DRAFT
Adult Social Care Self-Assessment

July 2024

Kirklees COUNCIL

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1 WELCOME AND PURPOSE

This self-assessment has been developed using ADASS/ LGA Getting Ready for Assurance guidance. It covers the four themes of CQC inspection, and the nine quality statement areas. This is a live document which will evolve as new intelligence, insight and voices of lived experience become available.

2 ABOUT KIRKLEES

Kirklees Metropolitan Borough Council, known simply as Kirklees Council, is one of five in West Yorkshire, and the 13th biggest local authority in the UK in terms of population and the third largest Metropolitan District by area covering 157 square miles. Since 1 April 2014 we have been a constituent council of the West Yorkshire Combined Authority. We are also part of the West Yorkshire Integrated Care System.

People and Population

Kirklees has a total population of 433,200 in 2021, 22.6% of the population are aged under 18, and 17.8% of the population are aged 65 or over. 20.9% of the population are from a black or minority ethnic (BME) population, and 23.3% of the population described themselves as non-white UK (i.e. not white British, English, Northern Irish, Scottish, or Welsh).

The median age of the population in Kirklees is 38 years. This is less than the median age for England, which is 39 years, and less than the median age for Yorkshire and Humberside which is 39 years. 15.7% of the population are aged between 65 and 84 years, and 2.2% of the population are aged 85 and above.

At birth, males in Kirklees can expect to live to the age of 78.4 years, with 62.8 years of life being in relatively good health. For females, their life expectancy at birth is 82.2 years, with 61.2 years in relatively good health. The healthy life expectancy measure adds a 'quality of life' dimension to estimates of life expectancy by dividing it into time spent in different states of health. The number of years of life in poor health is also important as it relates more closely to the demand for health and social care. At the last Census (2021) 5.8% of residents in Kirklees reported their health as poor or very poor, and 17.7% reported a long term illness or disability that impacts on their day to day activities.

Ageing Population

There are around 40,400 people aged over 75 living in Kirklees today which is 6,700 more than there were five years ago, and which is expected to increase, over the next five years by an additional 5,500 people. Five years ago, 1 in 12 (7.7%) people living in Kirklees were over 75, today this has increased to 1 in 11 (9%), and by 2028 it is estimated that 1 in 10 (10%) people living in Kirklees will be over 75.

There are around 10,600 people over 85 living in Kirklees today. This is 1,400 more people over 85 than there were 5 years ago. By 2028 it is estimated that there will be an additional 1,700 people over 85 living in Kirklees than there are today. If estimates are correct this would represent a 34% growth in this population group between 2018 and 2028, and a 16% growth over the next five years.

Some facts about our population of 433,200:

Around half the population are **female** and half are **male**

It is estimated that **0.6%** of the population are **transgender**

Around 2.6% of people are LGBTQ+

1 in 6

Adults are living with a disability

1 in 4

Children are eligible for free school meals

1 in 8

Children have a special educational need or disability

57% are **Christian**

16% are **Muslim**

1% are **Sikh**

0.4% are **Hindu**

26% have **no religion**

1 in **12**

Adults in Kirklees have ever served in the Armed Forces

9 in **10**

Of which are Male

1 in 6 – of the adult population in Kirklees are carers.

1 in 7 – 14-year-olds are carers.

Our changing population

White British

77% | 58%

Total population | School children

Pakistani

1 in 10 | 1 in 5

People | Mothers of new babies

English is not the first language for 3 in 10 primary school pupils

Local Economic Picture

Kirklees can be thought of as three distinct areas. North Kirklees includes Dewsbury (Kirklees' second-largest town), the urban centres of Mirfield, Batley and Cleckheaton and the more rural Spen Valley. Huddersfield which is the largest town in Kirklees and is the business and administrative centre of Kirklees, and Kirklees Rural which is the rural and semi-rural area south and west of Huddersfield which extends into Pennine moorland and parts of the Peak District National Park. This means that it is made up of two major centres of Huddersfield and Dewsbury and the smaller towns of Batley, Birstall, Cleckheaton, Denby Dale, Heckmondwike, Holmfirth, Kirkburton, Marsden, Meltham, Mirfield and Slaithwaite.

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The median gross weekly wage for full time employees living in Kirklees is £612 compared with an England wage of £683.40. 4.6% of working aged people in Kirklees are unemployed, compared with 3.8% nationally. (Ref 161)

Kirklees contains areas of high and low deprivation, with regions of highest deprivation found in some of the more densely populated urban areas to the north and east (including parts of Huddersfield, Dewsbury and Batley), and lower levels of deprivation found in the more sparsely populated rural areas to the south and west (including the Colne and Holme Valleys, Denby Dale and Kirkburton).

The Indices of Deprivation (Ref 122) combine a range of economic, social, and housing indicators to provide a measure of relative deprivation, i.e., they measure the position of areas against each other within different domains. A rank of one indicates highest deprivation. Kirklees is ranked sixty-four out of 152 local authorities in England on overall deprivation and is ranked sixty-seven out of 152 local authorities on income deprivation. Kirklees has an Income Deprivation Affecting Older People Index (IDAOPI) score of 0.149 (2019). This measures the proportion of all those aged sixty or over who experience income deprivation. The average for Yorkshire and Humberside is 0.217.

Driving Local Strategy

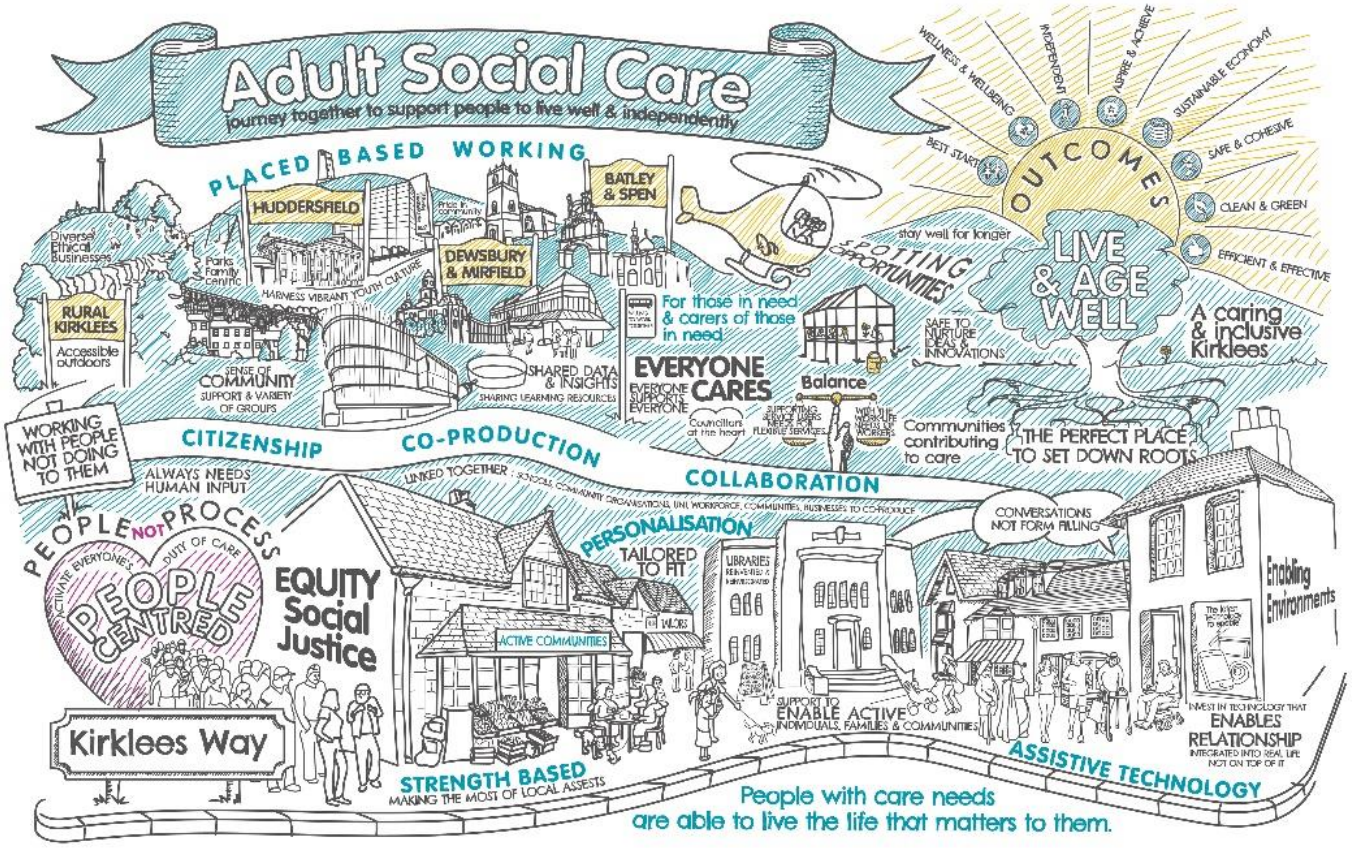
The KJSA (Ref 92) provides a picture of the health and wellbeing of Kirklees people and informs the commissioning strategies and plans of the Council, Health and Care Partnership (Ref 97), ICB and the local voluntary and community sector. It includes information about health needs and assets. Health assets help people and communities to maintain and sustain their health and well-being, such as skills, knowledge, their networks and connections and community spaces, for example parks.

There is also information about the different care markets and how they are changing in our **Market Position Statement** (Ref 26). This statement marks the next step in the ongoing and open dialogue between commissioners, providers, and citizens, with the shared ambition of developing a thriving care and support market in Kirklees.

3 OUR VISION FOR ADULT SOCIAL CARE

Our vision (Ref 1) and values have been coproduced and informed through the contributions of staff, people who use our services, carers, partners, and voluntary organisations.

We want every person in Kirklees who needs social care to be able to live the life that matters to them – with the people they value, in the places and communities they call home, and with an equal voice in co-ordinating their care.



4 OUR VALUES

The following values and principles are key to the vision for social care in Kirklees; they define who we are, how we will work and what people should expect from Adult Social Care in Kirklees.

Optimism – We will be optimistic, embrace change and take positive risks in supporting people to live better lives, build personal resilience and promote independence.

Communication – We will communicate openly and effectively, working in partnership to make the most of the contributions of people and partners in order to respond flexibly to changing circumstances.

Respect – We will promote inclusiveness, embrace equality of opportunity, cultural respect, and diversity to ensure meaningful engagement with individuals and their advocates.

Empowerment – We will work to give people freedom of choice, control, and confidence to make informed decisions for themselves without the constraints of bureaucracy.

Compassion – We will listen and respond with humanity and kindness to each person's need, recognising the powerful potential of kindness in building relationships, supporting wellbeing, and encouraging resilience.

Dignity – We will value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits.

Quality – We will continually insist on quality and strive to get the basics right through safe, effective services that are shaped through the experience of people using those services. We welcome feedback, learn from our mistakes, and build on our successes.

Integrity – We will be honest, transparent, and fair in everything we do. We will always do the right thing and will seek to co-produce with partners and people to ensure we deliver on our promises

Inclusion – We will ensure that people who have care and support needs, as well as their carer's, have an equal voice in what their social care should be, and how it reflects their individual needs. Their views are considered the same as everyone else involved in their care, and their interests and experience are valued as the most important factor in meeting their needs through a diverse care offer.

Our values have been coproduced and informed through the contributions of many staff, people who use our services, carers, partners, voluntary organisations. If our vision describes what we want to achieve and by when, then our shared values help to describe who we want to be, our shared identity, in order to achieve our Vision for Kirklees.

PART A - WORKING WITH PEOPLE

This section covers: assessing needs, care planning and review, arrangements for direct payments and charging, supporting people to live healthier lives, prevention, wellbeing, information and advice, understanding and removing inequalities in care and support, people's experiences and outcomes.

5 WORKING WITH PEOPLE THINGS WE ARE PROUD OF

- We are driven by our Vision for adult social care which was coproduced by people working within care and support services and people who draw on care and support.
- We are shifting towards working in strength-based way with people to understand and shape the support that matters to them following the disruption that the Pandemic caused to this journey
- We have a focus of community-based prevention and early intervention across our work.

6 WORKING WITH PEOPLE KEY AREAS FOR IMPROVEMENT

- Information accessibility is our public facing documents and data reports is an issue that surveys with people who use our services and their carers report, and we need to improve this.
- The quality framework (Ref 96) and ongoing management of quality needs embedding which will be more easily enabled by the implementation at the of the new electronic record system (MOSAIC) which started to go live at the end of February 2024.
- Assessment and review timeliness is a pressure in teams, leading to backlogs which our 2024-2026 change programme will seek to address
- We are not clear if our service change work removes barriers to access or reduced inequality.

7 ASSESSING NEEDS

7.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

The text from our vision best embodies our ambition in particular the element around people living the life that matters to them. We have been working to ensure people are at the centre of their care and support planning . We have also invested in resources that blur the lines between what may have been seen as preventative community universal services and more formal care and support such as home care in blended packages of support.

- **4 in 5** (78%) people who use services felt they had control over their daily life.
- **3 in 5** (63%) people were satisfied with the care and support they receive.
- **2 in 5** (42%) carers were satisfied with social services.
- Quality of life scores for people receiving care and support services were **18.9** out of 24.
- Quality of life scores for carers were **7.5** out of 12.
  (Ref 100 ASCOF 2022/23)

We have made significant progress in taking a strengths and asset based approach to care and support planning across our pathways from non-assessed community based teams, through our social care front door (Community Health and Social Care Hub), our Social Care Occupational Therapy (SCOT) and Movement and Handling team, our Personalised Care and Locality Wellbeing teams, Hospital Hubs, and those teams that support those living with dementia (Ref 2), mental health issues or learning disability.

We know, however that there is still additional work to do to fully embed this way of working, particularly as we move away from some of the working practices introduced in order to respond to the COVID pandemic and the post-pandemic NHS pressures and throughput. A diagnostic in summer 2023 found further opportunities for strength based practice, this is incorporated into a change programme commencing spring 2024. (Ref 99), this programme will include work to support increase legal literacy amongst the assessment workforce to ensure strength based working is consistent with our duties under the Care Act and other legislation we operate within.

Our front door (Community Health and Social Care Hub) is a key service area that builds independence amongst those that contact the team. Our forthcoming change programme will bring structural and capacity improvements to the front door, so a community first approach is better developed. They support on average 3,200 contacts a month. We are concerned about the increasing volumes of contact to the front door which is impacting timely and appropriate responses. That said, Community Health and Social Care Hub has over the past year been able to resolve 73% of contacts, this has included advice and guidance as well as around 1 in 10 (11%) getting equipment, adaptation or assistive technology as a result of front door contact. Satisfaction with Community Health and Social Care Hub has remained above 94% and did peak at the end of the 2022/23 financial year at 98%.

Building on the theme from the front door we have also seen the impact of our **redesigned SCOT service**, with up to 58% of referrals to the team coming from the Community Health and Social Care Hub, the SCOT team offers a wide range of solutions and opportunities that both improve wellbeing but also step around 92% of referrals back from more formal services so people can remain independent for longer. The SCOTs are a small, specialist team with an ethos of prevent, reduce or delay the provision of statutory services. The work of this team has led to wider changes such as the bringing back in-house of the OT assessments for the Blue Badge scheme, as the previous commissioned service was not taking the holistic and preventative approach we aspire to (Ref 139). The SCOT team work closely with our Movement and Handling team who support carers and providers with advice about how equipment can help people move and be supported to move safety either at home or in other sorts of care settings. They also work more widely across the Council to support the disability inclusive design of public buildings and spaces and to take opportunities to provide a more holistic response to requests for services in other parts of the Council such as requests for Assisted Bin Collections.

The approach to discharge and strength based community social work (Ref 3, 121, 162) in our hospital and community teams is integrated with our partners and builds on our strength based approaches to care assessment and support planning. We have also supported work with the ICB around supporting communications for carer discharge (Ref 163). We have developed a peripatetic team that supports care the service across assessment, review, safeguarding, and care home closures. Our joint work with KirCA (Kirklees Care Association) to develop and host trusted assessor roles has facilitated rapid discharge to care provision and the team has improved the quality of dialogue and wider relationships with care homes in Kirklees and wider afield. This team will also support our partnership based Care Home Early Support and Prevention Panel (CHESP) where quality, safeguarding and provider stability are addressed and proactively managed by the Council, ICB and community health partners.

Supporting people as they near the end of their lives is a critical part of our role, we have over a number of years developed strong and fruitful relationships with our local hospice The Kirkwood who offer in patient and community based support for those at the end of their lives. Over the past 12-18 months we have developed a trusted assessor team based at The Kirkwood this ensures limited hand-offs, removes barriers, reduces waiting times for assessment and puts trust in the experts supporting some of our most vulnerable people.

7.1.1 THINGS WE ARE PROUD OF

- We have rolled out and are embedding strength based practice and wellbeing conversations across different roles, and teams to ensure support plans are coproduced with service users, carers and other advocates.
- The investment in social prescribing roles in the community has supported people to access community based wellbeing support.

- The introduction and benefits realised by Personalised Care and Locality Wellbeing teams.
- The expansion of the front door offer and resources to support longer more detailed conversations with contacts.
- The investment in and benefits realised by the Social Care Occupational Therapy (SCOT) and Movement & Handling team.
- The investment in local integrated partnerships and the community anchors.
- Trusted assessor model in end of life care in partnership with the Kirkwood.
- Carer strategy group work and the involvement of carers in the commissioning of carer support services.
- Project search and Real Employment activities that are supporting those living with learning disabilities into paid employment.

7.1.2 KEY AREAS FOR IMPROVEMENT

- We have identified that a number of areas of practice have been impacted by responding to the COVID Pandemic and the post-pandemic pressures (including very significant increases in referrals from the NHS We have seen 11% average year on year growth in demand for discharge related referrals to social work overall since 2019 volumes have increased by 36% for instance)
- We need to consistently measure whether and to what degree people feel support reflects their wishes and improvements in wellbeing and emotional health are evidenced.
- The communication around eligibility and charging for support needs to be redeveloped.
- We need to measure the quality of the assessment and review experience with service users, carers and advocates and better share learning.
- Data quality processes and data interpretation skills need developing across teams.
- Access to information needs to be improved, with 2 in 3 (65%) of service users, and 1 in 2 (54%) carers saying they found it easy to find information about services. Our investment in TriX may assist with this but benefits will need to be measured.
- Timeliness of assessments and reviews are an issue, and we take a risk based approach to the prioritisation of assessment and review activities.
- The approach to waiting times and backlogs needs greater visibility and tolerance based triggers should be developed.
- Similar to other areas we have seen the complexity and skill requirement around case work intensify, we will work to understand the short and long term workforce skills requirements locally, this includes work to improve and share good practice around legal literacy.
- A robust trusted assessor approach needs to be developed across the wider independent sector building on the current arrangements with KirCA.
- Working in partnership with NHS, community health care and independent sector providers happens effectively in a large number of cases, there are strong connections and clear responsibilities across partners. This does need to be further improved to ensure the voice and involvement of the service user is not lost in inter-agency responsibility discussions particularly as resources are placed under increasing pressure.
- Our approach to quality management needs to be improved, the reviews of case practice is undertaken effectively at team and service level but the learning and sharing of findings is limited.
- There are gaps in consistency of quality audits across all teams, we want to involve service users and carers in a restorative way in our quality audit work.
- Our quality strategy is not clear or communicated well across teams, there is also a gap linking it back to the vision and other strategic documents.

- Our approach to ensuring we are meeting needs equitably for our diverse population needs evidencing and reporting regularly.

7.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

There has been a period of significant change and development across teams, pathways and service areas. To fully understand this we utilised an external consultancy (Newton Europe) to undertake an external diagnostic across our services, the primary objective of the diagnostic was to understand how we can improve outcomes for residents within Kirklees. The scope and activity of the diagnostic has been formed around this Vision for Adult Social Care with our residents at the heart.

The diagnostic sought to give an objective analysis of the greatest opportunities we currently have to support better outcomes for our residents and safeguard the Council's limited financial resources. Once understood, these opportunities have been rationalised against all existing transformation and efficiency work to give a holistic view of our opportunities.

The activities that formed the diagnostic ranged from time with our front-line teams (over 100 hrs) to the analysis of service user journeys captured in our data. In-depth reviews of 168 individual cases undertaken by our staff have formed the basis of our levels of confidence and have been backed up by surveys, 1:1 conversations, journey mapping, national benchmarking, detailed process mapping, gap analysis to national best practice and bespoke analysis to give a broad and deep understanding of these opportunities. (Ref 99). We also cross referenced the findings with feedback from the first stages of a Peer Review that could not be completed because of Review Team illness.

Data quality and integrity has been a recurring issue at team and service level, and even though performance and finance are regularly reviewed and actioned at a senior level there remains a lack of confidence in some data which in turn affects the ability to make robust decisions based upon that data, this was also identified in the recent diagnostic work. The implementation of MOSAIC will allow us greater opportunities to address this.

There are effective feedback mechanism and involvement in change from all levels of staff in the regular Shaping the Future workshops that are held (Ref 165). Feedback loops from supervision discussions are escalated through managers to senior leaders where issues are addressed, unblocked or a response action planned. Our Corporate Customer Standards Officer routinely attends the Social Care Leadership Team for reflection and to ensure that we can learn from national LGO cases and whether there are actions we need to undertake from the findings (such as 15 minute calls).

Service user feedback is less developed, there are formal compliment and complaint reports and response work at case, team and service level, but the shaping of change by service users is not consistent across all areas. The introduction of the co-production board in 2022 was the start of formalising the role of those with lived experience in change and the governance of services. Likewise the Carer's Strategy Board provides a good opportunities for insight, feedback on services and collaboration with informal carers.

7.2.1 FRONT DOOR

- Call resolution at the front door has increased with around 75-80% of contacts being resolved at the front door.
- A key part of resolution has been the shift to the front door issuing low level equipment to contacts rather than passing referrals to equipment services, this has reduced pressure in other teams and empowered front door staff to shape solutions with callers.
- The conscious increase of staff resource in the front door was to acknowledge the increase in demand, this has not seen a positive impact on call wating times. Calls have increased in complexity and therefor the length of time the call is taking has increased.

- There are shorter referral pathways to the social care occupational therapy team (SCOT) which means earlier in the pathway therapy interventions to support people to learn new skills or do things differently. Alongside equipment and other solutions are investigated and deployed before formal care services being delivered or developed to ensure we are maximising independence and carer resilience.
- We have introduced on-line self-assessment functionality in Better Care Support to enable individuals to complete financial and care assessments and reviews at a time that suits them and submit them to inform and support subsequent conversations with council staff.

7.2.2 CARE ACT ASSESSMENTS

- Over the past year across all teams 3,174 assessments have been completed, around 2 in 3 assessments requests had been completed within 28 days. Of those in the 1-28 day group just over half were responded to within 7 days.
- There are range of reasons for delays in assessments from staff capacity, family discussions and involvement capacity, other assessment such as MCA and financial assessment details. Cases are risk assessed regularly in teams to ensure changes in cases are noted and mitigated or the case is reprioritised.

7.2.3 CARE ACT REVIEWS

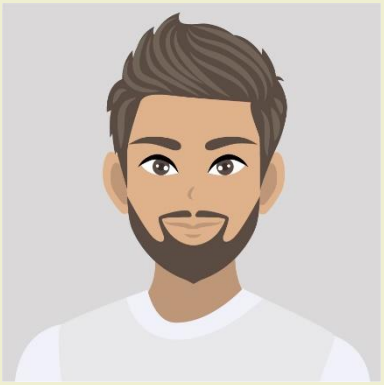
- Over the past year 12,054 reviews were undertaken 1 in 4 have been completed within 28 days of the due date. Broadly speaking reviews in care homes make up 2 in 5 (44%) and community based support accounts for 3 in 5 (56%). As with assessments there are a range of factors affecting the delay in reviews including capacity for all interested parties to agree support changes.
- Over the past year around 1000 people have requested or undertaken an early review between 60 and 200 days before it was originally due, this is commonly due to a change in circumstance.

7.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

- The forthcoming Change Programme will seek to focus on:
    - Effective resolution at the front door through fair and transparent decision making, timely interventions, signposting and quality advice, information and guidance.
    - Increasing the numbers of people benefitting from wellbeing and preventative services.
    - Increasing the numbers of people benefitting from reablement.
    - Maximise the use of technology and equipment in the delivery and effective management of support.
    - Strengths based practice is effectively deployed and builds on individual's abilities and natural support networks and promoting independence, wellbeing and control, including building on the principles in the co-produced Direct Payments policy.
- Our investment in the MOSAIC case management system should make case work more consistent and efficient. The pathways and processes that have been in use have been overhauled and designed into the system with staff. The reporting of progress at stages within an assessment for instance will also be easier and action can be taken, or resources deployed more effectively using the data.
- The Access Strategy will redevelop the routes into the LA including ASC and Community provision.
- Our investment in TriX an information and document software solution will make accessing information simpler for both service users and carers as highlighted in the ASCOF data, but also change the way our staff teams access, share and store documents with people and partners.

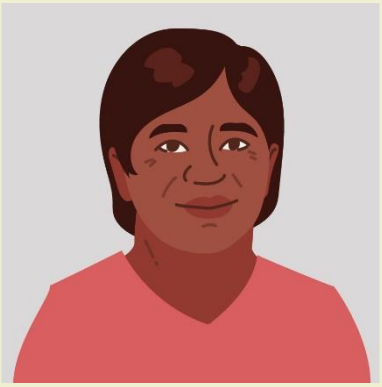
7.4 WHAT DO OTHERS SAY ABOUT OUR PERFORMANCE IN THIS AREA?

Spotlight on: **Shared Lives – Matthew's Story**



Matthew had recently lost his dad; the family needed some emergency support and time to think about the future. Shared lives found a match with carers available to support him in a matter of hours. The Matthew was introduced to Pat and arrangements were made for him to stay while an assessment took place. During the assessment process relationships blossomed with Pat, who supported him with new experiences and time to talk about his father. As the assessment process concluded it was clear that the arrangements made in an emergency were actually the match, he would have wanted all along. Matthew has stayed with Pat, he told us "It's really been life enhancing" Pat said "this has challenged how we think, and opened up opportunities and experiences to develop for both of us"

Spotlight on: **Carer's advocacy – Sue's story**



Sue is a carer for her husband who has a rare condition, needs medication constantly, and collapses every now and then without warning. He won't accept help from anyone other than Sue and they don't have family close by.

Sue contacted Carers Advocacy to help her speak up and ask for the services she needed. Her advocate referred her for a Carers Assessment and attended with her to help her speak about her challenges. Following the Carers Assessment Sue received funding to support her with cleaning and for massages.

Her advocate found Sue wasn't receiving the benefits she was entitled to. A Carers Count Information and Advice worker helped Sue apply for the correct benefits which she now has, and Sue also received some backpay. Sue was very appreciative of all of this and said she would have deteriorated in both physical and mental health without this support.

8 SUPPORTING PEOPLE TO LIVE HEALTHIER LIVES

8.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

Our ambition is in our Joint Health and Wellbeing Strategy that says, "People who live, work or study in Kirklees live their best lives with good health and wellbeing, free from inequality, stigma, discrimination and barriers, so they can do and enjoy the things that matter to them." This approach to the entire population has three priorities mental wellbeing, healthy places and connected care and support.

- **3 in 5** (62%) people were satisfied with the care and support they receive.
- **2 in 5** (42%) carers were satisfied with social services.

- **2 in 5** (41%) people using social care receive support through a direct payment.
- **4 in 5** (80%) people remained at home 91 days after discharge from hospital into reablement or rehabilitation support.
  (Ref 100 ASCOF 2022/23)

The joint Kirklees Independent Living Team (KILT) (Ref 4) is part of our commitment to improving wellbeing with the ethos of 'prevent, reduce, delay' at the heart of how the KILT operates. to the service bring together strategic oversight and support for reablement and intermediate care services through a partnership between the Council, ICB and LOCALA. Pathways have been redesigned to better utilise existing resources and streamline access to the multi-disciplinary teams and we have seen successes in this both from an outcomes and a system point of view. Our KILT team is also part of a national Urgent Community Response (UCR) pilot (Ref 5) to work on further prevention of acute admission or ambulance attendance where a care and support response is more appropriate.

All of our internal development is nothing without a strong care and support provider sector. We have invested in our VCSE and developed four anchor organisations (Ref 6) to lead and develop place based community programmes and services that focus on prevention and early intervention as well as more acute support outcomes, this work is driven by our Inclusive Communities Framework approach (Ref 7).

Our Local Integrated Partnership team has also seen growth in contact volumes, and improvements in reported outcomes against life satisfaction, life feeling worthwhile and happiness as a result of the support given by the service. (Ref 8). The Wellness Service has worked across communities to support people to find community based solutions through the VCSE and wider local authority resources (Ref 77, 78).

Our Emergency Duty service cover support requirements outside office hours and we are in the process of developing a new EDS model to better utilise the skills of the team across the pathway, a great deal of insight from local capacity studies is informing the new model of EDS aspects of which also fall within the Change Programme.

At a more preventative level, we have a programme of work in Local Integrated Partnerships to provide person centred inclusive and accessible services, utilising partnerships based in the heart of communities, promoting independence, leading to improved health and wellbeing across Kirklees. This includes developing the offer around Personalised Care (including Social Prescribing), the Wellness Service, Community Plus and the Libraries Service in collaboration with the VCSE and the Primary Care Networks. Knowing the impact that loneliness has on self-esteem and emotional health, we have developed a range of tools and support, working with the Jo Cox foundation and others to shape a range of local initiatives. (Ref 13, 14, 15)

Our approaches locally around health improvement and literacy can be seen across a range of programmes both for those with long term conditions and behaviours that may lead to poor health outcomes in the future. This extends to screening and diagnostic work overseen in part by our Living Well programme. (Ref IR10).

Ongoing successes has been made with the multi-agency Project Search which provides young people (aged 18-24) with a learning disability and/or autism the opportunity to gain the skills needed in a real work environment and achieve paid employment. (Ref 9). Project Search works with REAL employment which supports adults age 18+ with learning disabilities and/or additional needs connect with training, volunteering, and job opportunities by supporting people through the application process, interview stage and whilst people are in work. Real Employment has recently widened its criteria to include adults with Autism offering more support to get those with barriers to employment into work. (Ref 86).

We have co-produced a review of the direct payments policy (Ref 10). The policy, guidance and contracts have been co-produced by a people who use services. This has involved work over several months to go through every section of the policy, guidance and contracts. We are also co-producing the briefing sessions for the roll out of the refreshed policy and associated documents.

The Council and ICB jointly commission Kirklees Integrated Community Equipment Service (KICES). During 2023/24 just under 72,000 items of equipment were provided to people in the community. The number of equipment requests is increasing as people are coming out of hospital with around 500 urgent requests per month that supported rapid hospital discharge. We have worked with Medequip who operationally deliver the service, to improve re-use and reduce scrappage by two thirds. (Ref 89).

We have also developed tools such as our dementia design guide (Ref 11) which is available to people across Kirklees so they can make those minor changes that mean those living with dementia are safe at home for longer and changes in their condition can be mitigated through good design. This design approach extends to public spaces, as part of the Huddersfield and Dewsbury Blueprint regeneration schemes, we are deploying dementia friendly design approaches to make our town centres more inclusive.

We have invested, with our ICB in formalising our not for profit local provider trade body, Kirklees Care Association (KirCA) (Ref 153) which has given the independent sector a leading voice and become a key representative, and delivery partner. We have also actively supported current providers to change focus as demand has fallen in some sectors and grown in others. We support this with In2Care which delivers a recruitment and training service to all providers in Kirklees and has enabled us to grow domiciliary care hours by more than 150% since October 2019.

8.1.1 THINGS WE ARE PROUD OF

- The JHWS was developed with the voice of a wide range of people who shaped the priorities, and I statements relating to each priority.
- The JHWS is led by intelligence from KJSA which is itself developed using public health data and critically the large scale population surveys which for adults is CLIK, and for children the young people's survey.
- Our vision for adult social care sits alongside the JHWS and we used a similar co-productive approach to developing the vision. We have reported to the people of Kirklees how we have delivered against our joint plans under the vision using the local account.
- Our investment in Reablement through the KILT Partnership brings together care, community health and out of hours clinical support in one place.
- The alliance between Local Care Direct (LCD), Kirklees Council, Locala, and Curo to further support those in specific groups likely to be at risk of hospital admission further enhances our community offer through the Virtual Ward.
- The development of dementia friendly design guidance to support more inclusive design across communities and places.
- The revamped direct payment policy described above should allow greater use of direct payment funds to support wellbeing and community based support that service users feel will best deliver their chosen outcomes.
- Strong relationships and investments in KirCA, VCSE sector, community anchor investments and joint work around inclusion.
- Our work with partners on Ageing Well and Anticipatory Care and the focus from Public Health on the factors affecting the ageing population.

8.1.2 KEY AREAS FOR IMPROVEMENT

- Our overall Council approach to the VCSE sector is not always as well integrated as it might be, nor is the link between what we ask of VSCE outside of commissioned work and the ambitions of JHWS and the vision for adult social care.
- Risk management approaches and prioritisation of those most at risk of a decline are not formalised or monitored at a senior level to test effectiveness.

- The service performance across prevention services needs developing to ensure we are reaching the right cohorts and that services are positively affecting outcomes, wellbeing, preventing or delaying the need for formal care support and reducing inequality.
- The information we hold and can act on around wider health, economic and wellbeing factors are captured but typically in case notes which are not easily analysed. Therefore the opportunities for joint targeted interventions and support planning can be missed.
- Access to information needs to be improved, often people seek support from the LA some way into an issue, where an early intervention becomes more complex than it would if the issue been spotted and addressed earlier. This is particularly an issue for people living with sensory impairments.
- Continue improving opportunities for financial independence for people with autism and/or a learning disability via REAL Employment and Project Search.
- Services and information about services needs to be culturally appropriate and reflect the wide range of requirements within our population.

8.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

Senior leaders and teams receive performance and intelligence updates regularly and are involved in discussions about learning from complaints and the service change proposals based on such feedback.

Senior leaders and managers also review spending trends and forecasts with finance colleagues to assess how elements of the market are performing against budgets and where pressures are being seen both in assessment and care planning and spend within provision.

The approach to team level performance management through the quality improvement team and officers was well developed pre-pandemic but has slipped, this is being relaunched at team level so that staff have a better understanding of how they can directly affect team and service performance through their work.

There are feedback mechanisms and involvement in change from all levels of staff in the regular Shaping the Future and meet the Director workshops that are held. We have a no blame ethos across all teams, the aim of which is to learn and understand from our mistakes, we do need to improve the sharing of learning from such incidents.

Service user feedback is less well developed, there are formal compliment and complaint reports and response work at case, team and service level, but the shaping of change by service users is not consistent across all areas. The introduction of the co-production board in 2022 was the start of formalising the role of those with lived experience in change and the governance of services. The Carer's Strategy Group offers similar opportunities for informal carers..

8.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

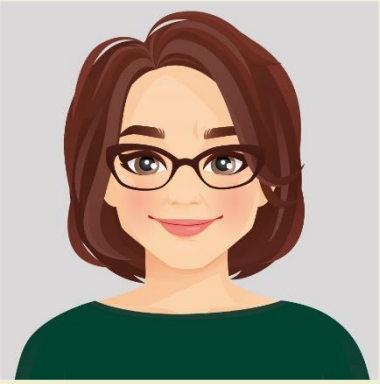
Our work is this area has developed at significant pace driven by our internal and partnership aspirations.

The forthcoming Change Programme (Ref 99) will seek to focus on:

- Effective resolution at the front door through fair and transparent decision making, timely interventions, signposting and quality advice, information and guidance.
- Increasing the numbers of people benefitting from wellbeing and preventative services.
- Increasing the numbers of people benefitting from reablement.
- Maximise the use of technology and equipment in the delivery and effective management of support.

8.4 WHAT DO OTHERS SAY ABOUT OUR PERFORMANCE IN THIS AREA?

Spotlight on: **Social Prescribing - Maryam's journey**

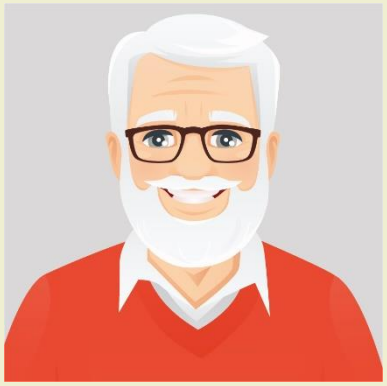


Maryam is a 45-year-old single mum, living in a busy village centre with her 14-year-old daughter. She had recently left an abusive marriage that left her mentally, physically and financially vulnerable. Her husband had used her name for business ventures that she was unaware of, leaving her with debts and unable to cope. Maryam also had health conditions and her young daughter had been caring for her.

Cara met Maryam at home to unpick Maryam's situation and turn it into manageable parts to tackle without Maryam feeling overwhelmed. She contacted the hospital and managed to help with Maryam's referrals which made her feel more positive about treatment moving forward.

They started meeting in the community for a coffee and built up a nice relationship where Maryam enjoyed going out again and started to contact friends to socialise more. Cara referred Maryam to Independent Children and Families Services and together they have managed Maryam's debts making a big impact. This really empowered Maryam to see the changes that were made and really gave her the confidence to tackle future problems. Maryam really felt Social Prescribing had changed her outlook and the support received was invaluable. She is now volunteering in the community, utilising her cooking skills to give back and continues to thrive for a better future for herself and her daughter.

Spotlight on: **Reablement – Alan's Story**



Alan is 85 years old and is retired. He worked in manufacturing, starting as an apprentice engineer and latterly working as a senior production planner. A keen piano player, Alan played in bands and in clubs for many years. He had a stroke last June and was admitted to hospital where he then contracted COVID. Two months later he was taken to Ings Grove for Intermediate Care. Alan has now been home for just over a month and has been supported by the Reablement team.

Alan told us: "I was with my daughter one evening. I wasn't walking right, and I was seeing double. I went to A&E, and they told me I'd had a stroke." Alan continues, "I'm getting better, but I still feel weak and tired. I'm walking with a Zimmer Frame now…. when I got to Ings Grove, I needed help in and out of bed, but they got me going with a frame."

Alan explains that since coming home, his physiotherapist has been Sean from the Reablement team. "He gets me going! He's tough! He's doing a damn good job. He's an understanding lad. Give him my regards! He's a good communicator – he gets his point across!" It was whilst Sean was teaching Alan sitting exercises that he suggested Alan played the piano as part of his rehabilitation. Because the piano stool was low, a glide about commode was used initially until it was safe for Alan to sit on the stool. Sean filmed Alan to show his progress.

Alan says it can be frustrating when recovery is slow. "I'm doing more than I could. It's easy to think you are not doing much but you have to compare yourself to 3 months ago." Although he still gets tired easily and says he often feels lethargic, Alan no longer needs carers and can make his bed and wash and dress himself. He has recently started practising walking short distances outside and is looking forward to warmer weather when he plans to sit in his garden. He continues to enjoy playing the piano.

9 EQUITY IN EXPERIENCES AND OUTCOMES

9.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

Our ambition is from our Joint Health and Wellbeing Strategy that says, “People who live, work or study in Kirklees live their best lives with good health and wellbeing, free from inequality, stigma, discrimination and barriers, so they can do and enjoy the things that matter to them.”

Our Council Plan articulates our approach to equity in its outcome - shaped by people, this means across Kirklees we want everyone to be able to take part in making the places where they live, work and play better. We want to know people in our communities well, understand and appreciate what we and others can offer, and for people to be able to get support when they need it. People should feel valued, respected, involved and listened to.

The Inclusive Communities Framework (Ref 7) is in place and all projects are subject to Integrated Impact Assessments. We are contributing content to the Kirklees Guide to Inclusion (Ref 17) and working with the Access strategy to explore how we can make council information more accessible to Kirklees residents. This also links in with our Sensory Strategy which is currently in development. (Ref 18, 19, 20, 21).

Ensuring equity often takes place in subtle ways such as the one off video produced locally to help people living with hearing impairment to understand what the national alert test was for and how they could respond to it. (Ref 120).

Within the directorate our guiding Vision for Adult Social Care was shaped by people with lived experience, which means both the vision and how we operate as a directorate is driven by the people we serve. The elements in the vision around working with people and not doing to them and the inclusive use of co-production and collaboration in an ever more of our work has built a new approach to strategy, service change, commissioning, recruitment and case level thinking. In our local integrated partnership services we annually review and reflect on our work around inclusion and equity identifying where we need to improve further. (Ref 87)

Our Access Strategy (Ref 22) makes clear that access is required across the whole life-course. We recognise that the type of contact and services required will vary throughout people’s lives. It is also important we design access that responds to individual needs and the needs of local communities, which are delivered in a way that provides value for their money. There are four principles in our wider access strategy: getting the basics right; tackling access inequalities; offering multiple contact points and working with people. During the covid pandemic we identified that many vulnerable people did not get the support they needed without interventions, by staff, partners, and volunteers at a local level. We learnt that developing access points more locally will improve outcomes for local people, give a sense of place and address access inequalities.

The Older People from Ethnic Minorities (OPEM) in Kirklees (Ref 151): Housing Needs and Preferences Study was commissioned to better understand how preferences in the ageing ethnic minority population affects housing (and housing related support) needs. A cultural shift in family structure – more older people from ethnic minorities are now living alone, and this will be more prevalent in the next 10-15 years. This could be through choice, where an older relative wants to live independently from their family, but also in some cases it is a necessity, for example where the family are working/live far away and are not able to look after an older relative. The majority of people say they want to stay where they are but there was a significant proportion of older people from ethnic minorities that were seeking to move to alternative accommodation.

All in-house provider services carry out regular user satisfaction surveys and involve people who use services / residents and their carers in planning any changes and improvements that improve experience. For example, at Cherry Trees, one of our respite homes for adults with learning disabilities, feedback from people who use services, and their carers was that they would like more outdoor facilities and improvements to the garden. We ensured we incorporated these improvements to the capital scheme

upgrade by including level access hard pathways, a wheelchair swing and standard swing, a gazebo with power, external lighting, a potting shed and wheelchair accessible benches etc. (Ref 23).

People who use services are regularly involved in recruitment in the respite teams and the Cherry Trees team received a lovely compliment from a gentleman regarding his input into recruitment and being part of the panel. (Ref 24).

We have involved carers and families is in the design and development of capital schemes incorporating inclusive design and the latest assistive technology including, most recently, at the Knowl Park House Dementia Day Centre and the new centre for excellence in Mirfield which will promote the independence of people living with dementia and support their carers to continue to support people at home for longer. This has been done primarily with the local DEEP group (Dementia Engagement and Empowerment Project) (Ref 25) which is part of the UK network of dementia voices, as many of the people living with dementia currently attending the services no longer have the capacity to input into discussions. We have also co-produced a number of paper based dementia resources in a number of languages for those living with dementia from our local communities, to support them to access information and support (Ref 12).

9.1.1 THINGS WE ARE PROUD OF

- Service change and projects produce and publish IIA consistently, it has become normal practice that the impact of change on protected characteristic groups is considered and acted on with any level of service change.
- The KJSA publishes details about inequalities across Kirklees and the groups affected, such as the details around adults living with learning disabilities and their health and mortality inequality.
- Our investment in anchor organisations has increased capacity to remove barriers to support.
- Workplan of the Access Strategy which will help to remove barriers in development and service change.
- Our work with Healthwatch to develop and shape local plans and key investigative work into service access and user experience.
- Our investment in our Front Door resources and the Support Options team has meant there are more skilled staff able to support and remove barriers to support.
- Our care and support planning processes and approaches are inclusive, staff are highly skilled to support people from a range of backgrounds.

9.1.2 KEY AREAS FOR IMPROVEMENT

- We have gaps in being able to show how services reduce inequalities.
- We are currently unable to consistently outline the barriers people experience to accessing care and support.
- We need to further explore whether our cared for cohort is representative of the demographic profile of Kirklees. This will help identify our hard to reach groups and support action to address equity gaps, and also understand where places see more under representation in our cohort.
- We cannot readily articulate who amongst our cared for cohort are more likely to receive poor care because of their protected characteristics. Audit work is planned to support this exploration.
- Our approach to responding to IIA at a strategic level is a gap and not monitored to assess trends.
- Our vision is clear around equity and inclusion, but this is not supported by a co-produced delivery plan that brings in experts by experience to support its delivery.
- Pathways need to be tested against accessibility standards and issues addressed.
- Information needs to be more rigorously tested against accessibility standards and issues addressed.

9.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

This area is a gap in its evidence of impact and detailed understanding of inequality and barriers to high quality support. Work is underway to build profiles around equality to better understand and address inequity of experience, access to information and access to support of hard to reach groups. The investment in the new MOSAIC case management system which allows for greater capture of protected characteristic information will assist with this, alongside other geodemographic information about our support cohort.

9.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

The Change Programme in 2024 has an equity strand throughout each workstream, supporting equity of access to advice, information, support and care as processes and services change will be a key part of the redesign work, working within our redeveloped Equality & Diversity strategy, inclusive communities framework and the ambitions of the health and wellbeing strategy. (Ref 99).

- Continue to work with the KirCA, VCSE sector and the anchor organisations to understand and address equity and inclusion gaps in information and services.
- Build on the KJSA to better understand and articulate inequality at place level.
- Explore the development of an equity dashboard so that service access and change impact can be measured.
- Work with the co-production board and others to develop a test programme for service access and experience with the seldom heard and PSED characteristic groups.
- Embed the actions in the Access Strategy and test its effectiveness at removing barriers and reducing inequality.
- Build on early work to provide guidance for carers for those living with memory deterioration whose first language is Urdu. (Ref 170).

PART B - PROVIDING SUPPORT

This section covers: market shaping, commissioning, workforce capacity and capability, integration and partnership working.

10 PROVIDING SUPPORT THINGS WE ARE PROUD OF

- Our provider and partner relationships are strong and have developed well at regional, strategic and operational levels.
- Our investment in the Care Association (KirCA) as a key delivery partner who are now actively supporting a number of programmes of work across health and care.
- Our work with the VCSE and the development of community anchor organisations to support the development of the sector and support key areas of prevention work across Kirklees.
- The work of the award winning In2Care employment support team.
- The innovative social impact bond KBOP model of investment and reach of their services.
- We have developed additional capacity in housing with support including accommodation for people with complex needs as a result of a learning disability and autism and extra care housing for older people.

11 PROVIDING SUPPORT KEY AREAS FOR IMPROVEMENT

- The future shape of the internal workforce in volume and skill level is not clear enough.
- Seeing our Vision reflected in case level feedback and support planning approaches is not consistent.
- Understanding and agreeing with partners the long term health and care landscape, so that it can meet the diverse needs of our changing population.
- How we support people to remain at home and adapt the properties they have rather than moving to more formal care settings.
- Whilst OFLOG data suggests that turnover in our care sector is lower than comparator authorities, we know that we have further to go in supporting our provider sector to pay and reward social care staff in a way that reflects the value of their work.

12 CARE PROVISION, INTEGRATION AND CONTINUITY

12.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

There are a range of market shaping and commissioning strategy development examples, but there are also areas where further progress needs to be made. Getting it right requires highly skilled colleagues and consistent ways of working and maintaining change with people.

- **3 in 4** (76%) people who use services felt they had control over their daily life.
- **2 in 5** (39%) people who use services had as much social contact as they would like.
  (Ref 100 ASCOF 2022/23)

The maturity of the relationship between the Council and the provider market has improved significantly through the work outlined above with a much better appreciation of the issues being faced by the Council and vice versa. Examples of this include work on improving the supply and return of community equipment to the care home sector (Ref 167) and the work to achieve the most successful roll out in West Yorkshire

of electronic care records in care homes by using KirCA to deliver this. KirCA are now working with a neighbouring Council to support their delivery. We have been working with our care providers to develop a **market sustainability plan.** This is supported by ongoing provider visits and market assessment work such as the recently completed Market Led Insights into The Older Peoples Care Homes Market in Kirklees activity and report (Ref 148,167) which set out with the ambition of building & strengthening relationships with providers, to learn and understand the challenges faced by the sector and improve the knowledge of the local independent care homes market. The work and subsequent actions around System challenges, Workforce, Fees, and Dementia Care are all set to be delivered by joint working groups with providers. This joint ownership of issues and mutual understanding across the care home sector will drive the success of this work as it develops.

The move to deliver more personalised care in people's own homes has been supported through increased collaboration, and the use of technology and equipment solutions (Ref 148). We have also moved to a DPS system which has encouraged more new entrants into the market. We have seen an increase in home care providers entering the market over the past couple of years, with a total of around eighty-six providers supporting 1,400 people and delivering 17,000 to 18,000 hours of support a week. Our market interventions in home care fuelled this growth and waiting lists for care at home have remained in single figures for most of the past year. We have seen average package size in home care increase and our intensive packages now make up around half of all packages which is up from around 40% since the start of 2020. We have supported the development of a Care Co-operative in the Colne Valley through both development funding and the provision of practical support which has been picked up as a national example of innovation. We have some providers who specialise in providing services to BAME communities, but further work is needed to broaden the offer and to explore the offer to the LGBTQ+ community,

We worked with neighbouring councils to develop very specialist accommodation at Mayman Lane in Kirklees for people with complex support needs who are being discharged from Assessment and Treatment Units as part of Transforming Care.

We work closely with housing colleagues to develop more of a pipeline of accommodation options. An example of this is the rebuilding of the existing Sycamore Grange retirement living scheme to be better able to support the needs of older people living with a disability.

We have for a number of years worked with our partners to develop effective seasonal planning, and although winter pressures has felt like a constant over the past 3 years, we continually discuss and problem solve pressures across the system at the Strategic Transfer of Care Group with partners from, acute, community health, independent care providers, housing and others.

Our joint work on Frailty and Ageing Well has brought together social care and wider prevention and early intervention from across the statutory and VCS sector. We have reframed our Frailty work, bringing together key programmes of work on, for example loneliness, under a refocussed "Age Friendly Communities" programme.

Having a strong commissioned voluntary mental health community provision and a developing relationship around accommodation with providers and developers supports our work in understanding and reviewing needs and future requirements. Many of the mental health services commissioned through social care are seen as preventative services and partnership working is and continues to be a strength. (Ref 79).

Our KILT Reablement Service is a key area of operation that prevents, reduces and delays ongoing support. Around 1 in 4 referrals comes from the community, we want to increase this we see the impact a hospital based discharge to KILT can have on ongoing support requirements. We have seen improvements in people ending reablement needing no further support or reduced support which ended the last three quarters of last year at over 80%. This positive trend is also seen in feedback from people who use services where the value and supportive nature of the service is frequently seen. There is still work to do on those still at home 91 days after discharge from hospital into reablement/rehabilitation services which has been around 80% for a number of years and dropped further to 72% in 20/21.

A review of the council's accessible home offer has been completed and initial expectations are that a more holistic approach needs to be developed in home based improvements. The second element of our accommodation work stems from our Market Position Statement (Ref 26) and Specialist Accommodation Strategy (Ref 27), in these places we describe our ambitions for the accommodation outside of people's own homes and what that market needs to look like based on the outcomes and aspirations of people who use services. We have invested in specialist assessment teams that can advise those considering more supportive forms of accommodation.

Our partnership working around accommodation is demonstrated in the Rough Sleeper Initiative was established a team based within Kirklees Housing Solutions to tackle the rough sleeping cohort across Kirklees. The team consists of trained housing and support outreach workers that deliver this mobile service where it is needed (e.g., hospitals, prisons, charitable organisations etc) and cases are worked together with adult social care. (Ref 28).

12.1.1 THINGS WE ARE PROUD OF

- Good availability of care through a wide range of providers including those that cater for individuals using a Direct Payment
- Steady improvement in the quality ratings of providers
- Our work with our sector through the provider forums, and the development of KirCA.
- Our work to develop the co-production board and its workplan.
- Market position statement development and market signals.
- The involvement of service users in redeveloping services such as Cherry Trees and Knowl Park House enables service users to shape support that meet their wishes and preferences.
- Our work with ADASS groups and networks across different disciplines.
- CHESP work to support the care home sector.
- Single care home programme of work across health and social care.
- Work with the VCSE on community based solutions.
- Our work with carers to operate an effective carer's strategy group.
- The development of In2Care, which has received national recognition, to boost employee and volunteer entrants into the care sector.
- Digital social care grant project in partnership with KirCA.
- Our contributions and work with the joint workforce strategy group.
- Development of a Care Co-operative as an alternative delivery model

12.1.2 KEY AREAS FOR IMPROVEMENT

- The involvement of the sector in development work needs improving, there is some level of engagement, but the sector would argue there are still instances of things being done to them.
- Long term workforce requirements in the sector and within internal care management functions is not clear or programmed to be delivered.
- We have tried to develop joint contracting arrangements, but these fail to be fully embedded.
- We need measurable feedback from providers on our performance and interactions as a commissioning authority.
- The monitoring of experience across provision, and what that is like for the end user.
- The development of micro-providers is a gap, we have undertaken pockets of work, but this is not fully embedded.
- Whilst we are expanding the range of accommodation with support options, we know that we need to further develop this both for Extra Care Housing and for supported living.
- Some activity is driven as a response to national short term funding opportunities or expectations and so is hard to sustain

12.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

We have a strong basis in our KJSA, JHWS and vision. The means and ways we have in place to work with the sector are co-productive and collaborative in the most part. The capacity to see the vision through into practice needs to be more apparent and measured to demonstrate if priorities are being delivered and people can hold us to account when they are not.

3 in 4 providers are judged as outstanding or good by CQC. Historically quality has always been higher in community services, but the picture is improving across all sectors. It is of concern that a small number of providers active locally are judged as inadequate, we work closely with CQC to understand the support the local authority can offer these providers in conjunction with our partners.

Complaint data shows a slight increase in over the past two quarters, but overall numbers remain low. This is balanced by a range of positive experiences, both areas inform ways of working but sharing of positive and complaint learning does need to be improved

12.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

The change programme in 2024 will develop and articulate the requirements for a more diverse community asset, care and accommodation market that can meet a broader range of complex support needs, building on the work already underway to develop new supported living and extra care (housing with care) such as the development of Ashview which will be operational late 2024 and work locally and make more effective use of existing capacity and housing stock. (Ref 99).

- To improve we need to test that we are making genuine differences, co-production and feedback is limited in areas of the directorate, and the skills to act upon this are also a gap.
- The delivery of the market sustainability plan will work towards fair funding arrangements in care. We agree with local providers that care staff should receive a level of renumeration that properly reflects the value of the work that they do. Whilst our fee rates are higher than at least some neighbouring councils, particularly for domiciliary care, the overall financial position of the Council makes realising our collective aspiration for staff pay more challenging.

13 PARTNERSHIPS AND COMMUNITIES

13.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

Our Joint Health and Wellbeing Strategy (Ref 31) was shaped by people, through a wide reaching approach, and a series of statements about health and wellbeing have been developed iteratively through various group and individual engagement. There was particular emphasis on ensuring reach across our diverse communities and places.

- **3 in 5** (62%) people were satisfied with the care and support they receive.
- **2 in 5** (42%) carers were satisfied with social services.
  (Ref 100 ASCOF 2022/23)

The district is served by 206 care providers made up of 123 care homes and 83 home or community providers, two acute NHS hospital trusts: Calderdale & Huddersfield NHS Foundation Trust and The Mid Yorkshire Teaching NHS Trust (which includes Dewsbury), and one mental health NHS Trust South West Yorkshire Partnership NHS Foundation Trust. There are nine Primary Care Networks (PCNs) in Kirklees.

There are a range of joint management arrangements locally building on the relationships established over time. Across the place there is the health and care partnership joint SMT, and the delivery collaborative (Ref 90) where ICB, Acute, Community Health, LA, VCSE and social care sector come together to deliver change and share governance across different programmes of work including the Better Care Fund (Ref 88). This is supported by Kirklees Health and Care Executive which brings together the Council's Chief Executive, NHS Chief Executive and the DASS, DCS and DPH in a regular structured but informal way. The Council's Chief Executive and DPH are members of the ICB Committee at Place. The Council's DASS and DPH are both actively involved sub-regional and national work.

Outside of social care there are various partnership boards and arrangements such as The Kirklees Communities Partnership Board that brings together the responsible authorities of Police, Police Crime Commissioner and Police and Crime Panels, Local Authority, Fire and Rescue Authority, Health and Probation to work in collaboration with other statutory and voluntary services and local people to create cohesive communities in which people feel safe and are safe/protected from harm. Our relationship with the West Yorkshire Combined Authority has developed and the West Yorkshire Mayor has brought forward priorities we are jointly working on around Housing and supporting those living with Dementia.

The Council and CCG have funded the development of a Kirklees Care Association (KirCA) who are rapidly becoming an invaluable part of our local system. This has been part of a journey of change from a traditional model of commissioning and "telling" providers, to one in which there is a greater partnership and co-production. KirCA are involved in a number of strategic and operational board and working groups bringing the voice of the sector to a range of work.

There are also many examples of where we have worked with KirCA on key issues such as digital care records where we worked with a range of health, social care and wider partners. This digital social care work has improved access across different providers to support the better management of safe direct care, this will continue to improve as shared care records across Yorkshire and Humber are developed.

A key development we have made is the introduction and development of our Co-production Board. This brings together people who use services, service leads and partners to both shape work and direction for the directorate, and test and explore how co-production is being used across the pathway and in time within case level work. (Ref 30). The work of the Co-production board is complemented by a number of user led groups and organisations such as KINETIC, Outlookers and Kirklees Disability Network, and a range of other carer and user groups. There are a range of co-productive spaces and groups where less formal co-production activities such as co-design and engagement also occur.

Our approach to strategy development puts people at the centre. Kirklees has a co-produced Kirklees Carers Strategy (Ref 32) outlining the key outcomes and areas of support carers have said are most needed. Linked to this, the Council facilitates the Kirklees Carers Strategy Group, a network of carers, council and health services officers, carer support providers, and other partners, which regularly discusses current issues affecting carers across Kirklees and enacts positive change. Agendas are led by carers and discussions influence current and future service developments.

The carers support commissioning process starts with talking to carers about their needs, including via the above strategy, strategy group, key partners, and individual carers and peer groups, and continues to involve carers throughout an ongoing developmental process. It is within these discussions that gaps in provision and new carer needs are identified and positive action to fill these gaps is agreed. (Ref 81).

Our local approach to more social and economic wellbeing is best seen in our Kirklees Better Outcomes Partnership (KBOP) (Ref 33, 34), and our Preparing for Adulthood work which each support those living with complex lives, and those living with learning disability to access skills development and employment opportunities that allow them to make their own contributions to society.

13.1.1 THINGS WE ARE PROUD OF

- People are at the centre of the vision, and the vision is the driving force for our service delivery.
- This is reflected in system level strategies and ambitions.

- Our relationships with partners are more mature than they were in the past. Honest and frank discussions take place and agreement, and consensus can be reached.
- The JHWS has been developed in partnership with partners and people with Healthwatch.
- The KBOP service is innovative in its funding model, and the range of partners involved in developing its delivery models.
- The work and partnership around ITOC.
- The investment in and development of KirCA across delivery and partnership working.
- The work with housing teams around specialist accommodation.
- Partnership working in libraries as part of community preventative interventions.
- Integrated budget and BCF approach.

13.1.2 KEY AREAS FOR IMPROVEMENT

- Checking whether the changes we are making improve people's lives and outcomes are delivered or are easier to deliver because of effective partnership.
- The consistent translation of the Vision into case practice and case level partnership working.
- There are elements of good partnership working across services, this need to be tested to ensure seamless services are being delivered in the way we think they are.
- Data sharing and collaboration around intelligence needs to be developed so joint care planning can be used, and the experience of people is one where their interactions feel more coordinated.
- There are still organisational funding barriers at case level, complex cases are reasonably well supported but consistency is required to improve the experience of users.
- Understanding our diverse population, its needs and changes to reduce inequity and inequalities needs to be developed.
- Continue the improvements with the Accessible Homes service to ensure that a more holistic approach is taken across the housing and care pathway.
- Our ability to demonstrate performance and progress in this area needs developing beyond cash benefits realisation. We have explored the measurement of outcomes in case and services, but this has not been delivered at scale.

13.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

We have strong high level relationships and processes for developing area level plans and strategies. These relationships increasingly involve those with lived experience, and we are building the infrastructure around involvement and feedback to allow this to happen more. In some areas such as Reablement and the Front Door it is working well.

As described in the areas for improvement, outside of complaint and compliment intelligence there is no consistent feedback from service users and carers. The large scale survey are bi-annual and cannot be used to measure experience in single service areas or care cohorts reliably.

13.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

- This self-assessment and peer review has flagged that we need to effectively manage the delivery of the vision and its performance at case level across care and community based preventative support, this change in approach is a part of our forthcoming change programme.

- Our change programme will work across partnership services such as the Front Door and Reablement and Community provision to further ensure the whole partnership realises the most benefits from the change work.
- The change programme will also work to develop new data intelligence products and systems thinking highlight demand failure and design this out by ensuring staff have effective tools and processes that support agile working and productivity.

13.4 WHAT DO OTHERS SAY ABOUT OUR PERFORMANCE IN THIS AREA?

Spotlight on: **Co-Producing Direct Payment approaches and Policy**

In Kirklees, some peoples' experience of taking and managing a direct payment is falling short of the intentions enshrined in policy. The review of the Direct Payment Policy is the first phase of how Kirklees Council will work in partnership with direct payment recipients in a mutually respectful and co-produced way. Co-productive work with local people has resulted in new Direct Payment Policy, Direct Payment Guidance, and Third-Party Agreement. Our next phase of work is focused on successfully embedding the new policy, processes and practice in a way which continues to demonstrate the principles of power sharing and collaboration, and which allows people to have more choice and control.

The Direct Payments Group has involved a diverse group of people who draw on care and support, including representatives from younger and older age groups, people with learning and physical disabilities, people who draw on mental health services, and unpaid carers.

People in the working group told us:

"The project team has recognised and acknowledged that those who use services, and their carer's are experts in their own right and are well placed to highlight best practice examples, what doesn't work well and how improvements can be achieved, and where there are gaps and how they might be appropriately filled."

"What did I enjoy? Collaborative partnership working, where all voices were heard… Sharing and acquiring lived experience, insight and learning, with and from all project team partners… Flexibility relating to the provision of feedback options…" "The experience of co-producing the documents… It was really good, it actually felt like co-production."

"I'm really hoping this work will do two things… Provide flexibility for how direct payments are used… historically it has been very prescriptive… Also, I'm hoping it will encourage more people to use direct payments as an option and develop support for people who use direct payments through their peers."

What our Co-Production Board say

We are a group of local people working in partnership with Kirklees Council and other local partners. We are people with lived experience and strive to play an equal role in designing, delivering and evaluating services, rather than making suggestions that professionals are responsible for deciding upon and implementing. As community members we are committed to working positively together as part of a team. We believe we can make a difference and would like more members of the community to come forward and join us to be part of shaping the future of care and support across Kirklees.

PART C - ENSURING SAFETY

This section covers: safeguarding enquiries, reviews, Safeguarding Adult Board, safe systems and continuity of care, safe systems and continuity of care.

14 ENSURING SAFETY THINGS WE ARE PROUD OF

- We have a no blame culture where sharing and reflection are used to learn.
- There is widespread collaboration and partnership working across services, partners and locations to support the effective safeguarding of the people we support.
- The CHESP quality support and monitoring function in the care home sector.
- Safeguarding skills and advice are available in the front door.
- The Safeguarding Board is strong and effective, with an independent chair and multi-agency support and shares learning for SAR's effectively.

15 ENSURING SAFETY KEY AREAS FOR IMPROVEMENT

- The sharing of learning across disciplines could be better developed and engaging.
- A community version of CHESP to support the wide range of non-care home providers is not yet fully implemented.
- Cross border working where people move areas needs to be improved.
- People need greater opportunities to be involved in safeguarding investigation work.
- The support offer for staff to gain safeguarding knowledge and experience needs to be formalised.

16 SAFE SYSTEMS, PATHWAYS AND TRANSITIONS

16.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

Keeping people safe and effectively managing risk is evident across our pathways and ways of working, non-more so than our work around Making Safeguarding Personal (MSP) (Ref 35, 36) which is a sector-led initiative which aims to develop outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

We receive alerts from contracts teams for out of area placement concerns and, when alerted to concerns by other Councils, the contract and monitoring team has a system in place for informing Heads of Service of placement suspensions for dissemination to the appropriate teams. In addition to this, where the team are alerted to CQC homes rated as the Care Home Early Support Programme (CHESP) is very active and can pull on resources across health and social care to support care providers. We also have a Market Failure Information Sharing Protocol in place to support this work. (Ref 66)

Specific improvements have been made around self-neglect and rough sleeping. The Risk Escalation Conference (REC) was implemented 2 years ago to respond to the increasing complexity of self- neglect referrals and the complex nature of the consequent work that takes place. This is a multi-agency group currently chaired by ASC with membership from Housing, Locala, Police, Calderdale Foundation Trust, Mid Yorkshire Foundation Trust, West Yorkshire Fire and Rescue Service and ASC. (Ref 38). We are currently in the process of reviewing this policy as a result of one of the outcomes from a SAR. The review will incorporate the terms of reference, panel membership, rotational chair, referral form, escalation process, learning log and exit matrix.

Following every LeDeR review conducted there is potential for learning. Through the review process there may be procedural outcomes relating to a specific service or there may be learning which then indicates

a multi-agency review. As part of the support offered to reviewers there is the opportunity to attend a 'learning into action group' and have the support from clinical leads.

The SEND transformation has been completed with significant involvement from Parent and Carer groups. Consultation indicated that parents, carers and people who use services often felt there was a 'cliff edge' during the transitions from Children's to Adult services. This feedback has formed the basis for much of the transformation work in the Preparing for Adulthood pathway.

Within Transition services we have organised a joint Children's Access to Service (CAS) Panel with Children's services, Education and Health. Complex and high cost cases are presented here to ensure that Adults can contribute to the decision around spending, understand commissioning gaps that may present themselves and work with health to ensure that CHC funding is honoured during transition. This has helped to ensure that budgets are managed better across the four service areas and care is sustainable for people once they reach adult care and support services.

We are aware of the growing issue of Human Trafficking and Modern Day Slavery in the Care Sector and have been working with colleagues across the Yorkshire and Humber ADASS region and with local Trades Unions and KirCA to improve our ability to respond to instances of concern.

We also have a wider offer within the Council for anyone who has been exploited through Human Trafficking and Modern Day Slavery including working with external organisations such as the Palm Grove Society.

Through our Principal OT, we have worked with both Acute Hospital Trusts and with care providers to develop improved moving and handling and transfer practice that makes better use of equipment and improves dignity and privacy for people who use services. This has reduced the need for 780 hours of domiciliary care each week which reduces un-necessary intrusion into people's lives).

16.1.1 THINGS WE ARE PROUD OF

- We have a no blame culture where sharing and reflection are used to learn.
- Making Safeguarding Personal is embedded across roles.
- There are West Yorkshire level safeguarding protocols that health and social care providers use.
- Weekly Vulnerable Adult at Risk partnership meetings and action sharing.
- MCA skills are in place in the front door safeguarding team so early advice can be given and actions delivered.
- There is professional and peer support through the virtual safeguarding clinics and MCA forum.
- There are strong case level ways of working across domestic Abuse, Modern Day Slavery, Self-neglect, Hoarding, Human trafficking and PREVENT.
- We have redeveloped the transition support for those who are supported by children's social care, the revised preparing for adulthood pathway and associated performance dashboard has led to fewer late case presentations and allowed for more early work with young people.
- The preparing for adulthood work is working to ensure those moving into adult social care are safeguarded and supported effectively to understand risk.
- The joint work of CHESP to support the care home sector with partners.
- Our approach to place and then agree funding splits and requirements after person is placed.
- The Care Home closure process is well developed and has safeguarding at its centre.
- The support and guidance offered by In2Care around safe recruitment practices.

16.1.2 KEY AREAS FOR IMPROVEMENT

- The sharing of learning could be improved, and learning be more rapidly available after a SAR has been conducted
- The consistent use of positive risk taking in care and support planning needs development.

- We need to ensure we have a more enabling approach to interventions during childhood to support children to maximise their independence and resilience.
- We need to test the usage of the Adult Safeguarding Improvement Tool.
- Case level safeguarding data needs to be better combined with other datasets to build a more complete picture of a person and help us understand any changing cohorts more likely to come through safeguarding pathways.
- The role of Support Options pathways in safeguarding needs to be made clear particularly where multiple providers provide elements of a care and support package.
- A community and home care version of CHESP needs to be considered for development.
- Support for service users moving between areas that ensures continuity of care needs developing.
- The training of care staff around medications and health care tasks is underdeveloped in the independent sector, although guidance and contract monitoring is in place.

16.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

We have a well-developed structure and set of procedures that support the effective delivery of safe care and support. The performance of the sector around safety is regularly monitored in partnership with other statutory partners and actions are taken to address issues.

The process around transitions into adult social care has been developed with end users and carers alongside professionals to ensure the journey is seamless and safe from the perspectives of all those involved.

We have worked to ensure safeguarding is considered early in pathways and made investments to ensure skills, advice and support are available to the sector, and can call upon additional resources at time of higher demand such as care home closures.

16.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

Understanding and supporting those Transitioning to adult care and support is a key area of our change programme with a particular focus on improvement pathways, involvement and better using strength based support approaches in younger adulthood. (Ref 99).

We are in the process of developing robust joint monitoring dashboard to capture partnership level trends and analysis of safeguarding data. This will be linked to monitoring of CQC ratings across provision locally.

Workforce capacity and the high level of skill and experience around safeguarding is an issue locally, there have been trials of specialist recruitment, but the market is highly competitive. Plans are in place to review pay and conditions for particular roles as further specialist recruitment projects. This is monitored through directorate risk register activity.

17 SAFEGUARDING

17.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

Our ambition is outlined in our strategic plan and says Safeguarding Adults means protecting an adult's right to live in safety, free from abuse and neglect. It is about working together to support people to make

decisions about the risks they face in their own lives and protecting those who lack the mental capacity to make these decisions.

The Kirklees Safeguarding Adults Board (KSAB) brings together the main organisations working with adults at risk including the Local Authority, KirCA, West Yorkshire Police and NHS organisations, who are statutory partners. The job of the Board is to make sure that there are arrangements in Kirklees that work well to help protect adults with care and support needs from abuse or neglect. The Board is supported by a Strategic Delivery Group (SDG) infrastructure that oversees and enables delivery of the work programme, coordinates sub and working groups and provides analysis and intelligence for the Board.

Within Kirklees there are five boards who work to promote safe and healthy communities: the Health and Wellbeing Board, the Safeguarding Children Partnership, the Safeguarding Adults Board, the Communities Board and the Children and Young People's Partnership. Whilst each board has its own specific and distinctive role, the boards and partnerships also have shared values and often shared priorities, alongside a shared view on delivering the best outcomes to meet local need which is managed through effective protocols, principles and ways of working. (Ref 141)

- **7 in 10** (70%) people who use services who feel safe.
- **9 in 10** (90%) people who use services say that those services made them feel safe. (Ref 100 ASCOF 2022/23)

Keeping people safe and effectively managing risk is evident across our pathways and ways of working, non-more so than our work around Making Safeguarding Personal (MSP) (Ref 35, 36) which is a sector-led initiative which aims to develop outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. In Kirklees, the process where all Section 42 concern are reported and recorded has been devised as a person-centred, outcomes-focused approach that enables the person to share their wishes and how they would like their needs to be considered and responded to, allowing us to learn lessons about the safeguarding journey. (Ref 37)

Through multi-agency working, we have developed a network of Safe Places to protect people who fear that they are at risk of harm or abuse. Within the Council, there is a Corporate Safeguarding approach that recognises that all parts of the Council have a role to play in creating safe communities and reducing the risk of harm for vulnerable individuals. There are special KSAB focus events on a number of issues such as supporting the navigation through health and care locally. (Ref 164)

Our specialist teams support the safeguarding of our population and also link with pathways and areas of work including Domestic Abuse, Modern Day Slavery, Self-neglect, Hoarding, Human trafficking and PREVENT. With our partners we have also instigated the Vulnerable Adults at Risk weekly meeting to ensure across all partners risks are being effectively and proportionately managed.

Our Learning and Development colleagues also work closely with the Safeguarding Front Door to ensure a consistent message is relayed to all staff regarding safeguarding and MCA. There are also good joint visit arrangements in place where there is a need for an emergency visit or immediate safety visit required. (Ref 39, 40).

We have a Mental Capacity Act monthly forum chaired by Deprivation of Liberty consultants and Legal to provide guidance, information, legal and case law updated on the MCA. It allows staff and partner agencies to discuss specific case related capacity assessments to ensure they are meeting the requirements.

We have a DHR Standing Panel that meets quarterly to monitor progress from any outstanding action plans and this group also considers learning that has come out of national themes. An example of this is the commitment to look at all cases recently that have involved a suicide and work through whether there is a rationale to conduct a review, where this may not have been considered previously. Similarly, we have

a SAR Subgroup that sits with the Kirklees Safeguarding Adults Board structure whose role it is to consider whether a potential SAR notification meets the criteria to commission a review; to promote national learning, disseminate learning from local SARs through a range of methods, such as practitioner network events for staff and partners. There is a comprehensive audit programme in place to assess that where specific training has been identified and rolled out, it is visible in practice – a recent example of this being the self-neglect audit which came from a SAR action plan (Ref 70, 71). Though in its infancy, it is hoped that the Cross Council Safeguarding Oversight Group will strengthen the learning from all reviews by widely disseminating appropriate information to the wider workforce.

Within the Learning Disability team, work was completed to understand the extent of the Council being legally compliant with Deprivation of Liberty in the Community and, as a result of this, it was agreed that a separate team would be resourced in order to respond to this. With LPS on the horizon, we have established a multi-disciplinary LPS implementation group to discuss issues in relation to DoLS/DoLiCs and LPS ensuring all partner agencies are aligned with each other with regards to undertaking and documenting mental capacity assessments.

17.1.1 THINGS WE ARE PROUD OF

- The partnership approach to safeguarding is person centred.
- Section 42 joint visits to respond to immediate risk using a partnership approach.
- The SAB is well developed with a skilled experience team supporting its work.
- Actions are clearly outlined in annual reports, and the sharing of learning is conducted through regular updates.
- There is strong cross partner working approaches on key areas such as domestic abuse, domestic homicide, Modern Day Slavery, Self-neglect, Hoarding, Human trafficking and PREVENT.
- The subjects of safeguarding enquiries are involved where possible in the investigation and can input their views.
- Our work with the Domestic Abuse Partnership Strategy group.
- Making safeguarding personal is well embedded with partners and providers, there is good West Yorkshire level work and collaboration including common policies and procedures..
- The work around MCA and DOLIC is ensuring safety and best interests are supported in work across our provision.
- The duties around safeguarding are a part of role descriptions across frontline and support roles, training and development around safeguarding is available across roles and training needs around safeguarding are considered at appraisal.
- The prevention of abuse is a key area of work, financial assessment teams are skilled is spotting early signs of abuse.
- Our work with West Yorkshire Financial Exploitation and Abuse Team (WYFEAT) to support cross border working and links with enforcement support, there are key roles in we have part funded.
- Information is shared regularly with providers and service users around safeguarding, and support is available through the front door to support decision making.

17.1.2 KEY AREAS FOR IMPROVEMENT

- The feedback loop from people involved in a safeguarding enquiry and how that has influenced process or investigation change is underdeveloped and hard to demonstrate.
- There are capacity and skills gaps across the workforce around safeguarding, this is affecting response times and the quality of involvement of subjects in safeguarding investigations.
- There are skills gaps around financial investigations, WYFEAT is a part of this, but local skills are required as these have become more complex

- Support for ASYE and other inexperienced staff is more limited that we would wish because of capacity issues, support is available, but this remains a pressure.
- Fully implement the Cross Council Safeguarding policy.
- Review the Self-Neglect Policy (as per SAR outcome) incorporating the Terms of Reference, panel membership, rotational chair, referral form, escalation process, learning log and exit matrix.
- Improve staff skills around MCA and Care Act principles across other areas of the directorate.

17.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

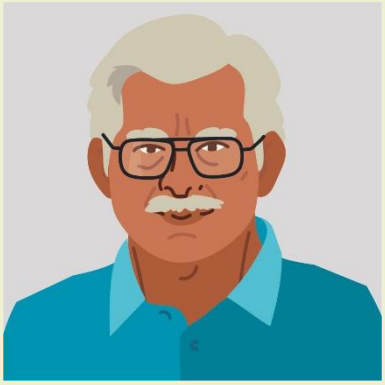
Performance reporting and monitoring arrangements in place around safeguarding alerts, outcomes and pathway progression. These are considered at service and senior manager level and monitored independently by the board. Key information is published annually in reports on the SAB website. There are good reporting arrangement with NHS and independent sector providers, these are also reviewed as part of the work of the board through the quality and performance group. (Ref 142, 143).

17.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

- We will continue to build West Yorkshire place and partner approaches to ensure networks and peer support is available to staff at all levels to share and access expertise.
- We will work across LA and partner boundaries to support safeguarding workforce capacity issues.
- We will continue to work with other safeguarding boards on front facing campaigns and work, and to develop operational responses and changes required to ensure the process and documentation around safeguarding is user focussed and can be acted on efficiently.
- We are moving policy and supporting guidance documents onto the TriX system which will make navigation and use simpler and updating more robust.

17.4 WHAT DO OTHERS SAY ABOUT OUR PERFORMANCE IN THIS AREA?

Spotlight on: **Safeguarding – Bilal's story**



Bilal is an 80 year old man who lives in Kirklees who has eligible care and support needs under the Care Act 2014. There had been a number of safeguarding concerns about Bilal and the relationship with his son Hamza. These concerns were relating to physical abuse, financial abuse and psychological and emotional abuse.

The social worker worked closely with Bilal to ensure that the work we did part of the S42 Safeguarding Enquiry were in line with making safeguarding personal.

Bilal was supported to give up his tenancy in the community and to move into a long term home within a safe environment with staff there and security in place. Bilal still remains in contact with his son and gives him money, therefore there continues to be risks associated with this, however Bilal has more **choice** and **control** as to when and how often he gives his money and is able to understand and manage any risks himself.

PART D - LEADERSHIP

This section covers: culture, strategic planning, learning, improvement, innovation, governance, management and sustainability.

18 LEADERSHIP THINGS WE ARE PROUD OF

- Our culture is shaped by our Vision for Adult Social Care which was co-produced by people who use services and front line staff.
- Strong and approachable leadership team, working with staff and teams to understand and support pressures and opportunities.
- Visible leadership through Shaping the future, quality summits, newsletters, meet the directors for new starters.
- Key communications links and activities between the front line and leaders, ideas, improvements and positive workflow well in both directions.
- POT and PSW are both chairs for the regional networks and are involved in national activity
- Services have been shaped with people who use services, such as the design and layout of new service provision.
- There are strong working relationships with the HCP and ICB in a number of areas of work.
- There is regular oversight and action around performance and financial management.
- The development of the co-production board to oversee the involvement of people in change.

19 LEADERSHIP KEY AREAS FOR IMPROVEMENT

- Data driven decision making needs development.
- Monitoring the impact of turning the Vision into action needs further developing, particularly through our Change Programme.
- The integration of health and care data systems needs to be improved.
- Equity approach and delivery plan needs to be developed.
- The involvement of people who use services in change programmes needs to be more consistent and the impact of their involvement measured.
- The future roles required in social care need to be better understood, and the development of progression routes across social care needs to be developed and linked to recognised frameworks.

20 GOVERNANCE, MANAGEMENT AND SUSTAINABILITY

20.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

It is intended that the Vision is the golden thread running through all services and work has been ongoing since the launch of the Vision to embed this across the directorate, with partners, elected members and with the people who use our services. (Ref 42). However, we do feel we could still do more in further embedding the Vision so that people who use our services are more at the centre of decision making. Earlier in this submission we talked about our co-production board but there are more opportunities closer to the delivery of care and support, where people using services are involved to help shape such as the work under the change programme.

Our top-tier strategies are all partnership-led and are:

- Joint Health and Wellbeing

- Inclusive Economy Strategy
- Environment Strategy
- Inclusive Communities Framework (Ref 7)

They explain where we are at in Kirklees, what our opportunities and challenges are, what we most need to do to improve, and the role each of us has as partners to make this happen. They provide an approach to collaborating with communities for these strategies, supporting activity in all areas to contribute to more inclusive communities and a sense of belonging.

20.1.1 OVERSIGHT

The Director of Adults and Health has been in post since 2015 but that role and the wider Leadership Team has or will be going through a period of change but connections to staff have remained strong. As a Leadership Team, we are risk aware and feel that we are better at determining tolerances and thresholds. Internally we have a number of mechanisms for managing/escalating risks from service level up to the corporate risk register. Decision logs are in place within the Adult's Social Care Leadership Team (SCLT) and assessed weekly which are followed by quarterly reviews and input to the Corporate Risk Register (Ref 73, 74). We also remain transparent around the identification and mitigation of risk through portfolio briefings, cabinet and executive level work and regular assessments of risk logs for specific projects. (Ref 53, 54)

The directorate has a 'no blame' culture but instead promote learning from when things have not gone well. As well as responding to learning from SARs, we are also active in the DHR and CSPR processes, which includes the adherence to any actions/learning for Adults and Health. Similarly, we have quarterly updates around compliments and complaints, both case specific and thematic to act on these longer terms. Specific work has included the introduction of a process to manage complaints at an earlier stage to prevent escalation and identifying a training need within certain teams. (Ref 56, 57)

As a Leadership Team, we recognise that we are still limited in our data capture and analysis and regional work around population health management. Our local anticipatory care work has also been hampered by systems not being well integrated or important data sitting outside of recognised systems and there are gaps at being able to capture and report on progress towards outcomes. Some of this we hope will improve with a new case management system (MOSAIC which was implemented at the end of February 2024) but there are still likely to be gaps which will become an increasing issue as we move some provision towards an outcome based approach.

We have however seen some successes in shared governance through our Kirklees Independent Living Team (KILT) Partnership model which brings together Kirklees wide intermediate care pathways provided by both the Council and Locala (the community health care provider) into one model. Integrated governance arrangements are in place to support with a single and shared view of demand, capacity, performance and outcomes through the Integrated Health and Social Care Dashboard.

We have a robust system in place to respond to complaints the learning from these to identify where practice or process may need to change. We work closely with the Ombudsman and include this activity in our public facing Customer Services Report (Ref 56). There are various additional oversight mechanisms in place such as Scrutiny and Portfolio Briefings and corporate check and challenge sessions that help us to share progress around transformation, learning and research but which also help with supportive challenge back from different perspectives.

Over the past three years we have received an average of 54 formal complaints per annum there was a drop in 20/21 but this was potentially attributable to the pressures of the pandemic and the kindness shown to services and providers during times of extreme pressure. Where people did make a complaint, the key issues were around charges for support and lack of or miscommunication around how such charges work or are billed. There were also around a third of complaints that related to Council policy or staff actions. Although numbers remain small there is still work to do to address how we explain Council policy and procedures to people using services and also shape those policies more with those affected by them. We

have a change programme in place around charging for social care services to improve processes and experiences alongside the challenges around the budget. (Ref 41)

There are a number of services that people associate with social care or are more likely to be used by people with social care needs (such as Blue Badges, Housing Adaptations, charging mechanisms for social care) which the public do not, understandably, differentiate from social care services and where they tell the Council that their experience is not always as they would wish, particularly in relation to timeliness. We are working closely with colleagues in other parts of the Council (which deliver these services) to share insights and improve outcomes.

20.1.2 WORKFORCE

Corporately, the People Strategy has been refreshed (Ref 46) which is the organisation's promise to its employees. One of the four main outcomes is to become an inclusive employer of choice (Ref 47) which has brought around changes to overall recruitment such as moving to 'blind' recruitment so that personal characteristics are not know to the panel in a bid provide fair opportunities for all. We also work across the HCP footprint and have a joint workforce strategy (Ref 91) and workstreams. We have several Employee Networks such as the BAME Employees Network, Young Employees Network and Disability Network. These are two fold in that they are supportive networks for staff but are also effective groups to consult and engage with regarding policy, procedure and recruitment. A recent example was sharing the draft Cross Council Safeguarding Policy and receiving feedback with regards to accessibility standards.

Staff in the Council and wider provider services have access to a number of development opportunities delivered in conjunction with the WY ICS including BAME leadership programmes, mentoring programmes, shared training opportunities in areas such as systems leadership and care quality.

There are ongoing pressures around vacancies and retention, despite our starters exceeding leavers by around thirty per year over the past few years. Our staff survey told us that although staff have the confidence in leadership locally, the pressures of work and its impact on wellbeing has worsened. We do have processes and support in place, but we need to do more. Our change programme has engaged front line staff who have told us about duplication and hand-offs that could be addressed through the change programme. The introduction of MOSAIC has reduced the need for staff to make duplicate entries into the electronic care records system.

Internally we are working on a broader recruitment and retention workstream to explore all aspects of recruiting and retaining staff such as the system used, timescales, induction, job roles and grades, progression, support for staff and stay and exit conversations. For hard to recruit posts a retention payment has been agreed whilst the work is undertaken, and we are also considering expanding the AMHP training to all social workers and reviewing pay associated with this. (Ref 58, 59, 60, 61, 62, 75, 76).

Internally our social work workforce was made up of 86% permanent roles and 14% temporary roles, our reliance on agency is a concern and work is underway to address this in key service areas. Our average social worker sickness was 12.5 days a year, this is more than our non-social work workforce. Although social work staff turnover improved slightly in the past couple of years it remains too high at around 19%. Our social worker staff are better representative of our local population than our wider care workforce with 21% from the BAME population and 4 in 5 in the 25 to 54 age group.

When looking at the wider workforce we need to continue to work to have a more representative workforce for our cared for cohort, those working in the sector continue to outline pay as an issue and barrier to entry and retention in the sector. In 2020 Skills for Care estimated that the staff turnover rate in Kirklees was 31.3%, which was similar to the region average of 31.0% and similar to England, at 31.9%. Local intelligence suggests pay along with flexibility around shift patterns and the need to work unsociable hours are a significant driver in this turnover of staff.

In 2017, In2Care was developed which is a Council delivered service aiming to support care providers by attracting more people to work in social care by providing a bespoke matching service between applicant and employer based around what applicants are looking for/interested in. It promotes an inclusive

approach because the service is accessible to anyone looking for work in the care sector. It also supports the recruitment of Personal Assistants (PA's) through advert writing, advertising and advice and guidance The service aims to engage a modern workforce through effective use of social media to promote care work and provide accessible communication channels for prospective applicants. It also helps providers with their recruitment so that vacancies can be filled in a timely and effective way. Since 2017 In2Care has supported approximately 1,700 local people into local social care jobs. (Ref 67, 68, 69).

Kirklees is part of large scale recruitment projects that complement our local In2Care work. We are a part of Care workers (Yorkshire and Humber) where YH ADASS working in Partnership with the Yorkshire and the Humber Care Association Alliance (YHCAA – of which KirCA are a member) have been successful in securing funds of £1.2million to support the ethical International Recruitment (IR) of care / senior care workers to be employed in social care. This scheme will aim to offer care providers financial assistance with the process and a one stop shop of information and support required to recruit internationally. The aim is to recruit 360 care workers into care providers in the region, with an ethical and sustainable approach. To meet higher skill level requirements West Yorkshire NHS ICB, NHS England and West Yorkshire Care Associations (including KirCA) are working with global partners to develop ethical international migratory pathways for nurses and senior care workers into social care. The West Yorkshire Integrated Care Board (WYICB) have signed an agreement with the Government of Kerala, India to enable the ethical recruitment of Registered Nurses, Care Staff, and health care professionals from Kerala to come and work in West Yorkshire.

Leaders and senior managers recognised the importance of health and wellbeing throughout the workforce and worked together with partners to promote good mental health and resilience. The hybrid working world created by lockdowns has continued and staff are well supported through effective informal wellbeing conversations and through restorative supervisions and appraisals. Disability Assessments (Ref 43) are undertaken both to ensure employee wellbeing, but also to provide additional support if required though Employee Healthcare (Ref 44, 45).

20.1.3 PARTNERSHIP

Internal leadership has needed to be flexible in order to sustain and develop relationships across the system, particularly with health around the move from CCGs to establishing the ICS/ICB arrangements and the creation of the Health and Care Partnerships and joint plans (Ref 97) . Locally we had strong operational relationships with our community health, ICB and acute providers which has developed into the Local Integrated Care Partnership Board, of which the Kirklees Council Chief Executive is a member.

Strong leadership is evident through the mature relationships we have with partners such as the Kirklees Safeguarding Adults Board and its subgroups with well established, active members. Strategically, senior leaders are also core members of the Children's Safeguarding Partnership, the Communities Board and the Health & Wellbeing Board to ensure that cross cutting themes and linked top tier strategies are not seen in isolation. (Ref 48, 49, 50, 51, 52).

The Domestic Abuse Partnership Strategy (Ref 152) has been refreshed (with a focus on working with survivors to influence practice) and initial work has started to develop the non-recent CSE delivery model and pathways.

20.1.4 THINGS WE ARE PROUD OF

- Strong, stable and approachable leadership team who regularly attend team and service meetings to listen to staff and update on developments.
- Diverse skillset and experience across the leadership team.
- Strong relationship with the portfolio holder, with briefings and updates from across the directorate.
- Investment in executive support to guide and monitor governance progress of directorate work.
- The annual budget cycle involves activity all year to assess intelligence, requirements, duties and budget pressures. There are strong relationships with finance and an in depth understanding of the requirements of corporate budgeting processes.

- Effective and experienced scrutiny committee.
- Highly developed joint work and relationships with HCP and ICB.
- Sector and VCSE representation at operational and strategic levels.
- Regular discussions around performance issues and the responses required.
- ICMS investment to support efficiency and make care planning more person centred.
- Regular review of service risks and escalation routes to corporate risk.
- Use of robust business case processes to reallocate resources which are reviewed by the leadership team regularly to test effectiveness.

20.1.5 KEY AREAS FOR IMPROVEMENT

- There are some gaps around making the vision and strategies a reality in case level personalised change and evidence of empowered self-determining service users using TLAP statements.
- Our data driven decision making is weak because of how data is stored and interrogated across the directorate.
- Our approach to quality and risk management needs to be clearer.
- We will continue to develop the Co-Production Board working with a wider range of people who use services and carers ensuring a representative member group.
- As a Leadership Team, we recognise that we are still weak in our data capture and analysis and regional work around population health management.
- Equity is embedded in JHWS and Vision but plans to address challenges are missing.
- The financial context for social care in Kirklees does risk creating constraints.

20.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

- STAFF SURVEY FINDINGS
- Feedback from partners and the wider health and care system

20.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

In delivering our vision we are moving to shift the balance of decision making and support design towards maximising the independence of people who use services and their informal carers and the assets that exist in communities. This increased shift will continue to mean more in-depth, cost conscious and creative thinking in package design is required across care planning, commissioning and delivery teams.

Through our change programme we want our workforce to be enabled to work effectively and innovatively to deliver strength based personalised, high quality outcomes. This requires refined processes that are responsive, proportionate and reduce duplication, performance data that allows individuals and teams to better track the impact that they are having and continued culture change. Working as part of the wider health and care system, prevention, care and support will be better coordinated with individuals and their carers determining how needs are to be met.

The programme seeks to prevent, reduce and delay demand across the health and social care system. The approach would be to design services around the user experience to ensure timely and strength based responses that avoid crisis and escalating need. It will seek to reduce duplication of effort, improve coordination and to embrace digital opportunities. (Ref 99).

21 LEARNING, IMPROVEMENT AND INNOVATION

21.1 WHAT IS OUR AMBITION AND HOW ARE WE PERFORMING?

Our ambition is to deliver our coproduced vision, bringing the insights from everyone into a way of working and culture of innovation that improves the experience and lives of the people we support and our highly skilled and dedicated staff teams.

We strive to promote a culture of continual learning both at an individual level such as encouraging practice reviews and reflective supervision, and actively seeking the voices of people who use services to help shape services as well as by acting on system wide learning from when things go wrong. We are active members to many regional networks, both through ADASS and the LGA, and senior leaders have been involved in many Peer Challenges bringing back insights to improve our working. In addition to this, we have strong relationships with equivalent staff in neighbouring Councils which helps to share our good practice but also means we remain abreast of initiatives that could be used in Kirklees. A recent example of this is linking in with Manchester City Council to understand their performance approach but them also being interested to understand the expertise we have built up around demand and capacity. (Ref 72) We worked jointly with Rotherham Council to commission research into the post-Pandemic residential care market and are working with Wakefield Council on a joint approach to next stage Assistive Technology.

Our Principal Occupational Therapist and our Principal Social Worker are involved in local and national research projects around shaping directives for practice, improving career development and progression opportunities across the workforce, they are also active in encouraging other staff to engage in research.

The Yorkshire Urban and Rural Teaching Partnership for social work was formed in 2016. The Partnership includes four local authorities and two universities in West and North Yorkshire. Over a five-year period, the partnership has had a significant positive impact on many areas of social work training, practice and delivery. There is information about the work of the partnership on the website here. (Ref 82). The Social Worker Degree Apprenticeship (SWDA) pilot scheme with the Open University (OU) is being introduced in Kirklees this is an exciting opportunity to get practical experience while undertaking a university programme to gain theoretical and academic knowledge.

Another area that we are currently developing is a two phased approach focussing on apprenticeships with ASC sector roles and the Nursing Associate role. The first phase will look at workforce planning which includes co-producing an understanding of the landscape in social care, including barriers both for the employer and employee. This should lead to some insight into what potential employees value and want from a modern care workforce and hopefully increase labour market status and succession planning. The second phase will focus on recruitment/retention and progression which we hope will lead to an increased uptake of apprenticeships in the broader care sector.

Our service development approach aims to deliver improved outcomes through co-production with people who use services, staff who deliver them and other stakeholders. We redesigned and reprofiled existing posts to introduce Service Development Managers as subject matter experts so that we could balance incremental/ business as usual changes against full scale change programmes. Across these workstreams, a report taken to the Executive Team in 2022, demonstrated a net saving across the first two years of £2.3m. (Ref 65).

Our investment and ongoing deployment of the new case management system has been driven and co-designed with our staff teams, from the initial visioning for the system to involvement in choosing a potential supplier, and a wide group of staff involved in designed and contributing to the design of pathways and workflows so the best of our local knowledge about system design is utilised and embedded in the new case management system. The design requires the new system to connect to range of internal and partner systems we have used expertise in teams. to agree what these connection should be and how they need to function to improve efficiency and the care experience of people connecting with us.

We have led innovation in on-line self-assessment functionality with, for instance, 95% of people choosing to use our on-line financial assessment tool to understand the amount that they may need to pay for their care and to then submit this information to calculate this charge. People can undertake on-line assessment and review activity themselves through Better Care Support and this will in time integrate into our new MOSAIC system.

We were a LGA innovation pilot site to co-produce, with people who use services, an on-line Care Account to give people who use services greater access to their own information at a time of their choosing.

21.1.1 THINGS WE ARE PROUD OF

- Our Vision and JHWS have been coproduced and shaped by people with lived experience.
- The co-production board to formalise and capitalise on the value of lived experience.
- Changing the design of our communities and places with the publication of dementia design guide.
- Service level change with service users such as direct payment policy, sensory strategy, care phones charging approaches.
- Sharing the learning and ideas from and with other places.
- LGA Peer review involvement as a recipient and staff being involved in reviewing other areas.
- The sharing of practice and project work with SCIE, other LA areas and partners.
- The development of KirCA and its value as a partner across the health and social care system.
- The joint work we have been doing to support people locally Ageing Well and reduce the impact of frailty on the people we support through effective joined up services.
- The effective scrutiny of our work by committee and peer review activities.
- Continue to expand apprenticeships with ASC sector roles and the Nursing Associate role.
- The stronger and more mature relationships with the independent and VCSE sectors building and innovating around common issues together.

21.1.2 KEY AREAS FOR IMPROVEMENT

- The improvement cycle that uses the voice of experience in change is underdeveloped.
- The work around recruitment and retention to respond to demand needs to be further developed.
- The use of strength based and reflective practice in care and support planning.
- Staff wellbeing is available corporately, but more tailored options need to be investigated, and available to the entire sector.
- Internal challenge around performance is hampered by lack of reliable data, and the skills to robustly analyse intelligence.
- The vision needs to be refreshed and action on areas for improvement actioned co-productively.
- Feedback becoming action is not as traceable and evidenced as it needs to be.
- Team huddle and issue escalation and sharing processes.
- The learning offer and role specific skills expectations needs to be formalised across teams.
- Support for people to assist in changing services needs to be developed so the best of their time and experience is used.
- Develop the Future Manager Programme with KirCA to help with retention issues.

21.2 HOW DO WE KNOW? WHAT MAKES US CONFIDENT WE UNDERSTAND OUR PERFORMANCE?

There is a culture of learning and innovation across the organisation, our approach to work across disciplines, levels and teams in projects has meant many staff have contributed to shaping positive change, such as MOSAIC pathway design and implementation work, and the work within Learning Disabilities to improve the pathway into adults for children and young people. Our service users and carers are also

involved in shaping future service either directly through co-production or in the feedback and information they share in surveys about their experience and how it made them feel.

21.3 WHAT ARE OUR PLANS TO MAINTAIN OR IMPROVE OUR PERFORMANCE IN THIS AREA?

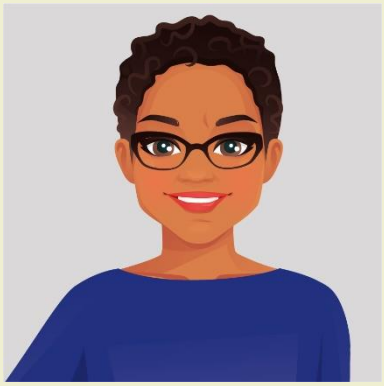
The Peer review feedback and the initial work around self-assessment has highlighted areas of work that need to be accelerated and developed to ensure effective quality improvement and responses to emerging risks across the directorate.

21.4 WHAT DO OTHERS SAY ABOUT OUR PERFORMANCE IN THIS AREA?

Spotlight on: **In2Care – "Megan's" Story**

Megan has been looking for work for a couple of months, In2Care explained the roles in social care and helped connect her with employers that were looked for someone with her skills. "I wanted to thank In2care for all their help and support in helping me find a role, I am over the moon. Through your service, I was inundated with over 30 phone calls from various providers, I was spoilt for choice! I was interviewed by a provider and within a day, I was offered a role. I couldn't have done it without the help of your team!"

Spotlight on: **In2Care – Sophie's Story**



I was faced with the daunting task of recruiting a full team of people to provide 24/7 care to my adult son who needs constant support. I had very little time to get it up and running. It has been invaluable not only to have the advertising from Kirklees Into2Care, but also the mini application form so I can screen the potential candidates. It is really easy then to get in touch with people with all the key information you supply. Thanks to the advert being shared on Facebook I have recruited two specialist support workers. I also have shortlisted three people for the team management role. This has all happened in just a couple of months. I haven't had to sign up to job sites, I haven't had to pay subscriptions and I am not constantly bombarded with emails from these companies. I am still delivering a lot of the care myself so having someone to take some of the pain out of recruitment has been absolutely fantastic. I wish you had been around years ago when I had Direct Payments before!