Dorset Council local authority assessment (June 2026)

How we assess local authorities

Assessment published: 4 June 2026

About Dorset Council

Demographics

Dorset is a county in Southwest England, known for its Jurassic coastline, rich history and picturesque towns.

Dorset Council is a unitary authority created in 2019 and covers the areas of Weymouth and Portland, North, West and East Dorset and Purbeck. The largest town is Dorchester. It sits alongside the unitary authority of Bournemouth, Christchurch and Poole. It has a total population of 383,809. Population growth has been primarily driven by older people moving into the area, with a greater proportion (30%) of the population aged 65 years and over than England and Wales (18%). West and East Dorset have 1 in 3 residents over 65 years. There has been a decrease in the working age population over the last decade.

The local authority covers a relatively affluent area. It has an Index of Multiple Deprivation (IMD) score of 3 (10 being the most deprived) and is ranked 119 out of 153 local authorities (with 1 being the most deprived and 153 being the least.) However, Weymouth and Portland have 10 (out of 11) of the most deprived areas in Dorset. The age gap in life expectancy between the most deprived and least deprived areas is 5.2 years for men and 4.6 years for women. Twenty percent of the population are classed as disabled and 2.2% identify as LGBTQ+ (3.1% for England and Wales).

Dorset residents are predominantly white British with 6.1% from an ethnic background – much lower than elsewhere in England (19.5%). Dorset's main non-Christian religious groups are centred in the main towns with 0.5% of Weymouth's residents of Muslim faith. There are concentrations around military establishments such as Blandford Camp where the Gurkhas and their families live, who are predominantly Buddhist and Hindu. Rurality is an issue with many in the rural communities facing challenges with access to housing, transport and essential services.

The council has been controlled by a Liberal Democrat and Green Party Coalition since elections in 2024 when it gained control from the Conservative Party. It is part of the NHS Dorset Integrated Care Board (ICB). Partner hospitals include University Hospital Dorset (UHD), Dorset County Hospital (DCH), Somerset NHS Foundation Trust, and Salisbury NHS Foundation Trust. There are 3 prisons in the area: HMP Guy Marsh, HMP Verne, both Category C prisons and HMP/YOI Portland, a training and resettlement prison and Young Offenders Institute.

Financial facts

- The Local Authority's total spend was **£721,184,000** in 2024/25, in comparison to a total spend of **£657,896,00** in 2023/24. In 2024/25, **27.27%** of the spend was spent on adult social care.
- The Local Authority's total spend on Adult Social Care was **£176,429,00** in 2024/25, compared to a total spend on Adult Social Care of **£155,579,00** in 2023/24. The Local Authority spent **£54,656,163** (adult social care spend) per 100,000 adults in 2024/25.

- The Local Authority has raised the full Adult Social Care precept for 2024/25, with a value of **2%**. Please note the amount raised through the Adult Social Care precept varies from Local Authority to Local Authority.
- Approximately **5,705** people were accessing long-term Adult Social Care support, and approximately **2,065** people were accessing short term Adult Social Care support in 2024/25. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

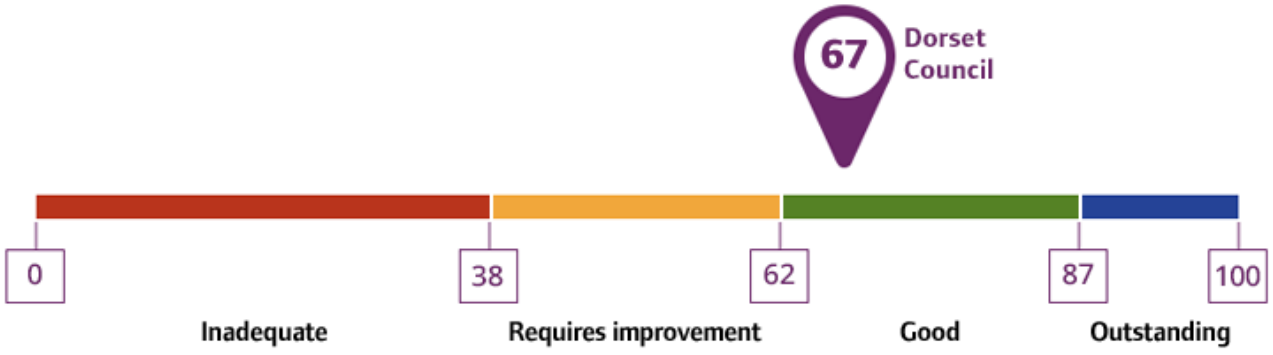
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Overall summary

Local authority rating and score

Dorset Council

Good



Quality statement scores

Assessing needs
Score: 2

Supporting people to lead healthier lives
Score: 3

Equity in experience and outcomes
Score: 2

Care provision, integration and continuity
Score: 3

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 3

Safeguarding
Score: 2

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People and unpaid carers feedback about their experience was generally positive throughout our assessment. This reflected the overall picture shown in national data, with Dorset largely performing in line with the national average. Where data indicated people experienced more negative outcomes, such as in reablement, the local authority shared more current information which showed an improving picture.

Local conditions had a wide-ranging impact on people's experience and wellbeing, particularly the challenges from the rurality of Dorset, such as access to transport and housing. There was a common theme of isolation, particularly given the significant ageing population.

People had positive experiences when they underwent an assessment or review of their care and support needs, as did carers who had a carers assessment, but this experience was hampered by the delays caused by lengthy waiting lists. Some people experienced delays in accessing equipment. However, people had some input from staff while they waited, with urgent needs and risks being picked up through the introduction of a waiting well initiative and improved monitoring of waiting lists. Improvements had started to address concerns over waiting times, with an improved focus on unpaid carers, more people's needs being assessed and met at the front door. People's needs were being considered more holistically and proactively, reflecting the increased focus on prevention with better signposting to Voluntary, Community, Faith and Social Enterprise (VCFSE) partners and earlier intervention such as provision of simple equipment and Technology Enabled Care (TEC).

Good quality care enhanced people's experiences and concerns about their safety were addressed promptly. People and carers benefitted from consistency and joint working due to the positive partnerships.

Enhanced pathways were improving the safety and timeliness of care journeys. We heard positive feedback from young people and their parents about moving from children's to adult services and from people moving from hospital to their home following the introduction of new ways of working by the local authority and partners. Recent changes in safeguarding processes and practice meant people received more consistent and robust responses to their concerns, plus an increasingly personalised approach.

People told us Dorset Council was a local authority that listened and changes were made in response to their feedback. People and unpaid carers were positive about coproduction, although they recognised some further work was needed to always ensure their voices were heard and embedded in strategic planning through to the delivery of services. They also told us there could be more effective communication about changes which would affect their wellbeing and outcomes. Some seldom heard or marginalised communities were communicated with well. However, there was scope to enhance this to ensure all communities benefitted from local services and positive links with the local authority.

Summary of strengths, areas for development and next steps

Performance across key adult social care indicators showed outcomes largely in line with the national averages, with some areas for improvement. This reflected the findings of our assessment. Strong leadership was committed to driving timely transformation, with new initiatives showing early positive impacts but requiring further embedding to ensure sustainability. Staff and partners were positive about how improvement were having a positive impact on the experience of people and carers.

Arrangements for assessment and reviews of people's care needs promoted strength-based, personalised practice. However, some people experienced long waits for assessments and reviews. The local authority had recognised this as and we found practical, effective measures in place to address concerns. New measures were fully researched, coproduced, and involved partners appropriately. These included changes to the front door, early interventions, a Trusted Assessor programme, and provider led reviews.

Prevention was key to the local authority's vision, aimed to prevent or delay needs from escalating and there was an ongoing drive to embed the wider prevention agenda in a coordinated way across all areas of the local authority. Significant changes to the front door arrangements supported this aim, with the creation of new therapy led teams aimed to support people to find solutions, reducing the numbers of people being transferred to more specialist and locality teams. The local authority highlighted the role of unpaid carers in its prevention strategy. Staff were passionate about prevention and the positive impact it was having on people's outcomes.

Reablement played a key role in the prevention agenda. New initiatives promoting 'reablement for all' such as changes to pathways and increased flexibility were improving access to reablement. Access to equipment and adaptations had been affected by the unplanned change in community equipment provider, which were out of the control of the local authority, and by waiting times. However, the local authority's practical response to these concerns was ongoing and it was working hard to ensure it minimised negative effects.

The local authority was committed to promoting choice using direct payment and individual service funds. We received positive feedback about the arrangements to support the use of these although the local authority acknowledged more needed to be done to promote the uptake of direct payment for carers. Negative feedback tended to relate to lack of choice and personal assistants in rural areas for people using direct payments.

The local authority had a good understanding of local communities and the barriers people faced in accessing care and support when and how they need it. There was effective engagement with the local community to understand these barriers. Effective relationships with local partner agencies supported the local authority's actions to promote equal access. There were good examples where action by the local authority and partners had targeted barriers for specific communities, such as current prisoners and ex-offenders, veterans and Gypsy, Traveller, and Roma communities. The local authority acknowledged the need to ensure equality, diversity and inclusion was threaded through all areas and highlighted the need to engage more with faith partners which it was progressing.

Local care provision was of a good quality and the local authority worked well with partners and providers to address quality and safety concerns. There was largely adequate capacity in the care market. However, there were some gaps in provision in rural areas and more needed to be done to ensure sufficient provision for those with more complex needs. The local authority had introduced the Dorset Care Framework to provide more consistency and address gaps, such as paying providers higher rates in rural areas. There were measures to promote micro-providers and personal assistants, to enhance local choice for people. The local authority told us the cost of care exercise and new framework supported provider sustainability, though providers fed back some concerns over fee levels, particularly for higher cost provision.

There were strong partnership arrangements locally which helped support consistent care. Partners told us the Better Care Fund was used to strengthen shared vision and priorities, such as through the Future Care programme, which was positively impacting hospital discharge pathways. There was an effective partnership with selected Voluntary, Community, Faith and Social Enterprise (VCFSE) organisations, who supported implementation of the local authorities' priorities. Some organisations felt systems outside this partnership were not effective and there was a risk that benefits from multiple smaller organisations could be lost.

The local authority managed risks to people's safety effectively. Improvements had enhanced pathways and helped ensure safer transitions, such as from children's to adult services and on discharge from hospital. Contingency arrangements were generally robust. Out of hours services were efficient, though staff reported a lack of emergency overnight respite provision which led to some avoidable hospital admissions and affected carers wellbeing.

A new hub and spoke safeguarding model had been implemented in 2025. Further time was needed to measure its full impact. However, staff were positive about the new model and early evidence showed an improvement in the management, consistency, learning, and practice around safeguarding. The improvements had led to a reduction in waiting times for safeguarding referrals to be actioned. However, there remained lengthy delays in progressing Deprivation of Liberty Safeguard applications which could mean people faced unlawful deprivations and not having their rights protected, even though the local authority monitored these closely.

There was an open culture at the local authority with visible leadership, and robust management arrangements. The learning and continuous professional development offer was highly praised by all staff. Learning and feedback was used to make improvements and there was a commitment to involving people in shaping future development. Leaders had driven a transformation journey based on strategic priorities, but more time was needed to embed the wide range of changes and to fully realise the benefits. However, it was clear staff shared the leaders' commitment to doing the right things at the right time and a vision focused on supporting and meeting the needs of people and local communities.

Theme 1: How Dorset 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

People could easily access the local authority's care and support services, and this was supported by the implementation of a front-door model designed to resolve more enquiries at first contact and reduce waiting times. Although improvements were still being embedded, we found they had started to improve outcomes for people, with more timely responses and faster progression for those requiring full assessment of their needs. People described assessments as accessible and well-coordinated, with staff sharing information clearly and explaining options to help them make informed decisions about their own care and support. There were systems in place to ensure people's needs and support plans were reviewed.

The local authority's approach to assessing needs was person-centred and strengths-based, with many people reporting that assessments were thorough, respectful, and focused on their wishes. People told us social workers listened carefully, explored their aspirations, and involved them meaningfully in decisions. Staff described a consistent focus on strengths-based practice, supported by review projects such as right-sizing care packages. We saw that the local authority showed good practice in trauma-informed and personalised planning, with staff adapting assessment and care planning to an individual's communication needs, support requirements, and identity. However, some people experienced inconsistencies, including instances where written plans did not reflect the support agreed during assessment, which created anxiety and uncertainty.

Partner feedback showed some variation in the quality of assessments. Many providers described effective communication and involvement, but others reported limited consultation during assessments or felt reviews resembled paper exercises rather than meaningful engagement. Some providers of older people's services reported that assessments for people with complex needs lacked sufficient detail, while providers supporting younger people with learning disabilities described more thorough and skilled assessments. Partners emphasised the need to continue reducing the number of assessments carried out in hospital settings to ensure more person-centred and community-based planning.

Feedback about communication was generally positive. People transitioning from children to adult services reported particularly good practice, highlighting that joint working between teams reduced duplication and avoided them having to repeat their story. At the same time, quality-assurance audits identified examples where people had experienced delays and frustration in contacting professionals, particularly for people with complex needs or those living in rural areas, suggesting accessibility and communication were not always consistent.

The effectiveness of pathways and processes had been improved through recent changes in structure, with negative feedback primarily relating to timeliness issues, which were being addressed by the local authority. The local authority had developed several structured processes to address concerns and support consistent, coordinated assessments and reviews. These included proactive identification of young people requiring transition support, multi-agency case consultations, provider-led review models with built-in training and safeguards, and trusted practitioner models designed to streamline review activity and reduce backlogs.

Staff shared examples of effective joint-working that helped avoid unnecessary referrals, improve coordination and response times. Staff working in the learning disabilities team told us weekly multi-disciplinary meetings supported timely triage. The Trusted Assessor model, in which partners were trained to support assessment at hospital discharge, was highlighted by partners as a positive development. Assessors acted as a bridge that reduced provider uncertainty, through improved communication and greater confidence in the information being provided to enable people to return home. The model supported more timely assessments which had reduced hospital discharge delays, promoted the safety and suitability of care settings for people leaving hospital.

National data for Dorset was similar to the England averages in relation to assessment, care planning, and review arrangements. For example, national data from the Adult Social Care Survey for 2023/24 showed 66.16% of people were satisfied with their care and support, which was similar to the England average of 65.39% and 78.63% of people felt they had control over their daily life, compared with an England average of 77.62%. Data also showed that 44.27% of service users reported they had as much social contact as they would like compared with a 45.56% England average.

Timeliness of assessments, care planning and reviews

Assessment and care planning arrangements in Dorset were improving but remained inconsistent, with some people continuing to experience delays at various stages of the pathway. The waiting list for Care Act assessments had reduced significantly over the past 18 months from 824 people in June 2024 to 442 in November 2025, with the median wait dropping from 152 days to 31 days and the maximum wait reducing from 1300 to 1127 days. Staff attributed this progress to strengthened oversight, the introduction of the "waiting well" approach, and performance management processes across services, including clearer in-tray organisation. However, delays were still evident for some groups. For example, adult mental health assessments had a median wait of 113 days, and learning disability assessments 133 days, with increasing complexity of referrals influencing timeliness.

People's feedback reflected mixed experiences. Some described long waits between referral and assessment. One person told us they waited around four months and that their condition deteriorated without any change to their position on the waiting list. Others said communication while waiting could be clearer, and regular contact would reassure people they had not been "lost" in the system. However, some individuals spoke positively about responsive practice once allocated, including prompt replies from social workers and timely adjustments to care where needed.

Staff reported improved processes to manage incoming work. Occupational therapy referrals were all triaged on the same day, including calls to understand need, urgency, and risk. Urgent cases were allocated immediately, supported by clear criteria for same-day visits, showing a robust response to areas of high risk such as pressing moving and handling issues, urgent equipment breakdown, or complex safeguarding. The occupational therapy waiting list had also reduced, from 360 in June 2024 to 173 in November 2025. The service used "waiting well" letters, risk-based red, amber, green (RAG) ratings and periodic checks on people whose circumstances may have changed. There were also plans to introduce clinics prioritising those who had waited longest and people in deprived or remote areas.

Undertaking timely reviews remained a significant challenge. Waiting list figures fluctuated, but the local authority reported in November 2025, 1318 people waiting for a review, with a median wait of 218 days and a maximum wait of over 1672 days (more than four years), though some of the longest waits were attributed to recording errors within IT systems. Partners and providers described the impact of delays in reviews and move-on assessments, particularly in care homes where the local authority considered people to be safe, and so delayed reviews, despite changes in needs and risk.

Staff described a range of approaches to reduce review backlogs, including provider-led reviews, the use of peripatetic staff, and streamlined processes such as preventing duplication by completing all reviews for a service at the same time. Feedback on provider-led reviews was largely positive; many staff and providers felt this approach strengthened relationships and helped ensure people were reviewed by someone who knew them well.

Hospital discharge processes had improved through stronger relationships between hospital and community teams, with staff reporting a clearer emphasis on assessing people at home wherever possible. Early preliminary assessments were still completed in hospital to ensure safe discharge, with rapid follow-up by community teams once the person had returned home. However, partners in acute care noted that capacity pressures within social care continued to impact on prompt allocation and assessment, affecting discharge pathways and prevention duties.

Referrals to adult social care had continued to increase year on year from 17,638 in 2022/23 to 21,249 in 2024/25, according to local authority data, adding pressure across assessment, planning, and review functions. Staff described high demand and told us people could be frustrated by the time they reached specialist teams due to delays at the contact centre. Leaders had recognised this issue and implemented measures to strengthen early intervention capacity to support timely responses to people and reduce unnecessary referrals into locality teams. Leaders confirmed there was an aim for 80% of cases to be resolved at the front door through signposting to other services, and through early intervention and reablement. The impact of these changes was too early to measure at the time of our assessment.

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

National data from the Adult Social Care Survey showed unpaid carers in Dorset reported experiences broadly in line with the England average. Most measures showed no significant statistical variation, including carer's satisfaction with social services, which was at 35.96% compared with the England average of 36.83%. The same data showed that 87.57% of carers said they had time to care for others compared with 87.23% nationally, 65.55% felt involved in discussions compared with 66.56%, 26.95% felt they had enough social contact compared with 30.02%, and the proportion of carers who felt they had encouragement and support was 30.25% compared with 32.44%.

The Survey of Adult Carers in England showed that the local authority performed positively in some areas, with fewer carers reporting they were not in paid employment due to caring responsibilities, 20.46% compared with the England average of 26.70% and 37.08% of carers reporting adequate access to support groups compared with a national average of 32.98%.

Unpaid carers told us they valued the support they received. Unpaid carers described sitting services, respite arrangements, and practical support. One unpaid carer told us the sitting service was supportive although it took time to arrange, while others referenced regular respite or having a carers card which they found helpful. Unpaid carers highlighted strong individual social workers, with one carer describing their current worker as “brilliant”. Written feedback gathered by the local authority and shared with us also showed examples of positive experiences, including unpaid carers welcoming face-to-face opportunities to contribute to reviews.

Staff described a system that recognised unpaid carers and looked to offer assessments as appropriate, with carers assessments being triaged to a dedicated Carers Assessment team. The local authority reported a shift toward more personalised short breaks and a more flexible approach to support planning, including enabling carers to use personal budgets for activities tailored to their own wellbeing rather than traditional replacement care. Staff described clear eligibility criteria, with agreed support documented in support plans. Carer case workers based in locality teams worked with partners to provide joined-up practice and identify carers in the community.

Partner organisations provided a more mixed picture about support for unpaid carers. One partner reported that while support had improved in recent years and unpaid carers were no longer as isolated, the formal carers assessment process was “cold” and carers often waited weeks before receiving feedback. They said waits for carer assessment outcomes could be 3-4 months (October 2025).

Data submitted by the local authority showed significant pressures on timeliness of unpaid carers assessments with a waiting list of 207 carers for assessment. This did not include young carers, who were allocated assessments without delay. The median waiting time was 49 days and the maximum 298 days, against a target of 28 days. The local authority's own quality assurance audit found unpaid carers were generally recognised and offered assessments, and that they valued respite and emotional support. However, it too showed delays and inconsistent follow-up for unpaid carers.

There had been improvements in support to young carers. Partners confirmed recent commissioning changes had addressed historical concerns and there were examples of effective support for young carers with improved responses and practice.

Commissioners described a new, outcome-focused service specification for the carers organisation, which included carers grants for those with assessed needs. This grant aimed to give unpaid carers greater flexibility, such as enabling access to leisure activities, and was developed with input from unpaid carers through a number of unpaid carers steering and engagement groups.

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, though this was less developed in some areas. The local authority funded several partner agencies to provide this support to people who did not have Care Act eligible needs, such as needs around housing.

Staff told us self-funding was a significant issue locally, with many older people self-funding initially and then running out of funds. Strategies to address this directly were still at an early stage of development. Staff told us a self-funding working group had been set up and told us about initiatives such as Technology Enabled Care and Independent Living lounges, which self-funders could directly access for advice and support.

Staff involved in hospital discharge told us that while everyone was entitled to a Care Act assessment, including self-funders, ward staff were expected to establish people's funding status and provide support in sourcing care where needed. This meant some practical support was available to people with non-eligible needs at the point of discharge.

Overall, the information and advice available to people with non-eligible needs varied, and much of the work to strengthen this support, particularly for self-funders and people with autism, was still in early development.

Eligibility decisions for care and support

National survey data showed that 68.70% of people in Dorset did not buy additional care or support privately, which was higher than the England average of 64.39%, suggesting most people were able to have their eligible needs met through local authority arranged support.

The local authority had clear written policies guiding eligibility decisions for adults and carers. These policies were underpinned by the Care Act, aligned with statutory guidance, and included reference to strengths-based practice. Policies were available to staff and partner agencies and included accessible routes for people to make complaints.

The local authority's policies and published guidance showed that there were established routes for people to challenge decisions, including easy access to the council's complaints webpage directly from policy documents. This gave a clear mechanism for people to raise concerns about eligibility assessments. The local authority did not currently have any appeals relating to Care Act assessments but there was an appeals process in place.

Financial assessment and charging policy for care and support

The local authority had a clear financial assessment and charging policy for care and support. People's experience of financial assessment was mixed. One person described a two-month delay in receiving their assessment outcome, resulting in an overpayment which negatively affected their wellbeing. Others told us assessments were completed promptly, supporting timely decisions on long-term planning. Some staff were unaware of delays and told us the process worked smoothly. Other staff told us they had raised concerns about delays in the past and the local authority had subsequently acted on this feedback.

There was a target of 14 days for financial assessments to be undertaken. However, data provided by the local authority showed people experienced delays. In July 2025 there were 343 people waiting for a financial assessment, with a median wait of 24 days and a maximum wait of 120 days. Following our site visit the local authority provided data showing there were 261 people waiting in January 2026. The local authority was increasing staffing to address delays and the introduction of digital tools to increase efficiency were being considered.

The local authority monitored appeals relating to financial assessments and reported 85 appeals. Of these, 49 were not upheld, 13 were partially upheld and 8 were upheld, demonstrating that clear processes were in place for reviewing decisions.

To support transparency and help manage expectations around financial contributions, the local authority had introduced a public-facing Financial Estimator tool. This enabled people to independently calculate any possible contributions and so help plan and manage their care arrangements.

Provision of independent advocacy

People had access to timely independent advocacy support in the local area, which helped them to participate fully in care assessments and care planning. Local authority data showed 1764 people were receiving advocacy in May to June 2025 which was a 111 increase from the same period in 2024.

Following recommissioning of the advocacy service in 2023, there had been a focus on promoting awareness of advocacy, which included the introduction of carers advocacy. Internal quality assurance activity highlighted concerns about the level of advocacy referrals and the Safeguarding Adults Board's (SAB) annual report 2023-2024 noted referrals were lower than expected indicating further work was needed in this area. However, there is no mention of this in SAB annual report 2024-2025.

People gave us mixed feedback about their experience of accessing and using advocacy. Some told us social workers recognised the role of both informal and independent advocates and arranged assessments at times that enabled both the person and their representatives to participate fully, helping them to feel empowered and heard. However, one person described how some social workers engaged more with their advocate than with them directly and did not always listen to the views they expressed, which affected how involved they felt in their assessment.

Staff told us advocacy was essential to ensuring the voice of people was central to assessment and planning and they had good access to advocacy services, where required. Staff provided examples where advocacy, translation services, and wider voluntary sector support were brought together for people with significant communication barriers, complex needs, or limited informal support, ensuring they were able to participate fully and receive coordinated help. Staff working with people with learning disabilities told us they could access specialist self-advocacy organisations which were funded in part by the local authority, and that dedicated carer advocates were also available.

Advocacy providers told us relationships with the local authority were, in the main, positive. They felt the local authority's website clearly linked to their services, helping to raise public awareness. They said senior leaders were responsive, understood the role of advocacy, and used quarterly monitoring meetings and reports to oversee performance and support improvements. The local authority was working on a proposal to increase capacity for non-statutory advocacy work.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

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

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

The local authority commitment

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

Key findings for this quality statement

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

The local authority worked with people, partners, and the local community to make available a range of services, facilities, resources, and other measures to promote independence, and to prevent, delay or reduce the need for care and support. People and unpaid carers gave clear examples of the positive impact of the preventative support they received. They described receiving advice and signposting at different hubs around the county, arranged by partners who had been funded by the local authority as part of their prevention approach. Other people described direct support from local authority staff. One person told us the support from staff had helped them minimise their risk of falls, forge local links in the community and make informed decisions about future care. An unpaid carer described how the local authority Technology Enabled Care (TEC) Team had helped their relative use an application on their phone to increase independence in household tasks, reducing the need for ongoing support.

Local authority staff were passionate about prevention and described many instances where they and partners had worked with people to avoid needs escalating. Examples included the use of TEC and counselling to support unpaid carers to continue caring for their family members. Partners were positive about the local authority's prevention approach. However, their feedback also reflected the challenges of providing services in rural areas, with many resources being based in larger towns. They noted the local authority had funded some organisations to carry out home visits which helped target these gaps, particularly in the north of the county.

Prevention was threaded through the local authority's strategic direction. There were several strategies and plans, such as key commissioning strategies, which were transforming how care and support was being provided and wider initiatives to embed prevention across the council. Leaders shared a draft prevention strategy setting out the ambitions for prevention, 'Preventative services across Dorset Council's Adults and Housing directorate'. Despite the strategy being in draft, it reflected a robust preventive approach with multiple examples of well embedded, as well as newly launched, innovative initiatives. The prevention approach was data driven, with an understanding of the local challenges around an ageing population and a large rural area; informed by local strategic reviews and national best practice.

Significant changes to the front door were key to the implementation of the prevention agenda. Occupational Therapy staff were now central to front door practice, offering prompt support, with specific consideration given to people at greatest risk of a decline in their independence and wellbeing. A new Prevention and Early Intervention team had been created in October 2025, and staff spoke with enthusiasm about the early impact of the changes. They described how they worked alongside people, unpaid carers, and partners in a holistic manner to find solutions which improved outcomes and prevented needs from escalating. Flexibility was key to this approach, enabling timely access to services such as reablement, TEC and equipment. Staff told us the approach had been well-researched, fully trialled for several months in advance, including seeking feedback from people. Changes had been made along the way to ensure continuous improvement and that the approach would have positive benefits for people. Therefore, although the team itself was new, it reflected a culture and approach which was already embedded in the front door.

Staff told us more people were being supported promptly at the front door which had led to a reduction in transfers to locality teams where people might previously have experienced significant waits for support. This had improved outcomes for people who often did not require further input after initial preventative support and enabled locality teams to focus on people with more complex needs. Staff contacted people and carers to review the outcome of early intervention which enabled any unmet need to be picked up before escalating further. There was robust oversight of the new arrangements, with staff collecting data to provide evidence of the impact of the new approach and to measure how independence was being supported, such as through equipment or referral to other agencies.

The local authority had embedded adult social care into other plans and strategies to support preventative care. Health partners spoke of the effectiveness of strategic partnerships in driving the Home First approach, supported by the Future Care Programme. A health leader described how the local authority ensured there was a dedicated social care service within the hospital emergency departments providing rapid intervention to prevent unnecessary hospital admissions. The shift towards integrated neighbourhood teams and neighbourhood health initiatives also reflected this proactive approach, building connections in communities.

Housing challenges such as lack of affordable housing, and difficulties in moving people on who no longer had Care Act needs impacted the prevention approach. Housing sat in the same department as adult social care. Leaders told us this supported a cohesive approach, based around people's needs, reflected in new housing plans where extra care housing solutions aimed to prevent people's needs from escalating. Staff shared examples where housing and adult social care staff had worked together in a person-centred manner to prevent people's needs escalating. For example, ensuring people being discharged home had the support they needed, such as equipment, care technology, advice, and access to a choice of care and local micro providers. Staff were positive about new developments such as a housing service for 18-25 young people which had helped reduce care packages for the first tenants and was helping them to move on to more independent living.

The local authority had taken steps through varied services and measures to identify people with needs for care and support that were not being met, such as unpaid carers who did not recognise themselves as carers, or people who were not in contact with the local authority. Voluntary, Community, Faith and Social Enterprise (VCSFE) organisations played a key role in this area.

The local authority had commissioned 7 VCSFE organisations, collectively referred to as the Dorset Integrated Prevention Partnership (DIPPs). These organisations reflected the breadth of the local authority's prevention offer, providing such services as community connectors, housing help and advice and volunteer support. Partners and staff gave us examples of how DIPPs had worked to promote independence or prevent admission to hospital. Staff told us DIPPs helped address inequalities for people facing multiple exclusion, such as acting as a bridge with the Gypsy, Traveller, and Roma community.

DIPPS and other partners were key to supporting the local authority wider prevention and Public Health initiatives, such as smoking cessation programmes, or pop-up dental surgeries in a community resource centre which was attended by former prisoners. Joint initiatives enabled those at risk of unmet need to be targeted, such as using data sources to focus on unpaid carers as an ideal cohort to be offered NHS health checks. The local authority engaged partners to support it to measure the impact of prevention approaches. For example, it had commissioned a partner organisation to help it understand why the smoking cessation offer was less effective in more deprived areas.

Provision and impact of intermediate care and reablement services

The local authority worked with partners to deliver intermediate care and reablement services to enable people to return to their optimal independence. National data in the Adult Social Care Outcomes Framework (2024-2025) indicated the local authority performed negatively in the area of reablement. Data showed 2.38% of people aged 65 and over discharged from hospital, received reablement services compared to the national figure of 5.77%. Likewise, 56.43% of people aged 65 and over discharged from hospital into reablement and who remained in the community within 12 weeks of discharge, which was lower compared to the national figure of 60.66%. However, other evidence, including partner feedback, reflected a more positive picture about the effectiveness of reablement.

Following our site visit the local authority supplied us with more current information to demonstrate how the changes in their prevention strategy were having a positive impact, though it was still early days. It had set a target of resolving 80% of requests for care and support at the front door. It exceeded this target (achieving 87%) following the introduction of the Prevention and Early Intervention Service. Between October 2025 and December 2025, 52 people completed a period of reablement delivered by this service; 46% were fully independent following completion and 30% were more independent although needed some further support. Commissioned services delivering reablement had achieved a small but steady reduction in the length of time people stayed in need of reablement over the later months of 2025 and January 2026.

Leaders had recognised the need to improve the provision of reablement, both to support hospital discharge and hospital avoidance. As part of the local authority's prevention agenda there had been a significant shift towards a default 'reablement first' approach. The front door aimed to ensure reablement was key to all conversations. While these changes were at an early stage, evidence indicated strong foundations had been put in place to continue to enhance and expand the impact of reablement.

Staff gave positive feedback about reablement, describing how they used it to flexibly target resources and have maximum impact. Staff gave many examples of positive outcomes for people who had received reablement, often resulting in no ongoing social care input being needed. For example, they had worked with the police and other partners to provide reablement support within 24 hours to a person at risk of harm. Another person with learning disabilities who was not eligible for services under the Care Act received targeted enablement support, in partnership with their GP, which helped them develop skills and promoted their independence, preventing their needs escalating.

Partners gave positive feedback about reablement. One health partner described how social care staff supported people who attended hospitals in an emergency to access reablement and prevent unnecessary admissions. They told us there were effective measures to capture people's improvements and goals which strengthened confidence around people being discharged home.

The Home First Accelerator programme reflected the local authority and partner agencies' commitment to improving reablement support. Plans included the scheduled build of a 56-bedded facility to provide therapy and opportunities for reablement, aimed at supporting people to regain independence and prevent unnecessary hospital admission.

The local authority funded several Recovery, Continuity and Resilience (RCR) providers to provide reablement services. Staff told us they could access the service promptly, including at weekends. A provider gave positive feedback about the initiative, reflecting an holistic approach which included supporting people to connect with their local community. The provider praised the flexibility of the system in preventing hospital admission. They described how people who called for emergency services might instead receive prompt and practical reablement support following a clinical assessment, enabling them to remain at home.

There was positive partnership working and effective oversight of reablement providers through regular meetings with key professionals, and clear targets which also helped support a consistent joined-up approach. Improved processes, such as referral routes supported the effectiveness of reablement. A new application had been introduced in October 2025 which helped measure achievements for people receiving reablement against outcome-based goals. Partners and providers gave us positive feedback about this innovative application.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to support their independence and continue living in their own homes. There were multiple examples of positive outcomes from the use of equipment and home adaptations, enabling people to remain independent or take part in former hobbies.

Negative feedback related to the length of time people had to wait for an assessment of their needs rather than the provision of equipment and home adaptations. Local authority data showed waiting times for assessment were reducing gradually. The local authority data showed the number of people waiting for provision of equipment on the 14 July 2025 was 146.

In 2025, there had been an unplanned transfer to a new equipment provider, due to the collapse of the previous supplier which had caused disruption locally. Staff and leaders told us there had been a transition phase when provision of equipment had been affected and priority was given according to urgency, such as equipment to support a person's discharge from hospital. Measures had been put in place to resolve access issues, such as setting up clinics where staff could see multiple people on the same day. Staff from the new provider were being trained as trusted assessors to dispense minor equipment and enable people to receive support in a timely manner.

People with the greatest risk to their wellbeing were prioritised for assessment and equipment provision, using risk prioritisation tools. Staff told us they could request prompt delivery where there was an elevated risk, such as if a person was at severe risk of injury. A person told us equipment had been provided promptly which had enabled them to return home from hospital and continue living independently. The local authority was expanding its trusted assessor model to enable trained staff to assess for smaller aids and equipment, freeing up specialist occupational therapists to focus on people with more complex needs.

Advice, information, and support was provided to keep people safe if they were waiting for equipment. Under the waiting well approach, staff spent time talking to people to check whether other preventative measures could support them while they waited for assessment, aids, and adaptations. People could choose to buy equipment themselves with advice from local authority staff rather than wait for an assessment. Local authority funded facilities offered access to free advice from occupational therapists with practical solutions and equipment for daily living. This increased the level of choice and control for some people.

Technology Enabled Care (TEC) was a central feature of the local authority's prevention approach. Leaders and staff spoke with passion about how technology made a difference to people's lives. A member of staff described how a young person's outcomes and wellbeing had increased using TEC, such as door sensors and trackers, reducing the need for the paid carers which they had found intrusive. Unpaid carers told us they had been involved in testing TEC, such as digital sensors, at the TEC lounges to help the local authority understand how these technologies could best support people and unpaid carers. Staff were positive about the lounges, including how self-funders could try out TEC and equipment before buying them.

The local authority's Disabled Facilities Grants (DFG) were delivered via the Dorset Accessible Homes services (DAHs) which covered major adaptations, minor works, and 'handyman' services. It told us it was in the top 11% nationally for DFG delivery times. However, the timeliness of DFG work was affected by the delays in assessments from occupational therapists. The local authority had responded by putting mechanisms in place to maximise the timeliness of the process and access of DFG, such as increasing the cost of minor adaptations which could be done without a DFG.

Occupational therapists offered informal advice to people who had the funds to carry out their own adaptations. This helped people meet their own needs promptly, whilst minimising risks to their safety. Occupational therapists were also involved in advising home builders on designs of new properties to ensure designs maximised safety and independence for anyone living in the homes. This aimed to help minimise the need for adaptations of the properties in the future.

Provision of accessible information and advice

People could access 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 funded or arranged their own care and support.

The Adult Social Care Survey reported 64.15 % of people who used services found it easy to find information about support, which was marginally lower than the national average of 67.88. The Survey of Adult Carers in England found 61.64% of carers found it easy to access information and advice, which was marginally higher than the national average of 59.06%.

There were challenges to the provision of accessible information and advice, with a highly rural, isolated, and ageing population. Alongside improving the uptake of self-service digital information, staff and leaders showed an awareness of the impact of digital exclusion and took measures to promote equitable access to information. A partner told us local authority staff had been trained to provide practical help to people struggling to access online information. Staff described how the local authority had addressed digital exclusion through multiple strategies, including physical contact points in libraries, and using existing networks. Leaders gave an example of using a food bank to support the spreading of information into local neighbourhoods. An unpaid carer told us they did not use the internet but had received information at a community group funded by the local authority.

The local authority was committed to improving access to information to the community it served as a key aspect of its prevention approach. Staff told us there was always an information platform available, with information designed to attract people who did not recognise they were unpaid carers or had needs under the Care Act.

The local authority had measures in place to ensure information was provided in multiple formats and languages, aligned to people's needs and communication methods. Staff described how the different formats such as easy-read documents or sign language videos positively supported people's access to information. Some carers told us they were members of the Information Design Group which aimed to make information more accessible. They told us they focused on ensuring communications from the local authority were jargon-free and services remained accessible to those living with health challenges or disabilities. Initiatives included coproducing information material for GP surgeries and a new guide to Adult Social Care for people and unpaid carers.

Findings in complaints and Safeguarding Adult Reviews had highlighted a need for better recognition of adjustments necessitated by Autistic Spectrum Disorder. Leaders told us training was improving communication with autistic people across the system but recognised further work was needed in this area to ensure equitable access to information and advice.

Direct payments

The local authority was committed to promoting direct payments to improve people and unpaid carer's choice and control about how their care and support needs were met. The uptake of direct payments by people across all ages was in line with the national average. The Adult Social Care Outcomes Framework/Short and Long Term (2024-2025) data showed 25.97% of people who used services received direct payments, compared to the England average of 24.51%.

Feedback from people was largely positive about the benefits of direct payments. One person told us it provided the freedom to be independent and access specific support groups which had enhanced their wellbeing. Negative feedback related to the lack of availability of local personal assistants which limited how many people could use direct payments.

Leaders acknowledged a relatively poor uptake by unpaid carers of direct payments. Local authority data showed the provision of direct payment to unpaid carers at 25.9% compared with 77.6% across England. However, there was limited evidence of a negative impact as a result of this uptake, as alternative services were provided, with people in rural areas having access to services provided by local micro providers. In addition, one unpaid carer described supportive respite arrangements which were set up as a direct payment for the person they cared for, rather than for them in their caring role. Staff shared examples where direct payments were being used to support unpaid carers, such as access to gym membership. The local authority told us they were committed to increasing the use of direct payments by unpaid carers and had provided staff with updated training. New flexible grants for unpaid carers had been introduced to help minimise impact while actions to increase the uptake of direct payments took effect.

The local authority understood the barriers to using direct payments and was taking steps to remove them to promote and increase uptake for both people and unpaid carers. In response to the findings of a peer review in 2023, there had been changes to staff training and a new outcomes focused budget setting tool was being developed to promote flexibility with direct payments. From June 2024 to June 2025 110 people stopped using direct payments, which was 12.15% of the total number. The local authority had analysed these figures to capture themes, using this data to implement changes to support uptake, such as improved training.

People with lived experience had been involved in promoting a more personalised, outcome-based approach. Staff told us they were positive about the changes, and the new training had been useful in raising the profile of direct payments. Staff said they focused on people's preferences to increase control about how care and support needs were met.

The local authority had recognised the lack of availability of personal assistants and flexible local services which affected people's capacity to use direct payments, leading to unmet need or reliance on commissioned services. It was actively addressing this. For example, by funding an organisation to promote the availability of micro-providers. Staff gave positive feedback about the increased availability of micro-providers.

The local authority actively promoted choice using Individual Service Funds (ISF), where providers supported people to manage their personal care funds. There were 8 providers and 64 people using this model of funding. Staff told us the uptake of the ISF was growing with more providers coming on board, including micro-providers. Changes were also being made to enable people to purchase support from VCSFE organisations, further enhancing local choice.

People had timely and ongoing access to information, advice, and support to use direct payments. People gave us positive feedback about the support they received with setting up and processing payments, including when they moved from children to adult services. Unpaid carers told us they had worked with the Direct Payment Steering Group to co-produce clearer letters and improve website information.

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 showed awareness of the unique challenges posed by the rurality of the county, and its population. This understanding had been enhanced by a commitment to wide-ranging coproduction including examples of effective engagement with local diverse communities such as the Gypsy, Roma, Traveller, farming and military communities. The local authority was particularly aware that its ageing population would increase considerably over the next decade and the impact this would have on equity. Access to transport in rural areas and lack of availability of services in these communities were repeatedly cited as barriers to accessing care and support, creating pockets of isolation, and limiting opportunities for social connection. Dorset was predominantly White British in its demographics. There were some examples of engagement with other communities, such as strong links with ex-Gurkhas. However, there was evidence the local authority had not fully engaged consistently with ethnic minority groups to understand their experiences. This was an area leaders told us they were aware of and addressing by increasing communications with faith organisations.

The local authority had a good understanding of the barriers people faced in accessing care and support when and how they needed it. Staff told us about specific issues affecting certain groups of people, such as the Weymouth area, which faced significant deprivation. There were some examples of effective engagement with the local community to understand barriers through outreach work and multi-agency work with partners such as GP surgeries. Effective relationships with local partner agencies supported the local authority's actions to promote equal access.

The local authority and partners targeted barriers for specific communities, such as current prisoners and those preparing for release, support for ex-offenders, military families, veterans and the Gypsy, Traveller, and Roma communities. The local authority also told us about positive work they had undertaken around community cohesion with a barge in Portland for asylum seekers, where safeguarding concerns, isolation and mental health issues were recognised and addressed.

The local authority had addressed equity through universal access models and improved pathways. For example, pan-Dorset strategies, pooled budgets and contracts, such as the Dorset Care Framework which has been in place since December 2017, ensured consistent access to equipment, housing adaptations, and care services regardless of geography or funding source. Recovery services were offered to all adults across Dorset, removing eligibility barriers and promoting fairer outcomes. Transition planning for young people was strengthened through standardised pathways and co-produced resources, reducing gaps and improving continuity.

Staff acknowledged there was a need to ensure equality, diversity and inclusion was threaded through all areas and highlighted the need to further engage with faith partners. It had begun to take steps to reduce inequalities, such as focussing on involving staff and the public in conversations about service design, with the aim of achieving more equitable outcomes by creating services people wanted. The voice of people was embedded in service design such as through initiatives including coproducing its website and developing a toolkit to promote participation. Projects like “100 Voices” showed commitment to hearing seldom-heard voices. Engagement extended to diverse communities, including Gypsy, Traveller and Roma groups and LGBTQ+ networks, although some partners noted farming communities were still underrepresented.

Processes to support equality and inclusion were clear. The local authority had an Equality, Diversity, and Inclusion (EDI) Policy, updated in June 2025. An EDI Engagement Panel had been set up in 2025 to act as a critical friend to the local authority and provide feedback on policies, strategies and service delivery. Staff took part in national programmes such as the Workforce Race Equality Standard and Oliver McGowan training for learning disability and autism. However, providers told us there was need to promote cultural competency training for care staff to support an understanding of the changing demographics.

Safeguarding arrangements included targeted support for people at risk of poorer outcomes, such as those experiencing self-neglect, hoarding, and alcohol misuse. The local authority also had a dedicated worker to support with transitional safeguarding. Housing officers worked with ex-offenders and people sleeping rough, including women who were supported through services, and individuals living in remote woodland areas. The local authority also collaborated with partners to address systemic barriers, such as digital exclusion.

Inclusion and accessibility arrangements

Appropriate inclusion and accessibility arrangements were in place to ensure individuals could engage in ways that suited their communication needs. This included access to British Sign Language (BSL) interpretation, enabling deaf or hard-of-hearing people to videocall council staff via a BSL interpreter. Video remote interpreting was also available in council offices, allowing immediate communication using tablets, phones, or laptops. Interpretation services offered face-to-face, telephone and video interpreting for non-English speakers. Easy read materials were also available and had been produced in partnership with a local self-advocacy group run by people with learning disabilities, to make information more accessible.

The local authority had an accessibility statement, outlining its commitment to improving digital accessibility through staff training and system upgrades. Staff working with people with sensory impairments were trained to undertake Care Act assessments and provide tailored support. Staff told us about a person in prison with visual impairment who received a symbol cane, lighting indicators, and a talking clock to aid mobility and independence.

We saw there were ongoing challenges in maintaining BSL provision. Proposals to increase funding and provision were under consideration, showing recognition of the need for improvement.

The local authority also had easy-read guidance and documents, videos and physical contact points in libraries and GP surgeries to address digital exclusion. These arrangements were complemented by engagement with community groups and digital champions to ensure equitable access.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity

- Partnerships and communities

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

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders and used available data taken from the Joint Strategic Needs Assessment (JSNA) and other local insights to understand the care and support needs of people and communities. The local authority demonstrated an understanding of the local context, the impact on health and wellbeing outcomes within an ageing, rural county, as well as how inequalities affected individuals and communities. Systems were being improved to aid in the analysis of data, such as more comprehensive dashboards. The availability of shared data such as that produced by the Dorset Insight and Intelligence Service (DiiS) supported the local authority in having a more holistic understanding of local need.

People and carers told us the local authority was pro-active in reaching out to understand the local context. People with lived experience described how the local authority provided practical support to enable their voice to be heard, or to reach out to people who might not be heard. An organisation led by people with learning disabilities told us the local authority funded them to find out what was going on for people with learning disabilities around Dorset. Another advocacy organisation told us the local authority's commissioners held brainstorming groups to understand what support was needed. These examples reflected the local authority's commitment to ensuring it had input from the right people and organisations to understand local need.

People, unpaid carers, and other stakeholders highlighted rurality as a key factor affecting local needs for care and support. They told us this affected all areas of people's lives, with concerns about lack of transport, social isolation, and a lack of local resources. The local authority's Market Position Statement noted 46% of Dorset's population lived in rural areas. Leaders and staff showed a good understanding of how this affected people, unpaid carers, and organisations and this shaped the commissioning approach. They spoke with empathy about rural loneliness and isolation, and the struggles faced by organisations trying to support people in villages in North Dorset. They highlighted how this affected those most likely to experience poor care and outcomes, such as people trying to source a personal assistant with specialist skills within an area of low population. The local authority also recognised these challenges were exacerbated for self-funders trying to source care where there was limited availability and high costs.

The local authority told us understanding the impact of an ageing population was also crucial to shaping their approach, with a proportionately higher number of older adults compared to those of working age resulting in pressures on social care. There was an understanding of not only the current context but projected changes and impact on care provision. Local authority data identified that by 2035 the over 85 population was predicted to increase by 40%. The JSNA noted individual circumstances behind these headline figures, such as the impact of deprivation on older people in areas such as Weymouth and the lack of support networks for people who had retired to the area in later life.

There was evidence the local authority used its understanding of local need to shape its strategic direction and care provision, through the Dorset Care Framework. Its proactive promotion of local community groups and micro providers reflected its understanding of the experience of rural communities, including self-funders. Engagement with the local community and coproduction was embedded as part of commissioning practice and culture within the local authority which supported an understanding of people's needs.

Market shaping and commissioning to meet local needs

People had access to a diverse range of support options that were safe, effective, and high-quality to meet their care and support needs. The Adult Social Care Survey (ASCS) (2024-2025) found 71.26% of people who used services felt they had choice over services which was in line with the England average of 70.28%. People and unpaid carers gave us positive feedback about their experience of using services. However, there were some concerns expressed about variation in availability across the county. For example, one person told us they were placed in a care home following discharge from hospital due to a lack of assisted living services in their local area. The local authority had targeted the inconsistency in care provision through the Dorset Care Framework which enabled them to shape supply in response to local gaps.

Partners, staff, and some autistic people told us there was a lack of local provision for people with autism which meant not everyone received the support they needed. Leaders acknowledged there was a lack of an overall autism strategy and told us this was being addressed as part of the transformation programme. They pointed to specific areas where they were already promoting care provision for autistic people such as newly developed specialist accommodation, targeted commissioning with specialist providers and the promotion of micro-providers who offered a more flexible local service.

The local authority developed commissioning strategies and market shaping activity to address current and projected gaps in provision. The strategy, Commissioning for a Better Life for Adults, 2023-2028, focused on ensuring people had the right support in the right place at the right time. There was an aligned strategy for supporting people as they aged. Market shaping outlined in these strategies targeted key issues facing local people with care and support needs such as rurality and accessibility. For instance, the Home Care Optimisation programme, stimulated the care market in rural areas by using the Dorset Care Framework and fee levels to proactively enhance people's access to care providers across the county. Staff told us of other initiatives, such as work between front line staff and commissioners to improve transport for people with learning disabilities.

Providers fed back that the local authority was positively affecting the market through its actions. Market shaping focused on bringing local support to people and communities, such as funding an organisation to develop the availability of micro providers. Staff gave us examples where micro providers had met people's needs and offered choice within their local community. However, they also told us there was still room to promote the growth of specialist provision locally, such as the availability of personal assistants for autistic people.

Commissioning strategies were aligned with the strategic goals of partner agencies, such as health and housing. This included the provision of suitable, local housing with support options for adults with care and support needs. The local authority told us about an example of close working with the probation service and charities around a housing scheme for ex-offenders. The involvement of adult social care representatives enabled a focus on preventative measures such as support for people at risk of domestic abuse and safeguarding concerns. Adult social care leaders also ensured strategies were aligned to wider local priorities and the Integrated Care System priorities, with pooling of commissioning responsibilities helping target intervention more effectively.

There was specific consideration given to the provision of services to meet the needs of unpaid carers. However, the local authority acknowledged there was still work to do in this area. The Survey of Adult Carers in England found 12.87% of carers accessing support or services allowed them to take a break from caring at short notice or in an emergency, which was in line with the England average of 12.08%. Through the co-produced strategy, Commissioning for a Better Life for Carers, the local authority aimed to improve how it delivered support to carers. A new carers organisation had been commissioned to provide support which was designed to be more flexible and improve outcomes, but changes were not yet fully embedded. Other developments in the pipeline included improved options for respite.

The local authority commissioned models of care and support alongside strategic partners that were in line with recognised best practice. For example, the Dorset Care Framework moved away from outdated time-and-task models of care to deliver more flexible, personalised outcome-based models of care provision. The co-produced remodelling of day support was in line with the national shift towards neighbourhood based preventative support. Likewise, the promotion of a 'technology before care' ethos, was clear in the discussions we had with staff, showing a commitment to driving improvements in line with research and national priorities.

Ensuring sufficient capacity in local services to meet demand

There was largely enough care and support services available to meet demand, and most people could access it when, where and how they needed it. Rurality affected supply across the county and partners told us there were gaps for some people with complex and specialist need. However, short waits for home care and care home placements evidenced the local authority had effective measures to meet demand.

At the time of our assessment the local authority told us there were no people waiting for a place in a care home due to lack of bed capacity, with only one person waiting for a nursing home placement due to specific need. Only 7 people were waiting for domiciliary care. Leaders told us capacity had improved significantly over the last few years which was echoed by staff working directly with people to source services. The local authority supported choice through promoting development of micro-providers. This also supported those who were self-funding to have access to an increased supply of local care providers.

Staff and partners told us increased engagement with commissioning meant improved planning, so the local authority was better placed to manage demand and stimulate capacity in areas of greater need. Partners told us the relationship between commissioners and front-line teams supported the market. Staff described how they met with commissioners and had trackers which helped plan supply. For example, for children who would require adult services in the future. They noted this had reduced requests for care in a crisis and promoted the supply of the right kind of care to meet individual need. A partner agency told us regular discussions with commissioners enabled them to address capacity challenges and adapt delivery models through effective partnership working.

Staff and partners told us there were some gaps in care provision for people with more complex needs, such as autistic people, dementia, forensic care, and working age adults with physical or learning disabilities who needed more bespoke provision. Partners and staff told us there was a lack of availability of specialist services, such as sufficiently skilled personal assistants and providers. Providers told us this meant there was not always somewhere for people to move on to when their needs increased. There were effective systems for staff, partners and providers to feed into the commissioning activity and shape the local authority response. Local authority leaders had acknowledged where there were gaps and described how they used measures such as the Dorset Care Framework to stimulate the market and increase capacity, such as attracting specialist providers skilled in Positive Behaviour Support. Staff gave examples of bespoke packages of care being developed around individuals, using local micro-providers or specialist services. The local authority had worked with a provider to develop a new bespoke 15 bedded unit, in response to gaps in service provision for people with learning disabilities and autism. Evidence indicated the actions being taken by the local authority with stakeholders were effective in addressing gaps in the market.

The local authority told us developing extra care was key to increasing capacity in the system and reduce need for higher end residential care. The local authority undertook a housing needs assessment in 2021 and found Dorset had a shortfall of 903 extra care homes and needed to develop 1,805 new extra care homes by 2038. There was a ten-year strategy in place driving the developments in extra care provision, with 5 new schemes already in place and an additional 4 schemes in development. The local authority had developed an extra care design guide to help promote expected standards.

The rurality of Dorset affected the availability of local services, with higher transport costs and difficulties with staffing affecting availability outside the main urban areas. The local authority had taken action to address this issue by offering higher rates for rural packages of care through the Dorset Care Framework and targeted reablement.

There were resources available for unpaid carers to have access to replacement care for the person they cared for. However, people, carers and staff told us there was a lack of emergency overnight respite accommodation, at times of crisis, such as when an unpaid carer was admitted to hospital. This led to some unnecessary admissions to hospital. This had been recognised by local authority commissioners who described plans to develop a short break service which would offer accommodation in a crisis. The local authority and partners had developed a number of responsive community services which supported people out of hours, giving time for plans to be set up to enable people to continue living at home.

The local authority data showed 464 people were placed out of area in July 2025. The local authority explained that three quarters of out of area placements were to adjoining counties and given the local authority's size, people often made the decision to move to neighbouring local authorities to be nearer to their family. For instance, a high number of out of area placements were in Bournemouth, in an adjacent local authority. Despite being counted as out of area placements for data purposes, there was minimum impact on people as the town is part of the county of Dorset. The plans to stimulate the market and increase capacity, such as through new measures in the Dorset Care Framework were aimed to enable people to move back to the area if they wished. The local authority told us these measures were having an impact, and they had seen a significant reduction in working age adults moving out of county. In the last year only 3 people moved to bed-based services outside the local authority area and its adjoining counties.

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 to support improvements where needed. The local authority had measures in place to gather feedback from people and carers about the quality of services. Feedback to us and the local authority from people who used services and their representatives was positive in relation to the quality of services.

There was a dedicated team to undertake quality monitoring activity to ensure commissioned services were of good quality, effective and efficient. The team undertook a range of audits, visits to services and surveys along with calls to people to assess the quality. Providers told us the local authority took a supportive approach when issues or concerns were found and worked with them to develop improvement plans to monitor actions to ensure improvement. They welcomed this approach. There were also quality monitoring procedures for out of county placements involving liaison with host authorities.

The local authority took effective action when concerns were raised about the quality of care or increased risk. This ranged from more formal sanctions to informal support to providers. Examples included supporting a provider to move from traditional care provision to a more flexible outcome-based model. In the year from July 2024 to June 2025, the local authority placed 18 blocks on care providers. Data provided and discussions with staff and providers reflected a robust, partnership response to concerns raised.

Quality intelligence was shared across teams and partners, supported by regular multi-agency meetings and robust governance arrangements via the Quality Assurance Board. Staff demonstrated a reflective and learning approach, with actions being taken addressing key themes across the provider sector, such as events to raise awareness of modern slavery and how this impacted on safeguarding.

The Dorset Care Association worked as an effective partner with the local authority to ensure the quality of local services. Providers told us the local authority's funding of the association had enhanced communication and relationships. There were multiple examples where this relationship had promoted quality. The association's annual report for 2025 highlighted areas such as international recruitment and training events. Activity was rated according to risk and priority, with developments aligned with joint priorities.

The local authority also worked with the association to develop innovative initiatives such as provider led reviews and the trusted assessor programme, with visible positive impact on efficiency, quality of care and outcomes for people. In addition, providers told us the local authority funded networks for registered managers and for nurses in adult social care, which was a positive way to link in with other providers for support and find out about best practice.

Ensuring local services are sustainable

The local authority collaborated with care providers to ensure cost of care was considered in funding agreements. The local authority told us comprehensive cost of care exercises, in consultation with the provider body Dorset Care Association, had supported the services to be sustainable. Leaders and staff described how they were moving from a task-based, price-driven model towards a more flexible approach focused on outcomes and partnership. Feedback from providers was mixed in relation to the approach. Some providers told us the local authority had not maintained sufficient uplifts in funding, with a resulting impact on sustainability. Others highlighted the negative effect on decisions around funding of care for people with the highest need, which raised the risk of providers leaving this area of care provision. In the period between July 2024 and June 2025, 3 home care contracts and 3 residential contracts had been handed back. Five of these related to service closure or finances.

However, senior staff told us the new Dorset Care Framework delivered more efficient contracting arrangements which provided stability for providers and allowed them to plan. It also told us some providers would take time to adjust to the new outcome-based model. They had worked hard to encourage providers to join the framework and told us 95% of care was now purchased at framework rates, reflecting positive buy-in from providers. The framework was flexible so it could respond to the market, and support areas of need and providers. Staff described how the higher rates for providers in rural areas, experiencing higher transport and staffing costs had supported the viability of care packages.

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 people had continuity of care provision in this event. Positive provider relationships and robust contract arrangements promoted open conversations. A provider described how they were able to raise concerns about the financial sustainability of their business, which resulted in responsive and timely action from local authority staff.

The local authority understood its current and future social care workforce needs. Staffing was a challenge for providers across Dorset, with high house prices and poor transport provision. Adult Social Care Workforce Estimates 2025-2026 showed a higher staff turnover rate of 0.35 compared to the national average of 0.24, though adult social care job vacancies and staff sickness rates were in line with the national average. The local authority worked with care providers, including personal assistants and other agencies, to maintain and support capacity and capability. It worked well with the Dorset Care Association to promote the local workforce. Regular engagement and sharing of good practice took place alongside flexible, targeted funding and commissioning measures within the Dorset Care Framework. It worked alongside health partners to jointly commission services and care packages and maximise, through collaboration, the funding available, such as through effective S117 funding arrangements.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

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

The local authority commitment

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

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans, and responsibilities. Partnership working reflected local and national objectives. Partners gave largely positive feedback about relationships with the local authority and the value of a shared vision for Dorset.

Leaders told us partners across Dorset were united in achieving greater integration; with shared priorities of prevention and early help, thriving communities and working better together. Health partners told us the journey to full integration was ongoing, with one partner highlighting the need for greater joint working around early prevention strategies. Local authority leaders described how they were supporting the shift towards prevention. For example, through working with the police and health professionals to set up a mental health response vehicle service to support people in mental health crisis and prevent unnecessary admission to hospital. They described how they were developing approaches which allowed earlier identification of care needs, particularly for people with complex needs, enabling the right support to be provided sooner.

System leaders, local authority leaders, partners, and staff all described putting people at the centre of everything they did. There was an increased focus on ensuring the needs of local communities were key to partnership working, with people and unpaid carers voice being central to decision making. Some carers described how the local authority brought together unpaid carers and partner organisations in the Pan Dorset Carers Steering Group which had helped shape the recommissioning of the new carers service.

In the recommissioning of day services, the local authority worked with partners to promote a shift from standalone services to ones which strengthened connections in communities and met local priorities. This included involving partners such as micro-providers and voluntary services who could support local need along with improving transport options. There was also a move towards increasing access to services for the whole neighbourhood rather than just for people with care needs, reflecting priorities around prevention.

The local authority was increasingly integrating or realigning aspects of its care and support functions with partner agencies to meet need more effectively. Leaders and partners told us there had been a cultural shift with the local authority promoting more collaborative relationships. These enhanced working relationships were starting to show improved outcomes for people. Overwhelmingly staff told us that despite challenging situations they worked with partners to prioritise people's needs. They described effective partnership working with many organisations to support people at risk of domestic abuse and homelessness. Partners told us relationships across the Integrated Care Board (ICB) had strengthened significantly over the past two years, enabling close collaboration.

Providers echoed this feedback, highlighting a move from a more paternalistic relationship towards one of greater maturity. They described how the local authority increasingly collaborated with providers to address quality issues rather than adopting a purely punitive approach. The funding of a coordinating provider organisation had improved relationships and had been central to developments such as the trusted assessor programme, which supported more effective hospital discharges.

Arrangements to support effective partnership working

Arrangements supported effective partnership working, promoting positive relationships which improved outcomes for people. There were clear, effective leadership and governance arrangements for partnership working through multi-agency partnership boards. A local authority leader explained how they used membership on these boards to ensure they were involved in decisions which affected local neighbourhoods. Health partners told us the local authority was well represented through strong visible leadership on the ICB and Health and Wellbeing Boards. The local authority worked strategically with partners to agree and align strategic priorities, plans and responsibilities. It also worked closely with the neighbouring local authority of Bournemouth, Christchurch and Poole on some safeguarding work, work with VCSFEs and sharing information and insight about high-risk issues that crossed both councils.

The local authority was proactive in promoting a shared vision across partners. For example, it had arranged an event to develop a collaborative approach to designing dementia services for the future. Providers told us this approach encouraged a shared vision and supported ongoing service design around existing and future priorities, which aimed to reduce the use of out of area placements for people with specific needs.

The local authority worked with partners to identify and use joint funding opportunities to improve specific outcomes and encourage efficiency. The local authority, NHS trust, and a neighbouring local authority jointly governed the Better Care Fund (BCF) through the Health and Wellbeing Board and the Pan Dorset Commissioning Board. Governance was shared, with joint leadership structures supporting delivery areas. VCSFE partners were also included as key partners in the BCF plan. The BCF was used to support the shift toward prevention and supporting independence in line with national objectives. Staff told us the local authority played an active role in system-wide transformation, including the BCF funded Future Care programme. This had led to improvements in hospital discharge processes, through initiatives such as the Home First service and an enhanced trusted assessor scheme. Health partners told us measures such as these had promoted positive outcomes for people, enabling smoother and safer returns home.

Co-located teams included the learning disabilities team which worked alongside health colleagues with some teams being fully integrated such as the community mental health teams. Staff and leaders told us these arrangements were well embedded and resulted in more consistency around decisions and reduced disputes between organisations. They gave us many examples where people had been enabled to live safe and fulfilled lives in the community, drawing on support from partners working in a joined-up manner. Staff told us working alongside health colleagues provided opportunities for learning and reflection such as in peer forums, where they felt able to address barriers to joint working.

There were systems in place to support joint working such as the S117 hub which had shared leadership arrangements around the pooled budget. Other key partnerships included joint advocacy, community equipment, commissioning, and brokerage arrangements. Staff told us about effective connections between teams and services, such as community connectors and GP surgeries. Carer case workers told us they had a key partnership role of collaborating with Primary Care Networks, GPs, hospitals, and other local organisations. Positive examples of shared ownership during emergencies, such as provider failure, illustrated strong ongoing relationships and robust partnership arrangements which upheld people's safety and wellbeing.

Leaders and staff highlighted access to shared records as a key measure promoting partnership working. They told us these arrangements were particularly useful when people with complex needs were transferring between professionals and services. Staff described how access to hospital health records reduced duplication, supported timely discharges of people from hospital and prompt escalation of safeguarding concerns. However, staff told us the use of a single system, or systems that spoke to each other across all partners would promote more effective working and reduce the risk of duplication and missing something.

Impact of partnership working

The local authority, alongside partners, effectively monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. Leaders demonstrated a reflective approach to shape ongoing development and continuous improvement.

Leaders told us the findings of the Dorset Integrated Care System (ICS) Urgent and Emergency Care (UEC) Diagnostic, published in 2024, were central to the understanding of performance issues, around hospital discharge and emergency care pathways. The local authority was working with partners to address concerns raised in the report around poor communication and bottlenecks in the system. They demonstrated an effective, targeted response which was improving communication with partners and outcomes for people. Practical responses such as increased social work presence in hospitals were supporting timely discharges.

Ongoing evaluation of partnership arrangements ensured the local authority understood the impact of different initiatives, and could shape activity going forward, through revised commissioning decisions, improved governance measures, and monitoring of existing contracts. Staff carried out analysis of partnership approaches, considering whether there had been a positive impact on people's outcomes. For example, people's feedback was central to the evaluation of the impact of provider led reviews. Data showed social work time had been freed up and the programme was addressing waiting times for reviews. Information gathered as part of the analysis was used to tweak processes, showing a commitment to continuous improvement.

Where the local authority held contracts with partners to provide a service, ongoing monitoring fed into service specifications. For example, monitoring of the services provided by the community connectors through the Dorset Integrated Prevention Partnership measured outcomes for people, such as increased links with their community, to ensure they were in line with the local authority's prevention strategy to minimise loneliness for people in rural locations.

Working with voluntary and charity sector groups

The local authority recognised the unique contribution of the Community, Voluntary and Social Enterprise (VCSFE) sector in the provision of care and support and actively promoted their involvement as equal partners. Whilst there was good engagement with many churches in neighbourhoods across the county, the local authority acknowledged the need to forge similar links with other faith groups. VCSFE organisations gave us mostly positive feedback. Organisations told us of good relationships with the local authority, with a good support infrastructure, with an assembly, newsletters, stakeholder engagement groups, and events. However, some organisations described issues with funding and contracts, poor experiences with tendering processes, and consultation processes which were not always accessible.

Organisations with established relationships and contracts were positive about their partnership with the local authority and told us there were efficient systems, shared visions and ongoing service design which focused on meeting people's needs and evolving around gaps. Dorset Integrated Prevention Partnership Service (DIPPs) was a joint contract between the local authority and seven VCSE organisations, with a focus on prevention and supporting people at risk of escalating need such as through crisis intervention and social reablement. Staff told us these organisations supported a 'no wrong door approach', helping ensure people received help when they needed it. Health partners told us these organisations were key in supporting discharge processes, falls prevention and community hubs.

However, some VCFSE organisations told us that partnership arrangements which sat outside established arrangements did not always work as effectively. They told us the process for applying for ad hoc grants was bureaucratic and had the impact of taking their staff away from service delivery, with less time to directly support people. They also told us transitions between contracts could be disruptive, particularly for people who used their services who told them they did not always feel communicated with fully.

We saw there was a risk that smaller organisations, who supported marginalised communities, might be overlooked as they were not part of established networks which could result in a lack of understanding of gaps in services or unmet need. Local authority leaders told us they had recognised this risk and there was a pilot project in progress to promote networks between smaller organisations to consider how sustainable funding could be achieved. They described how they carried out pre-tender events and workshops to promote opportunities for smaller organisations.

The local authority used evidence from research and recognised best practice to underpin working arrangements with VCFSE organisations and brought together partners to grow community support and VCFSE capacity. Learning was shared, highlighting actions to ensure VCFSE organisations were enabled to better support issues at the heart of the community, such as loneliness. Funding of key VCFSE organisations was aligned to the findings of the research and best practice with an increased focus on more flexible outcome-based funding arrangements.

The local authority collaborated with partners around the development of VCFSE organisations. For example, it had worked with the police when developing a carers counselling service. It also worked with Bournemouth, Christchurch and Poole Council to share arrangements with VCFSE organisations. This promoted efficiencies and seamless services for people across local areas.

Theme 3: How Dorset Council ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

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

Safe pathways, systems and transitions

Score: 3

3 - Evidence shows a good standard

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.

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

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

Safety was a priority for everyone at the local authority, and all understood the risks to people across their care journey. Risks were identified and managed well; the effectiveness of these processes in keeping people safe was routinely monitored. The views of people who used services, partners and staff were listened to and considered.

People's sense of safety was generally positive. National data from the Adult Social Care Survey showed that 70.99% of people who used services said they felt safe which was similar to the England average of 71.06% and 91.86% of people who used services said those services made them feel safe and secure which was better than the England average of 87.82%. In addition, 83.74% of carers said they felt safe which was similar to the England average. An unpaid carer told us that while assessments focused on strengths, aspirations and goals of the person being cared for, the social worker had also considered their safety as a carer. This included their ability to continue meeting the needs of the person being cared for and what their future safety needs might be as these needs changed.

Staff gave many positive examples of how they managed the risks to people across their care journeys. For example, approved mental health professionals (AMHPs) told us of a change in approach that had been introduced for Mental Health Act assessments. Staff now followed a multi-disciplinary team approach where health, social care, police, and any other relevant partners would meet with the person being assessed and involve their family as appropriate. A joint decision would be made about the best course of action for the person, following the least restrictive principles, which kept them and others safe. After the assessment, the person being assessed was asked to complete a survey about their experience of the process. This showed a positive partnership approach. Staff described how members of the peripatetic team could move between teams to fill gaps and bring specialist knowledge to locality teams to help them keep people safe and meet their needs. They also described how managers supported shared responsibility for managing people's safety and supported them to manage their workload.

Clear processes outlined the Emergency Duty team role in providing cover, including AMHP cover out of hours. Team members were clear about their responsibilities and were committed to providing safe care. They described clear handover processes, providing urgent care packages, solving problems for care agencies, and organising emergency support or arrangements when respite was needed.

Policies and processes about safety were aligned with other partners involved in people's care journey. Policies and processes about safety were aligned with other partners involved in people's care journey. High Risk Domestic Abuse meetings, Dorset's version of the Multi-Agency Procedures for the Protection of Adults with Care and Support Needs (MARAC meetings) were held 4 times per week, compared to MARAC meetings which had previously been held every 3 weeks. This approach increased the visibility and responsiveness to high-risk cases and ensured a multidisciplinary approach to managing risk. Learning from Domestic Homicide Reviews was embedded into training and policies, with themes shared across the SAB partners.

Staff told us the local authority played an active role in Pan Dorset Safeguarding Children's Partnership, and the Extra Familial Risk and Harm Panel had been set up to safeguard children and young people who may be at risk of harm, such as sexual and criminal exploitation outside of their family. They described how this was a particularly important in transitional safeguarding arrangements.

There were effective Multi-Agency Public Protection Arrangements (MAPPA) in place to manage and assess the risks posed by violent and sexual offenders living in the community. The local authority told us that it was committed to this work and always attended the MAPPA Strategic Management Board quarterly and person specific MAPPA meetings. Staff described the work they did with the three local prisons, the police, mental health colleagues, and providers to support offenders with care needs being discharged into the community. For example, they identified there had been an increase in people being released from prison who suffered from dementia and described how they worked with providers to support their specific needs. However, they also told us there were not enough providers in Dorset that could provide a service to ex-offenders.

In addition, the local authority met regularly with CQC to share intelligence about providers. This helped promoted information sharing about existing and emerging risk.

Safety during transitions

Care and support were planned and organised with people and partners in ways that improved people's safety across their care journeys and ensured continuity in care. This included referrals, admissions, and discharge, and where people were moving between services.

Children and adult services worked closely together to promote a whole family approach. The Multi Agency Child Protection Board meetings were attended by safeguarding adults lead and team members also attended other meetings with partner organisations demonstrating a commitment to a system wide approach to safeguarding children and families. Transitions from children to adult social care were planned early. For example, staff described engaging families from when a child reached age 14 to better prepare them and their families for adult services. Young people's experience of transferring to adult services was mostly positive. We were told the transition assessment processes was completed using a holistic approach, focussing on individuals' needs and the needs of all the family. This approach reduced anxiety of all involved and was supportive in building positive and trusting relationships. Dedicated allocation processes and regular tracking meetings had been introduced and all young people in transition had a Preparing for Adulthood plan to ensure the young person was at the centre of planning.

Staff described their role in helping young people become more independent as they moved into adult services. However, we heard that parents sometimes did not feel listened to once their child turned 18 years. Some parents told us information had been sent solely to their child, who was 18 years, but who did not understand the communication which they felt did not always show an understanding of the young person's needs and risks.

The Birth to Settled Adulthood (BtoSA) programme had been progressed in response to feedback from Dorset Parent and Carers Council in which they identified a 'cliff edge' at transition. Partners described the work on this programme as particularly joined up and collaborative although recognised there was still work to do. The BtoSA team came into being in April 2024; jointly developed between children and adult social care services. Staff told us the changes were positive. They described how young people and their families were now more informed through the provision of specific guides outlining processes and key points along the pathway, supported and prepared because of staff working closely with them. The team worked with young people who had learning disabilities. They told us they used to work with autistic young people but due to demand the young person now also needed to have a learning disability for the team to work with them. Autistic young people were supported by generic locality teams; however not all staff had the specialist knowledge and skills to provide the required support. Leaders recognised this and told us they were developing a specialist autism pathway as part of the transformation programme.

The Dorset Future Care Programme aimed to transform urgent and emergency care across Dorset by 2027, focusing on integrated, patient centred services that enhanced care delivery and reduced hospital discharge delays. Staff described how health and social care staff worked closely to forecast a discharge date so social care staff could line up a care provider for when a person was discharged, leading to a speedier discharge.

In addition, local authority staff worked closely with staff in the Transfer of Care Hub at Dorset County Hospital, which aimed to start discharge planning early. Staff told us if people who already had packages of care come into hospital, they would hold the package for two weeks which could then be reinstated immediately on discharge ensuring no delays to discharge.

Staff told us they used the principle of 'home first', with people being offered reablement where possible. Staff also described how people could be discharged from hospital to flexi beds in care homes if it were unclear what their long-term goals might be. Staff could undertake an assessment and then either look to support a safe discharge home or to a long-term placement. Hospital staff said social workers carried out assessments onsite and provided guidance materials, ensuring discharge plans reflected post-hospital needs. Staff emphasised the person-centred approach, including around discharge timescales and advocated for people's needs, especially when delays were linked to housing or support placements. This helped ensure people were discharged safely and with the right support in place. Staff continued contact after discharge, visiting and contacting people to check plans were working.

The Adult Safeguarding team worked closely with the hospital staff through a multidisciplinary home first approach, ensuring vulnerable adults with care and support needs were discharged safely while their rights and wishes were protected. The multidisciplinary team approach was used to manage complex discharges, reducing handoffs and ensuring people's immediate safety.

The local authority used a Trusted Assessor programme where independent assessors provided assessment of care and support needs for any care provider requesting it'. Providers described how this approach gave them more confidence in accepting people being discharged from hospital as they could ensure they could meet the specific safety and support needs of the person being discharged.

Partners told us the local authority's approach to supporting discharges reflected purposeful coordination rather than ad-hoc arrangements which showed positive intentions to support timely and effective transitions. Partners told us and recent reports showed significant improvement in hospital discharge time with an average delay for people considered clinically fit to leave hospital reduced from over 10 days to around 7 days. For people with complex needs, delays had dropped from 30 to 20 days over the last year (Health and Wellbeing Board report, Future Care Programme, March 2025). Hospital discharge processes and pathways were clear, and ensured people were discharged safely.

Specific consideration was given to protecting the safety and well-being of people who were using services which were located away from their local area, and when people moved from one local authority area to another. People supported in services beyond their local area were provided protection through clear policies, joint planning, and collaborative working.

We heard mixed feedback from providers about safe support when people moved between services. For example, some providers told us of poor communication, poor coordination, long drawn-out financial discussions, and a lack of support when a person's needs increased. Other providers said they had received excellent, responsive, and prompt support, good communication and the local authority worked well with providers when people's needs changed and they needed to move between services.

Contingency planning

The local authority undertook contingency planning to ensure preparedness for interruptions in the provision of care and support. The Business Continuity Plan was dated 29/11/22 and did not appear to have been updated. However, it detailed clear contingency and leadership arrangements to maintain service continuity. It ensured staff had the tools and support to operate remotely, prioritised critical functions like emergency local assistance, ICT failures, facility damage, and loss of staff, and had defined escalation pathways. This showed the local authority took preparedness seriously, enabling it to continue essential services during disruption and protect vulnerable adults from care gaps in times of crisis.

The local authority implemented a structured procedure for supporting social care providers at risk of failure. It had standard operating procedures in place in case of urgent and planned care home closures; domiciliary care agency closures or if services were decommissioned. Service decommissioning decisions were made collaboratively at a senior level.

Staff told us of an incident which involved the emergency evacuation of care home residents following a sudden, serious health and safety event. The local authority's response was immediate and structured, using its provider failure plan, with coordination through several targeted partnership groups. This ensured residents were moved to safe, alternative care quickly and with minimal harm, despite a highly distressing and complex incident.

The Emergency Duty team described the challenges when they received referrals from paramedics who may need to take a carer to hospital, leaving the cared for person at risk out-of-hours. Staff told us emergency respite provision was limited, and some instances resulted in a social admission to hospital. This indicated potential gaps in contingency respite arrangements for emergency situations, where people might be left unsupported unless relying on a hospital admission. Both staff and people told us not everyone had a personal contingency plan developed as part of assessments or reviews. The local authority was exploring its emergency respite provision options as part of its commissioning developments.

Funding decisions or disputes with other agencies did not lead to delays in the provision of care and support. We heard there had been some challenges due to issues around health funding. Despite this, partnership relationships remained positive, with a focus on working together to ensure people continued to receive the care they needed.

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. A new approach to managing safeguarding was proving positive even though this had only recently been introduced. There was still work to do to ensure practice was fully embedded consistently and robustly across the local authority and with partners.

The local authority had seen an increase in the number of safeguarding referrals it received, from 70 per week to 180 per week over the 5 years to the end of 2024. As a result, a waiting list had been implemented but the continued rise to 239 by September 2024 had raised significant concern over the level of both known and unknown risk and that practice was not sustainable. The local authority undertook focussed work between October 2024 and January 2025 to reduce the waiting list to 7. An external auditor was commissioned to review the operational model which resulted in a change in approach.

In August 2025, following a pilot project, the local authority introduced a hub and spoke model to transform how it safeguarded adults in their communities. Specialist managers, senior practitioners, and social workers were based in a central hub. All referrals were risk assessed, managed, and triaged within 24 hours by staff in the central hub. The triaged referrals were then sent to one of 4 locality hubs for intervention based on risk and assessment of needs. Specialist safeguarding staff from the hubs supported locality staff with progressing the referral, providing specialist advice and guidance or through taking the lead for progressing the referral. All staff we spoke with, without exception, told us changes to safeguarding arrangements were helpful and had transformed the approach to safeguarding, supporting partnership working and joint learning. They told us the approach was positive for people, had strengthened safeguarding systems to ensure quality and considerably improved responsiveness in managing risk. For example, in November 2024 there were 239 Section 42 referrals awaiting review and by November 2025 there were 0 waiting review and only 10 awaiting allocation.

The local authority had a performance dashboard to support oversight and regular meetings to discuss allocations and any delays. The monthly Safeguarding Oversight Support Group meeting also had oversight of the safeguarding pathway.

Feedback from partners was positive about developments and communications. All referrals now had to be made online, but some providers told us they would like the safeguarding triage phone line reinstated, as it offered opportunities for advice which they believed cut down unnecessary referrals and improved learning. The local authority told us it did not currently have a direct phone line as demand was so high it detracted from the team's ability to respond to concerns. However, it did have an email and daily duty rota system through which team members could respond and offer advice. In addition, several partners told us they would like more involvement in and communication about progress and outcomes of safeguarding referrals.

A range of additional developments supported the new safeguarding model and enhanced safety. These included a strengthened front door triage system providing timely access to information, advice and preventative support at first contact; the introduction of a Prevention and Early Intervention team to address risks earlier; and a "waiting safe and well" programme to manage risk for people awaiting assessment through regular risk-rated check-ins and guidance. Specialist roles had been introduced alongside close joint working with hospital discharge safeguarding. Roles included drug and alcohol and self-neglect practitioners and a joint transitional safeguarding lead, which had been recognised nationally as a good practice model. Collectively, these developments created a more visible, proactive, and preventative safeguarding approach. Whilst it was early days for many developments, and more work was needed to fully embed into practice across the local authority it was clear the approach had real potential to enable the earlier identification and effective management of risk.

The local authority had a small, centralised Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) team with an added 75 staff trained as Best Interest Assessors (BIAs) who supported on a rota. The team provided advice, guidance and training to staff and supported other partner organisations as needed. However, at the time of our assessment there were 1600 (1594 clients) applications waiting for progression. 307 of these were classed as priorities, as they were not settled or needed urgent support such as people requiring palliative care. The longest wait was 749 days with and average wait of 245 days. Staff told us the list was closely monitored and reprioritised to manage risk. The local authority had adopted the National Association of Adult Social Services (ADASS) prioritisation tool, the waiting list had been categorised using a Red Amber Green (RAG) rating meaning those of identified as high priority were addressed first. The local authority had categorised the majority of DoLS as 'standard'. We were told there had been a 13% increase on 2024 applications and the local authority was currently receiving approximately 60 applications per month. However, in 2023/24 there had been a 68% increase in granted DoLS authorisations. The Director of Adult Social Care (DASS) told us more investment was needed to bring about improvements although some redesign of the service and review of the workforce was currently taking place. However, leaders told us they had clear oversight of the waiting lists, and these were closely monitored including by the Safeguarding Adults Board.

The Safeguarding Adults Board (SAB) had been strengthened. There were now representatives from the three local prisons and an increased representation from faith groups, although partners told us they would like to see even wider representation. The Board had developed a pan-Dorset strategic plan setting out how it would meet the safeguarding objectives and how partner organisations would contribute. Dorset and Bournemouth, Christchurch & Poole councils' SAB held scheduled, joint board and subgroup meetings throughout the year and had developed a joint strategic plan. Through this the Boards and subgroups shared best practice, learning from Safeguarding Adult Reviews (SARs) and held multiagency learning events.

The SAB had 4 sub-groups responsible for supporting the delivery of the strategic plan objectives. The Quality Assurance subgroup focused on the analysis of data to support improvements in practice and that Making Safeguarding Personal principles were embedded; the Safeguarding Adults Review subgroup led on all reviews ensuring continuous learning of the wider system; the Community Engagement subgroup aimed to ensure the voice of people with lived experience was heard and the Mental Capacity Act Subgroup focused on strategic discussions about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Partners described the SAB as mature with a good culture, good attendance, and the ability to challenge and scrutinise safeguarding practice across Dorset. Local authority senior level leadership had good oversight of safeguarding work. The SAB Independent Chair met regularly with them to discuss strengths, areas for improvement and how changes were being embedded.

The local authority had a clear plan of how it would meet its safeguarding aims and key learning actions from Safeguarding Adult Reviews and showed the local authority's commitment to keeping people safe. Safeguarding Adults Reviews (SARs) consistently highlighted the importance of information sharing between partnership agencies. Therefore, a learning tool had been developed which captured the '7 golden rules of information sharing' designed to emphasise the importance of transparency, consent, and protection of individuals' rights. Information sharing protocols supported safe, secure, and timely sharing of personal information in ways that protected people's rights and privacy. Staff described consistent and timely sharing of safeguarding information across system partners.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks in Dorset. The local authority worked with safeguarding partners to reduce the risks of abuse and neglect occurring. For example, staff described work they were doing on suicide prevention, with staff able to volunteer as champions and attend suicide awareness training.

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. At the time of our assessment 2 reviews were in progress. All previous reviews had a detailed action plan which was overseen by the SAR subgroup to ensure the local authority and key partners took any necessary action and provided assurance. Staff teams told us learning was embedded following SARs and action was taken. For example, through lunch time learning sessions, briefings, the SAB newsletter, discussion in team meetings and support from the Specialist Safeguarding Team who worked alongside locality staff. The local authority identified that learning was also shared through tools and guides to support professional curiosity and Making Safeguarding Personal and the Multi Agency Risk Management, MAPPA and Self Neglect meetings.

Staff described how they had worked with the Children's team to develop a joint transitional pathway which recognised the needs of both children and adults and the risk of not sharing information. Transitional safeguarding had been identified as an issue in a SAR and was a high priority area for the local authority. An information sharing agreement was in place to enable adults and children's services to share appropriate information and transition team staff had access to both adult and children's safeguarding pathways to support their practice and enable risk to be managed effectively.

Responding to concerns and undertaking Section 42 enquiries

Systems supported consistency in decision making about when Section 42 (s42) safeguarding enquiries were required. As part of the improvements in safeguarding the local authority had improved its guidance on safeguarding and the thresholds for conversion to s42. Safeguarding referrals were received and triaged by the central hub team. Immediate actions were identified and responded to, and referrals allocated to the appropriate safeguarding hub and locality team where required. Specialist safeguarding staff from the hub worked with the locality team to decide whether to progress to a s42. Decisions to close or progress safeguarding concerns were overseen by managers.

If a decision was made to progress to a s42 an enquiry planning meeting was held which included the person and carers as appropriate, which ensured their wishes regarding an outcome were heard. Staff told us if a person had substantial difficulty being involved and lacked a suitable person to support them, the local authority would provide a Care Act Advocate or an Independent Mental Capacity Advocate (IMCA) to ensure their voice was heard. They told us they had received training to use compassionate enquiry approach and to look beyond what was detailed on the safeguarding referral form, especially where coercion or undue influence might prevent a person from speaking freely. The safeguarding process was then followed in adherence with the Making Safeguarding Personal (MSP) principles.

Most partners told us the process to raise safeguarding concerns with the local authority was simple and straightforward and spoke positively about collaborative working. The local authority told us the new hub and spoke model had been communicated widely, including in forums and newsletters. However, some partners fed back they would like to know more about the model, with others saying they had not heard of it. Some also felt they would like better communication about what to refer and when.

The local authority told us an analysis of safeguarding raised by providers found these were largely about falls and medication issues and work had been undertaken with providers to address this. It told us it had increased training for its staff and the provider workforce in response to an increase in self-neglect which complemented the learning on this from national SARs. In addition, the SABs Community Engagement Group acted as a mechanism for the local authority to listen and hear feedback from the community.

Local authority data showed 5673 safeguarding concerns were received in 2023-24 with 390 converted into s42 enquires, and 2217 leading to other safeguarding enquiries. There was a median wait of 19.5 days with a maximum wait of 55 days from receipt of the enquiry to the decision to convert to a s42 enquiry. In July 2025 there were 16 s42 enquiries awaiting allocation, with a median of 14 days and maximum of 232. However, updated information provided by the local authority for November 2025 identified that there were 10 S42 enquiries awaiting allocation with a median of 1 day and a maximum wait of 23 days. The local authority screened and triaged all referrals within 24 to 48hrs and passed onto locality hubs within a maximum of 4 days. Allocation within locality hubs was based on risk screening.

There were quality assurance arrangements for conducting s42 enquiries. Staff from the Specialist Safeguarding team often took the lead on complex safeguarding and staff with specialist skills, such as occupational therapists would lead or support on specific concerns. For example, manual handling, falls or pressure damage which meant they were able to bring their specialist knowledge. A safeguarding dashboard provided oversight of safeguarding work and managers reviewed this regularly to look at any delays and initiate action as needed. In addition, there were regular monthly meetings with the Quality Improvement team and Safeguarding team to share intelligence and information about provider concerns and trends.

To support staff development and understanding of safeguarding the local authority provided formal training events and courses, including mandatory annual updates. Staff told us they discussed safeguarding practice in teams and with line managers. In addition, the local authority delivered adult safeguarding webinars to partners across the pan-Dorset region focussing on modern slavery, MARM, MAPPA, transitional safeguarding, and Herbert Protocol. A total of 430 colleagues had attended these webinars.

Partners and providers gave mixed feedback about whether they were informed of the outcomes of safeguarding enquiries. Staff told us there was a process to inform the person and referrer of the outcome before safeguarding enquiries could be closed. Some providers said they were involved in safeguarding meetings and staff shared outcomes and learning. However, others told us they were not routinely involved in safeguarding and had to chase for outcomes of referrals they had made.

Making safeguarding personal

Following an independent review by the Local Government Association and the Association of Directors of Adult Social Services the local authority had been working to ensure Making Safeguarding Personal (MSP) principles were understood and embedded and safeguarding was 'everyone's business'. A Nominated Enquiry pilot was in progress where enquiries would be allocated, where possible, to a staff member who knew a person, with support from the Safeguarding Team. This aimed to personalise the approach and improve the understanding and awareness of safeguarding activity across all operational teams.

Safeguarding enquiries were carried out sensitively, keeping the wishes and best interests of the person concerned at the centre. People were supported to make choices that balanced risks with positive choice and control in their lives. Staff teams told us they were committed to Making Safeguarding Personal (MSP) principles and visited people to gather their views on how best to reduce risks. They also ensured the person was happy for them to speak with other agencies and the family about their concerns.

Staff told us they always spoke to people as part of the safeguarding process and that people were invited to multi-agency meetings to discuss risk; if they were not comfortable with attending then staff engaged with the person beforehand. Staff described working with a person where there were concerns about self-neglect and hoarding. They were introduced to an independent advocate, who along with staff, helped them to understand the risks, explore ways to keep themselves safe and agree a plan to ensure the person remained safe. Through this approach the person had been supported to remain living at home. Staff also told us about how they worked with a homeless person who cared for a son with care and support needs but did not trust formal services. Staff described how they sat in their car with the person to put them at ease, with their phone on loudspeaker to involve them in contacting partners to secure accommodation. They introduced the person to an independent advocate to support them to receive the support needed with finding permanent accommodation.

Staff told us they used independent advocacy to support people when needed and advocacy provision was good. National data from the Safeguarding Adults Collection for 2023/24 showed that 93.94% of individuals lacking capacity were supported by advocate, family or friend which was better than the England average of 83.38%.

Staff and managers told us the change to the new hub and spoke model had supported relationship-based practice as they could remain involved when concerns were raised. Additionally, inks to safeguarding specialists promoted a more person-centred process and continuous learning.

Partners, leaders and staff told us the local authority had a real focus on Making Safeguarding Personal (MSP) with data about MSP reported through the Quality Assurance subgroup to the SAB on a quarterly basis. The Quality Assurance subgroup conducted regular audits of safeguarding cases to verify that MSP principles were embedded in practice, specifically checking for documented evidence of the person's wishes at every stage. Partner accountability was managed by ensuring all agencies, including health providers and the voluntary sector provided annual assurance to the SAB that their staff were trained in, and applying MSP principles.

The local authority was committed to gathering people's voices and learning from their experience. There was ongoing work by the local authority and SAB to continually improve gathering of people's voices. The local authority's safeguarding plan included actions to improve MSP discussions between partners and people when they were referring safeguarding concerns.

Partners, leaders and staff told us lots of learning came through from SAB including from SARs and that the SAB also brought teams and partners together. For example, learning from audits had shown the need for better timeliness in information sharing and consideration of a more whole family approach in risk management. In response, multi professional High Risk Domestic Abuse meetings had been set up to drive improvement of the Multi-agency Risk Assessment Conference (MARAC) function.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability
- Learning, improvement and innovation

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

Governance, management and sustainability

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

People had responsive and respectful engagement, staff felt supported and involved in improvement work, and partners recognised a shift toward collaborative governance.

The local authority had sound governance, management and accountability arrangements which were, in the main, clear at all levels in the local authority. Political leaders described a culture which fostered strong relationships between elected members and local authority officers. Partners shared positive feedback about leadership, governance, and culture. Leaders were seen as capable and compassionate.

The Chief Executive (CEO) had been in post for four months at the point of the CQC visit. Both they and other leaders recognised the good things that were happening across the local authority but were also aware of where continued improvement needed to be made. Many initiatives were in progress and already having an impact. However, all recognised the need to continue to drive through improvements in a timely way to ensure high-quality care and support was provided to people in Dorset going forward. They told us that a key area of focus was on ensuring prevention became everyone's business across the local authority along with fully embedding the good work that had been started and was progressing.

All the staff we spoke with emphasised the visibility and accessibility of senior leadership. Leaders and managers were described as approachable and regularly engaged with staff through visits, workshops, and communication channels such as email and video meetings. This approach fostered collaboration and reduced hierarchical barriers, supporting a culture of transparency and shared responsibility for service improvement.

Staff consistently reported feeling well-supported by managers during challenging situations, highlighting the responsiveness of management teams. Peer support within teams was described as “unbeatable” with staff emphasising the benefits of close-knit teams and collaborative working relationships.

Staff reported that the local authority had embedded flexible employment practices, enabling movement across teams and roles at the same grade. This flexibility was seen as a key factor in retention and internal progression, with local authority data showing approximately 40% of recruitment coming from internal candidates. This showed the local authority’s commitment to workforce stability which resulted in continuity of care and support for people. Leaders and staff acknowledged there were challenges with capacity, particularly in frontline teams, and active recruitment was taking place to address these gaps.

Leaders promoted a person-centred culture based on people’s strengths. People described responsive and respectful engagement with staff, saying they were listened to and could raise concerns about their care and support should they need to. They told us staff were polite, professional, and generally had the skills and knowledge to do their job well. Some people told us some staff lacked the skills and knowledge to support autistic people and the local authority needed to develop specialism in this area. For example, an autistic person told us they had been sent a version of their needs assessment by a member of staff that had not shown any understanding of their communication needs. However, leaders were aware of this learning need and told us training had been put in place and was improving communication with autistic people across the system.

Leaders were driving a robust transformation programme, with a clear plan and timescales aimed at addressing concerns impacting on people's safety and outcomes and there was evidence this was having a positive impact. For example, changing safeguarding operational practice had significantly reduced the waits for referrals to be progressed and the changes to the front door was ensuring that more people received support earlier reducing those waiting for assessments. Staff told us there were significant changes being made and these were clearly communicated within a robust change management framework.

We saw steps were being taken to address the concerns over waiting times in all areas, though some areas of concern still existed, such as the long wait times for Deprivation of Liberty assessments. The new safeguarding hub and spoke model was driving improvement and safety. New teams, such as the Prevention and Early Intervention team had been created to support the transformation along with new roles, like the Carers Lead responsible for driving the vision to improve support to unpaid carers. However, there was still work to be done to ensure the transformation programme delivered the desired outcomes for people across Dorset.

There was a clear sense of community across Dorset and leaders worked positively in partnership to meet the need of the community and address the challenges presented by the rurality of the county. Feedback from partners was positive though there were some areas for development to ensure effective engagement with all communities, such as improved links with some Voluntary Community and Social Enterprise (VCSE) organisations.

Senior leaders were well sighted about risks. Risk and assurance processes linked directly to the corporate risk register, with issues actively escalated through clear reporting routes. The comprehensive and detailed risk register combined adult social care (ASC) and housing. Risks were identified for teams, with named officers allocated and up to date scores; controls helped show high risks. For example, a high scoring ASC risk was recorded around the impact on demand for local authority run services resulting from high demand for hospital beds. The local authority was playing an active role in the Future Care Programme to ensure effective control of this risk. Regular meetings allowed staff to speak directly with leaders about risks they saw and how these affected them and the people they cared for, supporting transparency.

Strategic planning

The local authority had commissioned the Local Government Association (LGA) to assess its readiness for its Care Quality Commission (CQC) assessment, showing a commitment to openness and willingness to learn. Strengths identified during the peer challenge, included the local authority's clear strategic direction, robust leadership, and committed adult social care workforce; key indicators of its ability to meet the Care Act duties. Our assessment, for the most part, reflected these findings.

Dorset Council's Plan 2024–2029 focused on 4 strategic priorities: delivering affordable, high-quality housing; growing a sustainable and innovative economy; building inclusive, resilient communities; and tackling the climate and nature crisis. The principles of partnership and prevention underpinned the plan which aimed to transform services, improve financial sustainability, and respond to residents' feedback to create a fairer, greener, and more prosperous Dorset. Its intention was to deliver its plan through working with partnerships across sectors, targeting investment in key priorities such as prevention to reduce long-term service demand.

Several specific strategies, plans and programmes supported ASC and housing to deliver the requirements of the local authority strategic plan. For example, the Adult Social Care Operations Service Summary 2025-26, which identified how ASC would delay entry into care through early intervention and reablement, how it would take forward the equality, diversity and inclusion agenda linking to integrated neighbourhoods and how workforce wellbeing, recruitment and retention would be addressed to support service delivery. The Transformation, Investment and Reform Programme August 2024, showed the commitment to improving the housing and accommodation offer within Dorset. The Prevention, Early Intervention and Assessment in Adult Social Care strategy identified how investment in prevention could address future problems and the Adults Engagement Strategy 2025-2027 which set out how co-production would be progresses through strengthened governance structures to amplify residents' voices.

Elected members showed a good knowledge of how the strategies linked and described how every paper presented to Cabinet or Board meetings had to cover the strategic priorities set out in Dorset Council's Plan. The Lead Member told us there was a strong commitment to ASC with the budget having been reviewed during 2024/25. They described how the local authority was now seeing some of the benefits; while demand for ASC had gone up, the unit cost of services had come down.

Leaders described the strategic ambition for public health which included "communities for all", along with the focus on prevention to ensure people lived healthier for longer. However, they accepted this was still in its infancy, and the coming years would see more of a focus on delivery. The local authority used the Joint Strategic Needs Assessment (JNSA) along with several other local insights to understand the needs of hard-to-reach groups in its population. Leaders also described the commitment to ensuring the voice of all people influenced the strategic direction, including describing investment in the co-production of a Carers Strategy.

Staff told us they had seen a strategic shift in the local authority commissioning priorities which had resulted in a move from time-and-task based working to an outcome focussed model, which emphasised wellbeing and person-centred outcomes. This was described as part of a whole-system perspective and a culture of "one team", supported by visible senior leadership and a non-hierarchical, empowering environment.

The Principal Social Worker (PSW) and Principal Occupational Therapist (POT) took responsibility for ensuring the quality of practice and keeping front line practice at the forefront of strategic improvements. One of the key areas of focus was embedding strengths-based practice across all teams and services. Monthly audits allowed oversight of the quality of practice, provided direct feedback to frontline staff and collated feedback from people who used services.

Staff described how workforce redesign was a current focus, with the local authority examining how resources could be best deployed to plan for future demand. They described how there was willingness to "test and learn," which they said showed a proactive approach toward continuous improvement rather than a static operating model. They also confirmed positive approaches to address shortfalls in workforce skills and numbers through the deployment of peripatetic staff to support teams and career opportunities such as apprenticeships.

The local authority recognised that whilst it had made some good progress in involving people in shaping some aspects of its strategies and plans and it had developed new services and implemented new ways of working it still had some way to go before co-production and new ways of working were fully embedded and the potential fully realised.

We found there still needed to be a focus on some approaches and services. There needed to be a greater focus on commissioning strategies to address gaps in the market. For example, for those with complex mental health, learning disability and physical disability needs. While some development of extra care housing was in progress this still did not go far enough to meet the needs of people. We also heard of gaps in service for people with dementia, for autistic people, for those requiring forensic services and in respite care in times of crisis. There were also challenges for people in accessing services because of transport and some lack of resources in local communities.

Some long waiting times for assessment and reviews and inconsistencies in care management highlighted the need for a more robust approach to workforce planning. In addition, there needed to be improved data collection and presentation of productivity key performance indicators to ensure timely and effective responses and demonstrate outcomes.

Leaders and staff recognised that the scale of the transformation along with day-to-day service delivery presented questions about capacity and sustainability. While leaders and staff were passionate and committed, they acknowledged a need for all across the local authority to focus on specific key priorities, such as the wider prevention agenda and the engagement of the 'whole community' in the strategic direction rather than a focus on individual services.

Information security

The local authority had arrangements to maintain security, records, and data management systems. There had been no significant data breaches and there were systems in place to maintain the integrity and confidentiality of data and records.

The co-located locality teams contributed to multidisciplinary plans of care and kept records up to date. Staff could describe how they maintained the confidentiality of information when sharing information across systems and organisations. However, staff told us information sharing could be improved further, such as systems that talked easily to one another. The Out-of-Hours Team told us that following a two-year pilot, the local authority had integrated their systems with the in-hours systems which had allowed better access to information through the one system, case notes and records, which staff described as critical for effective decision making and continuity of care.

Dorset was developing a shared digital care record connecting health and social care partners across Dorset Integrated Care System (ICS), this combined data from GPs, hospitals, community health, and Adult Social Care into one secure platform.

In addition, the Dorset Insight and Intelligence Service (DiiS) was a service dedicated to bringing together several cross-system insights and tools to enable users to make the best decisions for their populations. Leaders and managers told us the DiiS was a key development, enabling data-driven decision making through dashboards that identified trends and risks. This supported strategic planning and responsiveness to population needs.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

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

Key findings for this quality statement

Continuous learning, improvement and professional development

The local authority demonstrated a strong and ongoing commitment to workforce development through the promotion of an inclusive and positive culture of continuous learning and improvement. This included a focus on internal progression, accessible training, and reflective practice. Staff had regular access to a wide range of varied learning opportunities, including apprenticeships, workshops and specialist training which supported them in their roles.

We were told by all staff we spoke with that they benefited from a flexible working culture, a strong wellbeing offer, and accessible opportunities for career progression through clear pathways and apprenticeships. This was reflected within the local authority's workforce strategy which outlined aims to promote internal progression, opportunities to move between teams and move into different roles, embed a learning culture, and support staff to improve long-term sustainability.

Workforce intelligence was monitored through monthly dashboards that tracked sickness, retention, and recruitment, supporting targeted action. Supervision quality had also been a major focus, following a directorate-wide survey. As such, detailed supervision plans had been developed with SMART objectives, external support had been sought to develop a more effective approach to reflective practice, there was a strengthened expectation that supervision agreements and “My Road Map” recording was adopted as standard practice. Protected Continuous Professional Development time of up to five days per year further demonstrated investment in professional competence. Staff across teams described feeling well supported through regular supervision, peer forums, access to training and leadership visibility.

Staff also reported having the opportunity and flexibility to progress if they wanted to. One staff member described how their team accommodated apprenticeship commitments despite workload pressures, calling the culture “brilliant.” Another staff member told us they could move between teams to learn new skills, apply for promotion, and access quality supervision that covered reflective practice and wellbeing.

The local authority demonstrated creative and collaborative approaches to working with people and partners. For example, the local authority had developed an Innovation Focus Group as part of the transformation programme which had begun to develop how the authority listened to resident’s voices. The local authority had also developed a reablement app which showed a commitment to innovation and prevention. Staff described an appetite for test-and-learn approaches and early intervention.

In early 2025, the local authority had significantly expanded its approach to co-production and had embedded it as a statutory expectation within adult social care alongside mandating its use across major strategies, service evaluations, and public-facing work. A suite of lived experience forums supported this ambition, which included the Information and Development Group and the Quality Assurance Reference Group, both of which were described by participants as respectful, well-facilitated spaces where feedback was listened to and demonstrably acted upon. For example, changes to adult social care postcards within GP surgeries to include accessible language, telephone numbers, and clearer information on housing.

Wider co-produced work included redesigned direct payment letters and website content, a carers' training and skills booklet written by Carers for Carers, a strengthened Special Educational Needs and Disability (SEND) Participation and Co-production Policy co-authored with young people with learning disabilities, a Financial Estimator tool, a carers' training booklets and improvements to Dorset's Information, Advice and Guidance offer, which had been rewritten jointly with people, carers and subject experts. Co-production was also increasingly integral to commissioning, where people and carers contributed to tender processes, hypotheses testing and community front door redesign.

While some initiatives remained at an early stage, there was clear intention to fully integrate co-production throughout the local authority. People and carers told us the local authority had good intentions and had taken effective and timely action to move things forwards and embed co-production. However, we received some feedback from some people and unpaid carers that the local authority did not always follow up positive involvement with clear communication about actions taken following consultation or engagement. Examples included communication over the transfer to a new carers organisation and planned changes in day services. While the move to recognised best practice, flexible day care arrangements was generally welcomed by people and unpaid carers, some unpaid carers questioned whether the local authority had considered the impact the changes might have on them.

The local authority operated within a strong culture of innovation, with multiple examples of system-wide experimentation, data-driven improvement, and collaborative research. The Innovation Hub partnership enabled work such as the falls-risk dashboard, which was being 'live' tested with GPs and local authority teams, and several care-focused pilots selected through a competitive process.

The Community Connectors Hub demonstrated practical problem solving, having resolved more than 600 queries by linked practitioners with voluntary sector support. The local authority's Section 13 research project, which had received national recognition, had reduced unnecessary mental health assessments by around 50% by applying a social model approach, while the Home Care Optimisation (HCO) programme had brought package of care set up times down from 28 days to 4.5 days. Technology-enabled-care lounges, improvements to digital care planning, and hybrid care packages illustrated a broad commitment to innovation that supported independence and sustainability.

Staff across services described regular test-and-learn activity, including early intervention pilots resolving a high proportion of referrals within the first month, and joint hospital and emergency department training that improved cross-boundary practice.

The local authority demonstrated consistent learning from incidents, Safeguarding Adult Reviews, and complaints, with examples of revised protocols, improved discharge processes, enhanced professional curiosity training and strengthened risk management. The local authority shared learning, best practice and innovation with peers and system partners to influence and improve how care and support was provided. Collaboration with Oxford Brookes University also helped evaluate test-and-learn pilots, embedding evidence-based approaches into service design. The "100 voices" project, delivered with Bournemouth University and the Public Involvement in Research Network also trained people to conduct research and supported informed service development. The local authority also participated in national and regional occupational therapy networks and joined a national task force, showcasing local practice and learning from peers.

There was active participation in peer review and sector-led improvement activity. Dorset Council was part of a network of peers and partners to learn from best practice and improvement activities and received a national award for programme management in the Public Sector Awards 2025. The local authority also engaged with Partners in Care and Health for guidance on workforce strategy development and joint planning.

Learning from feedback

Learning from audits and lived experience feedback was consistently shared through regular meetings with staff such as quarterly occupational therapy practice meetings. This provided staff with the opportunity to reflect on their practices and improve outcomes for people. Audit forms had been redesigned to improve data capture around improvement actions, which showed the local authority acted on feedback to strengthen quality assurance processes. Auditing processes also included engagement through conversations with staff, engagement with individuals and advocates and case familiarisation, ensuring that learning was informed by multiple perspectives.

The local authority demonstrated a commitment to learning from people's experiences by embedding their voices into decision making and improvement processes. Feedback from individuals and families was gathered through co-production forums, quality assurance groups, and targeted engagement sessions. For example, carers in the Information and Development Group influenced communication materials by requesting clearer language and additional contact options on GP surgery postcards, and these changes were implemented. Similarly, audit processes included conversations with workers, individuals, and advocates to ensure the person's journey was understood and reflected in quality reviews.

There were processes in place to ensure that learning occurred when things went wrong. The local authority had implemented improvements after reviews of serious and low-level incidents, including better communication protocols, revised brokerage processes, and training in professional curiosity and suicide risk awareness. The authority had also introduced a structured review process for unexpected deaths, supported by the Programme Management Office, to embed systemic learning and prevent recurrence. Safeguarding Adults Reviews also informed commissioning and practice changes, with multi-agency forums and champions ensuring shared learning.

The local authority also had processes in place to ensure learning from good practice was shared. Provider representatives told us about "7-minute learning" sessions to share learning on specialist health conditions and staff also described forums and drop-ins to encourage reflective practice, discuss complex cases, or share learning.

There had been 10 detailed investigations following complaints to the Local Government Social Care Ombudsman (LGSCO) between 01 April 2024 and 31 March 2025. Complaints received were managed in a consistent, transparent, and responsive way. The local authority upheld 80% of complaints, which was above the average of 73.36% for this authority type. There were no incidents of late compliance, compared to the average compliance rate of 18.20%. These figured represented timely and appropriate action in response to complaints.

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