Torbay Council
Adult Social Care
Preparation for Assurance
Peer Challenge

June 2024

Feedback report

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Executive Summary

1. The integrated care offered in Torbay over the last 20 years is unique in the country and should be celebrated. However, it is not without challenges, which will need to be met head on to ensure its continued effective delivery for all partners, and for local people over future years. The new S75 legal agreement governing the partnership offers a further period of commitment and stability and is an opportunity to consider how key areas of leadership and performance can be consolidated (including through the new S75 Executive Group). Further consideration of improved line of sight for the Statutory Director of Adult Social Care (DASS), and Executive and Political Leadership of the Council, including through the Integrated Care Organisation (ICO) Executive, will be essential for future assurance, to provide visible strategic leadership for Adult Social Care which promotes key values and outcomes such as strengths-based practice and promoting people's independence and choice and control, and to ensure that these can be evidenced in future assessment processes.

2. The Transformation Programme will be essential to this journey, including financial impact and management of savings (or existing budget pressures) within this. It is an extensive programme of work which needs prioritisation, and consideration of where there may be shorter-term "wins" to demonstrate delivery may be important. Longer term, consideration of what happens at the end of the present contract with the delivery partner and local transformation team (in March 25) should be an urgent priority; this coincides with the re-procurement of the care management system (work on which is at an early stage, but implementation of which will be a challenging medium-term project), and recruitment of a new DASS – which when taken as a whole present a set of risks that will need to be carefully managed.

3. The Challenge found a commitment to providing quality care, with individualised care and support in general being well-provided through multidisciplinary teams which were felt to provide the right expertise and care at the right time. The case file audit undertaken as part of the Challenge found good practice, including around legal decision making, and least restrictive practice. Professional practice and line management support was spoken well of within the Challenge and can be used as a foundation for further work to promote a more strengths-based and risk-tolerant approach to delivering support.

4. There are some very strong areas of performance, for example in No Criteria to Reside (NCtR) and Length of Stay (LOS); however, it is recognised that targeted improvement is needed around residential care admissions, and direct payments. Whilst there are waiting lists (in common with many other adult social care services at the present time), including for DoLS, the Council is aware of these, and they are being actively managed. Consideration of the balance of priorities across health and social care performance needs to maintain focus on wider outcomes for people who draw on care and support, and to quantify the benefits of more preventative or social interventions.

5. The Challenge team did not hear about concerns relating to adult safeguarding practice or processes, but the limitations of the present Peer Challenge process for assurance should be noted in this regard, and recent work in this area used as the basis for ongoing assurance.

6. The Challenge heard some positive Lived Experience (in particular from working aged adults), but also of some challenges experienced by others who draw on support (notably carers). There is work in progress to develop a more strategic approach to coproduction, and it will be important to maintain and develop this work to maximise learning from people who draw on care and support, and engagement with your local communities. This will need to include and build on the renewed focus on Equality Diversity and Inclusion (EDI), where more can be done to develop engagement with both staff and local communities. In particular the development of this work (both coproduction and EDI) through and within the ICO can help to ensure that those delivering adult social care assessment and support (whatever their professional assignation) can speak well of this agenda.

Background

7. Torbay Council (The Council) requested the Local Government Association (LGA) to undertake an Adult Social Care Preparation for Assurance Peer Challenge within the Council and with partners. The work in Torbay was led by Jo Williams, Director of Adult Social Care at the Council, and supported on-site by a dedicated team.

8. The LGA was contracted to deliver the Peer Challenge process based on its knowledge and experience of delivering this type of work for over ten years. The LGA sourced the members of the Peer Challenge team and provided off-site administrative support.

9. The Council was seeking an external view about the preparation and readiness of the Adult Social Care Directorate for the arrival of the Care Quality Commission's (CQC) Local Authority Assurance inspections; as well as to inform their wider improvement planning.

10. The members of this Adult Social Care Preparation for Assurance Peer Challenge Team were:

    - **Alan Sinclair** (Lead Peer), Director of Adults & Health, West Sussex County Council.
    - **Councillor Izzi Seccombe** (Member Peer), Leader of Warwickshire County Council & LGA Vice-Chair.
    - **Leire Agirre**, Head of Safeguarding Adults, Quality Improvement & Principal Social Worker, Central Bedfordshire Council.
    - **Dr. Clenton Farquharson**, Chair of the Think Local Act Personal Partnership & Member of the National Co-Production Advisory Group.
    - **Tom Hennessey**, Director of Health Integration (ASC), Hertfordshire County Council.
    - **Corinne Moocarme**, Assistant Director for Community Services, Care Homes & Continuing Care, Lewisham Adult Commissioning Integrated Team.
    - **Victoria Baran**, Deputy Director, Oxfordshire County Council.
    - **Chris Rowland**, LGA Peer Challenge Manager.

11. The team was on site from 17th – 19th June 2024, following two days supported access earlier in June to carry out Case File Audits. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. These included:

    - interviews, focus groups, and discussions, with Councillors, people with lived experience, managers, practitioners, frontline staff, and partner representatives; in total over 40 meetings were included on the timetable, and the team gathered views from over 150 people within these;

    - preparatory work including a bespoke case file audit covering 11 case files, and reading documents provided by the Council both in advance of and during the Challenge; this included a Self-Assessment of progress, strengths, and areas for improvement and more than 30 documents;

12. The findings and recommendations in this summary report are based on the presentation delivered to the Council on 19th June 2024, and should be read with reference to it. The supporting detail and recommendations that it contains are founded on a triangulation of what the team have read, heard, and seen. All information was collected on the basis that no recommendation or finding is directly attributed to any comment or view from any individual or group; this encourages participants to be open and honest with the team. The report covers those areas most pertinent to the remit of the challenge only, focused on the CQC Themes as confirmed in November 2023; the

Challenge Team grouped evidence with reference to these themes and associated quality statements, and this report is structured around them. They are:

Care Quality Commission Adult Social Care Assurance Themes	
1: Working with People • Assessing needs • Supporting people to live healthier lives • Equity in experience and outcomes	**2: Providing Support** • Care provision, integration and continuity • Partnerships and communities
3: Ensuring Safety • Safe systems, pathways and transitions • Safeguarding	**4: Leadership** • Governance, management and sustainability • Learning, improvement and innovation

13. Peer Challenge is not an inspection, and it does not deliver a formal judgement; nor does this report suggest a definitive response against the CQC themes. Rather it offers a supportive approach, undertaken by 'critical friends', and an overview of key findings, with the intention of supporting the Council to form its own view, and to continue its improvement journey where necessary. It is designed to help to assess current achievements and areas for development, within the agreed scope of the Challenge. It aims to help identify the Council's current strengths, and examples of good practice are included under the relevant sections of the report. But it should also provide the Council with a basis for further improvement in a way that is proportionate to the remit of the Challenge, and recommendations where appropriate are included within the relevant sections of the report (as well as highlighted in the *Recommendations* section at the end).

14. The Peer Challenge process offers an opportunity for a limited diagnostic approach to material which is provided (whether through written materials, or through on-site interviews, focus-groups, or observations), as well as a critical appraisal and strategic positioning of this. It reflects a balance of views within the team, based on their experience, and the material made available to them. However, the level of "assurance" which can be provided through this format (whether of quality, outcomes, or good / poor practice, etc) is strictly limited. A Peer Challenge, whilst intensive, is not comprehensive. Peer Challenge is not therefore an alternative to inspection, or indeed to routine or exceptional internal quality assurance, and the Council is strongly encouraged to continue such work, hopefully informed by the findings of the Challenge.

15. The LGA Peer Challenge Team would like to thank Councillors, people with lived experience and carers, staff, and representatives of partner agencies for their open and constructive responses during the challenge process. The team was made very welcome and would in particular like to thank Jo Williams, Director of Adult Social Care, who sponsored the Challenge; and Cathy Williams and her team for their invaluable and excellent support to the Peer Team, both prior to and whilst on site.

1.   How the Local Authority Works with People

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

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

Equity in experience and outcomes: We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response.

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

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

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

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

Quality statements and I-statements from the CQC Interim Guidance for Local Authority Assessments, November 2023

Quality Statement One: Assessing needs

16. The Challenge found a commitment to providing quality care, with individualised care and support in general being well-provided through multidisciplinary teams which were felt to provide the right expertise and care at the right time. Staff were dedicated to relational social work, and had an understanding of risk-aversion and the importance of positive risk taking. There was an emphasis on wellbeing and disability confidence, and a desire to treat individuals as unique persons, which can lead to better engagement, satisfaction, and health outcomes, as well as promoting independence and thereby reducing the need for future care and support. It was suggested that a shared vision for strengths-based practice and a wellbeing approach to support might help to improve understanding and consistent application of these models across the teams (and indeed, that its development might prove to be helpful in facilitating further conversation about the vision and values of adult social care in the integrated delivery model).

17. The Challenge found inconsistency in how people are referred to within the service, with people who draw on care and support variously referred to as clients, patients, customers, or service users. This was also found in the Case File Audit where in addition some of the entries by professionals may need consideration in terms of use of language (and what it suggests), with an over-emphasis at times on medical terms ("patient", "client") and what the Challenge Team considered to be an overly strong emphasis on medical diagnosis. An agreed and shared language and narrative would help here, not only for consistency, but as a means to improve cultural understanding and sensitivity around the values and purpose of social care support. The language used in health and

social care settings can significantly impact how individuals feel about their care and support, and using person-centred language promotes dignity and respect, fosters better relationships between care and support providers and people who draw on care and support, and enhances the overall experience of care and support within and around the service.

18. The Case File Audit suggested that there was good person-centred practice, with a clear emphasis on keeping the adult at the centre of decision-making. In most cases there was a narrative about the person, who they are, and what matters to them; there were good examples of listening to the person or their advocate, and their wishes and feelings, to support person-centred practice; and evidence of trauma informed practice with positive outcomes for the person. Being able to evidence these aspects of professional practice and associated outcomes will be essential for future CQC assessment and relates positively to one of the questions posed by the Council to the Peer Challenge: whether the Council is able to effectively describe how it provides adult social care services and outcomes within an integrated provider organisation.

19. It was noted in the Case File Audit that the location of some records is not straightforward, including care and support plans not always being consistent in location on the recording system: there is some variance in recording of eligible needs, and narrative evidencing outcomes as goals was found located in various places. These might be areas to consider since summarising these in one area may be of benefit in order to measure and evidence outcomes more easily. More generally, tracing or understanding a person's journey on the case management system is not always easy, and it was sometimes hard to establish the reason for referrals to other services and outcomes afterwards. Staff also cited the case management system as difficult to use. All of this will bear consideration in the planned procurement of the new Care Management system, as it risks overshadowing good practice in presentation of local work and outcomes for people; or making it less easy to see clearly those areas for improvement (in practice or outcomes, or their cause) which may need to be addressed, or at least acknowledged in improvement work or practice improvement. Additionally, this will be an important aspect of the presentation of local work in preparation for CQC assessment, especially given their present "case tracking" approach.

20. There are waiting lists within the service, including for DoLS, but senior managers are aware of these, and there are plans in place to address them. These include a risk prioritisation tool and close oversight via triage and keeping in contact with the person waiting; and in Occupational Therapy specifically offering the option of an earlier telephone assessment. Work has been done to reduce the number of people waiting for care assessments, but the Challenge Team were told that there was a separate team for allocating referrals, so the triaging process was not fully understood by Social Workers; and it was acknowledged that the PARIS system is not strong for reporting on Waiting Lists, so in some places a local "whiteboard" method was used. Further work to manage and mitigate the impact of these waits will be ongoing and important therefore, and making their impact (and risk) clear within the ICO will be necessary. Short-term funding has been made available to bring down the DoLS list, but having a longer term and sustainable plan to manage demand will be key given the financial and workforce implications. Keeping these visible to the executive and political leadership of the Council will ensure that all are aware of the situation and associated risks, and can develop focus and support for plans to further address it.

Quality Statement Two: Supporting people to live healthier lives

21. The Challenge heard about positive integration and values, and how this promotes a good service: an effective and fully embedded Multidisciplinary Team (MDT) approach is working for people who need support; and there is an effective rapid response team, and such investment demonstrates a strategic approach to balancing cost and outcomes. Overall, integration in Torbay is not just a process but a fundamental value-driven approach to realising positive outcomes across health and social care, and in general it was felt that those who need short-term or crisis support received a good and timely service.

22. This was supported by the Case File Audit, which found there to be strong coordination of various disciplines in offering input advice and guidance where needed, something which is probably a considerable strength of the integrated delivery model. Urgent referral (or escalation) was responded to in timely and proportionate ways to meet needs and to understand and mitigate ongoing needs; there were joined-up approaches and planning across disciplines so the person does not fall through gaps between services; and alternative creative accommodation solutions were sought where secure placements were not yet available. In general there was strong consideration of risk, and good use of risk assessment tools, with evidence that the risk enablement framework was being utilised. This supported a robust consideration of least restrictive options and Best Interest decisions, and there was evidence of appropriate use of Legal Frameworks and applications to the Court. This points again to good professional practice for adult social care, and line management and oversight in support of this, which is significant (and important to be able to evidence, and evidence oversight and assurance of) given the integrated delivery arrangements.

23. However, there also appeared to be inconsistencies in referral processes, and what outcomes are developed for people moving through different parts of the system; in particular for those people who may have longer-term care needs (or risk developing these) there may be an over-reliance on traditional models of health and care provision (as evidenced by the high rates of residential care). The relative lack of visibility of social care spending may risk less ongoing "check and balance" on decision making processes and associated outcomes as might be the case in a more traditional adult social care department; and there is a risk of inequality of provision or outcomes in this regard, with the suggestion made to the team that there was a "gold-plated" service for some (perhaps in relation to shorter term interventions), but that this would not be affordable in the long-term for all. Further consideration of how to manage this within the financial position of the Council might help to focus attention on the question of whether present care packages (and approach to planning them) represent the best outcomes for local people; or whether there may be an over-emphasis on short-term health system outcomes, which accrue costs and poorer long-term outcomes (as further described below).

24. Panels have recently been introduced to oversee and provide critical challenge around funding decisions. There was mixed feedback in the Challenge about their effectiveness (with lack of clarity or agreement as to their purpose or benefit, whether they support better outcomes for people, and the work involved in their administration and how this impacts on both workload and timely decision making). However, with further communication and agreement as to their purpose these might provide a mechanism to support critical practice across the MDT's, and increased understanding and ownership of how commissioned care impacts on both budgets and outcomes.

25. There is an effective helpline and this is a critical component of the service, providing front-door access to social care that effectively manages the majority of referrals and reduces system

overload. This was described by some during the Challenge as being accessible and a source of information and advice for other professionals across the service; however, others were more critical of the helpline, describing it as "pot luck" as to who you got to speak to and whether they could deal with your query, and raising concerns that for those who were already known to the Council (some for many years) they would prefer to be able to bypass the helpline and go straight to a "key worker" who knew their circumstances, or that of the cared for person.

26. There is evidence that people are supported to plan ahead for life changes, with proactive engagement of community stakeholders, and commitment to individual coproduction and involvement in decision-making processes. However, pathways and outcomes for care and support plans could be made clearer, and more consistent implementation of personalized care and support planning could be developed in this regard, offering individuals and their carers (where applicable) more choice and control, thereby reducing anxiety about the future, and promoting better preparedness and improved quality of life.

27. Direct Payments are recorded as significantly below the England average. The good availability of commissioned domiciliary care may contribute to this, but the Challenge Team also heard of a number of process or capacity issues which may need to be addressed to support improvements here. The process for Direct Payments was not well understood or embedded in teams and there was no reference to a PA market within the area. Currently, there was not an efficient IT and/or administration function to deal with queries from clients currently in receipt of a Direct Payment; this meant going back through files to establish what the Care Plan entitlement and financial arrangements were. There was no team identified that could support education, training or queries from professionals or people drawing on care and support to develop the Direct Payment offer, and it was suggested to the Challenge that a small team focused on the administration and payment processes for Direct Payments would be supportive here.

28. Conversely, direct payments for carers are a strength, and a lot of work has been done to promote effective engagement with carers. Nevertheless, the Challenge was made aware of areas or concern (or individuals who were dissatisfied) around the carers offer, and this is something which the strong foundation for carers engagement might be used to quickly acknowledge and address. More long-term improvement in support and replacement care for unpaid carers (for respite, or in crisis, where care will otherwise break down) should be considered as an area for which cost can be offset by the benefit of not only good-will, but also the wellbeing and backup to make informal or family care sustainable. It was noted that many care homes do not accept the Short Break Vouchers that Carers are given to arrange respite. This needs to be addressed by the Commissioning Team and the Care Home Providers to ensure that there are sustainable and viable options for Carers seeking a respite placement in a residential setting.

Quality Statement Three: Equity in Experiences and Outcomes

29. Learning Disability and Autism Ambassadors were a very positive example of giving local people a voice. There are some strong examples of coproduction and community engagement, and in particular the team noted the work of and with the Autism Ambassadors who reported having affected real change to processes and having been supported to develop the "Autism Passport for hospitals" and access to the Leisure Card in Torbay without the need to evidence benefit entitlements. Learning Disability Ambassadors were also seen as a very positive example of

giving local people a voice. Building on this *The Big Plan* (which was coproduced with people with learning disabilities) is a very positive initiative, and the Challenge Team wondered whether it could be used as a model for further coproduction work with other groups of people who draw on care and support (or indeed more widely to meet the needs of the wider population of Torbay). Further examples of coproduction included the active listening and response through the Safeguarding Advisory Board, and the work that the Council has been doing on learning from complaints, noting that in general further feedback from people who draw on care and support will help to inform the Council's improvement journey.

30. Coproduction would benefit from a shared vision: the "why" as well as the "what" and the "how". Coproduction in Torbay health and social care is essential for creating a more equitable, inclusive, and responsive system. Addressing these themes at strategic, operational, and individual levels can support the Council and its partners to build a system that values every voice and meets the diverse needs of the community, and to develop impactful individual changes and transformative systemic improvements, leading to a more balanced and equitable approach to service development and delivery.

31. One practical way to promote further engagement, and thence to develop coproduction, might be through the development of a recognition and reward policy for lived experience contributions, an area of work for which a relatively small budget can support increased ownership and personalisation of local service delivery. Engagement with coproduction expertise might also help to develop both the case for this work, and its vision and purpose, and the Peer Challenge would be happy to signpost to relevant support or to pick up a further conversation in this regard.

32. The Council is developing its work around Equality Diversity and Inclusion (EDI), and there is an aspiration to look at EDI from a trauma informed perspective. This work needs to be more progressive and visible, both for the workforce and for local people, with a better integration of EDI principles across all levels of the service and partnership, increased use of data to demonstrate need and impact (of initiatives), and an understanding that intersectionality is an important aspect of this work: needing to see the whole person rather than individual aspects. There was little evidence within the Peer Challenge that the ICO or council could easily demonstrate that they are meeting the needs of the diverse population of Torbay, or of its own staff; and development in this area to show how it is threaded through other strategies and plans, including the self-assessment, will be important for future assurance and assessment with CQC. It was noted during the challenge that whilst there is a (corporate) Council lead for EDI, they are less in contact with the relevant leads in the ICO than might be expected; and the challenge for Torbay will be that evidence and data around EDI, any plans that are developed, and their impact, will all need to be taken forward through the Trust. Developing clear and shared leadership for this work (in adult social care) across the Council and Trust will therefore be essential.

2.   How the Local Authority Provides Support

> **Care provision, integration and continuity:** We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
>
> **Partnerships and communities:** We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
>
> - I have care and support that is co-ordinated, and everyone works well together and with me.
>
> *Quality statements and I-statements from the CQC Interim Guidance for Local Authority Assessments, November 2023*

Quality Statement Four: Care Provision, Integration, and Continuity

33. Staff at all levels consistently referenced the benefits of integration, citing co-location as the key factor in frontline relationships, and greatly improving response times to people drawing on services. Staff from across a range of teams were all able to cite examples of speaking directly with nursing, physiotherapy, community matron's, occupational therapists and other allied professionals to achieve the right advice, intervention and positive outcome for a person. This is particularly the case in times of crisis, with crisis situations described as being well-managed, with MDT responses provided quickly to people. Frontline practitioners described how people were appreciative of the wrap-around care that is offered to them from a multi-disciplinary perspective (something for which it would be helpful to provide further positive evidence from those with lived experience). Social care staff referenced the ease of access to information (with both health and social care staff using the same case management system) as being an enabler for joined up care, although some barriers were described by staff when needing to access substance misuse or mental health services.

34. It was noted that Occupational Therapists are now back in the adult social care structure. Staff report good collaboration between Social Work and Occupational Therapy, and OTs were described as "marvellous" once contact was made; however, Carers Groups suggested that information was not routinely provided to Carers on Disabled Facilities Grant (DFG) and Adaptations, and that they would appreciate signposting to this. The Occupational Therapy team hold a separate waiting list and therefore risks around the overall experience of the person should be considered along with opportunities for trusted assessment. Data reporting could be further supported by clearly identifying Occupational Therapy waiting times in the current suite. It is noted that DFG applications outstrip grant supply in particular, due to high numbers of home extension requests, and whilst local arrangements are in place in the short-term, performance reporting could support greater transparency of the scale of the financial issue and generate further insight into accommodation development opportunities.

35. The teams are proud of their approach to Social Work retention and growth and cite low turnover as a particular strength. Some staff reported that the focus for the Health Trust was on hospital flow and that this created a "demand and flow" approach to work. As such opportunities to practice relational Social Work and strength-based approaches can feel limited, and opportunities to focus on preventative models of support were also felt to receive

less attention, with concerns raised about a lack of positive risk taking, over prescription of care at the point of hospital discharge, and of a diluting of the Social Work profession. The self-assessment acknowledges the use of bed-based care with high rates of admissions to care homes. For adults admitted into Pathway 2 beds on hospital discharge staff report low numbers of people returning to their own home, and that people often experience multiple moves before being admitted to a permanent residential home. This stands in contrast to strong performance measured by low numbers for No Criteria to Reside (NCTR), for hospital discharge, and Long Length of Stay (LLOS). In summary, some social care staff expressed a concern that the voice of adult social care is lost (or risks being lost) in a medical model, and the Peer Challenge Team suggested that what counts as "good performance" might also risk being viewed through an NHS lens.

36. The Jack Sears unit is seen as a success story, and had just opened at the time of the Peer Challenge; it is due to provide 26 reablement beds and may support greater numbers of people to return to their own home. This will need to be monitored, alongside wider system data, since there is inequity of provision of reablement following hospital discharge, leading to some people experiencing poor outcomes, and potentially having to move care settings several times. Coverage of reablement services was noted to be in the top quartile for coverage of the population, however outcomes are in the lowest quartile (although this is in part caused by the Intermediate Care services being recorded together with traditional reablement). More engagement with people and their families is required to ensure that outcomes are met and preferences taken into account, and further work to explain the outcomes for people in Pathway 2 would be beneficial since these are not presently well described, and there is a risk that people are not being actively supported to return home. Consideration to pathways and data segmentation may further support an understanding of the opportunities to deliver enabling services and improve outcomes across both reablement and intermediate pathways for local people, and Capacity and Demand modelling for Pathways 0-3 could help to align this with national best practice.

37. Overall, the apparent focus on bed-based care rather than delivery of the adult social care strategy and independent living, results in admissions to care homes above the England average, and it was not clear that there is a clear operational plan to reduce this. This equates not only to less positive outcomes for local people (with an increasing number going into long term care), but also increasing costs which must be borne through adult social care budgets (albeit hosted within the ICO, but therefore experienced as a developing pressure within the agreed cost envelope). The ambition to further develop 72 Extra Care apartments through an Enabled Housing model is a positive step forward but is acknowledged that this alone will not be sufficient to provide long term feasible alternatives to residential care. The Challenge would recommend that there needs to be more focus on wider social care outcomes, and especially for those people who do not come via the hospital – people living in the community. This will need clarity of purpose within the ICO to drive change in practice (and with clear rationale as to the benefits for the system, for costs, and most importantly to improve outcomes for local people). This work will also need the support of the market plan to be delivered, with more strategic and operational planning across the partnerships, and including across the Council in housing, and commissioning.

38. There have been successful ongoing reductions in the number of people awaiting assessment, and subsequent requests for domiciliary care have resulted in a more timely response for people. The performance data report indicates that barriers to provision of domiciliary care

may include small packages of care e.g. 30 minutes per week. Consideration of how to embed strength-based practices utilising all community assets prior to commissioning care could be helpful to potentially reduce this type of request.

39. Carers leads and information hubs are embedded in all Primary Care Networks across Torbay, with Carer Support workers are available for drop-in advice and support. Torbay Carers has Carers Information and Advice Hubs in several geographical locations, and there are a wide range of support groups that Carers may attend. These include groups for Young Carers, Young Adult Carers, Parent Carers and those caring for people with Substance Misuse issues, Mental Health and Dementia. There is a Carer Advice Service at the Acute Hospital that supports Carers with any issues encountered in hospital and also around hospital discharge arrangements. Carers are provided with an orange lanyard so that they are easily recognised by hospital staff, and staff training is provided around the identification and support of unpaid carers. Carers also report that they have experience of being supported with safeguarding. All of this speaks of a good service offer, and the Challenge more generally heard about good and sustained relationships with carers groups. However, it was also evident from speaking with carers whilst on-site that there may be more work to do in terms of communication and expectation management, as well as explaining how different services interact with each other, to ensure the care management of residents is optimised.

40. The Public Health Team work closely with Commissioning Teams to ensure evidence-based commissioning. Whilst there is no analyst who works across Health and Social Care there have been collaboration on key pieces of work such as Dementia. Public Health support a data driven approach to taking a whole population view, but there may be further work to do to support better identification of unmet need and a more preventative approach before people arrive at the "front door". Similarly it was felt that there could be more focus on the development of Neighbourhood Health and Wellbeing Hubs and Children and Family Hubs as these both offer excellent opportunities for prevention interventions. Employment and Housing would both benefit from further focus, with a large number of working adults not in employment and a shortage of accommodation that can be adapted to ensure flow through the Homelessness/Substance Misuse pathway. The Public Health Team are keen to work more closely with Primary Care colleagues especially around keeping people in employment, and are utilising intelligence gained from sick notes to support this. There is a very good Healthy Ageing approach in Torbay, and it was felt that this could be more targeted and joined up across health and social care. The Mental Health Alliance is also strong and Public Health have worked with the alliance to support Suicide Prevention work.

Quality Statement Five: Partnerships and Community

41. There is a strong socio-economic community infrastructure in Torbay, with good community engagement and information sharing through advisory boards and marketplaces. The VSCE (Voluntary, Community, and Social Enterprise) infrastructure is well-organised, well-connected, and effective, with an overarching Assembly which identifies funding streams and directs to best outcome focused delivery, and provides opportunities for people in the local community. This is a valuable local resource which appears able to self-mobilise in crisis, and with good capacity within the VCS community to deliver for local people both in ongoing and more crisis situations. They are a strong partner much valued by all parties, and are regular attenders at Council Scrutiny, where they feel they have a voice. They are appropriately linked to the Council and the Trust and were described as doing a lot of "heavy lifting". Consideration should

be given as to how preventative funding and support to this infrastructure accrues longer-term benefits (and how to evidence this appropriately); and conversely the potential costs of any reduction in this capacity – something which is often at risk from budget reductions given that it is a non-statutory service.

42. The Care Home Quality Assurance and Improvement Team (QAIT) were cited as a valuable resource, enhancing health care support to the care sector (and much appreciated in this work). The team adopts a clinically led model, based at the Acute Trust, and support Care Homes, Domiciliary Care providers, and Supported Living. They are a small multidisciplinary team including nurses and OTs (jointly managed by Nurse and OT) and have access to Falls Specialist and Pharmacy support; their aim is to be supportive and responsive to the needs of social care providers. They work with Care Homes that have high ambulance call out rates to determine what support, guidance and training is needed to enable them to ensure that hospital admissions are avoided whenever it is safe to do so. There had previously been a focus on the NHSE Enhanced Health in Care Home Framework but this has diminished due to staff changes. The team have facilitated access to NHS training for nurses in care homes, and are in general seen as having positive, integrated approach to bringing health and social care staff together to drive up quality and experience for residents in care settings. Training offered to Care Homes include Restore 2 (Deterioration Tool) and Social Care providers can access the HIVE platform (NHS Training Hub).

43. Care Home providers expressed concern that there were no regular opportunities to interact with the Council; there is no Care Home Provider Forum and there appears to be an absence of other more regular networking opportunities. Meetings that were put in place during Covid have stopped, and providers felt that they had "no voice" and were not heard by the Council. As many Care Homes have a client base of mainly self-funders, they are not routinely contacted by the Council and negotiations around council funded residents take place on a "spot purchase" basis. Development of a Provider Forum could go a long way to securing market support and improving the outcomes and flow for people who need to draw on care and health services. It could also provide a place to develop the collaboration that will be needed with providers to support the delivery of the market plan. Care Homes have been left discouraged by the Fair Cost of Care process, which took a lot of input from them and then did not progress, and there is a real opportunity here both for funders to understand more about Care Home pressures, and for providers to understand the funding constraints faced by the Council (in common with the sector nationally); and thereby to move towards agreement on a realistic costing model.

3. How the Local Authority Ensures Safety within the System

Safe systems, pathways and transitions: We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safeguarding: We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

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

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

Quality statements and I-statements from the CQC Interim Guidance for Local Authority Assessments, November 2023

Quality Statement Six: Safe systems, Pathways, and Transitions

44. The Challenge heard about urgent referral (or escalation) being responded to in timely and proportionate ways to meet needs and to understand and mitigate ongoing needs; there were system wide joined-up approaches and planning across disciplines, so the person does not fall through gaps between services. Staff teams felt that their unique ability to call upon many professional disciplines meant that people received a timely, safe, and person-centred service without handoffs and delays. There is a very stable workforce with broad opportunities for rotation and development opportunities across health and social care, which results in good and rich practice. There is a "grow your own" approach for Social Work, and a strong sense of "family" amongst the Social Work team. This supports career development, excellent retention of staff, and robust ability to meet current and future service needs, and staff reported that their own knowledge and skill-set was enhanced by the opportunity of working so closely with other disciplines. There is strong cross-fertilisation of knowledge and skills as a result of integrated working, and staff teams saw that this enriched their knowledge on available services, and enabled them to be well placed to advice people about wide ranging options across health and care services.

45. Some partner agencies and people said that at times it was difficult to speak to a social work team to relay information about changing needs. Some adults with a learning disability who are open to learning disability nursing may not be visible to Adult Social Care in the current case management system due to the way in which the system is configured; this means that when a change in need is reported, they are at risk of waiting unnecessarily for an unplanned review. Staff suggested that access to mental health support for people with a learning disability would be an area that could be improved. This was further reinforced by a group of people with lived experience who pointed to a lack of face-to-face services, reporting that services had an overt preference for digital contact, which resulted in difficulties for people with a learning disability in accessing information, advice and support. Overall it may be the case that partner agencies (and indeed different teams across the service) are not always as familiar with the various teams and roles

and responsibilities as might be helpful, and further communication across the service and with partner agencies on any recent changes, and improving the information on the website on how to refer/report, may be an area for consideration.

46. The Case file audit found examples of joined up approaches in Transitions, with care and support being planned and organised with the person, their family and the advocate. The transition team were collaborative at working together with partners and communities in ways that improve their safety across their care journeys, and that ensures continuity in care where people were moving between services. There was careful consideration of the impact of transitioning on the person, and where changes in accommodation were considered there was robust risk assessment in relation to the adult and to other individuals in the community in which a person would live. There was consideration of moving at the pace of the adult to ensure personalised, safe and well-coordinated services when transitioning into adulthood, considering graded visits, phasing, sensory room, likes and dislikes, aspirations; therapeutic support was identified, and it was possible to "see the person" through the narrative.

47. Staff described difficulties engaging with Housing colleagues as resulting in delayed and poorer outcomes. Care provision for those with a learning disability is provided, but not always evaluated in a timely manner, and the Challenge Team heard that care packages could be reduced earlier to promote and support the persons independence; but the final steps to allow people to move into independence is housing and there appears to be significant lack of suitable independent living. Social Work teams were often finding innovative solutions to mitigate against a lack of provision for people requiring accommodation suitable to meet their complex needs, but there were references to the lack of coordination with housing and a lack of options for appropriate accommodation. In general there did not appear to be a clear means for Social Care to report areas of unmet need/development to the Council's Housing Team, and it is suggested that further collaboration with housing will be supportive of increased options for accommodation with support.

Quality Statement Seven: Safeguarding

48. There are strong quality checks for safeguarding and enquiry process, including the sign-off (closure) process. As part of a robust quality assurance arrangement there is a panel that undertakes a quality check for all completed Section 42 enquiries. In addition, there is regular auditing of decision making of not for Section 42 enquiries, providing assurance for statutory functions of the Local Authority, and sign off given by non-operational safeguarding leads. Multi-disciplinary input from disciplines across a varied range of health and social care professionals is readily available as part of Section 42 initial enquiries and/or further investigations. This brings invaluable expertise in to Safeguarding Investigations and provides assurance that the issues have been considered from a wide range of perspectives.

49. Operational safeguarding data is well monitored and tracked. There have been several audits to support Sector Led improvement into Safeguarding, the learning of which is being responded to and monitored. There is a strong learning culture that can be evidenced in the way that people talk and the way that people reflect on their own practice. There was a strong sense of "no blame" and openly discussing where things have gone wrong, and a sense of continuous improvement and learning from feedback.

50. Oversight of the Safeguarding Adults Board (SAB) in managing trends and learning activity is reflected on its website. Conferences are arranged for the benefit of the wider partnership and learning and development is offered across the system to upskill staff across disciplines. There

is an alignment between published learning from Safeguarding Adults Reviews (SARS) and information held on the website is available to both staff and the public; however, this needs to be timely, focused and further embedded. Some progress has been made but further energy and commitment is needed to ensure that learning recommendations from SARS have a clear plan for delivery and are tracked effectively, and that the benefit of the learning are evidenced and realised.

51. The SAB is leading several workstreams in coproduction and hearing from various people with lived experience of safeguarding. There are a number of initiatives and groups that have been created and there is extensive exploration of engagement with people through local faith groups. The Board has visibility and feedback from people with regard to Making Safeguarding Personal (MSP) with desired outcomes recorded in the SAC and MSP national framework.

52. Further work to develop closer working relationships with the Children's Board around Transitions will further support the SAB: developing strategic oversight in the Health and Social Care Partnership around pathways, transitions, risks and opportunities for young people transitioning into adulthood needs buy in across the organisation.

53. As a result of the various safeguarding adult reviews undertaken in recent times the SAB has highlighted a number of types of abuse which are emerging locally. There is a good example of information on these which is shared with other Boards. Notable, there has been a rise in instances of domestic abuse and self-neglect, and whilst this is in line with the national trend, targeted work across the partnership such as thematic auditing into these areas, may highlight opportunities for prevention and reduction of such instances.

54. Staff teams spoke of the need to improve support around homelessness, and the need to improve on the interface with Drug and Alcohol and Mental Health Services. Close monitoring via auditing on the experiences of homeless people via the SAB may support improvement or developments in this area: the national directive from the Department of Health and Social Care following the 2022 'Ending Rough Sleeping for Good' strategy, includes recommendations for how Safeguarding Adults Boards can support individuals rough sleeping.

55. There is a keen awareness of the present DOLS waiting list, and work is being done to address this. There is a robust triage and prioritisation process in place, and Section 21a challenges are effectively tracked. There has been a review of effectiveness and efficiency in collaboration with Regional and National colleagues. Whilst funding has been put in place to reduce these waits, this is non-recurrent, and a sustainable and funded plan for DOLs delivery is needed to reduce demand and meet statutory duties and Human Rights compliance.

4.   Leadership

> **Governance, management and sustainability:** We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
>
> **Learning, improvement and innovation:** We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
>
> *Quality statements from the CQC Interim Guidance for Local Authority Assessments,*
> *November 2023*

Quality Statement Eight: Governance, Management, and Sustainability

57.   The integrated care offered in Torbay over the last 20 years is unique in the country, and should be celebrated. The Section 75 has now been agreed for another 5 years, and offers a further period of commitment and stability. This provides a formalised structure that secures the Integrated Care Organisation (ICO) and integration programme for the medium term (albeit with a break clause on an annual basis with 12 months' notice), and the opportunity to consider how key areas of leadership and performance can be consolidated, and potential risks identified and mitigated.

58.   The support of the new S75 Joint Executive Group will be important to oversee this, including around delivery of the Adult Social Care Transformation Plan, and associated financial savings. However, further consideration of leadership for social care in the ICO at senior level (including the line of sight of the DASS, and Executive and Political Leadership in the Council and the ICO) will be essential for further assurance that Adult Social Care outcomes are achieved, that statutory duties are met, and that this can be evidenced to CQC as part of any future assessment process. To be clear: the Peer Challenge did not find (or take a view) that there were significant failings in these areas (although there were areas for improvement as noted elsewhere in this report); but it took the view that it was difficult to demonstrate that there could be thorough assurance at the present time, to feel confident that the Council would know if there *were* failings, or have sufficient leadership presence to identify and argue for prioritisation of improvements. To this end, the Challenge Team would strongly recommend that formal representation (most probably by the DASS) be considered on the Integrated Care Organisation (ICO) Executive.

59.   The integrated arrangement is not without challenges for Adult Social Care, and these will need to be met head on to ensure its effective delivery for all partners, and for local people over future years. Those most clearly identified by the present Challenge related to ongoing support for social care values and outcomes; prioritisation of key performance measures; and financial pressures and oversight. Whilst there is strong professional leadership for Adult Social Care in the ICO, more visible leadership at a more strategic level (as described above) can help to promote key values and outcomes (and their importance for local people). These include strengths-based practice and promoting people's independence and choice and control, as well as wider social outcomes and determinants of health and wellbeing; and to help to ensure that these can be evidenced in future assessment processes. Such leadership can also support the effective prioritisation of (and risk

assessment in relation to) key areas of adult social care performance, such as direct payments, or admissions into long term care – an area of current poor performance which will also contribute to increasing costs. In particular (in the context of the present Challenge), the future cost and wider implications of a less than Good CQC judgement, both for Adult Social Care and the wider partnership, risks having less emphasis day to day than key health partnership metrics such as NDtR or LLOS (which are monitored "live" and are seen as an immediate "must-do"), but it should not be underestimated.

60. In relation to financial risk, the scale of the partnership (and extent to which it is now seen as the only way forward) represents a significant challenge, in particular the ongoing ability to realise the funding from both strategic partners. Adult Social Care is seen by some as at risk of being lost in the ICO, or put behind health priorities; whilst for others, the financial pressures associated with Adult Social Care are seen as being carried or subsidised by health. The Council's financial commitment to the 5-year programme has been notionally structured on use of the Adult Social Care Precept for 3 years, based on increases of 3%, 3% and 2% – increases which have not as yet been secured through Government commitment, with the risk for the Council of needing to identify this resource from core funding if the precept were not to continue. In addition, there is concern from finance colleagues regards the cost of the partnership, and whether accruing social care costs may be less visible within it; and more widely, a present question for the ICS concerning the overall affordability of the wider system, across what is a fairly small health and care footprint.

61. To some extent being "eyes open" to the financial interdependencies, and able to model some of these in contrast to more traditional NHS/Local Authority systems and dynamics might be helpful here. There are strong relationships with the DASS and more widely across senior staff who hold some of this knowledge and oversight, and manage such tensions as they arise; these aid integration and partnership working (although this in itself poses a risk if roles or personnel or processes change). And the redesign and formalising of the S75 Executive Group is seen as a means of putting a structure in place to support this. Everyone is clearly committed to the model for many reasons including outcomes for local people – integration is seen as being "in the genes" of both NHS and Local Authority locally, and there are regular discussions and an openness between NHS and Local Authority colleagues, and relationships and colocation are seen as an important aspect to delivering timely and appropriate responses for people. But there was also some recognition that there is not an easy alternative at this stage ("there is no Plan B"), so there is a necessity to make this model work. There may be a danger that in seeing integration as the only or inevitable way, there is lack of clarity around risks or possible negative impacts of this approach in particular areas of delivery; or the work that needs to be actively done to mitigate these.

62. The Transformation Programme will be essential to this journey, including financial impact and management of savings (or existing budget pressures) within this. It is an extensive programme of work which needs prioritisation, and consideration of where there may be shorter-term "wins" to prove its benefit may be important. Given the financial risks noted above, it is essential that the transformation programme can deliver, and the Challenge Team suggested that there is a need for improved line of sight for the ICO and Council Leadership of the Adult Social Care Continuous Improvement Board and Transformation Programme. There was some evidence that senior staff across the Council and ICO and ICB have an awareness and understanding of the improvements and transformation projects, but it was not clear that there was full buy-in or understanding from all senior leaders of the impact, outcomes, and timescales of delivery for the programme – especially within senior leadership of the ICO and ICB. Nor was it clear that all senior managers (or other staff) understood it, or their role in it, or the importance of this programme to support the financial

position. In the short-term the Challenge suggested that delivery plans need to be clearer and to start delivering, perhaps focussing on some quick wins that can build confidence and momentum. In the medium term, it was noted with concern that the present transformation partner and budget for this work (including the local transformation team, who are all seconded) are uncertain beyond March 25; consideration of what happens at the end of the present contract should be an urgent priority, especially given that much of the work is longer-term than in-year projects.

63. More widely, there are some good plans in place (some of which have been coproduced) including an Adult Social Care Strategy, Market Plan, and the Big Plan. But there was a sense in the Challenge that there were a lot of plans, some of which were at an early stage, and will require further sign up from partners. The Challenge Team did not see clear delivery plans to follow up, and wondered whether without greater clarity and communication these might risk getting lost between the Council and the ICO. Some work to align or consolidate the different plans, take stock of progress and timescales, and to prioritise across them for further delivery might help the Council and its partners to identify key shorter- and longer-term deliverables, and to be clear about who is responsible for or supporting them. An evaluation of the Transformation Programme might also support planning for next steps, including through clarity of impact and outcomes.

64. The end of the present transformation programme (contract, and in-house support) also overlaps with the likely timescale for re-procurement of the Paris care management system (work on which is at an early stage). Getting the best specification for this procurement, as well as careful project management of implementation (which will be a challenging and costly medium-term project) will both be essential, not least because of the complexity of the necessary interoperability with local NHS systems. There are lessons that can be learned from other Local Authorities who have recently gone through similar re-procurements (in the South-West, or more widely), and members of the Peer Challenge Team suggested that amongst other things it will be important not to lose the good "person history" of the present system in whatever is commissioned for the future. In whatever case however, a detailed road map for procuring and introducing the new system is needed soon and will need to be communicated and visible to all key staff.

65. A final significant risk in the second half of the present year relates to the recruitment of a new DASS, following the retirement of the present post-holder (whose long and in-depth experience of the local integrated arrangements, and as DASS more widely of the local leadership and context, is invaluable). Whilst on-site the team heard about and witnessed the leadership of the present DASS; her significant local (and historical) knowledge of the system, and its people, complexities, dynamics, and processes; and the respect and trust with which this was held by Adult Social Care staff and partners. Her departure and recruitment to the post will therefore represent a significant change for the local system and services, and its management and leadership, and care will be needed in how this is approached and communicated (and noting that during the on-site Challenge, whilst some were aware of this change pending, not everyone was).

66. The Leader of the Council and Portfolio Holder for Adult Social Care were both engaged with the Peer Challenge and show strong understanding and commitment to the area. Introduction of a monthly *Marketplace Stall* allows people to be heard directly by them and this has been welcomed; and the Challenge heard about the value felt by people who use services in the engagement of the Leader and Portfolio Holder with them. As an example of this, during the development of *The Big Plan*, coproduced by people with a learning disability, the Leader spent a whole day with the Sector experiencing the different groups and providers. The Portfolio holder describes herself as a "champion for the sector", bringing experience and a clear passion to help people, and has grown in knowledge and experience since taking on the role a year ago. *Quartet Meetings* with the Leader,

Portfolio Holder, Chief Executive, and DASS are held regularly, and the Leader attends Regional-wide Partners meetings, and meets with Portfolio Holder at least weekly. The hope was expressed that "we know ourselves good or bad, and that we are on the right track".

67. It was unclear to the present Challenge how political leadership is working across the wider health and care system (including oversight of the ICO) or how it engages with the Integrated Care Board (ICB). There is a new ICB Chief Executive in post, and this (along with local NHS leadership) may take time to bed in, but this might be an area for further work. Whilst the Challenge did not hear about the Health and Wellbeing Board, this may be another forum which has a role to play in supporting political engagement with the wider health system. At a more operational level (given the role of the ICO in Adult Social Care delivery) it was suggested by the Team that regular meetings for the Portfolio Holder (briefed and supported by the DASS and her team) with the ICO Non-Executive Director could support and promote the ongoing work of social care within the ICO.

68. Scrutiny has been seen as positive in some areas, with themed meetings pre-coordinated, and often starting with a site visit to share wider learning. The Peer Team heard that whilst it has been subject to some recent political challenges, relationships are now found to be improving again, and fortnightly meetings with cross-party leaders have been used to resolve some of the tensions.

Quality Statement Nine: Learning, Improvement, and Innovation

69. Torbay's Integrated Care Organisation (ICO) is its USP: the model for social care delivery is seen as a pathfinder and national leader, and there is much learning that can and should be shared from this experience. The culture and leadership across the whole sector supports the integrated arrangements, and the Peer Challenge found committed staff across the system, who spoke enthusiastically about the integrated model of service delivery in Torbay, and how this can deliver good outcomes for local people. Staff who met with the team were all positive and passionate about the integrated way of working – and the Challenge Team heard stories of people who had moved from other Councils to work in Torbay.

70. Staff were in general completely committed to the partnership and the system, which is a huge strength, but as noted above, might at times risk eliding the question of whether there is anything risked (or lost) in this approach, or whether there is good practice that could be taken into the integrated model from non-integrated delivery elsewhere. Knowing "what good looks like" and how to measure this is as an important starting point to answer the question "why do we do this in this way here?" (rather than just "because we always have done"!). Being able to describe the rationale to key models, strengths, or risks, and in supporting staff to be able to do the same, is an important back-up to the Self-Assessment and introductory meetings with CQC (which starts the on-site assessment phase, as it does in the Peer Challenge). Supporting staff to engage with regional and national networks and groups where they can compare and contrast different aspects of what is possible in Torbay's unique delivery, with what and how things are done elsewhere, could be helpful to avoid tunnel vision in any one part of the service (whilst accepting that the integrated model needs to be the vehicle for delivery of the whole). This might include for instance benchmarking against comparator authorities' outcomes for key delivery areas; or learning from others in relation to best practice in delivery of wider social care outcomes; or involvement for middle and senior managers in SW ADASS Regional Networks or events, or as peers in LGA Peer Challenge Teams elsewhere in the country.

71. There was a strong culture of "grow your own" in the local workforce, with good evidence from staff about opportunities for development and promotion, and low sickness, vacancies, and

turnover rates. Staff who met with the team were very positive about the support they received from their colleagues and described good support from visible professional leadership and line management, including through supervision and appraisal, and more informally. Learning processes are in place to support improvements in practice, and more widely to assure it: this includes through SAR's, Oliver McGowan Training, working with people who draw on care and support, and working with the voluntary sector. Training was described as good, and there was positive engagement with Social Work Practice Weeks, where a focus on sharing good practice has engaged staff and senior managers.

72. Further work is needed to improve staff's awareness of priorities, plans and strategies, and how these will support future assurance and assessment processes, as well as Adult Social Care delivery. Staff awareness of the major plans and strategies was variable, and a significant proportion of the staff who spoke to the Peer Challenge did not seem to know about (or at least be able to talk confidently about) these or have an understanding of their part within them, including for instance the Self-Assessment, or Big Plan. It also includes the Strategic Workforce Plan (which builds on a "Grow your Own" workforce developed with the South Devon College who will be part of the delivery). Transformation is such an important part of the next five years, and whilst it has been "heard" by staff, there is not a plan that has been widely shared as yet and staff were not clear about the timetable or how it affects them. The Peer Challenge Team wondered whether visibility of Council plans across the ICO an issue might be, or at least could be perceived to be (on a future CQC assessment visit) on the basis of how staff presented to the team; it was certainly suggested that communication of new plans and strategies is not always strong and uncertainty remains in the staff about these.

Preparing for CQC Assessment

73. The Council worked hard to prepare for and facilitate a good Peer Challenge process. Dedicated time and resource and leadership were identified at an early stage, and were available consistently throughout the process. There can be a risk of under-estimating both the lead-time (including for different aspects of the preparations) and necessary resources needed to prepare for a Peer Challenge (or future CQC assessment process), but this was not the case here.

74. The Council developed a well-structured Self-Assessment which helped to guide the Challenge Team in line with the CQC Themes; this was supported by a prioritised, but nonetheless comprehensive set of further evidence materials. These were delivered in a timely way, and referenced in the Self-Assessment, providing a helpful means of aligning evidence to key statements or sections. Some team members felt that the self-assessment could more clearly signpost to good practice evidence (something which will be important for an incoming CQC assessment team); and in particular that the initial presentation could better help an incoming team understand how strengths and areas for improvement connect with the local service model (and how this may be different from elsewhere); these are perhaps areas for review.

75. It was noted that the compilation of some of these materials (including data and other evidence) needed to be developed through the ICO teams and infrastructure, and that this presented some time-challenge. This would suggest the additional importance in Torbay of undertaking the preparatory work for the CQC Information Return in advance of a CQC notification, since the turn-around time for the Information Return is presently the tightest part of the process (at just three weeks). All the materials were made available by email, along with other materials pertinent to the Challenge; this made the materials easy to access, but might not be a fully secure way of sharing sensitive materials. (This is unlikely to be an issue with CQC Assessment however, given that they have developed a portal for uploading all relevant materials in advance of the on-site work.)

76. The Case File Audit reviewed 12 case files, which had been selected by the Local Authority, but randomly so, and without prior audit (something which would not generally be the case for future CQC assessment, and which suggests a positive desire to learn and reflect from the present Peer Challenge process). The Case Files were drawn from across a variety of teams, and so represented the assessment of needs, and care and support provided, for a diverse range of people, including older people, those with a mental health diagnosis, people with a learning disability, people with complex needs, people admitted to hospital, a safeguarding enquiry, and a transition. The audit offers a limited "snapshot" of practice and processes, and some indicative findings; it is important to see these as the basis for further follow-up and assurance, and ideally more regular and thorough-going audit as part of ongoing practice development.

77. Consideration had obviously been given as to how to provide evidence of outcomes for people who use or have contact with council services, and this might be further developed and linked with the routine use of care management systems and future case file audits, as well as through inclusion of lived experience feedback in regular reporting on transformation and improvement plans. Evidence of this kind will also come through contact and conversation with front-line staff, so ongoing support to all staff across the ICO who have roles touching on Adult Social Care (given the unique delivery arrangements in Torbay) to answer the "so what?" question, will support any future assessment team in hearing about positive outcomes, and the reason for, and impact of any changes or improvements that are happening.

78. Ongoing consideration could be given how to involve people with lived experience in the preparation for and delivery of future assessment. This is work in progress for all Councils at the

present time, but early consideration of how to routinely engage a strong (and hopefully positive) lived experience voice as part of ongoing work will support not only the developing approach to coproduction, but also provide good evidence of this in CQC assessment.

79. The team were made to feel welcome, and many small details were planned for and delivered: staff were available to support access to the council offices (and IT / care management system for the case file audit); car parking access was made available; access needs were appropriately addressed and supported; refreshments and lunch were made available each day; and IT resources and wi-fi were made available whilst the team were on-site.

80. The area of the council offices where the team were situated was arranged specifically to accommodate the team (and is not routinely used by Adult Social Care). This offered some positive aspects such as good accessibility, co-located meetings rooms, and waiting space for interview participants. However, it did mean that the team (and those supporting the team) were at a distance from the Adult Social Care offices, with some logistical challenges for local staff associated with this.

81. The Challenge Team was aware that written briefings for staff and partners supported engagement with the Challenge, and this was to large extent successful: most of those invited to attend interviews or focus groups did so, and participants showed good engagement with and understanding of the interview and focus group process, as well as of the wider Challenge, its process, and purpose. Staff received debriefing sessions with the Deputy Director of Adult Social Care following meetings, something which is sometimes included as part of a feedback loop in e.g. OFSTED Inspection, and which can help the Council to respond to issues as they arise during the on-site phase of an assessment. During the Challenge managers were present in most meetings, but this does not appear to be the case in recent CQC on-site assessments; so this may be something to consider in advance of a future CQC assessment visit.

82. There was generally positive feedback about the process and the on-site team, and the positivity and engagement with which the Challenge was received was evidence of the positive attitudes and openness of staff towards the process, and indeed more generally within and around the Council.

83. Whilst the initial presentation from the Council was kept "in house", the final presentation from the Peer Challenge Team was open to wider invitees who had been involved in the Challenge, including partners and staff. This showed an openness and transparency in the process, and a desire to engage with stakeholders around assurance and improvement. It is understood that plans are in place to further disseminate the findings, and the resulting action plan.

84. The Council would benefit from quantifying the resources deployed in terms of staff time, and at all levels, both in preparation for the Challenge (e.g. in preparing the Self-Assessment and supporting evidence, development of timetable and diary management for invitations, etc), and whilst the team were on-site. Whether this may need to be built into CQC preparation either as a standing resource, or some kind of "on call" team with responsibility, experience, training, and allocated time as and when called on, could be something for future budgetary and role considerations. Those who were involved in preparing for and supporting the Challenge have developed good knowledge both of the process, and of resources in the Council which are required to prepare for and support it, and consideration might be given as to how to protect, harvest and grow this knowledge in advance of any future assessment process.

Recommendations for next steps

The Peer Team appreciate that senior political and managerial leadership will want to reflect on these findings and suggestions in order to determine how the Council wishes to take them forward. In due course the LGA will be pleased to work with the Council to consider progress in line with wider Sector Led Improvement work, and there is an offer of further activity to support this, including through ongoing engagement with Steve Peddie, the South West Region Care and Health Improvement Advisor (CHIA), and Paul Clarke, the LGA Principal Advisor.

Specific recommendations are included in the detailed report above, but the summary below outlines those areas where the Peer Team believe effort could best be concentrated in order to address the issues that they have seen during their visit:

85. Alongside the role of the new S75 Joint Executive Group, senior Adult Social Care representation (most probably by the DASS) should be considered on the Integrated Care Organisation (ICO) Executive. This can support greater visibility for Adult Social Care Leadership (including line of sight for DASS statutory duties, performance, and delivery of the Adult Social Care Transformation Plan, and associated financial savings).

86. Urgent consideration should be given to capacity to support and deliver the Transformation Programme following the end of the present contract with the delivery partner, and the standing down of the local transformation team in March 25.

87. In the meantime, a piece of work should be undertaken to prioritise and communicate widely (to staff, managers, and partners) the deliverables and rationale of key parts of the Transformation Programme, and the risks of non-delivery. As part of this work, it might help to identify and prioritise some "quick wins" to build momentum and prove the benefits of the work in the shorter term.

88. To undertake a piece of data-led analysis of Discharge Pathways 0-3 for the local system, including modelling (against best practice), and shadow costings associated with the present outcomes for local people, and how these might contrast with best practice elsewhere.

89. To replicate work undertaken on the Big Plan for other client groups across the authority, and to use this as a means to develop good practice and improved culture around coproduction, including in the ICO partnership teams.

90. Work with frontline staff and partners to better communicate key aspects of adult social care transformation, and improvement priorities and plans, would support greater ownership of their role within these, and to be more confident in describing these in future CQC assessment. This should include the Self-Assessment, with focus on strengths and areas of improvement and the direction of travel for their own teams and services.

91. The Peer Challenge did not reflect back any areas of immediate operational concern, but this is always a limited process, and the Council will continue to benefit from ongoing quality and practice assurance work. This can help to further assure and mitigate risks associated with waiting lists, to improve consistency in practice, and to bring learning from areas of strength (in delivery or leadership, and locally or elsewhere) to support improvement in those areas of performance that may be less strong.

Contact details

For more information about this Adult Social Care Preparation for Assurance Peer Challenge in Torbay, or more widely about the programme of Adult Social Care Preparation for Assurance Peer Challenge, please contact:

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For more information on LGA Adult Social Care Preparation for Assurance Peer Challenges please see our website: Adult social care peer challenges | Local Government Association