Essex County Council
Adult Social Care

Making the difference every day

Self-assessment report

June 2024

Contents

Overview and Summary

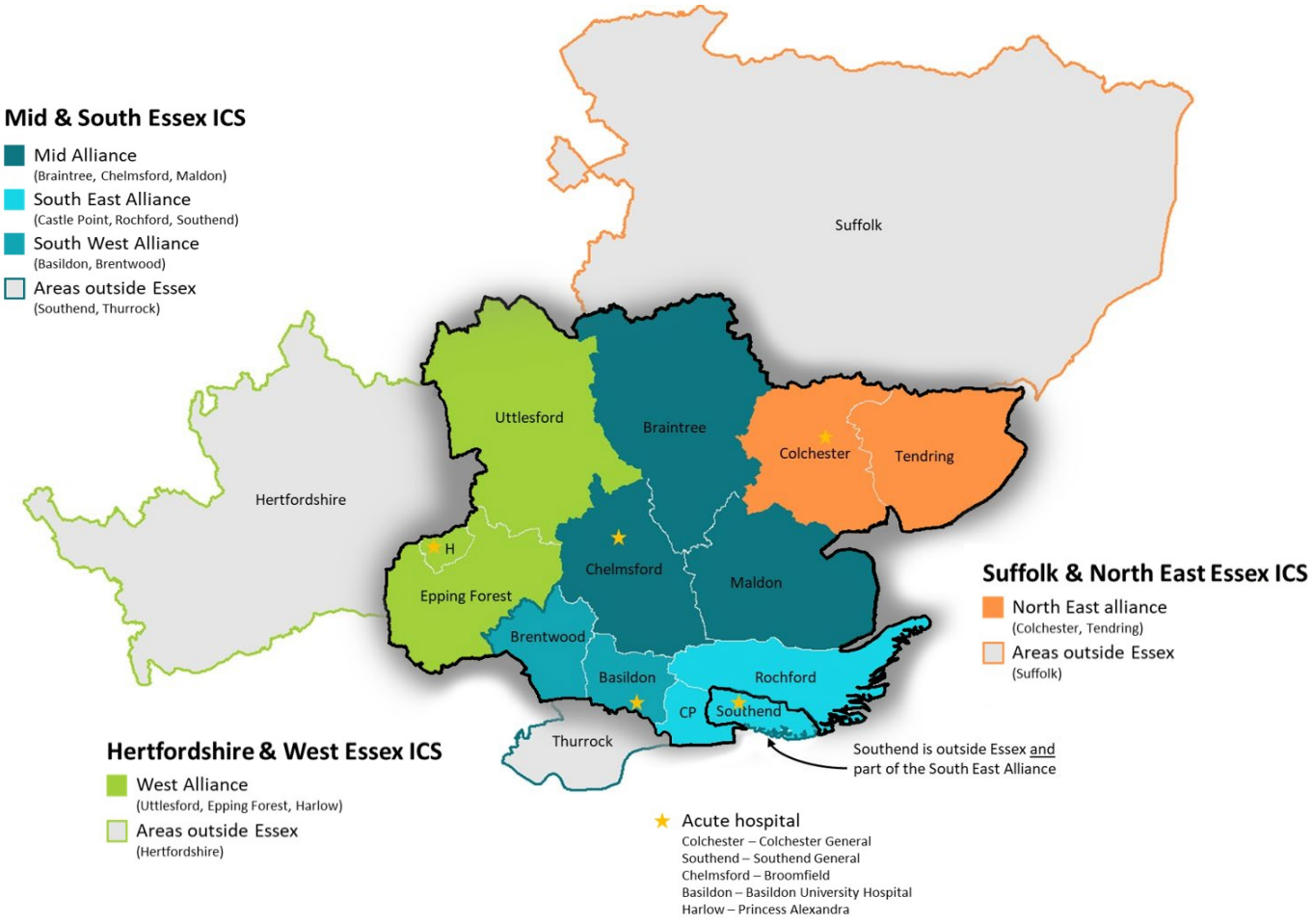
The county of Essex

Essex is **one of the largest local authorities** in the country with a population of 1.5 million. It has grown by almost 110,000 since the 2011 census. It is a county of urban centres and rural and coastal communities, with pockets of great deprivation as well as great wealth.

Essex has **12 district / borough / city councils** within our boundaries. Our geography means we border 9 other local authorities across our northern, western and southern borders, including the 2 Greater Essex unitary authorities of Southend and Thurrock, 4 London boroughs, and 3 counties.

We are **a member of 3 integrated care systems** (ICSs) that overlap our borders, covering Mid and South Essex (including Southend and Thurrock), Hertfordshire and West Essex, and Suffolk and North East Essex.

Across the county, Adult Social Care works within **5 place-based alliances** with a range of local government, NHS, voluntary and community sector and other partners. Essex has 5 acute hospitals (across 3 acute trusts), 4 NHS community providers, and an Essex-wide mental health provider. Essex also has an army garrison in Colchester and a Category B prison for men in Chelmsford, which is also a young offender institution. The county is home to one of the country's major airports (London Stansted) and to one of the major ports (Harwich International).



The **population** of Essex is older than average with c.21% (311,000 people) aged over 65 (England average 18.6%). The fastest growing age group in Essex between 2011-21 was the population aged 70-74, which has grown by 44% over the past decade.

Our **older adult population is growing nearly three times faster than our working age adult population,** with a slight decline among males in recent years, and we have a significant gap between the least and most deprived Lower Super Output Areas (7.5 years for men and 6.3 years for women). The population of people (aged 18+ years) with learning disabilities and autism is expected to grow by 4% and for people with autism by 5% between 2023 and 2030. The population of working aged adults (18-64 years) with some sensory impairments is also expected to grow in this time, with a 2% projected increase with serious visual impairment and a 2% projected increase with some hearing loss.

Over the last 15 years, the percentage of the **Essex population living in the 20% most deprived neighbourhoods in England has doubled**. Jaywick in North-East Essex has had the highest levels of deprivation of all neighbourhoods in England since 2010. There is a strong correlation between levels of deprivation and demand for health and care services.

Ethnic diversity has increased in Essex since the 2011 census, with 14.9% of the population identifying themselves as other than White British in the 2021 census, compared with 9.2% in 2011. The ethnicity of the local population **varies significantly** across Essex districts. Harlow and Basildon have higher proportions of “Black, Black British, Black Welsh, Caribbean or African” residents compared to the England average. Epping, Harlow, and Brentwood have higher proportions of “Mixed or Multiple Ethnic Groups” than the England average.

Data Sources:
The Essex Joint Strategic Needs Assessment and Essex Open Data

Essex County Council

Essex County Council (ECC) is **well-run and is financially stable**, with a track record of strong financial management and service quality. Our **children's services are rated as Outstanding by Ofsted** and the Council has been asked by Government commissioners to provide support to other local authorities in England that have faced service and/or serious financial challenges.

ECC's corporate strategy Everyone's Essex: our plan for levelling-up the county 2021-25 sets out the Council's strategic aims and accompanying commitments.

A key focus is promoting health, wellbeing and independence, which is underpinned by specific commitments to:

- ✓ Reduce health inequalities,
- ✓ Promote healthy lifestyles,
- ✓ Support people to live independently,
- ✓ Work with partners in a local place to deliver better care that meets local needs,
- ✓ Improve support to carers.

The Essex Joint Health and Wellbeing Strategy (2022-26) was developed jointly with health partners. Its priorities are to improve mental health and wellbeing, improve physical activity and healthy weight, support long-term independence, address alcohol and substance abuse and reduce health inequalities. The Essex Health and Wellbeing Board oversees progress against delivery of the strategy.

Our vision and strategy for Adult Social Care in Essex

Vision: Our vision for Adult Social Care is of **people in Essex living their lives to the fullest.** We support this with a preventative and localised community-based model of social care.

Mission: Our mission in everything that we do is about **making the difference every day**.

Key statistics about Adult Social Care in Essex:

£469.2m net / £809.4m gross
The budget for ASC in 2024/25

c.53,000 Adults
contacted ASC in 2023/24

1,460.2 FTE
(Headcount: 1,572)
ECC adult social care workforce
(18% of ECC workforce)

c.800 Care Providers

At any one time, we support around 16,000 people:

c.9,000
Older People

c.4,000 Adults
with Learning Disabilities and/or Autism

c.2,000 Adults
with Physical and/or Sensory Impairments

c.1,000 Adults
with Mental Health needs

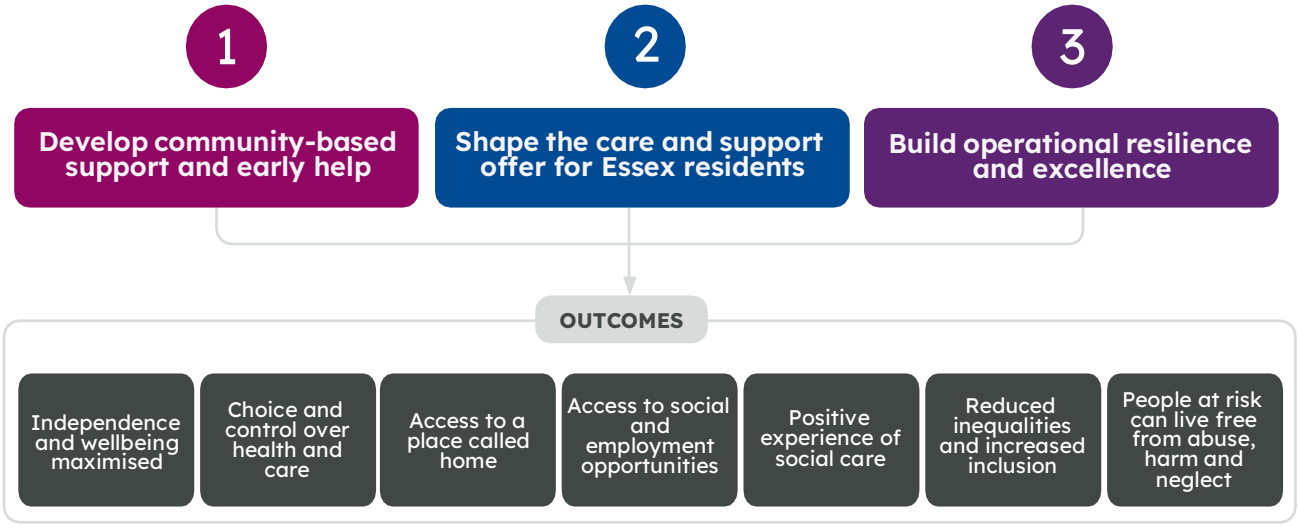
As with many areas, the Covid-19 pandemic has had an impact on adult social care and we have seen some increases in demand. We have seen significant increases in demand on our Mental Health teams and Safeguarding referrals since the pandemic.

Financial benchmarking

Essex **benchmarks well on many financial aspects** of adult social care, including spend on older people and care market rates. We have an excellent track record of managing within our approved annual budget and we have a financial strategy, supported by dedicated adult social care reserves, which supports our ability to invest and to mitigate in-year risks if necessary. We do, however, benchmark as a high-spend authority on adults with learning disabilities, which is largely a legacy of the long-stay hospitals in Essex.

The Adult Social Care Business Plan

The Essex Adult Social Care Business Plan 2024-30 sets out our objectives and the outcomes we want people to be able to enjoy so they can **"live their lives to the fullest".** We have identified 3 strategic areas of focus to enable us to achieve our ambitions:



Our commitment to equality, inclusion and diversity within our workplace

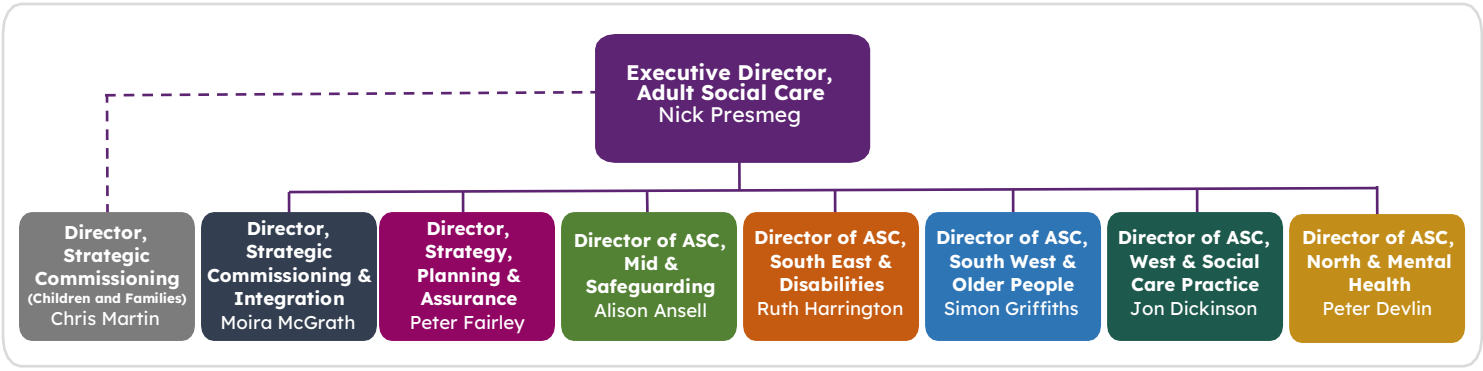
We value diversity. Our ECC Workforce Equality, Diversity and Inclusion Strategy 2023-25 sets out a roadmap to deliver on our objectives to recruit, retain, and nurture colleagues from a diverse range of backgrounds and to understand how cultural differences and inclusivity benefit our workforce.

We are proud of our **Equality, Diversity and Inclusion Steering Group,** co-chaired by workers with experience of marginalisation. We have undertaken a series of workforce-led "Quests" to explore the lived experience for our

workforce with protected characteristics such as race, disabilities, LGBTQIA+ and age, which has captured powerful data and lived experience insight to inform our proactive response.

Our structure and ways of working

Adult Social Care in Essex **embraces both county-wide and place-based working.** We have 2 directors with strategic countywide responsibilities, and 5 local operational directors who also hold a countywide lead for a theme. The DASS also holds joint accountability over the Director for Strategic Commissioning and Policy in Children and Families to ensure links and accountabilities around all-age challenges and transitions.



Essex also has dedicated countywide senior leadership roles for Principal Social Worker and Principal Occupational Therapist, who work together to develop our professional practice across ASC.

At a local level, we are structured around 5 localities (North-East, West, Mid, South-East and South-West) that sit within 4 quadrants, which are aligned to NHS place-based geographies, each with an acute trust. Each has a locality director responsible for operations, who operates within a consistent countywide framework, and provides systems leadership for adult social care with the NHS and other partners at a place-based alliance level.

Within each locality, **neighbourhood teams** align, as closely as possible, to primary care networks with populations of c50k. Each locality has teams for Discharge to Assess, Learning Disabilities and Autism, Physical and Sensory Impairments and Older Adults with Mental Health needs.

Essex has a social care management system called Mosaic, which is supplied by Access Group. We have established shared care records with each of our NHS integrated care systems.

Essex Public Health

We work closely with our Public Health service, particularly on support for carers, early help, and prevention (especially via the Essex Wellbeing Service). The Wellbeing, Public Health, and Communities Business Plan (2022-2025) outlines the approach to partnership and place-based working for the Essex public health team to address health inequalities.

System leadership

ECC plays an influential **leadership role** in each of the 3 integrated care systems that cover Essex. The Essex Health and Wellbeing Board provides strategic leadership for the population health outcomes and priorities for Essex, and oversees and approves the c.£200m per annum Essex Better Care Fund, which ECC manages on behalf of the system.

The Joint Essex Health and Wellbeing Strategy provides a set of countywide priorities, to which each integrated care system must have regard.

We have supported each system to develop an Integrated Care Strategy and have ensured there is a degree of consistency between our 3 systems. For example, all ICS strategies recognise the importance of building on people's strengths; embrace "I / We" statements; and recognise the importance of addressing the wider determinants of health.

ECC is represented on all 3 Integrated Care Boards (ICBs) by officers of the Council and on all 3 Integrated Care Partnership Boards (ICPs) by both officers and councillors.

We have played a key part in the establishment of our 5 place-based alliances, encouraging their membership to be diverse and inclusive and not just limited to statutory adult social care and NHS services. Our ASC locality directors are part of these alliances, along with representatives from children's services and public health; district / city council representatives; the voluntary community sector; and the NHS and others.

The **Essex Resilience Forum** brings together all partners to ensure that preparations are in place for major incidents and emergencies and to coordinate a response. During the pandemic, Adult Social Care chaired the tactical co-ordination group on health and care, recognising the central role of ECC in the Essex system.

Top strengths

1 **Discharge Outcomes and Home First:**

We have worked with partners through our 5 place-based alliances (each with an acute hospital) to develop an effective hospital discharge approach that enables people to return to their homes or community setting, supported by an extensive reablement offer and a comprehensive and innovative care technology offer. In the 2022/23 ASCOF benchmarking, Essex was in the **top 10%** of councils in the country for low rates of permanent admissions into residential or nursing care, an area in which we continue to perform well, and (among county councils) we have the second lowest rate of delayed discharges in the country. We continue to have a low rate of permanent admissions since the previous ASCOF release.

2 **Workforce:**

We invest in our workforce capacity and capability in both front-line operational teams and strategic commissioning and planning. This supports both operational resilience and innovation. Our committed and dedicated workforce follows strengths-based practice to maximise people's independence, supported by our nationally recognised Essex Social Care Academy (ESCA) and our Social Care Capability Framework. Essex practitioners are frequently recognised in national awards, including as the winner of the Adult Social Worker of the Year in 2021 and the Mental Health Team of the Year in 2023. We are proud of our innovative workforce-led 'Quests' approach to equality and diversity, which has provided lived experience insight into working in adult social care from the perspective of people with protected characteristics, and this has informed our workforce and other action plans.

3 **Market:**

We have built (and continue to build) good relationships with our stable and diverse care market, especially through our work with the Essex Care Association. We do this at both an Essex-wide level and through local place-based market forums, allowing us to set countywide frameworks and policies but with recognition of local conditions and challenges within a large county of 1.5m people. Market capacity and quality across Essex are good, supported by the work of our local Care Sector Hubs and countywide Provider Quality Team. Over the past 12 months there have been positive signs of workforce growth in the care market, especially in the domiciliary care market.

Areas of focus

1

Carers:

We developed a new All-Age Carers Strategy in 2022/23, because carers had told us we could do better. In April 2024, we launched a new and improved 'core offer' for carers, improving our identification of carers through our central point of contact (the Essex Wellbeing Service) and improving information, advice and guidance and support through direct delivery of services, technological and digital improvement and improved system working. As part of this change, we want to see increased contact and assessments between ECC and carers. We are also reviewing our approach to formal carers' assessments and short breaks.

2

People waiting:

Like most local authorities, Essex has people waiting for Adult Social Care assessments and other interventions and reducing waiting lists is a priority. We are part of a regional improvement board, which shows that the number of people waiting in Essex per capita is in line with other local authorities in the Eastern Region. We have implemented a clear, consistent risk management approach to ensure that people with the highest priority needs are seen quickly, and have a number of initiatives underway that have positively reduced the numbers of people waiting. We have made good progress in reducing waiting times.

3

Embedding co-production and capturing lived experience:

We have some good examples of co-production and are working to strengthen the consistency of our approach and spread best practice. We are working to embed a fully inclusive approach to using lived experience and have assessed ourselves against the TLAP ladder of co-production. We have identified the need to widen the number of people who are able to share insights with us and for ASC to make better use of that to drive service improvement and improve people's outcomes.

Challenges

1 **Workforce capacity:**
Like many local authorities and care providers, we have an ongoing challenge to ensure our workforce capacity is sufficient. Our front-line workforce is now 8.3% larger than March 2022. The overall vacancy rate for ASC is 12% but the Social Worker vacancy rate is higher at 15%. We face competition from London, which is challenging. Alongside a focus on recruitment and retention, we also have a focus on how we can support workforce wellbeing and optimise their time (for example, through supportive and enabling technology).

2 **Mental Health:**
Our mental health system is under considerable strain. Demand has been increasing for some time, exacerbated by the pandemic and cost of living crisis. There are continuing challenges around mental health assessments and supporting people with mental health problems out of hospital. Partners across Southend, Essex and Thurrock have developed a joint strategic approach that aims to ensure access to community-based support and improve pathways in acute and crisis services and wider recovery-linked services.

3 **Demand:**
A combination of the impact of the pandemic, demographic growth and economic factors has been driving increasing levels of demand for health and care services. We are also seeing increased complexity with higher numbers of people being supported at home. We have seen particularly high growth in demand in mental health, dementia and safeguarding since the pandemic, which has now plateaued but at a higher level than pre-pandemic. Our Mental Health Wellbeing Team has seen a 41% increase in referrals received between 2019/20 to 2023/24, whilst safeguarding referrals have increased 20% in the same period of time, and reablement has increased by 64%. As well as managing overall demand, we are concerned to ensure equity between different parts of Essex and different population segments. We are working with partners to understand the trends and opportunities in order to improve our response.

Section 1:
Working with People

This section covers:

- Domain: Assessing Needs
- Domain: Supporting people to live healthier lives
- Domain: Equity and experience in outcomes

Summary

Essex achieves **good outcomes for people** in many areas, as evidenced by our ASCOF. Our focus on strength-based practice, on **home first** and maximising independence and promoting inclusive employment is strong and well-established. We have low rates of permanent admission into residential care.

Essex has an effective front-door in Adult Social Care Connects (ASCC) that helps triage and sign-post initial contacts.

We embrace working with people at both a countywide and locality level, through some countywide operational and commissioning teams and through our locality-based teams that work closely with 5 place-based alliance partnerships.

The ASC Business Plan has prioritised investment in, and development of, our early help and prevention offer, working alongside our Public Health and Communities teams. This is supported by an innovative Public Health Accelerator Fund grant initiative, led by Essex Public Health.

Our commissioned **Essex Wellbeing Service (EWS)** offers a range of early help and support. This runs alongside our high-performing **care technology** offer.

We have made positive progress at reducing **waiting times for assessments, reviews and DoLs assessments.** Over the past 12 months, the overall number of people waiting for a Care Act assessment to start has reduced by 39%. The number of DoLS applications waiting to start has fallen by 40% over the same period.

Essex performs well at **enabling access to employment** for adults with learning disabilities (LD) and adults accessing mental health (MH) services. Access to inclusive employment is a central part of our transformational agenda for adults with LD and MH needs, with ambitious targets in place.

We are **improving the recording of protected characteristics** to understand more about inequality of access and outcomes.

Our key stats

Assessments and Reviews

360 assessments
undertaken by ASC per week – over 18,000 a year

53% of adults
supported for 12m+ have had a review in the past 12 months

Independence

19% of adults
supported for a Learning Disability are in a residential or nursing care setting

26.8% of adults
known to secondary mental health services live independently (2022/23)

Experience

63% overall satisfaction
with our services (2022/23)

66% of adults
who use services find it easy to find information about support (2022/23)

1.1 Domain: 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.

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

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

Case study 1:

Making the Difference Every Day:

Mercy's story

Mercy is 58, lives with MS and is currently awaiting assessment by the memory clinic. Mercy experiences extreme anxiety and was likely to call out in distress when visitors came to her home. Because of this, it was hard for the social worker from the neighbourhood team to talk with Mercy about her Care Act assessment without causing considerable distress.

The social worker reflected on how she might connect with Mercy in a way that worked better for her. She decided to try the assessment again, but this time with a **TEC Cat**. Mercy responded positively to the TEC cat seeming to benefit from the comfort it brought. This time she relaxed into the assessment and was able to tell the social worker about her life as a Jehovah's Witness.

Mercy now has her own cat which she has called Bob. Bob continues to offer her comfort and companionship. Mercy's level of anxiety and the amount she sleeps have also improved and Mercy is now able to accept visitors including carers into her home.

Case study 2:

Making the Difference Every Day:
Frank's story

Frank, a 90-year-old man who lived with his wife in their own home, was referred to ASC for an assessment as part of the process for considering NHS Continuing Health Care (CHC).

Frank was cared for in bed and did not want to be disturbed by professionals who were strangers to him. He said he **'just wanted to be left alone to die comfortably in his own bed'**.

When the social worker visited, Frank initially declined to speak to her but did accept the offer of a drink. The social worker noticed there was a piano in the house and picture on the wall with the words "Choir Leader". The social worker told Frank she was part of a choir and invited him to join her in song. Frank was initially uncertain as to whether he could still sing but, as the songs started to flow, he embraced the moment. Singing enabled the social worker to connect with Frank, who then started to open up and talk about how he used to duet with his wife.

"Thank you so much," he said,
"I didn't believe I could ever sing again,
this really means a lot".

From this contact, Frank was connected to the local parish with regular visits from the vicar and community choir. Frank's revealed love of music was also warmly received and nurtured by his carers, who connected with him using his piano.

Frank who has since died, gave his full consent for his video to be shared with others and it was also shared at his funeral.

Please see link to video here.

Case study 3:

Making the Difference Every Day:
Trey's Story

Trey is a 54-year-old man who was referred to Essex University Partnership NHS Foundation Trust (EPUT) mental health service by his GP, due to concerns around heightening paranoia and fluctuating mood. Trey had hit a further rough patch in his life and, with a history of childhood trauma and drug and alcohol abuse, he was struggling. He had low self-esteem and had become increasingly isolated and withdrawn. Trey was a painter by trade but had been unable to keep his job because of his episodes of paranoia. His world had shrunk, and he relied totally on his partner for all social interactions.

Under the Section 75 agreement, alongside clinical mental health support, the social worker offered Trey a Care Act assessment. Trey's partner of 13 years was recognised as a carer and a carer's assessment was offered.

Trey's aspiration was to get back out there and to explore voluntary work. But he was finding the thought of public transport overwhelming and was anxious he might become agitated in an enclosed space.

The social worker considered different options and it was decided an electric bike would help him get out and about in a way that worked for him. It was also recognised this would support his relationship with his partner who said **"I think it will be the making of him. … He will go out more and it will get him out of my hair!"**

Trey has chosen his bike and is planning his cycle routes. He is looking forward to giving his partner some space and then sharing stories of his trips out with her. Trey is feeling more positive about the future and is hopeful that, as his recovery progresses, he will rebuild his confidence and ultimately return to his trade.

Key elements:

✓ Accessing early help and support

Adult Social Care Connects (ASCC) is ASC's "front door". The teams take a personalised and holistic approach to help people at initial contact, e.g by providing accessible advice and information and connecting them to informal help in their community.

ASCC receive c700-800 contacts each week and handle around 60% of all adult social care new requests for support. Of calls to ASCC, c.30% are signposted to **community support options** such as the Essex Wellbeing Service, c.52% are **referred to our community equipment service / digital enabled care / occupational therapy, or reablement** and c.13% of contacts lead to further assessment. ASCC monitor the wellbeing outcomes they are addressing for people: over half relate to physical and mental health and emotional wellbeing, while control over day-to-day life and suitability of living accommodation are the next most frequent.

Within ASCC, the **Carers Telephone Assessment Team** completes c200 Carers Assessments per month and manages the Carers Emergency Planning service. Demand for Carers Assessments has increased by 68% over the past 12 months.

Our **Countywide Duty Team** (CWDT) handles enquiries from adults with ongoing care and support needs and a support plan where there is no practitioner allocated. This includes providing advice and guidance and carrying out unplanned reviews. It receives around 850 - 1,000 calls and 300-500 email referrals per week, which includes referrals from providers to amend support plans, and allocates unplanned work within 24 hours.

We also have an award winning Countywide Mental Health & Wellbeing Team, which is discussed in more detail in "1:2 Domain: Supporting people to live healthier lives".

At a local level, we work through neighbourhood teams, aligned as closely as possible to primary care networks with populations of c50k. Each locality has teams for Discharge to Assess, Learning Disabilities and Autism, Physical and Sensory Impairments and Older Adults with Mental Health needs.

Strengths-based approach to assessing and reviewing needs

Our aim is to support people to have the maximum possible choice and control over their lives. We do this by forming genuine, trusting relationships with the people we support and by adopting a strengths-based approach to help people locate their own resilience.

Our core guidance for practitioners is explicitly informed by strengths-based thinking. Our **framework of practice expectations** highlights the Prevention, Enablement and Support elements of Care Act guidance, whilst promoting the TLAP 'I and We Statements' to ensure the adult and their carer remain at the centre of all consideration and decisions.

An independent diagnostic of our learning disability and autism services by **People Too** in Autumn 2021 highlighted that our assessments are person-centred and focused on people's strengths.

Our existing strengths-based practice is evolving as we develop a **practice model** that pulls together the best of our existing practice and further embeds Prevention, Enablement and Support into the service offered by our teams. It will reinforce an approach in which the person and practitioner form a relationship to explore need, strengths and resilience.

The Essex practice model has been co-developed with a range of practitioners, managers and commissioners, with input from a group of people who draw upon ASC services. As a result of work to develop the model, senior practitioners now sit on the Practice Governance Board and its sub-groups. They have reported that they feel more involved and informed in governance and that their input is recognised and valued.

We are in the process of changing our existing assessment and support planning forms to give practitioners more freedom in the information they consider important to include. This will further strengthen the person's voice and narrative and we are currently procuring a new social care management system to support our practice requirements. The changes we have made so far have resulted in a significant improvement in front-line practitioners' experience.

Our **Systemic Practice training** is part of our essential training offer. Action Learning Sets are in place to embed learning. The Adult Leadership Team has also benefitted from systemic leadership training and is using systemic models to frame internal and external discussions. This aligns well with the approach in Essex children's social care.

Reflective practice: our weekly Supporting Independence Discussions, supervision, and quarterly *Time to Reflect* sessions enable practitioners to take time out to think about their practice and its impact upon people drawing on support. Staff surveys show that, since introducing these measures, 75% of respondents feel more able to make decisions that support achievement of the best possible outcome for adults and that they feel more confident and supported in dealing with complex cases. Our Principal Social Worker also facilitates reflective peer supervision sessions for Directors and Senior Managers to create time and space for focused reflection around practice and reinforce the need for reflective practice at all levels.

✓ Quality Assurance

Our **Quality Assurance Framework** is the means through which we monitor and evaluate practice to support continued learning and improvement. All quality assurance activity is overseen by our **Practice Governance Board,** which is chaired by our Principal Social Worker.

Quality Control takes place daily and requires any practitioner with supervisory or management responsibility to conduct a one case in ten "test check" against our Practice Standards and Expectations. The Practice Quality Audit Tool is used for planned monthly audits.

We introduced a new series of **practice audit tools** that are in line with our Practice Model in 2023. These are quicker to complete than previous recording and have been built into our regular monthly audits of safeguarding, mental capacity assessments and Care Act activity. The tools will yield quantitative and qualitative data about our practice to inform development activity. Our practice audits help us to identify areas for continuous improvement. For example, we are co-designing the Carers Assessment form, significantly reducing its length and strengthening the focus on the carer, and practice leads are developing a toolkit to support practitioners in reflecting cultural awareness in recording. Learning from audits also identified a need to re-focus on the core principles of the Mental Capacity Act. Essential MCA training for managers and practitioners encourages a focus on strengths-based practice beyond legal frameworks.

Our workforce carry out **diagnostic appreciative enquiries of front-line teams** to understand the support available to staff from their managers. Actions identified during the diagnostic are followed up after a 3-month period to learn about improvements to practice that have taken place as a result.

Outcomes and independence

Essex has an effective **home first approach,** working through each of our 5 place-based alliances and mainly our 5 acute hospital sites to promote and secure 'home first' outcomes. This is evidenced by a low rate of admissions into permanent residential or nursing care for adults aged 65+ (349 per 100k in 2022/23 vs national average of 561 per 100k). This is supported by both an extensive reablement offer to people in each locality on leaving hospital and an innovative and a comprehensive care technology offer, which supports people to maximise their independence and to achieve their own goals.

We perform very well in **minimising delays for people leaving hospital.** We have one of the lowest rates of delayed discharges in the country (10 per 100,000 population as of Department of Health and Social Care dashboard on 20 May 2024) – the second lowest in the country among county councils and one of the lowest among all council types.

Direct Payments are offered to everyone who is eligible and 2,648 people are currently in receipt of a Direct Payment as of 5 June 2024, of whom 838 people started a new Direct Payment in the past 12 months. Direct Payments can be managed via our commissioned Direct Payment Support Service or there is the choice of a Payment Card or direct deposit of funds into a bank account. We have strengthened and improved our commissioned offer following extensive engagement and co-production with people of lived experience.

Overall satisfaction with our services for 2022/23 was 63% compared to 64% nationally. In 2021/22, carers' satisfaction was below average at 33% compared to 36% nationally. This is a key focus in our Business Plan and has informed the extensive work with carers and carer organisations to improve our 'core offer' to carers, launched in April 2024 as part of delivering our All-Age Carers Strategy commitments.

Areas of focus:

✓ Support for carers

Our 2022 All Age Carers Strategy was informed by the lived experience of 583 adult and 92 young carers and sets out 6 commitments to:

1. ensure that carers can easily access the information, advice, guidance, and support when they need it early into their caring role;
2. develop professional practice and processes to improve identification and support to carers;
3. improve transitions for carers as they move through specific phases or life events in their caring role;
4. ensure carers have increased opportunity to access good quality support, including opportunities for breaks, to maintain their own wellbeing and that of those they care for;
5. ensure carers' needs and rights will be understood and recognised across Essex communities;
6. recognise that carers will be the experts that influence, shape and be involved in the decisions that are intended to improve their support and wellbeing.

We have worked intensively with carers and other key partners and stakeholders to **improve our support offer** to carers and to co-produce different component parts of our new Essex Carers Core Offer of Support (ECCOS). One of the carers involved said "I think this two-way dialogue has really helped develop a service that we hope will make a difference."

In April 2024 we launched a new, improved 5 year offer for carers. This includes:

- A **central point of contact** via the Essex Wellbeing Service (EWS). Carers can contact EWS directly for early information and guidance and can be referred on to our specialist offer or to social care. Call handlers are trained to identify people that call for other services as carers.
- **Specialist Carers Pathway Co-ordinators** are working with partners to improve identification of unpaid carers and their access to support.

- We have commissioned Action for Family Carers (West and North Essex) and Carers First (Mid and South Essex) to provide **specialist support** that includes information, advice and guidance; practical solutions to address specific challenges; and solution-focused interventions such as conflict resolution, mediation and emotional wellbeing support. They are also building the peer support networks.

- Our outcomes-driven early help **short breaks grants**, whereby carers can access up to £2,000 to achieve outcomes that will improve their own health and wellbeing. 1,100 carers have received grants over the past year, of which 100% said this had a positive impact on their wellbeing.

- Our **digital offer** is delivered by **Mobilise**, who support carers to access good quality information, advice and support, virtual cuppas, peer support and direct pathways to our specialist services. This offer has proved particularly pertinent to carers who need to access IAG outside of working hours. Between December 2022 and May 2024, 947 unpaid carers have used the Mobilise Carers Allowance checker tool. We estimate that if all those identified as eligible went on to claim Carers Allowance, they would be entitled to c.£1.7m per annum. Mobilise social media posts have received over 65,000 views by carers over the past year, engaged with over 3,600 and provided direct support to over 1,000.

In addition to this:

- Carers can access **learning and training** through our provider portal.

- We have ongoing **communications** campaigns and promotions that highlight our services, carers' rights campaigns or good news stories and connect people to our support.

- We have a **virtual offer** including a digital newsletter, *virtual cuppas,* challenge-based workshops, online 1:1 light touch support and information, advice and guidance.

- An improved **website presence**. Since improving the content, the page has received 4,100 visits in the past year.

- We have commissioned Healthwatch to build **direct engagement** with carers, through which we aim to increase the voice of **unheard carers**. This model was designed by our carers reference group.

- Our ***Think Carers Guide*** was developed by professionals and carers to support front line services, such as GPs, social prescribers, to identify and support carers and have meaningful conversations with them.

- 77 local community groups have benefitted from small grants made possible by a £1.75m **Carers Community Fund** that was developed and evaluated with partners and carers of all ages.

This work is underpinned by **practice-based improvements** through the production of new guidance for our practitioners, a revised carers assessment form and support plan co-produced with carers. This new, simplified approach to recording will serve as a pilot for our new practice model.

The latest census states there are 124,000 people who identify themselves as carers in Essex. 5,500 carers are supported via the core IAG carers service and we have set targets to reach 12,450 by 2027.

To improve clarity about the number of carers we are reaching we have worked extensively on our **data systems** (our own and commissioned services) to ensure we have a reliable data dashboard.

People Waiting

We have a **clearly defined and proactive approach to manage and reduce the risk** of people waiting too long for an assessment or activity to be completed.

As with many authorities, some backlogs arose during the Covid pandemic and we have seen some increases in demand for some services from an ageing and growing population.

We established a Service Improvement Team to oversee initiatives and track progress in reducing numbers of people waiting and in March 2023 we introduced a **Priority Risk Matrix for Adults and Carers awaiting Assessments and Reviews** to guide decisions on prioritisation of assessments and/or reviews. A Priority Matrix is also in place for Deprivation of Liberty Safeguards (DoLS) and for Safeguarding.

We have successfully **reduced the numbers of people waiting for an ASC intervention** from 10,555 people in June 2023 to 8,210 on 5 June 2024. Some areas of progress include:

- We have reduced the median wait for Care Act assessments by 42%, the maximum wait by 76% and the overall waiting list from 1,662 to 1,018 (39%).
- We have reduced the maximum wait for a Review by 51% and started to see the overall number of people waiting stabilise and now starting to fall.
- We have reduced the number of DoLS applications waiting to be started by 40% from 3,045 in June 2023 to 1,831 as of 5th June 2024 (despite a 51% increase in DoLS applications during 2023/24 compared to 2022/23)

This has been achieved through implementation of a number of actions:

- Recruited **Welfare Independence Practitioners** in 2023/24 to undertake face to face visits with adults who receive over 15 hours of care or are in a 24-hour care setting and are rated medium or low on the vulnerability matrix. A number have now joined our workforce.
- Recruited temporary business support resource to enhance the **County Wide Duty Team (CWDT)** to undertake telephone reviews for adults where this is a good outcome for them.
- Put in place additional capacity to manage DoLS assessments.

- Established a Reward Scheme to incentivise the ASC workforce to complete additional assessments or reviews (August 2023-January 2024). We have since established an overtime approach that also supports wellbeing (April – June 2024).
- Established a team of **Independent Practitioners** to focus on those waiting the longest for a review, particularly in relation to people with learning disability or autism.
- Introduced **Trusted Assessment** approaches via our own local authority trading company (Essex Cares Ltd), with procurements started at the end of May for further external support to undertake Care Act assessments and Deprivation of Liberty Safeguards.

We get c800 new requests for a financial assessment each month. The average (median) number of days that people wait for a financial assessment to start is 15 days. We have reduced the number of people waiting for a Financial Assessment by 72% between May 2023 and May 2024.

There is robust governance and oversight of People Waiting. Progress is reviewed weekly at a Priorities Review Meeting, and also monthly via quality assurance meetings, and monthly meetings of Operations Board and the Adults Leadership Team.

✓ Mental Health Service pressures

There is a growing prevalence of mental health in our Essex population, which is consistent with the national picture. Between 2019/20 and 2023/24, we have experienced increased demand of 41% in our Mental Health and Wellbeing Service, which provides time-limited personalised early intervention and prevention support to prevent, reduce and delay the need for long-term support. The service is continually adapting its offer in response to these capacity challenges through innovation, group work and the use of technologies.

In addition to the Mental Health and Wellbeing Service, the Council has a S75 Partnership Agreement in place with Essex Partnership University NHS Trust, through which it delegates its duties under the Care Act and Mental Health Act to the Trust for mental health whilst maintaining close partnerships, oversight and assurance. The Council and Trust are undertaking a detailed programme of review of the role of adult social care in the wider mental health system, with the intention of strengthening early intervention and prevention and personalised integrated care and support offered locally.

Our Approved Mental Health Professionals (AMHP) Service has seen an increase in demand for Mental Health Act Assessments grow by 23% between 2019/20 and 2023/24. Pressures on this service are further compounded by increasing wider system resource constraints affecting Health Based Places of Safety, mental health hospital beds and police and ambulance services. In response to these pressures, a comprehensive review of the AMHP Service was completed in 2023, which resulted in a new operating model accompanied by substantial investment in additional AMHP capacity. The implementation of the new model is in progress. The service has also reviewed its reporting and escalation procedures to ensure that there is visibility and shared accountability across statutory partners, including Police, MH trusts and Essex ICBs, for prioritising the deployment of resources to people in greatest need.

The Lampard Inquiry was announced by Government as a statutory Inquiry in November 2023 after it was initially established as a non-statutory inquiry in 2021. The purpose of the Inquiry is to investigate the circumstances surrounding the deaths of children and adults in mental health inpatients services and those who died within 3 months of discharge from hospital between 2000 and 2023. The Council is fully committed to supporting the Inquiry over the course of its work.

1.2 Domain: Supporting people to live healthier lives

We support people to manage their health and wellbeing so they can maximise their independence, choice and control.

We support them to live healthier lives, and where possible reduce future needs for care and support.

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.

Case study 4:

Making the Difference Every Day:

Alice's Story

Alice is 54 and lives alone. She has multiple health conditions. Alice was recently evicted from her privately rented adapted property and so moved into non-adapted social housing. Alice has requested help from Essex Wellbeing Service (EWS) in the past to stop smoking, access a toilet frame and find a local shopping service. She contacted them again following the move as she was feeling overwhelmed and isolated.

An EWS Community Agent helped Alice contact the housing provider. They arranged for adjustments and adaptations to be made to the home, including re-positioning the oven to an accessible height. Alice was also helped to apply for a Blue Badge and to contact Hearing Help Essex, and was introduced to a befriender through Age Well Essex.

Alice has since settled into her new home and expressed her gratitude for the support she received from the Community Agent. She said, **"Thank you for all your help, I did not know what services were available to me."**

The Essex Wellbeing Service (EWS) was designed during the pandemic and has since been scaled up. It provides a wide range of support and promotes wellbeing by preventing needs from escalating, reducing demand on health and care services.

Case study 5:

Making the Difference Every Day:

Judith's Story

Judith is 89 and lives with dementia. Her family and care workers were becoming increasingly concerned for her safety within her home, where she lives alone. They were uncertain about what she did during the day and worried about how much she was eating and drinking. Their worry was impacting Judith's confidence and she questioned whether staying at home was the right thing for her.

With Judith's permission, Anthropos daily monitoring equipment was installed, providing valuable learning about Judith's diet. It revealed increased bathroom activity, indicative of a potential urinary tract infection. This prompted testing and treatment for what had evidently been a recurring issue for Judith. Further insights from Anthropos and an OT assessment prompted installation of a bath lift and changes in her care and support plan.

Judith and her family were reassured by the improved understanding of her situation and were pleased with how the Anthropos technology had supported the right adjustments being made to her care and support plan. Judith's confidence to remain in her own home was also restored and she remains living at home which had always been her wish.

The Essex **Care Technology Service** provides access to a range of technology products that support people to maintain their independence; manage medications; prevent or respond to falls; and enable people to contact loved ones or care assistants when needed. Over 10,000 people now benefit from the service. The average age of a person receiving Care Technology is 78.6. We have trained almost 2,000 prescribers from a range of partners including NHS community providers, Essex Fire and Rescue Service, Red Cross, Community Agents, hospices, domiciliary care providers, and primary care.

The Service won the iTEC Transformation Award 2022 and was Highly Commended for Innovation in the LGC Awards 2023.

Key elements:

✓ Prevention and early help

The Council's corporate strategy Everyone's Essex includes commitments to level-up health outcomes, promote independence and healthy lifestyles, and support the wellbeing of carers.

Strengthening our early help and prevention offer is a strategic priority for ASC. We are developing our Early Help Offer to include:

- Universal access to good quality information.
- Safer neighbourhoods.
- Promotion of healthy and active lifestyles
- Reduction in loneliness and isolation
- Encouragement of early discussions in families or groups about future care or accommodation needs.

Adult Social Care works closely with Public Health colleagues as part of a strategic partnership within a single council portfolio. In delivering our Care Act duties around prevention, we have invested in a comprehensive early help offer to Essex residents.

Our Essex Wellbeing Service is commissioned by Public Health and provides a first point of contact for people, families and carers and a holistic range of information, advice and support. It provides access to support, including befriending services, emotional and mental wellbeing support, debt, housing and employment queries, child and family lifestyle services, and carers support, as well as a range of health improvement services including smoking cessation, physical activity, NHS health checks and weight management. Provide CIC (Community Interest Company) is the lead provider, delivering the **Single Point of Access** (SPA) to help people get the support they need. In 2023/24, 35,000+ calls were taken through the SPA. A **Care Navigator** from the SPA has a guided, holistic conversation with the person to identify their needs and identify the most appropriate support. Care navigation partners include the Alzheimer's Society, Carers First, Citizens Advice and Sports for Confidence. In 2023/24, EWS worked with over 600 carers and prevented 400+ from falling into crisis. With increased publicity of the specialist carers offer, the number has increased since 1st April 2024.

As part of the EWS we commission the following services:

- Our **Reconnect service** promotes physical activity to improve the lives of people living with disabilities and/or long-term health conditions and their carers. It uses an evidence-based Occupational Therapy-led model of support, using physical activity as a way of building and maintaining physical, mental and emotional wellbeing. An initial pilot, the Prevention & Enablement Model, run in partnership with Active Essex, was the subject of an independent assessment by the University of Essex that evidenced substantial beneficial outcomes and could lift the wellbeing and activity levels of a disabled person to levels similar to those living without a health condition or disability. The evaluation showed the programme might deliver up to £58.71 of social value per each £1 invested.

- The **Rural Community Council for Essex (RCCE)** provides Community Agents that support independent living and the **United in Kind (UiK)** coaches develop local initiatives to reduce social isolation. In 2023/24, **Community Agents** made 3,778 referrals to other organisations (specialist advice, assistive technology, befriending, housing, sensory, strength & balance) and United in Kind community resilience projects supported 12,740 individuals to connect with others in their community. 97% of people felt "some significant progress of needs had been achieved" or "needs fully met".

- **HCRG** care group work with families to improve their lifestyles, linking with school nurses and health visitors.

- **Terrence Higgins Trust** provide an outreach service for people who are unlikely to access mainstream services and help organisations with engagement and co-production activities.

- ***Essex Working Well*** workplace wellbeing initiatives reached 73 new organisations and supported 544 people to complete Mental Health First Aid training in 2023/24.

Essex Adult Social Care is working jointly with Public Health in relation to a £7.5m grant programme that will run for 3 years to stimulate small and larger scale community prevention initiatives to target gaps in our offer. This will be governed and managed locally with NHS partners at local Alliance level across Essex. Since launch, the grant programme has supported 19 organisations with large grants, in excess of £15,000, totalling £3,586,648. In addition, we have supported 40 small scale grassroots projects to a total of £426,259.65.

The Council has recently announced an additional £3 million in investment from its Public Health Accelerator Bid funds to support these areas and address socio-economic drivers such as housing, poverty, economic insecurity and skills.

✓ Supporting people to optimise their independence

The Essex Care Technology service, launched in 2021, now supports over 10,000 people to maintain their independence, and in February 2024 the service had an overall customer satisfaction rate of 90% feeling Happy or Very Happy and 94.8% would recommend care technology equipment to others. The countywide service (operated by Millbrook Healthcare Ltd and Provide CIC) is exceeding all operational and financial targets and delivering wider social and environmental benefits, as well as system benefits such as helping to avoid ambulance callouts. We have trained 1,954 prescribers across the community and created roles as part of hospital Integrated Discharge teams to ensure that technology is utilised to maximise independence.

The **Integrated Community Equipment Loan Service** was commissioned in 2023 in collaboration with Thurrock Council and our health partners. It promotes use of equipment to enable independence, offers information, advice and guidance (IAG) to the whole community and provides access to a range of equipment and adaptations to prescribers. 2,500 prescribers across the system can access a range of equipment and adaptations to promote independence and safety at home and support carers (formal and informal). Approximately 3,000 people are supported each month by the service. Key improvements include longer opening hours (8am – 8pm Mon-Sat), collection times within 6 days, a live, web-based ordering system accessible by prescribers, adults and families, and process automation to free up clinical time. A lived experience forum has been established as part of performance management and the continuous improvement of the service.

✓ Independent Workforce Team (IWT)

The **IWT** underpins our occupational therapy offer, providing effective **Occupational Therapy assessment and intervention** for people with a health or medical condition which significantly affects their quality of life. They specialise in assessments for complex equipment provision, moving and handling routines or major adaptations. Practice is strengths-based with an emphasis on physical activity, promoting the relationship between occupation, health, and wellbeing. They provide cost-effective solutions and enable people to remain in their own homes for longer.

Connecting people with communities

Each of our 3 integrated care systems is committed to neighbourhood working and our social work practitioners work collaboratively with partners in **Integrated Neighbourhood Teams (INT).** The teams are aligned to geographical areas of c50,000 populations and bring together the NHS, social care, housing and voluntary sector professionals, joining up systems, services and information. They focus on emerging needs and pressing challenges, which allows for a tailored approach to care and support, including when working with people from marginalised or seldom heard groups.

Our highly regarded **Countywide Mental Health & Wellbeing Team** won Team of The Year at the Social Work Awards 2023. They provide short term, **early intervention** support to people experiencing mild to moderate mental health needs, regardless of whether they meet Care Act eligibility thresholds. This includes support to carers supporting people with mental health difficulties. Support includes social prescribing, linking people to community resources, non-clinical direct support and evidence-based therapy. Referrals increased by 41% between 2019/20 and 2023/24.

The **Local Linked Support** team (active since March 2020) provides intensive, short-term support to adults with a learning disability and / or autism to achieve solution-focused outcomes via connections to community resources. At the end of April 2024, the team has supported 329 people, of whom 86% did not need any further input from ASC within 6 months after being closed. The Team uses a modified version of the Me.Planning Outcomes Tool to measure their impact on the adults they work with and has achieved an average improvement of 28% in how the adults regard their lives and wellbeing.

Areas of focus:

✓ Advocacy

Adult Social Care commissions an all-age and all advocacy type service on behalf of Adult Social Care, Children and Families, Mental Health and health partners. A service review highlighted that the advocacy service was delivering good quality advocacy provision and the single point of access meant people had smooth transitions from one type of advocacy to another, but there was a need for more specialist advocacy support, especially culturally appropriate advocacy support. We worked with partners and stakeholders, including people with lived experience, **to co-design, procure and mobilise a new Advocacy service.** This new service (launching in July 2024) will build upon the strengths of the existing service, retaining the single point of access, which is valued by all stakeholders, while strengthening access to specialist advocacy. The service will also increase the support offered in relation to non-statutory advocacy support, including peer and citizen advocacy support.

✓ Adult social care investment fund for prevention

Our strong financial management means we have been able to **create an investment pot** of £3.1m for public health investment in early help and prevention. These funds have enabled us to substantially increase investment in carers support, fund Strength & Balance services and expand our Reconnect Service (referenced above) across the county. We have recently agreed further investment in key areas that are known to support people's wider wellbeing and to manage demand on the ASC front door.

Specific initiatives cover:

- expanding care technology in a preventative way for people who do not have an existing ASC package;
- creating a single point of access (SPA) for financial advice and guidance;
- increased capacity for targeted support for homelessness prevention;
- additional Senior Housing Occupational Therapists (OTs) to improve access to the Disability Facilities Grant (DFG).

Work to mobilise these initiatives is currently underway, which includes developing a consistent approach to reporting and measuring impact on how these prevent, reduce, or delay people needing ASC services.

Information, advice and guidance

The scale and complexity of Essex means that we need to have a significant information, advice and guidance offer. Our approach includes a web-based offer; one-to-one support through our Adult Social Care Connect (ASCC) front door service; a variety of specialist commissioned arrangements through partners; and a broad community wellbeing offer. We work with our partners to ensure the ICSs host information and guidance and that there are bespoke service offers through our voluntary sector partners. The ECC website hosts a range of information including a guide to adult social care and support, which provides information that supports areas both locally and county-wide. 66% of people who use services report they find it easy to find information, which is marginally below England and East of England averages (67% and 68% respectively). Over the last year we have made improvements to our **online content** to support easier navigation to information and support, in order to prevent, reduce and delay the need for care and support.

Working with people to plan ahead

We recognise the importance of working alongside people to help understand their goals and strengths, and to help them chart a way towards positive achievement of their outcomes. Our Essex Wellbeing Service, Community Agents and Adult Social Care Connect Teams adopt a 'whole person' approach to requests for support. This means consideration of the person's immediate needs and also access to information and support to help them plan for the future. Thinking about future needs related to accommodation, employment, finances and other key areas of life is embedded in our practice and processes and included in the wide range of person-centred resources, such as our 'Thinking Ahead' toolkit available to our workforce.

1.3 Domain: Equity and experience in 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 to this.

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.

Case study 6:

Making the Difference Every Day:

Charlie's story

When only 13 years old, Charlie was shot in the head by a pellet gun resulting in a Traumatic Brain Injury. Charlie was later diagnosed as having an Atypical Autism and Organic Personality Disorder.

It was not possible for Charlie to return to his family home and he found himself moving through different health services with little stability and longevity. Now aged 38, Charlie has been living for 4 years in a long stay hospital placement, where he is progressing well. Collaborative planning is now underway with Charlie and ASC, including the Behaviour Advisors and the Multi-Disciplinary Hospital Team, to create a personalised life plan to support Charlie's discharge from hospital. This bespoke plan captures what is important to Charlie, such as his love of the outdoors, and how important it is for him to have things that he can call his own. It also addresses the health inequalities that Charlie continues to encounter in the lack of viable support offers.

Charlie's personalised life plan is helping to formulate a Service Specification for a future home which will be funded via an NHS Capital Grant bid. This recognises what's important to him in terms of location and type of accommodation along with the specifics for future care and support arrangements. The hope is that his current team of carers will be able to follow him into his own home to offer continuity.

Whilst Charlie is still on the journey towards discharge, he and his team are hopeful about his future and the possibilities that lie ahead, such as his aspiration towards employment.

Case study 7:

Making the Difference Every Day:

Simon's story

Having attended Essex Cares Ltd's day service in Basildon for 4 days a week for the past 34 years, 60-year-old Simon, who has learning disabilities, had an established routine which he enjoyed. But Simon had previously volunteered at a stables and would often reminisce about his experience with and love for horses.

With the support of an Inclusive Employment Consultant (IEC), Simon applied for a volunteering job working with horses at a local family run farm. He quickly settled into his new role, established a new routine, and flourished. This was recognised by his employer who, impressed with the standard of his work and passion for the job, offered Simon paid employment. Simon still works at the farm caring for the horses with diligence and skill.

In 2020, we awarded **Essex Cares Ltd** a 5-year **Learning, Innovation, Volunteering and Employment (LIVE)** contract to progressively transform building-based day services into an inclusive employment service. Over 400 adults with learning disabilities have now been supported to gain meaningful employment and there are now more adults in the inclusive employment service than in day services, which is a cultural and transformational shift.

All the adults have benefitted from:

- Bespoke career guidance and support including vocational profiling
- Vocational and accredited qualifications
- Work experience placements based on an individual's interests (leading to placements into a wide array of opportunities such as horticultural, facilities management, care, retail, and hospitality settings).

Case study 8:

Making the Difference Every Day:

Shiju's story

Shiju is a 23-year-old man living with his parents and grandmother in the family home. Shiju has many fun and energetic interests and family is very important to him. Shiju has a learning disability, autism, ADHD, and anxiety. Change is difficult for him and he sometimes shows his distress through behaviours such as hair pulling, hitting or being destructive within the home.

Shiju has a direct payment to pay for his carers but, following a distressing incident in which he became upset whilst out and about with his carers, the care agency gave immediate notice to terminate their service and his family reluctantly asked ASC for help to find a residential placement.

A prompt and co-ordinated social work and multi-disciplinary response (LD Enhanced Support Team, Psychiatry and LD nurses) introduced a new care provider and worked closely with the new workers while they got to know Shiju and his family and learned how to respond to his needs as a Hindu. Building a relationship with both Shiju and his family has been fundamental to understanding what matters most to them.

Shiju is building confidence in his new care team and will now actively seek support from them to go out. He is finding change to be less troubling and his family have expressed their appreciation of the support they have all received, stressing how culturally difficult it had been for them to contemplate residential care. The new support is working well for them too and is enabling them to continue caring for their son while he lives at home.

Key elements:

✓ Equity is identified as a central component of the Council's corporate agenda

ECC's Levelling-up Essex White Paper identifies **priority places** (including where there is a high level of deprivation such as Tendring, Basildon, Harlow, and Canvey Island) and **priority cohorts** (children and adults with SEND, learning disabilities or mental health conditions; working families; children on free school meals; and young adults aged 16-24 who are not in education, employment, or training) to guide a range of levelling up initiatives.

ECC commissioned Oxford Consultants for Social Inclusion (OCSI) to **develop a Community Needs Index** (CNI) which allows us to identify areas that suffer the dual disadvantage of high deprivation and high community need.

ECC has invested in a **6-point plan to support residents with** Cost-of-Living **challenges**. This includes delivering the Department for Work and Pensions **Household Support Fund**. In the period April 2022 to March 2024 there have been 91,745 payments to a total value of £10.5m: 8,334 to Unpaid Carers, 47,013 to Pensioners and 36,398 to adults with disabilities.

The **Essex Anchors Network** harnesses the potential of Essex's councils, hospitals, emergency services and universities to have a beneficial impact on the community through procurement of goods and services, employment, social and environmental activities and the promotion of inclusive employment. Members of the network have undertaken a range of initiatives to promote local employment, enhance collaboration and share resources with community organisations. Future areas of focus might include developing access to sustainable and active travel for the local workforce, diversification of local SME markets and development of sustainability initiatives. Over the past 2 years, ECC's Anchor Support Team and ASC have collaborated in the delivery of 5 Reverse Job Fairs (RJF). RJFs give job seekers with learning disabilities and autism the opportunity to showcase their skills and 'sell' themselves as potential employees. Employers move around the room to each job seeker as they remain in their place. The job seekers are identified by Essex Cares Limited (ECL), with potential employers coming from a wide range of Essex Anchor organisations including: the NHS, Police, Library Services and ECC.

Population Health Management (PHM)

We are committed to the development of Population Health Management across Essex with investment in a dedicated health and care analytics team. The team supports joint working with the 3 integrated care systems to embed **population health management approaches and the use of data and intelligence** to support commissioning, planning and strategic decision-making.

Each ICS has established a new data platform for their system and set up an intelligence function to coordinate joint insight to inform ICS work programmes. ECC is an active member in the development of each system's PHM programme, supporting and guiding the insights being generated for more proactive, preventative initiatives.

There are a range of projects to utilise the linked data, new platforms and intelligence capability including:

- A Dashboard for the Mid & South Essex ICS is being developed to provide insight on the health and care pathway for those being supported by our ASC services. **Utilising the new ASC client level dataset** linked to health care records, this interactive view will support improved understanding of demand drivers. Whilst we are starting with Mid & South Essex ICS, we plan to use the knowledge gained to work with our other geographies on developing something similar, once their own platforms are ready and able.

- **Connected Neighbourhoods**: a project with 5 primary care networks to accelerate the delivery of anticipatory care for people living with frailty, understand factors driving increased needs, and work with practitioners to design changes to care models to improve outcomes in Mid & South Essex.

- An algorithm was developed for Herts & West Essex ICB to identify high service use patients, the ***Vital Few,*** that had been found to account for over 18% of all intermediate care activity. 49 individual adults were identified of whom 12 were unknown to ASC. The Vital Few lists were provided to ASC teams to review, assess and recommend for multidisciplinary team intervention if needed. Next steps include improving and embedding the process within the system's PHM data platform.

- The **Clinical Frailty Scale** (CFS) tool, is used to assess frailty on a 9 point scale in order to optimise quality of life outcomes. Analysis of expected levels of frailty is used to provide insight and support

targeted action across the North-east Essex Alliance. Next steps are to share good practice, analyse demographics and referral routes and develop insights on how, who and where to target increased support for implementation.

- A **quality of housing model** has been developed to provide insight on areas of the county most likely to experience poor housing, which could be impacting health outcomes. Linked to ASC and health data, work is under way to identify cohorts of the population whose health needs could be exacerbated by their living conditions and provide early interventions.

- **Segmentation models** have been built as part of each ICS PHM programme. These models will provide insight for early intervention on specific cohorts experiencing gaps in care and can be utilised to inform work on preventing, reducing or delaying health and care needs.

✓ Supporting inclusive employment

In line with our vision to support people to maximise control over their lives, we prioritise supporting people of working age to access employment opportunities and to maintain that employment. For adults who are already in receipt of long-term services, Essex was in line with the national average (Essex 4.5% in 2022/23 compared to 4.8% nationally) for the proportion of adults aged 18-64 with a primary support reason of Learning Disability in paid employment. Our preliminary 2023/24 figure is now 5.9%. We are substantially above the national average (Essex 15.2% compared to 6% nationally) for adults known to secondary mental health services.

For adults with **learning disabilities,** we commission Essex Cares Limited **(ECL),** our local authority trading company, to provide supported employment services. The **ECL Live Contract** has consistently outperformed its targets since 2020 for both the numbers of adults supported to find employment and the total number of adults in employment. Retention of employment has been very strong for those adults who have been supported into employment through this service. As of 22nd May 2024, ECL had supported 406 adults with learning disabilities to gain meaningful employment and there are now more adults in inclusive employment than in ECL day services.

An **Inclusive Employment Service** was launched in August 2023 to provide intensive support and specialist advice to employers, and to potential employees and their families. It supports families to ensure that financial considerations are not a barrier to anyone wanting to work and will include

intensive support and specialist advice to sustain employment. **Our Business Grant Funding scheme** encourages Essex businesses to apply for grants of up to £25,000 to overcome barriers to employ people with a learning disability or autism.

For adults with **mental ill health,** our current employment rates are higher than the national average, with 15.2% of adults with mental ill health in employment. We commission 3 services to support people in employment:

- We commission **Individual Placement and Support (IPS)** on behalf of the Essex ICBs and Southend Council for people accessing secondary mental health services. This is delivered by EPUT in partnership with Employability. In 2023/24,the service received 1,090 referrals and 241 people were supported into work.

- ASC funds and commissions a **retention service** which is available to anyone in Essex who's in employment and struggling due to mental ill health. Most referrals come through clinicians, but people can self-refer. In 2023/24 it supported c.600 people from over 900 referrals and has worked with over 200 employers across Essex. We are currently re-commissioning both the IPS and the Retention Service, whose contracts end in 2025.

- In 2023, ASC was awarded DWP funding to expand the **Individual Placement & Support** service into primary care (IPSPC). Essex is only one of 12 counties to be given this opportunity. The service supports people with mild to moderate mental and physical health issues. Referrals can come from Primary Care, GPs, DWP or people can self-refer. Since the service started in late 2023/24, 106 individuals have accessed support (20 supported into work and 86 supported to remain in work) and it is ramping up to meet the target of 2,236 people over 18 months. We are in discussion with DWP to recommission IPS in Primary Care as part of the universal support offer when grant funding ends in 2025.

✓ Addressing health inequalities for adults with disabilities

We are committed to working with our partners through our 3 integrated care systems, and our 5 local place-based alliances. One of the examples we are most proud of is the Southend, Essex & Thurrock Learning Disability and Autism Health Equalities Programme (Transforming Care), which promotes health equality for all ages on behalf of the Southend, Essex & Thurrock (SET) ICSs and local authorities and is hosted by ECC. The programme delivers an integrated health, education and social care approach to key national targets including LeDeR, Transforming Care case management, the Dynamic Support Register for all-age risk of mental health admission, and Care (Education) & Treatment Reviews. It commissions specialist learning disability health services and Autism

Outreach and crisis avoidance and delivers national programmes such as Annual Health Checks and STOMP and learning disability & autism workforce development. The programme manages pooled funding for a key group of inpatients and other LD&A funds on behalf of partners.

The Programme works closely with individuals at risk of mental health admission and with advocacy groups to ensure lived experiences influences every aspect of the programme. An Experts by Experience Forum oversees the programme at the LDA Health Equalities Board and raises questions to the Collaborative Partnership through this forum. We have successfully co-developed service specifications for both Keyworker and Autism Outreach services and are currently reviewing the experience of our specialist LD health service through a Healthwatch survey and an inpatient interview through Summit.

Reportable measures:

- Reduction in adult mental health inpatients is currently 42, against a target of 41.
- Reduction in children & young people mental health inpatients is currently on target at 6.
- Against the target of 100% completion of LeDeR reviews within 6 months, SET is currently 65% (England average 45%).
- Against the national target of 75% LD Annual Health Check targets for people over 14, we have achieved the more ambitious local target of 81% (4,735 people).

✓ Sensory Support

ECC commission a holistic sensory service via a partnership between ECL and voluntary and community sector (VCS) providers to support people with visual, hearing or dual sensory impairments. The service offers information, advice, guidance and wellbeing support and, where needed, assessments for support, equipment, life skills and tools to manage daily living. The service includes access to qualified rehabilitation practitioners.

Prior to recommissioning Sensory services, ECC volunteered to trial a process, *Working Together for Change*, as a way of building local capacity for co-production. The project was match-funded by the Regional ADASS. These workshops were used to understand what matters most to people who use sensory services in Essex and to use that to redesign the pathway to meet future forecast demand. The new redesigned service went live in November 2023, using themes from this co-produced model for change.

ECL deliver 3 elements of the sensory pathway: a triage service (the front door for sensory referrals), the sensory registers which they manage on behalf of ECC for different severities of hearing or sight impairment or deafblindness, and specialist sensory rehabilitation services. Our VCS partners offer IAG and, from November 2023, 4 now also offer non-specialist sensory support, assessment and equipment, ensuring people get the help they need quickly and remain safe. In addition, ECL maintain the sensory registers for ECC for those who wish to be included. These registers are for different severities of hearing or sight impairments, and deafblindness.

In the first 5 months of the new pathway (November 2023 – March 2024), ECL have accepted 258 referrals for specialist sensory support with rehabilitation and the VCS have provided 306 assessments. Everyone coming through the pathway has received an assessment within 28 days, in line with RNIB best practice guidance. This demonstrates the pathway's additional assessment capacity with an overall quicker response time.

Within our Adult Social Care teams, deafblind assessor training is available for staff with varying levels of qualifications available. Completion of the top levels of specialist training allows staff to complete complex deafblind specialist assessments. One of our VCS partners is a specialist deafblind organisation providing IAG and support groups, and ECL have a deafblind specialist in their service for assessment and support. We also have a Physical and Sensory Impairment team within each quadrant and offer sensory awareness training to staff across all teams.

Areas of focus:

✓ Accommodation programme

We have been working with local housing authorities and registered providers of social housing to influence the availability of good-quality accessible housing and develop a strategic, joined-up approach to housing and accommodation for older people and people with disabilities. This includes improving the usage of the **Disabled Facilities Grant (DFG)** and growing the provision of affordable **Extra Care** housing for adults with disabilities as well as older people. There has been a 45% increase in DFGs delivered since 2020, from 666 in 2020/21 to 967 in 2022/23, and we are delivering DFGs faster than in previous years. We have reviewed the DFG with our district partners and are working to improve equality of access, waiting times, and uptake.

The vast majority of adults are living independently, with only 19% of adults whose primary support reason is a learning disability are in a permanent residential care placement. Our **Meaningful Lives Matter (MLM) transformation programme** for adults with learning disabilities and autism has worked extensively with people to understand housing and employment needs.

Our Independent Living Programme for older people aims to develop 9 new extra care schemes, providing 712 units of specialist accommodation with ECC nomination rights into 530 of these units. Average occupancy in extra care was 97% at the end of March 2024. We have sites for 7 extra care schemes; 2 sites have secured planning permission and we are preparing tenders, 5 are securing planning permission and we are seeking sites for the remaining 2.

In partnership with EPUT and the ICBs, we have transformed our **Mental Health** community accommodation offer.

We have **4 in-house residential homes all rated by CQC as good.** These consist of 2 short-stay and 2 longer stay residential settings, all supporting people with learning disabilities or autism. We are transitioning this service to a full enablement support programme. We have trained our workforce to take on a trusted reviewer role. We also have a **Shared Lives service** that currently supports 47 people, with 45 long-term and 19 respite hosts.

Recent activity includes:

- The development of flexible criteria for **Extra Care,** to ensure schemes are inclusive and can meet the needs of adults with a learning disability or physical and sensory needs as well as older adults.
- Promotion of the short-term use of Extra Care and sheltered housing, ***Stepping Stone Home,*** as an alternative to an interim care home placement for adults with care needs.
- In partnership with EPUT and the ICBs, we have transformed our Mental Health community accommodation offer. We have developed a tiered **Mental Health Accommodation Pathway** to provide holistic support to enable adults to recover from mental ill health and move on or step down into independent living. Supported by hospital and community teams of **Move On Facilitators,** the pathway improves flow and capacity across the whole mental health system.
- The development of a team of **Move On Workers** as part of an ASC **Accommodation Hub** to help adults with disabilities move to the most suitable home for them that maximises their independence.
- Work with **Essex Housing** (our in-house housing developer) to deliver 33 apartments across 4 supported living schemes for people with learning disabilities, securing planning permission to develop further accommodation units for adults with complex needs.

We implemented the first phase of our new mental health supported housing model in January 2023 and are in the process of rolling the model out across Essex. Our new model was developed with contributions and feedback from people with lived experience of mental illness, many of whom had personal experiences of mental health supported accommodation in Essex. People told us that existing services were not always personalised or focused enough on supporting people to acquire or regain the skills and confidence to live independently. This feedback, together with our wider review of previous services, has shaped the tiered approach to our new model and the inclusion of new move-on facilitator roles that play a critical connecting role with our teams, service providers, and housing agencies to enable people moving on towards greater independence.

Since the implementation of our new model, we have seen a substantial increase in the number of people moving through our supported housing services, which has released capacity for people coming through with higher levels of need from hospital and other settings.

Ensuring care and support meets the needs of communities

We have some good examples of our use of **lived experience** to inform service improvements, such as our Connect programme; our work with adults with learning disability or autism on inclusive employment; the redesign of our Direct Payments Support Offer; the development of our Carers Core Offer; and the refresh of the Essex All-Age Autism Partnership. We are working with Think Local Act Personal (TLAP) and ADASS to strengthen and further embed our approach to co-production. Further details are under Domain 4.2.

Leading on work to engage and empower seldom heard groups and those less likely to engage with statutory services, Terrence Higgins Trust, provides a cadre of specialist health and wellbeing coaches that are working and building trust within different sites in Essex. One such example is a monthly racial minority women's group attended by women from a variety of cultural backgrounds to promote health and wellbeing and reduce inequalities.

We are also working to improve our collection, analysis and use of **social care data** and information to inform our response to people with protected characteristics. See Domain 4.2 for further information.

Section 2:
Providing Support

This section covers:

- Domain: Care provision, integration and continuity
- Domain: Partnerships and Communities

Summary

The **capacity and quality of the Essex care market is good** and has been stable over time, with strong relationships between the Council and its providers. We have developed a clear Market Shaping Strategy and have started moving towards cost of care (especially in domiciliary care), but this remains a financial challenge for the local authority in future years.

We work with, and support investment in, the Essex Care Association (ECA). This provides a forum we can engage with, and consult with, as part of market shaping strategies and decisions. We also engage at a more local level through locality-based care provider forums.

We have improved access to domiciliary / home care. This has been achieved through increasing investment in line with the cost of care work and through provider recruitment, particularly international recruitment. This has reduced the numbers of people waiting for sourcing compared with 2021/22, when we had up to 150 people waiting for sourcing care. We have minimal numbers of people currently waiting due to capacity in the care market.

Since July 2021, Essex has had an **innovative and fast-growing care technology service** which is now supporting over 10,000 people to live more independently.

Essex has a **low rate of admissions into permanent residential or nursing care** and has an extensive reablement offer which supports adults to be as independent as possible.

Essex is good at the **timely discharge of people from hospitals** to social care, and Essex hospitals are among the best in the country (according to NHSE data) for the percentage of beds occupied by people who do not meet the criteria to reside, and have one of the lowest rates of delayed discharges per 100,000 population.

We have developed **inclusive place-based alliances** with our NHS, district / borough / city council, and voluntary and community sector partners to promote shared goals and collaboration.

We have **developed and have embedded a** Local Authority Pressures Escalation Level (LAPEL) **framework**, which is an equivalent to the NHS OPEL framework.

But we also have areas for improvement. ECC and NHS partners are **working on plans for more integrated intermediate care services** once the current contracts end in late 2024.

Work is also underway with our 3 integrated care systems to implement a **more consistent model of transfer of care hubs** (TOCHs). These are operationalised at a local level around the 5 acute hospital sites and our 5 place-based alliances.

Our key stats

Provider ratings

83% of Essex Care Market
is rated Good or Outstanding (April 2024)

84% of ECC-funded domiciliary care providers
are rated Good or Outstanding

71% of providers on the IRN framework
are rated Good or Outstanding

87% of providers on the Living At Home framework
are rated Good or Outstanding

Care technology

10,133 people
are currently supported by care technology

Care support

Rate of 349 per 100k adults aged 65+
admitted to residential / nursing care (2022/23)

Rate of 7 per 100k adults aged 18-64
population admitted to residential / nursing care (2022/23)

Discharge support

86.3% of older adults (aged 65+)
were still at home 91 days after discharge from hospital into reablement (2022/23)

2.1 Domain: 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

I have care and support that is coordinated, and everyone works well together and with me

Case study 9:

Making the Difference Every Day:

Kate's Story

Kate is 65 and has advanced vascular dementia. Kate has a very strong family network and her family is extremely important to her. After a difficult spell in hospital, Kate was discharged to a nursing home where, in accordance with the Discharge to Assess pathway, ASC contributed to her continuing health care decision process. Having decided that Kate did not qualify for ongoing health funded care, a Care Act Assessment was completed with Kate and her family.

In 2022, Kate's family wanted to have her home for Christmas but could only envision this being for 2 weeks before Kate would need to go back into a care setting. In a meeting with Kate and her family, the Social Worker talked with them about the benefits of care technology and how it could support her to return home with confidence and support. The Dementia team completed a review with Kate as part of a multi-agency approach. Support for Kate's husband as a carer was also reflected within the care and support plan to support the return home.

Two days before Christmas, Kate arrived at home with care technology and other professional support in place. Kate spent Christmas at home surrounded by her husband, daughters, and grandchildren. To encourage other people affected by dementia, the family posted a photo of Kate on Facebook saying:

“Mum responded when spoken to and even had a little smile when I said to her ‘mum we promised you would be home for Christmas’. We have had one of the most stressful, upsetting years of our life as a family but today was special!”

They sent their post to the social worker with the message **“I want to say thank you. You done this for our family! Merry Christmas”**.

Despite some bumps along the way, Kate is still living at home 18 months later and is looking forward to celebrating next Christmas with her family and new grandson.

Case study 10:

Making the Difference Every Day:

Adam’s Story

Adam is 57. He has autism and learning disabilities and a history of boundary testing with fire setting, sexualised behaviours and hoax-calling emergency services. After spending a significant number of years detained in secure hospitals, Adam was identified as a candidate for the Thistley Green's community supported living house. He has weekly social supervision reporting to the Ministry of Justice and he has a multi-disciplinary approach with a bespoke care and support plan. This was as part of the Transforming Care (Health Equalities) programme.

Adam embraced the opportunities presented to him and has now been living at Thistley Green for 3.5 years. This has not been without incident, but positive risk taking by the local authority, a consistent Social Worker, health partners and the provider service have enabled Adam to maintain his tenancy and avoid re-admission to hospital. Adam continues to take progressive steps towards greater independence and is preparing himself for unescorted walks in the local area.

Thistley Green was developed as part of the **Transforming Care Programme,** supporting implementation of the national service model for people with a learning disability and/or autism who display behaviour that challenges.

A property was purchased and adapted with oversight from a multi-disciplinary team (MDT), enabling 10 adults, who between them had spent 116 years in low and medium secure hospitals, to be supported to move into their own self-contained flats. The contract for care provision was awarded early in the process to allow good time for relationship-building with the adults and the MDT.

A robust and careful approach was taken to the assessment, care and support planning and transition of each person, with the addition of assistive technology to support them to take a sensible approach to risk and build independence. This included consideration of each tenant's mental capacity and their ability to co-produce their care plans. Tenants and their families were supported to personalise their flats and have choice and control over their environment.

The outcomes for the people at the Thistley Green scheme have been positive. All have had continuous and consistent access to the MDT, resulting in only one brief detention of a tenant under the Mental Health Act since Thistley Green opened in 2019.

Case study 11:

Making the Difference Every Day:

Patrick's Story

Patrick, aged 60, was in prison serving a life sentence and was due for parole. The referral to ASC said that, due to the impact of seizures, Patrick had been receiving care and support from his son (also in HMP Chelmsford) and would need care and support post release.

The Care Act assessment identified the need for daily care support to be introduced while Patrick was still in prison. Upon his release from prison to approved premises, the care provider continued to visit daily to support him with washing, dressing, managing his medication and taking care of his room.

But after spending so many years in prison, Patrick felt overwhelmed as he tried to re-discover a life in a now strange and unfamiliar technological world. The care provider worked sensitively with Patrick at a pace with which he was comfortable.

Whilst in prison, Patrick had been affected by health inequalities. The stress of adjusting to a new life outside prison contributed to a flurry of seizures. The social worker "stuck to Patrick like glue", challenged the discrimination

and stigma he faced and helped him find a GP, who in turn referred him to an epilepsy nurse and requested assessments that confirmed a non-aggressive form of cancer which required continued monitoring. As Patrick's mobility had been impacted by his seizures, he was also referred to physiotherapy, and epilepsy sensors were later explored to alert emergency services and his family to any further seizures.

Patrick has since moved in with his partner on a temporary basis and the seizures have abated. Housing options continue to be explored, as it is important to Patrick that he has his own home close to his family. Patrick feels this will bring him closer to his goal of being settled by next year when his son is due for release, as he would like to be part of his son's reintegration journey.

Key elements:

✓ A stable and diverse care market

Essex has a **large, stable, and diverse care market** of over 800 providers (c385 care homes and 428 community-based providers (May 2024) plus a range of unregulated services. Essex Cares Ltd (ECL), our countywide local authority trading company, provides reablement services (all rated Good or Outstanding by CQC), as well as inclusive employment, day services, and sensory services.

Our **policy is to source supply only from good or outstanding** providers. ECC funds a Provider Quality Team and quality improvement initiatives. Approximately 87% of providers on the ECC Living At Home Framework are rated Good or Outstanding.

The Essex Market Shaping Strategy (2023-30) sets out our approach and our **Market Sustainability Plan** provides a detailed picture of the existing market context. Our dynamic, online Market Position Statement provides market information via the Provider portal and is updated at least every 6 months.

Our market strategy aims to:

- **Reduce reliance on residential care**, where there is currently an over-supply of beds, in favour of supporting people in their own homes and communities;
- **Increase provision for complex care**, where there is growing demand, especially nursing and placements for adults with complex needs or behaviours;

- **Increase and evolve community-based services** such as domiciliary care and other services that support the adult to remain independent at home;
- Develop a **wider range of accommodation options** that can provide community-based alternatives to residential care, such as Supported Living services;
- **Increase the use of Personal Assistants**, Micro-enterprises, Individual Service Funds and Direct Payments to optimise adults' ability to exercise choice and control;
- Improve our **short term and early help service offer** to reduce demand for long term care services.

Our **market shaping strategy was developed with** care providers, people with lived experience, the ECC workforce, and NHS partners, through a variety of methods including surveys, webinars and face to face sessions.

We have improved access to domiciliary / home care over the past year. This has been achieved through increasing investment in line with cost of care work and through provider recruitment, particularly international recruitment. This has reduced the numbers of people waiting for sourcing compared with 2021/22, when we had up to 150 people waiting for sourcing care. We have minimal numbers of people currently waiting, due to capacity in the care market. Some people wait due to the need for complex care or in rural areas where it can be harder for providers to create viable rounds for carers. We have put in place block contracts in rural Braintree and Uttlesford to make it more sustainable for providers to deliver care. We have undertaken work to understand the reasons why people are waiting for complex care and for package hand-backs. These are mostly related to support for a small number of people who have dementia or cognitive impairment, who manifest behaviours that challenge others. This research is informing our re-commissioning of home care, when contracts end in May 2025, and of associated sourcing approaches.

We work closely with the **Essex Care Association (ECA)**, an independent member organisation for independent care providers, that provides a channel of communication between providers and ECC. We hold meetings once a month and conferences 3 times a year with the ECA, have funded dedicated capacity within the ECA for providers, and have fostered key relationships.

ECA are running focus groups with care providers in partnership with Adult Social Care in preparation for the re-commissioning of our home care and older people residential and nursing contracts at the end of 2024. We also hold local operational forums with ECA that take place 3 times per year across our localities.

The ECC procurement team is working with ECA and Care England to develop support offers to care providers on 'back office' functions to reduce costs and improve social value, such as climate change impact. We are currently testing an offer on Employee Assistance Programmes which was developed by Care England and is being tested in Essex. There is further work being tested on energy and food costs and planned work on food waste, subject to interest from care providers.

ECA ran a series of webinars on international recruitment in 2023 to support care providers. This was done in partnership with ECC. ECA is working with Essex Police to raise awareness of modern slavery and exploitation of international recruits.

The care sector is one of the biggest employers in Essex. There are c.39,000 jobs in adult social care, of which 32,000 are in the independent sector. The vacancy rate in the independent sector is about 11% (above the England average of 9.9%). We have worked closely with the care market on a Market Workforce Strategy, supporting a recruitment campaign and offering practical support to care providers, including social media and a digital marketing recruitment campaign. We have invested an additional £1.8m in the Nightingale Bursary to support more people with the training costs of entry to the care sector. All Essex Adult Community Learning is available via the Bursary. As of 31st March 2024, 350 Essex residents have undertaken a certificate or diploma course in health and social care. We have carried out care worker surveys to understand reasons for choosing a care career and reasons for leaving to inform our workforce activity. We are also developing a Centre of Excellence for care, whose key aims will be recruitment and training; improving technology within the sector and development of a Care Worker Charter.

Mental Health Strategy 2023-28

We have developed a 5-year all-age mental health strategy for Southend, Essex & Thurrock through a collaborative steering group with representatives from the 3 Essex Integrated Care Boards, from EPUT and NELFT (the adults and children's mental health providers), the 3 local authorities including public health, and Essex Police. The strategy was informed by the views of people with lived experience supported by the 3 HealthWatch organisations, as well as feedback from the wider voluntary sector and included a Health & Wellbeing Board seminar for all stakeholders.

The strategy sets out 3 priorities for adults:

1. **Prevention and early intervention**: access to local community-based support, and people with severe mental illness receiving full annual health checks.

2. **Acute and crisis services**: improved pathways and access to community-based support to avoid escalation and inpatient admissions.

3. **Supporting recovery**: including improved pathways to access housing, education, employment, and self-directed support.

Following the production of the strategy, we have initiated a series of programmes, including:

a) a county wide approach to involving people with lived experience in implementation of the strategy to complement ICB level work;

b) roll out of a county wide approach to supported accommodation;

c) a review of residential and nursing care provision across Southend, Essex & Thurrock;

d) initial scoping of EDI work undertaken with the aim of having a small number of equality objectives as part of strategy implementation;

e) producing a consistent model for peri-natal mental health, eating disorders and support to people with personality disorders.

Dementia Strategy 2022-26

The Southend, Essex and Thurrock Dementia Strategy was developed in collaboration and consultation with people affected by dementia, the workforce, and wider partners. The strategy **sets out 10 commitments** with aims to improve diagnosis and early help, develop a knowledgeable and skilled workforce, create dementia friendly communities, provide support to carers, and ensure people with dementia can live well.

An Essex-wide Network, which comprises accredited networks and people living with / affected by dementia, oversees Inclusive Dementia Communities accreditation and serves as a peer support network. We are working with partners towards a dementia-inclusive Southend, Essex and Thurrock and delivery of the commitments in the Dementia Strategy.

A key enabler of the Dementia programme is our Essex Community Dementia Support Service (CDSS) contract. Over the 48 months to March 24, this has delivered 11,826 interventions for 9,606 people. 54% of service users have reported no increase in need over this four-year period.

The Enhanced Support Team

Our **specialist Enhanced Support Team** assesses and provides ongoing support county-wide to people with a **Learning Disability and/or Autism and significant complexity of need**, their families, and the workforce who support them. The team takes a relationship-based, person-centred approach to hospital discharge, where people are likely to need a multidisciplinary team wrapped around them to support a safe and sustainable community placement.

Since the Team became operational, it has had successes in discharging young people and adults from various low secure, forensic hospitals, and locked rehabilitation and assessment and treatment units, sustaining young people and adults in the community. 32 people have been discharged to supported living placements, 23 to residential placements, and 4 to family homes, domiciliary care or fully health commissioned.

Improving our offer for self-directed support

We have **worked with a range of stakeholders, including adults who have drawn on services, to redesign and re-procure our** Direct Payment Support Services. Approximately 3,000 people have received a direct payment in Essex over the past 12 months and the redesigned system enhances the existing offer to those accessing a payroll service, which includes account management, and information, advice and training on employing a PA. We continue to review the opportunities for greater choice and control.

We have also developed the **Community Micro-Enterprise (CME) Project to support** the creation of local marketplaces across Essex for people accessing self-directed support: Direct Payment or Individual Service Fund users and people who fund their own care. The project supports people in local communities to set up organisations that can offer safe, quality and personalised services. It also creates a marketplace for personalisation, as enterprises can advertise their services for free on the Tribe Platform.

The CME project is well established in the north and south of Essex and is currently being expanded to mid and west Essex. Since the start of the project in 2021, we have received a total of 237 enterprise enquiries and supported 153 CMEs to join our programme, 100 of which have completed it fully and are now offering services locally and listed on Tribe. We currently have 29 Direct Payment recipients using micro-enterprise services in the north and south of Essex and, based on a recent survey, Tribe have estimated that a total of 966 people in Essex are receiving personalised care and support from the CMEs listed on the platform, for a total of 5,096 hours per week. An independent evaluation has shown that the service has created £4.4 million in social value and saved people funding their own care £1.04 million, whilst offering bespoke support from a local provider.

Areas of focus:

✓ Care market shaping strategy and Cost of Care

Our Market Shaping Strategy **sets out our actions to address 6 priorities** – i) workforce recruitment and retention, ii) effective management of capacity and demand, iii) putting lived experience at the centre, iv) good quality services, v) digital & technology that maximises independence and workforce efficiency and vi) financial sustainability.

We are looking to shape the market to provide more community-based services and more short-term and early help. We are working with the market to increase and evolve services to keep adults in the community and support people to remain independent at home. We are also seeking to increase the use of Personal Assistants, micro-enterprises, individual service funds and direct payments to optimise people's choice and control. We are also looking to improve our short term and early help service offer and to promote local community networks and voluntary and community services.

Adult Social Care has given **significant uplifts in rates** to care providers and is **moving towards paying Cost of Care rates** over 2023-25, subject to available funding in 2024/25. In line with our market strategy, the initial focus has been on significantly higher rates for home care and nursing care, as these are where we want and need to see continued capacity growth. In 2023/24 we increased home care rates by 12.3% (compared to 8.9% in the Eastern Region) and nursing care rates by 10.9% (compared to 9.6% in the Eastern Region). As a result of this, our rates are now in line with the cost of care for home care and nursing. We have also seen positive workforce growth in the domiciliary care market that is above other parts of the country (according to NHSE data) and have virtually eliminated problems in sourcing care in the domiciliary care market.

✓ Equality, Diversity and Inclusion

Improving equality, diversity and inclusion (EDI) is embedded within our Market Shaping Strategy and our ASC Business Plan. The key areas we are seeking to address are:

- **Data**: The performance of commissioned services in relation to EDI is not consistently reported or understood. We are looking to improve data capture within provider contracts in order to improve oversight of EDI data and insight.

- **Guidance**: to develop policy, guidance and communications for providers to promote a clear and consistent approach to EDI in the Essex market.
- **Training**: We are providing and promoting EDI training for commissioned providers and the care workforce. Essex Care Association includes regular EDI-focused sessions as part of their quarterly conferences, and we are working with them to look at other ways to share and promote good practice with providers.
- **Inclusive employment:** We have been exploring a range of **inclusive employment initiatives** to promote employment of adults with disabilities and are looking at ways to incentivise providers to employ adults with disabilities or from disadvantaged backgrounds.

✓ Optimising the role of our local authority trading company (ECL)

The Council's local authority trading company, Essex Cares Ltd, provides a range of services, such as reablement (all services rated Good or Outstanding by CQC) and inclusive employment and sensory services.

A Review was undertaken in 2023 to promote even closer working between Adult Social Care and its LATC, and a new joint leadership role has been put in place, with the ASC Director for Strategy also undertaking the role as managing director of ECL. The Review determined that ECL has a strategic role to play in continuing to help us to transform intermediate care services and disability services across Essex, and will be focused on collaboration rather than competition with the Essex health and care market. In April 2024, ECC's Cabinet approved a decision to award a lead role for ECL as countywide reablement provider for up to 10 years, to work alongside a series of local additional reablement providers in our 5 place-based alliances.

ECL is expected to collaborate more with key strategic partners in the NHS and care market and has developed a memorandum of understanding with NHS partners in Mid and South Essex to promote greater collaboration and better use of resources between the different organisations, and reduction of duplicate processes and hand-offs to improve the citizen's experience.

2.2 Domain: 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.

Leaders work proactively to support staff and collaborate with partners to deliver, safe, integrated, person-centred and sustainable care and to reduce inequalities.

Case study 12:

Making the Difference Every Day:

Joan's and Joe's Story

Joan lives at home and is cared for by Joe, her husband of 62 years. Joan's care and support needs are caused by her Hereditary Spastic Paraplegia, Alzheimer's type dementia and epilepsy.

The practitioner working with Joan and Joe shared their story within a Professional Neighbourhood Supporting Independence Discussion (SID) and invited multi-disciplinary contributions towards the care and support planning process.

The team recognised Joe's unpaid caring role and, alongside the practitioner, an extended multi-disciplinary team, including the Care Provider, Occupational Therapist, Speech and Language Therapist, and District Nurse, worked together to support Joan and Joe. A Continuing Healthcare needs assessment took place and whilst a primary health need was not identified, this prompted a review for Joan's breathing and asthma.

Holistic changes were made to the care and support plan with which Joan and Joe were extremely happy, as expressed in their own words in a podcast recorded by Healthwatch: the pursuit of happiness being an unpaid carer.

Case study 13:

Making the Difference Every Day:

Connect Programme

In November 2020, Essex County Council and NHS partners launched the *Connect* Programme – a multi-year programme aimed at improving outcomes for older people. It has achieved significant savings and efficiencies and is now embedded in our approach. The Programme won the 2022 Municipal Journal award for health and social care integration.

Outcomes include:

- A 'home first' approach resulting in c.640 fewer people per year relying on temporary residential care when leaving hospital.
- Following changes to the exit process, more adults who use our **reablement** before transitioning into long term care reporting that the transition is seamless (81.5% up from 71% in 2021).
- The number of adults who feel they are living as independently as possible as a result of our intervention having risen from 65% in 2021 to 71% in Q4 2023/24.

The **Connect programme Lived Experience survey** has captured the views of over 1,600 people. The results show that a clear majority of adults are:

74% **"Receiving care and support that is coordinated and everyone involved in their care works well together"**

77% **"The care team have reached the best possible outcome for the adult"**

84.5% **"I have all the resources in place to sustain or improve on my current level of independence"**

One example of an approach that is improving discharge outcomes is **Stepping Stone Home** which offers short-term flexible accommodation within sheltered housing / extra care schemes. This is described within the video made by Mike, Adrian, and Peter and is for individuals who are unable to return straight home from hospital. As an option, it can provide a safe, comfortable, and homely environment so that people can make plans for the future.

For more information: [The Stepping Stone Home Service (youtube.com)]

Context

Essex is **a partner in 3 integrated care systems**, covering Mid and South Essex, Hertfordshire and West Essex, and Suffolk and North-East Essex.

All Essex partners are signed up to development of a more integrated health and social care system with an emphasis on prevention, self-care and enabling people to live independently and access support in their community.

We have worked constructively with partners to **shape the development of Integrated Care Partnership (ICP) strategies**, and to achieve as much consistency as possible between the 3 Essex systems.

Our day-to-day work with NHS and other partners is centred on our 5 **inclusive place-based alliances,** which typically cover populations of 250-350k and bring together adults and children's services, public health, district / borough / city councils, the voluntary and community sector, and the NHS, as well as other key partners. The North-East Essex Alliance has been highlighted by the Kings Fund as a **national exemplar**. All our Alliances have a focus on tackling health inequalities.

Each system has made clear commitments to a **home first** ethos, multi-disciplinary neighbourhood teams and population health management approaches.

We lead and manage the Essex Better Care Fund**, worth c£200m a year,** on behalf of the Essex health and care system. This funds intermediate care services, community NHS services and investment in domiciliary care and supporting discharge schemes. A BCF Partnership Board brings together ICB and ECC leaders to agree strategic priorities. **Joint posts** have been created at both a delivery and commissioning level using BCF funds.

With partners, we have progressively transformed our hospital discharge processes to embed 'home first' approaches and significantly increase the proportion of older people who go home from hospital. We are among the best in the country at having a low rate of delayed discharges per 100,000 population and we have a low rate of permanent admissions into residential care.

We have numerous **joint commissioning arrangements** in place with the NHS, including for learning disabilities, mental health, and intermediate care.

We have **established shared care records with all 3** ICS systems.

Key elements:

Our leadership role in the integrated care systems and place-based alliances

The **Essex Health and Wellbeing Board provides strategic leadership** for population health outcomes and priorities for Essex, and oversees and approves the c.£200m per annum Essex Better Care Fund, which ECC manages on behalf of the system. ECC plays a leadership and coordinating role for the Better Care Fund, on behalf of our 3 integrated care systems.

We play a key role in the **5 place-based alliances**. ASC Locality Directors are the central point of contact for our alliance partners. ASC and NHS partners fund Alliance Delivery Lead roles through the Better Care Fund to support strategic development and programme delivery within localities. **Joint Commissioning Leads** in West Essex and the Mid & South Essex systems are working to join up commissioning on intermediate care.

The **Essex Resilience Forum** co-ordinates partners during emergency planning responses, supported by specific tactical co-ordination cells. During the Covid pandemic, Essex ASC led the **Operational Tactical Co-ordination Group** on health and care between the 3 ICSs to discuss and address system resilience challenges. This included compiling weekly Discharge SITREPs from across the health and care system. This can be reactivated at partner request during times of strain.

Working with our system partners, Essex ASC led the **development of a** Local Authority Pressures Escalation Level framework (LAPEL), which Essex, Southend-on-Sea and Thurrock use to assess and respond to pressures and access mutual aid. This is a local authority equivalent to the NHS OPEL framework. We assess our rating against the LAPEL framework each week and have an action plan against each LAPEL level.

All our integrated care systems are committed to **neighbourhood working.** Multi-disciplinary teams focused on smaller populations of c.25,000 to 50,000 are a key element of our approach to integration. Across Essex, our aim is for neighbourhood teams that bring together NHS, social care, housing and voluntary sector professionals; join up systems, services and information; and have a strong focus on early intervention and prevention and clear links into our transfer of care hubs. These provide an excellent means for us to join up different services in a holistic way to work with people, especially those from marginalised or seldom heard groups. For example, integrated neighbourhood teams have supported excellent outreach work with people living in retirement villages and caravan parks.

Home first and discharge to assess

Essex supports **timely discharge to social care** from the 5 Essex acute hospitals. All Essex hospitals perform better than the national average for the proportion of beds occupied by people who do not meet the criteria to reside (NHSE data) and we have one of the lowest rates of delayed discharges per 100,000 in the country (10 per 100,000 population as of 20th May 2024, making Essex the second-best county council in the country).

Essex has a **low rate of admissions into permanent residential or nursing care for the over 65 population** (349 per 100k in 2022/23 vs national average of 561 per 100k). The Essex rate fell during 2022/23, at a time when the national average increased from 538 per 100,000.

Essex ASC has led the design, creation and **implementation of transformational work with NHS partners** across our 3 integrated care systems via our **nationally recognised *Connect* programme** (2022 Municipal Journal Award for Health & Care integration) to introduce and embed new ways of working that promote **home first** and improve the effectiveness of reablement interventions. The programme was co-designed with Newton Europe and other system partners, in response to learning from a 12-week diagnostic exercise reviewing data and insights and case examples and learning from our workforce. Outcomes include:

- c.640 fewer people per year admitted to long-term residential care: 40 through more independent outcomes following assessments and 600 through better hospital discharge outcomes.
- A 62.7% reduction in care hours for people leaving reablement.
- A 12% reduction in length of stay in hospital for people aged 75+ (2023/24) via improved use of data in planning and monitoring discharge arrangements.
- 2,000 hospital admissions avoided (2022) as a result of an 87% increase in people accessing urgent community treatment services.
- C.£28m of savings at current run rate, measured across the health and care system by looking at reduced admissions to residential care, reduced domiciliary care packages and reduced length of hospital stays.

Our Connect approach includes:

- A *Perfect First Week* to support adults in Interim Care Home Placements to achieve their most independent outcomes.

- The development of *professional family trees* to identify team members' strengths and interests, supporting better allocation of work and informal support between team members.
- Weekly Supported Independence Discussions for teams to reflect upon the best response to people in complex situations.
- The realignment of teams to NHS neighbourhood footprints, allowing teams to work more effectively in local communities and draw upon health and voluntary provision.
- The introduction of rapid improvement cycle meetings to help sustain and maximise the benefit of improved service delivery, which then formed the basis for our current Quality, Performance and Assurance Meetings (QPAMs).

✓ Comprehensive reablement offer

Essex **offers reablement to a comparatively high number of older adults** on discharge from hospital (5% in 2022/23 vs an England average of 2.9%). These services are available to adults over 18 via ECL across the whole of Essex, and within each locality by an additional reablement provider.

Reablement services in Essex consistently **outperform the national average in terms of the proportion of those adults who are still in their own home 91 days later** (86.3% for 2022/23 vs an England average of 82.3% for 2021/22).

✓ Gathering and sharing information via digital markets

Essex has **several live digital market solutions** including:

- Care Provider Hub: used to share all communications, events and information with the market.
- Essex Care Search: client-facing bed booking system for (currently) 204 residential and nursing providers. Allows providers to manage capacity and advertise availability.
- In-house data exchange tool under development to enable Essex's 350+ domiciliary providers to share live data on scheduled and actual visits from their individual Electronic Homecare Monitoring systems.

- Working with our 3 Integrated Care Boards to improve digital maturity of providers and provide grant funding for providers to digitise care records across the social care market. To date, 95 grant applications received for Digital Social Care Records (DSCR). Current figures indicate 80-81% of Essex providers are using a DSCR system (which compares with 64% nationally).
- Shared Care Records established with NHS partners in Mid and South Essex, and Suffolk and North-East Essex in 2021, and with Hertfordshire and West Essex in January 2023. Practitioner forums with live events and training are being rolled out countywide to increase usage.

✓ Essex Disabilities Strategy

The successful Meaningful Lives Matter (MLM) programme has undertaken a range of engagement and co-production activities with people with Learning Disabilities and Autism, their families and carers since the programme began in 2020, and has more recently extended its focus to include people with physical and sensory impairments. This learning from people's lived experiences has helped to inform the Essex Disability Strategy, which **sets out 4 goals** for people living with disabilities:

1. To have good and meaningful relationships;
2. To have access to a place they call home;
3. To stay healthy, safe, and well;
4. To be active and have access to meaningful opportunities, such as employment.

The strategy guides the ongoing work of the MLM programme which, since 2020, has:

- supported 406 people into employment via the **ECL LIVE** contract (covered under Domain 1.3).
- implemented *Thinking Ahead* and *Ageing Well* toolkits to improve practice and health outcomes.
- worked with partners to increase accommodation options and quality.

- improved community engagement and early intervention with those not known to social care through our Local Linked Support initiative and befriending and peer mentoring pilot ‘Bfriends’.
- developed the Autism Navigator service from an ECC-only pilot to include all Essex local authorities and ICB areas. This new, wider service will provide advocacy support to c.400 people per year.
- worked with health partners to improve support to access health services.

Areas of focus:

✓ Care market workforce

We have seen an improvement in recruitment into social care providers over the past year. This has been particularly related to international recruitment. In line with the national position, securing and retaining a high-quality workforce is an ongoing challenge. Over a quarter of the workforce is aged over 55 and turnover rates are about 27%. Recruitment and retention is sensitive to changes in economic outlook and competition with retailers and hospitality businesses. Essex providers are increasing pay rates with support from the Council and we have a well-received workforce strategy including wider support on training and development. The ability to maintain a strong workforce base is dependent on national policy on international recruitment and the social care funding settlement. For this reason, we regard it as an ongoing area of potential risk.

✓ Transforming intermediate care

We are working with NHS colleagues and providers to further improve our comprehensive intermediate care offer and develop a simplified model, which will increase the numbers of people who are supported to stay at home, promote greater use of care technology and continue to reduce the need for long-term care. It will also:

- Improve flow & efficiency across services.
- Focus on outcomes rather than hours of support.
- Be integrated and guided by a single joined-up service specification.
- Ensure protected capacity for admission avoidance.
- Focus on continuous improvement across health and care services.

✓ Transfer of care hubs (ToCH)

All 5 place-based alliances are developing a Transfer of Care Hub to coordinate discharge and recovery and support admission avoidance. Following a 2021 review by Newton Europe of Discharge to Assess (D2A), we began work to establish ToCHs across the 5 Alliances within Essex boundaries. All areas have functioning ToCHs with varying degrees of

maturity. We developed a maturity matrix using the LGA High Impact Change Model, national guidance and local ambitions to monitor progress. We extended this in 2024 to monitor development of delegated assessment, neighbourhood team discharge support, service improvement and practice accountability.

✓ Supporting the Essex Voluntary and Community Sector (VCS)

We value the contribution of Essex's Voluntary and Community Sector and ECC has been exploring how we can improve support for the sector that builds on insight into what we need to ensure a sustainable community-led offer.

1. The VCS are important strategic partners that are members of the Essex Health and Wellbeing Board, are represented on each of the 3 Essex Integrated Care Partnerships, and are integral members of each of the 5 place-based alliances.

2. The VCS are important delivery partners. For example, as part of the Essex Wellbeing Service and support to carers; our Essex Sensory Alliance; and dementia services.

3. Through the Better Care Fund and winter discharge funding, ASC and the NHS commission the VCS to support work on timely hospital discharges and our 'home first' approach.

Essex County Council has committed to sustainable investment in supporting the Voluntary and Community Sector to thrive until 31st March 2031 and is working with the CEO of NAVCA, the national body for infrastructure organisations, to ensure a robust and quality assured support offer for the voluntary sector in Essex to help build resilience and capacity.

The Essex Alliance is a voice for the Essex VCS sector and facilitates the Sector's representation with stakeholders.

✓ General Needs Accommodation

Supporting working age adults into general needs accommodation from supported accommodation is a significant challenge. The cost of rented housing in Essex exceeds housing benefit in most parts of the county and there is a lack of affordable housing for those on the housing register. We are working in partnership with district, city, and borough councils to secure dedicated housing.

Optimising Disabled Facilities Grant

We are **working with the 12 City, District and Borough Councils to improve the utilisation of the Disabled Facilities Grant**. We are also looking to strengthen oversight of it through local place-based alliances and the Principal Occupational Therapist. Discretionary use of this funding has enabled the employment of 6 Housing Occupational Therapists who provide dedicated professional support within some housing teams. Further investment has been secured to increase this by an additional 3 posts in Autumn.

Section 3:
Ensuring Safety within the System

This section covers:

- Domain: Safe systems, pathways and transit
- Domain: Safeguarding

Summary

Essex prioritises work internally within Adult Social Care, and across our system partnerships, to ensure **robust and proportionate approaches** to safeguarding.

We work in partnership across Southend, Essex, and Thurrock (SET) to agreed policies and guidelines. In 2022, we undertook a peer review from Hertfordshire County Council to assess our working and identify areas for improvement.

Safeguarding referrals in Essex are high. As with much of England, demand has increased each year and we are working closely with key statutory partners to understand the trends, manage risks and progress opportunities to improve our safeguarding processes, so that we ensure quality and timely responses for adults at risk of harm or abuse.

Safeguarding alerts are raised through a web-based form on our ASC portal. They are **triaged by a central safeguarding team** and, when the criteria are met for a Section 42 enquiry, these are managed by practitioners in our teams, unless there are organisational safeguarding concerns, which are managed by our Specialist Organisational Safeguarding Team.

We provide quality **improvement support to care providers** and monitor provider risks, intervening where appropriate to ensure safety, quality and contractual challenges are addressed. The Organisational Safeguarding Team (OST) leads on responding to concerns raised within or about organisations.

As the key statutory partner with the lead responsibility for safeguarding adults, we ensure our support, participation, and commitment to the Essex Safeguarding Adults Board (ESAB) and its sub-committees. There is a clear line of sight between ESAB and ASC strategies and we maintain a strong strategic and operational ASC leadership commitment to the work of the ESAB.

Our practitioners are supported with a suite of safeguarding adults and related training (e.g Mental Capacity Act).

Our approaches to quality assurance actively look for evidence of **Making Safeguarding Personal** in safeguarding practice. We ensure that learning from serious safeguarding adult reviews and our safeguarding adults case file audits is shared with our workforce, our policy leads and our learning and development colleagues to further improve practice.

Transitions planning between children's and adult services is detailed, well-planned and effective. We have a robust approach to managing risk in our own system as well as with providers.

Our key stats

Concerns & Enquiries

20,342 safeguarding referrals
received in the last 12 months

4,700 Section 42 enquires
conducted per year

Outcomes

85% of Adults
asked what outcomes they wanted as part of a safeguarding enquiry

83% of Adults
outcomes were fully or partially achieved was 83% in 2023/24

3.1 Domain: 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

When **I** move between services, settings and 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

Case study 14:

Making the Difference Every Day:

Evangelina's story

Evangelina was an older woman of Greek Cypriot heritage. She lived by herself and took tremendous pride in her home. Evangelina had a history of depression, anxiety and memory problems; there were also concerns about self-neglect and, although help was offered, Evangelina could never feel able to accept it.

Following a spell in hospital, Evangelina was discharged to a residential home to re-gain her strength. An assessment of her mental capacity found she lacked capacity to make a decision about her care, but it was clear to the social worker that Evangelina wanted to be at home and her son said his mum should be supported to return home, as it was her wish to 'die in her own bed'.

The social worker was determined that any best interest decision made should enable Evangelina to get back home. Persistent and supportive care workers were found and plans made for home visits twice a day. The social worker arranged monthly meetings with the ambulance service's 'frequent caller' lead and the GP surgery to work together on a protocol to respond to Evangelina's frequent calls to emergency services and to collectively share the risk in supporting Evangelina to live her life in the way she wanted. Three years later, Evangelina died; she was in her own home and in her own bed.

Case study 15:

Making the Difference Every Day:

Rob's story

Rob is an autistic man with severe learning disabilities and a sensory processing disorder. He was referred for behaviour advice input from his social worker in the Young People with Disabilities Team (YPWD) in Mid Essex. It was felt a service specification would help identify what would work well for Rob in terms of somewhere to live that would meet his needs and choices and that he could call home.

Planning and support for his new home started when Rob was 18 years old and still in full time education. This included discussions and observations with his parents, tutor, day services, and support workers from his overnight short break service. The Behaviour Advice team were able to offer support and specialist recommendations to his overnight short break service.

The team were involved in identifying an appropriate residential service and in supporting transition planning and Rob's move to his new home. The multi-disciplinary team supporting Rob also provided specialist information with regard to his communication, sensory and behavioural needs throughout his transition. At his 6-week review, it was evident that Rob's quality of life had improved. He is flourishing in his new home and community.

Key elements:

✓ Managing provider failure

Our **Provider Quality Team delivers an extensive range of training and developmental support** to Essex care providers to tackle challenges such as falls, pressure ulcers, care of older people, dementia care, support to people with learning disabilities, various health conditions, wellbeing, end of life care and leadership. The training programme is derived from feedback providers give at forums, workshops and events. Over 340 providers have attended the training. Feedback on training ranges from 92% to 100% satisfaction.

We use **PAMMS (Provider Assessment and Market Management Solution),** a regional approach, to assess the quality of care delivered by care providers. As of January 2024, 531 Essex providers have had a PAMMS assessment. Of the 431 registered CQC locations in Essex that ECC currently commission with, 79% have had a PAMMS assessment.

Multi-agency Care Sector Hubs in each of our 3 ICS areas bring ASC, health partners and the CQC together to share safeguarding and quality intelligence with the care market. The Care Hubs provide a reliable flow of intelligence and a good countywide picture of provider concerns.

Our **Serious Concerns Review Group (SCRG)** meets weekly to review all significant concerns that have been raised relating to care providers and monitors safeguarding and non-compliance challenges. Concerns are identified based on intelligence, including our own quality assessments, CQC inspections, or safeguarding referrals. ECC work with providers to make necessary improvements to deliver a safe and effective service. If it is necessary to suspend the provider, restricting any new referrals into the service, as a result of safeguarding and quality concerns, the Provider Quality Team issues an Action Plan with realistic timescales for remedial action. If there is no improvement and a risk to adult safety remains, we may terminate the contract, identifying alternative arrangements for all adults. On average, we are tracking 20-25 services at any one time, which are reviewed weekly to agree actions and note improvements. Services remain with SCRG for an average of 5-6 months, while we work with the provider to ensure improvements are made.

Providers are appreciative of the support provided by ASC and specific feedback received in the past year includes the following:

- *"ECC Quality Team are always willing to support and guide us through any difficulties. Bringing the home from Inadequate to Good is a success story, highlighting the support we've received…"*
- *"[You] have spent several hours within the home helping me to build on the foundations of the home and have been a very valued person to assist with getting the correct paperwork in place to be able to raise the standards of the home to where it is now."*
- *"You and your teams do a fantastic job at supporting advising and helping providers out which I certainly appreciate. We are so fortunate to have such a proactive and committed team to call upon."*

The **Organisational Safeguarding Team (OST)** leads on concerns raised with organisations and works with the provider and partners to reduce risks and ensure that safety, quality, and contractual challenges are addressed. OST also chairs safeguarding adults meetings, leads information training for care workers in care settings and ensures that individual safeguarding enquiries are completed as part of the process. Working closely with Provider Quality, OST managers are part of the Serious Concerns Review Group (SCRG) that meets weekly.

Our **Provider Failure Guidance** comprehensively sets out our approach to managing situations, and ensuring the safety and wellbeing of adults is paramount in any provider failure situation. Over the past 12 months there have been 17 provider failures due to financial viability or quality / safeguarding concerns, comprising 9 care homes, 6 domiciliary care providers and 2 supported living services. Concerns relating to larger providers, such as mental health care settings, require a large-scale management response to ensure the safety of adults and ensure that we receive satisfactory assurance around improvements.

✓ Pathways and Transitions

ECC has **effective transition pathways** for young adults with learning or physical disabilities from children's services into adults' services, with 69 individuals fully transferred last year, in line with our protocol, and positive feedback received about the joint planning that takes place to support individuals and families.

ASC commissions the Children & Young People with Disabilities Team, hosted in the Children & Families Service, to work with young people from 16 to 25 years old and undertake assessments with a focus on:

- progressive, person-centred outcomes, preparing young people for their independent adult lives.
- employment and employment readiness with the support of SEND Careers Advisors and collaborative working with the ECL LIVE project.
- a focused accommodation and support approach.

This approach provides a strong base on which the handover to adult care services takes place, usually within 2 years of a young adult leaving education, but this is entirely flexible around individual circumstances.

We are currently undertaking work to improve transitions for young people with autism and mental health issues. As part of our ongoing work, it has become clear that young adults identified with autism and/or with mental health issues, open to front-line Children's Social Care Teams, and who do not have additional disabilities, need some specific focus, and the following work has been undertaken to address this.

'Working Together' sessions between adults' and children's services are held in each locality to allow joint planning for anyone coming through from mainstream children's teams who do not have disabilities but may need ongoing support.

We take a single all-age approach to transitions commissioning teams, to ensure we have commissioned services for people with autism, including community support and residential placements for people with high needs. Negotiations are taking place with EPUT (Essex Partnership University Trust, the Essex adults mental health provider) around how mainstream adult services can implement reasonable adjustments to support people who are neuro-divergent.

✓ Hospital discharge

In each of our localities, ECC and partners have committed to an ethos of **home first** that prioritises and enables the best outcomes for people and promotes and enables their independence. This has led to a low rate of admissions into permanent residential or nursing care, where we perform better than the national average.

Our goal is 'home first' for all adults, with the right wrap-around services in place to enable this. Where this isn't possible, we have robust processes in place to plan for ongoing support. This is supported as follows:

- Our **Discharge to Assess Teams** operate a 7-day rota to support adults, carers and consistent hospital flows. And they will carry out a Care Act assessment to support ongoing need.
- The **Connect Programme** (discussed under Domain 2.2) works to improve the effectiveness of reablement interventions.
- **Transfer of Care Hubs** (ToCH) (discussed under Domain 2.2) bring together all services to coordinate discharge and recovery and support admission avoidance. **Home First is a well-established ethos** within our transfer of care hubs, and use of step-down / temporary placements has reduced significantly (by as much as a third).
- **Readmission rates to hospital** during intermediate care interventions, and failed discharges are routinely **tracked**.

We have allocated £500k to trial the ***Stepping-Stone Home*** **model** to support hospital discharge. This is the short-term use of sheltered housing or extra care apartments with wrap-around support to provide an "enabling environment" for people with care and support needs who cannot yet go home after being discharged from hospital. Essex currently has 4 Stepping-Stone Home apartments, with at least 5 more planned to go live in 2024. This approach to the short-term use of Extra Care and Sheltered Housing, as well as the wider promotion of extra care as an alternative to residential care, has contributed to maintaining low numbers of people entering residential care.

Currently there are 3 well established **Self-neglect and Hoarding Forums** operating in Mid, North-East and South Essex. West Essex is developing the same. The forum enables a multi-disciplinary approach to planning and support.

Areas of focus:

✓ Use of interim residential care beds

We know from a Newton Europe diagnostic in Essex in 2019 (as well as other studies elsewhere) that, when people are discharged from hospital to an interim residential care bed, their chances of returning home fall rapidly – around 80% can stay in a care home. Our ambition is to see more adults leaving interim placements and returning home.

A **new approach to commissioning interim Recovery to Home Beds** has consolidated interim placements into a smaller number of care homes in each locality, supported by a multi-disciplinary team from health, social and voluntary agencies, with therapies attached for each bed. A therapy-led approach aims to better support the transition back to home and enable ongoing rehabilitation. People may be referred from hospital or the community if they need a period of reablement or assessment that cannot safely be done at home. Early indications from a review suggest that the scheme has reduced Length of Stay in interim placements by c. 9 days and increased the proportion of those returning home by more than double, from a baseline of 22% returning home vs 50% from the Recovery to Home Beds homes.

3.2 Domain: 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

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

Case study 16:

Making the Difference Every Day:

Mo's story

Mo is a 63-year-old man who lived alone following the death of his wife several years ago. Mo moved to the UK in the 1970s, had no children of his own and his only family were in Iran. His home is owned by his late wife's children, who wanted him to move out. The relationship appeared fraught and they had little to no contact.

Following a full leg amputation, Mo wore a prosthesis but, having lost a drastic amount of weight, this no longer fitted him and his reduced mobility meant he was unable to access health appointments to resolve this. Health professionals tried to visit Mo at home, but having observed hoarding and unsanitary conditions they withdrew, and the GP raised a safeguarding concern with Adult Social Care. The Fire Service also reported concerns to the Multi-Agency Hoarding Forum co-ordinated by ASC.

In responding to the concern and S42 enquiry, the social worker visited and discovered the extent of Mo's difficulties. There was little room to manoeuvre and, with the stair lift no longer working, Mo demonstrated how he 'dragged' himself up and down the stairs and around his home. He was unable to cook or use the

microwave and, with no accessible work surface space, it was unclear how he was preparing food. The bathroom was inaccessible, with Mo unable to access a shower and the toilet had been blocked and out of action for a year resulting in Mo using the bedrooms as a toilet. He also had sores on his remaining leg, for which he had been unable to get medical attention.

Mo showed good insight into his needs and situation, attributing the difficulties to his mobility and the loss of his wife, after which he had 'allowed things to get on top of him'. With the social worker's support, Mo recognised that his home was no longer safe and that his health was at risk.

Given Mo's presenting care and support needs, the Borough Council were unable to identify suitable emergency housing and Mo consented to the offer of a temporary residential stay, where he is currently benefitting from the care, support, and facilities on offer and is also accessing the necessary health care. The social worker has also supported Mo to connect with Refugees Action. Now feeling more in control of his life, Mo is ready to start considering his next steps.

Case study 17:

Making the Difference Every Day:

Ali's story

Ali had come to the UK seeking asylum. He had a number of medical issues and was staying at an asylum seekers' hostel in North Essex. A Care Act assessment found he needed someone to check on him when he was in the shower because of his frequent falls, but Ali was determined to remain as independent as possible and no support additional to this was thought necessary.

A month later, a safeguarding concern was raised because Ali was refusing to eat. Ali was protesting at the lack of decent or appropriate food at the hostel and of any support to help him move on. He'd recently suffered a hate crime in the local area and, as a result, no longer felt safe to go out. This was affecting his mental health.

The social worker had built a good relationship with Ali and he trusted her to advocate on his behalf. He fully understood the risks of not eating and the impact this was having on his physical and emotional wellbeing. The social worker called a multi-disciplinary safeguarding strategy meeting with Ali, the GP, community nurses, the accommodation provider, Ali's solicitor, and the home office, as well as the Integrated Care Board and the local asylum seekers' advocacy service. A plan was established to manage the risks around Ali not eating. This included the prescription of nutritional shakes and regular calls from the nurses and social worker to monitor Ali's health and wellbeing.

Ali was able to feel heard at the meeting and a decision was made that all the different professionals involved would write to the Home Office expressing their concerns for his safety and requesting that he be moved to appropriate dispersal accommodation. This approach was successful and Ali was transferred to dispersal accommodation in another town. Here, his refusal to eat ended. In his country of origin, he'd been a chef and was now able to cook his own meals and began to thrive. Ali said that moving had helped his mental health and he was starting to feel normal again, as he could now go out without being fearful.

As a result of the safeguarding enquiry, changes were made to the way support was provided at the hostel and, very importantly, a new contractor was appointed to provide food and meals for the people staying there. The new contractor offers choice, so the hostel residents are able to eat in a way that better suits their cultural requirements.

Case study 18:

Making the Difference Every Day:

Sandra's story

Sandra, who is 50, was living with her 68-year-old partner Ray and their dog, Sammy. Following a routine visit, a safeguarding concern was raised by the housing provider about the condition of the home, with concerns for Sandra's health and welfare. The concern reported an overwhelming smell of urine and faeces, discarded used sanitary products, dog faeces, dirt, and mould. Sandra was struggling to move around the home with her walking frame and was unable to access the bedroom because of the hoarded items. So she was sleeping in an armchair where she would spend hours and often days on end. Over the years, there had been numerous reports to Essex police of domestic abuse by Ray to Sandra.

The neighbourhood team liaised with relevant professionals including the referrer and Sandra's GP, who attempted a home visit but was unable to gain access. A considered approach was taken with 2 social workers and the housing officer calling at the house with a wheelchair in the hope that Sandra might agree to speak to them away from the house. Sandra did agree and, with the aid of the wheelchair, went with the workers to the local housing office, where an interview room had been arranged.

With some reassurance from the social workers and housing officer, Sandra began to talk about her life. She said she didn't want to go back home but was worried about Ray's cruelty to Sammy. She said 'I'm in such pain. My back is really hurting. I don't want to be with Ray anymore - all I care about is my dog. I love my dog so much.' Sandra wanted to feel safe and agreed to a temporary move to a care home, providing her dog would be ok.

A residential care home was arranged for Sandra and Ray was informed that Sandra would not be coming home. He was very cross, shouting to the social workers that she needed to stay as she was able to turn the TV over for him.

One of the social workers visited Sandra in the care home the next day. She had been supported to have a shower and was feeling more comfortable. As trust was established, Sandra was able to say more about the physical and verbal abuse she had endured for many years. She said her health had deteriorated and, despite her being in pain and struggling with her mobility, Ray had stopped her seeing the GP.

Now that she felt safe, Sandra was clear she did not want to remain in a relationship with Ray or return home; she wanted to get better and live independently. She decided it was best for Sammy to be rehomed.

Sandra's wishes were supported and she now has the care and support she needs in her own (independent living) flat, where she is building a life for herself. The housing officer commended the social workers' professionalism, time and patience as qualities that had literally saved a life.

Case study 19:

Making the Difference Every Day:

Kings Park

Following a noticeable rise in safeguarding concerns, particularly in relation to financial abuse and requests for support, at a caravan site on Canvey Island, the neighbourhood team reached out to build relationships and offer support.

Kings Park (an over 50s site) was also experiencing high levels of carer breakdown. The team linked with an existing but very small carers group, attending monthly meetings and supporting other professionals and services to join. The team has built positive relations with the community, enabling early help, and the number of carers attending has grown from 10 to around 30 regular attendees who support each other in their community.

"Since your team have been coming to our meetings, the help given to many people has been invaluable. Your team have helped so many people, they were lost when they came into our meetings. They came in crying and go out smiling"

- Founder of the Kings Care Group

Key elements:

✓ Our safeguarding processes

Safeguarding is everybody's business and people (or their representatives) are encouraged to participate in their own safeguarding process to make safeguarding personal.

The majority of **safeguarding alerts** are raised by people using a web-based form via a portal, with some also being raised by people phoning into our front door teams. The alerts are uploaded into our case recording system and are screened by our Central Safeguarding Triage Team within 24 hours or the next working day.

When the criteria for a **safeguarding concern** are met, the concern is progressed and prioritised for further information gathering, ahead of a decision being made to either progress to a **safeguarding enquiry**, undertake a Care Act review or offer advice, information and guidance. Where the criteria are not met and the person is not already known to ASC, the referrer is notified that the safeguarding alert will be closed and they will be provided with the contact details for the Essex Wellbeing Service and Adult Social Care Connects, should they wish to make a referral with the consent of the adult or their representative.

All enquiries are prioritised according to the level of risk. Priority 1 (high risk) is flagged for urgent allocation with the relevant team managers within 48 hours, with an initial agreed risk mitigation plan. Decisions to progress to Section 42 enquiry or a Care Act Assessment / Review are made within 72 hours or less, depending on the level of risk, and are sent to the appropriate locality or Organisational Safeguarding Team with a priority risk level applied in line with our priority matrix. Adults and referrers are notified of the decision made in our assessment of the safeguarding referral and are supported to understand this decision where a safeguarding response was not required, with clear signposting and advice also provided. Similarly, people are provided with the contact details of the Essex Wellbeing Service and information services to support them while they wait for a practitioner from the locality team to contact them.

Lower priority enquiries will have an initial risk management plan and protective factors identified to ensure the person's safety while waiting. When the safeguarding enquiry has been allocated, the allocated practitioner will contact and visit the person and will listen to what people would like to happen to help keep themselves safe. This will include

reviewing / updating the risk management plan, involving other agencies, and coordinating multi-agency safeguarding meetings as appropriate.

Once the process is complete, the practitioner will advise the person when they are going to close the safeguarding enquiry and their team manager undertakes quality checks and, once satisfied that risks have been reduced, they will authorise closure of the Section 42 enquiry.

The Head of Safeguarding and Mental Capacity oversees safeguarding across the county and works closely with the Essex Safeguarding Adults Board (ESAB). The role provides a quarterly report of safeguarding activity to ESAB's Performance and Quality sub-committee, which ensures there is partnership oversight at a strategic level. This facilitates collaboration between statutory partners to improve safeguarding effectiveness, while providing ESAB with assurance of ECC's work.

The **Essex Safeguarding Adults Board (ESAB) Business Plan** sets out its priorities and actions and benefits from a strong and experienced independent Chair, who meets monthly with the DASS and the Head of Safeguarding & Mental Capacity. ESAB meets quarterly to review performance and quality and helps drive our learning across the complex health and care landscape across Essex, including our 3 Integrated Care Boards, 3 acute trusts (operating across 5 sites), 4 NHS community providers, mental health services and large and diverse care market. Our risk register is owned and reviewed by the ESAB and its Executive. ESAB sub-groups are chaired by a range of partners.

We **partner with Southend / Essex / Thurrock (SET),** the SET Domestic Abuse Board, MARAC (Multi-agency Risk Assessment Conference) and Domestic Homicide Review (DHR). The health partners **System Quality Group** meeting focuses on safeguarding and quality. The Southend, Essex, and Thurrock (SET) policies and procedures clearly set out what constitutes a safeguarding concern and how concerns will be addressed in a multi-agency framework. There is a multi-agency information sharing agreement in place with all partners.

Safeguarding training is provided as part of the ASYE programme and within our core CPD offer. Our Safeguarding Adults training focuses on having a person-centred approach and our case file audits specifically look for person-centred safeguarding responses, evidence that the adult has had their voice heard and that their wishes and best interests remain at the centre of all we do.

ESAB also offer several e-learning and virtual training courses to promote good safeguarding practice / knowledge to support the provider market and key partners. In addition, they have a suite of documents which providers

can adapt and utilise to support them in writing and adopting policies / procedures.

Our **Practice Hub** ensures policies, procedures, and guidance are up to date, relevant and accessible. Our resourcing and triage processes have been revised, as described under *Areas we are working to improve* below, to improve flow and manage demand.

The Essex Domestic Abuse Commissioning Strategy 2021-24 sets out our approach to supporting victims of domestic abuse through partnership working and by increasing the provision on offer to all victims in safe accommodation. This strategy was developed in collaboration with survivors as experts by experience, who were able to influence decision-making and design appropriate support with ECC and our partners. We are in the process of developing a new strategy, which we expect to publish in the autumn.

ESAB and the Essex Safeguarding Children Board have a joint priority in relation to **Transitional Safeguarding** pathways for 18-25 year-olds who do not present with traditional care and support needs. To improve support for this group, ASC introduced monthly **Multi-agency Transitional Enablement (MATE)** meetings with partners in ASC, Children & Families, Essex Police, EPUT and others to consider risks to young people aged 18-25 who may not meet the threshold for "traditional" care and support, but may be at risk of experiencing exploitation or harm, or who may struggle to protect themselves. The purpose is to bring together partners, share information, review multi-agency activity and monitor action by partners to support the young adult to reduce risks or protect them from harm. The approach has good agency buy-in.

There is a safeguarding process in place for **asylum seekers** in community asylum accommodation or hotel accommodation. *Language Line* is used to support communication with adults where English is a second language, to ensure our intervention is person-centred and that all relevant information can be obtained. There are named Team Manager leads in each locality.

Service quality, safety and assurance

A **countywide monthly Quality Performance & Accountability Meeting (QPAM)** reviews all activity in relation to safeguarding and Deprivation of Liberty Safeguards. At a locality level, a monthly QPAM looks at all activity in the locality and establishes level of risk to target interventions. We have introduced a Directors' monthly QPAM to ensure they are fully sighted on all safeguarding activity across ASC and to strengthen consistency in

approaches to managing risk and people waiting safely. Monthly assurance is also provided at ALT, Operations Board and a monthly Operational Performance meeting.

The **Practice Governance Board** provides assurance to the ASC Leadership Team on service quality, safety and assurance controls. It is chaired by the Principal Social Worker, and has strong attendance from ASC directors, service managers, practice leads, representatives of the senior practitioner network and Essex Social Care Academy. Safeguarding themes and trends are shared with the Board by the Head of Safeguarding every quarter to allow learning and actions to be agreed. The Board has 5 subgroups, including the Safeguarding Adult Review & Independent Management Review Group which identifies early learning and actions in advance of more formal reviews and implements recommendations of SARs, Inquests and Domestic Homicide Reviews.

Practice Leads provide enhanced support for practitioners with a focus on quality assurance. There are dedicated roles for **Head of Safeguarding Adults and Mental Capacity, Principal Social Worker and Principal Occupational Therapist**, who champion and lead best practice and our partnership and engagement work.

We carry out 8 **Practice Audit** cycles a year, with a quarterly focus on Safeguarding, which are reported to the Practice Governance Board and inform how we target training to ensure improvements. Our case file audits specifically look for person-centred safeguarding responses, evidence that the adult's voice is heard and that their wishes and best interests remain at the centre of all we do. In the most recent audit (February 2024 which looked at work completed in December / January), 73% of the audited cases were rated as good or outstanding with the majority evidencing *Make Safeguarding Personal* principles. Audits identified that risk management plans were not consistently applied. We have revised the Mosaic safeguarding forms (on our social care management system) to ensure the risk management plans are accessible and easy to use and we regularly utilize workshops to ensure we share and embed learning. Outcomes of practice audits are shared at the Practice Governance Board. Practice messages are then fed back to locality teams by attendees for learning. Furthermore, direct feedback from audits is shared with Team Managers, so they are able to discuss with individual practitioners through reflective supervision. Further audits ensure improvements are implemented.

Learning from Safeguarding Adult Reviews (SARs), Independent Management Reviews (IMRs), DHRs and Inquests processes is well established.

The Head of Safeguarding and Mental Capacity chairs the SAR / Inquest / DHR sub-committee of the Practice Governance Board, which is attended by the Principal Social Worker, Service Managers and representatives from the Senior Practitioner Network. This group reviews learning from SARs, IMRs, DHRs and inquests and creates actions to improve practice and agree timescales. A quarterly report to the PGB shares learning outcomes and considers any changes to practice so that these can be disseminated to teams by PGB attendees.

The Head of Safeguarding and Mental Capacity and the Service Manager for Safeguarding take opportunities to **dip sample** and review work being undertaken and provide feedback to practitioners and Team Managers accordingly. They also dip simple concerns / enquiries on an ad hoc basis to ensure practice standards are being upheld, providing feedback as required.

Twice a year the Head of Safeguarding and Mental Capacity selects an IMR to be the focus of a reflective workshop involving the Principal Social Worker / Principal Occupational Therapist, adult leadership team, team managers and representatives from the senior practitioners' network.

The Essex Safeguarding Adults Board also creates a summary of SAR themes, what went well and key learning, which is shared by the Head of Safeguarding and Mental Capacity in regular bulletins to teams. The Essex Safeguarding Adults Board has also established a new Prevention and Awareness sub-committee that will have a particular focus on how ESAB partners work together to look at ways to reduce safeguarding concerns and ensure the safety of adults who need to draw upon services.

A positive focus on learning and improving our understanding of safeguarding

Safeguarding training is provided as part of the ASYE programme and within our essential and core CPD offer. Our Safeguarding Adults training focuses on a person-centred approach. In March 2024 we rolled out the National (Bournemouth) Competency Framework for Safeguarding and introduced 3 levels of training depending on roles and responsibilities:

- Level 1: Awareness for all workers including non-front-line teams.
- Level 2: Enquiry Officer 2 day training
- Level 3: Safeguarding Adult Manager 2 day training.

Safeguarding training is defined as *Essential* and must be refreshed every 2 years.

We have Time to Reflect **practice learning events** and practitioner forums and we are actively exploring all opportunities to engage with our practitioners, pull in learning from audits and diagnostics and assist with improving professional development, from newly qualified ASYEs through to our most experienced professionals.

During the **Safeguarding Peer Review conducted by Hertfordshire CC (2022),** our workforce said that they feel well supported by line management and the DASS, and value having a committed and informed portfolio holder. An action plan, developed following the peer review, has been fully implemented.

The Essex Safeguarding Adults Board has established a new Prevention and Awareness sub-committee that will have a particular focus on how ESAB partners work together to look at ways to reduce safeguarding concerns and ensure the safety of adults who need to draw upon services.

Areas of focus:

✓ Managing increasing demand

The **number of safeguarding referrals has increased,** averaging 1,695 per month or 81 per working day. In the year 2023/24, we received 19,910 safeguarding referrals, a 7.5% increase on 2022/23. We have taken a number of steps to ensure we can continue to manage demand well, including moving additional resources into triage and screening.

In March 2024, we introduced a new online form via a portal, which replaced the SETSAF1 paper form; this is known as the Safeguarding Alert. This enables providers, health partners, other organisations and members of the public to report safeguarding concerns to ASC in a consistent way. The portal is supported by information, advice and guidance to signpost people to appropriate pathways or sources of support. Once raised on the portal, alerts are moved to concern or closed, or actions are taken to connect people with the right support (e.g Care Act review). All alerts are screened within 24 hours and those that progress to a Safeguarding Concern are processed within 4 days.

Focused work to progress these increased referrals led to a significant increase in the number of S.42 enquiries waiting to be started by neighbourhood teams. This has been an area of focus for the service and since November 2023 we have seen a 75% increase in the number of enquiries completed each month, allowing us to meet demand. In November 2023, 406 enquiries were completed and in May 2024, this rose to 712 enquiries completed.

We are working with key partners to promote good practice. This has included workshops with the Police, the Ambulance Service, the Probation Service, the DWP and provider and partner safeguarding leads. Our Head of Safeguarding and Mental Capacity has also jointly led a SCIE Webinar that has been shared nationally, on the ESAB website and with all providers.

✓ Deprivation of Liberty Safeguards (DoLS)

We use a risk prioritisation tool, which builds upon the ADASS tool, to ensure that all high-risk requests for Deprivation of Liberty Safeguards are immediately allocated for action. Where we can't allocate a request for an Authorisation immediately, we liaise with the Managing Authority to ensure that adults are protected and any change in their situations is communicated to us immediately so we can take urgent action as required.

In 2023/24, we received 9,202 DoLS applications, which was a 51% increase on the previous year. A significant contributor to this was a change in process by acute hospitals, following a review.

In July 2023, we established a new team and increased the number of assessments given to external agencies to reduce the backlog and address the increased volume. In the last 12 months we have achieved a 40% reduction in people waiting for a DoLS assessment. We are currently undertaking 85 more assessments per month than the monthly demand and our forecast shows we are on target to remove the backlog by April 2026.

Making safeguarding personal

We are committed to **Making Safeguarding Personal** for all adults that require safeguarding. We always aim to see or speak to the adult who is at risk of harm or abuse throughout the process, to get their views and explain what we are doing and why.

The **proportion of people or their representatives who were asked about their desired outcomes** was 85% in 2023/24, similar to the previous year. This compares well with the Eastern Region (71%). The proportion of people whose outcomes were fully or partially achieved increased slightly from 82% to 83% in 2023/24. Work to improve this includes:

- increasing practitioners' familiarity with the safeguarding 'I' and 'we' statements through team discussions and workshops, essential safeguarding training on Mosaic, and a greater emphasis on lived experience in practice audits.
- updates to our Safeguarding Adults Policy to more strongly set out our commitment to Making Safeguarding Personal (MSP) and hearing the voice of the adults we are here to support.

Section 4:
Leadership

This section covers:

- Domain: Governance, management and sustainability
- Domain: Learning, improvement and innovation

Summary

Essex Adult Social Care has **stable and experienced senior officer and political leadership**. This provides an effective and influential voice for ASC, not only within Essex County Council, but also across our 3 integrated care systems and 5 place-based alliances.

We have a **strong and effective approach to business planning**. Our Adult Social Care Business Plan (2024-30) sets out a multi-year strategic plan, which is reviewed and refreshed annually. An Adults Business Planning Board meets monthly to oversee progress against Business Plan priorities, as well as overseeing the financial strategy around investment in sustainability and transformation.

Adult social care has **operated within its budget** for each of the last 6 years and is a **financially well-run service**. It has its own Financial Strategy and access to some dedicated council reserves (Adults Investment Reserve, Adults Risk Reserve). Nevertheless, financial challenges are persistent and are closely monitored and mitigated.

ECC's **People Plan 2021-2025 and our ASC People Plan** set out how we will support our workforce, including its wellbeing, learning, and inclusion.

Workforce development is a key area of strength, and the Essex Social Care Academy (ESCA) provides nationally recognised professional development and training for our adults' and children's practitioners. Recruitment and retention remain a challenge in Essex (as elsewhere), but we have a strong approach to manage this, developed alongside our workforce.

Our workforce has **pioneered within the council a "Quest" approach to equality, diversity, and inclusion**. This has generated richer insight into the lived experience of our workforce and created a new, empowered, bottom-up approach to driving change across ECC and adult social care. Our ambition is for EDI to be woven into everything that we do.

We have a data improvement programme, which has led the development of a suite of improved data dashboards for managers and is continuing to strengthen our systems, processes and skillsets, including data literacy.

4.1 Domain: 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

Case study 20:

Making the Difference Every Day

Apprenticeships

ECC is using Apprenticeships to grow our own Social Workers, Occupational Therapists and opportunities for the wider ASC workforce. We have an internal pathway for all ASC employees who want to become Social Workers or Occupational Therapists or want to become an alternatively qualified worker in ASC.

The Lead Practitioner in Adult Care (Level 4) delivers an 18-month programme in front-line practice that provides the academic experience to apply for a Social Worker or Occupational Therapist apprenticeship. It opens up the pathway for staff who may not otherwise have met the academic threshold.

In ASC, 118 staff have been through an apprenticeship since 2017, 27 of these on the Social Work degree and 12 on the Occupational Therapist apprenticeship degree.

ASC Apprentice Quotes:

"It has supported me to formalise my practice and gain a deeper understanding of what social work is all about."

"I feel incredibly supported by the management at ECC in the improvement and cultivation of my professional development. Without this support in place, I would be unable to fully develop my career, along with the emphasis on wellbeing and proportionate intervention."

"It makes me feel incredibly valued, especially as a disabled employee, that ECC would support and fund my progression. I have felt very supported during the completion of the degree by all the ECC staff involved and I know my success is celebrated by them as much as by me."

"ECC have been incredibly supportive and encouraging for me to start the social work apprenticeship programme. ECC have ensured that I have had every learning opportunity made available to me and there have been a vast amount of learning opportunities. ECC have ensured that we have been supported throughout the whole programme."

"I am undertaking the Social Worker apprenticeship with Essex County Council, and I feel fully supported by my employer and the university. I am so grateful to have this opportunity to learn and further myself in my career, and to have such a host of prospects available at the end."

Case study 21:

Making the Difference Every Day

Return to Practice

A key area of focus within the Resourcing Strategy is talent attraction, promoting Adult Social Care opportunities and Essex County Council as an Employer of Choice.

One of the newest programmes (launched in 2023) is "Return to Practice". This programme was launched by ASC to support qualified Social Workers and Occupational Therapists to return to their profession following a career break. This programme is focused on the "Returner", offering flexibility on working patterns and the full support of the team to re-register with SWE or HCPC, if required.

Returners join ASC in a Wellbeing & Independence Practitioner role for a period of 6 months, to build their confidence and support their return to practice with any training required. The training package is tailored to the individual, depending on the length of time since they have practised.

Sharing their experience of the programme, a Practitioner stated **"this programme and the support I have received has brought back my confidence to do the best for all the Adults I have been assigned to. Essex County Council is the best Council to work for, everybody I have been in contact with have been so supportive and very friendly and helpful."**

Following on from this success, the 2024 programme was launched in January and has been extended into a joint programme with Children & Families. The 2024 campaign has received 30 applications and interviews are taking place with a provisional start date of summer 2024.

Case study 22:

Making the Difference Every Day

Workforce Ambassadors

The employee voice has always been important in ASC and within the wider Council, and over the years we have introduced a number of forums for our workforce to collaborate and engage with our leaders. Such forums have included our employee forum, inclusion and diversity Quests, ways of working champions and wellbeing champions. Whilst the different groups have all been successful in their own right, we felt that there wasn't consistency in how they were supported and had access to ASC leaders.

As a result, we decided to bring together all our workforce forums to create Workforce Ambassadors (WA). Our WAs engage with their colleagues across the function and then advocate for them in a joined-up way. They champion and represent the employee voice within campaigns and initiatives across Adult Social Care and also corporately. ASC have been leaders within ECC to develop a WA network and have since championed and supported the rollout of WAs within the wider organisation. There are now 47 Workforce Ambassadors across the service. They have a senior leader sponsor and Service Manager lead, who provide a strategic link, but day-to-day activity is completely run by the employees themselves. The group champions diversity and inclusion within its membership and promotes this in the wider workforce. Whilst our WA group is still relatively new, we feel it will provide us with the opportunity to grow our workforce and develop as a function supporting our future needs.

One of our WAs said: **"my feeling is we have a 'safe space' where we can all contribute and have real authentic conversations that allow us to bridge the comfortable and also the uncomfortable and have a voice in this."**

Key elements:

✓ Leadership and responsibilities

We have a **stable and experienced senior leadership team with clear roles, responsibilities, and accountabilities**. The DASS has been in post for 7 years and the Cabinet Member for Adult Social Care has also been in post for 7 years.

There are **dedicated countywide Director-level roles** for Strategy, Planning and Assurance, and for Strategic Commissioning and Integration.

There are **5 dedicated locality Director roles** aligned to each Alliance for operations and local system working, with each role leading on a countywide strategic area: for example, Mental Health, Disability, Older People, Safeguarding or Quality of Practice. A Principal Social Worker and Principal Occupational Therapist work together to develop our professional practice across ASC.

The Director for Strategy, Planning and Assurance has moved into an **interim joint role between ECC and its local authority training company (ECL),** to promote even closer working between Adult Social Care and the LATC and to promote more collaborative approaches with the NHS towards intermediate care.

✓ Governance

The **Adults Leadership Team meets on a regular basis but meets formally twice a month,** with one meeting focusing on quality, financial, and operational performance, and the second on strategic development and business planning. ALT provides the strategic officer leadership of Adult Social Care and regularly monitors KPIs through a performance dashboard, which has a quarterly reporting cycle on performance, market, and outcomes.

A **monthly Business Planning Board oversees business plan development and delivery**, investment requests and resourcing and commissioning plans. This reports to ALT.

A **monthly Operations Board has oversight of budget, operational performance, and workforce**. This reports to ALT.

At a locality level, monthly **Quality, Performance & Accountability meetings** (QPAMs) are held to support action planning to maintain a safe and effective health and ASC system and services.

A **weekly meeting is held to review current system pressures and manage day-to-day business and risks**. It agrees our Local Authority Pressures Escalation Level (LAPEL) with any changes of LAPEL level communicated to system partners.

The **Practice Governance Board** is chaired by the Principal Social Worker and meets every 6 weeks to provide a forum for focused **oversight and quality assurance of professional practice**. It has 5 sub-groups:

- Research Governance Group
- Learning from Complaints / Local Government Ombudsman Investigation Group
- Practice Policy and Guidance Group
- ASC / Essex Social Care Academy Steering Group
- Safeguarding Adult Review & Independent Management Review Group

The **Essex Safeguarding Adults Board (ESAB)** meets quarterly to review performance and quality and helps drive our learning across the complex health and care landscape across Essex.

✓ Political and executive leadership

The Executive Director for ASC reports to, and consults, the **Chief Executive** and **Corporate Leadership Team** (CLT) on key matters and reports to the **Political Leadership Team (PLT)**. This is where we discuss our budget position and strategic plans, and the implications of national policy and legislative developments.

ECC has a corporate operations leadership team (OLT), which brings together key operational leaders across the council at a level beneath the corporate leadership team to help co-ordinate and drive implementation of key council work – ASC is represented on corporate OLT by an ASC director.

The **Cabinet Member for Health, Social Care and Integration** has been in post for 7 years, providing strong political leadership both within ECC and

across the system. Cllr John Spence is the Chair of the Essex Health and Wellbeing Board and a member of the 3 Integrated Care Partnership (ICP) boards. ASC and Public Health **performance is reported through a monthly Cabinet Member Portfolio Board**, with regular briefings on topical matters and forthcoming decisions. A weekly briefing meeting is also held with the Cabinet Member to support briefings on, and sign-off of, any relevant Cabinet Member Decisions.

ECC has a People and Families Scrutiny Committee, which examines topics that are focused on adults and children's social care within the purview of ECC. ECC also has a **Health Overview and Scrutiny Committee (HOSC)**, which oversees our work with integrated care systems and cross-system working. The 2 committees meet jointly to consider cross-cutting areas. The HOSC has also held joint meetings with other neighbouring authorities within our integrated care systems.

ECC has **secured representation from officers on each of our 3 Integrated Care Boards (ICBs)**. ECC is further represented by both senior officers and Cabinet Members on each of the 3 ICP boards. ECC is also represented on each place-based alliance through Adult Social Care, Children & Families and Public Health.

In May 2024, the Leader of the Council announced a **Caring Communities Commission** to look at how to address the increasing pressures on social care and explore local and community-based solutions to pressures on public services. The commission will launch in summer 2024 (subject to any delays due to the announcement of the general election in July 2024) and will focus on early intervention and prevention and how residents could be supported to enjoy better health and access services in new ways.

✓ Assurance and risk management

Risk is well managed through our governance approach to service assurance (for example, our dedicated Operations Board for performance and finance, and our dedicated Business Planning Board for major change programmes) and also on a day-to-day basis through Locality team levels to ensure safe services. This is set out in our Practice Approach documentation. Functional and strategic risks are held on our Corporate Risk Register, which is reviewed at least quarterly and more frequently during periods of high risk or escalating pressures.

The financial management guidance process is to give assurance that draft care and support plans (pre-sourcing) meet the eligible needs of the adult

where there is an ongoing commitment to paid-for services. Having this process gives assurance that decision are made at the correct level while not delaying meeting the needs of the person.

Information Sharing and Governance

We have developed our approach to **information sharing** with NHS partners. We have shared care record systems in place with our 3 integrated care systems, while we are also linked to SHREWD, a tool that displays urgent and emergency care data in one easily accessible dial view.

The Council has a very robust approach to Information Governance as laid out in our Information Governance Framework. Essex County Council has a centralised Information Governance team, who support the Senior Information Risk Officer and Data Protection Officer to ensure our policies and guidance around information handling and sharing are up to date and that we have appropriate sharing agreements and training in place.

As the Caldicott Guardian, the DASS plays a key role in ensuring that Social Care information is processed in line with GDPR and also within the individual's expectations. The Caldicott Guardian is an integral part of our accountability processes when approving Information Sharing Protocols and ensuring that Social Care staff are aware of their responsibilities when handling personal or sensitive information.

All Adult Social Care staff complete information governance training; this is part of the Council's Corporate Governance training, which is a set of mandatory eLearning courses which staff must take. Social Care new starters must also take a face-to-face course as well as the eLearning.

All Security Incidents are reported to the Information Governance team through our online portal and are investigated thoroughly. When investigating an incident, the team works with Adult Social Care to understand the concern and provide mitigating actions to reduce any damage a potential breach may cause. Further to this, all Data Protection complaints and Data Subjects Rights requests, including Subject Access Requests (SAR), are completed by the Information Governance Team on behalf of the Data Protection Officer.

ECC plays a leading role in developing approaches to population health management (described in Section 2), with data professionals aligned to each of the ICSs, and joint access to data platforms with linked data for health and social care projects.

Essex has recently secured £5m national funding over the next 5 years for a Health Determinants Research Collaborative.

The Essex Centre for Data and Analytics (ECDA) provides a platform for data sharing and joint research with key public sector partners, including the University of Essex and Essex Police. This has supported a wide range of projects, for example research into the social care impacts of road traffic casualties, which evidenced the link between acquiring an injury in a collision and going on to receive support from Adult Social Care. The report has been shared across road safety and social care services to raise awareness and help inform future activity.

✓ Statutory complaints and compliments

A **quarterly report on statutory complaints** is reviewed by the Adults Leadership Team. Complaints are reviewed by the relevant team and any learning or recommendations put in place. The majority of complaints relate to finance or delays in assessment. We are using this learning to make improvements to debt handling and financial decision-making processes and have reduced the numbers of adults waiting for financial assessment by 72% between May 2023 and May 2024. In 2023/24 we received 572 complaints, of which 308 were either upheld or partially upheld, and 149 compliments, and we receive more compliments locally in addition to those reported. The **Practice Governance Board** oversees learning from compliments and complaints, and there is a specific sub-group that proactively scrutinises monthly complaints data and considers the learning from Local Government Ombudsman cases, in order to identify themes, trends, and learning for operational practice.

✓ Our workforce

ASC has a workforce of c.1,500 employees. ECC's Your Voice 2022 staff survey showed **higher workforce morale** than the Council average; 76% of our workforce felt they belonged in ASC, 79% knew where to access support for their wellbeing, and 90% felt satisfied with their working pattern. However, the survey also indicated that our workers would like to have more time in the working week to be able to complete tasks and we are addressing this by reviewing our approach to ensure 'right person, right task' as part of our operational redesign later this year, while also ensuring a strong focus on employee wellbeing.

Our **ASC People Plan** has 5 focus areas and a range of actions, which are being taken forward as part of the organisation's People Plan or our own workforce review activity:

- **Right Size:** The number of people for the jobs and skills needed to achieve our goals efficiently and effectively, which focuses on recruitment and retention.
- **Right Shape**: A workforce composition in terms of structure and purpose, to ensure we have the right workforce in the right roles and at the right level for our future need, is being reviewed in a phased approach across the service.
- **Right Skills:** The necessary capabilities to bridge our current gaps and future needs, including work to ensure we have a resilient, experienced workforce with the ability to proactively manage the increasing level of complexity. This includes consideration of alternative roles to support registered practitioners, apprenticeships, review of our ASYE programme and ESCA support, career pathway mapping and increasing understanding of digital and technological solutions.
- **Right Cost**: An effective employee / cost ratio. Our salaries are annually benchmarked against local neighbouring authorities and our front-line roles benchmark well. We are reviewing the utilisation of attraction and retention payments. Contingent workers are used to support recruitment and retention challenges; however, we continually look to minimise their use.
- **Right Location**: Availability of the right people with the right capability in the right locations to meet our changing environments; requires us to ensure teams have the flexibility to work where needed to perform their role effectively and enable place-based working. We are reviewing all ASC offices in line with the organisation's Estates Transformation Programme and continually looking at ways to maximise teams' local knowledge and understanding.

✓ Business planning and financial management

We have a **strong and committed approach to Business Planning in ASC**. We have a multi-year Business Plan, which is refreshed annually. We have a dedicated Head of Business Planning and Delivery, and a monthly Business Planning Board ensures regular oversight of delivery against the business plan.

The Adult Social Care Business Plan 2024-2030 has 3 strategic objectives:

1. To develop community-based support and early help
2. To shape the care and support offer for Essex residents
3. To build operational resilience and excellence.

Allied to a strong focus on Business Planning is a **strong focus on financial management and strategy**. **Our Financial Strategy** sets out our medium-term approach to ensuring financial sustainability. Central to this is a shift towards greater spend on early help and prevention to support demand management initiatives.

Areas of focus:

✓ Further embedding EDI in everything we do

We have set an ambition for **each of our key programmes to have an equality objective** to set areas for measurable improvement. We will pilot inclusion of SMART equality objectives in our Disabilities and Mental Health programmes in Autumn 2024 and will then roll out across other programmes.

✓ Social Care Case Management System and other systems

We have had our case management system in place since 2014. We have listened to our staff on the changes they would like to see and made some improvements to support practice within the current system while we work through the procurement process and timescales to replace the current system.

In autumn 2023, we moved to an improved **cloud-based Microsoft Azure platform** and a suite of new interactive dashboards for ASC to enable on-demand access to data and insights across our workforce.

✓ Workforce recruitment and retention

Improving our workforce recruitment and retention position remains an ongoing priority. ECC turnover (12%) compares with England (13%) and the Eastern region (16%), but we have slightly higher turnover for Occupational Therapists. Vacancy rates currently stand at 12%, which is in line with Eastern region, but with higher vacancy rates (15%) for social workers.

The 2024 Local Government Association Social Care Health Check shows our social workers consistently report higher levels of satisfaction compared to national and regional counterparts. Our unregistered social care workers also report higher levels of satisfaction compared to regional counterparts. Our Occupational Therapists show lower levels of satisfaction. We are aware of the issues that have been identified by the health check and are working to a detailed action plan to address these.

We **continually invest in recruitment resources and campaigns** to attract talented individuals. Initiatives include:

- New video campaign, developed with our Workforce Ambassadors and showcasing achievements of individuals across various roles.
- Continual development of more apprenticeship roles.
- Annual recruitment campaign for newly qualified Social Workers and Occupational Therapists with a comprehensive learning programme. In 2024 we have offered 10 opportunities.
- An ongoing Return to Social Work / Occupational Therapy Programme. Attraction levels are low as anticipated, but it is a great way to attract returning talent to the sector.
- Attendance and sponsorship at Community Care Live and the OT show, enabling our workforce to showcase their great work.
- Inclusive Interview Panel pilot introduced at Manager level and above is now being rolled out more widely across the organisation, and we are exploring how we expand.
- Autism Internship Programme – we support ECC's campaign to provide opportunities for autistic individuals with career opportunities in a supported environment.
- Maximising our profile on social media and in schools and colleges. We attend careers fairs across the county and support at mock interview days.

4.2 Domain: 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

Case study 23:

Making the Difference Every Day

Our workforce 'Quests' on equality, diversity and inclusion

Adult Social Care had pioneered an approach to workforce "Quests" to understand the lived experience of our workforce from an equality, diversity and inclusion perspective. The Quests evolved from discussions after the murder of George Floyd in 2020. In ASC we wanted to acknowledge the impact his murder had on our global majority colleagues in particular. We held opportunities for colleagues across the function to talk about their experiences of marginalisation. These conversations were shocking for some and difficult for all. We heard them as a call to action to address the fact that racism and discrimination remain a reality in our society and for our workforce. As a result, the Quests were born, led by our workforce and supported by our leaders, so we could gain an honest view of where improvements and changes were needed.

'I have enjoyed being part of the Disability Quest, live events, and continuing to support other disabled colleagues who work for ECC. This includes people with diverse needs and backgrounds, enabling everyone to have an equal right in the workplace, embracing a career with as few barriers as possible. We continue to work hard to eliminate work place barriers, and strive for solutions.' – Quester

Our workforce has led quests on race, disability, LGBTQIA+, and age so far, with further ones planned.

Case study 24:

Making the Difference Every Day

Assessed and Supported Year in Employment (ASYE) Programme

We are committed to the development of Newly Qualified Social Workers and currently have 67 people enrolled in our Assessed and Supported Year in Employment Programme (ASYE). We received 71 applications for the most recent intake, from which we have made offers to 13 candidates. Our ASYE programme celebrates and encourages diversity: over 50% of Newly Qualified Social Workers are from Black and Minority Ethnic Backgrounds (BAME) and we have embedded our anti-racist statement of intent for students, NQSWs and teams.

We are introducing ASYE Lead Roles in each locality to provide additional support to team-based assessors and NQSWs to drive consistency and timeliness across ASC. The ASYE Lead will be the named assessor for some NQSWs, facilitating peer supervision and delivery of the ASYE programme.

We are relaunching the ECC ASYE Programme on 1st July 2024 to introduce the new portfolio paperwork introduced by Skills for Care in 2022; to align approaches between ASC and Children & Families; and to support with overall social worker retention. The relaunch will also introduce the opportunity for reflective presentations, which offer a more inclusive assessment method for NQSWs with a diverse range of learning needs.

“In making the transition from social work student to qualified practitioner, being part of a structured ASYE Programme has been an invaluable experience for me. It has help developed my self-esteem and confidence. Additionally, it has made me a reflective practitioner.”

Key elements:

✓ Workforce professional development

The Social Care Capability Framework is a mechanism to support the development of our front-line workforce. It establishes expectations of capability across all roles, providing insight into skills and experience required to develop within their role. This is an annual process across the workforce and links to our Social Care pay grades and workforce investment.

Essex Social Care Academy (ESCA) provides a framework for continuing professional development across Adults' and Children's services. ESCA support a range of courses and events, including our Practice Educator programme and delivery of an excellent ASYE programme. In 2023/24 they delivered 261 CPD sessions covering 28 topics. The ESCA website hosts a multitude of individual and group learning resources. These are internally and externally developed resources, including subscription services such as Community Care Inform and Research in Practice.

Links with Anglia Ruskin University, the University of Essex and the University of Hertfordshire enable us to grow our offer for employees looking to gain professional qualifications with an Occupational Therapy Apprentice degree pathway and a Social Work apprentice pathway. The first cohort of 10 social work **apprentices** graduated in September 2023, with newer programmes running successfully, and there are now also 2 Occupational Therapy apprenticeship graduates. We have a cohort of 10 Social Worker apprentices and up to 10 Occupational Therapy places each year. ESCA is currently working with the Principal Social Worker to develop a pathway for acquiring credits towards a full Masters qualification.

Virtual, interactive ***'Time to reflect'* sessions are held 4 times a year** for all practitioners. These popular and well received sessions are hosted by the Principal Social Worker and Principal Occupational Therapist and involve presentations from practitioners across our service. Themes for each session are based upon areas of focus identified by practice audits and have included reflection on support for carers, mental capacity and the Care Act wellbeing outcomes. We also have in-person Leadership and Learning events for staff with a leadership role held 4 times a year.

We created a customised **systemic leadership programme** for our leadership team, which has developed into an ongoing development programme for all leaders across the service and is centred around individual reflection, leadership team culture and how to be effective

leaders in the wider system. We are also working with our partners to develop system leadership skills though programmes such as **Leading Greater Essex** and the MSE **Quality Improvement Leadership Programme.** Many ICS and Alliance partnerships hold regular learning events that bring together a broad range of stakeholders across the system.

Equality, Diversity and Inclusion

ASC has embarked on a ground-breaking and regionally recognised series **of equality, diversity and inclusion 'Quests'** which have been show-cased at Community Care Live. As part of the Quests, up to 10 volunteers are released from their usual duties for 6 weeks to explore the challenges and opportunities to create positive change for our workforce. Each group of questors makes recommendations to support the creation of a detailed improvement plan, which is presented to our Adult Leadership Team (ALT) and Corporate Leadership Team (CLT) for action. We have so far concluded Quests on race; disability; LGBTQIA+; and age. Following the Race Quest, we now have a Race Lead who is ensuring that Quest recommendations are being taken forward. We have been testing reverse mentoring with senior managers and including diversity members in senior recruitment panels. This has been positively received and we are extending this work. We are also testing "Allyship" training to actively promote anti-discrimination and have established a Quest Network as part of our Workforce Ambassador network, to ensure recommendations are implemented and joined up across individual Quests. The Quests in 2024 will focus on Neurodiversity and Mental Health.

We established a monthly Equality, Diversity and Inclusion Steering Group in June 2023 to review EDI work in Adult Social Care, make recommendations, escalate challenges, and support and promote understanding of working with protected characteristics within ASC. The Principal Social Worker is a member, to create links with development of our practice model. We have agreed a set of anti-racist practice standards and established anti-racist locality networks as a focal point for discussing matters of discrimination and impact on practice. The Development Manager for Race, Principal Social Worker and Quest Sponsor for race are also key members of the Anti-racist Practice Board with Children's social care colleagues.

Insights from the Quests have fed into ECC's EDI Workforce Strategy launched in March 2023, which aims to ensure fair treatment and opportunity for all and eliminate prejudice and discrimination. Significant improvements have been made to delivery of Access to Work in response to the Disability Quest, and ECC is reviewing some of its policies in relation to disabled employees.

We hold quadrant-based anti-racist and anti-discriminatory forums, where we encourage our workforce to feel able to reflect on their experiences and challenge racism in all its forms, including on behalf of people they support.

We are participating in the **10,000 Black Interns** scheme, which offers access to paid internships across a wide range of industries for underrepresented individuals. To date, 16 interns have been taken on across ECC, 3 within ASC. Our autism internship programme begins recruitment in August 2024 and is tailored to enable individuals with autism to gain meaningful work experience. We have also funded 10 places on the Moving Up leadership programme for black and Asian managers who expressed an interest in leadership development.

✓ Wellbeing support

A **range of wellbeing support and resources is available**, advertised through newsletters and the ASC Microsoft Teams site and including excellent web-based resources on our My Learning website. All ASC employees are invited to include a weekly wellbeing hour in their calendar. From the recent ASC 2023 staff survey, 75% of colleagues felt that they were able to strike the right balance between work and home life and 79% knew where to access support for their wellbeing.

'Here for you' is a service available to ECC social care employees to address the need for more tailored wellbeing support, build resilience and provide emotional support to those in front-line roles. We also have an extensive corporate Employee Assistance Programme, which provides counselling and emotional support on a range of day-to-day practical matters.

We **recognise and celebrate the work** that is happening across our function through our **monthly Going the Extra Mile (GEM) awards** and annual celebration events.

We communicate regularly with our workforce through the fortnightly DASS newsletter, as well as virtual and face to face team meetings and a range of Live Events.

Our **Workforce Ambassadors** engage with colleagues across ASC and advocate for them, both within ASC and across the organisation, providing valuable insight and reporting any challenges or concerns against a range of themes. This is achieved through quarterly forums with the leadership team and an employee forum with the DASS. As part of the annual Social Care Capability Framework process, our Workforce Ambassadors are currently reviewing the guidance documents, so that colleague feedback is considered and inclusivity is at the centre.

Sector-led improvements

We **participate in ADASS regional and thematic groups, workshops, events, and programmes, and contribute towards sector-led improvement**. Branch meetings are attended by the DASS, with wider attendance at network meetings, with some local and national networks chaired by members of the ASC leadership team.

We **make use of our 'buddy' arrangements to share learning and experience**, meeting with our peers from Hertfordshire and Luton, as well as meeting independently with Kent as a neighbouring and similar-sized authority.

We are active in the performance network of the Eastern region of ADASS and **contribute to benchmarking of data and practice** and participate in the External Challenge sessions, which provide a comparative view of performance across the region.

We have been active in working with regional partners, TLAP and Curators of Change to develop the **'Over a Brew'** programme of work, as part of the Putting the People at the Heart of Care and Support ADASS East group. We are leading on an Essex-Wide 'Over a Brew' session, which will invite practitioners to work alongside leading national experts by experience and local people who have lived experience. The theme of this will be 'The power of human relationships and the links to wellbeing and mental health'.

Internal audit and external diagnostics

We work closely with our Internal Audit Team to agree an **annual audit plan**, which includes full audits as well as light touch reviews to assess performance and recommend improvements. Recent audits include a review of Front Door & early help, risk management, and an annual review of the Better Care Fund. For 2024/25, planned audits include Transitions, Fair Cost of Care assurance and Community Equipment. Tracking and monitoring by ALT and Internal Audit ensures that recommendations are agreed and implemented.

We also commission **external diagnostics**, with some recent examples including:

- **Newton Europe** diagnostics into intermediate care and hospital discharge outcomes (2019), transfer of care hub operating model (2021) and outcomes for adults with disabilities (2022)

- **PeopleToo** audits into our practice, first around Learning Disability & Autism and then more recently on the support we provide to people with Physical and Sensory impairments
- **Diagnostic reviews** into different aspects of our recording, reporting and use of data (Newton Europe 2021, Craig Derry 2022), which resulted in our current Data Improvement Programme.
- **Skills for Care** QA review of our ASYE programme (January 2023)

Areas of focus:

✓ Learning from peer reviews

We participate in **Sector-Led Improvement opportunities** and were the subject of an **LGA Peer Review** in February 2023. Feedback from this resulted in the development of 5 action plans to address areas of concern: People Waiting; Co-production and Lived Experience; Carers; Safeguarding flows; and EDI. A previous LGA peer review in 2019 also looked at ASC's partnership work with our 3 integrated care systems (which, at the time, were in non-statutory form).

ASC Directors have also contributed to sector-led improvement by volunteering to act as peer reviewers for other local authorities. Learning and reflections from this experience have been shared with colleagues and are helping to inform our own work.

Co-production and Lived Experience

Our ambition is to **deepen our systemic and consistent approach to co-production and to embed lived experience across all our work**.

As work continues to further develop our practice model **Essex Lives**, we are working with Think Local Act Personal (TLAP) and ADASS to raise our understanding of co-production, including leadership training. This will focus on the power of co-production and lived experience and how we can enhance our practice. We include people with lived experience within our Leadership and Learning events. Our Statement of Intent covers how and why ASC commits to co-production, how we will embed and deliver it and how people can get involved.

Collaborate Essex is our existing co-production forum established in 2019. It is co-ordinated by **Healthwatch Essex** and brings together people with lived experience, commissioners and providers of services to discuss issues of concern or for development. Lived experience members are drawn from a network of people and forums and are supported by HealthWatch to gather and capture experience from their networks on the agreed issues.

We have some good examples of co-production that we want to build on. These include the following:

- Development of the Carers Strategy was informed by the lived experience of 583 adults and 92 young carers. A Carers Working Group enables carers to check and challenge development of the new carers' offer. We have also established a reference group, Carers Voices, to provide an ongoing communication channel and facilitate engagement with carers and we have commissioned an independent, countywide carers voice service which is helping us to shape future services.

- We worked with direct payment recipients and other stakeholders as part of a co-production group to redesign and re-commission the Direct Payments Support Service. This strengthened the service design approach and should improve the support offer.

- We trialled the Working Together for Change process that builds capacity for co-production in a series of workshops with service users to inform the review and development of Sensory Services. We are also funding the Sensory Action Alliance, which is an alliance of organisations who have pledged to make changes to improve the lives of those with sight and/or hearing loss, to act as a lived experience led service.

- A Move-on pack was co-designed with people leaving mental health supported accommodation. They used their experience to identify gaps in support and what information was needed. The pack makes the process more person-centred and supports the confidence and independence of the person moving on.

We have an action plan for co-production development, covering:

- A co-production framework to guide ASC approaches to co-production and lived experience.
- The development of a reward and recognition policy to support involvement of people with lived experience – drafted subject to corporate governance
- Reviewing the impact of, and re-commissioning (if required), our Collaborate Essex model for co-production – review in progress with aim of completing Autumn 2024
- Commissioning enhanced market research support (the new provider likely to start in Autumn 2024) to give us capacity and capability to improve our experience and insight data across all our key areas of activity
- Using the insight to support training and development for the AC workforce

Equality, Diversity and Inclusion data

We continue to improve and refine **how we collect, analyse, and use** social care data and information to inform our response to people with protected characteristics. We undertook a 'deep dive' into our data at the end of 2023 to review against the information available on protected characteristics. We are currently working through the findings and their implications for key pieces of work and any associated actions. A new ASC self-serve suite, which includes the ability to report demographic characteristics for all KPIs, statutory reports and operational dashboards, was developed in November 2023. We have also made changes to our case recording system to capture a wider range of equalities data, to ensure we further understand the impact of our work.

Conclusion

Essex welcomes the opportunity to go through the CQC assurance process and has found the process of reflection in completing our self-assessment helpful.

We know that Essex is a large county and that we operate in a complex public sector landscape, including with 3 integrated care systems.

We believe we have some good and some elements of outstanding innovation and service excellence. Our focus on 'home first' and independence, promoted through our strength-based practice and our expansive services in reablement and care technology, mean that we perform well in terms of low rates of admissions into residential and nursing homes. We perform very well in terms of having low delays on discharges from hospital due to social care. Our focus on enabling people to live meaningful lives has led to some excellent progress at promoting inclusive employment opportunities for adults with learning disabilities and autism. And the work we have done to invest in, and shape, our care market means we have good capacity and quality in the Essex care market.

Our scale and our financial resilience mean we have been able to proactively invest in areas, including enhancing our Early Help and Prevention offer through our Essex Wellbeing Service and other services. Our Essex Social Care Academy supports investment in the continuous professional development of our workforce and we are proud that this has been recognised nationally in multiple awards for ESCA and for our practitioners.

But we are also aware that we have priority areas of focus, and these are set out in our multi-year approach to Business Planning. We have developed a new enhanced offer to Carers, which went live in April, because we appreciate the important role they play and because we know our previous offer was not as good as we or carers wanted it to be.

We have prioritised work to build operational resilience and are pleased that we have seen positive progress in areas such as reducing the time people wait for assessments to be completed. We have substantially increased the number of safeguarding enquiries we complete each month to meet a growth in safeguarding referrals and are working with partners to understand the reasons behind the growth in referrals.

We know we have further to go to fully embed good practice in co-production so that it is more systematically embedded across all that we do, and we have a programme of work in place to enhance this work.

We are also passionate about enhancing our work on equality, diversity and inclusion. We are very proud of the innovative workforce-led “Quests” we have pioneered within the Council to understand the lived experience of our workers with protected characteristics. This has helped shape our workforce plans, but we know there is still a distance to travel to create the same environment and experience that everyone, irrespective of race, sexuality, gender or disability, can expect to enjoy.

We believe this self-assessment provides a balanced overview of our strengths and areas of focus.

Ultimately, our ambition is to deliver on our vision to enable adults to live their lives to the fullest, and to do so through our mission of making a positive difference every day.

We look forward to the CQC assurance process supporting us to continue on that journey.

Nick Presmeg
Executive Director for Adult Social Care

List of useful documents

- Everyone's Essex
- Essex Joint Health & Wellbeing Strategy
- Essex Better Care Fund Plan
- Essex Autism Strategy
- Essex Carers Strategy
- Essex Disabilities Strategy
- Essex Mental Health Strategy
- Essex Dementia Strategy
- Essex Domestic Abuse Strategy
- Essex Care Market Strategy
- Mid and South Essex Integrated Care Partnership Strategy
- Suffolk and North East Essex Integrated Care Partnership Strategy
- Hertfordshire and West Essex Integrated Care Partnership Strategy
- ECC Workforce Equality, Diversity and Inclusion Strategy 2023-25
- Essex Wellbeing, Public Health, and Communities Business Plan (2022-2025)
- Guide to Adult Social Care and Support
- LAPEL process documentation

Essex County Council
Adult Social Care

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