Cumberland Council: local authority assessment

How we assess local authorities

Assessment published: 29 January 2026

About Cumberland Council

Demographics

Cumberland is home to over 273,000 residents. The population is predicted to fall by 0.3% by 2028.

Cumberland has an older age profile compared to England and Wales with ages 0 to 64 making up around 76.15% of the population compared to around 81.31% for England as a whole. Cumberland has an ageing population, with the number of people over 65 due to increase by 16.8% by 2028 (Office of National Statistics, 2020). The number of residents aged 16 to 64 is projected to decrease by 4.8% by 2028.

More than half of Cumberland's population live in classified rural areas, accounting for 51.7%. This compares to just 17.1% for England. It is much more sparsely populated than England with 91 people per sq km, compared to 395 people per sq km in England. Cumberland is 3,012 square km.

The 2021 Census did not specifically give ethnic origin data for Cumberland and instead data was representative of the wider area of Cumbria. Most of Cumbria's population identified as white, making up 97.64%. Asian and Asian British people made up 1% of the population. This was much lower than national averages of 9.61%. 0.8% of people identified as Mixed and multiple ethnicities, 0.2% identified as Black, Black British, Caribbean or African and 0.3% identified as 'Other' ethnicities.

The population has an Index of Multiple Deprivation score of 6 (1 is the least deprived, 10 is the most deprived) meaning it was neither one of the most or least deprived local authorities in England. Four community areas in Cumberland fall within the 10% most deprived nationally; approximately 8.3% of Cumberland's population (22,850 people). However, 10 community areas are amongst the least deprived.

Cumberland is a unitary authority and was established in 2023. Cumberland was a Labour-led Unitary Authority with a large majority at the time of the assessment. Most of the population of Cumberland was part of the North East, North Cumbria Integrated Care System. However, some of the South of the population was covered by the Lancashire and South Cumbria Integrated Care System.

Financial facts

- There was no available estimated total budget for the local authority in 2023/24 due to Local Government Reorganisation in 2023. Its actual spend for that year was **£460,670,000.00**.
- There was no available estimated total budget spend on adult social care in 2023/24 due to Local Government Reorganisation in 2023. Its actual spend was **£104,350,000.00.**
- In 2023/24, **22.65%** 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.

- In 2023/24 approximately **4465** people were accessing long-term adult social care support per 100,000 people, and approximately **1400** people were accessing short-term adult social care support. 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.

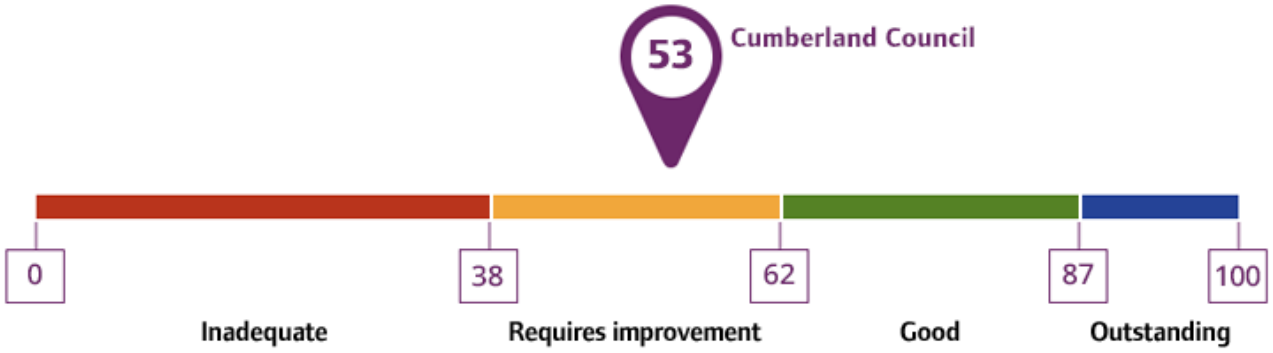
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

Cumberland Council

Requires improvement



Quality statement scores

Assessing needs

Score: 2

Supporting people to lead healthier lives

Score: 2

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 2

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 2

Safeguarding
Score: 2

Governance, management and sustainability
Score: 2

Learning, improvement and innovation
Score: 2

Summary of people's experiences

Unpaid carers were happy with the support they received from the commissioned carers service, but most carers found their caring roles challenging and time consuming. Most carers did not get access to breaks, with respite access more limited in some areas. Contingency planning for emergency breakdown of support was not always in place.

Some people experienced waits for assessments, annual reviews, occupational therapy assessments, equipment delivery, financial assessments and outcomes of Deprivation of Liberty Safeguards assessments. Despite this, those at most risk were supported in a timely manner through waiting well procedures. Steps were being taken to reduce waits for people, with decreased waiting lists for annual reviews, for example.

Most people were satisfied with their care and support and felt they had control over their daily lives. Some people's access to services was dependent on where they lived, with local provision more difficult to access in areas of Cumberland.

People and unpaid carers felt safe and people could access out-of-hours support for urgent support if they needed it. Most people had their outcomes met when subject to safeguarding enquiries. People could access statutory advocacy and were satisfied when they received it, but sometimes access was delayed depending on urgency of need.

People accessed reablement and intermediate care beds to support their independence following hospital discharges, but national data suggested pathway use and outcomes for people could be improved. Some people could experience increased handoffs between different services following discharges, due to delays setting up long-term care and support. People could be delayed from being discharged from specialist mental health hospitals due to a lack of available care provision.

People and unpaid carers were being involved more in co-production as the local authority developed its approach. The carers forum, living well-sub-group and community panels were supporting people to have a voice and be listened to.

People were supported to access interpreters, but this could be more challenging for some people depending on their needs. Accessible information such as easy-read information was not always available. People with sensory impairments were supported effectively.

Young people were safely supported to transition from children's services to adult social care and most people told us their experiences were positive.

Summary of strengths, areas for development and next steps

The local authority understood its areas for development following Local Government Reorganisation (LGR) and was on an improvement journey. A wide-ranging transformation plan was ongoing and as a result the impact of this work was still embedding. Resources had been allocated to improve services, but the impact of this was not yet always evident. The local authority had a commitment to learning, through external reviews and when things go wrong. Coproduction was being better developed, with some positive examples using people's voice. Strategies were being developed across the service.

There were staffing pressures across areas of the service, and this could impact how services were delivered. The local authority was using agency staff to support areas of the service, but these staff were not always local. Staff were supported effectively by managers to manage their workloads.

Unpaid carers found their roles challenging and most did not have time for themselves. Most carers did not access services to allow them to take breaks and respite provision. A commissioned service was supporting with a range of services, and most carers were positive about this support. A carers forum was embedding to support improvements to carer support.

Partners and carers told us contingency planning was not always in place, but staff told us they understood the importance of contingency arrangements.

There were significant waits for OT assessments and equipment. Equipment provider services were being reviewed in response to challenges. Risk was being mitigated for people waiting and there had been some improvement in equipment delivery rates. Mobile and static clinics were supporting some people to access assessments. Disabled Facilities Grant authorisations for home adaptations were timely.

There were some waits for assessments and long waits for annual reviews. Resources had been prioritised to reduce waits for people, but impact was still embedding. A Waiting Well Procedure was supporting people at most risk to be supported in a timely manner.

Person centred practice was being supported by a Practice Framework but there was opportunity to apply holistic and personalised approaches more consistently. There were positive examples of staff supporting people in personalised and creative ways to better outcomes. Direct payment uptake was recognised as an area for development.

A transfer of care hub supported integrated hospital discharge arrangements. Reablement and intermediate care pathways were supporting independence but there was opportunity to improve long-term outcomes following reablement. The local authority had increased intermediate care bed capacity and usage was increasing. There was opportunity to review overlapping pathways and resources with health as well as the opportunity to reduce handoffs for people following stays in hospital.

The local authority was developing its commissioning approach, with a new Adult Social Care and Housing Commissioning Strategy which was due for sign off. Specialist services, housing with care options and day opportunities were particularly difficult to access for some people. A lack of local services could create delays in discharges from, for example, specialist mental health hospitals. The local authority understood its market and was taking steps to improve provision such as through the new day opportunities framework.

In-house services were being reviewed to support efficiency and their suitability, alongside market need. Care providers faced sustainability challenges through recruitment and financial pressures. Care provider quality assurance work was mitigating risk.

The local authority recognised the need to engage better with seldom-heard communities. The geography of Cumberland was a key barrier in accessing local services for some people. The local authority had identified seldom-heard groups and communities and was developing their approach to engagement. Trauma-informed and inclusive practice was central to the Practice Framework. Interpreter and accessibility arrangements were not always consistent.

The local authority recognised a need to strengthen prevention. There was investment in the pre-front door and front door and there were early signs of impact. There was a need to improve the information and advice offer and the local authority was developing self-serve options. The health and wellbeing coaches (HAWCS) were a positive example of supporting a preventative approach, offering people flexible and empowering support.

Leaders were visible and accessible for staff. Staff were supported effectively with their continuous professional development (CPD) and new staff benefitted from targeted training.

The local authority had developed positive working relationships with key partners, supported by place-based arrangements. The Better Care Fund was being used to support better outcomes for people and was monitored effectively. Voluntary, Community and Social Enterprise (VCSE) partners were involved on strategic boards, but some partners felt more listened to than others.

Young people were supported effectively to achieve positive outcomes following transition to adult services. However, staffing pressures could impact on consistency of approach.

Safeguarding processes had been adapted following a bespoke peer review to help keep people safe. Decision making was timely, and enquiries were completed with a more person-centred approach. There was opportunity to provide improved guidance and training for partners around safeguarding. Outcomes of enquiries were not always communicated effectively.

There was a significant DoLS waiting list, with long waits for authorisations for some people. This left people at risk of being deprived of their liberty unlawfully. A prioritisation tool was supporting risk rating of applications and people at the highest risk to be reviewed first.

Theme 1: How Cumberland Council works with people

This theme includes these quality statements:

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

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

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Assessment, care planning and review arrangements

The local authority was developing access routes to assessments for people as part of its transformation plan. Referrals for assessments were made through the Single Point of Access (SPA) via telephone, self-referral forms and referrals from partners. It had been recognised there was a lack of self-assessment options and there was ongoing development of self-assessment toolkits which were planned to reduce waits for assessments. This was in the prototype stage at the time of assessment, but was part of the wider transformation plan for pre-front door and front door services.

A person's journey through the SPA included a 'start of assessment' where relevant, which collected initial information about people regarding their support needs to help inform whether full assessments were required. This decision was supported by a duty function or a multi-disciplinary discussion so the person could receive support from the appropriate pathway. A staff team told us the 'start of assessment' supported the assessment process. Where it was identified a full assessment was required, referrals were triaged and prioritised based on level of need. People who did not require an assessment were supported with signposting, or other preventative options.

The local authority had organised its frontline teams to be responsive to both urgency and type of need. For example, the Screening and Assessment Team (SAT) supported people who had been triaged as high or medium priority need, whereas the Long-Term Team would support people with lower priority need. A Mental Health Team and a Learning Disability, Autism and Transitions Team supported people with relevant primary needs. Staff told us co-working between teams supported identification of which team was best placed to support people, providing a more tailored approach to assessment and support planning. Teams were also broken down based on geography, with teams supporting people in the North and in the West.

The local authority was focused on providing a person-centred and strength-based approach to supporting people and assessing their needs. This was being supported by a Practice Framework launched in September 2024. A leader told us the framework was an attempt to empower staff, with development of trauma- informed, anti-racist and risk-positive approaches.

Staff teams consistently told us they were committed to applying a person-centred approach to achieving positive outcomes. A staff team told us, for example, about the face-to-face assessment process which began by finding out about the person and their background rather than just their condition or disability. This supported staff to build rapport with people and look at the whole picture, including the person's current support network.

Most people told us they felt involved in the assessment process and support planning, and this was also reflected in assessment documentation. However, some partners reflected that this approach was inconsistent and there was an opportunity to make assessments more holistic and empowering. A staff team also told us high workloads could make it difficult to apply a consistent approach to relationship building with people.

National data also reflected positive experiences for people. The Adult Social Care Survey for 2023/24 showed that 70.52% of people were satisfied with their care and support. This was somewhat better than the England average (65.39%). National data from the Adult Social Care Survey for 2023/24 showed that 86.02% of people feel they have control over their daily life. This was better than the England average (77.62%).

Timeliness of assessments, care planning and reviews

People did not always have access to timely assessments and reviews, and this could delay people accessing timely support.

There were some waits for assessments as demonstrated by local authority data. As of June 2025, data showed 127 people were waiting for an assessment, for the previous 12 months the median wait was 9.56 days and the maximum wait was 44.43 days. This was an increase of 9 people waiting since data provided for January 2025.

People faced longer waits for annual reviews. As of June 2025, 811 people were waiting for a review, with a median wait of 210 days and maximum wait of 1675 days over the last 12 months. This included 51 people who were overdue by over 1000 days. Most of these 51 people were said to be reviews which were under the learning disability service and all of these reviews were due to be completed by the end of July 2025. An update from the local authority provided in September 2025 confirmed 539 of the 811 outstanding reviews had been completed (66%) and the highlighted outstanding learning disability reviews were completed by the end of July.

The local authority was taking targeted steps to decrease waits for assessments and reviews and the impact of this was still embedding. This included extra allocated resources, both internally and externally. For example, agency staff were supporting staff capacity and teams were working flexibly across regions to support people to access assessments. An external service was also commissioned in January 2025 to complete 200 reviews. A staff team also told us they had also been completing non-urgent reviews where people's needs to support to reduce the backlog, over the phone. As a result of actions, the number of people waiting for reviews had decreased by over a third since January 2025. The local authority also forecasted all reviews to be completed within required timescales by June 2026. However, waits for reviews remained high.

To mitigate risks to people waiting, the local authority retained daily oversight and prioritisation of waits. An Allocation and Waiting Well Procedure outlined how people should be prioritised, with target timescales. For example, for assessments, a ‘high’ priority referral would require response/allocation within 24 hours. Whereas a 'normal' priority would require allocation within 2 weeks. The ‘low’ priority response was allocation within 6 weeks. People were also informed of the expected waits. Leaders told us they were uncomfortable with the waits for assessment and services, but waiting well procedures supported assurance and oversight of who was waiting and urgency of need. Staff also told us waiting well procedures were helping them to mitigate urgent risk, keep people updated and re-prioritise based on new information about people waiting.

Staff told us people’s waits could be impacted by capacity of teams. For example, they told us there were differences in staffing and resources between teams in the West and the North, which could impact wait and allocation times. A staff team also told us although they completed reviews, other complex work could be prioritised. Another team told us their team was limited in the number of visits they could complete due to availability of staff.

Partners told us of the impact of waits for assessment and reviews. Some partners felt the timeliness of reviews varied, with the local authority sometimes more responsive to more urgent need but this was not always consistent. A provider told us there were occasions where they had taken steps to increase services for people without local authority approval due to the delays in reviews at their own expense, with no guarantee of reimbursement. This presented a risk of sustainability of the support for both the partner and the person.

National data also reflected delays to reviews, but this was in line with national averages. The Short and Long-Term Support (SALT) for 2023/24 showed that 57.56% of long-term support clients reviewed (planned or unplanned). This was similar to the England average (58.77%).

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

The needs of unpaid carers were recognised as distinct from the person with care needs; assessments, support plans and reviews for unpaid carers were undertaken separately through a commissioned partner.

Most carers told us about the challenges of their caring roles, including finding it difficult to find time for themselves or other family members. Time constraints were also reflected in national data. The Survey of Adult Carers (SACE) in England for 2023/24 showed that 17.63% of carers were able to spend time doing things they enjoy. This was similar to the England average (15.97%). SACE data also showed that 36.02% of carers reported that they had as much social contact as desired. This was somewhat better than the England average (30.02%). This highlighted the impact of caring roles on carers' lives, with most carers not having time for themselves.

Identified carers were supported to access assessments through the commissioned partner. Most carers told us they found the assessment process helpful, supportive and informative. They described staff from the commissioned partner as understanding, approachable and knowledgeable. Carers valued the opportunity to talk and be heard, often feeling validated and less isolated. Carers also told us they could choose whether to have a phone or in person assessment.

There were sometimes waits for carer assessments and reviews. Local authority data showed, as of June 2025, there were 13 carers waiting for assessments, with a median wait of 14 days and a maximum wait of 371 days for the previous 12 months. Carer review data showed 101 carers waiting for reviews, with a median waiting time of 16 days and a maximum waiting time of 362 days from the previous 12 months. A partner told us reviews were risk-rated based on need and whether a carer needed a review after 6, 9 or 12 months. There was mixed feedback on the timeliness of assessments, with some carers telling us they were contacted quickly following referrals, but others had to wait longer.

The commissioned partner also offered a range of services to support carers. For example, there was provision for counselling and benefits advice. Carers were positive about other services offered by the commissioned carer service. Carers told us the partner could be contacted for information and advice, and they supported social activities, including for young carers. There was also positive feedback about emotional and mental support provided, with carers able to speak to the service when they were struggling. A carer told us, for example, they had tremendous support, and they were now able to cope better in their caring role.

National data from the SACE (2023/24) showed 38.54% of unpaid carers experienced financial difficulties because of caring. This was significantly better than the England average (46.55%). While unpaid carers in the area were experiencing less financial difficulty as compared to other areas, there continued to be over a third of carers who were being impacted financially by their caring role. The local authority continued to support carers with finances. For example, local authority data also estimated there had been 283 individual actions using a commissioned partner's carers allowance tool between May 2024 and September 2025, which enabled unpaid carers to apply for eligible carers allowance support. Usage of this tool was also increasing, which was supporting carers to better financial outcomes.

Some partners felt carers could be better supported with training for their caring roles. It was highlighted that carers would benefit from training in areas such as dementia support and manual handling. While there had been sessions for carers organised by the local authority, such as an OT session on falls prevention, this was not a regular offer. Further information provided by the local authority stated OT sessions were based on identified needs of carers. Partners told us, however, there needed to be better understanding of obstacles for attending any sessions, such as transport, as this had not been considered previously. A leader told us training was provided for carers when the cared for person had a direct payment, but this was not offered more widely. Further information provided by the local authority stated OT sessions were based on identified needs of carers. National data also reflected carer training as an area for development. The SACE for 2023/24 showed that 3.31% of carers accessed training for carers. This was somewhat worse than the England average (4.30%).

The local authority had identified unpaid carer support as a priority area for development, and this was reflected as part of their Achieving Excellence Plan. A leader told us there needed to be strong ongoing oversight of unpaid carer support and they felt the offer was improving, supported by the new commissioned contract which was due for renewal.

Central to improvements was the establishment of the carers' forum. The forum had supported the co-production of an upcoming carer's charter to help outline and embed improvements to the carer offer. Carers had also supported to produce the new commissioned partner contract. There were also other areas of ongoing development, such as a staff team telling us a self-assessment tool was being developed for carers to support them to identify their needs and request assessment and support.

National data also reflected the need for the local authority to continually develop and improve relationships and processes with carers. The SACE for 2023/24 showed that 34.02% were satisfied with social services. This was similar to the England average (36.83%) but showed the majority of carers were not classed as satisfied with services.

National data from the SACE for 2023/24 showed that 36.48% of carers accessed a support group or someone to talk to in confidence. This was similar to the England average (32.98%)

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

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs.

The local authority's front door, the SPA, was used for signposting, information and advice for people. Data provided by the local authority showed of 45,107 calls in 2024, 45.4% of which were recommended information, guidance and support and 8.7% of people were signposted to more targeted support. More recent SPA outcome data showed a further increase for April to June 2025, with 10.3% of all SPA contacts were externally signposted. However, some partner feedback suggested signposting and referrals was an area for development. For example, a partner told us the local authority front door was not well connected with the voluntary, community and social enterprise sector (VCSE) and referrals were not always made where people did not have eligible needs. The local authority provided further information which outlined the SPA did not primarily fulfil a referral function, but could make high priority telephone referrals to the VCSE or make referrals using the 'Joy' application, which was used to connect people to local services.

Staff teams told us they supported people to access alternative services where people were not eligible for services. For example, a staff team told us both the SPA and frontline teams would utilise local preventative services through both the VCSE and internal resources such as health and wellbeing coaches where appropriate.

The local authority was developing its pre-front door and front door approach as part of its transformation, which included the roll-out of enhanced self-service options, signposting and building capacity in the VCSE to support people to access local support.

Eligibility decisions for care and support

The local authority had assessment guidance and practice guidance to support staff with eligibility decisions, but both documents were legacy documents from the previous local authority before Local Government Reorganisation in the area. One of these documents appeared to be last reviewed in 2015. There was scope to review this documentation to ensure advice was still up to date for staff.

People's assessments showed the use of criteria to determine eligibility for services. For example, a person's assessment clearly identified the person's eligible needs under each domain and the level of impact this was having on their wellbeing. The eligibility outcome recorded also included a professional analysis of the identified need.

People who disagreed with the outcome of eligibility decisions were able to challenge decisions by following the local authority complaints process. This was following an initial discussion with the relevant assessing staff member or their manager.

Local authority complaint data provided from 24 May 2025 stated there had been 20 'issues' which were classified as 'disagree with council policy/ decision/ procedure'. This data was not broken down further and it was unclear how many of these raised 'issues' related to eligibility specifically. The local authority had not identified any practice themes yet as there had been a low number of upheld/ partially upheld issues.

Financial assessment and charging policy for care and support

The local authority provided people with information on financial assessments and their charging policy both on their website and within separate documentation. This supported staff to apply relevant procedures.

Local authority data provided as of June 2025 showed 204 people were awaiting completion of a financial assessment, with a median wait of 66 days and a maximum wait of 374 days over the last 12 months. Themes collected by the local authority on people's waits indicated financial assessments were taking longer due to mental capacity determinations, deputyship or financial appointee arrangements, changes in need/ support packages during the process or due to the time taken for people to return information. Progress of assessments was also said to be monitored weekly by the Community Finance Officer Team. While delays in financial assessments were not always in the local authority's control, there were still waits for people.

Some staff teams, however, told us financial assessments were generally completed in a timely manner. They told us people were supported with information about financial assessments and charging and they had these discussions with people as early as possible to support understanding. There was also said to be provision for staff to support people with financial assessments via phone or in-person. A person's carer told us they benefitted from an in-person visit and had received excellent support from the local authority around a financial assessment.

Some partners were less positive about the financial assessment process. A partner told us there were delays in financial assessments for people. Another partner raised concerns the financial assessment process was delivered without appropriate support for people with communication differences, contributing to inaccessible pathways. They also told us financial assessments could be a barrier for people accessing support, especially when people did not engage with the process and did not get support to complete the assessment. In response to partner feedback, the local authority provided further information about the support provided around charging and financial assessments. This support included ensuring a person's needs were met, whilst an affordability assessment was being undertaken. It was also outlined that no feedback on communication differences which could impact this pathway had been raised to the local authority.

Provision of independent advocacy

Independent advocacy support was available to help people participate fully in care assessments and care planning processes. The local authority had a commissioned provider for statutory advocacy. This included advocacy for the Care Act, Mental Capacity Act (IMCA) and Mental Health Act IMHA.

People's access to timely advocacy was dependent on the urgency of need. Staff teams told us advocacy requests were responded to promptly but there could be waits for advocacy to be provided. Referrals for safeguarding were said to be carried out in a timely way, but staff told us there could be more prolonged waits for less urgent need, with a staff team telling us of a wait of around 2 months. However, a staff team told us they could work closely with the commissioned advocacy provider to support prioritisation of need.

In the quarterly update for February- April 2025 for the local authority from the commissioned advocacy provider, there was acknowledgement of an increased demand for advocacy and staffing pressures, but no delays noted. There were plans to address staffing challenges through seasonal staff and volunteers.

Data for the quarter May- July 2025 showed a large reduction in time taken to allocate an advocate, prior to contacting the person, across all commissioned advocacy types provided. Data also showed for this quarter, people waited on average 27 days from the referral date to first contact for Care Act advocacy. Independent Mental Health Act advocacy (IMHA) and Independent Mental Capacity Act Advocacy (IMCA) was timelier, each with waits of 19 days until first contact on average. Relevant Person's Representatives (RPRs) made contact on average 32 days from referral.

Some partner feedback suggested advocacy referrals were not always consistent. This included where care and support decisions had been made before an advocate had significant input to support the person's voice. Staff teams told us they understood the need to ensure a person's voice was heard and knew how to refer for advocacy.

Data also showed, for the quarter February- April 2025, 93% of people were satisfied with the level of support received by the commissioned advocacy provider and the level of information provided to help them inform their decisions. This increased to 100% for the quarter May- July 2025.

Supporting people to live healthier lives

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority recognised the need to strengthen its prevention approach. Senior leaders told us there had been a shift in the approach of the local authority to achieve better outcomes for people through improvements to both the front door and pre-front door. This was reflected in the Council Plan (2023-2027) which outlined a focus on prevention and early intervention. Some partners felt the local authority's prevention offer needed to be developed. A partner told us there had not been investment in prevention such as through maintaining people's independence and building more structured community networks for people. They told us this meant more people's first point of contact was the statutory sector as a result. Despite this feedback, there was evidence of preventative investment, including across community-based support services, technology enabled care and home adaptations and housing support, for example. Preventative investment also included approximately 70% of the Better Care Fund budget.

The local authority had a strategic ambition to improve and embed prevention, as demonstrated by the Joint Health and Wellbeing Strategy (2023-2028). The strategy outlined the shared direction of the local authority and its partners to encourage a greater focus on prevention and early intervention. The strategy demonstrated an oversight of health inequalities and local challenges for people. It also outlined its approach to support across a range of areas, including employment, reduction of poverty, smoking cessation, gambling and substance use, housing and homelessness, emotional and mental health and wellbeing, social isolation and loneliness, for example. A Health and Wellbeing Framework and Delivery Plan set out how the local authority would take forward its priorities, with evidence of ongoing progress. Actions included the launch of local community hubs and work to enhance the pre-front door offer, for example.

Prevention support for mental health needs, suicide and substance misuse were recognised as a key challenge for the local authority. For example, the Public Health Annual Report (2023-2024) highlighted high rates of suicide, hospital admissions from intentional self-harm and drug-related deaths relative to national averages. Leaders told us there was ongoing work to better understand the higher rates of suicide, with a research project underway. There was also a suicide prevention leadership meeting to support oversight in this area. A staff team told us the local authority utilised the VCSE to support mental health and substance use prevention, with multiple organisations referred to. A senior leader told us the local authority also worked with partners to support relatives and loved ones following a suicide to reduce risks to them.

National data from the Adult Social Care Survey for 2023/24 showed that 64.13% of people said help and support helped them to think and feel better about themselves. This was similar to the England average (62.48%). National data from the survey also showed that 50.15% of people who used services reported that they had as much social contact as they wanted with people they like. This was somewhat better than the England average (45.56%). This showed around half of people receiving services were having the social contact they wanted with people, but around half were not.

Housing quality and availability was recognised as another local challenge. A senior leader told us there had recently been a housing condition survey and knew there were challenges for people with the condition of their housing, due to, in part, the age of buildings. They told us while there was almost no 'street homelessness' or rough sleeping in Cumberland, there was a wider challenge of homelessness, including 'sofa surfing'. However, they told us there were temporary accommodation resources available for people and had an example of several families being housed following an emergency incident. Staff and leaders told us a delivery plan was being developed for the new housing strategy to support local housing availability and quality. The strategy was signed off in July 2025. . The Homelessness Prevention and Rough Sleeping Strategy (2025-2030) also sought to address homelessness in the local area.

The local authority had a new Housing Adaptations and Assistance Policy which was focused on embedding the concept of healthy homes and in turn preventing increased use of adult social care statutory services. Staff teams told us about approaches to support healthy and safe homes. For example, there were opportunities for people to access grants or deep cleans and repairs to roofs. Staff also told us about VCSE resources they could access to support people with housing issues.

There was opportunity for the local authority to develop identification and support of unpaid carers to support prevention. A commissioned Healthwatch report published in April 2025, 'Ageing Well in Cumberland', highlighted the need to make services more accessible to carers through reasonable adjustments; create tailored support for older carers taking their age and health into account; identify and support carers earlier and involve carers in planning services. In response to some of these issues, the local authority had commissioned a provider to reach out to carers and the creation of the carers' forum supported with the upcoming carers' charter. The local authority recognised this as a continued area for development.

Staff teams told us they utilised partnerships with the VCSE to support people. For example, a staff team told us they utilised support for young people around employment opportunities. In a positive example shared, a person was supported to learn new skills and was eventually offered a job role following support from the VCSE partner.

There was an opportunity to better develop resources for staff with information about local services. For example, the 'Joy' app was being used by some staff as an information base to support people to access local services. However, this app was only applicable to the Copeland area of Cumberland as it was a legacy resource from the previous local authority organisation. A senior leader told us a new information, advice and guidance app was under development which would be used across the whole of Cumberland.

The local authority's health and wellbeing coaches (HAWCs), who were part of the public health directorate, positively contributed to prevention. HAWCs worked directly with people to support early intervention and in 2023 additional resources expanded the remit of HAWCs to engage more fully with people living in the top 20% most deprived areas. Their key focus was on supporting people with mental health and well-being needs but they supported a broad spectrum of people. A senior leader told us they were a multi-skilled team, which empowered people through techniques such as motivational interviewing. A staff team told us the HAWCs 'coached' people to progress to specific outcomes, with action planning and steps toward set goals. In an example, a staff team told us the HAWCs had supported a person to learn how to use transport to access their day service provision which supported them to a positive outcome. There was no set time frame for the involvement of HAWCs and they could work in conjunction with frontline teams to help prevent escalation of needs.

Data provided by the local authority showed, in 2023/24, the Health and Wellbeing Team received 1,436 referrals, 70% of referrals came from an organisation (rather than an individual). The percentage of cases closed with a positive outcome reported, such as reduced anxiety or depression or improved wellbeing or resilience, was 60%.

The local authority had shown improvements in its use of prevention through its information and advice offer at the front door. For example, a peer challenge exercise in May 2024, highlighted only 20% of calls received by the SPA were being redirected with information, advice and signposting. This meant most people were referred to frontline teams. Following transformative work and improvement planning, there were signs of improvement of prevention provided at the front door. As of January 2025, there had been an increase of 45% of contacts signposted, with an ambition of 70%. This supported a reduction in pressure on frontline teams and supported a preventative approach.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services that enabled people to return to their optimal independence, but this was a continued area for development.

The local authority had a reablement service jointly funded through the Better Care Fund (BCF). The service was offered to people in their own homes to support them to regain or maintain independence following hospital discharge or where at risk of hospital admission. An intermediate care pathway, which provided therapy, rehab and rehabilitation for people usually in residential care services, was also jointly funded through the BCF. This service supported both hospital discharges and community step-ups with the aim of maximising peoples' independence and supporting them to return home with no or reduced ongoing long-term care.

National data showed the need to improve the effectiveness of intermediate care and reablement pathways in supporting people to remain independent. For example, data from Short- and Long-Term Support for 2023/24 showed that 71.43% of people aged 65+ were still at home 91 days after discharge from hospital into reablement/rehabilitation. This was worse than the England average (83.70%). Data from the Adult Social Care Outcomes Framework for 2023/24 showed better performance, with 78.28% of people who received short-term support no longer required support. This was similar to the England average (79.39%).

Leaders told us the local authority was committed to support people to remain independent and in their own homes. The local authority provided their own data for between January and December 2024, which showed, on average, 59% of people supported by reablement services had no immediate ongoing care needs and 21% had reduced care needs. This demonstrated a positive direction of the reablement and intermediate care services, as most people were benefitting from the services.

There were examples of positive outcomes for people when supported by reablement services. A staff team told us personalised reablement plans were created based on the person's own wishes and goals. In a positive example of reablement use, a staff team told us about the reablement service working with an existing care provider to support a person to work toward new independence goals. The person had remained in the same condition for a prolonged period but had decided they wanted to improve their independence. This led to reablement involvement with the person showing improvement in their condition.

The reablement service did not include OTs, with a leader telling us the service was not therapy-led. Staff told us there were previously OTs based within reablement, but positions remained vacant after staff had left the team. The reablement service made referrals to OTs in other frontline teams, which were said to be very short-term interventions, or if appropriate, utilised the health OT community teams. There were trusted assessors within the reablement services who could provide low-level equipment which helped to reduce the need for referrals to other OT services. A senior leader also told us there were plans for a fully integrated therapy-led reablement and intermediate care service. They told us OT vacancies were mitigated using health and social care OT colleagues and they felt the current structure was not problematic. There remained, however, the opportunity for more embedded therapy within the reablement service.

National data showed reablement and intermediate care pathway use was a continued area of development. The Adult Social Care Outcomes Framework (2023-2024) showed 1.07% of people aged over 65 received reablement/rehabilitation services after discharge from hospital. This was significantly worse than the England Average (3.00%). Despite this, a partner told us they felt this may not have been reflective of use of these pathways and could have been a data issue. Another partner also told us reablement flow for discharge was working well. In response to ASCOF data, the local authority provided additional data which suggested a higher proportion of people using reablement pathways, which was more in line with partner feedback.

There was increasing use of intermediate care and reablement pathways to support people's independence. The local authority had invested in increased capacity of the intermediate care beds. A partner told us the intermediate pathway was a strength for the local authority and the pathway worked well. The local authority used their in-house services, 'Cumberland Care', to provide intermediate beds, which coincided with increased use of the pathway. From monthly data submitted by the local authority between April 2023 and December 2024, there was a clear trajectory of increased intermediate care placements per month from hospital discharges.

Data provided by the local authority in September 2025 also highlighted 97% of people using the intermediate care service returned home with an average length of stay of approximately 19 days. This showed how the intermediate service promoted people's independence.

The local authority had also invested in increased capacity for the reablement pathway. People discharged from hospital who were new to adult social care, or had a change in need, accessed reablement. Data provided by the local authority showed an increase of 51% in reablement capacity compared to 2023. While a staff team told us sometimes people who did not have reablement potential accessing this pathway could take up staff capacity, the local authority used this as an opportunity to support people to access the right level of ongoing care. This reduced the risk of providing too much support for people. Following accessing the reablement pathway, reviews were completed within 48 hours for staff to assess if people required reablement ongoing or were moved onto interim care while a long-term care package was sourced. When there were increased capacity pressures, staff told us they worked closely with health colleagues, who supported if required.

Reablement had also seen an increase of use, particularly from hospital discharges between April 2023 and December 2024. The local authority had plans to further expand their reablement offer, especially for step-up care from the community as part of their Achieving Excellence Plan. Improvements to pathways were supporting more people to be discharged from hospital and to regain independence.

Access to equipment and home adaptations

Access to equipment was not always timely. People faced delays to OT assessments and delivery of equipment. Those at the highest risk were prioritised.

Local authority data showed, as of June 2025, there were 219 people waiting for OT assessments with a median wait of 27.02 days and maximum wait of 133.98 days for the previous 12 months. There were also 185 people waiting for equipment, with a median time of 6 days and a maximum wait of 136 days for the previous 12 months. This demonstrated potential waits for people in accessing assessment and support.

The local authority used a Better Care Fund (BCF) funded community equipment service (CES) to support people to access equipment. A leader told us there had been problems in getting people the equipment they needed. They told us there were gaps in the service and unprecedented demand and there was a need for more funding. They told us people with technical expertise had left the equipment service following the Local Government Reorganisation and there had been a closure of a third-party equipment provider in the West of Cumberland in 2024. Staff teams told us when an item was not in stock, there could be waits for people except for urgent need.

The local authority employed waiting well procedures for OT assessments and equipment. The highest priority referrals meant people were contacted within 2 days, for example. People were also reprioritised if their needs changed and staff took steps to mitigate risks for people while they waited for assessments and equipment. Staff teams told us sometimes they needed to be creative, and they did keep some equipment in the office such as slings and bed management equipment. Staff also utilised health colleagues for some equipment in emergencies. There were systems to support oversight of waits for assessment and equipment.

The local authority had acted to reduce delays to OT assessments and equipment. For example, the local authority was utilising mobile and static clinics. Mobile clinics involved visits to more remote areas so multiple arranged assessments could be completed and equipment provided immediately where possible. Static clinics were an alternative to the conventional waiting list for people with lower-level equipment needs. Clinics were held regularly and a senior leader told us they were popular. A staff team shared a person's positive experience following a visit to the clinic, where further needs were also identified and referrals made to other services. While static clinics were not accessible for some people, due to location and transport needs, it offered some people the opportunity to have needs addressed more quickly.

There had been challenges in recruitment for the CES service but there was now said to be an improved position with positive proactive, knowledgeable management with OT experience in place. The local authority also highlighted a recruited service lead for the store supported a consistent and visible leadership approach. Staff also told us they worked closely with the equipment stores to reduce delays where possible. For example, a staff team told us there was a pilot where staff were working with the equipment store to gather stock and spare parts and a further working group to gather information on understocked items. A leader told us, however, they were concerned staff were losing time as they were spending time chasing delays in equipment delivery for people.

The local authority was also completing a review of the CES as part of its transformation, with plans to improve the operational efficiency. The review had found some of the demand coming to the equipment store was outside the available stock catalogue. A multi-agency review group had been established to update the stock catalogue and future funding arrangements outside of the BCF to support adequate resources.

The local authority was monitoring timeliness of equipment delivery and equipment collections when it was no longer needing. Data showed some improvements in this area, with an 84% rate of equipment delivered within 7 days for May 2025 (as compared to the previous quarter rate of 76%). Equipment collections were being collected within 7 days 57% of the time in May 2025 as compared to 51% the previous quarter.

When people accessed assessments, equipment and minor home adaptations, this supported them to maintain their independence and continue living in their own homes. For example, a person told us an OT had brave discussions with them about future plans and about promoting their independence. Another person told us equipment had been a big help in their life and enabled them to become more independent inside the home.

The local authority was also working with partners to help support prevention. For example, there had been targeted work with a local prison, with OTs providing training and advice on moving and handing as the prison had an ageing population. A senior leader told us this had resulted in no new referrals for people in the 10 months following this, helping to reduce need to access services.

Performance in providing major adaptations for people through Disabled Facilities Grants (DFGs) was an area of strength. From data provided by the local authority, for quarter 3 of 2024/2025, 100% of DFG cases progressed from complete application to approval within the 6 months statutory target. The local authority also highlighted high satisfaction scores from people (94%). Staff told us improved relationships with housing was also supporting DFG performance. They told us there had been changes to the way DFG was managed since the forming of the Cumberland Home Improvement Agency and adaptations under £10,000 were no longer means tested, which supported flow.

Provision of accessible information and advice

The local authority had a focus on improving the provision of information and advice on their rights under the Care Act and ways to meet their care and support needs. This included unpaid carers and people who fund or arrange their own care and support.

National data showed accessible information and advice was a continued area for development for the local authority. For example, the Adult Social Care Survey for 2023/24 showed that 61.88% of people who used services found it easy to find information about support. This was somewhat worse than the England average (67.12%). The Survey of Adult Carers in England for 2023/24 showed that 59.92% of carers found it easy to access information and advice. This was similar to the England average (59.06%). This suggested there were still large proportions (over a third) of people and carers who felt information and advice could be more accessible.

This was also reflected in some mixed feedback from people and carers. For example, a carer told us they wished more information was available to them about all services, but they were aware they could contact the commissioned carer's service for information and advice. A person also told us they were not initially aware of some community-based services, but when they spoke to the local authority, they were given information around this.

There was a focused resource in development of both the pre-front door and the front door within the Transformation and Service Improvement Plan (2024-2026). The local authority had invested in an external consultant, which a senior leader told us was supporting improvements to the front door and supporting development of the prevention model across the adult social care pathway. Transformation at the pre-front door included targeted improvements to the website to support people to better self-serve and provide self-assessment options. This was in the development stage, with a staff team telling us a self-assessment tool pilot needed to be refined to capture better information as more information was needed from people to support decisions on priority and risk. There had also been a recent alignment of customer services with revenue and benefits, and library services, which came under the Public Health directorate. A senior leader told us this was the development of a 'prevention service', which would explore with people whether they needed other preventative support beyond their initial contact.

Staff and leaders were mindful of the potential of digital exclusion for people when accessing information and advice. The local authority utilised local media, community settings and community groups to share information with people. There were also community hubs pilots, which brought together a range of co-located services to support people in their local communities and provide face-to-face information and advice on areas such as health and wellbeing, employment and adult learning courses. The local authority shared the positive impact of this approach for a person, where they were able to access further VCSE support for their needs. While each of these developments presented opportunities to better embed prevention, the impact of these approaches was not yet clear. Leaders told us there would be an expansion of the hub approach over the next 12 months.

The local authority had invested in improving their information and advice offer for unpaid carers. The local authority had commissioned an online partner to increase their reach to carers and since its launch, the partner had actively engaged with 2024 carers. Of the people accessing this service, 49% were in rural areas and 82% had not accessed support before. A staff team told us this service was a positive approach, especially because carers could access information and advice 24/7.

Direct payments

The local authority recognised direct payment uptake as an area for development. A leader told us uptake was an area the local authority needed to work on. They told us this was partly a legacy issue with the previous local authority organisation, but they felt the local authority could have been clearer with its messaging. A staff team also told us they felt the direct payment process could be a lot of paperwork for some people and could be overwhelming meaning the person may not complete it.

National data from the Adult Social Care Outcomes Framework for 2023/24 showed that 19.20% of people who used services received direct payments. This was worse than the England average (25.48%). Data also showed that 29.59% of people using services aged 18-64 received direct payments. This was somewhat worse than the England average (37.12%). This was consistent with people who used services ages 65 and over, with 9.72% receiving direct payments, which was also somewhat worse than the England average (14.32%).

Current systems meant initial conversations about direct payments were undertaken by frontline staff, while the brokerage service provided an administration function around direct payment accounts. Staff signposted people to a VCSE organisation, who gave people support to set up and manage direct payments, including support to identify personal assistants. A third-party website provided a list of micro enterprises working as self-employed personal assistants for people.

Staff and partners told us how direct payments were used creatively to support people and unpaid carers. For example, staff teams gave us examples of where direct payments had been used to help purchase equipment, including a recliner chair and a handrail which matched people's preferences. Another person with sensory impairment used their direct payment to support them to access specific computer software and updates. A partner also told us how a direct payment was used to support a person to access a community activity, although this solution was led by the partner and not the local authority.

As of 30 January 2025, over the preceding 12 months, there were 113 people who ended their direct payments. Of the 113 people who ended their direct payments, 102 ended direct payments to receive further, alternative services. Other people's direct payments ended due to the end of the service, moving to another area, self-funding or declining their service.

Direct payment systems and oversight were included in the local authority's Transformation and Service Improvement Plan 2024-2026, but this was in its early phases, and it was not yet clear what a new model might look like. National data on direct payment uptake was being used as a performance measure for improvements.

Equity in experience and outcomes

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act functions; there was an equality objective and an Equality Diversity and Inclusion (EDI) Policy Position which aimed to improve the experiences and outcomes for people who were more likely to receive poor care outcomes. Beyond the scope of the Equality Act (2010) protected characteristics, the local authority had also formally recognised care experience (young people who have left children's social care services) as a protected characteristic to support these people to be protected from discrimination.

The local authority understood and sought to address inequalities which impacted on people. Cumberland presented with some unique challenges, due to the size and rurality of the area, with local authority data showing 51.7% of people classified as living in rural areas (compared to the national average of 17.1%). A partner told us it was an area of sharp contrast between wealth and deprivation across areas, with high unemployment levels in Western areas and an increasing multi-cultural population. The EDI Policy Position also outlined the ethnic minority population had increased by 44% between 2011 and 2021, but this remained low at 5.1% overall (Census, Office of National Statistics, 2021).

Staff and leaders told us of the challenges and barriers for people due to the geography of Cumberland. A senior leader told us, for example, availability of services in different areas could be a 'postcode lottery', with in-person services not being available to all. The Joint HWB strategy (2023-2028) also highlighted access to services as a barrier for people in rural areas. Millom, at the Southern tip of Cumberland, was frequently mentioned by staff and leaders as an example of a rural area at risk of being isolated from services. Millom's geographical location and inclusion in a different Integrated Care System (ICS) to the rest of Cumberland presented challenges for staff and leaders, but there were processes to maintain them as part of strategic conversations. The local authority Market Position Statement (2025-2029) also recognised local gaps for Millom, such as nursing services and day opportunities, for example. In response to these challenges, the local authority stated they were actively demonstrating Millom was being well served, with increased homecare uptake, as well as a residential service and an extra care housing service available locally. Despite this, equitable access to local services remained a challenge for some people.

The local authority had processes to support considerations of EDI during decision making but there was opportunity to better embed this in adult social care. A combined equality impact assessment tool was used to consider how decisions impacted on communities, and this was part of the commissioning procurement process. However, a leader and staff told us there was need to further embed EDI consideration in commissioning decisions, with for example the need to better use equality impact assessments. While there was consideration of EDI during tender processes, this was an area for development to consider impact on people.

A new EDI in Adult Social Care and Housing Action Plan (2025-2028) had launched in July 2025 as a foundation to develop EDI understanding, tools and approaches. The plan was based across themes of the local authority's equality objective: "To tackle discrimination and advance equality of opportunity within Cumberland." This gave actions specific to the Adult Social Care and Housing directorate and demonstrated its focus on EDI across Care Act duties. This was the local authority's first plan of its kind and in its early stages, so the impact of this approach was not yet embedded but showed a positive direction.

The local authority was developing its approach to using data to support EDI oversight, recording and analysis. For example, leaders highlighted client-level EDI data had not always been recorded effectively, but new case recording standards highlighted the importance of this for staff. The EDI in Adult Social Care and Housing Action Plan (2025-2028) also outlined the need to use data to identify any themes relating to inequality, to review the impact of services and identify work required to improve approaches to addressing inequality. While there was a broad understanding of who was accessing services, with a leader telling us about demographic trends of people accessing adult social care, improved data collection and quality was needed to support effective oversight and to plan services appropriately. The local authority continued to develop its understanding of who was accessing services to better tailor support for communities.

There was ongoing work to better understand health inequalities, with the local authority securing funding through The National Institute of Health Research to develop research in this area. A leader told us the Health Determinants Research Collaboration (HDRC) would help the local authority to better understand the health issues in the area with key focus areas of poverty; access to housing; pathways to employment; mental health; drug and alcohol use; obesity and food insecurity. This research would include the use of community co-researchers with lived experience between 2025-2027 and again showed the positive direction of the local authority in developing in-depth understanding of inequalities.

The local authority understood which groups were at risk of unmet needs in Cumberland and an approach to engagement and supporting these groups effectively was still being embedded. A 'Stakeholder Map' highlighted a wide range of people at risk of unmet need such as asylum seekers and refugees; Gypsy, Roma and Traveller communities; neurodiverse people and people with learning disabilities; lesbian, gay, bisexual and transexual people (LGBTQ+); isolated or socially excluded older adults and substance use and recovery communities. The document did, however, group the Black, Asian and Minority Ethnic population (BAME) which could mask the needs of people of different backgrounds under this banner. Despite this, the document demonstrated broad oversight of different seldom-heard groups locally.

There was a need to better engage with some seldom-heard communities, with the local authority taking steps to address this. A senior leader told us, for example, they recognised the need to improve engagement with ethnic minority communities. As part of the EDI Adult Social Care and Housing Action Plan, and as outlined in the Stakeholder Map, the local authority was developing approaches for engagement with groups. While this was currently more high-level, it gave an overview of plans to both engage and reduce inequalities for a range of communities.

The local authority had examples of engagement with communities across Cumberland to help better understand inequalities and barriers, but evidence of impact of these approaches were not yet embedded. For example, in a localised approach, there were community panels across Cumberland to gather local peoples' voice for their distinct areas. A senior leader told us this was supporting the development of local neighbourhood plans and to break down barriers for seldom-heard groups. The local authority also worked with the VCSE to understand and work with communities. For example, Healthwatch had been commissioned to engage with communities through 'neighbourhood cafes' and complete projects such as 'Ageing Well in Cumberland' (April 2025), which engaged with over 600 people across 15 towns. The Ageing Well project highlighted the inequalities older communities faced across Cumberland with clear themes and recommendations for the local authority to consider. The wider impact of this work was still embedding.

There was ongoing need to ensure people had equitable outcomes when accessing local authority services. For example, people with learning disabilities were experiencing some of the longest waits for annual reviews and this showed inequitable outcomes for these people. Action was being taken to reduce long waits for reviews for people with learning disabilities and an update from the local authority confirmed the longest waiting outstanding reviews had been completed by the end of July 2025.

The local authority was supporting the needs of asylum seekers and refugees. The local authority had recently passed a motion to join the 'Cities of Sanctuary' network and work toward the local authority sanctuary award. This involved increasing the voice of these communities, working with relevant community organisations, improving community cohesion, improving their health outcomes and reducing discrimination to accessing services. A senior leader also told us there were processes to support referrals into health, social care and housing services to support people with their needs. A partner also told us there had been positive work with the local authority to set up mental health services for this community. In a positive example provided by the local authority, a refugee with a physical disability was supported in a trauma-informed and personalised way by staff, overcoming language and cultural barriers to access better healthcare, housing and support for social inclusion. The local authority continued to strengthen its support for these groups to help reduce inequalities.

The local authority supported staff with a range of training around EDI to help to reduce inequalities for people accessing services. The training offer included a mix of face-to-face and online training and included specific areas such as EDI; cultural awareness; dementia awareness; sensory awareness; disability inclusion; trans and non-binary inclusion in practice; learning disabilities framework tier 1 and LGBTQ+ inclusion.

Staff gave examples of supporting people from seldom-heard groups, from a mix of backgrounds, such as from rural, or socially isolated areas. Some staff teams also gave examples of where they supported people from ethnic minority backgrounds. In an example, a person from an eastern European background was supported to access community groups to help them develop links with a local community. In another example, a person's personal care preferences were considered and met based on their cultural background. This supported people to achieve positive outcomes with reduced barriers to their care and support.

Inclusion and accessibility arrangements

The local authority had inclusion and accessibility arrangements in place so that people could engage with the local authority in ways that worked for them, but this could be inconsistent.

There were interpreter services available to staff over the phone, through video call or in-person. There was mixed feedback on interpreter availability. For example, a senior leader and a partner felt there needed to be better interpretation resources to support asylum seekers and refugees. Staff teams told us they could usually get interpreters, but this may be over a call rather than in person. There were also occasions where staff used other staff members as interpreters for people. This was not considered best practice, but staff felt this was the best approach in some specific circumstances. Another staff team told us provision of interpreter services were increasing to support staff to access local interpreters, but this was a continued area of development.

In response to feedback about lack of interpretation resources to support asylum seekers and refugees, the local authority highlighted interpreter resource was available through its commissioned partner and its Global Resettlement Service (GRS) for these people.

Feedback on availability of British Sign Language (BSL) interpretation was also mixed. A partner told us people with hearing impairment had told them of their struggles in accessing BSL interpretation. A leader told us BSL interpreters were available to people but there could be challenge in access as there were only 3 interpreters currently used in the West of Cumberland. They told us there was ongoing co-production work with the deaf and hard of hearing community to look at this resource. The Equality, Diversity and Inclusion in Adult Social Care and Housing Action Plan 2025-2028 also included a planned ‘deep dive’ focus on the deaf community.

The local authority had systems to make information more accessible for people, but this was an area for development. For example, easy read material was not consistently available for people to support them to understand processes and documentation. A staff team told us they would mostly source their own easy read information to support people they were working with. A partner also raised easy read versions of assessments and support plans had not been made available to people. There were, however, systems to support people who were visually impaired, such as through larger print documentation or braille. This was not always consistently applied, with a person telling us, for example, they had not received a copy of their assessment in larger font despite it being identified as an accessibility need on their assessment. There was opportunity to better support accessibility to information and processes.

The local authority supported staff with inclusive practice. For example, they provided an inclusive language guide which helped staff to create a welcoming environment for people, with a focus on people's protected characteristics. A recent local authority thematic audit for April and May 2025 highlighted people's specific communication needs were being considered as part of assessments.

There was opportunity for the local authority to ensure their approach to supporting autistic people was inclusive. A partner told us local authority systems did not always recognise the needs and challenges of autistic people. For example, they told us staff did not always understand autism when it was present without a dual diagnosis with a learning disability and this could be a barrier to accessing services and meant assessments were not always appropriately tailored to them. A staff team also told us they felt they would benefit from further training to support their understanding. In response to this, the local authority told us staff were being supported with level 1 and 2 training around autism. They also told us there was a range of resources, practice tools and guidance to support staff. This included a LeDeR (Learning from Lives and Deaths –People with a Learning Disability and Autistic People) workshop around supporting autistic people.

People with visual impairments were supported to be included and access information and service. The local authority had an in-house ROVI (Rehabilitation Officer for Visual Impairment) service. ROVIs provided a range of services for people including equipment and adaptations, specialist orientation, braille training and mobility training to allow people to access communities and public transport. They also provided training for OTs and social workers. A leader told us the service had an amazing impact for people and supported prevention. The service had strong links with the VCSE sector. In an example provided by a staff team, a person had been supported with long-cane training by the service, which supported them to improve their confidence and go back to work. The ROVI service supported people to maximise their independence and raise the profile of supporting people with visual impairments.

There was ongoing work to improve accessibility of website information. A leader told us the website was being reviewed to support compliance with accessible information standards. There had also been input from the ROVI service to support accessibility of information, with improvements ongoing.

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: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand 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 was developing its approach to working with people, local stakeholders and using data to understand local care and support needs.

The local authority had recently launched its first Market Position Statement (2025-2029) which gave a clear overview of trends in the local population which might impact on local need. For example, Cumberland's 'super-ageing' population was highlighted, with an expectation of a 35-40% increase in people over 65 unable to manage at least 1 activity on their own or admitted into hospital due to a fall, by 2040. The statement also gave market strengths, challenges and gaps, broken down by local areas, which supported a localised view of the market. This localised view was also reflected in feedback from staff and leaders, with a staff team telling us rurality drove the local authority's approach to commissioning, which was locally based to respond to the issues of specific communities. This focused approach was beneficial for understanding the market due to the size of Cumberland and market differences across areas.

The local authority was developing its use of data to support understanding of local need. For example, a senior leader told us the Joint Strategic Needs Analysis (JSNA), which supported with data oversight of local need, was out of date but was being developed to better focus its scope for adult social care. In an example of data gathering to map future need, a staff team told us of a planned project to forecast residential care demand. They told us they currently used historical data, however, the local authority now wanted to enhance their approach, by using data such as from health partners to support a strong forecasting model. Strengthening data use presented an opportunity for enhanced understanding of local need.

Stakeholder and people's input was also supporting market oversight, but this was still embedding. For example, the local authority had introduced a quarterly regional care managers forum (CRCMF), alongside Skills for Care, to gather provider voice around the local market. There was some mixed feedback on the effectiveness of provider forums from providers, but they were said to be improving. Providers also gave mixed views around whether they were consulted around the needs of local people, with some feeling they were and others not. A partner also told us they had been asked by the local authority to support information gathering from people about gaps in local services and what they felt was needed before services were set up. This aligned clearly to the local authority's direction in including stakeholder and people's voice to support local understanding.

There was use of external resources to help understand current and future local need. For example, the local authority commissioned the Housing Learning and Improvement Network (LIN) to undertake an assessment of the future need, over the next 10-15 years, for specialist and supported housing and accommodation. This supported the planning of future strategies, such as the housing strategy and the supported housing strategy. The local authority was using resources to support understanding and to plan appropriately for future needs.

Market shaping and commissioning to meet local needs

The local authority was developing its approach to commissioning to meet local needs. With the recognised challenges of the Local Government Reorganisation (LGR) in 2023, the local geography and demographics of Cumberland, such as the 'super-ageing' population, a commissioning strategy had been drafted to help outline the local authority's strategic commissioning priorities. The strategy was due to be imminently published at the time of the assessment and outlined the local authority's intentions.

Despite local challenges, national data showed people had access to choice. The Adult Social Care Survey for 2023/24 showed that 89.58% of people who used services felt they had choice over their services. This was significantly better than the England average (70.28%).

The local authority was early in its strategic journey with key strategies still under development. Despite this, there was an aligned strategic focus evident across strategies. The new commissioning strategy had been developed in line with the Market Position Statement, the Housing Strategy, the draft Extra-Care Housing Strategy, the draft LIN Supported Housing Study and the draft Unpaid Carers Strategy. From the draft strategies reviewed, there was a focus on commissioning to promote independence and keeping people in their own homes, which was also in line with the wider Council Plan which included a focus on prevention and early intervention. Staff feedback also reflected a consistency in this approach, with a team telling us for example, planned new homes would include 'future-proofing' elements so they could be suitable for older people with mobility needs. This showed a consistent approach to shaping both care provision and housing for population need.

The new commissioning strategy set out the local authority's priorities, which included market shaping activity such as increasing supply of housing with care options, such as extra-care, expanding 'complex' care access and choices including dementia care; transforming and streamlining equipment services, and transforming day opportunities to support choice and independence. There was also a focus on using outcome-based commissioning by ensuring service specification and tendering included strength-based approaches. This was recognised by the local authority as a continued area of development. Priorities were reflective of local need and showed the direction of the local authority, with action plans due to be developed within 6 months of the strategy being launched.

There was a strategic focus of the need to increase housing with care options to meet local needs. This was being supported by findings of the LIN Supported Housing Needs Study and the draft Supported Housing Strategy which was due to be completed in December 2025. Some the findings, which were due to form the basis for strategic priorities, included: the need for further extra care housing development; the need for supported housing for people with learning disabilities, autistic people and people with mental health needs; the need for fully adapted homes for those with physical disabilities, and supported housing for younger people. These were all potential long-term developments but mapped out the direction of the local authority in shaping housing with care.

The local authority used both independent sector services and inhouse local authority services (Cumberland Care) to support people. Inhouse services included residential services including respite and interim care beds, homecare services, shared lives and day opportunities. The homecare service included both a reablement team and a domiciliary care team.

Cumberland Care was undergoing a review to better meet strategic priorities. A senior leader told us there was a vision to specialise inhouse services to help fill gaps in the market. For example, inhouse residential services were reviewed to see if they could meet local need such as dementia care, intermediate care and respite care. This involved the closure of a residential service which was not suitable for these priorities, which allowed for the reprioritisation of funding. As a result of the first phase of the review, local authority data showed respite placements in Cumberland Care services increased by 25%, dementia service placements increased by 20% (compared to April 2023) and discharge to assess (D2A) placements increased by 20% during 2024/2025. There was also increased reablement and intermediate care bed capacity. The review was supporting the local authority to shape services to local need and to support people's independence.

There were inefficiencies to Cumberland Care. For example, following a period of reablement, people awaiting an assessment and/or required ongoing homecare would be placed on an 'interim' chargeable homecare service provided by Cumberland Care. They would remain on this service until homecare was found. This involved a change from reablement care workers to interim care workers, who were not the same care team. A staff team told us moving people to an interim service gave the local authority more time to source an independent sector provider, but people were sometimes unhappy to be leaving the reablement service. This also meant some people would be supported by 3 different care teams across their care journey, increasing handovers between services, which risked impact on personalisation and quality of the services provided.

A senior leader told us the directive for staff was to limit the use of interim care as much as possible and this was also reflected in the feedback of a staff team. However, a staff team told us interim care could be a 'bottleneck' for people waiting for services and delays could be caused by lack of capacity, rurality of the person's location, assessment delays and seasonal pressures. Data provided by the local authority on 10 July 2025 showed 39 people receiving interim care, with 14 of these people assessed for a new service and 25 awaiting assessment. The median time on interim care for these people was 60 days. There remained a need to better shape inhouse homecare services for people at the time of this assessment.

There were positive examples of market shaping since the formation of Cumberland Council. For example, the local authority used frameworks to support access and choice of local services. The homecare framework, for example, supported people to have a choice of care providers who had offered to take on their care package. Since its opening in April 2023, the local authority had supported the growth of the homecare market, enabling people to access more commissioned services. This promoted people's independence and wellbeing.

Access to services to promote independence in more rural areas had also been supported by market shaping approach. For example, the local authority had worked with Community Catalysts to support 'micro-enterprises'. Micro-enterprises, which were spread across Cumberland, helped to provide activities and support to people in hard-to-reach areas where the standard homecare market may have struggled to meet need. A staff team told us this was a good system, and micro-enterprises were listed for people on a website. These were self-employed personal assistants, some of which could also provide personal care. Data provided by the local authority stated there were over 40 micro-enterprises in local communities, which had provided support to 252 people, where it had been challenging to deliver services previously. This demonstrated a creative approach to overcoming geographical obstacles to service provision.

Staff were supported by the brokerage service to source services for people, such as residential care and homecare. However, some staff told us they sometimes would have to source specialist or out of area services themselves. Staff teams told us this could create pressure on them as they were not always clear on prices to agree with providers, and it increased their workload. A team told us this was not a regular part of their work, but sourcing an appropriate service, checking quality and agreeing prices could be a challenge.

Ensuring sufficient capacity in local services to meet demand

People could not always access local care provision as capacity varied depending on their location within Cumberland. The local authority's Market Position Statement demonstrated an understanding of where there were gaps and strengths in service capacity.

The rural nature of Cumberland created challenges for some people to access timely homecare. This was dependent on where people lived, with more urban areas generally having better access to provision. Partners told us there could be waits for homecare, but a staff team told us there were homecare services which specialised in supporting people in rural locations. They told us the homecare framework also ensured new providers were aware of the rurality of Cumberland and were asked for assurances about being able to provide services. Data provided by the local authority for February 2025 stated the average wait time for homecare to commence was 7.6 days, which showed a more limited impact on people waiting.

Older adult residential services across Cumberland met demand, but specialist residential service access was more of a challenge for people. A person's assessment, for example, showed a person was able to access a local residential service, where their family could visit, which the person was happy with. However, the Market Position Statement outlined learning disability placements, mental health placements and dementia nursing placements were limited in areas of Cumberland. This could impact on people's choice of service, with a relative of a person telling us their loved one was placed a distance away as there was no local provision and they wanted them closer to them. Staff teams also told us there could be challenges in sourcing these types of placements for people, including when people were being discharged from hospital, such as from mental health inpatient settings. They told us, however, they worked with partners to minimise delays in discharges. People could therefore not always access specialist local provision easily.

Local authority data showed most residential and nursing placements were made within 14 days, but some people could face longer delays. Between October to December 2024, 161 placements were made from a hospital setting to residential and nursing care homes. Of those 161 placements; 69 were made within 7 days, 53 within 8-14 days, 33 within 15-28 days and 6 over 28 days. In the three months from October to December 2024, there were 46 placements made from the community to residential and nursing homes. Of those 46 placements; 24 were made within 7 days, 7 within 8-14 days, 11 within 15-28 days and 4 over 28 days.

The local authority had provision of day opportunities, with both in-house and independent sector services, but there were gaps in this area. Staff teams and partners highlighted people with more complex needs, young people and autistic people, did not always have access to appropriate day opportunity provision. A staff team told us people sometimes had to go into residential respite instead if they could not access day opportunities. The distance some people had to travel to access day opportunities was also highlighted as challenging. A staff team also told us there was recognition of a high spend on transport to support people to access opportunities as there was not always local availability, and there were plans to better stimulate provision in areas where it was needed.

The local authority acknowledged there had been some challenges for people newly accessing services in the West of Cumberland. Providers had ongoing recruitment processes to support increased demand for requests for support. The new commissioning strategy also outlined a new day opportunities framework with improved access to employability and skills programmes and opportunities for providers to arrange their own transport. The framework had recently gone live and extended the day opportunities offer to also include a 24/7 model, with day opportunities now available during early mornings, evenings, weekends, and bank holidays. This sought to address challenges and better personalise support for people.

Housing with care options, such as extra care and supported living, were recognised by the local authority as gaps but there was ongoing work to increase this provision. A senior leader told us there was ongoing work to increase extra care provision, but a staff team told us people could be waiting prolonged periods to access this and could end up in residential care. Commissioning of new supported living properties was a particular challenge as there was a lack of appropriate local housing stock to meet specifications. Staff teams told us supported living properties for younger people trying to build their independence, including those with mental health and substance use needs, were difficult to access locally. The upcoming Extra Care Housing Strategy sought to address a lack of housing with care options, but current provision could be a barrier to strategic objectives of reducing the need of residential care home services and promoting independence.

Unpaid carers did not always have readily available access to breaks. Some partners told us there was a shortage of respite provision. They also told us people who self-funded their provision were more likely to be able to access regular services than those who accessed respite through the local authority. This was in line with some carer feedback. A staff team told us they encouraged people and their carers to book respite provision well in advance as services were often booked up. A staff team also told us there was a set offer for respite of 4 weeks which could be used flexibly by carers, who were said to be reassured the offer was there and they could book respite flexibly directly with providers or through the brokerage service. Staff teams were also creative to find solutions when there were difficulties accessing respite. For example, a staff team told us how a direct payment was used to support a person to go on holiday with their family with support in place as they could not access respite initially. Shared lives, personal assistant support or out of area respite were all also used if appropriate.

National data reflected some of the challenges for carers accessing respite or breaks. The Survey of Adult Carers in England for 2023/24 showed 5.12% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency. This was worse than the England average (12.08%). The survey also showed that 9.44% of carers accessed support or services allowing them to take a break from caring for more than 24 hours. This was somewhat worse than the England average (16.14%). This showed most carers were not accessing services to take short term breaks from their caring roles.

In response to concerns raised about respite, the local authority outlined respite provision had been increased by 25% and provision was spread across Cumberland. Data provided by the local authority showed 30% of respite capacity was used between 01 April 2025 and 31 August 2025, which left 70% available for people. BCF funding for 2025/2026 for respite had also doubled internal Cumberland Care respite capacity to 8 beds compared to 2024/2025. BCF funding also supported beds to be ringfenced for pre-planned respite, as well as emergency respite if available.

The local authority followed Northeast Association of Directors of Adult Social Services (NE ADASS) protocols for placement decisions out of area. Staff teams told us people were placed out of area as a last resort and when people were placed out of area, where it was not their choice, they supported people to move closer to home when possible. As of February 2025, 118 people were placed out of area, with 16 made in the 12-month period from January 2024 to January 2025. Of the 118 out of area placements; 42 were due to the persons choice, 44 specialist needs, 7 lack of capacity in the sector and 25 were made out of area as a result of LGR in 2023.

Ensuring quality of local services

The local authority had clear arrangements to monitor the quality and impact of the care and support services being commissioned for people and it supported improvements where needed. This included dedicated resource for both independent sector and inhouse service provision.

The local authority was responsive to risk in services and worked with care providers to make improvements. For example, where there were quality concerns about a provider, a provider could enter the Quality Improvement Process (QIP) where the local authority would work with the provider and partners to address concerns and support improvements. This helped the local authority to maintain oversight of provider performance and improvement. The local authority also worked closely with providers and could place embargoes on placements where required, but they tended to work with providers and agree voluntary embargoes with them instead. Where embargos were in place, all new care packages were suspended, rather than just local authority commissioned placements. This was a robust approach to protecting people from potential risks while improvements were made.

While there was a dedicated quality assurance and governance team, the team was currently more reactive to concerns and was limited in making proactive visits to care providers. There was an aspiration to visit all care providers at least once every 2 years, but a staff team told us this was more of a 'desktop' exercise as an interim measure due to, in part, staffing pressures. Some providers also told us they had not had recent quality visits, but a provider who had received a recent visit told us this was a positive experience and felt like a partnership. The local authority remained responsive to risk, however, with targeted visits where there were concerns.

The local authority collected information from partners and people to support oversight of the quality of services. For example, a staff team told us there was a form for partners to share information where there were concerns about services. A regular 'RADAR' meeting also supported the local authority and partners to flag if there were concerns about a provider and supported joint decisions on which agency would take action to help improve the service. A staff team also told us frontline workers were encouraged to collect information where there was a change of provider request in case there were concerns about the services provided. The local authority also used people's voice to support quality assurance of providers. A staff team told us Healthwatch had gathered people's opinions on services on behalf of the local authority to support their processes. This supported oversight and quality of services as the local authority could respond to concerns.

As of January 2025, 2 homecare providers had agreed to voluntary embargos in the previous 12 months. The reasons for the suspension were concerns about quality, management and leadership, staffing, and concerns raised by stakeholders. Between January 2024 and August 2024, 5 residential providers agreed to voluntary suspension of placements. The reasons mainly related to concerns about the quality of care provided, safeguarding, staffing and management and leadership issues. Embargos were used to support improvements to care quality and to help people stay safe.

Quality monitoring of out-of-area services continued to develop. As there was a large backlog of annual reviews, there was a risk of a reduced oversight of the quality of services provided for people placed out of area, unless the local authority were informed by the host authority. The local authority, however, had recently signed off on using a 'Host Protocol' which was an agreed monitoring system for out-of-area placements across multiple local authorities within the region. A senior leader told us this was still being operationally established but would support the monitoring of safety and quality of people within services outside of Cumberland.

Ensuring local services are sustainable

The local authority was due to refresh their Market Sustainability Plan (2023), so it aligned with their recent Market Position Statement. The most recent plan was also before LGR changes, although it did include information specific to Cumberland.

The local authority used funding from the Department of Health and Social Care (DHSC) Market Sustainability and Improvement Fund (MSIF) to increase the fees paid to providers. The Commissioning and Procurement Risk Register outlined there had been engagement with the local market around their uplift for 2025 to support the sustainability of the sector.

There were financial pressures on the local market which put sustainability at risk. This included inflationary pressures, higher wages and increases to national insurance. Some care providers told us provider fees from the local authority were not supportive of their sustainability, as although they had received a recent uplift, this did not cover the increase in their costs. They also told us there could be delays in the uplifts, which risked their ability to fund their services.

The local authority took steps to support providers financially, such as through an in-year uplift for residential services and uplifts in response to inflationary and national insurance pressures. There were also price bandings based on level of need in residential care. The local authority highlighted rates for homecare providers were designed to enable providers to pay the real living wage to help attract and retain a skilled workforce. The local authority also used price bandings for homecare based on how rural the area was. The local authority continued to support providers with their sustainability, but there remained challenges in a difficult financial climate.

Similarly, the local authority's inhouse services, Cumberland Care, were also facing financial pressures. As part of their ongoing review of Cumberland Care, the local authority was completing their asset reconfiguration, rationalisation and investment to support the sustainability of these services. There were projected savings over and above estimates which would support long-term sustainability of these services.

Recruitment was a key challenge for local providers. Most providers told us it was difficult to recruit enough staff. A partner told us some more specialist services, such as those for mental health or learning disability needs in the West of Cumberland, were particularly fragile because of issues with staff recruitment. Most providers felt the local authority was not supporting them with their recruitment. Providers were using overseas workers to fill gaps in their recruitment and a staff team told us there was engagement and monitoring from the local authority as there needed to be enough work for providers to sustain this model of recruitment.

The local authority recognised the recruitment challenges of providers, and this was reflected in senior leader feedback and within the Market Position Statement. In response to these challenges, the local authority was promoting dialogue about recruitment challenges within provider forums, promoting ethical overseas recruitment, promoting the use of technology to streamline tasks, promoting the providers using the real living wage, supporting the development of an adult social care workforce strategy and partnership working with Skills for Care to provide training and support. There were also specific schemes to support workers to access employment. For example, a displaced care worker scheme, which supported workers who had lost their sponsorship to connect with potential care provider employers who had Home Office sponsorship status.

The local authority adopted commissioning frameworks to help support stability and sustainability of the local market. For example, frameworks supported agreed pricing structures with providers; market stability through longer term contacts and demand planning; streamlined procurement and encouraging improvements and innovation through mini competition between providers. There was some feedback from care providers, however, frameworks did not always support sustainability. Some providers felt there were too many services on the homecare framework making it more difficult to acquire care packages and there had been an increase in non-local providers which made competition a challenge for smaller providers. This was also reflected in a staff team's feedback, who told us some providers would contact them asking for more care packages, but the local authority were required to follow their framework process. The local authority had recognised the number of providers on the homecare framework and had closed it to new providers to support market sustainability.

There was some provider feedback that commissioned services could be better planned for providers. For example, they told us homecare was not always commissioned so providers could support people in similar areas to reduce the need for carer travel. This led to spread out care packages and there was a need for more oversight of this. A staff team, however, told us the local authority did have oversight of data around care packages being grouped more closely together. They told us they recognised it was unsustainable for care providers to only have spread out care and sought to support the providers with this.

Information provided by the local authority stated between January 2024 and January 2025, 47 homecare contracts were handed back totalling 548.25 hours. The reasons why packages were handed back were: the provider being unable to sustain care packages due to rurality; providers not accepting new home care rates; providers exiting the area and staff leaving their employment. No supported living contracts were handed back to the local authority in the same period.

For the same period, for residential and nursing home services, there had been a single residential provider home closure which resulted in 15 people needing to be moved elsewhere. The reason for the closure arose from concerns about the quality of care and the resultant actions taken by CQC to remove their registration. In addition, a total of 4 placements were handed back by a specialist care provider due to longer term sustainability issues because of staffing and location of the service.

The local authority, alongside Skills for Care was supporting providers to access training opportunities and best practice through their provider forums. In a positive example, a care provider told us there had been support for overseas workers to access training because of this being raised as an issue at a provider forum. There was also some provider feedback there was a continued need for more training for when supporting people with more complex care needs, which was increasing more recently. The local authority was continuing to embed support for local workforce development.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand 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 worked with partners to strengthen their relationships since becoming a unitary authority. This included working collaboratively to agree and align strategic priorities, plans and responsibilities for people in the area. This work continued to embed at the time of assessment, but aligned priorities were supporting positive outcomes for people.

There was recognition from the local authority of the complexities of partnerships with health. Cumberland spanned across 2 Integrated Care Systems (ICSs), with an ICS covering the majority of Cumberland and another covering a smaller Southern area. The North East and North Cumbria ICS, which covered the biggest area, also spanned across a large area outside of Cumberland. Leaders told us the local health structures increased the complexity of their partnerships but partnerships with health had strengthened over time. For example, a senior leader told us the local authority and health partners were making decisions together with improved processes and governance. They also told us the local authority was an active system partner, in the wider ICS.

There was strategic alignment between the local authority and health partners. The Health and Wellbeing Board (HWB) supported local strategic oversight, with membership from local authority leaders and key partners from health and the VCSE sector. The work of the HWB also supported a more integrated strategic approach with health. For example, the Joint Health and Wellbeing Board (HWB) Strategy (2023) was designed to complement the Integrated Care Board (ICB) Integrated Care Strategy. A priority of the HWB strategy was to develop integrated approaches to health, social care and prevention services. A partner also told us there was strategic alignment and good relationships with the local authority and this was built from years of working together.

A senior leader told us there had been a more recent alignment which was supported by a Health and Care Summit in 2024, which enabled a focus on shared priorities. The summit was attended by the local authority and key partners and the leader told us it represented a significant change in the nature of discussions and strategic direction. There was said to be a renewed focus on health and social care supporting independence and enabling people to remain at home. This was also reflected in a partner's feedback, who told us there had been a shift in focus to promoting people's independence when people were being discharged from hospital.

There were systems to support local place-based relationships, with the North Cumbria Integrated Place Board (NCIPB) and associated sub-committee supporting Cumberland-based health and social care partnerships to deliver wider shared strategic aims. A senior leader told us these arrangements supported relationships at the local level. A partner also told us the NCIPB worked well, facilitated relationships and allowed discussion of system issues between key partners. The Lancashire and South Cumbria ICB, which covered the Southern area of Cumberland, was also included in place-based conversations to support oversight and joined up working for people in this area.

The local authority was working with system partners towards shared goals. For example, the local authority had adopted the Housing, Health and Care Programme, which spanned across the North East and North Cumbria ICS, with the programme co-created by a range of partners, including the North-East Association of Directors of Adult Social Services (ADASS), the Integrated Care Board (ICB), the Northern Housing Consortium, and the TEC Services Association (TSA). This involved an improvement initiative focused on delivering better, more integrated housing, care, and support so that people could be healthy, live well, and stay independent in their own home. This included a pledge of better housing for people with 'complex' needs and older people. This demonstrated partnerships through a system-wide approach.

Arrangements to support effective partnership working

The local authority had governance and oversight arrangements to support the use of pooled budgets, such as the Better Care Fund (BCF). The BCF was governed as part of a Section 75 (s75) (NHS Act 2005) agreement between the local authority and ICBs. The Cumberland Joint Commissioning Board (CJCB) reported to the HWB in relation to the BCF. The CJCB was responsible for monitoring finance, performance and risk. A partner told us partnership arrangements and governance around the BCF worked well and supported discussions over any disagreements. These processes supported effective oversight and scrutiny of the use of pooled budgets.

The BCF was being used to support people's independence through a range of services and functions across Cumberland. For example, this included aspects of carers' support, home adaptations such as through DFGs, the community equipment services, intermediate care and reablement, discharge facilitation and low-level homecare support.

There was also close working between the local authority and the ICB to commission some services. For example, there had been an enhancement of the local authority's homecare framework to incorporate the delivery of Low-Level Health Care (LLHC) tasks on behalf of the ICB. This involved short visits to people's homes to support them with healthcare tasks such as taking their medication. This partnership approach supported people's independence at home.

The local authority worked with ICBs to support joint and health funding of people's care. For example, a leader told us local arrangements included a set 50/50 split of funding between the local authority and health for people eligible for Section 117 (s117) Mental Health Act (1983) aftercare. S117 aftercare refers to free aftercare for people who have been detained in hospital under the Mental Health Act and meet certain criteria when they leave. The leader told us the agreed split funding was an informal arrangement, and discussions were ongoing with partners about strengthening funding agreements.

Partners were also generally positive about operational arrangements around joint funding. Staff teams shared there could be delays with Continuing Health Care (CHC) funding conversations, but they had close operational relationships with health colleagues. In an example, a person was supported to access health funding and was able to access an adapted property with care and support to meet their needs. The local authority continued to develop partnership agreements to fund people's care and support.

The local authority had established partnerships to support service delivery and continued to pursue more integrated approaches with partners. For example, a transfer of care hub supported hospital discharges, which included both local authority and acute-based health staff. A partner told us the hub was established following challenges in discharge performance and these arrangements gave a better overview of discharges and strengthened relationships with the local authority. A senior leader told us the local authority was, in collaboration with partners, also moving towards a more integrated care model with health partners with the timeline for implementation still being established.

There were opportunities to review some working arrangements to support efficiency and reduce overlapping services. For example, hospital services within Cumberland used a 'Health Care Practitioner' (HCP) pathway to support discharges. This pathway supported people to return home and receive healthcare services from health staff with the aim of completion within 28 days. This was separate to the reablement pathway, and reablement could be accessed by people following the HCP. A partner told us the HCP had been commissioned during the Covid-19 pandemic, but there was a need to consider merging this with the reablement pathway and reduce hand-offs within the system. The BCF end of year report (2024-2025) also highlighted, on average, 50% of people remained on the HCP pathway on or over the designated 28 days. This was contributed to by delays in transfer to reablement pathways or in allocation and assessment of people by local authority staff. This was recognised as impacting patient flow and BCF resources were being used to support capacity and timely movement between pathways. The HCP and reablement pathways did, however, work closely to share capacity where required. The local authority continued to work with partners to support efficiency in discharge pathways.

The local authority was continuing to strengthen data sharing arrangements with partners. A staff team told us the local authority shared and received data from health, with an aspiration to strengthen this. In a positive example, the local authority had signed up to the Great North Care Record which would support staff to have up-to-date information about people they were supporting. Some partner feedback also reflected conversations about shared data collection systems to support some operational functions, with discussions ongoing.

Impact of partnership working

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

The local authority used data to support measurement of the impact of the BCF. The end of year BCF report (2024-2025) highlighted mixed performance across BCF metrics. For example, avoidable admissions to hospital and discharges to a normal place of residence showed the local authority on track to meet performance targets. The report highlighted step up in virtual ward capacity and intermediate care bed capacity supported this. However, falls and residential admission rates were not on track to meet relevant targets. The falls prevention activity included both health and local authority initiatives and this was due to be reviewed more closely by the HWB. While the report also acknowledged a higher than target residential admission rate, there was a year-on year-decrease in admissions, and this was seen positively given the local ageing demographic. The local authority continued to work with partners through pooled budgets to support independence and positive impacts on people.

Partnership working and funding was supporting people's independence. For example, a partner highlighted the shift of people returning home following hospital stays. They told us the use of bedded discharge pathways had reduced by around 60% over the previous 18 months, demonstrating the impact of the strategic alignment between health and social care on supporting independence. A staff team also told us multi-disciplinary working with health colleagues was supporting people to return home, including when people were admitted to hospitals outside of Cumberland. The local authority continued to work with partners to promote people's independence following hospital stays.

A partner told us there was specific project work with the local authority to support people's independence. In an example, they told us there had been a pilot between the local authority and ICB to support the discharge of people who had a stroke and support them in the community to prevent readmission. The pilot demonstrated 100 care hours had been saved and had improved people's independence and abilities.

Close operational work between frontline teams and health teams was also supporting people to positive outcomes. For example, a leader gave an example of a staff team working with community nurses to provide 'wrap-around' support for a person, which provided ongoing care and support, promoted their independence and supported them towards their goals. Staff teams also told us they worked closely with local health teams to help get people access to emergency interventions and help prevent admissions to hospital.

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 but there was an opportunity to strengthen this approach.

The VCSE sector was included at a strategic level to support oversight, scrutiny and decision making. For example, the VCSE was represented on the HWB. A senior leader told us the VCSE advocated for individual communities and was listened to at the HWB. Some partners told us they had opportunities to interact strategically with the local authority including through relevant boards. A partner also told us they were heavily involved with the board at a strategic level. A senior leader also told us there was VCSE inclusion at the Health and Care Summit in 2024, to support conversations about health and social care organisations working together. This supported the local authority to understand and meet local social care needs.

VCSE partners gave mixed feedback on relationships with the local authority. For example, some partners told us they did not feel valued and could feel more dictated to than feeling like a partner. Some partners specifically referred to not feeling part of commissioning processes or new tenders with an opportunity to better coproduce services with the VCSE sector. Despite this, some partners felt there were good relationships with the local authority, with a partner telling us they were accepted as an equal and partnerships with senior leaders were strong. Other partners told us they met regularly with the commissioners, including through quarterly meetings with relevant staff and partners present.

There was some feedback from VCSE partners on difficulties around funding for the sector. For example, a partner told us their contribution to local services was not reflected in the low-level funding they received from the local authority. Another partner told us there was a lack of investment in the sector. A senior leader told us they recognised the very important role of the VCSE sector and there was ongoing work to allocate more funding to areas with higher deprivation, allowing VCSE organisations to be more sustainable for the long term instead of receiving annual funding grants. Funding continued to be a challenge for VCSE partners.

There were positive examples of use of the VCSE sector to support people's independence. For example, a staff team told us there was a link worker from the commissioned carer service who attended a hospital each week to help identify unpaid carers so they could be supported. This arrangement was said to work well. They told us, however, this was not a consistent approach across all hospitals locally, with potential opportunity to expand this approach. The VCSE sector also worked within the discharge hub to support people to return home. For example, they could ensure a person's home was warm and there was shopping in the house. These arrangements supported people's safety and independence.

Theme 3: How Cumberland Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

Safety management

The local authority had developed their systems to support the management of escalating risk. They had implemented a Safeguarding Operational Support Group meeting which staff could attend to discuss people they were working with where there were concerns about high risk. There were a range of managers at the meeting and staff who attended told us they received strong support and guidance. Staff also told us they used their manager for support where there was risk. A leader also told us support for staff in this area was more informal. This meeting was for internal staff and was not attended by key partner agencies, but the local authority highlighted this was used as a complementary tool for staff alongside statutory safeguarding processes which included a multi-agency approach.

The local authority understood where there were risks to people's well-being across their care journeys. In their self-assessment, the local authority highlighted how their Allocation and Waiting Well Procedure had enabled them to develop more robust oversight and management of risk. Staff teams spoke consistently about how this procedure was used effectively in practice. They also told us there were good relationships between teams, which enabled discussions about which team would be the most appropriate to support the person and ensured safe transfer.

The local authority had systems to support people out of hours. There was an urgent care team with dedicated staff who were Approved Mental Health Professionals (AMHPs). This team also covered the AMHP services in work hours which a staff team told us reduced the number of handoffs between different professionals and promoted continuity. All out of hour's work was recorded on the local authorities' electronic system, which supported safe handover of information to other teams. A partner told us the service was responsive in relation to Mental Health Act Assessments, which were completed without delay.

The urgent care team had access to resources and were able to put immediate services in place to support people to remain safe. A staff team told us they received good management support and there were clear escalation systems for out of hours work which worked well. For example, in a crisis situation due to floods, they were able to get groups of staff together quickly to support people after escalating the risk.

Information sharing protocols supported safe, secure and timely sharing of personal information in ways that protected people's rights and privacy. Staff teams told us there were good information sharing agreements in place with housing and other partners. The local authority had a shared information system with health to support hospital discharges. Staff told us this ensured everyone involved with the person's discharge had the most up to date information. Carers assessments, completed by the commissioned partner, were recorded on the local authority's electronic system so relevant staff could access them. An area where staff teams told us information sharing was more difficult was for people with mental health needs. They said not having access to a person's health records within the mental health trust system made information sharing more difficult on a day-to-day basis, although in an emergency, managers ensured the necessary information was shared. Other health records were also available for teams through the Great North Care Record, for example.

Safety during transitions

Most hospital discharge processes and pathways were clear. Local authority staff were part of a Transfer of Care Hub within the acute hospitals, which was an integrated discharge team with multi-disciplinary staff. Staff teams told us the hub model worked well, and the multi-disciplinary team met every day to discuss and agree people's discharge pathways and the support they required, which enabled safe and timely discharges. The local authority also had specialist hospital brokers to source homecare and care home services, who were also part of the hub. There were systems in place to highlight urgent needs to brokers so these could be prioritised appropriately. Staff teams told us this worked well.

Some specific pathways for hospital discharge were not always clear. For example, the local authority often worked with a different health trust for people living in the South of the Cumberland area, in Millom. Partners told us they had worked with the local authority to improve discharge processes in this area, but staff teams said there still could be some confusion with this pathway. They told us, for example, there were occasions where care was being sourced for people on discharge without the local authority being aware and so this was not recorded on local authority systems. Referrals for this area were low in number and staff teams had taken steps to support partners to follow transfer of care hub processes. There was opportunity to continue to strengthen this approach.

Feedback from people about their experiences of hospital discharge was mixed. Positive feedback included examples of staff going above and beyond to provide emotional support to the person and ensuring their discharge was safe and well planned, whilst there was other feedback about a lack of communication prior to discharge. Care providers also shared mixed feedback. Partners told us there were some difficulties with embedding the local authority's home first approach as more people with complex needs were being discharged home and there were delays in sourcing care provision to meet their needs as it was more difficult to find a care provider. This was also confirmed by staff teams we spoke with.

Staff teams told us they could access support to ensure people's homes were suitable to be discharged to from hospital. They accessed 'Homelife', the council's home improvement agency which supported people with access to funding, information and signposting for in relation to home improvement. Examples included cleaning the person's home and putting in appropriate flooring for someone who used a mobility aid. They also told us about an initiative to give people access to a 'modular washroom' to make their homes suitable following hospital discharges or to prevent hospitalisation. This was a self-contained unit which was built offsite and could be installed into someone's home for as long as it was needed rather than more intrusive adaptations.

Partners told us there were delays for people being discharged from specialist mental health hospitals, due to a lack of community provision, which could be significant. They also said there could be improvements with information sharing at the early point of discharge planning which could impact on a person's timely discharge. A leader told us there had been recent discussions with partners to discuss all the care options available to people with mental health needs on their discharge from hospital, including intermediate care pathways.

Transition arrangements ensured people had a seamless transition of their care and support when responsibility moved from children to adult services. The local authority had transitions-focused practitioners who worked in the learning disability, autism and transitions teams. They attended Education Health and Care Plan (ECHP) reviews for young people from the age of 14, which helped to create links with adult social care before an assessment was required. The transitions worker completed the assessment with the young person and their family and then the person would be transferred to another staff member for ongoing work. This was so the transitions worker could support new young people coming to the service. Staff teams told us this handover could be challenging for the young person; due to the relationship they had built with the transition's worker. If a young person's primary need was mental health, the mental health team would complete the assessment.

Staff and leaders said there were good relationships between children's and adult's services which helped to ensure young people were identified and not missed out of the process. This included a meeting every 8 weeks with children's services, relevant partners and the young person (if they wished to attend) to discuss transitions planning. The transitions workers also worked closely with schools and special education needs coordinators to identify young people who might be eligible for a Care Act Assessment and other young people who may require support.

Overall people's feedback about their experience of transitions was positive. We heard about transitions workers becoming involved with the young person at an early age and the assessment being carried out before the person transitioned into adult services. Some more negative feedback we received included lack of communication. There were some staffing pressures for the transitions service due to increasing numbers of young people going through transitions, which could impact on elements of the service and consistency of approach. For example, staff could not always attend initial 'year 9' review meetings and other staff had to pick up transitions work. The local authority told us they were fully staffed to established transitions social worker posts and staff were supported by the wider learning disability, autism and transition teams when demand dictated the need. They told us there was not an expectation to attend 'year 9 reviews', but staff were invited to begin the transition process at year 9 and work was prioritised accordingly.

There was mixed feedback from care providers about how the local authority ensured people received coordinated and safe support when moving between services. Some providers described a good transition process involving the person and their families whilst others had experienced some difficulties due to lack of information and contact from local authority staff.

Contingency planning

The local authority's system for contingency planning to ensure preparedness for possible interruptions in the provision of care and support, were not always effective. Partners told us contingency planning for carer breakdown and for people with more complex needs was poor and at times resulted in the person and carer being admitted to hospital due to lack of alternative support. Partners said there needed to be stronger contingency planning to stop the situation reaching crisis point.

Staff had good awareness of the importance of contingency planning. They spoke consistently about ensuring there were contingency plans in place as part of support planning with the person and told us managers checked this when they approved the care plan. They shared examples of care they had put in place to support the person in an emergency due to carer breakdown, which included reablement support, extra calls in the night and respite care. However, staff also spoke about challenges to find care providers and arrange care for people with more complex needs. This gap in provision, impacted on contingency planning and the alternative options for people when their current care was no longer available.

Carers feedback was mixed in this area, with some carers telling us they had support to develop contingency plans whilst others did not. A leader acknowledge contingency planning for carer breakdown was an area for development and told us this was something the local authority were addressing as part of the new commissioned carer service contract.

The local authority had clear processes to respond to interruptions to people's care and support such as in the event of provider failure, emergencies and service disruptions. Their Service Interruption and Provider Failure Policy had been initiated several times in relation to home care providers. An example of this was when a home care provider could no longer provide a service and people's care was transferred to another provider. The local authority was able to work with the care providers to agree transfer of staff to enable people to receive consistent care.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Safeguarding systems, processes and practices

The local authority had effective systems, processes and practices to protect people from abuse and neglect. Following a Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) bespoke peer review on safeguarding effectiveness, the local authority had produced a safeguarding improvement action plan and made changes to their systems. This included action to improve responses to safeguarding concerns and section 42 (s42) safeguarding enquiries in a timely manner. A s42 enquiry is the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect.

Prior to the review, safeguarding work was carried out by 3 teams, the central safeguarding team, the mental health team and the learning disability, autism, and transition team. To make improvements, the local authority amended their operating procedure and reviewed their Operational Safeguarding Model. They made a change for practitioners in other teams to undertake safeguarding work where they were already allocated and working with a person. This change supported people to be supported by staff that were known to them following safeguarding referrals.

The local authority worked with the Cumbria Safeguarding Adults Board (SAB) and partners to deliver a co-ordinated approach to safeguarding adults in the area. When the LGR occurred, it was decided to keep a single SAB covering 2 local authorities. A partner told us this decision had been monitored, and it had been deemed to be a success and provided continuity for all and benefited from sharing good practice. The SAB had 4 subgroups which focused on specific areas of safeguarding. The subgroups were Learning and Development, Safeguarding Adult Review, Communication and Engagement and Performance and Quality Assurance. The subgroups fed into the SAB, for example the Performance and Quality Assurance subgroup reviewed and analysed safeguarding data and monitored if learning from safeguarding adult reviews (SARs) and incidents had been embedded.

A partner told us the SAB was a mature board with a good culture, with all partners attending and able to challenge and scrutinise safeguarding practice across the partnership. They told us they were confident in the local authority's senior leaders' ability to interpret safeguarding data and highlight any issues to the board.

There was senior level leadership and oversight of safeguarding work. The SAB chair met regularly with senior leaders to discuss strengths, areas for improvement and how changes were being embedded. The local authority had a performance dashboard to support oversight and team managers had safeguarding huddles twice weekly to discuss allocations and any delays. The monthly Safeguarding Oversight Support Group meeting also had oversight of the safeguarding pathway.

Partners told us the process to raise safeguarding concerns with the local authority was simple and straightforward and most partners spoke positively about collaborative working in safeguarding, with strong relationships at strategic and practitioner level. Partners said areas for improvement were the relationships at middle management level and information sharing in relation to safeguarding. Staff teams told us there was a lot of joint working and spoke positively about relationships with partners. An example was a manager working with the police to review the vulnerable adult report the police received and identify the people who needed support from the local authority.

The changes in the Operational Safeguarding Model meant some staff were undertaking safeguarding work who did not have previous experience. However, staff teams told us they had completed safeguarding training and felt supported to undertake safeguarding duties effectively. They spoke of a variety of ways they had received support including support from managers, from advanced practice leads and joint working with the safeguarding team.

National data showed positive experiences of how safe people felt. For example, data from the Adult Social Care Survey for 2023/24 showed that 72.34% of people who used services felt safe. This was similar to the England average of 71.06%. Also 91.19% of people who used services said that those services made them feel safe and secure. This was somewhat better than the England average of 87.82% (ASCS, 2023-2024). Also, for carers, 85.64% of carers felt safe. This was somewhat better than the England average of 80.93% (SACE, 2023-2024).

Responding to local safeguarding risks and issues

Lessons were learned when people had experienced serious abuse or neglect, and action was taken to reduce future risks and drive best practice. The SAB had clear systems to support decision making on whether referrals met the criteria for a SAR. For the 2 years up to the end of January 2025, the local authority had 3 SARs. Each SAR had a detailed action plan, which was overseen by the SAR subgroup to ensure the local authority and all key partners took any necessary action and provided assurance. Staff teams told us learning was embedded following SARs and appropriate action was taken. For example, through lunch and learn sessions, the SAB newsletter, discussion in team meetings, training with advanced practitioner leads and joint sessions with health.

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with the SAB and safeguarding partners to reduce risks, although there needed to be further development of response in relation to self-neglect. There had been 5 referrals for a SAR where there were concerns about self-neglect. They all met the threshold, so a decision was made to do a thematic SAR, which was ongoing. A leader told us self-neglect was a key risk area for the local authority and there was some practice issues identified around professional curiosity and relationship-based practice. A partner said they had seen some good practice in this area but also saw some difficulties where self-neglect concerns had been identified too late.

In response to this local risk, the local authority had launched their self-neglect strategy in October 2023, supported by briefing sessions. This was a brief strategy which gave an overview of self-neglect challenges and good practice in response to self-neglect. Although the strategy did link to a self-neglect practice tool and the detailed SAB multi-agency guidance, the strategy did not include robust localised guidance including responsibilities, timescales and oversight. The lack of localised guidance increased the risk of an inconsistent approach and there was scope for the local authority to review this further, following the more recent SARs. Further work to look at challenges in relation to self-neglect had also been identified in the bespoke safeguarding peer review, although this was not included as an action in the local authority's safeguarding plan. The local authority recognised an increase in self-neglect concerns and were committed to continued learning and supporting staff to respond effectively to self-neglect.

Staff teams were aware that self-neglect was a risk area and told us about actions in place to respond to this risk. For example, there was a 2-weekly meeting with the safeguarding team, the fire service and the home improvement agency to discuss concerns about people who were self-neglecting and high risk. Another example was staff using the clutter tool and the SAB self-neglect checklist to support the assessment of risk. A staff team also told us there was a focus on relationship building with the person where self-neglect was identified and joint working with other teams.

The SAB were introducing regular multi-agency practitioner forums for staff working with people at risk to promote good practice, share safeguarding examples and further understanding of roles and responsibilities. It formed part of the Cumbria SAB Learning and Development Strategy 2024/26 and was to be hosted on a quarterly basis, facilitated by colleagues across the partnership. The first forum was focusing on self-neglect and mental capacity and was to be co-chaired by a leader in the local authority. The local authority had commissioned training around safeguarding adults, 'complex cases', expected outcomes and the Mental Capacity Act, all of which included response to self-neglect and staff could access the Safeguarding Oversight and Support Group (SOSG) for advice and support around people at risk. However, a staff team felt there was still a gap in training around self-neglect and drug and alcohol use.

Responding to concerns and undertaking Section 42 enquiries

Systems supported consistency in decision making about when s42 safeguarding enquiries were required. Safeguarding concerns were received via the SPA team and went to the safeguarding, mental health or learning disability, autism and transition duty teams to decide whether the criteria was met to progress to a s42 enquiry. Decisions to close or progress safeguarding concerns were overseen by managers. This approach gave consistency in decision making, and the number of triage workers in the safeguarding team had recently been increased to support with the volume of safeguarding concerns.

Provider and partner feedback however, highlighted a lack of clarity in the understanding of safeguarding thresholds for referrals, and providers told us there had been no support or training from the local authority in this area. Some partners said the safeguarding threshold for a s42 enquiry was high, and in their experience very few safeguarding concerns progressed to a s42 enquiry. They shared an example of a referral where there were concerns about risk, but the person didn't meet the safeguarding threshold and there was a lack of support and contingency planning. A staff team told us there was a SAB threshold tool to support partners, but this was quite outdated and due to be updated. They shared an example of a session that was carried out with a specific partner who needed more support to understand safeguarding, however, they were not aware of any wider training for partners or providers.

The local authority had made changes to their safeguarding systems to ensure more timely identification of safeguarding concerns which met the threshold of a s42 enquiry. Delays to this decision making had been highlighted in the bespoke safeguarding peer review. The s42 decision was made by the duty worker in the safeguarding, mental health or learning disability, autism, and transition team. The practitioner would contact the person for more information to aid decision making. Managers told us prior to these changes, the decision to progress to a s42 enquiry was being made later in the process, causing delays. They told us oversight through data had helped them to understand the delays and to act. This had supported more timely safeguarding processes.

Local authority data submitted in June 2025, showed no safeguarding concerns were awaiting initial review. This showed an improvement from data received in February 2025, when 59 safeguarding concerns were awaiting initial review. Where a safeguarding concern progressed to a s42, the person's case was triaged as medium or high risk. Staff teams told us urgent work would be allocated to a worker on the same day and where the safeguarding was triaged as medium risk this would be overseen by a manager to allocate. Data received by the local authority in June 2025 showed for s42 enquiries there were 47 enquiries awaiting allocation: with the median wait time for allocation being 6 days and maximum wait time being 29 days.

There were quality assurance arrangements in place for conducting s42 enquiries. Occupational therapists led on specific concerns for example, manual handling, falls or pressure damage which meant there were able to bring their specialist knowledge. Managers used a safeguarding dashboard to have oversight of safeguarding work and met twice a week to look at any delays and take action. S42 enquiries were reviewed and signed off by managers, to ensure risks were mitigated, which staff said was positive and quality assured safeguarding work. The local authority also carried out case file audits, which could include people's cases where there had been safeguarding concerns. The audit included a dedicated section on safeguarding, although the local authority did not have a specific safeguarding audit. This meant there had not been specific focus on safeguarding work and quality assuring practice across teams. However, senior leaders told us in their audits in August 2025, the local authority was specifically focusing on safeguarding practice.

The local authority was exploring more opportunities for safeguarding enquiries to be conducted by other agencies, where appropriate. This had been highlighted in the bespoke peer review as a missed opportunity and a leader told us there were plans to progress this. It was included in the local authority's safeguarding plan, with actions to use stakeholder meetings to review concerns and agree enquiry leads and engage support from the SAB to promote shared understanding and engagement. A staff team told us there were occasions where partners led on safeguarding enquiries with oversight from the local authority. For example, a health partner led on a s42 enquiry where there were risks around the person's health needs. The local authority highlighted this work was being progressed at a safe and responsible pace in support of partners.

Partners and providers gave mixed feedback about whether they were informed of the outcomes of safeguarding enquiries. Some said they did receive outcomes and were involved in safeguarding meetings and learning from safeguarding was shared. Others told us they had to chase for outcomes. Staff teams told us they had to feed back outcomes before the safeguarding enquiry was closed and there was a process in place to inform both the person and referrer of the outcome.

There were delays in assessing DoLS applications which increased the risk of people's liberty being restricted. As of June 2025, there were 774 DoLS applications waiting for allocation. The median waiting time for people was 557 days with the maximum wait at 1989 days. A staff team told us there were not enough staff to meet the level of demand, but the size of the team was increasing. Partners told us DoLS work was a challenge for the local authority and were concerned the waiting time meant some people were potentially unlawfully deprived of their liberty.

Staff and managers told us improvements were being made to systems and the recording of DoLS work had moved onto their electronic care management system in April 2025. Prior to the move DoLS data was collated on a spreadsheet. They told us moving to the electronic system would enable them to use a Power BI report so they could have accurate and live information in relation to DoLS work. However, this reporting was not available until all the data had been transferred onto the electronic record, which was still in progress at the time of our assessment.

The local authority had systems for the prioritisation of DoLS, using the ADASS national prioritisation tool which supported staff to triage applications in relation to risk and urgency, this meant the more urgent authorisations were actioned first. There was also some project work underway to check historic applications to ensure the information was still up to date, and if the person still required an assessment.

Making safeguarding personal

Systems supported consistency in decision making about when s42 safeguarding enquiries were required. Safeguarding concerns were received via the SPA team and went to the safeguarding, mental health or learning disability, autism and transition duty teams to decide whether the criteria was met to progress to a s42 enquiry. Decisions to close or progress safeguarding concerns were overseen by managers. This approach gave consistency in decision making, and the number of triage workers in the safeguarding team had recently been increased to support with the volume of safeguarding concerns.

Provider and partner feedback however, highlighted a lack of clarity in the understanding of safeguarding thresholds for referrals, and providers told us there had been no support or training from the local authority in this area. Some partners said the safeguarding threshold for a s42 enquiry was high, and in their experience very few safeguarding concerns progressed to a s42 enquiry. They shared an example of a referral where there were concerns about risk, but the person didn't meet the safeguarding threshold and there was a lack of support and contingency planning. A staff team told us there was a SAB threshold tool to support partners, but this was quite outdated and due to be updated. They shared an example of a session that was carried out with a specific partner who needed more support to understand safeguarding, however, they were not aware of any wider training for partners or providers.

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There were quality assurance arrangements in place for conducting s42 enquiries. Occupational therapists led on specific concerns for example, manual handling, falls or pressure damage which meant there were able to bring their specialist knowledge. Managers used a safeguarding dashboard to have oversight of safeguarding work and met twice a week to look at any delays and take action. S42 enquiries were reviewed and signed off by managers, to ensure risks were mitigated, which staff said was positive and quality assured safeguarding work. The local authority also carried out case file audits, which could include people's cases where there had been safeguarding concerns. The audit included a dedicated section on safeguarding, although the local authority did not have a specific safeguarding audit. This meant there had not been specific focus on safeguarding work and quality assuring practice across teams. However, senior leaders told us in their audits in August 2025, the local authority was specifically focusing on safeguarding practice.

The local authority was exploring more opportunities for safeguarding enquiries to be conducted by other agencies, where appropriate. This had been highlighted in the bespoke peer review as a missed opportunity and a leader told us there were plans to progress this. It was included in the local authority's safeguarding plan, with actions to use stakeholder meetings to review concerns and agree enquiry leads and engage support from the SAB to promote shared understanding and engagement. A staff team told us there were occasions where partners led on safeguarding enquiries with oversight from the local authority. For example, a health partner led on a s42 enquiry where there were risks around the person's health needs. The local authority highlighted this work was being progressed at a safe and responsible pace in support of partners.

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There were delays in assessing DoLS applications which increased the risk of people's liberty being restricted. As of June 2025, there were 774 DoLS applications waiting for allocation. The median waiting time for people was 557 days with the maximum wait at 1989 days. A staff team told us there were not enough staff to meet the level of demand, but the size of the team was increasing. Partners told us DoLS work was a challenge for the local authority and were concerned the waiting time meant some people were potentially unlawfully deprived of their liberty.

Staff and managers told us improvements were being made to systems and the recording of DoLS work had moved onto their electronic care management system in April 2025. Prior to the move DoLS data was collated on a spreadsheet. They told us moving to the electronic system would enable them to use a Power BI report so they could have accurate and live information in relation to DoLS work. However, this reporting was not available until all the data had been transferred onto the electronic record, which was still in progress at the time of our assessment.

The local authority had systems for the prioritisation of DoLS, using the ADASS national prioritisation tool which supported staff to triage applications in relation to risk and urgency, this meant the more urgent authorisations were actioned first. There was also some project work underway to check historic applications to ensure the information was still up to date, and if the person still required an assessment.

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: 2

2 - Evidence shows some shortfalls

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

The local authority had undergone a significant restructure following the Local Government Reorganisation (LGR) in 2023 and as a result was on a transformation journey in its Care Act delivery. There was a wide-ranging Transformation and Service Improvement plan (2024-2026) and overlapping Achieving Excellence Plan. This included, amongst several other areas, pathway redesign, strengthening the front door and pre-front door, the Cumberland Care Review, discharge flow work (including intermediate care) and improving coproduction.

The LGR had presented the local authority with both challenge and opportunity. A leader told us legacy arrangements had impacted the timeliness of new systems and processes being implemented. For example, the local authority had not been able to separate some records from their legacy arrangements until November 2024, and this had limited changes in this space. However, leaders and staff also told us of the opportunities the LGR had presented. A senior leader described the overhaul of the previous legacy model, with the local authority now focussing on prevention work through a lower cost, higher outcome model. This was in line with a priority of the Adult Social Care (ASC) and Housing Vision and demonstrated the shared direction of the local authority.

Directorate structures supported the standing of ASC within the Council and aligned priorities between ASC and other services. Prior to LGR, there was no standalone ASC directorate, but a senior leader told us the introduction of an ASC and Housing directorate had given prominence to ASC across the local authority. The addition of housing to the ASC directorate was also referred to as a positive move by leaders and staff, with operational partnership working still embedding. There were positive outcomes for people because of close working between both ASC and housing staff.

There were functions of ASC which sat outside of the directorate. A senior leader told us there was a 'business partnership' model of working, where functions such as commissioning and the SPA (ASC front door) sat outside of the directorate. Feedback from staff and leaders was positive about the close working with commissioning. There were systems to support close working between the SPA and ASC, such as management within the SPA attending regular ASC operational leadership meetings and close operational working between SPA staff and social work practitioners. Internal partnerships continued to strengthen to support operational delivery.

Senior leadership was visible and supportive for staff. Staff teams consistently told us leaders were approachable and were supporting a positive culture. For example, a team told us staff felt more involved in discussions about the future, got to share their views and had better sight of the direction of travel for the local authority. A senior leader also told us there had been a culture change since LGR, which was more open and supportive of staff to speak up. A partner also felt senior leadership were visible, accessible and ready to listen to them. The local authority leadership was promoting a positive and safe culture for staff.

Governance structures supported senior leaders to retain oversight on performance and risk and this continued to embed. Regular Directorate Management Team (DMT) meetings were held with a rotating theme, which supported oversight of a range of areas to be covered regularly. Senior leaders, including political leadership, also met regularly to support oversight of risk and performance in ASC. There was, however, opportunity to ensure oversight was embedded in key areas. For example, a senior leader told us they did not get detailed performance information around safeguarding performance. This was despite systems in place to share safeguarding information across leadership positions. This included through, for example, the safeguarding dashboard and the strategic risk register for safeguarding. There was opportunity to ensure information was effectively shared to senior leaders to support governance further.

The local authority had developed quality assurance systems to support oversight of performance. The quality, improvement and care governance senior leadership team gathered information on performance through designated groups and sub-groups. A leader told us the work of the groups supported performance information to be shared to senior leadership as well as to operational staff. The local authority had developed a case file audit to quality assure staff practice. Audits were completed by managers monthly and included feedback from people to support quality assurance. Examples of feedback gathered between June and December 2024 showed the positive impact staff had on people's lives, with themes showing person-centred and strength-based practice. Themes from the audits were collated and presented to the DMT. There was opportunity to better embed the case file audit process, however, with the April and May 2025 Practice Theme Report highlighting only 22 out of 32 audits completed and this risked themes being missed. The July 2025 report did, however, have a 100% completion rate.

The local authority was developing its processes for scrutiny and challenge. There was a People Overview and Scrutiny Committee which was new following LGR. Senior leaders told us the scrutiny function was developing, with work ongoing to better set agendas and gather performance information to challenge effectively. Senior leadership in ASC were also working with the scrutiny committee to highlight current challenges. The Committee received quarterly ASC performance reporting to support their oversight and scrutiny of performance. There were also other examples of political leaders challenging decision making. For example, the HWB had challenged where they felt there was waste of resource which could be better used. A senior leader also told us they provided challenge and sourced external resources to support scrutiny, such as through the Local Government Association. Scrutiny was continuing to strengthen to better challenge decision making.

Strategic planning

The local authority was developing its strategic priorities to inform the direction needed to improve care and support outcomes for people and local communities. The Council-wide Cumberland Plan (2023-2027) set out initial strategic focus for the local authority and ASC direction was aligned with this. For example, the ASC and Housing Vision, was aligned to the Council's wider strategic priorities, with the vision of "People live fulfilled, healthy, independent lives in the place that they call home." Other key strategies for ASC, such as the Adult Social Care and Housing Commissioning Strategy which was due for sign off at the time of the assessment, sought to address local challenges and support people to better outcomes.

The local authority was proactive in their approach to resourcing improvements to services and outcomes for people. The Transformation and Improvement Plan was an ambitious and wide-ranging programme following a review of services post-LGR. The resourcing of this medium-term plan showed emphasis of the local authority in improving outcomes for people. A Transformation Board with associated project officers oversaw this work. While it was not yet clear on the impact of this work, it demonstrated a direction for ASC.

A Strategic Risk Register (2024-2025) was used to keep track of key risk areas and outlined relevant controls to help mitigate risk. For example, the risk register identified unsustainable demand and inability of health and social care to keep people sufficiently safe and the related impact this had on people. There were a range of controls to help mitigate this risk such as arrangements for oversight, waiting well procedures, transformational efficiency and recruitment.

While there was clear strategic oversight of risks, there was opportunity to focus resources to further support key service areas. For example, there was ongoing work to reduce waits for assessments, reviews, OT assessments, equipment and DoLS authorisations but waits were still significant for people. People at most risk were being supported in a timely manner, but there was risk of escalating need for people having to wait longer. There was evidence of some improvement in these areas following investment, with for example, reduced waiting lists for annual reviews, but there was a continued need to address waits for support for people effectively.

Workforce challenges were highlighted by staff and partners, with teams such as the SPA, learning disability, autism and transitions team and some teams based in the West of Cumberland particularly impacted. Staff and leaders told us the LGR had impacted on resources, in some cases disproportionately, which had led to increased pressure on teams. Some staff teams told us it was difficult to manage their workloads, especially with increased complexity. They also told us there were a lack of experienced or advanced practitioner staff embedded within some teams, who they would usually access for case support. While all teams had more senior roles within them, there could be difficulty accessing their expertise. As a result, this increased the ask of managers, as staff would contact them for case support. There was a separate advanced practice lead (APL) team, which could be contacted for support, but this expertise was not embedded within teams. The APLs also offered 1:1 support for staff, reflective discussion and advice in relation to complex work, for example. Where this resource was accessed, there was positive feedback on the APLs.

In response to staffing pressures, a senior leader told us the local authority ensured risk was mitigated. They told us agency staff (externally provided workers) were used to fill gaps if needed. They told us the frontline did not have excessive vacancies, but recognised workflow was an issue for some teams, with increased casework which may not be appropriate for their team. Staff teams also told us they were well supported by their managers, who helped them to manage their wellbeing and workload. The local authority was working to address these concerns further to help reduce these pressures.

The local authority had developed its use of data and insight to support performance oversight, risk management and service delivery. Despite challenges of legacy data issues following LGR, data dashboards provided managers and leaders with up-to-date information on service performance such as waiting lists. A leader told us, for example, dashboards were used in oversight and assurance meetings and supported leaders to identify and investigate specific areas of performance Staff and leaders told us there was still work to improve data collection and accuracy, including in data around outcomes for people, but there was recognition of the progress made in this area in a relatively short space of time. The local authority continued to strengthen its use of data for oversight and delivery.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems.

A staff team told us there were robust processes around data sharing and confidentiality. For example, they told us the local authority used a secure email system to support confidentiality of sharing information. People were also asked about their preferences around information sharing to ensure consent was gathered where required.

There was mandatory training on ICT and data management for staff as part of their induction. An information governance team also led on data management and provided advice around data security issues.

Learning, improvement and innovation

Score: 2

2 - Evidence shows some shortfalls

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

The local authority was on an improvement journey as it embedded changes following LGR. There was a learning culture which was supporting the development of using feedback from staff, people and partners to improve systems and processes.

There was a recognition of a need to use co-production more effectively to support service improvement. A leader told us a culture change around co-production was embedding and this was reflected in the appointment of a new co-production lead role, who had a wide-ranging action plan, along with a planned co-production charter. A Living Well sub-group of the local authority's Quality Assurance Board had also been created which was co-chaired by the co-production lead and a person with lived experience. The group acted as a point of consultation on co-production work and considered areas where co-production could be used. The local authority was also working with partners such as Healthwatch, the Improving Adult Care Together (IMPACT) network and Making Every Adult Matter (MEAM) to better embed their approach.

There were some positive examples of development of coproduction. For example, the introduction of the carer's forum. The forum was supporting improvement work for carers and the creation of the carer's charter, which was due for sign off. In a further example, a fictional case study had been developed with people with lived experience around the challenges faced by homeless people. A leader told us this story had been developed to be trauma-informed and was used as a tool to promote understanding for the local authority and key system partners. Each of these examples highlighted how people and carers were listened to, and this showed the intent of using people's voice to better influence strategy, processes and understanding.

People and partners also told us the local authority was developing co-production, but said this needed to be better embedded, more structured and with more representative groups of people. There was evidence of the local authority building relationships with communities to develop their approach, such as through a 'Power of Lived Experience' event which invited a range of partners and community groups to come together to discuss how lived experience can inform future practice. The local authority was also developing a more considered approach in practical arrangements for people, with for example, the development of a policy on compensating people involved in co-production work. The local authority had a clear direction to better embed co-production, and this continued as an area of focus

Staff were supported with learning, improvement and their continuous professional development (CPD). Staff teams told us they had supervisions which supported their wellbeing, progression and reflective practice. The introduction of the advanced practice lead team was supporting staff learning and improvement, through updates to processes, policies and directed learning from case file audits. Staff also told us of opportunities to progress in their roles such as through BIA and AMHP training or social work qualifications funded by the local authority. A new virtual practice library had also been developed which supported staff to access information, guidance and best practice which a staff team told us had over 1000 visits in its first 7 days.

There was a supportive offer for new staff, including students, apprentices and Assessed and Supported Year in Employment (ASYE) social workers. A staff team told us the social care academy delivered tailored workshops, which included case study examples, on a 12-month rolling basis to ensure new staff could continually access this support. This included, for example, OT specific sessions around moving and handling. There was also support for staff who had just completed their ASYE or OT preceptorships, and into the second and third years of their professional practice where it was required. This demonstrated the local authority's investment in the development of their staff.

The local authority recognised the need for more innovation and technology. The Transformation and Service Improvement Plan had a range of projects to advance 'tech-enabled care'. There were plans to recommission their assistive technology offer so it was more comprehensive and innovative. A positive example of the move towards better use of technology was the 'Ethel Care' pilot, which staff told us supported virtual prompting of tasks for people to support independence. Use of artificial intelligence (AI) to support efficiency was also being developed, with an ongoing pilot for an AI program to reduce staff administrative time, which staff told us was working well. A leader also told us AI was being developed to better forecast and planning around staff caseloads. The local authority was committed to developing innovation to support independence and efficiency.

Learning from feedback

The local authority learned when things went wrong such as following SARs and LeDeR reviews (Learning from Lives and Deaths – People with a Learning Disability and Autistic People). For example, there had been co-produced work with a relative following a LeDeR review, which had involved development of training to help improve local practice. A staff team told us there had been positive feedback about this learning and there were plans to widen its scope.

There had also been development of post-incident and serious success reviews, to support staff development. Post-incident reviews were cases which had not met the threshold for statutory reviews such as SARs, but where learning was identified. Serious success reviews highlighted positive case examples for staff. In an example given by staff, a post-incident review had led to the local authority and partners improving access to specialist equipment for people. Learning was provided for staff in 7-minute briefings, at team meetings and practice improvement groups to support staff development.

The local authority sought to learn from feedback from partners to learn and improve practice, but some partners felt feedback was not always acted upon. Key VCSE partners were members of strategic delivery boards, and they told us their feedback was valued by the local authority. However, some other partners told us although they felt heard, they felt feedback was not always acted upon as issues re-occurred. A partner told us the local authority was working with them to improve gathering of feedback.

The local authority used external expertise and best practice to support learning and improvement. For example, the local authority had benefitted from LGA and ADASS peer challenge exercises, including a bespoke review around safeguarding. The reviews had led to targeted improvements, particularly to recommendations around safeguarding to reduce waits for people. External consultancy was also being used to support transformation and improvement, with resource invested in support of improvements to the front-door and pre-front door. While some of these changes were not yet embedded, it showed the local authority's openness to learn from challenge and external resource.

The local authority was also using staff feedback to help develop their approaches. The local authority used 'what matters to you' sessions to gather feedback from staff. A staff team told us the use of this information had helped to inform improvements to the supervision policy and there was a focus on making changes collaboratively with staff. There had also been staff engagement as part of the transformation planning, with an interactive planning day and roadshows. This was a positive approach to including staff voice in the local authority's development.

The local authority analysed its compliments and complaints to draw out any themes. The local authority's Practice Improvement Group was a forum which could look at themes from this analysis. However, there had been a low number of upheld or partially upheld complaints which meant identification of practice themes was limited. Data provided by the local authority between January 2024 and January 2025 showed there had been 57 complaints and 11 compliments. The most regular issues highlighted from complaints were around care standards, quality and continuity, and disagreement with Council policy, decisions and procedures. There was also a range of positive feedback from people as part of the case file audits, which commended staff on their practice.

There had been 2 detailed investigations following complaints to the Local Government Social Care Ombudsman (LGSCO) between 01 April 2024 and 31 March 2025. Both of these complaints were upheld, with the local authority complying with the outcomes of these investigations. There was, however, 1 incident of late compliance.
