DATE 6 January 2025

**Yorkshire and Humber ADASS Preparation for Assurance Peer Challenge Report: Calderdale Council October 2024**

## 1. Background

Calderdale Council (CC) asked Yorkshire and Humber Association of Directors of Adult Social Services (YHADASS) to undertake an Adult Social Care Preparation for Assurance Peer Challenge at the council and with partners. The work was commissioned by the Director for Adult Services and Wellbeing who was seeking an external view from a team of regional peers about the experience of people receiving support from Adult Social Care and to comment on the council's preparations for Care Quality Commission Local Authority Assessment.

## 2. Purpose

Peer challenge is an improvement focused activity not an inspection. The purpose of a peer challenge is to support an authority, and its partners to assess current achievements, areas for development and capacity to change. The peer team use their experience and knowledge of local government and adult social care to reflect on the information presented to them by the people they meet.

## 3. The Peer Team

The members of the peer challenge team were: -

Ian Spicer, Lead DASS, Strategic Director of Adult Care, Housing and Public Health, Rotherham Council
Rachel Bowes, Assistant Director, North Yorkshire Council
Linda Thirkeld, Assistant Director, City of York Council
Nicola McVeigh, Assistant Director, North East Lincolnshire Council
Amanda Bannister, Principal Social Worker, Barnsley Council
Councillor Lucy Steels -Walshaw, Member Peer, Executive member for Health, Wellbeing and Adult Social Care for York
Michaela Pinchard, Peer Challenge Manager, Yorkshire and Humber ADASS associate.

## 4. Scope

The work of the peer team focusses on the four assurance themes in the Care Quality Commission (CQC) assurance framework used in the adult social care assessment process.

**Care Quality Commission Assurance themes**

| **Theme 1: Working with people.** This theme covers: | **Theme 2: Providing support.** This theme covers: |
|---|---|
| • Assessing need | • Care Provision, integration, and continuity |

| | |
|---|---|
| • Supporting people to live healthier lives<br>• Equity in experiences and outcomes | • Partnerships and communities |
| **Theme 3: How the local authority ensures safety within the system**. This theme covers: | **Theme 4: Leadership.** This theme covers: |
| • Safe pathways, systems, and transitions<br>• Safeguarding | • Governance, management, and sustainability<br>• Learning improvement and innovation |

**4.i Specific focus**
Calderdale Council asked that the peer challenge team focus on:

**Theme 1** How Calderdale Council works with people

Specifically
- How effective is the roll out of strengths-based practice
- How well is equity in experience and outcomes evidenced and articulated

**Theme 3** How Calderdale Council ensures safety within the system

Specifically
- The extent of the impact of recent changes made within safeguarding and the interface between safeguarding and quality
- The extent to which people are kept safe when transitioning from hospital
- Risk relating to waiting times for assessment and care provision – how well teams understand and apply any policies and procedures in terms of how risks are managed and monitored

**Theme 4** Leadership **-** Governance, management, and sustainability, and Learning improvement and innovation.

**5**. **Methodology**
Prior to being onsite, the peer team undertook a case file audit, and a review of a range of information and data.

The peer team were then onsite for three days holding interviews, focus groups, and discussions to understand the adult social care department and to develop feedback and recommendations through triangulating the evidence presented.

All information collected as part of the onsite activity was done so on a non-attributable basis to promote an open and honest dialogue.

In arriving at their findings, the peer team:

- completed ten case file audits
- held interviews and discussions with over 150 people across adult social care, partners and people with lived experience
- spent around 220 hours with the council and its documentation - the equivalent of circa 27 working days

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Initial feedback was presented to the council on the last day of the peer challenge and gave an overview of key messages. This report builds on the presentation and gives more detail related to the key messages.

Every effort is made by the peer team to triangulate evidence available to them in the time spent on site, and while the findings provide a good indication of strengths and considerations it cannot and does not represent a fully comprehensive assessment.

Although theme two – Providing Support was not in scope for this challenge, there were key messages about partnerships that the peer team felt should be included. However, it should be noted that due to the agreed scope, the peer team were not able to triangulate these messages with the council's commissioning team.

## 6. Acknowledgements

The peer team would like to thank councillors, staff, people with a lived experience, carers, partners, and providers for their open and constructive responses during the challenge process.

## 7. Key messages

There are observations and suggestions within the main section of the report linked to each of the CQC themes. The following represent the peer team's key messages to the council centred around the specific areas the council asked the team to consider.

### Working with people

**How effective is the roll out of strengths-based practice?**

There is a strong focus on the 8Ps [Strengths based practice framework] with colleagues demonstrating a good understanding of the model and a recognition that 'this is what we do'. This understanding also extends to partner colleagues. Physical activity is embedded in the 8Ps and in support planning with commitment to further embed this across adult social care. There is demonstratable commitment to quality of practice through consistent practice meetings and audit. Financial assessments are more timely, person-centred, and people are supported to manage debt and maximise income. As the programme continues to be implemented care will be needed to ensure new ways of working continue to be embedded, there is consistency of practice across all services and teams and there is capacity to evaluate audits.

**How well is equity in experience and outcomes evidenced and articulated?**

There is a joint commitment to understanding and reducing barriers to care and support and reducing inequalities, and a link between the corporate vision, equality

objectives, and the Adult Services and Wellbeing's Equality, Diversity, and Inclusion Action Plan. Evidence includes learning from the safeguarding adults review - Burnt Bridges, the Buying our Care report (which led to the development of a Governance and Partnership Assurance Board with the Council of Mosques, ICB and providers), Better Lives Hubs in areas of greatest need, co-production, and the Community Voice Panel.

There has been improvement in the use of ethnicity data to inform commissioning, an example of which is a recent report to the Adults and Wellbeing Scrutiny Board arising from recommendations made by a public scrutiny review - led by the chair of the Buying our Care working party. The report to scrutiny board updates on a recommendation to 'review commissioning processes by the Council and the NHS locally to provide assurance that religious and cultural needs are built into commissioning.' The integrated commissioning contracts and quality team has undertaken the review which has 'created an opportunity to strengthen commissioning systems and processes and identified areas where there is more, we [the council] can do to ensure religious and cultural needs are built into all commissioning processes.' This does provide the council with an opportunity to continue to further develop a culturally responsive market and ensure data on the needs of all marginalised groups is increasingly used to inform strategic commissioning plans.

There are some good examples of using translation and interpretation services with evidence of developments to make the website more accessible. It was recognised though that it is a still a struggle to reach some groups and there is a need for more consistency in the provision of translation and easy read information.

**Ensuring safety**

**The extent of the impact of recent changes made within safeguarding and the interface between safeguarding and quality.**
Teams are working hard and there is a passion and commitment to go the extra mile to keep people safe across Calderdale. This is supported by a strong sense of team with shared values and commitment to being a supportive colleague. The recent changes in adult safeguarding have been positively received as it is recognised this will result in a more coordinated, consistent response to adult safeguarding. There are good relationships between the Safeguarding Adults Board and partner agencies. There is an awareness of making safeguarding personal across all teams with a commitment to secure the best outcomes for people. There is good multi-disciplinary team and partnership working at an operational level including discharge from hospital, the high-risk multi-disciplinary team working, and reablement.

In terms of changes to the scope of the safeguarding team, the peer team felt that consideration needs to be given to capacity and expertise in the team to do this whilst also responding to large scale enquiries. There is further opportunity to improve communication channels and provide performance updates, to strengthen the feedback loop, to ensure learning is shared, and to support continued learning. Consideration should also be given to the concerns expressed around capacity within the team to undertake necessary training.

**The extent to which people are kept safe when transitioning from hospital**
The Reablement and Intermediate Care Teams (including Heatherstones Court) are providing good outcomes for people and achieving high levels of independence whilst also mitigating the risks presented by some hospital discharges. The improved hospital discharge process, the dedicated practice lead and jointly funded discharge flow coordinator which coupled with a good supply of home care and the urgent response team, is generating a greater sense of confidence especially going into winter. However, further work is needed to improve discharge into care homes. Shared key performance indicators and improved visibility around the quality of hospital discharges may help address some of the issues that teams face daily, highlight readmission rates, aid a shared understanding of the benefits of getting people the right care at the right time, and embed learning to prevent reoccurrence - thereby further improving outcomes for people.

**Risk relating to waiting times for assessment and care provision – how well teams understand and apply any policies and procedures in terms of how risks are managed and monitored.**
There are initiatives to embed support for people to wait well through frequent triage, waiting well letters, Better Lives Hubs, and managing risk, although the peer team heard some examples of different approaches being taken by the learning disability and occupational therapy teams. While this may be an agreed approach it raised some concerns about consistency of practice and risk management. This may contribute to how some teams feel 'outside' of the core offer. There was also some evidence of variation to how audits are completed in terms of priority given and level of importance.

The council may therefore wish to further assure itself about consistency in supporting people to wait well, particularly in teams where there are capacity issues and higher waiting lists.

**Leadership**

There is a supportive management culture demonstrating the core values of the council. Senior leadership commitment to the programme of change is evident along with the commitment to parity of esteem across the council. There is strong corporate commitment to be part of the adult social care change programme and greater confidence in delivery. There is clear recognition that change needs to be sustainable to meet not only the financial challenges but also to meet the needs of the community. There is palpable enthusiasm for change and commitment to the ideals (8Ps), and even when it's tough to implement - colleagues know it's the right thing to do. There is clear value in the visibility of the leadership team and the engagement programme with the workforce, and recognition of the need to further develop cultural competence and be representative of the community.

The success in recruitment has resulted in a more settled workforce and offer to the community through consistency and improvement in capacity and delivery**.** There is recognition and action that 'voice' is essential in the development of the offer in Calderdale and tangible evidence of activity and benefits**.**

Capacity to do the day job is impacted by pace of change so there is a need to ensure that all teams have the space to fully absorb the key messages and reasons for change.

Work to improve communication and engagement over recent times was acknowledged. Communications can however become lost during busy times or not land as intended. It may therefore be worth reviewing the communications framework to ensure it is both effective across all teams and streamlined.

This includes ensuring tangible successes, positive outcomes and changes are shared as equally as possible and that all communications are received in the way intended by checking in with front line staff and supporting managers to share information as required.

Staff said they valued the newsletter style updates that they received via email rather than receiving many separate emails. They also suggested that staff who are new to the organisation may need a different approach to those already 'living through the changes.'

If not already part of improvement plans, consider whether messaging can be further simplified, scheduled, and delivered in a more systematic way so that staff know what to expect, when and where to find information. This may be something that corporate communications can assist with.

It may also be helpful to take stock and evaluate the impact of key changes to ensure the pace is sustainable and deliverable. Greater clarity of the overall 'waiting well plan' to reduce and manage waiting lists would be helpful.

Assistive Technology appears to be an area that requires greater attention although this is something you are aware of and have ambitions for, once funding and resources are identified to take this forward.

**8. Case File Audit**

As part of the Peer Challenge, a case file audit was carried out on ten cases with feedback provided to the Principal Social Worker. Although this is a relatively small sample it was still possible to see some themes emerging, which have to a degree been consistent with the interviews with frontline staff and feedback from carers.

In summary there was some evidence of good practice but also variation in practice. Some case recording was clearly reflective of new ways of working but this was not always the case.

As the programme continues to be implemented, care will be needed to continue to embed new ways of working to further ensure consistency of practice across all services and teams.

**Strengths**

There was an excellent example of Mental Capacity Act Best Interest decision making with clear steps to involve the person and good use of Independent Mental Capacity Advocates. It was evident that practitioners were attempting to optimise an individual's ability to contribute to the decision at hand.

A complex safeguarding case was audited in which it was evident that the social worker effectively navigated a difficult set of circumstances with sensitivity and consideration of family dynamics and cultural issues.

It was clear in the case of a hospital discharge that the person had been given time to recover before a Mental Capacity / Best Interest Assessment had been undertaken. There was evidence of multi- disciplinary team collaboration and an outcome focused approach to support planning which would ensure the best outcomes for the person.

There was an excellent example of MDT working with a person at the end of life demonstrated by the practitioner taking a sensitive and relational 'think family approach', evidencing they had considered the impact on the person, carer and the child involved. This intervention was supported by thorough evidence and recording of the purpose of their interventions and demonstrated collaboration as a system.

Outcomes were clearly articulated in some case records. The approach of the Deprivation of Liberty Safeguards and Best Interest Assessment were clear with the person at the centre of the process. There was a good level of recording and closure summaries.

**Considerations**

In the transition case seen, there did not appear to be a clear process between children's and adults with no clear oversight or up-to-date carers assessment. The voice of the individual was not evident in the case reviewed.

In the case of a carers assessment, a direct payment was provided for practical support but the outcomes for the carer were not clearly articulated.

It was not clear from one of the more complex cases what the mechanisms were that would help spotlight when an approach was not working, and a different approach was needed.

It was not always clear which assessment documentation was being used and it was difficult to identify a stand-alone risk assessment.

The review documentation seen was limited in information with practitioners reliant on case notes to evidence the outcome of the review and next steps.

In some cases, it would be helpful to more clearly differentiate between the need and the outcome and for the voice of the person to be more evident in case recording.

**9.i Theme 1: Working with People**
This includes the quality statements covering, Assessing Needs, Supporting People to Live Healthier Lives and Equity in Experience and Outcomes

**Strengths**
There was a general sense that the 8Ps framework is becoming embedded. The associated documentation supports good practice by focussing on what matters to the person and ensuring all aspects of the person's life are considered in the assessment. This includes physical activity and equality, diversity and inclusion. Completing the strengths-based assessment in hospital means that better information is passed to teams responsible for ongoing support and there is a sense this is leading to fewer complaints and safer discharges. The framework is being shared more widely within the council and partners such as Active Calderdale and Voluntary and Community sector representatives are also aware of the 8Ps model and its principles.

The Principal Social Worker is creative and ambitious and evidences a think family approach. There is a positive regard for the work she is doing to drive the 8Ps, and she is considered by colleagues as being able to convey the importance of the improvement work whilst recognising the challenges of competing demands.

The Principal Social Worker has recently established a Consistent Practice Framework and while it is in its early days, the team did hear about the consistent practice forums, quarterly shared conversations, audits and supervisions. She is credited with being good at sharing [learning] with the teams and there is 'buy in' from teams and partners. Team managers recognise the role of audits in identifying themes and celebrating what works well.

There is a waiting well framework including a screening tool which the Principal Social Worker oversees. This includes waiting well letters sent by relevant teams and the Better Lives Hubs are seen as a valuable resource which enable people to access advice and low level, low or no cost support in their community - thereby reducing the need for people to wait for an assessment and/or supporting them to wait well.

*'When any of us talk about better lives we smile because what we do is so rewarding'*

There is now a greater focus on driving a reduction in waiting lists with mechanisms in place to maintain oversight and prioritise people on the waiting list. Performance information is now more readily available, and efforts appear to be having an impact with a decrease in backlogs in for example occupational therapy, financial assessment and personalised long-term support.

There is evidence in the case file audits of good collaboration with partners and multi-disciplinary team working. The peer team heard further examples of partners working well together at operational level to embed positive and enabling ways of working including the Making Every Adult Matter approach for people with complex lives, along with arrangements to ensure that discharges are properly planned and coordinated. For example, daily discharge meetings, shared competencies between

discharge staff, Trusted Assessment, and good relationships between therapy and care staff.

Investment in the financial assessment team and a subsequent reduction in backlogs means that the team are now able to spend more time with the people who need it most. Assessment and decision making are reported to be much quicker, which is resulting in fewer instances of debt being accrued due to improved clarity of what people will be charged at an earlier stage, timelier resolution of any issues and a reduction in appeals. This is said to be leading to a reduction in complaints and debt write off. A financial pathway process has been shared with social workers and social work practice to ensure teams are clear about their roles and responsibilities within the process and to prevent delays arising.

**Good links with social prescribers and the Voluntary Community and Social Enterprise Sector to provide prevention and wellbeing support** were highlighted along with the whole system approach to tackling inactivity. This is led by Public Health but integrated into social care. Physical activity is built into conversations, assessments and care planning across adult social care. For example, long term care teams promote physical activity and domiciliary care providers are asked to promote physical activity via care planning. **There are further opportunities to widen the offer of Active Calderdale across the pathways.**

The council is reaching out to communities to understand and reduce barriers to care and support and to tailor care and support in response. This includes the roll out of Better Lives Hubs in areas of greatest need, responding to the Buying Our Care report which highlighted concerns raised by a small number of families of poor understanding of cultural needs by some social care staff in one team, and a team within the ICB. This led to the development of the monthly Governance and Partnership Assurance Board with the Council of Mosques, ICB partners and providers.

Co-production is a strong theme in the council and while several initiatives are recently developed, there were clear messages about the opportunities for people to be involved in shaping and developing adult social care and support. The Community Voice Group is beginning to develop themes based on their experience of social care and people's voices are valued. The co-production lead was credited with making a positive impact in connecting peoples voices with adult social care.

**There are some good examples of using translation and interpretation services and evidence of developments to make the website more accessible**, The Shared Lives service translated some of their paperwork to ensure carers from a range of backgrounds could be part of the shared lives community. In addition, they use interpreters to support carers to understand documentation that hasn't been translated.

**Considerations**

There are difficulties in applying the 8Ps strengths-based model for people leaving hospital where there can be a risk averse culture within the hospital trust, and with trusted assessors which can lead to over provision on discharge. These cases then

require more work by social care teams when reviewed following discharge taking time away from other priorities. Pressure on teams was also said to be 'affecting enthusiasm for the model' because it takes more time to implement robustly.

Pressures are also impacting on the ability of Team Managers to undertake audit and supervision consistently, particularly where they are holding cases to relieve pressures on staff. The capacity of the Principal Social Worker to moderate and analyse the audits is currently also limited. The occupational therapy team would welcome the opportunity to be involved in strengths-based reviews and feel that their contribution to strengths-based practice and positive risk taking is currently underutilised.

It was not clear in all cases whether people who are waiting for an occupational therapy intervention are being followed up routinely in line with policy expectations. Good progress has been made on reducing the waiting time for an occupational therapy assessment, but the peer team heard that there were long waiting times post assessment for a Disabled Facilities Grant with people left to make contact if anything has changed rather than being proactively followed up. While staff were on board with the policy, they felt the required frequency of contact was not currently achievable.

There is some confusion amongst teams about the about the role and remit of the LINC team and how long they will hold cases. People with a learning disability do not appear to get the same opportunities for signposting and prevention at the front door. Some teams appear to be holding on to cases or keeping cases open when they could either be passed on to other teams or closed. This could result in 'bottlenecks.' **A clearer focus and more consistency in how cases are allocated, managed, reviewed and closed would be helpful.**

There are potential **opportunities to maximise referral and assessment processes through for example greater use of occupational therapy and by removing duplication in hospital discharge.** Not all referrals from Gateway were considered appropriate for the teams and had resulted in long term teams completing their own screening for referrals. There also appears to be a differential between referrals that Intermediate Care teams receive which were described as 'comprehensive and strengths based' compared to the Home First referrals that reablement receive, which were described as minimal. This means that reablement need to complete a full assessment and proportionate care plan. Work may be needed with hospitals to ensure referrals to the reablement team are more appropriate and to consider how the assessments taking place in hospital can be streamlined. For example, trusted assessor and living well assessments. There may also be an opportunity for occupational therapy to add value at the front door in reviewing care packages.

There are opportunities to **strengthen the carers offer to ensure equity of access and have a clearer focus on outcomes** resulting from the support provided. While there is a long established and valued carers service, there are gaps in support leading to some inequity of access. For example, support for working carers, out of hours support, carers advocacy, age-appropriate provision and provision for those

older age carers who don't ordinarily come forward. The recruitment of a carers lead, to expediate delivery of the carers strategy action plan, and co-ordinate work with partners, will help to address these issues.

The peer team heard from Integrated Care Board colleagues about some tensions around funding of care packages or care homes through continuing health care due to a differential in rates paid by the Integrated Care Board and Social Care. I.e. the Integrated Care Board contributes to the base rate - but this rate is not accepted by most providers. This coupled with a lack of awareness about strategic discussions to resolve these issues was leading to tensions between staff at operational level. There was a sense therefore, that there needs to be a more joined up approach to commissioning and **better joint working around funding allocation with Continuing Health Care** which would help address some of the tensions that exist.

The Voluntary and Community Sector (VCS) are holding the community on-line directory work and there is some frustration that it is still not launched. Corporate customer care colleagues were not involved as much as they could have been. There is however an awareness of the challenges and senior leaders in adult social care are making efforts to link the wider system in, and expediate the work. Nonetheless there is opportunity **to further embed the community directory of support and strengthen joint working with customer services.**

There is recognition of the potential of Assistive Technology to support people to live more independently and that investment in the Technology and the capacity to develop it is needed alongside a greater awareness amongst occupational therapists to ensure **greater utilisation of digital and assistive technology.**

There is a lack of accessible information such as easy read and translating care plans into ethnic languages. Teams suggested that the translation services can be difficult to access and currently there is no contract with language line. **More consistency in provision of translation and easy read information** is therefore needed

**9.ii Theme 2: Providing support.**
This relates to market shaping, commissioning, workforce capacity and capability, integration, and partnership working.

**Strengths**
The relationship between the council and partners at a strategic level is strong and inclusive of the VCS. Partners said that relationships with the senior leadership team are good, there is a much clearer vision, and they feel respected valued and listened to. They reflected that the partnership environment is one where challenging conversation can happen, and everyone is encouraged to think outside the box. There are some examples of effective partnership approaches such as the hospital discharge model, the Better Care Fund, the Care Home Programme Board and a Joint Quality Framework.

There is a real sense that every person matters in Calderdale with a commitment to quality of provision and getting the best outcomes for people.

The Voluntary and Community Sector reflected that that there have been great strides in terms of engagement with communities and efforts to engage with the wider sector.

There was a sense from partners that while **there is still lots to do, it is easier to do and get things done in Calderdale.**

**Considerations**
**There is an eagerness to move more into action through a robust programme approach with agreed priorities.** While there was a lot of positivity about the leadership, vision and strategy – relationships operationally were described as more challenging, and some frustrations were expressed by Integrated Care Board colleagues about the time taken to deliver change and demonstrate tangible improvements across the system. Financial pressures were acknowledged within this with a need to have conversations in a more joined up and more timely way.

The need to **work together to develop a clearer long-term vision for improving quality of care home provision** was also highlighted. Joint work to respond to provider failure is good, although Integrated Care Board colleagues felt there was now a need to move away from 'firefighting' and towards a more joined up longer term approach.

Overall, there was **a desire to get to know each other even better**, to better understand everyone's roles, responsibilities, accountabilities and drivers to reduce duplication and ensure stronger partnership exists at all levels.

**9.iii Theme 3: Ensuring Safety**
This theme includes safeguarding and safe systems pathways and transitions.

**Strengths**
Safeguarding pathways have been reviewed and the council has developed a dedicated safeguarding team which includes a dedicated operations manager, team manager, team leader, two practice leads, eight social workers and two service co-ordinators.

The team now provide first point of contact for most concerns. A standard operating procedure is in place and new threshold guidance to reduce the number of concerns coming through that do not result in an enquiry.

Safeguarding concerns are now dealt with more robustly and in a more timely way. Previously there were some challenges in progressing and closing cases, but the peer team were told this has now been resolved and is monitored more closely with power BI. Cases are not closed until there is assurance that everything is completed and there is management oversight throughout all referrals. Caseloads are discussed in supervision and there is work underway to establish a more dedicated safeguarding audit.

There is a good relationship between the quality team and care home providers and there is an open and honest working relationship with the safeguarding team.

There are good relationships between the Safeguarding Adults Board and partner agencies that extend beyond statutory partners. Encouragement to step beyond an individual's remit comes from the council's chief executive and is evidenced by initiatives such as the multi-disciplinary team approach to high-risk cases which arose because of learning from the Burnt Bridges safeguarding adults review. There is a large programme of change which is organised with good governance. The chair of the safeguarding adults board reports to the DASS monthly and described an 'open door policy' for any issues that need to be discussed. The council's scrutiny panel is supportive and reports such as Burnt Bridges also go to cabinet. The availability of data has improved. For example, data on Making Safeguarding Personal is now more readily available and there is greater confidence in the data.

The Making Safeguarding Personal questionnaire includes asking the person about whether their outcomes were achieved, and around 80% of people say they were asked the question about outcomes. Results are fed back individually at the time and if needed shared between managers.

The relationship between the Council's safeguarding team, the Safeguarding Adults Board and partners is good. There are close relationships between Mental Health and Learning Disability teams and the police and health team.

Partnership meetings include a Daily Risk Assessment Management meeting which includes services involved with domestic abuse incidents in the last 24 hours, Fortnightly Multi Agency Risk Assessment Conferences, Prevent, and a weekly Making Every Adult Matter meeting. Theme based training happens regularly for all staff.

Partners were complimentary about the **hospital discharge model** with discharges from hospital to reablement described as very efficient. The Home First pathway, pathway 1, was launched in August 2023. The urgent and community response team support people to return home following which an assessment is undertaken. People who will benefit from reablement are referred straight away and if not, they are referred for alternative provision. Response times were reported to have improved from an average of 5 days to within 24 hours.

There is a daily transfer of care hub meeting where discharges are planned and coordinated. Discussions were described as open and honest, and the joint funded discharge flow co-ordinator has a key role in supporting how the process and the partnership works.

The dedicated system flow coordinator supports the hospital team to raise issues with health colleagues prior to discharge to ensure people are discharged to the most appropriate place as timely as possible.

Positive and enabling approaches are used and there are shared competencies between discharge staff to support efficiency. There are good relationships between therapy and care staff.

There is a competency framework for all care staff in reablement to promote independence and improvements and the reablement team demonstrated their skills, confidence and commitment to maximise people's independence and have a clear commitment to outcome focused support.

The plan now is that all people will go through home first reablement from hospital. Funding has been agreed and recruitment is underway.

**Considerations**
The plans to move more work to the safeguarding team from the mental health and learning disability teams and Gateway have not yet been delivered due to the impact on the new dedicated safeguarding team of four large scale safeguarding enquiries since the teams' inception. This was unexpected and resource intensive despite support from other teams. A revised timeline is now in place.

Recent changes to the safeguarding process, alongside the workload generated by large scale enquiries is impacting on communication within the safeguarding team and their capacity to undertake supervision and training consistently.

The safeguarding adult team needs to be able to create the time and space to prioritise removing administrative and practice inefficiencies together with embedding the thresholds in order to release the capacity required for the team to take on all safeguarding concerns.

Alongside this consideration should be given to opportunities to strengthen the approach to prevention by appropriately screening and signposting some safeguarding referrals at the front door. The occupational therapy team identified an opportunity for them to be more involved in safeguarding by providing advice on poor moving and handling.

There is scope to work more closely with the Integrated Care Board designated nurse for safeguarding adults to more clearly identify issues about quality in health care settings rather than safeguarding concerns being raised.

The safeguarding board have identified disproportionality of representation in the safeguarding process of people in poverty and there may be opportunity to learn from approaches taken by other areas via the national ADASS Equality, Diversity and Inclusion Action Group.

**Completing the Living Well assessment as part of the hospital discharge process has resulted in better outcomes for people who have been discharged from hospital on the right pathway and has reduced complaints. However, there is some frustration within the hospital about duplication and delays.** A trusted assessment is completed and then people have a living well assessment before discharge. This was seen to be impacting on the timeliness of discharges.

The peer team heard about issues with mental health discharge in that it can be difficult to determine responsibilities and occasions when the S117 referrals are not received so discharges happen without adult social care input.

The team also heard that some people are still being discharged from hospital into care homes without the right level of support and or information, and that more could be done to embed learning from discharges so that the same issues do not continue to arise.

There would be benefit in taking the time to understand the impact of the change from pure reablement to the home first pathway to ensure the reablement service does not become a replacement home care service which may increase the risk of unsafe and or delayed discharge.

Having the disabled children's team working closely with adults has supported collaborative working and secured better outcomes for people. However, messages about this arrangement were mixed. The arrangement has enabled smoother transitions and greater learning between teams but is not maximising the opportunity for joint working. This is currently under review.

Teams identified the need to start involvement with children and young people at an earlier age and include those children and young people across education and social care not just the disabled children's team.

The links with the disabled children's team are good but Preparing for Adulthood impacts on a much wider group including care leavers and involvement at the optimum point is a challenge for the Learning Disability Team. The case file audit identified that the policy and process for young people transitioning into Learning Disability and Preparing for Adulthood needs to be clearer as do roles and responsibilities throughout the process**.**

**9.iv. Theme 4: Leadership**
This theme includes governance, management and sustainability and learning, improvement and innovation

**Strengths**
There is council wide leadership commitment, support for and ownership of the adult social care agenda with the chief executive, leader, politicians and corporate teams understanding the importance of the council providing the delivery of good support to local people.

There is a strong shared vision for Calderdale which is understood and a feeling of team, collaborative values and all senior leaders living the vision. The adult social care leadership team is approachable, inclusive and supportive and there is a sense that people care about Calderdale. They are listening to staff and encouraging innovation and creativity across all areas of adult social care including commissioning and partnerships which is resulting in tangible improvements such as person centered financial assessments. The work instigated by the adult social care leadership team is recognised at a corporate level in the council and providing confidence in delivery of the objectives.

*'I've seen a massive change in the past year they're not senior management. They are Cath and Anne, and they are sitting amongst us'*

There is a clear commitment from the Director and Assistant Director to the role and work of the Principal Social Worker with a very clear line of sight and trust in her to deliver. The Principal Social Worker reports directly to the DASS and is visible to staff and community groups supporting co-production with a clear commitment to do better.

The peer team were encouraged by the work done to stabilise the workforce and reduce spending on agency staff. The impact of this is evident and success is as much about the attraction of a community led approach and values as it is about improved parity of pay with neighbouring authorities.

*'Recruitment and retention of staff is good. It feels like there is a positive shift in mood in the authority– staff are committed.'*

There is targeted work to change a 'coasting culture' to a 'shared conversation and development culture.' There was some evidence that this is beginning to pay dividends in terms of connecting teams with improvements through better use of data and information and **a change in approach around waiting lists**

Focussed efforts develop a more inclusive culture, listen to and learn from feedback were evident.

Teams and managers are encouraged to speak openly and honestly, and they feel heard. There are several staff networks in place and network representatives sit on and can influence the corporate equality group agenda. There have been initiatives to attract applicants who are more representative of local communities and the directorate is committed to utilising the Partners in Care and Health **Diverse by Design** tool kit to improve equity, diversity, and inclusivity within the workforce.

The Voluntary and Community Sector's vision and aspiration is shared with adult social care and there is a joint commitment to co-production. A range of examples to involve people with lived experience were cited such as the people's panel, carers involvement in co-producing the carers strategy, and the inclusion of people with lived experience in the commissioning process

There is a greater focus on staff learning, development and well-being with a clearer career pathway, a positive ASYE programme, induction and support for new starters, cultural competence training, improved training opportunities for occupational therapists and joint training with partners.

**Considerations**
The peer team heard from some teams that the pace and scale of change is impacting on their ability to do the day job and notwithstanding the ambition and their enthusiasm around vision and leadership - capacity for some felt stretched. The peer team heard from some managers about tight and sometimes unrealistic and seemingly artificial deadlines, 'spinning lots of plates' and at times a lack of timely and/or consistent feedback.

Improvements in communication by senior managers over recent times was acknowledged but there was a sense from some teams of 'email overload with too much information being sent too often' at times, and some difficulties in finding information. The peer team heard that feedback loops are not always complete with messages not always filtering through the management layers. Some staff felt that they were unclear about the criteria for the LINC team and how long they hold cases for. The peer team also heard that decisions about care and support were sometimes delayed with teams left unsure as to how issues raised are being addressed.

The time needed to embed and realise the impact of changes was also cited by some staff as an issue. For example, old and new ways of working running simultaneously, teams continuing to deal with demand which is intended to be diverted away until new ways of working / new teams become embedded and new process taking longer to execute until they become familiar. (For example, safeguarding, reablement, LINC & Gateway)

The effect of waiting lists were also raised by some teams (for example occupational therapy and learning disability) with the peer team hearing several references to the combined impact on capacity to undertake supervision consistently, to engage in training and to continue to maintain quality of work.

With such a significant programme of change there is merit in understanding the impact of hybrid working - and how the availability and allocation of office space is impacting on:

- the support and professional development of staff - particularly those who are newly qualified,
- communication within and between teams, and
- capacity to deliver the change programme.

There is opportunity for corporate teams to further support adult social care to take stock and better understand and develop solutions to some of these issues.

For example: Working with the DASS to:

- Better understand the impact of hybrid working on the delivery of adult social care and develop an accommodation strategy that secures sufficient office space to enable teams to deliver more efficiently and effectively.

- Consider whether there is a need for additional capacity and expertise to help adult social care plan, communicate and deliver transformational change on such a large scale.

- Ensure the opportunities presented by digital and robotics are maximised to ease the load on the adult social care workforce.

**10. CQC lessons learned so far**

Partners in Care and Health have produced a suite of documents and tools to help councils prepare for Care Quality Commission's assurance including top tips. Below are some key learning points from experience so far that may help in 'telling your story.'

The narrative should be authentic and driven by data and personal experience.

Be able to thoroughly track the customer journey for a variety of different people with lived experience.

Share the narrative with those with a lived experience, carers, frontline staff, team leaders, middle managers, senior staff, corporate centre, politicians, partners in health, third sector and elsewhere.

Ideally this story is told consistently and is supported by data and personal experience - don't hide poor services. This will probably take the form of:

- What do we do well?
- What impact is it having and how do we know
- What needs to improve?
- What are the plans to improve?

Have mechanisms in place that enable staff and managers to practice telling their story and in a way that is rooted in observable data.

Think about how you will enable staff to be consistent in the messaging to give an accurate reflection of how things are.

Case examples written in the voice of people with lived experience help bring the narrative to life.

Think about how you will everyone to look after their own well being throughout the process - pre, during and after.

CQC want to find out how things really are. Experience so far is that they look for what is good as much as they look for issues.

They are interested in outcomes and impact from activity. This needs to be reflected in the self-assessment and documentation.

However, this is not a chat. Those interviewed should be able to give a clear description of what they do and the impact it has had on people's lives.

**11. Contact Details**

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