Essex County Council

People and Families Policy and Scrutiny Committee

10:00	**Thursday, 14 June 2018**	**Committee Room 1, County Hall, Chelmsford, CM1 1QH**

For information about the meeting please ask for:
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Telephone: 033301 36276
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		Pages
1	**Membership, Apologies, Substitutions and Declarations of Interest**	**5 - 6**
2	**Election of Vice-Chairmen for 2018/19 Municipal Year**	
3	**Minutes** To approve as a correct record the minutes of the meeting held on 12 April 2018.	**7 - 11**
4	**Questions from the Public** A period of up to 15 minutes will be allowed for members of the public to ask questions or make representations on any item on the agenda for this meeting. On arrival, and before the start of the meeting, please register with the Senior Democratic Services Officer.	

5	**Call-in: Review of Essex Education Services - FP/102/03/18** To consider report (PAF/13/18)	**12 - 30**
	The meeting will adjourn for approximately 30 minutes before the Committee continues with item 6.	
6	**Relationship Management** To consider report (PAF/14/18)	**31 - 94**
7	**Task and Finish Group - Hip Fractures and Falls Prevention** To consider report (PAF/15/18)	**95 - 133**
8	**Work Programme** To consider report (PAF/16/18)	**134 - 136**
9	**Date of Next Meeting** To note that the next Committee activity day is scheduled for 12 July 2018, which may be a private Committee session, public meeting, briefing, site visit, etc - to be confirmed nearer the time.	
10	**Urgent Business** To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.	

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

11 Urgent Exempt Business

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

Essex County Council and Committees Information

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Agenda item 1

Committee: People and Families Policy and Scrutiny Committee

Enquiries to: Graham Hughes, Senior Democratic Services Officer

Membership, Apologies, Substitutions and Declarations of Interest

Full Council on 15 May 2018 agreed changes to various committee memberships including the People and Families Policy and Scrutiny Committee. The following changes have been made to the HOSC membership:

1. Councillors Andy Erskine, John Moran and Lesley Wagland no longer serve on the Committee;
2. Councillors Graham Butland, Jude Deakin and Mark Durham are appointed in their place.

PEOPLE AND FAMILIES POLICY AND SCRUTINY COMMITTEE (18)
(10 Con :1 Lab: 2 LD: 1 NAG + 4 Co-opted)

John Baker
Graham Butland
Jenny Chandler
Jude Deakin
Mark Durham
Beverley Egan
Jeff Henry
June Lumley
Malcolm Maddocks
Peter May
Maggie McEwen
Patricia Reid
Clive Souter
Andy Wood

Conservative Subs:
Carlo Guglielmi
Mark Platt
Labour Sub:
Lee Scordis
Liberal Democrat Sub:
Mike Mackrory
NAG sub:

Cont… 1/2

Cont 2/2

Recommendations:

To note

1. Changes to the substantive Membership as shown on the previous page.

2. Apologies and substitutions.

3. Declarations of interest to be made by Members in accordance with the Members' Code of Conduct

Minutes of the meeting of the People and Families Policy and Scrutiny Committee, held at 11.20am in Committee Room 1 County Hall, Chelmsford, CM1 1QH on Thursday, 12 April 2018

Present:
County Councillors:
M Maddocks (Chairman)
J Baker
J Chandler
B Egan
J Henry
S Hillier (substitute)
J Lumley
P May
M McEwen
J Moran
P Reid
C Souter
L Wagland
A Wood

Also in attendance: R Carsen, education co-optee.

The following officer was present in support of the meeting:
Graham Hughes, Senior Democratic Services Officer

1 Membership, Apologies, Substitutions and Declarations of Interest

The report of the Membership, Apologies, Substitutions and Declarations was received and noted. Apologies for absence had been received from Councillor Erskine (for whom Councillor Hillier substituted).

The following declarations of interest were made for the item on educational attainment:

Councillor Andy Wood	Member of ACL Forum and champion for safeguarding. Wife is a safeguarding officer in a local school
Councillor John Moran	Partner is a school secretary at an academy trust.
Councillors June Lumley, Peter May, Jeff Henry and Richard Carsen	School Governor

2 Minutes

The minutes of the meeting held on 15 March 2018 were approved as a correct record and signed by the Chairman.

3 Questions from the Public

There were no questions from the public
The Chairman proposed, and it was agreed, to vary the order of business published on the agenda and take the items on Healthwatch Essex Relationship and the Essex Safeguarding Children Board next before reverting back to the order in the published agenda.

4 Essex Safeguarding Children Board

The Committee considered report (PAF/10/18) proposing that Healthwatch Essex be invited to attend future meetings of the Committee as an observer and accepted the proposal.

Agreed: That Healthwatch be invited to nominate a representative to be an observer at future meetings of the Committee and, at the discretion of the Chairman, to be able to ask questions.

5 Essex Safeguarding Children Board

The Committee considered report (PAF/11/18) providing a copy of correspondence between the Committee Chairman and the Independent Chairman of the Essex Safeguarding Children Board (ESCB) further to issues raised with the Committee when it discussed the work of the ESCB with voluntary sector representatives in February 2018.

Agreed: That the correspondence should be noted at this stage and that there could be further discussion on the issues raised at the next scheduled update from the ESCB in September or October 2018.

6 Educational Attainment in Essex

The Committee considered report (PAF/09/18) comprising an annual report on educational attainment specifically prepared for the Committee. It was noted that whilst all the data was in the public domain in various other formats and locations, this annual report produced it in one place.

The following introduced the item and participate in subsequent discussion.

Councillor Ray Gooding, Cabinet Member – Education.
Clare Kershaw, Director, Education.
Katerina Glover (Senior Analyst)

Background

A power point presentation was delivered highlighting key performance measures for educational attainment in the 550 maintained schools and academies in Essex. With recent changes in the way attainment was being

assessed nationally, it made direct comparison with previous years more difficult. Members stressed the importance of benchmarking against data from ECC's statistical neighbours.

Two key corporate priorities formed the basis of the report compiled namely (i) working towards an aspiration of every school being judged good or outstanding by OFSTED and (ii) that performance for all Key Stages in Essex sat in the top quartile nationally.

Currently, 94% of Essex schools were graded Good or Outstanding compared to 89% nationally. It was highlighted that back in 2012/13 the comparable figure for Essex was just over 60%. The breakdown by sector for 2016/17 was 93% primary school (380 schools), 97% secondary, 94% of special schools.

During subsequent discussion the following was highlighted and or noted:

(i) There was no typical profile of a school needing improvement/being inadequate. Schools often had issues that could not be predicted. However, some of the more challenging schools were small and often in rural locations where they specifically had difficulty with recruitment.

(ii) District breakdown - Brentwood was the highest performing district in terms of achieving an overall good level of development. Whilst there had been significant improvement in overall district profiles there had been a dip in performance in Tendring and a general increased focus on driving up attainment levels in Basildon and Harlow as well as Tendring.

(iii) Part of the decline in performance in Tendring was attributed to lower achieving cohorts coming through the system (particularly Year 6 this year) but also social and family challenges specifically in the Tendring area. It was acknowledged that the County Council have been prioritising achieving OFSTED stipulated outcomes and may not been following up on the actual progress of children as much as needed and will need to do this as well going forward.

(iv) Attainment 8 – Essex was slightly ahead of the national picture. Within that there were variations between districts with Brentwood, Chelmsford and Colchester positive and Braintree and Tendring minus.

(v) Post 16 qualifications – there had been a slight decline in the levels entering general apprenticeships but a slight increase in higher degree and higher apprentice levels.

(vi) Data for Absences and exclusions was more time-lagged. The rates of secondary school permanent exclusions was 0.6% which

was significantly below the rest of country. However, the rate in Essex was increasing - reflecting the increasing national trend.

(vii) There was a statutory duty to track and monitor outcomes for Children in Care at all times and the County Council had a specific team to do this. This was an increasingly challenging issue and the County Council was seeing an increasing trend of children entering care in their later school years.

(viii) Recruitment and retention did continue to be a challenge both locally and nationally - especially for maths and science teachers. The County Council had unsuccessfully tried working with recruitment agencies in Ireland and Australia. A Return to Teaching training programme had been more successful.

(ix) A review of alternative educational provision had been commissioned recently to look at effective practice and what was working well. There are approximately 1400 Essex children being home educated and the County Council had a general duty of care for them (especially in relation to safeguarding) yet had no real power of intervention (unless formal referral) or enforcing quality. Councillor Gooding had been lobbying local MPs to pressure Government to grant local education authorities some powers of intervention.

(x) The County Council had prioritised a school improvement service for every school irrespective of whether it was maintained or an academy. In addition, the County Council RAG rated all Essex maintained schools and aligned the degree of support/resources each school had offered to it so that it was proportionate to that rating. The County Council was also encouraging the development of a school-led improvement system – i.e. schools often can look towards other schools first for assistance - the County Council had now formed 37 clusters of schools and the County Council provided tools for them to assist conducting rigorous peer reviews within their respective clusters. It was important that even schools with good and outstanding status realised that it still required hard work to maintain those ratings.

Councillor Gooding suggested that he would like to see the peer to peer support extended to governing bodies.

(xi) The reasons for exclusion were recorded although they may not specifically record incidences of substance abuse and instead just record the resulting disruptive behaviour and whether it involved physical or verbal abuse.

(xii) Whilst the educational attainment report included data on academies, it did not include the independent sector. It was noted that independent schools often also took non-Essex

resident children and that they also did not have to follow the national curriculum. The County Council's only significant remit over independent schools was if safeguarding concerns were raised.

(xiii) Up to 20% of children in Essex were assessed with varying degrees of Special Educational Needs. The County Council was looking at working with a group of schools to develop/identify a minimum service entitlement for specific needs (providing more consistency of effective practice) and develop an outcomes tools framework. This was partly to acknowledge that schools can often struggle to track progress when it is not academic based.

Conclusion

The Chairman thanked the witnesses for their attendance. The following actions were agreed:

(i) That a glossary be produced for future reports.
(ii) That the Committee be specifically updated on the County Council's work to develop a minimum service entitlement identified for specific needs and develop/identify an outcomes tools framework.
(iii) A mechanism be developed to keep North East Essex County Councillors up to date on Tendring educational attainment issues and concerns and actions being taken.
(iv) Further information be provided on exclusion rates for districts.

7 Work Programme

The Committee considered and noted report PAF/12/18. The date for a member development session on gang culture would be circulated.

Date next meeting

The next Committee activity day is scheduled for Thursday 10 May 2018. Activity days may be a private session, meeting in public, briefing, site visit etc – to be confirmed nearer the time

There being no further business the meeting closed at 12.55am.

Chairman

	AGENDA ITEM 5
	PAF/13/18

Committee:	**People and Families Policy and Scrutiny Committee**
Date:	**14 June 2018**
Enquiries to:	**Name: Graham Hughes** **Designation: Senior Democratic Services Officer** **Contact details:** 033301 34574 Graham.hughes@essex.gov.uk

On 25 May 2018 the Cabinet Decision FP/102/03/18 - Review of Essex Education Services - was called-in by Councillor John Baker with the support of Councillor's Jude Deakin, Mike Mackrory and Stephen Robinson.

A copy of the decision paper is attached at **Appendix A**. A copy of the Notification of Call-in received from Councillor Baker is attached at **Appendix B**.

In line with the procedure for handling the call in of a decision, an informal meeting was held on 4 June 2018 and a note of that informal meeting is attached at **Appendix C**. After the meeting, Councillor Baker confirmed that he wished to bring the call-in of this decision to full committee.

Appendix D is a suggested procedure agreed with the Chairman for managing this call-in item in the meeting.

Having considered the decision, the Committee:

(i) may allow the decision to be implemented without further delay;
(ii) refer it back to the decision taker setting out in writing its concerns;
(iii) or refer the matter to Full Council also with a record of its concerns.

Upon a referral to a decision taker, the decision shall be reconsidered within five clear working days amending the decision or not before adopting a final decision.

If the Committee does not refer a decision to either the decision taker or the Council, the decision shall take effect at the conclusion of the meeting of the Committee.

Forward Plan reference number: FP/102/03/18

Report title: Review of Essex Education Services	
Report to: Cabinet	
Report author: Jason Kitcat - Executive Director for Corporate Development	
Date: 22 May 2018	**For:** Decision
Enquiries to: Jason Kitcat - email Jason.kitcat@essex.gov.uk	
County Divisions affected: All Essex	

Confidential Appendix

This report has a confidential appendix which is not for publication as it includes exempt information falling within paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972, as amended.

1. Purpose of Report

1.1. Essex Education Services ('ESS') is a traded part of ECC which provides services to schools. This report seeks agreement to conduct the sale of EES with a view to maximising the return to the Council because we believe that selling EES now would unlock value for ECC and would enable the business to be developed to the next level in the hands of the buyer.

2. Recommendations

2.1. Agree that, subject to the remaining recommendations, the Council sells Essex Education Services (EES) via a competitive auction process which includes the disposal of the asset, liabilities and contracts of EES.

2.2. Authorise the Cabinet Member for Education (in consultation with the Leader, the Cabinet Member for Resources, the Cabinet Member for Health and Adult Social Care, the Chief Executive, Executive Director for Corporate Development and the Executive Director for Corporate and Customer Services (S151 Officer)):

- Approve the final process to be followed;
- Approve the criteria to be used to select the winning bid;
- Finalise the Information Memorandum (IM) for the sale transaction for EES;
- Select the winning bid; and

- Enter into a contract for the disposal of EES in a form approved by the Director, Legal and Assurance.
- Enter into a contract for the future provision of serviced office space and IT infrastructure to the purchaser during a six-month interim period following the sale.
- Enter into a contract for the disposal of EES in a form approved by the Director, Legal and Assurance.

2.3. Agree that Essex County Council (ECC) will purchase a three-year insurance backed bond of £3m to cover the liability of the new employer to make pension contributions to the Essex Pension Fund with respect to EES employees who transfer from ECC to the new employer.

2.4. Agree that:

(a) the cost of such bond may be drawn down from the Transformation Reserve; and
(b) the cost of the bond be returned to the Transformation Reserve on completion of the sale.

2.5. Agree that the Council's Essex Outdoors, Schools Advertising and Initial Teacher Training services should no longer be managed by EES and that they should be retained by the Council.

2.6 Agree to the drawdown of up to £82,000 from the transformation reserve to cover the legal costs of the project.

3. Summary of issue

Background

3.1. EES is a traded business of Essex County Council (ECC) with its own recognisable brand in the market place. A key product, Target Tracker (TT), holds a 25% market share in primary school assessment software, securing its place as the market's largest single provider. It has more than 4,500 customers nationally, with a limited additional customer base internationally. EES is not a company but it operates as a traded service within ECC. This means that all EES staff are employees of ECC and all contracts with EES customers are contracts with ECC.

3.2. EES is a profitable business and it has grown steadily in recent years, developing both its product and customer bases. In recent years parallel schools funding has become increasingly constrained and new sales have not continued at the same rate of growth experienced as in previous years since 2016-17.

3.3. In 2016 the service had reached a pivotal point in its growth strategy. It was decided that in order to continue to grow and meet the demands of its customers, significant investment would be required both in existing and new products, and also the capabilities of those delivering the services. It was recognised that whilst ECC has built an excellent and valuable asset in EES and whilst EES is generating significant revenue for ECC. However, as a mature and sensible investor it was recognised that EES may require specialist investment, meaning that ECC may not be the best long-term owner for the business.

3.4. To determine the business direction for EES, a report was commissioned from CIL Management Consultants in Summer 2016 to review:

a. growth through acquisition (whether to obtain market share / profitability;
b. greater product range and/or management expertise/capacity);
c. realisation of the asset value through company sale (disposal);
d. continued organic growth only; and
e. growth through partnership.

3.5 The report concluded that 'the most suitable strategic option for this business is selling TT and investing in EES's professional and support services proposition via acquisitions, partnerships and through investment in organic growth'.

3.6 Furthermore, the report concluded *'without further investment, TT may currently be at the height of its market potential and risks losing ground to competitors if not developed further. Therefore, if EES decided that it did not wish to, or could not, back TT with investment or an acquisition, now is likely to be the ideal time to divest.'*

3.7 In December 2016, the then Executive Director responsible for EES commissioned a document to present the options around the future of EES and following consultation with the Leader soft market testing on the potential of selling TT was undertaken.

3.8 The feedback from the market was that EES is a 'market leading platform that is well positioned with the opportunity for growth'. Thus the market view was that ECC should consider selling EES in its totality, including TT.

3.9 During 2017 it became apparent that a significant downturn in the education professional development market was developing and this has continued to deepen into 2018. Despite significant restructuring EES is unlikely to recover to previous levels of profitability with additional significant investment.

3.10 In light of the market testing feedback a proposal to sell 100% or a majority of EES was developed. Market testing further confirmed that whilst a joint venture (JV) would enable ECC to be invested in, there was no appetite from the market. Despite the original recommendation from CiL of disposing only TT, and retaining the remainder of EES, evidence from market testing confirmed that this approach would not provide the Council with maximum value from the asset.

3.11 In June 2017 PwC were appointed, to provide 'consultancy services to advise on disposal of part or all of Essex Education Services'. Informal advice from PWC, as well as other experts in the education market, suggests that a private equity buyer for EES could be readily found.

3.12 In December 2017, PwC concluded that equity buyers "struggled to understand how a JV structure would work in practice given investment requirements and the need for control over ECC's exit. Based on our market soundings a

JV would be likely to severely limit the number of interested parties and adversely impact deal flexibility and value". The same report further concluded that "typically, private equity would seek to have control over key decisions and the timing of any future exit". Therefore the idea of the Council holding a majority share was removed from the proposed approach.

3.13 As a result it is now recommended that ECC should dispose of the whole of EES with the exception of Essex Outdoors and Initial Teacher Training.

3.14 All EES's services are non-statutory. Schools are therefore not required to buy from EES and EES is not required to sell to them.

3.15 In February 2018 PwC presented an update on their work which includes the parameters and outline timeline for sale.

Week ending	
April 6	PwC completes the Vendor Due Diligence
April 27	PwC completes the growth strategy review
May 18	PwC completes the Information Memorandum (IM)
May 22	Cabinet meeting to review the proposed option to sell
June 8	PwC launch stage 1 of the sale which involves sending the Investment Memorandum to interested parties
June 29	stage 1 closes with first round offers
July 6	stage 1 round offer clarifications and shortlisting to approximately five or six bidders
July 13	PwC launches stage 2 with shortlisted bidders receiving Vendor Due Diligence, sales and purchase agreement (SPA) and access to the Virtual Data Room
August 10	stage 2 closes with final offers and mark up of SPA received
August 17	clarify offers / negotiate and agree exclusivity with preferred bidder
August 31	period of exclusivity with preferred bidder to finalise diligence / documentation. Final decision

3.16 The legal work on the transaction will be undertaken in house by ELS but the cost of the work will need to be funded from the transformation reserve as ELS is not funded by ECC for the cost of project work. Accordingly, approval for a drawdown of £82,000 from reserves is sought.

4. Scope of the transaction

4.1 All of the services listed below are proposed to be disposed of as part of the transaction:

Service area	
Target Tracker	Software EES provides to allow primary schools to assess the educational progress of children.
Education Finance Support	A team who provide in school financial support and audit services
Support for Governors	Advice and guidance for subscribing governing bodies
Clerking Agency	Advice and guidance for subscribing governing bodies
Schools HR	A team who provide in school HR support and compliance services

Professional development	Training for all school staff and in school educational support.
Educational Visits	Advice and guidance for subscribing schools on residential and other out of school visits.

4.2 In addition, EES manages Essex Outdoors and Initial Teacher Training which are branded within EES and recruitment advertising. The recommendation is that the management of these services will be transferred to other Council services.

4.3 Previously ECC commissioners have bought outcomes from EES, though these have largely ceased. The remaining elements are:

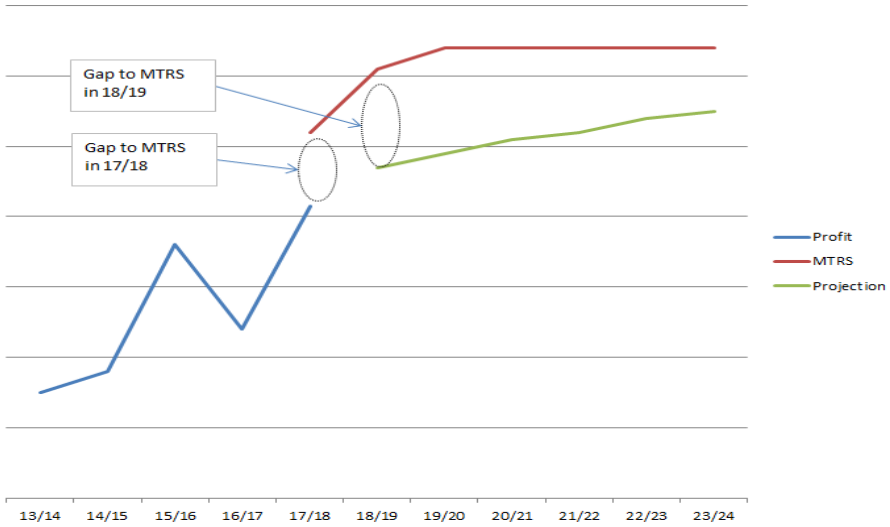
- Support for the recruitment of local authority governors to schools (this is planned to cease in the summer term 2018 with this being transferred to other parts of ECC); and
- Support for the education partnership with China (this will cease in 2018).
- EES supports the core Education team by managing centrally paid money for the termination of contracts for school based employees. This will be managed by the core Education team.

4.4 In addition other services in ECC use EES resources to support invoicing and marketing their traded services to schools (Essex Legal Services, Health and Safety, Early Years). This will cease after the transition agreement period when the new company can decide to offer this service to the Council if still required. This may impact on other council services in terms of maintaining market share and retaining customers. However, EES may decide to compete against ECC services and offer these services.

4.5 EES also occupies premises in County Hall. As part of the transaction EES will lease this space from ECC on commercial terms or find alternative accommodation. This may lead to additional space in County Hall, although a reduction in overall rental income.

Financial forecast

4.6 EES for Schools has grown significantly in terms of profit without investment but has reached the point at which the Council's expectation outstrips the ability of the service to deliver. The graph below shows the performance of EES without investment, previous years and original MTRS



5 Options

5.1 The options considered are:

- **A** service remain 'as is' without investment. The service will continue to deliver a contribution to the ECC revenue budget, although this will decline through lack of investment and as the market continues to change with competitors improving their offering. The 18/19 MTRS contribution from EES to the Council is £4.7 million.
- **B** invest in the development of renewing and improving the TT product. This option was reviewed extensively in 2016/17 and the conclusion was that the investment of between £4m - £7m into the business was unviable for the Council and did not produce sufficient return at an acceptable risk.
- **C** the Council sells all of EES for Schools. This option produces a capital receipt for the Council without the need to invest. The range of potential values is wide depending on the individual buyer and the market at the time of sale.
- **D** the Council sells of part of EES for schools. This produces a capital receipt, albeit lower than option C, but retains potential for a dividend.

5.2 If ECC is focused on maximising the value of EES, Option C is the preferred option. This approach provides the opportunity to significantly reduce the risk to the Council in terms of challenges in the education market. It also does not require the Council to invest in EES to secure the financial future of the business. For EES the sale provides a shift of ownership more suitable for the business in terms of growth, as well as access to investment, specialist business support and sales channels.

5.3 The proposed approach to achieve Option C is an auction process, with a two-stage process to shortlist preferred bidders that will meet ECC's minimum requirements, track record, ability to pay and future potential. Market feedback suggests potential buyers require a quick agreement on completion of the auction.

5.4 The strategic objectives for the transaction are:

- To achieve the best value for the business whilst investor interest is high;

- Post transaction to retain a significant presence in Essex and remain part of the Essex Economic Growth story which means that the company is a medium size employer contributing to the economic prosperity of Essex; and
- For EES to be seen as an employer of choice in Essex which means that the Essex community gains through the growth of the business.

6 Next steps

6.1 If the Cabinet approve the recommendations in the report, the next stage of this process is for the Council's appointed advisers to bring the business to market towards the end of Q2, 2018.

6.2 The final decision as to who will be the successful buyer will be decided through an unrestricted auction process. This will invite bidders to submit an offer for 100% of the business.

7. Issues for consideration

7.1 Pensions

7.1.1 A report was commissioned from Barnett Waddingham (the UK's largest independent provider of actuarial, administration and consultancy services) 'to advise the administering authority on the pensions information required in respect of eligible employees transferring their employment from Essex County Council (the Letting Authority) to a new employer'.

7.1.2 The report was presented to ECC on 2 January 2018 and found that the EES part of the ECC pension scheme was fully funded as at 1 December 2017, with future employer contributions, if the scheme was closed to new employees, calculated at around £1m per annum.

7.1.3 Where private company employees are members of the EPF the fund requires a bond to be provided. The report concluded that any transitional agreement which would allow the introduction of a defined contribution scheme for new employees while guaranteeing the funding of any additional contributions in relation to the legacy defined benefit scheme would be more attractive to investors. The most buyer friendly position would see ECC pay the bond, which could be purchased from insurers for three years with contributions capped at the current level. Provision of a bond is a legal requirement.

7.1.4 The Council could provide the equivalent in terms of the bond value through and insurance scheme for three years. This is estimated to be at a cost 1% of the total bond value for three years per year. The exact figure can only be determined at point of sale. ECC would not provide a bond beyond the three year period.

7.1.5 The buyer will take on the responsibility of providing the bond or insurance after three years.

7.1.6 PWC advise that ECC should pay for the cost of the pension bond rather than take out insurance and recover this through the sale.

7.2 Ongoing services between EES and ECC

7.2.1 Given the speed at which the sale is likely to proceed, it is likely that there will be a requirement for ECC to carry on occupying its current premises and using some ECC support services for a short period after the sale. It is proposed that we would enter into an agreement with the buyer to provide these services.

7.2.2 The scope of this agreement will be defined depending on the buyer however will likely encompass office accommodation and use of ECC's IT infrastructure.

- Currently EES for Schools pays £117,589 per annum for office accommodation. This includes facilities management and services such as confidential waste disposal and office cleaning. It is proposed that ECC should allow EES to continue to use its current premises for up to six months after sale. This includes all existing FM services including confidential waste disposal and cleaning.
- Currently EES for Schools pays £466,610 per annum for information technology services. Again, it is considered to be necessary that this continues for up to six months after sale. This includes: email, file access, telephony, mobiles, printers, internet access, network support and computer hardware.
- There will be a charge based on the existing charges in the MTRS budget.

7.2.3 ECC now buys very little from EES and in order to avoid procurement law issues, it is proposed that ECC will not purchase any services from EES after the sale.

8 Financial implications

8.2 The financial implications are outlined in the confidential Appendix of this report.

9 Legal implications

9.1 The Council owns all EES assets and it is not required to provide any of the services that EES provides. As a result, ECC can sell its assets to the highest bidder and this is not considered to be procurement activity as the Council will not be buying anything. The Council will need to ensure that there is a transparent process which results in the best return for residents. As part of this we will need to have a clear process for disposal.

9.2 As part of any sale the buyer will wish to verify that ECC can demonstrate ownership of the assets which are to be included in the sale and that they can be lawfully transferred to the buyer. ECC will also be required to give warranties about ownership. Draft sale agreements will be included in the documents issued to tenderers.

9.3 ECC Financial Regulation 7.1.5 states that all disposals over £5m require the approval of Cabinet.

9.4 The employees working in EES will transfer to the purchaser under the provisions of the Transfer of Undertakings (Protection of Employees) Regulations 2006 as amended.

10 Equality and Diversity implications

10.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful.

(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.

(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

10.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

10.3 The equality impact assessment indicates that the proposals in this report will not have a disproportionately adverse impact on any people with a particular characteristic.

11 List of appendices

Equality Impact Assessment

Confidential appendix (not for publication)

12 List of Background papers

None.

Notification of Call-in

Please submit this form to governanceteam@essex.gov.uk.

Decision title and reference number Review of Essex Education Services (FP/102/03/18)	
Cabinet Member responsible Cllr Ray Gooding	**Date decision published** 23rd May 2018
Last day of call in period 25th May 2018	**Last day of 10-day period to resolve the call-in**

Reasons for Making the Call in

The reason for calling in this decision by Cabinet is simple:

Selling EES (Essex Education Services) to a private company will, in my view, undermine democratic accountability over the education service in Essex and will not be in the public, that is, children's and families', interest.

My reasons for believing this are as follows:

1. Currently primary, secondary and special schools, including CofE (Church of England) VA (voluntary aided) and VC (voluntary controlled) schools, can become academies under current statutory arrangements and be directly accountable to their board of directors and ultimately to the Department of Education. Some powers, however, remain under the control of ECC (Essex County Council), particularly those which are related to pupils who have SEND (special educational needs and disabilities).
2. Many Essex secondary schools and a proportion of primary and special schools have already become academies through the democratic process, whereby governing bodies can opt out of ECC control;
3. Schools which fail their Ofsted inspection can be forced down the academy route and be taken over by existing multi-academy chains or similar arrangements.
4. From my educational background and experience, schools which remain part of ECC have made a decision to remain part of ECC through democratic processes, namely through decisions made at full governing body meetings annually. They have made this choice for positive reasons as they see the benefits, particularly linked to financial services, human resources, safeguarding, training and the general professional support and advice they currently receive from being part of the LA (local authority).
5. Selling EES and placing it into the hands of a private company would deny the democratic rights of individual governing bodies of every school which decided (through due process) to remain part of the LA. This would, in my view, significantly undermine democratic accountability.

Signed: Cllr John Baker With the support of: Cllr Mike Mackrory Cllr Jude Deakin Cllr Stephen Robinson	**Dated:** 25/05/18
For completion by appropriate Democratic Services Officer	Graham Hughes, Senior Democratic Services Officer
Date call in Notice Received 25 May 2018	**Date of informal meeting** TBC
Does the call in relate to a Schools issue? Yes	**If yes, date when Parent Governor Reps and Diocesan Reps invited to the meeting** TBC
Date of PAF Committee Meeting (if applicable)	**Date call in withdrawn / resolved**

Call-in of the Cabinet decision on Review of Essex Education Services (FP/102/03/18)
Notes of informal meeting held at 9am on Monday 4th June 2018 in C120, County Hall, Chelmsford

Present:
Councillor R Gooding (Cabinet Member - Education)
Councillor J Baker - (member calling-in the decision - also Vice Chairman of People and Families Policy and Scrutiny Committee)
Councillor J Chandler (Vice Chairman of People and Families Policy and Scrutiny Committee)
Councillor M Maddocks (Chairman of People and Families Policy and Scrutiny Committee)

In attendance:
A Boey (Cabinet Office)
G Hughes (Senior Democratic Services Officer)
P Randall (Senior Democratic Services Officer - observer)

Background:

The Cabinet had made the decision on the Review of Essex Education Services (FP/102/03/18) on 22 May 2018. The decision related to Essex Education Services, a traded part of the County Council, which provided services to schools and proposed to conduct a sale of EES. The decision was published and then called-in by Councillor Baker (with support from Councillors Deakin, Mackrory, and Robinson) on 25 May 2018.

Councillor Baker - summary of call in

In opening the discussion, Councillor Baker outlined his reasons for call-in.

- He stressed that he had not been lobbied by anyone on this and had called it in on his own volition.
- He had no issue with the actual decision-making process followed.
- He had concerns about the impact of the decision on democratic accountability and whether it would be undermined and so deny school governing bodies from being able to decide how they wished to continue to receive services from the County Council.
- He also had doubts whether the proposal was in the best interests of the school children and families and how that could be assessed?
- Discussion in full scrutiny committee would facilitate greater transparency of the issues and decision being proposed.

Cabinet Member response:

Councillor Gooding stressed that under the proposed decision the majority of services provided to the Education sector by the County Council would remain provided from within the Council.

- The Target Tracker software developed by the County Council was marketed and purchased by approximately 80% of Essex schools and also sold around the country. Some limitations with it had now been identified such as incompatibility with I-pads. The software was coming to the end of its current developmental cycle life and now needed significant further development and investment. Consideration had been given as whether to keep it in-house and commit to significant development and investment but it had been decided seek an external specialist company to do that instead.
- Included in the service being proposed to be sold were HR consultancy which was already traded, financial support for school (some of which has also been traded), and some educational visits. SEN provision would remain provided by the County Council.
- He had been advised that the value of any sale of the software would be much enhanced by including those other consultancy services although it was possible that there could be some companies who may solely look at the IT package as an investment, develop it and then sell it on - this would become clearer during the bidding process.
- The prospective market value of the software product further devalues as time passes.
- As now, schools would be free to choose whether they wished to continue to use any of these services and/or seek their provision from elsewhere.
- Democratic accountability lay with the school governing bodies anyway as they would make the purchasing decisions for these non-mandatory services and would presumably make them in the best interests of their own pupils, parents and staff.
- Councillor Gooding would be meeting Head Teacher representatives to further discuss the proposals (particularly around HR services) and was willing to report back on this to scrutiny colleagues if that was requested.
- Retaining a proportion of the business had been considered. This in effect would mean retaining a shareholding which would be difficult bearing in mind the service would need significant future investment (particularly around the further development of the Target Tracker software) and so the County Council would still end up being responsible for a proportion of this.
- The decision paper enabled the County Council to further progress discussions and procurement intentions.

Members then discussed possible options for further scrutiny of the proposals during the refinement of the procurement process. No conclusion was reached on that.

Conclusion:

Councillor Baker was advised on the process for continuing the call-in process should he wish to continue to do that. He agreed to consider the matter further and advise the Democratic Services Officer on how he wished to proceed over the course of the next day or so.

Councillor Baker subsequently confirmed that he wished for the call-in to proceed to formal committee. The matter would be considered at the next scheduled meeting of the People and Families Policy and Scrutiny Committee to be held on 14 June 2018.

Appendix D

Essex County Council
Call-in item procedure note - template

Within the parameters of the Council's Constitution, the Chairman of the relevant committee has some scope to adjust the format of the meeting in order to best adapt to the circumstances of a specific call-in(s). This applies in particular to the order of events and the amount of time given for each segment of the meeting (as indicated in the procedure note below). Where significant deviation from this procedure is proposed, it is recommended that the chairman share his intention with the parties to the call-in as much in advance of the meeting as possible.

The following text is to be completed by the Chairman and included in scrutiny committees' published agenda papers when considering decisions which have been called-in:

Procedure for the Committee's consideration of this call-in

A call-in may be withdrawn by the author at any time. If the call-in is withdrawn before this call-in item is held, this process will not be necessary.

The focus of the Committee for the call-in item at today's meeting should be the Cabinet Member's decision on the Review of Essex Education Services (FP/102/03/18) as set out at Appendix *A* to this report, and the debate should be limited to the specific reasons given for the call-in itself as set out by Councillor John Baker (with support from Councillors Deakin, Mackrory and Robinson in Appendix B to this report.

1. A procedure for the meeting is set out below. However the Committee may decide (as a committee) to depart from this process.

2. Any questions from the public will be asked at the start of the meeting, not at the start of this item. If any member of the public wishes to ask a question they must make their intention known to the Democratic Services Officer or Senior Democratic Services Officer before the start of the meeting. The Chairman may allow the question to be answered immediately, or during the call-in item as part of the debate, or may arrange for a written response to be provided after the meeting. If written answers are to be supplied after the meeting then the person must ensure their contact details are known to the Democratic Services Officer or Senior Democratic Services Officer.

3. At the start of the Call-in item the Chairman will:
    a. Introduce and welcome members and contributors.
    b. Remind members and contributors of the Committee's expectation that only the issues raised in the call-in notice (Appendix B**)** will be considered and that if anyone wishes to raise new matters then they may only do so with the permission of the Chairman.
    c. Indicate the proposed order of business (ie this procedure note)

d. Remind the Committee of the three courses of action open to them which are:
    i. To allow the decision to be implemented without further delay.
    ii. To refer the decision back to the person who made the decision with such recommendations as the Committee think appropriate (noting that the decision-maker may then amend the decision or not within 5 working days - it cannot be called in again).
    iii. To refer the decision to full Council (noting that full Council cannot overturn the decision. Full Council can either allow the decision to be implemented or refer it back to the decision maker).

4. As the originator of the call-in, Councillor Baker will be allowed a total of 20 minutes to present the call-in with up to *3* supporting contributors of their invitation sharing that time. Where there is more than one call-in of any one item of business this time will be shared between them.
   Everyone speaking must ensure that their speech is relevant to an issue in the call-in notice, unless the Chairman agrees otherwise.
   Thereafter, at the Chairman's discretion, there may be some limited questioning on points of clarification around the case for the call-in.

5. As the decision-maker, Councillor Gooding will be allowed 20 minutes to present a response to the call-in with up to 3 supporting contributors of their invitation sharing that time.
   Everyone speaking must ensure that their speech is relevant to an issue in the call-in notice, unless the Chairman agrees otherwise or they are responding to an issue already raised during the call-in item.
   Thereafter, at the Chairman's discretion, there may be some limited questioning on points of clarification around the decision made by Councillor Gooding.

6. There will then be a period during which the Committee may ask questions of anyone who has provided information in support of or in opposition to the call-in and may discuss any issues.

7. **Any member of the Committee may then propose either:**
    a. **To allow the decision to be implemented without further delay.**
    b. **To refer the decision back to the person who made the decision with such recommendations as the Committee think appropriate.**
    c. **To refer the decision to full Council.**

8. This motion must be seconded. The Committee will then vote upon that motion.

9. In the case that the Committee agrees option b or c, the chairman should describe arrangements for the committee's concerns to be recorded for the attention of the decision-maker or full Council as appropriate.

Appendix B - Extract from Essex County Council's constitution

20.15 Call-In

(i) Call-in should only be used in exceptional circumstances. Day-to-day management decisions or routine operational decisions should not be subject to call-in.

(ii) Subject to paragraph (xix) any decision taken by

(a) the Cabinet;

(b) any Member of the Cabinet; or

(c) any joint body or partnership specified in paragraph 13.3

may be called in to the Overview and Scrutiny Committee whose remit includes the subject matter of the decision. A decision may be called in by

(a) any Member of the relevant Overview and Scrutiny Committee;

(b) any Member of the Council who has the support of a further three Members of the Council; or

(c) with the agreement of the Chairman of the relevant Overview and Scrutiny Committee, any Member of the Council who represents a Division which is particularly affected by the decision in question.

(iii) Where a decision is made by the Cabinet or an individual Cabinet Member the decision shall be published (including where possible by electronic means) and shall be available at the main offices of the Council within three clear working days of being made. Members of the relevant Overview and Scrutiny Committee shall be sent copies of the notice of all such decisions also within three clear working days.

(iv) The notice publishing such decision shall bear the date upon which it is published and will specify that the decision will come into force and may then be implemented on the expiry of three clear working days after publication unless called in.

(v) A decision is called in if during the period specified in (iv) above a valid written call in notice is received which specifies the reasons for the call in. The proper officer shall then call a meeting of the Committee on such date as he decides (where possible after consultation with the Chairman of the Committee) and in any case within ten clear working days of receipt of the request to call in.

(vi) On receipt of a notice of call-in the Scrutiny Officer will:

(a) arrange for the notice to be acknowledged in writing;
(b) for the decision taker to be formally notified in writing of the receipt of a notice of call-in; and

(c) for the Chairman of the Overview and Scrutiny Committee to be informed where the Chairman is not a party to the call-in.

(vii) Prior to the meeting of the Committee arranged under (v) above, the Chairman may, with the agreement of the Member calling the matter in, arrange an informal meeting between him, the Member calling in the decision and the decision taker to discuss the issue.

(viii) Where the call-in has been made as the result of representations from a Member who is not a member of the Committee, that Member will be invited to attend the informal meeting. The Scrutiny Officer will attend the informal meeting and will within 24 hours produce a note for circulation to all parties to the meeting for approval.

(ix) Where at the informal meeting stage assurances are given by, or agreements reached with Cabinet Members, then those assurances or agreements must subsequently be confirmed in writing.

(x) A report of any call-ins that are withdrawn as a result of an informal meeting will be included on the Agenda for the next meeting of the Committee.

(xi) If the call-in is not withdrawn as a result of the informal meeting or an informal meeting is not held it will go to the Committee. The Committee should meet within 10 clear working days of the notice of call-in. Wherever possible scheduled meetings of the Committee will be used. Where this is not possible the Scrutiny Officer will liaise with the parties concerned and the Group Spokespersons on the Committee to arrange a special meeting.

(xii) The Scrutiny Officer will liaise with the parties concerned on behalf of the Chairman of the Committee to ensure that all those with a reasonable interest in the decision have an opportunity to be represented at the meeting, including any Member whose representations have led to the call-in.

(xiii) Having considered the decision, the Committee may refer it back to the decision taker setting out in writing its concerns or refer the matter to the full Council also with a record of its concerns. Upon a referral to a decision taker, the decision shall be reconsidered within five clear working days amending the decision or not before adopting a final decision.

(xiv) If the Committee does not refer a decision to either the decision taker or the Council, the decision shall take effect at the conclusion of the meeting of the Committee.

(xv) Following consideration of a call-in by the Committee, the Scrutiny Officer will liaise with the Chairman and Group Spokespersons to agree the formal notification of its decision to go to the interested parties and,

if the call-in is referred to Council, to agree the wording of the report to Council.

(xvi) If, following a reference of a decision from an Overview and Scrutiny Committee, the Council objects to that decision it will be referred to the decision taker together with the Council's views. The decision taker will reconsider the decision within five clear working days deciding whether or not to amend the decision before implementing it.

(xvii) If the Council does not refer a decision to a decision taker then the decision shall take effect at the conclusion of the meeting of the Council.

(xviii) A request to call-in a decision may be withdrawn at any time by those making the request.

(xix) The call-in procedure set out above does not apply where the decision being taken is urgent. A decision is urgent if any delay is likely to prejudice the Council's, the public's or individuals' interests. The record of a decision and the notice by which it shall be made public shall state whether in the opinion of the decision taker (if an individual) or the Leader of the Council it is an urgent one and therefore not subject to call in. The Chairman of the Council must agree both that the decision proposed is reasonable and that it should be treated as a matter of urgency. In the absence of the Chairman the Vice-Chairman's agreement is required. In the absence of both, the agreement of the Head of the Paid Service (or his nominee) must be obtained. Decisions taken as a matter of urgency shall be reported to the next available meeting of the Council together with the reasons for urgency.

All parties will be advised of this procedure each time an executive decision is called in.

	AGENDA ITEM 6
	PAF/14/18
Committee:	**People and Families Policy and Scrutiny Committee**
Date:	**6 June 2018**
Enquiries to:	**Name: Graham Hughes** **Designation: Senior Democratic Services Officer** **Contact details:** 033301 34574 Graham.hughes@essex.gov.uk

RELATIONSHIP MANAGEMENT

As part of its induction programme the Committee had briefings on the care market. The most recent in January 2018 was on quality issues in the care market and prompted discussion on a number of issues – one of them being supplier relationships. At the request of the Chairman and Vice Chairmen further scoping work was undertaken with a view that the Committee looked at supplier relationships again in more detail.

A review of supplier relationships was undertaken by County Council Officers and a report published in November 2016. Coming out of that review was agreement to conduct an annual supplier relationship survey – the first of these was undertaken at the beginning of 2018.

The Committee now has the opportunity to review supplier relationship issues in more detail using both the above November 2016 report, the results of the survey (challenging progress being made against the recommendations in the November 2016 report and highlight issues still not being addressed or progressed) and consideration of and alignment with the overall Care Market Strategy.

Links to the 2016 report and the care market strategy are within the attached presentation to be given at the meeting by Steve Ede, Head of Procurement (**Attachment B - starts on page 82 of the pack**). However, for ease of reading the whole 2016 report in one consolidated version forms **Attachment A**.

Action required:

(i) To consider the presentation and subsequent discussion.
(ii) To consider the draft scoping document (**Attachment C - starts p 91 of the pack**) and consider the structure of any further work on this issue.

Right Time...Right Place...Right Conversation:

Improving the Relationship between Essex Care Providers and Essex County Council

November 2016

Contact

Dr Simon Willson
simon.willson@essex.gov.uk

Tom Bendy
tom.bendy@essex.gov.uk

CONTENTS

EXECUTIVE SUMMARY AND FEEDBACK

1. BACKGROUND TO THE PROJECT

1.1 A project was undertaken between May and October 2016 looking at the relationship between Essex adult social care providers and the county council. It arose out of a previous project looking at the quality of the care market. The project specifically set out to:

a. Understand why relationships had worsened;
b. Understand how both parties now perceived each other;
c. Assess the appetite for working together in the future;
d. Clarify what people thought must change to make them feel the project had been successful (what became known as the 'Must Haves');
e. Identify areas for improvement; and
f. Suggest how these improvements might be made.

1.2 A mix of qualitative and quantitative research methods were used, drawing data from several different sources:

- A written questionnaire completed by officers and care providers;
- 7 workshops sessions (5 with officers and 2 with providers);
- A benchmarking survey completed by 6 local authorities in the East of England;
- Telephone discussions with some of ECC's larger care providers;
- Discussions with other local authorities; and
- Discussions with national provider organisations UK Home Care Association (UKHCA) and Registered Nursing Home Association (RNHA) and with local authority based care provider organisations in Devon, Hertfordshire, Norfolk and Surrey.

1.3 Recognising the importance of involving providers in the project, a core group of providers was established to 'guide' the project and to give detailed input into issues as they arose. This group met 4 times throughout the life of the project, culminating in a joint workshop with senior officers on 10 October 2016. See Appendix A and B.

2. WHY WAS THIS REVIEW UNDERTAKEN?

2.1 There were four factors that led to this work being undertaken.

<u>A Perception That Relationships Were Getting Worse</u>

2.2 There has been a general sense that some relationships with providers have deteriorated in the last two years due to the current financial climate; the retendering of major contracts; the cost of care exercise; the lack of clarity around the future shape of the care market in Essex; and the extent to which the current ECC structure has displaced care providers from Adult Operations.

<u>The Care Act and Shaping the Market</u>

2.3 The Care Act requires local authorities to help develop a market that delivers a wide range of sustainable and appropriate high-quality care and support services for users in their communities to choose from. This will not be achieved without providers and ECC working in partnership based on more integration and mutual collaboration. These new ways of working cannot be achieved without good communication, mutual trust and greater openness.

Pressures

2.4 There has been a steady increase in the pressures being placed on the whole care system due to increased demand, acuity and the overall reduction in resources. This has manifested itself in a reduction in capacity and concerns about quality and the overall ability to maintain and sustain a vibrant care market in Essex. There is also growing evidence that providers are starting to withdraw from local authority work because it is not financially viable.

Quality Improvement Work

2.5 Issues affecting relationships between care providers and ECC emerged as a significant issue when work was undertaken to look at care provider quality during 2015-16.[1] As part of developing the strategy for improving quality, relationship management became one of the four building blocks to improve quality and drive transformation and integration:

3. THE MAIN FINDINGS

3.1 A wide ranging set of issues were uncovered that were seen to be inhibiting effective relationships between care providers and ECC (see Part 3). These were explored in some detail with care providers and officers as they emerged and led to a consensus view as to what needed addressing and why.

Trust and Partnering

3.2 Rebuilding trust was a seen as an important issue that needed tackling in order for care providers and ECC to be able to build stronger relationships and to develop new ways of partnering. Better partnering was seen as crucial to driving integration and responding to the Care Act as well the current financial challenges. Both sides acknowledged that they lacked a shared understanding as to what this partnering might look like and questioned whether they had the necessary skills to make it happen.

Leadership

3.3 Leadership was identified as an issue for both care providers and ECC. For care providers this centred on their ability to be able to organise themselves better, be more representative in their engagement with ECC and create sufficient leadership skill and capacity to lead their sector in order to be able to respond to the challenges that lie ahead.

3.4 For ECC the leadership challenges were identified as being:

- The need to shape the care market more effectively;
- Clarifying which director(s) had the responsibility for leading the market given it requires a cross-organisational (i.e. adult operations commercial, commissioning, skills and economic development) and a systems wide (i.e. Health, housing, voluntary and community sector) approach; and
- Developing sufficient leadership capability to lead the market i.e. an understanding of what type of leadership style is required; do the leaders have the right leadership skills to lead the market; and are they given sufficient permission and capacity to work with the care market in the way that is required.

[1] Care Act: Quality of Care Providers

Engagement

3.5 The review showed quite clearly that ECC has an insufficiently developed infrastructure to support effective engagement with its care market. The elements that needed developing were identified as:

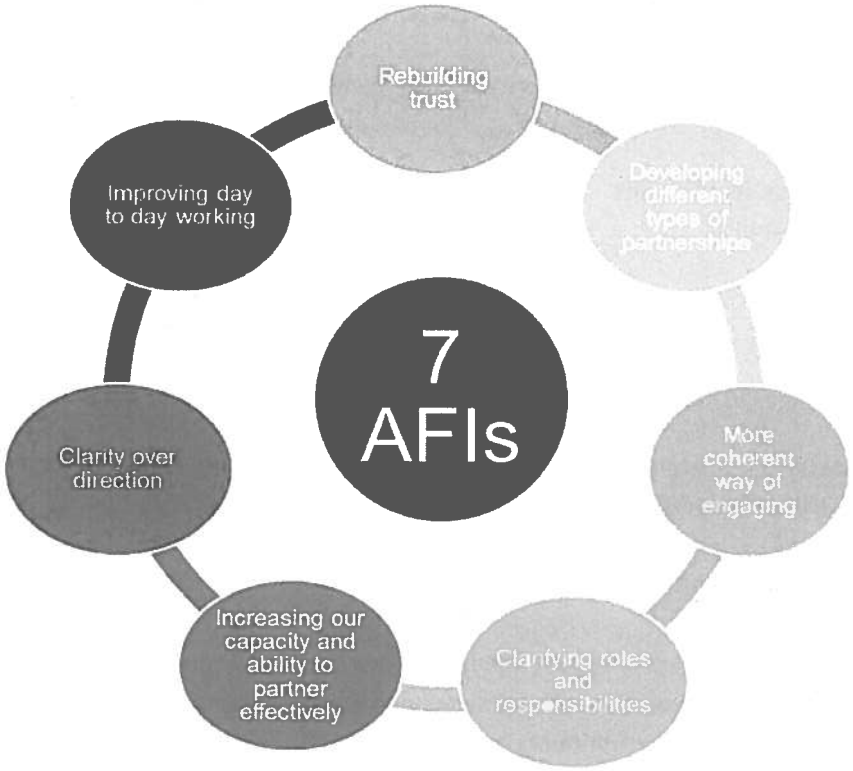
- A robust structure to support engagement work with the market;
- Creating a greater understanding as to what engagement actually means; and
- The skills (on both sides) to be able to talk and listen to each other more constructively.

Operational

3.6 The review highlighted that day-to-day relationships have also become strained and there was a need for operational teams to respond to the findings of the review and consider how they could develop stronger relationships, particularly with care managers and care workers in order to support better operational working.

4. AREAS FOR IMPROVEMENT AND RECOMMENDATIONS

4.1 Out of the main findings of the review, 7 areas for improvement (AFIs) were identified:



4.2 Subsequent discussions of these areas lead to the development of 29 specific recommendations (see Part 4) and a number of suggestions on how some of them might be taken forward.

5. CONCLUSION

5.1 Although the review has highlighted that there are a large number of areas that need improving on, the comparative work suggests that Essex is not untypical in this area. Nor should the outcomes of this review detract from the fact there is already a considerable amount of effective working going on between care providers and ECC.

5.2 However, we think the window of opportunity to make the changes required is limited because of three reasons. Firstly, hope and expectations have been raised by this review and some good will has returned to relationships between providers and ECC. This needs to be built upon quickly to re-energise and give further hope that both sides do want to find better ways of working together; secondly, the recent merger of EICA and CPN is a welcome development but must be seized upon to make it a success and to support the development of a single provider voice in Essex. This will greatly enhance engagement work and provide a stronger platform for driving change and integration; and, thirdly, if through improved relationships life is *not* made easier for providers, they will increasingly walk away from LA work and this will reduce capacity further, drive up costs and push down standards of care.

5.3 We believe the majority of providers and officers do wish to move forward from the current situation. However, we are quite clear that this will require drive, focus and effort from all parties. This will need to come from the leaders of *both* sides, building on those providers and officers that have already been instrumental so far in bringing this project to fruition. Initially, we would encourage incremental steps in order to rebuild trust and ensure whatever joint actions are agreed to take forward first, are delivered successfully in order to build more confidence and energy to make Essex the model others want to follow.

6. YOUR FEEDBACK

6.1 Responses to this consultation are very much welcomed. They can be sent via email ContractManagementAdults@essex.gov.uk or in writing to:

Contract Management Adults
Essex County Council
E1 County Hall
Chelmsford
CM1 1QH

6.2 We would be particularly interested in your feedback on the following questions:

a) Do you have any overall views on our assessment of the relationship between care providers and ECC? E.g. do you think it is a fair and balanced assessment? Have we missed anything important?
b) Have the right improvement issues been identified i.e. the 7 AFIs? If not, what else needs improving?
c) Do you think the actions (recommendations) we have made are the right ones? If not, why not and what else would you recommend we should be doing?
d) Do you have any other comments on this review and the way forward being proposed?

7. ACKNOWLEDGMENTS

7.1 The authors of this report would like to thank all those providers and officers that contributed to the review. We would particularly like to acknowledge the honesty and openness shown by all parties. We would like to specifically acknowledge the support given by the 'core group' of providers that gave up a lot of their time to support this review as well as Colin Angel and Ian Turner who helped to provide an invaluable national perspective to this work.

PART 1: INTRODUCTION, CONTEXT & APPROACH

1. PURPOSE OF THE DOCUMENT

1.1 The purpose of this document is to invite comments on the outcomes of the relationship management project undertaken by Essex County Council (ECC) between June and October 2016. This document summarises a range of recommendations for improving relationships between care providers and ECC. It highlights some initial actions that both parties have already agreed to undertake in the next few months, as well as proposing other possible ways forward.

1.2 The document has been agreed with those providers that volunteered to participate in this project and senior ECC officers. See Appendix A.

1.3 The document invites comments on the ideas and proposals set out below on the basis that:

a. The relationships between ECC and some providers has become increasingly strained over a number of years and both sides have recognised the need to rebuild trust and establish greater openness when working to meet the current challenges facing the care sector;
b. Improved relationships need to focus more on helping service users achieve their outcomes, not on the needs of ECC or individual providers;
c. Providing high quality care will only be possible through integrated solutions and joined up partnership working and this can only be achieved through building more positive and constructive relationships; and
d. Improving relationships will take time, commitment and resources, and will need to occur incrementally as both sides build their capacity to work more effectively in partnership.

2. WHY WE DID THIS WORK?

A Perception That Relationships Were Getting Worse

2.1 There has been a general sense that some relationships with providers have deteriorated in the last two years due to the current financial climate; the retendering of major contracts; decisions around cost of care; the lack of clarity around the future shape of the care market in Essex; and the extent to which the current ECC structure has displaced care providers from Adult Operations as a significant amount of their dealings with the county council have been through the Commercial and Commissioning Directorates.

The Care Act and Shaping the Market

2.2 The Care Act requires local authorities to help develop a market that delivers a wide range of sustainable and appropriate high-quality care and support services for users in their communities to choose from. This will not be achieved without providers and ECC working in partnership based on more integration and mutual collaboration. These new ways of working cannot be achieved without good communication, mutual trust and greater openness.

Pressures

2.3 There has been a steady increase in the pressures being placed on the whole care system due to increased demand, acuity and the overall reduction in resources. This has manifested itself in a reduction in capacity and concerns about quality and the overall ability to maintain and sustain a

vibrant care market in Essex. There is also growing evidence that providers are starting to withdraw from local authority work because it is not financially viable.

Quality Improvement Work

2.4 Issues affecting relationships between care providers and ECC emerged as a significant issue when work was undertaken to look at care provider quality during 2015-16.[2] As part of developing the strategy for improving quality, relationship management became one of the four building blocks to improve quality and drive transformation and integration:

Fig 1: The Strategy to Improve Care Provider Quality

We've Been Here Before

2.5 During 2014 a project led by Georgia Dedman[3] looked at how ECC engaged with care providers and identified a number of issues that had undermined relationships. These included, messages being sent to the market that were inconsistent; a lack of clear direction and leadership; and no joined up approach and co-production to engagement events. A series of recommendations were put forward, and improvements made, but not all have been implemented to date.

3. WHAT IS RELATIONSHIP MANAGEMENT?

3.1 Relationship management (RM) is a strategy in which a continuous level of engagement is maintained between an organisation and those it works with. In the context of this project, relationship management looked at the relationship between two 'businesses' (i.e. ECC and care providers) rather than relationships between ECC and services users (i.e. customer relationship management - CRM).

[2] Care Act: Quality of Care Providers
[3] Provider Engagement and Adult Social Care

3.2 Relationship management aims to create a partnership between the organisation and those it chooses to work with rather than considering the relationship merely as transactional. Therefore, providers who feel that ECC responds to their needs are more likely to want to continue working with the Council. Additionally, maintaining a level of communication with providers will allow ECC to identify potential sources of costly problems before they come to a head.

3.3 Underpinning good relationships is the need to partner effectively. Effective partnerships are generally said to be based on:

- Good information sharing;
- Effective communication;
- Openness and trust;
- Shared understandings; and
- Effective consultation and engagement.

4. CONTEXT

4.1 ECC is a large local authority and represents a very diverse community with differing educational, health, housing and economic needs. There are 16,700 older people (OP) services users and 3,700 adults with a learning disability in Essex.

4.2 Essex has a higher proportion of over 65s than England (20% vs 18%). In ten years the OP population in Essex is expected to grow by 24.67%, while the whole population of the county is only expected to grow by 8.9%. Currently the OP population accounts for 55.4% of all population growth in Essex (2015-2025) and 67% by 2035.

4.3 There are 464 services registered as care homes in Essex (excluding Southend and Thurrock) providing 12,977 beds and 450 providers of domiciliary care to ECC. The domiciliary care market is under the greatest pressure with insufficient capacity in the market to meet demand.

4.4 The care market and ECC's approach remains largely traditional and risk averse and operates in a challenged health economy that is complex due to its size and the way it is organised.

5. THE APPROACH

The Methodology

5.1 A mixed methodology was devised to identify current issues and find solutions to improving relationships between providers and ECC. The methodology also looked to test the perceptions and feelings both parties had about each other, as well as bringing a focus on learning from best practice. A mix of qualitative and quantitative research methods were used, drawing data from several different sources:

- A written questionnaire completed by officers and care providers;
- 7 workshops sessions (5 officer and 2 providers);
- A benchmarking survey completed by 6 local authorities in the East of England;
- Telephone discussions with some of ECC's larger care providers;
- Discussions with other local authorities; and
- Discussions with national provider organisations UK Home Care Association (UKHCA) and Registered Nursing Home Association (RNHA) and with local authority based care provider organisations in Devon, Hertfordshire, Norfolk and Suffolk and Surrey.

5.2 Recognising the importance of involving providers in the project, a core group of providers was established on a voluntary basis to 'guide' the project and to give detailed input into issues as they arose. Appendix B shows those providers who volunteered for that group. This group met four

times throughout the life of the project culminating in a joint workshop with senior officers on 10 October 2016.

5.3 The project was underpinned by standard project management practices and an impact model – see Appendix C. Specifically, the project set out to:

a) Understand why relationships had worsened;
b) Understand how both parties now perceived each other;
c) Assess the appetite for working together in the future;
d) Clarify what people thought must change to make them feel the project had been successful (what became known as the 'Must Haves');
e) Identify areas for improvement; and
f) Suggest how these improvements might be made.

5.4 The project did not look at issues such as the cost of care, payment of invoices and safeguarding practices i.e. issues that can greatly affect the quality of relationships although these were raised as issues by providers as examples of things that undermine trust and mutual respect.

Concepts

5.5 Each of the workshops held with providers and officers looked to establish some conceptual understanding of what might be required to improve relationships. In particular, addressing the need to attend to both infrastructure changes as well as changing the 'mood' around relationships – culture change. Both sides were encouraged to realise that one could not be achieved without the other and that the culture change required was likely to prove harder to deliver. This was represented as follows:

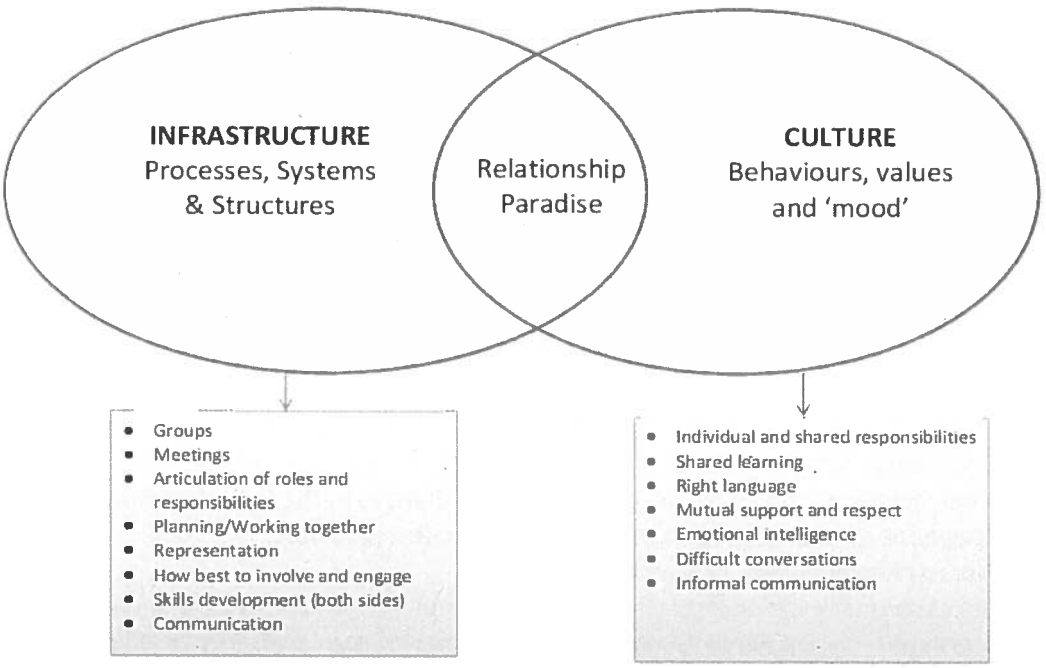


Fig 2: Model Showing the Need to Make Both Infrastructure and Culture Changes to Improve Relationships

5.6 Similarly, the need to examine, and distinguish between strategic and operational relationships, was also introduced early on as a concept.

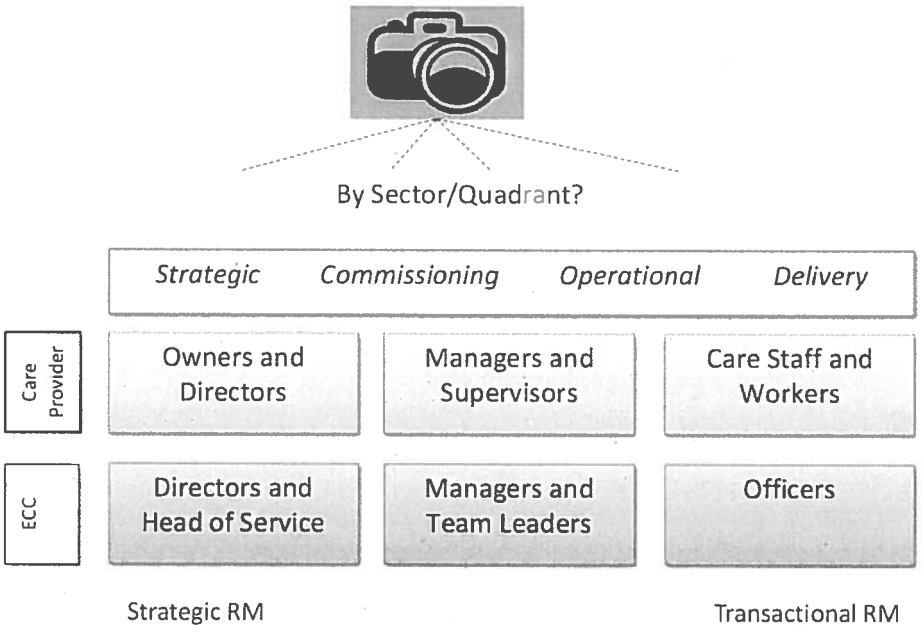


Fig 3: Strategic and Operational Relationships

PART 2: ANALYSIS OF THE ISSUES WE FOUND

6. WHAT WORKS WELL

6.1 As the start of each of the workshop sessions, both providers and officers were invited to identify things they thought worked well with regard to relationship management. See Figure 4.

Care Providers:

1. ECC trying to engage
2. Quality Improvement Team is very good
3. Some ECC officers were first rate
4. The Prosper project as an example of the right way to do things – the team listens and delivers
5. Single point of contact (contract managers)
6. Safeguarding Team has improved
7. Complaints were generally handled well

Officers:

1. The provider newsletter
2. Some of the provider forums
3. Quality Improvement Team has a good relationship with most providers
4. Single point of contact/'regionalizing' contract managers
5. Some good market engagement work
6. Cost of care exercise
7. Getting members engaged and visiting providers
8. We get positive feedback from some providers re: SPT's work
9. Link worker role
10. Mentoring for MCA/DoLs work

Fig 4: Things That Work Well

6.2 Providers and officers did not always agree as to what worked well e.g. many care providers have been critical of the cost of care work. More strikingly was how modest the list appeared to be and confined to relatively few areas of work. There were some acknowledgments that providers and ECC did try to engage but most of the comments were qualified in some way. The references to various specific teams seemed to highlight that effective relationships were built as much on successful one to one and small group interactions as they on getting the overall arrangements right for engaging providers.

7. PERCEPTIONS

7.1 As part of the workshop sessions, both providers and officers were invited to discuss and debate a series of statements about how they perceived each other. These statements were based on comments both parties had previously made about each other, as observed by the authors of this report, in a variety of situations and settings. Both sides were invited to explore why they thought each of the perceptions had come about; whether they were in fact true; and whether they applied to all groups of providers and officers. Figure 5 sets out each of the statements that were discussed.

How Care Providers Perceive ECC

1. We believe ECC is driven by commercial (financial) considerations only – nothing else matters.
2. Care providers are only seen as part of the problem not a possible solution by ECC. There is little acknowledgement that we have some of the answers.
3. ECC struggles to understand the pressures we are under, expecting us to deliver far more than is realistically possibly.
4. ECC is only concerned with keeping the acute sector happy.
5. We are not convinced ECC knows what it wants to achieve.
6. ECC doesn't understand our business needs and what's involved in running a care business
7. ECC see us as quite vocal and uncooperative.
8. ECC thinks we are only concerned about money and profit.

How ECC Perceives Care Providers

1. ECC should only have a commercial (contractual) relationship with care providers – we pay you to deliver x, y and z – just get on with it.
2. ECC knows providers are important to delivering our vision, outcomes and savings etc., but we still know best so we will continue to specify what we need and tell you what we want you to deliver.
3. Despite all our work together ECC still doesn't trust providers have faith that you will deliver for us.
4. ECC knows we really need providers and we really do understand, but we struggle to prioritise working with you because of other pressures.
5. Providers have little idea of the challenges facing the ECC and find it far too easy just to just criticise us.
6. ECC sees providers as only interested in price and money.
7. ECC thinks providers only provide poor quality as we seem to spend a disproportionate amount of time supporting these types of providers.
8. ECC doesn't think providers are always honest about telling us when you are struggling.
9. ECC thinks you're good at care, but not so good at running your businesses and contracting.

Fig 5: How Care Providers and ECC Officer Currently Perceive Each Other

7.2 By consensus, it was agreed that each of the statements had an element of truth but were probably based upon only a partial awareness of each other's worlds and past experiences. Putting aside the extent to which any of these statements are *actually* true or not, collectively they seem to suggest the following:

- Providers overall feel ECC has a pretty negative view of them and they certainly don't feel part of the care system as whole; and
- ECC officers, whilst overall holding a less consistent view of providers, seem to have two dominant perceptions. Firstly, differing views about the type of relationship ECC needs/wants with providers. Secondly, there is a significant level of mistrust about providers based on perceptions about money, quality and business acumen.

7.3 Overall, we feel this exercise also reveals the extent to which ECC is quite autocratic and dominant as a partner and this is a 'state of mind' that is pretty entrenched and will need to change if ECC and providers are to work more in partnership in the future.

7.4 Moving forward, it was suggested that these perceptions would need to be challenged if both sides wanted to make efforts to improve on how they worked together. It was felt important that past experiences should not inform future thoughts as progress was made in improving relationships.

8. ISSUES AFFECTING RELATIONSHIPS – WORKSHOP OUTCOMES

8.1 As part of the seven workshop sessions held with provider and officer groups, people were also invited to identify those issues they thought were inhibiting positive relationships the most. This naturally yielded a lot of material for analysis and proved particularly effective in starting to draw out what the key 'sticking points' were between providers and ECC.

8.2 From the analysis a number of distinct themes arose - see Figure 6 and Appendix D. These were separated out to highlight the differences but also show the similarities between what providers and officers were thinking and feeling.

Care Provider Workshop Issues

- Theme 1: **Money** – it's all about costs not outcomes and we're angry
- Theme 2: **Value** – we feel undervalued and exploited
- Theme 3: **Transactional** – the day- to-day has become much harder
- Theme 4: **Partnering** – we are not part of the system
- Theme 5: **Strategy** - we're confused about the strategy/ies for care providers (market, commissioning and longer term)
- Theme 6: **Communication** – we live in different worlds
- Theme 7: **Contractual Relationship** – you're inconsistent
- Theme 8: **Engagement** – it needs to be more meaningful

Officer Workshop Issues

- Theme 1: **Leadership** – we need to show more (appropriate) leadership
- Theme 2: **Engagement** – we need to improve on what we currently do
- Theme 3: **Communications** – getting the basics right would help
- Theme 4: **Behaviours and Skills** – we're off the pace
- Theme 5: **Hygiene** – getting the basics right
- Theme 6: **Roles and Responsibilities** – for relationship management and other things as well
- Theme 7: **Service Users** – back at the centre of things
- Theme 8: **Innovation and Collaboration** – to support integration and new ways of working

Fig 6: Themes Arising from the Workshop Discussions

8.3 Although providers and officers were asked to do this exercise separately, a number of shared issues can be discerned from the 16 themes overall. Namely:

- The need to improve the quality of engagement activity;
- The desire to work more collaboratively and innovatively through increased partnership working;
- Improving day-to-day working; and
- Creating a stronger sense of direction (leadership and strategy).

9. THE 'MUST HAVES' – WHAT PEOPLE WOULD LIKE TO SEE CHANGED

Overview

9.1 As part of managing the outcomes for the project, at each workshop session three 'Must Haves' were requested from each participant. These were described as being the three outcomes each individual wanted from the Relationship Management project. Attendees were asked to come up with their 'Must Haves' at the end of each session after discussions had taken place. The 'Must Haves' helped to identify those issues people were most concerned about individually, by inviting them to focus and prioritise those issues they wanted to see progressed. They also highlighted what needed to change for people to judge the project to have been successful.

9.2 To aid analysis, the 'Must Haves' were written up and categorised, and the results from providers and officers placed next to each other. See Appendix E. The categories were only defined after a large enough response had been received and clear trends identified. It was noted that some responses could have been put into more than one category but, for the purposes of this activity, each one was placed within the 'best fit' following a short moderation process. Some 'Must Haves' were not directly related to improving relationships but could be said to have a bearing on relationships, if not resolved e.g. not paying providers on time. Also, it was rightly observed that the way in which the issues are addressed e.g. good communication and involving providers to improve and develop systems to make the payment process better, could have a direct bearing on improving relationships. It should be noted that fewer individuals from providers attended the workshops, compared to officers, and so there are fewer responses from providers.

9.3 From the list of 83 'Must Haves', the three overall areas that were of particular interest to providers and that we would argue would therefore need careful consideration and improving the most were:

- Better cooperation and collaboration;
- More effective meetings, events and communication; and
- Increased market/business understanding.

9.4 Officer responses also showed these to be the main areas of importance to them particularly the first two.

Detailed Analysis of All of the Must Haves

9.5 Providers seemed to think there was a knowledge gap amongst officers concerning the care market. We have already seen that there is a perception that officers do not understand the issues some providers face. Similarly, officers didn't think providers understood the difficulties of working for a local authority. One suggestion for the cause of officer knowledge gaps is staff turnover and restructures. It was noted that a lot of knowledge was lost after the last major restructure in 2014.

9.6 Providers and officers highlighted 'inconsistent approaches' across ECC, especially in its communication and management of the provider forums. It was noted that the forums are not always very well attended and often ECC 'decision makers' (i.e. senior officers) are not present and that the attendees from the providers ranged from front line staff to owners, meaning some discussion points were not always relevant. It was also noted that very few 'big providers' attended the forums.

9.7 The discussions and resultant 'Must Haves' also showed an inconsistent approach to communicating ECC's strategies. This included confusion amongst officers about what the

council's approach was to some issues e.g. the use of framework and spot contracts, top-ups and pricing.

9.8 Communication between those on the frontline was identified as another issue. Providers are frustrated by response times, particularly from social workers, with it sometimes taking weeks to get a response. The result of which was poor relationships and negative conversations, in addition to it having an impact on service users. Officers felt that, at times, some providers were very defensive and not sufficiently open about when things were going wrong particularly with regard to safeguarding and quality issues.

9.9 Other issues raised were providers wanting to be more part of the care 'system' - an equal partner along with Health and ECC. Officers felt this may not always be necessary for all providers but that the focus might be better placed on a few 'strategic partnerships' where these were key to delivering major outcomes or more complex objectives. Where ECC was procuring small volumes of care, or less complex packages of care, it might be better to ensure the transactional relationship was effective and this was key to positive relationships.

9.10 A lack of trust and honesty was mentioned, with ECC's 'culture' being partially to blame. Providers felt that officers were sometimes too scared to open up and be honest about issues and stuck with being too rigid when communicating with providers.

9.11 Of particular interest from officers was the lack of a clear provider voice. Often at events/meetings officers are subject to numerous provider issues and complaints. With such meetings being held across each area of the county the creation of a 'provider voice' which collates all provider issues and discusses them with appropriate ECC officers on a regular basis was seen as a beneficial 'Must Have'.

9.12 It's clear that there is work that needs to be done to improve certain aspects of the relationship. It should be pointed out that there were positives, with some providers saying they had no issues with their relationship with ECC. From this work it appears that resolving a number of 'issues' would be enough to improve the 'relationship' in the short term. Some appear to be easily resolvable so there would be no reason why they could not be actioned. For example, the creation of a contact list / structure charts, including the decision makers.

Summary

9.13 In summary, focusing on Communication, Collaboration and a Mutual Understanding of each other would cover the majority of 'Must Haves'. These are continuous and long term and if done correctly, the smaller issues would be managed well as a matter of course. We also need to remember that the issues of now will not be the issues of tomorrow and an effective relationship will help ensure we have the ability to manage future challenges more easily.

9.14 On a final note, a few discussions highlighted that all sides needed to keep front of centre the purpose of the work we do – to help those in need of care and support. This, it was suggested, was the opportunity to refocus everyone on a common goal to help people move on productively.

10. RELATIONSHIP MANAGEMENT SURVEYS: MEASURING THE ABILITY TO PARTNER THROUGH OPENNESS AND TRUST

Overview

10.1 In addition to holding the workshops a survey was also sent to all providers and about 50 officers to complete. The survey was based upon the 'Catalyst for Change' Workbook devised by the

Department of Health/Warwick Insights in 2003. Both providers and ECC officers were asked the same eight questions (see paragraph 10.3) with the provider questionnaire differing slightly as it asked them to score ECC not only as one organisation, but by individual departments (see paragraph 10.4).

10.2 Each question had a scoring range from 1(low) to 4 (high) with two contrasting statements at either end to define what was 'bad' and what was 'good'. '0' meant the provider/officer had no contact.

The Survey

10.3 Questions Asked:

1. How well do care providers and ECC share information?
2. How well do we trust each other?
3. How inclusive and involving are we when planning and making key decisions that will impact upon service users?
4. How integrated is our working?
5. How well do we manage conflicts?
6. Do we understand what our respective roles and responsibilities are?
7. How clear are we of our strategic direction?
8. How responsive are we to each other's needs?

10.4 Providers were asked about the following departments:

Adult Operations - Senior Managers
Adult Operations - Service Teams
Adult Operations – Service Placement Team
Safeguarding
Community Agents
Commissioning Officers
Finance
Procurement (aka Category Management)
Contract Management
Quality Improvement

Analysis – Provider Responses

10.5 Due to a low response from providers, which for some geographical areas was as low as two, the results of the survey cannot be considered wholly reliable when broken down although some of the results are supportive of the finding of other parts of the research carried out. Overall providers scored ECC 2.23 out of 4 - see Figure 7.

QUESTION	Question Avge for all Services (1-4)
1. How well do care providers and ECC share information?	1.91
2. How well do we trust each other?	2.32
3. How inclusive and involving are we when planning and making key decisions that will impact upon service users?	1.92
4. How integrated is our working?	2.23
5. How well do we manage conflicts?	2.48

6. Do we understand what our respective roles and responsibilities are?	2.38
7. How clear are we of our strategic direction?	2.27
8. How responsive are we to each other's needs?	2.35
Total	**Overall Avge 2.23 (4)**

Fig 7: Provider Responses to RM Questionnaire

10.6 A more detailed analysis seems to suggest the following, bearing in mind the low scoring overall and the size of response. Some of the responses also contradict what had been said in the workshops with providers and ECC officers.

a. Overall the scores were low to mid for each of the questions suggesting providers feel ECC is more transactional, with some inclusion, in its approach to its relationship with providers.
b. Overall, Responsiveness, Managing Conflicts and Understanding Roles and Responsibilities were the areas with the highest scores.
c. Sharing of Information with providers, and Inclusion and Involvement in planning and key decisions had the lowest scoring out of the 8 questions.
d. The Safeguarding Team had the highest overall score, with understanding of roles and responsibilities being their best score.
e. Finance, overall, had the lowest score.
f. Providers based in the North of the county gave the highest scores, scoring particularly high for Responsiveness and Roles and Responsibilities, and clarity of strategic direction.
g. County Wide providers also scored ECC high compared to those providers operating in specific quadrant areas.
h. Providers based in the West were least happy, closely followed by those based in the Mid. Sharing of Information was the lowest score for the West area. The South's score was also low, with inclusion and involvement in planning being the biggest issue.
i. Homecare providers scored ECC marginally higher than Residential providers.
j. Overall small providers scored ECC the highest with Responsiveness, and Roles and Responsibilities being the two best areas for ECC.
k. Directors/Senior managers overall gave higher scores to ECC than both owners and care managers.
l. Providers, whose service user base is between 0-25% ECC sourced, gave the highest scores. Scores were particularly high for Responsiveness, Understanding Roles and Responsibilities and Managing Conflicts.
m. Those with between 25-50% ECC service users gave the lowest scores, scoring particularly low on Sharing Information, and Inclusion in Planning and Decisions.
n. Procurement and Community Agents had the highest number of 'No Contact' responses from providers (an average of 12 per question). Commissioning Officers had an average of 11 'No Contact' responses and Adult Operations Senior Managers 10.
o. AO Service Teams, SPT and Safeguarding had the fewest 'No Contact' responses with an average of 2 per question.
p. Trust, Inclusion in Planning, and How Integrated our Working were questions with the highest 'No Contact' responses.

<u>Analysis – Officer Responses</u>

10.7 The officers' responses seem to suggest the following:

a. On average the higher the position an officer held in ECC the lower the score they were likely to give to a question.
b. Overall, having a clear strategic direction was the single biggest issue for officers.
c. Trust was the biggest issue for heads of service and managers
d. Heads of service also saw roles / responsibilities and being responsive as the major issues for ECC.
e. Taking all the scores into account, the Commercial Team scored relationships as the most positive, followed by Adult Operations, and then Commissioning.
f. Overall trust, involvement in decisions and clarity of strategic direction were issues scored the lowest by officers.

Cross Analysis

10.8 We also looked to compare the results given by providers and officers - see Figure 8. Comparing overall scores, some responses were very similar e.g. Involvement in Planning, Integrated working, Managing conflicts and Understanding Roles. However, providers were less convinced than ECC officers that the Council shared information well. Officers thought there was less trust between the two parties and also felt that clarity of strategic direction and responsiveness was more of an issue than providers did.

10.9 Although the low response causes some issues when comparing across quadrants, some of the results are interesting if inconclusive:

- Providers from the North gave the highest scores for ECC. ECC officers covering the north gave the lowest scores – citing inclusion and involvement in planning as the worst area for ECC;
- Although officers in the South gave the highest scores, with Mid closely following they only account for 2 responses so this can be discounted; and
- Aside from the North, most ECC responses were from officers who covered county wide. For them trust was the biggest issue.

Question	ECC	Providers
1. How well do care providers and ECC share information?	2.40	1.91
2. How well do we trust each other?	1.80	2.32
3. How inclusive and involving are we when planning and making key decisions that will impact upon service users?	1.95	1.92
4. How integrated is our working?	2.33	2.23
5. How well do we manage conflicts?	2.28	2.48
6. Do we understand what our respective roles and responsibilities are?	2.43	2.38
7. How clear are we of our strategic direction?	1.98	2.27
8. How responsive are we to each other's needs?	2.08	2.35
Overall	**2.15 (4)**	**2.23 (4)**

Fig 8: Officer Response to RM Questionnaire

11. TIER ONE PROVIDERS[4]

11.1 A number of 'Tier One' residential and nursing, and home care providers were contacted directly to gather their views on relationship management as it was noted by providers that they were often absent from engagement sessions with ECC.

[4] A Tier One provider is a provider that has high momentary values, critical to supply, longer and a business critical service.

11.2 They reported the following:

- Generally more positive relationships with ECC
- Positive experiences of working with the Contracts Team, less so Safeguarding and, whilst they acknowledged this had improved, they felt that at times the approach was too heavy handed and inconsistent;
- A greater self- reliance to tackle quality and recruitment issues;
- A desire to work more collaboratively;
- Concerns about pricing method and relationship between cost and quality;
- Social workers were often slow to respond and yearly reviews were not being done;
- A general lack of appreciation of the demands now being placed on providers e.g. 24/7 working; and
- Some dissatisfaction with the help to live at home (Domiciliary) procurement work.

11.3 What they wanted most from ECC was:

- Promoting the care profession more strongly in Essex;
- Taking a stronger lead on the whole recruitment and retention agenda;
- As much clarity as possible about future direction;
- Being less risk averse and traditional in its approaches; and
- A fairer and consistent pricing structure that recognised complex needs and acuity.

12. FORMAL ENGAGEMENT ARRANGEMENTS – THE CURRENT SET UP

12.1 A previous mentioned, the project led by Georgia Dedman in 2015[5] looked specifically at how well ECC engaged with care providers. It concluded that messages being sent to the market were inconsistent; that there was a lack of clear direction and leadership for provider engagement activities; and there was no joined up approach to engagement work. The project concluded that this had resulted in providers being confused and frustrated which, in turn, adversely affected relationships.

12.2 In a survey conducted as part of the 2015 project, providers highlighted a desire to have quarterly face-to-face meetings, wanted engagement events to give feedback and for these events to be tailored more to care provider issues. A clear message from providers at that time was they did not know whom to contact when they had a query and didn't know when/if they would ever receive a response. These themes have emerged again in the research undertaken as part of this project.

12.3 The 2015 project identified and recommended that ECC should focus on the following key 'contact points' with providers to try and improve relationships:

- Provider events;
- Provider newsletter;
- Contract management enquiries; and
- Councillor engagement.

12.4 At the time each of these activities were reviewed and improvements made with a follow-up survey suggesting things had got better.

12.5 Having re-examined the outcomes of this project, and taking into consideration comments from our workshops, it is recommended that some of the areas from the 2015 project could be usefully revisited – see Parts 3 and 4, pages 16 and 27.

[5] Provider Engagement and Adult Social Care

12.6 Further research undertaken as part of our project, suggests that ECC has remarkably few formal meeting points with providers given the size of the authority and the number of providers it contracts with - see Appendix F. Furthermore, of these, the provider forums are still relatively new, as is the Essex Employment Skills Board (EESB) care sector group. Neither have clear terms of reference. Appendix F sets out these groups and an assessment of their maturity.

12.7 The ability to engage systematically with care providers is also hampered by the limited extent to which providers have self-organised themselves into groups that ECC can engage with collectively. There are three organisations that currently operate in Essex and between them they 'represent' about a quarter of the care market:

- Essex Independent Care Association (EICA);
- Care Provider Network (CPN); and
- South Essex Care and Health Association (SECHA) – operating largely in the Southend and Thurrock area.

12.8 Comparisons to other local authorities (LAs) in the region suggest that most other LAs have some kind of formal arrangements to engage with providers. However, these were not always considered robust or effective. There was a general tendency to rely on 'one-off' or ad hoc arrangements to engage on key issues such as contract issues, resourcing levels and tendering processes. Some LAs worked through 'forums', whilst others had more formal strategic meetings with providers. Overall most LAs have meetings with providers every three to four months in some shape or form.

12.9 Providers are self-organised in two of the six LAs surveyed in the Eastern Region, with three others suggesting there are no 'associations' of providers, and one describing a 'partial set up'. Only one LA has a provider organisation that represents all the providers they contract with. Where providers have self-organised, their LAs offer resources in order to help them do that.

13. LEARNING FROM OTHER LOCAL AUTHORITIES (LAs)

13.1 Outside of the Eastern region, five other LAs spoken to reported having some difficulties in their relationships with care providers in recent years. Some specifically noted things had become more strained in the past two years due to the financial challenges facing the sector and the increased demand for services. Those who reported the most positive relationships said that talking and listening was key to maintaining effective working, whatever the challenges.

13.2 Four out of five LAs spoken to said directors led all significant discussions with providers and for some authorities it was seen as the responsibility of at least one senior officer (normally at director or assistant director level) to maintain regular formal and informal contact with providers.

13.3 Most of the LAs in the Eastern Region reported that they felt able to have 'difficult conversations' with providers but that these were often challenging.

13.4 Whilst not completely off the pace, in comparison to other LAs, Essex is probably behind in terms of having a mature structure to engage with care providers, and with regard to clarity as to where the responsibility lies to develop and maintain an infrastructure to work effectively with providers.

PART 3: COMMENTARY

14. PERCEPTIONS – STRIVING FOR A NEW DEAL

14.1 It is clear that providers and officers hold very definite ideas about one another, most of which are not positive. These perceptions are not universal but have sufficient currency to be affecting how both parties currently relate to one another. If not addressed, they will undoubtedly inhibit the development of increased partnership working which both sides have expressed a desire to achieve. We have seen that, excluding evidence from the survey, domiciliary care providers hold more negative views of ECC than other provider groups, probably due the increasing fragility of their businesses and the scepticism arising out of the recent cost of care work and current retendering process. Conversely, larger providers hold a more positive view of ECC which may be attributed to the fact that most of these have regular contact with a named contract manager.

14.2 It goes without saying that the current negative perceptions, and the attitudes that flow from them, are not helpful. Moving forward there is a need for both providers and officers to set aside how they currently feel about one another and to demonstrate sufficient progress in developing more positive relationships so that these perceptions can genuinely alter.

14.3 It is recognised that these perceptions will not change overnight. However, if both parties operate with more goodwill, flexibility and a stronger sense of collective endeavour then they will develop more trust and confidence in each other, and be better placed to meet the current challenges and those that lie ahead.

14.4 At each of the workshops we tested the commitment of both parties to want to work together. Whilst it was clear that both sides have an appetite for this, it was felt that this could only happen if certain 'conditions' were met. These collective conditions focused specifically on issues related to trust, openness, honesty and respect.

14.5 Providers felt that they would increasingly opt out of LA work if it not only proves to be financially unviable, but also if it continues to be too difficult and complex to deliver what ECC wants. For this reason, it was particularly important for providers that ECC was more honest about what can be achieved in the current climate. ECC needs to respond to this issue if it wishes to maintain a vibrant and diverse market, as market forces alone will not address the challenges ECC is facing in terms of provider cost, quality and need.

14.6 In turn, ECC requires more collaboration from providers i.e. a better level of engagement and responsiveness to the challenges it faces.

14.7 Moving forward, this commitment to work together and to remain focused on making a difference to the lives of vulnerable adults, and how this relationship will be constructed will be all the more critical given the current operational realities - statutory, financial and commercial. It will need to function in a way that clearly supports and values everyone working well together in a positive and constructive manner.

14.8 It is suggested that a 'New Deal' is agreed between ECC and the majority of its providers. This would set out the principles of closer working based on the agreed assumption statement that was explored during all of the workshops. If this way forward is agreed, both parties will have to explore how they can ensure the majority of providers, and all relevant officers, sign up to these principles and ensure they are fully enacted - see Figure 9.

Care providers and ECC are committed to working together through greater collaboration and strategic partnering on the basis that:

- *There is sufficient money in the market to make it viable;*
- *There is greater trust, openness and respect between all parties;*
- *Both sides meet their commitments which sometimes will go beyond contractual agreements;*
- *ECC is more responsive to care providers' business challenges including the desire for most providers to want to pay a decent wage. This would also recognise the variety in the market which encompasses providers that are charitable and not for profit, as well commercial organisations; and*
- *It is understood that the vast majority of providers are motived by a vocation and not profit, but this shouldn't be taken advantage of by ECC.*

Fig 9: The 'New Deal' - Suggested Terms of Care Providers and ECC Working More Closely Together

15. TRUST

15.1 Lack of trust has emerged as a significant issue during this process. As trust is a critical factor in developing strong relationships and better partnership working, there is an urgent need to rebuild trust between providers and ECC. This, in part, will be achieved by both sides being more honest and respectful of one another and also by discussing important issues sooner rather than later, particularly those regarding quality, safeguarding and finance. There is a need for ECC to be more upfront about the future direction and emerging thinking about the challenges ahead for the care market. ECC also needs to champion care providers much more as a valued part of the health and social care system.

15.2 A specific issue that is undermining trust is that some officers do not fully understand the challenges of running care businesses. As a whole, ECC has become too officious and remote from care providers. In the worst cases it is imposing too many solutions, on parts of the market, which are often unrealistic and impractical in the current environment. ECC needs to listen and engage with providers about what is achievable within the current available resources, looking to find the best *collective* answers to meeting service users' outcomes as well the organisational and business needs of both parties.

15.3 For their part, providers need to engage more in understanding the financial, statutory and legal environment in which ECC has to operate. It needs to be understood that ECC has to balance a range of priorities, as determined by a wide and diverse community, and that the current care crisis is not one of its own making. In essence, the nature of the conversation has to change fundamentally – it needs to genuinely recognise the realities for both providers and ECC; accept the challenges that lie ahead; and to find a way to work together to achieve the best possible solutions that put service users' needs at the centre of any future partnership working.

15.4 In addition to more open communication, real engagement, collaboration and timely information sharing, it must also be understood that rebuilding trust has to start with the individual. This trust needs to exist on a one-to-one basis as well as between groups and, ultimately, between ECC and the majority of providers. Trust is determined by how people act and behave and not by what they say. Trust, therefore, needs to start with each individual believing that people have the best intentions and that they are working in the interests of all parties. All other trust-building

behaviours flow from this. As a starting point Appendix G sets out a step by step guide to building trust for officers and providers to consider and adopt.

16. DEVELOPING AND STRENGTHENING PARTNERSHIP WORKING

16.1 The survey results, supported by other evidence collected as part of this project, suggest very strongly that the relationship between ECC and providers is currently more transactional than collaborative, and is certainly *not* inclusive. As we have already observed, there is a clear lack of information sharing which has fostered a low level of trust, thereby reducing the capacity to partner effectively. Despite this, vast majority of providers and officers we have worked with on this project have stated a clear desire to work together more closely. Conversely, however, whilst contracts and contractual relationships are necessary these were often seen as an inhibitor to progressing joint working.

16.2 Essex has a large and diverse range of providers. Within this range there are very small and very large providers, local and national organisations and private as well as not for profit companies. This undoubtedly has some benefits, but represents a significant challenge when trying to contract and collaborate with so many different types of providers in a rapidly changing and demanding environment. The capacity, or indeed the desire to partner (i.e. to move beyond a purely transactional relationship) with <u>all</u> providers, was not considered practical or necessary by most providers and officers involved in this project. Instead, although there was a clear willingness, need and desire to encourage more collaborative working, it was felt by both sides that any partnering arrangements would need to be *proportionate* and *appropriate* for both ECC and providers.

16.3 As a result, it is anticipated that most contractual relationships will continue to operate under either a framework or spot contract arrangement. For framework contracts, providers will continue to be grouped by level of spend and importance to business need based on three tiers. Tier One providers would continue to have a named contract manager. Alongside this, there is now an emerging view that it will be increasingly necessary to develop agreements beyond these frameworks to help develop different and closer ways of working based on a higher degree of collaboration and partnering. This is likely to be with providers that are more 'strategically' important because of:

- The number of SUs they support;
- Their importance in developing new ways of working related to innovation and integration;
- The role they play in providing specialist services;
- The need to join-up different client groups with single providers; and
- The need to promote more locality/neighbourhood based working.

16.4 As yet it has not been specified what this 'partnering' might look like in practice, other than the development of much closer working arrangements based on a higher degree of collaboration and risk sharing. It must be *stressed* that developing new partnerships would not be at the expense of commercially disadvantaging other providers, nor would it suggest that other relationships and responsiveness to all providers would become less important. Indeed this work has shown that, transactionally and operationally, ECC needs to be much more responsive to all providers when required. In this sense the ability to ensure a small provider: is paid on time; knows where to go to discuss a safeguarding issue; and knows who to contact to raise an issue of policy or practice, will be as important as large providers being effectively engaged in a new service model that may require them to operate differently.

16.5 The ability to partner effectively is an issue that has arisen consistently during this review. Some of this is about issues touched upon elsewhere in this report e.g. the desire to work together, trust, clarity of direction and leadership. Fundamentally, however, for both sides to be able to partner more effectively there is a need to agree and understand what partnering might look like in a complex and highly regulated system. In reality, partnering between providers and ECC would probably also need to involve other organisations such as CCGs, hospitals and voluntary groups.

16.6 The survey questions offer a model of how to improve partnership working by advancing five elements that underpin effective relationships, greater joint working and integration. Figure 10 summaries this model and Appendix H gives a fuller understanding of how this approach works. In essence, as well as being a diagnostic tool, the survey can also be used to help partnering groups to discuss and identify what actions they might take to improve working together to progress integration, and also to help them assess their success.

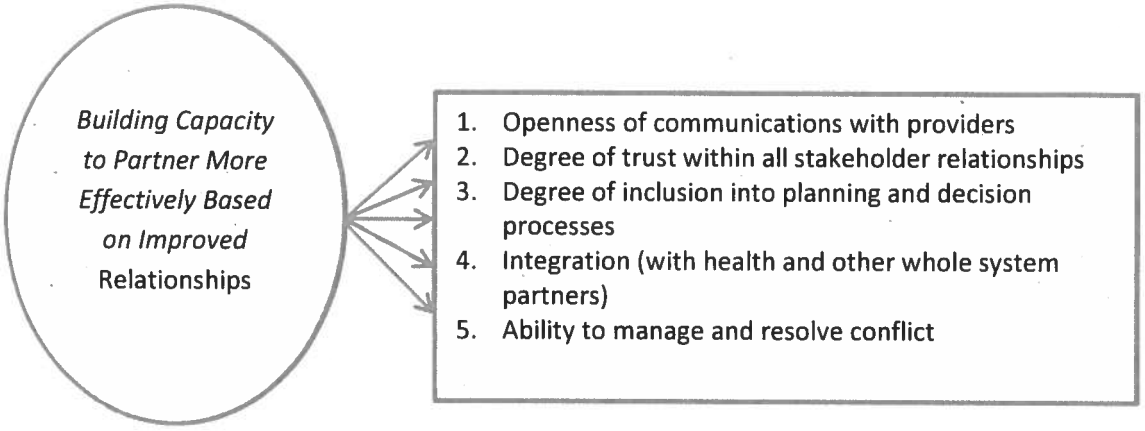


Fig 10: Five Elements to Improve Partnering

16.7 On the assumption that the recommendations in this paper are taken forward, it is suggested that the survey is repeated annually as an objective measurement of how much relationships have improved. However, a much larger response rate would be required to ascertain with more certainty whether relationships are improving and what some of the specific issues might be. A larger response rate will also allow for the better identification of issues by provider type, geographical area, officer seniority and operational teams.

17. ENGAGEMENT

17.1 Engagement has been a key theme arising from all the research work undertaken. The 2015 project led by Georgia Dedman made significant recommendations in this area. Both providers and officers have agreed that this is still an area that is not working as well as it needs to. We think this is for several reasons:

- A lack of understanding as to what engagement *actually* means;
- A lack of a clear approach and structure that enables ECC to engage with care providers at the right level (who), the right time (when) and the right place (where);
- When providers and officers do engage, these activities are less effective because:
    i. There is often a lack of clarity about the purpose of engagement events, their anticipated outcomes and who they are aimed at
    ii. The skills to run engagement events need strengthening e.g. event design, facilitation and evaluation
    iii. There is an inability on both sides to talk and listen constructively

iv. There is confusion as to who is best place to lead and facilitate individual engagement events with providers;
v. There is a reluctance to identify and commit resources to engagement work
vi. There is a jadedness about the usefulness of these events, hence attendance is often variable.

A Lack of Understanding as to What Engagement Actually Means

17.2 Engagement is a term that is applied to a variety of situations when two parties need to share or exchange information and ideas. However, a lack of understanding as to what kind of engagement is most appropriate, why and with whom is significantly undermining current engagement activities with providers.

17.3 In particular, officers need to distinguish more clearly between the need to:
- Just **inform** care providers;
- **Consult** providers to seek their views, normally on a range of options or possible solutions/ways forward;
- **Participate** with providers to maximise shared input into problem solving; and
- **Collaborate** to identify issues and then co-produce and design solutions together.

17.4 Depending on which 'mode of engagement' is most appropriate, this will determine what mechanism should be used to engage providers e.g. if it is just to inform then it would generally be more appropriate to use emails, newsletters, letters. If there is a need to be more exploratory (i.e. the precise issue or problem was not clear or the solution unknown) it would probably be necessary to design a one-off workshop that maximised the input of all participants in an open ended way. See also Appendix I.

The Lack of a Clear Approach and Structure to Engage with Providers

17.5 Once the mode of engagement (inform/consult/participate/collaborate) has been determined, there is also a greater need to understand *who* needs to be involved, *when* and *where*. Too often officers are taking the wrong issues to the wrong provider groups at the wrong time.

Who – The Right Level

17.6 Officers (and to a lesser extent providers) need to stop thinking about the care market as a homogeneous whole. Residential and nursing care, domiciliary care and other types of providers (e.g. for Learning Disabilities, Independent Living) often have differing needs and, therefore, require different types of engagement to find solutions that suit them best. To aid thinking about 'whom do I need to talk to?' we have already introduced the concept of thinking about providers operating at three levels: owners and directors/care managers/care workers – see Figure 3, page 5. This recognises that, for example, not much will be gained by discussing commissioning strategies or complex resourcing issues with care workers, but that much will be learnt by accessing their expertise and knowledge to determine, for example, how best to operationalise a new medicine management scheme. Similarly, care owners will want to use their pressurised time on engaging and influencing decisions about pricing and contracting issues, rather than focusing too much of their effort on operational details which are more appropriately dealt with by their care managers.

When – The Right Time

17.7 *When* to talk to providers has also become an issue. The research has shown ECC is incredibly poor at planning ahead. As a result, engagement activities are often arranged at short notice and are not co-ordinated, even when the need to engage with the market is known well in advance. Similarly, too many engagement events run simultaneously. For example, at the same time last year ECC was actively engaging with the care market on the cost of care, quality improvements, and re-tendering the residential and nursing contract as well as holding four area forums. Our suggestions below (see paragraphs 17.8-17.17) on tightening up the formal engagement groups will help with this issue. We are also recommending that this needs to be accompanied by a forward plan/events calendar. This would allow officers to plan ahead and determine what group they should be discussing their issues with and give care providers good notice of what issues are going to be raised when and where.

Where – The Right Place

Strategic Groups

17.8 We have already noted that ECC has very few formal engagement points with care providers and those that do exist are not as well organised and as mature as they need to be – see Appendix F. We think there is a pressing need to strengthen the current formal engagement points with providers and to add two new 'strategic' provider groups. Overall, and with the right development and discipline, these groups will eliminate the need for ad hoc engagement events. This will save time and money as well as decreasing the likelihood of providers not engaging with ECC. We would also expect an improvement in the quality of the conversation that takes place.

17.9 The first new group being proposed is an overarching strategic provider and officer group that would be led by the director of adult social care and attended by other directors as necessary. Its membership would be drawn from the newly proposed Essex Care Association (ECA) and Tier One providers from residential and nursing, domiciliary care and other key providers representing learning disability, independent living etc., at a senior level. The suggestion is that this group would meet twice a year and its focus would be on key strategic issues related to finance, market direction and major new initiatives. It would also be encouraged to have oversight of quality, safeguarding and workforce issues.

17.10 The second new strategic group would be a quality group that again would be led at director level, but chaired by a care provider in the same way as the current Essex Employment Skills Board (EESB) Care Sector Group. Its membership would also be drawn from a range of providers at a senior, and care manager, level. The suggestion is that it would meet three times a year and that its purpose would be to oversee the development and implementation of the care provider quality improvement plan. Its chair would be a member of the overarching strategic group.

17.11 We also suggest that the EESB Care Sector Group and the Essex Safeguarding Board (ESAB) Provider Group are retained, but strengthened in terms of representative membership and officer support. It is suggested that the chairs of these groups should also have a place in the proposed new overarching strategic provider group.

17.12 Together, these four groups will form a 'strategic hub' allowing care providers and ECC to focus on key issues at a strategic and developmental level. With the right support and nurturing from both sides, they would work collaboratively to identify issues and to develop any necessary responses

(i.e. strategies and practical plans) to foster a diverse, sustainable and vibrant care market in Essex.

17.13 Subject to the response to the suggestions set out in paragraphs 17.8-17.12, there could be scope to merge the Quality and Safeguarding Strategic Groups into one and/or consider their removal on the basis that issues related to quality and safeguarding could be progressed through the Tie One Provider groups - see paragraphs 17.14-17.15.

Provider Self-Organisation and Tier One Providers

17.14 One of the issues that has arisen from this project is the recognition *by providers* that they are not as well organised to represent themselves as they need to be. At the moment there are three provider 'associations' in Essex (EICA, CPN and SECHA). In total these have a membership of about 200 providers, although the CPN is more of a networking group so doesn't have members as such. In advance of this report, and stimulated by this project, there is a proposal for EICA and CPN to merge and for the resulting new organisation to increase its membership to become more of a single body representing the care market in Essex. This is a welcome development and one ECC needs to support actively.

17.15 Over time, if this new organisation becomes suitably representative of the care market, it may become *the* strategic group ECC works with and can replace the four strategic groups being proposed above – see paragraphs 17.8-17.13. For this new organisation to become representative of the market, ECC would need its Tier One providers to be amongst its members. Until this is achieved, we think there is a need for ECC to meet more regularly and formally with Tier One providers as it is crucial for ECC to improve and foster its relationship with this group.

Provider Forums

17.16 We also suggest that the provider forums should continue but have noted that these are still not as effective as they need to be. We think the forums will be greatly improved by:

- Being focused more on the implementation and operationalisation of key issues and initiatives, as well as seeking feedback and ideas on what needs to improve;
- Being more directly targeted at care mangers and care staff;
- The Adult Operations Local Delivery Directors having full responsibility for them;
- The compulsory attendance of officers from Commisioning, Quality Improvement, Contracts, Safeguarding and the Service Placement Team;
- Insisting partner organisations (e.g. CCGs and Acute Sectors) attend;
- Being split between residential and nursing, and domiciliary care providers with perhaps a networking overlap session;
- Meeting a minimum of three times a year with the dates being set in diaries 12 months in advance;
- Having a forward plan of items to which providers should be asked to contribute; and
- The notes and actions being properly recorded and distributed, and each event being properly evaluated.

17.17 Appendix J sets out a visual representation of the proposed provider engagement structure for Essex. On the basis that the arrangements and structures set out above were agreed we would suggest that ECC should limit or stop all other ad hoc engagement events with providers. Where separate engagement events were considered necessary e.g. those related to procurement

activity, these would need to managed and delivered on the basis of the principles set out in this paper.

When Providers and Officers Do Engage These Activities are Less Effective Than They Should Be

17.18 We have already stated that more thought needs to be given to the *who*, *when* and *where* of officer engagement with providers. We think another reason why engagement activities are not as good as they need to be is because *how* these events are designed and run also needs strengthening. We believe there is a need for officers to think harder about 'event design' i.e. content, appropriateness, outcomes, and questions to be asked, and who is best to lead and facilitate the event. Furthermore, all engagement events should be properly evaluated and any feedback acted upon. We think, therefore, there is a clear and critical need for officers to be upskilled in this area.

17.19 Similarly, we think both providers and officers would benefit from developing their listening, talking and questioning skills. It is suggested that consideration is given to senior officers and key provider representatives undertaking some joint training in this area.

17.20 All of the above depends upon sufficient resourcing. However, as we have noted, there is a reluctance to identify and commit resources to engagement work. A failure to do this is a false economy because ECC is already spending money in this area but it is largely being wasted on badly organised and ineffective engagement work and events. A clear structure, with properly identified and committed resources, will:

- Create efficiencies and save money i.e. fewer engagement events;
- Improve effectiveness i.e. better quality events, better decision making, etc., and
- Increase attendance i.e. many events are poorly attended due to provider jadedness about their value and usefulness.

17.21 The Provider Engagement and Adult Social Care project recommended establishing a new role of a Provider Engagement Manager to help join up and create a more consistent approach to ECC's engagement work with providers. If resources were found for such a role (and we believe this review has provided further evidence for justification for such a role), it could also be assigned the responsibility for leading on the implementation of this review.

18. CLARIFYING ROLES AND RESPONSIBILITIES AND THE IMPORTANCE OF LEADERSHIP

Roles and Responsibilities

18.1 Clarifying roles and responsibilities has been identified as a key 'Must Have' and is generally felt to be a quick win that will help to improve relationships and operational delivery. The recommendation is to provide a list of 'who's who' to support operational working; to clarify the roles and responsibilities for managing relationships with the market; and for providers to map out the key people and organisations it thinks that ECC should be in regular contact with. It has been observed that providers feel relationships have been negatively affected as a result of ECC becoming too distant, and due to a lack of continuity amongst officers. Whilst it was noted that there is always likely to be a degree of staff turnover, clarifying roles and responsibilities and keeping names of key contacts up to date will help mitigate against the loss of continuity if key members of staff leave the county council. It will be important, therefore, to task someone with ensuring that the contact list is kept up to date and circulated to all providers on a regular basis.

18.2 As observed, the single strongest message from other LAs we have spoken to is the need for senior officers to have regular contact with providers. As part of this, it needs to be acknowledged that this will take time but it is necessary to ensure that the market operates and develops as smoothly as possible. We think that, currently, there is a lack of clarity with regard to which director(s) have the prime responsibility for managing relationships with providers. This may be too big a job for one director given the size of the care market in Essex and the fact that relationships need to be attended to at both the *strategic* and *operational* level. As part of the current restructuring of the county council, ECC needs to be absolutely clear which senior managers *are* responsible for leading the development of positive relationships with the care market; to put these arrangements in place as a priority; and to communicate them to care providers.

18.3 The lack of clarity as to who is responsible for leading the relationship with the market has also affected the quality of leadership for setting the overall direction for the market in terms of 'shape' and strategy. This is a complex area as it encompasses a number of strands related to market shaping that cross over organisational functions i.e. commissioning intent, commissioning delivery, commercial activities (including procurement and contract management). Increasingly commissioning strategies are multiple, affecting different client groups, and require integration with health strategies, all of which adds a further layer of complexity.

Leadership – Both Care Providers and ECC

18.4 There is currently a lack of a strong, united and visible leadership of the care market. This needs to come from care providers and ECC working separately and together. ECC needs to show stronger leadership in setting out a clearer direction for the care market and also to suggest how this might be done. ECC needs to involve care providers and other partners in articulating this vision and, therefore, needs to think about the most appropriate leadership style to do this. This will require a degree of 'systems leadership' to enable all partners to work together to lead the care system in Essex.

18.5 For their part, providers need to show more leadership in organising and representing themselves better to engage and work with the whole care system. This will help create workable solutions to meet everyone's needs and, in particular, the needs of SUs. They also need to create more leadership capability to develop stronger peer influence in order to help improve standards and practice. Together ECC and care provider leaders need to be able to drive the whole system, collectively and the parts of it which are their individual responsibility, and to do this with *one* voice.

18.6 It is our view that the lack of leadership of the care market is not just down to role confusion but is also about *capability* and *capacity*. All the relevant senior leaders at ECC need to focus more on the care market working in the ways described above. In addition, their capability also needs to increase in terms of how best to lead a large and diverse market in the current dynamic and challenging environment. We are inclined to suggest that this capability relates to the ability to lead change better, manage complexity and ambiguity and lead across organisational boundaries.

19. DIRECTION AND FUTURE SHAPE OF THE MARKET

19.1 Both the workshop discussions and the 'must haves' have highlighted the need for greater clarity about the direction and future shape of the market. It should be noted that this was an issue

raised as much, if not more, by officers as by providers. We think providers and officers are asking for three issues to be addressed about the future:

i. The future shape of the market - this includes shape/look/feel and makeup of the market; likely developments and changes linked to new opportunities; innovation and improvements required; workforce implications; and new business opportunities;
ii. Setting out more clearly defined expectations - this is in relation to overall standards and quality (performance) and, crucially, is about what is affordable and achievable in the current climate; and
iii. Clarifying issues around costs – this includes much greater transparency about pricing, top-ups and other details related to financial matters which directly affect providers.

19.2 In raising these issues there was sense that the absence of any clarity and transparency around them has allowed confusion and suspicion to arise. This, in turn, has contributed to increasing the level of mistrust between providers and ECC. The lack of clarity is also making an already a challenging environment even harder to work in for both parties.

19.3 Setting out the future direction of the market will require ECC to be much clearer about what it sees as the future shape of the market and for it not to be afraid to 'pull' providers into these discussions. This work has to be driven by 'strategists' and commissioners, not procurement and commercial activity. For ECC, clarification of its commissioning intentions in the short to medium term, and articulating how they anticipate this will impact upon providers, will also be important. In addition, ECC needs to set out where the opportunities lie to shape and deliver these. In response, providers will have to get better at managing change, show more flexibility and understand that, at times, ECC will not be able to clarify every single issue in the way providers would like.

19.4 Providers are clear that, in their view, what ECC specifies from them in terms of quality and standards at the moment is not affordable. This is an area of tension, with providers very often left in the middle having to explain to relatives and friends of SUs why some things are not possible. Conversely ECC remains concerned that poor quality providers, although a relatively small percentage of the whole market, are still considered too numerous and take up a disproportionate of time to manage and distract resources from supporting the wider market. They consider that for many of these the issue is not a lack of resource or understanding about what is required, but just poor management and competence. There is a need for both parties to examine more closely their performance expectations and to bring a greater level of understanding and sharpness as to what is achievable. This could possibly be achieved by using the 'four box model' of quality which was agreed with providers earlier this year - see Appendix K.

19.5 Whilst there is an overriding issue about the cost of care, that was not in the scope of this project. However, tensions over money have the potential to undermine relationships and need discussing in the manner described in this review i.e. openly, honestly and respectfully. The key issue here is that providers want clarity, an understanding about how fee levels and pricing mechanisms are determined by ECC, and assurances that they are being applied equitably and, where possible, set out over the medium term.

20. OPERATIONAL ISSUES

20.1 There has been clear evidence throughout this project that day- to-day relationships need to be strengthened. We have suggested that there are four areas that need to be worked on:

- ECC becoming less remote and officious, and quicker to respond to providers' needs;

- ECC being more consistent and open in its approach around costs, placements and safeguarding;
- Accessibility of social workers; and
- For all providers to actively engage in operational issues and not withhold information related to quality, financial uncertainty and safeguarding

20.2 Some of these issues will be addressed by many of the actions suggested above (e.g. rebuilding trust, ECC paying more regard to its transactional responsibilities, providing a clearer direction to the market and setting out clearer performance expectations). However, we feel there is an equal need for local service teams and providers to discuss more openly some of the issues set out above in paragraph 20.1, and more widely in this report, in order to devise local actions that can improve relationships. Some of these might be quick fixes but others may require more time and effort. As part of the Provider Engagement and Adult Social Care project a recommendation was made that all emails for providers should be responded to within 24 hours, advising who will respond and approximately when. We think that this remains a reasonable service standard for ECC to adopt and would go some way of strengthening local relationships between care managers and service teams.

PART FOUR: RECOMMENDATIONS AND MOVING FORWARD

21. RECOMMENDATIONS

21.1 We suggest that both providers and ECC give consideration to agreeing and implementing the following recommendations.

Working Together (The New Deal)

1a. On the basis that providers and ECC have agreed in principle to work more closely together in the future, it is recommended that they make a formal agreement to do this and agree a set of principles to help underpin how future working will operate as suggested in Figure 9, page 17.

1b. If this way forward is agreed, it is recommended that both providers and ECC explore how they can ensure the majority of providers and all relevant officers sign up to these principles and ensure they are fully enacted

Trust

1c. It is recommended that providers and ECC develop strategies and approaches that will help rebuild trust. We have suggested a model to help build trust (see Appendix G) but we would encourage providers and ECC to explore other ways of rebuilding trust over and above what is being recommended in this report.

Partnering

2a. Providers and ECC have agreed there is a need to develop more strategic partnerships. However, we have observed that there is a lack of understanding as to what this might mean and how these might be achieved. We have suggested a model and process for developing strategic partnerships (see Figure 10, page 19 and Appendix H). It is therefore recommended that in the first instance, ECC decides where it wants to develop strategic partnerships with the providers, and to put forward how this might be done, noting we have cited a lack of knowledge and skill from providers and ECC in this area. To this end, we are also recommending that thought should be given to establishing a small number of 'pilot' strategic partnerships to help test and evaluate new models of partnership working so that the lessons learnt may be applied to other partnership arrangements in the future.

2b. It is recommended that the establishment and development of any strategic partnering arrangements should be done openly, paying due regard to procurement rules and not implemented at the expense of maintaining and improving other more purely transactional relationships with providers which need to improve.

2c. It is recommended that providers should increase their ability and skills to partner more effectively with ECC and other organisations in the care system and ECC should enable providers to do this.

2d. In order to measure the health and development of relationships between providers and ECC, it is recommended that the survey is repeated annually but noting there is a need for a greater response rate from providers to make it more reliable. Providers should take more responsibility for ensuring a greater number of responses are returned.

Engagement

3a. It is recommended that the formal structure for engaging with providers as set out in paragraphs 17.7-17.17 and Appendix J, including the creation of two new strategic groups as outlined in paragraphs 17.8-17.13 is adopted and implemented with immediate effect.

3b. As part of implementing 3a, it is recommended that ECC supports the reenergising of the EESB Care Sector Group and ESAB Safeguarding Group.

3c. It is recommended that ECC supports the proposed creation of a new care provider association in Essex subject to further discussions that should be concluded by the end of December 2016.

3d. It is recommended that until the new association becomes *the* key representative group of providers in Essex, ECC should consider meeting its Tier One providers on a more formal and regular basis every three months.

3e. It is recommended that the provider forums should continue but in the way suggested in paragraph 17.16.

3f. It is recommended that a forward plan is developed and maintained for all provider engagement activities.

3g. On the basis that recommendations 3a-3f are agreed, it is recommended that ECC should limit or stop all other ad hoc engagement events with providers.

3h. It is recommended that ECC gives consideration to offering training to officers that are regularly involved in engaging with care providers and, as part of this, identifies and develops a number of 'super facilitators' that can be deployed to advise and lead engagement events with providers. It is also recommended that consideration should also be given to offering this training to a number of provider representatives as well.

3i. It is recommended that consideration is given to senior officers and key provider representatives undertaking some joint training in the areas of, listening, talking and questioning.

3j. It is recommended that ECC develops a proper resourcing plan for care provider engagement work, knowing that such a plan is likely to save money and as well support the achievement of a more mature and overall stable care market. This resourcing plan should give consideration to establishing a new role of provider engagement manager.

Roles and Responsibilities

4a. It is recommended that a list of 'who's who' is published and kept up to date to support operational working; to clarify the roles and responsibilities for managing relationships with the market; and to set out the key people and organisations that providers think that ECC should be in regular contact with.

4b. It is recommended that an owner is assigned to keeping the 'who's who' list up to date and circulated to all providers on a regular basis. This first list should be published by January 2017.

4c. It is recommended that ECC needs to determine who has the key responsibility for leading and managing the overall relationship with the market.

Leadership

5a. It is recommended that ECC, working with providers, needs to think and agree as to what would be the most appropriate leadership style to lead and develop the market and to ensure the designate care market leader(s) have the necessary skills to do this.

5b. It is recommended that that care providers focus more of their leadership effort on organising and representing themselves better to engage with ECC and to work better with the whole health and care system.

5c. It is recommended that providers need to create more leadership capability to develop stronger peer influence in order to help improve relationships, standards and practice.

5d. It is recommended that that ECC needs to increase its leadership capability in order to be able to lead the large and diverse market that exists in Essex more effectively, taking into account the current dynamic and challenging environment. We have suggested that this is something about leading change, managing complexity and ambiguity and being able to lead across organisational boundaries.

Direction and Future Shape of the Market

6a. It is recommended that ECC needs to provide much greater clarity about the direction and future shape of the care market and needs to actively involve providers in these discussions. This direction needs to clarify its commissioning intentions; articulate how this will impact upon providers; and set out what the commercial opportunities might be available for providers.

6b. It is recommended that there is a need for providers and ECC to examine more closely their performance expectations and to bring a greater level of understanding and sharpness to what is considered achievable in the current environment.

6c. It is recommended that ECC needs to clarify and help providers understand how fee levels and pricing mechanisms are determined, and to give assurances that they are being applied equitably.

Operational Issues

7a. It is recommended that Adult Operations Local Delivery Directors give full consideration to the findings and recommendations in this report and work with their providers and service teams to agree what actions need to be taken forward to improve relationships on the basis of the issues set out in paragraphs 20.1-20.2.

22. MOVING FORWARD

Initial Actions

22.1 At the conclusion of the research phase a detailed analysis of the data (see Section 2) was shared and presented to the core provider group and a group of senior officers representing Commercial, Adult Operations and Commissioning. Both groups met separately to discuss the analysis and

agree possible areas for improvement (AFIs) before attending a joint session on 10 October 2016 (see Appendix A). At this session seven areas for improvement (AFIs) were agreed in principle on the basis that more detailed work was required on how these might be taken forward. Figure 11 sets out the seven AFIs.

Areas for Improvement (AFIs)

1. Rebuilding trust and mutual respect will be an important pre-condition to carrying this work forward
2. The market is too big for a one size fits all solution – proportionate arrangements will need to be jointly developed, supported by providers organising themselves better
3. We need to find a more coherent way of engaging / working together – this incudes having the right conversations, at the right time, with the right people.
4. Clarifying roles and responsibilities and adopting an appropriate leadership style that is collaborative and supportive but also direct
5. Increasing our capacity and ability to partner effectively will require both sides to upskill, increase knowledge and develop better ways of 'talking' and 'listening'
6. Clarity over direction (market and commissioning) and expectations of each other's role to help deliver improvements, integration and innovation will be vital
7. Operational pressures/day to day relationships need to be strengthened:
    - ECC has become remote, too officious and slow to respond
    - More consistency and openness in approach around cost, placements, safeguarding
        - Accessibility of Social Workers
        - All providers need to actively engage on operational issues

Fig 11: The Seven Areas for Improvement (AFIs)

22.2 The group also agreed to take some initial actions to be completed by the end of December 2016 whilst awaiting a set of more detailed recommendations. These actions were as follows:

1. The merger of EICA and CPN and the desire to grow the new association to represent more providers, particularly larger providers;
2. To re-invigorate the ESB Care Sector Group, the ESAB Care Provider Network and to continue to develop the locality provider forums, building on the concept of 'the right people, having the right conversations, at the right time';
3. To develop a forward plan that ensures providers can shape the agenda of key engagement meetings/groups, and advice is given to how this should be done;
4. Clarifying roles and responsibilities and who and where decisions are made that affect providers;
5. To arrange an initial strategic discussion with care providers to discuss some of the '6 month challenges' linking this to a way of drawing in more providers into the relationship management work and the renewal of EICA/CPN network; and
6. A joint communication should be sent out to all relevant officers and care providers related to the outcomes of the meeting and the project overall.

<u>A Limited Window of Opportunity</u>

22.3 If the majority of providers and officers wish to move forward from the current situation, and this review suggests that they do, it will require drive, focus and effort from all parties. This initially

will need to come from the leaders of *both* sides, building on those providers and officers that have already been instrumental so far in bringing this project to fruition.

22.4 Initially, we would encourage incremental steps in order to rebuild trust and ensure whatever joint actions are agreed to take forward first are delivered successfully and made known to everyone. As confidence and trust grows then the pace of change can be accelerated. We do not see why, with the right commitment from both sides, that most of the recommendations set out in this report cannot be implemented within 9 to 12 months.

22.5 We have argued the cost for doing this would be small due to the overall efficiencies it would create as well as improving the quality of decision making between providers and ECC. This in turn will ensure strategies and plans for delivering services to SUs will be stronger and more robust in an increasingly unstable environment.

22.6 We think the window of opportunity to make the changes required is limited because of three reasons. Firstly, hope and expectations have been raised by this review and some good will has returned to relationships between providers and ECC. This needs to be built upon quickly to re-energise and give further hope that both sides do want to find better ways of working together; secondly, the merger of EICA and CPN is a welcome development but must be seized upon to make it a success and to support the development of a single provider voice in Essex. This will greatly enhance engagement work and provide a stronger platform for driving change and integration; and, thirdly, if through improved relationships life is *not* made easier for providers, they will increasingly walk away from LA work and this will reduce capacity further, drive up costs and push down standards of care.

22.7 We have a 'vision' for the care market in Essex[6] and this will not be achieved without improving relationships between care providers and ECC.

Vision

1. ECC wants the best possible care providers to meet service user outcomes
2. ECC, in partnership with all stakeholders, will lead and develop interventions to support care provider improvement
3. By 2018 Essex will be recognised for the quality of its care providers both locally and nationally

22.8 In summary this will require:

- Buy-in and leadership to make the recommendations in this report real, starting with a serious and unified commitment to the 'New Deal';
- Care providers, and their leaders, to grow their capacity and capability to enable the majority of providers to engage and work more effectively with ECC both strategically and operationally;
- ECC officers to trust, respect and involve providers more in the work that affects them most which, in turn, will require officers to pay more attention to the day to day, as much as to setting out a clear direction for the market and being more honest about what can be achieved in the current environment; and
- All sides to recognise that improving relationships will not happen overnight but is eminently achievable as well as necessary.

[6] Care Provider Quality Improvement Strategy

Appendix A

Care Provider and Senior ECC Officer Attendees

Care Provider Representative	*ECC Officers*
1. Clive Weir - Board Tye Residential Home and Chair of Essex Independent Care Association (EICA) 2. Linda Hollingworth - Estuary Housing and Vice-Chair of Essex Safeguarding Adult Board 3. Alan Betts - TLC Carehomes 4. David Ashworth - Newton Chinneck Limited 5. Colin Angel UKHCA 6. Amanda Cowan – Care Providers Network	1. Andrew Spice – Director of Commercial 2. Simon Froud - Director for Local Delivery Adult Operations (Mid) 3. Nick Presmeg – Director of Commisioning 4. Jackie Gregory - Supplier Relationship & Contract Mngt Lead (Adults)

Appendix B

Care Provider Core Group

Name	*Organisation*
Julie Ripper	Essex Independent Care Association (EICA)
Phil Roseman	South Essex Care & Health Association (SECHA)
Daniel Wylie	Aldanat Care / Care Provider Network
Colin Angel	United Kingdom Homecare Association (UKHCA)
Clive Weir	Board Tye Residential Home / Chair of EICA
Rachel Van Staveren	Cloud 9 Care
Ian Turner	Registered Nursing Homes Association
Kathryn Bennett	Estuary Housing
Lind Hollingworth	Estuary Housing
Alan Betts	TLC Carhomes
David Ashworth	Newton Chinneck Limited
Nick Fleming	Carewatch Southend
Mike Higginson	RCH (previously Ranc Care Homes Ltd)
Rahul Jagota	Corner House Care
Amanda Cowan	Essex Independent Care Association (EICA)

Impact Model for RM Project

Vision

1. ECC wants the best possible care providers to meet service user outcomes
2. ECC, in partnership with all stakeholders, will lead and develop interventions to support care provider improvement
3. By 2018 Essex will be recognised for the quality of its care providers both locally and nationally

Overall Project Outputs, Benefits and Strategic Outcomes

Overall Project Output

Clear actions to improve relationship management supported by key care providers and the sector as a whole

Business Change

- Shift to a stronger collaborative (improvement) culture
- Agreed structures and mechanisms to assist communication, engagement and coproduction with care providers
- Agreed expectations around roles and responsibilities as well as behaviours to assist good RM
- Establishing a baseline for measuring improvements in RM

Outcome

- New approaches for improving RM
- Measured improvement from baseline measures

Early Benefit

- Better understanding on how best to communicate, engage and work with care providers
- Increase in trust and openness
- Improved decision making
- Greater collaboration with care providers
- Greater efficiencies when working with care providers

End Benefits

- Joint working to drive outcomes, manage resources and increase resilience
- Clear structures and mechanisms in place to aid communication, engagement and co-production with care providers
- Mature dialogue & discussions can take place
- Providers seen as equal part of the system

Strategic Outcome (Impact)

- Better decision making – the right people, having the right conversations at the right time
- Increased (shared) risk taking
- More stable but also evolving care market
- More innovation
- More adaptive and responsive 'whole system'

Themes Arising From Care Provider & Officer Workshops - Detail

Issues raised by care providers that are having an impact on relationships both strategically and operationally

Prioritised based on number of comments and references, as well as, on 'strength of feeling'

Theme 1: Money – It's all about costs not outcomes

1. All issues related to money: not enough money, pricing mechanisms, cost of care, tops ups, quality versus price, rates. The issue is how and where are prices are negotiated? The focus on money goes against person centred delivery. Providers are getting challenged for being 'too expensive' or for charging different rates for different people. Not enough money for complex needs
2. Clarity of the approach to how money is 'allocated' - consistency, equity and transparency re: pricing and costs
3. Service Users focus - most suitable package is not always the cheapest, focus on the person not the budget

Theme 2: Value – providers feel undervalued and exploited at times by ECC

1. Our expertise is not valued particularly by social workers
2. We see our work as a vocation and you sometime exploit this e.g. managing complex needs
3. We are not recognised professionally
4. You have become faceless, bureaucratic and officious to us
5. You do not understand us as organisations and businesses – commercial, charitable and non profit

Theme 3: Partnering – as providers we are not part of the system

1. Opportunities to collaborate are under utilised
2. There is a lack collective openness, trust and mutual support
3. Honest conversations are not possible
4. Providers and officers do not listen to each other anymore

Theme 4: The strategy/ies for care providers – we're confused

1. We need to understand ECC's strategy is for care providers/want to hear about your hopes and expectations
2. What role do you want providers to play and what type of relationship do you want with providers?
3. What role does the SU play in relationship management?
4. We need to build a shared understanding of the future
5. There needs to be a consistency of approach (strategy, policy and people)
6. What involvement do you want providers to play in decision making?

Theme 5: Communication – providers and ECC live in different worlds

- Clash of cultures big, corporate, bureaucratic versus often independent and/or small medium organisations
- ECC and providers talk differently
- Providers perceive ECC as controlling and top down
- ECC communicates in different ways across different mediums and providers don't always have time to digest everything you send us and or want to talk to us about

Theme 6: Transactional – the day-to-day is being made been harder

- Some social workers have become over demanding (particularly around safeguarding), unavailable, slow to respond and unresponsive, and yet yearly reviews are not always completed on time
- Safeguarding is not always consistent or considered in terms of its impact on business both for us and you
- A lack of openness and accountability for decisions made regarding placements, safeguarding and funding
- Duplication of requests for information

Theme 6: Contractual Relationship – you're inconsistent

- Some providers are unsure what type of contractual relationship ECC wants with providers. Whilst 'one size fits all' may not be appropriate, clarity is required
- Lack of understating and transparency as to why some providers are being chosen over others regarding placements
- You seem to both love us and hate us – make your mind up

Theme 7: Engagement – it needs to be more meaningful

- The provider forums have become unproductive
- There needs to be more clarity on the position of the provider representative required to attend events eg. owners or care managers
- Decision makers form ECC need to attend more events and meet with providers – make themselves known.

Issues Raised by ECC officers that are having an Impact on relationships both strategically and operationally

Theme 1: Leadership – ECC needs to show appropriate leadership

1. More member involvement
2. Be clear with providers about what we want and why and how we need their help to get things right – explaining ourselves better
3. Developing strategic relationships and other partnerships and alliances
4. Better planning with providers
5. Need to be consistent in intent and behaviours

Theme 2: Engagement – ECC needs to improve on what we currently do

1. Need to ensure we get the right providers at engagement events

2. ECC needs to plan better for meetings with providers
3. Senior officers need to attend more engagement events
4. Need to be more consistent with surveys and the questions we are asking providers
5. Engagement events are rarely two way

Theme 3: Communications – getting the basics right would help

1. Being clear what we need to say to providers, why and when
2. We send providers too many messages and instructions via different routes and people

Theme 4: Behaviour – both sides

1. We are inconsistent with how we treat providers – both friend and enemy depending on the issue
2. Likewise providers can be 'hot and cold'
3. We need to create more respect and understanding
4. More consistent in our approach

Theme 5: Hygiene – getting the basics right

1. Need to ensure we get operational issues right e.g. payments, accessibility of social workers
2. We need to communicate internally better about care provider issues

Theme 6: Roles and Responsibilities

1. We need to clarify roles and responsibilities for ourselves as well as for providers

Theme 7: Service users – back at the centre of things

1. We should focus more on meeting SU outcomes not works best for us

Appendix E

'Must Haves' Responses from Providers and ECC Officers

Must Have's ECC & Providers FINAL.pdf

Appendix F

ECC Formal Groups with Care Providers (Summer 2016)

Group	Frequency	Who Attends?	Purpose	Maturity (1-4)	Administrator	Comments
Provider Forums South	Quarterly	All types of providers/Commissioners, Ops & Commercial	Opportunity for ASC and Health commissioners to meet with care providers to discuss area based issues.	1	ECC Commissioners	No clear funding strategy has meant quarter one forums were not held
Provider Forums North	Quarterly	All types of providers/Commissioners, Ops & Commercial		1	ECC Commissioners	No clear funding strategy has meant quarter one forums were not held
Provider Forums West	Quarterly	All types of providers/Commissioners, Ops & Commercial		1	ECC Commissioners	No clear funding strategy has meant quarter one forums were not held
Provider Forums Mid	Quarterly	All types of providers/Commissioners, Ops & Commercial		1	ECC Commissioners	No clear funding strategy has meant quarter one forums were not held
ESAB Care Provider Forum	Quarterly?	Providers and OST	To progress and reviewed approaches to safeguarding	3	Paul Bedwell	Chaired by care provider with representation on the main safeguarding board
Employment Skills Board – Sector Group	Quarterly	Care Providers and Nicola Faulkner	To support the delivery of a skilled care workforce	1	Nicola Faulkner?	Chaired by care provider with representation on the main ESB
MHL Professional Development Group	3 times a year	39 MHL 'graduates'	To provider facilitated ongoing support for care managers who were attends of the MHL programme	3	MHL and Lesley Cruickshank	
Mangers Networks x 4	3 times a year	12(36) care managers per network	Peer support programme	0	Skills for Care and Simon Willson	New – Not yet established

5 Steps to Re-Building Trust Quickly

Step 1: You must choose to believe that people have the best intentions and that they are working in your interest, not just their own. All other trust-building behaviours flow from this.

Step 2: Start with your own behaviour:

- We tend to judge ourselves by our intentions but we judge others by their behaviour. This means that the people around you judge you by what you **do**, not what you **intended**.
- So, do what you say you're going to do, when you say you're going to do it.
- If you trust yourself to deliver, you can start to trust other people to deliver too.
- Micro managing is often a sign that you don't trust yourself to deliver, which is why you over focus on what others are doing. This promotes distrust, undermines people and discourages them from taking the initiative.

Step 3: Declare your intent and assume positive intent in your partner(s). This clearly signals your goals and intended actions in advance and generally assumes that others also have good intent and want to be worthy of trust.

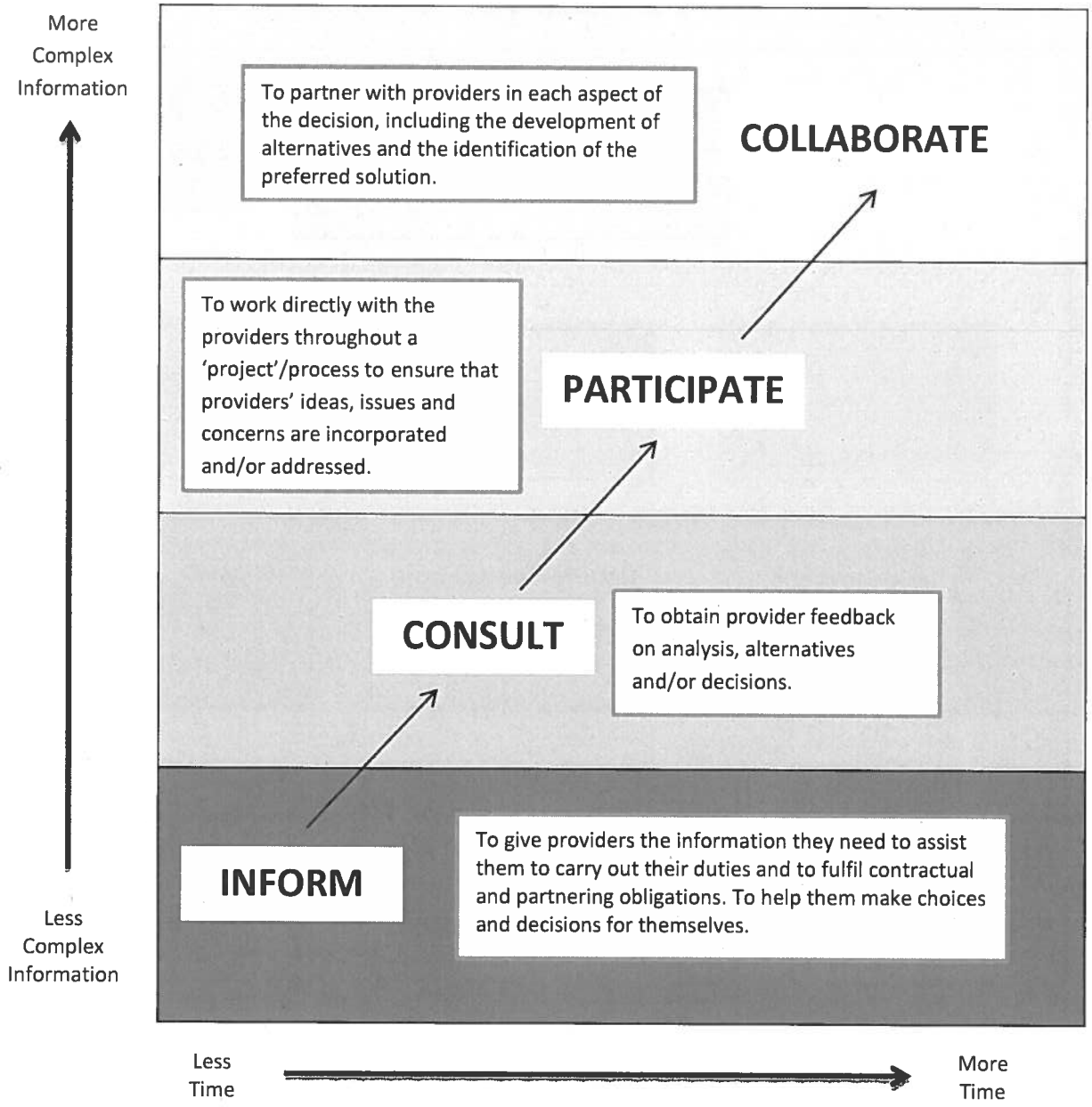
Step 4: By following your lead, your partner(s) will start to do what they say they are going to do, when they say they are going to do it - carrying out their declared intent.

Step 5: The individuals you extend trust to will, in time, also start to extend trust to others. This creates a virtuous cycle that leads to a much more profitable partnership and a more innovative and inspiring working environment.

The Five Elements and Model for Assessing And Advancing Partnership Working

	Element	*Level 1: Securing The Basics*	*Level 2: Thinking Differently*	*Level 3: Developing Strategically*	*Level 4: Sustaining High Performance*
1	**Openness of communications with care providers**	Information is shared via formal routes only when required or requested without any information sharing agreements in place	Information is easily accessed and readily shared, as required, in response to specific needs	Information is shared freely on a two way basis or on an across the system basis and gives rise to ideas and opportunities	Information needs are understood; shared data forms the cornerstone of joint working and planning service improvements and changes
2	**Degree of trust within relationships between care providers and ECC(NHS) Commissioners**	Working practices assumes expectations of relations including accountability for poor quality/performance/delivery	All partners enter into all discussions consistently and with some mutual understanding	High degree of understanding and accommodation of other partners' needs and requirements	Implicit trust and understanding where all commitments are honoured by all partners
3	**Degree of inclusion in planning and decision processes (related to business planning, commissioning and contracting)**	Information only, limited consultation through formal mechanisms	Consultation takes place before key decisions are made	Involvement in main decision-making processes	Decisions are made with the firm involvement of all achieving a consensus where possible
4	**Integration with social care and health commissioners and adult operations, including the wider systems (e.g. SUs, Housing) where required**	Partners operate within their own plans and priorities in an independent and isolated manner	Active seeking of other partners' perspectives, issues, concerns in order to establish links and best way forward	A common frame of reference exists for all partners – we all understand each other's perspectives	Hospitals, housing, transport, recreation, community support are all included in planning and shaping decisions and are also integral partners
5	**Ability to manage and resolve difficult issues (conflict)**	Transactional, adversarial purchaser-supplier relationships exist focusing on own needs	Conflict management approaches/protocols are used to constructive effect to promote win-win solutions	Creative approaches are found for existing problems through a natural dialogue with mutual understanding	Conflicts are resolved with a win-win solution for all partners

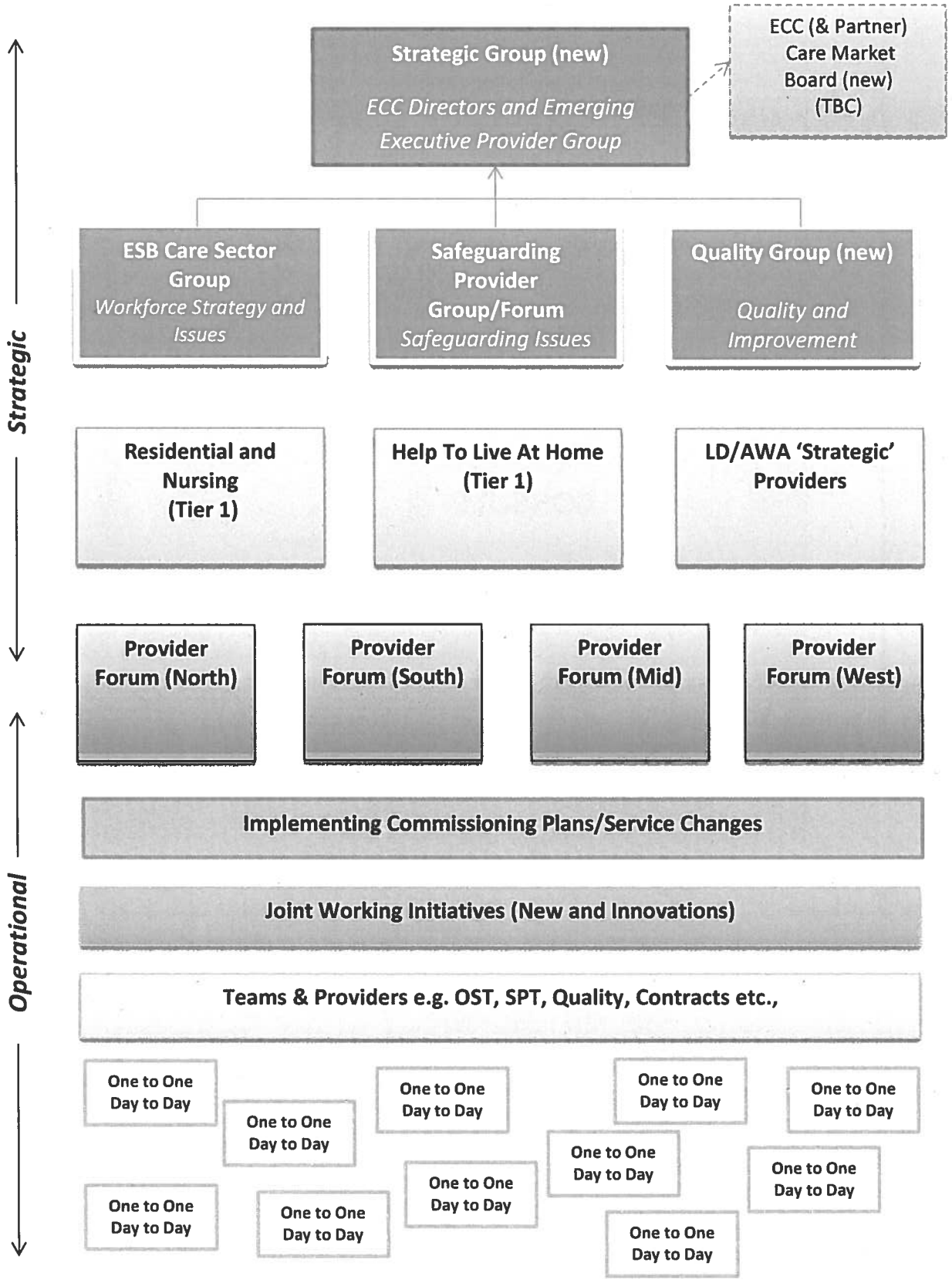
Modes of Engagement[7]



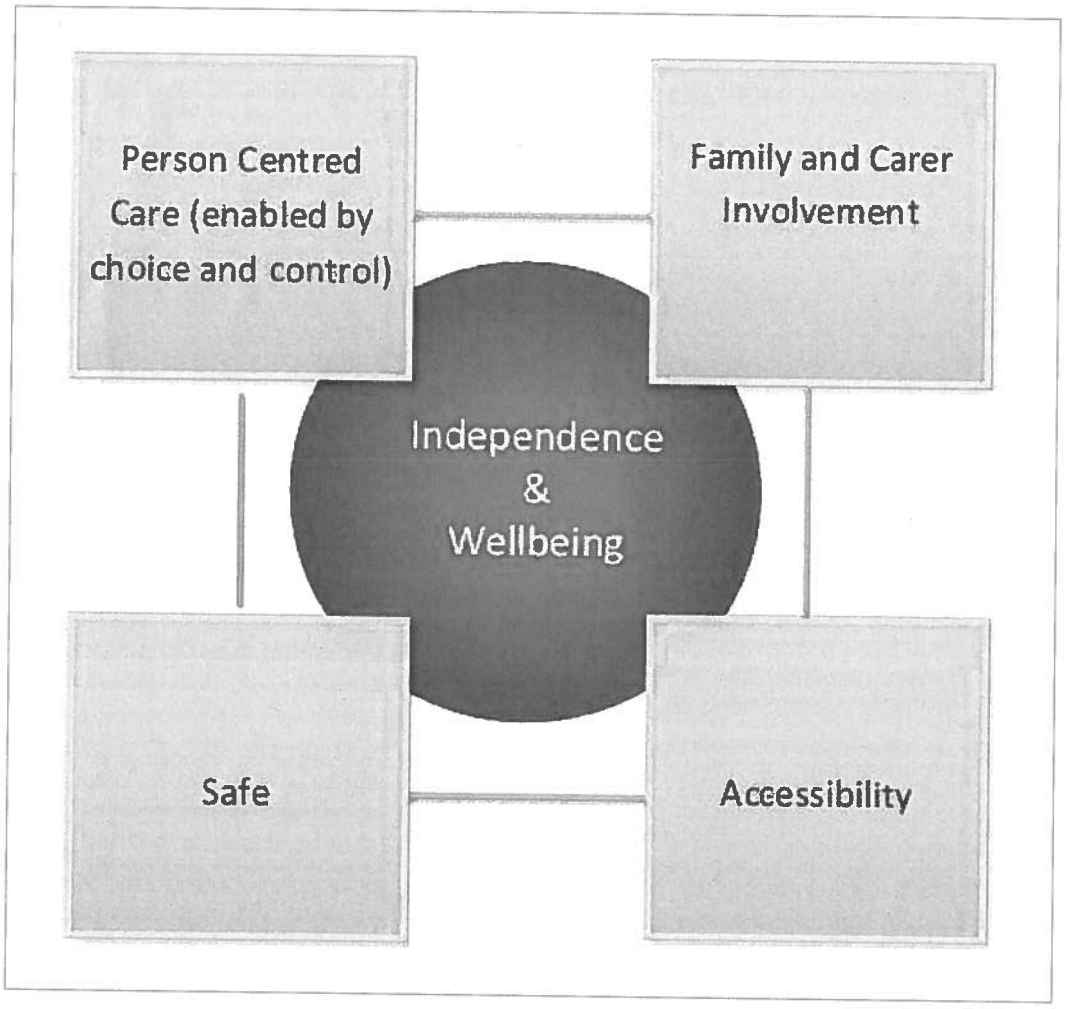
Mode of Engagement	How
Collaborate	Referendum, deliberative forum, open space, advisory panel, action research, appreciative enquiry
Participate	Participatory workshops, reference group, jury, search conference, action research, appreciative enquiry
Consult	Response to questions, consultative workshops, surveys, polling
Inform	Emails, letters, face to face briefings, written briefings, newsletter, website postings

[7] Adapted from Les Robinson The Public Participation Matrix (2002)

'Right Time, Right Place and Right Conversation': Building The Formal Structure To Support Better Relationships



The 'Four Box' Model of Quality



Procurement Services

Relationship Management

Report to People and Families Scrutiny, June 2018

Essex County Council

Background

A project was initiated in 2016 to fully evaluate the relationship between ECC and it's adult social care supply base and to consider how matters could be improved. The reasons for this project were:

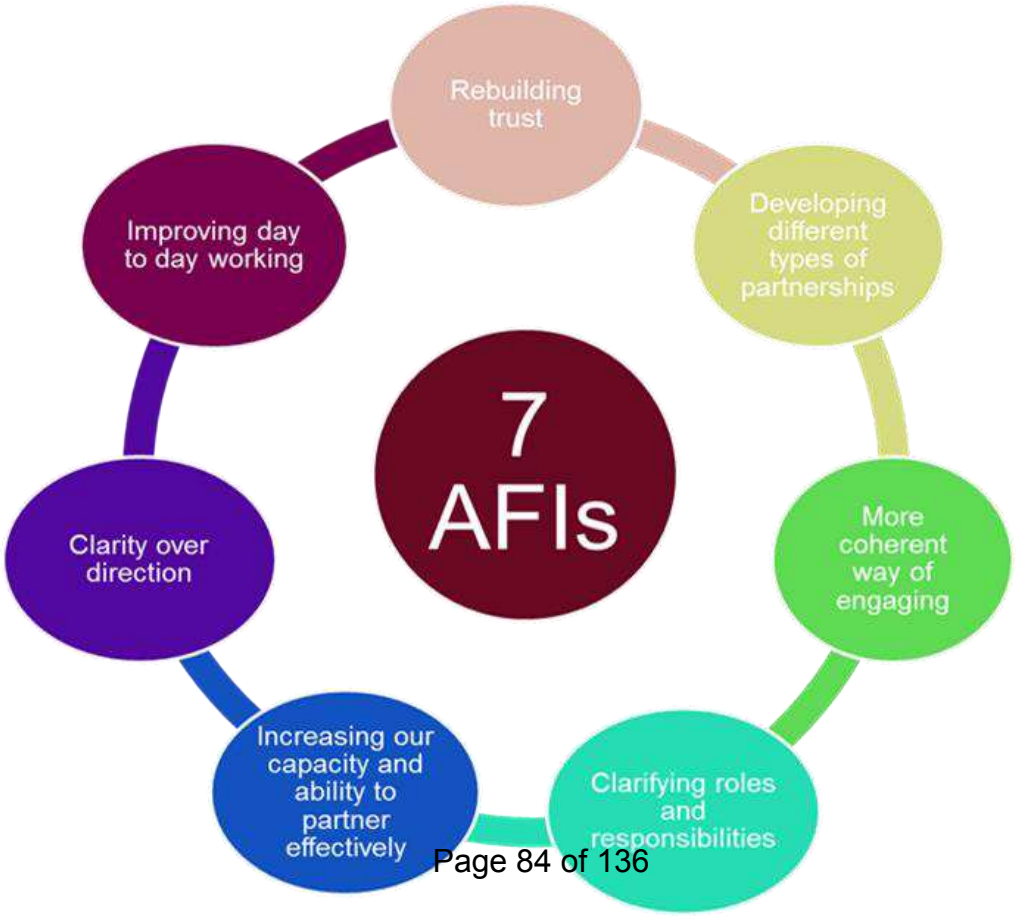
1. A perception that relationships between ECC and the care market were poor and getting worse.

2. Additional responsibilities imposed by the Care Act around market management and sustainability. ECC recognised that it could not meet these new duties without improving relationships with the care market.

The project produced the following report.

Recommendations

The November report identified 7 Areas For Improvement (AFIs):



Actions to date

Care Provider Information Hub - to improve ECC's communication and to be open and transparent the Council set up the hub to act as a 'one stop shop' for news, details of events, key documents, contact details, etc.

Essex Care Association (ECA) - the Council has repositioned its relationship with the ECA. ECC directors and senior officers regularly attend their events. Simon Harniess has been seconded into the role of Development Director to help them grow their business and forge improved links with the Council.

Annual Relationship Management Surveys - since the relationship management report was published, ECC has committed to conduct an annual survey of providers and officers to measure the development of relationships.

Care Market Strategy 2017-21 - the Care Market Strategy 2017-21 has been developed to detail ECC's future direction for adult social care, setting out how the market in Essex needs to develop over the medium term.

Actions to date (2)

Workforce Initiatives - a number of workforce initiatives have been developed to help alleviate the issues of recruitment and retention. This has included a newspaper supplement, funded by ECC, which promoted careers in care.

Strategic Provider Groups - ECC has set up a Live at Home strategic provider group for the domiciliary market to discuss issues with senior officers and improve collaboration.

Strategic groups for other specialisms will be set up in 2018 and details of these will be published in the relevant pages in Working with Us.

An Advisory Forum – the inaugural meeting of this group will be held in July.

The Forum will develop ideas and shape thinking between ECC and a number of key players in the market.

Actions to date (3)

Quadrant Provider Forums - quadrant-based forums, which give providers a chance to discuss local-level issues with senior ECC officers, have been revitalised.

Roles and Responsibilities – it can be difficult for suppliers to navigate between the various departments and teams in ECC involved with the market. Roles and responsibilities therefore need to be clearly defined, with contact details provided. Work has begun and can be found on the Meet the Teams section of the Hub.

Payment Issues - a project team has targeted this complex area. Aged debt has reduced to around £1.2m, helped by a major focus on improving processes. This represents less than one day's spend.

Have relationships improved?

- The 2017 Relationship Management survey reported a 208% increase in provider responses, and a 10% increase in overall scores, compared to the 2016 survey. Issues still remain, but good progress is being made.

- The various forums / provider groups have discussed many issues with actions being managed and progressed centrally. Previously, it was apparent actions from similar forums had no ownership, which was a cause of frustration for providers.

- At a subjective level, it is clear that discussions with providers are now more strategic in nature. Less time is spent discussing operational concerns or payment issues.

Summary

- Significant progress has been made. Most of the recommendations in the November report have been implemented, although we have consciously chosen to adopt a different approach in some areas.

- Providers welcome the opportunity to have face-to-face contact; this helps to build rapport and trust.

- The Care Provider Information Hub has received 100% positive feedback. The site has content which is in direct response to recommendations from the relationship management report (eg. roles and responsibilities).

- Although good progress has been made, more work is needed to effectively deal with operational frustrations.


Questions

Essex County Council

People and Families Policy and Scrutiny Committee (PAF)

6 June 2018

WHAT ARE WE LOOKING AT?	
Review Topic (Name of review)	CARE PROVIDERS - RELATIONSHIP MANAGEMENT
Type of Review	TBC

WHY ARE WE LOOKING AT THIS?	
Rationale for the Review	To review what progress has been made in implementing the Relationship Management Review report (Right Time…Right Place…Right Conversation) https://www.livingwellessex.org/vision/market-shaping/ and to ascertain whether this has been sufficient to ensure improved relationships with care providers There has been some anecdotal feedback from providers since then that they have welcomed a change in approach and more openness that was expressed by ECC in that review but how significantly is it changing and is it going to be sustained? A repeat survey of care providers started late 2017 with results expected early in 2018 and there is the opportunity to challenge progress being made against the recommendations and highlight issues still not being addressed or progressed. The issue is relevant to the Council's strategic objectives and corporate priorities, namely that: (i) residents Enjoy Good Health and Wellbeing http://www.essex.gov.uk/Your-Council/Strategies-Policies/Documents/Enjoy_good_health_wellbeing.pdf (ii) people in Essex can Live Independently and Exercise Choice and Control over their lives http://www.essex.gov.uk/Your-Council/Strategies-Policies/Documents/Independent_living_choice_control_over_lives.pdf A member focus can also approach the issue in a non-partisan way and provide challenge to the wider system on collaborative and partnership solutions. It can raise the profile of issues that may need a wider system approach.

WHAT DO WE HOPE TO ACHIEVE?	
Indicators of success	Poor relationship management would manifest itself in delays in assessments, client choice, and providers deciding not to work with ECC and thereby further reducing choice and capacity. Through challenging progress made on improving relations with care providers the intention of the review is to identify and highlight where issues still remain which could impact on the choice and quality of services being offered to clients and suggest mitigating actions.

HOW LONG IS IT GOING TO TAKE?	
Timescales	The review should be conducted over a three month period. Any extension beyond that would need to be approved by the Scrutiny Board and justified in terms of anticipating and achieving significantly improved outcomes (conclusions and recommendations) by spending further time on it.
Provisional Timetable	January/February 2018 - Scoping Document to be further developed in conjunction with discussions with other officers and Cabinet Member. February/March 2018 – Start of review February to April/May 2018 – Seek evidence and data from witnesses, site visits etc. May 2018 – Finalise report

FOR COMPLETION FOR AGREEMENT OF THE COMMITTEE

WHAT INFORMATION DO WE NEED?	
Terms of Reference	To consider the current relationships with care providers and identify areas for improvement that will further improve the quality and choice of services available.
Key Lines of Enquiry	i) To what extent have recommendations made previously been pursued and implemented? ii) To what extent have relationships with providers improved? iii) To what extent are there still issues around provider relations needing further attention and what can be done about them?
What primary/new evidence is needed?	Evidence to understand the views of care providers, members and officers as to the level of improvement in relationships and has this been sufficient?
What secondary/ existing information is needed?	TBC
What briefings and site visits might be relevant?	Possible site visit to particular care providers
Other work being undertaken/Relevant Corporate Links	

WHO DO WE NEED TO CONTRIBUTE/CONSULT? (INITIAL MEETING TO ESTABLISH THIS)	
Relevant Portfolio Holder(s)	Cabinet Member, Health and Adult Social Care Cabinet Member, Children and Families
Key ECC Officers	Commissioning Directors ECC Commissioners (Heads of commissioning) Adult Operations - Local Delivery Directors Head of Procurement – Steve Ede
Partners and service users	Care providers

WHAT RESOURCES DO WE NEED?	
Lead Member and Membership	TBC
Co-optee's (if any)	TBC
Lead Scrutiny Officer/Other	Graham Hughes, Senior Democratic Services Officer
Expected Member commitment	TBC – a guide would be two commitments per month for the duration of the review.

WHAT ARE THE RISKS/CONSTRAINTS?	
Risk analysis (site visits etc.)	
Possible constraints	

WHAT WILL BE REQUIRED FROM STAKEHOLDERS?	
Internal stakeholders	Is any support from the Communications team likely to be needed?
External stakeholders	

WHO ARE WE DIRECTING ANY RECOMMENDATIONS AND ACTIONS TO?	
Recommendations to (key decision makers)**:**	To relevant Cabinet Member(s), health and social care partners
Reporting arrangements	
Follow-up arrangements	

ADDITIONAL INFORMATION/NOTES	

LESSONS LEARNT/SCRUTINY EVALUATION

To be completed in an end of review Workshop* (align to findings of Scrutiny Survey to be attached as an annex). This form should be used in the evaluation of the process adopted by the Scrutiny review Committee/Task and Finish Group and will be used to inform future Scrutiny Reviews.

Evaluation workshop at the end of the review will typically involve Committee Chairman/T&F chairman, other T&F group members, scrutiny officer, topic proposer and key stakeholders (if applicable)

DATE OF REVIEW EVALUATION:	
1. Organisation & Planning	
What could have gone better?	**Recommendations for future reviews**
What were the strengths and weaknesses of the approach used? Proposed and actual start/completion dates: Was the time allocated adequate?	

2. Resourcing	
What could have gone better?	**Recommendations for future reviews**
Was officer time/resource adequate for this review?	

3. Evidence sessions/site visits	
What could have gone better?	**Recommendations for future reviews**

4. Stakeholder and Communications	
What could have gone better?	**Recommendations for future reviews**
5. Report and Recommendations	
What could have gone better?	**Recommendations for future reviews**
Was the purpose of the review achieved? Has there/is there likely to be any influence on service delivery as a consequence of the review?	

PAF/15/18

Committee People and Families Policy and Scrutiny

Date 14 June 2018

TASK AND FINISH GROUP – HIP FRACTURES AND FALLS PREVENTION

Report by County Councillors Jo Beavis and Dave Harris

Recommendation:

The Committee is asked to:

(i) receive the Final Report of the Task and Finish Group that looked at hip fractures and falls in Essex;

(ii) consider timing and arrangements for reviewing the implementation of the recommendations;

Background

During the summer of 2017 both the Health Overview Policy and Scrutiny Committee (HOSC) and the People and Families Policy and Scrutiny Committee (PAF) received a briefing from Councillor Spence, Cabinet Member for Health, on some of the key issues and challenges in health and social care. One of the issues highlighted during that presentation was that Essex was an outlier from national average for the rate of hip fractures in over 65-year-olds even allowing for local demographics.

A 'follow-up' briefing on hip fractures and falls prevention was provided for both committees in a joint session. Thereafter, a Task and Finish Group (comprising members from both committees) was established to look at aspects around the incidence of hip fractures and falls in Essex.

Scoping and review

The report details the scoping undertaken and the final approach taken towards the review, the work undertaken and the evidence obtained.

With evidence indicating that most falls happen at the time and location where people spend most of their time (i.e. both private homes and residential care homes) the Group concluded that it would look at the support in place in residential care homes. Such a focus would also give an opportunity for some 'self-focussing' on the support that the County Council specifically provides, how it is embedding the right quality improvement ethos in the care homes where it is making placements and to what extent it is pan-Essex or can become pan-Essex. In addition, whether such a quality improvement ethos could be extended into other settings.

As part of its initial investigations the Group became aware of the PROSPER programme (Promoting Safer Provision of Care for Elderly Residents and subsequently renamed promoting Safer Provision of Care for Every Resident) and agreed that it would focus on the effectiveness and future potential of that programme as the core component of its review. PROSPER is a toolkit and training programme that empowers care home staff to identify and make improvements to how they provide care and to create good practice.

The Group HAS conducted some site visits and spoken to County Council officers and care home staff to inform its review. The Group has been impressed by the potential of the PROSPER programme and that many care homes in Essex have embraced the methodology behind it. The Group has concluded that there is significant potential to extend some, or all, of the programme into other social settings and that there needs to be certainty of future funding to facilitate that.

A list of all the Recommendations are on pages 4-5 in the attached report and reproduced below. As part of considering these the Committee will need to consider to whom each recommendation is addressed, and timing and arrangements for reviewing the implementation of the recommendations.

Recommendations

Recommendation 1 (Page 9):

That the People and Families Policy and Scrutiny Committee should consider seeking further information on waiting times for occupational therapist assessments and completing adaptations to ascertain if delays could be contributing to a higher incidence of falls.
Responsibility: Chairman of People and Families Policy, Scrutiny Committee

Recommendation 2 (Page 10)

That County Councillors be encouraged to visit their local care home(s) on an informal basis from time to time to build up a rapport with staff and residents so that they can also see the democratically accountable side of the county council and have an alternative way of raising issues if they so wish.
Responsibility: TBC

Recommendation 3 (Page 12):

That an annual awards event emphasising quality and improvement in the care sector and highlighting good practice in both service and staff should be supported.

Responsibility: TBC

Recommendation 4 (Page 18):

That the Group feels there needs to be sustainability and certainty of future funding to enable planning a stable team to consolidate and further expand the reach of PROSPER into other settings.
Responsibility: TBC

Recommendation 5 (Page 19):

That, whilst participation in PROSPER is not mandatory in the Integrated Residential and Nursing Contract, there should be a requirement to indicate what falls prevention and quality improvements are pursued by the provider (citing participation in PROSPER as an example)
Responsibility: TBC

Recommendation 6 (Page 20):

(i) That further work should be done to investigate extending PROSPER principles and methodology (adapted as necessary) into other community settings, utilising social prescribing and Community Agents where appropriate.

(ii) **That work be undertaken to explore the viability of disseminating information on falls prevention via media outlets, social media and the already established Live Well and Living Well websites.**

Responsibility: TBC

Recommendation 7 (Page 21):

That the potential to work jointly with the NHS on future PROSPER work be investigated.
Responsibility: TBC

Recommendation 8 (Page 22):

That the Health Overview Policy and Scrutiny Committee should lead in receiving a regular update on the rates of hip fractures in Essex, prior year comparisons and identifying ongoing trends.
Responsibility: TBC

Scrutiny

Improving public services

Hip fractures and falls prevention

Task and Finish Group established by the People and Families Policy and Scrutiny Committee in partnership with the Health Overview Policy and Scrutiny Committee

25 May 2018

Essex County Council

CONTENTS

Foreword

This report is a combination of a three-month review by members of the Task and Finish Group looking at the incidence of hip fractures and falls prevention initiatives in Essex. The fundamentals of this report are primarily about falls in the elderly population of Essex. The report before you will set the scene as to why we embarked on this piece of work, our journey to help us to carry out our research and finally our conclusions which leads you to why we make our recommendations.

As a group and in some cases, as individuals, we have travelled the county of Essex meeting staff, our commissioning staff, volunteers and residents and family members (many of them in the setting of our Essex County Council care homes).

It quickly became apparent that there was a project that we could research further to understand the benefits it is bringing to help resolve falls in older people: that project is called PROSPER which is used in many (not all) Essex County Council owned care homes. PROSPER is a simple document management system designed to be picked up and used by care home staff to ensure that every opportunity is explored to reduce falls. The PROSPER framework is both flexible and adaptable to suit the needs of each individual care home user and setting and has been designed to train and develop staff, volunteers and residents to ensure a greater focus on the prevention of falls rather than the treatment of falls. PROSPER encourages staff, volunteers and residents to find solutions to further improve safety in care homes.

Members of the Group at a recent the Community of Practice event.

The PROSPER framework chimes with the recommendations of the Sir Tom Hughes Hallet “Who Will Care” Report insofar as it is encouraging staff, volunteers, family, friends and residents to work together to provide services. PROSPER has the potential for a greater reach into services for young people, mental health and other social services.

The review was prompted by data showing Essex was an outlier for its rate of hip fractures; we are pleased to note that the latest data (which became available during the review) shows Essex is now in line with the national average (see page 22).

My thanks again to the dedicated team of Officers, Members, Staff and care home residents that have made the journey in bringing this report to you possible.

COUNCILLOR JO BEAVIS
Lead Member - May 2018

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Responsibility: TBC

Background

Preparatory briefings

During an initial briefing on Public Health issues for new members after the 2017 County Council elections, the People and Families Policy and Scrutiny Committee and the Essex Health Overview Policy and Scrutiny Committee were advised of the high incidence of hip fractures for over 65s in Essex. A further specific briefing on the issue was provided for both committees in joint session and thereafter a Task and Finish Group led by the People and Families Policy and Scrutiny Committee was established drawing membership from both committees to look at the issue further ('the Group') and the Group conducted its review between February and April 2018.

Membership

County Councillor Joanne Beavis (Lead Member),
County Councillor Dave Harris
County Councillor June Lumley
Maldon District Councillor Neil Pudney
County Councillor Pat Reid
County Councillor Clive Souter

County Councillor Malcolm Maddocks, Chairman of the People and Families Policy and Scrutiny Committee, also attended meetings in an ex-officio role.

Acknowledgements

A list of witnesses who informed the review through either oral and/or written evidence is listed in Appendix x and the Group would like to thank them all for their co-operation and time in assisting them during the review. The Group would also wish to thank the two care homes visited as part of the review for their hospitality and willingness to take an active part in this scrutiny exercise.

The Group also wish to express particular thanks to Maggie Pacini, Public Health Consultant, Lesley Cruickshank, Quality Innovation Manager, Rod Manning, Quality Improvement Officer, and Karen Williams, Placement Co-ordinator, who have supported the Group throughout the review, facilitating engagement at off site events and/or accompanied members on their visits to care homes.

Findings and evidence

Context

National picture

Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75 in the UK. Over 400,000 older people in England attend A&E Departments following an accident and up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture.

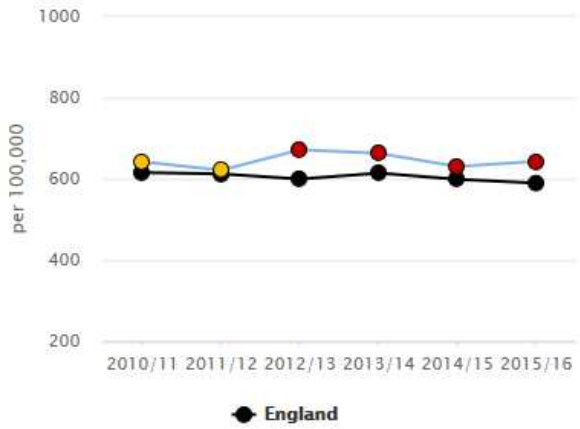
Osteoporosis, a condition characterised by a reduction in bone mass and density increases the risk of fracture when an older person falls. Fractures occur most commonly in the hip, spine and wrist. One in three women, and one in twelve men, aged over 50 are affected by osteoporosis and almost half of all women experience an osteoporotic fracture by the time they reach the age of 70.

Hip fracture is the most common serious injury related to falls in older people, resulting in an annual cost to the NHS of around £1.7 billion for England. Of this, 45% of the cost is for acute care, 50% for social care and long-term hospitalisation and 5% for drugs and follow up. Half of those suffering an osteoporotic fracture can no longer live independently.

Risk factors for hip fractures:

- Increasing age
- Being female (relates to lower bone density in women)
- Chronic medical conditions (for example osteoporosis – low bone density – or Parkinsons or stroke which increases falls risk)
- Certain medications (for example steroids which weaken bone mass, or poli-pharmacy which increases falls risk)
- Nutritional problems (including adequate hydration)
- Physical inactivity
- Tobacco and alcohol use
- Previous history of fracture

Essex



Essex hip fracture rates, time trends

Source PHE profiles

Allowing for the specific demographics in Essex and a higher concentration and incidence of elderly people in parts of Essex, the rate of fractures for over 65- year-olds in Essex has been an outlier to national averages.

As part of the Group's initial investigations, the information sought was broadened out to also include information on falls as it was intrinsically linked to fractures. Data was presented with a breakdown by district, sex and age, and time trends; the data was not suggestive of a single consistent factor for why Essex was an outlier. Information was presented on risk factors for fractures and falls; whilst there was little data to show the distribution of these risk factors (other than age and sex), the variability of excess fracture rates across districts across time could not be explained by changes in prevalence of risk factors as these do not change drastically year by year and so do not present clear reasons for the variation by geography by year. The report also included a description of local falls prevention services and that there is no direct relationship between the level of specific provision of such a service and the local fracture rates. The full report can be found as Appendix 1 to this report.

Scoping and final focus

Four possible key areas of focus were considered by the Group:

(i) looking at support in place for daily living in residential homes and other settings;
(ii) looking at the provision of disabled facilities grants and housing adaptations;
(iii) looking at the collection of more on-scene data collection (primarily through the ambulance service); and
(iv) through hospitals, gain greater local understanding of fractures mapping against geographical wards and areas of deprivation.

As part of its deliberations the Group were conscious that their time for the review was limited and needed to be conducted quickly and that this would have some bearing on the final focus for their review.

The first two options were based on speaking to key informants. The latter two were considered more around data collection exercises which would also have implications for timings. In turn each option was discussed and evaluated for potential to influence change and drive improvement, feasibility, availability of support and information, and appropriateness of timing a review at the current time.

Looking at the provision of disabled facilities grants and housing adaptations the Group were conscious that this could be a significant piece of work, initially ascertaining with partners the current waiting times for assessment by occupational therapists and then, whether there was any indication that any delays were having an identifiable impact on the incidence of falls (and consequently in some cases, hip fractures) and look at any opportunities for further streamlining of the process. However, the Group feel that this is an area of investigation that should be pursued.

Recommendation 1: that the People and Families Policy and Scrutiny Committee should consider seeking further information on waiting times for occupational therapist assessments and completing adaptations to ascertain if delays could be contributing to a higher incidence of falls.

Significant literature already describes the circumstances of falls. It was felt that the only gap could be around actual data collection on the circumstances of outside falls where perhaps less was known. It was reported that the Ambulance Service may just capture the postcode of where people fall but do not routinely collect anything extra which might help explain the cause of the fall. However, the Group had reservations about specifically working on collecting such further data and whether it would really provide anything extra that was not already known or expected and what actual actions could lead from conducting such an exercise. In addition, the Ambulance Service had moved to a new electronic data system so the timing would not be ideal if the Group wanted them to provide resource to assist the review at this time. However, it was noted that some further enquiries on data collection could be pursued by the Health Overview Policy and Scrutiny Committee when it next engages with the Ambulance Service in late summer or Autumn 2018.

Similarly, pursuing a project asking hospitals to map data onto addresses to smaller areas (e.g. geographical wards) and against areas of deprivation would be more of a data collection/data analysis nature rather than pursuing particular lines of enquiry. Whilst it could have the potential of being able to target potentially higher risk areas and, perhaps, proactively offer home hazard assessments. However, it was known that Rochford District Council and Rochford community and voluntary sector were already doing something similar by piloting door knocking in some target housing areas and some CCGs were mining their data and concentrating on offering advice to the top 2% homes with elderly people so a further update on this could be requested by one of the committees at a later date.

The agreed key focus of the Group:

With evidence indicating that most falls happen at the time and location where people spend most of their time (i.e. both private homes and residential care homes) the Group concluded that it would look at the support in place in residential care homes. Such a focus would also give an opportunity for some 'self-focussing' on the support that the County Council specifically provides, how it is embedding the right quality improvement ethos in the care homes where it is making placements and to what extent it is pan-Essex or can become pan-Essex. In addition, whether such a quality improvement ethos could be extended into other settings.

As part of its initial investigations the Group became aware of the PROSPER project (Promoting Safer Provision of Care for Elderly Residents and subsequently renamed promoting Safer Provision of Care for Every Resident) and agreed that it would focus on the effectiveness and future potential of that programme as the core component of its tightly focussed review.

Limitations of the review

The Group is content that it has received a range of views and collected evidence from a number of key witnesses. This has enabled it to come to some reasonable evidence-backed conclusions. However, the Group also acknowledge that, due to time and resource constraints, they have only just 'dipped below the surface' on many of the issues highlighted.

There were further investigations that could have been made and other witnesses with whom the Group could have consulted. Whilst members visited two care homes, the Group acknowledges the limitations of not visiting more homes in drawing up conclusions but feels that the two visits gave a taste of what care homes who practiced the PROSPER methodology thought of it. There is an opportunity for further work to be undertaken to specifically look at care homes who have chosen not to practise PROSPER and whether they are using other methodology and practices that could be as effective as PROSPER.

The Group have not spoken directly with providers of falls services nor any of the agencies involved with supporting those that have fallen.

The Group did not look at the links between certain physical or mental conditions and tendency to fall although there is significant evidence to indicate such links, for example, with medication, obesity, health conditions and poor balance.

The residential care market in Essex

At the time of writing this report, Essex had 272 Older People Residential and Nursing Homes with the County Council commissioning placements at 249 of them.

Total number of beds – 11,502

Total number of ECC placements – 4260

The County Council also commission packages of care from the 85 Residential Providers in Essex registered for Adults with Disabilities.

Through commissioning such numbers of care placements the County Council has significant leverage to influence cultures and attitudes in care homes. At the same time there is also an opportunity for county councillors to build relationships with their local homes and demonstrate a wider support for the caring culture being developed.

Recommendation 2:

> ***That County Councillors be encouraged to visit their local care home(s) on an informal basis from time to time to build up a rapport with staff and residents so that they can also see the democratically accountable side of the county council and have an alternative way of raising issues if they so wish.***

The PROSPER Programme

The PROSPER project (originally Promoting Safer Provision of Care for Elderly Residents – now renamed Promoting Safer Provision of Care for Every Resident) is a toolkit and training programme that empowers care home staff to identify and make improvements to how they provide care and to create good practice. The programme has been running for four years and started as a collaboration between care homes, Essex County Council, the health sector, UCL Partners (an academic health science partnership) and Anglia Ruskin Health Partnership. Rather than being based around handing out a document to passively read, which often does not work, the programme instead facilitates inspiration, vision and leadership within care homes for them to drive their own identified changes and this is the core ethos of the PROSPER.

PROSPER seeks to introduce systemic approaches to improving quality into care homes and reduce the incidence of three of the most common safety issues in care homes and the three most common reasons for ambulance call-out:

(i) falls;
(ii) urinary tract infections; and
(iii) pressure ulcers.

The published literature suggests that the risk of falling is particularly high in persons in communal establishments such as residential and nursing care homes. NICE (2004) suggests that the incidence of falls in nursing homes and hospitals is 2-3 times greater than the incidence in the community. Furthermore, complication rates as a result of a fall are also significantly higher. This is unsurprising since those persons requiring residential, nursing or hospital care are most likely to be those that are frail as a result of physical health problems or with cognitive impairment.

The programme provides some introductory training about quality improvement but focusses on how it can be applied in practice rather than theory. It then encourages care home staff to be creative in their thinking and provides a framework and some suggested measurement tools to guide improvements. PDSA (Plan, Do, Study, Act) methodology is used to empower carers to be in-charge of change and encourage the idea that even small changes can lead to big improvements. The programme seeks to change behaviours and instigate long-term culture change. It can also be the opportunity for further professional development for care home staff.

It is important to stress that PROSPER is not imposed on care home staff who are free to adopt as little or as much of PROSPER methodology as they wish and to adapt measurement tools for their own local circumstances. Instead the programme supports a change in behaviour by empowering care staff to think creatively and act differently, creating Prosper Champions and investing in the development of those Champions with Study Days, newsletters and community of practice events.

The evaluation report identified key success factors for the programme including:

- Providing opportunities for homes to share ideas and learn from each other worked well, including having regular get-togethers for managers and carers with a 'taught' component but also ample opportunity to share learning
- Having ways to engage a wider range of care home staff, rather than solely managers, was crucial to success. PROSPER 'champions' included carers and domestic staff.
- It is important to allocate enough capacity and capability in the implementation team to provide regular proactive support to homes.

Above: Members of the Group visited Mundy House Care Home in Basildon and the Haven Care Home in Colchester to help inform their review. Councillors Pat Reid, Dave Harris and Jo Beavis attended both visits whilst Councillor Lumley attended the Basildon care home.

> "*Provide opportunities for Care Homes to develop a sense of identity and pride in the health and social care system.*"
>
> Improving resident safety in care homes - Learning from the PROSPER programme in Essex (November 2016)

The Champions Days are important to care home staff as they provide an opportunity not only to share experiences but drive further improvement. The Group feel that it is important to encourage and recognise innovative improvement and, therefore, supports an annual awards event for care homes.

Recommendation 3:

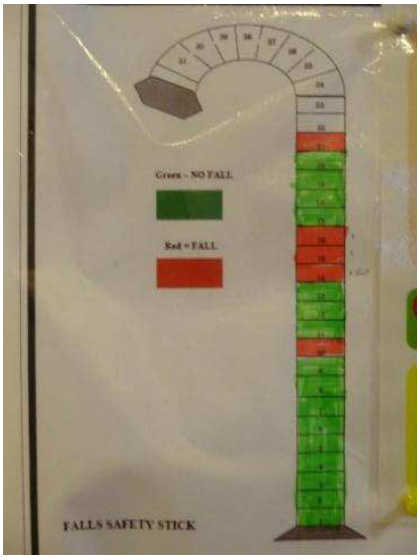
That an annual awards event emphasising quality and improvement in the care sector and highlighting good practice in both service and staff should be supported.

Through talking to care home staff in their work environment, and at a Community in Practice and Champions Days events (where care home staff can meet staff from other homes and share ideas, knowledge and experience), the Group have been impressed by the enthusiasm and sense of self-empowerment that the programme

gives to care home staff. By attending recent PROSPER events the Group heard care home staff clearly having those discussions where they felt that certain approaches and measures just did not work or that they needed to be adapted for their local circumstances. The Group viewed this as a positive that there was the flexibility to adapt or reject the methodology as part of keeping participants engaged.

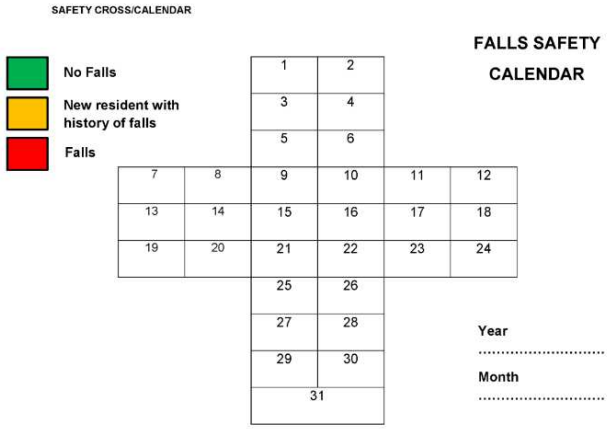
Right: The Community of Practice event promotes the PROSPER programme and enables care home staff from different homes to share ideas, knowledge and experience. Members of the Group spoke with participants at the event held in February 2018 at the Essex County Cricket Ground.

What is working well?

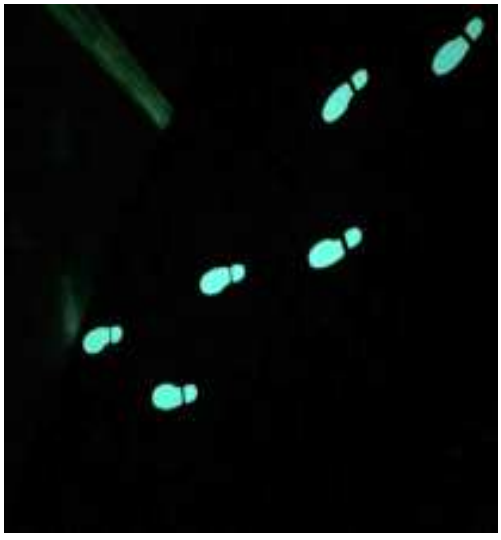


The PROSPER programme is changing the culture of safety in care homes by encouraging more proactive prevention strategies. Using simple tools help care home staff make data collection a core part of everyone's role and interpret it easily to inform improvement. Examples of this are graphs showing monthly incident rates and the Falls Safety Stick (see left) and Safety Cross (see below) which are coloured red or green each day depending on whether there have been any falls or not and which some homes have since further adapted by splitting it into three to record falls at different times of day and to map where falls actually happen within a care home.

Right: The Safety Cross template competed by many homes to help identify if there are higher risk times during the month. This has been further adapted by some homes to illustrate the time of day of the falls as well.



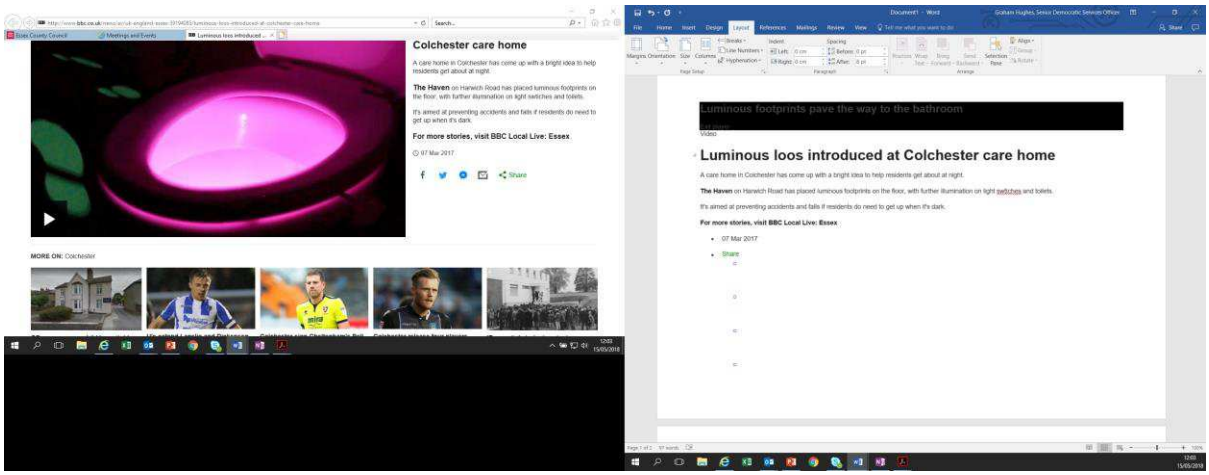
Other initiatives that address underlying falls and fracture risks have originated from care home staff as a result of using the PROSPER methodology are now becoming more widely practiced within the programme. For example, a person's mobility, strength, gait and balance contribute to their risk of falling and the most likely location for falls include managing stairs or steps, or transfers from bed or chair, or from slips and trips hazards. Most falls occur during the day when people are most active yet a proportion of falls occur at night when people get up to go to the bathroom which may be due to continence urgency, change in blood pressure and fainting or vision or cognitive impairment affecting gait and balance.



Above left: Decorated walking frames for people living with Dementia to help them identify with their own equipment (i.e. the one set at the right height etc)

Above right: Luminous footprints leading to the bathroom, luminous paint around door frames and light switches, and lights on walking frames and toilet seat

Below: some innovation coming out of PROSPER has received national coverage such as the BBC coverage above highlighting the luminous toilet seats assisting elderly and infirm residents at night.



Left: The GERT age simulation suit. Essex County Council also offers further specific training such as on age simulation to raise the awareness of care home staff of the mental, physical and social challenges faced by older people

Common complications associated with dehydration include low blood pressure, weakness and dizziness which can increase risk of falls. Ensuring that residents remain hydrated can also be a key part of helping residents maintain their balance and minimise falls and care homes can provide specific training for staff. Residents and relatives to highlight the importance of keeping hydrated. Care Homes have taken innovative actions to promote hydration such as the wearing of badges, lights on beakers or coloured doily's to remind residents to drink, as well as activity sessions to encourage (non-alcoholic) drinking and rehydration including the consumption of jellies!

The Group have also been impressed at how SMART technology is being embraced by many care homes with Apps being developed so resident care can be tracked remotely by family and friends. This appetite for more instant monitoring data should be encouraged as it is illustrative of a heightened awareness by care homes that family and friends want to be kept informed about the care of their loved ones. However, it is recognised that there can be a cost to providing such technology and that there may be other ways to also keep friends and family updated.

Where is there still a challenge?

The PROSPER programme encourages care homes to use a monthly mapping data collection tool to include number of residents, number of falls, number of different residents falling (otherwise could just be the same person regularly falling), and hospital admissions and these are anonymised and consolidated for county wide analysis. However, getting homes to complete the anonymised monthly mapping data can be a problem. Homes do not always see that it is a crucial methodology tool for them and that it is their data to collect, present and use as they see fit.

However, PROSPER argue though that it can be good evidence to show the Care Quality Commission when they are conducting an inspection of a Care Home. PROSPER has offered a monthly mapping training session to show how the recording and paperwork is done but to date this has not been well attended. It is an important aspect of the programme that care homes feel they have control and are self-empowered to apply the methodology as they see fit for their local circumstances so care should be taken not to add pressure to complete something that the care homes do not feel that they need to dedicate time to do. It is important that PROSPER continues to be seen as a helpful framework and not an inspection regime. A balance needs to be found in seeking data that encourages incentivisation and continued improvement and innovation but does not feel that it is going to lead to any judgement.

> *Homes reported that being able to **compare** themselves with other homes was motivating, such as through anonymised 'average' incident rates and monthly newsletters. However, any perceived judgements about differences in performance were not welcomed.*
>
> Improving resident safety in care homes - Learning from the PROSPER programme in Essex (November 2016)

PROSPER reach

Approximately 160 care homes have had the PROSPER methodology training with about 100 actively involved. A breakdown of the reasons given by homes that have chosen not to participate at all is below:

Prosper homes not engaging	
Number of Homes	Reason
3	Contract terminated/closed

12	Home feels they already have systems/processes in place and would not benefit.
3	Overarching organisation wants to be associated with Prosper when Prosper received national recognition but individual homes not committed.
7	Managers left – although the home is still on Prosper but having to build up momentum again.
5	Homes lack commitment and difficult to book visits with manager/staff
3	Safeguarding issues
33	

127 homes, having received PROSPER Methodology training, are still engaging and benefiting from PROSPER although at different levels of engagement. Officers have now been revisiting homes that were in the original cohort four years ago to re-enforce the message to continue to drive improvement. However, some homes can lose focus – especially through change of management and staffing.

PROSPER framework

The initial intention of the PROSPER project was for the Quality Improvement team (8 Officers) to provide support to the homes, however at the time the team was aligned to Adult Safeguards and this work took precedence over PROSPER, there were also issues with officers having to wear two hats one supportive the other regulatory and made it difficult to gain the homes trust. This meant initially support to homes was sporadic and not consistent.

From cohort 2 onwards support was provided by one dedicated PROSPER Officer and a Project Manager, although capacity was limited it provided guaranteed support.

> "*Having members of the implementation team visit regularly was useful. Care homes that received regular visits reported more changes in culture and processes than those that were visited infrequently. Care homes visited more frequently were also more favourable about PROSPER overall.*"
>
> Improving resident safety in care homes - Learning from the PROSPER programme in Essex (November 2016)

From September 2015 to October 2017 PROSPER had been staffed by 2 support officers who worked countywide. These roles are very important to the success of, and acceptance by care homes, of the programme with them undertaking personal visits to homes, providing advice and help in formulating and collating data.

From November 2017, with additional funding from the Integrated Better Care Fund, the PROSPER team has had 3.5 full time equivalents permanent Officer posts working with Older People residential care homes and 1 officer and 1 assistant fixed term officer until 31st March 2019 working with the Adults with Disabilities sector.

The wider Quality Innovation Team includes 5 Officers and 3 Assistants working with the domiciliary care market and Dementia/End of Life Care specific projects which are fixed term until 31st March 2019.

The initial pilot phase of PROSPER was evaluated for change in care process and safety culture as well as resident outcomes such as a reduction in falls. Two-thirds of care homes reported changing some of their care processes as a result of PROSPER and two-thirds of homes reported changes in safety culture. The initial findings were suggestive of a significant reduction in the number of falls after PROSPER was introduced.

Table 2.1. Number of events and event rates among the 64 care homes

	No of events	No of residents	Rate of events	p value
Falls				
pre	3058	12884	23.7%	<0.01
post	4714	22564	20.9%	

The study identified that falls related hospital admissions did rise over the study period (non-statistical increase). The study identified some savings due to falls reductions yet also hospitalisation cost pressures to set alongside the costs of the programme. There were, however, a number of caveats around the study methodology – which may both over and under estimate the impact – which limits the strength of the findings.

The Group feel that it is important to allocate enough capacity and capability in the PROSPER implementation team to maximise the programme's potential. This involves providing regular proactive support to homes including the development of educational programmes and tools all of which requires considerable resource.

However, the Group views that committing support to the PROSPER programme is not solely about making a monetary investment but also about changing mindsets and culture through empowering people in the community to find their own solutions.

Recommendation 4:

> ***That the Group feels there needs to be sustainability and certainty of future funding to enable planning a stable team to consolidate and further expand the reach of PROSPER into other settings.***

Residential care market

The current Integrated Residential and Nursing contract which is the ECC framework for preferred suppliers, currently has a key performance indicator (KPI) on the number of falls. However, the KPI this has a number of contributing factors including the size of home, complexity of residents (i.e Dementia/Parkinson's/ medication) and whether it involves one person or multiple people. Therefore, the KPI is currently being reviewed in favour of requesting for management information around falls and processes in place. The PROSPER project and its monthly data mapping tool could be used as a way of demonstrating the home has a process in place to monitor and record falls in-order to establish patterns and trends, using the quality improvement methodology to introduce preventative measures. If PROSPER was made a mandatory requirement of the contract there is a danger it becomes a tick box exercise and is not properly implemented as the home does not buy into the concept or fully understand the benefits. However, there could be value in emphasising that a PROSPER, or similar approach, to quality of care would be well received by the Care Quality Commission when conducting their inspections rather than as a strict contractual obligation.

Recommendation 5:

That, whilst participation in PROSPER is not mandatory in the Integrated Residential and Nursing Contract, there should be a requirement to indicate what falls prevention and quality improvements are pursued by the provider (citing participation in PROSPER as an example)

PROSPER in other sectors

PROSPER is now being piloted in the adults with disability sector including learning disabilities and autism. The first cohort of homes has just commenced their Quality Improvement Methodology training and this will have a focus on falls, diet and digestion and dementia. This will use the same model as PROSPER for Older People in Residential Care and Nursing Homes, utilising a starter toolkit, community of practice events, PROSPER Champion Study days and support visits.

The PROSPER team have looked at how the programme could be transferred to the Domiciliary Care market and tested out elements such as the Champion Study days and Community of Practice events. However, the workforce in the domiciliary care sector is more transient, with acute recruitment and retention issues exacerbated by a more prominent part time workforce meaning that attempts to run whole day study days with this sector are not supported and do not work. After consulting with domiciliary care providers, the PROSPER team have concluded that a 'Train the Trainer' model would be more suitable, enabling in house trainers or senior carers to cascade learning as part of routine in-house training or induction. Community of practice events for the trainers and managers have been successful to date and

Domiciliary Care providers have welcomed the opportunity to network with other organisations and to be able to contribute to how future support could be delivered.

The PROSPER team have also run health and wellbeing sessions with residents in 5 sheltered accommodation schemes in the Rayleigh and Rochford area, focusing on falls and nutrition/hydration. These events have adapted some of the sessions and tools used with care home staff such as the falls game whereby participants are given objects relating to falls such as medication boxes, worn ferrules and old slippers, and have to say what the link is to falls and how you can prevent them; hydration facts such as the fluid content of different foods are also provided as an additional way of increasing awareness of hydration and the effects of dehydration on the body. The PROSPER Team consider that the Quality Improvement methodology of PDSA cycles (small tests of change), root cause analysis and Safety crosses, along with an educational programme for both care staff and residents, could be suitable for the scheme managers to use and could be transferrable to this sector.

The Group support these initiatives to extend the reach of PROSPER into other sectors.

Opportunities to further expand the spread of PROSPER

The Group also suggest that there is potential for the methodology and tools used in Prosper to be used in further settings such as Day Centres and Sheltered accommodation, with customised study sessions and Community of Practice events provided not only for staff but for people living in the community**.**

Prosper has already run sessions for local scout groups and college students to raise awareness using the GERT Age simulation experience, nutrition/hydration awareness and a falls game. These could be rolled out to schools and then further into the community**.**

The Group feel that it is important to capture the general learning about falls prevention from the PROSPER programme and explore ways to further disseminate that advice and information in both other formal settings and in less formal settings as well: this could be disseminated in a similar manner as some of the current social prescribing and Community Agents' initiatives where they use combinations of direct training and Train the Trainer, keeping in touch, networking and sharing of good practice, rewards and awards:

(i) An information sharing session could be created using the Dementia Friends model of cascade, creating champions in the community to share the information with a focus on falls, nutrition/hydration and other contributing factors - champions could include community groups and statutory partners.

(ii) Bite size information on falls prevention could be drip fed via a media campaign with short messages.

(iii) Explore the potential for falls prevention information to be included on the Livewell and Living Well websites possibly through adding a gallery of ideas etc [reference to Rally Round http://health2works.com/rally-round/

Recommendation 6

(i) That further work should be done to investigate extending PROSPER principles and methodology (adapted as necessary) into other community settings, utilising social prescribing and Community Agents where appropriate; and

(ii) That work be undertaken to explore the viability of disseminating information on falls prevention via media outlets, social media and the already established Live Well and Living Well websites

In the above initiatives it may be in someone's job description, their whole job, or part of a job; they may be geographically dispersed under an umbrella organisation or drawn from a multitude of organisations. Such dissemination requires tailored approaches to engage staff and keep them motivated across different settings with different goals and has to be underpinned by an infrastructure to support the work 'on the ground'.

Partnership working

It is suggested that in future PROSPER could be jointly branded as a local authority and NHS initiative. One NHS organisation has been considering funding PROSPER in their area. NHS teams have been providing some falls prevention training to complement the PROSPER programme. Frontline NHS teams could play a more active role in delivering training and following-up on improvement progress with a jointly branded initiative. For instance, a falls team or community nurses may be able to monitor the extent to which care homes implement changes following training, providing further accreditation for those who achieve certain milestones.

The Group understands that NHS stakeholders have had some ideas about ways they could work more collaboratively and add further value if the initiative was run jointly. However, there was variation across Essex, due to the number of different commissioners and NHS provider organisations in place.

Recommendation 7:

That the potential to work jointly with the NHS on future PROSPER work be investigated.

*There is benefit from having a **wider support team** to input ideas, including care home staff, members from elsewhere in the Council, healthcare professionals and improvement experts from the evaluation team. Joint working with NHS colleagues has been important in offering a wide range of substantive training. Joint ownership by the local authority and NHS could be worthwhile in the future.*

Improving resident safety in care homes - Learning from the PROSPER programme in Essex (November 2016)

Future monitoring

The investigation of this issue has highlighted to the Group that there is no consistent process of monitoring key health indicators by scrutiny committees and to what extent there should be. The Group are conscious that scrutiny committees should not be 'bogged-down' with excessive and routine key performance data (expecting that commissioners would provide the initial challenge on contractual under-performance) but that they could extract key measures that it felt required regular review due to recent trends and make the issue more transparent.

Recommendation 8:

> ***That the Health Overview Policy and Scrutiny Committee should lead in receiving a regular update on the rates of hip fractures in Essex, prior year comparisons and identifying ongoing trends (involving the People and Families Policy and Scrutiny Committee as appropriate).***

Conclusion

The PROSPER project is looked at nationally as an exemplar and has won several national awards with the most recent being the national **Patient Safety Award for 'Changing Culture to improve Patient Safety'**

"There was an authentic approach taken to the project, which is visibly improving the lives of their patients. This is gold standard with huge potential for impact across the country"

Judges – Patient Safety Award for 'Changing Culture to Improve Patient Safety'

The Task and Finish Group also regard the PROSPER programme as an example of outstanding practice using well organised training, encouraging collaborative working and sharing of experiences and getting the participants fully engaged, maintaining their enthusiasm, delivering simple messages with a practical implementation.

As noted in the Foreword, the rate of hip fractures in now in line with national averages based on latest national data. Just as it was difficult to explain the reasons for being an outlier it remains difficult to explain the improvement. The Group understands that the County Council will continue to work with its partners in minimising the risk factors for fractures and falls with PROSPER an example of a prevention programme that is working well.

Glossary

Anglia Ruskin Health Partnership	Partnership between five Essex NHS bodies, Essex County Council and Anglia Ruskin University to enhance the quality of health and social care by collaboration in service delivery through innovation, research and education. AR Health Partnership
Care Quality Commission	Independent regulator of all health and social care services in England. It monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety - www.cqc.org.uk
Clinical Commissioning Groups	Clinically-led statutory NHS bodies responsible for the planning and commissioning of most health care services in their local area. Their governing body is made up of GPs, other clinicians including a nurse and a secondary care consultant, and lay members;
County Council	An upper tier local authority which will provide county wide services such as education, social services, transport, strategic planning, police, fire services and, since 2013, Public Health.
Day Centres	A service managed by the local council, NHS or voluntary or private body, where people who are socially isolated can attend during the day to meet other people, have meals and take part in activities. some basic personal care may be available
Dementia Friends	An Alzheimer's Society programme to change people's perceptions of dementia. It aims to transform the way the nation thinks, acts and talks about the condition using both face-to-face Information Sessions and online material. https://www.dementiafriends.org.uk/
Domiciliary care	Care that is provided to people who still live in their own homes but who require additional support with daily activities and household tasks, personal care or any other activity that allows them to maintain their independence and quality of life
GERT	The GERontologic Test suit. It is an age simulation suit offering the opportunity to experience the impairments of older people such as reduced visibility, hearing loss, and reduced coordination skills.
Health Overview Policy and Scrutiny Committee (HOSC)	An Essex County Council Scrutiny Committee with its membership comprising elected Councillors. Meeting agendas and papers
IBCF/ Integrated Better Care Fund	A pooled budget made up of health and social care funding to be spent on meeting adult social care needs, reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready, and ensuring that the local social care provider market is supported
Integrated Residential and Nursing Contract	Essex County Council agreement with care providers who wish to receive care placements from the County Council. It covers care in a residential setting for social

	care placements, for older people (aged 65+) and adults with non-complex mental health needs.
Live Well	The Livewell campaign is designed to engage communities, families and individuals with the aim of providing information about all that is on offer in Essex to improve health and wellbeing. for people across Essex. https://www.livewellcampaign.co.uk/
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice for health, public health and social care practitioners. https://www.nice.org.uk/about
People and Families Policy and Scrutiny Committee	An Essex County Council Scrutiny Committee with its membership comprising elected Councillors. Meeting agendas and papers
PROSPER	Originally standing for Promoting Safer Provision of Care for Elderly Residents. 'Elderly' has subsequently been changed to 'Every' to reflect expansion into other social settings.
Public Health	The team within County Councils and unitary councils which commissions preventative health services such as health checks, weight management programmes, and other healthy lifestyle programmes.
Quality Improvement Team/ Quality Innovation Team	Internal Essex County Council teams tasked with driving improvement in the quality of care services commissioned by the County Council.
Residential care (home)	Long-term care given to adults or children who stay in a residential setting rather than in their own home or family home. It includes access to on-site personal care (help with washing, dressing and medication). Some care homes are registered to meet a specific care need (e.g. dementia, learning disabilities).
Sheltered accommodation/housing	These are generally owned, run and maintained as social housing by a local authority or housing association.These are usually independent, self-contained homes with their own front doors and the tenants are usually able to look after themselves. Many schemes also have communal areas where tenants can socialise. Many schemes will also have their own on-site 'manager' or 'warden'.
SMART technology	Usually electronic gadgets that are able to connect, share and interact with its user and other similar devices, that understand simple commands sent by users and help in daily activities. While many smart devices are small, portable personal electronics, they are in fact defined by their ability to connect to a network to share and interact remotely.
Train the trainer	Train the trainer is a learning technique that teaches students to be teachers themselves.
UCL Partners	UCLPartners is an academic health science partnership of more than 40 partners from the NHS, social care and academia, supporting improvements in discovery science, innovation into practice and population health - https://uclpartners.com/who-we-are/

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The information contained in this document can be translated, and/or made available in alternative formats, on request.

Published – May 2018.

ANNEX 1

Briefing note to People and Families Scrutiny Committee on local rates of hip fracture: Maggie Pacini, Consultant in Public Health, Essex County Council

Purpose

To respond to a query about Essex being an outlier for hip fracture rates:

- To present data on hip fracture rates for Essex
- To describe the risk factors for fractures and falls
- To outline the current position on falls prevention services
- To outline some key lines of enquiry for the committee

To answer the question 'why is Essex an outlier for hip fracture rates' there are two distinct aspects to be explored:

1. Does Essex have a greater prevalence of the risk factors that lead to hip fractures
2. Does Essex have the right services in place to reduce the risk of hip fractures

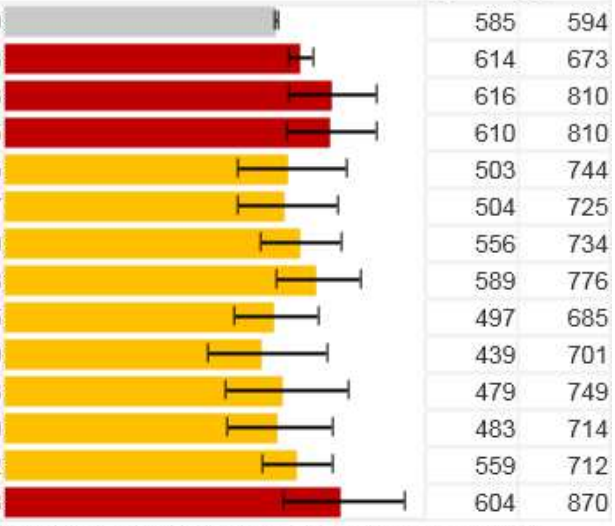
It is worth placing this question in the wider context of fractures and falls prevention as the two are intrinsically linked.

Hip fracture rates in Essex

Essex as a county has statistically significantly higher rates of hip fracture than national average (see figure 1; 15/16 data). Essex is the only area in east of England with a higher than national average fracture rate.

Figure 1 Hip Fracture in people aged 65 and over (rates) by district council area, 15/16

Area	Value	Lower CI	Upper CI
England	589	585	594
Essex	643	614	673
Basildon	708	616	810
Braintree	705	610	810
Brentwood	615	503	744
Castle Point	607	504	725
Chelmsford	640	556	734
Colchester	678	589	776
Epping Forest	585	497	685
Harlow	559	439	701
Maldon	603	479	749
Rochford	590	483	714
Tendring	632	559	712
Uttlesford	728	604	870



Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Source PHE profiles

Figure 1 also shows the breakdown by district council area. Overall, most of the council areas have fracture rates that are not significantly different than national average. Basildon, Braintree and Uttlesford all have significantly higher rates in 15/16 (latest data available).

There are higher rates than national average in females in Braintree and higher rate in males in Basildon (Figure 2a and 2b).

Figure 2a Hip Fracture in people aged 65 and over (rates) by district council area, 15/16 females

Area	Value	Lower CI	Upper CI
England	710	703	717
Essex	765	725	808
Basildon	786	661	927
Braintree	877	740	1,031
Brentwood	798	634	991
Castle Point	720	577	889
Chelmsford	757	638	892
Colchester	820	693	962
Epping Forest	726	599	872
Harlow	694	525	898
Maldon	625	462	828
Rochford	668	523	839
Tendring	759	653	876
Uttlesford	879	701	1,089

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Figure 2b Hip Fracture in people aged 65 and over (rates) by district council area, 15/16 males

Area	Value	Lower CI	Upper CI
England	416	410	423
Essex	469	429	511
Basildon	617	478	782
Braintree	466	343	619
Brentwood	*	-	-
Castle Point	432	299	603
Chelmsford	481	366	621
Colchester	467	353	606
Epping Forest	389	276	532
Harlow	*	-	-
Maldon	567	383	805
Rochford	488	331	691
Tendring	463	365	579
Uttlesford	537	371	750

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Adjusting for age profiles, there are higher rates of fractures in people aged over 80 in Braintree, Colchester and Uttlesford (figure 3b).

Figure 3a Hip Fracture in people aged 65-79 (rates) by district council area, 15/16

Area	Value	Lower CI	Upper CI
England	244	241	248
Essex	251	230	274
Basildon	351	276	440
Braintree	231	167	310
Brentwood	*	-	-
Castle Point	205	141	288
Chelmsford	283	217	362
Colchester	256	193	333
Epping Forest	195	134	275
Harlow	*	-	-
Maldon	253	166	370
Rochford	216	145	311
Tendring	265	209	331
Uttlesford	253	167	366

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Source PHE profiles

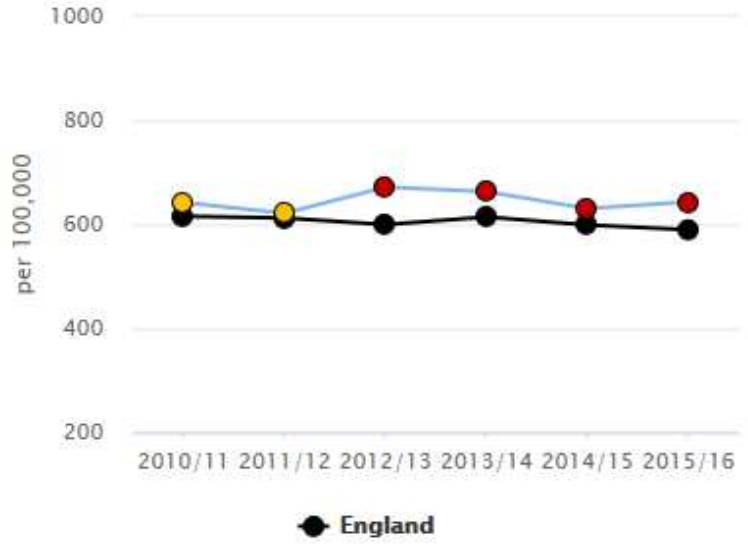
Figure 3b Hip Fracture in people aged over 80 (rates) by district council area, 15/16

Area	Value	Lower CI	Upper CI
England	1,591	1,575	1,606
Essex	1,779	1,686	1,875
Basildon	1,746	1,466	2,063
Braintree	2,080	1,767	2,433
Brentwood	1,903	1,528	2,343
Castle Point	1,772	1,423	2,180
Chelmsford	1,678	1,414	1,978
Colchester	1,899	1,611	2,223
Epping Forest	1,717	1,430	2,045
Harlow	1,409	1,053	1,844
Maldon	1,615	1,216	2,103
Rochford	1,676	1,322	2,094
Tendring	1,698	1,467	1,956
Uttlesford	2,107	1,702	2,578

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

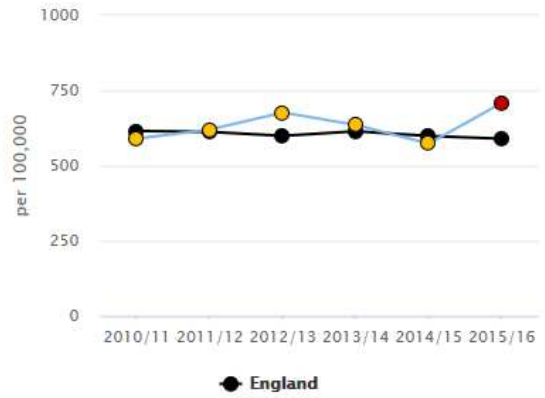
Figure 4 shows the trends over the past 6 years for Essex; Essex has had significantly higher fracture rates since 12/13. This was driven by Chelmsford, Epping, Harlow and Tendring in 12/13; Chelmsford and Uttlesford in 13/14; and no clear indication in 14/15; (data not shown). For 15/16 - the latest year available - this was driven by Basildon, Braintree and Uttlesford (figures 5a, 5b, 5c).

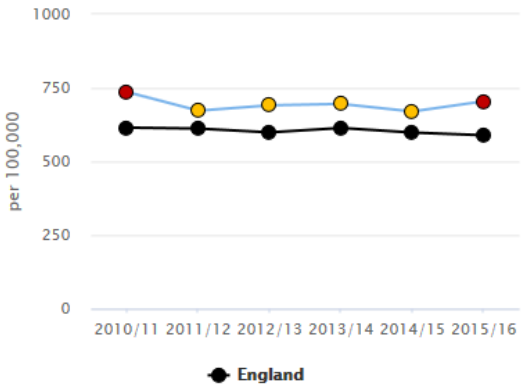
Figure 4 Essex hip fracture rates, time trends



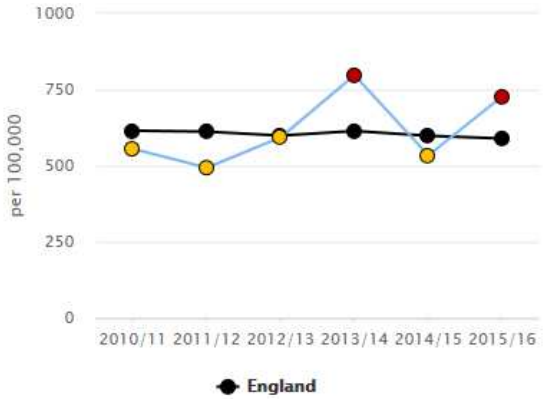
Source PHE profiles

Figure 5a Basildon trends; 5b Braintree; 5c Uttlesford, Hip fracture rates, time trends





Source PHE profiles



Presenting the data by district, age, sex and over time indicates no clear pattern within Essex district councils that drives the overall Essex rate above national average. Below is presented information on the risk factors for fractures and falls. We do not necessarily have data to map the distribution of these risk factors across Essex (except age and sex). That aside, these risk factors do not change drastically over single years in each district and so do not present clear reasons for the variation by geography by year.

Risk factors for hip fractures

- **Age**. The likelihood of hip fractures increases with age; this may be a combination of the factors below that also increase with age but also reflect the increase likelihood of falling such a poor vision or weakened balance.
- **Sex**. About 70 percent of hip fractures occur in women. Women lose bone density at a faster rate than men do, in part because the drop in estrogen levels that occurs with menopause accelerates bone loss. However, men also can develop dangerously low levels of bone density.
- **Chronic medical conditions**. Endocrine disorders, such as an overactive thyroid, can lead to fragile bones. Intestinal disorders, which may reduce absorption of vitamin D and calcium, also can lead to weakened bone and hip fracture. Cognitive impairment also increases the risk of falling.
- **Certain medications**. Cortisone medications, such as prednisone, can weaken bone if taken long term. Certain drugs or certain combinations of medications can make a person dizzy and more prone to falling.
- **Nutritional problems**. Lack of calcium and vitamin D in the diet when someone is young lowers their peak bone mass and increases their risk of fracture later in life. Serious eating disorders, such as anorexia nervosa and

bulimia, can damage the skeleton by depriving the body of essential nutrients needed for bone building.
- **Physical inactivity**. Weight-bearing exercises, such as walking, help strengthen bones and muscles, making falls and fractures less likely.
- **Tobacco and alcohol use**. Both can interfere with the normal processes of bone building and maintenance, resulting in bone loss.
- **Previous history of fracture**

Risk factors of falls

Medical Risk Factors	**Demographic Risk Factors**	**Environmental Risk Factors**
• Osteoporosis • Parkinson's • Diabetes • Stroke • Arthritis • Gait and balance deficit • Psychotropic medication use • Depression • Cognitive impairment • Personal history of fracture / falls • Family history of osteoporosis • Dementia / poor health / frailty • Poor vision • Use of oral glucocorticoids for > 3m	• Female gender • Older age • Caucasian • Low body weight and body mass index • Low calcium intake • Smoking / excessive alcohol intake • Low level of physical activity • Use of assistive devices • Impaired activities of daily living	• Home hazards such as lighting, slippy surfaces, trip hazards

Interventions that reduce the risks for falls and fractures

NICE recommends the following interventions to reduce the risk of falls:
- Screening
- Comprehensive assessment for those screened as high risk
- Home hazard assessment and home improvements
- Equipment
- Vision assessment and interventions
- Medicines review
- Strength and balance training
- Management of osteoporosis

There are also interventions relating to the primary prevention at earlier ages
- Early development of bone health eg nutrition and strength (in childhood)
- Building and maintaining strength and balance (in adulthood)

ECC has been funding falls prevention services across Essex since 2013 within the public health grant. The decision was made to decommission in June 2017 and providers are working out their notice periods. The decision paper to ECC Cabinet is enclosed

ECC is actively working with providers, voluntary sector partners and CCGs to look at alternative community led approaches to preventing falls. Some activity within the

falls prevention NICE guidance compliant multi-factorial Intervention can take place as part of other existing NHS and social care pathways. For example the service includes medication reviews, prescribing and vision assessments which are already funded by the NHS through general practice, pharmacy and opticians. Other elements of the service, such as home equipment assessments are already funded by NHS and social care under frailty assessment services. iBCF funds have been identified to continue the strength and balance training component for another 2 years.

We plan to minimise the impact of decommissioning the service through alignment of the falls prevention agenda with existing community resilience work streams, and adopting a community asset approach in line with the new ways of working outlined in the Public Health strategic approach. Regardless of the funding situation this is an opportune time to review delivery with a view to greater integration of provision and commissioning responsibilities as was always intended with the S75 approach.

Potential key lines of enquiry

I. What role can ECC – namely social care – continue to play with regard to falls prevention within its already commissioned services?

II. How do we reframe our intentions for falls prevention into the prevention and management of frailty more broadly eg holistic and integrated health and social care approach rather than seeing it as a separate service?

III. What are the opportunities for community resilience in the falls prevention agenda especially earlier intervention? Who are the key stakeholders to engage with?

ANNEX 2
Essex County Council
Overview and Scrutiny Committee
Extracts from Scoping Document

Health Overview, Policy and Scrutiny Committee (HOPSC)
and the People and Families Policy and Scrutiny Committee (PAF)

3 JANUARY 2018

WHAT ARE WE LOOKING AT?	
Review Topic (Name of review)	Hip fractures and falls prevention – social care and other support for daily living
Type of Review	Joint HOPSC and PAF Task and Finish Group

WHY ARE WE LOOKING AT THIS?	
Rationale for the Review	Essex as a county has statistically significantly higher rates of hip fractures than national average. Essex is the only area in east of England with a higher than national average fracture rate. The issue is relevant to the Council's strategic objectives and corporate priorities, namely that: (i) residents Enjoy Good Health and Wellbeing http://www.essex.gov.uk/Your-Council/Strategies-Policies/Documents/Enjoy_good_health_wellbeing.pdf (ii) people in Essex can Live Independently and Exercise Choice and Control over their lives http://www.essex.gov.uk/Your-Council/Strategies-Policies/Documents/Independent_living_choice_control_over_lives.pdf A member focus can approach the issue in a non-partisan way and provide challenge to the wider system on collaborative and partnership solutions. It can raise the profile of issues that may need a wider system approach.

WHAT DO WE HOPE TO ACHIEVE?	
Indicators of success	Through investigating aspects of the commissioning and provision of support in care/nursing homes, the intention of the review is to identify quality improvements and changes in standard operating procedures to further prevent the incidence of falls and hip fractures.

WHAT INFORMATION DO WE NEED?	
Terms of Reference	To consider the type of social care and other support available for daily living in more formalised settings that can minimise falls
Key Lines of Enquiry	(i) Does Essex County Council commission care homes/nursing homes with the safest environments? (ii) What is the attitude of care/nursing homes to risk management? (iii) What further quality improvements can be made to minimise the risk of falls and hip fractures?
What primary/new evidence is needed?	Informants: (i) PROSPER lead manager; (ii) care homes; (iii) service users; and (iv) site visits.
What secondary/ existing information is needed?	TBC
What briefings and site visits might be relevant?	(i) The work of PROSPER which works with care homes to embed a quality improvement ethos and roll out quality improvement methods. (ii) Site visits to a selection of care homes

Annex 3

EVIDENCE

Advance reading material/background reports and publications

1. Improving resident safety in care homes - Learning from the PROSPER programme in Essex – UCL Partners November 2016.

Written evidence during the review:

2. Briefing note from Maggie Pacini, Public Health Consultant – August 2017 - Briefing note on local rates of hip fracture to People and Families Scrutiny Committee.
3. Briefing note from Maggie Pacini, Public Health Consultant on the Epidemiology of falls and fractures – December 2017.
4. PROSPER newsletters.
5. Power point presentation on the methodology behind PROSPER (dated 2 February 2018.
6. Documentation provided at Community of Practice Day and PROSPER Champions Days referred to below.
7. Documents used by Mundy House Care Home to monitor falls.

The Group has met 5 times (the first two on 7 November and 15 December 2018 spent scoping the review) – and formal evidence sessions on 2 February, 12 March, 13 April 2018. The Group then met on 2 May 2018 and [other dates] to finalise this report and discuss conclusions with the Cabinet Member – Health and his deputy.

Oral evidence

Witnesses in the order of appearance:

Mike Gogarty, Director, Wellbeing, Public Health & Communities (briefing provided in advance of the formal review starting)
Gemma Andrews, Commissioning Support Manager, Essex County Council.
Maggie Pacini, Public Health Consultant, Essex County Council
Lesley Cruickshank, Quality Innovation Manager, Essex County Council
Rod Manning, Quality Improvement Officer. Essex County Council
Karen Williams, Placement Co-ordinator, Essex County Council.
Josi George, Manager of Mundy House Care Home, Church Road, Basildon SS14 2EY and other staff at the home.
Ryan Mooring, Manager - The Haven care home, 84 Harwich Road, Colchester CO4 3BS and other staff at the home.
Simon Evans, Category and Supplier Relationship Specialist, Essex County Council.
Jenny Peckham, Quality Innovation Manager, Essex County Council
Participants at PROSPER Community of Practice event on 15 February 2018 at Essex County Cricket Ground, Chelmsford.
Participants at PROSPER Champions Days held in Basildon, Colchester, Clacton and Harlow.

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Published – May 2018.

	AGENDA ITEM 8
	PAF/16/18

Committee:	**People and Families Policy and Scrutiny Committee**
Date:	**6 June 2018**
Enquiries to:	**Name: Graham Hughes** **Designation: Senior Democratic Services Officer** **Contact details:** 033301 34574 Graham.hughes@essex.gov.uk

WORK PROGRAMME

Briefings

Further briefings and discussion days will continue to be scheduled on an ongoing basis as identified and required

Task and Finish Group activity

A Joint Task and Finish Group (with the Health Overview Policy and Scrutiny Committee) looking at hip fractures and falls prevention has completed its review and the final report of the Group is attached elsewhere in the agenda.

Chairman and Vice Chairmen meetings

The Chairman and Vice Chairmen meet monthly in between scheduled meetings of the Committee to discuss work planning and meet officers as part of preparation for future items. The Chairman and Vice Chairmen also meet the Cabinet Members for Education, Children & Families, and Health and Adult Social Care on a regular basis

Formal committee activity

Items already programmed and/or being considered to come to full committee are listed in Appendix A.

Action required by Members at this meeting:

To consider this report and any further amendments/additions necessary.

People and Families Policy and Scrutiny Committee: 6 June 2018
Work programme (subject to further investigation, scoping and evaluation) for 2018/19 municipal year

Date/timing	Issue/Topic	Focus/other comments	Approach
		Items identified for formal scrutiny in full committee	
June 2018	Essex Education Services	Cabinet Decision FP/102/03/18 - Review of Essex Education Services	Consider a call-in of this decision.
June 2018	Care Market	Care Act duties and market shaping and sufficiency and looking at relationships with providers.	(i) Look at relationships with providers by reviewing actions arising from a November 2016 report on the issue and subsequent survey conducted. (ii) Identify any follow-up work and focus which may be conducted in full committee or by Task and Finish Group.
July 2018	0-19 Contract with Virgin Care	Review contract performance after a year of operation (KPIs, involvement of CVS etc).	(i) Initial private briefing in July on the rationale and aspirations behind the contract placement (joint with HOSC–PAF leads); (ii) Formal session then to follow to challenge performance. (iii) Identify any follow-up work and focus which may be conducted in full committee or by Task and Finish Group.
August 2018	0-19 Contract with Virgin Care	Possible date for follow-up work.	
September 2018	Safeguarding - Children	Rescheduled timing to align with publication of Essex Safeguarding Children Board Annual Report and future priorities	(i) Formal session to challenge performance and priorities (ii) Then more detailed update on looked-after children/Child Sexual Exploitation and gang culture.
October 2018	Safeguarding - Adults	Rescheduled timing to align with publication of Essex Safeguarding Adults Board Annual Report and refreshed business plan	Formal session to challenge performance and priorities.
November 2018	Young Carers	A new Young Carers Service has been delivered in-house by ECC from 1 April 2018. The Cabinet decision was called-in on but later withdrawn after an informal meeting with the Cabinet Member.	(i) Follow up on scrutiny report and recommendations (ii) Post-implementation review of new service (after six months after commencement of contract) as agreed as part of the withdrawal of the call-in during September 2017
April 2019	Educational Attainment	Annual update and discussion.	TBC
April/May 2019	School Places planning	Private briefing update held in May 2018 on refreshed 10 Year Plan and primary and secondary 'Offer day'.	Likely private briefing update – timing TBC

Task and Finish Group reviews

To be confirmed

Issues still under consideration and/or for further evaluation

TBC	Educational Attainment	Separate session to the scheduled Annual update to focus on specific issues raised at the time of the last Annual update	TBC.
TBC	The Care Market	Care Act duties and market shaping and sufficiency and looking at relationships with providers.	(i) Private development session held in November 2017; (ii) Further briefing on quality improvement initiatives planned for January 2018. (iii) Further review of relationship management (to be scheduled for June 2018. (iv) the personalisation agenda and the sustainability care provider workforce being scoped.
TBC	Learning Disabilities	A wide ranging cross-cutting issue – will need detailed focus if go beyond a preliminary briefing.	Private reparatory briefing from ECC officers on structures and issues in October 2017. Follow-up work TBC;
TBC	Disruptive children	Could look at the criteria for access to support services.	Further investigation with key officers necessary before being able to scope any review.
TBC	Gang culture	Identified by Cabinet Member as issue of concern.	Further investigation with key officers necessary before being able to scope any review.
TBC	Residential and Domiciliary Care	A previous Task and Finish Group made recommendations on recruitment, retention, staff training and raising the profile of carers in the community	TBC