Local Authority Assessment

Appendix B

Name of Local Authority: North Lincolnshire Council

Date of publication:

Assessing how local authorities meet their duties under Part 1 of the Care Act (2014) is a new responsibility for CQC. We have been piloting our approach to these new assessments in five local authorities who volunteered to participate. Our assessment of North Lincolnshire Council was part of the pilots. We will be incorporating any learning from the pilots and evaluation into our formal assessment approach.

Demographics

The population of North Lincolnshire is 169,940. This is predicted to grow by 2% over the next 20 years. There are more older people living in North Lincolnshire compared to other areas and numbers are predicted to grow rapidly between now and 2043; the number of people over 65 is expected to grow by 27% and the number of people over 85 is expected to grow by 76%.

The county is a mix of urban, rural, and coastal communities; 57% of the population live in urban areas. The Index of Multiple Deprivation is 5 (10 is the most deprived).

There are 19 electoral wards that have been aggregated into 5 localities, grouping wards sharing similar demographic characteristics. 94.32% of the population is white, with the largest population of people from ethnic minority groups in the North Scunthorpe locality. The current political makeup of the local authority is 27 conservative seats and 16 Labour.

Financial facts:

- The LA estimated that in 2022/23, its total budget would be £265,148,000. Its actual spend for that year was £284,105,000, which was £18,957,000 more than estimated.
- The LA estimated that it would spend £53,625,000 of its total budget on adult social care in 2022/23. Its actual spend was £55,639,000, which is £2,014,000 more than estimated.
- In 2022/2023, 20% of the budget was spent on adult social care.
- The LA has raised the full ASC precept for 2022/23 but did not for 2023/24. Please note that the amount raised through ASC precept varies from LA to LA.
- Approximately 2,285 people were accessing long-term ASC support, and approximately 1,225 people were accessing short-term ASC support in 2022/23. Local authorities spend money on a range of adult social care services, including supporting individuals. No two care packages are the same and vary significantly in their intensity, duration, and cost.

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

LA Indicative Rating:

Good = Evidence shows a good standard of care and support

Summary of strengths, areas for development and next steps

Summary of strengths

People's needs were assessed in a timely way. A strengths-based approach was embedded into social work teams focusing on people's abilities, needs and wishes. Approved mental health professionals (AMHP) worked well across teams. Waiting lists were well managed and a 'Trusted Reviewer' pilot had been introduced which is working well to manage the backlog with reviews.

There was a cohesive preventative offer through local authority run community hubs with good use of the voluntary sector and partners. The support in the hubs was delivered through a 'making every contact count' approach, bringing information, advice, and guidance, alongside community facilities such as libraries and leisure centres into one location. This meant if people approached the hub for a 'small' enquiry that contact could be used to make them aware of further support available.

Partnership working was well established with strong relationships at all levels. Some aspects of service delivery were integrated with health, for example around hospital discharge and through a pilot in an integrated neighbourhood hub. The local authority worked well with the voluntary sector, particularly in relation to wellbeing; ensuring people had support in their local communities to maintain their independence and prevent or delay future care needs.

The supported housing and homelessness function had been brought into Adult Social Care, which was viewed positively both internally as well as with partners. This enabled better early intervention and support in vulnerable client groups, such as people leaving mental health hospitals, people leaving prison or homeless people, by ensuring people's housing needs were met which improved outcomes from other interventions.

Co-production with people with lived experience was embedded in the local authority's approach from the front line to the development of strategy and learning and improvement. People with lived experience had been involved in the co-production of the 'Experts together tool' to inform best practice in co-production and communicating and working with people with lived experience.

There was an open culture within the local authority, with clear leadership, effective governance, and lines of accountability around performance, quality, risks, and assurance. There was a learning culture with opportunities for learning embedded across the organisation and with partners.

Areas for development and next steps

There needed to be a greater focus on identifying and understanding the needs of seldom heard groups, and groups who find access to local authority services more difficult. While front line teams worked hard to engage local communities, there was no strategic oversight to ensure that all voices were heard, and communities felt able to access services. While the local authority was engaging some local groups, we heard from some community groups that there needed to be more flexibility and consideration given to using varied approaches to engage people from different communities. Faith leaders were keen to strengthen the faith covenant (a set of principles to guide engagement between faith communities and the local authority) and improve understanding of the work of faith communities. The local authority had identified they needed to improve co production around substance misuse and homelessness.

There was a desire to use data to inform the Adult Social Care strategy and the local authority had identified there was more work needed both to improve the available data and the supporting intelligence underneath the data. Data had been used to evaluate the preventative approach and the resultant savings in services to support people, but more work was needed to plan ahead, to ensure this will enable the local authority to meet the needs of the rapidly ageing population.

The Local Authority had identified that further work is needed to improve the offer for young adults in moving them towards independence and employment. They had begun to progress this work. For example, the focus for short term reablement so far had predominantly been around services for older people in supporting and preventing hospital discharges. There is now a similar focus on the needs of younger adults in terms of expanding the housing and support options and the skills of the workforce.

There was a strategic ambition both within the local authority and with partners, to develop integration. This included consideration of shared data systems and joint working on the winter plan, so integrated working improves a person's 'journey' between services, removing barriers between health and adult social care organisations. To achieve this, the models of integration and pilots that have been developed so far need to be built on with a focus on what is necessary to deliver at a larger scale.

Summary of people's experiences

People with lived experience gave us positive feedback about their experiences. The Experts Together Pledge developed by the Experts Together Partnership was the overarching strategic document for co-production with 'Ask Listen Act' being the focus of the approach. There was an accompanying workforce tool to support the workforce in co-production. Most people told us they had good open relationships with social workers who supported them to achieve their outcomes. Unpaid carers told us they had access to a range of activities to support their wellbeing.

People who had been involved in co-production with the local authority spoke positively about their experience and felt they had made a difference. They said leaders knew them by name and they felt listened to and involved, leading large training events such as conferences as well as being involved in the development of strategies. The effectiveness of co-production at board level varied for different groups of people. We were told that this worked well in the learning disability board, however people with mental health difficulties, autistic people and members of faith communities felt more work was needed for them to engage and influence change at this level.

Theme 1: How the local authority works with people.

Assessing needs Indicative score: 3

Evidence shows a good standard.

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

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

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

Key findings for this Quality Statement
People's needs were assessed in a timely way. A strength-based approach was embedded into social work teams to achieve the best outcomes for people, focusing on people's abilities, needs and wishes. Staff told us the approach meant assessments were more holistic. There was a good flow from the first point of contact through to assessment of needs. Social workers described how responsive the local authority was and everyone who called in would get a response. They worked well with other organisations, particularly the voluntary sector and the use of social prescribing. This is a provision where GP's can refer people to local community groups and services, to improve people's ability to manage their own health in relation to needs that are not eligible for support from the local authority.

Assessments of needs and the plan for support, were co-produced with people. People told us they were involved in their assessments and social workers listened to what they told them. However, we did have isolated feedback from one person that communication was poor and there were delays in the financial assessment as a result. Teams gave examples of how they had used the Experts Together tool to co-produce what is important to vulnerable people to be safe, well, prosperous and connected. Front line staff had a prompt card produced by the Experts Together Partnership promoting good practice around communication and meeting people's needs.

Staff told us they worked closely with family carers, considering the whole family's support to prevent a crisis. They told us support for the family carer was central and they ensured carers were in touch with wider carers networks as part of the assessment. The local authority had done a lot of work recently to raise awareness to engage and identify more carers. This had resulted in an increase in the number of carers in contact with them and having assessments. Carers told us they felt involved in the assessment for the person they were caring for and they felt listened to in the process.

There were no people waiting for assessments within the frontline teams. There were a number of people who were awaiting an annual review of their care and support needs. The national data showed that 68% of long-term support clients had been reviewed which is above the national average. At the time of our assessment the local authority told us the percentage of people who had reviews had increased to 80%, so that 20% (298) of people

eligible for a review were still waiting. The local authority was piloting a trusted reviewer model, where responsibility for reviews could be delegated to approved providers, overseen by the local authority case worker. This was helping to clear the back log and both staff and providers were positive about the impact this was having on ensuring that people's needs were reviewed in a timely manner.

The local authority had a high take up of direct payments, 42% of people which compared to the England average of 26%. The local authority told us they used direct payments as a way of increasing autonomy and choice. Social workers told us they had the freedom to be creative in the way they used services and described how this could be good for people from ethnic minority groups as it enabled care packages that were more culturally appropriate.

Supporting people to lead healthier lives: Indicative score: 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
The Adult Social Care Strategy focused on a preventative approach, based around promoting people's independence and support in the community. Through this approach 93% of people who had received short term care and support no longer required support, this was above the national average and demonstrated the focus on support to enable people to maintain independence to prevent or delay long term needs for care. Both health and voluntary sector partners understood the approach, and there was an integrated health and care strategy, 'Community First'. There was a sense that everyone was working to the same goals. This approach was well understood from leaders through to front line workers.

Community hubs delivered the approach with effective use of the voluntary sector. For example, the local authority funded a social prescribing project with the voluntary sector to prevent or delay the need for care. Interventions were delivered as part of a 'making every contact count' approach, bringing information, advice, and guidance, alongside community facilities such as libraries and leisure centres into one location. This meant if people made contact at a hub with a query for advice and support, they could also be connected to other services and activities that they may not have been aware of, with the aim of improving health and wellbeing.

The local authority had an online resource 'Livewell' that was a directory of local services and support within communities, this was being co-produced with community groups. There was still work to do to develop this resource, but it aimed to help people identify sources of support and activities within their local communities.

Public health data was used to identify issues in particular communities and target activities to address them. Community workers worked with people's physical and mental wellbeing. For example, encouraging people through behaviour change, to become more active and address issues such as obesity or smoking cessation. There was a wider focus than just public health targets, the hubs used 5 ways to wellbeing principles, beginning with supporting people to be more connected including through arts and heritage activities.

Community enablers worked within and beyond the hubs, to help people be more connected in their community. They worked closely with community groups, looking at the strengths within communities and connecting communities where there were gaps. We had feedback from carers who said they had been able to access a range of community groups and activities that kept them connected and gave them a break from their caring

role. There was further work needed which the local authority had identified, to improve the offer for young adults in moving them towards independence and employment.

The local authority recognised housing was a key issue in addressing wellbeing and had restructured to make the supported housing and homelessness function part of adult social care. Both staff and partners gave positive feedback about this, describing how this has resulted in much better outcomes for people experiencing mental health difficulties, substance misuse, ex-offenders, or domestic abuse, preventing future need for adult social care support in these vulnerable populations.

Equity in experience and outcomes Indicative Score: 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:
Data from the joint strategic needs assessment and public health was used to identify health inequalities including areas of deprivation, age, and geography. For example, there were issues identified that were making it difficult for people living in rural communities to access home care, so the local authority had looked at models in other rural authorities and reviewed their framework to improve access. It was less clear however, how the areas of deprivation and health inequalities, linked in with communities of people with protected characteristics. We had some feedback that there was a focus on older vulnerable people but not on other inequalities.

Local teams understood communities well and had local knowledge of hard-to-reach groups. This included social work teams and the early intervention and preventative support through the hubs. Teams told us that translation services were easy to access where necessary.

The teams were engaging with communities they had identified as being ‘hard to reach’ including some people from ethnic minority groups, LGBT+ groups and a public health project targeting cancer screening for Asian women. However, if there were communities not ‘visible’ to local teams and hubs they may have been missed. These groups may require different interventions and allocation of resources for them to engage and benefit from adult social care services, both preventative support as well as people with eligible support needs. Feedback from partners was that more work was needed to engage those groups who found it more difficult to engage with adult social care services. For example, the local authority’s equality impact assessment for the carers’ strategy showed support for carers was predominantly used by white British people. Partners also raised the issue of women specific services; they felt that more women only services would support access for some women from ethnic minority and faith groups who would otherwise not access mixed services. We received feedback that further work was needed by the local authority to develop their understanding around the needs of faith communities. This included developing more flexibility in their approach and building on the strengths in those communities to provide effective support and preventative work as they have in other communities. The local authority told us they had started work to strengthen their relationships and understanding of faith communities including the development of a faith covenant. The faith covenant included a set of principles to guide engagement between faith communities and the local authority and is due to be signed off later this year.

The ‘Experts Together’ tool was used effectively for co production. People in the group with lived experience told us they felt listened to and respected and had been involved in the development of strategies and staff training; conferences for example in person centred care and safeguarding, as well as supporting recruitment of both leaders and

front-line staff. Voluntary sector partners had been involved in working with a range of people with lived experience including involvement in co-production, which was working well for people with learning disabilities. However, we had feedback that there was further work to do for other groups of people for example autistic people or people with mental health difficulties. There was a feeling that a more flexible approach was required, for example in understanding the reasonable adjustments people might need to participate. The local authority had identified they need to do more work around co production with people who experience substance misuse and homelessness.

Theme 2 – Providing support.

Care provision, integration, and continuity Indicative score: 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:

The local authority understands the care and support needs of local people and was actively working to shape the market to meet those needs. There were a variety of providers including for home care, residential care, and nursing care. There was a reablement team that could provide an immediate response to people's needs, working closely with the access team as well as hospital discharge. The use of assistive technology was also being developed to support people's independence.

The local authority recognised there was over provision of residential care, and that more capacity was needed in domiciliary/home care to deliver on their strategic priorities and meet population needs. This was being addressed through the brokerage team that worked closely with providers, planners, and housing to create community housing that met people's needs. This approach was most developed for older people where the local authority had made their own investment into Extra Care housing for people with dementia. They had started to develop more housing that was adaptable and accessible through a 5-year housing plan. Leaders recognised further work was required to meet the needs of younger people with complex needs and this was confirmed by what people told us. One person told us they were now happy with the support they receive, and they have positive outcomes, but their choice was limited due to the lack of provision in the area.

The local authority had started a project along with health partners to review the care of people who had been placed out of the local authority area, to understand why this had happened and how local services needed to change to better meet people's needs. This work was currently in progress. There was a commitment to using the findings from this work to further transform the local care sector to include services that could meet complex needs in the future and enable people to be rehoused closer to home and prevent future out of area placements.

Discussions were beginning with residential care providers to understand how buildings could be repurposed or used differently to provide additional community resource alongside residential care to address the issue of the oversupply of residential care. Providers told us the review of the way local authority was commissioning services had improved relationships with the local authority, so they were working together to meet local needs. They said there was a good focus on people's outcomes being balanced with provider needs. The local authority was addressing workforce challenges through their 'Proud to Care' initiative which was set up to support recruitment and retention of the

social care workforce by supporting childcare, providing scooters for ‘wheels to work’ and subsidised gym membership. They also used this initiative to develop skills in the workforce to meet people’s more complex needs. This work was just starting to have an impact, and staff gave examples where this had worked well to enable people to stay in their own homes with home care support. Further work was needed to embed this model to ensure consistency.

We received positive feedback from most people about their contact with the front-line social work teams. Social work staff described how they worked across teams internally as well as with external partners such as health and the voluntary sector to support people to get the best outcomes; building on people’s strengths to help meet needs in a way that helped maintain their independence. There was good joint working with health partners as well as the voluntary sector. This included with mental health provision. Approved Mental Health Professionals (AMHP) were located close to social work teams which enabled them to work well together.

The local authority had systems in place to manage the quality of care that people experienced from providers including surveys, and ‘mystery’ shoppers from the Experts Together Partnership. The local authority had recently reviewed the framework for monitoring quality in services, and providers were positive about this and felt it was more supportive. Ratings for services in the local authority area were above the national average, for example 78% of nursing homes, 86% of residential homes and 89% of domiciliary care agencies were rated good or outstanding, this compared to 77%, 83% and 82% respectively for the national average. The team described opportunities to work with providers to support innovation, through additional funding. The provider market was stable within the local authority area. There had been no providers exiting the market in the past 12 months and no situations where providers had said they were unable to provide care at short notice.

Partnerships and communities: Indicative score: 3

Evidence shows a good standard.

What people expect:

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

The local authority commitment:

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

Key findings for this Quality Statement:

There was good partnership working, both with health integration and use of the voluntary sector. There was evidence of strong partnership working both strategically and at the front line. Integrated working was focused in particular areas, for example in a pilot integrated neighborhood team and through hospital discharge. There was a strategic ambition to develop integration further, based on the Community First preventative approach. For example, moving to shared data systems between health and social care, and joint working on the winter plan to remove barriers for people when they move between services, or receive support from both health and social care. However, further work was needed to deliver integration on a wider scale. There were clear leadership arrangements for a system wide approach to integration and partnership working, with senior politicians chairing or attending the Health and Wellbeing Board, and the Integrated Care Partnership place group. Senior officers showed a clear commitment to joint delivery in significant areas in the Integrated Care System (ICS). Health partners spoke positively about the joint working with the local authority and said the relationship had strengthened over the past 5 years. They described working together to address issues for example around hospital discharge and the winter plan, sharing rather than shifting responsibility.

The local authority worked closely with external housing partners, reflecting the inclusion of the local authority's own supported housing and homelessness function within Adult Social Care. The local authority worked closely with planners, housing associations and builders to deliver their housing strategy, recognising that housing was a fundamental basis for wellbeing.

The voluntary sector was seen as a key partner in helping deliver better outcomes for people including unpaid carers, contributing to the range of activities that people told us they accessed. They were recognised as being in contact with diverse communities and people with lived experience, and we received feedback that there had been an improvement in the partnership working between the voluntary sector and the local authority since the Covid-19 pandemic. There was a feeling that there had been positive work in this area, but there was still work to be done, particularly in the partnership with faith communities where was a lack of continuity and direction in this work.

Theme 3: How the local authority ensures safety within the system.

Safe pathways, systems and transitions Indicative score: 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.

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

There was an integrated hospital discharge team that worked across health and care to deliver holistic support to ensure people were safe on discharge from hospital. There was a 'Home First' approach for this service that was understood by all partners and at all levels of the organisation from front line to leaders. 'Virtual wards' were used, where a person was able to receive nursing care in their own home. The voluntary sector had been involved in the design of a 'welcome home' service to support people with non-eligible needs on discharge for example shopping or social needs.

When issues were identified in the flow from hospital, such as capacity within the homecare market, the local authority piloted an 'accelerated learning event' to trial a 'perfect discharge' for 2 weeks. Learning from this had been embedded in the service and had improved outcomes for people and reduced the waits for discharge. The local authority had their own reablement service to support people on discharge which helped with flow, so people could be discharged from hospital as soon as they were well enough. They had also repurposed a residential home specifically to support reablement for people on discharge from hospital that were unable to go straight home. People told us discharge worked well and described how they were supported with physiotherapy and occupational therapy as well as support to regain their independence so that they could go home. Providers were paid financial 'retainers' so if a person in receipt of care went into hospital, the local authority continued to pay the care provider for 7 days which helped continuity and meant people could be discharged back to the same care provider if it was still appropriate. Where there were challenges in relation to discharge, the responsible officers had regular calls each day to discuss discharge and find solutions across all partners.

There were robust transition pathways for young people; transition started early at 14 years old, with close working between children's and adults continuing beyond 18 where necessary. People gave us positive feedback about the support they received, and described how direct payments were used to ensure personalised support that promoted the young person's independence as they moved into adulthood, so they were less reliant on their family.

Joint working within the housing team supported safe pathways during transition for vulnerable people, for example a staff member in the supported housing and homelessness function worked with probation to support people when leaving prison and a jointly funded mental health post to support people on discharge from hospital. The team described how, by focusing on housing first this meant the safety and effectiveness of other interventions and support was more likely to be successful. If people don't have a safe place to live then they cannot deal with other issues such as domestic abuse, mental wellbeing or finding employment. One person gave negative feedback about their initial experience of support from the local authority in relation to mental health when moving between services. However, they said more recently they had a positive experience and had a good relationship with the new social worker with open discussions about the options available with a flexible approach to meeting their needs resulting in positive outcomes for the person.

Safeguarding Indicative score: 3

Evidence shows a good.

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

There was robust partnership and integrated working across the safeguarding system including police, health, and fire. Partners described positive relationships that were respectful, strong, and open to challenge, to improve understanding and prevent 'group think' and focus on the safest outcome for people. There were strong partnerships with people with lived experience. The Experts Together Partnership were positive about their involvement in co-production with safeguarding.

Section 42 enquiries were dealt with in timely way with no backlog, so concerns were triaged on the same day. A section 42 enquiry is where the local authority believes that someone is at risk of abuse and therefore a full investigation needs to be carried out. There was a focus on ensuring a personalised approach with the wishes of the person at the heart of the process. The safeguarding team worked well with other teams to ensure an integrated approach both internally as well as with health partners.

There was a comprehensive dashboard with information about safeguarding. Data was used to analyse themes and trends, to target preventative interventions to reduce the number of safeguarding concerns and to raise awareness within communities. There was a risk-based approach to managing safeguarding thresholds and the data dashboard enabled leaders to monitor themes and trends even if concerns did not meet the threshold for a S42 enquiry. The current approach was introduced following a review of the data which showed inconsistencies in reporting. As part of the introduction of the new approach, there was awareness raising and development work with providers, voluntary sector partners and communities to enhance understanding of safeguarding, when referrals should be made and how to ensure that all referral forms were completed with the information required by the team. There was also co-production with people with lived experience to make a more accessible version of the safeguarding concern form in an easy read format. Providers and partners gave positive feedback about the changes and felt that the system worked better as a result.

The data dashboard enabled leaders to see increases in the number of referrals as well as gaps in the data to enable targeted approaches. For example, awareness raising was targeted through 'roadshows' at community events in communities where there were less referrals and less knowledge about safeguarding. Training and awareness raising sessions were held with local voluntary and community groups, to build on the community first approach to wrap around support.

The safeguarding dataset had also highlighted an increase in self-neglect, in line with national trends following the pandemic. As a result, they looked more closely at self - neglect cases and worked across the partnership to develop multi agency training involving all partners including environmental health and fire. This included a person with lived experience to talk about their experience. This had improved awareness of self-neglect and understanding of what needed to be referred to safeguarding and identification of cases where support can be offered through signposting to other organisations, without the need for safeguarding referral.

Deprivation of liberty safeguards were well managed, there was no waiting list and conditions were used effectively to support independence and wellbeing for example, through social connections.

There was a proactive approach to learning from serious abuse or neglect, including oversight of national and regional learning to look at whether it could be used to improve safeguarding locally. Locally, learning from Safeguarding Adult Reviews (SAR) was shared both internally with teams as well as with partners, through training and briefings. In response to one of the SARs, a forensic examination service had been set up as a pilot for adults at risk who may have sustained a non-accidental injury because of physical abuse or neglect. The pilot had been externally evaluated and extended as a result.

Theme 4: Leadership

Governance, management and sustainability Indicative score: 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

There was stable leadership within the local authority with effective governance and accountability processes. There were clear lines of accountability for the senior leadership team including performance, quality, risks, and assurance to the Director of Adult Social Services and to cabinet and councillors. Policies and strategies went to cabinet with additional challenge through scrutiny. Challenge and accountability were also managed through partnerships and integrated working, particularly where joint strategies and policies were developed, for example safeguarding and commissioning. Risks were well managed including for example, risks relating to partnership working, as well as demography and projected changes in the ageing population. There was awareness of these risks amongst both senior leaders and councillors and there were systems in place to monitor and manage them.

Staff spoke positively about the leadership team, describing them as approachable and easy to speak with. There was a feeling of a ‘One Council’ approach at all levels. Strategies were embedded and well understood within the local authority from front line staff through to leaders for example, the adult social care model focusing on a preventative approach to address the pending issue of rapid increase in the number of over 65’s. Staff felt supported in their roles and listened to. There were opportunities for staff to undergo professional development through apprenticeships in partnership with local education providers. This had helped with retention of staff and local knowledge resulting in a stable supportive staff team.
There was a culture of working openly with partners, and partners spoke positively about their engagement with the local authority. There was a feeling that relationships were robust and open to challenge. There was widespread agreement that partnerships had developed over the past 5 years to a partnership of equals, and that this is now developing from partnerships to a “system”. The ambition is that the focus moves from the 'system' to person-centred service delivery, looking at the person and their journey rather than the system. This was reflected in positive working ‘on the ground’ with a wide range of partners in health and the voluntary and community sector, and a focus on a person-centred approach producing positive outcomes for people.

The voluntary sector providers spoke positively about recent changes in the relationship with the local authority which they felt had enabled voluntary and community groups to influence strategy and the approach of the local authority, in a way that resulted in positive outcomes for people.

There was a desire to use data to inform the ASC strategy and understand people’s journeys; there was an understanding that more work was needed both to improve the available data and the supporting intelligence underneath the data. For example, in the

data available to identify people with protected characteristics and identifying hard to reach or hidden communities. Data had been used to evaluate the effectiveness of the preventative approach over the past 7 years, however further work was required to predict forward to ensure that preventative work would continue to offer savings to continue to meet population needs as the number of people over 65 increased.

Data and feedback from people and partners, was used to inform the local authority about strategies, the effectiveness of interventions, the targeting of resources and what action was needed to improve outcomes for people. People who had been involved in co production said they felt valued, felt they had made a difference and said they were recognised by leaders when they visited the local authority buildings.

Learning, improvement, and innovation Indicative score: 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
There was a learning culture embedded within the organisation through continuous learning, innovation, and improvement. Staff told us there were opportunities for learning and their own professional development. The practice development team led by the principal social worker supported the training and the development of best practice in teams. There were mechanisms in place to support a learning culture, for example social care forums, audits, feedback (compliments/complaints), line of sight practice sessions and reflective supervision.

The Experts Together workforce tool was embedded at all levels, ensuring that co production with people with lived experience informed the development of strategies and contributed to the improvement of services. Experts with lived experience were involved in reflection, learning and feedback through training and conferences, for example in relation to safeguarding and person-centred care.

Pilots were used as a learning tool to trial new ways of working and target resources to address issues; for example, the accelerated discharge event for integrated discharge over a ‘perfect fortnight’, the forensic examination pilot and integrated community hub. Learning from pilots was evaluated with partners to inform future models of working. The local authority was open to using evaluation by external organisations to enhance learning.

A continual learning and improvement model was applied to work with partners including the quality monitoring of registered providers which encouraged a culture of continual learning and improvement in services. There was a culture of learning from communities to share the strengths of one community to address gaps elsewhere.

There were a range of systems in place to apply learning from themes and trends, for example in complaints, safeguarding adult reviews, serious incidents and national themes and trends. Surveys were used to understand people’s experiences to influence the future design and development of services. A survey and engagement with unpaid carers for example was used, to set the priorities for commissioning services for unpaid carers. A survey of care homes focused on healthcare support resulted in an action plan to ensure that people living in care homes had access to GP services to help prevent hospital admissions, as well as looking at the support care homes needed to enable them to better support discharge from hospital.