London Borough of Camden: local authority assessment

How we assess local authorities

Assessment published: 28 February 2025

About London Borough of Camden

Demographics

Camden is an inner north London borough with a population of 210,100. The population had decreased by 4.6% since 2011, with those aged over 65 increasing by 3.4% and those aged 18-64 decreasing by 4.7%. It is one of the country's most unequal boroughs, with highly affluent areas and significant areas of deprivation. The gap in healthy life expectancy between the most and least deprived parts of the local authority is very high, at 20 years. It has an Index of Multiple Deprivation score of 5. Camden is within North Central London (NCL) NHS Integrated Care Board area, which spans 5 local authorities.

The population of Camden is more ethnically diverse than the England average (19%) with 40% of residents from a Black, Asian or other ethnic group, this has increased from 34% in 2011. There are more than 85 different languages spoken and 17% of people identified as LGBTQ+ in comparison to the national average of 14%. There are fewer disabled people (15.2%) as a share of the population than the national average (17.3%). 35% people were economically inactive, which was higher than the London average (30%).

Camden is a Labour-led unitary council with 55 elected councillors. There are 43 Labour councillors, 5 Liberal Democrat, 3 Conservative, 1 Green and 3 vacant councillor positions.

Financial facts

- The local authority estimated that in 2023/24, its total budget would be **£589,322,000**. Its actual spend for that year was **£608,572,000**, which was **£19,250,000** more than estimated.
- The local authority estimated that it would spend **£122,330,000** of its total budget on adult social care in 2023/24 Its actual spend was **£113,990,000**, which is **£8,340,000** less than estimated.
- In 2023/2024, **18.73%** 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.
- Approximately **1425** people were accessing long-term adult social care support, and approximately **3420** people were accessing short-term adult social care support in 2023/2024. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

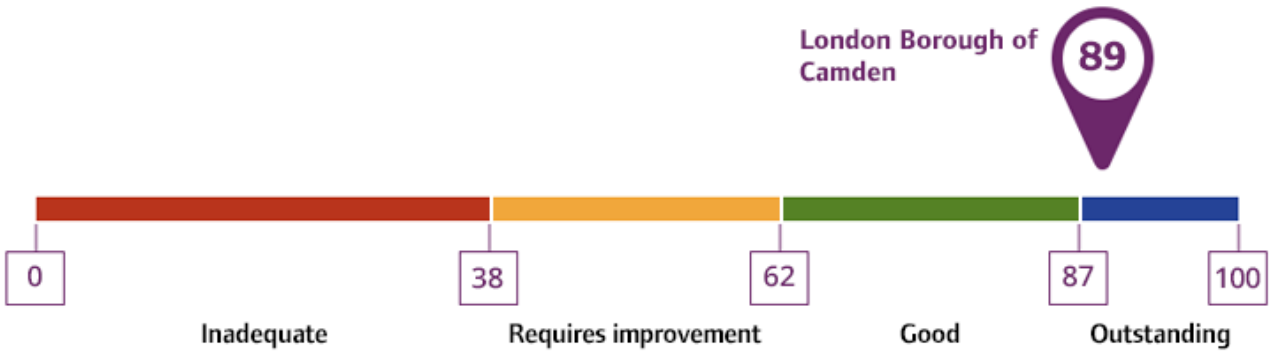
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

London Borough of Camden

Outstanding



Quality statement scores

Assessing needs

Score: 3

Supporting people to lead healthier lives

Score: 3

Equity in experience and outcomes

Score: 4

Care provision, integration and continuity

Score: 3

Partnerships and communities

Score: 4

Safe pathways, systems and transitions

Score: 4

Safeguarding

Score: 3

Governance, management and sustainability
Score: 4

Learning, improvement and innovation
Score: 4

Summary of people's experiences

Case tracking showed very positive experiences of care planning and assessment. The local authority's strength-based social care model, their partnership model and planning for the future carefully and sensitively came through from case notes, and from people we spoke to. Person-centred care was evident in planning and future care journeys were carefully thought through, and people were consistently supported to have choice and control over their care.

There were some gaps in provision and support for some carers and there was mixed feedback from carers regarding the usefulness of the assessment process and the support received. Carers were, however, very complimentary of the carers organisation that was commissioned by the local authority.

National data on people's experiences was mixed, with some outcome measures lower than national average. The evidence gathered during the assessment corroborated the carers data. However, people we spoke to said they were given person centred and supportive care and choice within a market that was facilitated and supported by the local authority. There was a significant effort to support people before needs became eligible under the Care Act as a result of the significant needs of the population, for example in housing, refugee and asylum and mental health support. The local authority utilised partnerships extremely well to understand and respond to particular communities and personalise support.

Summary of strengths, areas for development and next steps

The local authority placed equity at the forefront of its vision, strategy and workplace culture. It was led from the top of the organisation and was visibly a golden thread through all teams and partners and how people experienced services. It had an outstanding approach to partnerships and governance, and the practice of this led to excellence in safe systems. Excellent practices were also found in care provision and safeguarding, however national data in these sections was mixed, along with some mixed carers feedback.

The local authority's vision 'We Make Camden' was co-produced using a citizens' assembly. Together with it's strength based social care model, called 'What Matters', it demonstrated a commitment to person centred self-directed support and empowerment for people. We saw significant numbers of examples of staff and partners living and breathing a relational power-sharing approach with each other, with partners and with people, and this led to excellent service delivery. Staff consistently spoke with one voice about the shared culture and joint working practices, there were no barriers to communication between teams and between partnership multidisciplinary teams. This was particularly evident in the integrated (0-25 year old) transition service.

There were no waits for hospital discharge, no waits for care placements, no waits for social care assessments, nor were there any waits for safeguarding assessments or standard deprivation of liberty safeguard (DoLS) cases. Additionally, and importantly for the population in the local authority, there were no waits for homelessness accommodation. Their approach to partnership working both inside and outside the local authority allowed them to meet the very high demand for people with mental health difficulties, loneliness, homelessness, refugee and asylum seekers and effectively address a very wide language and cultural diversity.

There were effective models of care provision and support such as the test and learn Adult Early Help offer, and the neighbourhood-based teams worked very well. The organisation was continually improving and supporting staff to provide a better service, such as with the piloted East integrated neighbourhood team. Home-care had also been put on a stable footing via a neighbourhood-based commissioning of services ensuring continuity and availability.

Partnerships with Integrated Care Board (ICB), commissioning arrangements and safeguarding adult board work were excellent and successful practice in the use of family group conference was embedded across the local authority.

The local authority had identified areas it wished to improve in its self-assessment, such as further support for people with autism, better co-production and comprehensive support for unpaid carers. They were developing a new model of mental health social work, which was under a Section 75 arrangement. The local authority intended to strengthen the offer for people experiencing multiple disadvantages, because of the numbers of people with serious mental illness, drug and alcohol issues and people with multiple needs. We could see that this work was underway and particularly with the autism work. We saw very innovative art-based projects which involved autistic people in shaping services.

Theme 1: How London Borough of Camden works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

Arrangements were in place to receive and process referrals and requests for support. 'Contact Camden' was the telephone contact centre for the local authority which gave general advice to the public and was the main way for individuals, families or carers to request care and support. People and partners were positive in their feedback about using the contact centre and accessing the service. Upon receiving requests for support, the contact centre sent referrals through to a triage system which then forwarded cases to the appropriate neighbourhood team or to another specialist team for assessment. There was also a simple referral mechanism available to health and care partners which partners said was accessible. The local authority operated a neighbourhood team structure, where social workers and occupational therapists were co-located in five neighbourhoods, with a 'duty' system and had other specialist teams operating across the local authority.

At the time of our assessment the local authority was undertaking a 'test and learn' pilot and the findings were under review. The pilot was trialling an increased throughput of the volume of contacts from the contact centre directly to the relevant team, removing the triage 'front-door' arrangement. Leaders described the rational had been supporting a 'no wrong door' approach. Although we heard some mixed feedback from staff, the proposed arrangement was not established practice and the local authority was evaluating it and leaders said they were taking feedback into account. We found the assessment system was well resourced and provided a responsive service. There were clear pathways in place from referral to obtaining the right level of support including via safeguarding referrals.

Staff shared many examples of a strength-based approach to social work assessments and support. Reports of the 'three conversation approach' and the local authorities 'What-Matters' approach was referenced and described consistently in the practice of all specialisms, frontline teams and leaders we spoke with. There were also many examples of care assessments which demonstrated this approach in action, and it was reflected consistently from people who had care assessments. Partners also reflected consistent positive feedback about assessments and care planning.

The mental health social worker teams were situated within health teams as part of a Section 75 arrangement. This is an agreement between local authorities and NHS bodies which can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partners. A review of this arrangement was underway at the time of our assessment, to look at improving support for people with mental health needs. Leaders and staff described this review positively and as a way to better assess and then prevent, reduce and delay people's needs and embed staff more closely within local authority teams. One partner raised an issue about people with dual diagnosis being less catered for within the system and possibly being referred for inappropriate therapies.

Despite very positive accounts and a lack of any delays to assessments, performance data from the Adult Social Care Survey (ASCS 2023-24) showed the local authority was in a 'tending towards negative' band on relevant metrics during this period, compared to the national average. For example, 58.7% people were satisfied with care and support (England average 65.4%); 70.0% people felt they had control over their daily life (England Average 77.6%) and 34.6% people reported they had as much social contact as desired (England average 45.6%).

Timeliness of assessments, care planning and reviews

There were waiting times for occupational therapy assessments. We found staff, leaders and governance panels (such as the scrutiny committee) had oversight and actions had been taken to mitigate risks including by outsourcing some assessments. We heard about a new data dashboard that was helping leaders and staff to manage waiting lists and 'waiting well' initiatives such as a quick contact from the social worker on duty to a person who's waiting. People's feedback about assessments and reviews said they were timely and respectful, ensuring relatives and the person were involved.

There were high numbers of reviews overdue, however a significant reduction had been achieved since Oct 2023. Partners also gave positive feedback about timeliness of review assessments. We heard about some people being classed as overdue for review where careful planning was underway to meet the person's needs effectively. Partners and staff said care assessment reviews were completed in hospital if someone was admitted who had a review overdue. Data from the Adult Social Care Finance Report (ASCFR)/Short and Long-Term Support (SALT) (2023-2024) showed fewer, (38.57%) long-term support clients had had their care assessment or plan reviewed, than the England average (58.77%) which was also in the 'tending towards negative' band.

Partners consistently gave positive feedback and said local authority staff were compassionate when assessing needs and took a non-defensive approach to managing challenges. The local authority had taken significant action to reduce waiting times and the recent neighbourhood restructure had brought in additional capacity, investing in 12 additional social worker and occupational therapy posts across the teams. They had also initiated a mental health action plan to adjust assessments through the Section 75 governance arrangements.

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

People told us mixed accounts of the carers assessment and review process. Feedback on the usefulness of assessments and views on how well they were supported during the assessment, was also mixed. However, people said they welcomed recent work on co-production with carers. The commissioned carers organisation completed carers assessments on behalf of the local authority and staff consistently recognised carers were entitled to an assessment separate from the person. We also heard about carers direct payments or carers budgets being used to support carers breaks, of between £200 and £1000. The local authority had identified support for carers as an area for improvement ahead of our assessment. Carers generally said it was difficult to carry on with their lives and more flexible support would help them. Data provided by the local authority showed a significant waiting list size for carers assessments and reviews of 642 people with a median waiting time of 206 days and a maximum waiting time of 1018 days.

There were more carers in the local authority accessing support or someone to talk to in confidence (46.73%) than the England average (32.98%). Broadly the same proportion of carers accessed support to keep them in employment (2.88%) as the national average (2.79%) and accessed training for carers (4.72%) as the England average (4.30%). However significantly more carers experienced financial difficulties because of caring (61.11%) than average (46.55%) and significantly more (46.84%) were not in paid employment because of caring, compared to the national average (26.70%). These metrics could reflect deep inequalities in the local authority's central London location, however other metrics were also slightly worse for carers than the national average. Fewer (27.70%) carers reported satisfaction with social services than the England average (36.83%). Fewer (59.90%) carers felt they were involved or consulted as much as they wanted to be in discussions, than the England average (66.56%). And fewer (23.15%) carers had as much social contact as desired, than the England average (30.02%) (All from SACE 2023-2024).

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

The local authority used a ‘three conversations’ approach of strength based social work when supporting people. The early help and ‘front door’ arrangements were therefore not centred around an eligibility assessment. Support was available for people’s non-eligible needs and the local authority showed a commitment to supporting wellbeing and preventing needs escalating. Housing and other partners said this worked well and ineligibility for a care act assessment was not a barrier to support. Contact centre staff had been trained to support people who contacted the local authority. Family Group Conferencing (FGC) was a tool effectively used across the local authority to support people to make plans and decisions, who may not have eligible needs, and look at their strengths and promote engagement with local community groups. The local authority also used data-led initiatives to examine non-eligible prevention needs which are detailed in other sections of this report. Part of the rationale for reviewing the Section 75 arrangement, was to better support people’s non-eligible care and support needs. We heard examples of housing solutions being found to meet people's ineligible needs and support prevention of future need especially around homelessness and mental health needs. Staff said there was a large amount of accommodation available to people with non-eligible needs. Some carers did not feel their needs were supported if they were ineligible for support due to financial limits.

Eligibility decisions for care and support

Eligibility was not an initial part of the assessment system. We heard the three conversations approach was consistently used and eligibility was discussed after conversation 1 and 2 was explored. We found staff were therefore adopting a prevention-based conversation approach regardless of eligibility. This was also demonstrated by national data where more (71.48%) people in the local authority area did not buy additional care or support or pay to top up their care and support, than the England average of (64.39%) (ASCS 2023/24). Staff said they were able to make urgent authorisations in an emergency for a service in collaboration with a manager which was then taken to a panel to authorise. If the support service was under £500 a team manager could approve it, if it was more than £500 a panel made the decision. Staff described the eligibility decision process as timely and there was clear governance around the process to ensure consistency.

Financial assessment and charging policy for care and support

Financial assessment waiting times were low, with a median waiting time of 14.5 days. Staff used a tool in relation to high-cost placement calculations across all client groups and sectors under placements with specialist staff supporting the process.

Provision of independent advocacy

We heard extremely positive accounts from people using advocacy services. Advocacy was described as consistent and effective. In 2023/24, 514 adults were supported by some form of advocacy. The process of accessing advocacy was straightforward and timely. Autistic adults were involved in the re-commissioning of the advocacy service which led to a partnership with the autism hub and the advocacy service to develop smoother referral pathways. We saw examples where advocacy had supported people to stay at home and have a better outcome. People who didn't meet the criteria for a Care Act advocate could equally get advocacy support. Advocacy was timely, referral pathways were well understood by staff and there were no waits for the service. Advocacy rates for people in a safeguarding enquiry was very high in the local authority.

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

A prevention approach was evident at all levels of the local authority. Leaders and staff described prevention in their work and approach to supporting people, consistently. The local authority understood the specific challenges to health and well-being in its population and demonstrated many examples of working to promote well-being in vulnerable groups and the wider population. Because of the demographic and contextual make-up of the local authority and its population, this involved working with refugee and asylum seeker communities, people with drug and alcohol issues and the homeless population to improve wellbeing and prevent an escalation of need. The local authority had been awarded full accreditation as a 'Borough of Sanctuary' in recognition of their response to demands relating to refugee and asylum seeker populations arriving.

The local authority used asset-based and community wealth building approaches to support this work, for example through the Community Wealth Fund (a social impact investment fund) and Camden Giving/We Make Camden Fund which secured investment from local businesses and involved Camden's communities in decision-making. The authority's 'We Make Camden' overall vision and strategy was centred on people rather than services and focused on well-being and communities. A prevent, reduce, delay approach was evident in the widespread use of family group conferencing, in the 'Living a Good Life – opportunities planning' project (supporting people with learning disabilities to choose from a range of opportunities in a person-centred way) and in their 'What Matters' approach to strength based social care. In this way, the local authority supported people with eligible and non-eligible needs to positively reduce and delay the need for statutory care services. Partners said the local authority worked with them to support people's goals and challenge barriers people faced. People were supported in self-directed decision making and supported with practical and mental health needs, as more people (99.9%) who used services received self-directed support than the England average (92.2%) (SALT 2023-2024). We saw examples where people received good information about discharge planning and on services available to return home.

There were many examples of the Voluntary, Community and Social Enterprise (VCSE) sector being commissioned to provide services which was beneficial including befriending services, transport and shopping. Despite the challenge of available housing in Camden, joint work was successful between adult social care, housing and the VCSE to support people, we heard about an example when large numbers of refugees arrived in the local authority and were quickly supported through these partnerships. A number of VCSE services were commissioned to support people with mental health and housing needs in the community. The market position statement also set out the intention for support for people to regain or maintain maximum independence.

Despite this work, the ASCS (2023-2024) and ASCOF SALT data (2023-2024) showed a similar to or slightly below England average performance on most metrics. We heard mixed feedback from carers about how support had affected their well-being. Positively, 63.93% of people said help and support made them think and feel better about themselves with the England average around the same level at 62.48%. However, fewer people (58.03%) reported they spent time doing things they valued or enjoyed than average (69.06%)(negative variation). Fewer people described their home as clean and presentable (89.51%) than average (94.05%) and fewer people felt clean and presentable themselves (90.82%) than average (93.28%) or felt they got adequate food and drink (90.49% compared to national average 93.71%), (all from ASCS 2023-2024). The ASCS data (2023-2024) showed only 57.56% of people who received short term support, no longer required support, which was much lower than the national average of 77.55%. Fewer carers (75.00%) than average (85.22%) found information and advice helpful (SACE 2023-2024).

There had been work undertaken with public health to identify, using data and learning through evaluation, better ways to prevent, reduce and delay needs. Winter wellness checks and a mobile health bus supported both vaccinations and access to health services in communities which may not otherwise access them. We heard from partners that despite high rates of mental health issues, for this group of people there were good rates of physical health checks and people were supported into employment and supported housing. Partners said they were very supportive of the neighbourhood joint-working model. There were also initiatives to reach people such as an obesity group and a health and well-being group individuals in receipt of care could join to tackle isolation and promote well-being.

Provision and impact of intermediate care and reablement services

Reablement was delivered by three external providers on a localised footprint and feedback from people was positive. The Better Care Fund was used well to fund home care and reablement services to support discharge. There were no recorded waits for these services and people could get a service as soon as they needed it. There was a clear commitment to a 'Home First' approach across the system which was evident from staff and partners. This was supported by SALT data (2023-2024) which showed more people aged 65 and over (4.74%) received reablement or rehabilitation services following discharge from hospital, than average (2.91%), and more people aged 65 and over (87.18%) were still at home 91 days after discharge from hospital into reablement or rehabilitation, than average (83.70%).

Access to equipment and home adaptations

Some people had experienced long waits for equipment, although the local authority had taken actions to improve performance including through a joint performance and improvement plan. The local authority provided data showing their median waiting time was 49 days with a waiting list size of 295 people. Further data provided by the local authority around the time of the assessment, showed a waiting list of 220 people and an improved median waiting time of 3.74 days. A cyber-attack in 2024 had affected the delivery system and during this time mitigating actions had been taken for people. For example, some people were given temporary personal alarms, rather than a careline pendant, in order to avoid a delay in being discharged from hospital. Occupational therapists worked within neighbourhood teams on a geographical basis and also worked together as a whole team across the local authority, providing a 'duty' (on call) system.. By doing this they shared any risks around waiting times effectively across the local authority.

Adaptation works had an average wait of 12 months, when financial information or permissions were needed, but adaptations by the local authority's housing adaptations team took 6 to 12 months from the date of recommendation. We heard about work with the local authority's housing and planning departments around proactively building homes-for-life with accessibility needs built in.

Provision of accessible information and advice

The local authority had a dedicated website providing information and advice and an accompanying directory of services for people which was well maintained. We saw a booklet of services containing healthy living resources in the local authority. It included practical help and advice, from finding a toilet in the area to providing advice about long term conditions and contained information about local services such as social prescribing. A small welfare rights team supported prevention and early help across adults and housing and supported people to understand what was available to them. According to ASCS data (2023-24) around the same proportion of people who used services (65.94%) found it easy to find information about support as the national average (66.26%). People told us about very positive examples of support with information from social workers and care providers, including what to do in an emergency.

There was, again, mixed carers feedback on the availability of accessible information and advice. SACE data (2023-2024) showed fewer carers (53.33%) found it easy to access information and advice than the national average (59.06%) (tending towards negative variation).

Partners were generally very positive about the availability of information and advice. There were also many easy read documents and information packs. Although we heard about some challenges from partners about general digital access issues for some people and it wasn't clear if the local authority was aware of these concerns.

Direct payments

The direct payments process for people in receipt of care services was well understood by staff and a direct payment was easy to set up. The local authority had a commissioned service to support people to find and source their own Personal Assistant (PA). The PA market was described as challenging by staff and people, in terms of workforce retention and availability. The numbers of people taking up direct payments had reduced and leaders and staff said people increasingly chose to receive commissioned home care. Following its re-framing around neighbourhoods, they said home-care providers' quality, availability and ability to meet people's particular needs had improved. Despite this reduction, national data (SALT 2023/2024) showed 27.86% of service users received direct payments which was broadly in line with the England average of 26.22%.

Some carers however, didn't know about direct payments as an option available to them and some staff didn't show an understanding of direct payments for carers. We saw a co-produced document for people on direct payments and there was a working group to improve the experience of people using direct payments. The local authority had set up a new direct payments system, which was starting just after our assessment visit, in December 2024.

Equity in experience and outcomes

Score: 4

4 - Evidence shows an exceptional 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

The local authority centred equity at the heart of its adults' services which came through consistently throughout our assessment. They had employed a photographer 'Artist in Residence' to document and celebrate the lives of people using adult social care services, which led to a compassionate approach to people. We saw the work being used to personalise publications and strategies and the approach was consistent with their approach to understanding communities, empowering people and building on their strengths. Staff consistently spoke about people as individuals with hopes and aspirations and there were many examples of 'going the extra mile' for individual people. The use of family group conferencing (FGC) across all teams and disciplines, was innovative and supported excellent outcomes. We heard an example of a person who was homeless using FGC to link them into support networks and examples of young people being presented with a range of providers who could support them. Partners gave consistent feedback about the local authority's approach to working with communities in terms of equity and said they gave power back to communities. There had been a citizens assembly used to create the vision and plans for the local authority which had seen impact in the approaches used to support communities. The joint work between departments demonstrated this approach, as there were no barriers between services across the local authority and staff spoke with 'one voice'.

The level of challenge in the local authority was high in terms of meeting and preventing the escalation of people's needs across different communities and there were high levels of deprivation. The local authority was the fourth most expensive place to live in London, but had an Index of Multiple Deprivation (IMD) score of 5 reflecting the differences between communities, with a twenty-year difference in life expectancy between more deprived and less deprived areas. There were significant demands for temporary accommodation and leaders told us there was significant intergenerational unemployment. The local authority had high rates of loneliness, depression and severe mental illness and some of the highest presentations in England of street homelessness and those seeking asylum or refugee status. Because of the needs of the population there was a focus on supporting people with non-eligible care needs as a whole organisation and with partners. The strong links between departments and with partners meant they provided excellent homelessness support and mental health services. There were no waits for hostel accommodation.

The local authority understood its local population profile and demographics. It analysed equality data and used it to identify and reduce inequalities in people's care and support experiences and outcomes. Custom data sets had been used over the last two years, to establish the drivers for some of the challenges faced by people in the local authority, for example looking at loneliness in younger people and in those using home care services.

The ‘State of the Borough’ and other documents such as the Health and Wellbeing strategy and deep dive analyses following the Joint Strategic Needs Assessment refresh, showed an understanding of populations and an approach to finding smaller sub-sections of communities and an awareness of dynamic population changes. The Better Care Fund (2024) included a proposal to improve the health and social care outcomes for Bengali and Somali communities by addressing the inequalities they faced. Leaders described work in the area as ‘leaning into’ difficult conversations with communities and as the basis of the investment in early help and prevention. Following work with the local authority’s equality data group, local residents had been involved in co-producing a ‘local account’ of their experiences of ASC. There was a co-design group involving people with drug and alcohol services as experts by experience. Carers with diverse needs including LGBTQ+ carers had been involved in designing the carers action plan.

Actions had been taken for specific groups. The ASC race equality action plan update (June 2024) demonstrated work to address racial inequality in the workforce and in the population, which included an equalities data action group. A LGBTQ+ learning framework around LGBTQ+ people in later life had been rolled out and we heard about work being done to look at better supporting people in care settings and care networks. An ASC learning and development report (2023-24) involved a commitment to tackling inequalities for staff. VCSE partners said the diverse needs of the different communities in the local authority was understood and partly addressed by commissioning many, varied VCSE services. Leaders told us about examples of hyperlocal services in place for this purpose. Partners and people told us elected members were rooted in communities and provided a strong voice for them which improved the responsiveness of staff and leaders. In advance of the integrated pilot in the East neighbourhood team, there had been a ‘discovery’ project undertaken to learn which communities would most benefit from the approach and identified those at risk from poor outcomes. By taking an asset-based approach to commissioning the VCSE sector, the local authority was able to reach into different communities and respond to their different needs.

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions. Local authority staff involved in carrying out Care Act duties had an excellent understanding of cultural diversity within the area and how to engage appropriately. We found the culture of listening and sharing power with people and communities came from the top of the local authority and was evident throughout the teams we spoke with and the documentation we saw. There was also lots of challenge and accountability around equity and the approach to people, in the governance and scrutiny system. Partners said the local authority did support 'hard to reach' or underserved communities and worked with partners to identify them. Some partners gave excellent feedback on the way the local authority understood its very challenging and complex population.

Inclusion and accessibility arrangements

There were appropriate inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that worked for them. For example, the accessibility and inclusion of five specific groups had been identified as priority work areas. These were people with learning disabilities, people with sensory loss, people facing multiple disadvantages, autistic adults and people with interpretation requirements. We saw this in action in the specialised financial assessments team who ensured different communication needs were respected. Some partners said there were issues around accessibility and communication methods for people, including for people who had hearing difficulties, or for those whose first language was not English. An interpretation telephone service guide was provided to staff and staff said they felt able to access interpreters. Staff consistently described measures to capture communication preferences.

The needs of autistic people had been considered and staff said the autism lead had conducted a number of sessions with them to improve their practice. A person told us about positive action being taken with them to communicate with their service effectively and their use of an advocate. We heard from partners that advocacy services were consistently provided to people from diverse and seldom heard groups. We saw evidence of people being supported in a person-centred way, including with their sensory disabilities and access needs. There was a range of training provided on the provision of accessible information including talking mats training, converting documents into easy read formats and British Sign Language training. Staff said managers and leaders were very supportive in recommending them to access training, including cultural awareness training.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

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

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority demonstrated a good understanding of its community's support needs. The Joint Strategic Needs Assessment (JSNA) was refreshed in 2020 and the local authority had since developed more focused documents such as a health needs analysis and 'deep dives' into specific topics such as social isolation, drugs and alcohol needs, inclusion health groups, long covid and employment. The health and well-being strategy 2022 to 2030 and the North Central London (NCL) population health and integrated care strategy alongside the public health directors report 2023, detailed the needs of the population.

This analysis was live and ongoing with partners. An inclusion health needs assessment published in March 2023 showed the NHS Integrated Care Board (ICB) commissioned the local authority's public health department to conduct a needs assessment around 6 distinct groups. They were: people living with multiple disadvantage; homeless people; individuals with a history of imprisonment; people who sell sex; vulnerable migrants and Gypsy, Roma and Traveller communities. The health and well-being strategy reflected their principles around prioritising prevention, tackling inequalities, empowering communities and integration and communication. Priorities and ambitions were clear with lead organisations and timelines attached.

The drug and alcohol needs assessment in January 2024 incorporated a 'think family' approach. These partnership considerations led to preventative work and a pathway design from the criminal justice system to substance misuse services. It demonstrated a strong use of data approach, making recommendations to rectify gaps in data and promoted better use of co-production. The local authority had invested in data analysis to good effect and the changes from public health moving from a bi-borough approach to a local authority approach had allowed specialist academic and data lead resources to be deployed more effectively in the service of groups in the local area. This involved a better understanding of people at risk of deteriorating health and care outcomes as result of cold weather and other vulnerable groups. Data was used innovatively to evaluate the demand of reablement services and performance of providers in the local authority. The reablement service had been recommissioned from two providers to three as a result of support provided from this analysis which helped to tailor the service to the population and had been used in continuous monitoring with commissioners.

It was clear the local authority had used its housing resources effectively to respond to the local challenge in sourcing care resources. They had considered the full range of people and care needs and had provided innovative solutions. For example, the extra-care model was used effectively to provide flexible and person-centred care to a variety of groups of people including younger adults with disabilities. We heard this had supported people's independence, wider life goals and ambitions. They also had further extra-care schemes in development and had remodelled some sheltered housing into extra care services. Support through shared lives was also used creatively by expanding to meet the needs of people with mental health challenges and people leaving asylum provision. These changes had been co-produced and consulted upon with the new potential people. Staff said the local authority had invested heavily in shared lives and support for shared-lives carers had been enhanced recently with financial incentives for people sharing their home.

The local authority had other clear ambitions to support people at home and clear plans to alter commissioning strategies when current provider arrangements expired. These included the further integration of health and social care, the roll-out of integrated neighbourhood teams, further workforce development and in-house community-based services with testing underway until 2026. Commissioners worked throughout the whole commissioning cycle and had both design and lead roles. We found commissioners engaged with the community, providers and people in Camden.

Market shaping and commissioning to meet local needs

The local authority used commissioning and effective market shaping to meet local needs. There was a long-term care, support and reablement commissioning strategy which showed plans to commission one provider per neighbourhood of the long-term care and support of people at home market and two providers of reablement support on a localised footprint. There were examples of the provider sector being convened by the local authority to support a good market culture and provide the most appropriate placement. In general, people had access to a diverse range of local support options that were safe, effective, affordable and high-quality to meet their care and support needs. There was a NCL partnership market management update which described joint work to sustain and shape the market. The market position statement described current provision for residential, nursing, home care, supported living, extra care, community-based care and reablement. It also highlighted the role of unpaid carers with some suggested future improvements.

The local authority had set out their intention to meet demand for nursing and residential care more locally. The market sustainability plan detailed plans to change the home care arrangements from 32 separate providers which had taken place and was effective. There were now stable home care organisations providing locality-based home care in neighbourhoods. The market position statement said the local authority were looking to develop a greater number of care home placements for people with dementia, mental health needs and those with distressed behaviours through working in partnership with providers and colleagues in NCL. Community day services had been reorganised so people could stay in services and not move around based on level of need. Partners were generally extremely positive in their feedback about the local authority's market management relationship with them. Providers were supported to participate in consultation and were consistently treated as equal partners in discussions around residents' placements and contract management issues. The local authority's relational and power sharing approach to market management was strongly appreciated by partners. Their commissioning practices encouraged a collaborative culture between organisations, rather than a competitive one.

However, ASCS (2023/2024) data showed fewer (59.90%) people who used services felt they had choice over services, compared to the England average (70.28%).

The integrated health and local authority strategic commissioning teams were separated in 2024, reverting the shared team and budget to separate local authority and ICB teams. Despite this change, mental health and learning disability funded services were commissioned in an aligned way with services unaffected by the change. We heard many examples from staff, leaders and partners of joined up effective relationships and services. The local authority had worked with the autism hub to redesign the tender for advocacy and autistic people had designed elements of the tender by giving examples of the challenges they faced and then reviewing and scoring the tender responses to these scenarios. We heard about creative commissioning such as an example with social prescribing, areas of joint commissioning with the ICB and a data led approach.

Leaders described work undertaken over recent years to understand and improve access to carers services and had identified this as an area for improvement. This included learning from other local authorities and bringing proven governance methodologies to the local system. There was a clear strategic and service level delivery plan to implement and monitor improvements. We heard praise from carers for the commissioned carers organisation. There was one example where a person had attended a day centre for young carers which they had found useful, and another reported they had been supported with a housing issue. We heard another example where a person had received money for a short break, although another said they didn't think the council would help them and they would rely on family instead. We also heard examples of effective support for a carer who was going into hospital. However the nationally published data (SACE 2023-24) showed fewer carers (5.71%) accessed support or services allowing them to take a break from caring at short notice or in an emergency, than the England average (12.08%)(negative variation); fewer carers (11.43%) accessed support or services allowing them to take a break from caring for more than 24 hours, than the England average (16.14%)(tending towards negative variation), and around the same proportion of carers (16.67%) accessed support or services allowing them to take a break from caring for between 1-24 hours, than England average (21.73%)(no statistical variation).

The local offer for young people with transitional needs was excellent, with meaningful day opportunities, skills support and employment support offered consistently to young people. The integrated 0-25 team was able to support young people in their education setting and the 'living a good life panel' was a person centred and empowering way for young people to speak directly to service providers and understand what support and community activities were available to them, depending on their interests. It was also an innovative approach to market management.

Ensuring sufficient capacity in local services to meet demand

The local authority provided data showing there were no waits in finding a place for people in home care, residential or nursing care services. Staff said there were no capacity issues with home care, and they used 'spot' providers when needed. This was supported by no waits in hospital discharge. Staff had regular meetings with providers and commissioners to plan for capacity in known pressure points such as during the winter period. Partners reported an excellent working relationship around placements and meeting demand.

There were high levels of people placed out of area due to a lack of residential nursing services directly provided in the local authority. 55% of these placements were within North Central London and a further 22% within the Greater London area. We heard from staff about how out of area placements were managed, reviewed and supported with some choosing to live nearer family and there was clear evidence of people out of area being supported well. Partners also said the residents placed out of borough were well supported. However, we heard about one example where a person waited a long time for a placement because they needed specialist accommodation, which wasn't easily available in the area.

Capacity in supported housing and services for people with learning disabilities was considered and planned for as a result of the local authority's ambition to move people away from residential care. The learning disability accommodation strategic framework refresh (2024) showed 26 supported housing schemes for people with learning disabilities had been inspected annually and red, amber, green (RAG) rated. Recently, 11.4% of the schemes had been rated Red, which had improved from nearly one third in 2019. Plans showed the local authority had 17 new letting units in development, intended to be delivered by 2027/2028 and further shared life schemes and schemes offering people more support in their home.

There were now five home-care providers contracted with one in each neighbourhood team area. Staff said this meant providers act as partners to one another rather than in direct competition. There were examples of creative working with providers and building networks between them to support trauma informed work, cultural competency and working in a relational way. There was a trial underway with a small group at the time of our assessment to improve and support care practices.

Staff working with emergency placements and mental health placements told us the local authority was supportive in helping them find a placement as close as possible to the person's preference, and there was positive working with social workers and families. Staff said the local authority was flexible in its funding decisions for placements. The local authority's supporting people connecting communities accommodation plan, 'a place to call home', set out 5 ambitions to meet accommodation needs in the next 10 years. It detailed a commitment to co-production and hearing people's voices whose views were seldom heard. There was significant joint work with housing to review accommodation needs capacity and extra care and other housing schemes. There was also evidence of a 'Home-First' model in use and we heard examples of supporting people to live with family again, by enabling the move of a person to an extra care scheme from a care home. Staff consistently told us there was sufficient supply for all types of accommodation for people in the local authority and there were no barriers to sourcing care or housing for people and partners confirmed this. Although national data showed carers breaks were not as available as they could be and carers gave mixed feedback about availability of respite and short breaks.

There were no delays to hospital discharge and the reablement service was person centred and effective. The demand for care placements exceeded the capacity in the borough year on year and so the spot placement market across and beyond North Central London was key to the local authority. Commissioners worked at the 5 borough level to find joint solutions through a joint market management strategy which included workforce development initiatives. There was effective collaboration with VCSE services providing emergency support to vulnerable residents. The central London local authority location meant they experienced increased numbers of homelessness presentations, and they had people with no recourse to public funds awaiting a decision from the Home Office. Despite these levels of demand, we heard consistently about the availability of homelessness services and a very strong collaborative and supportive working relationships between housing and adult social care.

The local authority expected young people to be in education until age 19, to facilitate this there were a number of colleges well equipped for those with complex needs and those with more profound learning disabilities.

Ensuring quality of local services

There were effective arrangements to monitor the quality and impact of care and support services commissioned for people. The local authority was proactive in identifying concerns with local providers and supporting improvements, including in out-of-area placements. There was a provider oversight board, and commissioners held quarterly meetings with providers. There were no commissioning embargoes currently in place at the time of our assessment. There were clear action plans in place when quality concerns had arisen. In one example where a provider had received a 'Requires Improvement' (RI) rating from the Care Quality Commission (CQC), the local authority worked with them to create a plan to improve. The local authority was proactive in establishing concerns around quality rather than reactive to CQC ratings and findings. Providers described an equal partnership and a supportive relationship about learning from issues or problems and finding improvements together. There was a provider oversight and quality assurance arrangement procedure, which showed regular contract monitoring and management quality assurance visits to providers, involved residents and carers feedback and monitoring of CQC ratings and intelligence. There were regular meetings of the quality assurance teams in order to produce up-to-date information as well as monthly provider oversight board meetings which were used to share significant safeguarding actions or concerns about providers. They were attended by commissioners and senior adult social care staff. Staff and partners equally said any issues or concerns were raised at the monthly meetings. Arrangements were effective in creating a culture of quality assurance oversight and joint working. In addition, integrated neighbourhood teams met quarterly with local providers to consider the quality of services and met with community coordinators to enable them to gain knowledge about the local community and support available within each integrated neighbourhood team. Providers said they were encouraged by the local authority to work collaboratively and plan together. One provider gave negative feedback about their experiences of going through a provider concerns process.

There was a small market of care providers based in the local authority area and from those, 50% of nursing care homes were rated good, 33% Requires Improvement (RI) and 16.67% were not rated. 60% of residential care homes were rated good and 40% were rated RI, 6.67% of Home Care Services were rated outstanding, 57.78% good, and 15.56% RI, with 20% unrated. 100% of supported living services were rated good by CQC. Two locations had been de-registered within the previous 12 months.

Ensuring local services are sustainable

The local authority took steps to ensure there were appropriate working conditions and pay in practice reflecting requirements in commissioned contracts. Staff, during annual provider visits with a safeguarding colleague, looked through staff files including payslips and ensured they were paid the London living wage and travel. Individual staff members were also contacted individually on pay and whether they felt supported at work. Monitoring provider meetings also happened quarterly. Home care had been recommissioned onto a neighbourhood model, where a single provider had responsibility for the service in each neighbourhood area. This meant home care staff worked in a local area which reduced travel and effectively supported service sustainability. The local authority was a signatory to the Ethical Care Charter and staff said they wanted to offer specific hours to workers, however following feedback found many staff like the flexibility offered by flexible contracts. Staff and partners said the home care recommissioning had been a success in terms of staff and service sustainability. A forum for care workers had been facilitated by an arts organisation on behalf of the local authority to support team development and bringing people together. They also provided some cooking sessions to improve cultural competency in the home care workforce.

A workforce strategy was launched in 2024 (alongside a Health and Social Care Academy) which had a focus on workforce sustainability and a commitment to good governance and long-term planning. The NCL partnership had given guidance to providers on international recruitment. We found the local authority knew about levels of pay, the percentage of staff on zero hours contracts and vacancy rates among commissioned providers and had future workforce projections. Skills for Care workforce estimates data (2023/24) showed there was a staff vacancy rate of 16.78% compared to an England average of 8.06% in the local authority (significant negative variation), but a 0.10 adult social care staff turnover rate, which was a significantly positive variation to the England average of 0.25. The local authority also had an average sickness rate of 5.30 days, consistent with the England average of 5.33 days.

The NCL social care workforce programme stated it had made progress towards recruitment and development of an adult social care workforce. We heard training in the 'What Matters' approach was delivered to providers and there was a bespoke 'What Matters' induction for new staff within providers. There was training for providers around safeguarding, occupational therapy, manual handling and on trauma informed care. Partners said the local authority worked well with them to develop a training package for staff in managing distressed behaviours in the workplace. 'Proud to Care' was a website dedicated to the recruitment training and development of staff within the NCL area and it contained an employer's hub to be used by providers seeking to employ social care staff, which was user friendly.

Partnerships and communities

Score: 4

4 - Evidence shows an exceptional standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority had a very strong partnership working culture. Leaders consistently described integration with partner agencies and the alignment of strategic priorities and plans. For example, we heard consistently positive reports from staff, partners and people about the work around hospital discharge and rapid response teams as well as the work around neighbourhood teams and the integrated neighbourhood team pilot. Adult social care demonstrated impactful leadership in the development of local integrated arrangements by the Director of Adults Services (DASS) chairing the local place-based partnership, the local authority was effective in leading and shaping the health and care strategic partnership locally and we found this to be a sustainable relationship. A prevention, social care and public health focus was evident in this partnership and was reflected in leaders and partners feedback from within the local authority and the wider system. Staff reported the neighbourhood team structure was successful in bringing them closer to the community, built stronger relationships within communities and a better understanding of resources in that area. We heard very positive staff feedback about the benefits of closer working between ASC staff, health workers, community staff, VCSE, GPs and others in the East neighbourhood integrated team pilot.

As a result of these leadership arrangements we saw many examples of partnership forums and delivery partnerships as a way to better understand communities. For example, we heard about staff facilitating meetings within local libraries, schools and council buildings with people using services which had fostered an openness and eased anxieties in families around transitions. A 'shared objectives around working with partner agencies' document detailed how groups and forums were used to support the delivery of local and national priorities. These included the autism partnership board, the mental health partnership board, the learning disability partnership board (called planning together), a carers working group, an anti-social behaviour task force and a co-production network among other groups. These groups oversaw delivery and strategy of their respective areas of work.

As a result of partnership arrangements, there was an effective recording system which allowed social care staff to view the health details of a person and some clinical information such as medication and diagnoses from health systems. Health partners could also view who the allocated worker was and any safeguarding concerns. Staff consistently reported that communication was good between the NHS and local authority, they felt they could ask for support from managers, their professional skill sets were valued, they felt trusted to make decisions and were able to quickly put care plans in place in an emergency. We heard about emergency carer provision being put in place which effectively met some peoples' needs through partnership working.

There were examples of partnership working well in each of the priority areas detailed by the NCL integrated care systems partnership groups. There were business plans in place to meet the needs of the local population and to meet the strategic direction set by the health and well-being board. Examples included: care home and learning disability accommodation market management; workforce digital health and care system planning; and children and young people which were effectively driving changes in these areas. We heard an excellent example of work with academic partners which allowed public health staff to risk stratify and analyse themes such as modelling long term conditions, adding value to adult social care by changing the allocation of resources across the partnership.

There were innovative uses of the better care fund, such as a linked recovery worker working closely with accident and emergency departments resulting in fewer admissions. There were several beneficial partnerships between housing, the VCSE and adult social care, working jointly with the same focus. For example, staff described a home improvement service had been redesigned using better care funding.

The local authority had convened a health and care citizens' assembly to contribute to the health and well-being strategy (2022 to 2030). Furthermore, local partnerships with the community were evident through the use of community support networks within their 'What Matters' approach.

Partners said social work was pivotal in various ways, for example in discharge from hospital meetings. They said safeguarding and Care Act assessments were central to multidisciplinary teamwork. There was exemplary joint working and sharing between health and local authority staff including occupational therapy, for example in hospital discharge rapid response and within the mental health partnership. Partners said the integrated neighbourhood team pilot approach was excellent. The health and wellbeing board had done joint work with the homeless partnership which health partners attended as executive sponsors. This had supported the provision of stable accommodation and employment for people. Health partners said the local authority had influenced them to think and practise differently around integration and Section 75 agreements.

Staff, seconded as mental health social workers, said changes were being considered to their teams to enhance opportunities for strength based social care in their roles. Leaders also described planned changes to the Section 75 arrangement, to centre social care activity rather than health-based activity for those workers. Leaders and partners therefore had carefully evaluated the effectiveness of joint arrangements. Amendments had clearly been proposed to improve services, without over-stretching the partnership and by relationships being strong, generated delivery and innovation. Mediation with the ICB had taken place around the use of better care funding which was resolved. This demonstrated partners could disagree and have difficult conversations in pursuit of better services for people.

The integrated young people's team in which children and adults' social workers worked as one team with 0 to 25 year olds was an excellent example of integrated working. Their partnerships with education, third sector and care sector partners provided many and varied, person centred opportunities and a more seamless service. We heard examples about holding events and forums, training sessions for parents around issues relating to autism and other wider health concerns such as housing and employment. Strong partnerships with service providers meant young people had a range of services on offer to them.

Arrangements to support effective partnership working

There were clear arrangements in place for governance, accountability, monitoring, quality assurance and information sharing in partnerships. We saw a 'shared objectives' working arrangement with partner agencies on the integrated learning disability service (CLDS). And there was a joint funding arrangement between health and social care, in an early intervention and prevention focused mental health alliance 'Reach Out', jointly funded with the ICB. There was also a 'shared objectives' document around a partnership with North London mental health partnership (NLMHP) which involved social care practitioners operating within multidisciplinary community mental health teams, and those commissioning, with joint funding for an integrated day service for people in crisis needing reablement or long-term support. Networking within staff in the NCL partnership was strong and by meeting regularly they had supported the partnership between the local authority and the NHS. The local authority hosted the North Central London Councils' Local Authority Programme. Through this, recent funding had been secured for digital social care projects and social care workforce projects through this partnership office.

Partnerships governing the use of the better care fund were found to be extremely effective. Use of the better care fund was decided in partnership with health and VCSE sector. It funded eighty projects, including contracts, staffing teams and services, underpinned by the health and well-being strategy. There were no delays to hospital discharge and all feedback around integration in hospital discharge, reablement and admission avoidance was positive. There was evidence of funding being awarded to the carers organisation to develop GP liaison support, allocations to support recuperative care in care homes, for reablement workers and for the pilot for integrated working in the East neighbourhood team. Data provided by the local authority showed they had reduced the number of permanent admissions to care homes, for the past three years. Their data also showed reablement was effective at 86% in 2023-2024 and up from their 2021 to 2022 performance of 75%. They measured reducing hospital admissions following a fall, which was a better care fund focus in 2024-2025. An initiative called 'Wish+' was funded to ensure residents had access to a range of preventative services through a single initial referral. The progress towards targets and metrics was demonstrated with a clear partnership governance arrangement.

Impact of partnership working

The local authority used evaluation and research to demonstrate the effectiveness of new approaches. Neighbourhood 'discovery' findings in April 2024 evaluated the introduction of integrated neighbourhood teams. It was comprehensive and learning was identified with recommendations for improvement. Partners agreed partnership working was evaluated in terms of its impact through for example using citizens panels. Partners told us about service improvement learning and using provider partnerships through contract monitoring and meetings such as 'planning together' which included the voice of people with lived experience. Partners feedback was consistently excellent about the relational power sharing culture the local authority had fostered with the VCSE sector and the provider market.

The local authority used a 'Population Health Management' approach which involved segmenting the population by need or condition and relied upon strong partnership networks of planning and delivery. We saw evidence of delivery around for example health equity audits which evaluated who was taking up services. There was an emerging long term conditions strategy and an adult respiratory disease focus which fed into the neighbourhood team's work with interventions for better health and prevention, such as guided walks to improve lung function.

Working with voluntary and charity sector groups

The local authority had a range of ways it worked collaboratively with voluntary and charity organisations. They provided funding to around 50 VCSE services as community assets, which allowed them to pursue other opportunities to encourage growth and innovation and respond to communities. Public health was embedded in the adults and health directorate and each public health consultant had a group with the relevant VCSE services pertaining to their work for example around physical activity. Public health also commissioned VCSE sector organisations as delivery partners. We found the local authority valued small VCSE sector organisations in order to reach into communities around specific needs. For example, there was a play service on a specific housing estate which provided after school care to families. There were some specialist drug and alcohol services which included small VCSE services and other examples included walking groups.

The local authority used VCSE partnerships to meet diverse needs in communities and reduce inequalities using tools such as family group conferencing and helping to connect people with networks, community groups and agencies. Partners told us the local authority did reach out to the VCSE to seek current knowledge of the community landscape and were inquisitive to the needs of the community. Examples provided by partners included the local authority reaching a Somali community, an Irish community and small pockets of emerging groups. VCSE partners said they were involved with the local authority's work, for example local authority staff attended community walkabouts and VCSE partners were invited to local authority training events and we heard local authority staff attended training hosted by the VCSE partners.

As part of learning from community responses to the COVID-19 pandemic, the local authority funded organisations to exist as community assets, to ensure their operations continued, without specific commissioning or contractual reporting requirements. This was in keeping with the local authority's power-sharing partnership culture and their equity-focused approach to community well-being. 'We make Camden' the framework for joint working and co-production for delivery of services for and by the people who use them, was evident in this approach. Partners said there were many VCSE partnerships within the health and care system focused on reaching underserved communities, including a structured learning programme for people with type 2 diabetes in the Bengali language. The VCSE were represented on the safeguarding adults board and there was joint safeguarding training that involved VCSE community organisations.

Theme 3: How London Borough of Camden 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: 4

4 - Evidence shows an exceptional 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 told us very positive accounts of their experiences of moving through their care journeys. We heard excellent accounts of planning for the future well in advance of any changes, from both carers and from people in receipt of care and support. We found the proactive relational nature between local authority staff and other providers allowed safety in transitions across the board. One case referenced 'thoughtful planning' in planning for the future and we found this consistently in the evidence we saw and heard from people. Demographics in the local authority meant transitional arrangements were a high priority in terms of prevention of escalation of future need. There was a lot of multi-agency working and a high risk panel, which effectively met needs early. There was focussed work to prevent their care-leaver population becoming part of their homeless population between adult social care and children services.

Providers and partners reported systems were safe and well planned and we found the out of hours service supported emergency arrangements and safe transitions between services. For example, we saw the emergency placement flow chart and process maps and staff and partners said this was implemented and worked extremely well. Providers and health partners said they were involved with the prevention agenda and safety management. For example, there were multi-disciplinary meetings for people with complex needs: when people were not known to social care, they were then identified through these arrangements. The high-risk panel also involved external partners such as the police which worked very effectively. We saw effective governance procedures were in place around provider oversight and provider concerns with escalation processes mapped out and we heard from staff and partners these were used effectively and appropriately. Staff said the test and learn pilot of the 'front door' arrangements had been intended to further join-up support so people would not need to tell their story more than once. Staff positively referenced the pilot of the east integrated neighbourhood team with health colleagues, they said it reduced handoffs, improved efficiency and supported safety across the care journey for people. There was trauma informed guidance on safety, trust and transparency throughout the co-production process. Guidance for staff also described how the provision of supervision and peer support better enhanced safe and effective practice and staff reflected consistently this was evident in their practice.

All people waiting for a community DoLS (deprivation of liberty safeguards) decision were appropriately allocated to a neighbourhood or specialist team, discussed with the line manager and the DoLS team and monitored through a tracking document. With no waits for standard DoLS or other safeguarding inquiries, we found the local authority to be very effective in managing safety around safeguarding. There were sufficient staff trained and supported as best interest assessors and they were supported by robust procedures.

Safety during transitions

The local authority ensured safety during transitions and continuity of care during referrals, admissions, discharges and transitions between services. People consistently reported positive accounts of the support received during transitions. There were no waits for hospital discharges and therefore flow through the system was well managed. Social workers were based in local hospitals and had high numbers of successful discharges. Good communication was reported between disciplines and staff consistently reported the multidisciplinary teams (MDTs) and the neighbourhood teams worked very well. Weekly MDTs took place with health staff where workers self-allocated cases and all parties took a strength-based approach to working with people. All staff we spoke with described excellent coordination across system partners and internal teams with no barriers to information sharing or joint working in service of people needing care and support. We heard from staff about work within a hospital where daily meetings with discharge planning teams and ward meetings involved them consistently. There were good relationships between out of hours teams, rapid response teams and district nurses at the weekend. For example, when people had been discharged home and they required reablement, out of hour services were able to put the support in place. Providers said, because there was effective communication between social workers and NHS trusts they had never had an unsuitable or ‘unsafe’ hospital discharge. They reported miscommunication didn't happen in the local authority and teams worked effectively to ensure the safety of people.

Regarding safety during waiting for occupational therapy assessments, detail about a triage system was provided which mitigated risks appropriately. Occupational therapists were based in neighbourhood teams and were local to their population, however they had their own duty team across the local authority. Having one central waiting list enabled them to work together, manage risk and prevented information being lost. A dashboard had been introduced to prioritise cases in social work teams and to mitigate risk. Staff said it had enabled them to improve monitoring of cases and provide a responsive service. The duty system also effectively allowed risk to be managed for unallocated cases and highlights from the dashboard were shared with frontline staff in supervision.

Transitional arrangements for young people were excellent. Partners said consistently the 'planning together' meetings were used effectively to meet the needs of a young person. The 'good life steering group' placed young people at the centre and afforded them choice and control over their future. We found these forums also supported strong relationships between the local authority and providers and a collaborative culture within the sector. We heard about workshops for parents and carers around subjects relating to transition and service providers such as internships, education and workplace opportunities were clearly provided and available. Young people were supported for transitions at age 14, and at age 16 for handover to health services. Although there had been cases which were held until the person was aged 25 and a half, this was very unusual. This collaborative planning was proactive, person centred and involved and supported parents and carers and the individual to choose the best outcome available from a healthy market offer.

Contingency planning

Provider failure and service interruption procedures were in place and updated in July 2024. Staff and leaders explained what they would do and what they had done in cases of provider failure. Partner feedback demonstrated the local authority were responsive and supportive in planning for and responding to difficulties. There were mutual aid arrangements in place with neighbouring boroughs and the 5 borough NCL arrangement supported joint working and support across local authorities in times of disruption or emergency. Leaders and staff told us about home care mutual aid across neighbouring local authorities.

There was an example given of effective response to disruption: a care setting experienced extreme effects from heavy rain. The local authority provided swift action in keeping residents safe and identified solutions quickly for displaced residents. They also evaluated their actions following the incident which led to the development of a specific emergency placement flow chart and protocol. There was a joint business continuity plan for staff teams which detailed scenarios of potential disruption.

Safeguarding

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

There were effective systems processes and practices to make sure people were protected from abuse and neglect and the local authority worked very well with its partners and the safeguarding adults board to deliver a coordinated approach to safeguarding adults. This was evidenced by having no delays on standard DoLS and no waiting lists for safeguarding. Although community DoLS had some waiting times they were managed safely. Additional resources had been allocated to safeguarding over the last few years. The Multi Agency Safeguarding Hub (MASH) worked well and there was a dedicated DoLS team. Pathways to Safeguarding, MASH and the local authority's decision-making arrangements were clear from the information provided to us by the local authority. Leaders said the local authority had prioritised safeguarding and the elimination of waiting times. Safeguarding arrangements were well resourced, and staff consistently described the arrangements in place and how to manage complex cases.

Partners said the local authority worked well to safeguard people, and they were accessible, responsive and knowledgeable. The safeguarding adults board (SAB) annual report showed multi-agency work included the NHS, the Metropolitan Police, the national probation service and the VCSE, with agreed priorities for each agency. It set out governance arrangements and relevant performance data including section 42 enquiries. There was also a delivery plan within the five-year strategy which referenced over 40 SAB partnership members. Strong partnership working was evident in the safeguarding adults arrangements involving a regional safeguarding adults board which the SAB chairs attended and collaboration along ICB geography. The pan-London safeguarding policy arrangements worked well, and its policies were amended to the local authority's needs. Safeguarding in transitions was managed through the integrated young peoples team and communication worked well.

Staff consistently described how, both in and out of working hours, contact was made with a person and the duty system worked well in safeguarding people. Partners described support from the local authority in reviewing and shaping their own safeguarding policies. 'Family group conferencing' was referenced by partners, leaders and staff as providing an exemplary approach to safeguarding adults and placing them at the centre of their care. We heard an example where family group conferencing had been used to support homeless people and this was used effectively to safeguard individuals while supporting holistic outcomes for people involving their networks and communities.

The local authority had identified themes and trends in relation to safeguarding adults with a breakdown of the types of abuse which led to referral and provided comparative data across 2022/23 and 2023/24. There was clear evidence of extensive staff safeguarding training with an emphasis on legal updates, including the Mental Capacity Act and Court of Protection, which demonstrated a commitment to safe and effective practice and the involvement of safeguarding leads and regular safeguarding forums. A case file audit had demonstrated to the SAB practice had improved following training and there was an evident learning and quality assurance cycle.

However, ASCS data (2023-2024) showed fewer people (63.93%) who used services felt safe than the national average (71.06%) (negative variation) and fewer people (79.34%) who used services said those services had made them feel safe, then the national average (87.82%)(negative variation). 74.07% of carers felt safe compared to the England average (80.93%) (tending towards negative variation).

Responding to local safeguarding risks and issues

Staff said there was effective learning undertaken following safeguarding adult reviews and we heard about a clear interaction communication and responsibility cascaded to frontline teams. The principal social worker role and their team of lead practitioners supported a quality assurance process and learning from people's deaths. An example of an emerging safeguarding risk involved ‘cuckooing’ and staff and leaders ensured guidance was then cascaded to teams about this safeguarding issue.

Some concerns were raised from partners in relation to accessibility of mental health and dual diagnosis support between partners in the local authority area. Leaders said the current review into the Section 75 arrangements where mental health social workers were placed within health teams, sought to address this issue. Partners described an extremely positive safeguarding culture and said the local authority worked with them to support people to stay at home and within their existing support networks. We heard about an example where staff supported a partner agency to raise a safeguarding concern - in relation to services provided to a person in a provider setting, which improved the situation and allowed the person to remain at home safely.

We heard examples from staff about supporting people in housing settings with hoarding behaviours. Staff reported an understanding of their levels of hoarding in the local authority area and lessons had been learned from a safeguarding adult review (SAR) case. The local authority provided commissioned support for deep cleaning and staff said they used supportive therapeutic and psychology services, with experience in hoarding, to support individuals in the community. Staff said there was training available to them around hoarding in order to avoid self-neglect. There was a hoarding panel which had an overview of cases and outcomes. Partners said self-neglect was emerging as the largest category of safeguarding challenges and the preventative work on homelessness and issues which came to the high-risk panel meant the local authority understood the safeguarding risks and issues in the area.

A practice lead from the local authority worked with the safeguarding adults board chair to coordinate learning from SARs. Methods included seven-minute briefings, monthly audits of cases and safeguarding adults board cases and quarterly learning sessions. There had been a recent learning event held on both childrens and adults safeguarding reviews which included sub-regional collaboration and learning.

Responding to concerns and undertaking Section 42 enquiries

Partners said they were informed of outcomes of safeguarding concerns in a timely way and kept informed and involved. Because there were no delays in safeguarding cases and partner feedback was positive, the local authority was responsive to safeguarding concerns. The percentage of initial inquiries that moved on to becoming a Section 42 enquiry was between 30% and 33% across each of the last five years (taken from safeguarding adults collection data). There was clear guidance and detailed information on the referral and assessment pathways for safeguarding concerns and Section 42 enquiries. This included details around quality assurance arrangements and safeguarding adults' partnership board and annual general and thematic audits. Newly closed cases had been reviewed weekly and RAG rated, shared with commissioners and used in provider oversight board meetings which supported effective governance and learning from concerns raised. Safeguarding pathways from concerns to Section 42 enquiries fully involved staff and partners and the safeguarding system was clear and well resourced. The MASH had all referrals routed through it. It was a virtual hub, however there were police co-located in the local authority building and a mental health representative who screened cases and gave advice and support. We found MASH worked well, similar to other multidisciplinary or multi agency partnerships in the local authority.

Making safeguarding personal

People's outcomes were very well embedded in safeguarding procedures and practices. 94.12% of individuals lacking capacity were supported by an advocate family or friend with the England average being 83.38% (Safeguarding Adults Collection data 2023-24)(tending towards positive variation). Partners said the local authority was an early adopter of the 'making safeguarding personal' approach and case audits in the SAB had shown it to be evident in practice. Significant safeguarding challenges existed in the local authority area and partners, leaders and staff spoke to us about this in detail. Complexities around mental capacity, homelessness, self-neglect, transitional safeguarding, people with drug and alcohol needs and those leaving care were high within the local authority and there were emerging difficulties around 'cuckooing'. Partners said preventative outreach work took place which was effective and the local authority promoted safeguarding as everybody's business. Family group conferencing received safeguarding referrals from MASH, to be used in a Section 42 enquiry for a person. This approach placed people within their communities and networks at the centre of the safeguarding process and was used effectively to make safeguarding personal.

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: 4

4 - Evidence shows an exceptional 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

Governance management and accountability arrangements were extremely clear at all levels in the local authority. People and partners gave excellent feedback on leadership, governance and culture, how leaders sought and acted on feedback and how they demonstrated they valued staff. Leaders consistently centred equity in their explanations around their leadership of workplace and service delivery culture. Their power sharing relational culture had been set from the top of the organisation and was strongly evident in every interview we had, including with staff, partners and people. The approach to supporting people in the local authority area began with generating a sense of belonging and ownership of the area they lived in and intended to support people to access opportunities available to them in a central London location. The priority of creating equity and celebrating the diversity of populations and staff members was very clear from leaders. Leaders described workplace initiatives they had initiated following international events relating to racial unrest, which had an impact on staff well-being and morale. This showed they lived their values when difficult events happened. 'We Make Camden' was an example of how language and strategy around ownership in the local authority area sought to empower local people and create sense of belonging and stability.

The adult social care strategic delivery plan demonstrated overall governance responsibilities within the 'Supporting People Connecting Communities' programme board. There was a dedicated steering group which delivered bi-monthly and quarterly reviews on programme progress and risks. There was a transformation programme section and a senior management team business planning priorities section with 32 work streams covering all areas of adult social care and lead officers were named for each work stream. There was visibility and assurance to the work plan governance arrangements. There was a quality assurance framework and clear wider council and adult social care governance written in the context of the Care Act. It included co-production and the 'What Matters' approach with identity, language and trauma-informed practice central in its guiding principles. The quality assessment framework made links with the adult social care outcomes framework and equality and equity and set out staff roles and accountabilities including commissioners and elected members.

The political and officer leadership of adult social care were well informed about the potential risks facing adult social care and we heard how this was taken into account in decisions across the wider council. There were excellent, mutually supportive links between departments in support of adult social care such as with housing, economic growth and supporting communities to thrive. The levels of demand in the local authority area of adults with a variety of support needs, meant this work was central to preventing escalation of future need. The approach was again led from the top of the organisation and was consistently reflected from staff. Staff said childrens and adults directorates had clear communication between them at all levels, which allowed the learning and sharing of knowledge and practice. They said it felt like one, rather than two separate directorates. This was particularly evident in the integrated transitions team for people aged 0-25 years, where the joint work between childrens and adults social workers was seamless. This saw benefits in providing excellent education and work opportunities and in relationships with parent carers who were supported across the transition process.

There was a stable and consistent leadership team with no significant transformation programmes underway. Leadership approaches had been embedded across the organisation and had seen benefits for communities. Leaders had built on their work around staff culture, by focusing on 'psychological safety' and fostering a 'speaking-up' transparent work culture. Local authority leaders were seen by partners as strong local leaders of place with significant knowledge and reach into communities for them to draw on. 'Courageous leadership' training for leaders had been very effective in embedding a relational approach in the leadership at all levels. Leaders modelled this and it was reflected in staff at all levels.

The ‘Data’ function in adult social care had been a priority for leaders over the preceding 4 years. Investment in this area had improved the integration of public health and adult social care intelligence and activity and allowed a greater understanding of prevention pathways such as the adults early help model, working across housing and children's services. There had also been a greater level of investment in safeguarding, the neighbourhood model and the occupational therapy hub which had led to vastly reduced or no waiting times for assessments or safeguarding concerns. A review of the Section 75 arrangements had been initiated to improve the efficiency and effectiveness of use of resources and provided better mental health social work. Improvements to service governance and delivery were being made as part of ongoing improvements rather than wholesale transformation, alongside already successfully embedded leadership practices and service delivery.

Staff gave consistently excellent accounts of supportive leadership, governance and supervision and their working conditions. Staff said they wanted to remain in the local authority because of the working culture and leadership style. We found this leadership style and culture had been in place for many years. Staff also reported a supportive relationship within peer colleagues, and we found a consistently supportive culture between staff on different teams, between staff on MDTs and staff in partner agencies equally. Staff spoke consistently about supporting colleague well-being when dealing with complex cases and sometimes high levels of trauma of the individual staff worked with and said they felt supported when they were on duty. The principal social worker and their team of lead workers were well embedded within the senior leadership team and the wider staff team. Their roles worked in supporting staff in dealing with complex cases and improved good practice.

Elected leaders were embedded and involved in the business of the directorate. They described a collaborative relationship, responsive to them which supported their roles in scrutiny and accountability. Both elected and officer leaders were accountable for the decisions they made and gave examples of consciously taking decisions in collaboration with communities, people, partners and other elected members. Officers and elected lead members had regular meetings and away days. Staff and partners also described this collaboration as the leadership style within the local authority. Adult social care had a high priority in the council. Elected members from all parties and levels said the adult social care senior leadership team utilised them as assets within their communities and their feedback about what was happening in communities was valued and acted upon.

Strategic planning

The overarching strategic plan for living and ageing well in the local authority was 'Supporting People Connecting Communities' which also set out the strategic plan for adult social care. It focused on prevention, reducing and delaying the need for care and on the wider determinants of need. It demonstrated a strength-based approach and the strategic importance of integrated neighbourhood teams. The local authority's self-assessment showed inequalities had been worsening, there was a life expectancy gap of almost 20 years between the most deprived and least deprived areas and loneliness levels were high compared to other local authorities. In light of the reported high levels of homeless presentations, arrivals of asylum seekers and refugees and levels of mental health and drug and alcohol issues affecting many adults, the strategic planning of the local authority was appropriately orientated towards early help and was cross-council and cross-partnership in nature. A focus on empowering communities and links with the VCSE was demonstrated through strategic planning to support this. The use of academic and data insights, alongside public health to demonstrate the levels of need and effectiveness of services was innovative and fed into both ICB and local authority strategic plans.

The local authority's data team monitored service level activity and reported to staff so they had an understanding of the difference they were making. This included finance colleagues who were provided with predictive analysis of the demand and levels of care and support services that would be required over the next two years. There was a quarterly report to the corporate management team to provide high level data across all services and a monthly oversight board evaluating how many people were contacting and coming into adult social care and how many people were moving into residential care.

VCSE partners said they sat on boards and forums within the local authority and gave regular insights into local authority policies and strategies. This included co-production and involvement from deaf advice services and representation from homelessness organisations. There was an up-to-date and detailed carers action plan which involved external agencies. There was also a set of adult social care qualitative outcomes which had been produced with experts by experience which ranged from feeling safe in the community to being satisfied with relationships and with their care workers. A 'good work and employment needs assessment' described the impact of economic inactivity on people.

There were joint committees that supported strategic planning, including a health committee with a neighbouring local authority. There was a joint adult social care and health scrutiny committee that covered 5 local authorities (NCL). They also used a Population Health approach to strategic planning. The local authority therefore had a detailed understanding of demographic data across the health and care partnership and linked to the health well-being strategy across the 5 local authorities.

Information security

There were shared care records in use and information sharing agreements between health trusts and the local authority under a Section 75 arrangement, which provided governance to ensure people's data was safe. We saw arrangements to manage data integrity and confidentiality in case tracking. There was a well-resourced data team who provided support around information security. The shared care record extended across the NCL area between local authorities and health partners. The data team monitored usage and access using a data protection and governance approach. They had developed dashboards for managers and teams which helped to show the flow of work and service pressures with insights to practitioners on their caseloads. Staff said the record keeping systems they used were good and the systems were incorporated into processes and allowed them to adequately share information.

Learning, improvement and innovation

Score: 4

4 - Evidence shows an exceptional standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

Staff, leaders and partners consistently told us there was an inclusive and positive culture of continuous learning and improvement. Local authority staff had ongoing access to learning and support towards care activity duties which was very effective. The staff team were well trained, motivated and worked collaboratively with people and partners to actively promote innovative and new ways of working on an on-going basis. Proactive joint working was undertaken with partners to influence and improve how care and support was provided. The documentation around co-production demonstrated a clear approach and staff and leaders gave examples of sharing power with people. Some feedback was mixed around the effectiveness of co-production activities from people. Staff consistently reported they had regular supervisions and the training and opportunities to advance in their career was available to everyone equally. Training opportunities were offered in a variety of settings and ways and training was available on specific issues if they were requested. For example, one social worker had accessed special training about continence care in care homes following a request. The induction process for all adult social care staff included a 'What Matters' induction where information on the direct payment offer was included. Partners described examples of research and surveys carried out by the VCSE sector providing feedback to the local authority was used as a source of informative data on the needs of communities.

Building on place partnerships and work done within the 5 local authority areas, we saw evidence of collaborative work to commission services across local authority areas, which had improved efficiencies and economies of scale. Examples of impact included, finding partnership savings on new care home placements; the implementation of digital care records in 65 care services; securing over £1,000,000 from a government initiative to adopt innovative practices and build capacity in health and social care. They had secured funding to pilot a digital service which involved technology support placed in people's homes to monitor the every-day activity of people, by observing patterns and trends and spotting potential signs of need or difficulty. The intention was to enhance people's independence and reduce care home or hospital admissions.

The local authority had used citizens assemblies and panels as part of their co-production approach to get people involved in designing services and making policy. There was a co-production plan created with 38 residents including seldom heard groups, which detailed their aim to constantly learn and improve. The framework for co-production had incorporated learning from resident feedback, staff experiences and partners views. Diverse groups had been involved and a carers action plan had been developed using it. It showed they had used feedback to drive continuous improvement. An Autistic-led reflective workshops programme had shared the findings from research autistic people had undertaken. Other lived experience perspectives were also incorporated in the reflective space attended by autistic people and service representatives. This demonstrated another example of the local authority's relational approach to sharing power and making informed decisions. These reflective sessions had led to a creative project in partnership with the British Association of Social Workers (BASW) to create a film based on this local autistic-led participatory research. There was also a network of autism champions in development, with plans to develop 'autism informed walkthroughs' of services by autistic people to inform and improve service delivery. There was a co-production framework which showed the mental health day service had been co-designed and there was a co-production service for adults with learning disabilities supporting creative solutions and equality of experience. A number of autistic people had completed a leadership programme and a new role of 'Autistic peer consultant' had been developed at a local disability charity with the local authority's support, they provided training with a focus on inclusive employment. Mechanisms to track progress of co-production in the local authority area included setting up a resident advisory board and using monitoring and evaluation. The specific needs of seldom heard groups were embedded in the vision for co-production, for example the Skills for Care LGBTQ+ learning framework demonstrated a commitment to inclusive practices.

Staff consistently described having the required training to assess and support people in a person centred way and included any specialist fields. They also described using multidisciplinary teams and partnership environments to support. Managers reported having access to funding to hold away days with their teams. Leaders had undertaken 'courageous leadership' training, and this was led from the top of the organisation. It had focused on creating spaces to have early conversations and giving people agency to deliver. It covered the local authority's 'missions', which were clear statements of partnership delivery. Leaders allocated resources to the work and encouraged staff to think cross-sector. For example, private sector buildings had been used as assets in delivery of the local authority missions and a community wealth fund had been set up. We heard examples from the transitions team of young people utilising local private sector resources and buildings, with support.

There was a range of methods of listening to and involving staff, there was an inclusive innovation network, where people were given space and a place to pause and reflect and all staff 'atriums' where staff came together to tell their story. Staff said they were managed and supported in a way which fostered innovation.

There was a lived experience advisor strategy which demonstrated an inclusive learning orientated environment and a practical approach to managing conflict where open discussion and learning from different viewpoints were valued. There were specific measures evaluating the impact of lived experience advisors and demonstrated ongoing adaptation and learning from people's experiences. We saw a reward and recognition draft guidance for co-production which involved financial incentives for participation in co-production activities. People told us the lack of financial reward for the time involved in co-production had been a barrier to them and through this plan the local authority were responding to that feedback. Co-production principles and vision were excellent and staff and leaders were fully committed to involvement and co-production. They had recognised and sought to address the barriers faced by people to involvement, some of which had yet to be fully implemented. We found co-production guidance was trauma informed and provided tools, resources and a framework focused on reflection and well-being. There had been positive feedback from a government department on the culture of mutual respect and collaboration between people and the local authority.

Service innovation such as the integrated neighbourhood team pilot had been influenced by an innovative use of data. We heard staff working with data had time for learning and creative exploration. They worked closely with commissioners and had the capacity and freedom to look for themes and trends and use their professional and technical skills. There were apprenticeship opportunities in data analysis. In partnership with a local higher education institution, staff had looked at pathways and prevention and drivers within a person's journey. Public health staff described an effective and innovative partnership on this work and how staff enjoyed working with data and making tangible changes in neighbourhoods and service delivery.

Learning from feedback

The local authority listened to people and learned from feedback about peoples experiences of care and support and experiences of co-production and effectiveness of involvement. People were informed and involved in strategy, improvement activity and decision making. Staff said the local authority took action when concerns were raised and staff said they were proud they were able to maintain a high standard in their work. The quality assurance framework showed complaints and compliments were incorporated and the audit process included weekly reviews of section 42's enquiries. There was use of external auditors and an annual audit programme. People and partners said communication with the local authority worked well and we heard an example of the local authority listening and acting on feedback from people about direct payments contracts and the wording of the contract following the feedback. There were many examples where feedback from staff had been sought and acted upon through focus groups, listening events, surveys and staff forums. There was evidence of feedback being given to staff following a listening event. Leaders spoke consistently about their commitment to listening to people and demonstrated a commitment to identity and people's stories. There was a virtual listening box where contributions from staff could be given via a dedicated e-mail inbox or an online form. The exercise, for example, had gleaned suggestions about improvements to supervision which allowed leaders to take action. Elected members had been involved in developing frameworks to measure, for example, co-production challenges and then the resulting plan had funding allocated. Partners were very positive in their feedback around how the local authority listened to them and involved them. We found the learning and feedback culture was consistent across all teams and disciplines.
