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:

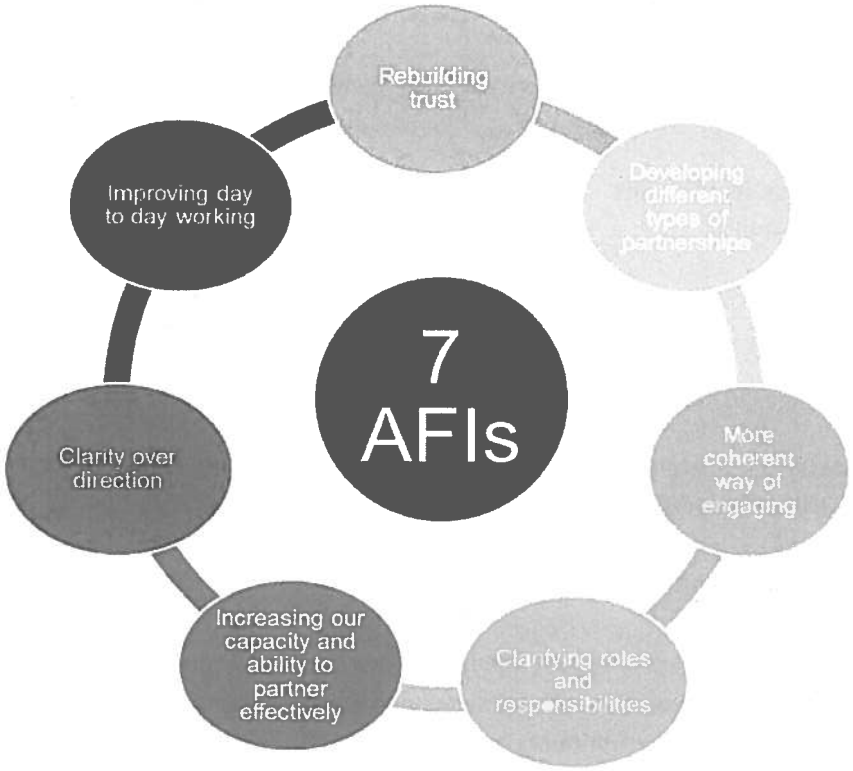
- A robust structure to support engagement work with the market;
- Creating a greater understanding as to what engagement actually means; and
- The skills (on both sides) to be able to talk and listen to each other more constructively.

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:

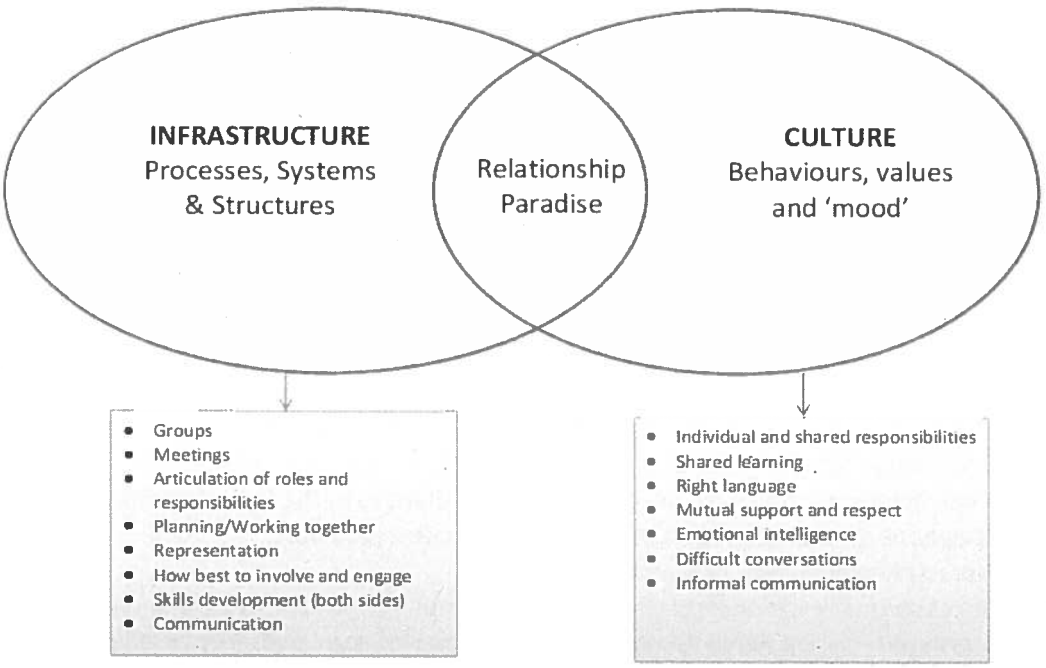


Fig 2: Model Showing the Need to Make Both Infrastructure and Culture Changes to Improve Relationships

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

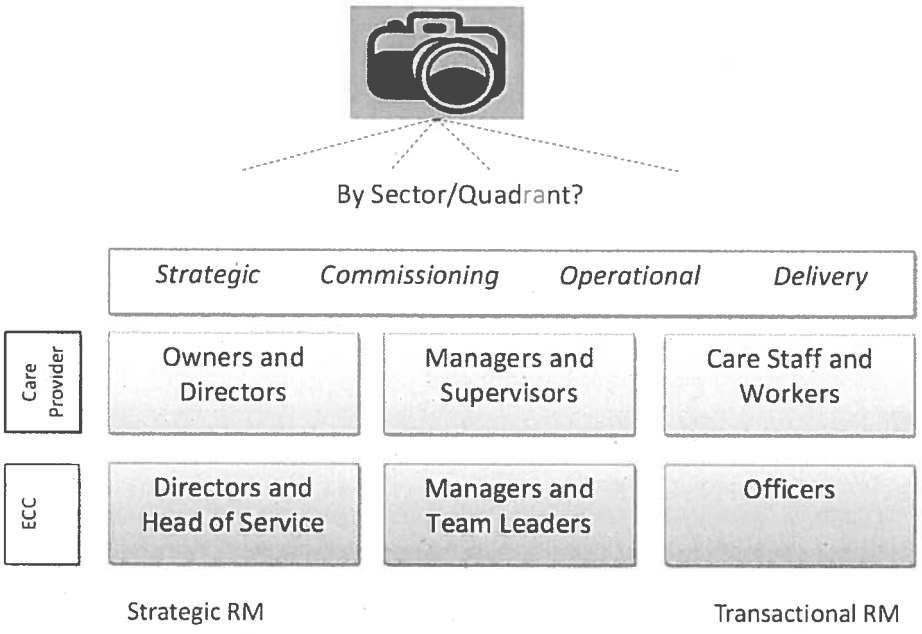


Fig 3: Strategic and Operational Relationships

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.

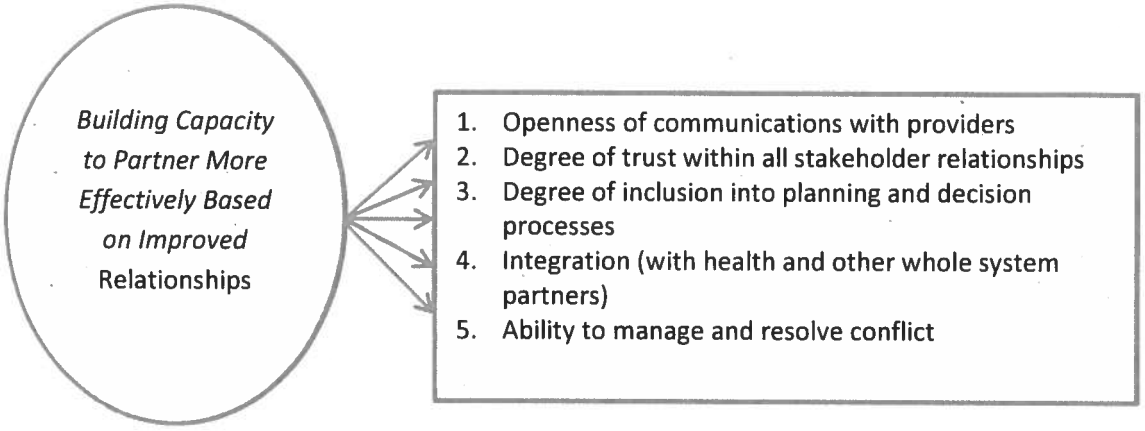


Fig 10: Five Elements to Improve Partnering

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.

<u>Leadership – Both Care Providers and ECC</u>

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)

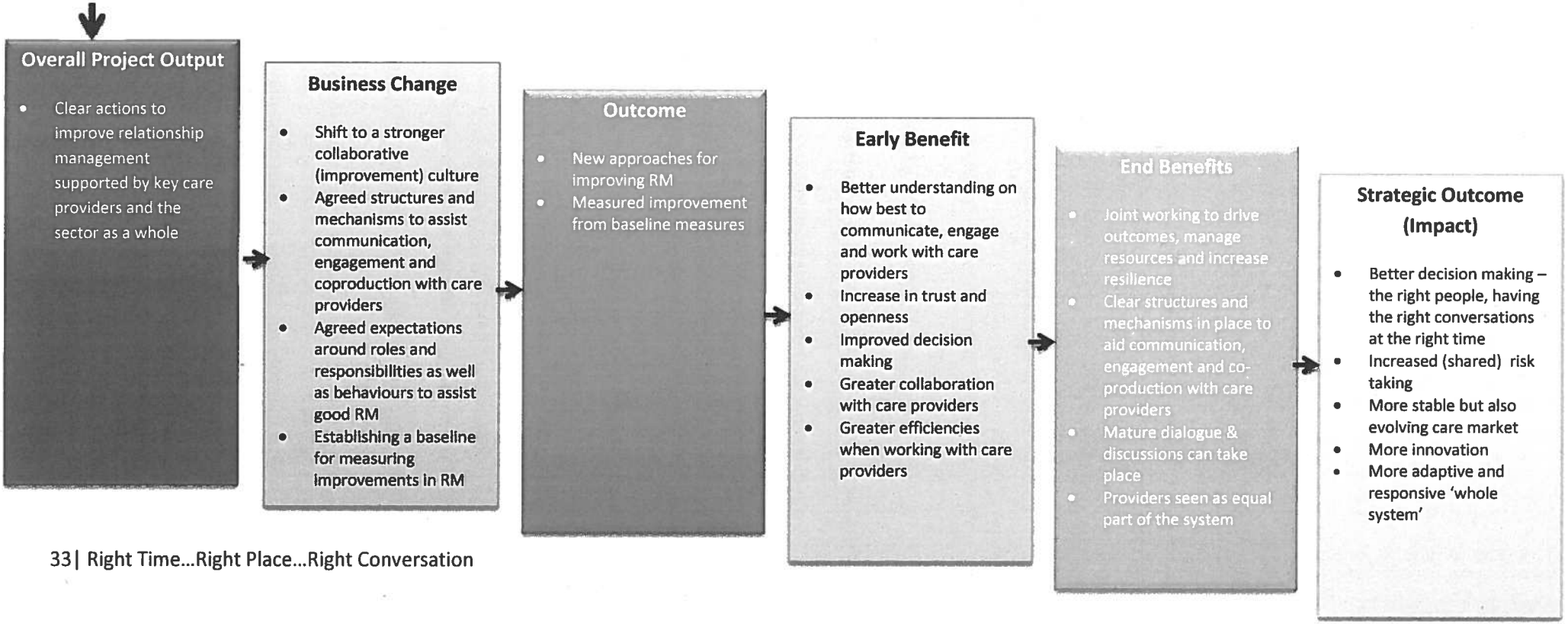
Appendix C

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



Appendix D

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.

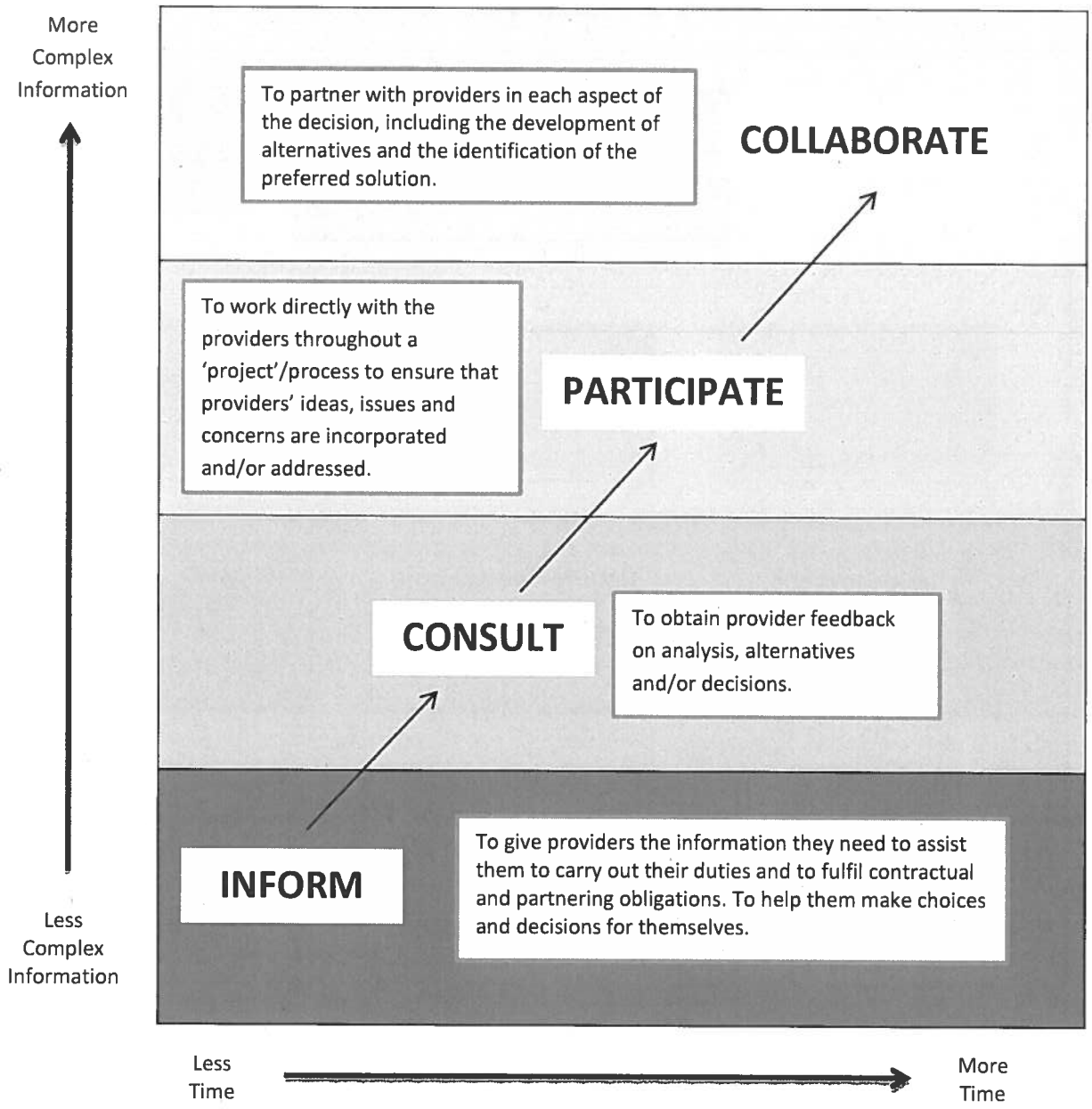
Appendix H

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

Appendix I

Modes of Engagement[7]

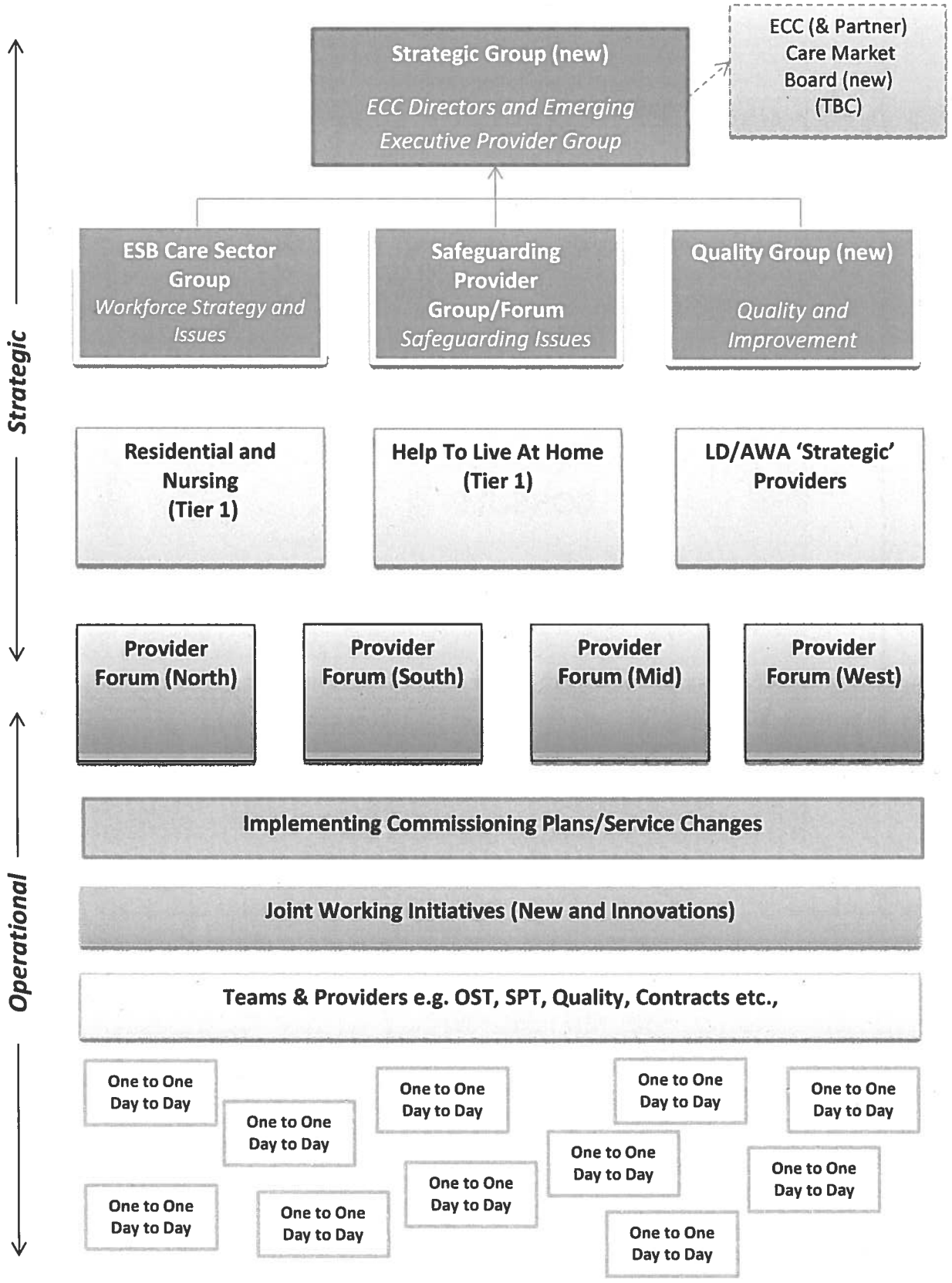


Mode of Engagement	How
Collaborate	Referendum, deliberative forum, open space, advisory panel, action research, appreciative enquiry
Participate	Participatory workshops, reference group, jury, search conference, action research, appreciative enquiry
Consult	Response to questions, consultative workshops,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

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

Appendix J

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



Appendix K

The 'Four Box' Model of Quality