how peoples care needs were met by referring them to a care provider that was available to meet their needs. This meant people could not freely decide between a range of options which would give them more control and help them to make more effective and personalised choices over their care in a way that works for them. This was a known challenge for the local authority and there was ongoing transformational project work, particularly to address the offer of direct payments.

Timeliness of assessments, care planning and reviews

At the point of first contact with the local authority, people were given timely information, advice, signposting or were referred for assessment. People and partners told us about delays in carrying out a Care Act assessment and some related difficulties in contacting frontline teams post initial contact when people did not have allocated workers. Staff told us different teams or specialisms had differing wait times for assessments.

There had been a project approach to reducing waiting lists for care assessments and this had made significant progress. In April 2024 the local authority told us 256 people were waiting for a care assessment with a median waiting time of 26 days and maximum waiting time 90 days. The highest maximum wait time in the previous 12 months had been 723 days (June 2023). However, compared to April 2023, Dec 2023 had a 51% decrease of people waiting for a care assessment. A reduction in numbers had been directly improved by the local authority's Prevention and Wellbeing Team completing a 'week of action' to visit people and assess individual risk on the waiting list. Waiting times had reduced and continuing action was taking place to further reduce wait times within a reasonable range.

Senior leaders told us about a 'waiting well' approach to managing waiting times for assessment and reviews. This included actions to reduce any risks to people's wellbeing, while they were waiting for an assessment. For example, giving people an indication of how long they must wait, having a flexible resource of staff to meet changing demands and empowering a person to use their own strengths and resources to resolve issues. Staff and leaders told us if there were any concerns such as a change in risk, there were escalation processes to reprioritise the work.

Processes were in place to identify, record and review the risks of people waiting for a care assessment through allocation referral forms and embedded risk assessments. If new information was received, an allocation form and risk score was updated. Staff reviewed referrals a minimum of weekly and used a measuring tool that assigned a numeric Red, Amber, Green (RAG) risk value to each referral for prioritisation purposes. There were duty managers available if a discussion or advice was needed about referrals or prioritisation. Urgent visits could be carried out by a worker on duty and if there was an imminent risk they could refer to teams such as rapid response, urgent care, and the emergency duty service. There was a feature on the digital recording system used which provided a breakdown of the waiting list featuring highest risk, longest wait time, summary of the person, and action needed. However, we found there was more to be done to understand the impact that waiting for assessment had on some groups of people, particularly people living with dementia and autistic people. Staff told us they had confidence with this system and referred to it as 'a good safety net'. This enabled staff to understand both the risks around a person waiting for assessment and actions that could be taken, to reduce any risks to people with care and support needs. Senior leaders had oversight, there were projected impacts of the work, and the risk measuring tool ensured a standardised approach to prioritisation.

Overall staff and senior leaders told us the transformation projects underway were based on performance indicators which provided visibility on the improvement trajectory. They felt the improvements made were sustainable and that further improvements were achievable. The local authority was looking for more opportunities for improvement and were piloting a 'demand forecast tool' to support resource planning, improve people's experiences and ensure staff wellbeing in respect of their workload.

There was also improvement work underway to improve the timeliness of care reviews. Annual review targets were in place, as well as 6-week targets after care and support had started. In April 2024 the local authority told us 990 people had overdue reviews (median waiting time 116 days and maximum waiting time 699 days). The highest maximum wait time in the previous 12 months had been 1483 days (October 2023). There was a new review team to reduce review wait times, some staff told us they were concerned the target to reduce overdue reviews could compromise a person-centred approach, and there remained some reliance on care providers or people themselves to phone the local authority and ask for a review. Quality audits were taking place, and there remained performance group oversite to minimise these risks.

In contrast, the mental health team had no wait list, reviews took place with the staff the person worked with, and joint working took place to assist a person-centred approach. There was sharing of good practice and flexibility agreements across teams to support demand and risks, for example the mental health team supported locality teams where needed.

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

There was no delay in wait times for young unpaid carers assessments. Staff had confidence in identifying young unpaid carers and described how they shared information with children's services and created contingency plans for unplanned/ emergency situations. The young unpaid carers offer was well established with robust oversight from senior leaders.

Unpaid carers needs were noted as a priority for staff when carrying out people's Care Act assessments and they actively made referrals for unpaid carers to be individually assessed to maintain their safety and personal well-being.

The local authority was aware of wait times for unpaid adult carers assessment, care planning and reviews and progress had been made in reducing these. Assessments were carried out by external commissioned providers for the local authority. In April 2024, 146 adult carers were waiting for an assessment (median waiting time 35.5 days and the max waiting time 91 days). The highest maximum wait time in the previous 12 months had been 742 days in November 2023.

This aligned with national survey data relating to the experiences of unpaid carers in Wiltshire. National data showed 19.83% of carers who reported that they had as much social contact as they desired was a negative statistical difference compared to the England average of 30.02%. Additionally, 13.79% of carers in Wiltshire who felt they had control over their daily life showed a negative statistical difference compared to the England average of 21.53% (Survey of Adult Carers in England, SACE 2023-2024).

However, most unpaid carers we spoke with during our assessment, gave positive feedback about their support. We were told about an example of a staff member going above and beyond to ensure a whole-family approach to support was provided. We were also told about the benefits of unpaid carers accessing personalised support for them to join a gardening club, return to swimming and visit the hairdressers. The local authority had events where senior leaders actively listened to people about their caring role. We were told about support groups, specialist therapy, emergency identification cards, unpaid carer grants and short breaks. This reflected the work the local authority had recently carried out to prioritise and improve experiences for adult carers in Wiltshire.

There was a coproduced carers strategy, and a newly procured consortium of voluntary organisations sourced with carers input and feedback. The consortium had begun carrying out assessments for the local authority from April 2024. The local authority had provided short-term resource to support the transition and bring down the adult unpaid carers assessments wait list. The local authority had started to see a trend of reducing numbers of people waiting, and there were internal quality assurance processes in place to monitor this. However, at the time of our assessment it was too early to demonstrate sustained improvements or to see the overall effectiveness in relation to outcomes for people.

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

People were signposted or referred to appropriate voluntary services to meet non-eligible care and support needs. This mostly took place at initial contact to the local authority through self-assessment, online, telephone or a professional's referral.

There was an adult social care Prevention and Wellbeing team that worked with the Advice and Contact team to link people to their local communities specific to the persons preferences. They worked with local charities, food banks, housing associations, and police. There was no criteria and no time limit to the length of time people could be supported.

There was more to be done to improve help for people with mental health or drug and alcohol needs where they did not meet the threshold for support under the Care Act. Staff told us about a multidisciplinary approach in the south of Wiltshire, where the Mental Health Triage team worked with the Prevention and Wellbeing team to look at who can offer the right support at the right time. However, partners told us there were delays in accessing preventative help and for some people this resulted in crisis situations.

There were processes to collect people's feedback, the outcomes for them and analyse the effectiveness of preventative approaches. There was an ethos of always looking for ways to improve and strengthen the early support and prevention offer for people.

Eligibility decisions for care and support

People received copies of their assessments and care plans which outlined personal eligibility decisions for care and support including examples of joint working to support eligibility outcomes. However, we heard one person with specific communication needs told us their assessment was not presented in a way that worked for them and this meant for them decisions and outcomes were not clear.

The local authority had an assessment template with guidance to support staff to complete each section of an assessment and areas to explore in deciding eligibility of needs across Care Act specified outcomes. There were also appeals and complaints processes for eligibility for care and support, this information was available on the internet for public access. However, there was not direct access to alternative formats and easy read documents and there was a risk some people could not understand and seek clarity around decisions about their eligibility for care and support.

Appeals were monitored and responded to informally and formally depending on the stage and criteria. At the time of our assessment, the local authority had ongoing appeals around personal budgets (for example conflicts over direct payment amounts). These were being resolved through alternative provision or re-assessment.

Financial assessment and charging policy for care and support

There was a multidisciplinary approach to ensure people had the correct financial information at the point of contact. The Finance and Benefits team worked directly in the advice and contact service. This supported staff skills and enabled people using services to have choice and control in knowing their personal budget. Referrals for assessing and charging adults were allocated and contact made in 2 days, as a result the local authority told us there were no wait times for financial assessments and they ensured initial decisions and outcomes were timely and transparent. The local authority also provided a Wellbeing Line, this responded to an increased need for people wanting financial advice and guidance due to cost of living challenges. Performance in this area including peoples' feedback was monitored and was found to be making a positive impact on people's lives and wellbeing.

Feedback was less positive for people who were already receiving care and needed re-assessment due to depleting funds. Unpaid carers and partners told us delays in these re-assessments meant uncertainty around accommodation and financial situations of individuals and providers.

The local authority offered multiple ways to assess finances including through an online portal, face to face visit at home, face to face visit in a hub, through email, and phone. However, we found this was not yet consistently applied. We heard frustration around digital processes which for one person was said to be an added source of stress at a time of crisis. Another person suggested there needed to be further support to explain what needed to be done in a way that worked for them. The local authority was aware of these challenges and was taking action to improve accessibility and worked collaboratively with 'pioneers' (local co-production groups) to improve the quality of the service.

For young people moving on to adult services, there was an easy read pre-assessment form that outlined what to expect from an assessment and referred to care contributions. There was joint working between finance and social work staff to offer early support and advice including in young people's and families own homes, to ensure people felt informed and supported in preparation of potential charging for care and support.

Provision of independent advocacy

Social workers and occupational therapists were trained and confident to carry out mental capacity assessments that supported people to make their own decisions in line with the law. Where someone could not fully take part in conversation about their needs for care and support and they had no one to help them, the local authority had access to advocacy to support the person's involvement in their assessment and plans. We found the duty to provide advocacy was considered from the point of first contact with, or referral to the authority.

Partners and staff told us about specialist advocacy provision for young people up to the age of 25, and the positive involvement of the young people's council that regularly met with senior leaders.

At the time of our assessment, the local authority was in a period of change for its adult advocacy provision, and this impacted how widely available advocacy was. Staff told us they undertook joint visits with advocacy service to ensure a person's wishes and rights were obtained. However, not everyone had access when it was needed, there was a waiting list which had built during the change to a new provider. The local authority was aware of the challenges and as a result had actions to support priority of people's needs. Some staff used their own knowledge and experience to work around the delays, and there was an option to commission self-employed advocates. This reduced the impact of the delays on people's outcomes. However, it was too early to determine how effective or sustainable this was.

The local authority worked with people and their carers to drive service improvements, for example guidance was developed around the use advocacy and what to expect, this also came as an easy read and pictorial guide. There was also promotional work in community settings to engage, share information and assist in understanding the need for independent advocacy.

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

Prevention was embedded across the council and in relationships with partners and local communities. Partners told us the local authority had a positive focus on prevention and on strengthening local communities. Reflecting the 'One Council' vision, the different departments, such as Adult Social Care, Public Health and Housing worked well together to drive the prevention agenda. Housing had a focus on tenancy sustainment and prevention work, with leaders seeing this as an important element to preventing, reducing or delaying people's care and support needs. There had been targeted work to reduce the number of people living in temporary accommodation, and collaborative work with a national charity which supported people in crisis to access home furnishings. The local authority had a Preventing Reducing and Delaying Eligible Needs Policy (2024) which detailed their aim to prevent, reduce and delay eligible needs. It outlined interventions intended to reduce the likelihood a person would need hospital admission or permanent residential care. It was aimed at people with or without current care needs and focused on enabling people to remain at home. Leaders outlined how people with lived experience were being increasingly involved in the direction of the local authority. Themes from people's views were reflected in the prevention strategy with plans for a fully co-produced strategy in the future. The local authority's Prevention and Wellbeing Strategy (April 2024) stated the importance of universal services in supporting people and communities to build resilience. There were multiple examples showing the prevention offer was for all people to access, not just those with eligible care needs. Staff confidently talked about signposting people to services in their local community such as the hot meal service, befriending options, care coordinators in GP surgeries, and social prescribers. They also referred people to a healthy living program with health coaches with classes discussing nutrition, food, and the impact of a healthy lifestyle. Central to the prevention agenda was the adult social care Prevention and Wellbeing team which was set up to support people to find solutions in their own communities, reducing the need for formal care services. This team of 17 staff knew local communities extremely well and worked with people who did not meet the eligibility criteria for adult social care to promote their independence and wellbeing. The staff team were passionate about their role and told us of multiple examples where people had achieved positive outcomes. For example, they had introduced an isolated person to a 'men in sheds' group and supported another

person to gain confidence in using transport to regain links with friends and family. Partners gave us positive feedback about the Prevention and Wellbeing team and told us there was a grass roots approach with a strong presence in local communities, working flexibly depending on need. They described how in one area, staff had worked with partners to introduce a bus to run to a local supermarket, impacting directly on wellbeing and outcomes for the local community. The local authority used the team to monitor and test the benefit of its prevention strategy and the outcomes for individuals and the community. The team fed back knowledge about the needs of local communities into governance structures, which allowed leaders to have oversight of the effectiveness of the prevention work. There was clear evidence of output from the preventative work, but further work was needed to articulate the outcomes. At the time of assessment, the local authority was carrying out a review of their Prevention and Wellbeing team for this purpose. Measures were in place to support people most at risk in relation to a decline in independence and wellbeing. For example, the local authority had employment and specialist transport support services for adults with special educational needs and disabilities, including autistic people. There were examples of early interventions and prevention with people with sensory needs including partnership working with the fire service to fit specialist fire alarms in people's homes and direct support provided by rehabilitation workers to help people to develop independent living skills. These initiatives supported people to maximise their independence in their own homes and the focus on home and community was in line with the vision which had been co-produced with people with lived experience. Some partners told us more needed to be done to ensure people with mental health needs had access to effective prevention services. The local authority had recognised this and partners told us they had commissioned a project involving people with a disability, autism or mental health conditions. The vision was co-created by people with lived experience and council staff and was wide ranging, including reviewing initiatives in the prevention agenda. The local authority was committed to ensuring unpaid carers who were not in contact with the local authority would be empowered to access support when needed and helped to prevent a decline in their independence and wellbeing. They had improved their focus on unpaid carers across the local authority and this had increased visibility and recognition of the role. Unpaid carers

told us they now felt someone was listening to them.

Provision and impact of intermediate care and reablement services

The local authority had set up Wiltshire Support at Home (WSAH) in May 2020 to provide people with person-centred support to prevent unnecessary hospital admissions and safe discharge from hospital. The Rapid Response team was part of WSAH. Integrated with community health partners, the team provided an urgent crisis response, aiming to provide stability and maintain people at home while assessments were completed into future care needs. The local authority reported positive outcomes after support by the rapid response team. Out of 137 accepted referrals from April 2024- August 2024, 87% of people were supported to remain at home, with their unpaid carer having been provided with more support to continue in their caring role. The local authority spoke with people who had used the Rapid Response offer and they gave positive feedback as to the benefit of the service. The local authority also had an in-house, therapy-led reablement team which worked with people to help them regain their independence and continue living at home. According to local authority data between April 2024- September 2024 76% of referrals into this team were for people in the local community opposed to people accessing hospital discharge pathways. The local authority had a strong community offer, and we were told by staff that reablement was always considered as a first option when people presented with care and support needs. Staff gave us examples of people who had achieved good outcomes after reablement support and avoided hospital and care home admissions as a result. On average people received four weeks of reablement and 69% were fully independent leaving the service. However, national data showed 0.55% of people aged over 65 years received reablement or rehabilitation services after discharge from hospital, this was a significant negative variation than the England average of 2.91% (NHS Digital, Adult Social Care Outcomes Framework 2022-23). Senior leaders, staff and partners told us this was a reporting difference. The figures only reflected the reablement services fully funded and managed by Wiltshire Council, and did not include joint funded arrangements with the NHS where they provided post-discharge rehabilitation and reablement. The local authority was working with strategic partners within the NHS to improve this area. They outlined plans to develop a different model to promote consistent therapy-led discharge from hospital and establish robust and reliable data collection processes. In addition to the reablement team, the local authority had specialist enablement service that worked with people with learning disabilities and/or autism, and

some who may have additional mental health needs. This service was flexible, offering the options of outreach and intensive support, depending on people's individual circumstances. There was evidence this helped people develop person-centred goals, examples included preventing hospital admission at a time of crisis, developing independent skills, maintaining tenancies and accessing universal services. Frontline staff across the reablement and enablement services gave positive examples of working operationally with partners to flexibly meet people's needs. For example, referring people for debt support or for food parcels. There was also a proactive holistic approach when working across different internal services, such as referring to the Prevention and Wellbeing team, who had the skills and networks in the local community to support good outcomes for people.

Access to equipment and home adaptations

The occupational therapy service was embedded in teams across the local authority from the advice and contact team through to specialist provision like the optimising care team. Data provided by the local authority showed between April 2023 and March 2024 there had been a reduction in the overall wait for assessment, achieved by service improvement and the use of short-term agency staff. At the time of our assessment, the local authority told us they only had 4 people waiting for an occupational therapy assessment. Commitment to the improvements in occupational therapy services were shown by the creation of a dedicated Principal Occupational Therapist role. Staff described examples of best practice such as the occupational therapist risk prioritisation tool to support with the management of waiting lists. There was a joint contract across the Integrated Care Board area for the provision of community equipment, which was managed by the local authority under a Section 75 agreement with the NHS. A section 75 agreement is used to pool resources and delegate functions between partners. Data provided by the local authority showed between October 2023 and March 2024 the contract exceeded its 95% performance target on deliveries, targets were regularly updated based on the individual risk to the person and in line with set practice standards. The only wait was for adaptations made through Disabled Facilities Grants (DFG), for example, it could take 4 to 6 months for a bathroom adaptation. There were specialist housing occupational therapists to support people with the grant process and to allow faster processing of applications. The occupational therapy service had a clear process for managing risk while people were waiting for assessment and reviews. Manual handling reviews were reviewed at 6 months or a year depending on risk, and these were completed within target timescales. The occupational therapy service had been involved in projects, for example the 'optimising care' project which boosted care providers' knowledge and reduced over-provision of care. The local authority described an example where occupational therapy staff had worked with a partner to promote equity of access, providing adaptations to minimise the risk of falls for a person living in a caravan. The Technology Enabled Care (TEC) Strategy (2023-2028) was co-produced and stated an ambition to use technology to empower people with care and support needs. There was a technology-enabled care team funded by the disabled facilities grant to support this aim. Staff in the team described how they accessed technological solutions which made a

practical difference to people's lives. For example, through introducing people to equipment such as voice sensor kettles and lights. There were clear examples of focused commissioning projects to test out the effectiveness of standard and more bespoke technology. Digital assistance was used for environmental control, phone applications to support people to learn independent living skills and robotic pets to provide meaningful activity for people with dementia. In addition, the team championed a technology-first approach in assessment but also with housing colleagues, promoting an understanding of the importance of Wi-Fi access when considering new property developments. Technology-first approach refers to the strategy in which technology is at the forefront of decision-making processes and is used to drive the growth and development around the offer around technology enabled care. Work was ongoing to develop the use of technology to support independence and to evaluate the benefits.

Provision of accessible information and advice

The local authority told us most requests for information and advice came through their Advice and Contact Centre. The local authority told us this multidisciplinary team was skilled at providing information and their internal audits showed most people experienced a swift response to their requests for information, advice and signposting. Partners told us staff at Wiltshire were passionate about engaging with local communities to ensure they had equality of access to information and service. Initiatives were in place to tackle inequalities and prevent deterioration in independence. Staff told us it was important not just to give information out but to make sure people felt able and confident to understand what they had been told. A partner organisation had worked with the local authority to produce the Adult Care and Support Guide which provided wide ranging, comprehensive, clear advice and was available as a booklet and electronically. It included lists of care providers as well as internal information such as about telecare, benefits, direct payments and financial assessments. National data showed 69.69% of people in Wiltshire who used services found it easy to find information and support, this had no statistical difference compared to the national average of 66.26% (Adult Social Care Survey, 2022-2023). Additionally, 64.52% of carers in Wiltshire found it easy to access information and advice, which was tending towards a positive statistical difference from the England average of 59.06% (Survey of Adult Carers in England SACE, 2023-2024). One person told us the local authority had been very good at providing information. They had been overwhelmed by the number of leaflets they had received but they had appreciated the social worker giving them a direct line and telling them to ring at any time, and who to ring in their absence. There was evidence of the local authority supporting digital literacy, through schemes in the library and with the traveller community. The local authority funded a digital platform with information about local events, volunteering and groups and organisations in Wiltshire. Partners and people told us the local authority could improve its offer by providing information in more languages and formats, especially for communities who may not be familiar with local systems, or who would struggle to access information online. While information in alternative formats and alternative languages, including British Sign Language was offered, it was not an initial option provided on entering the local authority's website. The local authority had audited the website in line with Web Content Accessibility Standards and it was compliant

to these standards, which allowed people to navigate the website using standard computer accessibility features. A parent carer gave positive feedback about work that had been done on the SEND website, which was hosted by a different provider, this had been produced with the parent carers council and was regularly reviewed and helped to inform parents about transition.

Direct payments

The local authority was committed to the use of direct payments to improve people's choice and control about how their care and support needs were met. Rates for people who were receiving direct payments were lower than the national average at 19.16% compared to 26.22% for England (Adult Social Care Outcomes Framework ASCOF, 2023). The local authority had acknowledged this was an area for improvement and they aimed to increase direct payments to 26% by March 2026. They told us they had channelled investment into promoting self-directed support and this was a priority in their transformation programme. A carer told us that despite being overwhelmed by the amount of paperwork, they had still used direct payments as it meant they could use a small care provider in their village which was their preference. The local authority had recognised systems needed to improve to promote self-directed support. To understand the barriers, the local authority had carried out a detailed review into why people stopped using direct payments. One reason given was the system was too cumbersome. The local authority had clear plans, which were already underway, to address the issues raised around direct payments and make them a more attractive choice for people. These included trained direct payment champions in each team and service, producing training videos and working with people who used services to review the current policy and practice. Meetings had been held with direct payment champions as part of this improvement drive, and in one meeting the Principal Social Worker had offered staff specialist advice on a complex funding issue. The local authority was also promoting the use of independent service funds which provided a person with their own budget but with extra support given by the care provider. The local authority told us they retained oversight of these by using a 'virtual wallet'. The option of using the independent service fund provided a supportive alternative to direct payments which still promoted choice while the local authority was addressing the concerns people had with current processes. The local authority had detailed guidance for staff on direct payments. Staff showed an understanding of direct payments and told us this choice was offered and gave us multiple examples of flexible use of direct payments with positive outcomes achieved. For example, funding a robotic vacuum cleaner for someone who would have otherwise needed support to clean. The local authority funded an external organisation, to provide people with support with direct payments. Staff told us the organisation was very

approachable and had carried out information sessions in team meetings. Staff had fed back to the local authority a low uptake of direct payments for deaf/deafblind people because of a lack of specialist services. In response, the local authority described actions being taken to address the specific issues for people with sensory needs taking up direct payments. Not all unpaid carers and people we spoke with had been offered direct payments indicating improvements were still being embedded.

Equity in experience and outcomes

Score: 3

3 - Evidence shows a good standard

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

Promoting people's equity of experience and outcomes was a central aim of the local authority's transformation of adult social care. The local authority had considered its Public Sector Equality Duty (Equality Act 2010) to consider how people with different protected characteristics are affected in the way it carried out its Care Act functions. Senior leaders were passionate about changing the culture and direction of the council to ensure equality of outcome for all the communities across Wiltshire, with evidence of this in developing strategy, policies and services.

Senior leaders described how they were assured people were not discriminated against during the assessment process, this monitored through audits, case sampling, feedback, and performance groups. Staff reflected this commitment and demonstrated a person-centred approach when they talked to us about their work with people. They gave specific examples where they had adopted a flexible approach to ensure people's diverse needs were met, for instance incorporating faith and cultural information in needs assessments.

Senior leaders acknowledged strengthening knowledge and practice about equality, diversity and inclusion was an area for development and were already taking action to address this. For example, the local authority had commissioned the, "Voice It, Hear It" project to help ensure people from minority groups voices were being heard. The local authority had completed a thematic equality, diversity and inclusion audit, and was using the findings to encourage improvements in this area. Generally, the audit was positive about staff attitudes but highlighted a lack of staff awareness about the understanding of different cultures. Actions taken in response included requiring senior leaders to take part in the reverse mentoring programme. Reverse mentoring involves pairing senior leaders with more junior staff. The local authority told us they were using this approach to help enhance managers' understanding of people's protected characteristics. Training provision had also been improved. Staff told us they had attended a cultural competence course as part of this initiative and described how this learning had helped them have a greater understanding when working with local communities.

Leaders and staff told us Wiltshire was becoming more diverse, despite being a largely 'white British' population. However, systems and data collection were still being adapted to allow leaders to fully understand the equality of outcomes for people from ethnic minority groups . For example, it was refining the safeguarding data it currently collected about people's religions, to provide increased granularity and insight into the experiences and outcomes for people with different religious beliefs.

Some staff told us although data and performance was discussed at team meetings, there was limited information on the experience of people with specific protected characteristics, for example, whether people from the LGBTQ+ community or from different ethnic groups accessed services equitably. Leaders told us they were working with people from diverse backgrounds to adapt audit questions to help them better analyse the impact on people and feedback learning to frontline staff.

The local authority was working in partnership with public health and other stakeholders to tackle inequalities across Wiltshire. There was a focus on reducing the inequalities arising from the rural nature of Wiltshire such as social isolation, lack of amenities and public transport. Some actions had been taken to reduce the impact of this, including public health initiatives such as 'pop-up' clinics at local horse fairs and developing a flexible pre-bookable public transport service.

The local authority had a good understanding of barriers to care and support about local communities, in particular the military and boating communities, as well as resettled communities, such as people who had arrived in Wiltshire from Ukraine. There had been proactive engagement with these communities, which enabled the local authority to develop strategic priorities informed by local people. Wiltshire Council's boater survey, carried out in 2023 incorporated the voices of 218 people who lived on boats, which offered a valuable means of understanding their perspectives and concerns. Senior leaders described how they had targeted preventative funding in response to findings from the survey.

Wiltshire had the largest military settlement nationally and the local authority outlined the multiple ways they had engaged with military and veteran representatives to promote equality of opportunity. Veteran representatives confirmed their involvement with the local authority, including developing a 'Military Covenant', which reflected the council-wide commitment to their community. The council led the Military Civilian Integration Partnership which was the first of its kind in the country and brought together stakeholders to promote joint working in this area. Staff and community representatives working with veterans felt staff had a good awareness of the community's needs. However, they described how the general lack of resources for people experiencing a mental health crisis and the move of information online had a negative impact on veteran's wellbeing and outcomes.

There were limited examples of adult social care leaders working strategically with smaller community groups and their representatives to help inform the direction of travel and improve equity of outcomes. One person from a minority community group told us improved direct engagement and targeted support to smaller ethnic groups was needed to ensure their unique needs were met. Staff responsible for housing, migration and settlement were part of the adult social care workforce in the local authority. This provided oversight of the work being done with communities, such as people arriving from Afghanistan. Along with supporting prevention work, the migration and resettlement team could help people access adult social care services who might otherwise have experienced barriers or felt they could not ask for support.

The local authority had a hearing and vision team to provide dedicated specialist support and help minimise barriers to equality for people with a sensory impairment. This team included staff with lived experience of sensory loss which provided the team with a greater understanding of the barriers faced by the people they worked with. A partner told us the local authority could improve how it involved people with sensory loss strategically in the development of practice and services. They told us there was often a focus on risk at the expense of promoting independence. Other partners told us how the culture in the local authority was changing and leaders were now listening more to the right people when designing services. This was evident in the development of the new carer's strategy. Senior staff told us the local authority had listened to views of people they had not traditionally heard from in the past and incorporated these voices into the strategy.

The local authority understood the importance of having a social care workforce which was representative of the demographic profile of the area. They had produced a corporate Inclusive Workforce Strategy as part of their equality objectives. The strategy outlined the workforce data being collected, which was used to understand the experience of staff. For example, data was collected about the reasons for leaving employment and where possible this was broken down for staff with different protected characteristics. An equality, diversity and inclusion steering group had been set up to support the delivery of the strategy and address any findings and gaps. Measures taken included the creation of staff networks, such as the armed forces, carers and disability staff networks.

Inclusion and accessibility arrangements

The local authority had inclusion and accessibility arrangements which took into consideration people's varied communication needs and preferences. These included British Sign Language interpreters, lip speakers, deaf translators, speech to text reporters, note takers, interpreters for deafblind people and remote interpreting.

The local authority produced information in different formats to support people to have equal access to information, for example, enabling their website to be read using speech recognition software. Information was also available in different formats such as braille, easy read, large print or audio recording. A document for people enquiring about social care was available as a booklet, electronically and available in an audible format.

A partner organisation told us the local authority's website was not very clear, particularly for younger people who used their mobile phones to access information. Another organisation told us local authority staff sent out information in large print for people who asked for it. We were told that systems needed to be more joined up to provide information to specific people in the format they needed, rather than people having to ask for it multiple times to different departments. The local authority had recognised where improvements were needed and said they were frequently hampered by technical limitations. They had produced a website accessibility statement which outlined where measures were being taken to encourage improvements, such as working with developers to make improvements and ensuring all new content met accessibility standards.

Partners told us some people found it difficult to access information equally while living in rural locations or because of digital exclusion. Staff from the advice and contact team felt it was important when people rang the contact centre they always spoke to a person and there was a focus on outcome and solution focused conversations, not just referring people to their website or signposting them if they needed more support to access information.

The local authority had considered how rurality and digital exclusion impacted on equal access to the information as part of their public health strategies, including their work with Gypsy, Roma, Traveler and Boater communities. A partner told us veterans and other disadvantaged groups who may struggle to access information electronically had suffered as a result of the closure of physical community hubs. Actions taken in response to this had included providing appointments and postal resources for rural clients as well as access to tablets through the digital inclusion scheme.

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 co-ordinated, 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

Commissioning was shaped by community engagement which enabled the local authority to understand local needs and facilitate effective services in the area. People, carers and partners told us the local authority listened and used co-production. This approach took longer to complete projects, but the local authority was seeing positive impact and outcomes through implementation plans aligned to corporate planning. Overall feedback around involvement was positive. However, we found there was more to be done to include the voices of people who were less likely to be heard. The local authority was aware of this and were committed to improve. For example, the 'Voice it hear it' contract was used to gather performance indicators, development, and evaluation of the approach. Staff told us that involving people, especially those harder to reach, was challenging, but by working with very small groups the outcomes were likely to be better.

The local authority used and shared some data with partners to understand the care and support needs of people and communities. There was a published Joint Strategic Needs Assessment (JSNA) and a commissioned video called 'Christine's story' to bring the work of the JSNA to life and show how health inequalities can impact someone over their life course. The JSNA shaped and aligned the local authority's funding decisions and recommendations with the joint health and wellbeing strategy, and through the population health board particularly around preventative approaches. Data from the JSNA and other local-level data was used to inform partnership working and address shared priorities. For example, data had shown a correlation between hypertension and depression and a focused preventative piece of work was taking place between the local authority and health partners to tackle this.

Commissioning teams used the JSNA and other national and local data to develop services which would improve people's outcomes and meet current and future demand. For example, the local authority's independent living strategy drew on national demographic forecasting to understand how many adults with learning disabilities, autism spectrum conditions and mental health conditions lived in Wiltshire, and how this would change over the next 20 years.

We also heard the local authority commissioned external consultancies to carry out wide ranging needs analyses. For example, analysis of accommodation-based care and support to inform commissioning intentions up until 2025. This identified a likely 25% increase in commissioning spend, the need to reduce out of county placements and improve the use of Shared Lives provision. The local authority used data and co-production in understanding and supporting their biggest challenges in commissioning. These challenges were identified as being their ability to meet the needs of people with multiple or advanced health and social care needs, noting an ageing population, those living with dementia and in rural areas.

Market shaping and commissioning to meet local needs

There was enough care and support available to meet the demand for care at home, and no delays for homecare provision. For unpaid carers we heard there was a good offer of short break options which carers could use direct payments to support or to replace care for the person they cared for, in both planned and unplanned situations. According to the Survey of Adult Carers in England 2023-2024, national data was low overall in relation to carers reporting they had access to support and services allowing them to take a break from caring at short notice or in an emergency. However, in Wiltshire there was a positive statistical difference (22.12%) compared to the England average (12.08%).

The local authority was carrying out monitoring and analysis around the availability of supported living and care home services. There was a need for people to use services or support in places outside of their local area. The local authority told us they had a total of 328 out of county placements and 62 people had been placed out of county in the last 12 months (April 2023- April 2024). There were two main reasons for people moving to accommodation outside of Wiltshire. Firstly, from choice, for example people moving to be closer to relatives. Secondly due to a lack of suitable provision within Wiltshire. Data provided by the local authority between January to March 2024 showed had people waited an average wait of 41 days for supported living and an average wait of 26 days for nursing and residential care.

There were plans and processes to address the gaps in provision. The local authority worked with people, staff and partners including Care Quality Commission (CQC), Integrated Care Board (ICB) commissioners, health and neighbouring local authorities to ensure people were considered for in county options first and had processes to reduce risks to people while they were in another county including people who funded their own care. There were plans to provide more care and accommodation for people living with dementia, autistic people and people with mental health needs, so people could move back to Wiltshire if they wished to do so. This included but was not limited to remodelling their mental health provision and purchasing new properties to increase supported living provision in Wiltshire.

Local authority staff spoke passionately about how they ensured people received high-quality care and accommodation, the support they provided to settle people into their new homes and the positive impact this was having on people and their carers. However, we also heard about people who had no access to mental health and drug and alcohol support, leading to a revolving door effect where people without suitable support went in and out of hospital. The local authority was addressing this concern. Social care staff worked with commissioning teams to identify gaps in the market, and gave examples where complex care services had been created locally to bring people back into the county and avoid residential care placements. The local authority was outcome focused and was working with local landlords and wider council estate teams particularly to meet the supported living needs of people with mental health conditions. We were told that social care staff had worked with a local organisation and commissioning staff to listen to autistic people, and as a result had set up an autism hub to address the gap in services for autistic people who needed specialist support.

There were multiple community services available for people with a learning disability and autistic people in Wiltshire. These included: short break services; a learning disability and autism Outreach and Enablement Service; Mental Health Intensive Enablement Service (IES); and Shared Lives (incorporating Shared Days). Wiltshire had in-house registered services providing short breaks for people with learning disabilities and physical disabilities. These benefited local people as there was a focus on supporting people to build and maintain friendships, try new experiences, learn new skills, and engage in community-based activities. The services featured accessible kitchens, sensory rooms, and resource rooms. Staff told us how one service had supported people to take part in money management, food hygiene and customer service courses, helping them gain the skills and confidence they could use when volunteering in the local authority's 'Waverley Café'. The volunteering opportunities in the café also helped people connect with their community and improve their confidence, skills and abilities.

The local authority acknowledged there was always room for improvement in their care provision and said they were pro-active in seeking feedback and constructive challenge around ways to meet current and future social care needs. A senior leader told us about a 'think tank' to challenge any set views the local authority may have. One senior leader told us the local authority were thinking 20 to 30 years ahead to meet gaps and future gaps in provision or lack of capacity. The local authority planned on Technology Enabled Care (TEC) influencing and impacting the way they support people in their homes. We found the local authority were confident in making changes in the market by overturning existing models of care to prepare and improve the market, for example utilising old care home models for supported living initiatives and reviewing provider fees to ensure more equity in the system.

Ensuring quality of local services

When considering the quality of services, local authorities must facilitate markets that offer a diverse range of high-quality and appropriate services and have regard to ensuring the continuous improvement of those services. There were 301 active adult social care provider locations registered with CQC in Wiltshire (CQC data, September 2024). CQC assess registered adult social care services in the Wiltshire market, services had an overall rating on the quality of care using 4 descriptions: outstanding, good, requires improvement, or inadequate.

Homecare in Wiltshire was statistically positive with 68.91% of services rated good compared to England average of 59.45% (CQC data, September 2024). Wiltshire local authority had five in-house homecare services including shared lives and reablement services, 4 were rated good overall and 1 was yet to be inspected as of September 2024. Feedback from leaders indicated the local authorities' internal provider services had been a success, and this success had shaped future commissioning and re-commissioning planning to provide additional internal services to ensure quality was high. We received consistent feedback from people that use services and their carers, that the quality of care in Wiltshire was good and was having a positive effect on the wellbeing of people and their carers receiving care and support.

In Wiltshire, 2% of residential homes were rated outstanding and 76% rated good, 1.67% of nursing homes were rated outstanding and 73.33% rated good (CQC data set). Partners mainly spoke positively about the local authority's quality assurance and the scheduled audits conducted, describing an approachable team and supportive processes which included engagement with people using services and staff at all levels as well as carrying out checks on relevant documentation.

The schedule for quality assessments could be adjusted flexibly if needed, and the local authority was proactive in managing provider risk. The local authority provided data to show they had carried out 66 commissioning suspensions because of quality or safeguarding concerns including concerns raised by partners between April 2023 and April 2024. In September 2024 Wiltshire had no residential or nursing care homes rated inadequate, this was statistically a positive difference than the national average of 1.25% for residential homes and 1.54% for nursing homes. The local authority communicated well with health and regulation partners around services including those with people from Wiltshire living out of area. Early conversations, regular meetings, multidisciplinary working and action plans supported people to be safe and access quality services. However, staff and partners told us the local authority could be risk adverse when responding to quality concerns. For example, people could not be returned to a care home if they were admitted to hospital and the home had a local authority suspension in place despite this being where they lived. This also happened when safeguarding concerns were raised regardless of the nature of the concern or persons desired outcomes. The local authority had a low threshold when suspending services and we were told this did not routinely include people using services or their representatives to weigh up risks and make informed choices. There were written processes to demonstrate it was best practice where possible or practical to place peoples wishes at the heart of plans, and processes to inform people at the end of strategic decision making. However, more could be done to ensure risks were communicated earlier with people using services, to allow them to make choices in care providers and for some people where they wanted to live. This would ensure people using services voice remained a priority and was central to any actions about how and where their individual care and support needs would be met.

Ensuring local services are sustainable

There was a market sustainability plan linked to strategy identifying strategic risks which included workforce, inflation and current payment rates to providers. It identified actions the local authority planned to take to support market sustainability, including working towards a fair cost of care, support for recruitment and retention, and improved working with providers. However, there was mixed feedback from partners about how effectively the local authority collaborated with providers to support provider sustainability.

We heard about tensions across local authority and provider relationships caused by the competition of the self-funding market and differences in fees and fee uplifts (In April 2024 there was a difference in uplifts of 8.23% to homecare and 5.87% to residential care). The local authority was transparent about their current 'all age framework' needing to be improved. For example, care provided for people of working age was paid at a lesser rate to those aged 65 and over, this was said to not be sustainable for providers. The local authority was actively increasing focus groups, had well attended forums for engagement, and co-production approaches to hear from different providers and voices. However, we found providers did not always have a good understanding of the local authorities' strategies, risks, and plans in transformation work. There was more to be done to develop and encourage trusting relationships with providers to better meet the needs of people in the area and understand the impact on people's experiences of any actions taken.

The local authority was not the most significant purchaser of care and support for care providers in the area because of Wiltshire's large self-funding market. Therefore, there was a need to consider the impact on the local market beyond those services which the local authority contracted. The local authority had block, spot and framework contracts, the impact of this had mixed feedback from staff and partners. Block contracts is where the local authority commissioned the purchase of a large volume of services from a particular provider. Spot contracts are where the local authority purchases care for immediate delivery either due to specialism or non-availability within the block contract. A framework contract is how the local authority decides which care providers can deliver care to people in Wiltshire from a list of pre-approved providers with agreed terms and conditions. Spot contracts for nursing or residential care went to providers in the Wiltshire Care Home Alliance (WCHA) first and then providers who were not in the alliance. To join the alliance there was a quality assurance process, and according to local authority's data 95% of placements were with providers on the alliance. The contracts were working as there was enough supply of providers, however the number of differing contracts per provider was a source of frustration for staff and partners, and wider transformation plans were addressing this.

There was mixed feedback from providers about the fee levels paid by the local authority' and how the fair cost of exercise was carried out. Some providers viewed their involvement as tick box exercise and told us it did not impact the outcome. Some providers told us that fee levels were not sustainable for some providers in the long-term and that some contracts had been handed back due to them being no longer financially viable. In contrast, there was positive feedback supporting the change and modernisation of how the local authority commissioned care and how rates paid above the national average allowed providers to plan. For example, one national provider told us the fees permitted them to create a workforce that was paid better than any other county in England (outside of London), this allowed high-quality services to individuals to support their wellbeing. National data showed that the average weekly rate for nursing care was over double the England average making Wiltshire was the highest payer of nursing care in England. Residential care and homecare were also paid higher than England averages (NHS Digital: Adult Social Care Finance Return (ASC-FR) 2022-2023).

According to CQC data, September 2024 there were 11 providers who became de-active or left the market in the last 12 months. At the time of our assessment there was sufficiency of provision to meet current demand for services.

The local authority demonstrated it was monitoring and checking the effectiveness of the adult social care workforce, including care provider workforce which had experienced an increase in workforce vacancy rates since 2021. In the Wiltshire area the total adult social care workforce vacancy rate was 10.76% tending towards a negative statistical difference from the England average of 9.74%, and staff turnover rate 0.37% tending towards a negative statistical difference from the England average of 0.29%. (Adult Social Care Workforce Estimates 2022-2023). However, we were told by the local authority, 59.3% of new workers had been recruited from within the existing adult social care workforce as opposed to leaving the sector or the council area meaning some skills, knowledge and experience were transferring across local employers. One senior leader told us this allowed adult social care staff to explore career opportunities which was important for workforce retention.

The local authority had a Market Sustainability Improvement fund (2023- 2024) to support with internal and external workforce capacity and retention. They distributed their funding across several areas including extra occupational therapist roles, one-off incentives for providers to join their framework, an internal staff market supplement, extra commissioning capacity to support with adult social care transformation and the undertaking of a peer review.

The Wiltshire Care Partnership (WCP) a provider forum, was funded by the local authority, and had worked with key national organisations in developing the wider workforce. However, there was mixed feedback from partners about the effectiveness of this, some told us they didn't always know what support the local authority was providing around workforce. In contrast some shared positive feedback about workforce support including an annual recruitment fair that co-ordinated recruitment across Wiltshire, the Market Sustainability Grant, and training offers. Therefore, communication between partners and the local authority specifically about workforce support could be improved to maximise the potential benefits.

The local authority told us they were continually looking for ways to improve and had several schemes planned for 2024- 2025 to continue to support workforce strategy to ensure they have enough capacity and capabilities in the workforce. These included extra resource for an internal staff recruitment and retention incentives, and promotion of co-production and design work.

Partnerships and communities

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is co-ordinated, 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 with the Integrated Care System (ICS) in shaping intentions and ensuring they meet the needs of the local population through collaboration among social care, health care and the voluntary and community sector representatives. The ICS had an Integrated Care Strategy (2023-2028), and the local authority had a shared focus on some of its objectives such as early intervention and prevention, health and wellbeing outcomes and health and care services. Plans included optimising technology and data, shifting funding to preventative approaches, developing their workforce, joining up local teams and specialist services. Wiltshire as a partnership had identified current assets they were drawing on such as supportive communities, existing partnership working, an above average health profile, high-quality services, a committed workforce and local industry and employment.

The local authority also worked across other types of partnership arrangements for example had been proactive in bringing together stakeholders in relation to military, mental health and safeguarding. There were partnership boards covering a range of priority areas in autism, unpaid carers, and learning disability. These boards had been used to inform and agree strategic priorities in areas such as commissioning for people with a learning disability and unpaid carers. Frontline staff told us about positive relationships between them and their colleagues in health services including within safeguarding, hospital discharge, mental health and learning disabilities services. There were shared workforce development initiatives and developing joint strategies.

There was mixed feedback from people using services and their carers about how effective partnership between health and social care in relation to mental health, transition services, and intermediate care services were in Wiltshire. For example, for one person, mental health services had joined up positively and agreed risk assessment and plans to improve their experience and outcomes. In contrast a partner service was concerned about veterans 'slipping through the net' caused by mental health and social care not agreeing who should provide support.

Where the local authority had integrated functions there was evidence of monitoring demand and capacity of services. There was forward planning to predict future demand, support flexible working, quantify funding gaps and improve positive impact on people.

Arrangements to support effective partnership working

The Wiltshire Integrated Care Alliance (ICA) had developed since its implementation in 2022. ICA leaders from the local authority, integrated care board (ICB), NHS hospital, community and mental health trusts, health and care providers, Healthwatch and the voluntary care sector agreed principles to work within place-based partnerships. The ICA oversaw Better Care Fund planning and monitoring. For example, the Better Care Fund was used to support carers, and services for people with mental health needs. Following engagement and a co-production approach with unpaid carers, new assessment and support contracts had been awarded together with a 24/7 digital information and support to improve their experiences. For people with mental health needs, the community enablement service had received extra funding to expand its offer to more people.

There was no formal partnership agreement for services across the mental health trust and the local authority. We heard health and social care managers met regularly to support service delivery specifically to reduce risks and improve outcomes for people. However, this was not extended to the voluntary sector, which meant some people may not have received the same joined up support as others.

The local authority had a joint funding matrix for health and social care funding agreements to provide timely support for people requiring services. The matrix was due to be reviewed with an agreed focus that joint arrangements would be person centred, for example offering choice through direct payments. It was identified there was more to be done by partners in joining up work around an individual, rather than arranging what services were provided by which partner. However, there was a real commitment from health and social care partners to improve working together with a co-production approach favoured to ensure the person was the starting point for planning.

Impact of partnership working

The Integrated Care System (ICS) was formed in 2022 before this the group of public services had not been a formal partnership. Therefore, there were evolving relationships and priorities. Strategic partners and senior leaders acknowledged challenges around partnership working which had impacted the development of system thinking to promote joined up health and care for the benefit of the whole population. Working with different management styles, transparency about funding and financial controls, agreeing agendas around what constituted as preventative approach and planning integrated service offers, were all areas that required further work to build collaborative and meaningful partnerships that start with people and focus on what really matters to people in Wiltshire.

There was a shared approach to provider quality across the local authority, integrated care board and CQC, joined up working informed safeguarding concerns as well as regulatory compliance, with regular information sharing between health and regulation partners. Staff spoke positively about this with good sharing of information and intelligence to ensure that where people were funded by health, staff had access to information about the quality of provision to make informed decisions. Other examples of the impact of partnership working in Wiltshire included some reduction in the number of people waiting to be discharged from hospital using the care provider trusted assessors model, co-location of mental health services delivering joined up work across community teams, and development of services for people with learning disabilities. The local authority was committed for local people with care and support needs to receive high quality services and had a preference to keep services in-house to ensure high quality. However, partners told us this comprised the spirit of partnership working. There was a need for system thinking to make the right decisions about service changes, how money is spent and improving safety, experience and performance together.

The local authority was in the early stages of evaluating the impact of its partnership working for people being discharged from hospital. The Better Care Fund was used to pool budgets to provide and review hospital discharge pathways. The local authority was exploring differing ways to provide integrated services rather than formal integration, with a focus on the benefit for people with care and support needs. For example, working together to support people in their communities and developing solutions together could benefit system resources such as finances and staffing, and as a result positively impact more people's experiences. The local authority demonstrated they were an active partner within the ICS especially in encouraging a prevention agenda. However, there remained more to be done to help understand complex problems, improve decision-making and promote sustainable solutions by considering the interconnectedness and interdependencies between health and social care. This included defining responsibility and sharing of outcomes and risks. The local authority acknowledged there was always room for improvement and welcomed scrutiny to enhance people's experiences.

Working with voluntary and charity sector groups

The local authority funded voluntary and charity sector groups to work for them to understand and meet local social care needs. Partners told us there were gaps in providing support to smaller groups and, how uncertainty of funding and competitive procurement decisions was a challenge for the voluntary sector. Many opportunities for funding were short-term, making it difficult for them to plan for long-term projects or maintain continuity of services. The need to reapply for funding could cause strain on resources. This was particularly challenging for smaller organisations with limited administrative capacity.

Small charities are an integral part of communities. They often serve as expert support, a number for people to call for advice, and a welcome safety net during a crisis. Funding from the local authority was often directed toward specific priority areas, which did not always align with the needs or goals of people in the area. This could limit the availability of support for seldom heard people accessing small and local projects or communities.

Larger organisations tended to have a better experience of partnership working. For example, a charity met with the local authority every month to discuss ways of working and what needed to happen. They had actively been involved in the development of the Dementia Strategy and described meetings as honest, open and had felt listened to.

A voluntary and charity sector group that was commissioned by the local authority, told us they were working with commissioners, strategic partners and the local authority's engagement team to improve strategic relationship and refresh an agreement between local authorities and voluntary organisations. Some partners felt historic workshops held had been unsuccessful, and described actions taken as not followed up. However, there was increasing commitment to improve communication and support, and the local authority was described as 'wanting to do the right thing'. For example, we heard about Community Engagement Managers employed by the local authority for children and families to create welcoming and inclusive communities by supporting and enabling groups and individuals, which was extended to adults with care and support needs. There were 'Area Boards' across Wiltshire which supported local decision making within communities. There were 18 Area Boards across Wiltshire, with each one holding delegated powers and devolved budgets to facilitate community action at a local level. The boards coordinated local Health and Wellbeing groups that brought together representatives from the voluntary and community sector, local health partners, and the local authority including elected members. Adult social care managers were each linked to a Health and Wellbeing Group. This supported the local authority to be embedded in local communities, connected to local groups and services and listen to what is important to people living there. These groups evaluated local evidence and data, developed projects, identified gaps in provision and made recommendations to the 'Area Board' on how to allocate their devolved funding.

Theme 3: How Wiltshire Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

People and their carers had access to local authority support 24 hours a day and 365 days a year. Processes were in place to keep people safe including formal escalation and handover processes when people moved between services. There were on call processes that meant people in need could access emergency care or housing support out of usual working hours.

During the previous year the local authority had used staff feedback and audits to identify there were unclear boundaries and delays in transfers across some internal teams. As a result, the local authority had taken actions to improve internal pathways. They had reviewed organisational structure documents and handover guidance to provide greater clarity. Staff told us that where communication was once poor, they were now confident and trusted the handover processes which had improved communication with people using services and reduced delays.

Information sharing and processes to support safety were effective. For example, staff told us that processes supported co-working and a cohesive approach between the advice and contact team and the emergency duty team. Staff accessed the same digital systems and people contacted the same telephone numbers day or night. There was the need for some staff to access multiple systems such as health or provider records, and we were told this was provided. Staff told us where the digital record systems didn't link up, good professional relationships made up for this to support personal information to be shared in ways that protected people's rights and privacy.

Safety during transitions

Transition is a time when the differences and gaps between services and support can be particularly evident and problematic. A joined-up approach across relevant partners and agencies is critical, to achieve the best outcomes for young people, adults, unpaid carers and their family and reduce risks of any loss of continuity in care and support. The local authority had processes to support pathways when people moved between services and agencies that included children into adulthood, hospital discharge, moving to another local authority, transferring between services and for people who could no longer fund their own care. We heard positive feedback from staff about support from residential care into supported living, improvement and co-production working with prisons, and out of area quality and commissioning support to enhance people's safety.

There was mixed feedback from people, staff and partners about the arrangements for safe transitions from child to adult services in Wiltshire. The 'Moving On Service' was a new and dedicated team to support young adults between the ages of 18 and 25 years old. An allocated worker model mirrored what was offered in children's services; link workers could support people from age 15 to 16 years old to begin transition preparation. Referrals came through the advice and contact team and children's services teams (apart from referrals for young people with a disability which followed a different pathway). The service bridged the gap between children's and adult services with clear processes for young people already known to services, children in care and young people who were not already known to services and did not already receive support from the local authority.

However, the local authority was aware there was still room for improvement in this area and acknowledged partners, young people, and their carers experiences, some of which had described transitions to us as a 'cliff edge' and 'falling through gaps'. There was ongoing project and improvement work to develop ways to identify these young people and their needs such as the work around transitional safeguarding, neurodevelopmental pathway, child and adolescent mental health services as well as deep dive audits. Senior leaders and partners told us the Parent Carer Council influenced projects and services including through strategy which had been fully coproduced with young people and families. We heard from carers and partners examples where concerns had been raised and quickly addressed as a priority. For example, some people who were due to transition from college education, were told they could not refer until 6 months before their education ended when they contacted the advice and contact team. This was raised by unpaid carers and partners as a contradiction to communication in college presentations which encouraged referrals as early as possible. As a result, this barrier was raised with managers and a clear message agreed with the advice and contact service.

Signposting, internal referrals for housing support and the promotion of the local authority's in-house services, such as day services, were in place to support successful transitions. For example, the local authority supported young people and their families to view services; offered easy-read information about service; cross-working and collaboration with the school's cafe and taster days. Staff told us working with young adults was not just a job but a passion, they took pride in knowing people well and had a strong want to 'do the right thing'.

The Care Act places a duty on local authorities and the NHS to work together to ensure the safe and timely hospital discharge of people with care and support needs. The NHS and local authorities should use the best evidence available, develop and apply local processes that ensure all people with care and support needs to achieve appropriate, timely and safe hospital discharge. Referrals to arrange physical health hospital discharges went to one of three Transfer of Care Hubs (ToCH) in the area. A ToCH is a health and social care coordinating centre linking all relevant services to aid discharge and recovery decisions, and the local authority is a key partner in effective delivery. If a person was transferring or returning to a care provider at the point of discharge, there were processes to support this. People using services and their carers gave positive feedback about physical health hospital discharges in Wiltshire.

The Trusted Assessor (TA) service was a service for people who are being discharged from hospital to a care service run by providers (in the Wiltshire Care Partnership). The Trusted Assessor service undertook assessment of the person's care needs on behalf of another care provider. Any care provider could access the service, and it covered the whole of Wiltshire including neighbouring counties where needed. Partners told us the service is trusted by local care providers and provided full assessment for people being transferred from hospital. Senior leaders told us this service helped to move people through the system smoothly and quickly. Between July 2023 to December 2023 the service completed 224 assessments for care providers.

When people moved from one service or local authority area to another there was access to seven-day integrated brokerage supporting adults and children across Wiltshire. They provided a same day response rate and no waiting list to start sourcing support. The brokerage service actively took part in daily multidisciplinary meetings to ensure any barriers to discharge could be resolved quickly. The local authority said there were an average of 7000 referrals per year to the brokerage service to support people. There was an escalation process to escalate a change in urgency for a package of care or a change in need. This supported people's experiences of hospital discharge and minimised their length of hospital stay.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for possible interruptions of its delivery of duties under the Care Act, including interruptions in the provision of care and support. There were policies and processes to ensure the needs of people receiving care and support services continued to be met in untoward events such as, imminent business failure of a regulated care provider, immediate deregistration and closure of a regulated care provider by the CQC, a major and immediate unplanned business interruption (for example a significant fire or flood), and where the care providers' own business continuity plan was unable or had failed to reduce the impact of risks on the people they supported. For example, staff described the actions taken when a care home was closing for financial reasons and had an inadequate CQC rating. The local authority organised a multidisciplinary group of professionals to manage the risks and understand people's needs, whether the local authority funded them or not. A responsive specialist public health protection nurse role had been created which supported business disruption events relating to quality, transfers of care and infection prevention and control concerns.

Specific consideration in relation to safeguarding, quality, contracts and commissioning was given to protecting the safety and well-being of people who were using services which were located away from their local area. There was sharing of information across local authorities about out of county placements. The local authority held an out of county tracker to support oversight. In the event of the local authority being notified by another local authority of a regulated provider business failure in their area (and when people who ordinarily reside in Wiltshire were supported by that provider), then appropriate operational support was allocated to help people to move to alternative services, commissioning and brokerage were also involved in this process to minimise the risks to people's safety and wellbeing.

Activating emergency response groups, use of market oversight meetings, and analysis of data to monitor risks to provider business continuity were used. There was a good awareness of how data informed actions to support and reduced risks to people using services. For example, at a market oversight meeting it was recognised through data analysis, a care home had a theme of safeguarding incidents. This triggered an existing link worker to focus on this area during their ongoing visits to the care home. This allowed the local authority to prepare for possible disruptions and provide targeted support to care providers.

Staff and partners told us about work carried out in relation to international recruitment by care providers, and risks in Wiltshire of modern slavery with unethical international recruitment practices highlighted by the police. There had been good partnership working in this area. As a result, the local authority used an 'International Recruitment Risk Analysis tool' to identify the level of risk presented by care providers who used sponsorship licences (for example, risks created by licence revocation) to decide the level of monitoring or action needed. The local authority knew the number and ratio of staff operating under the certificate of sponsorship scheme within care providers in Wiltshire. This was balanced with the number and needs of the people the provider supported. The tool supported decision making around what action needed to be taken (for example when the local authority needed to move people to another provider if there were risks in the current one). This included people that self-funded their own care to ensure safety was a priority.

Funding decisions or disputes did not lead to delays in the provision of care and support. Depletion of a person's finances could lead to a move between services of their choice. However, there were processes in place should a person not be able to continue paying or contributing towards their care and support to ensure there was continuity of support.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

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

Safeguarding is the process of ensuring people at risk are not being abused, neglected or exploited. Wiltshire had a Safeguarding Adults Board statutory function that aligned with safeguarding children and community safety partnership (Safeguarding Vulnerable People Partnership). The safeguarding partnership board was attended by the local authority, police, health services and other local organisations, this did not include advocacy or provider services. There was an adult safeguarding subgroup of the board that had a wider membership (Safeguarding Adults System Assurance). The local authority had other groups and forums that supported staff to enhance and share safeguarding adults practice and learning. The safeguarding partnership board heard from staff about current safeguarding practice. However, it was recognised more could be done to ensure people's voices could also be heard at a strategic level. The local authority had also identified the need for independent scrutiny on the safeguarding partnership board to hold them to account on changes needed and was recruiting to this post.

There was a multi-agency safeguarding hub (MASH) during weekdays that included a team of investigating managers, police and a nurse funded by the integrated care board (ICB). We heard examples of joint working with housing, environmental health professionals, ambulance service and community health professionals to reduce risks to adults in Wiltshire. The MASH was described by staff as supportive and flexible. This allowed information, knowledge and expertise to be shared quickly, and initial concerns to be actioned without delay. The MASH was also aligned to the advice and contact team for any extra support around managing risks. There were processes for handing over urgent safeguarding concerns and interventions between the MASH and out of hours team through manager-to-manager telephone calls, backed up by documentation.

Staff had access to training to support them to carry out safeguarding duties. Safeguarding training promotes an understanding of what preventative actions can be taken to reduce risks to adults. It also aids the quality of referrals made and the skills and knowledge required to investigate concerns for people with care and support needs and/or their carers. The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions for people who may lack the mental ability to do so for themselves. 38.70% of the wider social care workforce in Wiltshire had completed Mental Capacity Act and Deprivation of Liberty Safeguards (MCA, DoLS) training and 44.14% had completed safeguarding adults training. This was not statistically different from the England average of 37.48% for MCA, DoLS and 48.81% for Safeguarding adults (Adult Social Care Workforce Estimates, Skills for Care 2022-2023). Internal local authority staff had compulsory training in these areas as well as more training for staff that carried out specific safeguarding duties, for example investigating officer training. Partners could also access training on offer from the local authority to support their staff.

Responding to local safeguarding risks and issues

The local authority reported on safeguarding risks and issues in the area. The most common types of abuse outside of care home settings in Wiltshire were physical, psychological, neglect and acts of omission, and domestic abuse. The safeguarding partnership board had a strategic plan with 3 themes: learning and improvement, supporting a prevention approach and developing leadership and culture. There were 5 areas of practice identified as priorities with one focused on children's safeguarding only, the other 4 priorities had an all age or family approach to safeguarding people in Wiltshire. Domestic abuse was both a theme and a priority in relation to safeguarding adults. Processes were in place and there was evidence of good partnership working where there was domestic abuse. For example, the local authority worked with primary care colleagues to meet and work with the adult at risk in a way and place that was best for the person. This provided a safe place to give advice, support and options to adults at risk to protect their right to live in safety.

The safeguarding partnership board's strategic plan had descriptors to support improvements in practice. Outcome measures were identified or under development. However, there was areas that lacked detail to demonstrate what the local authority was doing to deliver its part of the plan. The local authority was working on improved engagement with the public, people using services, unpaid carers, voluntary sector and providers.

Transitional safeguarding was another priority in the strategic plan. Transitional Safeguarding in Wiltshire was an approach to safeguarding for people aged 16 to 24 years old. Staff and partners told us about pilot and improvement work, this included a multi-agency 'creative solutions' board that focused on preventative work, trauma-informed practice and early intervention to support better outcomes in adulthood. The local authority had identified gaps in support for young adults leaving care who didn't have care needs that met Care Act thresholds but were posing risks to themselves or others. There was ongoing work to address this concern including the development of 'Risk Outside of the home' tool. Staff described how senior leaders ensured a close multi-agency approach and offered solutions around reducing high risks to young adults.

The safeguarding partnership board in Wiltshire had an overview of safeguarding reviews, between 2022 and 2024 there were 3 Safeguarding Adult Reviews (SAR), 1 of which had been completed and 2 of which were underway. They had 5 referrals for SAR that had not met the threshold. There was also 1 LeDeR (Learning from lives and deaths) review, 2 domestic homicide reviews and recommendations about a Child Safeguarding Practice Review. Themes identified from these reviews were: the use of the Mental Capacity Act, working with people that are at risk of self-neglect, management of high risks including escalation, and care being provided by a family member including unpaid carers.

There were clear governance processes for sharing learning and carrying out actions from safeguarding reviews. However, there were gaps in the local authorities plans and overall assurance of how successful learning and practice was embedded and if future risk of reoccurrence to people and unpaid carers had been reduced.

Staff told us with confidence how they internally used data and analysis to monitor trends and how this influenced practice. For example, there had been a recent increase in concerns relating to self-neglect. MASH investigating managers each had lead roles in specialist subjects. One manager led on self-neglect and they had led a safeguarding forum for staff to focus on self-neglect in response to the trends seen in data. Investigating managers took on a lead role to represent the local authority at partnership forums such as MARAC (multi-agency risk assessment conference; a meeting where information is shared on the highest risk domestic abuse cases) and Wiltshire Sexual Exploitation Panel. Staff told us about external workshops to share 7-minute briefings with partners (easy read learning from SARs in 7 minutes), and other topics.

Responding to concerns and undertaking Section 42 enquiries

The safeguarding partnership board website promoted 'if in doubt refer' for professionals making safeguarding referrals in Wiltshire. National data from the Safeguarding Adults Collection (NHS Digital, 2023- 2024) between April 2023 and 2024 showed a conversion rate of 40.08% for safeguarding initial concerns moving to a safeguarding enquiry under section 42 of the Care Act. Section 42 enquiries are the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. The number of concerns and enquiries had reduced from the previous year, and was lower than the average number of concerns and enquiries for the local authority over the past five years.

All safeguarding concerns came to the Multi-Agency Safeguarding Hub (MASH), each concern was actioned by an investigating manager. There was support from information officers to gather specific information to aid the triage and decision making. When the threshold for a section 42 safeguarding enquiry was met there were investigating officers in locality teams to progress this. Investigating officers could be occupational therapists, social workers or social care practitioners dependant on who had completed the required training and who was best placed to support the adult at risk. Referrers or providers did not receive formal feedback when the enquiry was closed as there was no formal process to be followed. Staff and partners told us about differing methods to feedback such as over the phone, through email, in a meeting or passing of information to an investigating manager. Staff explained how they did not always inform care providers depending on the nature of the concern raised. Therefore, more could be done to ensure feedback was consistently shared when it was necessary to the ongoing safety of the adult concerned.

There were processes for safeguarding enquiries to be carried out by a care or health provider. A risk tool aligned to best practice and legislation supported staff to consider whether a provider was suitable to carry out the enquiry. When partners did carry out investigations for the local authority there remained oversight of a named investigation manager to lead on meetings, check the quality and outcomes before closing the enquiry. Where there were organisational abuse enquiries to be carried out, senior leaders led on these with managers carrying out the investigating officers' role. This showed the local authority kept responsibility for the enquiry and the outcomes for people to ensure people were protected from abuse and neglect.

Concerns raised in relation to discriminatory abuse were 6 times higher in Wiltshire's care homes than that reported in other settings. 'Provider referral forms' were used where internal staff in the local authority could raise concerns about care providers to the quality team. This meant all organisational quality or safeguarding concerns were reported. However, staff and partners feedback described reporting concerns without informing providers and/or people using services. There was concern any immediate risks to people using services were not addressed at the time by care providers as they were not told. There were low numbers of organisational abuse enquiries completed despite the high numbers of concerns relating to providers as a source of risk. However, there was evidence of the local authority applying statutory guidance to dealing with organisational abuse to improve outcomes for people.

There was mixed feedback from partners about safeguarding advice and guidance. For example, partners described social workers as very knowledgeable and approachable around safeguarding. In contrast, there could be inconsistency over section 42 threshold decisions and feedback about outcomes and learning. While safeguarding is not a substitute for providers' responsibilities to provide safe and high-quality care and support, local authorities must cooperate with partners to protect adults. It is necessary to create strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse or neglect. A threshold matrix for safeguarding enquiries, aimed at improving consistency in section 42 threshold decisions, was pending feedback from care providers at the time of the CQC assessment. However, there was more to be done around developing a positive learning environment across partnerships and at all levels within them, to help breakdown any risk averseness and blame cultures which could negatively impact on adults at risk in Wiltshire.

Deprivation of Liberty Safeguards (DoLS) are legal protections (authorisations) that ensure people who are unable to consent to their care and support arrangements either in hospital or in care homes, are safeguarded. The median number of days people waited for an authorisation was 149 days. The maximum wait had gradually increased over the year to 3195 days and then dropped significantly in March 2024 to 1545 days after focused work on lower risk requests and found many people had a change in situation (data provided by the Local Authority April 2023 to April 2024). In April 2024 the number of DoLS requests waiting was 1729, by September 2024 this had steadily dropped to 1693 requests waiting. The local authority had a separate DoLS team, we heard staffing resource was growing and there was a focus in the team to reduce risks to people by considering less restrictive options. Administrative support monitored the waiting list, and priority was identified through the local authorities' own criteria. Staff told us they had worked hard to make improvements using best practice guidance tools as a guide. Staff felt this had allowed them to be more proportionate and as a result were working with more people.

There was more to be done for people living in the community unable to consent to their care and support arrangements such that may constitute a deprivation of their liberty, having these arrangements legally authorised; for example for people living in independent housing. A recent review identified staff needed more training to recognise where such authorisations may be needed. Training was carried out to improve confidence and knowledge and as a result there was an increase in referrals for authorisations but improved triage and oversite of the extra waiting list. Senior leaders were committed to address the risks, and there was monitoring through governance and performance frameworks which was maintaining the position of the waiting list. However, it was highlighted the list wasn't coming down fast enough, this meant there remained risks to people being deprived of their liberty without authorisation.

There were quality monitoring arrangements for safeguarding enquiries which included when enquiries were delegated to health or care providers. Staff described an open culture of learning and good management support. We heard about regular risk meetings which also covered out of county placements with managers from safeguarding and contracts teams, and partners such as Care Quality Commission (CQC) and the Integrated Care Board (ICB). The local authority used data and analysis for monitoring and informing safeguarding adults' performance and improvement. There were internal and external audits covering multi-agency triage and peer casework. The audits included speaking to people who used services to understand their experience. Audit outcomes were reviewed at a quarterly assurance meeting to identify gaps in knowledge and arrange for training and development of staff. According to local authority data there were no waits for safeguarding concerns requiring initial threshold decision-making between January 2024 and April 2024 except for 1 referral with a 1 day wait. Partners did not receive regular or direct information about the timeliness of safeguarding enquiries or if there were any themes around delays to complete enquiries and plans. However, issues could be escalated to the safeguarding partnership board (of which there was none at the time of CQC assessment), and the business unit of the board monitored the themes of safeguarding outcomes through information received from sub boards.

Making safeguarding personal

Making safeguarding personal is an approach to safeguarding to keep the wishes and best interests of the adult at risk at the centre of the safeguarding enquiry and any plans to reduce future risks to them. The principle is to support and empower a person to make choices about how they want to live their own life, seeking to improve quality of life, wellbeing and safety. We heard how processes and practices supported this approach in Wiltshire.

Where possible, staff who knew the adult at risk best would carry out an enquiry. This reduced the amount of times people needed to share their experiences and promoted an approach to align actions with the care and support needs they had. Staff worked together to identify desired outcomes of the adult at risk. We heard how this was not a 'tick box exercise' and there was continuous learning and improvements to ensure the person's views, wishes, feelings and beliefs were central to the safeguarding processes.

The local authority had a leaflet and video to raise awareness and understanding of safeguarding using simple terminology. Staff could access translation or interpreter support for people once they had been referred to the MASH, to support the person's desired outcomes to remain central when carrying out an enquiry with them. However the local authority could not demonstrate how it was assured information and advice to support prevention and ensure appropriate reporting safeguarding concerns. For example, people from a black, Asian or other people from ethnic minority groups background were underrepresented in safeguarding referral data. The local authority could not show through data or feedback how effective and far-reaching the information they provided about safeguarding was to ensure people from a black, Asian or other people from ethnic minority backgrounds were fairly accessing safeguarding information and advice to reduce potential risks to them.

A subgroup of the safeguarding partnership board used audits to monitor the compliance of recording people's desired outcomes, the quality of plans to ensure safeguarding responses were appropriate, and the principle of 'making safeguarding personal' was embedded. Although we heard about how peoples feedback was sourced, there was no clear place for people's voice to be recorded in the audits and any impact of people's protected characteristics was not considered in audit. Staff were completing cultural competency training. However, at the time of CQC's assessment, learning and improvement around people's experiences in safeguarding work remained limited.

Staff told us they considered advocacy support for people at the point of agreeing risks that met thresholds for section 42 enquiries. If the adult at risk didn't have a family or friend to support them, and they lacked mental capacity around the concerns then referrals were made for independent advocacy support. Advocacy support prioritised safeguarding referrals depending on the level of risk. 100% of people that lacked mental capacity around their safeguarding concerns were supported by an advocate, family or friend in Wiltshire. This was a significant positive statistical difference from the England average of 83.38% (Safeguarding Adults Collection, NHS Digital 2023-2024). Staff described advocacy arrangements as effective through joined up working. This showed there was a focus on the person to understand their rights, including their human rights, their rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010 and they were supported to make choices that balanced risks with positive choice and control in their lives.

There was an ethos of there always being room for improvement. Staff and partners told us there was ongoing support for quality and consistency of social work practice in fulfilling its' safeguarding responsibilities, and proactively hearing peoples' voice rather than only through complaints and case reviews.

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

There were governance, management and accountability arrangements at all levels in the local authority. These provided visibility and assurance on quality, sustainability and risks to the local authority when carrying out its Care Act duties.

People with lived experience were aware the local authority had made changes to structures to improve the impact on people's care and support experiences and outcomes. People that attended local authority forums and co-production groups described honest and transparent conversations. We were told the local authority really valued people, which was part of their ethos, and 'they put what they say into action'.

The local authority had a 'One Council' approach. This supported internal risk management, performance and escalation arrangements in adult social care and the wider council including public health, commissioning and children's services. Risks were reflected in a corporate risk register showing accountability through monitoring and action. Senior leaders across the council worked well with each other, and this extended to all levels of staff. Partners described evolving relationships around risk management, and open and honest escalation arrangements.

The local authority had been politically stable for a long period of time which had been helpful in providing long-term clarity on the local authority's priorities. The chief executive officer was new into post and the director of adult social services (DASS) had been in post for 18 months. Although new into their current posts, both had worked for the local authority for many years and knew Wiltshire well.

Social care commissioning had an 'all-age' approach and its own director. Senior leaders told us there were benefits of having two directors providing support and cover for the adult social care and care commissioning functions. For example, in the event of provider failure, both directors had oversight and input to ensure people's safety. However, we were also told that aspects of commissioning, quality and brokerage could be disjointed and there were plans for this model to be reviewed.

Senior leaders including elected members had a visible presence and were well informed about successes, risks and future planning in adult social care. The local authority had robust performance and outcomes groups and boards, and performance reviews. Elected members had areas of Care Act responsibilities within their portfolio including Adult Social Care, Safeguarding, and Health and Wellbeing. The local authority recognised the opportunity to further enhance the scrutiny of adult social care, and to increase its focus to ensure parity with other areas such as health or children services. Overall, the current scrutiny function was seen as having a good understanding of the system, with potential for continued improvement.

We found senior leaders and staff to be curious, passionate and committed. Principal Social Worker and Principal Occupational Therapist roles were aligned in the organisational structure and independent from team management. This showed value and credibility to lead, develop and standardise practice through engagement with front line staff. There was less opportunity for these roles to influence or shape strategy. However, we heard how they linked with senior leaders around risk and practice considerations. Where there were shortfalls in carrying out Care Act duties, for example, waiting times for care assessments, staff were clear about how the local authority was working towards reducing risks to keeping people safe.

Strategic planning

Local differences meant the local authority developed and implemented strategic plans to reflect their circumstances and to meet the needs of its population. There were priority matters to tackle, and these were addressed through their strategies and identified in their corporate risk register (for example, risks posed to people living outside of the county and people on waiting lists for assessments). There were workstreams to oversee delivery of strategies such as the Autism Strategy, the Independent Living Strategy, BSW Mental Health Strategy, Older Adults Accommodation Strategy, Carers Strategy and the Learning Disabilities Strategy. The strategies were published on the local authority's website. They had designated leads, resources allocated and delivery plans that showed how legislative duties and corporate responsibilities were being met. Progress against strategies was checked at governance boards and shared at operational groups. The local authority had an adult social care strategic plan to help them carry out the corporate overarching 10-year business plan. The four main themes of the plan were 'Prevention and early intervention', 'Understanding communities', 'Improving social mobility and tackling inequalities' and 'Working together'. The adult social care strategic plan was in two parts, one focused on 'Living and Ageing Well' and the other focused on 'Whole Life pathways'.

Commissioners focused on providing a consistent, quality service across the whole of adult social care to ensure there was a joined-up, collaborative approach to meeting needs and achieving outcomes.

The local authority worked with partners within the Health and Wellbeing Board to carry out Joint Strategic Needs Assessments for their areas and to develop strategies. The Wiltshire Health and Wellbeing Joint Strategic Needs Assessment (JSNA) and Community Area JSNA (Community JSNA) informed Wiltshire Adult Social Care's strategic approach. For example, the over 65s population was rapidly growing, with an increase of 43% predicted by 2040 and by 87% for over 85s in the same period. The under 65s population in this same period was expected to decrease by 3%. The local authority had considered the potential impact of this and the likely need for more resource across all health and social care services. They carried out future planning based on prediction trends and data. As a result, they were aware of the need to consider and position capacity and resources appropriately, through their operational, commissioning and financial planning. As identified in their Local Government Association (LGA) peer challenge report, Wiltshire's financial planning was noted as robust in the budget setting process and there was dedicated financial leadership in the adult social care directorate.

The local authority used information about risks and performance to carry out the actions needed to improve care and support outcomes for people and local communities. For example, Wiltshire aimed for consistency in their approach to assessments, reviews and support planning through its practice quality assurance framework supported by the Principal Social Worker and Principal Occupational Therapist. They used a ‘Plan, Do, Study, Act’ methodology to identify points of good practice, areas of development and closing the learning loop.

Key strategies had been co-produced with residents of Wiltshire including people who used adult social care services. The local authority also had strategies in development or under review, for example, the Dementia Strategy. Staff and partners told us about the good engagement around the local authority's Dementia Strategy 2023-2028. This aligned with wider national and local priorities, and strategies. The strategy built on the previous 2014 strategy and had a clear vision and aims to make Wiltshire a 'dementia-friendly county'. The strategy took account of local and national context including population and research data. It had been co-produced alongside housing staff, people living with dementia, carers and partners including care providers and the mental health NHS trust. Voluntary sector told us they had been involved in the Dementia Strategy last year and contributed heavily to this. They told us they also sat on the Dementia Delivery Board and the Leadership Alliance Board.

People and their carers felt they were embedded as strategic partners in the local authority. This was primarily with children's services but extended to a positive relationship with adult services and commissioning. Most voluntary community and charity partners gave very positive feedback about their involvement in strategic planning. However, we heard how smaller organisations had limited opportunities to interact with the local authority at a strategic level and were pursuing more formal and regular involvement. This would ensure there was a visible and effective link between preventative spend and preventing crisis interventions. We were told about the 'Voice It Hear It' partnership which was funded by the local authority to engage with various different groups of people across the community. The partnership was helping raise the profile of people who felt unheard and unsupported.

Information security

The local authority was certified as compliant with Public Services Network standards and they were proud of audit exercises to ensure compliance. They had corporate arrangements to maintain safe systems around information governance, confidentiality and sharing of information. This ensured there were effective tools, staff training and expert advice to remain compliant with legislation and kept people's information secure. There were data sharing agreements and processes, privacy notices and consent standards in place.

All users of the local authority's digital case management system had to sign end user agreements before accessing peoples' data and, for example, during case file auditing, peoples' records were checked for any inappropriate access and action was taken if found. When abuse or neglect was raised, staff could access past incidents, concerns, risks and patterns so they could take the necessary action. Staff confidently told us about the support and training available to them, as well as how they kept peoples' information safe in practice. For example, there were mechanisms to check emails were safe. They had a good understanding of not sharing information unnecessarily and only in a proportionate manner. They told us they shared learning with each other about data safety, for example, staff had discussed a near miss about an email which had looked safe but had not been.

We heard data protection and information governance were standing items on corporate agendas in the local authority. There were business continuity plans, audits, reports and actions to address findings. For example, ensuring new and existing staff received up-to-date training on information governance and partners receiving guidance on data security. The local authority also had overarching agreements with partners around information sharing where this was appropriate to fulfil duties to cooperate under Section 6 of the Care Act.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

The local authority worked collaboratively with people. Co-production, as a two-way partnership with people accessing services, was valued by the local authority and seen to be embedded throughout commissioning, assessment, quality assurance and transformation work.

We were told about ‘innovators’ (people with care and support needs and unpaid carers) and ‘pioneers’ (staff) who had impacted specific projects. There was a commitment to involve people, carers, and internal staff at all stages through design, delivery and evaluation, rather than simply requesting ‘feedback’. For example, people told us they were part of staff induction for new social workers, occupational therapists and social care practitioners and promoted ways of working that improved people's social care experiences and outcomes such as good communication and accessibility of information.

The local authority funded independent organisations who worked with people through arts and music. For example, in recommissioning the all-age unpaid carers contract and all age unpaid carers strategy, unpaid carers expressed their voices experiences and challenges to inform the development of the next five years of unpaid carers’ support. People had created artistic projects about their experiences such as poems and songs. As another result, there was a launch of a campaign named 'caring around the clock' to encourage carers to talk about their lives ‘every day, anytime’, as 'the care does not stop'.

There were many ways to learn and share best practice. We found a vibrancy amongst staff that showed a positive culture of wanting to improve and serve the people of Wiltshire well. The local authority was open to feedback and challenge to ensure improvements were inclusive and proportionate.

Data was used to encourage performance improvement so Care Act duties were carried out safely and effectively. There was a strong culture of pulling on knowledge, analysing data and identifying subjects for development at all levels. For example, staff tracked people's enablement outcomes using data and tools to identify goals, and measure preventative outcomes. Through continuous review, they celebrated successes as a team and identified areas for improvement and training needs. This was linked into the work of Performance Outcomes Groups (POG), which focused on data and audit outcomes. The local authority within POGs measured its own performance against targets it had set to improve quality and efficiency of its workforce and processes.

Assessment, care planning and review activity was supported by Principal Occupational Therapy and Principal Social Worker roles to reinforce and celebrate best practice and improvement. The local authority had a quality assurance framework, it particularly effective within occupational therapy as the Principal Occupational Therapist role was well established. This included peer reviews and groups covering topics such as mental capacity; thematic audit to respond flexibly around new practice and emerging risks or concerns; as well as annual audit plans with topics including equality, diversity and inclusion.

Development was a priority for the local authority. Senior leaders considered staff as sources for solutions, we found there was an ethos of ‘everyone’s agenda mattered’ and ‘anyone can change services for the better’. Staff told us working at the local authority was a 'safe space' to ask difficult questions and challenge things. For example, we heard positive experiences of a reverse mentoring programme for staff being linked with other staff at more senior levels. Staff told us the key to supporting inclusivity was remembering one person doesn’t know everything and can't get everything right all the time, which was evidenced in their learning and development approaches.

Senior leaders told us about areas for improvement, for example, there was not a strong enough focus in current practice around the use of technology enabled care and they intended to build on the current provision to compliment other ways to provide care and support. There was a strategy and workstream to focus on collaborative ways to work with health partners and test innovative and new ways of working to enhance care and support to improve quality of life.

Staff supervision audits were in place, and they embedded good quality support for staff. There was dedicated time for staff to focus on staff wellbeing, and the outcomes of their work on people who use services, and how these could be improved. The local authority had used audit and data to cross reference staff sickness levels, impact surveys and the quality of staff supervision. It identified the need for compulsory refresher training on staff supervision and templates were updated using 'I' and 'We' statements from Think Local Act Personal (TLAP) 'Making it Real' statements. The local authority had since seen staff sick absence reduce which they told us was a result of these actions.

Recruitment and retention of staff was improving, and the local authority was relying less on agency staff. We were told how outcomes from the Local Government Association (LGA) annual Employers Health Check had informed their workforce strategy and ensured staff had the right training offer. There was a 'grow your own' ethos for staff development and career opportunities. Social work and occupational therapy apprenticeship schemes supported staff moving from roles in provider services into the registered professional's workforce. For newly registered professionals there was bridging support from student to practitioner. There was success of recruitment and retention for approved mental health professionals (AMHP). However, the local authority told us for best interest assessors (BIA) this was not as successful.

Staff had opportunity to explore professional interests. For example, one staff member told us they were funded to gain a rehabilitation degree and level 6 qualification in sign language. They were provided with study leave, felt well supported and celebrated by colleagues and senior leaders. We heard of inventive ways to keep staff motivated and interested in careers at Wiltshire Council. Occupational therapists had opportunities to work on rotation across mental health, children's social care, adult social care, reablement and housing areas within the local authority. This supported staff to be multiskilled, raise the profile of different roles across teams and enhance people's experiences with a confident and happy workforce.

There was a range of training on offer. In one example, staff told us how national compulsory training was delivered face to face and co-delivered by people who had a learning disability and autistic people. We were told that training was followed up with what was described as 'the real learning' through shadowing opportunities across teams to allow any learning to be applied to individual staff members roles in practice.

Staff and leaders engaged with external research work. For example, one staff member had been supported to carry out a research fellowship. They were developing how to measure wellbeing as an outcome for people using services. The research would span 12 months, and the results would be used to improve experiences for local people. There was also a research café for staff, and the Principal Occupational Therapist was involved in national work on steering groups as an adult social care representative. All staff including senior leaders had membership for online research resources. This showed the local authority's commitment to embed evidence-based practice and expertise in the organisation.

Learning from feedback

People and partners' feedback was sourced through co-production and data collection. The local authority also had a 'contact and connect' service an automated call service to gather peoples' feedback following each interaction with the local authority. They sought views around experiences of adult social care, understanding the market, quality of services, contract management, and safeguarding enquiries. We found people's feedback was an integral part of the design, delivery and evaluation of strategy, services and practice improvement.

There were processes to ensure complaints and learning happened when things went wrong. There had been 10 Local Government Social Care Ombudsman (LGSCO) complaints made between 4 April 2023 and 22 March 2024 (excluding housing related complaints). The highest number of complaints were in the services that supported people with learning disabilities, autistic people, young adults transitioning from children's services to adult's services and people with mental health needs. Three of the complaints were upheld. The local authority demonstrated learning around quality of assessment, cultural competence and appropriate care plans, risk management, partnership working and transitions between children and adult services. For example, there had been changes to staff induction and compulsory training to enhance evidence-based knowledge and skills.

A theme across all 3 complaints highlighted quality concerns of Care Act assessments. There had been efforts to embed strength and asset-based approaches including through co-production. However, the work was relatively recent and at the time of our assessment it was too early to demonstrate the effectiveness of the new operating models.

The local authority promoted and analysed staff surveys. Feedback had been used to provide staff with updated information about best practice and learning and had supported joint working opportunities. Staff had access to an 24/7 online link for sending feedback to senior leaders about their experiences as well as through regular surveys and groups. Senior leaders told us how Transforming Adult Social Care (TASC) programme and reference groups supported actions from feedback, and focused on targeted projects to hear from staff and ensure all staff were fully informed and engaged.

Staff were passionate about providing an excellent service to people with care and support needs in Wiltshire. They confidently told us about learning from feedback, incidents, near misses and complaints which supported transparency, continuous professional development, and improved outcomes for people and their carers. There were learning and reflection forums for staff across all service areas to promote learning from complaints relating to the assessment process, and individual practice concerns were managed in supervisions and with extra training. Case and supervision audits took place to evidence implementation of learning from complaints.
