Adult Social Care Local Account

2023 - 2024

worcestershire county council

Contents

Introduction

Welcome to the Local Account for Adult Social Care in Worcestershire. This report is a summary of what we have achieved to support people across the county during the last year, how we have invested public money, what you - the residents and carers we support have told us, and importantly, what we aim to do in 2024/25.

Worcestershire is a great place to live and work! We are thankful for our dedicated and compassionate workforce, our excellent partners in the NHS, voluntary organisations, Primary Care Networks, district councils, providers, and carers.

Adult Social Care is part of the Adults and Communities Directorate within the County Council, and we are committed to enabling people to live their best lives and to improve their health and wellbeing and we believe this can be achieved by ***'building together to live a good life'***.

In Worcestershire, we know that everyone is different, so we offer a broad range of services to support the lives of people who need assistance.

This report shines a spotlight on some of the services we offer, and we share our aspirations of how we continue to improve our services based on your feedback.

We know that providing high quality services means working together with people, families, communities, and local partners. We have a strong sense of community across our county and our partnership work places us in a strong position to focus on the challenges presented to us.

We hope you will find this report both interesting and helpful in providing understanding about what we do, what progress we've made, and what challenges we're facing.

Mark Fitton
Strategic Director for Adults and Communities

Councillor Richard Morris

What is Adult Social Care?

Who do we provide services to?

Adult Social Care (ASC) is the support we offer to adults of all ages to help them live an independent life.

Social care may be available to adults of all ages including young people moving into adulthood and those of working age-with a diverse range of needs (people with a learning disability or physical disability, older people, people with mental health conditions, people who are neurodiverse, people living with dementia and other long-term conditions such as frailty).

Care and support cover a wide range of activities to promote people's wellbeing and support them to live independently, staying well and safe.

How we meet people's needs?

The Care Act 2014 sets out our responsibilities as a local authority for understanding and meeting people's needs.

Support can be delivered in a variety of ways including our in-house services, services that we buy from other social care providers, the community and voluntary sector, or by support from family and friends providing informal care.

Many people directly employ individuals ('personal assistants') to provide their care and support, funded using a direct payment from the council instead of receiving care provision from a council appointed care provider as a matter of choice.

We are responsible for making sure that people can choose how their support is provided, that it meets their needs, is well coordinated and effective.

We have a duty to ensure that there is support available in Worcestershire to meet the needs of local people. Some people may have to pay for all the support they need or part of it, depending on their financial circumstances.

Our key statutory duties

As a local authority, we are classed as a statutory organisation. This means we have a legal responsibility to do something, and our role and powers are defined in law.

Our responsibilities are defined in the Care Act 2014. Specific duties that we are responsible for relate to:

- Provision of social care (assessment of individuals' and carer's needs, providing care and support plans, a duty to meet the needs of someone assessed as eligible for care and support);
- Promoting wellbeing;
- Preventing the need for care and support - providing information and advice;
- Protecting adults from abuse and neglect (safeguarding);
- Promoting health and care integration, and
- Market shaping (quality, choice, ensuring we have enough resources to provide services).

Adult Social Care Priorities

Our Vision

We enable people to live their best lives in a place they call home. We put people at the heart of everything we do, providing the right support, in the right place, at the right time. We work in partnership with local people, building thriving and connected communities where everyone feels included and safe. We offer easy access to high quality and efficient support when needed. We are future-focused to deliver this vision.

How will we do this?

Collaborating with our partners will enable delivery of integrated health and social care services which improve access, choice and promote independence and opportunities for the people of Worcestershire.

Our commitments to people who need to access our services

Providing the right support, in the right place, at the right time.

We will offer care and support that is coordinated and enables individuals to live as they want to, being seen as a unique person with skills, strengths, and goals.

We will enable people to make informed choices to manage their health and wellbeing at a time and place that's right for them.

Working in partnership with local people.

We will work together across Worcestershire to provide a holistic approach to the health and care needs of our community.

We will support people to feel connected to their community and ensure their feedback and experience is used to shape services and make changes.

Being Future-Focused.

We will understand and respond to the many changes and opportunities that face social care, now and in the future.

We will work with people and our partners to maintain safe systems of care, making safeguarding personal by concentrating on improving people's lives.

For full details of Worcestershire's Adult Social Care Strategy or to request information in another language or format please email: **Peopleexecassistants@worcestershire.gov.uk**

Adult Social Care Customer Journey (How does ASC work in Worcestershire?)

By Phone	By Professional/Carer Referral	Referrals from the public
01905 768053	Referrals from Professionals	Adult Front Door Referral

How can I help myself?

The customer journey begins with someone thinking about how they can help themselves. There are lots of available resources in the community such as family and friends, voluntary organisations, libraries, community centres, or the internet. We also have a detailed **Community Services Directory** for local services and organisations which may be able to help you.

Advice and Signposting from our Adults Front Door

The Adult Front Door provides information, advice and guidance. An Adult Front Door advisor will help the person get the right information for their specific needs and can signpost them to relevant external services or organisations if required.

Short Term Support

Adult Social Care offer a range of short-term support to promote and enable independence, this includes our Targeted Adults Support Teams (TAST) who work with residents to offer a targeted package of support designed to prevent, reduce, and/or delay residents' needs reaching the point where Adult Social Care support is required.

Long Term Support

Area Social Work Teams

Works with adults over 18, they will explore the provision of support such as home support, day opportunities, supported housing, respite, residential care and seek to maximise an individuals independence where possible.

Mental Health Teams

A multi-disciplinary team that works with adults with mental health conditions to support recovery. The team provide a broad range of interventions to support the individual and their family and work closely with other organisations such as the NHS to provide a holistic approach to support.

Safeguarding Team

A specialist team who works with adults over 18. The team will initially consider (triage) the concern and act accordingly to protect adults who are being abused or are at risk of being abused.

Approved Mental Health Professionals

Approved Mental Health Professionals may be qualified social workers, nurses, occupational therapists, or psychologists who have gained an additional qualification which allows them to undertake the Approved Mental Health Professional Service role.

Approved Mental Health Professionals undertake Mental Health Act assessments alongside authorised doctors and can make an application under a section of the Mental Health Act to detain a person in hospital for a period of assessment or treatment if required.

Learning Disabilities Teams

A multi-disciplinary team that works with adults with learning disabilities to promote independence. The team provide a broad range of interventions to support the individual and their family.

Hospital and Reablement Team

Reablement is a service provided at the individual's home and aims to promote and maintain an individual's independence and reduce the need for formal care and support services.

Young Adult Team-Preparation for Adulthood

Supports adults turning 18 (or about to turn 18) until age 26, they will explore the provision of support such as home support, day opportunities, supported housing, respite, residential care.

Adult Neurodiversity Team

The team work alongside people over the age of 18 diagnosed with a neurodiversity, (autism, associated conditions, or learning difficulties) that have presenting needs in accordance with the Care Act 2014 and maybe at risk of significant harm associated with diagnosed learning difficulties.

The team promote independence and recovery through signposting and encourage self-reliance and community support aligned to the recently published **Autism Strategy**.

Out of Hours Support

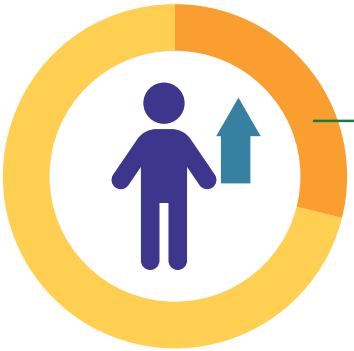
Emergency Duty Team

The Emergency Duty Team (EDT) provides an out of hours response, on behalf of Worcestershire Social Care Services and Herefordshire Children's Services, to emergency situations that arise outside normal Social Care office hours.

The challenges facing Adult Social Care in Worcestershire

Worcestershire has an adult population of 485,737. Our population is older than the national average with 1.5% of the adult population receiving support from Adult Services. The population is growing and more of us can expect to live longer.

Demand for Adult Social Care is growing



29%

Increase by 29% by 2038.

The number of adults (aged 18-64) requiring care is forecast to increase by 29% by 2038.

57%

Increase predictions of over 65 year olds may require support

For people over 65 years old predictions are even higher at a 57% increase in people who may require care and support.

More people are living with long term conditions

Many of us will be living with two or more long term health conditions at any one time. However, we are also living longer, and our needs may become more complex as we age. This can make care and support more difficult in later life.

Costs are rising

We know that the costs of delivering care and support are rising. Currently £16.5bn is spent by Local Authorities across the country and all are seeing increasing demand and complexity of needs of their population. In 2023/24 Worcestershire County Council spent £309m on services for adults with a net budget for Adult Social care of £145.8m, (after the deduction of grants and income received).

Workforce pressures

Nationally across social care there are significant staffing challenges. In 2023, the national social care vacancy rate is reported as 9.9% (approximately 152,000 vacancies) particularly regarding specialist roles such as Approved Mental Health Professionals, Social Workers and Occupational Therapists.

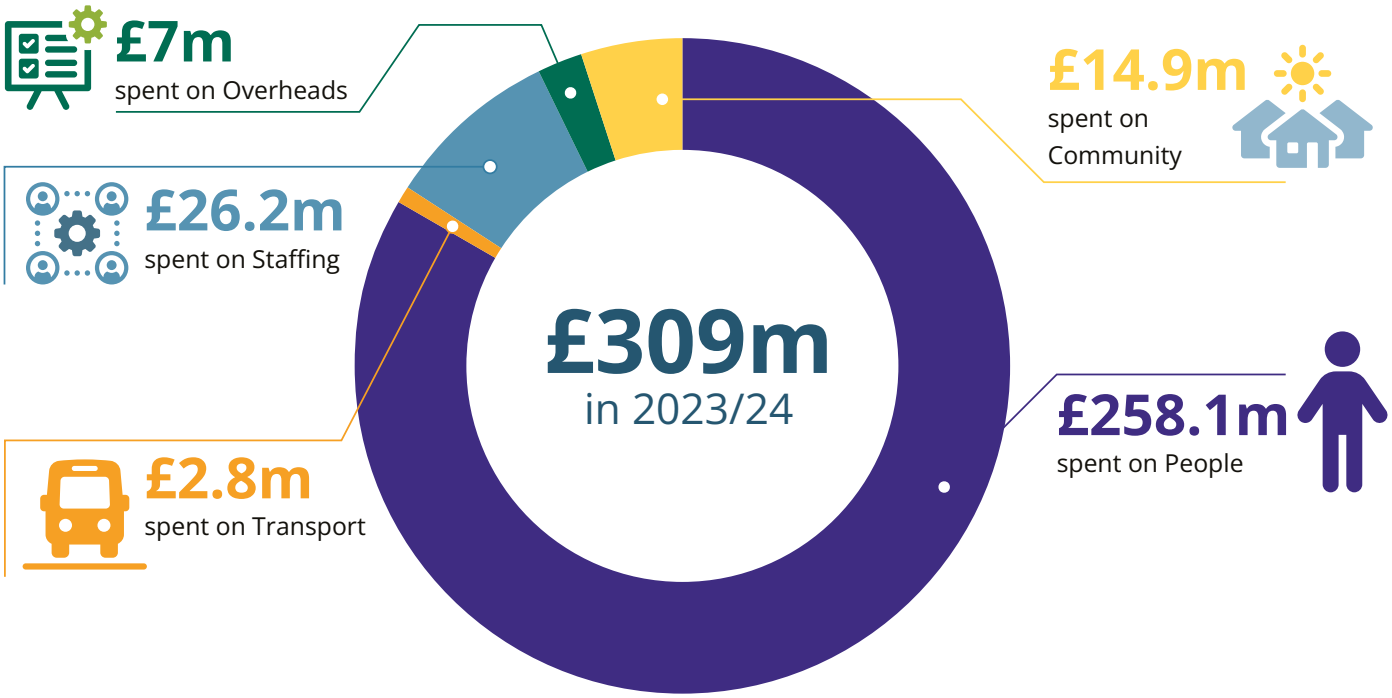
We have experienced challenges finding the people that are needed to deliver the services we provide, but we have always maintained safe staffing levels and are supported by our Council's Workforce Strategy.

Despite these challenges, we believe we can overcome them by working together as a whole system with the community, our partners, carers and the people of Worcestershire. The illustrations on the next few pages highlight the challenges we face:

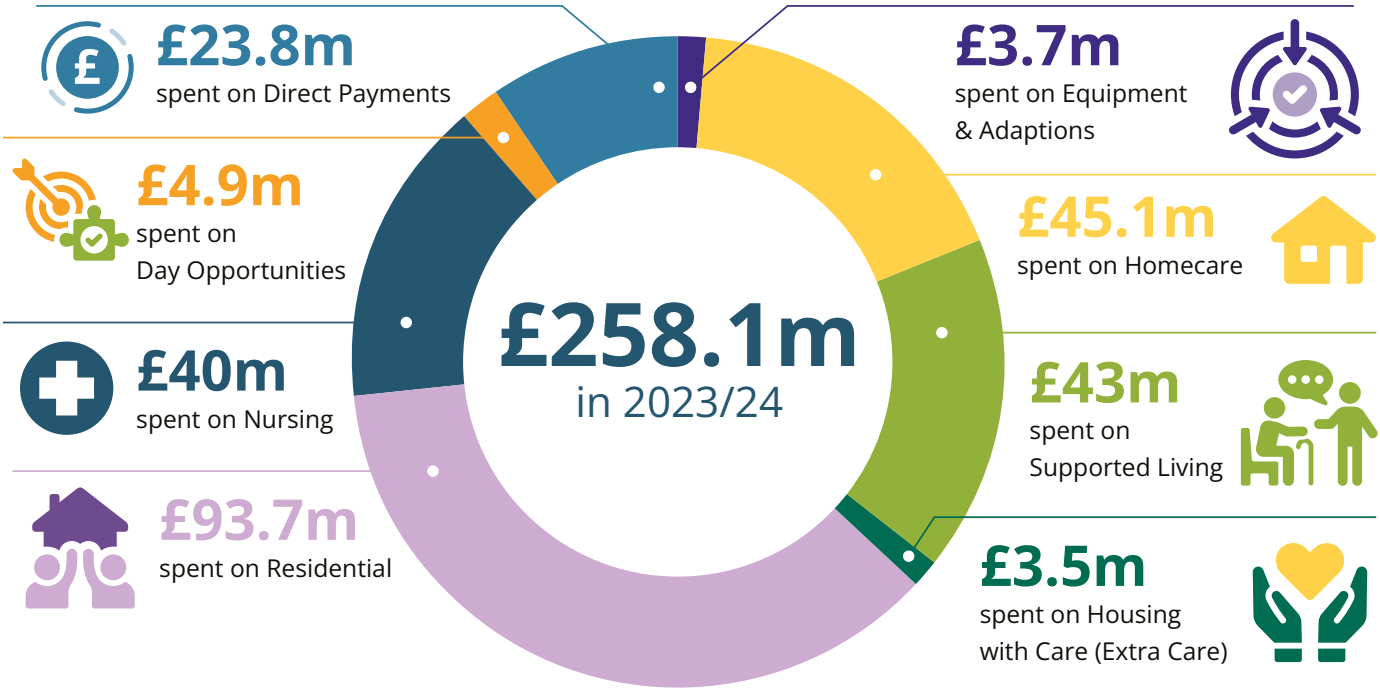
- **Budget** – How do we spend our money.
- **Activity** – Facts and figures about the services we provide.
- **Our demographics** – The needs of Worcestershire residents.
- **Our workforce** – The people that provide support where required.

Budget

The gross Adult Social Care spend (minus any income we receive) was **£309m in 2023/24** compared to **2022/23 spend of £272m**.



The 'Spend on People' referred to in this chart is **£258.1m**. This increased from **£231.2m in 2022/2023**. 'Spend on People' is money directly spent on the provision of care.



Activity Data

People receiving support

Adult Social Care receives many requests for support daily. Our aim is to maximise independence and enable people to live their best lives and improve their heath and wellbeing. All contacts are managed by our Adults Front Door team.

26,444
new requests for support were received during the last year.

6% ↑
of these requests resulted in a long-term service (a 1% increase on last year's 5%).

73% ↑
received a service to promote independence (an increase of 19% from last year, which demonstrates the effectiveness of our Adult Front Door and Targeted Adults Support Teams)

84% ↑
of people do not need ongoing services after short term services to promote independence.

27%
of people are in receipt of services on 31st March 2024, an increase of 6% from last year.

89% ↑
of people receive an annual review of their care and support needs.

73
people transitioned from Children's Services to Adult Social Care services compared to 79 last year.

Carers receiving an assessment

A carer is someone who provides unpaid support and care to an adult (aged 18 or over) who is ill, frail, disabled or has mental ill-health or substance misuse problems. A carer may be a relative, partner or friend and may provide emotional support, medical care, personal care, physical care and/or domestic tasks.

The number of carers identified in Worcestershire was 52,736 in the last census in 2021. Of this figure **51,754** are adult carers and **982** are young carers and young adult carers.

1243 ↑
carers received support, an increase of 5% from the previous year.

1889
carers had their needs assessed or reviewed in 2023/2024.

Safeguarding

Protecting adults to live in safety, free from abuse and neglect is a core duty of all health and social care agencies. Members of the public and professionals are required to report safeguarding concerns to Adult Social Care if it is believed that a person with care and support needs is experiencing or at risk of abuse or neglect. The rising rate of safeguarding concerns reported suggests people know how to report abuse. The number of concerns addressed without the need for an enquiry indicates that safeguarding concerns are reported when an alternative response is required.

4455 ↑
safeguarding concerns received, an increase of 543 concerns from previous year.

27%
the rate of concerns that led to an enquiry, down 11% from last year.

1025
Section 42 Safeguarding enquiries commenced, a decrease from 1309 the previous year.

82% ↑
of people were asked about their outcomes, an increase from 73% last year.

1305 ↑
completed safeguarding enquiries were undertaken in the year compared to 1141 last year.

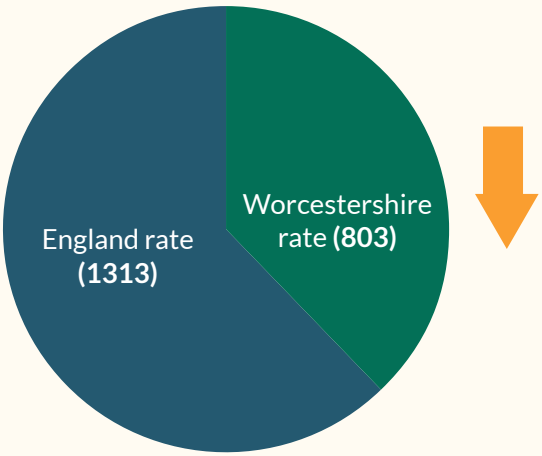
99%
of people fully achieved/partially achieved outcomes, which remained the same as last year's figure.

We continue to closely monitor our all activity and have recently reviewed and implemented new ways of working to improve our systems and processes.

How do we compare?

Worcestershire has a lower rate of concerns per 100,000 population in 2022/23 **(803)** compared to the national rate in England in 2022/23 **(1313)**. Worcestershire has a lower rate of enquiries started in 2022/23 (269) compared to England in 2022/23 **(387)**.

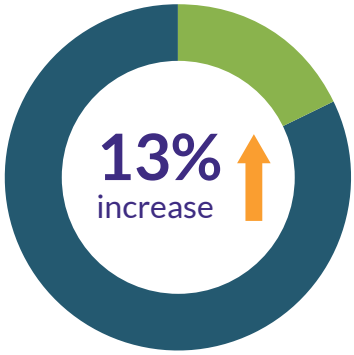
Worcestershire has been able to reduce waiting times and continues to work hard in this area. 2023/24 comparator data is due to be published in Autumn 2024 on:

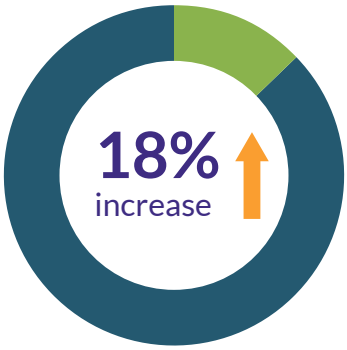


Safeguarding Adults, England, 2022-23 - NHS England Digital.

DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005.
The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.





3963 ↑
DoLS applications were received, which is an increase of **13%** from last year.

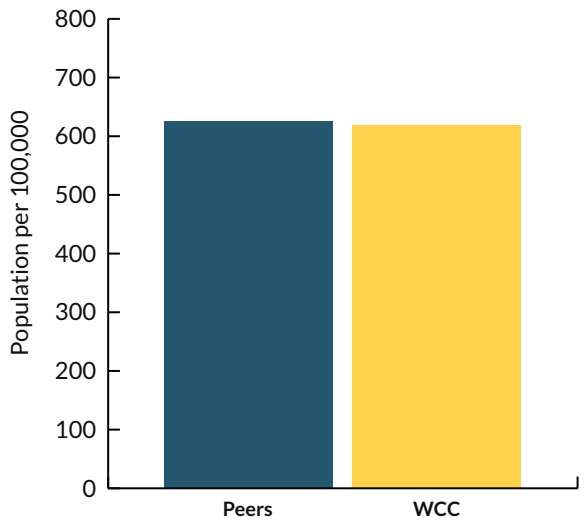
3933 ↑
DoLS applications were completed, which is an increase of **18%** from last year.

1549
people are waiting for an assessment as of 31st March, of which **406** are classed as high priority.

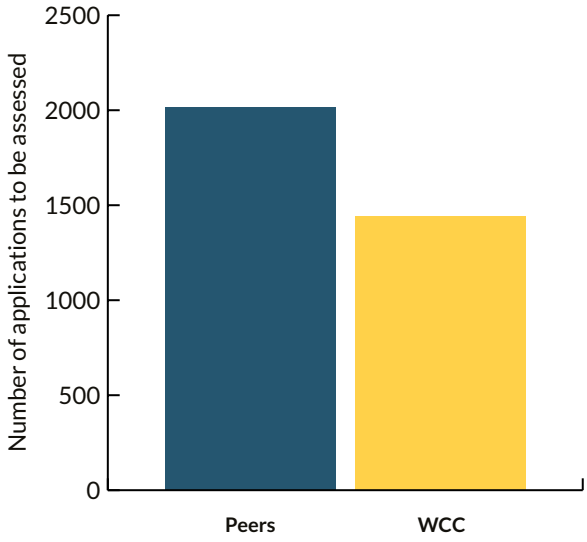
How we compare

Comparator information will be published at the end of 2024 however, we know that last year we received just below the average number of applications per 100,000 population compared with nearby local authorities. We are also just below our neighbouring local authorities regarding the average number of applications completed per 100,000 of the population (peers 625 and WCC 618).

Average number of applications completed for DoLS among local authorities



Average number of applications waiting to be assessed for DoLS among local authorities



We have worked hard during the year to reduce waiting times for people and are proud that we are well below the average on the number of applications waiting to be assessed (peers 2016 and WCC 1440). We continue to work hard to further reduce waiting times for people.

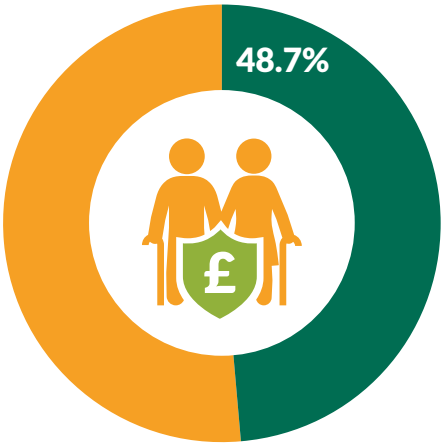
Our Demographics

Worcestershire's population is growing and changing.

Worcestershire has an adult population of **485,737**. The Council's Adult Services supports **1.5%** of the adult population, of which the majority, **61%**, are older residents.

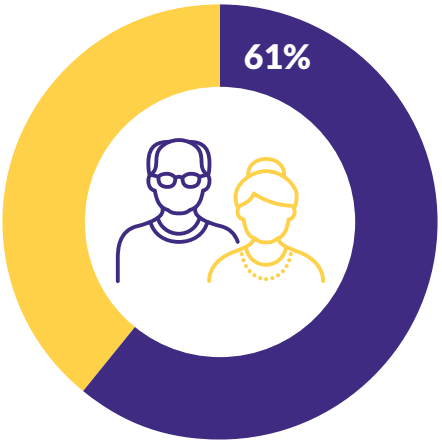
485,737
is the adult population in Worcestershire county.

This number is forecast to increase by almost **3.7% in the next 5 years**. Around **48.7%** of adults needing care in a care home can fund the costs of this care themselves (known as self-funders).



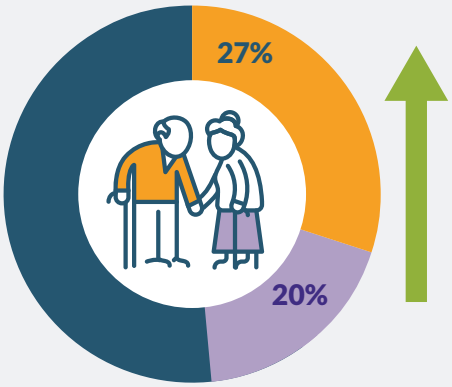
48.7%
of adults needing care in a care home can fund the cost themselves

1.5%
of the adult population is supported by the Council's Adult Services



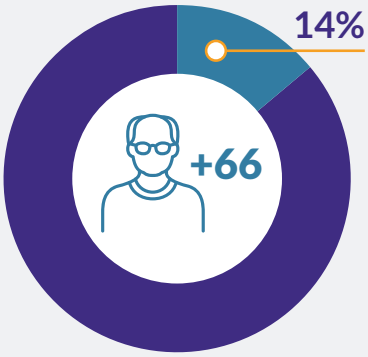
61% of the **1.5%** adult population is older residents.

The 2021 Census shows:

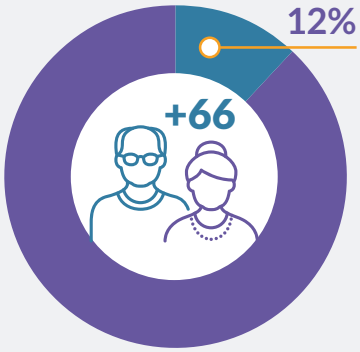


Worcestershire maintains a higher proportion of older people than the national average which has seen a **27%** rise in 65+ population compared to national average increase of **20%**.

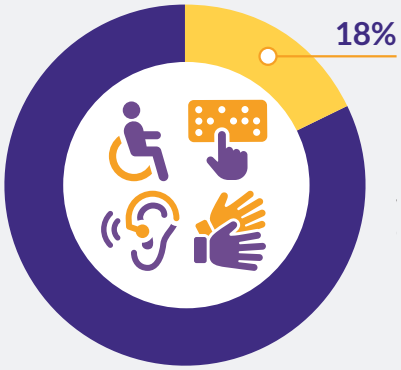
The number of people in receipt of funded Adult Social Care is increasing year on year. **7,128** adults in Worcestershire are currently receiving a monthly service, of which **60%** are aged 65+.



37,100 (14%) one person households aged 66+.



31,600 (12%) one family households, all occupants aged over 66.



18% of people in Worcestershire have a disability under the Equality Act.

Almost **44,000** people **(7.2% of the population)** have a disability with their day-to-day activities limited substantially.

Our Workforce

989
Internal Staff

81% female
19% male

Average age of workforce is
47 YEARS

45%
workforce aged over 50

95%
workforce is white

Vacancy rate is **31%** in Mental Health,
38% in AHMP and
10% in remaining teams

4.89%
of workforce is minority ethnic

Leaver rate is
6.96%
(113 people)

New starter rate is
26%
(252 people)

The wider Adult Social Care workforce in Worcestershire amounts to
12,000 jobs
which includes staff working in **255** CQC registered establishments.

Equality, Diversity and Inclusion (EDI)

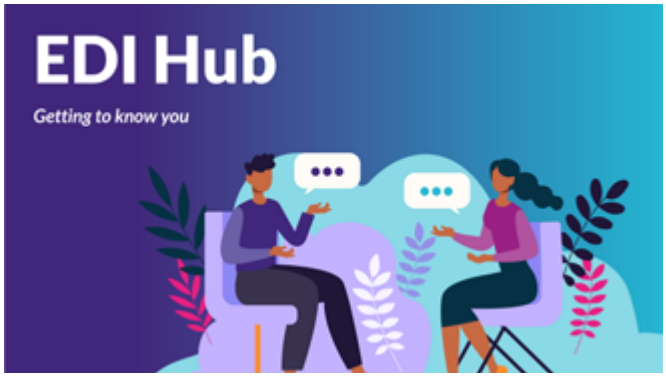
Within the Council and Adult Social Care we have had a strong focus on Equity, Diversity and Inclusion (EDI) and in the last year we are proud to have developed a comprehensive action plan to improve co-production and better collaboration as part of the overall Council's EDI Strategy, to comply with our Public Sector Equality Duty.

We have established an Adults & Communities Directorate Equality Group who contribute to the development of plans to improve how inclusive and accessible the services we provide are and how we support our workforce.

We have an established coaching and mentoring programme in Adults Social Care. We are committed and proud to support the 'Moving Up' programme, which supports Black and Asian colleagues who are managers or aspiring managers to further develop their skills and potential.

We have created bespoke training to ensure awareness and understanding for our staff for Gypsy Roma and Traveller communities, this course was co-produced and well received and we will evaluate what impact this has had in practice.

We have strengthened our social media engagement via targeted groups and forums, such as our Building Together Co production group, through external events and activities and through partnership working directly with relevant impacted groups and communities.



We developed an EDI Hub on our intranet for resources, learning and support for colleagues and we launched two staff networks to hear from marginalised colleague groups.

Signing the Race at Work Charter has also seen an increase in awareness of anti-racism and our commitment to improve in this area.

We continue to commit to a data driven approach to understand diversity and intersectionality, of both our service users / residents and colleagues.

Our **Annual EDI Report** will be strengthened by analysing data from the census, and colleagues disclosing their protected characteristics.

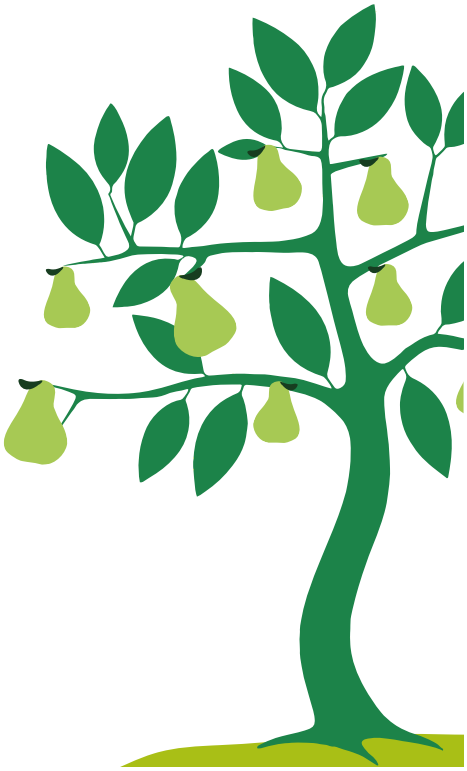
We have amended our staff demographic categories to align with census data, to enable us to make measured comparisons, and new data collection methods and increased understanding of accessibility, along with new systems to support attraction, recruitment, and retention will allow us to improve and analyse demographic information and make impactful change through our EDI action plans.

Key achievements

The previous pages shared some of our data and comparisons across several areas of performance. The data highlights that Worcestershire supports a high number of people with ongoing care and support needs and due to the complexity of need, a substantial amount is spent on Adult Social Care.

People Directorate
Guiding Principles

Partnership	Listening to and engaging with people, communities and partner organisations
Enabling	Empowering people to have control over their lives
Accountable	Being accountable and transparent in the service we provide
Respectful	Respecting diversity in our communities and workplace
Strengths	Working with people's strengths and assets to determine outcomes



We are aware that we need to change our focus to support people to be as independent as possible, we have started this work by developing an Early Intervention and Prevention Strategy with three key priorities:

'Reducing Loneliness and Social Isolation'

'Living Life Well'

and providing people with good quality **'Advice, Guidance and Information'.**

This will enable us to support people where independence has been lost or reduced, work with people to regain skills and where levels of independence have been limited we will work with people to improve this. Our goal is for people to, where possible, live independently within their own homes and have the knowledge and information to **'Live Life Well'.**

The examples in this report give an overview of how we have delivered this approach to date, aligned to the commitments in our **Adult Social Care Strategy 2023-2028**. This work has been underpinned by our guiding principles which is embedded into our practice and puts the individual at the heart of everything we do.

Case Study 1: Providing the right support, in the right place, at the right time

> **Offering care and support that is coordinated and enables individuals to live as they want to, being seen as a unique person with skills, strengths and goals.**

Two young adults who are siblings live with their parents in Worcestershire. Both siblings are autistic, have a learning disability and selective mutism and have been home schooled for several years. Recently both siblings have been experiencing anxiety and the Child and Adolescent Mental Health Service (CAMHS) have been supporting the family.

What was the situation?

The siblings had started to refuse support from their parents and other professionals regarding their daily living activities and were becoming more upset the harder people tried to help.

They had stopped wanting to participate in education and would not attend any health appointments. As such they had become isolated and withdrawn, not leaving their home or participating in their normal hobbies and interests.

Their needs were very similar and at times the siblings would only communicate to each other and no one else, as such the family felt the siblings were being treated the same rather than as individuals with their own unique skills, strengths and goals. The family were struggling to cope and didn't feel they had the right support to enable them to move forward.

What did we do?

Hayley, the allocated worker, met with the family and completed a social work assessment. At the initial visit she talked to the family and asked them what they wanted to achieve.

The parents were clear about the need for additional support to enable them to continue to look after their children and to help the young people reach their full potential. Whilst the siblings were part of the visit, it was clear that they were distressed by the presence of a new person in their home, and all felt that having an allocated family worker from the Young Adults Team to provide regular visits and support would help build a rapport with the siblings and reduce their anxiety about working with new people.

Work was undertaken with education colleagues to look at ways to engage the young people back into home learning ensuring that the individual needs of the siblings was central to moving forward.

With the consent of the parents and discussion with the young people, medication was prescribed to reduce their anxiety which was impacting on all aspects of their life. The parents felt that the support was coordinated and personalised to their needs through regular meetings, agreed goals and targets. Visual aids were used to support the siblings and ensure that they had a voice and were part of all decision making.

What difference did it make?

The support provided to the parents gave them the knowledge, skills and confidence to further support and develop their children. The siblings began to engage and participate more in their daily activities.

The trust and rapport they built with the family support worker made a positive impact from the first visit where they struggled to maintain eye contact and had very little communication, to two young people who were able to verbally express how much progress they had made over the recent months.

How are things now?

The support provided over the months has had a positive impact on all members of the family, to the point that they no longer need social care and feel confident and able in their own abilities without the need of social care being involved.

The siblings are now engaging in community activities and utilising public transport with the support of their father.

They have a new routine in place which enables them to be independent from their parents and are engaging with home learning.

Both young people are growing as individuals and exploring their own identities which are encouraged and supported by the family and other professionals involved.

The family have had increased support from their GP and CAMHs are offering individual sessions to the young people to enable them to live as they want to, being seen as a unique person with skills, strengths and goals.

Case Study 2: Providing the right support, in the right place, at the right time

> **Enabling people to make informed choices to manage their health and wellbeing at a time and place that's right for them.**

Kyle is a single person who lives alone in his one-bedroom flat. Kyle describes himself as sociable and hard working, with two grown up children.

What was the situation?

Kyle was experiencing insomnia and anxiety; he was having frequent panic attacks particularly when he left the house. Kyle had no hot water as he didn't feel able to let the housing association enter their property to perform the required gas checks.

Kyle's insomnia left him exhausted, this coupled with some physical health issues at the time meant that he had struggled to keep his home free of clutter. Kyle often drank alcohol due to increased feelings of loneliness and felt trapped in his situation.

What did we do?

Kyle attended an appointment with his GP who recognised he would benefit from additional support. A Social Prescriber from the surgery contacted the Adults Front Door who contacted Kyle to discuss what was working well for him and explored any areas he felt he needed support with. During this discussion, the Council provided information, guidance and information focusing on Kyle's strengths rather than what his was struggling with.

At the end of this conversation Kyle was signposted and referred to several voluntary agencies to enable him to progress with the outcomes he wanted to achieve. This included help to access public transport, support with his finances including bills and access to schemes that provide short term grants.

He was able to access a voucher to promote and access physical activities and practical support to work through unopened correspondence in his home. Kyle was also referred onto some health services, to provide some therapeutic intervention and look at aids that may assist his daily living. The Targeted Adults Support Team (TAST) coordinated the support and made onward referrals, they provided Kyle with information for local social groups in the community and provided short term intervention to give Kyle the confidence and support to move forward with the information, advice and guidance provided.

What difference did it make?

Kyle built up his confidence and began accessing a local support group, he also started doing his own shopping and have even accessed a train to travel further afield independently. He is attending their local gym and is also swimming.

There have been positive changes in Kyles physical health as his fitness has improved significantly and this has given him more confidence which has also improved his mental wellbeing.
This support has changed Kyles life.

Without it, it is likely his physical and mental health would have continued to decline, it is likely he would have continued to rely on alcohol and his living condition and financial situation would have deteriorated further.

How are things now?

Kyle expressed that being able to use the gym has changed his life, he feels happier, fitter and less isolated. Kyle has said that he is sleeping better for the first time in 5 years and has made new friends with whom they enjoy socialising with. Having meaningful friendships and support in the community has enabled Kyle to stop drinking heavily and embrace life taking control and making positive choices about his future.

Case Study 3: Working in partnership with local people

Enabling people to make informed choices to manage their health and wellbeing at a time and place that's right for them.

Mohammad is a 28-year-old male, who has complex emotional needs due to severe childhood trauma. He has spent many years in hospital due to extreme self-harming behaviour and suicidal ideation.

What was the situation?

Mohammad wanted independence and to leave the hospital ward and move into his own place. It was acknowledged that in doing so he would need support to keep himself safe and build confidence and skills to undertake aspects of daily living.

Specialist mental health Social Workers, collaborated with NHS ward staff and housing colleagues, to identify a local provider who could meet Mohammads needs, however, many local providers felt they could only do this by providing 24 hour care with three staff on duty. All professionals involved recognised that this was a very restrictive approach and would not enable Mohammad to reach his full potential and regain his independence, which was his desired outcome.

What did we do?

Working closely with Mohammad to understand his needs, professionals ascertained that the more staff that supported him resulted in increasing his levels of distress and as such, increased self-harming behaviour. Professionals recognised their duty of care to keep Mohammad safe whilst minimising the risk of harm to himself and others.

We organised a multi-agency meeting to agree a plan to work with Mohammad on the ward to maximise his potential and enable discharge. This included support, commissioned by a health partner, from an independent provider which provided a type of talking therapy to support people who experience emotions very intensively. This led to him learning effective coping strategies.

Whilst Mohammad was receiving additional and specialist support, professionals from all different agencies came together to identify a holistic approach to his health and care needs in the least restrictive environment whilst maximising his independence and safety. We worked with specialist housing providers and involved Mohammad in the process to look at the best way to support his as an individual.

What difference did it make?

After much planning between agencies and the success of specialised support, Mohammad began to develop new coping mechanisms when he was distressed and felt ready to leave the ward and move into his own home.

Staff were confident that with the right support in place and partnership agencies working closely together they could minimise the risks and enable Mohammad to be more independent without the need for 24 hour support from three staff, this provided greater opportunities for Mohammad to achieve his full potential.

How are things now?

Mohammad is successfully living in his own self-contained flat. He has support staff visiting for a few hours per day from agencies which can meet health and social care needs, to support him with coping strategies, social interaction and access to the local community.

He has some practical support with daily living skills such as cooking, cleaning, paying bills and budgeting which all enable his to develop life skills to manage independently. Mohammad has also got a pet which brings him much enjoyment. Professionals meet on a weekly basis to discuss any concerns and plan appropriately to maintain Mohammad's health and wellbeing in the local community.

Case Study 4: Working in partnership with local people

People feel connected to their community and their feedback and experience is used to shape services and make changes.

Helena is 23 years old. She loves spending time with her family and going out to music events. She is very sociable and enjoys being part of her local community, her main aspiration is to seek paid employment however, Helena can be very shy and becomes anxious in new situations or if she is meeting people for the first time.

What was the situation?

Helena had spent the last three years of her life at a residential college, when it was time to leave, she was going to move into her first supported living placement. Unfortunately the placement became unavailable, and she moved back home. Whilst Helena was happy at home, she quickly began to lose her confidence and the independence skills she had developed whilst being away from home and became worried about moving into a supported living placement.

What did we do?

Helena talked about how important having paid employment was to her but recognised she needed some experience beforehand. Supported by her Mum, they explored volunteering opportunities to help Helena gain skills in her areas of interest. Kelly, the allocated social worker, worked in collaboration with Helena and her Mum to identify day opportunities which would rebuild her confidence and maintain her skills.

As Helena spent more time volunteering and attending day opportunities her confidence grew and she advised she was ready to look at moving into a support living placement, but was also very scared at this new step in her life.

Listening to Helena's feedback, Kelly (social worker) worked closely with providers to identify a bespoke placement in the local community which would meet Helena's individual needs. Listening and understanding Helena's wishes and views was important to ensure the placement would be a success. A transition period was agreed and put in place to successfully support Helena build up the amount of time she spent at the placement, starting off with having dinner at the placement to spending her first overnight stay.

What difference did it make?

Helena can have a fulfilling life where she is an active member of her local community, has meaningful purpose in her life and has choice and control over her decision making. Her family were able to see her reach her full potential whilst still living close by in their local community. Relationships with local housing providers continue to be strengthened with the aspiration of supporting people with the right accommodation, at the right time and at the right place, supporting the Housing Strategy for residents of Worcestershire.

How are things now?

Helena is thriving and has a very active social life and is confident about her transition into adulthood. Her family are delighted at Helena's achievements and feel very proud of the independent young adult she has become. Both Helena and her family are grateful for the support received and how they felt listened to which enabled services to work in partnership with each other and help them stay connected to their local community.

Case Study 5: Being Future Focused

Understanding and responding to the many changes and opportunities that face social care, now and in the future.

Peter is an 82-year-old with early on-set Alzheimer's disease. Peter lives on his own and is keen that he continues to remain in his home and maintain his independence as long as possible.

What was the situation?

Peter's daughter and his family were concerned about his safety at home but felt that moving Peter to a more supportive environment would have a detrimental impact on his wellbeing and further exacerbate his mental health.

They were also aware that this was against Peter's wishes and wanted to explore different ways to enable Peter to maintain his independence whilst the family were assured that he was safe in his home.

What did we do?

After receiving the referral from the Adults Front Door, a referral was made to the local Community Housing Team who were able to consider a number of technology enabled care services (TECS) to support Peter maintain his independence in his home, whilst providing additional peace of mind to his family, knowing that they could monitor and support Peter from afar.

Peter was supported by his family to have a needs assessment which resulted in a small care package to support with some aspects of his daily living activities.

A carer's assessment was carried out with his daughter to identify and provide support for her needs and signpost to appropriate organisations which offered additional advice and support.

What difference did it make?

The TECS has been crucial in enabling Peter to remain in his home. His daughter, with the agreement of her Father, set up a monitoring system which was able to track Peter's movements and check his daily routine to ensure his safety.

The system includes features like door sensors to alert when an external door is open and alerts for potential health issues which enabled his daughter to communicate with caregivers and monitor Peter's activities in real time always ensuring his wellbeing and safety.

How are things now?

Peter continues to live in his own home and has maintained his independence with the ongoing support of the Technology Enabled Care Services. His daughter credits the system with enabling her Father to remain at home, emphasising its critical role in maintaining his safety and her peace of mind.

We know that the population is ageing, and more people will be living with long term health conditions, many of which are complex in nature.

Utilising technology now and in the future will enable us to continue to reduce and delay the need for traditional care services such as residential and nursing care and illustrates the transformative impact of TECS when managing complex health and social care needs at home.

Caring for the Future

A dedicated team of adult social care commissioners work closely with providers of care services to ensure that we can access and procure quality care for the residents of Worcestershire.

Ultimately, the commissioners are responsible for ensuring sufficient supply of sustainable, affordable and innovative quality care to meet the needs of our residents through market monitoring, market shaping and market development, but commissioning is much wider than procurement processes and contracts.

Substantial time is spent on agreeing the purpose for commissioning services, developing options with a wide range of stakeholders, and crafting the specification of the service to be delivered.

This work is informed by an understanding of the market and of procurement best practices but is not constrained by them with commissioners actively:

- **undertaking research and engaging with the market to both understand and influence the existing and future demand for our services.**
- **investing in enhancing our category, supplier, and contract management activities; pursuing partnering and collaborative opportunities.**
- **co-producing strategies and monitoring action plans to ensure the conditions are right for people with social care needs to flourish and;**
- **engaging with people who have lived experience of services including carers and family.**

Worcestershire County Council commissions care services for all adults with "eligible social care needs" as defined under **The Care and Support (Eligibility Criteria) Regulations 2015 (legislation.gov.uk)**. This care may be delivered at the person's own home, or in a residential setting and the care delivered by a trained care workforce.

The County Council also commissions other supporting services, such as those providing technology that helps maintain independence safely, advocacy, support for unpaid (often family) carers and more.

The care we procure from the commissioned services for individual residents is subject to strict quality assurance, and our dedicated quality assurance team (QA) monitors this, addressing poor quality of care (against the service specification and contract) via a risk matrix.

Whilst not responsible for safeguarding, the quality assurance team work with the safeguarding team where there are issues that cut across both areas of functional responsibility.

They also work jointly with colleagues from the Integrated Care Board (ICB)/NHS to support nursing homes in improving standards of quality. The QA team are well placed to identify any financial issues relating to the provider and the provision of care.

In 2023, the Department for Health and Social Care (DHSC) said:

> "High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to commission services directly to meet needs and the broader understanding of, and interactions it undertakes with, the wider market for the benefit of all local people and communities."

Dynamic Purchasing System (DPS)

The Older People Nursing and Residential Dynamic Purchasing System was launched in April 2024 following engagement with partners and providers.

The DPS is a contractual arrangement where eligible local care home providers are able to join it to offer placements in care homes. The DPS introduced capped fees for different levels of care (previously there was residential or nursing). Currently there are **55 care homes** on the DPS with further expressing interest. The DPS aims to stabilise fees for care homes.

Caring for the Future (continued)

Twice each year, commissioners undertake a significant piece of work to understand how the market is operating and to ensure that there is sufficient capacity available, not just to meet the needs of today, but also of tomorrow.
This work provides:

- an assessment of current market sustainability;
- anticipated impacts on market sustainability;
- the cost of care for the local area and an explanation of how the exercise was carried out, including provider engagement and;
- a reflection on the data and positions of the local authority between March 2022 and March 2023.

Comparing this data with that from the most recent census and health projections and statistics (detailed in our refreshed **Market Position Statement and Commissioning Strategy**), commissioners can then develop market specific strategies for shaping, improving and/or maintaining sustainable markets over the coming years that meet the projected needs for the county's population and which are also in line with the DHSC requirement.

An example of such work and its impact in practice is outlined below.

Jack is an 18-year-old with learning difficulties and epilepsy, who lives with his parents but seeks greater independence.

To assist Jack, a personalised assessment identified the technology suitable for his needs. These tools helped Jack manage his daily routines by providing clear alarms and reminders for tasks such as preparing lunch, taking medications, and other daily activities.

The reminders are delivered in various formats, including picture messages and audio, which are crucial to assist Jack. Jack's parents can also monitor whether tasks have been completed, allowing them to intervene if necessary.

This system has significantly increased Jack's confidence and ability to manage daily routines, thereby enhancing his independence and improving his quality of life both at home and at college.

Partnership Working and Integrated Care System

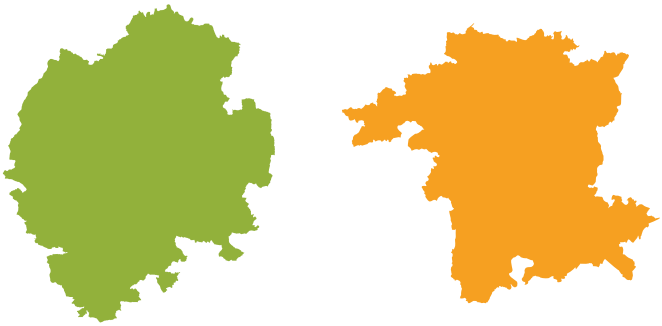
Integrated care is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions which, in the past has meant that too many people experienced disjointed care. Integrated care systems (ICSs) were first developed in England in 2018.

An ICS brings together NHS organisations, local councils, and wider partners in a defined group to deliver more joined up approaches that improve health and care outcomes. We know that access to, and outcomes from, health and care services are not experienced equally across our population and addressing this is core to our strategic priorities.

Over the last year health, local government and wider partners have published an Integrated Care Strategy which focuses on building a healthier future for local people in Herefordshire and Worcestershire. The strategy builds on the existing work that partners are delivering, whilst using the partnership arrangement as an opportunity to accelerate progress in improving the health and wellbeing of everyone who lives and works in Herefordshire and Worcestershire.

The Health and Wellbeing Boards (HWBBs) and the Integrated Care Partnership (ICP)

There are two Health and Wellbeing Boards – one in Herefordshire and one in Worcestershire.



These provide the platform and foundations for local partners to come together to develop and oversee delivery of initiatives to improve population health and wellbeing, focusing on the wider determinants of health including housing, leisure, employment, and environment.

The ICP was established by NHS Herefordshire & Worcestershire, Worcestershire County Council and Herefordshire Council as a joint committee.

The wider integrated care partnership assembly (ICPA) comprises of the ICP members and local statutory partners such as district councils, police, fire and Healthwatch with a wide range of representative members from the Voluntary, Community and Social Enterprise (VCSE) sector, education establishments, care providers, housing organisations and more.

The role of the ICP is to oversee the development and delivery of the integrated care strategy and is a platform for engagement and collaboration.

Collaboratives and Partnerships

The ICS operating model has been developed around the principle of subsidiarity (equality and independence of organisations regardless of their size) and local partnerships.

There are two 'places' in the ICS, Herefordshire and Worcestershire, these are aligned to upper tier local authorities, Herefordshire Council and Worcestershire County Council.

In Worcestershire, the partnerships are built around 10 Primary Care Networks working alongside 6 District Collaboratives, coming together under the support of the Being Well Strategic group.

Being Well
IN WORCESTERSHIRE

Partnership working in Worcestershire

We recognise the required shift to achieve greater integration and have continued to work collaboratively to establish a framework for the culture within which we will work, between key partners, by putting people in our communities at the heart of everything we do.

We understand that an equal partnership between NHS and health, local government and our Voluntary, Community & Social Enterprises Alliance (VCSE) sector is vital, and we have been developing shared health and wellbeing principles as follows:

Together we will:

- Place equal value and emphasis on the physical health and mental health and wellbeing;
- Protect health and focus on supporting the conditions for good health;
- Focus on prevention; to prevent, reduce or delay need for care and support;
- Improve health disparities particularly for those who are vulnerable, disadvantaged or living with a disability;
- Listen to people who use our services and strive to improve, ensuring a quality experience;
- Deliver proactive and better coordinated care to help people to stay healthy and independent, based on each person's needs;
- Work together in an evidence-based way to take to system wide approaches to improve health across the life course;
- Maximise shared funding opportunities to achieve best value (including social value);
- Develop and support our workforce.

Our Worcestershire system spans many partner organisations and sectors, as demonstrated on the diagram.

Whilst many have been working together for years, this is now being extended to deliver even greater collaboration as we strive to fully integrate health, public health and social care.

How we are delivering good outcomes together

Fully integrated health and social care system based around the person

Placing residents at the heart of everything we do must be a key ambition of our truly integrated health and social care system. Whilst we have good examples of joint working across Worcestershire, we need to change our approach, we need to listen more to our communities, supporting a **'carer friendly Worcestershire'** and genuinely valuing their voice, rather than being driven by targets. We can achieve this by:

Engaging people, integrating care, ensuring the right level of care at the right time - an example being greater collaboration between NHS partners and our reablement team to support people and expedite hospital discharges.

Supporting people to build knowledge, skills and confidence and to live well with their health conditions – connecting services to enable residents to have a clear understanding of how to access support and advice, starting from prevention at early years through to our aspiration of integrated health and wellbeing hubs.

Examples of this joined up approach can be seen at our Adults Front Door Service, the Voluntary Sector and the recently commissioned Healthy Worcestershire led by Public Health.

Supporting people to stay well and build community resilience, enabling people to make informed decisions and choices when their health changes - our work to promote greater supported self-management has seen good results which we continue to grow.

This includes roles such as our Targeted Adult Support Teams, social prescribers and community builders to enhance community-based support.

Taking system-wide approaches to improving health across the life course

We recognise that our shared priorities are not individual NHS, Social Care or Public Health challenges and often, when working in silos, duplication of resource and effort can arise. The introduction of the ICS, our joint working principles and strategic work programmes now encourage us to take a system-wide approach to improve health across the life course. We recognise that the whole system plays a part; from General Practice through to hospital, in Public Health, Social Care, emergency services, the VCSE, housing and beyond.

We are working to take collaborative action, which will be a long-term challenge, but one that we are starting in many priority areas. A few examples demonstrating this approach include:

- **Best start in life –** coordinating efforts to optimise health and support before conception, during pregnancy and post birth and to reduce the impacts of smoking, obesity and poor mental health and to work together to support additional vulnerabilities to reduce risk which can contribute to infant mortality.
- **Housing and health –** progressing integrated working in areas such as supporting independent living, participation of housing providers in mental health and wellbeing programmes, and social housing residents accessing NHS training or employment.
- **Quality of life and care as we grow older –** ensuring as people age, they are as healthy and independent as possible through initiatives such as falls prevention, a focus on enablement, provision of suitable accommodation and assisted technology, and appropriate support at end of life.

Integrated strategic work programmes

The aim is to work together to integrate services around people's needs ensuring we reduce duplication and pool resources to provide better support for delivery of our key priorities.

We have established a range of county-wide forums to bring relevant partners together to share information around various disciplines such a data or engagement. These 'place-based cells' include a Clinical and Practitioner Forum, Intelligence Cell, Communications Cell and Engagement Cell. There are additional forums for specific health and care priorities such as access to urgent care and mental health services.

Provider Collaboratives

Our providers are working collaboratively with others both within and beyond our county boundaries e.g. through the Mental Health Provider Collaborative and The Foundation Group. Our two provider trusts are working collaboratively across Worcestershire to maximise the positive impacts on healthcare provision and integrated pathways.

Supporting Place (Worcestershire) as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services.

Voluntary Community and Social Enterprise (VCSE) Alliance

Worcestershire's VCSE organisations play a critical role, both as service providers and as vehicles for community engagement and voice. They are important strategic partners in terms of delivering improvements in health and wellbeing and reducing inequalities – which often involves working more closely with communities.

Through the Worcestershire VCSE Alliance, the sector is bringing organisations together to collaborate and develop new and robust approaches to innovative service delivery.

Worcestershire VCSE Alliance is building capacity and gathering community intelligence and developing methods to measure the impact of its services. It will continue to:

- Support people and communities through commissioned activities
- Work with local communities, providing intelligence and acting as advocates
- Provide a perspective different from statutory agencies
- Co-produce and work in partnership to identify interdependencies and identify solutions
- Work in a person-centred way; and
- Support with delivery.

Quality assurance

In 2023/2024 we will remain focused on ensuring we work with the care market to ensure we have good quality care, value for money and support people to be as independent as they can, in the place they call home.

Our quality assurance (QA) professionals work with care provides to address any possible areas that could indicate care quality concerns. This could be anything which is indicative of failing to meet the required standards of care, dignity, or professionalism that we expect. The QA team also work collaboratively with colleagues from the Integrated Care Board (ICB)/NHS to support nursing homes in improving standards of quality.

By remaining focused on co-production and collaboration, we involve people in the design and shaping of services and ensure Equity, Inclusion and Diversity is the golden thread in all that we do. Amongst many transformation initiatives, Adult Social Care will also have its first Care Quality Commission Inspection, a new inspection regime that has been introduced to ensure we work with people, provide the support required, keep people safe and that the service is well led.

Ensuring we have a work force who feel supported by the Council is critical for us, and we remain focused on staff wellbeing and ensuring we have people with the right skills, knowledge and values to deliver our Adult Social Care duties and priorities.

Principle Social Worker report

Most areas have a Principal Social Worker for Adults Social Care, supported by national and regional networks. The Care Act 2014 says local authorities should make arrangements to have a 'qualified and registered social work professional practice lead' in place. In support of ensuring visibility for the role and celebrating achievements, our Adults Principal Social Worker, **Kelly Palmer**, produces an annual report which summarises the key achievements and developments made during the year.

In the period 2023/2024, the key achievements were noted as:

1. **Building Together Co-Production Forum** – this was launched in April 2023. Since then, progress has included recruitment of people with lived experience of receiving adult social care and carers to the Building Together board, launching of the peer network and workforce group.

   The forum has co-produced the Building Together Co-production Plan of Action (Strategy) for Adult Social Care 2024-5 which is on track to launch late spring.

2. **Launch of Adult Policies, Procedures and Practice Resource**. This provides staff with access to the most up to date policies, guidance/procedures and strategies related to Adult Social Care. Along with resources for professional development.

3. **Quality Assurance Framework** – which included establishing a Quality Assurance Practice and Performance management subgroup which has a focus on learning from a wide range of sources, including serious incidents and audits.

Priorities for the next year (Key areas requiring development over the next year):

1. Continued development of **carers services**, including co-producing updated assessment, support plan and review documents. Refreshing guidance and further development of carer awareness within Adult Social Care, working in partnership with Worcestershire Association of Carers.
2. Review and further development of **direct payments**, including refresh of processes, guidances, information, and training to be co-produced with people who use direct payments services.
3. Continued the embedding and development of Building Together through **co-production**.
   This will be achieved via the launch, action plans and embedding related to Building Together Co-production Plan of Action (Strategy) for Adult Social Care 2024-25 and continued promotion and development of the Building Together Forum.
4. Continue to strengthen and further develop links between learning from different sources and identification of themes via the continued development of the **Quality Assurance Practice and Performance** sub-group and Quality Assurance Framework.
5. To further develop methods of obtaining and utilising feedback from staff and people who use services and their carers to further develop **quality assurance and service development**.

Celebrating Success

In line with our vision and recently published strategies, we have continued to enable independence for the people we support, which is demonstrated by comparing performance over the last year.

73% of people who were referred to ASC received a service to promote independence which is an increase of 19% from last year, utilising assistive technology, our Adults Front Door Team, our Targeted Adult Support Team and Reablement intervention.

From this group of people, **84%** did not need any further service after this short-term service, which is a fantastic achievement for people to retain their independence and achieve their full potential with minimal help.

We will continue to embed different ways of working with a sharp focus on our priorities in the **Adults Social Care Strategy** and the **Early Intervention and Prevention Strategy** to continue to build on our success and provide the best outcomes for the residents of Worcestershire.

What's next? Key areas of improvement for Adult Social Care

We continue to focus our improvement work on both our internal and partnerships programmes. The key elements of each of these areas are summarised as follows:

Equality, Diversity and Inclusion - We will continue our community engagement events to raise awareness of Adult Social Care, including specifically within neighbourhoods and communities whose voices are seldom heard.

Co-production - We will increase opportunities for engagement and co-production, expanding and further developing our Building Together Forum.

Transformation Programme for Mental Health - We will work closely with the Health and Care Trust to continue to enhance services that support people with mental health conditions, with a focus on discharge pathways and S117 register and aftercare plans.

Learning Disability - We will continue to build on collaborative working with our partners and people with lived experience, with a specific focus on the development of in-house provider reviews and ensuring that all information is available in easy read and reasonable adjustments are in place.

Workforce - We will continue to develop and support our internal and external workforce to ensure we have good retention and recruitment processes in place and drive forward a culture of continuous learning and improvement.

Prevention and Enablement - We will continue to work with key partners to embed preventative approaches to support the overall health and wellbeing of Worcestershire residents.

Market Development - Working closely with the voluntary sector and community groups we will continue to develop the social care market; this includes both the range of regulated services and alternative support options. This will increase the range of local choices available to adults.

Financial Management - In a challenged financial environment, we will continue to review and ensure our systems and processes are lean without compromising the quality of care. We will seek innovative solutions to support the population and champion the use of digital technologies to enable residents to maintain their independence without the reliance on services.

Safeguarding - We will continue to robustly manage Deprivation of Liberty Safeguards and Community Deprivation of Liberty to minimise waiting times alongside embedding and evaluating our new model of safeguarding. We will carry out a review of the Worcestershire Safeguarding Adults Board Safeguarding Adults Review protocol.

Adult Neurodiversity - We will continue to develop and embed this new team and ensure improved outcomes for individuals.

Areas Social Work Teams - We will launch and embed the new Needs Assessment and Support Plan, to ensure focus on strength-based practice, aligned to the customer journey to ensure consistency and timeliness for individuals.

Closing remarks from Mark Fitton,
Strategic Director for Adults and Communities

I am pleased to share with you an update on our ongoing efforts and accomplishments in supporting the adults within our community. Our commitment to providing high-quality, compassionate care remains at the forefront of everything we do, and it is through our collective dedication that we continue to make significant strides.

Over the past year, we have made considerable progress in several key areas:

Enhanced Service Delivery: We have streamlined our processes to ensure timely and efficient service delivery, reducing wait times and improving access to essential services. Our team has also embraced new technologies to better serve individuals where needed.

Community Outreach and Engagement: Our outreach programmes have expanded, enabling us to connect with more individuals in need. We have strengthened partnerships with local organisations, community groups, and healthcare providers to create a robust network of support. These collaborations have been instrumental in addressing the unique needs of our diverse population.

Staff Development and Training: We recognise that our staff are our greatest asset. To that end, we have invested in ongoing professional development and training opportunities to ensure our team is equipped with the latest knowledge and skills. This investment not only enhances the quality of care we provide but also fosters a supportive and motivated work environment.

Inclusive and Person-Centred Care: We are committed to delivering care that respects the individuality and dignity of every person we serve. Our programmes are designed to be inclusive and responsive, ensuring that all adults, regardless of their circumstances, receive the support they need to lead fulfilling lives. We are proud of our Building Together Forum which ensures that co-production is at the heart of everything we do.

Innovative Programmes and Services: We have focused on new ways of working with a preventative approach to promote independence, wellness, and social engagement. Many of these programmes have been developed by Public Health, including the recently commissioned Healthy Worcestershire which provides wellness workshops and community-building activities that encourage active participation and connection.

Looking ahead, we are excited about the opportunities to further enhance our services and make a positive impact on the lives of those we serve. Our priorities include:

- **Expanding our reach:** Increasing our presence in seldom heard areas to ensure that all community members have access to our services.
- **Enhancing mental health support:** Developing new programmes and resources to address the growing need for mental health care and support.
- **Fostering community partnerships:** Strengthening our relationships with local voluntary organisations to build a more integrated and comprehensive support system.

We are grateful for the trust you place in us and for the ongoing support from our community. Together, we can continue to build a compassionate, inclusive and supportive environment where all adults can thrive.

Glossary

Advocacy - Advocacy means getting support from another person to help you express your views and wishes and help you stand up for your rights. Someone who helps you in this way is called your advocate.

Approved Mental Health Professional (AMHP) - AMHPs are mental health professionals who have been approved by a local authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating assessments and admission to hospital if a person is sectioned under the Act.

Child Adolescent Mental Health Teams - CAMHS stands for Child and Adolescent Mental Health Services. The CAMHS teams offer specialist mental and emotional health support to children, young people (age 0-18 years) and their families.

Carer Assessment - If you care for someone you can have an assessment to see what might help make your life easier. This is called a carer's assessment.

Collaboratives - Provider collaboratives are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations.

Commissioned - The establishing of contracts to deliver against a service specification and at a required quality standard. Individual "packages of care" may then be procured from these commissioned (contracted) services.

Co-production - When an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.

Dialectical Behaviour Therapy - Dialectical behaviour therapy (DBT) is a type of talking therapy. It's based on cognitive behavioural therapy (CBT) but it's specially adapted for people who feel emotions very intensely. The aim of DBT is to help people understand and accept their difficult feelings.

Disparities - Disparity is the condition of being unequal, and a disparity is a noticeable difference.

Holistic approach - A holistic approach provides a comprehensive, individualised approach that considers the whole person such as their physical, mental, emotional and spiritual well-being rather than defining by illness or a label.

Integrated Care Systems (ICSs) - Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services and to improve the lives of people who live and work in their area. 42 ICSs were established across England on a statutory basis on 1 July 2022.

Market Shaping - Market shaping means the local authority collaborating closely with other relevant partners, including people with care and support needs, carers and families, to encourage and facilitate the whole market in its area for care, support and related services.

Neurodiverse - Neurodiversity refers to the different ways the brain can work and interpret information. It highlights that people naturally think about things differently.

Oppressive - A situation in which people are treated in an unfair and cruel way and prevented from having opportunities and freedom.

Promoting Independence - Short-term services which aim to maximise the independence of the individual. At the end of the support, ongoing care and support services will be arranged as required.

Safeguarding - Safeguarding is how we work with people to prevent them experiencing harm from others or sometimes themselves. It includes helping people recover when they have been abused.

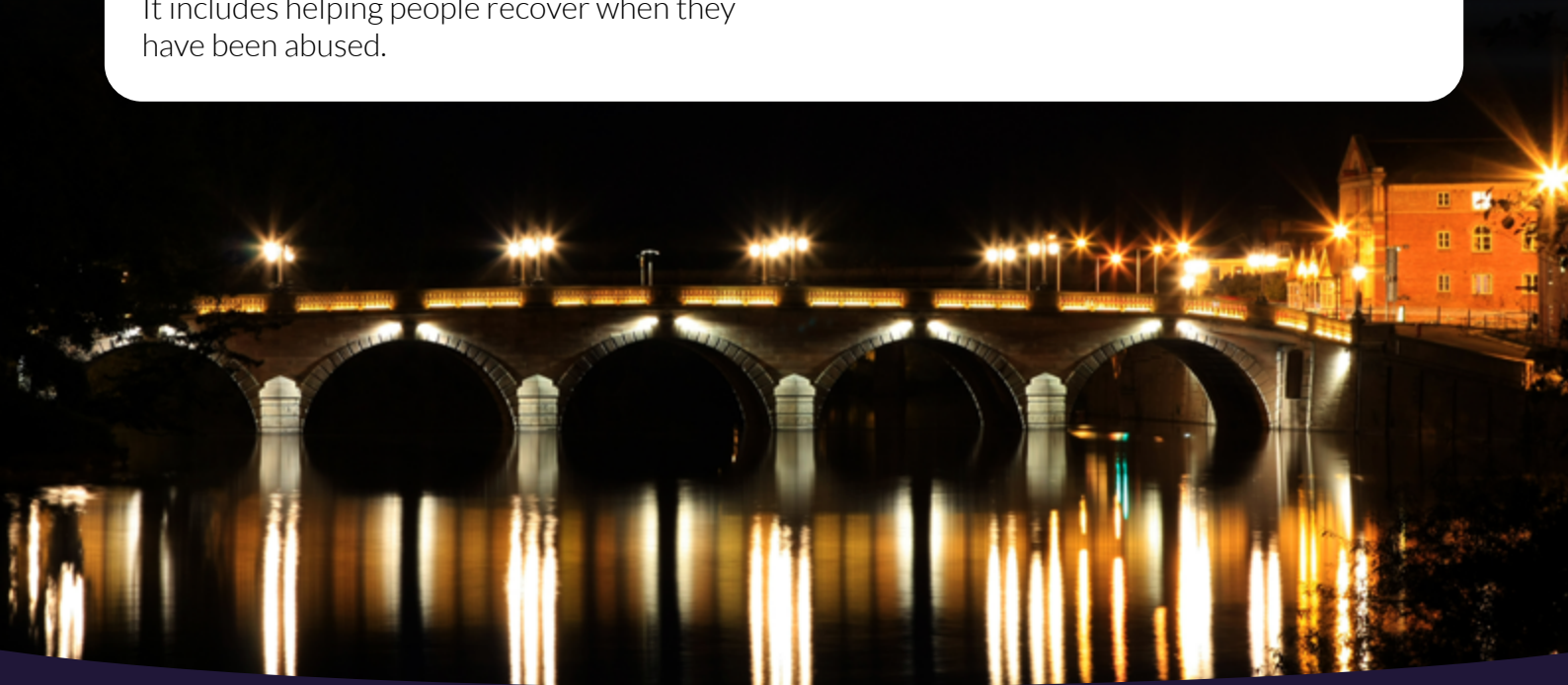
Section 75 Partnership Agreement - These partnership agreements, legally provided by the NHS Act 2006, allow budgets to be pooled between local health and social care organisations and authorities. Resources and management structures can be integrated, and functions can be reallocated between partners.

Selective mutism - A child or adult with selective mutism does not refuse or choose not to speak at certain times, they are unable to speak. The expectation to talk to certain people triggers a freeze response with feelings of anxiety and panic, and talking is impossible.

Short-term Support - Short-term support that is intended to be time limited, with the aim of maximising the independence of the individual and reducing or eliminating their need for ongoing support by the Council.

Statutory - Statutory means relating to rules or laws which have been formally written down.

Transformation Programme for Mental Health Integrated Care Systems (ICSs) - received funding to develop and begin delivering new models of integrated primary and community care for adults and older adults with severe mental illnesses.



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