City of London Adult Social Care Self-Assessment
February 2024

Overall Summary and Assessment

The City of London and its governing body, the City of London Corporation are unique. There are 8,600 residents who live in the Square Mile, 14% of whom are aged 65 or over. There is high life expectancy in the City of London and this, coupled with the high number of rough sleepers in the City of London, create the key drivers of demand for health and social care support in the City of London.

Our vision is for residents to get the right information, advice, support and care to live their best lives, maintain their health and wellbeing, and live safely in the place of their choice.

There is one commissioned homecare provider and a high rate of people who have a direct payment to purchase their own provision. There are no accommodation-based support options within our boundaries and placements are therefore spot purchased. A project is underway to make this process more efficient, to strengthen quality assurance and to triangulate this with our practice and systems.

The City of London Adult Social Care workforce is stable, experienced and generic, creating a flexible and agile response to need. A strengths-based approach practice model and manageable workloads allow staff the time to build relationships and trust with people to identify and meet their outcomes. Strong partnership working across the system supports this approach.

Our service is innovative and impactful, operating in a complex, high risk and financially challenging environment. Complex hospital discharge and rough sleeper cases present specific challenges for us but a new hospital discharge model and innovative rough sleeper social worker post within homelessness have helped reduce some risk. These areas remain specific challenges for us, however. Census data shows there are nearly 500 unpaid carers in the City of London. Recently, specific support to unpaid carers has been strengthened and more unpaid carers have been identified. A new Carers Strategy will continue to focus on this.

Innovative approaches to care and support planning in partnership with the individual are put in place and people are supported with direct payments where desired and appropriate. Our aim is to co-produce the ASC services that are needed. Going forward our feedback and engagement with service users will be strengthened to have richer data on how outcomes are achieved and the impact this has. The information provided to services users and how is currently being reviewed.

Safeguarding Practice in the City of London is robust, and the promotion of safety and reduction of risk is built into both our internal and external systems. Our Safeguarding Adults Board function is delivered jointly with the London Borough of Hackney but with an additional sub-group for the City of London to ensure a specific focus.

The City of London Corporation is governed by a committee system and the Adult Social Care Service and budget is governed by the Community and Children's Services Committee. There are also strong links to the Health and Wellbeing Board and services are also scrutinised by the Health and Social Care Scrutiny Committee. There is strong political support for Adult Social Care.

In response to new legislative requirements and knowing our areas for development, an Adult Social Care Transformation Programme is currently being delivered.

Our overall assessment is that our practice and service to residents is good quality but that there are areas of development around systems and processes. One of our key strengths is our personalised and

strengths-based approach to identify and deliver individual outcomes and there is strong partnership working to deliver this. Though there are specific challenges around complex needs, there has been a proactive and innovative response which has reduced risk in this area. Some of our key areas of work include strengthening triangulation around commissioned placements, developing a stronger performance culture within the service, strengthening quality assurance and improving on some specific processes such as timeliness of reviews.

Overview

The City of London

The City of London, also known as the Square Mile, is the financial centre of the UK. It has 8,600 residents, half a million daily commuters and 10mn visitors a year. It sits at the heart of London and is surrounded by 7 local authorities.

The number of residents in the City of London has increased by 16% since 2011. The majority are working age but there are 1200 people - 14% - who are aged 65 and over. Although the percentage of population aged over 65 has stayed the same between the censuses, the actual number of people has increased. There is high life expectancy in the City of London with females having a life expectancy at birth of 90.7 years and males 88.8 years.

Compared with the England average, overall, the City of London has significantly lower levels of income deprivation, child poverty and older people in deprivation. However, according to the Indices of Multiple Deprivation 2019, the City of London's most deprived ward, Portsoken, on the east side of the City of London, was among the top 20% in the country for levels of income deprivation, including income deprivation affecting older people. The Mansell Street & Petticoat Lane area is the most deprived in the City of London falling into the 40% most deprived in England.

Asian people are the largest global majority group in the City of London accounting for 16.8% of the population; and 3% of the City of London population are Black according to the 2021 census. Portsoken, in the east of the City of London is the most ethnically diverse ward.

Census data shows that the City of London has 496 self-identified unpaid carers. The majority provide 19 hours or less of unpaid care per week. However, there are a small percentage who provide upwards of 20 hours per week.

There are a significant number of people sleeping rough in the City of London. In 2022 (the most recent full year data) 372 people were rough sleeping within the boundaries of the City of London which is the 7th highest level amongst London's local authorities. Many of these rough sleepers have significant mental health or substance misuse issues.

There is one GP Practice in the City of London which has around 75% of City of London residents registered while around 16% of residents (on the east side of the City of London) are registered with Tower Hamlets GPs. All these practices now sit within the North East London Integrated Care System. In terms of acute hospitals, City of London residents generally go to the Royal London Hospital in Tower Hamlets or University College Hospital London in Camden (which is in the North Central London Integrated Care System). Community Services for City of London residents are provided by Homerton Hospital. This creates a complex pattern of service delivery for City of London residents.

The City of London Corporation

The City of London Corporation (the City Corporation) is the governing body of the Square Mile and provides local authority services to its residents. The City Corporation has 125 Members operating on a committee system and has its own Lord Mayor and independent police force.

The Department of Community and Children's Services delivers local authority services including social care, homelessness and rough sleeping, public health, education and SEND, housing and libraries.

The Corporate Plan is being relaunched in 2024 and the Community and Children's Services Business Plan will support the outcomes in the Plan. The Departmental Business Plan focuses on safety, independence and choice, potential, health and wellbeing and community.

The Department also delivers several strategies including Homelessness and Rough Sleeping, Carers, and Joint Health and Wellbeing.

Adult Social Care

Key Statistics

181 Residents requesting support from ASC services (2022/23) **94** April – December 2023	**102** Discharges from hospital supported (2022/23) **86** April – December 2023	**96** Adults receiving a Long – Term Service on 31 December 2023	**34** Carers Supported on 31 March 2023 **33** 31 December 2023
24 Safeguarding Enquiries (2022/23) **16** April – December 2023	**50%** Percentage of all working age clients receiving care and support related to Mental Health on 31 December 2023	**42%** Percentage of all clients aged 65+ receiving Personal Care and Support on 31 December 2023	**£6.3mn** Adult Social Care Gross Budget 2023/24

Our vision is for residents to get the right information, advice, support and care to live their best lives, maintain their health and wellbeing, and live safely in the place of their choice.

Our skilled workforce will work with people through the options, and actively champion equality, diversity and inclusion so all people can get the support they need, when they need it.

This underpins all our work and our practice model. The table below sets out some of the key principles of the Care Act 2014 and ASC good practice and how the City Corporation approaches this.

Principle	City of London Corporation Approach
Empowerment, engagement and co-production	A Strengths Based Approach practice model is used in the Service which places the individual at the centre, working with individuals to identify their outcomes and using these to underpin all the actions taken together from there. Individuals or their advocates are involved in care planning and review processes. Innovative approaches to care and support planning in partnership with the individual are put in place and people are supported with direct payments where desired and appropriate (see theme 2). In 2021, the homecare service was recommissioned, and this was a co-produced approach (see theme 2). There is a recognition that we need to strengthen our approach to co-production with service users and we are currently developing this approach. Going forward our feedback and engagement with service users will be strengthened to have richer data on how outcomes are achieved and the impact this has. The information provided to services users and how is currently being reviewed. An Anti-Racist Practice Framework has recently been adopted across Adult Social Care which is being embedded into the service with staff. There is also a range of other initiatives to strengthen our approach to equality and inclusion (see theme 4) and a key area of work for us is to strengthen the collation and recording of equalities data and use this to inform and shape service delivery.
Safety, protection and risk management	Safety, protection and positive risk management are all embedded into our system work (see theme 3). This is in place right from the start, in our preventative work, with our commissioned providers and with our colleagues at the City Corporation. In meeting our statutory requirements around safeguarding, a timely, proportionate and person-centred approach to managing risk is used. There is good feedback from Making Safeguarding Personal in terms of meeting people's outcomes and reducing or removing risk (see Theme 3) ASC are active partners in the local Safeguarding Adults Board (City and Hackney Safeguarding Adults Board) but also have a specific City of London focus through a designated sub-group which is chaired by the Chair of the Safeguarding Adults Board.
Prevention and delay of needs	Prevention is a key tenet of all our work in ASC and is delivered in a wide range of ways including an innovative Early Intervention Project, a commissioned Early Intervention and Prevention Service and through a range of information and advice (see theme 2). There has been significant investment in prevention through our new Target Operating Model which at a time of financial constraints, prioritised ASC and

	prevention and saw the establishment of Strengths Based Practitioners in the service.
Working in Partnership	Partnership working is a key principle of our Strengths Based Approach (see theme 2). There is good partnership working with local health partners, commissioned providers and other stakeholders. Despite its size, the ASC team has to build relationships and partnerships across a wide breadth of partners. Innovative responses such as the Care Navigator post which provides links between several acute hospitals, GPs and social care helps facilitate some of this partnership working.

Workforce

Our ASC Team is a generic team of experienced practitioners with good rates of retention. The Team includes Social Workers, Occupational Therapists and Strengths Based Practitioners. The Strengths Based Practitioner roles were introduced as part of a new Target Operating Model and reflected the organisation's commitment to Adult Social Care and prevention in a context of financial constraints. These innovative roles are designed to support people at the edge of care with short term interventions to improve wellbeing and delay the need for care.

Caseloads in the team are manageable and are managed dynamically, taking into account complexity and aiming for under 20 cases per social worker (this can include assessments, support planning and reviews). This gives staff the time to develop positive relationships with residents to enable effective and ongoing assessment of need and subsequent care and support planning.

Within the team, there are designated champions who act as expert leads in certain areas such as carers, dementia or transitions. These champions keep up to date with current good practice and engage in local and national partnerships and support peers to develop in these specific areas. This is also designed to help support development of leadership skills.

An ASC workforce development plan for ASC has recently been updated to ensure it is fit for purpose and meets needs. Social Workers have access to a wide range of training, both internal and external and over the past year have attended training on applying the legal framework of the Mental Capacity Act and the need for speed to discharge people safely, Safeguarding Adults Level 3, Motivational Interviewing and Making Every Contact Count. Recent team wide training has focused on development of the Strengths Based Approach and the specific skills required for this.

ASC has recently appointed a dedicated Principal Social Worker (PSW) as a standalone role, rather than it being embedded into the Head of Service role, to strengthen practice governance and staff development amongst other things. The Principal Social Worker is consolidating some of this skills-based training noted above.

A survey of the children's and adult social care teams was undertaken in September 2022, based on the Employers Standards. Though feedback was generally positive, an action plan has been developed (across both services) to consolidate reflective practice, career development and improved induction for new staff (this is also reflected in a wider corporate commitment as part of the People Strategy).

Case Study – Feedback from Staff Survey (Survey, September 2022 and Suggestions Box, January 2024)

How do we respond to staff concerns and suggestions?

Staff feedback: *"Being part of such a small stable team, has lots of positives but also challenges. New **ideas**, ways of working, wider conversations are less likely to happen. It's important to keep practice current and alive rather than falling back on our 'uniqueness' which can sometimes stop changes in our practice to align ourselves with the London LA's."*

We listened:
We now have full-time stand-alone post of Principal Social Worker, and our Senior Occupational Therapist is a member of Principal Occupational Therapists Network. These practitioners enable local and national networking, share policies and guidance, and make improvements to our processes and practice.

We also have a "Staff Suggestions digital box" system, where our staff can make positive suggestions and share their views, and we learn from our Exit Interviews, which are reviewed by the Principal Social Worker.

We invite external guests and speakers to our events, to boost our engagement in ASC national and local agenda, such as at World Social Work Day or visit by Chief Social Worker, Lyn Romeo.

Staff feedback: *"I think there is a well-balanced understanding of case workload and stress. I feel listened to and understood, for example if I ask for a little space/time to finish off work before new cases are allocated."*

We listened:
We also review themes shared as positive feedback to ensure we maintain good mental health of our practitioners.

An anonymous staff comment through our Suggestions Box: Response to question what we can do to improve our work: *"A total review of ASC proportionality of roles and how work is distributed."*

We listened:
Principal Social Worker (PSW) addressed the issue of allocations and how work is distributed with the Head of Service (HoS). Agreed and shared with the team an action for PSW and HoS to review the allocation and distribution of long-term and short-term cases, safeguarding work and other tasks. At the same time managers updated case allocation Case Note template on Mosaic to include specific information about the case, its complexity, timeframes, and expected tasks, which can help practitioners to manage caseloads better.

Supervision plays an important part in supporting and developing our workforce and our commitment to this is demonstrated by:

- The development of a new supervision protocol and new supervision forms that include a reflective approach
- Auditing supervision as part of the annual audit schedule and annual staff survey
- Establishment of new peer group reflective supervisions, held once a month on complex case studies using a reflective model

Other support is provided to social workers around wellbeing including an Employee Health and Wellbeing Hub and various team wellbeing tools. There is also guidance for Managers in the Team about how to support wellbeing. Social Workers also have access to the PSW for individual practice improvement sessions or wellbeing support.

The City Corporation has joined the South East London Teaching Partnership (SELTP) which brings together Goldsmith and South Bank Universities, Royal Borough of Greenwich, London Borough of Lewisham, London Borough of Southwark and now the City Corporation. The SELTP's ambitions align with the Department for Education's vision for teaching partnerships and aim to raise standards in children and adults' social work by supporting high-quality training for social work students and qualified practitioners.

ASC supports students on regular basis, which enriches practice with their academic research, social work models and theory. Having a social work student in the team has a positive impact on the workforce, enhancing motivation and enthusiasm levels. At the same time we embrace our partnership with academia and contribute to developing the social work profession.

Working in Partnership

Working in partnership has been a key approach in our work over recent years but is specifically strengthened in the Strengths Based Approach practice model.

There are good working relationships with the one NHS GP practice in the City of London and the relevant GP practices in Tower Hamlets. A social worker or the Care Navigator attend the Multi-Disciplinary Team meetings at these practices.

The City Corporation is part of the North East London Integrated Care System which provides some benefits as it includes Tower Hamlets where 16% of our residents are registered with a GP and access health services. As noted above, the pathways for delivery of health services and therefore integration are complex for the City of London.

More locally, the City Corporation is part of the City and Hackney placed based partnership, reflecting our previous partnership with City and Hackney CCG. This local partnership is well developed in terms of integration and has a neighbourhood model for care closer to home and out of hospital services. It is underpinned by a principle of tackling health inequalities. Primary Care Networks across City and Hackney mirror the eight neighbourhoods across City and Hackney. Our unique situation and different infrastructure means that often bespoke models for integration have to be developed for us, for example in the neighbourhood.

At the neighbourhood level, social workers are active members of the Multi-Disciplinary Meetings which are designed as a space for complex cases to be considered, owned as a group and lead organisation agreed. A number of City of London cases have been taken here and this has been beneficial in terms of partners being accountable and taking responsibility for certain areas of work.

There are a number of new roles emerging within the neighbourhood structure such as care co-ordinators, health and wellbeing coaches and Care Co-ordinators for proactive care. Community

Mental Health Services have also been re modelled on to neighbourhood footprints with Community Connectors. The Service is proactive in making connections with all these roles to ensure that City of London needs are recognised and responded to and that services work for us.

The voluntary and community sector in the City of London is small but vitally important for our residents and our practice model. There are two key voluntary sector providers of large contracts – a City Advice Service provided by Toynbee Hall and an Early Intervention and Prevention Service (known as City Connections, provided by Age UK). It is recognised that there are other smaller VCS groups providing support within the community and there is work currently underway looking to build the capacity and scope of the VCS in the City of London to play an ongoing role as key partners. There is also a strong Healthwatch organisation within the City of London.

Our Care Navigator, who is part of our Early Intervention and Prevention Service, plays a key role in building partnerships between acute hospitals, GPs and ASC to facilitate safe hospital discharge from a number of hospitals that City of London residents attend.

There are strong relationships with our other commissioned providers such as the London Borough of Hackney who provide our out of hours service, the East London Foundation Trust who provide our Approved Mental Health Practitioner (AMHP) Function and the providers of our reablement and rapid response service.

Having external providers for these services ensures capacity and continuity of service and in the case of the AMHP, ensure there is appropriate clinical supervision and embedding within a relevant discipline.

CQC Theme 1: Working with People

Our Strengths

- Experienced and knowledgeable workforce (managers and staff with good rates of staff retention) and a workforce who know our residents well and develop positive relationships
- Strengths Based Approach Practice Model
- A co-ordinated, multi-agency approach to the assessment and support of our residents

Areas for Improvement and Direction of Travel

- Continuing to strengthen our Strengths Based Approach practice model
- Exploring timeliness and impact of assessments and reviews
- Capturing and recording equalities data more effectively and using this to shape services
- Improving the quality and accessibility of our information offer for residents

Key statistics

181 Residents requesting support from ASC services (2022/23) **94** April – December 2023	**49** Supported Self-Assessments (2022/23) **33** April – December 2023	**31** Occupational Therapist assessments (2022/23) **38** April – December 2023
8 New Carers Assessments completed (2022/23) **10** April – December 2023	**0** % waiting more than 6 months for an assessment (any assessment) (April – December 2023)	**64%** **(37 cases)** % ongoing reviews completed within 12 months of previous review (April – December 2023)
	26 Receiving a Direct Payment 31 December 2023	

ASC operates within the People's Directorate which includes Children's Social Care and rough sleeping. It also works closely with the Education and Early Years Team who sit within the Education Unit. This enables cross-cutting work across, for example, transitions or homelessness. There are monthly People's Senior Management Team meetings (which also includes Education and

Early Years) where various policies and initiatives are discussed, and cross-cutting work is identified or reported back on. There is also a complex cases meeting where teams from across the Peoples Directorate bring their most complex cases and teams work together to share ideas and good practice and identify if / where they may need to be involved.

A Strengths Based Approach Practice Model

The ASC Team use a Strengths Based Approach Practice Model which was implemented in 2022 and is designed to support people to maintain their independence and meet their outcomes and aspirations. The model is built on:

- Working in collaborative ways on mutually agreed goals
- Using the community as a resource
- Having trusted and workable relationships

Empowering residents through preventative measures and clients through our assessments, service planning and delivery is a key tenet of our approach. This includes:

- Working together on assessments to ensure that the individual is able to identify and express their outcomes
- High rates of Direct Payments. In 2021/22 placed 28th out of 151 Local Authorities for direct payments)
- Service users are part of various commissioning cycles for example for the Homecare Service which was recommissioned throughout 2021. This was co-designed with service users, carers, Healthwatch and City Connections. Stakeholder feedback was used to understand service priorities and needs, which shaped the service model and specification, the procurement approach, and the design and scoring within the tender.

The ASC service meets the Care Act duty to prevent, delay or reduce needs wherever possible in a variety of ways including Occupational Therapy, Reablement, Commissioning and Social Work Practice, all set within the wider context of a strengths-based approach across the service.

ASC developed an innovative Early Intervention Service which is a pot of funding that empowers ASC practitioners, together with a resident, to identify and implement low-cost one-off interventions which help improve wellbeing and in turn prevent, reduce or delay needs. This has included things like a microwave so that someone was able to have hot food to eat, a zoom licence to reduce social isolation amongst unpaid carers and fishing equipment to help improve mental health. During an 8-month pilot period in 2022, 26 individuals were supported, and 46 purchases were made costing a total of £5,288. All the people supported in the pilot had identified social care needs but were considered to be 'at the edge of care' in relation to the meaning of the Care Act. Of the 26 people supported, none were receiving costed social care support and in all cases no care needs increased.

The pilot has now been made a permanent service. Work has now been undertaken within our system to report more systematically on the impact of the intervention and evidence is now showing that there is greater take up and confidence in the use of the fund by social care practitioners. One practitioner noted:

'*Having the support from management to use my initiative and listened to what would actually be helpful to the service user, led to improved outcomes for clients and improved relationships. I could show to clients that we actually do want to help in a person-centred way and prioritise what they need to make meaningful change'.*

The City Corporation also commissions an Early Intervention and Prevention Service called City Connections. This is provided by Age UK and includes a signposting service, a general wellbeing support service and a specific memory café for people with memory issues and their carers. Recently, a specific carers support service has also been provided through a sub-contract (see Theme 2).

Case Study – working in partnership with the voluntary sector.

The Carer is 40 years old, caring for a parent-in-law and lives in a small household with 4 other family members. They are linked in with the City Connections service commissioned from Age-UK by City of London. The Carer reports that the caring role can sometimes be frustrating, and they feel they do not have time for themselves. In addition, the Carer does not use English as their first language and can sometimes find it difficult to access services.

As a result of living in a small space, it was important that the Carer was provided with opportunities to have break from their living situation by encouraging them to join as many community activities and trips as possible with one of our community groups. City connections took into account the Carer's religion and culture when planning these with them.

The Carer took part in many of the organised trips, such as Hampton Court, Kensington Palace, Sky Garden, and Buckingham Palace. They said that they enjoyed the outings very much as it enabled them to see places in the city. The carer was able to go out with people from the same estate and it helped them make new friends.

The Carer also accessed the exercise classes and commented, **"The exercise we do is hard, but when I go home, I feel good. I like that the classes are every week, whereas before when it was only two times a month."**

City Connections linked in with another City of London commissioned service, City Advice, to provide an information session. The whole group were actively engaged in the topics being discussed. This particular Carer engaged with City Advice advocate coordinator, who speaks the same language, and they talk about issues with housing and the support they would like to receive.

This was a good example of voluntary services working together, City Connections providing the space and audience for City Advice to do their work and it has shown how important multi-agency can be for residents in the City of London.

The ASC service has also developed innovative winter warmth packs and summer cooling packs to respond to cost-of-living pressures and extreme weather. These are given out by the Strengths Based Practitioners and include things like fleeces, cuppa soups, a small fan and jelly drops which help with hydration.

Case Study – Strengths Based Practitioner Support

A resident described our Strength Based Practitioner as outstanding saying: **"she has an outstanding gentle, step by step approach to making progress in a friendly way".**

The Adult is a 74-year-old and had a number of medical conditions including persistent pain, weight loss and a skin condition. There was a general lack of strength to cook and care for themselves and concerns over possible self-neglect.

The Strengths Based Practitioner's intervention was planned with the intention of re-establishing a personal care routine, support with setting up a self-funded package of care with a previous provider. The practitioner enabled the Adult to build back their personal care routine and improve skin condition. This was achieved through going through the skin care procedure together, setting up a system of text prompts to remind the Adult to carry out the skin care routine regularly and then visiting again to check in.

This resulted in improving their general wellbeing and self-confidence. The adult reported in their feedback that they had benefitted from the intervention and that they felt more independent because of it.

Following the intervention and final visit, the Strengths-based practitioner arranged for a social worker to visit as the adult wanted to discuss future options around potential private residential care.

Case Study – Strengths Based Practitioner Support

The Adult had been married for over 50 years until their partner passed away 2 years ago. They had kept themselves to themselves, not been known to local services and were not registered with a GP. The property was very cluttered and the adult, who is in their 90s was very reluctant to engage with Adult Social Care.

The Strength Based Practitioner engaged with them on weekly basis via telephone and in person building a relationship learning about their history, estranged family and love of Jazz. SBP persevered over an extensive period of time and despite initial reluctance the adult began to discuss the risks in the home with the SBP and agreed to suggestions on how to mitigate these with equipment and support at a level acceptable to them.

The SBP also supported him to access a GP and navigate the phone call system.
The Adult is now more excepting of care and support and engages with ASC, equipment and telecare have been installed, and domestic home care support is in place, which keeps him safe, independent, and living at home. They are now registered with a local GP and engages with the surgery, is more confident and has made contacts & friendships within the local community.

The SBP used the Eary Intervention pathway to provide a fan during the heatwave and a fire safe heater for the cold weather.

The Adult said that the SBP had been wonderful & they didn't know what they would have done without her. They reported that he has regained confidence due to the SBP encouragement, reassurance, and support.

Case Study – Social Worker support

The Adult came to the UK in 2022 as a sponsored refugee from Ukraine and presented to the City Corporation as homeless, unable to speak English and with possible care and support needs. At that time, they were supported by a daughter who was caring for them.

Our work focused on needs and risks, for both Adult and Carer, while enhancing their independence and resilience. The social worker completed a Care Act Assessment, assisted with applying for sheltered accommodation and helped to access a range of different grants (for clothing, furniture, bedding, and kitchen items). Reablement support was provided followed by a longer-term package of care. The Adult and their Carer were both referred to City Advice, for assistance with a benefits review. A Carers Assessment was offered several times. Social Worker guided both through our processes and understanding of relevant legislation, offered advocacy when needed, and emotional support, time, and empathy.

Information was given to the daughter about Ukrainian groups, befrienders, churches, and church groups.

The adult's anxiety and depression began to improve, and the number of panic attacks reduced. Her needs stabilised and they are now independently accessing their local community, supermarket, and shops.

They moved into sheltered accommodation in another local authority, and while it took time for the adult and their daughter to access the appropriate benefits the accommodation is now stable. They have a lot of phone contact with their extended family, and they occasionally go and stay with a sister, who lives outside of London.

<u>Feedback from the daughter of Adult with care and support needs (10.05.2023):</u>

"I just want to express my heartfelt appreciation for all the support and assistance you provided to me and my … (parent) during one of the most difficult times in my life. Your unwavering dedication and commitment to helping my … (parent) and me through our struggles were truly invaluable. I will always be grateful for your guidance in funding resources and solutions that were tailored to my …(parent's) unique situation! Your expertise in navigating the complex web of services available to my ...(parent) was a true blessing, and I am confident that I would not have been able to find my way without your help! I want to commend you for your professionalism, kindness, and dedication to helping those in need. Your passion for helping others truly shines through in everything you do, and I feel incredibly lucky to have had you as my …(parent's) social worker! Thank you! You have made a lasting impact on my ...(parent's) life, and we both will be always grateful for your support."

Within our practice model, the Strengths Based Approach is operational from first contact. Rather than 'screening out' at the front door, practitioners are expected to be 'helping out' with information, advice and signposting. ASC are the main referrer to the City Connections service which supports people to access some of the services signposted to.

A commissioned information and advice service (City Advice), covers a range of issues and provides advice to residents and workers in the City of London along with our tenants in housing in various London boroughs. Part of the specification for the service includes some of the basic information and advice about accessing social care services. During 2022/23, there were 27 requests for this information. Our carers webpages were recently reviewed with carers and updated to make them useful and user friendly. Other ASC service pages are currently being reviewed to ensure that information is most relevant and user friendly.

Our mechanisms for feedback and how people's outcomes from the service are measured are currently being strengthened (see theme 2).

Assessments

The service uses a supported self-assessment model for assessments and there is an expectation that timeframes are responsive to the needs of and risk to the individual and their family. They can also be impacted by other factors such as the need to discharge someone from hospital. There is an expectation in our practice standards that assessments will be completed within 30 days, while our current reporting uses an indicator of 28 days. We will review and align these targets. Where assessments are more involved, discussion around this would take place within supervision.

Summary

- Our ASC workforce is experienced with good rates of retention and with manageable workloads allowing presence and time for strong relationship building as a core of our Strengths Based Approach
- The generic nature of the team allows for a flexible and agile approach and a more holistic view of the person
- A new Target Operating Model for the City Corporation recognised the importance of Adult Social Care and of prevention and as a result a new innovative role – Strengths Based Practitioner was developed
- A new standalone Principal Social Worker Post is in place which will allow for the strengthening of practice assurance and personal development
- Working in partnership is well established but is strengthened within our Strengths Based Approach
- There is active engagement with our place-based partnership and within this, the neighbourhood model
- Relationships with the voluntary sector are strong but the voluntary and community sector in the City of London is small. This is an area for development
- Strong relationships with health providers provides a base for working in a co-ordinated and multi-agency approach to assess and support residents (see also theme 2)
- Our approach to service delivery is person centred and empowering, but it is recognised that feedback mechanisms and measurement of outcomes from our work need to be strengthened

CQC Theme 2: Providing Support

Our Strengths

- A strong hospital discharge model
- Agile and flexible approach with the ability to spot purchase to meet needs
- Well established integrated care models locally and established relationships with health and Voluntary and Community Sector organisations

Areas for Improvement and Direction of Travel

- Improving the timeliness of reviews
- Improving triangulation of quality assurance of services
- Strengthening collection of feedback and measures of outcomes from service users

Key Statistics

21 Receiving domiciliary care directly on 31 December 2023	**26** Receiving a direct payment on 31 December 2023	**23** Living in supported housing on 31 December 2023
1 Using Day Care on 31 December 2023	**18** Living in residential care on 31 December 2023	**7** Living in nursing care on 31 December 2023
	14 Received a Reablement Service April – December 2023 **92%** those over 65 who required less support following a period of reablement April – December 2023	

Agile and flexible approach to meeting needs

Our approach to commissioning services is set out in our Market Sustainability Plan, and our Market Position Statement is emerging. Our strategic commitment is to support people to remain at home, which shapes demand for homecare, also informs a more complex need, and costly delivery when a placement is required.

The City of London has no accommodation-based support within its boundaries other than a sheltered accommodation unit which is provided by a housing association.

There has been a consistent level of demand for residential and / or nursing home care over the past 5 years. It is expected that at any one time there would be 20 – 25 placements in place, with an annual placement rate of around six to eight. The growth and ageing of the resident population have not led to a corresponding increase in demand for residential care provision.

As part of the ASC Transformation Programme, a project around brokerage is currently underway. This is designed to make our processes around commissioning residential, nursing and supported living placements more robust, to increase the strength of quality assurance and to ensure that all information on placements is triangulated through our social care system, Mosaic.

There is one commissioned homecare provider and a number of people who have a direct payment to purchase their own provision – some people chose a direct payment when the homecare provider changed, and they wished to remain with the previous provider.

Rough Sleepers

There has been an innovative approach to supporting rough sleepers with a permanent social worker post within the homelessness service but with professional supervision from the Head of ASC. This brings knowledge and expertise to working with a cohort who experience some of the highest health inequalities and poorest outcomes. Our work with rough sleepers involves strong engagement with outreach and mental health services to support and inform effective assessments.

As part of our approach to meeting the needs of rough sleepers, a complex needs hostel for City of London rough sleepers was established in partnership with a homelessness charity and a neighbouring local authority. This year, a specific rough sleepers assessment centre to bring together all our assessment services into one physical place will be opened. The Rough Sleeping Social Worker will have strong links into this assessment centre.

Case Study – Rough Sleeping Social Worker

An adult was rough sleeping in and around the City of London for 15 years prior to the pandemic. They made a claim for asylum, but this was declined.

The Adult was experiencing a mixture of mental and physical health problems and was assessed as having care and support needs under the Care Act (2014) and that the local authority had a responsibility to offer support under the Human Rights Act (1998). Following an Occupational Therapy assessment, temporary accommodation was organised.

The adult had a care package of support, which over time was reduced and later discontinued, as they readapted to living independently and their mental and physical health improved.
Our Strengths Based Practitioners supported the adult over time, building their confidence and relationship within the local community and with services.

The strengths-based practitioner helped him look into aspirational training courses which he had identified, such as security and forklift driver, following his lead to help him work out what he can and can't do rather than shutting doors. They also supported him to attend the local library to use their computers, so that he can do his own research.

The adult appealed the previous asylum decision, and in summer 2023 was granted asylum status in the UK. Now with our support they are building a new life. The adult is being supported to present as homeless and it is hoped that they will soon have an option to move into a property provided via the statutory homelessness pathway.

Adult's views/ comments:

The adult says that their community – the GIANTS group with Praxis, the British Red Cross group, and the African Rainbow Family – have all given them "a sense of motivation and encouragement even when times have been hard". They say that it is something they really value and enjoy. The adult has recently been in the GIANTS group's published cookbook talking about food they enjoy. GIANTS group with Praxis is a peer group for men applying for asylum, the British red cross is a similar resource, and African rainbow family is for people originally from Africa who identify as LGBTQI+. These groups have given the adult a sense of community and belonging, and motivation when times have been hard.

The adult also reported that Homelessness and ASC staff working with have been like 'therapists' and added: "I am not good in a crisis" and "a problem shared is a problem solved", as an appreciation of being supported by us.

Carers

The ASC Team were supporting 33 carers at the end of December 2023. All carers' assessments are carried out by social workers ensuring that carers assessments are carried out with a high degree of expertise and support plans are developed together. Carers receive individual budgets in the form of a direct payment to meet individual need, and these are not means tested.

In October 2022, an internal audit was carried out to assess the quality of carers assessments. Findings were largely positive with carers reporting a good overall experience with some recommendations for improvement. This included developing a toolkit for practitioners to improve consistency in approach to assessments and a guide for carers outlining what to expect before, during and after the assessment to help improve both experience and outcomes. There was also a recommendation for management to strengthen monitoring of carers assessments including monitoring of annual reviews to ensure timeliness and avoid slippage.

Initially, general wellbeing support for carers was provided through a commissioned early intervention and prevention service (City Connections). Following engagement with carers, it became evident that there was a need for a higher level of specific support for carers. This was piloted and will now be continued as a standalone service.

The Carer Connections service has been running since October 2022 with a dedicated Project Manager, through the Tower Hamlets Carers Centre. Initial work reflected the national picture that there are a significant number of hidden unpaid carers in the City of London who may not recognise themselves as a carer, and who are not in contact with a carers support organisation. A creative approach to community outreach identified 45 new carers, 51% who identified as being from a Black and global majority background and 49% who live on the east side of the City of London. This has been a significant area of focus for us.

Feedback from carers who had used the service showed an average score of 6.1 / 10 that they are consulted and co-produce the services delivered for them and an 8.2 /10 that they can stay independent and get help when they needed it.

A new Carers Strategy is now in place and to inform this, an innovative peer researcher approach was used to gather the views of carers which allowed us to reach a wider range of carers than usual.

Hospital Discharge

The number of hospital discharges the service has supported has increased since the pandemic but more significantly, so has the complexity of these cases as people are discharged more quickly. During 2022/23 102 hospital discharges were supported by the service (86 April – December 2023).

There is a strong model of services around hospital discharges including the Care Navigator who supports safe hospital discharge by building bridges between services, a rapid response service who can provide intensive care and support for short periods to facilitate discharge to assess and to prevent hospital admissions in the first place, a commissioned reablement service and an in-house Occupational Therapy team. There is also close working with health services such as therapy services.

The City Corporation discharge model is designed to best meet local need. Since April 2020, weekend discharge activity represented just 0.02% of overall discharges and therefore a fixed 7-day discharge service was not appropriate. The approach is built on the following:

- A full discharge service operates during normal working hours of Monday to Friday 9-5. A clear expectation is set for the service to work flexibly outside these hours, subject to demand and need
- Friday pressure points are expected, which may require ASC cover outside of normal hours; allowing weekend discharge arrangements to be secured
- The City Corporation's Rapid Response Service provider can support pre-arranged weekend discharge
- Bank holidays will not typically be covered, however, cover arrangement requirement will be assessed and responded to, with cover provided based on discharge demand and 'in hospital' figures. The ASC Head of Service provides the final decision on the requirement of responsive weekend cover
- Placing significant emphasis on prevention and early intervention in relation to safeguarding
- Ensuring that appropriate actions are taken where there is reasonable cause to suspect that an adult with care and support needs is at risk of abuse or neglect

Our Better Care Fund Plan is the primary source of funding for most of our hospital discharge work.

Case Study – Hospital Discharge, Care Navigator

The Care Navigator from Age UK worked with an Adult in hospital who had been struggling at home for some time but had been reluctant to ask for help and to share information. However, working with the Care Navigator, the individual wanted to be fully involved in their discharge planning but had a difficulty hearing, so by using email, they were able to provide more information about needs and requirements to help with the discharge home.

The Care Navigator acted as a bridge to adult social care to create positive outcomes for the adult by ensuring equipment such as key safe and pendant alarm were in place to prevent delays and ensure a safe discharge. The hospital did not provide a discharge summary for the Adult, but the Care Navigator ensured relevant details were shared with the GP including the arranged outpatient appointments.

Despite the level of complexity, the work of the care navigator helped facilitate a whole range of organisations working together to support the adult home safely and to meet their needs.

Feedback from the Adult

The Adult said they were proud of their independency and had not had to rely on social services for support before, but, as they said: "things are getting difficult for me now".

The person continued: "I have a hearing problem so using the phone is difficult, but I like using iPad", so they asked the Care Navigator to inform ASC to contact them directly about future discharge to help if access home visit was necessary so "I can point things out things I am concerned about".

The Adult shared that they enjoyed "computers and music in the past, like the trombone and guitar, but these have become more difficult to do now".

During a follow up meeting with the Care Navigator the Adult expressed their anxiety around the home environment being ready for their discharge and their wish to be fully involved in the discharge planning.
The Care Navigator spoke to Adult Social Care Duty on their behalf and a social worker was allocated, instead of managing the discharge through the duty team. The social worker visited the Adult in hospital and completed joint home access visit with an occupational therapist, ensuring the Adult was fully informed and in control of their own discharge.

Learning Disabilities

There are currently 12 adults with Learning Disabilities open to the adult social care team, 1 is aged under the age of 30 and the rest are aged between 30 and 60. 4 live in their own homes in the City of London (2 with family) 1 lives in residential care and 7 live in supported living setting.

There is a joint Learning Disabilities Service in the London Borough of Hackney which brings together the Local Authority and health services for Learning Disabled people together. City of London residents with Learning Disabilities are able to access the health services through this model.

Transitions

The ASC Team are part of a Transitions Group with the Education and Early Years Service and Children's Social Care. A register is kept of children and young people who will need to be reviewed to assess whether they need to transition to ASC services. There is also an ASC social worker who is a champion for transitions cases.

There have been very few transition cases in recent years, but these have been well planned from the age of 14 (through the Transitions Group) and have been a smooth transition.

Summary

- There is an agile and flexible approach to meeting need with spot purchasing, direct payments and innovative approaches
- In responding to the complex needs of rough sleepers we have a homelessness rough sleeper who has had excellent results in providing person centred approaches and linking up with specialist services
- Hospital discharges have become more complex and in response, a new hospital discharge model was developed to meet government requirements. This is supported by our Care Navigator who supports safe hospital discharge and acts as a bridge between partners
- Carers have been a specific area of focus for us over the last couple of years with an audit on carers assessment and associated actions and the development of a specific carers support service

CQC Theme 3: Ensuring Safety Within the System

Our Strengths

- Strong City and Hackney Safeguarding Adults Board with multi-agency support and commitment for safeguarding; but with a distinct focus on City of London through a separate Sub-Group
- Robust and rapid professional response to safeguarding concerns, incidents and provider issues, ensuring safe and personalised responses
- Safety built into all levels of the system

Areas for Improvement and Direction of Travel

- Implementing robust and routine feedback from people who have been safeguarded
- Safety challenges around the Cost-of-Living Crisis and Rough Sleeping
- Responding to the complexity of hospital discharges

Key Statistics

50 Safeguarding concerns inside COL (2022/23) **31** April – December 2023	**24** S42 Enquiries (2022/23) **16** April – December 2023	**29** S42 conclusions (2022/23) **18** April – December 2023
63% Of Safeguarding concerns were related to neglect and acts of omission and self - neglect (2022/23) **63%** April – December 2023	**21** Cases where outcomes were expressed (2022/23) **15** April – December 2023	**86%** Percentage of outcomes that were fully or partially achieved (2022/23) **87%** April – December 2023
24 Number of cases where risk reduced or removed (2022/23) **12** April – December 2023	**5** Number of MCAs which took place (2022/23) **2** April – December 2023	**20** Number of clients with a DOLs in place on 31 March 2023 **25** 31 December 2023

City and Hackney Safeguarding Adults Board

The City and Hackney Safeguarding Adults Board (CHSAB) is a multi-agency partnership including statutory and non-statutory stakeholders. The role of the Board is to assure itself that robust safeguarding procedures are in place across City and Hackney to protect adults with care and support needs who are at risk of abuse and neglect. Where abuse and neglect does occur, the Board and its partners are committed to tackling this and promoting person-centred care for all adults experiencing abuse or neglect.

The CHSAB has been chaired by Dr Adi Cooper, architect of Making Safeguarding Personal, for more than five years which has provided strong and stable leadership around safeguarding locally.

The Assistant Director for People chairs the Safeguarding Adults Review sub-group for the CHSAB and although the City of London has not had any Safeguarding Adults Reviews for a number of years, a discretionary one was carried out in November 2022 in relation to a rough sleeper who died in the City of London. A multi-agency action plan is currently in place via the CHSAB and all actions for the City Corporation Homelessness and ASC teams have been completed. This led to a full review of our participation and engagement work with rough sleepers and the development of an innovative participation project with Groundswell which is now in place.

ASC has been proactive in reviewing any SARs from Hackney and nationally to consider and embed any recommendations where appropriate.

Case Study – Learning from Safeguarding Adult Reviews

Following two Safeguarding Adult Reviews in Hackney, a panel was established to provide a person-centred, timely and effective multi-agency response to situations where the person referred has been assessed as a high level of risk because of complex self-neglect, fire risk or other high-risk issues. The aim of the panel is to ensure that all relevant agencies work together to provide a co-ordinated and accountable response to the person's presenting issues and risks and to focus on the outcomes the person wants to achieve to the greatest extent possible given individual circumstances and risks.
The panel has strong representation from partners and oversees a whole range of interventions form long term therapeutic work with adults with hoarding disorder to short term preventative measures.

For example, in 2022/23 £1,790 was spent on fire prevention equipment for adults in the City of London, this included replacing fan heaters or other high risk portable heating devices with safe electric oil filled radiators, replacement of multiplugs with fused power boards, and provision of fire-retardant bedding.

The Chair of the panel (Head of ASC) also attends the City and Hackney Safeguarding Adults Board SAR group creating strong links between both groups and the ASC service. Following a fire leading to the death of a resident in March 2022 a SAR referral was made. While the referral was not adjudged to meet the SAR criteria, and the Coroner concluding the death to be the result of an accident, it has been agreed with the CHSAB independent chair to hold a discretionary learning review to examine how services across the City of London may be able to learn and improve from this.

In terms of work of the Board, the City of London have been active partners in this work. Historical work has included financial abuse and self-isolation and more recently a focus on the impact of the cost-of-living crisis.

The Board provides training for professionals in 3 key areas:

- Recognised safeguarding training at the required levels
- Specific training commissioned by the SAB relevant to the work it is doing
- SAR learning events

To ensure that there is sufficient focus on the City of London, there is a City of London sub-group of the Board which is again independently chaired by Dr Adi Cooper and includes more local City of London partners and providers. The role of this sub-group is to provide assurance, accountability and the sharing of good practice in relation to the City of London. It considers City of London specific data and priorities in the Board's workplan.

Robust and rapid professional response to safeguarding concerns

The ASC service has a personalised approach at the forefront of its safeguarding work, alongside the assessment and mitigation of risk. These principles are applied equally to the proportionate responses taken to those concerns not meeting S42 enquiry criteria.

As with other London local authorities, the Service applies the London Safeguarding procedures. It is also familiar with Transitional Safeguarding and Joint Working with Children and applies these to support a smooth transition to adulthood.

Within the Team, social workers are qualified to undertake Mental Capacity Assessments and the AMPH, who is provided by the East London Foundation Trust, carries out any Mental Health Act Assessments as necessary. Best Interests Assessments are spot purchased from an independent provider to ensure independence although several of our social workers have training in this to ensure an understanding within the service and a link to the commissioned provision.

Mental Capacity Act (MCA) Assessments and safeguarding are included in our schedule for annual audits.

A system wide approach to safety

The promotion of safety and the understanding and management of risk is embedded across all elements of the system, both internally and externally. This includes:

- A corporate Safeguarding Policy which sets out expectations for Members, Officers and commissioned providers around their role in safeguarding
- Regular safeguarding reporting to Members of the Safeguarding Sub-Committee
- Online Safeguarding Awareness Training across the organisation
- An early intervention project focused on prevention and improving people's wellbeing by keeping them safe in ways defined by themselves
- The Care Navigator who facilitates safe hospital discharge and links hospitals and GP practices supporting more informed hospital discharges and sharing of information to reduce risk
- The ASC Team Manager and Deputy Team Manager are embedded in the Neighbourhood Multi-Disciplinary Meetings

- Social Workers and the Care Navigator attend GP Multi-Disciplinary Team Meetings in the Practices where residents are registered
- The People's Directorate working closely together with ASC presence at all cross-service meetings and work together with colleagues to minimise risk and support safer and more informed transitions between services
- Working closely with colleagues in commissioning and having a quality alert process in place to pick up domiciliary care concerns that are below the level of formal safeguarding and ensure that these are resolved at any early stage and prevent harm. When clients are placed in supported living, residential or nursing care our aim to use providers who are rated good or above wherever possible. When alerts about safety arise, commissioning work with the host local authorities to assess risk. Performance improvement letters are issued where safety or quality is a concern
- Providing access and support to training for commissioned providers such as City Connections and involving them in our City Safeguarding Sub-Group

Summary

- There is a robust approach to ensuring safety that is built across the system including Members, Officers, Health Partners and Commissioned Providers
- Although our Safeguarding Adults Board is a joint one with Hackney, there is a City of London sub-group which is also Chaired by the independent chair of the Board to ensure appropriate focus on the City of London
- Responding to the complex needs of rough sleepers and hospital discharges continues to present a level of risk but our innovative responses have helped to reduce some of this risk
- Though there have not been any mandatory City of London specific Safeguarding Adults Reviews any learning from SARs in Hackney and nationally have been reviewed and responded to accordingly – for example with the establishment of the Hoarding and Self-Neglect Panel

CQC Assurance Theme 4: Leadership

Our Strengths

- Strong, stable political and officer leadership across the City of London Corporation, underpinned by robust and effective financial management including scope for innovation that supports ASC. The development of the Target Operating Model facilitated growth for ASC when there were corporate pressures to reduce budgets elsewhere
- Clear visibility and access of senior management within the Department
- Assistant Director of People's Services provides leadership across all relevant services

Areas for Improvement and Direction of Travel

- Work to increase diversity across the service, as part of wider organisational approach, to reflect our community
- Retain a skilled workforce who are constantly learning

ASC benefits from strong officer member relationships which provide accountability and direction. This is underpinned by an effective formal and informal governance structure.

Informal governance

The ASC Senior Management provide visible and supportive leadership to staff as well as wider health and care partnerships.

There are monthly ASC Management Team meetings as well as People Management Team Meetings which allows cross cutting themes and issues to be considered. There is also a complex needs panel for ASC, a Category Board for the Department and Adult Performance Meetings.

There is also an internal Integration Programme Board which consists of a range of relevant staff and provides the space for system partners to come and talk to us at the City Corporation about our involvement in certain integration initiatives as an efficient way of gaining our input rather than us attending multiple meetings.

Formal governance

The Community and Children's Services Committee is the committee which holds responsibility for ASC and its associated budget. There are regular meetings between the Chair and Deputy Chair of the Committee with the Director of Community and Children's Services and the Assistant Director of People.

Members on the Community and Children's Services Committee also sit on committee relating to the Integrated Care system, the Safeguarding Sub-Committee and the Health and Wellbeing Board providing a strong cross cutting approach to key issues. These all underpin our strategic decision making and include regular scrutiny of our performance data. The Health and Social Care Scrutiny meets 4 times a year and specifically includes social care items on each agenda. Recent items have included an evaluation of the early intervention pilot, hospital discharge processes and proactive care in the local integrated care system.

As noted under Theme 3, our Adult Safeguarding Board function is delivered jointly with the London Borough of Hackney. The Assistant Director of People chairs the SAR sub-group of the Board.

Although the City Corporation attends and participates in key ICS and place meetings, it does not hold any specific leadership roles within this.

Quality Assurance

There is a strong golden thread and connection from management to operational practice with annual direct observation of practice from the Assistant Director of People as well as the Head of ASC alongside that of the Principal Social Worker and operational management.

ASC has recently appointed a dedicated Principal Social Worker (PSW) as a standalone role rather than it being embedded into the Head of Service role to strengthen practice governance amongst other things. This is already having a range of positive benefits including:

- Keeping Social Work practitioners up to date with relevant developments on areas that link with their practice. This is done through a weekly bulletin and a weekly 5-minute reflection is also sent to the whole directorate for use across services. This has enhanced communication with the team and built a habit of reflective practice
- Enabling us to engage more widely across the PSW network regionally as well as nationally and learn from this to update our practice. Recently, the PSW has taken part in an LGA peer review in Bournemouth, learning from other LAs and bringing this good practice back
- Strengthening our approach to Quality Assurance with the development of an annual audit schedule and feeding back learning into the service and reporting to ASMT. For example, following the audit of carers assessments, a guide for practitioners was developed to strengthen the approach to assessments. This was based on direct feedback from carers.

It is recognised that quality assurance could be strengthened by the addition of some external quality assurance. This has been taken forward and the first round of external audit took place in October 2023. A full report is due shortly.

Using Performance Data

The Departmental Performance Team produce monthly performance scorecards for the service which provides Senior Managers and the service with intelligence and performance data to provide assurance that statutory obligations are being met, that any risks are identified and mitigated, targets are being met and any emerging trends or issues are identified. The monthly performance scorecard is discussed at an officer performance meeting in the service. A more detailed summary of safeguarding data is scrutinised at the Safeguarding Sub-Committee quarterly.

Performance monitoring identified that some reviews were not taking place within timescale and changes have been made to the Mosaic system to flag these up so that none are missed.

Across the Directorate, there is a move towards the use of more PowerBI dashboards. One is being developed for ASC and our strategy is that different levels of dashboards will be developed so that they can be used at the front line to support self-management of work and performance.

Leadership on diversity and inclusion

- The Head of Service and Assistant Directors attended Leadership in Colour Conference and reflections from this were discussed at the People's Senior Management Team meetings and the People's Equality Group

- A People's Equalities Steering Group who monitor approaches in this area and established a book club for staff to read and discuss the book Me and White Supremacy
- Anti-Racist Practice Standards have been introduced which are being considered section by section at Team meetings led by the Head of Service, Principal Social Worker and Team Manager
- Reflection and learning on good practice around recording people's diverse needs in our Care Act Assessments were included as part of internal training on the Strengths Based Approach
- During celebrations of World Social Worker Day in March 2023, Tricia Pereira was a guest speaker at the City Corporation. Tricia is the Co-Chair of the Department of Health Social Care (DHSC) Social Care Workforce Race Equalities Standards Advisory Group and is the co-author of Strength-Based Practice Framework and Handbook published by DHSC in 2019

Comment by Principal Social Worker.

"City of London Community and Children's Department's senior leaders monitor the impact our work has on safety and wellbeing of people in our community by leading various board meetings and forums, such as Transformation Board, People's Senior Managers Meeting (PSMT)or Adult Senior Managers Meeting (ASMT), reviewing complaints/compliments and feedback from our citizens and encouraging co-production.

They are interested in wellbeing and performance of our staff receiving regular updates and listening to staff concerns by utilising quarterly meetings between DASS and PSW and by establishing Staff Forum. Both of our Executive Directors, Judith Finlay and the Assistant Director Chris Pelham, and Head of Service Ian Tweedie take part in our quality assurance activities by undertaking Direct Practice Observations of our front-line practitioners, which is very well received by the workforce and champions core ethics and values of our profession.

Example from observation notes, by Chris Pelham, October 2023: "There were interesting dynamics in terms of the relationship between the couple. SH's wife was from Thailand and there was a lot of consideration given to the relationships between the family members. Maria (SW) demonstrated curiosity re. these family relationships and how they might impact in terms of where the 'power' sits within the wider family systems – i.e., SH's wider family and SH not wanting his wife to go to Thailand without him/leave him at home. In doing this, Maria was considering both SH's needs as the cared for as well as his wife the carer."

Our senior leaders are visible and easily accessible having their offices next to operational teams, often "doing the walk" speaking with individual staff, attending our larger and smaller events, such as World Social Work Day or opening of ASC Library.

As PSW I feel reassured that our senior leaders encourage culture of learning and partnership working while promoting wellbeing of the workforce."

Summary

- There is strong and active political commitment to ASC in the City of London
- Senior Managers within the Department are visible and accessible to staff
- Opportunities for staff to develop leadership skills are being rolled out with staff having the opportunity to be champions in certain areas and the PSW focusing on personal development with staff
- Staff undertake a range of training and reflective supervision is developing. There is always the opportunity however to ensure that staff are continuously developing
- There are several initiatives promoting diversity and inclusion amongst staff and within the service. Promoting more diversity amongst staff to reflect our community is a priority

Areas for Development – Summary

Area	Response / Activity
Strengthening triangulation around commissioned placements quality assurance	Undertaking brokerage project as part of Transformation Programme
Developing a stronger performance culture within the service	Power BI dashboards being developed which will be able to be used at different levels of the service including at the front line, to help staff manage their own performance Training planned for Social Work Teams on understanding the role of data and the importance of data quality. Ongoing training in use of Mosaic to ensure correct data is added in correct place Review of reporting and KPIs underway as part of the Transformation Programme
Strengthening Quality Assurance	An external quality assurance mechanism has now been added
Timeliness of Reviews	Traffic light system has been added to Mosaic system to flag reviews. ASC are working with performance and MOSAIC teams to address system issues leading to differing target dates being indicated. Work is underway with practitioners as a whole and individually to ensure timeliness of reviews. Options are being explored to capture reasons for delays in reviews taking place.
Capturing and recording equalities data more effectively and using this to shape services	Review of system and recording of equalities data has taken place and changes identified – will be taken forward as part of the Transformation Project
Improving the quality and accessibility of our information offer for residents	Review of offer underway as part of Transformation Programme
Strengthening co-production and collection of feedback and measures of outcomes from service users	Currently underway as part of the Transformation Programme. Also wider piece of Departmental work underway to look at our framework for

	engagement and co-production and a reward and recognition policy.
Implementing robust and routine feedback from people who have been safeguarded	Currently underway as part of the Transformation Programme
Increase diversity across the service to reflect community	Will be taken forward as part of Corporate wide approach