Care Quality Commission

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders and used available data (for example the Joint Strategic Needs Assessment (JSNA) to understand the care and support needs of people and communities. This included people who were most likely to experience poor care and outcomes, people with protected characteristics, unpaid carers and people who fund or arrange their own care, now and in the future.

The local authority collaborated extensively with local people, stakeholders, and partners to understand care and support needs. They engaged with voluntary sector organisations, Healthwatch, carers' groups, and providers to gather lived experiences and feedback. For example, Healthwatch Richmond reported that views of people with lived experience and unpaid carers were gathered during a dementia day services review and used to shape service redesign. A partner confirmed that the local authority consulted widely with the voluntary sector, including specialist organisations, to ensure services reflected community needs. Richmond Carers Centre highlighted that the local authority invested in the local community by commissioning the carers hub contract, demonstrating a commitment to carers' needs. Another partner noted joint efforts to address workforce sustainability through apprenticeships and career pathways across health and social care. Providers also confirmed that the local authority communicated local needs through a care home manager forum and supported recruitment via job fairs and events.

The local authority also worked internally across teams to anticipate future demand and shape services. Commissioning teams consulted providers on the Market Position Statement, using population growth and health service data to predict demand for 2030. They undertook a deep dive into older people's care home provision, mapping needs and developing tools to help social workers match people to appropriate placements. Leaders acknowledged challenges in housing, mental health, and dementia care, and initiated projects to address gaps, including plans to increase dementia nursing beds. Data and performance teams integrated insights from Power BI, NHS capacity trackers, and safeguarding information to monitor risks and enable early intervention.

People described how they relied on a community group, Friendship, Independence, Support and Help for older people (FISH), for support before being allocated a social worker. They said, "That's where I learnt most – they were amazing. We felt they were our only support until we were allocated a good social worker." While helpful, the group was not enough to provide proactive, personalised, preventative support. This example illustrates how community engagement and feedback informed the local authority's understanding of gaps in dementia support.

The local authority also demonstrated collaborative working through initiatives such as the Right Bed Right Care project. This involved commissioners, brokers, and providers reviewing over 125 residential care cases, mapping provision, and creating tools to support social workers in identifying needs. The aim was to use AI to match people's needs to suitable care homes. Similarly, the Provider Relationship Survey gathered feedback from providers on priorities, challenges, and opportunities, which informed commissioning strategies and service models.

Richmond's JSNA provided a comprehensive overview of population needs and informed strategic planning. It predicted a population increase to 206,080 by 2034, with the largest growth among those aged 80 and over. Life expectancy was above London and England averages, but healthy life expectancy declined among females. The JSNA highlighted inequalities, noting that males in the least deprived areas lived 5.3 years longer and females 1.2 years longer than those in the most deprived areas. It identified unpaid carers' needs for emotional support, contingency planning, housing engagement, and financial advice. The JSNA estimated 2,778 older people with moderate or severe visual impairment and 928 with registrable eye conditions. It also reported health inequalities for people with learning disabilities, including variation in GP registration and access to mainstream services. While most residents reported happy and satisfied lives, a subset experienced low levels of happiness and high anxiety. The JSNA's "Community Voice" section highlighted development needs in mental health support, carer support, disability services, reducing health inequalities, and preventing digital exclusion.

Market shaping and commissioning to meet local needs

People had access to a diverse range of local support options that were safe, effective, affordable and high-quality to meet their care and support needs. The local authority ensured that people could access a variety of care and support options that were tailored to peoples needs. Services were designed to be safe, effective, and affordable, while maintaining high standards of quality. These options included home care, supported living, residential care, and community-based services. Adult Social Care Survey (ASCS) data showed 72.73% of people who used services felt they had choice over services, which was broadly similar to the England average of 70.28%. This indicated that most people experienced a level of autonomy in selecting services that met their preferences.

Commissioning strategies were aligned with the strategic objectives of partner agencies, including health, housing, and public health. This collaborative approach ensured that services were integrated and responsive to local needs. Commissioning strategies included the provision of suitable, local housing with support options for adults with care and support needs including supported living. This helped maintain independence and improved quality of life for people requiring care.

There was specific consideration for the provision of services to meet the needs of unpaid carers. The local authority recognised the critical role of unpaid carers and incorporated their needs into commissioning plans. Services were developed to provide respite and emergency support for unpaid carers. Data from the Survey of Adult Carers in England (SACE) 2023/24 showed 12.90% of carers accessed support or services allowing them to take a break from caring at short notice or in an emergency, similar to the England average of 12.08%. Similarly, 15.63% accessed support for breaks longer than 24 hours, similar to the England average of 16.14%, and 21.54% accessed support for breaks between 1–24 hours, similar to the England average of 21.73%. These figures demonstrated that local provision was broadly in line with national averages, though opportunities remained to expand flexible respite options.

The local authority commissioned models of care and support that were in line with recognised best practice. Commissioning focused on outcomes rather than tasks, giving providers flexibility to deliver services in ways that met people's preferences. This approach promoted person-centred care and innovation. For example, the local authority commissioned for outcomes rather than specifying rigid service tasks. Outdated models of care were decommissioned where necessary to release funding for new, evidence-based approaches that improved outcomes for people.

Commissioning staff supported new and innovative approaches to care provision, where this led to better outcomes for people. Commissioning teams encouraged innovation and supported providers in adopting new models of care. This included piloting technology-enabled care, integrated service delivery, and community-based initiatives. Examples included introducing digital platforms for care coordination and monitoring, improving efficiency and responsiveness; supporting providers to develop flexible care packages tailored to people needs rather than standardised service blocks; and collaborating with voluntary and community sector organisations to expand local support networks.

Ensuring sufficient capacity in local services to meet demand

There was sufficient care and support available to meet demand, and people could access it when, where and how they needed it. The local authority reported that a wide range of services was available to meet diverse needs, and these were sustainable and coordinated. People experienced smooth transitions and continuity of care through joint working with partners. For example, staff told us they kept people at home whenever possible and sourced specialist placements promptly when needs increased. Brokerage teams were available at weekends and had undertaken training with provider forums, which improved relationships and responsiveness. Examples such as the hospital discharge team sourcing care packages early for people with complex needs showed that proactive planning reduced delays. This meant people could leave hospital sooner and return home safely, which improved their experience and reduced stress.

The local authority highlighted that its home care innovation platform and reablement contracts were well embedded, with no current waits for home care or reablement. The average time to enable hospital discharge had been reduced by two days. This helped people return home more quickly, supporting independence and reducing anxiety about prolonged hospital stays.

There was sufficient capacity for unpaid carers to have access to replacement care for the person they cared for, in both planned and unplanned situations. People told us respite care was limited, although social workers acted when needed. A voluntary sector partner said there needed to be more choice in respite for unpaid carers. They noted the local authority was reviewing dementia day service provision and hoped this would improve support for unpaid carers. This work aimed to give unpaid carers better access to planned and emergency respite, reducing stress and helping them maintain their caring role.

The local authority provided extra care housing for older people and supported living schemes for people with learning disabilities and mental health needs. For example, there were 66 extra care units across two schemes, 88 supported living units for people with learning disabilities, and 109 units for people with mental health needs. Specialist placements were sourced when required, such as for younger people with complex needs. The local authority worked with providers to co-design services and used market insights to maintain a strong, sustainable provider market. This ensured people with specific needs could access appropriate care locally.

Challenges remained in finding placements for young people with autism and people with complex needs. Staff told us that accommodation for these groups was limited, although new supported living frameworks and developments were underway. Partners highlighted gaps in preventative services such as transport and social engagement, which were underfunded despite their role in delaying care needs. Recruitment and retention of care staff were also issues, linked to housing costs. The local authority responded by zoning tenders, incorporating travel costs, and commissioning creative solutions through expert panels to increase supported housing supply. These actions aimed to reduce spot purchasing and improve local capacity.

Interim beds were available through block booking, and brokerage teams acted promptly to source care packages. This reduced waiting times and helped people return home sooner, improving recovery and wellbeing.

There was minimal need for people to use services or support in places outside of their local area. When support was being accessed from outside of the area, there were plans to provide it in the local area, so that people could move back there if they wished to do so. The local authority aimed to place people within the local area unless they wished to live elsewhere. When out-of-area placements were needed, these were usually close to home and often in neighbouring boroughs. For example, a person was placed in Surrey when their needs increased and could not be met locally. The local authority reported that 85% of placements were within Greater London. They were working to improve local specialist capacity through new supported living developments and investment in dementia and mental health services. This meant people could stay near their support networks or return to the borough if they wished.

Some services were commissioned jointly with other agencies. In these instances, there were clear roles and accountabilities for monitoring the quality of the services being provided and the outcomes for the people using them. Joint commissioning arrangements supported continuity of care and smooth transitions. Policies and procedures set out clear roles for monitoring quality and outcomes, including checks on safeguarding and service standards for out-of-area placements. Strategic partnerships with health and voluntary sector organisations enabled co-produced plans, such as dementia strategies and mental health commissioning plans. These arrangements ensured accountability and improved service quality, which benefited people by providing consistent and safe care.

Ensuring quality of local services

The local authority had established clear and robust arrangements to monitor the quality and impact of the care and support services it commissioned for people, ensuring that improvements were supported where needed. These arrangements were underpinned by strong governance and assurance frameworks designed to maintain oversight of service quality and outcomes.

Monitoring was carried out through a structured programme of contract management, which included regular quality assurance visits, formal contract reviews, and performance monitoring meetings. These processes enabled the local authority to assess compliance with contractual obligations, regulatory requirements, and local quality standards. Oversight was informed by a combination of quantitative and qualitative data, drawing on safeguarding alerts, complaints, and provider performance metrics, alongside feedback from people who used services, their families or carers. This approach ensured that the local authority not only tracked measurable outcomes but also understood the lived experiences of those receiving care.

A risk-based methodology was applied to prioritise oversight, meaning that providers identified as higher risk, whether due to Care Quality Commission (CQC) ratings, incident reports, or workforce instability, received enhanced monitoring and tailored support plans. The local authority also worked collaboratively with health partners, CQC, and provider forums to share intelligence and coordinate improvement actions, ensuring that concerns were addressed promptly and effectively. These measures helped identify quality issues at an early stage, reducing risks to people and driving better service outcomes.

In addition to monitoring, the local authority actively supported providers to improve quality through a range of targeted interventions. This included offering training opportunities, workshops, and access to best practice resources to strengthen leadership, workforce capability, and care delivery standards. Where concerns were identified, the local authority worked closely with providers to co-produce quality improvement plans, setting out clear actions, timelines, and monitoring arrangements to ensure progress was achieved.

To promote sustainability within the care market, the local authority supported providers with initiatives focused on recruitment and retention, digital transformation, and business continuity planning, helping to maintain resilience and stability across services. Learning from feedback was central to this approach; insights from complaints, compliments, and engagement with people who used services were systematically reviewed and used to inform commissioning decisions and provider development. Furthermore, the local authority encouraged innovation and co-production, working with providers to adopt new models of care and involving people with lived experience in shaping service improvements.

Through these combined efforts, the local authority demonstrated a proactive and collaborative approach to ensuring high-quality care and support, underpinned by strong governance, continuous learning, and a commitment to improving outcomes for people.

Ensuring local services are sustainable

The local authority collaborated with care providers to ensure that the cost of care was transparent and fair. The local authority worked with providers to make sure costs were clear and reasonable. For example, brokerage teams used a cost benchmarking system to check that fees offered value for money for people and the local authority. Commissioners also negotiated fee structures in partnership with providers rather than imposing rates. This approach meant people received care at a fair price and providers could maintain services without compromising quality.

The local authority's contracting arrangements were efficient; they provided stability for providers and allowed them to plan ahead. Contracts were designed to give providers security and continuity. For example, voluntary sector partners said contracts awarded for five years gave them stability and confidence to plan long-term services. Commissioners also agreed fixed hourly rates and inflationary uplifts for the duration of framework agreements. This enabled providers to manage financial planning and sustain services, which helped people experience consistent care without disruption.

The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping with them. Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruption or provider failure; contingency plans were in place to ensure that people had continuity of care provision in this event. The local authority maintained regular engagement with providers through forums and surveys to identify risks early. For example, provider forums met quarterly to discuss workforce issues, cost pressures and tendering processes, with commissioners attending to address concerns. The local authority also used a Market Viability Tool to monitor risks such as vacancies, safeguarding concerns and leadership issues, and to map alternative capacity. These actions meant the local authority could respond quickly to challenges and ensure people continued to receive care even when providers faced difficulties.

Data provided by the local authority showed there were no delays in sourcing homecare, supported living or extra care services. It also showed that 12 people waited for residential or nursing care due to capacity issues, with an average wait of 12 days for a care home placement. The locality authority identified pressures in dementia bed availability but secured 77% of placements without delay. Similarly, information on contracts handed back and reasons was monitored through quality assurance processes, though no widespread failures were reported.

The local authority understood its current and future social care workforce needs. It worked with care providers, including personal assistants and other agencies, to maintain and support capacity and capability. The local authority recognised workforce challenges such as high turnover and skills gaps and took steps to address them. For example, the workforce strategy for 2024–2027 set out actions to improve recruitment and retention, including international recruitment, apprenticeships and supported placements. The local authority collaborated with providers through a Workforce Working Group, which was established in 2024, and offered access to training resources. It also partnered with the South West London Social Care Academy Hub to promote careers and provide pathways into employment. These measures helped sustain workforce capacity so people could access care when needed.

Richmond's Market Position Statement highlighted a high turnover rate of adult social care staff, at 29.4%, higher than the London average of 19.6%. In response the local authority priorities included building a resilient workforce, improving collaboration and supporting provider sustainability. Similarly actions they had taken included developing career pathways, promoted equality and inclusion, and created a recruitment site for providers. National data from the Adult Social Care Workforce Estimates 2024/25 showed 57.16% of adult social care staff with a care certificate in progress or partially completed, or completed, similar to the England average of 57.67%.

There were also additional social care workforce development plans. For example, the local authority aimed to engage 230 employers, bring 600 people into training and 500 into employment by March 2025. Additional initiatives such as the Great Employer Programme focused on improving organisational culture and retention. There was also a Provider Workforce Group which supported co-produced actions on recruitment, retention and apprenticeships.

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