

Adult Social Care

Self-assessment

September 2025



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I've got my own house, I have got my own support now. I am so happy now. I can cook for myself and I can go to places I like to go to. I am more than happy I've got my own house. I go to my courses on my own and I can get the train on my own. If I am stuck, I can call [my support] to help.

Person with learning disabilities supported through an Individual Service Fund

“”

I often feel that no one really understands the full impact these kinds of issues have on me, so to have you articulate it all with such clarity and care means a great deal. I'm incredibly grateful for your support.

Person supported in West Suffolk

“”

I can't tell you how much this means. As you know I'm really struggling all round [with my carer role] but if I can alleviate some of the pain, I know it'd help make everything else a bit more manageable.

Carer in Ipswich using Carer's direct payment for reflexology & massage

“”

What we are proud of

Our workforce, and their application of our strengths-based, person-centred approach –

based on the most recent available data (ASCOF 2023/24) we were ranked 18th out of 152 local authorities nationally and 2nd in our comparator group for 'overall satisfaction of people who use services with their care and support', and 39th out of 152 local authorities nationally both for the 'proportion of people who use services who report having control over their daily life' and for the 'proportion of people who use services who find it easy to find information about services'.

Our commitment to coproduction, engagement and codesign – we have carried out extensive codesign, engagement and coproduction to inform our transformation programmes, with more than 230 attendances at public workshops and coproduction forums to develop the People at the Heart of Care strategy. Coproduction is especially strong in our work with adults with a learning disability or autism and with adults who have a mental illness; it is systematically embedded and has a direct impact on commissioning and on social work practice.

Our diverse and high-quality care market – our standards of care are among the highest local authorities nationally, benchmarking at 86.4% of all locations with a published rating good or outstanding by CQC compared to the regional average of 82.1% and the national average of 84.1%. Within this our proportion of providers with an outstanding rating is 11.7%, more than double the regional average of 5.4% and nearly three times the national average of 4.5%.

At Suffolk, I'm empowered to do the job I trained for, supporting people and carers with confidence, compassion, and professionalism. My skills are recognised, my growth is encouraged, and I'm trusted to lead, mentor, and shape services that truly matter. What started as a locum role quickly became a permanent home, where I'm not just developing, I'm making a real difference.

Senior Social Worker, Waveney

“”

Foreword

We are pleased to introduce this self-assessment as part of Suffolk County Council's participation in the Care Quality Commission's baseline inspection programme. Being part of this process as a pilot site since 2023 has provided us with valuable insight and challenge, helping us to shape our journey of continuous improvement and transformation in Adult Social Care.

Over the past two years, we have evolved significantly. Our strategy, People at the Heart of Care, reflects our commitment to co-production and the voice of those we support. We have well-established strengths-based, personalised approaches and work closely with residents, carers, and partners to design services that promote independence, dignity, and choice. This is underpinned by our Signs of Safety practice model and our Integrated Neighbourhood Teams, enabling more holistic and responsive care.

We are immensely proud of the dedication shown by our staff and managers every day. Their compassion, professionalism, and resilience—especially through recovery from the pandemic and ongoing pressures in the health and care system—have been instrumental in delivering high-quality outcomes for people and communities across Suffolk. Their work continues to inspire us.

We also recognise the challenges we face: increasing demand, workforce pressures, and the complexity of operating within a changing NHS and local government landscape. Yet, we remain ambitious. Looking ahead, we are embracing digital innovation through initiatives like Cassius, expanding trusted assessment models, and deepening our integration with NHS, VCFSE, and primary care partners. We are preparing for future reforms, including devolution and Local Government Reorganisation, with optimism and resolve. Our strong partnerships, and our excellent track record in innovation and transformation, will help us to meet these challenges while taking Suffolk's services from strength to strength.

Above all, we are proud of the culture we have built in Suffolk Adult Social Care—one that values people, listens deeply, and strives to make a meaningful difference every day.



Rebecca Hopfensperger
County Councillor &
Lead Member for ASC



Gareth Everton
Executive Director for
Adult Social Care

Overview and summary

About us - Suffolk

Suffolk is a county located in the East of England, bordering Norfolk to the North, the North Sea to the East, Essex to the South and Cambridgeshire to the West. Our total population is around 786,231 people living in a mix of rural and urban areas (ONS, July 2025). Suffolk is the 68th largest county in the UK. Ipswich, the county town, is the largest settlement, followed by Lowestoft in the north-east and Bury St Edmunds in the west. Suffolk boasts over 50 miles of coastline, world famous beaches, and beautiful countryside.

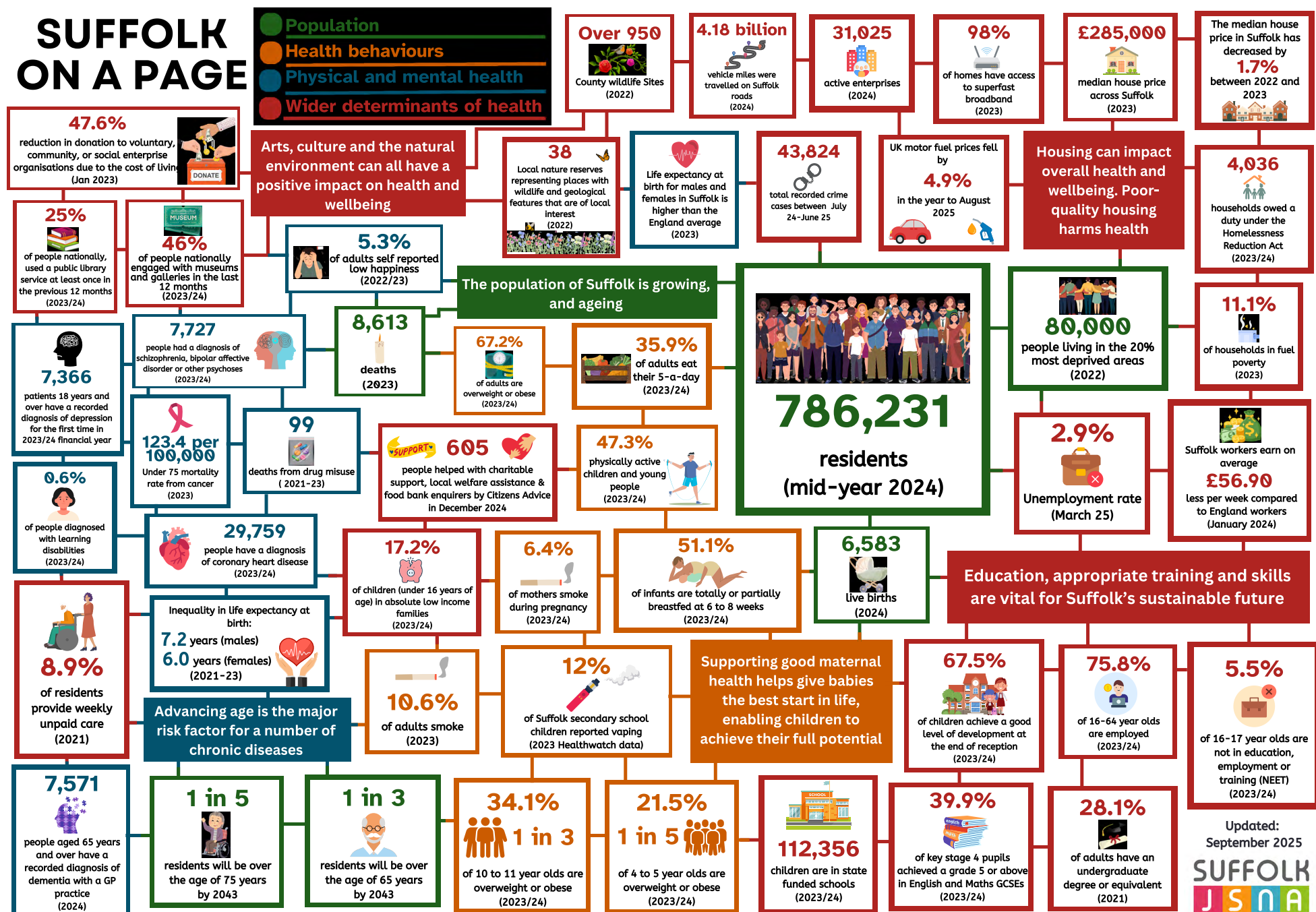
Just over 80,000 people in Suffolk live in the 20% most deprived Lower Super Output Areas in England – this is approximately 10% of Suffolk's residents. Ipswich is the most deprived district in Suffolk with East Suffolk, primarily Lowestoft, next. Areas of relative deprivation can be found in more built-up areas such as Beccles, Bury St Edmunds, Felixstowe, and Stowmarket. Nearly 1:4 people living in Suffolk are over the age of 65 years and 6.9% 85 years or older (compared to 5.1% in England). There is clear evidence of health inequalities in Suffolk with life expectancy differences between the most and least deprived areas being 7.4 years for men and 5.0 years for women.

Suffolk has a strong care market allowing direct commissioning of most direct service provision. The vital Suffolk voluntary sector has approximately 16,000 registered charities, community interest companies, registered and unregistered societies and groups, faith groups and community amateur clubs, with around 35,000 employees supported by over 223,000 volunteers. There are over 65,000 identified family carers living in Suffolk and for many more, caring for ill, older or disabled family members, it is 'just something they do'.

Suffolk County Council has had a Conservative administration since 2017 and is currently on the fast-track programme for devolution and Local Government Reform, which through the introduction of new unitary councils will provide opportunities to further join up services for the benefit of residents.



SUFFOLK ON A PAGE



Adult Social Care (ASC) in the Suffolk system

Suffolk ASC works through a well-established, devolved place structure, combining the benefits of a whole-county approach with the ability to tailor its offer to the needs of local neighbourhoods and communities. ASC employs over 1,350 people across three localities: Ipswich and East, West Suffolk, and Waveney. We have countywide specialist Learning Disability & Autism (LD&A) Services, Mental Health (MH) Teams and Safeguarding Team. We also have a county wide sensory team, Sensing Change, supported by other countywide commissioning, support and oversight functions.

Access to ASC is via our Customer First service and a range of preventative services including the Independence & Wellbeing Service. We work within the framework of a three-tier model covering 'Help to help yourself' (universal, Tier 1 services); 'Help when you need it' (Tier 2, short term support including reablement, recovery and progression) and 'Ongoing support for those who need it' (Tier 3, long term care and support services).

ASC works closely with other Suffolk County Council directorates. These include Public Health and Communities (PH&C), who lead work with the voluntary and community sector on behalf of SCC and host our strong Insight & Intelligence function and our Population Health Management dataset, and Children & Young People's services (CYP) with whom we collaborate to support young people transitioning to adult services, young carers, and to provide wider family support. We benefit from an experienced Cabinet Member who has held the Adult Social Care portfolio for over ten years.

We have strong and mature relationships with health partners across the two Integrated Care Systems (ICSs), Suffolk & North-East Essex (SNEE) for the majority of Suffolk and Norfolk & Waveney (N&W), covering the north of the county, and key providers such as Norfolk & Suffolk Foundation Trust (NSFT). Through our Integrated Neighbourhood Teams – recognised as national exemplars by the NHS Federation – effective joint delivery of the Better Care Fund (BCF), management of the local care market, and during discharge from hospital to home, we jointly deliver shared health, care and wellbeing ambitions for individuals, carers and local communities.

We have an established shared care record via the Health Information Exchange, a well-developed Population Health Management linked dataset and are key partners in Suffolk's new Integrated Care Academy, based at the University of Suffolk.

Each month, approximately 12,000 people receive ASC services. Of these, 1,200 manage their own care by way of a direct payment which gives them choice and control over how their care is delivered. Nearly 4,000 will be in supported housing, residential care or nursing care. Just over 5,000 people receive care in their own home or through day-service provision and 2,400 are supported by our Learning Disability & Autism teams. Our Home First reablement service helps around 700 people monthly and more than 4,700 people in a year.



Our mission, strategy and approach

Work with individuals and communities to keep them safe, healthy, well and cared for is at the centre of our role as a County Council. Adult Social Care is at the core of our corporate strategy whose priorities include:

- **Looking after our health and wellbeing** – with Adult Social Care a key delivery engine for health and wellbeing in Suffolk
- **Strengthening our local economy** – with Adult Social Care a major commissioner and key partner with Suffolk care providers
- **Providing value for money for our residents** – with Adult Social Care focusing on innovative and efficient delivery to support financial sustainability

Our values and behaviours, WE ASPIRE, which were coproduced by our staff, for staff, embody the way that we work in Suffolk to deliver for residents. Our Customer Commitment sets out strong principles that help support high standards of customer service and care that we can all endeavour to consistently demonstrate.



W

Wellbeing – We look after ourselves, each other and the planet

e

Equality – Respecting, valuing, embracing and celebrating everyone's unique differences

A

Achieve – We are the best we can be

S

Support – We work as one team

P

Pride – We are passionate about making a positive difference to the people and place of Suffolk

I

Innovate – We believe in making every penny count and every minute matter, and reducing environmental impact

R

Respect – We give and earn respect

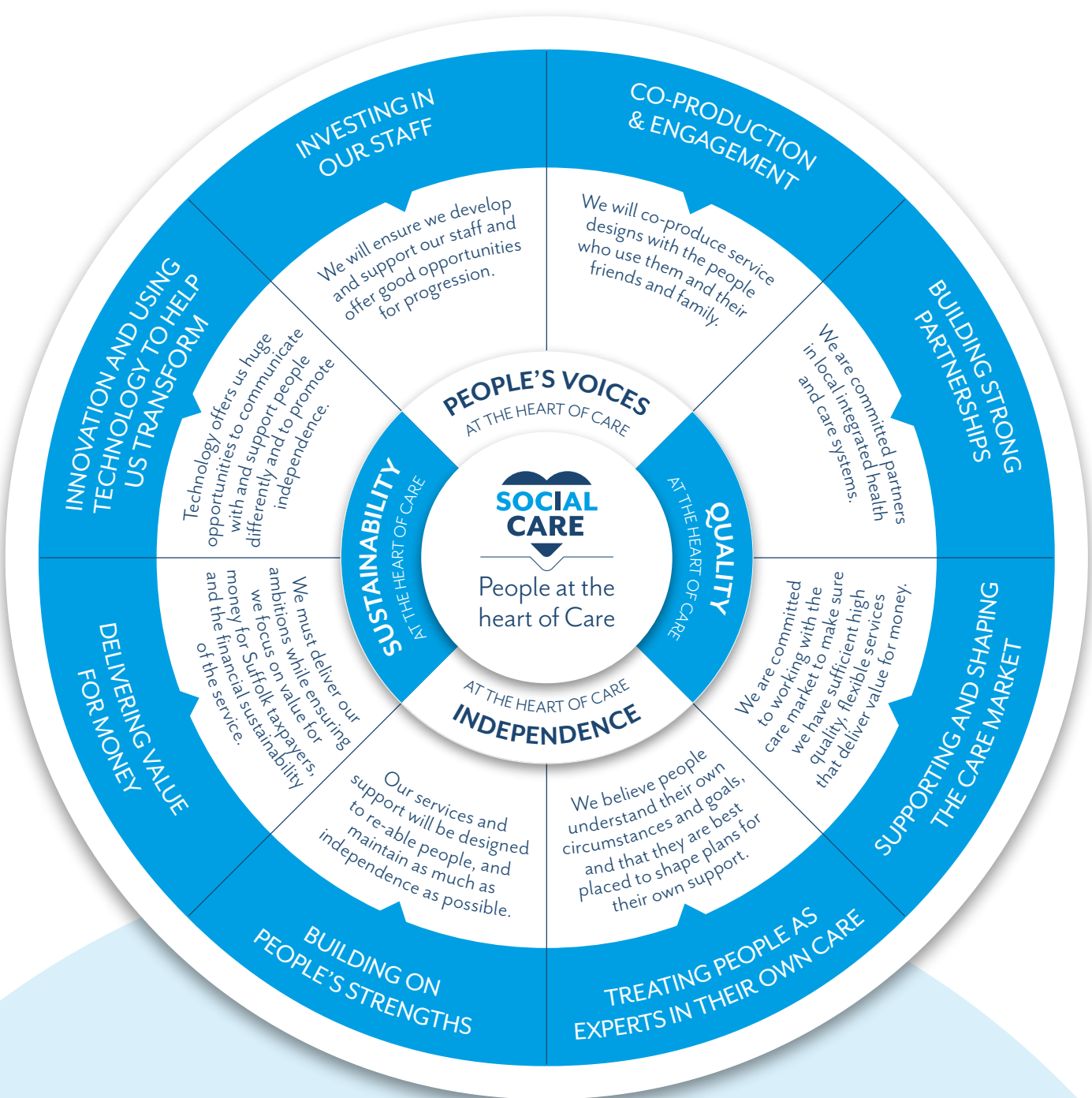
E

Empower – We empower, encourage and motivate

People at the Heart of Care

Our ASC mission is for people to live fulfilling and independent lives. People at the Heart of Care is our strategic approach and sets out how we work to support people to achieve this, drawing on the national People at the Heart of Care White Paper and applying it in the context of the Suffolk vision and landscape.

Our Care and Support Compass sets out the four strategic outcomes and eight guiding principles of our strategy:



We are delivering on our strategy by:

- Increasing choice and control by focusing on **personalisation** – through increased use of direct payments and individual service funds. We have redesigned and streamlined our direct payments policy and process, created a central direct payments team focused on practice excellence, and diversified the market offer in Suffolk.
- Building our **strengths and asset-based approach** to practice. We have enhanced our Signs of Safety model through trauma-informed and restorative approaches, with staff training further embedding relational practice and a stronger focus on lived experience.
- Increasing our use of **coproduction** through a joined-up, strategic approach and focus on people's lived experience. We have embedded coproduction more systematically with particular strengths in LD&A and Mental Health.
- Utilising **digital tools to increase independence** – for advice, self-assessment and through our Cassius digital care offer. We have introduced supported self-assessment for, and coproduced it with, adults and carers.
- Enhancing our **preventative services**. We have invested in reablement capacity in Suffolk over the past 24 months, including specific investment in reablement and progression offers for people with a learning disability, autism or a mental illness, and formalised our Adult Social Care prevention offer to clarify our approach for staff, partners and communities.
- Improving support for people who require more **complex support** including successful work through the Transforming Care Partnership, development of joint practice approaches across LD&A and MH, and development of dedicated assessment and recovery support for people living with dementia and other conditions.

Learning from our CQC Pilot Assessment

In September 2023, Suffolk ASC participated as one of five pilot assessment sites nationally – one of only two County Councils involved. Suffolk ASC was proud to have achieved a Good overall rating reflecting our key strengths, including:

- Our staff's love of working in ASC and how this promotes better outcomes for the people we support
- Our commitment to personalisation and knowing the impact we have in people's lives and local communities
- Support, autonomy and training provided to staff and managers to do their job well
- Our digital care ambition – connecting people and implementing sustainable ways to deliver care and support
- Providing consistency of support and outcomes, while addressing differences in local needs
- Our values and culture in ASC

The impact of our improvement work

Over the past 24 months, we have achieved the following:

- Reduced delays in people accessing the service with the mean waiting time for allocation for a long-term care assessment decreasing by 38% over the last 12 months.
- Addressed social worker and occupational therapy workforce vacancies with posts now fully recruited into.
- Reduced the length of time people are waiting at our front door, with the longest wait for a preventative assessment at 63 days.
- Introduced carers' self-assessment and halved our outstanding carers' reviews.
- Trebled the proportion of financial assessments completed within 28 days.
- Increased DoLS assessments authorised by 36% since 2023/24.
- Increasingly positive feedback about outcomes for people in receipt of a direct payment.
- Grown Cassius digital referrals with over 6,000 people supported.
- Undertaken joint work with Children and Young People's Services and coproduction partners to improve the transition of young people into ASC, with audit evidence demonstrating earlier assessment and better outcomes.
- Introduced a Principal Occupational Therapist to provide strategic leadership for our therapy offer.
- Formalised our ASC prevention approach and supported development of an SCC-wide strategy.
- Implemented a coproduction framework, alongside continued work with ACE Anglia and Suffolk User Forum on transformation including direct payments, accommodation and digital care.
- Embedded our data use through the development of live Power BI performance dashboards and the use of sophisticated population health management data from the front line to Directorate leadership team.
- Rolled out the Health Information Exchange in Waveney and grown monthly usage by 81% since the pilot, further supporting integrated working.

Like everywhere, Adult Social Care in Suffolk faces increasing demand and financial challenges, reflected in our focus on sustainability at the heart of care. Since 2018 our transformation programmes have saved £84.5m while also improving outcomes, enabling us to deliver a balanced budget in 2024/25. Importantly, this means we can continue to invest in innovating and meeting people's needs in more effective, creative ways.

Equality, Diversity and Inclusion (EDI)

At the time of the CQC pilot, significant work had been undertaken to embed EDI within the workforce, including equality networks, team champions, and targeted training. Initial efforts had also begun to support staff in applying EDI principles in their work with people. However, it was recognised that further progress was needed in how teams engaged with people in their communities, particularly in embedding inclusive approaches into everyday practice.

Since the pilot assessment in 2023, we have raised awareness of EDI for our staff through broader training, performance development objectives, and further Team Talks and agreed new EDI practice standards, which have been recognised by ADASS as an exemplar. We have made progress embedding EDI into our strategic and operational delivery through a refreshed ASC EDI Action Plan 2022 – 2026, accountable to SCC's Strategic Equalities & Inclusion Board, and are now adopting the Cultural Inclusion through Voice, Insights & Communities (CIVIC) framework to further focus our ambition. We have seen the impact through examples of inclusive practice and through the development of specific work to meet the needs of specific groups such as people with sensory impairments, cultural or language needs, or at risk of social exclusion e.g. veterans, rural communities.



Theme 1

Working with People in Suffolk



Anything that gives others the opportunity to flourish as [my son] has done since having his own home and supported by 1 to 1 should be celebrated and encouraged. He has emerged as a confident, positive person, engaged and fulfilling his potential thanks to his new Care and Support package.

Parent of a person with learning disabilities who transitioned from supported living to independent living.

“”

Our Key Strengths and Achievements

- **Strengths-based, person-centred approach:** Our nationally recognised Integrated Neighbourhood Team model enables a multidisciplinary, strengths based, holistic and person-centred approach to care, drawing on local networks, neighbourhood resources, and care technology to respond to people's needs in a holistic, innovative way.
- **Well-established practice model:** Our practice is underpinned by our well-established Signs of Safety practice model, further enhanced through the integration of trauma-informed restorative practice, deepening our understanding of lived experience.
- **Prevention is strongly embedded:** Our prevent, reduce, delay approach embeds information, advice, guidance and signposting throughout the customer journey supporting early intervention and informed decision-making.
- **Improved access to support:** We have significantly improved the speed of access to initial assessments through our Independence and Wellbeing service, evident in a fall in the numbers of people waiting from 578 in September 2023 to 241 at the end of August 2025.
- **Timely financial assessments:** We have significantly improved the speed at which people get a financial assessment, going from 28% of financial assessments completed within 28 days as of September 2023 to 89.5% completed within 28 days in August 2025, with the median waiting time reduced to 14 days.
- **Improved access for carers:** We have introduced carers' self-assessment and halved the number of outstanding carers' reviews to 1,171, from 2,152 in October 2024.
- **Innovative use of digital care:** We have a robust and innovative care technology offer reflected in high uptake and strong satisfaction ratings.

Areas of focus

- **Advance equality, diversity and inclusion in ASC:** Roll out our new EDI practice standards, further align our ASC EDI plan with corporate EDI priorities, and embed the People at the Heart of Care coproduction framework to ensure that seldom-heard groups and people with protected characteristics consistently shape decision-making and service design.
- **Increase choice and control through Direct Payments:** Continue to drive cultural and practice change to increase uptake, strengthen review processes, and expand digital options, ensuring Direct Payments are used as a flexible tool for personalised care and support.
- **Continue to improve people's waiting times at the Front Door:** our pilot assessment highlighted waiting times for Customer First as an area for attention. Planned improvements, including the introduction of an initial assessment team, have had a positive impact though this has been offset by other issues affecting resilience. The service has now been stabilised, and the improvement programme is continuing to make good progress.
- **Tackle demand and waiting times strategically:** Deliver a sustainable, whole-system approach to reducing assessment and review waiting times, through risk stratification, guidance for managing risk while people wait, provider-informed reviews, and use of digital and AI tools to reduce the recording burden, releasing practitioners' for more direct work with people.
- **Transform the Occupational Therapy offer:** Develop a new strategic plan for OT led by our new Principal OT, reducing waits and enhancing timely access to equipment and adaptations that promote independence.
- **Embed prevention in ASC commissioning:** Working with colleagues including Public Health & Communities, implement our council wide prevention strategy to systematically shift resources towards early intervention and community-based support.
- **Further strengthen information, advice and digital inclusion:** Coproduce further improvements to Information, Advice and Guidance (IAG) with carers and community partners, ensuring our Front Door is accessible, inclusive, and digitally enabled.



1.1 Assessing Needs

Our Adult Social Care teams provide timely, consistent assessments and co-produced care and support plans, focused on clear, transparent outcomes and regularly reviewed. We work closely with partners and offer a range of specialisms, including complex care teams and dedicated services for mental health, learning disabilities and autism, sensory impairment, hospital discharge, safeguarding, Deprivation of Liberty Safeguards (DOLS), and Direct Payments.

Our Integrated Neighbourhood Teams (INTs) support our joined up, strengths based, person centred and multidisciplinary approach to working with people, maximising opportunities to connect people with resources in their local communities and neighbourhoods, while embracing care technology, creative practice and other innovation. Our INT model has been in place over ten years in bringing care closer to home. It is supported, variously, through colocation, jointly funded posts and strong relationships, and is developing further through the National Neighbourhood Health Implementation Programme and through local ambitions to develop system enablers such as system interoperability. Further information on the INT partnership model is set out under Theme 2.

Our experience with the Adult Social Care Occupational Therapy Service was exemplary. A and I were reeling after a life changing diagnosis of Motor Neurone Disease. [The OT] came to our house and offered a calm dose of experience and common sense. She helped to guide our thoughts on the need for a ground floor wet room, riser recliner chair and hoist. She very quickly put us in touch with the people needed to deliver these projects, arranging home visits and attending with each of the suppliers.

The big project was obviously the wet room and [the OT] put us in touch with S from the DFG Team and the two of them have kept in touch throughout the whole project.

We are now in a good position to face the challenges ahead and a lot of that is due to the care and attention given by this team.

Person diagnosed with MND supported by ASC OT

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Assessments and Reviews

We work to fulfil our Care Act duty to assess people in a timely manner and review support at least annually, ensuring individuals' needs are understood, outcomes met, and risks managed. Assessments are delivered through a mix of initial interventions, Care Act and OT assessments, and carers' assessments. Our ambition is to complete Care Act assessments within 28 days for medium priority cases and 42 days for low-risk referrals. Our median waiting time for a long-term care assessment across all priority groups currently stands at 14 days. High-risk referrals get an immediate response from our duty teams. Our assessment and review services operate in the context of increased demand. Between August 2023 and August 2025 there was a 7.1% increase in demand for ASC services. In August 2025, 11,753 people accessed long-term support (CPLI), of whom 3,936 were aged 18-64, and 7,817 were aged 65 and over.

We have been an early implementer of supported self-assessment for adults and carers, enabling people to complete their assessment at a time of their choosing, promoting independence. Self-assessments centre people's voices and ensure they are heard – for example, a practitioner reading a carers' self-assessment reported: "I didn't realise their caring role significantly impacted their life to that extent. The self-assessment gave the carer an opportunity for deep reflection." The approach was co-designed with adults and carers also releasing practitioners' time to work with people with more complex needs.

Our Independence and Wellbeing Service (IWS) helps to manage demand by ensuring cases are triaged effectively while also providing tailored early support. An Intervention and Prevention Team was introduced at the front door in 2023 to provide early non-complex interventions, with an average response time of just 13 days.

Our workflow steering group, established in 2022, drives oversight of assessments and reviews. Using Power BI business intelligence dashboards, we track waiting times for initial interventions, Care Act assessments, OT assessments, and reviews. This data-informed approach has supported the decreases in waiting lists seen above.

Alongside this, we have transformed financial assessments, introducing the Searchlight system (which automates information-sharing between agencies) alongside revised business processes, to clear backlogs and reduce median waiting times to 14 days.

While progress has been made, we recognise challenges remain, particularly as demand rises. We ensure people who are waiting receive regular meaningful contact, advice, and signposting to interim support and equipment whilst risk to wellbeing is assessed and RAG rated, embedding risk stratification through our improved 'Managing Risk whilst people wait' guidance. We are piloting AI enabled recording tools which are helping to release professional capacity. In Ipswich and East, a project is rolling out the live allocation of OT work across the INTs to reduce delays further, building on learning from West Suffolk, and has so far reduced waiting lists by 53%.

Alongside the improvements to waiting times for initial assessments highlighted above, since the pilot we have also worked to reduce waiting times at Customer First, consolidating the Independence & Prevention Team offer and improving self-service digital provision. While we had some success in improving wait times, with abandonment at a low of 18% in December 2024, in 2025 resilience was affected by the national issues with LiquidLogic, our electronic case management system, between February and April, alongside an office move which in the short term impacted on turnover and vacancies, and we have seen waiting times increase again. We have now stabilised the service and are near completion of the initial design for our new Front Door which will increase resource for preventative services, make best use of technology, improve work with partners and redesign pathways to ensure we are best placed to meet future rises in demand. An experienced Digital Systems and Innovation Manager has also been appointed to lead on future LiquidLogic development.

We are also strengthening our review process through innovations such as provider informed reviews, and through coproduced 'Doing Reviews Differently' work undertaken in LD&A and Mental Health, detailed below. Continuous monitoring through the workflow steering group and DMT oversight ensures accountability and sustainability. Annual review performance is on an upwards trajectory with month-on-month improvements in the last quarter. From July 2024 to July 2025, 66.3% of adults in receipt of long-term care and support received their annual review within 12 months. Our ambition is to achieve 80% or higher compliance with annual reviews, building on work in Mental Health services which has seen the percentage of reviews completed currently sitting at 82.6%.

We maintain a comprehensive, evidence based and inclusive set of Adult Social Care (ASC) policies, practice guidance and procedures to support our practice. These resources are informed by current research, lived experiences of people gathered through compliments, complaints and feedback about our services, and input from practitioners and partners. Resources are aligned with our legal duties, the Signs of Safety practice model, specialist areas of practice and LiquidLogic, and are regularly reviewed by our Principal Social Worker (PSW) and Practice Leads to ensure compliance and alignment with best practice.

We provide robust, regular supervision and oversight of practice led by our PSW. Our staff access a good range of training and practice development. Learning is strengthened and supplemented through a central team of Practice Leads each of whom has a service specialism. We have good staff retention levels in our region and monitor staffing levels to ensure that we have the appropriate level of experienced staff available at any time. We respond to any gaps for example, a co-produced workforce campaign in learning disability and autism and mental health services has supported recruitment and retention of social workers. As a result, these services have gone from a 30% vacancy rate twelve months ago to having fewer than ten vacancies across the teams. Our staff value the progression and professional growth opportunities actively promoted within ASC, for example:

Over the last few years I have held a number of roles within SCC, transferring my professional skills as I have moved around the organisation. I began my career in Suffolk as a Social Worker in CYP's Disabled Children and Young People's Team, having previously worked in a Transitions team within a different local authority. I went on to secure a role as Senior Social Worker in our LD&A and MH service where I started to develop my leadership skills, then secured a management role in the new Transitions into ASC team. More latterly I have been promoted into the role of Operations and Partnership Manager for MH. Along the way, I have been supported through our Workforce Development offer and Professional Development Reviews to check and support the progress of my career, helping me to identify strengths, skills and opportunities alongside any areas for improvement.

Operations and Partnerships Manager, Mental Health

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Person-centred and strengths-based practice

We work collaboratively with individuals and their families to empower people to exercise choice and control, through personalised, outcome focused conversations at every stage of the assessment and review process. We recognise that taking supported risks is part of living independently and work with individuals to develop plans that balance needs, risks, and aspirations.

We monitor success through performance data, practice audits, reflective supervision and direct feedback from people and their carers. 80% of people using services in Suffolk report that they have control over their daily lives (ASCOF 2023/24 measure), placing us 39th nationally and demonstrating the impact of this approach.

We continue to develop our practice, placing greater emphasis on outcome-based support planning and encouraging innovation. Our digital tools are streamlining recording to release capacity for more meaningful conversations.

69.5% of those in long term support funded by Suffolk were satisfied with their care and support in ASCOF 2023/24, placing Suffolk in the upper quartile for England and second among our nearest statistical neighbours.

Person's experience

Z, a young man with Down's syndrome was living in shared accommodation with two other men supported by agency staff. Z was unhappy where he lived and was subsequently given notice of eviction which caused him great distress; he also worried about his future care and support.

Z was clear that he had an opinion on how his care was to be provided and that he could make some decisions for himself. After his parents purchased a property for Z to live in the social worker supported Z to identify what was most important to him now and in the future. Due to his past experience Z wanted to live alone and all decided that an Individual Service Fund was the most flexible way to support Z, working with a provider and his parents within a budget, to find the best way to provide his ongoing support.

Z now lives in his own home, has developed lots of independent living skills, travels independently to community activities and knows he has help on hand if needed.

Z said "I've got my own house, I have got my own support now. I am so happy now. I can cook for myself and I can go to places I like to go to. I am more than happy I've got my own house. I go to my courses on my own and I can get the train on my own. If I am stuck I can call [my support] to help."

His parent said "The ISF has made my life so much easier [as his Deputy]. This last year has been amazing. I've got my son back again which I did not have. He's totally empowered. He's fulfilling his potential now. The social worker helped make this happen. It's transformed his and our lives."

Incorporating feedback from people in the assessment process

Alongside compliments and complaints, feedback is gathered through multiple channels, including national surveys (ASCS and SACE), monthly monitoring of Customer First webchat contacts, Experience of Received Services (ERS) forms, commissioned research by Healthwatch Suffolk, and Adult Social Care (ASC) practice audit processes. This ensures feedback is continuous, diverse, and reflective of lived experience.

The Quality, Engagement and Practice (QEP) Board, chaired by an Assistant Director and/or the PSW, identifies key themes and insights from compliments, challenges, complaints and other feedback and disseminates these across ASC. Feedback drives meaningful change, for example, responding to a theme emerging from Ombudsman complaints relating to charging for care, our finance team ran education sessions with practitioners following which Ombudsman complaints on this subject have decreased.

We have engaged extensively with frontline staff to inform our People at the Heart of Care strategy and transformation plans, six workshops across the county attended by a total of 226 staff and 342 attendances at online drop-in sessions. Staff feedback directly shaped additional themes and considerations for our transformation plans, for example, focused work to establish fair rates for care provision accessed through a direct payment. Staff also highlighted opportunities to promote and clarify the Adult Social Care offer via partners, which has informed development of our system wide approach to developing our new Tier 1 and front door services.

Public engagement through over 230 attendances at public workshops and coproduction forums has also informed the People at the Heart of Care strategy, including our new direct payments model and Front Door redesign. People at the workshops told us that they needed more clarity about how to stay in contact with their team or allocated worker and we have implemented clear guidance for staff to achieve this, with the impact currently being monitored.

Our Independent Lives programme has coproduced improvements to the review process for people with learning disabilities and autism. People told us that reviews weren't timely and person centred enough and that people didn't always know what a review is for. As a result, we introduced 'Doing Reviews Differently' which takes a proportionate approach to reviews including online options such as Teams alongside telephone reviews, alongside a suite of information on the Suffolk Ordinary Lives website to explain what the Care Act is, what a review is and what to expect. As a result, we have increased our annual review rate for people with a learning disability or autism to 66%, from 49% in August 2024 – well over the national average of 30%. These are part of wider programmes of public engagement and coproduction, captured elsewhere in this self-assessment.

We embed lived experience into other routine processes. For example, ASC audits include a Person's Feedback section within the LiquidLogic audit form. We continue our regular analysis of Customer First webchats, which have increased by 16% in 2025/26 compared to 2024/25. Our Lessons Learnt Protocol encourages reflection and improvement following specific challenges. ASC is also embedding co-production more consistently beyond LD&A and Mental Health, supported by the recruitment of a strategic coproduction partner.

Carers

We recognise and value the vital role of unpaid carers in Suffolk. We co-produced a five-year All-Age Carers Strategy in 2022, supported by a detailed action plan developed in collaboration with leads and stakeholders and overseen by the Family Carers Partnership Board in which family carers and organisations play an equal role.

Actions include working with the private sector to promote improved access to carers' IAG for their employees, establishing stronger links with health services to raise awareness of young carers' needs, and holding community engagement events which enable carers to shape systems and services. A carer-focused working group has been formed to address health and wellbeing priorities.

We strengthened our approach to carers' assessments and reviews following high waiting lists identified during our CQC pilot. We have implemented a new carers' review approach which is a trauma-informed, carer led process that places carers in control of the timing of their carers review. The new approach maximises the benefits of our established supported self-assessment option, while ensuring the facilitated option remains available where preferable to the carer or where there are safeguarding or carer breakdown risks. Each carer is consulted individually to inform a personalised approach tailored to their individual circumstances. We have also provided additional capacity alongside Suffolk Family Carers to meet demand. This approach has received positive feedback from carers, reduced delays and has better integrated carer reviews with adult reviews. Between October 2024 and September 2025, the number of overdue carers' reviews fell from 2,152 to 1,171 with further improvements expected.

Person's experience

G was offered a carers' assessment with ASC. Initially the only support she sought was a cleaner, but through a strengths-based conversation the practitioner was able to support G to consider her needs more holistically and reflect on her broader wellbeing. This led to the offer of a direct payment to enable her to attend singing lessons, allowing her to engage in a meaningful activity and promoting her love for art and music.

G fed back that she felt listened to and energised by being able to pursue her own hobby and have a meaningful break from her caring role.

Support resulting from a carers assessment could include a Direct Payment, connection with local support groups, carers' breaks, or other activities aimed at maintaining and improving carers wellbeing, including commissioned support from Suffolk Family Carers. These include information, advice and guidance, advocacy, workshops, events, drop-in sessions, and family carer groups.

Sometimes I just need to talk to someone who understands what it's like to be a carer, your emotional support has been so valuable.

Feedback about Suffolk Family Carers' services

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It means a lot that I have had a safe space to discuss things and knowing there is someone who understands to support us. It's really helped me get through a hard time.

Feedback about Suffolk Family Carers' services

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Alongside Suffolk Family Carers, we commission the Suffolk Advice, Guidance and Emotional Support (SAGES) service, which offers free, confidential support to family carers, relatives, and friends of individuals experiencing mental and emotional wellbeing challenges, and in response to carers' feedback, have coproduced a Carers' Digital Champions project with VCFSE partners to help carers build confidence in using digital tools and accessing online resources. Parents/carers working with LD&A or MH services are offered opportunities to talk directly with a senior manager via regular focus groups (co-chaired by the AD and an employee with lived experience). As a result, parents/carers have led sessions at staff practice workshops.

As a parent/carer voice on several Suffolk working parties, I have been involved in many co-productions with Adult Social Care teams from Suffolk County Council. I continue to be impressed by their willingness to share developments, to listen to input from service users, parents/carers and members of other agencies like care providers. Working together in this way is really helping to reshape mindsets and culture; this is undeniably moving toward a much more proactive and supportive service.

Parent/carer of a person with learning disabilities

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We perform well on carer satisfaction measures – 42% of carers reported that they were extremely or very satisfied in the Survey of Adult Carers 2023-24, which places Suffolk in the top quartile nationally. However, we recognise the need for continued improvement. There was a marginal decrease in the proportion of carers who reported that they find information easily in SACE 2023-24, with 56.5% indicating this, placing Suffolk just below the regional average of 56.6%, while feedback from carers obtained during development of the Carers' Strategy was that information was fragmented and difficult to navigate. Through our Carers' Strategy Action Plan and our IAG and Prevention Programme we are already improving this and have worked with Suffolk Family Carers to review digital resources, redesign Infolink pages, and embed clearer signposting to carers' support within MySCC. Early feedback has been positive, with carers reporting that information is easier to find, and this has also contributed to a steady increase in new registrations with Suffolk Family Carers (547 in Q1 25-26 compared to 421 in Q1 24-25). These improvements are continuing; in the interim we will continue to embed the changes to assessment and review and closely monitor these for improved timeliness and carer experience.

1.2 Supporting People to Live Healthier Lives

We support people to live healthier, more independent lives through our focus on prevention, early intervention, and strengths-based practice, underpinned by our Care Act duties and delivered in partnership across health, public health, and the voluntary, community, faith and social enterprise (VCFSE) sector.

Prevention is embedded in the Suffolk Joint Local Health and Wellbeing Strategy 2022–2027, the Norfolk and Waveney Integrated Care Strategy, and Suffolk County Council's corporate transformation programme, Fit for the Future. These enable Adult Social Care to align commissioning, operational practice, and workforce activity to support people at the earliest stage possible, maximising independence, improving wellbeing, and reducing demand for higher-cost and more intensive services.

We commission a wide range of preventative services, including in-house and externally commissioned reablement services; equipment and adaptations delivered through the Independent Living Service; and digital technology-enabled care through the Cassius partnership, which now supports over 6,200 people. We also commission housing-related support, carers' services, and a broad information, advice, and guidance offer enabling people to plan ahead and make informed choices. This offer is complemented by services led by Public Health and other partners.

Our prevention offer is informed by coproduction with people with lived experience and engagement with VCFSE organisations, such as our strong relationship with Suffolk Family Carers.

Suffolk Family Carers has built a robust, collaborative relationship with Adult Social Care over several years. Building an equitable, honest, open and transparent partnership has enabled us to work together within the system to ensure we develop the support unpaid family carers need in Suffolk.

Being welcomed into strategic planning and developments has enabled influencing, awareness raising and the opportunity to ensure family carers are included in design, and planning. Together we have built new services, helping to fill gaps in family carer provision with innovations such as digital inclusion projects.

The health and social care system in Suffolk understands the value in working together with the voluntary sector to help prevent crisis for family carers and their families.

Deputy Chief Executive, Suffolk Family Carers.

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Our pilot assessment highlighted areas for development, including reducing waiting times at the contact centre, and ensuring voluntary sector partners are fully integrated in prevention planning. In response, we have mobilised a system-wide programme to redesign services, embed digital self-service options, and implement a new Customer Relationship Management system to improve referrals and joined-up working across ASC and partners. The latter is a long-term programme and is making good progress with go-live due in May 2026. We are investing in leadership and capacity to embed prevention across all levels of practice, including the creation of the Principal OT role to enhance OT's preventative focus.

Access to services, information, and advice

We have a strong, multi-layered offer of IAG which is embedded throughout people's journey with ASC, from universal signposting through to tailored support for people with complex needs. We offer this through digital platforms, face-to-face support, and targeted outreach to ensure equity of access across communities. Our ASC Survey 2023-24 found that 71.6% of respondents reported that finding information to contact the department was easy, representing an improvement of 5.5% from the previous year, placing Suffolk in the upper quartile in England. Adults and carers consistently tell us that access to timely, reliable IAG helps them to feel more confident, independent, and better able to manage their own situations. Feedback from our pilot assessment emphasised the importance of digital options, improved signposting, and early access to advice, and the IAG and Prevention programme has enabled clearer pathways, including rewrites of webpages focused on dementia and carers' support carried out in collaboration with adults and carers and receiving positive feedback from them. Engagement with people with a learning disability, autism, or a mental health condition has also influenced development, ensuring resources will be accessible and are co-produced with the communities who need them most.

People can access high quality digital resources including the Care and Support for Adults webpages and Suffolk Infolink, which are used at scale, together receiving over 130,000 visits per month. These platforms were recently updated and reviewed for accuracy responding to feedback from adults and carers. Alongside this, voluntary and community organisations provide commissioned IAG across Suffolk, for example through Suffolk Family Carers, the Suffolk User Forum, ACE Anglia, and the Rural Coffee Caravan, which brings information and advice to rural and isolated communities.

For those requiring more tailored support, Customer First acts as the primary front door into Adult Social Care, offering advice and guidance before any referral is made to social work teams. The Independence and Wellbeing Service (IWS) provides in-depth preventative advice, while reablement and progression services incorporate IAG as part of supporting people to regain independence. IAG provision is designed to be inclusive, with adapted formats and targeted resources for people with a learning disability or autism available on request. Responding to feedback, we are developing further dedicated resources at the front door for people with a learning disability or autism or people with a mental illness, shaped through co-production with people with lived experience.

Since the pilot we have improved the speed at which people get an initial assessment from our Independence and Wellbeing Service as well as maintaining the Independence and Prevention Team to provide enhanced support in Customer First. People requiring preventative support access the Independence and Prevention Team within 28 days and waiting lists across IWS have reduced to under three months in all teams as of July 2025, ensuring more responsive support than in previous years.

In April 2025 ASC took over the management of the Warm Handover Referral Scheme from Public Health, which enables referrals into preventative support across statutory and voluntary sector organisations. Over 150 partner organisations are signed up to use the scheme with around 275 referrals made each month. For example, during a Home Fire Safety visit, they were able to identify the person had some physical and mental health support needs; through the Warm Handover, Fire & Rescue made referrals to housing, mental health services and befriending services. The practitioner reports that "within days each of these referrals had progressed, and the appropriate support and changes were being put in place."

We have formalised our Adult Social Care prevention offer through our IAG and Prevention programme and this approach was formally signed off in September 2025. The Accelerating Reform Fund is being used to fund specific improvements to carers' IAG and digital inclusion, coproduced with Suffolk Family Carers who sit on the IAG programme board. We are investing in new digital tools, including pilots of AI call transcription within Customer First, working with corporate colleagues to introduce additional technology and innovation, including AI-assisted search across organisations and platforms, and embedding a system that will streamline referrals and support joined up working across ASC and partners. Alongside this, we are strengthening Preparing for Adulthood pathways and further digital inclusion activity, ensuring equitable access to information and advice for all communities, particularly those at risk of exclusion.

Learning disabilities and autism

We are undertaking extensive transformation of our learning disability and autism services, working alongside partners to develop new system-wide "Front Door" pathways, designed in co-production with people with lived experience, which will create a single point of access and ensure smoother transitions into adulthood.

Through the Independent Lives programme (centred on prevention, recovery and progression) we are changing the way we deliver ASC to people with a learning disability and their support networks. The programme brings together health, education and social care partners with people; all changes are co-produced with residents, families, and advocacy groups with ACE Anglia leading the way for people with a learning disability, supporting ASC to make sure their voices are heard and inequalities addressed. There is a strong forward plan of regular co-production in place through focus groups and all-day events, co-chaired at a senior level with a Peer Educator with lived experience.

At ACE Anglia, we believe our partnership with ASC at SCC is both unique and deeply valued. Through co-production on the Learning Disability Strategy, we ensure that the voices of people with learning disabilities are not only heard but actively shape the direction of services and support. Colleagues are listening and responding to the real issues and themes raised through our advocacy work. This collaborative approach is helping to drive meaningful change and move the strategy forward in a positive direction.

Self-Advocacy and Engagement Lead, ACE Anglia Ltd

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Whilst the programme's primary focus is on promoting independence and wellbeing, it also enhances the way we assess and review needs through a strong practice improvement theme which is embedded by regular all-staff practice workshops.

The practice workshops in LD&A and MH have been a really powerful way of sharing ideas and improving practice which includes both senior management and staff on the ground. The best way to make positive change is through all those across the service sharing the same vision. They have enabled us to draw on practice matters, finding the strengths and limitations within the service. They have supported us to improve the experience for those we work with, helping us to apply legal and policy frameworks. Because of the sessions, I have been able to make the improvements required in our team and share better ways of working.

Senior Social Worker, LD&A



The programme has successfully achieved roll out of national Oliver McGowan training across staff and providers in Suffolk, with 1,206 staff across ASC having undertaken the first part of the training.

A new Transitions into ASC team was created and this team has worked with just under 800 young people since its conception, supporting them to lead an ordinary life. The use of digital care has increased year on year across LD&A and redesigned day opportunities/ refreshed employment frameworks are improving progression opportunities. Supported housing in Suffolk has had a wholesale review, ready for the development of a new strategy that will feature progression at its core. A strong reprovisioning programme is in place, maximising efficiencies and improving the delivery of care and support to people. A comprehensive review of all Tier 2 services has been undertaken to identify progression gaps and potential for better join up with health partners.

A new outreach service has been established, working with people on the Dynamic Support Register to avoid admission into hospital (90% of those supported have been successfully enabled to remain in the community). This has played a key role in the Transforming Care Partnership being the best performing of the 42 ICB/TCPs in the country for adult inpatients, with out of region hospital placements now being rare and adult inpatient numbers across secure and non-secure services having steadily decreased over time.

Through co-production, people told us that people with an LD&A and poor mental health require a skilled intervention and specialist knowledge. We now have closer join up across our specialist LD&A and MH services, with a shared senior manager and joint teams, including Forensic, Transitions, OT and Review.

Mental health and wellbeing

Supporting people to maintain their mental wellbeing is a key part of our strategic approach to prevention and supporting healthier lives. Suffolk County Council Public Health, in partnership with the NHS, and the voluntary and community sector, developed a broad programme to strengthen protective factors for mental health and wellbeing across the population, building on research – an Emotional Needs Audit – completed with over 15,000 residents in 2023. Findings showed that unmet mental health needs often related to relationships, work situation, and financial security, with groups such as the unemployed and those with mental health conditions scoring lowest. This evidence base shaped the development of system-wide initiatives, including strategies on suicide prevention, physical activity, poverty reduction, and workplace wellbeing. ASC contributes through preventative services, and through its work at the Front Door.

Alongside these, over 100 grassroots community projects were delivered through the Public Mental Health Programme, targeting areas such as poverty, cost-of-living pressures, and physical activity. Projects funded through the programme helped local people feel more able to manage the challenges of daily life, reduced social isolation, and improved overall wellbeing. For example, workplace initiatives enabled employees to feel better equipped to manage pressures and contribute to organisational wellbeing, while participants' mental wellbeing scores linked to the physical activity projects improved from 21.9 to 23.7 over the lifespan of the programme. Across all projects, participants highlighted that access to non-clinical, preventative support improved confidence, created opportunities to connect with others, and gave them practical skills with long-term benefits. One participant stated "When I started meeting up with [project worker] I was very scared and isolated, with no friends or interests. I am now in a social group and at cooking sessions really enjoyed chatting to people and achieving so much more. I know for the first time what it's like to live in the real world, and it has shown me that it isn't as scary as I thought. Thank you so much."

We are undertaking further intensive transformation of our mental health services through our Independent Lives programme. Following the return of mental health social work staff to the county council on dissolution of the S75 agreement with NSFT three years ago, we have developed a strong service with high staff retention rates. We continue to work with the nationwide Think Ahead Programme and have supported 4 students per year for the last 4 years, rising to 8 in 2025/26. All but 2 students have been successful in becoming qualified social workers and have remained employed within ASC.

People with a mental illness in Suffolk now receive a robust Care Act assessment and timely review, with an 88% annual review rate for the MH service. Our MH Forensic team has received recognition from MAPPA for its outstanding contribution and one of our Forensic Social Workers won Gold Award for Adult Newly Qualified Social Worker of the Year Awards 2023.

We have created a strong community of practice through our regular practice workshops, working with a wide range of partners such as MAPPA, Probation and CYP to deliver training, supporting learning and strengthen our working relationships. We have used these sessions to improve our understanding and knowledge of legislation and policy, such as the Mental Health Act and the role of the social supervisor. We were recently commended by the QEP board for our response to the latest Safeguarding Adult Review, which boldly addressed concerns.

We have a strong coproduction partner in Suffolk User Forum (SUF) and a forward plan of activity to ensure that we take a 'nothing about us without us approach.'

SUF and SCC Adult Social Care form a valuable partnership. With our user networks we bring local knowledge and the established trust of service users, which has been built up over many years. Through coproduction and service user involvement in mental health, together we can work to ensure that people are at the heart of care in a meaningful way, ultimately aiming to provide the right care, at the right time, by the right person.

CEO Suffolk User Forum

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We have restructured our Approved Mental Health Professional (AMHP) service using a hub and spoke model, creating a dedicated permanent team alongside a county rota of AMHPs from across ASC and Norfolk & Suffolk Foundation Trust. Partnership arrangements with the MH Trust are maturing, with SCC and Norfolk County Council coordinating work with NSFT for consistency:

NSFT, Suffolk ASC and Norfolk ASC have recently set up regular meeting[s] with key leaders including Executives from the Trust. The purpose is to promote and progress collaborative working around a small number of key priority areas within adult mental health that impact each organisation – with joint solutions developed through a more integrated approach across health & adult social care. This should result not only in improved system relationships but sustainable joint solutions to ensure better outcomes for people through a more integrated approach.

Chief Operating Officer, NSFT

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We are working collaboratively with NSFT to help shape their transformation and ensure join up at every opportunity, and strengthening other areas of delivery such as S117 Aftercare, working with NSFT, the ICB and coproduction partners to strengthen the S117 Register, map and improve pathways and further improve S117 review performance.

We have developed a new service specification for MH supported housing which is currently out to tender and will seek to maximise independence. Similarly, our Housing Related Support Service provides a robust example of prevention.

As with learning disabilities and autism, ASC is exploring new Front Door models for Mental Health as well as improved IAG, ensuring people and families experience smoother access and better coordination between statutory and community-based services.

Direct Payments

Direct Payments and Individual Service Funds are at the heart of our personalisation strategy, supporting people to exercise greater choice and control. Over the past year, we have strengthened the infrastructure that underpins Direct Payments, clearing review backlogs, reducing processing times, and introducing improvements such as prepaid card accounts and joined-up care and finance reviews.

These have ensured people can access support in a timely and transparent way and resources are used effectively. For example, the number of people waiting more than 12 months for a Direct Payments review has reduced from 1,297 in 2021, when this work began, to 13, who all have allocated workers.

The central Direct Payments team now provides a single point of oversight, ensuring new arrangements are set up promptly and existing ones are reviewed with consistency and clarity. Processes have been streamlined, and training, policy documents and practitioner guidance have all been refreshed and co-designed with people with experience of Direct Payments, staff, and providers, embedding improvements in areas such as employing family members and calculating contingency costs. Financial management has also been modernised. Prepaid card accounts are improving transparency and streamlining administration, while revised financial assessment processes ensure greater clarity for people using Direct Payments.

Our approach has been shaped by extensive engagement. More than 300 residents and staff contributed to the co-design of a new end-to-end Direct Payments process, supported by workshops and targeted engagement with people with learning disabilities and mental health needs, ensuring the system reflects lived experience and practitioner insight. We have also worked with providers to align the Care Market Strategy, introducing standardised rates for Personal Assistants (PA) and expanding microenterprise models through our partnership with Community Catalysts. The 'Small Good Stuff' website acts as a directory for people to source a PA while a full PA register is in development. These steps have improved confidence in the system, widened the pool of available support options, and ensured consistent practice across Suffolk.

We know this approach is having an impact. While uptake of Direct Payments has remained steady since 2023/24, people's increasingly positive feedback is a clear sign that they feel supported to choose this route and appreciate the benefits. The central team are now working with other services to improve access to direct payments for new and existing customers. We are further assured through our supporting systems and direct payments monitoring mechanisms, which show fewer inappropriate uses of direct payments and a decrease in unspent funds needing recoups.

We are continuing to deliver improvements including full rollout of the redesigned process, a new PA register, Marketplace tools for more efficient brokerage, and practitioner training.

Person's experience

Y lives with dissociative identity disorder (DID) and was referred to Adult Social Care (ASC) after her increasing forgetfulness placed her at significant risk. A holistic assessment revealed that Y required 24/7 support but had no formal or informal care network. Traditional care such as a live-in carer were unsuitable, as they compromised her privacy and autonomy.

Working closely with Y, ASC explored alternative ways to meet her needs while promoting her wellbeing. Through collaborative support planning, it was agreed that an assistance dog would offer consistent, non-intrusive support, avoiding the need for a 24/7 carer. ASC funded the dog's training via a Direct Payment alongside a lifetime membership to a specialist service offering ongoing guidance.

This personalised solution not only supported Y's safety and independence but also enhanced her emotional wellbeing. As she shared: "A dog allows me to be independent and have privacy... It gives consistent and reliable support 24/7 as well as unconditional love... [our dog] cares for us and we care for him... how great is that!"

Digital Care

Digital care (our technology enabled care offer) is a core element of our approach. Through the Cassius partnership we support over 6,200 people across Suffolk with digital technology that enables them to remain independent, manage risks in their own homes, and reduce or delay the need for formal care. We use a wide range of devices such as sensors, smartwatches, responder phones and fall detectors to ensure people's needs are met in a personalised, safe and proportionate way. We have Digital Care Practice Leads within each service, supported by a countywide digital champions' network; dedicated digital discharge coordinators embedded in acute hospital pathways, ensuring that technology is considered early in the discharge process. Alongside this, initiatives such as Mobile Digital Care Hubs are extending the reach of digital care into rural communities to ensure they have equal access to information about technology, hospital discharge pathways, and preventative services, while we are embedding digital care into our reablement provision and working with SNEE commissioners on an integrated falls response service.



Feedback from people using Cassius technology is strongly positive, with a 'happiness' rating of 99.3% satisfaction with the installation and onboarding process. In West Suffolk Hospital alone, over 3,000 people have been supported by digital discharge coordinators with 35% of interventions preventing admission and 65% supporting timely discharge. We collect regular case studies to monitor our impact and share learning. By preventing escalation of need through digital care, Suffolk has delivered approximately £40 million in savings and cost avoidance. In 2023, the service received national recognition with industry awards and was also showcased at the European Social Network conference in Sweden.

Person's experience

P lives in Waveney and has a diagnosis of Alzheimer's dementia, lives alone and is having increasingly regular falls. The family visit daily and were becoming increasingly concerned due to falls, a recent hospital admission and P forgetting to take medication and were considering a residential placement.

Using technology at home to alert the family to any falls, including sensors to monitor routines and risks across the day and night, they were assured that the level of risk was lower than they initially thought. Simple Dementia Signage was put into place to prompt P to press their care alarm to prevent any long lies. An "Emergency Room Alert" notification was enabled to automatically alert the family if the sensor system suspects a fall. The family purchased a digital dementia clock for medication reminders.

P has been safely supported to remain living at home with a variety of care technologies and clear contingency planning. No long-term care services are needed currently. By using sensors and access to the Cassius Data Portal, the family now feel reassured and better able to support P to remain at home.

In 2025/26 we are working with commissioning colleagues and care providers to expand digital care into residential and supported accommodation, trial virtual wellbeing calls for people living at home and enhance our falls response and hospital discharge pathways so that digital solutions are embedded at the earliest opportunity.

Reablement services

Reablement and progression is a core element of our prevention offer. Our in-house Home First service operates 365 days a year, delivering intensive short-term reablement in people's homes following hospital discharge or community referral. Support is goal-focused, co-produced with individuals and carers, and designed to promote daily living skills. This ensures that people return safely to their homes and communities, with the maximum independence achievable.

We have expanded the service significantly over the last 24 months through Better Care Fund investment. This included recruiting 52 additional reablement staff and commissioning additional external capacity through the care market. We have also strengthened integration of OT into reablement. Home First support up to 100 new people each week, make over 800 visits a day, and deliver more than 11,500 hours of reablement each month.

66.4 % of people who accessed reablement services in Suffolk completed and did not need long-term care, whilst a further 14.7% were partly re-abled. Independent population health management analysis showed the service reduced A&E use by 23.5% and readmissions by 64.6% compared with a matched cohort, demonstrating its impact on both individual independence and system flow.

Demand for reablement has increased by 20% compared with 2023/24, with referrals rising from an average of 582 to 680 per month. We are continuing to improve reablement provision: consolidating the additional capacity to ensure timely access, further mainstreaming digital care, and increasing the integration of OT into everyday practice. We are also developing more specialist reablement, recovery and progression pathways for people with learning disabilities and autism or a mental illness.

Occupational therapy, aids and equipment

Reablement and progression is a core element of our prevention offer. In our Home First reablement service we make strong use of occupational therapy, equipment and adaptations. Occupational therapists are an integral part of social care, reablement and progression teams, supporting people to access equipment and adaptations. Simple equipment and minor adaptations can also be accessed via non-OT staff who have completed the Trusted Assessor Training. OTs make use of the Cassius service in their practice. SCC also hosts the Independent Living Service on behalf of district and borough councils to discharge their statutory duties in relation to the Disabled Facilities Grant (DFG).

An underspend on DFG in 2024/25 has triggered focused work with partners to improve utilisation, provide more capacity to manage DFG waiting lists, and ensure more people benefit from adaptations at the right time. Our Principal OT is providing leadership to drive innovation, strengthen the integration of OT across services, and oversee strategic development of OT.

Further work is underway to reduce OT waiting times. In the West locality, waiting times for OT assessments have been reduced through skill mixing, with an increase in Occupational Therapy Assistant roles to support less complex tasks. This approach led to a reduction in the number of people waiting from 211 in August 2023 to 84 in September 2025. Ipswich and East currently have a proof-of-concept project underway within their Integrated Neighbourhood Teams (INTs), where triaging of OT waiting lists is shared across health and ASC, building on learning from West Suffolk which has lowered OT waiting lists from 160 at the start of July 2025 to 75 at the start of September. We are reviewing the learning to identify similar opportunities for the North locality where waiting lists currently remain higher. The LD&A OT offer has developed significantly over the past two years and has worked with 409 people since our pilot assessment.

Social Prescribing

Social prescribing is embedded across Suffolk. ASC practitioners refer individuals as part of assessments and discharge planning, helping address wider determinants of health and reduce avoidable admissions, while ASC leadership ensures the model is fully integrated and aligned with Care Act duties. Feedback from people highlights benefits such as improved mental health, increased confidence, new friendships, and enhanced employability. Delivery is through LifeLink in West Suffolk, Connect for Health in Ipswich and East Suffolk, and an all-age, system-wide model in the Norfolk and Waveney ICS area.

The services work at scale: for example, in 2024/25, Connect for Health supported 3,604 referrals across Ipswich & East, including hospital to home pathways where ASC and link workers jointly addressed barriers to recovery and reduced the risk of readmission. Data from Ipswich & East shows that A&E attendances reduced by over 40% in the six months following a first social prescribing contact, with unplanned admissions reduced by 45%. Personal health budgets are used to deliver social prescribing outcomes. In surveys, 89% of participants reported feeling more confident in accessing the help they needed, while 99% were satisfied or highly satisfied with the support received. Personal wellbeing scores improved, showing tangible outcomes in life satisfaction, reduced anxiety, and increased confidence.

1.3 Equity in Experience and Outcomes

Equity in experience and outcomes is central to Suffolk's vision for ASC, to ensure that every adult can access services in a fair, timely, and inclusive way, and that outcomes are consistently equitable across our diverse communities.

We approach this by removing barriers to access, ensuring people can obtain information and support in formats and languages that meet their needs. We work to reduce inequalities in outcomes, addressing systemic and structural factors that can leave some groups disadvantaged, whether through digital exclusion, immigration status, or discrimination. We embed equality, diversity, and human rights into all levels of the organisation, from corporate strategies such as our Race Equality Action Plan to service-level Equality Impact Assessments.

Coproduction and community voice are central to our approach. We work with advocacy partners, forums, and lived experience groups to shape services, ensuring the perspectives of people and their carers influence decision making. Finally, we translate equity into practice through personalisation, employment, and inclusion initiatives that support independence and wellbeing.

Removing Barriers and Improving Accessibility

We are working to ensure all adults in Suffolk can access information, advice, and support in ways that meet their needs, recognising that barriers to communication or service access can reinforce inequalities. To do this we combine practical tools, reasonable adjustments, and targeted accessibility measures.

Case study: Health Outreach

The Health Outreach team provides help and support to people who would not normally access healthcare, such as the homeless, Gypsies, Travellers, Roma, refugee and asylum seekers, migrant workers, ex-offenders and Black and Minority Ethnic groups. The team works closely with local GPs, voluntary sector, social services and many more to provide access to healthcare and treatment to people who find it difficult to access mainstream services. The team will signpost people to appropriate services that suit their needs. The team is made up of nurses, mental health nurses, social workers, support and advice staff, counsellors and trainers.

Interpreting and translation services are available across ASC, covering a wide range of languages to support people whose first language is not English. This is complemented by translation of written materials, ensuring residents can access essential information about their rights, entitlements, and local services. In response to learning from a complaint, we introduced a Reasonable Adjustment Flag within our case management system which ensures that any personalised adjustments such as communication support or environmental changes are clearly recorded and visible to all practitioners.

These arrangements are supported by online accessibility resources which direct residents and carers to web-based tools and services that can meet a wide range of needs, including commissioned support for sensory impairments, interpreting and translation services, digital accessibility guidance, and the council's broader commitments to equality and inclusion. We have invested in ensuring our front door is accessible by both telephone and online contact routes, embedded translation and interpretation support into our core offer and are building on this in our work to improve Front Door accessibility for people with a learning disability or autism. We are working to capture impact more systematically through feedback mechanisms and will strengthen our evidence by accessibility measures to people's outcomes.

We operate and deliver Sensing Change, a specialist sensory service for people with sight and hearing loss which provides Care Act assessments of need, social work and rehabilitation support, and equipment to promote independence, ensuring over 114,000 Deaf or Hard of Hearing residents and more than 5,000 people with sight impairments can access tailored support. The service promotes inclusion, offering information, equipment, mobility training, and sensory support which help people access other services.

Person's experience

H, a woman with dual sensory loss, profoundly deaf and severely sight impaired, was initially scared and lacked confidence but wanted to manage her benefits independently, contrary to the DWP's suggestion of needing an appointee. Sensing Change worked with the adult to empower her to take control of her situation. The team advocated directly with the DWP to challenge misconceptions and ensure H's needs were understood including challenging organisational and structural discrimination failing to adapt to H's needs.

H was introduced to a profoundly deaf support worker, which created immediate trust and understanding. This culturally sensitive approach was crucial in building rapport and facilitating effective support. British Sign Language was used throughout to ensure H fully understood her rights and options including translation to support access to information.

H received a laptop and support to navigate digital systems. She began to feel empowered, recognising that the barriers were systemic, not personal. She said "I was so scared and felt useless. Now I feel I can and will be independent."

Inclusion and Reducing Inequalities in Outcomes

We have developed Equality, Diversity, and Inclusion (EDI) Practice Standards for ASC, which provide a robust framework for embedding inclusive, person-centred, and equitable approaches into everyday practice. These standards ensure all staff are equipped and supported to recognise and respond to individuals' diverse and intersectional needs, including those linked to protected characteristics, personal histories, and lived experiences. The standards are shaped by the Think Local Act Personal "I" Statements and align with our WE ASPIRE values, Customer Commitment, and People at the Heart of Care ambition. They have been recognised as an exemplar by ADASS and are being recommended for national and regional adoption. Our staff are increasingly confident in their ability to work sensitively with people and consider their identities and cultures.

We have targeted strategies and policies to support groups who are more likely to experience poor outcomes or exclusion. Our ASC Working with Adults from Abroad Policy provides clear guidance to practitioners on supporting individuals who may face additional challenges linked to immigration status, language, or access to entitlements, reducing the risk of exclusion for people new to the UK. Our Code of Practice on third-party harassment, developed in partnership with Suffolk Care Association, addresses the risk of abuse or discrimination towards staff in community or care settings.

Our care technology promotes digital inclusion, particularly in rural communities where access to services can otherwise be limited. For example, our Cassius team worked with a man in his 40s with a learning disability and diabetes, who lives in a village and was at risk of missing insulin injections when out of the house. By using a smartwatch and responder phone linked to Cassius, the district nursing team could safely monitor and locate him, avoiding the need for him to leave his home or have other more restrictive interventions. Digital inclusion is supported by a dedicated network, led from within Public Health and Communities.

We use evidence to identify groups at higher risk of exclusion or poor outcomes, drawing on our Joint Strategic Needs Assessment (JSNA) and Population Health datasets. In Suffolk these include veterans, street drinkers, minority communities, including Portuguese, American, Romanian, Bengali, Gypsy, Traveller and Windrush, and people living in rural and coastal areas. We work to ensure our staff can respond to the needs of these groups and that our service delivery is inclusive.

Person's experience

T, a young man became homeless following a family breakdown. Initially presenting with memory loss, low mood, and signs of trauma, he was supported by the local district council housing group, Health Outreach, and Anglia Care Trust (ACT) as well as being discussed at the Rough Sleeper Working Group weekly meeting which ASC attend.

Professionals suspected a brain injury and substance misuse, later confirmed as long-term drug misuse. ASC completed a Care Act assessment, identifying that he lacked basic life skills and required daily prompting for self-care and support with managing his finances and maintaining a home.

Since being housed at ACT, T has made significant progress. He now receives full housing benefit (bi-weekly payments), and support from a local healthcare service, Youth Mental Health, and Department for Work and Pensions. He is managing simple tasks independently, taking prescribed medication, and is open to exploring supported housing. His journey reflects dedicated multi-agency collaboration and T's growing willingness to work together to build independence; he was ultimately assessed as independent, with no long-term social care needs.

Embedding Equality, Diversity and Human Rights

Our council Race Equality Action Plan sets out specific commitments to tackle racial inequalities across the organisation, including improving representation in the workforce, addressing disproportionality in outcomes, and ensuring that staff have the tools and training to challenge racism. It is supported by our refreshed ASC EDI Action Plan 2022-26 and our adoption of SC-WRES. Our council Equality Statement and WE ASPIRE values provide a clear framework for decision making, reinforced by Equality Impact Assessments (EIAs).

Mandatory training including anti-racism, unconscious bias, sexual harassment, alongside the Oliver McGowan learning, embeds equity into our day-to-day practice, supported by directorate and corporate awareness-raising events. We hold a broad programme of Equality Team Talks: structured, values-led conversations fostering awareness, understanding, and inclusive behaviours across all protected characteristics. Guided by lived experience, they help staff challenge non-inclusive views, centre marginalised voices, and take personal responsibility for learning. These talks have improved awareness of cultural diversity, intersectionality, neurodiversity, gender identity, sexual orientation, disability, and other protected characteristics, enabling more inclusive, person-centred practice. Our Care Act Assessments and Care and Support Plans include a section on identity and culture, ensuring individuals are considered holistically, recognising and supporting their unique strengths, values and needs. An EDI Practice event, focused on anti-racist practice and working with LGBTQ+ older people, has given staff insight into the unique challenges faced by individuals, and strengthened their confidence and skills to apply this understanding in ways that improve people's experiences and outcomes.

Person's experience

S and T, twin siblings with learning disabilities, were primarily cared for by their mother. Creatively using a direct payment and working with local Community Catalysts, ASC supported the twins' mother to create a CQC-registered agency employing a 'care network' of personal assistants. As a result, the twins are supported by a team who are best placed to provide tailored, skilled and consistent care. This allowed the twins' mother to direct and participate in their care, while most importantly for her, releasing time to be their mother.

She said: "I have twins with highly complex needs and have never found a service that could meet their needs. So, I developed one myself using direct payments. In the last eight years, I've watched my children thrive and blossom because they are truly listened to and given choice and control over their own lives."

Via Sensing Change, we also provide support to health, social care, fire, and education organisations to understand and remove barriers for people with sensory loss. Professionals receiving the training report that "I will be able to communicate effectively with customers that have a sensory loss" and "I will have some practical methods to employ when working with people with a sensory loss."

Coproduction and Community Voice

We recognise coproduction plays a key role in ensuring equity and work alongside adults, carers, and advocacy organisations to achieve this. Our Dementia Strategy, Learning Disability Strategy, Autism Strategy, and All-Age Carers Strategy were all coproduced or codesigned with residents, carers, and community partners. Through the Independent Lives transformation programme, we have embedded coproduction in the redesign of housing, reablement, and transitions. People with lived experience actively shape priorities through workshops and forums, enabling us to align practice change with what matters most to people who use our services, ensuring transformation reflects the aspirations of individuals and their families.

We use evidence to underpin inclusive commissioning, again drawing on our Joint Strategic Needs Assessment (JSNA) and Population Health datasets to identify groups at higher risk of exclusion or poor outcomes. Insights from this work inform targeted engagement and coproduction, ensuring seldom heard voices are captured and reflected and shape plans to reduce inequalities. For example, work with people in prison is leading to additional support from our specialist acquired brain injury (ABI) service to prison staff, given the high incidence of prisoners with ABI. Our digital innovation has also been shaped by coproduction. Adults and carers were extensively involved in designing and evaluating our supported self-assessment forms, while our care technology offer was codesigned with people with lived experience, ensuring it meets practical needs such as helping people maintain social networks and manage daily living tasks.

We commission POhWER to deliver the Suffolk Independent All Age Advocacy Service in partnership with local advocacy organisations Ace Anglia, Suffolk Family Carers, and Suffolk User Forum, to ensure that people who may otherwise be marginalised can access independent advocacy. This strengthens their rights and ensures these are represented in care planning, safeguarding, and service design. Feedback from carers and providers emphasises that this model has increased trust and transparency, giving people greater confidence that their views lead to tangible changes.

Looking forward, ASC is embedding coproduction even more systematically across Adult Social Care. While we have strong evidence of engagement with specific groups, we are linking this through an overarching framework to guarantee that all voices are consistently represented: the new People's Voices at the Heart of Care coproduction framework, which brings together evidence, engagement, and action. The accompanying action plan will move our approach from targeted projects to a consistent, comprehensive strategy, ensuring equity across all areas of service design. Alongside this, we will continue to deliver the co-produced strategies and action plans described above.



Equity in Practice: Employment and Personalisation

Employment is another area where equity must be strengthened. Our Independent Lives Transformation Programme is reshaping supported employment opportunities, with coproduction partners including ACE Anglia helping to design inclusive employment pathways. These initiatives aim to reduce inequalities for people with learning disabilities and mental health needs, ensuring they have access to meaningful work, training, and volunteering opportunities.

Market analysis within the ASC Market Position Statement reinforces this ambition, highlighting the need to expand supported employment provision and create progression routes into work. This integration of commissioning intelligence with coproduction ensures that employment support is designed both to meet market gaps and to deliver equitable opportunities for individuals. We have strengthened personalisation by transforming our direct payments offer and are now diversifying options including developing micro-enterprises.

Direct payments and Individual Service Funds themselves allow care to be tailored to cultural, ethnic, and language needs.

Person's experience

V, a Portuguese woman had been supported with daily tasks by a strong network of friends to maintain her nutrition, hygiene, wearing appropriate clothing, laundry and being safe within her home. She was referred to ASC's Home First service as her support network were becoming overwhelmed. V declined support from Home First, as she was unable to communicate with support workers who did not speak Portuguese and would panic when strangers came to her home.

Recognising V's need to be supported by people who shared her identity and culture and to be able to communicate clearly to feel safe, ASC offered her a direct payment to enable her to retain her main carer and sustainably employ other Portuguese-speaking personal assistants from her local community.

Alongside this, our capability led commissioning approach ensures that support is designed around individual aspirations and strengths rather than the categories people fall into.

We recognise we need to capture more systematically the experiences of people at greatest risk of unmet need, including those from minority ethnic backgrounds, LGBTQ+ communities, and people with intersecting vulnerabilities. Looking ahead, our priority, through our refreshed ASC EDI action plan, is to ensure equity for all seldom-heard groups and people with protected characteristics is further embedded and made integral to commissioning, service design, and frontline practice.

Person's experience

M was born with no vision and relied on her mum for many aspects of her life but wanted to learn more for herself. M's mother has a profound hearing loss and poor health so in the future will not be able to support M as much as she used to, and M wanted to learn new skills so she could support her mother in return.

ASC Sensing Change team worked with M to teach her further independent skills. She learned safe new routines outside using a long cane, and ASC sourced funding to provide a talking microwave, a PenFriend labelling device, a colour detector, and an Alexa for digital assistance to plan her days, set reminders and communicate with services. She learned everyday living skills including hoovering, chopping food and looking after clothes, along with personal care advice such as looking after her hair. She was supported to get a PIP medical assessment. The PenFriend and colour detector enable her to select things for herself including choosing her own clothes for the first time.

M says, "I am now able to use the microwave, hoover, mark items using the PenFriend and the colour identifier so I can identify things myself. I can pick my own clothes myself. I can go for a walk now, with no roads to cross."



Theme 2

Providing Support in Suffolk



Key areas of strength

- **Strong and effective partnerships:** ASC has strong relationships with its providers and health partners, providing a solid foundation for shaping local policy, monitoring care quality, designing services that meet local need and delivering effective services together. Our standards of care are among the highest local authorities nationally, benchmarking at 86.4% of all locations with a published rating rated good or outstanding by CQC compared to the regional average of 82.1% and the national average of 84.1%. Our proportion of providers with an outstanding rating is 11.7%, more than double the regional average of 5.4% and nearly three times the national average of 4.5%.
- **Neighbourhood delivery:** Our Integrated Neighbourhood Teams deliver personalised, place-based care through health, social care, and voluntary professionals. Using local needs assessments, they embed tailored care plans, promote community-based alternatives to hospital care, and champion innovation, improving reablement and reducing delayed transfers of care.
- **Innovating to provide complex support:** We have responded to the challenges identified in our pilot assessment relating to availability of accommodation for people with complex needs, including co-developing an innovative assessment and reablement service for people with higher and more complex needs at Wickham House, and a successful capital build programme, market development through the Transforming Care partnership, and related outreach services helping people remain in their own homes for adults with learning disabilities, autism or mental illnesses.
- **Embedding personalisation through coproduction:** Our coproduced Care Market and Accommodation Strategies reflect extensive engagement with Suffolk residents, carers, providers, and professionals. They embed personalisation and independence throughout planning, promote innovative care models and micro-enterprises, and support timely hospital discharge through sustainable, person-centred provision tailored to local needs.

Areas of focus

- **Increasing our focus on strategic commissioning:** We are actively strengthening our strategic commissioning capacity to ensure prevention and progression are embedded earlier in service design. Through our recent restructure, we have reshaped key roles to focus more on commissioning and are recruiting an Assistant Director with a dedicated portfolio in this space.
- **Increasing Care Market capacity & capability:** We are continuing to increase market capacity to support people with complex needs, including dementia, in the medium term through a strategic plan for commissioning residential and nursing care.
- **Strengthening relationships across the VCFSE sector:** Feedback from VCFSE partners has highlighted a need for greater clarity in strategic leadership and coordination across the sector, particularly in relation to prevention. Work is underway to strengthen this through enhanced engagement, formalised governance, and a council-wide approach to prevention and strategic commissioning.

2.1 Care Provision, integration, and continuity

We commission and deliver high quality care, informed by a detailed understanding of the preferences of adults and carers, using our strong relationships with Healthwatch and with our co-production partners ACE Anglia and Suffolk User Forum.

Our Health and Wellbeing Strategy sets out a vision for improving population health through integrated, place-based working. The strategy is underpinned by population health data, including the Joint Strategic Needs Assessment and local insight tools, enabling targeted interventions where need is greatest. We have shared system performance metrics across hospital discharge pathways, reablement and intermediate care which are reported into our system governance forums. Our population health management (PHM) dataset brings together information from across Adult Social Care and health to inform strategy and interventions, and this data led, integrated approach ensures resources are aligned in a joined-up way to reduce health inequalities and improve outcomes.

Case study: Woodbridge Holistic Assessment Team (WHAT)

Ipswich & East Alliance used the PHM reporting suite and linked datasets to understand why falls are a powerful predictor for high system usage across primary care, acute, social care and community services. The analysis explored the demographics of those who had experienced a recent fall compared to a similar cohort who had not fallen, including a comparison by key health conditions, risk factors, the average number of contacts with services in the year, and the average costs per person per year by service used. Population projections from the Office of National Statistics were combined with this data to forecast future falls activity and cost to the system.

The analysis identified a high prevalence of falls in the Woodbridge area which drove the conception of the Woodbridge Holistic Assessment Team, an early intervention for first fallers, near misses, stumbles, and people who are anxious around falling. The 'one stop shop' team offers a whole person and carer assessment of needs in one afternoon – combining social care, therapy, matron, pharmacist, social prescribing and wider review and support. They offer health and care advice, support, and guidance to minimise the need for several appointments and visits to multiple professionals over several days with much longer waits, instead minimising the risk of further falls and offering a unique quality service for their community.

The Director of Ipswich & East Alliance, describes the team as 'a practical example of our partnership' and notes 'the customer/patient feedback and emerging longitudinal data shows a reduction in falls and improving wellbeing.'

'It was a very useful morning. It's not often one gets time to focus on a range of related issues. Your organisation certainly has some clout. I had only been home for a couple of hours last Wednesday when my doctor's surgery was on the phone to book the blood tests and lend me a blood pressure monitor as suggested by your pharmacist!!'

'From entering the hall until leaving, everyone was most welcoming, helpful and informative. We never felt that we were wasting anyone's time, indeed, as much time as was needed was accorded to each individual. We both learnt a lot and received heaps of useful information, mental, physical and financial. My husband was a different man walking out from the one who walked in. His whole personality had changed back from the old, bent, shuffling shell, to the man he had always been, and the change has continued throughout today.'

'Although it was a falls and balance clinic it was about wellness which was most important for me.'

“ ”

Working with partners to deliver joined-up care informed by local needs

We work closely with colleagues across the Council, in the NHS and the VCSE to meet these needs and to provide joined up care wherever possible. This approach is evident in strong partnerships with providers, health, districts and boroughs, adults, carers, and community organisations.

In Suffolk and North-East Essex (SNEE) ICS we deliver support through our INTs, while in Waveney the Great Yarmouth & Waveney Community Collaborative supports transformation based on a nationally recognised Primary Care Home model. We understand the unique characteristics of local communities, including health inequalities, social determinants, and local assets. Integration can be structural, including integrated roles and/or achieved through strong working relationships, depending on the locality.

This collaborative model enables services to be shaped around the individual, supporting choice, autonomy, and personalised care. INTs also use detailed Place Based Needs Assessments (PBNAs) and dashboards to understand the unique characteristics of their communities, including health inequalities, social determinants, and local assets. PBNAs inform service design and resource allocation, ensuring interventions are flexible and holistic in response to people's needs.

These outcomes reflect a strategic shift from reactive care toward a proactive, integrated model that prioritises wellbeing and enabling interventions. In the past 12 months, Suffolk has accelerated INT development through enhanced collaboration between health and social care occupational therapists, addressing delays and improving preventative support and through community clinics which improve local access to social care such as our new Woodbridge site. Success can be seen in Suffolk's strong performance in relation to hospital discharge metrics, set out in more detail in Theme 3.

Suffolk County Council Social Care is an integral partner within the Ipswich and East Suffolk Alliance. We work, as health and care partners, in strategic and operational planning as well as to manage day to day pressures and for individual residents to join up and provide holistic care. Our community and care teams are all co-located with single management leadership, and work in partnership with GP practices, mental health and voluntary sector partners in each of our different neighbourhoods, enabling priority needs to be met. Our partnership is enabled by both pooled and aligned funds.

Director, Ipswich & East Suffolk Alliance

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Person's experience

R, an older person recently bereaved and living at home, was refusing engagement with health professionals and not following health advice for the management of his home oxygen, resulting in periods of shortness of breath. R had previously had negative experiences of the NHS and was declining all offers of help. He was sleeping in a soiled armchair, neglecting his personal care, not having regular meals and was at risk of greater self-neglect.

The INT offered a coordinated response involving multi-agency professionals including GP, Community Matron, ASC, a Social Prescriber and INT Coordinator to build a relationship to enable clearing of space in R's home for a profiling bed and wipeable rise & recline chair. R eventually agreed to trial some care and support with his personal activities of daily living and meals too.

Due to the coordinated and sensitive approach used, R subsequently agreed to long-term support, can now position himself in his profiling bed, and his personal appearance and mood has improved. Although still not always in agreement with his home oxygen management, his health has also improved.

Our countywide specialist Adult Social Care services work together with the Integrated Care Boards and with coproduction partner ACE Anglia to support adults with a learning disability or autism, governed through the Independent Lives programme. This has included significant work to improve services, reshape Supported Housing provision and to begin recommissioning other services including day opportunities. Our specialist countywide Mental Health services likewise work closely with the ICBs, with co-production partner Suffolk User Forum, and with NSFT to support people with a mental illness.

Over the past eighteen months the Independent Lives programme has developed a specialised brokerage function for LD&A and MH to support social work teams in sourcing appropriate care. Adult social care teams also work closely with Children and Young People's services to support young people transitioning to Adult Social Care and are currently building on this to develop a Preparing for Adulthood model. The ICB and NSFT are active members of the Practice and Funding Escalation Forums within LD&A and MH where person centred commissioning, practice and joint funding arrangements are agreed.

Joined up decision making about care

Delegated decision making, collaborative commissioning and management of integrated services with our ICB partners happens through Alliance and Place Boards across Suffolk. Adult Social Care plays a prominent and influential role in Alliance decision-making, with SCC senior leaders actively shaping the ICB's Joint Forward Plan, particularly in areas such as Ageing Well and Living Well. For Mental Health services, this governance is replicated in the Mental Health collaboratives where commissioning budgets are formally delegated and supported by a shared transformation team across SCC, SNEE ICB and NSFT. Integrated governance is also in place to support LD&A services through the LD&A Integrated Board for health and care, the Independent Lives programme board for transformation, and the LD&A Partnership Board supporting partnership working with people with lived experience.

We collaborate with providers to co-produce services, support innovation and enhance adults' choice and independence across our core portfolio areas of care homes, supported housing, extra care, homecare, day opportunities, short breaks and respite, community equipment, support for carers, advocacy, information and advice as well as special projects such as the Afghan and Syrian refugee responses. The Joint Suffolk Care Partnership, co-chaired by the Cabinet Member for Adult Social Care and the Chair of the Suffolk Care Association, supports collaboration with the sector, underpinned by provider engagement and provider forums.

We recognise the opportunity to strengthen our strategic commissioning capacity and embed prevention and progression more consistently within commissioned services from the outset. During a recent restructure, Strategic Commissioning and Contracts roles were realigned to place greater emphasis on commissioning skills. The new Assistant Director for this area, once in post, will build on this work to develop more proactive and outcomes-driven commissioning.

Person's experience

Wickham House is a jointly commissioned, complex assessment centre featuring a strong wraparound support offer from social care, community health, therapy and NSFT.

K was admitted to Ipswich Hospital, where she appeared agitated toward her husband and refused to accept her admission, saying she wanted to return home. Her husband reported a decline in her memory over the previous six months, including misplacing household items and refusing medication. She appeared confused and attempted to abscond from the ward, stating, "I want to leave to mind my children."

K was admitted to Wickham House, where the team conducted a thorough assessment, including a medication review, mental health support, GP involvement, and investigations into possible dementia or delirium. With Wickham House's support K has regained confidence in self-care and returned home to live with her husband. K was initially discharged with domiciliary care support but no longer requires care as she feels capable of managing independently.

Working with the market to ensure choice and independence

We work proactively with the market to ensure that people have choice and independence through a blend of robust market oversight and forward-looking strategies, focusing on personalisation, choice and innovation alongside the sustainability of the care market.

When designing new strategic approaches, staff have worked with adults, carers, commissioners, providers and other professionals to build research and lived experience into the strategy design process. Recent examples include the Care Market Strategy, Dementia Strategy, Carers' Strategy, and the draft Accommodation Strategy. Through this work, we have established a clearer picture of the diverse health and care needs of people and our local communities, helping us move towards more joined up, flexible care that supports choice and continuity. As a result, we have jointly commissioned services such as discharge support for physical and mental health, rehabilitation and reablement services. Specialist provision, such as the Shaftesbury Icanho Community Rehabilitation Service, supports choice and personalised approaches to local need, working alongside INTs.

Case study: Suffolk Care Market Strategy

The Suffolk Care Market Strategy 2025-2030 was developed from the outset with adults, carers, providers, commissioners, and professionals, ensuring the strategy was shaped by those who are supported and those who work within the care system.

The engagement included workshops, surveys, and targeted consultations to gather insights into what people value most in care – flexibility, personalisation, and the ability to live independently. These views directly informed the strategy's emphasis on expanding direct payments and individual service funds, supporting micro-enterprises, and promoting innovative care models offering greater autonomy and tailored support.

Providers were actively involved in shaping market priorities, ensuring the strategy aligns with operational realities and future workforce needs. We worked with health partners and Healthwatch Suffolk to reflect health and care integration, supporting seamless, person-centred care.

As a result of this collaborative approach, the strategy promotes independence and innovation, and strengthens the foundations of choice and continuity. These commissioning priorities are informing further engagement and coproduction with people and partners, including development of the Accommodation Strategy which has involved district and borough councils, Integrated Care Boards, housing providers, and children and young people's services to align future housing and care developments.

Case study: Suffolk Dementia Strategy

In 2023 ASC commissioned research from Healthwatch Suffolk into people's experiences of dementia in Suffolk: 'A roundabout without signposts'. The outcomes heavily informed the co-produced Suffolk Dementia Strategy 2024-2029 - Suffolk County Council and subsequent action plan, which will be delivered by 2029.

Feedback from people with dementia and their carers included 'We had come to a roundabout with no signposts, there were many exits from that roundabout and we didn't know which one was the best one - or even which one was the right one to take... so we just went nowhere'. As a result, the strategic priorities and action plan include improving information, advice and guidance targeted at dementia support alongside reestablishing dementia champions within teams.

The coproduction work also heavily informed the specification for recommissioning the countywide dementia support service, which is jointly commissioned between Suffolk County Council and the SNEE ICB and provided by national charity Shaftesbury. Shaftesbury Neurological Services Manager told Healthwatch:

"The contract specification was based on the views and experiences of people living with dementia, which were gathered in Healthwatch Suffolk's insightful report... This report has been the blueprint for the model we will provide. We are acutely aware of the importance to deliver a service based on what people need and have said is important for them. The feedback and recommendations... are extremely helpful to guide us in our approach and... hold us to account when the service is evaluated."

Early feedback on the new service has been strong:

This is the first time I have been directed to the correct services.

“”

The resources you shared have given me a much clearer understanding of how to approach dementia caregiving. Worthwhile conversation and rewarding, I have learnt so much.

“”



Case study: Sudbury Gardening Group

The INTs work closely with local communities to develop solutions to local needs. For example, in Autumn 2023, the Sudbury INT codesigned a therapeutic gardening group with people, transforming an unused courtyard into a vibrant, accessible space at Sudbury Health Centre.

The initiative offered six-week programmes tailored to individual therapy goals. OTs from social care and health worked alongside community partners to deliver flexible, person-led sessions. Participants chose how they engaged, whether planting, designing, or simply connecting with others.

Outcomes included improved mood, motivation, and social connection, with people reporting they felt “listened to” and “in control.” The project has won two national awards for innovation and service development. The Sudbury Gardening Group extended its six-week sessions across multiple seasons, now running from Spring through Autumn 2024 and into 2025, and has welcomed a broader range of participants, including those with mental health needs, long-term conditions, and carers seeking respite and wellbeing support.

Case study: Community Catalysts

In November 2023, we launched a two-year pilot in partnership with Community Catalysts to develop community micro-enterprises supporting flexible, personalised care for older and disabled people. The initiative has increased options for people to access local, community-based care. Community Catalysts work with people who wish to set up their own small-scale care businesses to offer care and support such as home help, companionship, household support, or creative community-led activities and also support established local groups aiming to diversify or expand their offerings, publicising these through an online directory (Small Good Stuff). As of August 2025, the programme has developed 160 new or existing community micro-enterprises offering over 5,260 hours of support to 1,100 people (with additional capacity available).

For example, one microenterprise owner received guidance from her Community Catalyst on everything from marketing and training to insurance, regulations, DBS checks, and accessing funding and launched her own business earlier this year. By April, she had begun providing support to four local clients, delivering 25 hours of highly personalised care every week. Over half of her enquiries came through Small Good Stuff. R, who lives with dementia, is one of the people receiving support. R has found new joy, companionship, and confidence – her daughter feels that “Mum is a person again, with a life to talk about and experiences to share.”

SCC continues to fund the Community Catalysts work and has now strengthened links between the programme and the central Direct Payments team to ensure more people are aware of and can access local microenterprises.

Ensuring high quality commissioned care

Quality is a core outcome of our People at the Heart of Care strategy. We have a comprehensive framework for monitoring commissioned services, integrating operational oversight with strong strategic governance. Contract managers are integrated into locality teams, working alongside frontline staff and business and finance.

Contract monitoring is proportionate, risk-based, and embedded within wider safeguarding, commissioning, and market oversight functions. Services receive a mix of routine visits and targeted interventions. The Provider Assessment and Market Management Solution (PAMMS) is used consistently across care types, providing a clear and comparable picture of quality, and feeds directly into provider escalation pathways, allowing risks to be identified and managed at an early stage.

For example, a care provider reported 9 medication errors through SCC's Provider Incident Report process during May and June 2025 – an unusually high number. While all incidents were investigated with the provider and closed as no harm had been caused to residents, the number reported raised concerns. The Contracts Team analysed themes, trends, lessons learnt and how many staff members were involved in the incidents. As a result, the provider was signposted to health partners and the Multi-Agency Safeguarding Hub, who provided training and advice on preventing further errors. In July and August, the number of incidents reported by the provider decreased to 2. The improved service quality was noted in a PAMMS completed in July, for which the outcome was 'Good.'

Our escalation framework underpins this system, with tiered responses, clear risk ratings, and joint escalation panels that bring together commissioners, safeguarding, and ICB partners. Contract teams maintain close dialogue with providers and where concerns are raised, targeted improvement plans are agreed with providers and closely monitored until assurance is restored. At strategic level, senior forums review themes and risks. This layered oversight ensures learning from individual situations informs system-level improvement. If care quality issues arise, different parts of the system work well together and with people to protect continuity of care.

Our Cabinet Member for Adult Social Care has oversight of provider risks and concerns as needed via a fortnightly briefing cycle, with more detailed briefings provided if escalation thresholds are reached. She also receives quarterly briefings on the Adult Social Care Strategic Risk Register, providing opportunities to discuss and review emerging care market risks.

This approach is supported by structured assurance mechanisms, performance data, and thematic evaluation. PAMMS outcomes generate measurable insights into provider quality, highlighting both strengths and areas for focus. Findings are triangulated with safeguarding intelligence, complaints, and CQC inspection outcomes to create a rounded picture. The effectiveness of our approach is evidenced through our consistently high levels of 'good' or 'outstanding' CQC ratings for care providers in Suffolk compared to the national average.

Lessons learned from post-escalation reviews are shared across commissioning teams and used to refine future responses. Senior leaders receive reports collating PAMMS trends, provider risk registers, and escalation themes, allowing resources to be directed strategically where risks are greatest. Data and assurance inform commissioning strategies, market shaping, and workforce planning. For individuals, this means care is safe, coordinated, and sustained even when providers face challenges.

People's voices are central to monitoring arrangements, including information from Healthwatch, complaints, compliments, provider forums, and feedback from visits. For example, Healthwatch surveys identified that while many individuals feel safe and supported, some experience variability in communication when providers are under review or facing challenges. In response, clearer communication protocols were embedded to ensure families are kept informed during escalations. We build feedback into provider improvement plans and use it to shape commissioning priorities.

During a typical PAMMS assessment contract managers speak with residents, family members, or next of kin to gather their views and feedback about the service provider.

Case study:

During a PAMMS assessment of a residential care home, the lack of activities and overall stimulation & activities was highlighted despite positive general comments about staff. Resident and family feedback also highlighted concern about call bells not being answered promptly. One resident commented, "I do complain, bells keep going off sometimes for ages" while a family member stated, "I think he misses the activities, which we haven't had for the last few weeks. I understand they should be starting up again soon, let's hope so. We've always had dogs; it would be nice if dogs could visit."

The ASC contract manager discussed this with the interim care home manager, who provided assurance that recruitment was underway to address the gap in activity provision within the home and this was identified as a priority area for the action plan. There are now three activity coordinators in place, with activities planned seven days a week. The home has also increased community involvement, organising events such as choirs, a summer fête, fundraising for sensory equipment, and entertainment for residents. At the recent relatives' meeting, significant improvements in the range and quality of activities offered were noted and positively received.

Experience of Received Services (ERS) forms also allow people using services, their representatives, or professionals working with them to provide feedback on home care services. Completed ERS are generated either following a scheduled or unscheduled review or after a partner intervention with a person using services. They are sent to the contract manager who investigates further if necessary or reviews against any previously received so that trends and themes are picked up and addressed. Over 12 months, 598 ERS were received, reviewed and acted on by Strategic Commissioning and Contract Management staff. This approach complements Provider Incident Reports, other data held on PAMMS records, and our use of ad hoc complaints and compliments alongside more dedicated codesign, coproduction and engagement activities.

Monitoring arrangements are strong, and we continue to strengthen them to ensure that we consistently deliver joined up and flexible oversight. For example, while we already receive valuable input on lived experience, we are developing approaches to capture direct resident and carer feedback more systematically and embedding earlier triggers within PAMMS, linking more explicitly with safeguarding pathways so risks can be identified sooner.

2.2 Partnership and communities

Our partnerships are key to driving greater integration and better outcomes. Suffolk's Local Joint Health and Wellbeing Strategy, recently refreshed by the Health and Wellbeing Board, sets out a vision for improving population health through integrated, place-based working, supported by clear governance and shared accountability with partners. Alliances and Place Boards each drive local implementation through collaborative commissioning and service integration, alongside our joint boards for mental health and learning disabilities. Strategic planning is delivered via the Suffolk Health and Care Strategic Planning Group with the Norfolk & Waveney Strategic Operational Delivery Group also playing a key role in Waveney, enabling coordinated system level decision-making.

Funding streams such as the Better Care Fund and former Discharge Fund are jointly planned and, in SNEE, pooled, with allocations managed through Alliances and the Mental Health Collaborative. Commissioning arrangements include joint contracts for adult carers, dementia support, and Transforming Care. Our shared strategies are co-developed and aligned with system priorities. Transformation programmes are jointly designed and monitored through multi-agency boards with the Strategic Planning Group taking an active governance role in system-wide programmes such as strategic reviews of Continuing Health Care provision.



Case study: Integrated Care Academy (ICA)

Hosted by the University of Suffolk, the ICA is a collaborative partnership supporting integrated care learning across Suffolk and North-East Essex. Founding partners include SCC, Healthwatch Suffolk, SNEE ICB, and voluntary sector organisations such as Suffolk MIND. The ICA focuses on three priorities: improving mental health and wellbeing, supporting quality of life, and optimising end-of-life care. Operating through co-production, inclusivity, and diversity, the ICA Co-production Hub ensures these values are embedded in all activity, sharing information and learning with partners and collaborating for improvement, supporting a confident, capable workforce and joined-up services for better health and wellbeing.

Case study: Shaftesbury Icanho Community Rehabilitation Service

The Icanho Service is an example of joint commissioning to deliver personalised, responsive services. With ICB partners, we developed a model supporting independence and choice for people with complex neurological needs.

The service offers tailored rehabilitation through a multidisciplinary team, allowing people with acquired brain injuries or stroke to pursue recovery in line with their own goals. The service uses advanced rehabilitation technology, funded through local fundraising and charitable partnership, to accelerate recovery. In 2024/25 the services saw 230 patients, with most individuals avoiding escalation into statutory services and reporting other positive outcomes. For example, 92% of people who were unable to walk without assistance at admission were able to walk independently at discharge.

Support also includes guidance to individuals, families and professionals navigating neuro pathways, helping them make informed decisions and access the right support at the right time. Open-access, inclusive 'neuro-cafes' provide wellbeing support and foster peer connection and community resilience. The service also provides expert input to support ASC and community teams to increase their skills and knowledge in supporting people with complex neurological needs.

Feedback from people and their families highlights the impact. T said of her husband's experience, 'I can't thank you enough. N came into Icanho in a wheelchair with a frame and now with the exercises there is such a difference, he can walk independently,' while N himself reported 'It was very good. You taught me how to walk again and go upstairs and go in the garden and make a cup of tea for my lovely wife.'

Multidisciplinary team approaches are in place in hospitals and communities supported by partnership working at the ASC front door and via other universal services, allowing people to be referred between partner organisations including VCFSE services. The Transfer of Care Hubs (ToCHs) located at Ipswich and West Suffolk hospitals deliver an integrated, person-centred discharge service through robust multi-agency collaboration. The hubs are co-developed by ASC, housing, VCFSE and health partners. Outcomes are evidenced, for example, through our strong performance in relation to transfers of care, set out in further detail in theme 3.

Adult Social Care has good connections with the voluntary sector. VCFSE partners are members of the Alliances, supporting strong joint working at INT level. Teams gain understanding of VCFSE activity in their localities through the Connect structure in Ipswich & East or service development days in Waveney.

During our pilot assessment, some VCFSE partners felt strategic leadership for the relationship with the sector in Suffolk could be clarified and that this would also support more clarity over our leadership of the prevention agenda. Over the past two years ASC has begun addressing this, through the Collaborative Communities Board which leads SCC's work with the VCFSE and by building relationships with key representatives such as Community Action Suffolk (CAS) – for example, the Chief Executive of CAS attended a recent Directorate Management Team meeting to discuss the State of the Sector report and identify key action points to respond to the findings. Our prevention work includes redesign of universal services and the Front Door in collaboration with statutory and voluntary sector partners, alongside a council wide workstream taking forward an SCC wide approach to prevention and strategic commissioning, with the DASS as co-sponsor.

Working with the Care Market

We proactively engage and manage the care market through our locality based Strategic Commissioning and Contract Management and countywide Strategic Planning and Resource Teams. We maintain strong, collaborative relationships with current and future care providers through regular forums and market engagement events, using open dialogue, co-production, and shared learning to support a resilient, high-quality care market. The Joint Suffolk Care Partnership (JSCP) is recognised as a key route for providers to collaborate with SCC and to be able to influence quality across the care market as a whole. Suffolk Care Association (SCA), which co-chairs the Partnership, describes it as 'a unified platform to address care-related issues affecting residents across Suffolk... These meetings serve as a vital forum for discussing local issues, sector developments and influencing local strategy, policy and funding.' SCA recognises that the relationship also enables it to influence discussion on funding and sustainability and 'ensures care providers are better informed, better connected, and better equipped to deliver safe, high-quality care across Suffolk.'

Our engagement shapes commissioning strategies, clarifies provider challenges, and promotes innovation. For example, the Social Care and Health Sector Skills Plan for Norfolk and Suffolk reflects a coordinated partnership between County Councils, sector stakeholders, and the care workforce. Developed through consultation and robust analysis, the plan addresses challenges in recruitment, retention, and workforce development in social care and related health roles. Regular partnership meetings enable shared learning, alignment with wider strategies, and access to funding opportunities.



Case study: ASC's External Reablement Model

ASC's external reablement model was developed in collaboration with providers to drive innovative outcomes. Funded in the SNEE ICS through a pooled Better Care Fund budget across health and care, it integrates the strengths of the in-house Home First service's approach with the agility and capacity of the private sector.

Rather than relying on traditional transactional contracts, ASC's model fosters genuine collaboration and shared learning. It builds on successful pilot programmes and active market engagement, positioning care providers as equal stakeholders alongside Home First.

Home First operates with an open-book philosophy, granting providers access to its reablement training, methodologies, and documentation. This shared foundation of

best practice is further strengthened through joint working with Home First social care practitioners, ensuring that reablement outcomes consistently meet the high standards set by the Home First team.

The model avoids enforcement-based compliance, taking a partnership approach and supporting private providers to build capability where it is most needed, guided by ASC's quantitative data on unmet demand. This creates a mutually beneficial environment: providers make informed, confident business decisions, while ASC strategically develops the market in priority areas.

Nayland Care, who partnered with SCC to deliver the pilot, were one of the providers commissioned to co-deliver the new model. Nayland's CEO, says: 'it was recognized through market engagement that there needed to be an element of financial security for providers to be able to take that on. One of the key features was also having quick and responsive access to social workers and therapists because the multidisciplinary working is absolutely crucial for effective reablement. There was a really good workflow

and the elements of it that worked really well were taken through to the contract which was really good. The fact that we managed to make it work and we've helped to actually shape the current contract as it is now has been a huge achievement for us, it's something that we're really really proud of.'

When Home First reaches full capacity, private providers can now deliver short-term, high-impact reablement services, addressing past issues with access and capacity. As providers work directly with the same social care practitioners as Home First, combining Home First's proven reablement approach with the flexibility and scalability of the private sector, we together ensure continuity of ethos and practice and reduce reliance on long-term care. The service has supported 413 people since June 2025; of those who completed reablement between June and August, 56% were fully reabled and 13% partially reabled. We are working to further align these outcomes with Home First performance.

The service receives regular compliments:

- S says 'carers have been brilliant, helpful and polite and one carer made me a very tasty omelette.'
- M is going to miss the carers smiling faces each day and all the encouragement they gave her to feel confident going into town on the bus again.
- D wanted to inform us that she rated the carers as 10/10 for their wonderful care and is sorry she won't be needing them anymore. D will especially miss making the carers jump when she is hiding in the shed having a cheeky cigarette.

Our Market Position Statement was developed in collaboration with providers, voluntary and community sector partners, health colleagues, and people to ensure the strategy reflects current and emerging challenges and needs. For example, we together identified insufficient provision of care for people with complex needs countywide, coupled with a lack of nursing care in Waveney. To address this, we are building on examples of strong service models already providing complex support in Suffolk, such as Wickham House. We are delivering a successful capital build programme alongside market development through our successful Transforming Care Partnership. To address this gap in the longer term, we have begun work on a strategic commissioning plan for residential and nursing care.

We continuously review our contract monitoring framework with providers to ensure they deliver high-quality services and can demonstrate impact. We share information and learning from contract monitoring with partners and collaborate for improvement.

Case study: Drummond Court

In 2023 Drummond Court was a large residential care service with over 30 residents. It is owned by Mencap who also provide the on-site care. Due to a range of challenges there was a risk that the service would have to close, and residents be rehoused.

Commissioning and contract management staff worked closely with Mencap to explore solutions and together saw an opportunity to transform the service to increase service quality and promote greater independence for residents, while at the same time delivering more efficiently. SCC provided additional short- to medium-term funding to pump-prime the transformation, ultimately aiming to return to the baseline service cost with a higher quality more sustainable service model that is also financially and operationally sustainable. The project built on a strong relationship between SCC's contract manager and provider, enabling open and honest conversations about the financial and other challenges.

As of 2025, while some people remain in residential accommodation, most provision has

been deregistered and converted to supported housing. The team developed a "hub and spoke" model which also leverages digital technology to support residents and enable progression to greater independence, including ultimately moving into their own homes. Digital solutions were introduced to reduce night-time support needs and provide less restrictive support, with ongoing work planned to further enhance independence. The approach included reviewing all residents to identify those suitable for supported housing, supporting them to move from residential care where appropriate, and using on-site flats to support progression. Working closely with operational teams, continuous reviews and further quality assurance processes were implemented. These include an annual health check alongside regular feedback from contract officers and residents.

The changes have resulted in improved quality of life for residents, with everyone now living in appropriate accommodation and receiving the right support.

For example, A is a resident at Drummond Court and says he found the move a little stressful because his mum was poorly at the same time, but he is now living more independently, his cooking skills have got better, and he cooked his mum a meal one evening which made him very proud.

The partnership is now exploring further innovation, such as Individual Service Funds (ISFs), virtual support for those moving to greater independence, and extending the support offer to people living in their own homes onsite and receiving domiciliary care. Learning from this model is being fed into the wider redevelopment of the supported housing offer in Suffolk.

Theme 3

How the local authority ensures safety within the system



Our Key Strengths and Achievements

- **Embedded learning from Safeguarding Adults Reviews:** In collaboration with the Safeguarding Adult Board, learning from Safeguarding Adults Reviews (SARs) is applied through a range of media including targeted roadshows, bespoke training, drop-in sessions, podcasts and accessible guidance materials.
- **Making best use of MASH capacity:** In 2024/25, enhancements to our Multi-Agency Safeguarding Hub (MASH) delivered measurable improvements in timely and personalised support. Overall demand decreased by 20.5%, and sharper referral processes ensured a more proportionate response. 24.1% of concerns required no further action, down from 33.1% the previous year, ensuring specialised MASH resource focuses on the right referrals. Oversight of high-risk situations has been strengthened through consistent use of Risk Registers, embedded in the Managing Unmitigated Risk Protocol.
- **Strengthened MCA compliance and understanding:** Mental Capacity Act (MCA) compliance has been strengthened through evidence-informed training, targeted masterclasses, and enhanced quality checks, with ongoing MCA practice development and resource creation resulting in more robust and legally sound decision-making.
- **Reduced DoLS waiting lists:** We have reduced the numbers of people awaiting a DoLS intervention from 2,526 to 1,886, via a three-year recovery plan.

Areas of Focus

- **Continue improving transitions to Adult Social Care:** Deliver our action plan to continue improving transitions, including the need for earlier planning and involvement by ASC, better information sharing and improved information, advice and guidance for young people and their families and are being taken forward.
- **Increase interoperability:** Building on our successful use of HIE, work with system partners towards full interoperability between Adult Social Care and health IT systems, with a first stage system implemented in 2026/27.
- **Continue to improve safeguarding systems and pathways:** Including system improvements to make feedback to referrers more consistent; strengthening how adults' lived experience is captured during safeguarding enquiries, and using predictive analytics and tools to improve areas of focus for preventative work, monitored through new KPIs.
- **Scale up DoLS capacity to focus on the highest priority assessments:** Complete the DoLS recovery plan, which in 2025/26 focuses on the Priority 1 list; building on learning from this approach a further plan will be developed for 2026/27, including options to scale up DoLS capacity to focus on the highest priority assessments in a sustainable way.

Safe systems, pathways and transitions

Transition between services

The safe transfer of casework between services is underpinned by our ASC Case Transfers guidance and our System for Safe Workloads and Case Allocation. Through our Signs of Safety approach, risk stratification and use of case summaries are recorded in LiquidLogic to ensure a consistent focus on what is important to the person and on achievement of the best outcomes. Where work cannot immediately be allocated to a practitioner, our Managing Risk while People Wait guidance is used. The workflow ensures referrals go to the right services with joint working across services encouraged. Any dispute can be escalated to a senior manager; however, in practice this is rarely needed.

Admission avoidance

In Ipswich & East the Reactive Emergency Assessment Community Team (REACT) provides a 7-day 8am-8pm multi-agency service covering health, mental health, social care and voluntary sector coordination supporting people experiencing a health, social care or wellbeing crisis. In West Suffolk, a similar service is provided by the Early Intervention Team merged within local INTs, and in Waveney, social care is available as part of the overall Urgent Care Response. Suffolk ASC is working with NHS partners to design and implement more out of hospital pathways alongside new hospital build developments in our area.

Person's experience

M, living with advanced dementia, poor mobility and frailty, was brought to Ipswich Hospital due to serious safeguarding concerns involving her main carer. There were longstanding concerns about coercive control, emotional abuse and physical harm and neighbours noting the carer was aggressive. A GP paramedic raised further concerns, and the carer was subsequently arrested. There was minimal food in the house and significant cluttering.

There were no acute medical needs requiring an admission to hospital; however, M was unable to make informed decisions about her care needs, had no package of care and her next of kin and neighbours were expressing serious concerns about safety and the threat by the carer.

The REACT social worker and team completed therapeutic and social care assessments, liaised with M's network and worked with A&E colleagues. A step-down, short-term placement was arranged at Avocet in Ipswich to enable further assessment outside the hospital environment including safeguarding arrangements.

REACT were able to support M to the most appropriate setting for her care after a 1-night hospital stay, avoiding hospital acquired infection and decompensation, and released acute hospital bed capacity for those most needing it. M was eventually supported to move to a long-term residential placement.

Leaving hospital

Our timely, coordinated and person-centred hospital discharge pathways are underpinned by the nationally mandated three-pathway model, with clear operational responsibilities, risk stratification, and a recovery focus. We support people to return home after their hospital stay and aim to maximise access to reablement and intermediate care. This offer is available based on need.

Each of our district general hospitals – Ipswich, West Suffolk, and James Paget – is supported by a Transfer of Care Hub (ToCH), where Health and Social Care multi-disciplinary teams (MDTs) work together to coordinate safe transfers to the community with the right reablement support. These hubs include social care assessors, reablement leads, digital care support, and discharge planning coordinators working alongside NHS, VCFSE and others.

A Home First approach is prioritised in accordance with a person's wishes using a risk positive approach. For people leaving hospital on Pathway 1, they are provided with an accessible, plain language leaflet explaining the reablement offer provided by Home First operating 7 days a week. Reablement goals are set with the person in their home, in an integrated approach alongside community health therapists. This has enabled timelier discharges from the hospital with increased numbers of assessments in people's own homes, not on a hospital ward. Both Home First and NHS therapists feel able to make more risk positive decisions compliant with D2A principles. It also allows Home First to positively risk take more as there is the opportunity to link up with health therapists quickly if there is a need for urgent therapist intervention. Reablement is provided at nil charge to the person. We have further improved access to reablement by commissioning a new framework of external home care providers working to the same key performance indicators as our in-house service.

For people leaving hospital on Pathway 2, needing a period of short term bedded recovery care post discharge, we maximise the use of local intermediate care options in community hospitals and other specifically commissioned beds providing MDT wraparound support. We actively avoid use of short-term beds in care homes where there is no recovery or reablement offer and are working with providers to introduce digital care technology into short-term assessment placements. For people being discharged on Pathway 3, where they have a likely long-term placement need, we have ASC assessing staff based at hospital sites to undertake early supported discharge planning, focused on providing choice and enabling the person to go to the right placement first time.

We use data from the SNEE ICS Intelligence Function to monitor pressures, risks, and discharge outcomes in real time. These include escalation bed use, delayed transfers of care, occupancy of Pathway 3 beds, and the proportion of patients ready for discharge and awaiting a plan. For example, while delayed days fell by over 50% in 2024, pressures remain highest in Ipswich Hospital, where escalation bed use and Pathway 3 demand are increasing. In Waveney, we use James Paget University Hospital performance reporting which is embedded in the Norfolk & Waveney SHREWD and the Optica cloud system.

We maintain clear governance over hospital discharge through Suffolk Health and Care Strategic Planning Group and the Urgent & Emergency Care (UEC) Boards. These groups oversee all UEC performance including hospital discharge and a portfolio of discharge schemes funded through the Better Care Fund, with system partners jointly accountable for operational delivery, service integration, and measurable outcomes. Investment has substantially increased over the past two years utilising the additional discharge fund, and is strategically targeted at embedding admission avoidance approaches, seven-day discharge coordination, rapid response roles, and reablement capacity supporting Suffolk's acute and community settings.

The investment, delivered through our strong partnership working, has had a clear impact as of January 2025 compared to a baseline 12 months prior. In Ipswich Hospital, length of stay decreased to 25 days against a baseline of 35 days. We increased digital care referrals to support reductions in length of stay in West Suffolk, from 155 to 199 across quarters (against a targeted increase of 5%). Access to short term community care hours increased by 22% in Ipswich and East, and by 68% in West Suffolk, through greater reablement capacity. The percentage of patients fully reabled increased by 5% in Ipswich and East and remained consistent in West Suffolk. 81% of all people who received reablement from Home First services were fully or partially reabled.

In recognition of local challenges supporting acute mental health hospital discharges, we have developed a dedicated role that leads on the co-ordination of these discharges across the county. The role acts as a single point of contact for NSFT, has streamlined communication with wards, and has strengthened discharge processes. We work in partnership with our NHS partners to ensure people who are experiencing mental ill health are discharged from hospital with the same access to recovery and reablement in a timely manner, managed through weekly joint patient flow meetings held across the county.

While we already use insight from compliments, complaints and feedback in ongoing discharge redesign, to strengthen assurance we recognise the need to include lived experience and/or co-produced evaluations more systematically. Plans for 2026/27 will include structured collection and use of lived experience to inform Better Care Fund planning with system partners. Working with NHS partners, we are also strengthening real-time data monitoring and assurance to identify risks earlier, with new discharge dashboards tracking occupancy, delayed transfers, and reablement outcomes. We are continuing to review transitions between hospital and community-based care, which includes extending 7-day working and scaling up digital care support.

Transitions into Adult Social Care

Transitions into ASC and Preparing for Adulthood (PfA) was highlighted as an area for improvement during the CQC pilot inspection and the last Suffolk SEND inspection. In parallel, Healthwatch published research, "Feedback about the Experience in Suffolk of the Transition from Children's to Adult Health and Social Care Services," which covered a broad range of PfA issues across health and social care services.

Following receipt of the Healthwatch feedback, ASC set up a new Transitions into ASC team within the LD&A and MH services. This small, dedicated team collaborates closely with CYP and system partners to support young people transitioning to ASC. Referrals are triaged by this team, with a small number routed through to the INTs if the young person has a physical disability. A strong progression offer is applied prior to a Care Act assessment and any offer of long-term care and support, maximising opportunities for young people to gain more independence.

Since its establishment, the Transitions into ASC team has seen an increase in referrals from 140 in 2022/23 to 356 in 2024/25, a year-on-year increase that continues into 2025/26. CYP services are the largest single source contributing on average 41% of referrals. However, the pathways into the team are well socialised and used across the Suffolk system with an average of 26% of referrals from families and 32% from police, probation, Suffolk Family Carers, MASH, housing, health providers such as NSFT, and young people themselves. On average 80% of referrals come to LD&A and MH teams and 20% are managed by the INTs.

There is now close partnership working between ASC and CYP services, evidenced through regular joint forums providing opportunities for troubleshooting, problem solving and planning, early discussions and 'warm' handovers. Joint practice and transformation workshops take place, with a forward plan including improvement areas such as Mental Capacity Act for CYP staff and EHCP reviews for ASC staff.

As part of the well-developed progression offer, ASC commission a provider called 'Leading Lives' to support a period of short-term progression to maximise independence – regardless of eligibility – by looking at areas such as travel training, building life skills and use of digital technology. Last year, 57 young people were supported into full or partial independence following their Short-Term Assessment Plan with Leading Lives. In addition, providers such as 'Multiply Suffolk' and 'Realise Futures' support preparation for employment and/or volunteering. Carers are routinely offered Carers' Assessments, to ensure whole-family needs are recognised.

An ASC 'Transitions into ASC Panel' assists planning for young people with additional needs. CYP operate a monthly Transition Panel for 16- and 17-year-olds, attended by District and Borough Councils, Staying Close and the Police. The panel meets to support the transition of Care Leavers into independence at age 18 via social housing or supported accommodation, and tracks their housing needs post-18 to ensure they are offered safe and secure accommodation. Fortnightly Housing Advice Surgeries with District and Borough Councils support Care Leavers and professionals to provide advice about care leavers' housing needs and the options available to them. A 'Skills for Life' programme, part of a Skills Academy offer, ensures all accommodation providers are aware of the Staying Close offer. An Education, Employment, and Training (EET) Panel hosted by CYP meets 6-weekly, with representation from a broad spectrum of providers to support young people to find the right option for them, including the Virtual College, The Skills Academy, Suffolk Provider Network, Family Support Team (formerly Early Help), Inspire Suffolk, Apprenticeships Suffolk, Multiply Suffolk, Volunteering Matters, Department for Work and Pensions (DWP), Realise Futures, WS Training and Suffolk Refugee Support Service.

The 'Family Business' is Suffolk County Council's innovative corporate parenting employment model, designed to empower Care Leavers. It includes ring-fenced apprenticeships, employment opportunities with local businesses, and a bespoke training and support programme. ASC is working with SCC's Skills Team to ensure that the needs of all adults with Care Act eligibility – including those who transition into ASC – are reflected in the work to improve employment rates through the national Get Britain (Suffolk) Working plan. This includes specific actions around preventing economic inactivity, finding and engaging those that require support, providing targeted support to address barriers and equip people to move forward and continuously progressing individuals through support, education, training and into and within employment.

As part of the SEND improvement work underway in Suffolk, governance and leadership have changed significantly. There is a new SEND and Inclusion Strategy delivered through a new Local Area SEND Improvement Board and its associated operational groups – including a new PfA from the Early Years workstream. The Independent Lives Steering Group maintains oversight of Transitions into ASC activity, feeding into PfA, with links to Supported Housing, Day Opportunities and Community Support planning groups. Our SEND Operational Group also holds accountability for PfA delivery across agencies, escalating risks via the Local Area SEND Board.

ASC has been working with CYP services (supported by Newton Europe) to improve the Transitions into ASC offer further, creating a strong foundation for the new PfA model and building on feedback received from the Department of Education inspection earlier this year. This included mapping Transitions into ASC pathways with immediate reductions delivered to waiting times and transfers, followed by an Outcomes Review deep dive with CYP and ASC staff, working with coproduction partners to agree what good looks like. The work was undertaken with the following vision in mind: "To create a Social Care offer that ensures that young people and their families have a proactive, seamless, and timely transition into ASC, so that they can be empowered to thrive and live as independently as possible."

During the deep dive, staff audited the journeys of 50 young people transitioning into ASC, starting from the outcome of young adults' first Care Act assessment by ASC and tracking back to age 14. A variety and spectrum of needs were identified. 90% of people were found to have an EHCP and a significant proportion (25%) were Care Leavers.

The deep dive found that 56% of the young people audited had reached their optimal outcome, with examples where lives had been genuinely transformed. Learning has been built into practice improvement to ensure optimal outcomes are consistently met. Other opportunities for improvement were identified, including the need for earlier planning and involvement by ASC from the age of 14 (addressing capacity accordingly), better information sharing and improved information, advice and guidance for young people and their families and are being taken forward, feeding into PfA planning.

Out of County Placements

ASC currently has 457 out of county (OOC) placements predominately in the neighbouring local authority areas. 53% for people with a LD&A or MH primary need and 47% for older people and working age adults. The use of OOC placements is driven by people's choice, proximity to other county boundaries and access to specialist resource for LD&A and MH, jointly funded with ICBs. To ensure people using services OOC are safe, LD&A and MH have a dedicated team to undertake timely reviews and respond to quality matters should they arise. For older people and working age adults, Workflow Coordinators and locality senior managers track and prioritise annual reviews and responding to unplanned events through the responsive Flexible Care & Support Teams.

Information sharing protocols and Shared Care Records

We use a range of information sharing protocols with people using services and partner agencies to support joint working. We have strong information governance arrangements captured in our Adult Social Care Privacy Notice. These support our Population Health Management approach as well as enabling wider information sharing and interoperability.

The Health Information Exchange (HIE) shared care record tool, used across Suffolk, enables access to ASC and health data by making select information from one system visible within another. The HIE is trusted – it is accessed more than 11,000 times a month – and secure, and benefits people because it reduces the number of times an individual has to tell their story. Staff in different agencies also benefit by accessing essential information about people more easily, enabling more effective risk stratification and prioritisation of interventions.

Health and care staff still need to work across multiple ICT systems even when part of the same team and working with the same person. A programme of work to increase system interoperability and for ASC to join other HIE sites is underway with digital transformation teams currently proposing a new option for greater integration across LiquidLogic and System One used by NHS staff as the next step towards a joint health and care IT system.

Contingency and Emergency Preparedness

We have a clear, proactive, and multi-layered approach to contingency planning and emergency preparedness in Suffolk, ensuring care continues safely and consistently during system pressures or provider disruption. Our Adult Social Care Escalation Framework sets out how we coordinate the system response to pressure using the LAPEL model (Local Authority Pressure Escalation Levels). This four-tier framework provides defined thresholds, response actions, and governance oversight—from “business as usual” to “unable to meet care needs.”, ensuring we can quickly escalate risk, convene tactical response meetings, communicate with system partners in a shared language, and implement mitigation plans supported by weekly operational monitoring.

Prevention is at the core of our contingency and emergency preparedness, bringing together internal expertise across operations, commissioning, safeguarding teams and including system partners in regular system intelligence meetings, sharing local insight and mobilising support to providers at risk, supported by our robust PAMMS and quality monitoring processes as described under Theme 2.

Our comprehensive suite of Business Continuity Plans, covering our operational services and diverse care market define service-specific responses when either ASC or a provider cannot provide continuity of service. These include clear escalation governance, a consistent five-step response cycle, and checklists for redeployment, provider communication, and safeguarding activation. Real-time triage and prioritisation of people most at risk during any service disruption is underpinned by a risk management framework and lessons learned exercises are undertaken following incident responses.

The Provider Escalation Process integrates contract management, quality, risk, and safeguarding concerns through a unified escalation pyramid, ensuring timely interventions where early indicators of fragility are observed. Our robust, tested systems ensure people experience seamless transitions and are protected from the impact of care market fragility. When provider disruption occurs, our multi-agency business continuity processes are activated without delay.

Case Study

In November 2024, SCC terminated a residential home contract in North Suffolk, home to 18 older people many living with dementia, following significant organisational safeguarding concerns. Using the coordinated emergency protocol, all residents were safely relocated in four days. Feedback included: "Mum has gone from the Travelodge to the Hilton," evidencing that people experienced continuity and improved outcomes despite crisis transitions.

Another family member said "I can safely say this on behalf of all the families involved: what you guys do really does make a difference and does change people's lives for the better."

Out of hours support

SCC delivers Emergency Duty Services (EDS) through a team of social work staff – experienced practitioners/managers in daytime roles across CYP and ASC – who operate on an on-call basis, supported by a team of call coordinators. All interventions by EDS are to avert an emergency that can't wait until the following working day, providing a crisis response or supporting a plan put in place by allocated workers/teams. This can include support for adults and their families including victims of abuse and domestic violence, accessing emergency accommodation and providing other practical assistance. All referrals requiring ongoing intervention are passed back to Customer First to ensure they receive the necessary support from ASC or CYP. In the 12 months to July 2025, this included over 5700 referrals on ASC matters and nearly 1500 referrals for approved mental health assessment. Governance and performance oversight of EDS is through a quarterly joint CYP and ASC EDS Partnership Board.

ASC also operates an on-call manager rota of SMT or DMT members to respond to a range of business continuity matters affecting people accessing Adult Social Care services, to support providers in emergency situations and help teams operating outside core working hours if required.

Our pilot assessment identified consistent 24-hour mental health provision as a potential gap. We have subsequently worked to develop the service through collaborative workshops to ensure seamless pathways and improve recording protocols and established a new structure to ensure the service is consistently resourced. The AMHP service now ensures consistent cover through a staff of 40 authorised AMHPs across the county, operating through 3 rotas based on localities: East, West and Waveney. Each area has a responsibility to ensure their daytime rota is covered and the out of hours element is covered by EDS. We have up to 2 AMHPs on duty at any one time in each rota area and they can receive up to 7 referrals per day while the daytime AMHP service averages 110 referrals per month.

Safeguarding

Person's experience

A non-statutory safeguarding enquiry was received for K, who previously had been sexually assaulted by multiple men and was at risk of domestic abuse from her partner. K was homeless at the time and known to misuse alcohol, making it difficult to locate or communicate with her.

Jointly working with a local authority housing officer, ASC persevered to consistently engage with K, often outside core hours to build a trusting relationship over time. ASC coordinated safeguarding meetings involving the Police, local borough council, Rough Sleeper Team, Health Outreach Team, Housing Action Group, GP Surgery, an IDVA and other Housing support to ensure a holistic assessment of health & care needs was undertaken.

By working together, K was supported into a new tenancy with housing related support to sustain this, accessed increased GP help for her ongoing health needs, checks by the Police to prevent cuckooing, an ASC care and support plan to meet eligible needs and a referral for a personal welfare order to the Court of Protection.

K was further made safer by the partner leaving the property, police bail conditions being applied, and two Domestic Violence Protection Orders.

Our effective systems, processes and practices make sure people are protected from abuse and neglect. Section 42 safeguarding enquiries are carried out sensitively and without delay, keeping the wishes and best interests of the person concerned at the centre. People can participate in the safeguarding process as much as they wish and are supported to make choices that balance risks with positive choice and control in their lives. They are supported to understand safeguarding, what being safe means to them, and how to raise concerns when they don't feel safe, or they have concerns about the safety of other people. People are supported to understand their rights, including their human rights, rights under the Mental Capacity Act 2005 and their rights under the Equality Act 2010.

Our safeguarding processes and systems are embedded across Adult Social Care, spanning the Directorate Management Team, Safeguarding Adults Board (SAB), and frontline operational teams. There is a clear understanding of key safeguarding risks and issues in Suffolk and a clear, resourced, strategic plan to address them. Lessons are learned when people have experienced serious abuse or neglect, and action is taken to remove future risks and drive best practice. Strong governance, supported by Risk Panels and strategic oversight, underpins our practice. Pathway improvements have had a positive impact on the Multi Agency Safeguarding Hub (MASH), streamlining demand and improving the quality of responses.

Our practice model, Signs of Safety+, provides a strengths-based approach to safeguarding that empowers people to make decisions about their safety. The model is committed to relationship-based practice and recognises the importance of a trauma-informed approach that particularly supports practice with harder to reach adults. We continue to improve practice and outcomes for people through multi-agency learning, and the integration of learning from national and local Safeguarding Adult Reviews (SARs).

Suffolk ASC was ranked 42nd nationally in 2023/24 through ASCOF, with 73% of 'people who use services' feeling safe.

Safeguarding Adults Board

Suffolk has established a robust, all-age safeguarding partnership through the Suffolk Safeguarding Partnership (SSP), underpinned by equal statutory responsibility across Suffolk County Council, Suffolk Police, and Integrated Care Boards. The Safeguarding Adults Board (SAB) operates within this framework, supported by a formal governance structure comprising the Safeguarding Adults Delivery Board, Learning and Improvement Group (LIG), Safeguarding Adults Review Panel (SARP), and health and housing subgroups.

The Suffolk Safeguarding Adults Board (SAB) has strengthened its partnership through compliance with Working Together 2023, focusing on person-centred decision-making and systematic learning. Achievements include improved safeguarding reviews, thematic systems findings reviews, and the Safeguarding Improvement Plan. The SAB is committed to values-led interventions and a dedicated workforce. Priorities include better application of learning from reviews, doing the basics better- addressing poor information sharing, strengthening multi-agency working, and building evidence-based multi-agency datasets to understand the impact and outcomes of safeguarding interventions.

Independent Chair of the SAB



With a clear focus on learning, assurance and continuous improvement, the SAB oversees how adults at risk of abuse and neglect are protected. SSP's strategic priorities for 2025–26 reflect a shift toward improving leadership and front-line delivery, with evidence-based workstreams aligned to areas such as suicide prevention, homelessness, and transitional safeguarding. A strong emphasis is placed on "doing the basics better" by improving the impact of learning from SARs, enhancing risk decision-making, and embedding lived experience into strategy.

The SAB ensures safeguarding activity in Suffolk is underpinned by a learning culture and multi-agency accountability. Lessons from local and national safeguarding reviews are used to strengthen practice, with Suffolk's Learning and Improvement Strategy applying across both the Adults' and Children's Boards. Learning is disseminated through podcasts, events, and practical guidance for frontline professionals. ASC also applies S44 Care Act criteria for SARs through the Safeguarding Adults Review Panel (SARP), which operates with clear thresholds and governance. Additional assurance is drawn from system level safeguarding audit cycles, both of which provide evidence that practice monitoring and assurance extend across the system.

Feedback from roadshow events co-hosted by the SSP and ASC in 2024, which shared learning from safeguarding adults reviews (SARs), indicates that professionals value the practical insights and their relevance to frontline decision-making. One attendee stated: "I was unaware of the amount of cases and the effect... the roadshow tested my assumptions and helped me reflect on my own practice." Another said the sessions helped them understand "how to put lessons learned into practice." A staff network of safeguarding champions supports teams by sharing good practice and informing improvement work.

Early 2025 saw a relaunch of the refreshed Herbert Protocol to help families and practitioners locate people who are at heightened risk if they go missing. ASC practitioners can add details of the Herbert protocol to an individual's record and further work is being carried out to enhance this with a dedicated badge in the LiquidLogic record.

People with lived experience have directly contributed to shaping the safeguarding system. For example, individuals with dementia have been engaged in co-producing awareness materials and protocols. The SSP Engagement Strategy outlines ambitions to embed lived experience in all areas of core business, including safeguarding. Despite capacity challenges, the SAB continues to prioritise inclusive safeguarding by working with individuals and families to inform system change and develop proportionate, person-centred approaches. We are carrying out outreach with faith groups and work with people experiencing homelessness, ensuring equitable access to safeguarding support.

The SAB is improving system oversight and decision-making through better multi-agency data. In 2025, work began to address longstanding gaps in safeguarding intelligence across partners, supporting the development of dynamic, real-time data sharing processes to inform decisions and escalate concerns where risks are emerging.

Safeguarding Duties under the Care Act

Suffolk's approach is rooted in Making Safeguarding Personal (MSP). Through strengths-based conversations, practitioners understand what is important to the person and balance autonomy and risk. Continual improvement of Making Safeguarding Personal (MSP) is a key area of focus. We continue to strengthen understanding and application of MSP by providing refreshed guidance, learning, and embedding person-centred approaches across safeguarding activity. Safeguarding audits are undertaken to identify what is working well and what areas require development. For example, an audit completed in July 2024 focused on transferable risk in safeguarding enquiries and found positive examples of the person's voice being captured. In response to increased complexities in managing financial abuse, the Financial Abuse Guidance was produced, a comprehensive multi-agency guide on identifying and responding to financial abuse.

We are strengthening our feedback mechanisms for gathering feedback from the person and, or their representatives during safeguarding enquires. For example, Quality Assurance & Practice Development (QAPD) are auditing enquiries that are closed at the individuals request. We also plan to implement key performance indicators for end-to-end safeguarding processes focusing on timeliness and MSP. This ensures that we act on the best information about risk, performance and outcomes.

The SSP multi-agency framework on raising safeguarding concerns supports those working with adults across a range of agencies to have a shared understanding and consistent approach to identifying and reporting concerns, and clarifies the distinction between quality issues, incidents to be managed by internal policies and procedures, and safeguarding. The framework is continually reviewed against national best practice.

Safeguarding concerns are triaged by experienced practitioners within our Multi Agency Safeguarding Hub (MASH), the single point for receiving and assessing unallocated referrals. Concerns not meeting statutory safeguarding criteria are transferred to appropriate support or preventative services, ensuring proportionate responses that still maintain safety.

I just wanted to say that the framework that they have is the best thing they've ever done, I know it was done a few years ago now, but it's our bible, we go to the framework all the time, so from that perspective that's been really helpful for us as a provider.

Home Care agency - East Suffolk



During 2023/24 there was a 39% increase in referrals to the MASH. In response, ASC worked with Partners in Care and Health to better understand the current customer journey and experience and identify improvements. A thematic review of resource capacity in the MASH was initiated to better understand both current and projected demand. Work commenced with the care sector and with Strategic Commissioning and Contract Management teams to redirect quality concerns to appropriate pathways, reducing the volume of referrals requiring MASH triage. This was supported by our longstanding Professional Consultation Line which offers quick, expert advice to professionals with a potential safeguarding concern on the best course of action, handling 3,780 calls in 2024/25 and 2,861 so far in 2025/26.

These actions have been completed and led to the introduction of three new processes:

- Front door triage of safeguarding concerns is now undertaken by a skilled MASH practitioner at Customer First.
- A Provider Incident Report (PIR) pathway enables providers to report incidents to the local authority that are not reportable safeguarding concerns. These reports are regularly audited for appropriateness and learning themes which are acted upon through SCCM in collaboration with system partners.
- When a person is already allocated, the existing allocated worker undertakes the triage and enquiry to prevent handoff between teams supported with MASH advice.

The successful implementation of these processes in 2024/25 led to a 20.5% reduction in concerns managed by the MASH. Data shows that 24.1% of concerns were resolved in the MASH with no further action, compared to 33.1% the previous year, demonstrating referrals are being managed through the right pathway, which was confirmed in a recent audit. The abuse types reported have all decreased in line with the overall decrease in demand. Psychological abuse remains the highest reported abuse type.

I had a need to call MASH for some guidance following a concerning conversation I had whilst I was engaging in a group yesterday morning.... The lady on the end of the phone was very approachable with her style of communication, very professional and handled my call in such an understanding way. Her ability to understand very clearly how I felt as a result of the experience as well as understanding the scenario I brought to the call was so helpful to me. I have since spoken with Customer First to get Social Care involvement and help is underway for the family concerned.

Engagement & Community Officer,
Healthwatch Suffolk, discussing MASH
Professional Consultation Line support

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The system is exceptionally user-friendly, offering a straightforward and intuitive experience that makes daily tasks more efficient. Its clean layout and logical navigation allow users to quickly access the tools and information they need without unnecessary complexity. This ease of use supports a smooth workflow and reduces time spent on training or troubleshooting.

Charlotte's responsiveness and clear guidance around escalation further enhance the system's effectiveness, fostering transparency and confidence across the team.

General Manager, Care Home in Woodbridge
talking about Provider Incident Reporting

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Adult Social Care leads represent the department at a range of statutory forums, including the Multi-Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC), and the government's counter-terrorism strategy, Prevent.

The Central Adult Safeguarding Team provides specialist oversight of organisational abuse and other high risk safeguarding cases. They coordinate multiagency enquiries for care homes, domiciliary providers, and community settings where systemic concerns or patterns of abuse emerge, ensuring serious risks to groups of adults are escalated rapidly and organisational learning is embedded in care provision. For example, in 2024/25 the central team supported four people who were at risk of honour-based abuse. The substantial risk of these situations and gaps in provision when people have no recourse to public funds resulted in a quick reference guide being produced for all practitioners, complemented by a seven-minute briefing, case study, and overview of the steps taken to support that person. The practitioner was invited to take part in a podcast with the SSP, to share the work across the safeguarding partnership.

The Suffolk Self-Neglect and Hoarding (SN&H) Policy was reviewed in 2025 alongside the ASC SN&H Pathway and Practitioner guide to reinforce the focus on trauma-informed practice and incorporates the 'Understanding Non-Engagement' Practitioner Guide. Learning from a SAR, we introduced locality led multi-agency SN&H Forums, updated referral forms to explicitly capture risk to others, and produced nonengagement guidance to support staff to respond proactively when people decline involvement. We continue to commission a specific Self-Neglect and Hoarding training course for ASC staff to ensure continued knowledge.

The last year has seen the embedding of Risk Registers in each service area, under our Managing Unmitigated Risk Protocol. The Risk Registers hold information about complex situations where there is concern that the risk cannot be reduced to a manageable level. At the time of the pilot, Risk Register Panels were held in two service areas. This has since been extended to all service areas to ensure consistency in oversight and support across the county. A Risk Register Panel meeting is held each month by the service area to discuss each situation, chaired by the Assistant Director to ensure robust management oversight, and offering support to the practitioners working with the person. This Protocol will be reviewed, alongside the effectiveness of the Risk Registers and Risk Register Panel meetings, in 2025/26.

Learning from Safeguarding Adults Reviews

Learning from Safeguarding Adults Reviews (SARs) informs both system governance and frontline practice. SAR governance is embedded within the Suffolk Safeguarding Partnership (SSP), where the ASC Assistant Director and Head of Adult Safeguarding provide leadership on decision-making and learning dissemination. Cases meeting the SAR criteria are reviewed through a multiagency SAR Panel, with findings reported to ASC's Directorate Management Team (DMT) to ensure leadership oversight and organisational learning. This governance supports prompt information sharing and coordinated responses.

To embed SAR learning, we have prioritised practitioner engagement and reflection. Three in-person Learning Roadshows in summer 2024, SAR themed drop-in sessions, and commissioned training have reinforced best practice and multiagency awareness. Collaborative initiatives, such as the Think Family Network refresh and joint learning from other local authority SARs, ensure lessons extend beyond ASC into the wider safeguarding system.

Mental Capacity Act

During the pilot, we identified Mental Capacity Act (MCA) practice as an area for ongoing improvement. Since then, we have taken an evidence-informed approach, using audit and practice insights to shape both the re-tendering of MCA training for all operational roles and the commissioning of targeted MCA masterclasses. Approval and quality checking have been strengthened, with increased legal support for complex decisions. MCA is now a core element of routine practice audits, with evidence of improved compliance and more robust, legally sound decision-making. Two Practice Leads now have MCA in their portfolio and will lead targeted practice development and resource creation to further embed best practice across the service.

Deprivation of Liberty Safeguards (DoLS)

DoLS applications plateaued in 2023-24 at around 2,500 but are expected to rise further in 2025 to approximately 3,000. Our central DoLS Team manages all DoLS applications and sets their status using the Suffolk Prioritisation Tool. Recognising local and national challenges with managing DoLS demand, ASC DMT agreed a plan in 2023 that has reduced the DoLS waiting list from 2,526 (May 2023) to 1,880 (September 2025) overall, with marked reductions in priority 1 referrals (529 to 125) and priority 2 (227 to 125) in the same period.

This has been achieved by:

- Using Best Interest Assessors (BIAs) and Section 12 Doctors resource via a trusted agency, to complement our inhouse capacity, allowing an additional 569 assessments to be undertaken
- Recruiting 2 new BIAs to the permanent team
- Increasing business support capacity and capability and refreshed forms and processes
- Increasing the number of trained authorisers using an external training and consultancy company
- Optimising use of business intelligence including data quality checks.

BIAs actively uphold people's rights including clear evidence of supporting "S21A challenges" to contest DoLS authorisations in the Court of Protection.

Person's experience

A 39D IMCA raised concerns for a person being deprived of their liberty who was objecting. The IMCA's worries were that the Relevant Person's Representative (RPR) was not going to make an application of Court on their behalf to challenge the DoLS. The allocated BIA completed a review, contacted the RPR, who was a family member, and explained the role of the RPR highlighting their responsibility to hold the person's rights. The RPR felt strongly that the person should not return home (as per their wishes), and the appeal would be a waste of time and money.

The BIA was able to balance the concern of the RPR while upholding the person's right to appeal that decision and involve a 39D IMCA support for the RPR with the application process. The application was subsequently made.

Our legal team note that they receive a significant number of legal challenges to Standard Authorisations under s21A Mental Capacity Act 2005, in the Court of Protection and state: "The vast majority of these cases are concluded quickly in the COP which is due to the excellent quality of the assessments carried out by the DoLS Team. The assessments are very rarely challenged within the court proceedings due to the thorough and detailed nature of their assessments. This secures a timely decision for the person which is clearly a significant factor in maintaining their wellbeing. The DoLS Team are quick to act when a DOLS authorisation is required urgently. The DoLS Team regularly provide training on the MCA 2005 to practitioners which is very well received and implemented in practice."

Looking forward, continual improvement of Making Safeguarding Personal (MSP) is a key area of focus. We continue to strengthen understanding and application of MSP by providing refreshed guidance, learning, and embedding person-centred approaches across safeguarding activity. We are strengthening our feedback mechanisms for gathering feedback from the person and/or their representatives during safeguarding enquiries. We also plan to implement key performance indicators for end-to-end safeguarding processes focusing on timeliness and MSP. This ensures that we act on the best information about risk, performance and outcomes. We continue to explore further improvements to DoLS management with our corporate leadership team, including options to secure additional resource.

Theme 4

Leadership in Suffolk



Our Key Strengths and Achievements

- **Strong corporate and system governance:** ASC benefits from clear and embedded governance arrangements that link corporate oversight with system-wide leadership. The Executive Director ensures strategic alignment of corporate, system and directorate delivery and transformation. This ensures that decisions on strategy, resources, and risk are collaborative, transparent, and firmly focused on the needs of Suffolk residents.
- **Robust quality assurance and risk management:** The Quality, Engagement and Practice Board (QEP) provides strategic oversight of quality assurance, safeguarding, and person-centred practice. Using reviews, our Lessons Learnt Protocol, a well-developed audit programme, feedback and formal reporting routes to the Departmental Management Team (DMT), we translate insight into action. Our governance is underpinned by comprehensive quality assurance and risk management frameworks. We actively participate in regional improvement and benchmarking through ADASS, Local Government Association and Partners in Care & Health to complement our approach.
- **Data-led decision making and resource flexibility:** ASC has developed a mature, data-driven culture that underpins strategic and agile operational decision making. Data ownership is devolved to operational, commissioning and business and finance teams to manage performance, quality and finances with central oversight.
- **Visible and engaged leadership culture:** Leaders across Suffolk ASC are committed to being visible, accessible, and engaged with all staff. Countywide roadshows, leadership forums, webinars, and DASS-facilitated sessions provide open forums for dialogue and feedback. This is reinforced through staff surveys, topic-specific engagement, and exit interviews, which inform workforce priorities and continuous improvement.

Areas of Focus

- **Systematically embedding co-production:** Although we have developed strong examples of co-production and codesign, we have greater ambition to embed this consistently in how we design, implement and evaluate our services. Our People at the Heart of Care framework gives us the ability to scale up from project-based approaches to a whole-system model.
- **Strengthening outcome evaluation and impact measurement:** Suffolk ASC is committed to embedding more systematic approaches for evaluating outcomes to demonstrate the real impact of services on residents and communities. While audits and QA processes are well developed, we need to further develop stronger tools for outcome evaluation, and evidence how our interventions improve wellbeing, promote independence, and reduce inequalities.
- **Increasing engagement with seldom heard voices:** Suffolk ASC will continue to amplify the voices of people from seldom heard groups. Effectively harnessing national and local data in JSNAs, Equality Impact Assessments and community-based working, we will include more voices to improve access and influence design and evaluation of social care services.

1.1 Governance, management and sustainability

Leadership and Governance

We have clear responsibilities, roles, systems of accountability and good governance. These enable us to deliver safe, high quality, sustainable care and support, informed by the best available evidence on risk, performance, and outcomes. Our Councillors provide leadership and accountability across the local system. The Cabinet Member for Adult Social Care ensures our work is grounded in local community priorities. Several members of the Directorate Management Team retain professional registrations to enable them to actively participate in practice with current and relevant professional knowledge. Our governance arrangements ensure accountability, sustainability, and delivery of Care Act duties.

ASC senior staff work to provide visible, approachable leadership, driving an open, inclusive culture. Feedback from within SCC and from our partners evidences this:

Visibility of our leaders within ASC is appreciated and valued. The culture is one of positivity, trust, and respect.

Team feedback

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SCC leaders have built strong partnerships that keep people at the heart of care, through strategic and operational forums focused on neighbourhood delivery e.g. Place Board, UEC Alliance, East Executive Oversight Group and the Community Collaborative through which SCC colleagues role model the WE ASPIRE values.

Through our shared aims the Community Collaborative, consisting of County Council, ICB, Acute, Community, Mental Health and Primary Care providers has; supported consistent 80% UCR target compliance; through a Home First ethos ensured less than 4% of people in bedded reablement require new placements; enabled collective responses to individual needs e.g. ensured the needs of a person in a condemned house had their needs met; kept residents in a care home, deemed inadequate by CQC, safe and in familiar surroundings and introduced a Health Connector role with a respiratory focus in response to population health needs to support wellbeing and keeping people at home.

We are proud to be partners with SCC.

Executive Director of Operations,
East Coast Community Healthcare CIC

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Our strategic direction is set through the People at the Heart of Care framework and embedded in the ASC Business Plan 2025-26. These establish clear priorities for tackling inequalities, improving outcomes, and ensuring financial resilience. Oversight is provided through robust mechanisms that connect corporate and service-level decision-making.

Governance is multi-layered. The DASS provides strategic leadership as part of the Corporate Leadership Team, working alongside the Chief Executive, Cabinet, and elected members. The Directorate Management Team (DMT) and Senior Management Team (SMT) meet weekly to oversee performance, quality assurance, finance, and transformation, ensuring leadership is visible, responsive, and grounded in strong professional values. We work closely with other directorates including CYP and Public Health & Communities, with a Public Health AD a member of ASC's DMT. Scrutiny Committee provides additional democratic oversight, influencing policy and holding ASC accountable for outcomes.

Information and performance management underpin decision making. ASC has developed business intelligence dashboards, monthly performance reviews, and quarterly assurance reports, enabling leaders to act swiftly on emerging risks, inequalities, and opportunities for improvement. This is triangulated with the voice of the workforce and insight from people we support. Complaints, compliments, and scrutiny feedback are routinely analysed to strengthen governance, with clear evidence that lessons are learned and embedded. Assurance is also provided through the Council's Audit Committee and through compliance with the CIPFA and SOLACE principles of good governance.

Our Principal Social Worker and Principal Occupational Therapist

Since the pilot inspection, we have elevated our PSW to a senior manager level and have recently introduced the role of Principal OT. These roles have considerable visibility and influence at all levels of the directorate, firmly placing social work and occupational therapy standards & quality at the heart of decision making. Our PSW is a valued strategic advisor to the DASS, plays an active role in DMT meetings and plays a strong regional and national role as the Regional Chair of the PSW network, member of several ADASS regional networks and the BASW 80:20 campaign PSW representative.

Our Principal OT is undertaking a review of occupational therapy services, working with an external consultancy to develop a new strategy and work plan which will drive even better therapy, prevention and reablement outcomes in the future.

Strategic Planning and Delivery

Our approach to strategic planning ensures ASC is aligned to Suffolk County Council's corporate priorities while remaining responsive to local needs. The ASC Business Plan sets out clear objectives for service transformation, prevention, and personalisation, supported by our People at the Heart of Care strategy which translates national policy and reform commitments into local delivery, ensuring our workforce, partners, and communities have a shared understanding of the vision and delivery priorities. Planning is responsive to an ongoing cycle of delivery, review, and adjustment. Progress against the business plan is monitored through our Transformation Board, DMT, SMT and scrutinised by our Cabinet Members, enabling transparent accountability and ensuring political and executive leaders remain sighted on progress, risks, and resourcing requirements.

Strategic planning is also shaped by our commissioning responsibilities and population-level intelligence. Our Market Position Statement and Accommodation Strategy evidence bases demonstrate how ASC uses market analysis and sufficiency modelling to inform planning. These documents, alongside our coproduced Dementia, Learning Disability, Autism, and All-Age Carers strategies, ensure that our planning is operationally robust and strategically ambitious.

Performance, Risk and Assurance

Strong governance in Suffolk is underpinned by clear and transparent approaches to risk management and assurance. The ASC Risk Register provides a live record of operational and strategic risks, including workforce capacity, market fragility, and financial pressures. A transformation risk register captures programme delivery risks. Both are regularly reviewed by senior leaders and feed into the council-wide corporate risk register, ensuring ASC risks are fully integrated into corporate decision making. This gives assurance that the most significant threats to service delivery and sustainability are visible at both directorate and council level.

Our Corporate Risk Management Strategy sets out the principles, roles, and processes for managing risk. Specific mechanisms, such as the Unmitigated Operational Risk Protocol, clarify the escalation routes when risks exceed tolerances, ensuring timely operational intervention and accountability. These frameworks are overseen by DMT, connecting strategic risks to transformation and operational priorities and ensuring mitigating actions are aligned with delivery plans.

A well-established Information Governance (IG) Board has oversight of IG risks and decisions, monitors incidents and breaches, and manages actions to address these.

Sustainability and Resources

Our ASC strategy highlights sustainability as a core priority, balancing immediate pressures with longer-term transformation by embedding prevention, managing demand, and reducing inefficiencies while maintaining quality of care. Financial and operational sustainability are monitored through ASC's risk registers, which identify risks relating to demand, budget pressures, market fragility, and workforce capacity. Alongside detailed monthly financial forecasts, these are reviewed quarterly to ensure mitigating actions are in place and resourcing decisions are aligned with strategic priorities.

Workforce sustainability is a critical enabler. In addition to Exit Interviews undertaken with staff leaving ASC, we utilise the annual Local Government Association (LGA) Employer Standards Health Check as a key component of our quality assurance approach to workplace experiences. Our ASC average overall responses are consistent with regional and national performance, and show particular strengths in both social work and OT surveys including supervision, compassionate leadership, our open-door approach for staff to discuss stress or workload matters, and our staff having a sense of pride in their job, which positively reflects our workplace culture, the impact of our quality assurance activity in creating the conditions for good practice, and a supportive working environment. Individual staff feedback supports this: 'If I make a mistake I learn from it and it's important that I feel safe to do that. I get feedback that feels fair.' Workforce data is used to inform scenario planning, and improvements in training and career development are being implemented to build long term resilience.

While Suffolk has robust governance and planning processes in place, we acknowledge ongoing pressures on financial resources and market stability and manage these through a mixture of short- and long-term actions. We develop robust annual business plans annually and deliver these through our successful transformation programmes. We work with other agencies, including our ICB partners, to pool funding and agree collaborative approaches to solving system challenges. We actively manage our resources, including shifting staff capacity where needed to meet the most urgent priorities, alongside workforce planning for the future for both ASC and care providers, and work with the care market to manage immediate inflationary pressures, while longer term sustainability is addressed through our Care Market Strategy.

1.2 Leadership, learning, improvement and innovation

Our culture encourages continuous improvement, innovation, curiosity, openness, and reflection, with staff and leaders working together to embed evidence-based practice and new ways of working that improve people's outcomes. We listen carefully to feedback from people, carers, and our workforce, and ensure these insights shape our priorities for improvement and innovation.

Our approach is outward-looking and collaborative. We work alongside NHS partners, SNEE and, Norfolk and Waveney ICBs, VCFSE organisations, and national networks such as ADASS to share learning and adopt best practice. Through this, we have built a strong track record of responding to challenges with creativity, resilience, and ambition.

Quality Assurance

Quality assurance in ASC is a collective responsibility, embedded across all levels of operational practice and leadership, through a culture of learning, accountability and improvement. Our Quality Assurance Framework sets out this approach and is underpinned by a set of practice standards focusing on the quality of people's experiences of our practice and how this impacts on their lives. It is shaped by feedback from people, research, best practice, and strategic priorities reflected in the daily work of practitioners, managers, and leaders across the directorate.

Governance of quality assurance is provided through the Quality, Engagement and Practice (QEP) Board, which is chaired by an Assistant Director supported by the Principal Social Worker. QEP brings together senior leaders, operational managers and practice leads to learn from people's experiences, identify themes, monitor progress, and ensure that learning is translated into action, and reports into the Directorate Management Team (DMT).

The Quality Assurance and Practice Development (QAPD) team, led by our PSW working alongside our Principal OT, provides coordination and expertise to practice improvement, overseeing the delivery and impact of our various quality assurance activities within clear schedules and evidence informed priorities. QAPD lead on creating the conditions for good practice to flourish, operational risks to be identified and addressed, and up-to-date learning to be shared. Our staff are equipped and supported to deliver the best possible outcomes for the people of Suffolk. Policies and guidance are created or updated in response to quality assurance findings, in consultation with people with lived experience. Well-attended and recorded practice drop-in sessions are hosted by the PSW and Legal service to engage with staff, co-develop practice changes and communicate and embed learning to supplement our formal training offer. Heads of Service also lead service-specific practice events. Responsive digital communications and resources are available to staff, tailored to different learning needs.

Quality assurance is embedded in the day-to-day practice of our teams through ongoing reflection, supervision, and peer support to uphold standards and improve outcomes. Team Managers routinely review casework, provide feedback, and facilitate learning conversations. These everyday activities are essential to maintaining a culture of openness, curiosity, and continuous improvement.

Since the pilot assessment, QAPD has introduced a series of appendices to the Quality Assurance Framework, offering more detailed guidance on each assurance activity, including who is responsible, how frequently it should be carried out, and what good looks like in practice. They include templates, protocols, and examples to support consistency and clarity across the directorate. Co-developed with the workforce, these resources are designed to be practical and accessible. Their impact is monitored through feedback, implementation checks, and reporting to QEP. One example is the provision of Direct Observation of Practice tools, which enable a safe and supportive learning environment where supervisors observe practitioners in action, gather direct feedback from adults and carers, and reflect with the practitioner to celebrate good practice and support professional development. Team Managers have fed back that these tools are supporting them to oversee practice more effectively.

QAPD has also relaunched and expanded the Adult Social Care audit programme, introducing a more responsive and collaborative approach. Building on previous learning, the programme now includes Thematic and Collaborative audits, Person's Journey audits aligned to the CQC framework, and responsive, commissioned spot checks. These are designed to proactively assess whether practice is making a positive impact on people's lives and meeting statutory and regulatory expectations. Audits are undertaken in collaboration with adults, carers, practitioners, and managers, with feedback from people embedded as a standard expectation. We have strengthened the programme by using practice audits to gather feedback from practitioners about their conditions of practice, recognising the impact of staff wellbeing, supervision, and support on the quality of people's experiences. We have also introduced a new requirement to seek feedback from external partners about our practice and collaboration, reflecting our commitment to partnership and integrated working.

The audit tools have been streamlined for efficiency, and support is offered to auditors through guidance, drop-in sessions, and 1:1 assistance. Audit findings are analysed and shared across the service, with action plans developed locally and follow-ups conducted to track progress.

Learning and Continuous Improvement

ASC demonstrates a strong learning culture, where complaints, compliments and wider feedback are routinely reviewed at QEP, DMT, and local levels to drive improvement. Lessons are embedded into practice, contributing to our low complaint levels compared to other local authorities. We share learning across regional and national networks, including ADASS, and work with the University of Suffolk to strengthen research, evaluation and innovation. Regular benchmarking with other local authorities provides further assurance that our practice remains responsive and outward-looking.

We recognise effective governance and high-quality outcomes for residents depend on our ability to learn from experience, respond constructively to feedback, and embed change across our workforce and systems. This culture is embedded through our Lessons Learnt Protocol, Quality Assurance Framework, and QEP ensuring learning is actively translated into improvements in practice and service delivery.

Learning is systematically drawn from a range of sources including serious incidents, safeguarding reviews, Ombudsman outcomes, whistleblowing, and Coroner's Regulation 28 reports. We learn from local and high-profile national reviews and provide thematic safeguarding briefing sessions for our staff to promote effective learning, best practice, and system improvements where necessary. Additionally, we learn from inquests undertaken into the cause and circumstances of a death where it is suspected that the person may have died due to abuse, neglect or missed opportunities to support or safeguard them.

We use our Lessons Learnt Protocol to identify and take learning from 'near misses.' Examples of when this protocol is applied include where an adult who has a safeguarding plan in place unexpectedly dies when the SAR criteria is not met, or a near miss when an adult could have experienced significant harm. Where an incident or near miss has been part of Provider Failure, the Business Continuity lesson learnt process is followed by the Contracts and Service Development team. QEP decides how learning will be disseminated across ASC, and if it is to be shared with other departments in Suffolk County Council and external agencies. The Head of Adult Safeguarding maintains a Lessons Learnt log so that system themes and trends can be efficiently identified and addressed.

Over the past 12 months, ASC has applied its relaunched Lessons Learnt Protocol to incidents such as safeguarding failures in residential care homes, a serious safeguarding breach that resulted in the termination of contracts, and a hospital discharge followed by readmission where learning was shared across health and care pathways.

As part of our continuous improvement approach, we have introduced an annual comprehensive Practice Gap Analysis across ASC, overseen by our DMT. Heads of Service, Team Managers, and practitioners reflect on how well current practice aligns with our Quality Assurance Framework, the Care Act and other legislation, the CQC Local Authority Assurance Framework and the outcomes set out in our People at the Heart of Care strategy to identify opportunities and strengths in current practice, leadership, and people's experiences. These findings have informed targeted improvement planning and have shaped the QAPD workplan and priorities for 2025/26.

The impact of this structured approach is clear:

- Embedding the "Reasonable Adjustment Flag" into our case recording system, following Ombudsman findings.
- From Coroner's reports, we issued concise information guides for Approved Mental Health Practitioners, strengthening referral pathways to Crisis Resolution and Home Treatment Services.
- Contract terminations at care homes led to updated guidance for monitoring providers, reinforcing expectations for quality and safety
- Following a Regulation 28 Prevention of Future Deaths report, referral pathways across ASC and Children's Services were updated with prompts to consider risk to both children and adults. This action has increased professional curiosity and improved joint working across service boundaries.
- Targeted learning from complaints about delays in assessments led to the introduction of prompts in the case recording system and new practice guidance for managers.

We also emphasise informal learning across teams. Practice development sessions, myth-busting workshops, and drop-in sessions have been used to reinforce core statutory duties and responsibilities. This approach has increased practitioner confidence in reviewing and updating Care and Support Plans, leading to more positive experiences for people. Each service area develops an annual 'Learning Calendar' to forward plan local learning events based on the teams' learning requirements. Informal learning is further embedded through team meetings, where managers share targeted lessons that link directly to casework. For example, our Mental Health and Learning Disability services joint practice workshops have been a key platform to develop and manage the risk register.

We proactively use data and intelligence to identify patterns that signal emerging risks, enabling us to act before issues escalate. For example, our business intelligence dashboards now provide real-time monitoring of safeguarding referrals, complaints, and review timeliness, which are discussed at monthly DMT and SMT sessions. This ensures senior leaders and frontline managers are working from a shared evidence base and can take swift corrective action where needed. The impact of this systematic approach is visible in practice: for instance, reminders for staff on handling sensitive information have reduced data breaches.

We also learn from provider level incidents. Thematic audits following care home closures have been used to refine our risk stratification tools, ensuring people awaiting assessment or transfer continue to receive timely information and support. This learning has informed our market oversight processes and strengthened resilience across Suffolk's care system.

Looking forward, we are committed to strengthening our culture of continuous improvement. We are embedding digital tools such as Copilot and Magic Notes to streamline documentation, freeing up staff time for direct engagement with people. We are also developing a more systematic approach to capturing and analysing feedback from seldom-heard groups, ensuring that our improvement activity reflects the diversity of Suffolk's communities and advances equity.

Workforce Development and Professional Standards

Suffolk recognises that workforce capability and confidence are the foundation of a clear vision for strengthening skills, capacity, and professional standards across ASC. To do this we embed continuous professional development, supporting staff through training pathways, and ensures compliance with the national Employer Standards for Social Work and Occupational Therapy, which provide an external benchmark.

Our workforce training offer is detailed in a Training Matrix, mapping mandatory, specialist, and leadership training across all ASC roles. This ensures staff are equipped to deliver safe, personalised care and that emerging needs such as digital skills and equality, diversity, and inclusion awareness are built into development planning. Alongside this, the Exit Interview Questionnaire provides valuable insights into staff experience, enabling leaders to address issues of retention, workload, and wellbeing.

Learning is also embedded through regular supervision, reflective practice, and peer learning forums. These structures provide staff with opportunities to share knowledge, embed lessons from case reviews, and translate organisational priorities into daily practice. While evidence demonstrates plans for development, Suffolk supplements this with insights from corporate staff surveys and the Adult Social Care Business Plan which positions workforce development as a key enabler of transformation and sustainability.

EDI is a standard consideration in our Practice Audits, ensuring that the diverse identities, experiences, and needs of the people we support are recognised and reflected in our assessments and planning. This helps us evaluate whether our practice is inclusive, person-centred, and responsive to individuals' protected characteristics, and informs continuous improvement in how we work with people.

Staff Wellbeing and Career Pathways

Suffolk monitors workforce experience, including staff wellbeing, through the Exit Interview Questionnaire and the Employer Standards Health Checks for Social Workers and Occupational Therapists. These tools provide insight into why staff join, stay, or leave, as well as into pressure points such as caseloads, supervision, and work-life balance, which is used to inform targeted retention strategies and development opportunities.

Our ASC Staff Wellbeing Pack provides resources and support including Mental Health First Aiders, financial health, and stress management. Since its introduction in February 2024, it has been accessed 1358 times.

The Workforce Development Business Plan identifies career development as a priority, setting out plans to expand apprenticeship routes, strengthen practice education for social work students, and support advanced practitioner roles. This is complemented by Suffolk's involvement in national accreditation pilots for social workers, which provide opportunities to benchmark practice standards and prepare staff for evolving professional requirements.

We are building on the success of our existing apprenticeship programme which has seen two apprentices progress to Senior Social Worker roles within two years of completing the qualification in two consecutive years, both of whom also won the Social Worker of the Year Award in the Newly Qualified Social Worker category. Staff say:

I have thoroughly enjoyed completing my ASYE, particularly the support and expertise from my assessor... The ASYE has given me the confidence to approach my career with enthusiasm and a desire to continue to learn and grow as a practitioner.

Mental Health Social Worker

“”

The apprenticeship has deepened my understanding of systemic and institutional discrimination... I have progressed beyond non-discriminatory practice to confidently adopting an anti-discriminatory approach, actively challenging biases, and systemic inequalities... Throughout the course I have been inspired by the passion and skills of my peers and tutors, who have been endlessly patient and encouraging and given me the confidence to grow.

Apprentice Social Worker

“”

We are embedding staff wellbeing into our refreshed ASC EDI action plan, aligned to corporate priorities, recognising that staff from seldom heard groups and those with protected equality characteristics may experience different challenges in the workplace. We ensure our staff can access any of the eight SCC staff networks for fellowship and support including the Black & Asian Network, LGBT+ network, and Mental Health network, which in turn help develop awareness and training, and influence corporate policy and approaches.

Coproduction and Community Voice

Coproduction is a central focus across ASC and is embedded in our approach to learning and improvement. The Independent Lives Transformation Programme has demonstrated how lived experience can directly shape commissioning and service design, with people influencing models of reablement, housing, and employment, while our key strategies also evidence strong use of coproduction. These lessons are now being applied across other programmes to ensure that services reflect what matters most to residents and carers.

Our People's Voices at the Heart of Care framework provides a systematic model for embedding co-production within governance and improvement loops, helping us move from project-based engagement to a consistent, whole-system approach. It will also provide mechanisms for systematically capturing the impact of co-production and demonstrating how feedback influences decision-making.

As a family carer member of the Family Carers Partnership Board, I work strategically with other family carers and members from the public, community and voluntary sectors on improving the lives of carers and those they care for. It enables me to contribute my lived experience as a carer and ensures that carers are seen, and their voices are heard.

FCBP member

“”

Our working relationship with Suffolk County Council has produced many excellent examples of coproduction in action over several years.

ACE Anglia

“”

Through these mechanisms, Suffolk ensures that community voice is heard and acted upon, strengthening accountability and embedding equity in our improvement culture. Although ASC has developed strong examples of co-production and engagement, we are continuing to develop our skills at learning from lived experience by building on existing good practice through the more systematic approaches described here.

Innovation and Digital Transformation

Innovation is core to our culture. We are a local authority frontrunner in digital innovation, evidenced in our early implementation of supported self-assessment and in our strong, creative, and established digital care offer which goes beyond traditional care technology, set out in earlier themes. We have also implemented the Marketplace platform which allows CQC rated providers to promote their services directly to residents, recently implemented e-brokerage and are working towards this becoming the platform for people to broker their own care as a self-funder or through a direct payment.

We build partnerships to drive innovation: in addition to the examples already cited, recently partnering with a digital developer, Spark, to develop Reverie, a new virtual reality (VR) solution to enhance the lives of people living with dementia in Suffolk. Reverie provides supported immersive experiences to improve wellbeing, communication and cognitive ability for individuals living with dementia, responding to evidence that VR can deliver improved outcomes for people living with dementia, as well as their loved ones and carers, by helping to provide a fuller and more satisfying quality of life. The partnership has ensured Reverie will be available to all care settings in Suffolk at a reduced rate and will be developed to support people of working age who require care and support by providing work experiences and travel training to promote their independence.

We use innovation to support our workforce, for example our pilots of AI-supported case recording tools. These are reducing the administrative burden and releasing staff time for direct work with residents, and include a proof-of-concept we are developing with System C that imports information directly into LiquidLogic forms, further reducing the need for rekeying. Early feedback shows that these tools have the potential to improve accuracy and efficiency, while supporting staff wellbeing by reducing workload pressures. We provide digital CPD and e-learning to ensure staff are confident in using new technologies and embedding them in practice, evidenced in positive feedback: "I will cry when the [AI recording] trial ends. I feel it has allowed me to bring much more of myself to conversations. Assessments have been less like a question-and-answer sessions (to support accurate recording) and more like a natural, relaxed space where I can really understand the customer experience." (Senior IWP, hospital team).

Our approach to innovation includes new models of commissioning and service delivery, including the work already referenced to develop microenterprises, complex assessment functions (Wickham House), ToCHs, and the WHAT falls prevention team. All these models enable greater choice and flexibility by further tailoring and personalising care and by bringing services together around individuals.

Looking forward, we will build on our improvement culture and strong track record delivering transformation to introduce further innovation including interoperable systems between social care and health, and natural language search to join up public sector IAG at the front door. We are currently developing a new ASC faculty of learning which will support us to further develop our training offer to support our staff to continue to innovate and transform.

These developments will ensure ASC is well placed to the changing local government and partner landscape, including the NHS 10 Year Plan and Local Government Reform.

Glossary

ABE	Achieving Best Evidence	EDS	Emergency Duty Service (out of hours social work)
AD	Assistant Director	EDI	Equality Diversity and Inclusion
ADASS	Association of Directors of Adult Social Care	EIA	Equality Impact Assessment
AI	Artificial Intelligence	ERS	Experience of Received Services
AMHP	Approved Mental Health Professional	FCEP	Family Carer Emergency Plan
ASC	Adult Social Care	Head of Ops	The head of operational social work service across one geographical area
ASCS	Adult Social Care Survey	HIE	Health Information Exchange
ASYE	Assessed and Supported Year in Employment	HR	Human Resources
BCF	Better Care Fund	ICB	Integrated Care Board
BIA	Best Interest Assessor	ICP	Integrated Care Partnership
CAST	Central Adult Safeguarding Team	ICS	Integrated Care System
CEO	Chief Executive Officer	IMCA	Independent Mental Capacity Advocate
CF	Customer First	INT	Integrated Neighbourhood Team
CHC	NHS continuing healthcare	ISCRE	Ipswich and Suffolk Council for Racial Equality
CIPFA	Chartered Institute of Public Finance and Accountancy	IWP	Independence & Wellbeing Practitioner
CLN	County Lines Network	IWS	Independence and Wellbeing Service
CMS	Case Monitoring System	JCAD	Risk Management tool
CPD	Continuous Professional Development	JSNA	Joint Strategic Needs Assessment
CQC	Care Quality Commission	LAPEL	Local Authority Pressure Escalation Level
CYP	Children and Young People	LD&A	Learning Disability and Autism
D2A	Discharge to Assess	MASH	Multi-Agency Safeguarding Hub – The Multi-Agency Safeguarding Hub (MASH) is made up of a range of organisations in Suffolk who are responsible for safeguarding adults and children.
DA	Domestic Abuse		
DAP	Dementia Action Partnership		
DASS	Director of Adult Social Services		
DHR	Domestic Homicide Review		
DHSE	Department of Health and Social Care		
DoLS	Deprivation of Liberty Safeguards		
DPIA	Data Protection Impact Assessment		
DMT	Directorate Management Team		
DNARCPR	Do Not Attempt Resuscitation		
DV	Domestic Violence		

These organisations include:

- Suffolk County Council
- Suffolk Police
- health services
- District and Borough Council Housing Services
- Education
- Probation
- The Youth Offending Service

MAPPA	Multi-Agency Public Protection Arrangements	RPR	Relevant Person's Representative
MCA	Mental Capacity Act 2014	R&R	Recruitment and Retention
MDT	Multi-Disciplinary Team	S21A	a Section 21A Mental Capacity Act challenge
MH	Mental Health		
MSP	Making Safeguarding Personal	SACE	Survey of Adult Carers England
NRM	National Referral Mechanism	SAR	Safeguarding Adult Review
NQOT	Newly Qualified OT	SAIP	Suffolk Association of Independent Care Providers
NQSW	Newly Qualified Social Worker		
NSFT	Norfolk & Suffolk Foundation Trust	SARP	Safeguarding Adult Review Panel
N&W	Norfolk and Waveney	SCC	Suffolk County Council
OPEL	Operational Pressures Escalation Levels	SCCM	Strategic Commissioning & Contract Management Teams
OT	Occupational Therapist	SDQ	Strengths & Difficulties Questionnaire
PAMMS	Provider Assessment and Market Management Solutions	Section 42	An enquiry under The Care Act 2014 (Section 42) where there is belief an adult is experiencing, or is at risk of, abuse or neglect.
PCL	Professional Consultation line		
PDR	Professional Development Review		
Personalisation	Putting the individual at the centre of their own care, giving greater choice and control over how their care needs are met	SEND	Special Educational Needs and Disability
		SMT	Senior Management Team
		SN&H	Self-Neglect and Hoarding
PfA	Preparing for Adulthood	SNEE	Suffolk and North-East Essex
PMO	Programme Management Office	SOLACE	Membership network for public sector and local government professionals.
PSW	Principal Social Worker		
QAPD	Quality Assurance & Practice Development	SOP	Standard Operating Procedure
QEP	Quality, Engagement and Performance Board	SOS	Signs of Safety
		SP	Senior Practitioner
QEPD	Quality Assurance and Professional Development	SSW	Senior Social Worker
		TiP	Trauma-Informed Practice
RAG	Red, Amber Green – risk assessment	TOCH	Transfer of Care Hub
Reablement	Short term, goal orientated social care that helps regain skills, confidence and independence	TPO	Trusted Partner Organisation
		VAWG	Violence Against Women and Girls
		VCFSE	Voluntary, Community, Faith and Social Enterprise