Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area. North Tyneside had integrated aspects of its care and support functions with partner agencies where this was best practice and when it showed evidence of improved outcomes for people.

Partners told us they had strong strategic and operational relationships with the local authority. Relationships had been built up over a long period and allowed for constructive oversight and scrutiny. The local authority had strong links with the ICB through their joint Health and Wellbeing Board, the North Tyneside Health, Care and Wellbeing Executive, and the SAB. Joint strategic commitments to North Tyneside were set out through the Equally Well strategy (2021-2025), Ageing Well (2020-2025), and North Tyneside's Commitment to Carers (2024-2029).

Senior leaders told us the local authority used pooled resources to create strong integrated services with health partners. For example, the new Gateway Access Plus service was funded by the Integrated Care Board and delivered by the local authority in line with the national CORE20PLUS5 approach. Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The service worked with people with multiple social exclusions and included a dedicated nurse working alongside adult social care workers.

The joint-funded Strategic Manager for Integration role was based within the adult social care senior leadership team, ensuring joint health and social care arrangements worked well, overseeing support to people during and following discharge from hospital. In August 2024 data provided by the local authority showed they were lead commissioner for 322 people who were receiving joint-funded aftercare support in the community after discharge from hospital under s.117 of the Mental Health Act.

People told us the local authority had strong partnership links which provided positive outcomes for their health and wellbeing. For example, the Whole Life Disability Partnership arrangement with Northumbria Healthcare Foundation Trust provided specialist adult social care services for disabled children and young people, offering assessments, support, and services to help them live fulfilling lives into adulthood, including those with complex needs.

The commissioned review of support for unpaid carers identified areas of development, including greater focus on social isolation and transitions for young carers. The Carers Partnership Board were working with the voluntary and community sector to further develop community-based support.

Arrangements to support effective partnership working

When the local authority worked in partnership with other agencies there were clear arrangements for governance, accountability, monitoring, quality assurance and information sharing. The Health, Care and Wellbeing Executive was the strategic link to partner organisations, with performance scrutiny and overview via the Integrated Care Partnership.

Roles and responsibilities were clearly defined through section 75 agreements to avoid duplication of actions and ensure effective use of pooled resources. A section 75 agreement is an arrangement between NHS bodies and local authorities to share resources and commission health and social care services.

Partners told us examples of joint working included shared information systems to aid hospital discharges, joint-funded posts supporting North Tyneside's home first approach, and the development of intermediate care across the borough. Public Health allocated over £1 million annually to adult social care for various preventative programs. For instance, to support the Drug Strategy and Alcohol strategic objectives, funding a Specialist Substance Misuse Lead Social Worker connected to the North Tyneside Recovery Partnership, enhancing residential detox and rehab service for people struggling with alcohol and substance misuse.

Senior leaders told us more robust quality assurance processes were being developed, including partnership information-sharing arrangements and a review of dashboard-level performance data sharing. For example, local authority staff now had access to the Great North Care Record, which was a software plugin integrated into the local authority's case management system. This tool gave staff direct access to NHS health information through the Health Information Exchange.

A Falls Strategy has been in place in North Tyneside for several years and working groups, including people with lived experience, were developing a 5-year refreshed strategy at the time of our assessment. Partners told us there was a multi-agency Falls Service in place allowing the local authority to work closely with police, fire and health colleagues to reduce the need for people to attend A&E.

Senior leaders told us they used opportunities to pool budgets and jointly fund services with partners to achieve better outcomes for people using adult social care services. For example, BCF had been used to provide investments into community-based services, which included Care Point, intermediate care (including bed-based facilities complemented by a community rehabilitation team), out-of-hospital community health services, and a hospice-at-home service for end-of-life care.

Staff and leaders told us BCF supported the ongoing development of the frailty pathway and the integration of existing provision, including mental health roles supporting the multi-disciplinary health and adult social care offer. Improvements relating to urgent community response and the introduction of a virtual ward approach for frailty also supported this provision. Existing BCF schemes included Care Call who supported the Reablement, and the Community Rehabilitation teams with access to equipment and adaptations. Community health services funded by the BCF provided a multi-disciplinary team providing admissions avoidance and whilst Care Call focused primarily on discharge services, approximately 25% of their referrals were 'step-ups' within the community to prevent hospital admissions.

People told us communication between the local authority and health partners around CHC funding could be improved. People could often assume they would be given full CHC funding and could be frustrated when this did not happen. Partners told us the issue may be around the different local authorities having different processes in place for CHC leading to people inadvertently being given inaccurate information. Staff and leaders told us CHC commissioning was agreed at a regional level, supporting joint-funded packages but leading to short-notice of decision making on care packages.

Impact of partnership working

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

Whilst people felt partnerships, particularly with health partners, were strong, they told us they were concerned about succession planning. They spoke about 'corporate memory' and how information, and strong partner relationships could potentially be 'lost' when long-term staff moved on.

Staff told us partnership arrangements between mental health services and housing had significantly improved, with joint meetings taking place to discuss people with complex needs who were unlikely to be eligible for adult social care services were highlighted as vulnerable were they to become street homeless. Partnership working had supported joint understanding of their holistic needs, and this had been embedded by the incorporation of a mental health nurse as part of the housing team. This approach had also supported people in prison who required adult social care support to transition back to the local community.

Partners also told us the extra care step-down flat provision had been a positive experience for people. It stopped delays in discharges and meant people were able to get back to their homes more quickly.

People told us about the positive impacts of partnership working in North Tyneside. For example, the continued development of Care Point within the integrated frailty service implementing the 'home first' response to hospital discharges had led to improved access to equipment and occupational therapists.

Staff and leaders shared how, in response to an independent national review of drug treatment, the local authority had developed a new residential rehabilitation pathway in collaboration with key agencies and people who had lived experience of recovery services. The pathway was supported by a multidisciplinary team, including a specialist social worker and other professionals from local health services.

Data provided by the local authority in September 2024 showed the Gateway Access Plus service worked with 28 people, with outcomes including a reduction in safeguarding alerts, A&E attendances, an increase in GP registrations, improved engagement with North Tyneside Recovery Partnership (NTRP), and increased access to mental health services.

Senior leaders shared how partners jointly shared quality assurance and scrutiny functions through multi-agency audits. The framework agreement allowed work to be audited by managers from the various agencies involved in people's support, using the same tool to enable triangulation. These audits were used to evaluate people's experiences of receiving support and whether they received outcomes meaningful to them.

Learning was fed back to support service improvement plans. Staff and leaders told us they used Care Point performance data to align local authority staffing levels to the effective support of hospital discharges. Local authority staff attended daily hospital ward handovers and recorded discharge destinations to inform joint-commissioning decisions.

Staff and leaders also told us about the establishment of the 6 Week Review Team, reablement specialists who provided functional assessments and short-term rehabilitative support for people who had recently started receiving a homecare service for the first time. The set-up of the team was driven by a recognition frontline teams often implemented a package of care in a crisis, after which initial support needs could subside. Working in a multi-disciplinary model, including priority access to occupational therapy expertise, they 'right-sized' care packages in an evidence-based manner.

Working with voluntary and charity sector groups

The local authority worked collaboratively with voluntary and charity organisations to understand and meet local social care needs. North Tyneside had an umbrella organisation to represent and develop the community and voluntary sector in the borough, who were also commissioned to deliver specific projects. To support this the voluntary and community sector was represented on senior level boards by the umbrella organisation to support key decision making and deliver preventative support on behalf of adult social care. Senior leaders told us the outreach to seldom-heard groups was undertaken by the local authority directly, with the PSW and Corporate Engagement team engaging with voluntary and community sector organisations and faith leaders in line with the Adult Social Care Strategy Project Plan. However, not all voluntary and community partners fully understood their partnership with the local authority and felt communication could be improved.

People told us the Living Well North Tyneside Partnership operated the Living Well North Tyneside website on behalf of the local authority and ICB. The site promoted the prevention and wellbeing focused offer in the area, providing information about activities to support healthy lives and social inclusion as well as sources of support and advice in the area provided by the voluntary and community sector. In March 2024, the local authority worked jointly with partners to deliver a professionals networking event to celebrate both the relaunch of Living Well North Tyneside and World Social Work Day.

The local authority provided funding and other support opportunities to encourage growth and innovation. However, voluntary and community partners told us contracts were often only set for 12 months, making it difficult to plan ahead to ensure continuity of provision and support for community groups. Senior leaders told us this was being reviewed, with the possibility of longer contracts being offered in the future.

Senior leaders told us in October 2024, an analysis of Lived Experience Feedback interviews enhanced confidence in the local authority's own thematic analysis and provided critical and independent suggestions for improvement activity. For example, areas for improvement were identified such as unpaid carer support, access to respite, transitions, and consistency of core customer service.

People told us surveys of unpaid carers were completed annually by the Carers' Centre in partnership with other voluntary and community organisations. The intelligence gathered directly shaped the work plan of the multi-agency Carers Partnership Board. Partners said North Tyneside were proactively working together with voluntary and community carer groups to improve the impact of support services for unpaid carers, for example through joint work on the Carers Ways to Wellbeing process.

Partners in the voluntary and community sector told us about a commissioned project to support hospital discharges. The project was jointly funded between the local authority and health partners using BCF grants. The 'Settle at Home' scheme used volunteers to support people at home in the community to support people upon hospital discharge to ensure they had food, heating, and a point of contact. People felt this was going well and they hoped the funding would continue.