What are we proud of?

directors of adass
adult social services
eastern region
connecting innovating improving

2021

East of England Adult Social Care

Foreword

We are proud of our collaborative work in the East of England, and believe it has supported real improvement and innovation both locally and regionally. We put considerable time and effort into our Sector Led Improvement Programme, and identify both the challenges and what we're proud of.

Adult Social Services continues to have a value that is distinctive and important: through our improvement work we put the people we serve first, in our duty to safeguard, to promote independence, and to stand up and support communities to grow.

Despite particular pressures on our services during COVID, it remains important to promote work that we're proud of, and why – spreading learning and challenge for further improvement, recovery and reform; and making the case for investment and recognition of the role of Adult Social Services.

Although we are far from COVID recovery, it is clear that the huge amount of good work in response to the pandemic is being built upon to ensure what matters to people, and that we don't want to go back to the old ways, some of which we know didn't provide the best solutions and outcomes for people.

I hope that you find these examples useful; please make contact with the relevant council or with the ADASS East Branch direct if you want any further information.

Tandra Forster
Executive Director, Adult's and Communities, Southend Borough Council

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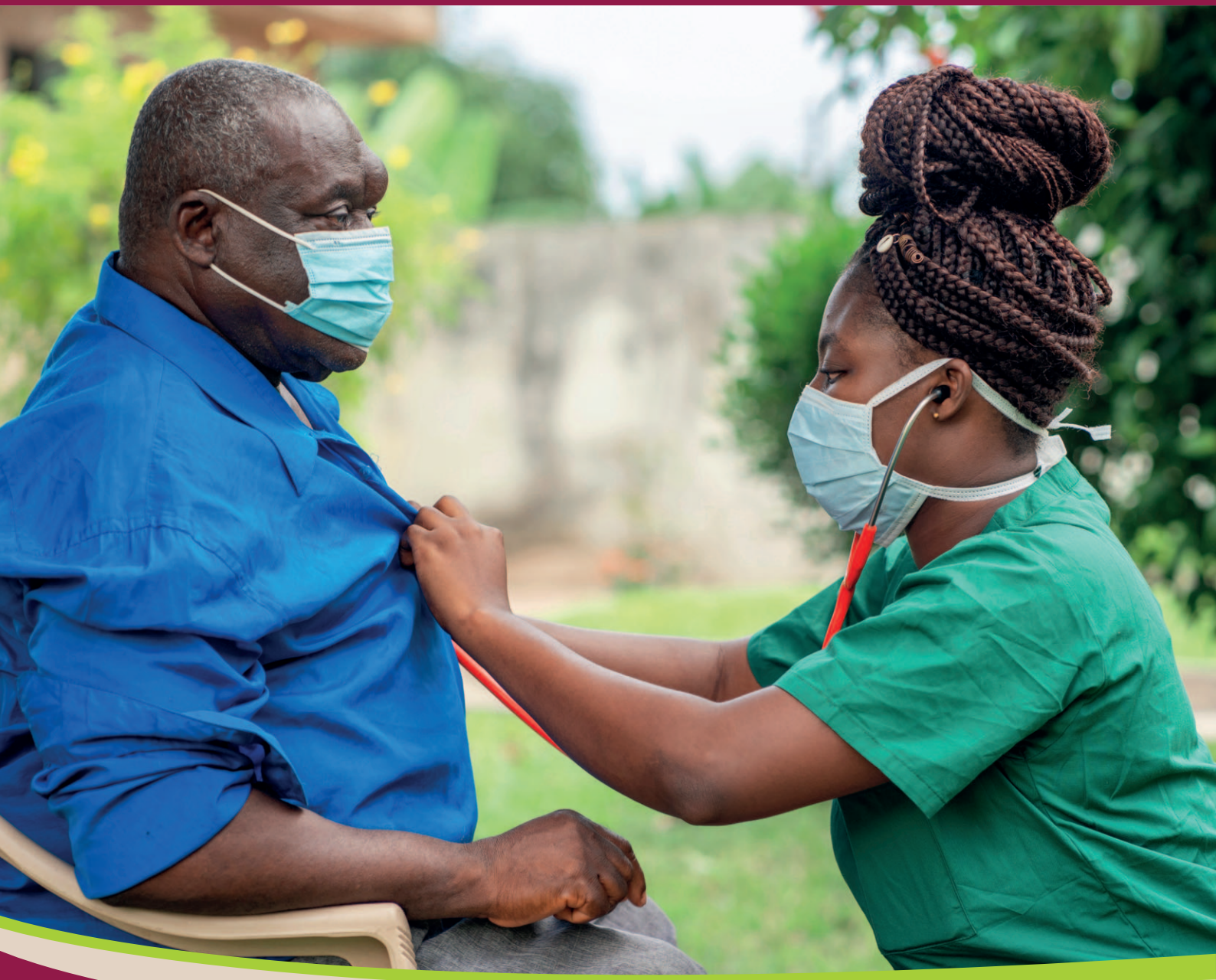
Supporting care providers during the pandemic



Essex County Council

System wide emergency planning during COVID – nothing is impossible

System wide partnership working to manage the impact of COVID on care homes and care providers, and develop an enduring framework for emergency escalation.

On the 28th December 2020, the NHS in Mid and South Essex declared a major incident due to the significant pressures being faced from rising COVID cases. System partnerships across the Greater Essex footprint including NHS partners and the three local authorities of Essex County Council, Southend Borough Council and Thurrock Council came together to respond, but by the 8th January 2021, the Directors for Adult Social Care were reporting critical pressures in social care with the spread of COVID challenging the ability of care providers to operate a safe service.

There were significant outbreaks in care homes with large numbers of staff affected, and homecare and reablement services had increased numbers of staff testing positive or having to self-isolate. This combined to create significant risk to the ability of the local authorities to support the 20,000 people in care while also maintaining critical discharge from hospital.

While local systems each had in place their own business continuity arrangements to respond to pressures and disruption, the scale of the pandemic was unprecedented and the rapid rate of infection across the county warranted an integrated, system wide response.

The NHS and local authority system partners used a Tactical Co-ordination Group (TCG) that reported to the Essex resilience forum to develop and agree a plan of emergency actions. This included detailed scenario planning so that in the context of a failure in the ability to provide care, the local authorities would have adequate, tested plans in place to ensure that care could continue to be offered safely, and that local responders were prepared and plans were mutually understood and ready for implementation.

To enable each local authority to align their escalation protocols to a standardised model, partners worked together to create a Local Authority Pressure Escalation Levels (LAPEL) framework which broadly aligns with the NHS Operational Pressures Escalation Levels (OPEL). This framework enabled the system to clearly identify the risks, provide a mutually agreed framework for social care system pressures, set out principles and priorities for working and identify the triggers for mutual aid and types of system support that would be needed.

Virtual workshops were held with key stakeholders and system partners to design the co-ordinating support that would be required to be called upon at each pressure level within the new LAPEL framework, the outcome included a LAPEL support team approach. A number of processes and communications were rapidly designed, on-call rotas were put in place and commissioning and procurement teams were able to be stood up as required.

Agreements were made around who would lead emergency responses and how local stakeholders would take a lead including via Care Home Hubs in local areas. Data and insight tools were designed to enable informed decisions to be made.

The approach also included ways in which volunteers could be mobilised via the newly launched Essex Welfare Service, catering and cleaning companies could be sourced and measures could be taken such as moving residents to safe environments in cohorts if needed due to workforce issues. The Councils considered the different approaches needed for different settings including Residential and Nursing Homes and Supported Living. Alongside this, procurement colleagues sourced 'Provider of Last Resort' capacity which could be called upon when needed to avoid provider failures and support those providers with urgent staffing shortages.

There was potential opportunity to call on the internal social care workforce, so a Lifeboat Crew was set up. The Lifeboat Crew comprised of 48 staff who were trained, vaccinated, supported with PPE and equipment. They operated on a stand-by-rota across three crews and were a key resource to be deployed as an emergency response.

The impact was in having clear escalation plans in place so that people knew who to call on and when. Some of the solutions designed were then called upon in real time, showing where they needed to be refined, this was done in an agile way. There is now a good set of processes and procedures to build into business continuity plans should there be a need to draw upon them in future emergencies.

Some of the barriers identified were:

- Complex systems and set of relationships – had to run lots of design workshops in parallel to fit in with local placed-based systems and then come up with a framework which worked across Essex – good relationships made this possible
- Systems and processes – sometimes used to rapidly mobilise new ways of working but the pressure of the pandemic made this a bigger ask. People stepped up to the challenge, committed time and effort and went above and beyond to prevent situations escalating. Passion and commitment to ensuring people were kept safe in communities were part of the conditions to make this happen
- Organising, kitting out and maintaining a rota of crews in a very short space of time was a challenge

Conditions for success were:

- Having in place shared plans that all system partners agreed with, together with a clearly defined escalation process that aligned with health systems and was understood by the emergency responders, were key success factors
- Recruiting, training and kitting out 48 social care workers so that they could respond in the event of a provider needing immediate assistance
- While there were occasions when providers were desperately short-handed because staff were infectious or self-isolating, the lifeboat crew were not needed to mobilise or go through the full LAPEL escalation process

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Essex County Council

Care market hubs to support care providers

Set up and continuation of care market hubs to provide overarching support to care providers during and post COVID.

The pandemic brought about unprecedented challenges for the care market. Pre-COVID support mechanisms were not designed to support providers under such circumstances. The risk was identified early on and Essex rapidly set up care home hubs initially to support older people residential care providers. These were later expanded to other services and renamed care market hubs. Five hubs were set up to provide more localised support alongside health colleagues.

The focus of the majority of the hubs has been on managing care home outbreaks as they pose the biggest risk to vulnerable residents. The hubs also intervene to support with access to Personal Protective Equipment (PPE), testing and vaccinations.

The hubs are essentially a support network for care providers. Helping to identify issues proactively and support providers to ensure safety of those in their care. The hubs consist of colleagues from Essex County Council adult social care teams, Public Health and representatives from health, providing whole system wraparound support.

Regular meetings, along with data and analytical support, ensure the hubs provide rapid support, and can quickly react to changing situations.

Tasks of the hubs include, but are not limited to:

- Close monitoring and tracking of outbreaks
- Visits to red/amber/green (RAG rated) care homes by clinical staff to assess wellbeing of residents
- Visits by ASC staff to high risk services
- Arrange access to emergency supplies of PPE as required
- Ensuring safe and appropriate use around infection, protection and control (IPC) and use of PPE
- Advice and guidance where required around outbreak management from Public Health Team and Clinical Commissioning Group (CCG) IPC leads
- Council worked collaboratively with the CCGs to provide IPC training
- Council worked with CCGs to provide equipment to support care homes to monitor symptomatic residents (oximeters, blood pressure etc.)
- Advice and support with interpretation of government guidance around testing, visiting, outbreak management for staff and residents as required
- Supported the rollout of vaccinations of care home residents and staff

This was a collaboration between Essex County Council and health to support the provider market. Regular meetings ensured good working relationships which continue today, and will do so for the foreseeable future.

The hubs provided support for 567 outbreaks in 303 care homes between March 2020 and May 2021. The peak month for outbreaks was December 2020 with 133 outbreaks recorded. April 2020 saw the highest number in the first wave with 84 outbreaks.

The barriers were identified as being:

- Keeping abreast of frequently changing government guidance
- Asymptomatic spread of infection
- Availability of PPE
- Availability of testing
- Maintaining safe staffing levels

The conditions for success were:

- Reducing numbers of outbreaks
- Safe staffing levels
- PPE and testing available
- Access to information about vaccinations and dispelling the myths

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Hertfordshire County Council

Provider Support Hub, a service to be immensely proud of

The Hertfordshire Care Provider Association (HCPA) Provider Support Hub was created in collaboration with Hertfordshire County Council at the start of the pandemic. From creation the hub has run a service which has supported care providers seven days a week both in and out of service hours on all things COVID19 related.

The hub offers both a dedicated telephone helpline and email. Since its inception in March 2020, it has been staffed by a dedicated team of HCPA colleagues offering a triage service and also a complex enquiry response service, to ensure rapid support is provided when it is required. Supported by a network of partners across Hertfordshire's health and adult social care sector, the hub is heavily integrated with the Hertfordshire County Council Home Outbreak Cell and the Strategic Cell.

Those working on the hub have a wide range of knowledge and have been able to assist and reassure a variety of providers from across Hertfordshire. Through collaborative partnership the aim of the hub has been to deliver consistent messaging around guidance and information with an immediate response throughout the pandemic.

The key to the success of the hub has been its strength in continued conversation and a collective vision to offer the best guidance and support possible for providers.

What were the conditions for success?

Being reactive and responsive has been critical to the hub's success with over 4660 calls and 7227 emails to date, this is evidence that the hub has been a lifeline to providers, supporting them across all aspects of care and other challenges that have arisen throughout the pandemic such as:

- Easing of lockdown
- Guidance
- PPE
- Training
- Appeals/outbreaks
- Flu
- Staffing concerns
- Funding
- Vaccinations
- Isolation
- Testing
- Visiting

Delivering above and beyond the initial service helpline and email, Hertfordshire Care Provider Association has striven to inform and support providers across all platforms and by all means available. As the guidance from government changed, sometimes on a daily basis, the team has been reactive in sending daily newsletters, ensuring that providers are kept fully up to date on the latest information being given both on local and national levels. To date over 297 newsletters have been circulated to providers across Hertfordshire.

Creating a library of go to resources was also key. The hub offers an up to date library of COVID19 resource including dedicated web pages covering all topics from testing, funding, vaccinations, Here For You and much more. Accessible through the HCPA website the COVID19 pages are easily navigable and updated on a regular basis by a dedicated team.

All resources are further enhanced by regular webinars which have been proactively created and based on official guidance and demand from live enquires to the hub.

From March 2020 to March 2021, HCPA has hosted over 55 webinars, with an audience of over 550 providers, that figure to date has increased to 1331.

Hertfordshire has continued to provide support and guidance beyond COVID19. Such has been the success of the Provider Support Hub in delivering exceptional services and support throughout the pandemic that the decision has been made by Hertfordshire County Council Adult Care Services to fund the continuation of this unique support service. Working diligently to ensure providers will be kept up to date on legislation and guidance from leading professionals and resources, the hub will continue to inform and support beyond COVID.

Some of the areas that the Care Provider Hub will support providers with include:

- Government guidance, laws, standards and expectations
- Funding, contracting and commissioning
- Business development and continuity
- Monitoring
- Liaison with local authority and other stakeholders in the sector
- HR, staffing and recruitment
- Training and education
- Equipment
- Insurance
- Data protection
- Staff wellbeing and recognition
- The hub carries on providing signposting and guidance on all matters related to COVID

Here are some testimonials

"Good morning, whilst we are all working to full capacity and inundated with emails, guidance etc., I felt it important to share positive feedback. CQC inspectors are maintaining regular contact with our providers, we are receiving positive feedback from all areas about the support, guidance and advice they are able to access from Hertfordshire County Council and the Hertfordshire Care Provider Hub. The outcome is that they are feeling supported and not feeling alone in facing this emergency. Just wanted to share!"

Inspector, Care Quality Commission

"Dear HCPA, thank you for your swift response, information and advice, it's very straightforward and easy to follow. We will order from Herts Full Stop today. You continue to be the most proactive Care Provider's Association and your weekly newsletters are second to none. You make our job much easier and less stressful, and your support means a lot to us, thank you!"

Manager of Home Care

"Thank you so much for the prompt reply. There is always a different scenario to ponder at the moment. We shall be clapping for you guys too. Your service has been invaluable to us."

Manager of Home Care

"Good morning all at the Provider Hub. Just a quick note to say thank you for all the help and support that you have given us since the start of COVID. Your updates have made an already demanding period that little bit easier for us, and without them we truly would have been lost. I have found all of the team to be very responsive, with some going above and beyond to assist me at times. Keep up the good work."

Manager of Home Care

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Suffolk County Council

A risk and relationship based approach to supporting the care markets

Suffolk has taken a somewhat different approach to other local authorities since 2016, when their commissioning, contract management, quality assurance and provider improvement functions were combined into one, called "Service Development and Contract Management". Over time this has worked well, and the Council has seen improved Care Quality Commission ratings. During COVID it truly paid off and the Council gained a better understanding of the care market, and how good relationships with providers really helped to support the care market respond well to the pandemic.

Despite the improvement in Care Quality Commission ratings, the provider market in Suffolk was fragile before the pandemic. Many providers struggled with recruitment and retention, margins were low, and there was little investment in new services. The Council was worried that the impact of the pandemic on the fragile market would lead to care needs remaining unmet, hospital discharges being delayed, and overall poor outcomes for people.

The Council knew that they needed to step up their collaborative work with care providers and understand the issues they face so they could provide the right support to keep them active in the care market. This would ensure that the providers could continue to meet people's needs at a time when it was needed more than ever.

The Council put into place a set of specific and targeted actions to build on their previous work and support the provider market through the COVID pandemic. These worked well to a large extent because from 2017, the Council invested in a significantly expanded contract management resource to provide allocated contract management to all adult social care providers. There is an in-depth relationship with care providers. The combined contract management has been working proportionately to balance quality, risks and development opportunities.

By the start of the pandemic the well-established relationships and risk understanding permitted adult social care to quickly pivot to routine information gathering, this included risk monitoring and escalation through scripts and trackers provided to staff which enabled the local resilience forum to effectively deploy targeted support.

What did we do?

- At the start of the pandemic Suffolk Adult Social Care Contracts and Service Development team created and introduced a comprehensive COVID19 and provider risk tracker. This permitted Adult Social Care to track cases and deaths from mid-March 2020, as well as capturing business risks such as staffing levels and PPE stock to proactively inform local resilience forum response activities within a single platform. This also enabled providers to easily transition to the capacity tracker as recording opened for COVID19 factors.
- The Council implemented a revenue support programme to all adult social care providers in March 2020. This provided guaranteed revenue to providers until September 2020. The Council also created a provider support fund to meet exceptional costs associated with PPE and workforce demands.
- Early in the pandemic, adult social care set up a Care Cell which had representation from all health and care partners, including Public Health England, Care Quality Commission and care providers. It initially met twice weekly and provided a link to other cells such as the PPE cell, and was a key part of the Suffolk response to the pandemic enabling issues to be escalated quickly. It continues to meet once a week and is one of the few cells that has never stood down throughout the pandemic. It has helped the health and care system to learn and adapt to the changing dynamic and prepare for living with COVID19. This cell fed directly into the local tactical co-ordination group to provide direct feedback from the provider market as well as commissioning organisations.
- The Service Development and Contract Management Team and the Care Cell have helped to ensure a high percentage of residents in care settings and care workers have been vaccinated by direct dialogue and feedback loop between NHS vaccination work-stream leads and representatives from the care sector. This co-ordination also provided effective dissemination of information, promotion through webinars, and supplying of data and information to NHS colleagues.
- The Council worked closely with local NHS partners to co-ordinate clinical as well as infection control advice and support. This included the monitoring and follow up deployment of vital signs equipment and other technology. Adult social care's existing relationships with managers at services allowed for rapid deployment of NHS support mechanisms. This closer working with NHS partners during the pandemic ensured that adult social care contact managers were able to rapidly escalate clinical concerns or problems in a way that the Council was confident that lives had been saved because of this co-ordination.
- In March 2020, adult social care pivoted its existing provider bulletins into COVID19 updates. These updates have been collated by an editorial team with input throughout from the local resilience forum. During the early pandemic these provided an essential communication line on local and national directives and alerts particularly to non-regulated care services. ACS contract managers provided an essential feedback loop to ensure providers were reading and understanding the contents. Included in this editorial process, a parallel resource page continues to be maintained for providers on the Council's website.

- Adult social care also provided its front door, adult care services Contracts helpdesk, to manage a co-ordination and escalation point around care setting outbreak management on behalf of the local resilience forum (LRF). This function liaises with other professionals, in co-ordination with contract managers, across the LRF to support care services.
- Following the first wave, adult care services developed a comprehensive support package to day/evening/weekend services and opportunities. This included a sustained revenue support package to subsidise reduced in person attendance and fund digital or alternative offers. It also included a risk assessment process to permit attendance of one individual to multiple services. Providers also received significant testing, infection prevention and control, and contract tracing support to enable them to reopen with confidence. This was all underpinned with individual provider relationships to co-ordinate these on a provider-by-provider basis. It enabled all such services to remain open since July 2020, with minimal COVID19 cases during the second wave.
- Feedback surveys completed in late 2020 identified high levels of satisfaction and confidence in the response from adult social care and the wider local resilience forum. In particular, providers gave strong positive feedback around the clear communications from adult care services and the value of dedicated relationship resource during the pandemic.

The strength of the relationship between strategic partnerships and care providers and their representative organisations was central to this. Due to the investment of time into building relationships before the pandemic, the Council were well placed to have open and honest conversations about what the care market needed and how this could be provided. This allowed the Council to avoid adversarial approaches or reliance on formal contractual terms and conditions, and for both sides to be open and honest about their needs.

The Council was able to move quickly and agilely. For example, at the start the focus was very much on financial stability, PPE and providing additional capacity to help hospital discharge. Over the course of the pandemic, the focus changed to health support to providers, testing and vaccinations.

It is hard to prove the impact of this approach, but the Council is confident that it worked well. It received much good feedback from care providers about how they have worked together, listened to and supported them through the pandemic.

What were the barriers?

- The fragile state of the care market before COVID
- The large number of care providers in Suffolk
- Rapidly changing central government guidance, often changed at short notice
- The huge scale of the challenge to the care market, including the loss of self-funder income which has hit many hard
- A history of poor communication between health and care, especially around discharge and winter pressures

What were the conditions for success?

- Really knowing each care provider on a personal level, what their strengths and weaknesses are, what they do well and not so well
- Good data on each care provider to inform risk assessment, to be used alongside the relationship based knowledge, not in place of it
- Trust built up over time, the Council could not have offered the same level of partnership and support if this had not been built up before the pandemic.
- Being flexible and not being tied to contractual terms during a rapidly moving time of change

For further information, please see *here*.

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Norfolk County Council

Day services – from pandemic response to transformation

Norfolk County Council is proud of its work with all providers of day services supporting approximately 2500 people in Norfolk.

To set the context, here is a description of the day service market in Norfolk:

- **Learning disabilities and autism –** there is a mixed approach to the delivery of day services within the learning disability and autism market, whilst there are those who operate from a building, there are also providers who utilise other methods of delivery
- **Older people and physical disabilities –** this market has a range of providers, including local community groups, local charities, private organisations and one user led group. There is a diverse delivery model
- **Mental health –** day services within the mental health market predominantly offer an outreach model to support individuals

With a focus on regulated care services during the pandemic, there was a risk that day services providers would be left without an infrastructure of support. Given the numbers of people supported through day services, and the support they give to enable people's resilience and independence (including their role in supporting families with caring responsibilities and preventing carer breakdown by providing daily support), it was important that Norfolk developed a clear package of support and engagement. They also needed day services to explore alternative ways of supporting people in response to the COVID restrictions.

The range of support provided can be split into the following three areas:

Engagement

- Ensured that adult social services officers working across the different specialisms, came together to work as one, ensuring there was a consistent and singular approach
- Norfolk County Council increased engagement and contact by offering a dedicated inbox with resource available to respond to queries, which were then fielded to the relevant commissioning team. This was so successful that the team was recognised by Lord-Lieutenant of Norfolk in December 2020 via a provider nomination
- Regular provider-focused webinars were held and attended by operations, finance and procurement, creating a strong support network for day services providers. Attendance at these forums grew from 40 to 80/90 people, with strong positive feedback received on the open and transparent nature of these webinars
- Regular meetings with individual providers to help support them at what was a challenging time. These have been important in developing links with the market, gaining better insight and helping Norfolk to tailor its support to achieve the best outcomes

Financial support

It was recognised very quickly that the Council needed to put a financial package of support in place that would give reassurance to providers of income and ensure market sustainability. The financial support offered included:

- Norfolk County Council moved from a spot payment model and provided an average block payment based on a providers' income of Jan-Feb 2020 (for LA commissioned placements). They also supported providers where they had lost Direct Payment income
- Enabled financial support using and distributing infection control monies to day service providers
- The Council recognised that the support they were able to provide was only part of the equation – and offered to discuss bespoke open financial arrangements
- Provided additional non-financial support regarding specialist Health and Safety advice to support with risk assessments

Encouraging innovation

Some of the innovation encouraged included:

- Introduction of a centralised staffing resource – deploying day service staff to support in other areas e.g. supported living settings
- Facilitating the sharing of good practice and ideas between providers at webinars – some providers have collaborated to share virtual sessions, reducing costs and sharing workforce
- Worked with providers to develop an outreach model which drove innovation in the market. Providers developed new services to support their clients and importantly reached out to other people in the community. Examples included shopping, medication collection, meals out to people who were isolating, befriending and phone calls. Providers know their community better than commissioners do and are better placed to identify the gaps
- During the pandemic introduced Alcove Video Carephone pilot to support day service providers. Norfolk County Council worked in partnership with Alcove and RETHINK partners to rollout Video Carephones as part of the response to the COVID19 pandemic. The aim was to ensure people most in need of care and support could stay involved and connected to services, friends and family

One provider produced some wonderful creative examples of delivering their services to individuals during the pandemic:

- Banqueting bus
- Activity packs
- Delivery of a game show on Facebook Live

Another provider really engaged with technology to deliver their services. The Alcove Carephones which were offered via Norfolk County Council were also used to facilitate sessions such as:

- Socially distanced yoga
- Staying connected
- Baking separately but together

What were the conditions of success?

- The providers really are the experts, involving them in any change process early will have a positive outcome
- Day services are often overlooked in government guidance and funding decisions, there is a need to be their advocates to drive market parity alongside the rest of the care market
- There is definitely a place for technology as part of a blended day services offer
- Exploring new financial models to support providers moving forward. One of the challenges is for the existing system infrastructure to enable that to happen, and the use of flexible arrangements with stakeholders when considering the payment methods

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Supporting people through discharge to assess and reablement

Central Bedfordshire Council

Changing culture, improving performance and productivity by reablement

During the pandemic, the reablement service adapted to meet the emerging needs. The focus was on speedy hospital discharge and upskilling staff to support the increased acuity of people leaving hospital.

Through changes in the way the reablement service worked, productivity increased significantly and by giving staff permission to make decisions on the ground rather than to return to their line manager, performance to customers improved. Consequently, the service became truly person centred, improving the quality of the service and motivating the staff team.

The pandemic placed significant pressure on the demand for hospital beds and to manage this increase in demand, hospitals ensured that once a person was deemed well enough to leave an immediate discharge took place. Consequently, the reablement service took all referrals quickly and without question, and in order to facilitate this close collaboration among all stakeholders was required. While there were a few unsafe discharges, in the main, co-operation between the hospital and the Council worked well and the service was able to support people back in their own home the same day they were assessed as fit for discharge.

The service shifted from a 2-3 days timespan to arrange support for someone to go home, to a matter of hours. To meet this increase in demand a review of staff allocation took place, the subsequent rearranging of staff increased the speed of response and capacity. Additionally, staff skill sets had to be developed further to ensure that they had the necessary skills to support people in their own home who had significantly increased needs.

Almost overnight the service pivoted from a reablement service to a 'discharge to assess' service, a can-do approach was adopted by everyone in the service with a strong focus on what needed to be done to support someone rather than 'can we' support this person. This switch in focus was empowering for all staff as traditional hierarchical roles were replaced with working collaboratively to ensure that every person discharged and assessed as suitable for the service was accepted. Referrals increased noticeably and now included those who did not have reablement potential at the time they were discharged. The skills that staff needed to support this latter group were different so additional training was identified and put in place. The way of working had changed but as staff noticed their skills increasing and saw the benefits this brought for the individual in the service, they became more motivated, their confidence grew and they contributed further towards decision making for people in the service.

Rotas were adjusted to take account of the increased demand and this enhanced productivity by significantly, in addition when demand was very high managers would work from people's homes while supporting them. To speed up discharge from the service and to remove bottlenecks, care staff who were the closest to the customer and best able to know when they should move on, were given responsibility for deciding when someone was ready to benefit from reablement, and also for identifying any small pieces of equipment the person needed as part of their reablement. Whilst this was a practical decision to make it had the added benefit that staff felt valued and trusted as they were given this responsibility and this empowered them further. They now contribute significantly to the way the service operates.

There were daily triage meetings between the hospital, social care and the reablement service. The people in this meeting worked together to agree how each individual referred would be supported. They were also aware of the wider picture and this resulted in everyone being very clear on the overall picture and consequently responses were timely.

The top barriers were:

- The need for staff to self-isolate
- The reduction in staff as they caught COVID
- Bureaucracy
- Staff skills sets
- Initially, not all staff wanted to change the way they worked

The top conditions for success were:

- Horizontal leadership, leadership at all levels within the organisation
- Permission to make decisions without fear of reprisals
- Daily catch ups to ensure everyone was well
- Can-do approach by all
- Praise and recognition of staff

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Cambridgeshire County Council and Peterborough City Council

Technology Enabled Care supporting early intervention, prevention and reablement services

Technology Enabled Care Services (TECS) and the Home Service Delivery TEC Team are part of Cambridgeshire County Council and Peterborough City Council's Prevention and Early Intervention Services. A core aim of these services is to promote people's wellbeing by preventing, delaying, or reducing the need for formal community or acute care and supporting informal carers.

Even in the midst of the pandemic, this innovative service launched new developments. In October 2020 the teams launched a new lifeline (personal alarm) service in Cambridgeshire providing support 24 hours a day, with the aim of becoming even more proactive in preventing escalation of needs.

Cambridgeshire County Council's Technology Enabled Care Service (TECS) supports anyone to use technology to improve their life. Technology is a less restrictive option than a formal care package and can facilitate new or existing skills. TECS provide a range of electronic, technological devices to support people and their carers to manage risks and enhance their independence.

There are currently 10 potential outcomes of a TEC assessment, four of which produce a social care saving, the other 6 producing an overall saving to the system through a TEC first approach. All outcomes look at what support the individual was likely to need if TEC had not been involved. In 2020/21 it was calculated £3.66 million of avoided costs attributed to TEC in Cambridgeshire. In Peterborough, care cost avoidance due to TEC was £1.11 million and cost savings were £139,100.

However, the full preventative benefits of assistive technology are difficult to deliver where there is a lack of connectivity to the technology monitoring and response service. The delivery in the County was fragmented across a number of services. Therefore, in the autumn of 2020 Cambridgeshire County Council established an in-house lifeline service.

In Peterborough, the City Council has brought together teams across Adult Social Care and Housing creating a "One stop shop" approach for clients which looks at both their ability to carry out activities of daily living and their physical home environment. Therefore, ensuring the focus is kept on people living in their homes independently and safely for as long as possible.

The Adult Early Help Team discuss TEC with each contact as part of a strength-based conversation. This enables individuals to access the most suitable equipment or technology at the earliest point in their contact with the council.

Peterborough City Council has a Smart Flat that is designed to showcase how the latest technology can support independent living. The equipment is fully operational and ranges from voice activated bed sensors, to property exit sensors and medication reminders. The Lifeline personal alarm system is also live so can be demonstrated to see how the control centre responds to calls.

A wide range of technology and equipment is displayed in a home environment. All items can be tried by the visitors so they become familiar and reassured with what is available, and what they may want to try at home. All visitors to the flat get a 30-minute personalised session with a TEC worker to discuss the best options.

When the pandemic stated, an immediate review of how TEC services delivered was necessary to continue to provide a service for vulnerable people and ensure that workers had the resources available to help them in their decision making. This was quickly executed under challenging circumstances.

In October 2020, the Cambridgeshire TECS launched as a new lifeline service, providing support 24 hours a day through a lifeline button, to be more proactive in preventing escalation of needs in the community. Cambridgeshire County Council provide a free trial for six weeks, then the person can opt to continue the service at personal cost.

Before becoming a lifeline provider and since the launch, the team has worked on ensuring they have the best offer of both digital and analogue technology devices. The team worked closely with both their call centre Astraline, and various technology companies to find the products that are simple to use and provide the functionality they require. They have just completed a period of trailing and testing with Chiptech and are now happy to have a digital offer ready for the digital switchover in 2025.

Since TECS launched as a new lifeline provider in mid-October it has been more successful than planned, installing more than the targeted number of lifelines every month since implementation. Against a target of 72 per month, in practice the average has been 94. The target retention rate was 76% and the team are currently operating at 88.8%. This success has been achieved during the COVID pandemic and without any outside marketing.

The Council is now starting to see a move forward within the wider system towards a TEC first approach, with increased activity for earlier interventions such as lifelines. In 2021, there were 1,996 outcomes resulting in hospital prevention and 1,053 supporting informal carers. This shows that TEC is not just supporting adult social care but the system in general.

In Peterborough the TEC team created “How to” videos on the use of a wide range of equipment which was then accessible for staff via the intranet. Useful guides and self-help documents and links were also provided as a comprehensive range of TEC information.

Many assessments were done virtually, and a TEC prompt document was produced covering a range of potential questions as part of the social care assessment, to guide the user to a more detailed conversation and a suggestion of possible TEC to resolve the problem with pros and cons.

Becoming a lifeline provider means Cambridgeshire Count Council can offer a more rounded end-to-end service for its customers. The service links with the Enhanced Response Service (ERS) who sit alongside the reablement service, both are Care Quality Commission registered. In 2020/21, ERS avoided ambulance call out in 3,295 cases, supporting informal carers in 132 cases and prevented the need for a package of care or placement in 120 cases, enabling people to remain at home. The support from ERS is more than just support following a fall, interventions include assistance to get up from floor, assistance to mobilise/transfer, food and drink provision, personal care, premises checks, reassurance and support with medication.

The Enhanced Response Service can refer onto the reablement team for short term care to help the individual get back to independence, or raise any concerns about escalation in need with family, medical staff or providers.

As a lifeline provider, Cambridgeshire County Council receive daily reports concerning call outs on the system by people who access care and support. With this data, they can identify earlier when people's needs are increasing or if there is a change in need. This means adult social care becomes involved at the right point in someone's journey without the person reaching crisis point. It also enables them to support self-funders if they notice their current package of care is not meeting their needs. The TECS have set up processes with the Fall's Prevention Team and Adult Early Help team to alert them to individual cases requiring further discussions or onward referrals. This in turn allows for preventative actions to be implemented and reducing the need for individuals to keep contacting services themselves.

TECS have started projects with the Reablement Assessment Team to look at how the lifeline call centre can provide outbound calling, to enable people to reduce the more intrusive formal care package calls, provider reassurance and support, provide system announcements and updates as well as being used to help support people on discharge from hospital or other care services.

In Peterborough, the introduction of TEC has been part of the strength-based conversation that is now held between the professional and the client. This had led to the clients being enabled to remain independent and not need care packages or need smaller care packages. The TEC service is part of the Home Service Delivery model in Peterborough which brings together an innovative mix of processional teams to create a holistic and seamless preventative service to clients. The team includes:

- Adult Early Help
- Reablement
- Therapy Services (including sensory impairment, learning disabilities, occupational therapy and assistive technology)
- Care and Repair Home Improvement Agency
- Housing Programme

The TEC workers deliver TEC first training to a wide range of professionals, utilising the making every contact count (MECC) approach to ensure TEC is part of all conversations. Training has been delivered to Social Workers (specialising in both Adults and Children's), Housing Officers, Surveyors, Home Improvement Agency Caseworkers, Environmental Health Officers, Older People's Mental Health Team, Occupational Therapists, Social Prescribers, Primary Care Network Integrated Neighbourhood Mangers, COVID19 Hub Workers, Reablement Support Workers, Reablement Practitioners, GP Patient carer groups, Healthcare Assistants, Pharmacists and Mental Health Trust colleagues.

What were the challenges and successes?

Launching the lifeline service during the pandemic was not without its challenges due to changes in the patterns of service delivery and referrals. However, the embedding to the TEC first approach has meant that referrals to the TECS did remain comparatively high.

Feedback from people who access the service is extremely positive, it is a credit to the TEC service within Cambridgeshire and Peterborough that during a national pandemic, they have not only started a new service, that it has flourished beyond expectation without any marketing, but that also they have worked tirelessly to ensure that the best product is being provided to the person at the centre of this.

The outcomes from their interventions are not only supporting individuals to remain independent and take control of their lives but is also supporting the wider system to improve service delivery and provide savings. The TEC teams do not work alone and together with other preventions services and partners are offering a rounded service that will be of benefit to all living in Cambridgeshire and Peterborough breaking any stigma around technology enabled care.

To find out more information, please see: *TEC*

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Listening to the experience of people and communities

Essex County Council

Lived experience of residents requiring care and support during the pandemic: "None of us has a manual for this"

Commissioners and senior leaders across Essex County Council adult social care seek insight in people's experiences of COVID19 to inform their work with partners (including the NHS) and to inform recovery plans.

The COVID19 pandemic has impacted on all communities, but it has had a profound impact on people at most risk and people with disabilities. Public agencies response to the pandemic has brought about changes in the way public spaces and public services work, including care and support services. The Council wanted to research with people to understand how they had coped, what challenges they had, what could be different and ideas for the future. This was critical for recovery so that the Council were aware of those who felt less well supported, and could respond in new ways in the future and inform the models of care and support provided and commissioned.

This research provided new opportunities to engage with residents who wouldn't usually have participated with face-to-face research. Bringing stakeholders on the journey achieved attention from senior political and executive leaders and established resident's needs as a top priority for commissioners, ensuring that vulnerable residents had a voice that was listened to. Finding out about residents' experiences during the pandemic was key not only to the Council's response but also the responses from other organisations including partners, providers and commissioners.

> *"The biggest challenge was not having the support, not understanding what was going on in the outside world. I haven't been in a shop since February"*
>
> **(Deaf Blind Focus Group, August 2020)**

The research consisted of a survey (paper-based and online), ten focus groups and nearly 30 phone or online interviews with people who access care and support and informal carers. This research built on the methods developed to enable co-production and engagement with those who have an experience of disability and drew on Summit Services and Healthwatch Essex (who also run the Collaborate in Action Forum) to deliver some of the research.

It also prompted system-level action planning and landing via the Health and Wellbeing Board (HWBB). This was possible because the research was based on partnership working from the start, and shared at numerous partnership and internal groups. It was vital in ensuring that residents who most needed support were listened to by the partnership recovery groups, adult leadership team, commissioners and social workers. Findings were

also communicated effectively to engage different audiences using bespoke reports which included relevant headings and survey results, emotive case studies and quotes. The Council ensured that research was robust, and was overseen by Essex County Council researchers who analysed the collective outputs to achieve a coherent and thorough picture. Summit Services and Healthwatch Essex extended the research further than what was possible for the Council to deliver alone.

The council ran webinars, to share the complex insight in an engaging way, providing the opportunity for the 70 partners, community leaders, commissioners and social workers to collaborate and move the insight into action via breakout session discussions, as well as build on the positive work already being done. The Council publicised the webinars through board meetings, newsletters and community organisations. A lived experience speaker for each webinar attended, telling their own story and making the insight real. Breakout sessions were facilitated by ASC colleagues taking responsibility in their individual areas.

> *"People can be nasty when you are out with the guide dog and accidentally brush them or don't follow the arrows"*
>
> **(Visual Impairment Focus Group, August 2020)**

The work shone a light on some of the real challenges people with disabilities were facing, including adapting to social distancing and lockdown measures. This collaborative group were also able to identify the pieces of good work to build upon. The Council has been able to use this to influence partners and providers to change ways of working and to be more sensitive to people's needs. This includes:

- Reports shared at health and social care partnerships and other relevant forums
- Better use of social media to share advice and answer questions
- Support for those with sensory needs to navigate social distancing measures and reduce isolation, and a public awareness campaign
- Expanded Essex Wellbeing service, mobilising volunteers
- Connecting people with befrienders and welfare calls and visits
- Utilising the Kickstart programme creating work placements for 16-24 years olds
- Community groups helping to prepare people for lockdown, providing advice and activities
- Digital buddy support and care tech services
- Virtual dementia care training, out of hours crisis cafes and Motivated Minds in Basildon funded by the Clinical Commissioning Group and supporting all age mental wellbeing
- Review of the management of GP waiting lists, learning disability and autism support and access to surgeries

"I was really surprised that I could get that help. Essex Wellbeing Service was great; they called me every Friday to see if I was OK … it was a lifeline"

(Mike, 50s, interview)

The barriers identified as part of this work were:

- Unable to use traditional face-to-face methods for focus groups and interviews
- Keeping Essex County Council, partnerships and voluntary sector colleagues engaged when webinars had to be moved due to lockdown and increased work pressures. Sharing a short video of what they could embed in their practice right now
- Moving people from insight into action. A lived experience person sharing their story at the webinar helped to connect people to real lives and real stories, along with case studies, quotes and insight framed around "feelings" with the message of actions that help people feel supported, included, connected and confident to go about their lives

Conditions for success include:

- Finding the right ways to recruit and engage with those less listened to, used a paper-based survey to social care users in addition to an online survey for recruitment and also used social media, newsletters and organisations to promote the survey
- Offered a range of ways for people to engage, surveys, phone, Zoom and Teams and in partnership with Summit Services and Healthwatch Essex to ensure the Council reached out to those that would not usually engage.
- Online partnership meetings enabled the Council to virtually move around Essex engaging with more groups than previously for 15-minute slots to facilitate interest, on the spot action-planning and decisions
- A real appetite and acknowledgement, that together in partnership system-wide challenges can be tackled

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Supporting unpaid carers

Norfolk County Council

Carers Matter Norfolk and Carers Voice Transformation Journey and the UK's first social impact bond for carers

Norfolk County Council worked with unpaid carers, local carer organisations and a social investor to overhaul the support available to the 99,000 unpaid carers who play a vital role in the community. Previously separate services and interventions have been brought together under one service, Carers Matters Norfolk, empowered to identify support needs and provide for them.

Working closely with carers through lockdown via virtual engagement, the Council has implemented a new offer where assessments are proportional to the support they unlock, and the emphasis is placed on sustaining outcomes that lower the instances of carer breakdown and increase carer's wellbeing.

This saw carer satisfaction scores in Norfolk move from below the levels seen nationally and in the East of England, as well as at comparable local authorities, to above average on all counts.

Local authorities across England and Wales touch a fraction of the carers in their communities, all too often meeting carers for the first time when the need for expensive formal services like respite become desperately needed.

In Norfolk, early engagement with carers revealed bureaucracy and complexity in how carers accessed support. Analysis of the social work practice confirmed that meeting the challenge of supporting an ageing population often resulted in prioritising the person and their care, rather than the carer. Examination into the Council's long-term packages of care and support highlighted the significance of supporting carers in an emergency.

Developing a new service began with meeting carers, social workers and carers organisations. The discussions explored strengths of partnerships, carers navigation and how to support the independent voice of carers.

Norfolk County Council made a successful application for a social impact bond with the Life Chances Fund and the Department of Culture, Media and Sport, the first one for carers in the UK; securing additional funding and financial risk sharing that enabled the Council to increase the pace of change. The expertise of the social investment partner Bridges Outcomes Partnerships, who would take over management of the new service, began to bring significant benefit.

Through spring and summer of 2020, a project team and delivery partners co-designed the new service with carers. Working closely with carers through lockdowns and managing regular virtual engagement, the Council developed awareness of the requirements and challenges that different parties saw for the service, identified issues, found solutions and built shared expectations of the future.

Recruiting practice-based carers enabled extensive engagement with the social care workforce in order to lay the foundation for change whereby the service became the first port of call for carers support, rather than a social worker, as well as training Carers Matters Norfolk professionals to undertake new legal responsibilities as part of this new way of working. Alongside engagement and training came system development and new quality assurance initiatives to monitor performance and governance, to reflect the new shared responsibility for running the service.

Since the launch of Carers Matter Norfolk, the number of carers registered with the service has increased, along with the number of interventions and assessments completed. This has led to improved outcomes for carers as they continue to receive better access to advice, support and information, helping to manage their caring duties and own wellbeing, better sustaining their caring work.

The views of carers at the start of this work were that information and support was difficult to navigate, leading to frustration. This echoed the Council's results in the 2018/19 Survey of Adult Carers in England (SACE), where Norfolk scored below the averages for England, the Eastern Region and its comparable local authorities (family group). To gauge improvement, the Council commissioned an interim survey with the same scope of the SACE and saw a 7.8% increase in carers satisfaction, and an increase from 57.7% to 65% in ease of finding information and support. In both measures Norfolk has risen above the average scores for England, the Eastern Region and comparable local authorities.

The transformed approach is made possible by the service and the underpinning social impact bond contract, doing away with barriers between assessed social work, universal information and practical support, between commissioner and provider, assessments and services.

Combining the existing separate budgets for carers into one pot, it is then managed on behalf of carers and Norfolk County Council by the social investment partners, Bridges Outcomes Partnership. Procuring Bridges Outcomes Partnership as the prime contractor has provided a unique opportunity to improve the quality of service delivery through their dedicated outcome-focus to contract management.

At its core, the contract specifies outcomes for identifying carers and maintaining their wellbeing, which the social investor is paid against. The new type of working and contract offer potential for more flexible interventions to improve outcomes than a traditional commissioned contract. Increasing creative approaches and thinking about interventions to support people will help ensure that the desired outcomes are achieved.

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Strength based approaches to care and support

Cambridgeshire County Council and Peterborough City Council

Strength based approach to COVID19

At the start of the pandemic, Cambridgeshire County Council and Peterborough City Council established a combined response to support local community needs.

At the start of the pandemic, the Councils wanted to be front and centre in the fight against COVID to ensure communities were protected from harm, and residents who were likely to be most in need were getting the help they needed, and that services were able to operate despite immense demand.

The goal was to build on the existing place based and strength based models in delivery of the Council's response and the COVID19 co-ordination hub was born.

The hub enabled a place based, person centred approach to be the dominant factor that identified ways to support residents. The Councils rapidly drew in the vital voluntary, community and faith sectors that have been equal partners, and working alongside the Councils throughout. The hub turbo-boosted the "Think Communities" model of delivery, catapulting it into addressing real-time challenges. The work that had already been done by applying the Think Communities and Adults Positive Challenge Programme principles created the perfect platform from which the COVID response could be built. The Council, its partners, community groups and communities were definitely more prepared as a result of this work, some of which is described below:

1. Support to the clinically extremely vulnerable and older people whilst shielding

A Shielding Case Officer Team was created, comprising of 130 redeployed council staff responsible for making proactive contact on a frequent basis, sometimes to chat, sometimes to answer questions, sometimes to arrange for practical help. At the same time, the Team sourced an empty warehouse, filled it with food and other supplies, entered into a partnership with British Red Cross, and delivered hundreds of food parcels to people who would otherwise have struggled. The hub managed prescription collections, created a formal befriending scheme, and worked with Care Network to provide support for people who were feeling isolated.

Using the Think Communities principles (putting people at the heart), extended that support to anybody feeling in need, including people feeling isolated or lonely. The libraries service, for example, set up and launched a multitude of digital offerings, delivered thousands of food parcels via the mobile library service, provided practical support for people in need such as gardening and dog walking, and launched a brand new web service called "open new doors" giving people the opportunity to learn new skills, connect socially, or participate in different events whilst they were isolating at home.

2. Supporting informal carers

Adult social care worked with the hub and commissioned voluntary sector services to identify and reach out to informal carers. The hub created a dedicated team of over 30 redeployed council staff who made direct and regular contact with 1,557 carers in Cambridgeshire and 433 in Peterborough, to check that they were coping, to provide advice, and to connect them to local support where it was needed.

3. Redeployment of staff into front line care

During the first lockdown the hub supported people in need and council staff selected for redeployment who might have the skills and experience to support front line care roles. Training and support was provided, and a number of workers were able to give support in frontline roles within reablement teams. This experience led to a number of those involved applying for more permanent roles within the service, or continuing to offer bank shifts even after returning to their substantive roles.

4. Developing workforce capacity and skills

The pandemic has shone a light on the needs of our most vulnerable residents and given the wider council opportunities to think differently about how engagement happens. Ensuring staff are supported in their roles with the right skillsets has been an important element of the work. The relationship between the hub staff and colleagues in adult social care became very strong, ensuring that hub responses were informed by social care theory aligned to the Adult Positive Challenge Programme.

The change champions ran sessions on how to apply strength based conversations about the principles of post lockdown engagement. Sessions were also carried out with the hub team to explain the adult social care pathway to ensure that principles of strengths based conversations were being maximised and appropriate referrals made to social care and voluntary sector provision.

Embedding the Adult Positive Change Programme principles within the hub from the outset has helped to make the support offer more person centred and enabling. Sessions with hub co-ordinators covered how to focus on what conversations were about:

"What is strong" rather than *"what is wrong"*

This has led to a positive experience for those contacting the hub, who might have been reluctant to come forward and ask for help. A selection of comments from those using the hub are below:

"I was very embarrassed asking for help and nervous"

"Helping us survive at this point"

"One payment was good but would benefit if it was not just a one-off help"

"I have never been in a situation like this before because I have always worked"

"Lightened the immediate stress, slightly ashamed I had to ask, means I can buy some new (badly needed) clothes for my daughter"

"I found my experience to be wonderful. I felt bad for asking for help yet the people I talked to were so lovely and never judged me. They were very helpful"

"Really helped over Christmas and January and took some of the stress and worry away. The lady I spoke to was really helpful and understanding. Easy to talk to without feeling judged."

The unique circumstances of the pandemic alongside the existing foundations of the Council's Think Communities and the Adult Positive Challenge Programme, and the ways in which traditional ways of working have been disrupted by the pandemic, taken together have enabled a fundamental change to occur. Egos and name badges have been left at the door, conversations with partners have been open and focused on sharing, data has become more widely accessible, and decisions have been made collaboratively and creatively. These features have become part and parcel of the offer and will be strengthened and normalised way beyond the pandemic.

Cambridgeshire County Council and Peterborough City Council now intend to focus on recovery, particularly tackling social immobility and inequality, both caused by the pandemic and which was present beforehand. Using the features of the hub, the conditions for success are:

- Building on existing networks and intelligence and not starting from scratch
- Combining data with community intelligence and the lived experience of residents. Going where the need is, but in ways that make most sense to people
- Adapting the fleet-of-foot rapid response approached deployed throughout the pandemic
- Finding ways to take opportunities and interventions as close to communities as possible
- Delivering a system wide collaborative approach, councils, health, voluntary and faith sector, communities and employers
- Learning from what works well and adapting as a result – nationally and locally
- Developing approaches that are sustainable and permanent
- Ensuring a firm grip and frequent oversight

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Luton Borough Council

Side by Side

The Side by Side Programme changed the way that people are supported in Luton. It is based on the "3Conversation" model, which aims to create a new relationship between professionals and people who need support and a programme that delivers on the promise of personalisation, and is practiced in the context of community and asset building, local area co-ordination and other like-minded approaches.

Luton wanted to aim for best practice, place the person who accesses care and support at the heart of assessment and planning and establish a culture that recognises strengths and opportunities within the individual and communities. The Council was also looking to manage increasing demand and a reducing budget.

There were three elements to consider:

1. Affordability and managing demand

The number of people needing long-term support was increasing and this was clearly evidenced in the data and spend. There was a particular increase in the number of people requiring long-term care.

2. Integrated/partnership working

Some services had waiting lists and the workflows were difficult to navigate. There was a need for better integration between services, leaner processes, good quality commissioned services and shaping the market.

3. Sustainability/capacity

There was a need for a whole system review to provide an active early intervention and prevention service for those not already in the system. The Council aimed to build a strengths based review of the 2390 people who access care and support to offer them the same opportunities to regain the confidence to self-care and manage their lives with their own personal assets, family, friends and communities. Also, to work with people so they could experience greater choice and control.

Luton Adult Social Care was restructured to ensure the right capacity and skills were in the right place.

The Council set up a project delivery programme with input from a whole range of partners. The proposed new approach was shared and discussed with staff and relevant partnership boards, which had representation from residents and providers. All the internal and external staff were trained on strength based approach. This was developed based on a bottom-up approach bringing teams together to build a sustainable model that worked for the whole system and for people accessing care and support.

The impact has been:

- The Council has evidenced that the majority of people were managed within Early Help Prevention and Short Term Support, with fewer proceeding to longer term care
- The Council can confidently say the new strategy has been a success. It knows this because in the theory of change, it expected to see fewer people needing long-term support and that is clearly evidenced in the data and spend. Evidence showed a significant reduction in commissioning new long-term services in the first year
- Better outcomes were achieved for both the residents and staff
- Helped to prevent social isolation
- Better access to information and options – more choice and control
- More opportunity to take account of health and wellbeing
- The early intervention offer prevented or reduced crisis
- Better customer feedback and increased customer experience

What were the barriers and challenges?

- Strength based approach can only work if there are alternatives to traditional models of care. Market availability to create choice was a challenge. COVID has restricted some options in the last 18 months
- Getting partners fully on board and ensuring their practice after training – this is an ongoing challenge
- Transitioning from the older to the new – this created some resource and data issues
- Project management and resource time

What were the conditions for success?

- Commitment from leadership team and managers in adult social care, a good understanding of this approach is being embedded and evidenced in practice. As a result, the Council has seen a dip in unit costs
- Commissioners are developing new service options in the community
- Residents are considering alternative solutions to traditional care with the support of staff
- Increased use of assistive technology and a reduction in a person's ongoing care package as they gain the skills for living independently
- Focusing on early intervention and short-term support resulting in people being diverted to non-statutory services
- A strong voluntary sector
- Better outcomes and experience for residents and carers
- Improved staff satisfaction

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Thurrock Borough Council

Place based social work

The development and impact of place based and strength based social work in Thurrock – Community Led Support teams.

What were Thurrock's aims?

- To make social care accessible to all
- To take account of what was available within the community
- To understand the specific requirements of the community
- To shift power from professionals to individuals
- To forge good working relationships with statutory and non-statutory organisations at neighbourhood level
- To develop innovative solutions – consisting of formal and non-formal options
- To reduce bureaucracy and release time for increased face-to-face contact
- To increase the focus on prevention and early intervention
- To develop greater integration across existing service areas – particularly health, housing and social care; and
- Ultimately, to improve outcomes for people by focusing responses on delivering what mattered most to them

Thurrock established a "test and learn" Community Led Support (CSL) social work team in September 2018. The team consisted of social work practitioners who had expressed an interest in challenging and changing the current way of working. The team was given "permission" to "do things differently". This included being without a permanent base. The team would need to find locations within the community to work from e.g. libraries, GP surgeries and community hubs. The team would also need to identify strengths and assets contained by and within the community so that people requiring support could be offered more innovative solutions, broader than traditional service solutions. Building relationships with statutory and non-statutory partners would also mean that solutions could be more integrated and reduce the need for "hand-offs" and cross-referrals.

Since the first Community Led Support site was launched in 2018, Thurrock now has full coverage. This has resulted in a number of improved outcomes for individuals. The relationships built within community and statutory partners working in the CLS areas prior to the COVID pandemic by the CLS team has also enabled those good outcomes and innovative solutions to continue throughout the past 18 months.

Relationship building along with staff having the permission to work differently has provided the base from which a completely new approach to public service has been built.

A number of solutions have helped make Thurrock's CLS approach successful. These included the development of Thurrock's micro-enterprise programme which meant that there was broader choice even when people did require a service. The new Community Led Support social work teams set up "talking shops" prior to the lockdown in numerous locations across their respective geographical patch. This meant that people were able to drop in and have conversations about concerns they might have, or to receive information and advice. Talking shops were often run jointly with other service areas to enable people to receive a response regardless of the nature of their concern. This led to fewer formal assessments being required and to reduced waiting times. The approach also reduced the "formality" of seeing a professional and equalised the relationship between the "professional" and the "individual". A more conversational approach to assessments also enabled a greater focus on "what mattered" and resulted in different solutions being discussed and agreed. One of the CLS teams engaged volunteers to support with conversations and to provide information and advice. One of the CLS teams started to work differently with social care providers, providing a joined up approach to support planning and being part of team meetings.

During the pandemic, the relationships built by the teams in their areas allowed innovative and joined up conversations and solutions to continue. Each team held regular meetings with key partners in their area, often discussing joined up solutions to individual cases, or sharing information and best practice to inform ways of working. A number of good outcomes were delivered for people as a result:

1. One man was unable to leave the house due to severe epilepsy and a fear of having a fit when out. A traditional solution would have been to put in place a care package based around needs. The CLS team working with the gentlemen was able to investigate different solutions which led to an inexpensive technical solution. An app was placed on the gentlemen's phone which displayed key contacts at all times and meant that if he did have a fit, people would know who to contact. A bracelet worn gave information about his epilepsy and also alerted people to phone information. The whole solution cost £13, and more importantly enabled the gentleman to have the confidence to go out and live a far more independent and fulfilled life.
2. Working with the Local Area Co-ordination and Housing Team, one of the CLS teams developed a solution for an individual who was a hoarder and whose health and wellbeing was suffering as a result. Joint working and the relationship built with the individual meant that he was persuaded to move temporarily to extra care housing whilst his home situation was managed and a very small level of support put in place to help him to maintain his living conditions.

3. A woman was referred to one of the CLS team due to a decline in her health and mobility. She had previously been known to the mental health team, was a persistent caller of emergency services, and also known for anti-social behaviour within the community. Her health issues meant that she was stuck on the first floor of her property (Council owned) and her mental health was declining. Numerous visits to the lady established a good and trusting relationship and also focused on what mattered to her, which was to move to a property that she could manage, move around in, and to be able to enjoy a garden. Working with Housing, the team were able to identify a suitable property and help with the bidding process. One of the micro-enterprises was also engaged to provide a low level of support. Following the move, the emergency calls have all but stopped, the support being provided is minimal, including no recurring support required from mental health team. The wellbeing of the individual has significantly improved.

There are numerous examples in which working within and as part of the community has resulted in better outcomes.

The barriers identified have been:

- Inflexible and restrictive processes
- Partners at different stages in terms of integration and their ability to work differently
- Lack of integrated budgets across health and care
- Thresholds for accessing certain teams and services
- Cultural change required

The conditions for success have been:

- Leadership – giving "permission" and believing in what's being attempted
- Staff who want to work differently and are prepared to try and work differently
- Good relationships with partners (including the voluntary and community sectors)
- Starting small and growing upwards
- Being prepared to lose control

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Enhancing integrated working to improve outcomes for people

Essex County Council

Connect programme – supporting adults to achieve their best possible outcomes

A major transformation programme in Essex between the County Council and NHS to improve outcomes for people.

Older adults who are supported by Essex Adult Social Care (ASC) more often receive great care and support, however, sometimes adults do not receive their ideal outcome or end up on the incorrect pathway/care setting.

Essex County Council commissioned Newton Europe in 2019 to undertake a diagnostic review. This found that 44% of older adults discharged from hospital could have had a more ideal outcome at the point of discharge, and that there were opportunities for more people to benefit each year from reablement services and to avoid admissions to residential care. It found that people were more likely to return to their own home after a hospital admission if they were discharged to a community hospital setting or reablement (up to 78% return home) than if they were placed in a temporary residential care setting (a 27% likelihood of returning home). The diagnostic review found that there were opportunities to improve this by supporting more integrated working.

Addressing these findings has the potential to improve outcomes for older adults and to deliver benefits worth up to £16.9m a year.

Essex County Council and NHS partners in Mid and South Essex Integrated Care System (ICS) invested in a joint programme, called "Connect", to improve outcomes for older people. The programme is jointly funded, jointly governed and is underpinned by a system benefits realisation group so that benefits can be validated.

The Connect programme has five work streams:

1. Improving the efficiency and effectiveness of reablement services. The programme has identified improvements to reduce delays in the service and is working on a multi-disciplinary pilot to test ways to improve the effectiveness of reablement, with a particular focus on being goal-orientated and the appropriate use of therapy and equipment. The aim is to enable about 1,240 more people each year to benefit from reablement.
2. Supporting more independent outcomes through social care decision-making. The Council has introduced new Supporting Independence discussions and created "professional family trees" at hyper-local levels so the right skills, assets and connections between different professionals can be made to support more independent outcomes. After pilots in a locality of 30-50,000 the Council is now scaling up the approach across the county. The aim is to enable about 1,500 more people to achieve more independent outcomes and avoid higher packages of care.

3. Improving discharge outcomes. The trial wards have seen significant decreases in those moving from acute bed to an interim placement each week. These improvements have continued whilst scaling up across the acute site. The aim is to avoid about 240 admissions to residential care each year.
4. Admission avoidance. The aim is to reduce admissions of older people to acute wards by 11%.
5. Improving community hospital flow. The aim is to reduce delays and length of stay in community hospitals by 23%.

All of the ways of working are underpinned by visible data and improvement cycle methodology to ensure sustainability and continuous improvement.

Whilst the COVID pandemic has caused some delays and challenges to implementation, the work so far indicates that the overall quantum of benefits in terms of improved outcomes and financial benefits remains achievable.

Teams have also reported that they feel they are able to better draw knowledge from other team members, they have more structured conversations that promote better outcomes and that they are more effectively using other disciplinary knowledge.

The initial diagnostic, completed in 2019, involved interviews with adults who access care and support, and their families. It also involved around 300 extensive case audits, studies of work flow, and interviews with staff and leaders across health and care services. Over two million data points were also analysed.

The barriers to the programme were identified as:

- Initial programme set-up and buy-in: getting the scope agreed, the professional and leadership buy-in for a major programme during the pandemic
- Capacity and the pressures of running business as usual services, especially during a pandemic, whilst delivering transformational change in parallel
- Mindset change, embedding an evidence based culture where data is used at every level of the system to inform the decisions taken
- The complexity of the Essex geography, each quadrant is vast in size with varying demographics and needs. Enabling consistency across the whole of Essex and providing space for local variations

Conditions for success include:

- Senior leadership buy-in and focus: this was reinforced by having a common “case for change” that was evidenced through the 2019 system diagnostic
- Regular and clear messaging/engagement with frontline staff
- Access to subject matter experts to inform transformation
- Ownership of the changes and ways of working by frontline teams

For more information, please click *here* for a video about the Connect programme.

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Supporting people with disabilities into employment

Essex County Council

Supporting people with disabilities into meaningful paid employment

The launch of the Learning, Innovation, Volunteering and Employment service otherwise known as the LIVE service.

The Council's local strategic ambition is to increase the number of adults with learning disabilities and/or autism within meaningful paid employment, which is aligned with national policy and legislation.

Many young people and adults with disabilities who currently attend day opportunities have told the Council that they want paid jobs in a variety of industries but that support and opportunities for them to access this employment is limited.

The British Association for Supported Employment (BASE) and the Association of Directors of Adult Social Care (ADASS) are championing employment and recognise the role that local authorities have in supporting this agenda.

BASE and ADASS published top tips on supported employment which set out that:

> *"Councils can play an important role in helping people with a disability who are in receipt of social care to find and maintain a job if they want one, at the same time managing future demand for council-funded social care and helping employers to benefit from a more diverse workforce"*

The Care Act 2014, introduced a general duty for local authorities to promote adult's wellbeing including:

- Participation in work, education, training or recreation
- Physical and mental health and emotional wellbeing
- Personal dignity
- Social and economic wellbeing
- An adult's contribution to society

Provided by Essex Cares Ltd, the LIVE service was launched to provide day opportunities for older people and adults with disabilities and to also provide a comprehensive inclusive employment service including support to retain employment.

The LIVE service offer includes:

- Social and emotional skills, readiness for work – the LIVE service works with individuals, family members and other services to build an individual's confidence, resilience and motivation for work
- Pathways into employment – the LIVE service links with employers to increase employment opportunities, internships and apprenticeships and work placement schemes
- Job and skills retention and progression – the LIVE service provides support in the workplace in partnership with individuals and employers

The LIVE inclusive employment service is committed to:

- The principle that anyone can be employed if they want paid employment when sufficient support is provided
- Enabling people to be job ready
- Increasing employment opportunities
- Increasing the number of people entering meaningful paid employment
- Ensuring people receive appropriate support needed to sustain their employment
- Being flexible and providing a continuous process, designed to meet all anticipated needs
- Ensuring people have access to appropriate support to enable them to consider job progression, change and/or career development

Under the Meaningful Lives Programme, the Council has launched a dedicated and proactive social media campaign showcasing video testimonials, signposting, resources, micro-campaigns and explainer animations.

This was designed to put the LIVE service in the spotlight of key stakeholders and target communities. The content was all generated in-house and co-produced by the Meaningful Lives Programme Team.

To date, the LIVE service has supported 65 adults to secure meaningful paid employment.

Essex's Meaningful Lives Matter transformation programme hosted a 100-day challenge for adults with learning disabilities and autism across three day centres.

The broad focus of the challenge was to explore more meaningful activity for those adults attending the centres, particularly to progress them into employment.

During the 100-day challenge, the Council learned that:

- Many young adults with learning disabilities and/or autism want similar lives to most people
- There are many employment opportunities for adults with learning disabilities and/or autism
- People with learning disabilities and/or autism have more abilities and strengths than known about and with support can achieve their goals
- It is possible to demonstrate to the public the contribution people with disabilities can make

Within the 100 days, nine adults secured paid employment which reduced the use of commissioned services. A further 14 adults accessed volunteering as a step towards paid employment and this provided further evidence for the local authority and partners that there are adults known to services who are "job ready" and opportunities for progression and employment already exist in Essex and can be achieved when facilitated.

Here are some testimonials from adults who were supported through the LIVE service:

R is 29 years old and pre-COVID he had worked up to four hours per week at the Frontline Partnership Crown Café since 2017. R had one to one support at work. Following an adult social care review, R was referred to the Essex Carers Limited (ECL) LIVE service. ECL worked with R around interview skills to job search and apply for opportunities that matched his skills and interest. R expressed that he enjoyed being outdoors.

Within eight weeks, R was successful in a job application. R started his new role as a yard assistant within his local garden centre for three hours per week in March 2021. At the end of his first day, R was offered an additional working day and is now employed for nine hours per week. ECL supported R to settle into this new role for the first six weeks and now R is working independently. R's manager has shared that he is impressed with how quickly R has settled in and with how hard R works.

In R's words: "Working gives me a reason to get up during the week. I have increased my working days from one day to three days which is making it easier for me to be independent. Earning my own money helps me to pay my bills and one day I hope that I would be able to move out of supported living into my own property. Being supported to find work has supported me in spending more time doing things that I am passionate about. I care about the environment, and I have found employment where I can help make the environment a cleaner place."

K is 41 years old and pre-COVID was working two and three quarter hours each week at a café where K has worked since 2003. K had one to one support at work. Following K's adult social care review, K was referred to the ECL LIVE service for supported employment support. ECL supported K around interview skills, to job search and apply for opportunities that matched her skills and interests.

Within 14 weeks, K received a new job offer. K started her new job in May and is undertaking a range of tasks including making hot food and drinks. K is initially working two hours per week with a view to increasing this to eight hours per week. ECL continue to be in touch with K.

In K's words: "Being supported to find employment has helped me to meet new people and make new friends. I was supported to find employment that suited me and matched my skills. Without ECL's support I wouldn't have a CV or have felt confident enough to go into shops and restaurants and hand it out. It has helped me grow as a person. I have completed a food hygiene e-learning course thanks to my inclusive employment support which is useful for the type of employment I want to find. I feel more positive within myself. I have a reason to get up and leave my house. It has made me happy. My inclusive consultant has been the best and I am glad I have their support. I was anxious to find employment during the pandemic and I was nervous to find employment until lockdown was lifted but I was supported to overcome my own worries."

In partnership with Essex service providers the programme has identified the following as emerging outcomes:

- Adults in new employment working independently
- Adults working towards working independently, without ongoing one to one support at work
- Adults in new employment working more hours/days to suit them
- Adults participating in opportunities fitting with their interests and wishes
- Adults in new paid employment that offers variety of tasks
- Adults supported to choose not to work
- Adults support to choose to volunteer as their preference
- Adults supported to return to work after furlough
- Reduction in day centres attendance
- Adults leading more fulfilling and meaningful lives

Some of the barriers are:

1. Long term attendance in day centre or in volunteering placements. Through engagement with residents, many adults shared that they wanted paid jobs in industries that they are interested in. A large proportion of people with learning disabilities and/or autism are in long term volunteering or work based training and there is evidence to suggest people's skills could be transferred and utilised within paid employment opportunities.
2. Family anxieties/fears about employment. Historically, individuals and families have discussed day centre attendance rather than potential for employment. The LIVE service is working with the whole family and is working with schools and colleges to promote earlier conversations and recognition of the potential benefits of employment, as an alternative to long term day centre attendance.
3. Inconsistent awareness among employers. Nationally, the four main sectors of employment for people with learning disability and/or autism are horticulture (garden centres), animal care, retail (charity shops) and hospitality (cafes). These sectors do not always match interests and ambitions. People that have engaged are interested in much wider employment sector and opportunities, including setting up their own business, engineering and health and beauty industries.
4. Benefits implications. Individuals and families are often unsure how entering paid employment might affect their benefits and financial circumstances. The LIVE service provides benefits/income advice and potential scenarios with individuals and families at an early stage on the employment pathway.

The conditions for success are:

1. Focus on strengths
2. Adults with aspirations for employment
3. Families well informed and supportive
4. Employers on board and engaged
5. Positive relationships through LIVE service, Adult Social Care, ACL, health, schools/colleges etc.

As part of the Meaningful Lives inclusive employment micro campaign and to complement wider messaging, here is a selection of materials which might help, published on a dedicated Facebook channel. The videos were viewed more than 12,000 times:

New co-production officer with lived experience case study for Meaningful Lives: Meaningful Lives Essex – *New co-production officer for Meaningful Lives | Facebook*

Promotional video for inclusive employment and three case studies: Meaningful Lives Essex – *Meaningful Lives inclusive employment – three case studies | Facebook*

SEND funding grant initiative to promote inclusive employment market among Essex businesses: Meaningful Lives Essex – *Grants for Essex businesses to employ adults with additional needs | Facebook*

Vacancy for new officer with lived experience within the Meaningful Lives Learning Disabilities and Autism Team: Meaningful Lives Essex – *Vacancy in learning disabilities and autism commissioning team | Facebook*

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Connecting people using digital technology

Southend Borough Council

Project 49 – social distanced but not socially isolated

On-Line 49 is a Facebook based "virtual" service for people with learning disabilities. There is a range of activities throughout the week which are interactive.

Social distanced, not socially isolated is key; as soon as Southend realised that Project 49 would be closed because of lockdown the Council knew that if they wanted to keep the people who attended Project 49 during the COVID19 crisis, they had to be innovative in their approach. The Council quickly moved much of the service online and created a Facebook group called "keep in touch".

A lot of the content is "live" and interactive as opposed to just watching recorded content which is quite passive. Although initially for the people who attended project 49, the group is now open to people who do not usually attend. The Council has had a number of people who attend other day services become active members, and has been hosting live Zoom meetings with new friends in New Zealand.

The use of Zoom, which can be broadcast live on Facebook, is the latest addition to the programme and adds another layer of interaction to the programme.

Here are two case studies which show how the project 49 programme has helped individuals:

Case study 1

During COVID, M was keeping a more nocturnal routine, gaming until late into the night and staying in bed until well into the afternoon. M was introduced to the Facebook "keeping in touch" page and once discovered M found some purpose to get up if he wanted to catch certain activities and comment and respond. M has continued to engage with the various activities and sessions that he likes and has commented that he can do this every day whereas he is only entitled to two days of service so has more opportunities to join in. M's mother has found that for him to engage and have a focus has eased some of the tensions that have been building up at home.

Case study 2

The Facebook "keeping in touch" group was introduced and a particular member of staff realised the importance of this for L and A. She would support them to take part in activities especially music and more gentle exercise sessions. The member of staff would ask L and A for their comments about the sessions and post these to the page increasing their engagement and interaction. She would also take videos of the women (with permission) and post these to the Facebook page which helped with engagement as they then saw themselves represented there.

What were the barriers?

People who access care and support didn't always know how to use digital technology or have IT equipment at home. Funds were gathered via grants and equipment for those that needed it. Direct Payments were used for people to buy tablets to access services.

What were the successes and conditions for success?

- Offers a virtual one-stop shop for active engagement
- A dynamic and agile model of delivering a service
- Enables respite for families and carers within the home environment
- Reduces the likelihood of breakdown in relationships/placements at home
- Reduces isolation and offers a sense of engagement with a wider community and creating new forms of community, friendships and common interests
- Supports good health outcome/reduces health inequality e.g. via active engagement with community dentistry and GP specialist
- Supports pathways into other services, for example supported employment
- Increases people's skills sets and strength based assets
- Increases people's confidence and capability to use technology
- Breaks down barriers between people with learning disabilities and the wider community

For further information, please see the following links:

Southend On-Line 49 – Coronavirus (COVID-19) social care provision:
Stories of promise – Covid-19 information – Think Local Act Personal

Project 49 – *Southend Care*

The Facebook page can be found *here*.

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Suffolk County Council

Keeping care networks connected virtually

During restrictions in the COVID pandemic, many people who needed care and support could not access their normal support networks. By utilising digital care technologies, Suffolk connected people with their providers, services and perhaps most importantly, their loved ones.

At the beginning of the COVID19 pandemic, there was a real fear around the capacity of the health and care system to continue to support the needs of people who access care and support while managing the demands of infection rates, the risk of cross-contamination and the restrictions of lockdown.

At any one time, Suffolk is providing care and support in some way, shape or form to around 11,000 people on a long-term basis, as well as other short-term support. With nearly all of this support being face to face, it was critical for the Council to think innovatively about how it could sustain vital services against the challenges faced.

After discussing the problems being faced and managed with care technology, the Council felt the best opportunity was to provide a connected device to support virtual care. Suffolk County Council commissioned Alcove Limited and Rethink Partners to deploy 1,000 video carephones to vulnerable residents, as well as to services, to enable contact to remain through the various challenges and restrictions of working in lockdown.

The solution encompassed three key elements – hardware, software and connectivity. The Council provided not just a carephone (tablet) to those that needed it, but also the video calling software built into the device which was connected through a model data SIM. This meant that everything that was needed came in one ready to use out of the box package, so the Council could quickly support people who had no experience of technology or who didn't have their own connectivity.

In the last 12 months through the pandemic, the Council rolled out just shy of 1,100 carephones in total to a huge range of recipients and with many associated benefits. They have enabled nearly 225,000 minutes of video calling between people and their networks, totalling 58,000 calls. The work has pushed forward the digital agenda in Suffolk as well as supported in overcoming some preconceptions around people and digital capabilities – three of the people using carephones are over 100 years old.

To enable the success of this work, it was vital that the Council worked in collaboration with commissioners and providers, as the formal support networks for many residents who access care and support.

In addition, the Council engaged with other parts of the care and health system in Suffolk and found cases that would benefit from the technology in many places that were not originally anticipated, these included mental health services, speech and language therapy, voluntary and community sector organisations and many more.

Most importantly, the Council engaged with people to ensure that they had the necessary support to use the devices in a meaningful way. This was enhanced through the data that the devices captured, being completely digital, the Council could identify where there may be problems e.g. battery low, not turned on for days, or difficulty making calls and offer proactive support to enable the best outcomes.

Some of the barriers were:

- The variability and changing of the pandemic restrictions and infection levels
- Preconceptions and digital technologies
- Capacity to consider the opportunity in light of all other urgent challenges the pandemic created
- The pace and scale of delivery and decision making. The Council had to be iterative which is not usual behaviour

Some of the successes were:

- Collaboration with all stakeholders
- Agility in response and approach
- Being led by where the best opportunities to support better outcomes lay e.g. flexibility rather than prescription
- Accepting failure is part of the process and applying learning from what didn't go so well

For further information, please see the following links:

Suffolk Virtual Care Response Service | Suffolk County Council

Covid19 Response – Stay Connected Service – Alcove Shop (youralcove.com)

Largest and fastest roll-out of digital care technology ever – Kent, Suffolk and Essex County Councils – *Rethink Partners*

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Bedford Borough Council

Going live system change, with a strengths based focused priority

Bedford Borough Council had undertaken work to procure a new solution. The go live data was planned but the pandemic developed during the same time, which left the Council with a decision to pause or progress work.

The Council had been using an outdated database which required a care management focus rather than an up to date solution. This affected the ability to capture performance data in a systematic way and strength based way. A modern system was needed, to support frontline staff to move away from "feeding the system" to allow time to work in a new way with people who may have care and support needs. The Council spent two years working through a project to get the new system successfully secure which would complement the good practices in place, support new approaches and better informed data.

The Council procured a new system and spent time reflecting on what needed to change to help frontline staff to manage caseloads, allowing time to work in a more agile focused and coproduced way, spending less time sitting at the desk working on a system that no longer supported what was needed. The Council had already worked within a strengths based ethos, but wanted to develop this further to improve outcomes and to move away from the "deficit" model.

At the same time, pressure from the pandemic was building and the Council was already seeing increased staff absence across the market creating an even more need for recording and managing data. As a result, and despite the short term pressures, senior management and team managers made the decision to progress with the rollout of the new database and training scheme.

The engagement with managers and frontline champions was so successful one of the managers commented "we can't not afford to go live, with the advantages the new system will bring, even though we have a pandemic and a range of new challenges to contend with".

Although there were many crunch points and pressures, the rollout was achieved on time. The Council took an opportunity to further develop the assessment formats in the new system to reflect the strengths based approach with coproduction at the heart.

There are many benefits including the ability to collate and manage data has improved since go live and this has also enabled the Council to monitor and support every social care provider. Such rich data and information will be key as the market reshapes and the data will inform any potential decisions made during this time. The readiness of data has also enabled the Council to take some pressure off the frontline, and other areas of the Council, freeing them up to support wider work around the pandemic and other areas.

The Council has been able to offer a more varied approach to engagement and co-production with people who access care and support, through the use of the new care management system. For example, implementing self-assessment, finding ways for citizens to access to their own account/records and provider review. The modular nature of the portals, which bring the additional functionality, has enabled the Council to stagger the upgrades to fit the needs of the people and local community. Throughout the integration of the new database the council has also been focused on developing knowledge on the new system within the various teams, ensuring there is the ability to affect change internally, without the need to go out to external agencies, in the majority of cases. This has helped to offer a wide range of development opportunities for staff. Bedford Borough is also considering being part of ADASS pilot "Landscape – spend and activity project, which will expand the data collation locally and regionally, support budget monitoring and has the ability to forecast trends.

This joined up approach, linking the training to the IT system rollout has also improved outcomes for individuals. For example, people who were accessing traditional resources have since been assessed around their strengths and are now taking part in groups that link to their work life profession. This brings added value to them, and enables individuals to be an active and valued part of that particular community.

As the Council builds on the success of the local co-ordination already in place, it envisages the networks growing and starting to feed each other. The outcome of the in-depth strengths based training has been very positive, including the feedback from the specialist training facilitators. The Council is looking to develop more specialist strength based training to further the journey and strengthen the practice and knowledge base that has been developed. This will be further underpinned by policies and practice throughout.

The barriers were

There were some real challenges to going live, as well as opportunities, going from agile working to more people working from home. Adapting remote "floor-walkers" to support and embed the new system where there had previously been planned face to face support.

The conditions for success were

Having the technology to enable people to use the system at home and to have support for any queries. Also a great success was the way the frontline staff were able to make suggested final tweaks after go live to help to further embrace the changes and add in more benefits in real time. Success was also achieved through a skilled and trained workforce who were willing to give it their all, in unprecedented times, to support the people. This work was the beginning and continues to evolve and develop. The Council is proud of the way staff responded to the challenges to bring about new ways of working.

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Facilitating affordable specialist housing and investing in long term solutions

Norfolk County Council

Specialist housing programme – facilitating affordable specialist housing in a non-housing authority

A social care, upper-tier authority, not usually responsible for housing. Norfolk County Council recognised and responded to the need for appropriate and affordable specialist housing, to ensure people can live as independently as possible in the communities they are connected to.

Living in appropriate housing increased the social connections that allow people to thrive and improves people's wellbeing, including reduction in feelings of loneliness. With financial benefits to health and social care systems too, such as reducing GP appointments, reducing falls and preventing or delaying a move to residential care, Norfolk County Council have committed to investing in long-term solutions.

Current housing options are limited, meaning lots of residential care admissions are being used for people with low care needs whose homes become no longer suitable. Norfolk has a higher than average number of over 65s living in single person households.

Alongside population needs analysis, Norfolk County Council recognised that affordable specialist housing cannot be brought by the market alone. Ensuring rents were covered by housing benefits was a critical factor in acknowledging that build costs would exceed rental income, unless capital funding was available to fill the development viability gap. This gap becomes starker as the non-rentable communal space requirements increase or high specifications are sought to accommodate complex disabilities.

Norfolk County Council made the clear case that capital funding in affordable specialist housing was a pragmatic investment and it compared favourably to savings against future residential care.

To facilitate specialist housing for older populations and working age adults with disabilities, by providing alongside nomination and design requirements, Norfolk County Council worked with partners to establish two dedicated capital programmes with a combined public commitment spend of £47 million.

Norfolk County Council also established a housing strategy as part of its wider objectives which included recognising that Council owned land was to be considered for specialist housing as a priority for any disposal. Partners involved in the work include new and existing registered social landlords, care providers, local councils, councillors, Norfolk residents, co-production groups and the NHS.

Independent living to increase the provision of extra care housing by 2028 was established in 2019, supported living to increase the provision of supported housing for working age adults was established in 2021. The schemes are run by two full time staff who work extensively with partners across Norfolk.

There were a number of ways in which people, commissioners and providers worked together.

Partnership working: navigating the different languages of planning and adult social care. The relationship with housing and planning colleagues in district councils was paramount to the programme's success.

- Time with colleagues to understand their perspectives and what information they needed was critical in schemes developing. The programme's success is every partner's success.
- Partners developed a mutual understanding, acknowledging the roles of different tenure types in encouraging right sizing, such as older people's shared ownership, as well as learning from each other about different regulatory obligations. One officer's Care Act 2014 is another officer's Town and Country Planning (Local Planning) (England) regulations 2021.
- A study was finalised with all district councils to look at the need for all tenure older peoples housing to ensure specialist housing was recognised for its variations in options.

Research

Research was undertaken to hear about Norfolk residents' views and establish what they knew already about different housing options. The results were as follows:

- People did not understand what specialist housing options were available, nor how to access them. For the programme to be a success, the approach would have to widen beyond development to encompass an effective communications and engagement plan
- The voice of Norfolk residents was loud and clear. Good housing options were about continuing to live, and not making judgements about what being old meant

An immediate result of the research was to change the name of the programme to Independent Living. To date, work has been commissioned to:

- Create branding which shows specialist housing as a positive option
- Campaign to help people understand what housing options exist
- Produce videos for staff to promote schemes and the independent living concept with potential tenants and families
- Ensure staff were equipped with knowledge and enthused about new schemes

It was vital to go beyond bricks and mortar. The Council was not only financially supporting building work, it was actively helping people to access the buildings, and supporting partners, whether housing colleagues or scheme owners, to fill them.

The first Independent Living scheme opened in May 2021, Meadow Walk by Housing 21. It has:

- A mix of affordable rent and shared ownership
- Been shortlisted for Inside Housing's Best Rural Development for Older People
- Specific dementia friendly features including a "nostalgia shop" replicating an old-fashioned shop which will sell non-perishable items and an indoor workshed".

The second scheme with Saffron Housing Trust started on site and is due for completion 2022. The third, fourth, fifth and sixth schemes are currently in pre-planning and expected to be completed in 2023/24. A further eight schemes are also in early discussion stages.

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Safeguarding people

Luton Borough Council

Adult safeguarding rapid review

Luton Safeguarding Adults Board (LSAB) have been piloting an approach already used by Luton Safeguarding Children's Board (LSCB) to inform the decision making around whether to undertake a learning review such as a Safeguarding Adults Review (SAR).

The process for notification of a potential SAR and then making a decision as to whether it met the criteria, meant it could take six months or longer from an incident to a decision being made. In a number of cases there were further delays as information from other agencies also needed to be requested.

Luton Borough Council wanted to put into a place a process, where:

a) All partners provided relevant information

b) A meeting took place relatively quickly (normally three weeks) which could pull together learning and identify if SAR criteria were met

c) A decision could be made at that meeting rather than having to wait (up to eight weeks for next SAR/ Child Safeguarding Practice Review Group sub group) to make the SAR determination

The LSAB prepare and send out a template to all partners (Clinical Commissioning Groups, health providers, police, adult social care, housing etc.). The template includes a short chronology and some reflective questions on the quality of practice. The responses are collated and a summary of emerging themes is circulated ahead of the meeting where relevant organisations are invited.

The meeting is chaired by the LSAB independent chair, the legal advisor (if they can also attend), alongside participants from all relevant organisations. The meeting focuses on:

- Gathering the facts about the case as far as they can be readily established at the time
- Discussion on whether there is any immediate action needed to ensure the person's safety and share any learning appropriately
- Considering the potential for identifying improvements to safeguard the adult
- Deciding what steps should be taken next, including whether or not to recommend a safeguarding adult review

Decision making is quicker and actions can be put into place without needing to wait for a SAR to take place.

Whilst the rapid review pilot is fairly early on in its delivery, early feedback is that it's working well and partners see the benefit of identifying themes and learning early on.

Some of the barriers are:

- Initial concerns around whether the rapid review process would work in adult service
- Concern about the number of rapid reviews that might come through the system
- Speed in which to collate information and return for analysis

The conditions for success are:

- Multi-agency buy-in to the pilot – positive, focused and active
- Identification of good practice – shared to aid learning and development across organisations
- SARs being identified more appropriately – reducing the number of SARs being requested that did not meet criteria
- Having a safeguarding process in place to co-ordinate between partners

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Norfolk County Council

People from Abroad Team – responding to need

The People from Abroad Team (PFAT) deliver innovative approaches to whole-family social work directly in the community. They demonstrate best practice in local government social work; finding novel and unique solutions to address needs efficiently and economically, promoting independence and self-reliance, challenging discrimination and inequity.

PFAT has continued to deliver specialist support services to asylum seekers in need, migrants and refugees during the pandemic, effectively addressing practical and social aspects of social care, responding to changing pressures and the competing demands of COVID19 and Brexit.

Delivering a dedicated health and social care work service to Norfolk's refugees, migrants and asylum seekers, PFAT were established in 2016 to deliver the Syrian Vulnerable Person's Resettlement Scheme. They have since expanded to deliver specialist support to migrants who are victims of:

- Human trafficking/modern slavery
- Domestic abuse
- Honour-based abuse (HBA)
- Forced marriage

and to:

- Children and their families who have no recourse to public funds (NRPF)

PFAT take on an integrated health and social care provision for newly arrived asylum seekers placed in asylum dispersal accommodation.

In the pandemic, the team needed to continue maintaining and improving support and access to vital services for people they helped. This meant providing access to housing, employment, health services and education and more.

They also had to address the significant risks to health and welfare arising from the Home Office placing a large group of asylum seekers at a rural, isolated location as contingency accommodation during the pandemic.

Norfolk County Council responded quickly to the COVID19 pandemic and fast changing national and local guidance, for example:

- Responded to the "Everyone in" instruction and worked closely with district councils to support NRPF migrants who were rough sleepers or homeless, finding exit solutions for 72 individuals. This included securing funding to establish a Housing to Work scheme for EU migrants to secure employment and move-on housing, assisting them to apply under the EU Settlement Scheme (EUSS) at the same time. As of March 2021, 121 EU nationals have been supported to apply.

- Responded to the Home Office placing a large group of asylum seekers at a rural, isolated location. In partnership with the CCG and local care providers, PFAT established a "welfare unit" at Jaguar House which provided social work and healthcare support, including health and care screening assessments and referring.
- Rose to the challenge of supporting people at Jaguar House in a socially distanced or remote way for those who had little or no technology. Established Zoom classes with local volunteers, a library, recreational activities such as an indoor gym, payphone with Freephone access to Migrant Helpline, immigration solicitors and NHS 111, a youth group in partnership with Norwich International Youth Project, a women's group and an art club.
- The Council's efforts ensured the site didn't experience problems seen at similar provisions. The work was praised for providing vital support in the pandemic by Lord Dannatt on behalf of his wife, the Lord Lieutenant of Norfolk.
- At Jaguar House, effectiveness was measured through the number of crises that occurred (compared to similar provisions) such as number of emergencies call-outs, cases of self-harm, COVID19 cases (0) and resident deaths (0). The outcomes demonstrate the effectiveness of safety precautions implemented and PFATs efforts to keep people meaningfully occupied whilst residing.
- Demonstrated best practice in collaborative working in responding to need. Working with district councils, Home Office, libraries, NHS, voluntary sector, schools, adult learning, social workers, hospitals, Serco, hotels, local employers, youth groups, and many other organisations; to continue delivering vital support services to refugees in need, migrants and asylum seekers, many of whom were on the fringes of society and many who had no entitlement to welfare benefits and homeless services.
- Ensured that non-EU migrants could continue vital learning and increasing employability prospects from home. Working with Norfolk Adult Learning the Council moved vocational language classes online and obtained computers and 4G plug-in routers during pandemic restriction, enabling learners to quickly transfer online.
- Worked collaboratively to address need, promote improved access to mainstream services and nurture independence to support newly dispersed asylum seekers in Norwich. Through an integrated approach, a nurse and support worker from the NHS transferred to PFAT. Work included supporting the delivery of COVID vaccinations for asylum seekers and homeless migrants at delivery sites and via the mobile Vaccine Bus to reach isolated communities.

The feedback has been positive:

"We feel loved and truly supported. We are experiencing real Humanity and I say thank you to all of you".

Person seeking asylum, May 2021

"Norfolk's PFAT have provided excellent co-ordination and support in the UK resettlement of refugees; and played a valuable role in achieving the successful resettlement of 20,000 people under the Vulnerable Person's Resettlement Scheme. They have applied a positive proactive approach, formed strong collaborative relationships with partners and competently managed and supported vulnerable families with complex needs, to make a new life in the UK"

Resettlement Operations – Local Authority Contact Officer, Home Office

"Thanks for all the things you did for me at the Jaguar building, it was a great pleasure to meet you … I feel now that I have found myself and I feel happier than ever".

Former Resident at Jaguar House

"I work within the Multi-Agency Safeguarding Hub for Norfolk Police, specifically focused on Modern Slavery and Human Trafficking. We work in partnership with the People from Abroad Team on planned safeguarding matters and dynamic incidents. We have built a trusted relationship where we can discuss concerns and share information to safeguard those most vulnerable. PFAT have always been willing to help vulnerable adults in need of extra support and have previously assisted in finding safe accommodation whilst police investigate possible offences. This can be vital to police but also for the victim to have their support and reassurance.

It's invaluable to have this working relationship where we can offer another service should they choose to disengage from the police.

Recently, Norfolk housed a large number of asylum seekers during COVID19 outbreak. I was able to rely on the PFAT to assess and address any modern slavery concerns with every single person placed in our county. This was invaluable to ensure we were protecting those in need of safeguarding. They took the lead and spoke with every person themselves, this would have been work that my small team would have otherwise had to absorb".

Feedback from a Detective Sergeant colleague in the multi-agency safeguarding hub

Some of the barriers were:

- Continuing to deliver services to non-English speakers with no access to the internet in a COVID safe way
- Working across conflicting agencies' priorities
- Managing a Transfer of Undertakings (TUPE) service transfer at the beginning of lockdown
- Responding to emerging priority needs in the community during the pandemic
- Lack of funding and advance planning

Some of the conditions for success were:

- Supportive senior managers who have faith in practitioners to manage the situations safely and pragmatically
- Good channels of communication across involved agencies including regular online meetings
- Mutually supportive team members with a wide skills base to draw upon
- Taking a “can do” approach and a willingness to explore alternative solutions
- Good business continuity skills

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