Open Agenda

Health and Social Care Scrutiny Commission

Tuesday 18 April 2023
7.00 pm
160, Tooley Street, SE1 2QH

Supplemental Agenda One

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Contact

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Date: 13 April 2023

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Councillor Evelyn Akoto

Cabinet Member for Health and Wellbeing

Cllr Akoto leads the council's work to improve the health and wellbeing of our residents. This includes our work on COVID-19, public health, adult social care and our partnership with the NHS. She also leads the council's work to ensure older people and people with disabilities are fully included in the life of our borough. She will work to reduce health inequality in the borough including those faced by our Black, Asian and minority ethnic communities. In addition, Cllr Akoto will safeguard the needs of vulnerable adults and the provision of personal social services.

Cllr Akoto will be responsible for delivering our commitment to:

- make Southwark a Right to Food Borough
- ensure all Southwark residents can access mental wellbeing support
- reduce inequalities in access to healthcare
- expand our Community Health Ambassadors network
- provide a defibrillator (AED) for every school and in public buildings
- introduce support for all unpaid carers
- roll out our new Residential Care Charter
- every care home having a Family Forum
- open a new nursing home and more extra care housing
- seek opportunities to bring social care services in house
- campaign to keep our NHS in public ownership
- establish a modern centre for Black African and Caribbean elders run by and for the community they serve
- establish a new Inclusive Southwark Forum

Cllr Akoto will have wider responsibility for:

- COVID-19
- older people
- adults with disabilities
- public health, including health improvement, protection and intelligence
- adult social care, including nursing and care homes
- local health services, including GP practices
- integration of health and social care services
- childhood obesity (working with the Cabinet Member for Children, Young People and Education)
- drug and alcohol services
- sexual health, contraception and HIV
- commissioning of supported, extra care and sheltered housing

Agenda Item 6

Southwark Safeguarding Adults Partnership

Contents

Foreword

Message from the Chair

It is my pleasure to introduce the Southwark Safeguarding Adults Board's (SAB) annual report 2021/22. The aim is to provide insight to the activity over a 12-month period, and the collective response of our partners within the SAB. It has been positive to observe continued collective approach through the work of the Board at a strategic level and within the subgroups, and the content of this report provides assurance on that commitment and activity.

The report articulates the review of the overarching governance arrangements that have been implemented to strengthen the effectiveness of the Safeguarding Adult Board, enhance the community engagement and drive forward local and national learning into practice. This includes hearing the range of voices of members and stakeholders, establishing and working together on co-produced priorities, connecting SAB sub-groups firmly into a shared vision and work plan.

Work throughout the year has been informed by the wider (and local) evidence base in adult safeguarding and includes surveys and consultations across stakeholders and its membership which demonstrates a commitment to inclusivity. Looking forward, the SAB will build on this foundation to facilitate further feedback and challenge from the wider community to really develop methods of engagement and explore lived experience.

Over the past year, the areas of focus included homelessness, complex safeguarding and Domestic Violence and Abuse and this report articulates the breadth of work that has been done and continues to be embedded and measured. The revised arrangements have allowed for strengthened approaches to Safeguarding Adults Reviews (SARs) with particular emphasis on how the learning impacts practice and outcomes. Seeking assurance that local safeguarding arrangement help to protect adults from abuse and neglect is the main objective of a SAB and further development throughout the coming year will strengthen the methodology for continual assurance.

I would like to thank the team in its very widest sense for their tireless commitment to the work of the SAB.

Anna Berry
Independent Chair, Southwark Safeguarding Adults Board (SSAB)

The Southwark Local Safeguarding Context

Southwark Adult Demographics

In 2021, Southwark's estimated population decreased by over 12,000 people compared to the previous year

The census was taken during the COVID-19 pandemic, with respondents required to answer questions based on their place of residence on Census Day. At this time many COVID-19 restrictions were still in place

Though there was an overall increase (18%) in numbers of residents aged 90+ over the past 10 years, the 2021 year saw a substantial drop of 22% when compared to 2020

Southwark's usual resident population on Census Day 2021 was 307,700, an increase of 7%, or 19,400 people since 2011

The number of adults aged 55 to 70 in Southwark between the 2011 and 2021 Census was up by 12,500 people, or 47%

1. The Board

Our Vision

We believe all adults at risk that are living in or visiting Southwark have the right to be safe and protected from harm. We will all work together to support these adults and their carers to make informed choices and to provide the highest quality services so they can live full, independent and self-determined lives.

Southwark Safeguarding Adults Board's primary objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults who are at risk of/or experiencing abuse or neglect.

The Board will hold agencies to account for their key safeguarding responsibilities, so that:

- All those who work with vulnerable adults know what to do if there are concerns about possible harm or abuse.
- When concerns are raised regarding an adult who is vulnerable to harm / abuse, action is taken in a timely manner and the right support is provided at the right time.
- Agencies which provide services for vulnerable adults ensure they are safe, and monitor service quality and impact.

Key strategic questions for the Board

- Is the help provided effective? How will we know our interventions are making a positive difference? How will we know all agencies are doing everything they can to make sure vulnerable adults are safe?
- Are all partner agencies meeting their statutory responsibilities as set out in The Care Act (including Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability), Mental Capacity Act and Deprivation of Liberty Safeguards?
- Do all partner agencies quality assure practice and is there evidence of learning and improving practice?
- Is safeguarding training monitored and evaluated and is there evidence of training impacting on practice? This includes multi-agency training.

1.1 Our Partners

Partnership work is vital to the successful delivery of safeguarding services and interventions in Southwark. We remain confident that safeguarding is at the heart of the services delivered by statutory and voluntary services in Southwark, and we also remain committed to maintaining an open dialogue with all our partners, and working jointly with partners to ensure the best, person-centred outcomes to protect adults who are vulnerable to harm / abuse.

To ensure the Board fulfils its duties effectively, our membership is made up of senior officers from across the partnership who are able to promote the respective priorities of the organisations around the partnership.

SSAB Membership

Southwark Council	ICB/NHS	Police	Other Organisations
Independent Chair, SSAB	Chief Operating Officer, Southwark, SELICB	Chief Superintendent Southwark and Lambeth BCU	Borough Commander, London Fire Brigade
Strategic Director of Children's and Adults Services	Designated Nurse for Adult Safeguarding (ICB)	Detective Superintendent - Head of Public Protection	Head of Probation Service, Southwark
Strategic Director of Housing and Modernisation	Named GP for Adult Safeguarding (ICB)		Community Southwark
Strategic Director of Environment and Leisure	Head of Safeguarding Adults (GSTT)		Provider Representatives
Director of Adult Social Care	Safeguarding Adults Lead (KCH)		
Director of Communities	Safeguarding Adult and Child Lead (SLaM)		
Director of Public Health			
Director of Resident Services			
Director of Commissioning, Children and Adults' Services			
Assistant Director, Community Safety and Partnerships			
Principal Social Worker for Adults			
Cabinet Member for Community Safety			
Cabinet Member for Council Homes and Homelessness			
Cabinet Member for Health & Wellbeing			

1.2 Governance Arrangements

During 2021/22 the Independent chair of Southwark Safeguarding Adults Board (SSAB) undertook a governance review with a focus on whether our current arrangements had a strong focus on holding agencies to account for their safeguarding activity. There was an emphasis on quality assurance, learning and improving practice, ensuring a feedback loop across all agencies and with the frontline was evident.

The purpose of the review was to ensure the SSAB achieved the following functions;

- Sharing, promoting, and embedding learning
- Assurance of the effectiveness of safeguarding practice/ services
- Independent oversight
- The voice of the service user / people with lived experience

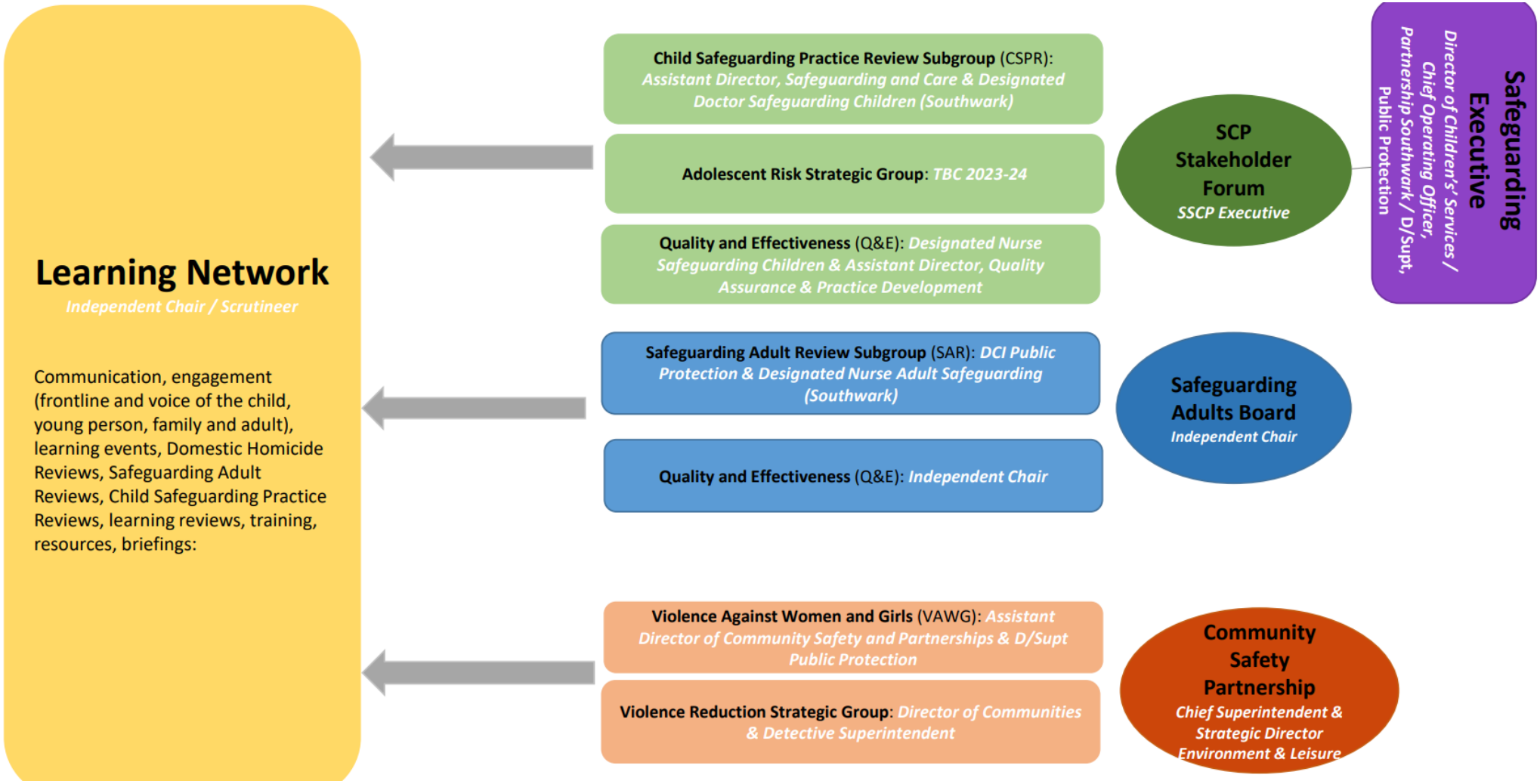
As part of the governance review, consultation took place across the partnership with focus groups being held with the following groups:

- Safeguarding Executive Group
- Health, including ICS representatives and provider organisations
- Police
- Adult Social Care
- The VCS
- Community Safety
- Public Health
- The consultation was communicated widely to all sub-groups and comments invited.

The review considered the connectivity between the Southwark Safeguarding Adult Board (SSAB), the Southwark Safeguarding Children Partnership (SSCP) and Southwark Community Safety Partnership (CSP) and how they can operate effectively in terms of Safeguarding by being clear on respective roles. These could be considered as the three core partnerships integral to safeguarding practice and thus the focus of the review was to ensure that the arrangements demonstrated a commitment to cross partnership working, the connectivity across the sub-groups was strengthened and a shared learning function was implemented.

Southwark Safeguarding Adults Partnership

Refreshed Governance Structure 2021/22



1.3 Communications

It is vital that key messages are cascaded to front line staff and as a partnership we are committed to continually strengthening our approaches to this. As a result. During 2021-22 we circulated 3 newsletters, containing key safeguarding messages. These were shared widely with partners, including the community and voluntary sector.

The SSAB remains committed to promoting a culture which values and facilitates feedback from front line staff and users of services but acknowledges this is an area that would benefit from being strengthened. With that in mind, a key work stream for the newly established Learning Network is the development of a communication and engagement plan. This plan will embrace the 'think family' approach and engage with service users, families and wider community. We will challenge ourselves to identify the best way to share messages with the public and professionals and to capture the voice of service users and residents.

Looking ahead to 2022 – 23;

- We will ensure that we ask the frontline staff in Southwark what is working well for them and where there are challenges or barriers.
- We will engage with people receiving services in Southwark and learn from them what works well and what could be improved
- We will consider the best techniques and create innovative methods to get key messages out, including the use of social media, roadshows, themed events and videos.
- We will not overcomplicate messages as we recognise that safeguarding can feel daunting and complex to many frontline staff.

1.4 Our Subgroups

Learning Network

The Learning Network subgroup is a joint subgroup of the SSCP and SSAB. It is chaired by the SSCP/SSAB Independent Chair. Following the governance review and development of a new structure, there has been a transition away from focusing on training, towards a renewed focus on the implementation of learning, developing communication and seeking assurance. The establishment of the learning network will enable a strengthened approach where learning is embedded in the culture of all safeguarding practice.

The SSAB is committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve future practice and partnership working. This approach facilitates robust mechanisms to review, analyse and develop practice. We are confident that our approach to learning and development drives improvements in the wider safeguarding system as well as in the outcomes experienced by users of services.

During 2021/22 this network has focused on aligning our Quality Assurance processes for adult and children carefully with our learning approach to ensure that we are able to measure effectively the changes that we embed across the partnership. In addition, the network has reviewed its multi-agency safeguarding training offer, ensuring it is relevant to the partnership priorities whilst recognising that this is only one part of embedding learning into practice.

A key work stream of this group has been the development of a referral pathway to enable other subgroups and professionals to advise the network of key messages that need cascading and embedding. To support this, a ‘7 minute briefing’ template has been developed and is being utilised for learning from safeguarding Adult Reviews (SARs) in particular.

Looking ahead into 2022/23 this network will be focusing on its Communication and Engagement Plan to ensure engagement with both frontline staff and people receiving services in Southwark, to enable a better understanding of what is working well for them and where there are challenges or barriers.

Quality and Effectiveness Subgroup

The purpose of the Quality and Effectiveness Subgroup is to provide the Safeguarding Adults Board with assurance around the quality and effectiveness of the safeguarding responses within Southwark, and through this to improve effectiveness. One of the key assurance pieces of work undertaken was the safeguarding self-assessments: the key themes from these audits are reported on below. In addition, this subgroup drives forward the priorities of the SSAB, such as the development and roll out of the complex case pathway and the domestic abuse deep dive.
Work is ongoing to review the existing performance dashboard and align it with the Board's agreed priorities.

One of the main areas of focus for this subgroup is the safeguarding Adults Partnership Audit Tool (SAPAT), which all partners complete annually. This group identifies the key themes from the assessments which informs the priorities for the forthcoming year. In addition, the group has driven the recruitment to the London Safeguarding Voices Group (LSVG) to ensure that people with lived experience of safeguarding and their voices are at the heart of governance and practice. Whilst the recruitment process locally was unsuccessful, we continue to benefit from the London wide initiative. In addition the group has undertaken a thematic review into domestic abuse, received updates on the development of the Integrated Care System, including their Safeguarding Governance and Accountability framework, as well as developed a Complex Case Pathway.

Safeguarding Adults Review (SAR) Subgroup

This is a newly formed subgroup, launched in the final quarter of 2021/22. Prior to its existence, this area of work was subsumed within the Quality and Effectiveness subgroup. However, it was acknowledged that to align with our commitment that the lessons we learn within Southwark, from national learning and the findings from reviews or other investigations will have a positive impact on frontline practice, it was essential that a standalone SAR subgroup was established. This group will review and discuss recommendations regarding learning from the National SAR Analysis and take forward priorities for sector led improvement as well as gain assurance from across the partnership with regards to SAR recommendations and action plans. Other emerging areas of focus as we move into 2022/23 include SARs in rapid time.

Safeguarding Adults Partnership Audit Tool (SAPAT)

Under the Care Act (2014), Safeguarding Adults Boards must have an audit process to monitor and evaluate their performance and that of the member organisations. The SSAB disseminated a self-assessment audit tool to all partner agencies and following submission, with a specific focus on areas held a multi-agency Challenge event.

The key themes that were identified from the 2021/22 SAPAT include:

1. Management of complex cases
    - The complex case pathway has been developed but next phase is embedding it into practice.

2. Engagement of Service users
    - Appropriate structures are required to enable those with lived experience to feed into reviewing and improving the systems in place in Southwark

3. Dissemination of learning from SARs
    - Partnership pathways to be formalised for embedding learning regarding from SARs, and for monitoring single agency and multi-agency action plans

These areas have begun to be addressed, and will continue to be driven forward by the subgroups of the Board during 2022/23.

1.5 Financial Arrangements

SSAB receives financial contributions from a number of agencies and other forms of in-kind support.

Money received in 2021/22 is detailed here.

Contribution	Total
Police (MOPAC)	£5,000
NHS Southwark CCG	£55,000
London Fire Brigade	£500
London Borough of Southwark	£63,421.50
Total from contributions	**£123,921.50**

1.6 Core Adult Safeguarding Data

During the 2021/22 period Adult Social Care (ASC) received a total of 1400 concerns.

401 of the concerns received led the Social Worker to conclude that an enquiry was necessary. 75 cases were however managed under the guise of non-statutory enquiries.

ASC had plans in 2021 to deep dive in to the types of cases that constituted 'non-statutory enquiries'. This piece of work is now scheduled for 2023/24.

The conversion rate for concerns to enquiries was 29%, which is 2% greater than the previous year's figures but still 6% less than national figures which presently stand at 35%.

Risk was identified in 100% of the completed enquiries. Risk was subsequently reduced or removed in 94% of cases.

Of the individuals who were asked to define the outcome they wanted from the enquiry, 67% expressed an outcome.

In the instances where an outcome was expressed, individuals felt this had been fully or partially achieved in 98% of concluded enquiries.

It is important to note that a data cleanse has taken place since this period, meaning that figures presented to the board for 2020/21 have changed (please see the column highlighted below for updated figures). The data cleanse is part of an ongoing effort to improve the validity of the data that ASC holds. As

such, a comparative account with figures previously presented to the board would not be a true representation of any trends. Any comparisons made will instead be to newly cleansed data. New training was commissioned for Safeguarding Adults Managers (SAM) in 2020/21. The uptake for this during the 2021/22 period has however not been high. Attendance rates will be reviewed over the course of 2022/23 and consideration will be given to the frequency at which training should be repeated as this is not presently mandated.

It is noted that the desired outcomes recorded by individuals is relatively low at 67%. Through further analysis of a selection of the cases where no outcomes were recorded ASC have been able to identify that this may have been attributed to the following: clerical errors, mental capacity or unwillingness to contribute toward the enquiry. Further work will be done to promote Making Safeguarding Personal (MSP).

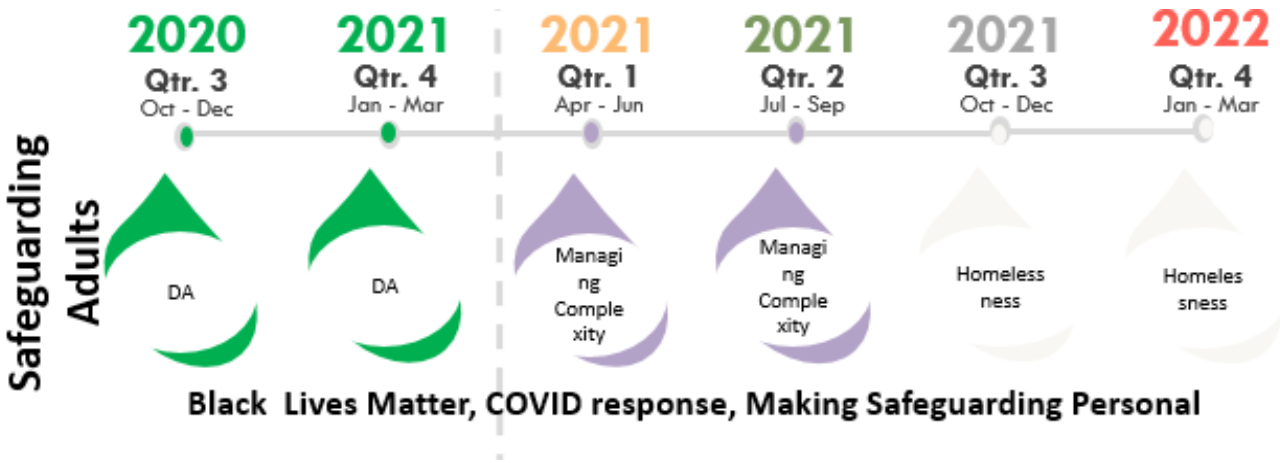
In 2020/21 the outgoing PSW and Safeguarding Lead planned to take deep dives in to specific areas in order to inform further analysis of practice and process review. The intention was to gain further understanding of the types of cases that constitute 'non-statutory' enquiries. As aforementioned this piece of work has been delayed until 2023/24 to allow for a review of the current safeguarding pathway. The review will initially focus on simplifying the workflow and changes to ASC forms. It is anticipated that the knock-on effect of these changes may have an impact on the percentage conversion rate of concerns to enquiries.

Concerns and Enquiries	2020/21 (Cleansed data)	2021/22	S42	Other
1. Safeguarding concerns received	1458	1400	-	-
2. Safeguarding enquiries commenced	398	401	326	75
3. Rate of Concerns to Enquiries	27%	29%	-	-
4. Safeguarding enquiries concluded	398	401	326	75
5. Safeguarding enquiries concluded within 30 days	285	277	220	57
% of enquiries	*72%*	*69%*	*55%*	*14%*
6. Concluded enquiries where the individual assessed as lacking capacity	94	100	91	9
7. Safeguarding enquiries concluded where risk was identified	398	401	326	75
% of enquiries	*100%*	*100%*	*81%*	*19%*
8. Where risk identified - risk reduced or removed	365	377	308	69
%	*92%*	*94%*	*77%*	*17%*
9. Safeguarding enquiries for which the individual expressed desired outcomes	325	268	217	51
% of enquiries	*82%*	*67%*	*54%*	*13%*
10. Safeguarding enquiries for which the individual's expressed outcomes were fully or partially achieved	244	263	213	50
%	*75%*	*98%*	*79%*	*19%*

2. Our Priorities

Due to the pandemic, the priorities for the previous year (2020/21) were not formally agreed until September 2020 to enable sufficient time to implement, and therefore it was agreed that the SSAB priorities would remain the same in 2021/22. While the partnership will work on all the priorities during this period, there will be a quarterly focus on particular priority areas as detailed below.

Quarterly areas of focus



2.1 Domestic Abuse

Sadly, domestic abuse affects thousands of people in Southwark every year. It is often hidden but its impact spans generations. Despite the successful work already undertaken locally, the Covid 19 pandemic and the imposed lockdowns had a negative effect on the number of domestic abuse incidents. During 2021/22 anecdotally partners were reporting an increase in family members abusing other family members within the home. In light of this, the SSAB, in conjunction with the SSCP undertook a thematic review to establish locally if there was there a noticeable trend of intergenerational abuse during Covid.

Although the review did highlight an increase, this increase was not as significant as predicted. It is possible that this could be attributed to an under reporting of such abuse. The vast majority of cases reviewed involved adult children abusing their parent and the findings highlighted that the parent often minimised the level of abuse and were reluctant to report to the police for fear of criminalising their child and / or making them homeless. Furthermore, the victim parent (usually the mother) and parenting ability was often the focus of the assessment and subsequent intervention, not the perpetrator of the violence and abuse. Responsibility was therefore, not being rightfully placed, with the focus being on the victim / survivor as opposed to the perpetrator. Following this identification, work is being undertaken to ensure this position is improved and our support offer is strengthened.

With the introduction of the new Domestic Abuse Act during 2021/22, the partnership focused on raising awareness and understanding about the devastating impact of domestic abuse on victims and their families and the implications the Act will have on everyday practice. There was a specific emphasis that domestic abuse is not just physical violence, but now also includes emotional, controlling or coercive and economic abuse. Partners of the SSAB, together with the SSCP and the Community Safety Partnership are working collaboratively to ensure all aspects of the Act are understood and implemented.

2.2 Managing Complexity

Findings from our recent Safeguarding Adults Reviews (SARs) have identified concerns about how agencies worked together effectively to support adults at risk of self-neglect, where the risks (both known and unknown) are increasing, and where providing support for the person is either challenging or those support pathways are unclear.

These risks and challenges can often be compounded as the adult may not meet the criteria for a formal adult safeguarding response, or the person may not be in receipt of a service with clear responsibility for overall care co-ordination that takes into account the entire well-being of the person, or the person may fall outside eligibility criteria for statutory services.

In response to this, the SSAB have developed a Complex Case pathway, which seeks to;

- promote a *pro-active responsibility to act* on the agency that identifies the concern,
- encourage the facilitation of multi-agency conversations about risk
- develop on-going consideration of risk and actions through the identification of a lead agency

During 2021/22 this pathway was launched and whilst it is still in its infancy, its use has demonstrated that the complex case pathway is a helpful tool in bringing agencies together to assess and manage risk in complex situations relating to self-neglect. The facilitation of multi-agency discussions provided an effective space for professionals to focus and think creatively about managing risk. Looking ahead to 2022/23, the partnership will embed the use of this pathway, together with reviewing its effectiveness.

2.3 Homelessness

During 2021/22 Southwark Safeguarding Adults Board requested an update to the Joint Strategic Needs Assessment (JSNA) on the health and wellbeing needs of Southwark's rough sleepers (December 2018) to include the current picture and the impact of COVID-19. This highlighted that during 2020/21, Southwark had the 6th largest population of rough sleepers in Greater London, with our rough sleeping population increasing by 83% from 2017/18 to 2020/21. Furthermore, during 2020/21, three in four (72%) of the rough sleeping population in Southwark had at least one complex support need, confirming the decision for homelessness to be a priority of the SSAB.

A Homelessness task and finish group was established, to review the current homeless pathways for multiple disadvantage service users, with the aim of identifying gaps with the various partner agency 'touchpoints' and how this can be improved. The work also includes the development of a shared Risk Assessment toolkit to safeguard service users with multiple complex needs. This work commenced in September 2021and will continue into 2022/23.

3. Learning from Case Reviews

3.1 Safeguarding Adults Reviews (SARs)

The SSAB must carry out a SAR when an adult at risk dies or is seriously harmed, and there is concern that partner agencies could have worked more effectively to protect them.

During 2021/21 three referrals were received for SAR consideration. Whilst none of these have progressed to a SAR, one is being undertaken as a Domestic Homicide Review and due to two of the referrals intimating suspected cuckooing, the SSAB have commissioned a thematic review into the prevalence of cuckooing in the borough, and the findings of this review will be reported in 2022/23.

The two SAR's that commenced in 2020/21 have been locally completed but have yet to receive formal ratification and thus these are scheduled to published in 2022/23. The learning from these reviews included developing a pathway for cases where an adult with capacity, whose needs are not considered to be eligible for care and support but there is a risk of serious harm. As a direct result of this identified area for development, Managing Complexity was agreed as a priority for the SSAB in 2021/22 and progress on this is citied above.

3.2 Learning Disability Mortality Reviews (LeDeR)

The Learning Disability Mortality Review (LeDeR) programme was set up by government to ensure that possible learning opportunities from circumstances leading to individual deaths are captured and shared. All deaths of people with learning disabilities aged four and over must be reviewed.

LeDeR is reported annually and the key themes are presented to the SSAB Quality and Effectiveness subgroup. During 2021/22 the key themes, learning points and recommendations from these reviews included:

- Closer collaboration and integration amongst health and care teams regarding people living with learning disabilities and autism.
- To consider training in national health and social care curriculums for understanding learning disability and autism.
- The wider health and social care workforce should ensure they fully understand the complexities of identifying and working with people with learning disabilities.
- A stronger emphasis on the delivery of the actions coming out of the reviews and holding local systems to account for delivery, ensuring there is evidence of service improvement locally.

4. Looking Ahead 2022/23

It is evident that throughout the year and across the partnership, significant work has been undertaken on our priority areas. In addition, a new governance structure has been implemented. As we move into 2022/23, the SSAB has agreed to carry through the priorities from 2021/22, acknowledging that these areas of work do not fit neatly within a financial year framework. This will also provide the opportunity for the new governance structure to be fully embedded. Although the thematic priority areas remain the same, during 2022/23 there will be a specific focus on gaining assurance on the progress of these priority work streams to demonstrate the positive impact on front line services.

Contact information

If you have any questions about the content of this report, or thoughts about what we should include in future reports, please contact ssab@southwark.gov.uk.

If you are concerned about an adult at risk in the borough of Southwark you should notify us immediately on OPPDContactteam@southwark.gov.uk.

If the adult has been injured you should seek advice from their GP, or in an emergency call 999.

If you believe a crime has been committed you should notify the police.

Female Genital Mutilation (FGM)

Southwark's Joint Strategic Needs Assessment

Public Health Division

Children & Adults Department

April 2023

GATEWAY INFORMATION

Report title:	**Female Genital Mutilation (FGM) in Southwark**
Status:	Public
Prepared by:	H MacDonald
Contributors:	S Garry, C Williamson
Approved by:	S Leahy
Suggested citation:	Female Genital Mutilation (FGM) in Southwark. Health Needs Assessment. Southwark Council. London. 2023.
Contact details:	publichealth@southwark.gov.uk
Date of publication:	April 2023

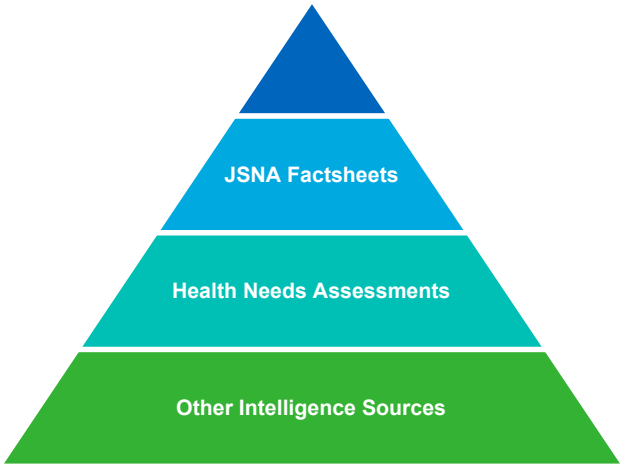
Health Needs Assessments form part of Southwark's Joint Strategic Needs Assessment process

BACKGROUND

The Joint Strategic Needs Assessment (JSNA) is the ongoing process through which we seek to identify the current and future health and wellbeing needs of our local population.

- The purpose of the JSNA is to inform and underpin the Joint Health and Wellbeing Strategy and other local plans that seek to improve the health of our residents.

- The JSNA is built from a range of resources that contribute to our understanding of need. In Southwark we have structured these resources around 4 tiers:



Tier I: The Annual Public Health Report provides an overview of health and wellbeing in the borough.

Tier II: JSNA Factsheets provide a short overview of health issues in the borough.

Tier III: Health Needs Assessments provide an in-depth review of specific issues.

Tier IV: Other sources of intelligence include Local Health Profiles and national Outcome Frameworks.

- This document forms part of those resources.
- All our resources are available via: www.southwark.gov.uk/JSNA

This health needs assessment reviews the prevalence and needs of women and girls affected by FGM in Southwark

AIMS & OBJECTIVES

This health needs assessment aims to aid understanding of the prevalence and associated health risks of Female Genital Mutilation (FGM) in Southwark.

The objectives of this assessment are to:

- Use the latest available data to understand the likely prevalence of FGM in Southwark and the characteristics of affected women and girls.
- Summarise the current outreach, training, referral pathways and treatment services available to prevent and support women and girls with FGM.
- Understand key insights and concerns of women in Southwark living with FGM and front-line professionals involved in identification or support.
- Synthesise evidence to outline gaps in the current offer and use this to make recommendations to improve prevention, identification and treatment approaches.

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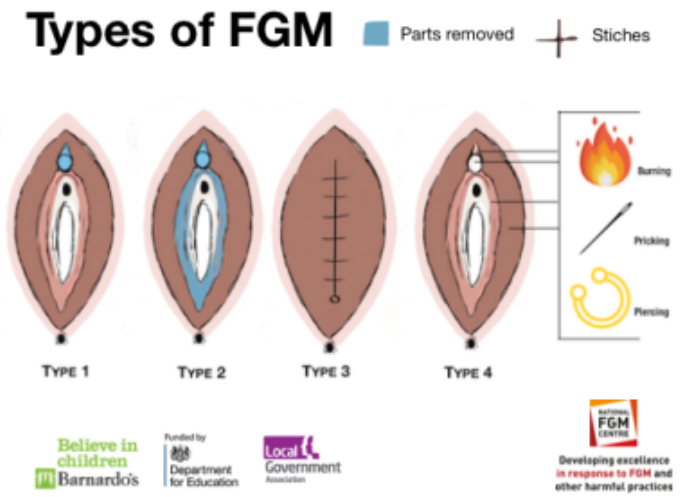
Female genital mutilation is the partial or total removal of external female genitalia for non-medical reasons

INTRODUCTION

"All procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO definition of FGM, 2022)[1]

Female genital mutilation (FGM) is classified into four types:

- **Type 1** (Clitoridectomy): the partial or total removal of the clitoris and sometimes only the prepuce (fold of skin surrounding the clitoris)
- **Type 2** (Excision): the partial or total removal of the clitoris and the labia minora with or without excision of the labia majora
- **Type 3** (Infibulation): narrowing of the vaginal opening through the creation of a covering seal. The seal is created by cutting and repositioning the labia minora or labia majora sometimes through stitching
- **Type 4**: all other harmful procedures to the female genitalia e.g. pricking, piercing, incising, scraping and cauterisation



1. WHO Fact Sheet: Female Genital Mutilation. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation
2. Image from National FGM Centre. http://nationalfgmcentre.org.uk/fgm/

CONTENTS

Southwark has committed to tackling FGM through a range of local actions

LOCAL POLICY

Southwark's Violence Against Women and Girls (VAWG) Strategy 2019-24 commits to tackling all forms of VAWG locally, including FGM[1]:

- Southwark's Safeguarding Children and Safeguarding Adults Boards have developed a multi-agency intervention framework to identify, assess and respond to FGM.
- The council promotes partnership with stakeholders including statutory agencies, Public Health, the National FGM Centre, schools and local voluntary and community (VCS) organisations to carry out community engagement, communication and awareness raising.

Recent activities Southwark has undertaken in an effort to prevent FGM include:

- Setting up an FGM clinic in a local school/children's centre as part of a new approach to encourage wider community engagement.
- Hosting learning events with professionals from health, education and social care sectors
- Covering FGM in mandatory safeguarding training for school staff and two yearly Designated Safeguarding Leads training.
- FGM is included in Southwark's local "Personal, Social, Health and Economic (PSHE) & Wellbeing Education Curriculum Framework" and "Resource Bank" to which all schools have access.

Aims identified in the strategy include to:

- Develop a communications strategy to raise awareness of FGM, including as part of the National FGM Day, consideration of culturally appropriate approaches, and in partnership with local voluntary groups.
- Continue enhancing and delivering training on VAWG issues to front-line professionals to maximise confidence in identifying and reporting concerns.

1. Southwark Council. Violence Against Women and Girls Strategy 2019 to 2024. www.southwark.gov.uk/community-safety/domestic-abuse/information-for-professionals-about-domestic-abuse/violence-against-women-and-girls-strategy-2019-to-2024

CONTENTS

The estimated rate of FGM in Southwark is almost 8 times that for England among those aged over 15 years

PREVALENCE

FGM is highly prevalent in some countries of Eastern and Western Africa, the Middle East and Asia and is almost always performed in people who were born or who have ancestry in those countries.

- Women and girls who move to the UK from these countries may have a prevalence of FGM equivalent to that in their countries of birth. This helps to estimate prevalence of FGM in the UK[1].
- Due to sociodemographic differences between people who choose to migrate and those who do not, actual prevalence of FGM is likely to be lower among migrants to the UK[2].

Estimates suggest that as many as 5,900 women and girls are affected by FGM in Southwark, with the vast majority of cases among women and girls aged over 15 years old[3].

- The estimated prevalence of FGM in Southwark is significantly above that for London and England.
- Around 500 girls aged under 15 may be affected, in addition to 5,400 women and girls aged over 15.
- Of those women and girls with FGM aged over 15, 1,700 are estimated to be aged 50+.
- Over-inflated estimates risk racial stigmatisation. Therefore this should be considered an upper estimate.

Figure 1: Estimated prevalence of FGM per 10,000 girls aged 0-14 years, 2021

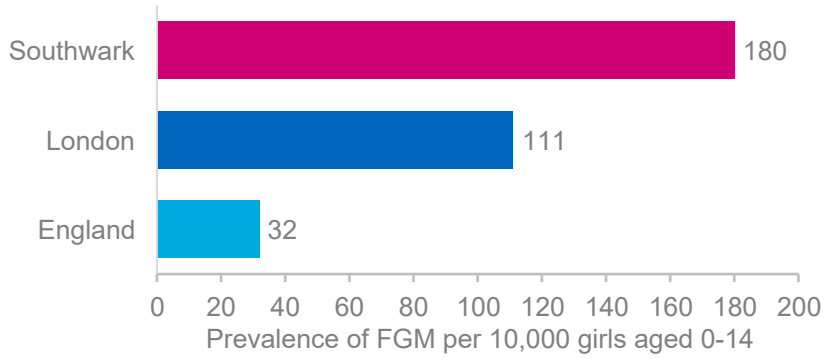
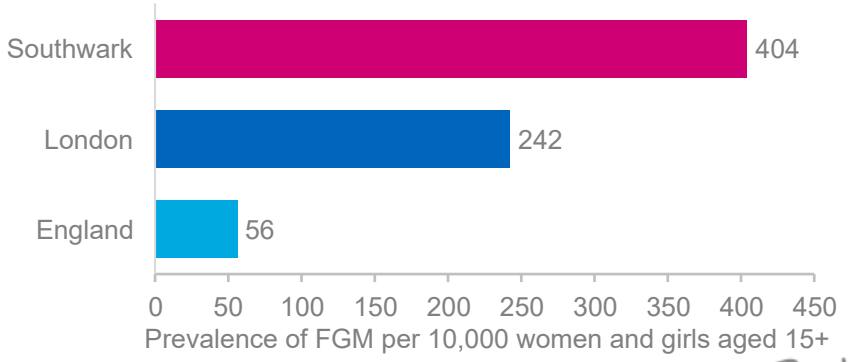


Figure 2: Estimated prevalence of FGM per 10,000 women and girls aged 15+, 2021



1. McFarlane, A. 2015. Prevalence of National and Local FGM estimates
2. Johnsdotter, S; Essén B. 2016. Cultural change after migration: Circumcision in girls in Western migrant communities.
3. Details of methodology can be found in Appendix D (available on request)

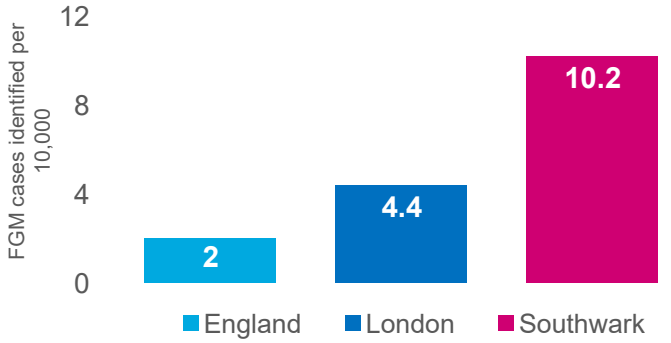
NHS services in Southwark recorded 160 women with a history of FGM in 2020-21, with 80 new cases

FGM ENHANCED DATASET 2020-21: TYPES OF FGM[1]

Southwark has a higher rate of women and girls found to have FGM than London and England:

- 160 Southwark resident women and girls were recorded as having FGM, more than twice the rate for London and 5 times the rate for England.
- 80 of the 160 women and girls were newly identified as having FGM, around 5 new cases of FGM for every 10,000 women and girls in Southwark.
- This may represent a real difference in prevalence or a better detection rate in Southwark.

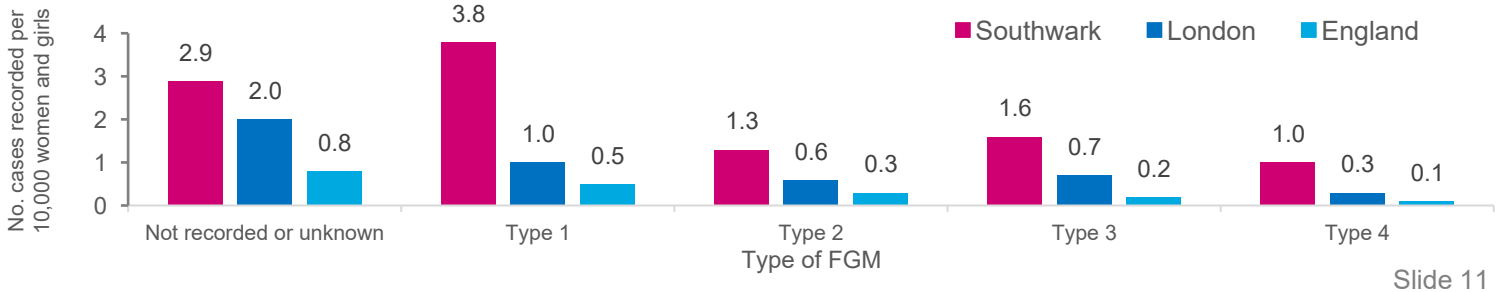
Figure 3. FGM cases identified in the NHS Enhanced Dataset per 10,000 women, April 2020 – March 2021



Type 1 (clitoridectomy) was the most commonly seen FGM in Southwark, London and England.

- Type of FGM was unknown in over a quarter of the 160 cases recorded in Southwark.
- Southwark had the highest number of cases per 10,000 women and girls for all types of FGM.
- Of FGM cases in Southwark where type was recorded and known, a relatively higher proportion had Type 1 or Type 4 FGM, and a lower proportion had Type 2 compared to London and England.

Figure 4. Types of FGM identified in the NHS Enhanced Dataset, April 2020 – March 2021



1. NHS Digital. Female Genital Mutilation (FGM) Annual Report – April 2021 to March 2022. FGM additional data table: by Local Authority

Of the 160 FGM cases in Southwark most women were aged 30-39, and none were aged under 18

NHS ENHANCED DATASET 2020-21: AGE OF WOMEN & GIRLS AFFECTED[1]

Around 79% of the 160 FGM cases identified in Southwark in 2020-21 attended when aged 25-39

- Around a third of Southwark resident women recorded as having FGM were 35-39 years old.
- None of the 160 FGM cases recorded in Southwark were under the age of 18.

Where known, most women with FGM underwent the practice during early to mid-childhood.

- Most frequently, women in Southwark, London and England were aged 5-9 at the time of FGM, with very few women and girls experiencing FGM in late childhood and into adulthood.

Figure 5. Cases of FGM recorded per 10,000 women and girls by age of attendance when FGM recorded, 2020-21

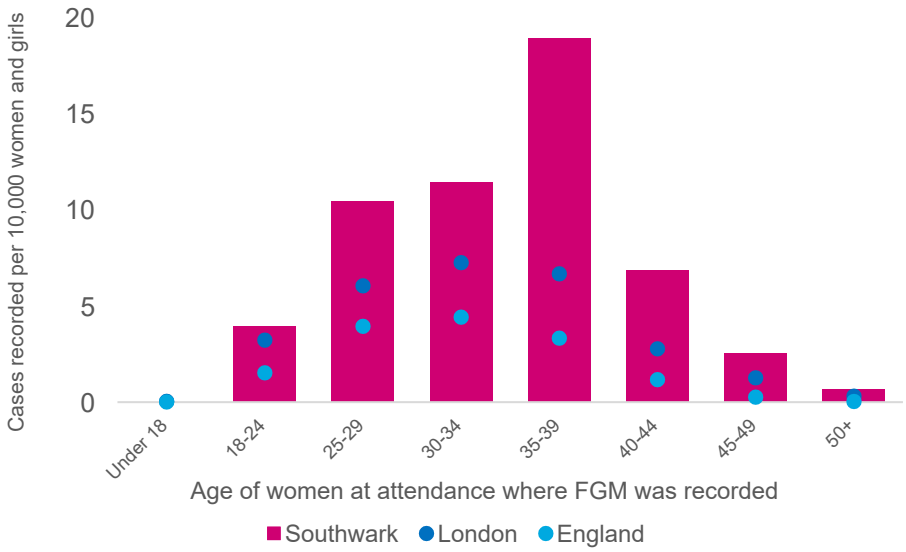
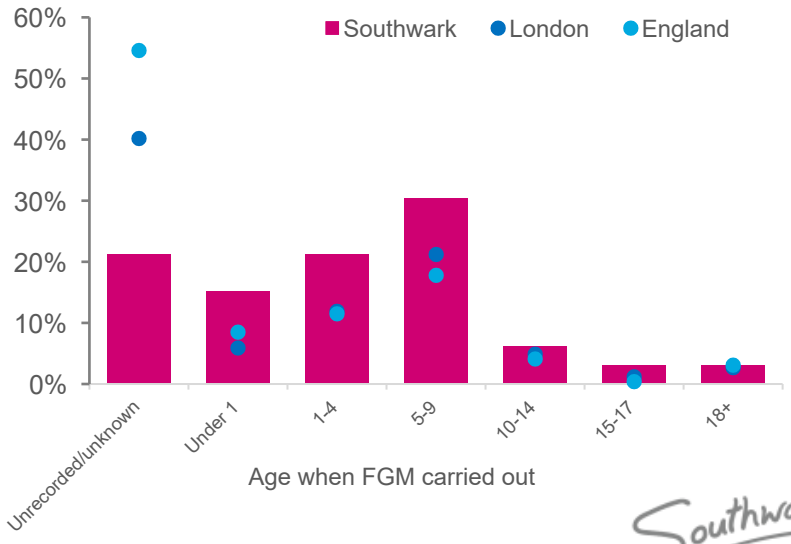


Figure 6. Age of women at the time FGM was performed for women attending NHS services 2020-21



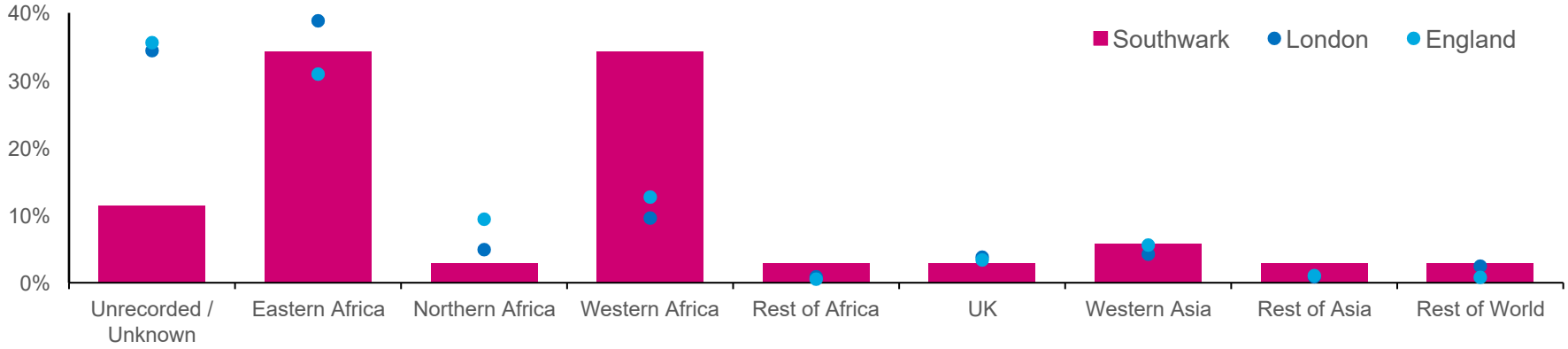
1. NHS Digital. Female Genital Mutilation (FGM) Annual Report – April 2021 to March 2022. FGM additional data table: by Local Authority

Of the 160 FGM cases in Southwark most women presenting were born in Eastern or Western Africa

NHS ENHANCED DATASET 2020-21: COUNTRIES OF BIRTH AND FGM[1]

Of the 160 Southwark resident women recorded to have FGM in 2020-21, two thirds were born in Eastern or Western Africa. A small proportion (2.9%) were born in the UK.

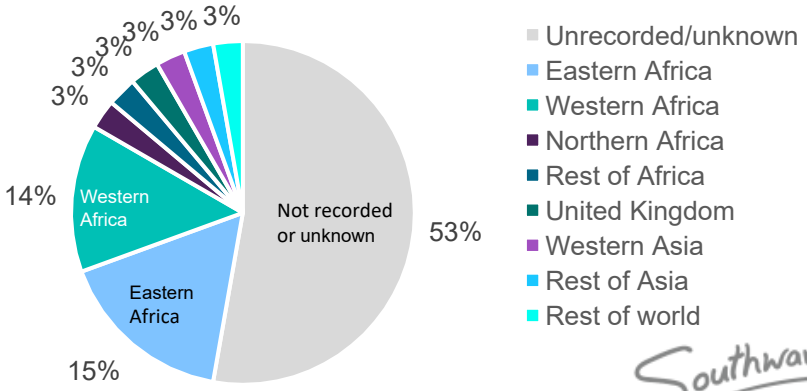
Figure 7. Country of birth among women attending NHS services recorded as having FGM in 2020-21



30% of the 160 women in Southwark underwent the practice in Eastern or Western Africa.

- Around 2.8% of cases reported that they had their FGM performed in the UK.
- In over half of cases the country where FGM was performed is unknown or unrecorded.

Figure 8. Country where FGM was performed for women identified with FGM by NHS services in Southwark



1. NHS Digital. Female Genital Mutilation (FGM) Annual Report – April 2021 to March 2022. FGM additional data table: by Local Authority

Of 2020-21 NHS attendances by Southwark women around 90% were identified in midwifery services

NHS ENHANCED DATASET 2020-21: WHERE FGM IS IDENTIFIED[1]

The 160 women with FGM in Southwark collectively made 195 attendances to NHS services where their FGM status was recorded. Of these, 90% of reports were via midwifery.

- No records of FGM were made by GPs or paediatric health services.
- At nearly all attendances, FGM was identified by the woman self-reporting.

Figure 9. Attendances by Southwark resident women at which FGM was recorded by NHS service type, 2020-21

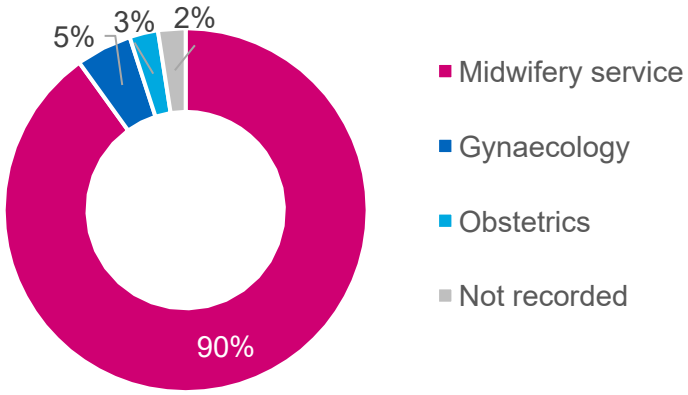
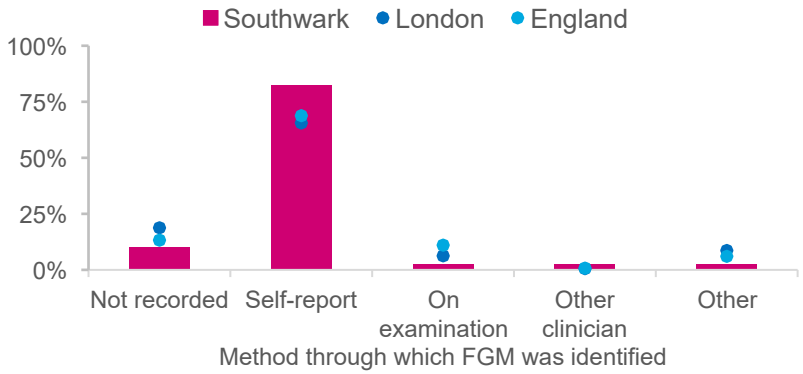


Figure 10. Method through which FGM was identified as a proportion of NHS attendances by Southwark resident women where FGM was recorded, 2020-21



Women identified to have FGM should be advised of the health and legal implications. Of the 195 NHS attendances by women in Southwark where FGM was identified:

- The health risks of FGM were described on at least 90% of occasions.
- It is unknown whether the legal status of FGM was discussed on 87% of occasions, but this did occur on the remaining 13% of attendances.

1. NHS Digital. Female Genital Mutilation (FGM) Annual Report – April 2021 to March 2022. FGM additional data table: by Local Authority

Around 3-4 Southwark resident girls per year have been referred to the specialist paediatric FGM clinic

UCLH CHILDREN'S FGM SERVICE, 2015-2022

University College London Hospital (UCLH) Children's FGM Service specialises in the identification and treatment of FGM in children and young people (CYP) aged under 18.

The service takes referrals from across London for girls suspected to have had FGM. Most referrals are made by social care services. Other routes of entry into the service have included[1]:

- Parents, particularly if new in the country or concerned for the welfare of their child left in the care of a female relative in a country that practices FGM.
- Girls themselves e.g. girls who were born in a practicing country who learnt about FGM at school and consulted the service to find out if they had been affected.
- Early years practitioners e.g. if concerned about genital abnormalities noticed while changing nappies.
- Midwives to whom a pregnant women disclosed that an existing child underwent FGM.
- Charities working with FGM survivors for FGM prevention e.g. FORWARD.

The service has been running since September 2015. In this time:

- 25 suspected cases of FGM were referred to the service from girls living in Southwark, a rate of 3-4 referrals per year[1].
- Of these 25 suspected cases, 19 had no physical evidence of FGM on examination[1].
- The 6 remaining children who were confirmed to have FGM had undergone the practice in their county of origin before moving to the UK[1].

1. Clinical Nurse specialist in Paediatric and Adolescent Complex Gynaecology. Email correspondence from October 2022

CONTENTS

Southwark works with partners to change attitudes on FGM within practicing communities

LOCAL RESPONSE: COMMUNITY OUTREACH & PREVENTION

Southwark Council proactively works to prevent FGM through a multi-agency framework:

- Agencies include Public Health, the National FGM Centre, Barnardos, Community Southwark, Africa Advocacy Foundation and schools.
- A 2017 Ofsted inspection recognised Southwark's strong performance in community outreach work to prevent FGM, particularly the multi-agency approach.

FGM is part of the school curriculum in Southwark:

- The Personal, Social and Heath Education (PSHE) and Wellbeing offer at all Southwark schools covers FGM.

The Voluntary & Community Sector (VCS) delivers vital outreach activities to help change perspectives on FGM within practicing communities that statutory services cannot reach e.g. :

- The **Iranian & Kurdish Women's Rights Organisation (IKWRO)** raises awareness of FGM within the Middle Eastern communities of Southwark and provides support and advice to women and girls at risk.
- The **Africa Advocacy Foundation** campaigns to end FGM while also training community champions and professionals to engage with affected communities around FGM.
- The **Dahlia Project** runs community workshops to promote women's health in practicing communities, provides training to therapists and other frontline professionals, and develops and promotes guidance on best practice.
- **Keep the Drums, Lose the Knife**, based in Peckham, delivers grassroots educational workshops for local communities and professionals both in the UK and abroad to help end FGM.

Professionals in Southwark are trained to identify and respond to risk factors for FGM

LOCAL RESPONSE: TARGETED PREVENTION

The Southwark Safeguarding Children and Adults Boards have produced guidance and flowcharts for front-line professionals to aid in FGM risk assessments:

- The Multi-Agency Risk Assessment and Referral Pathway outlines steps for identifying and acting on FGM concerns.
- Children (under 18) and Adults (18+) FGM pathways provide guidance on age-appropriate referral options and actions.
    - Professionals should refer to the Multi-Agency Support Hub (MASH) whenever there is concern around the risk of FGM for a child under the age of 18. MASH will investigate and may take preventative action, potentially including applying for an FGM Protection Order (FGMPO) on the child's behalf.
    - Where a woman is found to have had FGM, or a parent is found to come from a community where FGM is practiced, professionals should give a Health Promotion Advice Leaflet and advise on the legal implications of FGM.

Training is promoted for the council workforce and its partners:

- Council staff and partners are able to access FGM training from the Home Office
    - More advanced training is available from the council's 'MyLearning Source', including around how to approach conversations with families, identification, detection and prevention of FGM.
- All NHS healthcare staff receive training on FGM with increasingly enhanced training provided to those working with children and families, or more likely to work with women and girls subject to FGM.

FGM is included in safeguarding training for all school staff:

- The designated safeguarding lead (and any deputies) undergo training to carry out the role which is updated at least every two years.
- All staff receive appropriate safeguarding and child protection training at induction and this training is regularly updated. In addition, all staff receive safeguarding and child protection updates (for example, via email, e-bulletins, and staff meetings), as required, and at least annually.

The NSPCC FGM Helpline provides support for anyone who is concerned about the risk of FGM being performed on a girl aged under 18.

Identification of existing cases relies on a combination of self-disclosure and recognition of signs

LOCAL RESPONSE: IDENTIFICATION

Midwives are trained to ask about FGM at the booking appointment

- Relies on the pregnant woman self-reporting, when asked, that she has had FGM and being able to describe the type of FGM.
- Identified cases are flagged, with appropriate referrals made to the GP, health visitor and/or link consultant.

School staff are trained to identify indicators that FGM has been performed

- Indicators that FGM has been performed include spending longer than usual in the bathroom or toilet or unexplained reluctance to take part in PE following a holiday.
- All concerns should be reported to the designated safeguarding lead (or a deputy) who can risk-assess whether a referral to Southwark Multi Agency Safeguarding Hub (MASH) is indicated.
- There is also a specific legal duty on teachers to report to the police if, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl under the age of 18.

National guidance for GPs prompts vigilance for FGM when there are clinical indicators

- The CQC advises GPs to consider the possibility that a woman or child has FGM when presenting with symptoms including repeated urinary tract infections, urinary incontinence, dysmenorrhea (period pain) or difficulty getting pregnant.
- The BMJ advises GPs to consider FGM when conducting initial health assessments for newly arrived asylum seekers and refugees, especially where it is prevalent in the country of origin.

The National FGM Centre produces guidance to help professionals identify different types of FGM.

- Awareness can help front-line health and care professionals to identify FGM during clinical examinations and procedures.

Women and girls with FGM in Southwark can be referred to specialist clinics and access VCS support

LOCAL RESPONSE: TREATMENT & SUPPORT

Women and girls known or suspected to have FGM in Southwark can receive NHS treatment and support at the following services[1]:

Girls (aged under 18)

- UCLH Children's FGM Service – offers diagnosis, support and treatment of FGM in children.

Women (aged 18+)

- Nearby FGM clinics include: St George's Hospital, Croydon University Hospital, UCLH, Whipps Cross Hospital or St Mary's Hospital.
- Specialist clinics offer medical advice and psychological support to affected women, access to surgical deinfibulation for Type 3 FGM, gynaecological and obstetric support, and referral onto other medical specialties for the treatment of FGM's long-term health consequences.

VCS organisations in Southwark offer a range of social and emotional support:

- The **Dahlia Project** provides therapeutic support groups, individual counselling and empowerment programmes for women affected by FGM.
- The **Africa Advocacy Foundation** runs support activities, specialist one-to-one counselling and peer support groups.
- **FORWARD** have an FGM support helpline, provide one-to-one and group counselling, peer support groups and signposting to other services that promote health and wellbeing.
- **Solace Women's Aid** can provide emotional and practical support to women and girls (aged 16+) affected by FGM.

1. NHS. National FGM Support Clinics. https://www.nhs.uk/conditions/female-genital-mutilation-fgm/national-fgm-support-clinics/

CONTENTS

Women with FGM believe culturally-sensitive community outreach could prevent risk to girls in Southwark

COMMUNITY AND STAKEHOLDER VIEWS: COMMUNITY

Attendees at the Ending FGM Workshop in Peckham hosted by Keep the Drums, Lose the Knife		
	Topic	**Detail**
Prevention	**Occurrence**	• **FGM may be being performed at earlier ages** (pre-school) to bypass checks in later childhood and opposition from the girls themselves. • **Diaspora and migrant parents face overwhelming cultural and social pressures** to perform the practice when travelling back to home countries to visit family. • **Children may be incentivised not to tell if they have had FGM** e.g. with a new iPad • **Women entering into inter-racial marriages may be at risk** of FGM in adulthood.
	Messaging / outreach	Messages should be: • **Delivered by representative community members**, but not faith or other community leaders who may spin messages to suit their own values and ideals. • **Uncompromising in their warnings** on the health harms and legal implications of FGM (i.e. "why do you want to harm your child?", "why are you going to put yourself in prison for 10 years?") • **Careful not to come across as an attack on culture** and ethnic identity. • **Inclusive of men.** Men can often protect girls from FGM e.g. by stating that they will not marry affected girls or by refusing permission for their daughter's to be cut. One father was said to have been talked out of allowing his daughter to have FGM after being presented with the health risks, and some fathers later in life who, when confronted with the harms they had allowed, were said to be full of regret. • **Sensitive to language used by members of the community** (e.g. 'Bundo' in Sierra Leone)
	Education	• **Parents and children need education** on how to get support if they have concerns. • **General population awareness campaigns** (e.g. to all parents) could help in identifying signs of FGM.

Women with FGM may be isolated, need mental health support, and representative healthcare

COMMUNITY AND STAKEHOLDER VIEWS: COMMUNITY

Attendees at the Ending FGM Workshop in Peckham hosted by Keep the Drums, Lose the Knife

	Topic	Detail
Support	**Geography**	• **A choice of local and out-of-area clinics was preferred.** Specialist clinics are located a long-distance from some women who need support which may prevent those who need to visit discretely from attending. • Other women prefer to visit clinics outside of their area to minimise the risk of stigma.
	Mental health	• **Most women affected by FGM have mental health needs** and need specialist support services • **Peer support from other women affected by FGM** is often a necessary step before women build the confidence to seek health and social care advice from professional services themselves.
	Isolated groups	• **Many women who need support are isolated** and not well integrated into UK society (e.g. limited English) which affects their ability to seek support. • **Women who have No Recourse to Public Funds** suffer additional barriers including feeling pressurised to stay with abusive or controlling partners, not understanding their entitlements to free care for FGM, and being less likely to attend front-line public services where FGM may be identified.
	Trust	• **Front-line services should be representative of affected communities** to give women confidence that their concerns will be understood and that they will not be judged. • **Continuity of care should be ensured** (e.g. the same midwife throughout pregnancy) to help build trust.

Professionals view schools as a crucial pillar in giving girls the information to seek support and prevent FGM

COMMUNITY AND STAKEHOLDER VIEWS: PROFESSIONALS

Consultant midwife, designated safeguarding midwife and nurses for children and adults at Guys and St Thomas' Trust (GSTT), and Senior Psychotherapist at The Dahlia Project

	Topic	Detail
Prevention	Occurrence	• **Relatives may be becoming more aware of the timings of key health checks** and periods of high scrutiny and aiming to bypass these through having FGM performed earlier in life (pre-school). • **Relatives may take opportunities to disguise suspicious travel** (e.g. there was concern over parents taking children to Qatar for FGM using the opportunity of mass-travel for the World Cup in 2022) • **Low levels of FGM prosecutions may result from cases collapsing** due to children not wanting their parents to go to court.
	Schools	• **Schools should teach all girls about the health harms and illegality of FGM** at the appropriate age so that they can identify their own concerns and seek support. • **Posters could be placed in discreet areas in high schools** (e.g. in girls' toilets) with QR codes so that girls can access information privately.

Professionals recognise many barriers to seeking support making training to identify FGM an important tool

COMMUNITY AND STAKEHOLDER VIEWS: PROFESSIONALS

Consultant midwife, designated safeguarding midwife and nurses for children and adults at Guys and St Thomas' Trust (GSTT), and Senior Psychotherapist at The Dahlia Project

	Topic	Detail
Identification	**Risk groups**	• Around half of the referrals for support received by The Dahlia Project come from **asylum seekers, refugees or undocumented migrants.**
	Barriers to seeking support	• Girls may be discouraged from disclosing they have had FGM if they **fear that it is going to get their relatives into trouble**. Services should work with police to discuss the best approach. • **Prospect of reliving the trauma** of FGM may discourage some women from seeking support. • **Women may find it difficult to discuss FGM with friends and family** so peer groups can be helpful for getting mutual support. • **Many women affected by FGM experience language barriers** that prevent them from understanding the harms of FGM, the support available, and from feeling comfortable accessing services. • **Marginalised women will often face financial difficulties** that may place barriers on being able to travel to get support, and prevent them from accessing public services (e.g. if they are NRPF)
	Training	• While FGM is covered in mandatory **safeguarding training** for health and care staff, it **was not seen as comprehensive** in helping staff identify FGM, FGM risk factors and subsequent referral pathways. • Training was seen as **more in-depth and complete for health and care staff who work with children** (e.g. health visitors).
	Opportunities for earlier identification	• **Sexual health clinics may be an opportunity for earlier identification of FGM** before women enter into maternity services. • **Posters could be placed in maternity services** spreading information about how to access support and emphasising confidentiality.

Closure of the GSTT specialist clinic and barriers to mental health support were seen to result in unmet needs

COMMUNITY AND STAKEHOLDER VIEWS: PROFESSIONALS

Consultant midwife, designated safeguarding midwife and nurses for children and adults at Guys and St Thomas' Trust (GSTT), and Senior Psychotherapist at The Dahlia Project		
	Topic	**Detail**
Support	**FGM specialist clinics**	• **There has been a gap in support provision at GSTT** since a specialist midwife in FGM retired. The FGM clinic was subsequently closed as a decision was made that FGM support sat with obstetrics/paediatrics and not midwifery. • There is a need to **understand whether restarting a specialist clinic is cost-efficient** (maternity services currently see around 14 women per month with FGM). • **Women are not routinely referred to specialist clinics at Croydon or Whipps Cross hospitals** following identification of FGM in midwifery. They are informed about the health and legal implications of FGM but will only be referred to a link consultant if Type 3 FGM is identified and the woman needs support through pregnancy (e.g. deinfibulation).
	Mental health support	• **There are waiting lists** of women with FGM to access specialist therapy • **Many marginalised women are unfamiliar with mental health services** as they are either not common in their home countries, or are associated with serious mental illness and where attending carries a risk of stigma. Education is needed around mental health using non-stigmatising language, to help all women understand why it is important and how to access it.

CONTENTS

Working with women affected by FGM could help improve safeguarding training and community outreach

SUMMARY & RECOMMENDATIONS: PREVENTION

What do we know?	What's happening in Southwark?	Recommendations
▪ Anecdotes indicate that girls in Southwark are at risk of undergoing FGM, either in the UK or abroad. ▪ Nearly all women and girls known to have FGM in Southwark experienced it 30 or more years ago outside of the UK. ▪ Support for the practice of FGM continues within some communities living in Southwark. ▪ A key component of prevention is who delivers the message as identified from speaking to women living with FGM.	▪ Representative VCS organisations, such as Keep the Drums, Lose the Knife in Peckham, work to change attitudes around FGM in communities where support for the practice continues.	**Work with representative community groups to agree a coproduced local strategy** for sharing preventative information and advice to women, girls and men in at-risk communities.
▪ Professionals and women affected by FGM told us that those seeking to practice FGM may bypass existing safeguarding mechanisms (e.g. by practicing at younger ages or disguising suspicious travel).	▪ FGM is included in mandatory safeguarding training for front-line professionals in health, social care and education services. ▪ There are safeguarding reporting pathways for escalating concerns. ▪ These may not include novel scenarios where relatives seek to bypass traditional checks.	**Together with local women affected by FGM, ensure that culturally-sensitive mandatory safeguarding training is up-to-date, complete and available for a wider range** of health, social care and education professionals.

Improved communication and training could help professionals better identify FGM at earlier time-points

SUMMARY & RECOMMENDATIONS: IDENTIFICATION

What do we know?	What's happening in Southwark?	Recommendations
▪ The NHS Enhanced Dataset is a national compilation of data from mandatory FGM reports by NHS services. ▪ Large gaps in the NHS Enhanced Dataset exist because women were either not asked about, did not know or did not disclose. This is most notable for the age FGM was performed and the country that it was performed in.	▪ NHS Digital is responsible for coordinating the collection and processing of data in the NHS Enhanced Dataset. ▪ Currently, only the NHS number, full name, address and date of identification are mandatory.	**Train NHS professionals on the NHS Enhanced Dataset** to better inform policy and service design. Reasons for questions should be clearly communicated with staff which might increase buy-in and completeness.
▪ Over 90% of cases of FGM are identified in midwifery, around 30 years after being performed, and mostly through self-disclosure (e.g. telling the midwife) rather than during clinical examinations.	▪ Midwives, GPs and school staff are trained to recognise the signs of FGM and escalate concerns. ▪ Midwives routinely ask pregnant women about FGM at the booking appointment.	**Evaluate training around FGM identification for front-line professionals**. Specifically, this should consider its effectiveness at improving confidence and empathy when talking to women about their history of FGM, as well as identifying different types of FGM (if clinically examined). This may improve the detection rate and accuracy of information in the NHS Enhanced Dataset.

Support for women with FGM could be improved by greater access to physical and mental health services

SUMMARY & RECOMMENDATIONS: TREATMENT & SUPPORT

What do we know?	What's happening in Southwark?	Recommendations
▪ Closure of the FGM specialist clinic in Southwark in 2017 has led to: ▪ confusion over referral pathways for follow up support; ▪ geographical barriers for women to access support.	▪ The nearest FGM specialist clinics for women are at Croydon University or Whipps Cross Hospitals, while children can access support at UCLH.	**The need for a specialist FGM clinic in Southwark should be kept under review.** This will need to balance the utility of a closer service with the costs of an additional South London clinic.
▪ Many women affected by FGM have mental health needs but barriers to accessing support includes stigma, lack of knowledge about services, and waiting lists.	▪ A number of community organisations provide emotional and mental health support in Southwark.	**The mental health offers from existing VCS organisations and the NHS should be evaluated** and options for organisations to increase capacity should be considered.
▪ Fear of getting relatives into trouble, fear of reliving trauma, language and cultural barriers, and having no recourse to public funds are barriers to accessing treatment. ▪ Women affected by FGM often prefer support from staff representative of their community because of fear of judgement.		**Consider additional training for a wider cohort of health staff** on FGM and its associated social, physical and mental health related effects so that staff can be sensitive to the needs of women affected by FGM attending the NHS for other reasons (e.g. a smear test).

CONTENTS

Summary of recommended actions to improve prevention and support for FGM in Southwark

NEXT STEPS

Action	Who	When
Review mandatory safeguarding training to make sure it is up-to-date and complete and available to a broad range of health, social care and education professionals.	ICS, Southwark Council VAWG, and women affected by FGM	June 2023
Start conversations with local advocacy groups (e.g. Keep the Drums, Lose the Knives) on developing a shared prevention outreach strategy.	Southwark Council VAWG, local community groups	June 2023
Enhance communications with professionals on the importance of complete and accurate data in the NHS Enhanced Dataset.	ICS	ASAP
Evaluate training on the identification of FGM among front-line health professionals.	ICS	June 2023
Keep the need to re-open a specialist FGM clinic in Southwark under review.	ICS	Ongoing
Commission wider training on FGM for health professionals to support women with FGM with cultural sensitivity and understanding.	ICS	June 2023
Evaluate the mental health offers from local VCS and NHS organisations for women with FGM.	Public Health and ICS	June 2023

Find out more at southwark.gov.uk/JSNA

Public Health Division

Children & Adults Department

Agenda Item 8

Item No. 8	Classification: Open	Date: 18 April 2023	Decision Taker: Health & Social Care Scrutiny Commission
Report title:		Care Contributions update briefing	
Ward(s) or groups affected:		N/A	
From:		Pauline O'Hare, Director for Adult Social Care	

Additional information as requested at the Health and Safety Scrutiny Commission held 2 February 2023

1. A breakdown of the £8.4 million received through care charges by cohort, including working age and pension age, including a breakdown of the amount of money received in income for each year between 2015 and 2022

Breakdown of payments received from the 4 main client groups

	2019/20 (£)	2020/21 (£)	2021/22 (£)	2022/23 (£) *
Mental Health (Over 65s)	-2,893,035	28,608	-365,762	121,704
Learning Disabilities	1,349,334	1,206,944	1,351,811	1,130,995
Older Peoples Services	6,048,166	5,049,674	6,316,231	6,180,853
Mental Health (18-65)	85,903	49,215	152,155	193,826
Monthly Total	**4,590,369**	**6,334,442**	**7,454,435**	**7,185,587**

2. Norfolk judgement – Challenge to charging, as seen as discriminatory to those who can work and those who can't. In SH v Norfolk County Council [2020] EWHC 3426, the High Court decided that Norfolk's charging policy unlawfully discriminated against severely disabled people in the enjoyment of their benefits income.

We understand that Southwark Council has been reviewing its own Fairer Contributions Policy in the light of this judgment. Can you tell us where you are up to with this review?

The UK Government requires local authorities to treat income earned through work and income through benefits differently for the purposes of adult social care charging.

Norfolk County Council, in attempting to make its charging policy less generous and to bring its policy in line with minimum income standards, attracted a legal challenge on its application of this UK law and the justification it had given for

changing its policy. The case against Norfolk council contained a number of challenges to it charging policy and also highlighted a potential inequalities in the original legislation, which Local Authorities now consider as part of their in their financial assessment process.

Southwark Council was planning to undertake a full review of our charging policy in 2022/23 in preparation for the UK Government's planned charging reforms. As part of this, we were planning to address this different treatment of income through work and income through benefits, by affirming that we were applying UK law and undertake full equality analysis on the impacts of this application of UK law. Given the delay to the UK Government's charging reforms this policy review is now planned for 2023/24.

3. ***Confirm that the council does add 25% to the Minimum Income Guarantee (MIG) and clarify if this is set out in the Fairer Contributions Policy.(or is a government-applied buffer)?***

No, this is not the Council's policy. We work to the UK Government's minimum income guarantee levels.

4. **Information and support available to enable disabled people and carers to understand Care Charges and Disability Related Expenditure**

The Council has produced a leaflets for residents and their carers on charges for residential (Appendix 1) and non-residential services (Appendix 2). The non-residential charging leaflet includes a section of disability related expenditure. In addition, our non-residential financial assessment form (Appendix 3) includes a specific section on disability related expenditure and the kind of costs that can be taken into consideration. We have also produced an easy to read guide to charging, which is currently under review and therefore not available on the website (Appendix 4)

5. **A Copy of the Fairer Contributions Policy.**

See Appendix 5. The policy is also available on the Council's website at: https://www.southwark.gov.uk/social-care-and-support/adult-social-care/arranging-and-paying-for-your-care/adults-with-care-needs/charging/paying-for-your-care-and-support

Charging and paying for your social care

Residential care

Who this leaflet is for

The information in this leaflet is for adults who receive residential care and support from the council's Adult Social Care services. This includes care and support in a residential care home or nursing home.

How we decide who we support

If you are entitled to receive care and support from the council it is most likely you will need to contribute to the cost of your care. We will complete a financial assessment with you to find out if you need to make a contribution, and if so how much. **If you do not provide information to allow us to complete the financial assessment you will need to pay the full cost of your care.**

A social worker will assess your needs to see whether you are eligible to receive care and support from the council. In order to receive support from the council you must meet the criteria set out in the Care Act 2014. You can find more information about eligibility criteria by going to the following website:

https://www.southwark.gov.uk/social-care-and-support/adult-social-care/care-and-support-from-the-council/adults-with-care-needs/can-we-help-with-your-care-and-support-needs

Temporary and permanent care home placements

If your stay is intended to be less than a year and you have a set date to return home, your placement will be treated as temporary. If your home is empty, we will normally make allowances for you to continue to pay certain costs. If you make long term arrangements, your placement will be considered to be permanent. This matters because your charge can differ depending on the type of placement.

Who can get financial support

Once your needs have been identified we will carry out a financial assessment to work out what you need to pay towards the cost of your care. You will not be asked to pay more than you can afford. If you do not qualify for help from us, we will provide you with information and advice and tell you about other help available to you.

If you have eligible needs and meet the capital and income requirements (see below) you will be entitled to financial support to pay for care.

Capital limits

The first stage in a financial assessment involves looking at how much money or other assets you have. Collectively, this is called Capital. If you have capital valued at over £23,250 you will not be entitled to financial support from the Council and you will need to make your own arrangements with the care home. We will still assist you with this process by providing you with information, sourcing a care home and telling you the things you need to take into account.

If your capital gets near to or falls below £23,250, you will need to apply for financial assistance. You are advised to make contact four months before your capital drops below the limit, as it can take this long to assess (or reassess) your eligibility for care services and to conduct a financial assessment. If you make contact after your capital drops below the limit, we will not put your capital back up to the limit. Once your capital drops below the capital limit, you will still need to make a contribution towards your care.

If your total amount of capital is valued at under £14,250, it is ignored for financial assessment purposes. We still need to know how much capital you have even if it is under £14,250. Please note that you will still be assessed to pay towards your care based on the amount of income you have.

Disposing of your savings, capital or income

If you have disposed of savings, capital or income in order to avoid or reduce your charge for care, we can by law still treat you as having that asset, or in some cases ask the recipient of the asset to make payment instead.

This means that you may be charged up to the full cost of your care. We reserve the right to take civil legal action against anyone who has disposed of their asset or received the asset.

Disposing of assets can include, but is not limited to:

- Transferring the title deeds of a property to another person or into a trust
- Spending money on a valuable possession such as jewellery or art
- Making large or unusual gifts to relatives
- Paying off a debt that is not due to be paid by you

When deciding whether you have deprived yourself of assets in order to avoid or reduce care home charges, we will take into account your circumstances.

This includes:

- The reason for the disposal
- The date it took place
- Whether the person could reasonably foresee the need to move into a care home

It will be for the person to prove that they no longer own the asset and to satisfy the council that the disposal of the asset was not done to avoid or reduce care charges.

Paying for residential or nursing care services where we arrange your placement

If following a social care assessment we agree that residential care is needed to support you, we will help you find suitable accommodation.

Nursing Care

If you get Funded Nursing Care, the NHS pays the contribution directly to the care home.

Third Party payments

If the accommodation you choose costs more than the amount we usually pay for someone with similar care needs, a third party (or more than one) will be asked to pay the difference. This additional payment is usually referred to as a Top Up arrangement or a Third Party Top Up. This will require entering into a legal agreement, and failure to fund could put your placement at risk.

You are not allowed to top up your own care fees, except in very limited circumstances. For more information, please see further information about top up payments which is included within this pack.

Using your property to help pay for care

If you own or partly own your property and if that property is being considered in your financial assessment, you will be responsible for the full cost of your care (after any disregard, such as the 12 week property disregard described on page 8).

If you do not want to sell your property or are unable to sell your property straight away we offer a Deferred Payments scheme to help you pay for your care.

This is a loan from us, using your home as security. They are different to conventional loans and you do not receive a lump sum of money when you join the scheme. We pay part of your care bills for as long as necessary. You will need to repay all of the funds paid on your behalf.

Please be aware that interest is charged from the start of the loan

Before you can get financial support under this scheme a social care worker will need to assess your eligibility for the service. We will also need to carry out a financial assessment of your ability to contribute towards your care. You will still need to make a contribution towards your care costs. We will lend you the weekly fee (less any NHS contribution) less your charge. The money borrowed under the Deferred Payment Agreement is then repaid when the money tied up in your home is released or if you find another source of funds to pay back the debt.

Deferred Payment Scheme

You can apply to join this scheme if you do not want to sell your home during your lifetime. You are able to rent out your home to generate income to help pay your care fees, but you must tell us before you do this as there are some conditions to be met. You will be expected to use most of the rental income to help pay your ongoing care fees, which means the amount we lend you under the scheme is reduced. Please be advised that tenancies must be made under an Assured Shorthold Tenancy.

Please note there are certain conditions which must be met before you can join the Deferred Payment Scheme. We will tell you if you qualify when we have completed a financial assessment. Nobody is entitled to join the scheme if we cannot register a legal charge with HM Land Registry.

Important information to note before applying for funding assistance

Please ensure you seek independent legal and financial advice before applying for funding assistance from the council under the deferred payment scheme. The council is not responsible for any fees you incur as a result of obtaining this advice.

Interest is charged on a daily rate and is compounded monthly. The rate changes every January and July and is based on the cost of government borrowing. If you join one of the schemes, we will notify you of the interest rates whenever they are due to change.

If you use either of these schemes then Attendance Allowance or the care element of DLA or the daily living element of PIP can become payable again.

How we calculate your contribution

The Financial Assessment

We will need to confirm your income, outgoings and assets (including savings). We ask for evidence such as bank statements, pension payslips and letters from the Department for Work and Pensions (DWP) or Jobcentre Plus to support your assessment.

It is important that we get correct information as soon as possible. Any delay can result in you being required to pay the full cost of your care. Once we receive the information we need, we will make any adjustments needed.

When completing a financial assessment, we will make sure you are left with the statutory Personal Expenses Allowance which is **£24.90** per week.

The capital we take into account includes the value of your share in buildings and land in this country and abroad. In certain circumstances the value of your main home (if you own it) will be disregarded.

Capital - including savings, shares and premium bonds

The amount of capital we take into account is added together:

- If the total amount of your capital is less than **£14,250**, your capital will not affect your financial assessment
- If your capital is valued at more than **£14,250**, but less than **£23,250**, the national charging rules allow the council to include £1 per week for every £250 of savings you have above £14,250 - but less than £23,250 - when it works out the weekly contribution you will have to pay towards the cost of your care. This is called tariff income
- If your capital is valued above **£23,250**, you will need to pay the full cost of your care.

Tariff Income is meant to represent an amount a resident with capital over a certain limit should pay towards their care, not the interest earning capacity of that capital.

An example – Thomas

Thomas is 71 and has savings of £15,000. This is £750 above the £14,250 limit – or 3 x the £250 levels of savings.

So the council will include £3.00 per week as income when working out Thomas' assessed charge.

The income we take into account when working out your charge includes:

- Most state benefits, including the State Retirement Pension
- Widowed parent's allowance
- Occupational (works) personal pensions or retirement annuity contracts (see below)
- Most annuity incomes
- Property rental income (we do make some allowances so that you can pay any tax on the income and keep the property maintained)
- Other income not specifically disregarded by regulations

Occupational (works) or personal pensions or retirement annuity contracts

If you move into a care home without your partner, spouse or civil partner and if they are not better off claiming benefits in their own right, you can choose to pass on half of your occupational pension, personal pension or retirement annuity to them. If you do so, we will disregard that amount from your assessment when working out your charge. We are only able to disregard exactly 50% of this income and not more or less than this amount. We are unable to disregard any other income (such as State Retirement Pension) for these purposes.

Income not included:

Most charitable or voluntary payments

- Child Tax Credits
- Guardians allowance
- Christmas Bonus and Winter Fuel Payments
- Disability Living Allowance (Mobility Component)
- Personal Independence Payment (Mobility Component)
- Gallantry awards
- War Disablement Pensions
- War Widows supplementary payments

Income we include in part:

- War widow's or widower's pensions
- The Savings Credit element of Pension Credit (we only take into account amounts above £5.75 per week)

How the charge is worked out:

- We add up the amount of income we can take into account (this includes Tariff Income described above)
- We deduct certain household allowances (in limited circumstances)
- We deduct certain allowances on rental income you receive
- We deduct Personal Expenses Allowance of £24.90
- We deduct up to £5.75 per week if you have savings credit

The amount that is left over is your Maximum Assessed Contribution

The value of your home (if you own it)

The value of your share of your main home will not normally be taken into account for the first 12 weeks of your permanent placement in a care home. This period is called the 12 week property disregard. The disregard may not apply in certain circumstances. For instance, it does not apply where you have already been paying the full cost of your care for more than 12 weeks or for property that you own but were not living in prior to going into care.

Additionally, the value of your property will continue to be ignored for as long as it is occupied by:

- Your partner / a relative or a member of your family who is aged 60 or over, or who is incapacitated (someone who receives an incapacity or disability benefit or would qualify for such benefits) or who is a child under 18 who you are required to maintain.

In these circumstances, it must be clearly evidenced that the relative was living at your home before residential care was considered and you did not foresee the need for a move to residential accommodation when they moved in.

If your main residence is or becomes unoccupied or is occupied by someone who is not listed above the value of your share of that property will normally be taken into account when we work out your charge. You may need to contact your insurance provider to check that your policy still covers a vacant property.

If your total assets, **excluding** the value of your home, are more than £23,250, you will have to pay the full cost of your care home placement.

When the financial assessment has been completed, we will tell you in writing how we worked out your charge and you will be advised on what you can do if you think the charge is wrong.

What to do if you think your charge is wrong

We calculate your charges based on information in the Care Act 2014, *Care and Support Statutory Guidelines*, and charging regulations. The rules behind calculating charges can sometimes be complex, so if you feel your charge is incorrect, please call the charging team on 0800 358 0228 or email us at ChargingTeam.AdultSocialCare@southwark.gov.uk.

Your initial financial assessment

Your very first financial assessment will be conducted by the charging team, you will need to return the financial assessment form to them. When you return the form you will need to provide documentary evidence to support your claim. Please note that if you are unable to supply evidence, and if we cannot obtain evidence elsewhere (for instance from the DWP), then you will be charged for the full cost of your care.

Annual reassessment

Each year we reassess the amount you will have to pay and let you know of any change to your charge. This is a good time to check your assessment and see if your details are up to date.

Changes in circumstances

You must tell us of any changes to your circumstances that may affect your charge. This includes changes to your income, savings or other capital. If your property is being disregarded, we need to know of any changes that will affect that disregard. For instance, if the property is being disregarded because your spouse is living there and your spouse subsequently leaves the property, this will affect your disregard and we must therefore be told about it. If you are unsure, please let us know anyway.

Reviews

You can ask us to review your financial assessment at any time by writing to the charging team giving reasons for your request.
Please note that if we have applied a Tariff Income in your financial assessment, we will usually only review the tariff income amount once a year unless there are special circumstances, such as an unavoidable expense you have incurred.

What care home fees cover

Care home fees should cover all the normal things a care home would be expected to provide, including your meals, laundry and heating. The care home should not ask you for more money, except to pay for any extras you may choose, such as buying

newspapers, going for outings or hairdressing.

Please note that if you go into hospital while in residential care, you will normally be expected to continue paying towards your placement. We will be paying to keep your room available to you in your absence, so you will need to continue contributing towards that fee, even while in hospital. Your charges will continue for as long as your room is kept open for you. If you are getting Attendance Allowance or the care element of DLA or the daily living element of PIP because you are self-funding, these will stop after 28 days in hospital.

State Benefits and care home accommodation

Going into a care home, whether temporarily or permanently, may affect your entitlement to certain state benefits. You should seek advice to ensure you, your partner or your carer are claiming all the benefits you / they are entitled to.

If you pay for your care home yourself

If you lived with a partner before you moved into permanent residential care, your state benefits will be reassessed as though you were both single. Both you and your partner will need to claim benefits in your own rights, as single people, even if you are still married, were living together as a couple or in a civil partnership.

If you pay the full cost of your accommodation without help from us or if you receive help under the Deferred Payment Scheme or the Letter of Undertaking Scheme, then your benefits will be paid at the same rates as if you were still living at home but as a single person. You should let the DWP or Jobcentre Plus know of your change of address and circumstances. If you were not already getting one of the benefits listed below, you should apply for them as soon as possible:

- Attendance Allowance (for those who are over pension age if not getting either of the below benefits) Disability Living Allowance (care component) - please note that you cannot make new claims for DLA, so if you were not already receiving

DLA or PIP (see below), then you should apply for PIP.

- Personal Independence Payment (daily living component)
- The mobility element of DLA and PIP can be paid even if we are paying care costs.

If you do not pay for the full cost of your care

If we pay towards your placement (regardless of whether the placement is temporary or permanent), Attendance Allowance, Disability Living Allowance (Care Component) and Personal Independence Payment (Daily Living Component) will all stop. They will also stop being paid 28 days after a hospital stay, a care home placement, or a combination of hospital and care home placement. If the DWP are not informed of your change in circumstances, these benefits will be overpaid and you will be expected to return the overpaid amounts.

If these benefits stop being paid, it may lead to a reduction in the amount of Income Support, Employment Support Allowance, Pension Credit or Universal Credit you receive. If this happens, your charge for care will also reduce.

If your carer is paid Carer's Allowance

If someone who looks after you is paid Carer's Allowance or the Carer's Premium of some means tested benefits, they should inform the relevant benefits office of your move to a care home. Their own entitlement to benefits may be affected if you lose Attendance Allowance, Disability Living Allowance or Personal Independence Payment, or if they stop being your carer (except for temporary periods).

If you give half your Occupational (works) pension, personal pension or retirement annuity contract to your spouse

If this is given to your spouse and if they get means tested benefits in their own right (such as Income Support, Employment Support Allowance, Pension Credit, Universal Credit, Housing Benefit or Council Tax reduction), they may wish to seek independent advice as their benefit entitlement will be affected. The DWP must be informed of this

extra income if they are in receipt of a means tested benefit.

If you rent as a tenant

Permanent admission to a care home may lead to immediate loss of entitlement to housing benefit or the housing costs element of Universal Credit. If your move to a care home is temporary and you intend to return to live in your home (and if it is not being sublet in your absence), you may continue to be entitled to help with your housing costs for some or all of your absence. You should speak to your local district or borough council for advice on housing benefit and to the DWP about universal credit.

Useful Contacts

If you require further information about how to pay your assessed charges, contact the Collections Team on 020 7525 1111 or by email at collections@southwark.gov.uk.

If you have questions about the financial assessment or the amount you are asked to pay, contact the Charging Team on 0800 358 0228 or by email at ChargingTeam.AdultSocialCare@southwark.gov.uk.

Disablement Association (for adults with physical disabilities)

Tel no: 020 7358 7744

Website: https://*www.sdail.org* *(Internet Explorer not supported - use different browser)*

Southwark Wellbeing Hub (for adults with a mental illness)

Tel no: 020 3751 9684

Website: *www.together-uk.org/southwark-wellbeing-hub*

Lewisham and Southwark Age UK (for older people)

Tel no: 020 7701 9700

Website: https://www.ageuk.org.uk/lewishamandsouthwark

Southwark Information and Advice Team (for adults with special educational needs and disabilities)

Tel no: 020 7525 3104

Website: https://localoffer.southwark.gov.uk (Internet Explorer not supported)

Citizens Advice Southwark

Tel no: 0344 499 4134

Address: 8 Market Place, London SE16 3UQ

Website: https://www.citizensadvicesouthwark.org.uk

Money Helper (formerly called Money Advice Service)

Tel no: 0800 138 7777

Typetalk: 18001 0800 915 4622

Open: Monday to Friday, 8am to 6pm

Website: https://www.moneyhelper.org.uk/en

Department for Work and Pensions

Advice and contact details for the Pension Service and Jobcentre Plus

https://www.gov.uk/government/organisations/department-for-work-pensions

Charging and paying for your social care

Non-Residential care

Who this is for

The information in this leaflet is for adults who receive non-residential care and support from the council's Adult Social Care services.

Examples of non-residential care include (but are not limited to) –

- Home care (also known as domiciliary care) includes support around the home with tasks, personal care and/or any other activity that enables you to maintain both your independence and quality of life.
- Care and Support in Extra Care Housing.
- Day care services.
- Telecare services (sensors and pendent alarms that can be fitted in your home. These sensors can alert your family or emergency services if you are hurt and/or fall).

Do I receive non-residential care & support?	
I receive care and support and -	
Live in my own home	✓
Live in Extra-Care/Flexi-Care accommodation	✓
Live in shared living accommodation	✓
Live in a nursing home	×
Live in residential Care home	×
If you live in a nursing or residential care home you should read our 'Charging and Paying for Your Social Care, Residential Care' leaflet	

Services that need to be paid for (chargeable services)

The below table provides examples of care and support that must be paid for, and care and support that is free –

Chargeable Non-Residential services	Free services
Homecare Extra Care Shared lives accommodation Supported accommodation Day care services Telecare Transport	Information and advice Needs Assessments and Care and Support Planning Services of the following advocates- ▪ Independent Advocates ▪ Independent Mental Capacity Advocates ▪ Independent Mental Health Advocates Services provided to Carers Minor Equipment and gadgets to help you in your home (up to value of £1,000)

We also do not charge for the following care and support:

- **Rehabilitation and reablement** support if you are in hospital or at home and require support to:
    - help recover from illness or injury at home so that you do not go into hospital unless you really need to
    - settle back into living in your home if you have recently left hospital
    - improve functionality, remain independent, safe and well at home and prevent the need for you to require longer term care

  Rehabilitation and reablement support generally lasts up to six weeks but may be ended earlier or even in some circumstances extended. You can find more information on the council's Rehabilitation and reablement webpages.

- **Aftercare services.** If you have been detained in hospital under the Mental Health Act for treatment or sent to hospital by a court or from prison we will not charge you for Aftercare services related to your mental disorder when you are discharged. However, we will charge you for the cost of meeting needs which arise from your physical health or for reasons unrelated to your mental disorder if we assess that these needs must be met. You can find more information on Aftercare services in our s117 Aftercare leaflet

Calculating the Cost of meeting your care and support needs

Personal budget

If we assess that you have Care Act Eligible needs that the Local Authority needs to meet we will develop a Care and Support plan with you.

We will use your Care and Support Plan to understand how much it will cost to meet your needs. The cost of meeting your needs is called a personal budget.

How a personal budget is paid for depends on your financial or personal circumstances. If you have sufficient capital, you will need to pay for all of the cost of your personal budget. Most people, however, are assessed by the council as only having to pay for part of their personal budget with the Council covering the rest of the cost. In some circumstances, the council pays the total amount of your personal budget.

Your personal budget amount will change over time. This is because –

- We may not be able to immediately provide you with an accurate personal budget. We will only be able to provide you with our best guess of how much it will cost to meet your needs. This best guess is called an indicative budget. We may not be able to provide you with an exact personal budget until we -
    - Identify available and suitable care and support providers to meet your specific needs
    - Agree with the care and support provider how much support you need and how much this will cost
    - Determine how much you should pay towards the cost of your personal budget
- Your needs may change over time. If your needs worsen you may need additional care. If your needs reduce we may be able to purchase less care.
- The providers of care services may increase or lower the cost of the services they provide.
- Alternative means for meeting your needs may become available, for example –
    - Suitable free services may become available
    - We may arrange for you to access equipment or gadgets which mean you are able to manage your needs without additional support
    - An alternative provider may offer more cost effective services
    - Your carer may take on additional responsibilities
- Your contribution towards the personal budget changes.

Arranging and purchasing your care and support

Council purchased care

The council has expertise in purchasing care and support and long standing relationships with providers of care and support services. Because of this many people ask us to arrange and purchase care and support on their behalf.

If you decide that you would like the council to arrange your care and support we will arrange and pay for your care and support upfront. If we assess that you must pay for some or all of the care and support you receive we will invoice you on a 4 weekly basis. You can pay your contribution using a range of methods (see ***Paying your Contribution***).

Direct payments

You may decide that you (or a trusted party acting on your behalf) would prefer to arrange and pay for your own care and support.

We can pay you the value of your personal budget through a Direct Payment. If for example we calculate that it will cost £500 a week to meet your care needs (your personal budget), we will make a direct payment to you of £500 per week less the value of your contribution (see ***Paying your Contribution***). If your contribution is £30 per week, we will pay £470 and you will pay £30.

If you opt for a direct payment we will create a pre-paid card account for you and credit our payments to this account. You can then use your pre-paid card to purchase services.

You are responsible for paying your contribution to the care provider. If you fall behind in your contributions we may terminate your direct payment.

Mixed option (council purchased care and direct payments)

If you decide that you would like us to purchase some of the services you need, but you would like a direct payment to arrange certain care and support this is also possible. If we assess that you must contribute towards your personal budget we will pay you the direct payment minus

Direct payments

Direct payments can be paid to you or someone you consent to manage the payment on your behalf (a family member, friend, carer or even some care providers). We will not be able to provide you with a direct payment in some circumstances (for example, you are an offender and subject to court orders or you have been detained under mental health legislation). We can advise you on this

Direct Payments can be used to pay for services to meet your eligible needs, such as care and support to help you live in your own home, to employ a personal assistant to help you with activities, or short breaks and leisure activities.

Direct Payments cannot be used to pay for household bills, residential care, health services, gambling or anything illegal.

Mixed Option Personal Budgets

You have a personal budget of £500 per week. We assess that you must contribute £30 towards your personal budget.

You arrange care that costs £200 per week. You pay for this using a direct payment. Because you must pay £30 towards your personal budget we make a weekly payment of £170 to you. You top this payment up by £30 per week to bring the total payment to the provider up to £200 per week.

Meanwhile the council arranges and pays for care that costs £300 per week using the remainder of your personal budget.

your contribution (as with the above example, if your contribution is £30 per week, we will pay £470 to you).

Third Party Managed Service

A third party managed service may benefit you if you want the benefits of receiving a direct payment but you do not want to take on all the responsibilities of administering the account. If you opt for a third party managed service we will make the direct payment to a Third party who will manage the account on your behalf.

Using your direct payment

If you purchase care and support using a direct payment you must keep up to date records of the services you purchase. On occasion we will ask you to provide proof that you are using the direct payment to purchase the care and support set out in your care and support plan.

If you are not using your direct payment to pay for appropriate services we may terminate your direct payments and opt to arrange/purchase care on your behalf. We may also refer any misuse of direct payments to the council's Anti-Fraud and Internal Audit Service to investigate, this could result in the council taking legal action against you to recover any misused funds.

Self Funders

If you are responsible for fully funding your care and support we can still support you in identifying care providers and negotiating care packages on your behalf. Alternatively you can make your own arrangements. We do not need to be involved at all if you prefer.

If we arrange care and support on your behalf you will need to pay an arrangement fee of £200 for the service. You will need to pay another arrangement fee if we need to arrange new services for you at a later date as a result of a significant change in your circumstances.

You will need to pay for your own care and support if you have access to capital in excess of the upper capital limit (currently £23,250). Over time the value of your capital may fall below the upper capital limit. If the value of your capital falls below this threshold we can assess your income to determine how much the council should pay for meeting your needs and how much you must contribute.

You are responsible for letting us know when the value of your capital has fallen to close to the upper capital limit of £23,250. The sooner you let us know the sooner we can arrange to assess how much we can pay towards meeting your care and support. We will only pay towards the cost of meeting your care and support at the point we complete the financial assessment with you. If you approach us when your capital falls below the capital limit (for example you approach us when the value of your capital falls to £15,000) we will not consider how much we would have paid for your care if you had approached us earlier.

For more information see *Income and Capital*.

Calculating how much you will need to pay for your care and support

Financial assessment

You must complete a financial assessment to determine if you need to pay for some or all of your assessed care and support.

You should complete the financial assessment as soon as possible. This is to ensure that you know if you need to contribute to meeting the costs of your care and support, and if so, how much you must pay. If we are unable to calculate your contribution in a timely fashion we will backdate any money that you owe us to the time that you first received the care and support. This may mean that you are owed money for costs going back weeks or months.

We will ask you to complete a full financial assessment if it appears that you may not have to pay for any of your care and support or you may be required to make a contribution.

If it is likely that you will need to pay for all of your care and support (because your income and capital clearly exceeds the thresholds set by the government) we may conduct a light touch assessment with you. This is so that we do not ask you unnecessary additional questions and have on record information about your finances that we do not need to have.

You will need to pay for all of your care and support if you do not complete a financial assessment or if we cannot complete a light touch financial assessment with you.

It is important that you provide accurate information about your income and capital so that we are able to correctly calculate if – and how much – you must pay for your

assessed care and support. We will increase your charges retrospectively if we learn that we have undercharged you because –

- You provided us with incorrect information.
- Your circumstances change and you do not tell us.
- You gave your assets to other parties in order that the assets are not included in your financial assessment. For example you transfer the title deeds of your property to a family member or make significant financial gift or purchase for a friend.

Capital and Income

Capital refers to most types of savings and investments. For the purpose of the financial assessment for non-residential care the home you live in is not counted as capital. However, other properties and land that you own will be included.

Income refers to money that comes to you on a regular basis, for example benefits and pensions. If you earn a wage/salary, this is not included as income in your financial assessment. Any wages you earn are yours to keep.

You will need to fully fund the care and support that you need if you own capital in excess of £23,250 (the upper capital limit. This figure is set by the government).

It is likely that you will need to contribute towards the cost of your care and support if the value of the capital that you own is less than £23,250. We will consider your income levels to determine how much you must contribute. We will also apply a tariff income of £1 for every £250 worth of capital you own between £14,250 (the lower capital limit threshold, also set by the government) and £23,250. We won't apply a tariff income if you own capital worth less than the lower capital limit, but will still assess your income.

Examples of income and capital

Capital includes (but is not limited to):

- Property (but not the home you live in).
- Bank, building society and post office savings
- Savings certificates
- Stocks, bonds and shares
- Premium bonds
- Trust funds
- ISAs

Income includes (but is not limited to):

- Employment and Support Allowance
- Universal Credit
- Attendance Allowance
- Disability Living Allowance (care)
- Personal Independence Payment (daily living)
- Pension Credit
- State Retirement pension
- Severe Disablement Allowance
- Rental income from property

The below table provides an example of how we calculate the tariff income:

You receive benefits of £100 per week (your income), and own capital worth £16,000. This means that you own capital of £1,750 above the lower capital limit of £14,250.

Value of capital in excess of the lower capital limit		Tariff charge
£250		£1
£250		£1
£250		£1
£250	equal to	£1
£250		£1
£250		£1
£250		£1
Total £1,750		**£7**

We will apply a tariff charge of £7 against your capital, giving you an income of £107 per week.

When considering your income we will not include income from the following sources in your financial assessment –

- Wages
- Savings Credit of Pension Credit
- Working Tax Credits
- Child Tax Credits and Child Benefit
- Disability Living Allowance (mobility)
- Personal Independence Payment (mobility)
- Armed forces Independence Payment (mobility component)
- War Disablement Pensions
- War Reparations Payments (the first £10 is disregarded)
- War Widows Supplementary payments
- Certain charitable and voluntary payments
- Christmas bonus and Winter Fuel Payments

Protected income – the Minimum Income Guarantee

You will always be left with a certain level of income. This figure is referred to as the Minimum Income Guarantee. The Minimum Income Guarantee is the amount that the government says you can live on.

How much you are left with depends on your circumstances and could range anywhere between £72.40 per week and £232.25 per week if you are single and have no children.

Your Minimum Income Guarantee is calculated using figures provided by the Department of Health and Social Care and takes account of:

- Your age
- What benefits you get or could get
- If you are single or part of a couple
- If you live alone or with somebody else
- If you get, or could get, certain premiums in your state benefits such as Enhanced Disability Premium and Carers Premium
- If you care for a child who lives with you

Disability related expenditure

Disability related expenditure refers to the additional money that you need to spend on items/services that are specifically related to your disability. For example your electricity costs are higher because you charge an electric scooter, you pay someone for domestic tasks that you are unable to do yourself, or you need to buy specific foods/supplements due to your dietary requirements.

You will need to provide information about your Disability Related Expenditure (if you have any) in your financial assessment. How we calculate your Disability Related Expenditure depends on the need/cost in question:

Cost	Such as	How we calculate it
Regular ongoing costs	Domestic help or window cleaning	These costs are converted to weekly amounts, and usually allowed in full. Some expenses may be capped if cheaper alternatives are available.
One-off equipment purchases	Wheelchairs, disability aids, adaptions to your home	We will spread the cost of the equipment over its expected lifetime. If the equipment is expected to last one year, we will spread the allowance over 52 weeks (one year). So if the equipment cost £520 we will allow £10 per week in the financial assessment (£520 ÷ 52 weeks = £10 per week). If cheaper alternatives are available we will only make an allowance for the lower cost.

Cost	Such as	How we calculate it
Utility costs	Gas, electricity and water charges above what is considered 'normal' usage.	**Electricity and gas costs** We compare how much you spend over a whole year with the average cost for your type of property. If you spend more than the average cost we will allow the difference between what you spend and the average cost. **Water charges** Excess water costs, perhaps because you have to do more loads of laundry, can be taken into account if you are on a metered water connection. If you are on a metered connection, this means you pay for water you use and the amount you spend can go up or down. We will compare how much you are charged with the average for your household and allow the difference between the two. If you are not on a meter, you are charged a standard amount and the amount of water you use does not affect how much you pay. Normal water costs are an everyday expense and are not allowed as disability related costs. If there is more than one adult receiving care living in the same property, the excess amount is usually shared equally between each adult. If there is a cheaper tariff available to you, the council will calculate the excess based on the cheaper tariff and not on what you are paying.
Future costs	Plans to replace a piece of equipment at some point in the future	An example of a future cost is if you want to replace your wheelchair next year, you have not incurred any costs yet, so nothing can be allowed in your financial assessment. We will not make an allowance for future costs (items or services that have not yet been paid for) unless there are exceptional circumstances. These costs will only be allowed as part of the appeals process.

Paying your contribution

We recommend that you pay your contributions by **direct debit** (this is often the preferred and easiest method of payment), however you can also pay using the following methods:

- **Debit or credit card** either over the phone or online at our website. Please see the back of your invoices for information on how to pay.
- **Standing order** which you set up with your bank. You are responsible for changing the amount of your standing order if your charge changes. This method of payment is not recommended unless you have online banking and are being charged the same amount each month.
- A **swipe card** is similar to a gas or electric card or key. You must contact us to request this method of payment. We can only agree to this method if you meet certain criteria (for example you must have a Post Office account).
- **Cheque** payments should be crossed and made payable to Southwark Council.

Useful contacts

If you require further information about how to pay your assessed charges, contact the **Collections Team** on **020 7525 1111** or by email at collections@southwark.gov.uk.

If you have questions about the financial assessment process or the amount you are asked to pay, contact the **Charging Team** on **0800 358 0228** or by email at ChargingTeam.adultsocialcare@southwark.gov.uk.

The below table includes the details of independent financial advisors or organisations that you might find helpful.

Organisation	Contact details
Age UK	**Tel**: 020 7701 9700 **Website:** https://www.ageuk.org.uk/lewishamandsouthwark/
The Money Advice Service (now called Money Helper)	**Tel no:** 0800 138 7777 **Typetalk:** 18001 0800 915 4622 **Website:** https://www.moneyhelper.org.uk/en
Citizens Advice Southwark	**Tel**: 0344 499 4134 **Website:** https://www.citizensadvicesouthwark.org.uk/
Southwark Disablement Association (for adults with physical disabilities)	**Tel no:** 020 7358 7744 **Website:** www.sdail/org
Southwark Wellbeing Hub (for adults with a mental illness)	**Tel no:** 020 3751 9684 **Website:** https://www.together-uk.org/southwark-wellbeing-hub/directory
Society of Later Life Advisors	**Tel no:** 0333 2020 454 **Website:** https://societyoflaterlifeadvisers.co.uk/
Southwark Information and Advice Team (for adults with special educational needs and disabilities)	**Tel no:** 020 7525 3104 **Website:** https://localoffer.southwark.gov.uk
Department for Work and Pensions	**Website:** https://www.gov.uk/government/organisations/department-for-work-pensions

SOUTHWARK COUNCIL ADULT SOCIAL CARE

FINANCIAL ASSESSMENT FORM

RESIDENTIAL CARE

Mosaic ID	

Office use only

Clear Form

Southwark Council

Clear Form

FINANCIAL ASSESSMENT FORM

COMMUNITY SUPPORT SERVICES

We will use the information provided on this form to calculate your contribution towards the cost of your care and support needs. It is in your best interests to complete this form so that we can take your financial circumstances into account.

If you choose not to complete this form we will assume you are willing to pay the full cost and not receive any subsidy towards the amount.

Do you need help with this form?

- We can answer your questions on the telephone
- We can send you a copy of the form in large print
- We can visit you at home and help you fill in the form

FREEPHONE NUMBER 0800 358 0228

Are you completing this form for yourself? (if you are go to section 2 below), Or

Are you completing this form on behalf of someone else? (please complete section 1 first)

1. I AM COMPLETING THIS FORM ON BEHALF OF SOMEONE ELSE

My relationship to the client

Lasting/enduring power of attorney ☐

Appointee ☐

Deputy ☐

Please provide evidence if you have one of these legal positions

If your position is not one of the above please give details

Surname First name

Title Mr ☐ Mrs ☐ Ms ☐ Other

(please tick one)

Address

Postcode Tel no.

Email

You should now complete the rest of this form answering the questions as if you are the client.

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2. ABOUT YOU (THE SERVICE USER)

Surname | First name

Title Mr ☐ Mrs ☐ Ms ☐ Other | Date of birth

(please tick one) (day/month/year)

National Insurance Number

Address

Postcode | Tel no.

Email

Some people do not have to pay a contribution because of the type of illness/disability they have

Do you suffer from Creuzfeldt Jacob Disease (CJD)? Yes ☐ No ☐

Are any services being provided under Section 117 of the Mental Health Act? Yes ☐ No ☐

Do you live alone? Yes ☐ No ☐

If you don't live alone, please tell us who you live with

Name | Relationship to you

(e.g.partner, son, daughter)

We may need to contact you for further information

3. ABOUT YOUR INCOME

3a. IF YOU DO NOT WANT TO DECLARE YOUR INCOME

Please fill in this section if you do not want to give details of your income and assets and so you agree to pay the full cost of the service. If you choose to sign below you will not have to give us your details but you may lose out financially as your contribution will not be based on your own circumstances.

Your signature | Date

Witness signature | Date

If you have signed above you do not need to fill in the rest of this form and please return it now to;

Charging Team
Adult Social Care
PO BOX 10906
Nottingham, NG6 6EN Email: ChargingTeam.AdultSocialCare@southwark.gov.uk

Otherwise please continue

3b. YOUR INCOME AND STATE BENEFITS

Please let us know about any of the state benefits listed below that your receive. If you receive any benefit as a couple (for example Pension Credit), halve the amount and write it in the space below. For example if you and your partner get £130 per week, put £65 in each of the spaces headed "How much?" and then put "1" in the "How often" space.

Type of Benefit	How Much		How Often
	Yours	Your Partner	Every week/month/year
Pension Credit Guarantee Credit	£	£	Every
Pension Credit Savings Credit	£	£	Every
Severe Disability Premium	£	£	Every
State Retirement Pension	£	£	Every
Income Support	£	£	Every
Unemployment Benefit	£	£	Every
Incapacity Benefit	£	£	Every
Employment Support Allowance	£	£	Every
Attendance Allowance	£	£	Every
Industrial Injury Benefit	£	£	Every
Reduced Earnings Allowance	£	£	Every
Industrial Diseases Benefit	£	£	Every
Disabled Persons Tax Credit	£	£	Every
Disability Living Allowance (Care Component)	£	£	Every
Disability Living Allowance (Mobility Component)	£	£	Every
Invalid Care Allowance	£	£	Every
Industrial Injuries Disablement	£	£	Every
Personal Independence Payment	£	£	Every
Fostering Payments	£	£	Every
War Widows Pension	£	£	Every
Statutory Maternity Pay	£	£	Every
Maternity Allowance	£	£	Every
Guardian’s Allowance	£	£	Every
Child Benefit	£	£	Every
One Parent Benefit	£	£	Every
Housing Benefit	£	£	Every

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3b. YOUR INCOME AND STATE BENEFITS (CONTINUED)

Type of Benefit	How Much		How Often
	Yours	Your Partner	Every week/month/year
Council Tax Benefit	£	£	Every
Widows Benefit	£	£	Every
Working Families Tax Credit	£	£	Every
War Pension	£	£	Every
Community Care Trust	£	£	Every
Social Fund	£	£	Every
Other	£	£	Every

If you have applied for any of these benefits recently, but are not receiving them, please tell us about this below

Are any debts or loans deducted from your benefits before you get them?

(e.g. court order, debts, loan repayment, previous over payment) Yes ☐ No ☐

If yes tell us about them and how much is deducted and how often

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3c. OTHER INCOME

Please let us know about any other income you have

If you receive income in both you and your partner's name, halve the amount and write in the space below.

If you have a job you do not need to tell us about income from your job. This is because we do not take it into account.

Type of income	How Much		How Often
	Yours	Your Partner	Every week/month/year
Income from an insurance policy	£	£	Every
Income from renting rooms or a property or land you own	£	£	Every
Income from a personal or company pension	£	£	Every
Income from a trust	£	£	Every
Income from the independent living fund	£	£	Every
Other income			
	£	£	Every
	£	£	Every
	£	£	Every

4. YOUR CAPITAL AND SAVINGS

Savings include any cash you have; any savings kept, for example, in a bank, a building society or post office account as well as money held in premium bonds, National Savings certificates, stocks and shares.

4a. BANK/POST OFFICE/BUILDING SOCIETY/SAVINGS

Name of bank, building society etc	Amount	Held in your name only or jointly
	£	☐ Own / Joint ☐
	£	☐ Own / Joint ☐
	£	☐ Own / Joint ☐
	£	☐ Own / Joint ☐

We may need to contact you about this at a later date to obtain further information

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4b. PROPERTY

The value of your home will not affect your contribution. However if you own other land or property we need to know about this.

Do you own any land or property in this country or abroad other than the home you live in?

Yes ☐ No ☐

If yes address of the property

Value £ Held in your name only or jointly

4c. OTHER SAVINGS, INVESTMENTS AND CAPITAL INCLUDING MONEY HELD IN TRUST

Description	Value	Held in your name only or jointly
	£	☐ Own / Joint ☐
	£	☐ Own / Joint ☐
	£	☐ Own / Joint ☐
	£	☐ Own / Joint ☐

(attach sheet if necessary)

5. YOUR SPENDING

5a. YOUR RENT OR MORTGAGE

If you rent your home	How much	How often Every week/month/year
Your total rent	£	Every
Less housing benefit you receive	£	Every
Amount you have to pay	£	Every

If you are buying your home	How much	How often Every week/month/year
Your total mortgage and service charges	£	Every
Less income support you receive towards your mortgage and service charges	£	Every
Amount you have to pay	£	Every

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5b. YOUR COUNCIL TAX

	How much	How often Every week/month/year
Your council tax	£	Every
Less council tax benefit you receive	£	Every
Amount you have to pay	£	Every

5c. THE EXTRA COST OF BEING DISABLED

Please supply evidence or receipts for these expenses

Extra costs you have to pay because of your disability	How much	How often Every week/month/year
Medicines or treatment	£	Every
Special foods / diet	£	Every
Laundry costs (inc costs of any special washing powders)	£	Every
Bedding (for example because of incontinence)	£	Every
Clothing or footwear (for example items that need to be specially made or costs of additional wear and tear)	£	Every
Extra heating costs	£	Every
Privately arranged cleaning, domestic or personal help (inc window cleaning)	£	Every
Purchases, maintenance or repair of any special equipment or aids	£	Every
Help with the garden	£	Every
Respite care	£	Every
Transport costs (over and above the amount of any mobility component of Disability Living Allowance you receive)	£	Every
Other – please explain		

5d. SPECIAL CIRCUMSTANCES

If you have any special circumstances that might affect your contribution, or your ability to pay it, please tell us below about them. Tell us for example about any debts that affect how much money you have at your disposal.

6. PAYING FOR YOUR CARE

Once your financial assessment form has been processed you may be required to contribute towards the cost of your care. If this is the case we will notify you in writing.

We can offer a variety of payment methods to suit your circumstances.

To discuss payment options further, you can phone 020 7525 1111

Please turn the page and sign the form

7. DECLARATION

The details supplied on this form will be used to calculate your contribution and will be kept on file. You may wish to keep a copy for your records. Please read carefully and sign the declaration below.

- I understand why I have completed this form and do not want an advocate to further assist.
- I declare having read this form or having had this form read to me, that the information is true to the best of my knowledge and belief.
- I authorise the council to make any necessary enquiries to verify the information on this form. I authorise the council to verify the information I have given with other sections within the council, other councils and Benefits Authorities.
- I authorise the council to approach the Benefits Authorities on my behalf to obtain information as an ongoing arrangement.
- I will let Southwark Council Adult Social Care know if my financial circumstances change and I understand that I may be asked for more information from time to time.
- I will pay the Southwark Council the amount I am assessed as owing. If I cannot afford to pay I will inform the council who will consider my circumstances.

It is important that you are aware that Southwark Council undertakes local data matching on a regular basis and additionally participates in the Audit Commission's National Fraud Initiative. This means we may use the information you have provided, and also share this with the Audit Commission and credit reference agencies for the purpose of the prevention and detection of fraud. For further information please see https://www.southwark.gov.uk/council-and-democracy/anti-fraud-work-including-anti-tax-evasion-and-national-fraud-initiative

Your signature Date

The information you provide will be used fairly and lawfully and Southwark Council will not knowingly do anything which may lead to a breach of the Data Protection Act 1998.

Please return this signed and completed form to

Charging Team
Southwark Council
PO Box 10906
Nottingham, NG6 6EN

Email: ChargingTeam.AdultSocialCare@southwark.gov.uk

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CHECKLIST

Please use this checklist to ensure you have filled out the form and to remind you to return evidence to support your claim for funding from the council.

1) I have completed all relevant sections ☐

2) I have provided copies of all relevant documents to support my claim ☐

3) I have included full information of income and capital, including shares, NS&I investments (including Premium Bonds), etc. ☐

4) The form has been duly signed and witnessed ☐

5) I have enclosed my Power of Attorney or Deputyship (if applicable) ☐

6) I have saved a copy of this form for my own records ☐

INFORMATION FOR SERVICE USERS

Financial Advice

We frequently ask our clients to seek independent financial or legal advice. Some organisations provide free, impartial advice, whereas others charge. If you need advice, here are some organisations you can approach.

Citizens Advice Bureau (free advice)
https://www.citizensadvicesouthwark.org.uk/
Telephone - 0344 499 4134

Step Change (for free debt advice)
https://www.stepchange.org/
Telephone – 0800 138 1111

Age UK (free advice)
https://www.ageuk.org.uk/lewishamandsouthwark/
Telephone - 0800 678 1602
Open Monday to Friday 9:30am to 5pm

Society for Later Life Advisors
(Charges may apply)
https://societyoflaterlifeadvisers.co.uk/
Telephone - 0333 2020 454

Further information is available in our Charging Leaflet. If you have not received a copy, please request one by calling 0800 358 0228.

Paying for your care and support

This page explains how we work out how much you could pay for your care.

Click here to download a leaflet about organisations providing independent advice: Independent Financial Advisors

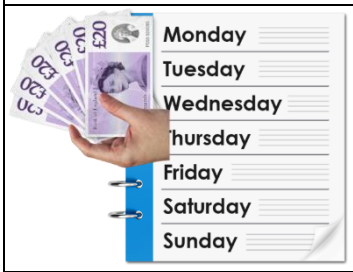
Financial assessments

To find out if you need pay for your care, we will carry out a **financial assessment**.

We will work out what you can afford to pay by finding out:

- how much it costs to provide care and support to meet your needs

- what your **personal expenses allowance** or **guaranteed minimum income** is.

	The government sets the **personal expenses allowance**.
	This allowance is the money everyone needs to spend on other things every week.
	If you give us information about your money quickly,
	we can decide what you need to pay quickly too.
	**Working out what you need to pay**
	So that you only pay for the care you can afford, the charge is based on your income.
	The **financial assessment** tells us: • your **income** • your **capital** We explain these terms on the next page.

	• any costs you have because of your disability.
	**Income** Your **income** includes benefits such as: • Personal Independence Payments
	• Attendance Allowance
	• Income Support.
	If you have a job, we **do not** include your salary in the **financial assessment**.
	Capital Your **capital** includes: Property – houses, flats and offices

	• stocks and shares
	• premium bonds
	• savings
	• land.
	You will have to pay the total cost of your care and support if your **capital** is more than **£23,250**.
	You will have to pay towards your care and support if your **capital** is from **£23,250** to **£14,250.**
	To work out your income we add a tariff of **£1** for every **£250** of capital you have that is **more than £14,250**.

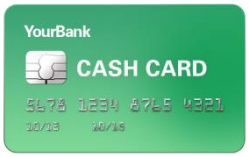
 	We do not add a tariff of **£1** if your capital is **less than £14,250**.
	Here is an example of how we work out the tariff:
	• Your benefits are **£100** per week
	• Your **capital** is worth **£16,000**.
	• So your capital is **£1,750 more than £14,250**.
 	This means your tariff will be **£7** giving you an income of £107 per week.

	**Other care and support**
	You **will not pay** for other types of care and support, such as home care, if your income is **less than** the **Minimum Income Guarantee**.
	If your income is **more than** the **Minimum Income Guarantee** you **will pay** for your care and support.
	You **will not pay** for your care and support if your weekly charge is **less than £3**.
	Financial assessments are carried out,
	using the guidelines in the Care Act 2014 Statutory Guidance.

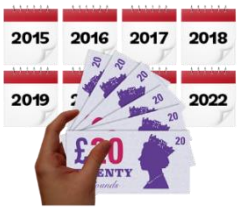
Paying for care and support

If you have to pay for your care and support you can use:

- a cheque.



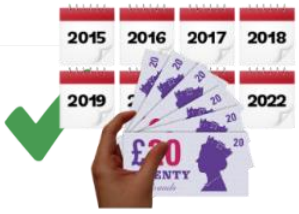
- a swipe card.



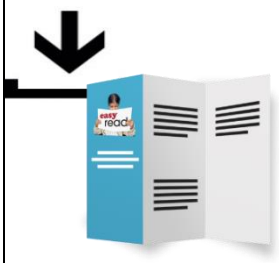
You can use **deferred payments** if you get care and support at a care home.

DIRECT Debit

The best and easiest way to pay for your care and support is Direct Debit.



Deferred payments

	If you move into a care home or a nursing care home, and you qualify for **deferred payments** you can pay the costs later on.
	For more information go to the Deferred payments page.
	**Reviewing what you pay** We will carry out a **financial assessment** every year to check that you are paying the right money.
	If your income or savings change, you should tell us as soon as possible.
	Useful information
	Click this link to download our leaflet about paying for care and support: Fairer contributions policy summary and FAQ
	**Get in touch**

	If you have questions about the **financial assessments**, you can.
	Call **0800 358 0228**
	or email ChargingTeam.adultsocialcare@southwark.gov.uk
	We use the income we collect to carry on providing services for people with support needs,
	so it is important that your payments are made on time.
	Call **020 7525 1111** for information about making payments
	Email collections@southwark.gov.uk .

APPENDIX 1

Southwark Council
southwark.gov.uk

Fairer Contributions Policy

Contents

1. Introduction

Southwark Council has a responsibility to ensure that adults in our local community who are unable to achieve everyday outcomes by way of a physical impairment, mental impairment, or illness, are able to achieve the outcomes that matter to them in life.

To ensure that we can afford to meet the needs of adults who receive support from adult social care, we will work with the individual to work out how much they can afford to contribute towards the costs of meeting their care and support needs.

Our aim is to complete a financial assessment with all service users. Where a financial assessment is not possible or disproportionate, we aim to complete a light touch financial assessment. If we are unable to complete a full financial assessment or light touch financial assessment, we will usually ask the adult to pay for the full cost of their care (see section 6 for details of how adults without mental capacity might be affected).

Following an assessment, if the value of their capital does not exceed the upper capital limit[1], we will ask them to contribute to the cost of their care, provided that they have sufficient income. To ensure that the adult only pays what they can afford, we will assess their charge based on their individual circumstances.

When calculating what they can afford, we will consider:

- how much it costs to provide care and support to meet their needs. We will never charge more than the cost that we incur in meeting their assessed needs,
- what income they have access to.

If the adult owns capital in excess of the upper capital limit, we will ask them to meet the full cost of their care needs until the value of their capital reduces under the upper capital limit. This is subject to the deprivation rule (see section 5.7 for details).

2. Scope

This policy applies to adults with care and support needs, with the exception of adults:

- with Creutzfeldt-Jacob Disease,
- in receipt of aftercare services provided under section 117 of the Mental Health Act[2].

We do not charge carers for the provision of services to meet their eligible needs.

All parts of this policy apply equally to charges for residential care services and non-residential care services, unless stated otherwise.

3. Legislation and Key Documents

- The Care Act 2014 & associated regulations
- Care and Support Statutory Guidance Issued under the Care Act 2014 (DOH)
- The Mental Capacity Act 2005
- The Mental Health Act 1983
- The Equalities Act 2010
- Regulation of Investigatory Powers Act 2000

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[1] For a definition of Upper Capital Limit, see Chapter 8 (Charging and Financial Assessment) of Care Act Statutory guidance
https://www.gov.uk/government/publications/care-act-statutory-guidance

[2] See Top-Up policy for details of where a top-up charge may apply.

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- Welfare Reform Act 2012
- Data Protection Act 2018 (which incorporates the General Data Protection Regulation)

4. Definitions

Most of the terms in this document are explained in their own section. Further explanation is provided below for some terms that require a clear explanation of what they mean.

Adult	A person over the age of 18 who is in receipt of adult social care services and for whom this policy applies.
Arrangement fee	This is a fee that is charged to adults who are responsible for the full cost of their care services and have asked the council to arrange their care. This fee is not payable for residential care, but if there is a deferred payment agreement in place, additional fees may be payable under that scheme. These other fees are explained in the deferred payment agreement policy.
Deferred Payment Agreement	A contract the adult with care and support needs (or their legal representative) signs with the council, which gives the council the ability to secure a legal charge on property, and provides terms and conditions of the deferred payment scheme.
Deferred Payment Scheme	A national scheme whereby people can delay paying for their care and support, or part of it, until a later date, provided they meet the eligibility for the scheme.
Deprivation of income or capital	This term is used when an adult has 'deprived' themselves of an asset in order to reduce their liability to pay for care. Where deprivation occurs, the council will treat the adult as if they still had the asset, or in some circumstances, may pursue the person who received the asset.
Financial assessment	This is a means-test to determine how much the adult should contribute towards their care. Financial assessments are worked out as a weekly amount.
Light touch assessment	A light touch (financial) assessment is a mini assessment that takes place in cases where the council does not need to complete a full financial assessment. More information is provided in section 5.7.
Notional income or notional capital	Income or capital that the adult could claim if they applied for it. The notional capital rule is also applied in cases where deprivation has occurred.

5. Approach to fairer contributions

5.1 Charging principles

Our approach to charging for care and support is guided by the following principles –

We will:

- not charge adults with care needs more than we can reasonably expect them to pay,
- apply a robust and consistent approach to assessing contributions,
- have transparent processes, and clearly explain financial assessment implications,

- employ a person centred approach, and place the adult's wellbeing at the forefront of the process,
- incentivise employment, education and training,
- employ a sustainable approach.

5.2 Information and Advice

We will publish information on our approach to assessing and charging adult's with care and support needs, including clear information or signposting on:

- money management
- benefits entitlement
- why and how we carry out financial assessments, including charging implications
- requesting support to meet eligible needs even when the adult must pay for their own care (including information on any costs incurred as part of this process)
- advice and support available to people making their own care arrangements
- income/capital we will include in the assessment, and capital/income we will disregard
- how we calculate the contribution, including information on protected and available income
- services that are chargeable
- methods of payment, including information on deferred payments and top-up charges
- independent financial advice
- care caps
- safeguarding and financial abuse

We will make information on our approach to charging available online and will be available in community languages and in accessible formats on request. We will also signpost individuals to independent financial advisors where independent advice is appropriate.

Social care staff conducting assessments must ensure that the adult with care needs (and those supporting them during the assessment) are adequately informed about the financial assessment process, and charging implications.

5.3 Charges for care

5.3.1 Services charged for

We charge for care related services, including (but not limited to) –

- Telecare
- Homecare
- Meals at home/day centres
- Day centre attendance
- Long term residential home placements
- Respite care
- Transport
- Community Support
- Services purchased via a Direct Payment
- Long term nursing home placements

We review the cost of services annually in order to ensure that the services are sustainable and offer good value for money. In some cases, changes to the cost of services provided will affect how much the adult is expected to contribute towards their care services.

There is a presumption that any adult care services not referred to above, or those that may develop in the future will be chargeable under this policy unless:

- Southwark Council has chosen to exercise its discretion not to charge, or
- Where that service is exempt under statute.

Where an adult going into a care home chooses accommodation that costs more than the council will fund, a Top Up will normally apply. In limited circumstances, the adult can pay their own top up, but

normally the top up is paid for by a third party, such as a relative. Please see our Top Up policy for more information.

5.3.2 Arrangement fee for self-funders

Adults who are responsible for the full cost of their care services in the community and who ask the council to arrange their care will be charged an arrangement fee of £200. This fee is initially payable when services begin and where there is a significant change of circumstances.

The fee is charged to cover administrative costs involved in making arrangements for self-funders. The fee is payable even if the adult receives care for part of the year.

This fee was introduced on 01 April 2020. Adults who were self-funding their care prior to this date will not be asked to pay any retrospective fees, but will be charged the fee where there is a significant change of circumstances.

The arrangement fee will not be applied in cases where the adult is only in receipt of the Telecare alarm service, as charging this fee would be disproportionate to the level of service. Should the adult begin to receive other chargeable services at a later date, and if the adult continues to be responsible for the full cost of their care, the arrangement fee will be payable from the date that the additional services began.

Examples of when the fee will apply to existing adults
We would apply the arrangement fee for an existing service user in circumstances such as:

- Moving from single handed to double handed care,
- Increase in care package significantly such as from one hour per day to four hours per day
- Service user previously only in receipt of an alarm service, is allocated a personal budget to meet their needs.

Arrangement fees are payable irrespective of the adults mental capacity. Arrangement fees cannot be deferred and are payable upon presentation of an invoice.

5.3.3 Services not charged for

We will not charge for the following services –

- Aids and minor adaptations that cost under £1000,
- Up to 6 weeks of Intermediate or Reablement care services,
- Care and support to meet the needs of adults with Creutzfeldt-Jakob disease,
- After care services provided under section 117 of the mental health act 1983[3],
- Services the NHS is under a duty to provide (including Continuing Healthcare and the NHS contribution to Registered Nursing care),
- Services we are under a duty to provide under other legislation,
- Assessment of needs and care planning.

5.4 Identifying the need to carry out a financial assessment

Where an adult is in receipt of one or more chargeable care service, we will usually offer a full financial assessment to work out the person's ability to contribute. In some circumstances we may carry out a 'light touch' assessment instead, which will normally happen in the following circumstances:

- when the adult chooses not to disclose their full financial details but would like us to meet their care needs,
- when we charge a small / nominal amount for a service which the adult is clearly able to meet and carrying out a financial assessment would be disproportionate,

[3] We do not charge for core services, but where a top-up applies the adult may be charged accordingly. See Top Up guidance for more information.

- where the adult is in receipt of particular state benefits which demonstrates that they would not be able to contribute towards their care and support costs.

We will notify adults of the outcome of their financial assessment or light touch financial assessment. If we have completed a light touch financial assessment, we will offer them the opportunity to complete a full financial assessment.

If we have been unable to complete both a full financial assessment and a light touch financial assessment, we will asses the adult as having the ability to pay for the full cost of their care and support and will charge them on this basis.

If the service user subsequently chooses to engage with the council, we will review their case if based on the evidence that they present.

5.5 Capital and the financial assessment

5.5.1 Determining which capital to assess

We will follow statutory guidance[4] which provides information on types of capital that should be:

- treated as income instead of as capital, or
- be included in full in the financial assessment, or
- be partially disregarded, or
- be fully disregarded, or
- be disregarded for a fixed period of time.

Some types of capital are treated differently depending on the adult's care setting. For example, an adult who lives in the property that they own will have the property disregarded (ignored) in a financial assessment, but if that adult goes into residential care, that property may be included.

5.5.2 Ownership of capital

If there are concerns about the ownership of the capital, we will seek documentary evidence to verify who the capital belongs to. For jointly owned capital (such as a joint bank account or a jointly owned property), we will split the total value in equal shares between the joint owners (unless there is evidence that they own an unequal share).

If the adult is the legal owner of a property, but they do not have rights to any proceeds from the sale (i.e. they are not the beneficial owner), then we will not treat the property as capital. This is subject to the deprivation rule (see section 5.10)

In all circumstances, if there is doubt as to the true ownership of capital, then we will request evidence. In cases where a bank account is in joint names only for ease of administration of the adult's money, all of the capital in that account will be treated as being owned by the adult.

5.5.3 Determining the value of the capital

The adult or their representative is responsible for providing accurate information on the amount and types of capital they hold. In some cases, we can determine the value of capital by checking with National Savings and Investments (NS&I), or by checking property prices online.

Capital which is not immediately available to the adult, for example National Savings Bank investment accounts, will be taken into account at its face value. The amount included in the financial assessment may need to be adjusted when the capital becomes available or where the value is confirmed. If the adult chooses not to realise the capital (i.e. they reinvest it), the value will be reassessed at regular intervals, usually annually.

If the value of the capital is not immediately obvious, we will value it based on either the current market value, or the surrender value of the property (whichever is highest) minus –

[4] Care and Support Statutory guidance, Annex B – Treatment of capital

- 10% of the value if there are actual expenses involved in selling the asset, and
- any outstanding debts secured against the asset (for example a mortgage).

If there is a valuation dispute, we will seek a precise valuation from a professional valuer except where it is clear that the value will not take the total value of their capital above the upper capital threshold. It will not be necessary to obtain a precise valuation if the adult and the council agree that the net value of the capital exceeds the upper capital limit, or falls below the lower capital limit.

We will follow statutory guidance[5] on how to deal with assets held abroad.

5.6 Income and Expenses

5.6.1 Determining which income to assess

We will follow statutory guidance[6] which provides information on types of income that should be:

- treated as capital instead of as income, or
- be included in full in the financial assessment, or
- be partially disregarded, or
- be fully disregarded, or
- be disregarded for a fixed period of time.

Where an adult is in a care home and has a spouse or civil partner who is not living in the same care home and is paying half of the value of their occupational pension, personal pension or retirement annuity to their spouse or civil partner, the council will disregard this payment. The council can only disregard 50%. Advice will be given to the adult to confirm that if the spouse or civil partner is on means-tested benefits; their benefit entitlement will be affected by this payment. This allowance does not apply to state retirement pensions.

We will help the adult maximise their income by highlighting any benefits they are eligible to claim. All eligible benefits can be included in the adult's financial assessment. See 5.8 Notional Income and Capital for more information on how the council treats potential income as notional income.

5.6.2 Allowances in financial assessments

Apart from allowances made in respect of protected income (see 5.9.3 below), we will make some allowances based on the adult's circumstances. Broadly, there are two types of allowances we can make:

Housing costs (for adults living in the community)
Some household costs that the adult incurs can be allowed in the financial assessment. Examples are:

- Council Tax that they pay (i.e. Council Tax net of Council Tax Reduction)
- Rent (net of any Housing Benefit). If the adult lives in a communal setting and has lighting or heating included in rental charges, these elements are not allowed for as they form part of normal daily living costs
- Mortgage repayments
- Service charges
- Ground rent

Housing costs (for adults in residential care)
The same housing costs above can be allowed for adults in residential care. In addition, we will allow nominal gas / electric costs if the property is left vacant. For long term placements, we allow housing costs for the first 6 weeks of the placement. For short term placements, we allow housing costs for the duration of the placement.

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[5] Care and Support Statutory guidance, Annex B – Treatment of capital, Paragraphs 20 to 22
[6] Care and Support Statutory guidance, Annex C – Treatment of income

Housing costs that we allow are reduced if the property is occupied by a non-dependent. The amount allowed will be the cost divided by the number of non-dependent adults living in the property.

If the adult owns the property and it is left vacant after they enter residential care, housing costs can continue to be allowed after the first 6 weeks if requested by the adult. If the adult does not own the property, it is assumed that the property should be vacated and so further housing costs will not normally be allowed.

Disability Related Expenses

A disability related expense (DRE) is an expense that the service user incurs as a result of having a disability. Whilst there is not a defined list of these, statutory guidance does provide some examples. Generally, expenses that are considered to be normal costs of daily living will not be considered as a disability expense. Expenses will also not normally be allowed if the council is already meeting the particular need of the adult that the expense relates to.

If the adult claims expenses of more than £20 per week, then this will trigger a review by a senior team member to ensure fairness and consistency.

When a full DRE assessment is done, the way expenses are calculated differs depending on the nature of the expense. This is explained below:

- **Regular ongoing costs** – these costs are converted to weekly amounts, and usually allowed in full. Some expenses may be capped if cheaper alternatives are available to the adult.
- **One-off equipment purchases** – these costs are allowed over the expected lifetime of the equipment. For example, if a piece of equipment is expected to last one year, we will spread the allowance we make in the assessment over one year (52 weeks). Therefore, if the cost of the equipment was £520, the council would allow £10 per week in the financial assessment (£520 ÷ 52 weeks = £10 per week). If cheaper alternatives are available, the council will only make an allowance for the lower cost.
- **Extra heating costs** – Normal gas and electricity usage is not considered a disability related expense in a financial assessment as these are normal costs of living. If the adult has high heating costs because of a disability, the council will make an allowance for the extra cost. This is worked out by comparing the adult's annual gas / electricity costs, and comparing with the average for that type of property. The difference between the two will be allowed in equal weekly amounts. If there is more than one adult receiving care living in the same property, the excess amount is shared equally between each adult. If the adult has a cheaper tariff available to them, the council will calculate the excess based on the cheaper tariff and not on what the adult is paying.
- **Extra water costs** – normal water charges are not considered to be disability related as they are normal costs of living. If the adult has a metered connection and has high water charges because of a disability, the council will make an allowance for the difference between what they pay and the average cost.
- **Future costs** – the council will not make an allowance for any future costs (items or services that have not yet been paid for) unless there are exceptional circumstances that warrant making such an allowance. These costs will only be allowed as part of the appeals process.

5.7 Light touch financial assessments

Conducting a light touch financial assessment usually involves gathering data from various different sources, such as from the DWP. If there is sufficient information available from these sources, then this information is put together to calculate a light touch financial assessment. Light touch financial assessments are calculated in the same way as a full financial assessment.

Usually, a light-touch financial assessment will be possible if:

- the adult has already told the council that they have more capital than the upper capital limit
- the adult does not have recourse to public funds
- the adult is in receipt of means-tested benefits.

Apart from the DWP, other sources of information that the council can use are shown below. This list is not exhaustive and other sources may be used from time to time.

- Housing department
- Housing benefits and council tax records
- Electoral register (open version only)
- HM Land Registry
- Any previous financial assessments or social care records

When a light touch assessment has been completed, the council will let the adult know that they can request a full financial assessment at any time. There are evidence requirements for a full financial assessment and the adult will need to provide evidence to support the whole length of their claim (i.e. backdated evidence if the adult asks for a backdated financial assessment).

The council does not have any right to approach banking institutions, investment firms or private / work pension providers for information to complete a light touch assessment. Therefore, if the adult does not get a means-tested benefit, the likelihood of the council being able to complete a light touch assessment is reduced.

5.8 Notional income and capital

We will consider notional income or capital when conducting financial assessments. These may include:

- income that is due, but has not been received;
- income or capital available on application;
- income or capital the individual has deliberately deprived themselves of to reduce the amount they are liable to pay for their care (see section 5.10);
- a person of retirement age has a pension plan, but has not purchased an annuity or arranged a draw down of the maximum annuity that would be available.

We will not treat the following sources of income as notional income –

Figure 1[7]

A. Income payable under a discretionary trust,
B. Income payable under a trust derived from a payment made as a result of a personal injury where the income would be available but has not yet been applied for,
C. Income from capital resulting from an award of damages for personal injury that is administered by a court,
D. Occupational pension which is not being paid because:
   (i) The trustees or managers of the scheme have suspended or ceased payments due to an insufficiency of resources; or
   (ii) The trustees or managers of the scheme have insufficient resources available to them to meet the scheme's liabilities in full.
E. Working Tax credit

Notional income is treated as if it were actual income. Notional income will be calculated from the date it could be expected to be acquired if an application were made. If we include notional capital in the adult's financial assessment, we will reduce the sum of the notional capital weekly, by the difference between the weekly:

- charge the adult is paying for their care, and
- the rate the adult would have paid if the notional income were not applied.

We follow statutory guidance on the treatment of capital. Examples[8] of how we will treat notional capital and income are outlined below:

Example of notional income

[7] Care and Support Statutory guidance, Annex C – Treatment of income
[8] Care and Support Statutory guidance, Annex C – Notional income

Andrew is 70 and is living in a care home. He has not been receiving his occupational pension to which he would have been entitled to from age 65. After contacting his former employer, they state Andrew will be paid the entire pension due from age 65. The local authority can therefore apply notional income from age 65.

Example of notional capital
Hayley is receiving care and support in a care home. She is assessed as having notional capital of £20,000 plus actual capital of £6,000. This means her assets are above the upper capital limit and she needs to pay the full cost of her care and support at £400 per week.

The notional capital should therefore be reduced by the difference between the sum Hayley is paying (£400) and would have paid without the notional capital (£100).

If she did not have the notional capital it would not affect her ability to pay. This is as she has an income of £120.40 and a personal allowance of £24.40 per week and would therefore be assessed as being able to pay £100.

5.9 Deprivation of assets and savings

If the adult claims that they no longer have an asset or income they must demonstrate that they no longer have ownership of the asset. When considering whether the adult deliberately deprived themselves of the asset, we will consider the following –

Figure 2

Deprivation of assets	Deprivation of income
▪ Was avoiding charges for receiving care and support a significant motivation? ▪ Did the individual have a reasonable expectation of having to contribute to the costs of their care and support? ▪ Does the timing of the disposal raise suspicions?	▪ Was the income in fact the individuals? ▪ What was the purpose of the disposal? ▪ Does the timing of the disposal raise suspicions?

If we suspect that the individual has deliberately deprived themselves of assets we will investigate further. We may charge the adult as if they still possessed the asset, or seek to recover the debt from the third party who benefited from the transaction. The third party will be liable to pay the difference between what we would have charged had deprivation not occurred, and what we did charge.

If the adult has converted the capital into another asset of lesser value, we will treat them as notionally possessing the difference between the value of the new resource, and the asset they deprived themselves of.

5.10 Determining the adult's financial contribution to their care costs

5.10.1 Capital limits

For financial assessment purposes, there are two capital limits. There is an upper capital limit and a lower capital limit. In the financial assessment, these are treated as follows:

- If the adult has more than the upper capital limit they must pay for the services in full,
- If the adult has less than the lower capital limit then capital will not make any difference in the outcome of the financial assessment (i.e. the capital is disregarded),
- If the adult has capital between the lower and upper limit, the tariff income rule will apply (see 5.11.2).

If the adult's capital exceeds the upper capital limit and they ask us to make arrangements to meet their needs, we will charge them towards the cost of putting the arrangements in place. This administrative charge does not apply to care home placements. See section 5.3.3 for more information on this charge.

5.10.2 Tariff income rule

Tariff Income is a notional income which is added to income from other sources before working out the weekly charge. Tariff Income is meant to represent an amount a resident with capital over a certain limit should pay towards their care, not the interest earning capacity of that capital.

It is calculated by taking the actual amount of capital the service user has, then deducting the value of the lower capital limit and dividing the result by 250. The final result is then rounded up to the nearest £1.

Example of tariff income
Nora has £16,455 and the lower capital limit is £14,250; their tariff income would be £9. The calculation is shown below:

- £16,455 - £14,250 = £2,205
- £2,205 ÷ 250 = £8.82
- £8.82 rounded up to nearest £1 = £9

5.10.3 Protected Income

When assessing how much the adult can contribute towards the costs of their care and support, we will leave the adult with a minimum protected amount to spend as they choose. The amount of protected income is set by the government.

Personal Expenses Allowance (PEA) for adults who reside in care homes

The PEA rate is determined by the Department of Health and communicated in documents called Local Authority Circulars[9]. The amount of PEA is set, but may be adjusted in certain circumstances. We follow statutory guidance[10] on how to treat and adjust PEA in financial assessments.

Minimum Income Guarantee (MIG) for adults whose needs are being met outside a care home

MIG rates are determined by the Department of Health and communicated in documents called Local Authority Circulars. There are a number of different rates that will be applied, depending on the adults' circumstances. The Local Authority circular tells councils how to work out the amount of MIG to allow in financial assessments.

Disposable Income Allowance (DIA)
This allowance applies where there is a deferred payment agreement in place to pay for care home fees (see 5.10.5 for more information on deferred payment agreements and eligibility criteria). The adult can choose to retain up to £144 per week from their income.

5.10.4 'No charge' rule

We will not charge where the outcome of a financial assessment means that the adult should pay less than £5 per week.

Example of the No Charge rule

[9] Local authority circulars can be found at:
https://www.gov.uk/government/collections/local-authority-circulars
[10] Care and Support Statutory guidance – Annex C

Sophie has had a financial assessment to determine how much she should contribute towards her care. The outcome of the assessment means that she has been assessed to pay £4.78 per week. As this amount is lower than £5 per week, she will not be charged.

In the following year, Sophie has a financial reassessment. The outcome of that assessment is that she is assessed to pay £5.52 per week. As this amount is higher than the £5 limit, she will be charged £5.52 per week.

5.10.5 Payment options

Adults can choose to pay their contribution using a range of methods (including swipe cards, cheques etc.). The preferred method of payment is Direct Debit.

In some circumstances, the adult can defer their charges to pay for care home fees. This is called a Deferred Payment Agreement. See the Deferred Payment Agreement Policy for more information on deferred payments.

5.10.6 Backdated contributions

We will usually aim to complete financial assessments within 10 working days. It may take significantly longer to complete a financial assessment. For example:

- there have been delays determining the value of the adult's capital,
- we have had to apply to the Court of Protection to address capacity concerns,
- the adult delayed providing the required evidence.

Where we have been unable to establish the adult's contribution in a timely fashion, in most cases we will backdate the adult's contributions to the date we would otherwise have charged

5.11 Financial assessment outcomes

We will provide the adult (and where appropriate also their advocate, appropriate individual, or other nominated parties) with a copy of their financial assessment within 10 working days of its completion. We will also clearly communicate:

- how the assessment has been carried out,
- the amount that the adult must contribute, and how often,
- the reasons behind any fluctuations in their payments (if relevant).

6 Mental Capacity

If the adult lacks mental capacity, they may still be assessed as being able to contribute towards their care. Where possible, we will work with someone who has the legal authority to make financial decisions on behalf of the adult who lacks capacity.

If there is no such person, we will recommend that an application is made for either a DWP Appointeeship or a Court of Protection appointed Deputy. In some cases it could be the Council that acts in one or both of these capacities.

See section **5.11.6** for information on backdating assessed contributions if we cannot complete a financial assessment straight away.

7. Reviews

We will review the adult's financial assessment at least annually, or

- in response to changing circumstances (for instance the adult inherits significant capital, or they no longer have a dependent child),
- if the adult requests a review.

8. Debt Recovery

If the adult has accrued a debt for care fees, we will consider County Court proceedings to recover the debt if all other reasonable avenues have been explored.

Other reasonable avenues could include the use of securing the debt against the adult's property if they own it, by utilising the deferred payment scheme.

All efforts to recover the debt will be guided by *Appendix D: Annex D - Recovery of debts.*

Southwark Council will give adults 28 days to pay any invoices or statements of account presented to them. If these invoices are not paid (and are not under dispute), then the adult will be sent a reminder letter or will be phoned by a council debt officer. Debts still outstanding after a further 14 days will be referred for legal action.

9. Appeals and complaints

If the adult has concerns that their contribution is too high, we will advise them of their right of appeal, and provide them with information and advice on our appeals process (including which forms and supporting documentation must be submitted in order to process the appeal).

Appeals will be administered by a senior officer within the team as a review. Following careful consideration of the adult's submission, they will make a recommendation on the outcome of the review.

If the adult disagrees with the outcome of the senior officer's review, then they can request that a manager looks at the case again.

If the adult is still unhappy following a review by the manager, we will direct them to Southwark Council's Complaints policy. Complaints are subject to the procedure as set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

10. Related Policies

This policy should be read alongside the following documents -

- Top up Guidance
- Deferred Payments Agreement Policy

Document control

Approval date		Last amended	
Last reviewed		Version	3.0
Scheduled review date			

Agenda Item 9

Care Contributions Scrutiny Review Report

Health and Social Care Scrutiny Commission

April 2023

Contents

Summary of recommendations

Recommendation one

Raise the Minimum Income Guarantee increase the government mandated buffer of 25% with an additional local buffer of 25% to a total of 50%?and provide an impact assessment to understand cost to the council and benefit to disabled people and carers.

Recommendation two

Provide better information, advice and support to enable disabled people and carers to understand care contributions generally, and their right to have adequate Disability Related Expenditure taken into account in financial assessments.

Recommendation three

Take steps to reduce the adverse impact of care contributions on the incomes of people reaching pension age, both disabled people and their carers. In particular take action to mitigate the steep increases that can be incurred once a) a disabled person reaches pension age and their employment related pension becomes assessed b) carers facing reductions in income as they reach pension age and lose Care Allowances and income from paid work.

Recommendation four

Cabinet revisit the Fairer Contributions Policy Cabinet agreed in 2015, and revised in 2020**.**

Introduction

Disabled people are eligible for a personal budget from their local authority, which they use to pay for care and support appropriate to their needs. However, clients are also asked to contribute financially towards this. ‘Fairer contribution’ is the Council’s framework for assessing what people should contribute towards the cost of their care, taking into account all their income and assets, as well as any expenses they have linked to their disabilities. Contributions are means-tested and based on income (including benefits but not employment).

Local Authorities provide and fund social care services under Section 9 of the Care Act 2014. This legislation also provides Local Authorities with a duty to complete an assessment of an adult’s needs for care and support and a power to make a charge. Councils do however have the scope to vary charges, and the Act specifies that people will only be asked to pay what they can afford.

Southwark Council adopted the Fairer Contributions Policy in 2015, which outlines the way the Council financially assess recipients of social care services and ensure this is affordable. In March 2020 cabinet amended the Adult Social Care Fairer Contributions Policy and this revised approach was implemented in April 2021.

The Commission heard there was considerable consultation prior to both policies being adopted, however the impact of the cost of living crisis has happened following the last major change. Disabled people and older carers have been particularly hard hit by increases to energy and food costs, and the squeeze on incomes.

Officers told the Commission that the number of people requiring support to manage their social care needs is increasing year on year. Whilst unpaid carers continue to provide support across the country, the financial cost for Local Authorities to meet the social care needs of their residents continues to increase.

The Council spends close to £130m on Adult Social Care, while the projected income from charging for services is £8m.

The Commission decided to hold a one off session to investigate care contributions following a meeting hosted by Bede House bringing together councillors and carers of people supported at the Bede Centre. At the meeting, many carers and service users raised their concerns about the impact that the care contribution charges were having on them and the people they care for.

Contributors to the review

The Commission received the following evidence at the meeting held on 2 February:

- Bede House provided a briefing on care charges for councillors and a report of a meeting hosted on 20 October 2022. This was an afternoon for clients with learning disabilities and their carers to meet local councillors. 11 relatives or carers and 5 Bede clients met with 3 local councillors and the London Assembly member for Lambeth and Southwark.

- Two carers received moral support from Mencap to tell their stories to the Commission. Alan Burnham presented to the meeting. He is the brother of a client that has attended Bede House for some years. Mary Kumar provided a written statement. She is full-time carer for her adult daughter, who also attends Bede House.

- Pauline O'Hare, Director Adult Social Care, provided a briefings and presented.

- Southwark Disablement Association – David Stock, CEO provided a briefing and presented.

Cost of living crisis, care contributions and the cumulative impact on disabled people and their carers

People receiving local authority-arranged care and support other than in a care home need to retain a certain level of income to cover their living costs. Under the Care Act 2014, charges must not reduce people's income below a certain amount, but local authorities can allow people to keep more of their income if they wish. This is a weekly amount and is known as the Minimum Income Guarantee (MIG)[1].

The government raises the MIG annually to reflect inflation, however Bede House highlighted recent increases have been below the actual inflation rate. The MIG increased by 3% this year, but this is much lower than the current rate of inflation, which is at 9.9%.

The Commission heard that the cost of living crisis is impacting disabled people particularly hard, as a higher proportion of their living costs will go on basics such as energy and food. These have seen the largest inflationary rises.

This is backed up by documents produced by the Council to support the budget process and ensure that people living with disadvantage are not unfairly impacted by future changes to the allocation of resources [2]. A Public Health document looking at the impact of the cost of living crisis on disabled people found that:

- Deaf and disabled Londoners were twice as likely as the average Londoner to be going without essentials (16% v 8%).

[1] https://www.gov.uk/government/publications/social-care-charging-for-local-authorities-2023-to-2024/social-care-charging-for-care-and-support-loc

[2] Cost of Living Crisis: Impacts across protected characteristics. Public Health Division Children & Adults Department January 2022, Page 7 Disabled people.

- Among Southwark respondents to the 2019 Survey for London, fuel poverty was higher than average for people with disabilities, indicating that they are at greater risk of fuel poverty during the cost of living crisis.
- Between July and August 2022, Citizens Advice Southwark saw an increase in the proportion of their clients who had long-term health conditions from 25% to 40%.
- Previous financial crises have had disproportionate negative impacts on people with mental health conditions. Nationally, 44% of adults with mental health problems who fell behind on bills either considered or attempted suicide during COVID-19.
- Money worries can lead to people feeling lonely or isolated. Amongst Southwark respondents to the 2019 Survey for London, just over 1 in 4 people reporting a long-term mental health condition also said that they felt lonely often, compared to 1 in 11 Southwark respondents overall. (2)

Although care contribution assessments are for individuals, many disabled people live in families where income is pooled and any care contributions come out of a shared household budget. The Commission heard that the cost of living is placing a general strain on household budgets, which mean that the care contributions cannot be absorbed without carers cutting back on essentials.

Officers told the commission that the MIG figure is reviewed at least annually to ensure that any adjustments to the sum are reflected in our charging practices. The Council currently increases the MIG amount by 25%[3].The CEO of Southwark Disablement Association highlighted that the 25% uplift to the MIG was decided prior to the more recent cost of living increase and proposed the MIG is increased by 50%, which the Commission agree with.

Recommendation one

Raise the Minimum Income Guarantee increase the government mandated buffer of 25% with an additional local buffer of 25% to a total of 50%?and provide an impact assessment to understand cost to the council and benefit to disabled people and carers..

Financial assessments and Disability Related Expenditure (DRE)

The carers who gave evidence all stressed the additional cost that disabled people incur because of their conditions. For example people with learning difficulties often require food that is easy to prepare; there may be extra energy costs associated with electrical equipment to charge scooters; or keep warm; or to undertake more laundry

[3] This needs a reference – request sent to Director of Adult Social Care

because of incontinence. Officers told the commission that Disability Related Expenditure (DRE) ought to be deducted during the assessment process to ensure that each person has the Minimum Income Guarantee.

The carers who gave evidence did not think these expenses had been taken into account. Members who attended the Bede House event also heard from families where DRE did not seem to have been factored into the assessment. Many of the complaints from Bede House clients and carers centred on the assessment process. The Bede House reported that people with learning disabilities, and their carers, did not understand how the care charges had been worked out and complained that the charging letters did not provide a clear breakdown.

The Commission asked officers, and undertook desktop research, to establish the information, advice and advocacy available to ensure disabled people and their carers could claim all the DRE that is due and obtain a fair assessment. The exercise did not provide adequate reassurance that this is sufficient - a leaflet did not provide much explanation of DRE, website links were broken, and the organisations providing advice were hard to find.

Concern was also raised by Bede House that DRE is being increasingly narrowed by local authorities and averages around £5 per week, which they said does not reflect the scale of additional costs that disabled people face.

Bede House clients and their carers also complained about a disjointed and confusing assessment process. Some were not aware that the forms they were asked to fill in were to undertake a financial assessment for charges, and complained about a lack of transparency. Other people said they were receiving notices for backdated payments to pay for charges that they did not know about, and there was concern they would fall into debt or face a visit from bailiffs.

This year the council's budget process set out an intention to increase the income raised through more efficient collection of contributions from service users towards the cost of their care, and notes that this could have a negative impact on some disabled service users[4]. This highlights the importance of minimising this risk and ensuring that service users and their families are assessed fairly, that their Disability Related Expenditure is fully accounted for, and families have a well-managed assessment process.

Recommendation two

Provide better information, advice and support to enable disabled people and carers to understand care contributions generally, and their right to have adequate Disability Related Expenditure taken into account in financial assessments.

Pensioners and care charges

[4] Policy and Resources Strategy Initial Cumulative Equality Analysis 2023/2024 Disability: Council Delivery Plan Page 18

The Commission heard that increases in care contributions have adversely impacted pensioners in particular, both disabled pensioners and carers who are pensioners.

Disabled people's contribution to their care is means-tested and based on some but not all income; benefits are included but not income from employment. However pensions are assessed, including work based pensions. In some cases receiving a pension can tip people over an assessment threshold with £5 in extra income week leading to a significant increase in charges, per week. The Commission heard that when one disabled person reached state pension age he was required to pay over £470 in contributions, when previously none had been incurred. Such steep charges were very difficult to manage and the Commission recommended that steps are taken to mitigate these sharp increases.

Carers who were also pensioners were another cohort of concern. On reaching pension age some carers reported losing their Care Allowance (on receipt of the state pension), losing income from paid employment, alongside facing a reduced capacity to care and their own age related health needs. The cumulative impact of this was causing hardship. One family told the Commission that care contributions meant that they could not afford to adequately heat and light their home, which was impacting in their health and wellbeing.

Recommendation three

Take steps to reduce the adverse impact of care charges on the incomes of people reaching pension age, both disabled people and their carers. In particular take action to mitigate the steep increases that can be incurred once a) a disabled person reaches pension age and their state and employment related pension becomes assessed b) carers facing reductions in income as they reach pension age and lose Care Allowances and income from paid work.

Conclusion

The implementation of changes made to the "Adult Social Care Fairer Contributions Policy" in April 2021 may well explain why families of users of Bede House only started to get upset around this time. In addition the impact of the cost of living crisis could well be pushing families over the edge when they face steep, unexpected or unaffordable care contributions bills, because of a change in circumstances.

There is a risk that this situation could get worse, without measures to mitigate the impact of increased collection of care contributions, once the more efficient collection of contributions set out in the budget takes place.

Disabled people and their carers are raising significant concerns with the both process and in some cases real hardship at the amount of care contributions levied. Disabled people are one of the most disadvantaged groups in our community. Carers are often also pensioners who have given much of their lives to caring and deserve both an understanding of their increasing vulnerability as they age , and also a system that is as fair and well managed as possible, in recognition of the unpaid contribution carers are making to the community.

At the same time the Commission recognises that the Council is facing an increasing need for care provision, rising inflation and no extra resources. The Council therefore has to allocate resources judiciously, and protect those most in need.

The Commission believe that the recommendations outlined in the report will go some way to protecting those residents on some of the lowest incomes in Southwark. The Commission also recommend that the Fairer Contributions policy is more thoroughly reviewed.

Recommendation four

Cabinet revisit the Fairer Contributions Policy Cabinet agreed in 2015, and revised in 2020**.**

Agenda Item 10

Health café conversation notes

6 March 2023 1.30pm to 3.30pm

Copleston Centre Café, Copleston Road, Peckham.

Introduction

Residents of Southwark were invited to share their views on GP surgeries and health services at an afternoon event at Copleston Centre Café. The event was targeted at older people in particular, but not exclusively. Most people were regular users of the busy local community centre, who promoted and hosted the event. All participants were women. The event was held in the café, just after a regular 'warm up' soup lunch. Tea, fruit and cakes were served, and the discussion was held on three tables in small groups. Councillors led the conversation with support from the scrutiny officer and Healthwatch.

The following prompt questions were used:

- How easy do you find it to get an appointment at your surgery with a doctor? What could be improved?
- Have you been offered a face to face, telephone or video consultation? How did you find that? What could be improved?
- Do you see other health professionals at your surgery such as nurses? Anybody else?
- Do you see the same doctor or different doctors? How do you find that?
- Do you visit your pharmacy for healthcare ? Such as repeat prescriptions? Any thing else?
- If you have a long term condition, such as diabetes, or a lung condition, how do you find your care treatment plan? How do find the communication between the hospital and your doctor?
- Is there anything else you would like to tell us?

First table : Cllr Maria Linforth-Hall

6 ladies were interviewed who use four local surgeries.

Although all of them very much support the NHS, they think that the service has changed for the worse. (Especially since the Pandemic)

Two surgeries were described as inadequate.

They all find it extremely difficult to get an appointment. Some of the surgeries only run block appointments for the day and sometime the day after, if not urgent they are asked to call the following week or go to A&E.

One Surgery seemed to be better organised and they are more respectful of people's problems.

Most surgeries only offered telephone appointments and in one case a video appointment. They all said that face to face appointments are things of the past. They all find it difficult to communicate well by phone. For example the GPs usually ask do you have a Blood Pressure Arm Monitor at home. If they say no, they suggest you buy one or go to the GP Surgery as most of them have a reader in their reception area and then give the results to a receptionist.

Most of them thought that one of the main problems is the incompetence and bad manner of the receptionists.

Some of the ladies have seen nurses more than GPs.

None talk to the same doctor regularly which makes things difficult as not all the GPs know them as a person or as a patient, so they have to recount their problems before there can be any discussion of their case,

None of them visit a pharmacy other than to collect prescriptions. They don't trust their pharmacists and believe that their turnaround of staff is too big, making it impossible to form a relationship with a pharmacist.

Long term conditions and treatments are difficult as there is no continuity of care and often difficult to manage a hospital and GP relationship.

The main problem seems to be getting appointments. Also continuity of care and it is referrals.

Follow ups or obtaining results of blood and other tests is almost impossible.

Not only they but also relatives or friends have been either misdiagnosed or diagnosed too late, so their conditions have progressed without treatment. For example, every month delayed on cancer treatment can raise the risk of death. (A GP of one local surgery was recently struck off because of malpractice)

Because of the crisis in doctor surgeries some of the ladies have found that a digital based GP service is a way to get an appointments sooner.

They also comment that calling 111 is a help but you must have patience as it takes a long time to get through to them.

They all hope we can help resolve the problem but they don't have ideas or solutions to offer.

Second table: Cllr Suzanne Abachor, Cllr Naima Ali, Julie Timbrell (scrutiny project manager)

Appointments

Two people struggled to get an appointments. One person said she was able to access a nurse practitioner quickly and was satisfied.

The two people who found it difficult to get an appointment; both said that they have to ring up the surgery at 8am, however despite waiting for an hour on the phone the appointments have all gone by 9am. The remedy of follow up phone calls do not come at the expected time, despite people waiting in all afternoon.

People wanted better access to their GP.

An improvement would be reverting to the previous walk in appointment arrangements. People said they did not mind waiting for a couple of hours in the waiting room, as long as they knew they would be seen . Another solution would be to enable appointments to be booked in advance – even a number of weeks as long as this provided a guaranteed slot for non urgent care .

Continuity of care

The perceived demise of yearly health screening was lamented. The ending of yearly checks for blood pressure and to check for other problems was considered a significant loss.

There was a complaint that a blood test had not been actioned by a surgery.

Someone complained that a short operation scheduled pre-pandemic had not happened despite a 4 year wait. The patient was willing to make herself available for cancellations at short notice and suggested that as a potential remedy.

People were generally happy to see more than one doctor .

There was a comment that previously information on a long term conditions had been shared between the hospital and GP, but not recently .

A women with diabetes said she was once part of a group to manage her condition, but as she was able to generally self manage well her placement ended. However she commented that the GP has not been able to take up the slack adequately to monitor her condition.

Appointment delivery (face to face / telephone)

People were generally unhappy with the lack of face to face contact and considered phone consultations inadequate to receive a proper diagnosis as there was no physical observation. Some people considered that a short telephone call ought to only be used to triage and to plan a face to face appointment.

Digitisation , and the notion of a doctor on your electronic device , was not welcomed .

Pharmacies

These were used for repeat prescriptions, and advice on occasions.

One person had a treatment review by the pharmacy but considered this barely adequate.

There was concern by a couple of people that pharmacies push pharmaceutical drugs, however other people gave experiences of more holistic care and a broader range of helpful health options being accessed at their pharmacy.

Other comments: on the delivery of health care

There was a view by some attendees that the medical model of health is not working and that by continuing to push this system we are on a hiding to nowhere with diminishing returns.

In some peoples view the fundamental flaw in the present system was that the medical model was the only approach, or very predominant , and this was led by the pharmaceutical industry. Rather they wanted to see a pluralistic model that honoured people's diverse health promoting traditions. They said that people are multicultural and multiracial with health traditions such a Ayurveda, herbalism, massage, etc

The pharmaceutical model was critiqued as being profit led and on occasions doing harm, for example antibiotics destroying gut flora or generally over prescribing or failing to look at the causes of ill health and this was jeopardising the fundamental principle of 'do no harm'.

The pharmaceutical, and power of drug companies were cited as the reason for the dominate paradigm of the medical model. There was also concern with large corporate ownership of surgeries and the possibility of asset stripping.

Rather than just a medical model they wanted more choice, including complementary therapies and a more holistic, person centred approach , where the causes of ill health were addressed by a collaborative approach with different specialisms contributing to a treatment plan. They wanted to see an empowered model of health – with concern the present model is disempowering.

People thought that GP surgeries ought to offer front line provision that promotes health. The Integrated Model, and practitioners such a physiotherapists, were seen as linked to this vision but the Integrated Model was still viewed as the medical model - instead of delivering interdisciplinary healthcare which involves a range of practitioners to address underlying causes of disease and promoting good health holistically. The Peoples Health Alliance was referred to https://the-pha.org/ as an alternative positive vision.

The approach to Covid was also criticised as over emphasising medical approaches to controlling contagion (isolation and vaccines) and under emphasizing , or denigrating , other methods such as improving the underlying health of the population and promoting social wellbeing. They bemoaned that lack of a multifaceted approach.

There was anger at national politicians and central government perceived profiteering from Covid (PPE contracts) using the pandemic to further transfer wealth to a few and widening inequality.

A better approach to ageing well was advocated . People referred to Death Cafes where people could openly discus and plan for their end of life, and consider the emotional , social and in some cases spiritual aspects of death. There was concern that a much worse alternative would be ending their life with the withdrawal of water and food in hospital.

People thought good health was linked to a healthy ecology, and health food and conversely that ill health was linked to poor quality food, poor air quality and a poisoned earth.

There was a suggestion that work be done to look at those who have good health but do not use the health service, or only rarely, to understand what they are doing to stay well.

Third table: Daniel Johnson (Healthwatch Southwark) , Cllr Esme Dobson

Appointments

Virtually impossible to book an in-person appointment. Having to call at 8am in the morning every morning is a very stressful process.

General feedback stated that there the system was preferred before Covid-19.

There was a general tendency towards preferring telephone appointments for some people as they were able to.

Continuity of care

There was a sense that people wanted to see the same doctors again to build up the trusted relationships which they had previously experienced.

A complaint was made around GPs not calling at a certain time that they had previously committed to creating stressful situations.

Appointment delivery (face to face / telephone)

The lack of face to face appointments concerned individuals as they believed that real diagnosis can not be made over the phone.

Pharmacies

Overall experiences were good but there was a need for a friendlier reception service to be provided.

Other comments: on the delivery of health care

There was general confusion around the new Integrated Care System. One person wanted Homeopathy promoted in the new system of care and criticised the Healthcare system as being reactionary rather than preventative.

An acceptance of an over-stretched service was referenced many times and therefore the care would reflect this. For example nurses were mentioned as being seen in GP practices but they were deemed to not have the time.

There was negative feedback given around people’s experience with SLAM and how they were treated.

There were mixed views on GP surgeries and how they were run.

Next steps for integrating primary care: Fuller Stocktake report

Commissioned by NHS England and NHS Improvement from Dr Claire Fuller, CEO (designate) Surrey Heartlands ICS

MAY 2022

Introduction from Dr Claire Fuller

For generations, primary care has been at the heart of our communities. Health visitors, community and district nurses, GPs, dentists, pharmacists, opticians, and social care workers are among the most recognisable of a multitude of dedicated staff delivering care around the clock in every neighbourhood in the country.

Every day, more than a million people benefit from the advice and support of primary care professionals – acting as a first point of contact for most people accessing the NHS and also providing an ongoing relationship to those who need it. This enduring connection to people is what makes primary care so valued by the communities it serves.

Despite this, there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it.

Inadequate access to urgent care is having a direct impact on GPs' ability to provide continuity of care to those patients who need it most. In large part because of this, patient satisfaction with access to general practice is at an all-time low,[i] despite record numbers of appointments: the 8am Monday scramble for appointments has now become synonymous with patient frustration.

At the same time, primary care teams are stretched beyond capacity, with staff morale at a record low.[ii] In short, left as it is, primary care as we know it will become unsustainable in a relatively short period of time. It is against this backdrop that the Chief Executive of the NHS, Amanda Pritchard, asked me to lead this major stocktake of integrated primary care from the ground up.

I want to start by thanking all primary care staff – and staff right across the health and care system – for their magnificent efforts during the pandemic. Since the inception of the NHS, there has not been a generation of leaders and staff who have faced the kind of overwhelming challenges as those working in our system today, and despite the very real toll COVID-19 may have taken on them personally and professionally, they will forever be able to wear their contribution as a badge of honour.

When I agreed to lead this work in November 2021, I don't think I fully appreciated the amount I would personally gain. As a GP for over 25 years, a clinical commissioning group (CCG) chair, a CCG accountable officer and an integrated care system (ICS) CEO designate, I have been involved in numerous system reviews and reforms. However, I do not think I have ever had such an opportunity to share ideas, listen and learn from others, build relationships, and challenge my own understanding, as I have during this process. It's been a pleasure to have met and worked with so many fantastic colleagues during the past six months.

During that time, we have had over 12,000 individual visits to our engagement platform, over 1.5 million Twitter impressions of *#FullerStocktake*, and close to 1,000 people directly involved through workstreams, roundtables and one-to-one meetings. The levels of engagement have been unlike anything I have seen for many years – all driven by a collective desire to create the conditions by which primary care can be supported to thrive in the future.

A moment of real opportunity

Despite the current challenges, there is real optimism that the new reforms to health and social care

– *if properly supported to embed and succeed* – can provide the backdrop for transforming how primary care is delivered in every community in the country.

We are weeks away from the inception of the new ICSs and with it the biggest opportunity in a generation for the most radical overhaul in the way health and social care services are designed and delivered. Primary care must be at the heart of each of our new systems – all of which face different challenges and will require the freedom and support to find different solutions. In an extraordinary and welcome display of common purpose across health and care, each of the CEOs of the 42 new systems has added their signature to this report.

But these new systems alone can't fix all the problems: we need action at every level. This report sets out a limited number of recommendations for NHS England, the Department of Health and Social Care (DHSC), and other national bodies that will enable local systems to drive change in their communities and neighbourhoods. This includes ensuring future national policy is designed to *support and enable* local systems to do what they need to do rather than apply a one-size-fits-all approach.

Support, enablement and respect have been among the most common themes throughout this stocktake. Emerging from the pandemic, it is clear that we all want to build on the best elements of our response to COVID-19 and work together wherever possible: delivering what works locally in step with our communities. As leaders, we have to ensure that we lead in an inclusive, compassionate and respectful way: setting the right tone will accelerate and embed the kind of change we all want to see delivered.

Some – but not all – of the changes needed in this report will require us to grow overall primary care capacity. Additional investment is by no means the main or only answer to the issues we need to solve: we will also need to think differently about how we design integrated primary care services that better anticipate the needs of different groups of people.

It is vital that we retain continuity as one of the core strengths of primary care, but we must also recognise that people's needs and expectations are changing. On the one hand, a growing number of people have complex needs, such as multiple long-term conditions, requiring highly personalised care and support. On the other, many people who are normally in good health would prioritise faster access to advice from a wider group of professionals.

A vision for integrating primary care

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**

- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to**,** those with multiple long-term conditions

- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

It is the collective judgement of the people who have engaged closely in our stocktake that the vision for integrating primary care set out in this report is achievable if we create both the conditions to enable locally led change *and* the supporting infrastructure to implement it: indeed, as demonstrated by many of the case studies contained in this report, systems are already working in this way.

Primary care has always had an entrepreneurial and innovative spirit. We have recently seen the significant, rapid and life-saving adaptations that were made during the pandemic response; including through the COVID-19 vaccination programme delivered together with local authorities, pooling resources to establish COVID-specific 'hot hubs', safeguarding care home and domiciliary visits, ensuring community pharmacy kept its doors open to the public throughout, and shifting to virtual consultations to protect patients, carers and staff.

Locally led, nationally enabled change is a consistent theme in these pandemic success stories. This report offers a vision for transforming primary care led by integrated neighbourhood teams that will be supported to lead change, drawing from the wealth of positive change already underway.

There are no quick fixes, and we have tried through this report to set out pragmatic actions for ICS leadership teams that move us further on the journey, as well as some broader recommendations for national policymakers that will unlock the longer-term changes we need to see.

Improving the experience of accessing primary care is essential to restoring the confidence of the public, who rightly expect us to be there when they need us. Even more important in my view, is the opportunity this new vision for integrating primary care presents in helping people to stay well for longer. This will not only have the greatest impact on the future sustainability of health and care services overall but can genuinely help to transform lives.

All too often, the vast majority of our effort is focused on treating people who have already become sick. We need to create a sense of urgency around providing proactive care and improving outcomes for our population – not only will this help our citizens to lead more active and happier lives, it will help us to reduce the pressure on the NHS and social care in the medium to long term.

This is only achievable if we work in partnership addressing health inequalities through the Core20PLUS5 approach, and taking action to address the wider determinants of health.

Aligned leadership

In my view, ICSs come just at the right time, tasked with achieving four aims: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development.

The ICS CEOs believe that achieving these aims will only be possible if we support and develop a thriving integrated primary care system. This will need to be built as locally as possible, drawing on the insights, resourcefulness and innovations of patients and their carers, local communities, local government and NHS teams, other care providers and wider system partners, as well as, of course, primary care leaders. *This philosophy of partnership is at the heart of my report.*

I am hugely grateful to our workstreams and task and finish groups. By rapidly bringing together a wide range of experience and expertise, they informed our understanding of the current landscape

and what the future should look like. For those who gave us 10 minutes or 10 hours of your time, your input has helped shape this report and I hope you are encouraged by its conclusions. Thank you particularly to all our workstream and task and finish group chairs: Tracey Bleakley, Dr Nick Broughton, Glen Burley, Daniel Elkeles, Professor Kevin Fenton, Professor Simon Gregory, Dr Jaweeda Idoo, Fatima Khan-Shah, Joanna Killian, Dr Neil Modha, Thirza Sawtell, Dr Harpreet Sood, Jan Thomas, and Rob Webster. I'd also like to thank Adam Doyle, who has acted as a critical friend throughout the production of this report.

This report has also been informed by the findings of a King's Fund literature review on levers for change in primary care, commissioned as part of the stocktake, which has provided invaluable insights into what truly drives change: a leadership culture that promotes an enabling and psychologically safe environment, and the capacity, time and skills for people to learn and experiment.

Leading this work has been a privilege, and meeting so many enthusiastic and solution-focused leaders across the health and care system has solidified my optimism for the future.

This report is only the start. To implement these recommendations requires the continued input and effort of my ICS CEO colleagues, the integrated care board (ICB) and integrated care partnership (ICP) chairs and primary care leaders, as well as the support of our system partners. I look forward to being on this journey with you all.

Building integrated teams in every neighbourhood

At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

This is usually most powerful in neighbourhoods of 30-50,000, where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.

The development of PCNs, established just prior to the pandemic, has already enabled many neighbourhoods to make progress in this direction. However, we've heard consistently that a lack of infrastructure and support has held them back from achieving more ambitious change.

Healthy Hyde PCN employs 34 people across many different disciplines, all of which are working to tackle health inequalities. The PCN covers 77,000 people, over 60% of whom live in the top two deciles of most deprived postcodes in England. It has six health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. Healthy Hyde is working with local voluntary organisations, statutory bodies and community services to provide a full holistic approach to a person's needs. It has set up groups that are run weekly and monthly by professionals ranging from GPs, nurses, social care, citizen's advice bureau, health visitors and mental health professionals. These groups run for people aged 0 to 100. The team has clinical leadership, managerial and admin support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.

Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

This requires two significant cultural shifts: towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community; and realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams.

The key ingredient to delivering this way of working is leadership – fostering an improvement culture and a safe environment for people to learn and experiment. We heard consistently throughout our engagement that a 'top-down' approach of driving change and improvements risks alienating the workforce and communities and hinders development of trusting relationships: something emphasised in the King's Fund literature review.

Many ICSs are already thinking about how to ensure neighbourhood teams have, for example, sufficient leadership capacity and support to develop a collaborative multiprofessional workforce. Delivering integrated neighbourhood teams will require a step-change in progress, with a systematic cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods. For example:

- full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints', working alongside dedicated, named specialist teams from acute and mental health trusts, particularly their community mental health teams
- making available 'back-office' and transformation functions for PCNs, including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (eg GP federations, supra-PCNs, NHS trusts)
- a shared, system-wide approach to estates, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

This will not only unlock improvements in patient care but will also help individual PCNs and teams better manage demand and capacity, building resilience and sustainability.

Integrated clinical pharmacy service in Wirral

Staff working across PCNs and the hospital trust in Wirral Place deliver a shared clinical pharmacy service, hosted by Wirral University Teaching Hospitals NHS Foundation Trust. The service was co-designed and developed with partners, resulting in an environment where those actually delivering the service are 'system thinkers' focused on the patient, regardless of their organisation. Their ability to link with clinicians and other professionals across the local system through the shared use of IT systems, as well as the trust and relationships which have developed, support the speedier resolution of any issues which might impact on patients and the local population – team members are always cognisant of the impact their actions may have in another part of the system.

As well as supporting members of general practice to resolve medicines issues encountered, the joint pharmacy team are also invaluable assets in the day-to-day running of practices. They have their own clinical caseload, run medicines optimisation clinics and support implementation of medicines safety strategies. While working in hospital, they undertake clinical ward rounds across a range of specialties, with a particular focus on admissions and frailty to support safe transfer of care.

The service grew out of an initial pilot, involving just four members of staff, to a team of 25 within just two years. Some staff rotate across the sectors, while some are permanently working in split roles across both sectors.

The pace at which these teams can be built will depend in part on the pace at which we can deliver the national and system changes set out later in this report. However, with the right support, we heard that systems should aim to have them up and running in neighbourhoods that are in the Core20PLUS5 most deprived areas by April 2023.

This will not only ensure that we can start to better support those communities who need it most, it will create the necessary pace and ambition to move to universal coverage throughout 2023 and by April 2024 at the latest.

Working with people and communities

Throughout the stocktake, we heard that the PCNs that were most effective in improving population health and tackling health inequalities, were those that worked in partnership with their people and communities and local authority colleagues. This partnership focuses on genuine co-production and personalisation of care, bringing local people into the workforce so that it reflects the diversity of local communities, and proactively reaching out to marginalised groups breaking down barriers to accessing healthcare.

Community Health and Wellbeing Workers (CHWWs): Westminster City Council, Pimlico Health at The Marven and Imperial College London have launched a pilot scheme of trained CHWWs to run from May 2021 to June 2023. CHWWs visit local households monthly, irrespective of need, and deliver a broad range of activities including promotion of healthy lifestyles, reminders for vaccinations and screening and management of chronic diseases. In this pilot, CHWWs are available to talk to residents about their health, offer social care support where appropriate and inform them about available services, whether they have existing health issues or not. This proactive, universal and comprehensive role helps to capture health and social care issues as they arise. CHWWs in the pilot have identified undiagnosed serious mental illness and domestic violence and improved cervical screening uptake in Muslim women. Due to the initial success of this pilot scheme, this model is now being adopted by the National Association of Primary Care to promote nationally.

We have a fantastic opportunity to build on the outreach model that characterised the COVID-19 vaccination programme: developing meaningful and sustained relationships within communities, using the expertise, resources and relationships held by the NHS and local government, voluntary, community and social enterprise (VCSE) sector teams and community groups and leaders to understand the local social, demographic and cultural factors.

As a part of this drive, our workforce needs to be given the time and resources to meaningfully undertake this work. Outreach should not be considered a bolt-on to the day job – it's central to people's roles and should be reflected in protected time and job plans, for both current and upcoming roles.

Growing Health Together in east Surrey is a place-based approach to prevention and health creation, which uses ecological design principles to support population health, health equity and the environment. Clinicians in each PCN have regular protected time to work collaboratively with local citizens and partners to co-create evidence-based conditions for health and wellbeing. Solutions differ according to the location, reflecting the unique priorities, needs and strengths of each community. Listening to and building relationships within communities form the foundation of this work. Quality improvement methodology is utilised, and the work is supported by population health data and a community of practice. A comprehensive independent evaluation is underway, exploring quantitative and qualitative impacts on both the health system and wider community.

ICSs have a real opportunity to use their scale and convening power to foster meaningful partnerships between sectors, emphasising the importance of health and care organisations as anchor institutions: for example, with schools and higher and further education (HFE) providers, through outreach, work experience programmes and apprenticeships, to drive the recruitment of a more diverse and representative primary care workforce, including health inclusion groups, people with a learning disability and autistic people.

Working in this truly integrated way with people and communities offers the NHS a real opportunity to deliver more effective and sustainable change and paves the way for a much bigger prize: creating the space and opportunity to do far more on the most pressing challenge for health and social care systems: tackling the determinants of ill health and helping people to live happier and healthier lifestyles.

Ultimately, these integrated teams – rooted in the community and working across the spectrum of health and care – are the central conduit through which we can deliver the new model of integrated care.

Stort Valley and Villages PCN has created a **Young People's Social Prescribing Service** to support young people aged 11 to 25 with their physical and mental health. The PCN developed this model because they recognised that services for young people can be confusing and difficult to navigate. The service aims to signpost young people and their families to appropriate community-based and statutory services after they have been assessed by a GP; support general wellbeing among young people and their families in the local community; highlight how effective community interventions can be within PCNs; offer preventative interventions such as the Family Wellbeing Health Coaching Service provided by Mental Wellbeing in Schools; and work alongside other services with a view to creating activities and groups for those who have been referred. The service has had over 500 referrals since its creation in September 2019 and received positive feedback from young people and their families.

Delivering the change our patients and staff want and need: improving same-day access for urgent care

The two issues that have dominated the debate throughout this stocktake are the need for people to access same-day urgent care *and* the need for GPs to be able to provide continuity of care to those patients who need it most.

In reality, they are two sides of the same coin. Creating a resilient infrastructure and resilience around GP practices that enables same-day access to urgent care to be delivered *creates* space to deliver more continuity of care.

To get there, we are going to need to look beyond a traditional definition of primary care and understand that NHS urgent care is what patients access first in their community – typically from their home or high street and without needing a GP referral. That might be online advice on symptoms and self-care, going to a community pharmacy, a general practice appointment, an urgent treatment centre, or the 111 out-of-hours clinical assessment service. As part of accessing urgent care, a patient may then get immediate referral into emergency care or go online or talk to somebody before walking into a hospital emergency department.

People waiting for an appointment with their GP prioritise different things. Some *need* to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, *but certainly not always*, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly.

Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.[iii]

We saw throughout the stocktake some fantastic case studies of practices and PCNs that are already working as a single urgent care team, including allied health professionals, community nursing teams and others to offer their patients the care appropriate to them when they call the surgery or book an online appointment.

The Foundry Health Centre is a single practice PCN in Sussex with 28,500 patients. Since 2019, it has sought to improve access and keep patients out of hospital. Patients are streamed using systematic triage and clinical judgement and identified as green (generally well – continuity less important), amber (long-term conditions – continuity important; appropriate reactive care delivered), and red (vulnerable or complex – continuity paramount; proactive care given). Combined with creating a dedicated 'green' site for those needing on-the-day access (and 'amber' overflow), capacity across the multi-site practice is easier to plan and manage, drawing on MDTs so patients see the right health professional at the right time.

This approach has improved continuity of care, improved access to a range of services through partnership working, and better utilised additional roles, such as pharmacists, nurses, paramedics, physiotherapists, social workers and those working on behalf of the voluntary sector. Compared with other practices on South, Central and West Commissioning Support Unit programmes, and based on the GP clinical system data, Foundry's top 5% of frequent attenders only use 30% of GP consultations compared with 40% elsewhere, and it has reduced the number of appointments being 'avoidable' from 9% to 6.5% in late 2021, with other primary care services reporting an average of 27% as 'avoidable' appointments.

Managing access for multiple services at a practice level is achievable and scalable if we create the right conditions for this to happen. Working together to make better use of capacity and workforce – as well as creating resilience to deal with demand – can not only help to significantly relieve the burden on practices struggling to cope with finding appointments for their patients, it can also help to reduce demand on other urgent care services across the NHS.[iv]

The truth is, we *can* create a much better offer for all our patients, but it requires effective collaboration across primary care and with the wider health system in a way that we have not managed to date.

Implementing the vision for integrating primary care will enable local systems to plan and organise a coherent urgent and emergency care service by developing an integrated urgent care pathway *in the community*.

Humber Coast and Vale ICS implemented an Operational Pressures Escalation Levels (OPEL) system to understand and manage demand and capacity across primary care. Practices log their on-the-day status online, and if a practice reports capacity issues, the CCG will support and work with it to find a solution.

Though some practices were initially wary of reporting their data, through the relationships of trust between GPs and the CCG and the intelligence that OPEL provides to the system, practices now confidently report their pressures.

This has been particularly successful in Vale of York CCG where all 11 practices report OPEL escalations daily, following three years of relationship development. York CCG's practices have now gone further to improve this system by developing their own anticipated pressures reporting system through the GP Federation, to get ahead of expected demand and capacity issues the day before. Thanks to joint contributions to a shared budget, practices can confirm additional resources are in place before a busy day even begins.

How do we get where we need to be?

We should start by recognising the current system is not fit for purpose – it is fragmented and causing frustration among patients and staff. In the face of rising demand, we need to move to a streamlined and integrated urgent care system – and primary care has an essential role in achieving this.

We need to enable primary care in every neighbourhood to create single urgent care teams and to offer their patients the care appropriate to them when they pop into their practice, contact the team or book an online appointment.

The importance of improvement support, data and leadership is central to making this work and we set out some key recommendations on these later in this document.

Critically, we need to create the conditions by which they can connect up the wider urgent care system, supporting them to take currently separate and siloed services – for example, general practice in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community

response services, home visiting, community pharmacy, 111 call handling, 111 clinical assessment – and organise them as a single integrated urgent care pathway in the community that is reliable, streamlined and easier for patients to navigate.

This will require some shifts to national policy too, specifically the approach to NHS 111, which we heard via the stocktake can often result in duplication of effort for patients, carers and clinicians. At the moment, we do not have a clear and consistent way of counting and measuring same-day urgent access, or unplanned waits for routine appointments. NHS England should consider developing these to support local improvement activity, linked to its wider work with systems in bringing together a set of key primary care standards.

The ultimate arbiters of the success of this approach will be our patients. We should measure patient satisfaction rates throughout this journey, and there should be a move to roll out the new National Patient Reported Experience Metric as quickly as possible. If patients are happier tomorrow than they are today because they are receiving more appropriate care when they need it, then we will be heading in the right direction.

Personalised care for people who need it most

Continuity of care, specifically the relationship between a named GP and their patient, is directly linked to improvements in patient experience and lower mortality, especially for more complex patients.[v,vi] This is a core strength of primary care and we repeatedly heard the fundamental importance of this from staff across primary care and patients alike.

As described earlier, not all patients want or need continuity of care; equally some patients may want continuity of care more generally but be happy to see different professionals as part of their overall care.

By managing urgent care differently and supporting the growth and development of integrated neighbourhood teams, we can create the capacity for team-based continuity, focusing specifically on those people most likely to benefit – aligned to the Ageing Well agenda, for example.

Determining which patients benefit most from more personalised continuity of care can depend on a range of medical, psychological or social reasons and should be determined through conversations with patients and using clinical judgement, as well as supported by risk stratification using the wealth of data increasingly available to primary care teams.

A personalised care approach means *'what matters to me, not what's the matter with me'.* We heard a strong message via the stocktake that we must start with people's abilities and work with them to support self-care and self-management of complex and long-term conditions.

This means shared decision-making with patients and carers and improving availability and usability of patient-held records – for example, ensuring that reasonable adjustments for people with a disability are seen and accessed by all people involved in their care. It also means the further planned expansion of personal budgets and building on the progress made to date in expanding the role of social prescribing in primary care teams.

As integrated neighbourhood teams develop, they will then play a vital role in supporting people with multiple long-term conditions, who we know benefit from a team approach,[vii] drawing in

expertise from primary care, secondary care, social care providers and the VCSE sector to ensure there is comprehensive and co-ordinated care around the patient.

Teams should be collocated and built around the needs of the local population, with a blended mixture of primary and secondary care expertise to provide holistic care for people with more complex and chronic long-term conditions. There should be easy access to a range of diagnostics from phlebotomy, electrocardiogram and spirometry to more complex diagnostics like MRI and endoscopy, without having to bring patients into hospitals, capitalising on the nationwide rollout of community diagnostic centres.

Connecting Care for Children (CC4C) is a partnership between hospital and community health providers, GP federations, PCNs, local authorities, charities, patients and citizens in north west London. Nine child health GP hubs have been set up to provide an integrated child health model of care across multiple agencies and community-based services, with GPs and paediatricians providing specialist clinical input.

MDTs come together to discuss and manage clinical cases, sharing learning on a regular basis. As these teams have matured, they have expanded and now also focus on quality improvement, planning and identifying opportunities for proactive, preventative care: for example, bringing together child health professionals and dental experts to improve children's oral health for the GP practice population. More than 35 CC4C systems have also been established across the UK.

The programme can evidence that it has improved outcomes across patient and family experience of care; staff experience and learning; population health through preventative interventions; and reducing per-capita cost.

At place level (which we recognise will often mean local authority footprints covering populations of around 250-300,000), neighbourhood teams working together and with wider system partners, will provide more intensive support to patients. This should consolidate the multitude of existing models and teams focused on discharge to assess, virtual wards, mental health crisis response, enhanced health in care homes and urgent community response to support people who are unwell to be cared for safely at home, and for those requiring hospital treatment, to ensure safe and effective transfers into and back from hospital. Carers – and the fantastic role they play as well as the additional capacity they provide – will be essential partners to these teams.

This reorientation of our existing workforce to support our most vulnerable and complex patients to stay at home and access care in the community will, over time, contribute significantly to efforts to reduce growth in hospital demand and signal a shift away from a hospital-centric model of care that is no longer suited to the population we serve.

We have seen some excellent examples of good practice from outreach work and joint MDTs for child health, to population-based approaches to management of chronic disease, and partnership working on end-of-life care. All these were characterised by strong relationships, trust and mutual understanding between primary and secondary care clinicians. Capacity and organisational development support for changing clinical models must be identified as part of the implementation of these new teams, supported by practical tools such as job planning and e-rostering across the whole workforce.

In Frimley, an anticipatory care model was introduced to support people with either moderate frailty with eight or more co-morbidities or moderate/severe frailty with no GP encounter in the last six months. The aims are to maximise people's wellbeing, maintain independence and empower people to make their own decisions about care.

People identified as eligible for anticipatory care have a holistic assessment and then comprehensive MDT review, which is led by a geriatrician. Recommendations from the MDT are based on an individual's needs and wishes. The MDT brings together a range of professionals, including older people's mental health services, social care and reablement, pharmacy, community health, occupational therapists, a geriatrician and the GP clinical lead for frailty.

There are a range of interventions provided for people on the pathway, based on what matters to them. Typical interventions include medication reviews, falls prevention, social prescribing referrals, end-of-life planning, nutritional advice and referrals to VCSE services. Anyone in the MDT is able to input into the shared care record, which is then accessible to urgent care services.

The enduring connection to people is what makes primary care so valued by the communities it serves: creating the conditions where we can use integrated neighbourhood teams to support practices by providing personalised care to those people with greatest need, and on-the-day urgent care where appropriate, keeps the connection in place for the future.

Improving urgent care and providing more personalised care to those who need it the most will be central to improving the access issues that have beset the NHS for some time now. Beyond that – and just as importantly – it will create the backdrop and headroom for local systems and teams to work together with communities to tackle the wider determinants of health.

Preventative healthcare

As a nation, life expectancy since 2010 has been stalling, while the amount of time people spend in poor health has been increasing.[viii] This trend is driven in large part by wider socio-economic determinants and a failure to address the health inequalities that result, and it masks significant variability in outcomes, especially between more affluent and more deprived areas where healthy and overall life expectancy are lower.
Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions.

People in the most deprived areas of England develop multiple health conditions 10 years earlier than people in the least deprived areas.[ix] The incidence of multiple conditions is rising; without concerted, targeted responses in our most deprived communities, progress on inequalities in healthy life expectancy will continue to stall.

We have known about the inverse care law,[x] where services are often under-resourced in areas with high deprivation compared to areas with no deprivation, for over 40 years, but efforts to address inequalities in the provision of GP services have not eradicated them.

The Core20PLUS5 approach provides a focus for reducing healthcare inequalities across systems, identifying a target population comprising the most deprived 20% of the population of England (the

Core20) and other groups identified by data (plus groups), alongside five clinical priorities for action to reduce inequalities.

Primary care already plays an essential role preventing ill health and tackling health inequalities. Through the stocktake, we have identified three areas in which primary care is taking a more active role in creating healthy communities and reducing the incidence of ill health: by working with communities, more effective use of data, and through close working relationships with local authorities.

We know that health starts at home, and we need to continue to build on successful national programmes providing lifestyle advice, from stop smoking campaigns to 'Couch to 5k'. Alcohol awareness campaigns, national messaging and campaigns on improving health and wellbeing will also remain important.

This needs to be matched with positive action in local communities; health coaches and social prescribing link workers provide a fantastic opportunity for neighbourhood teams to take a more active role in improving health, and where successfully incorporated into primary care, teams are transforming not just the lives of people and families they work with but also the culture and function of the clinical teams they work alongside. Where used most effectively, these roles can help form an effective bridge into local communities, building trust, connecting up services and galvanising the wealth of expertise in the VCSE sector.

We heard very clearly through the stocktake that the wider primary care team could also be much more effectively harnessed, specifically the potential to increase the role of community pharmacy, dentistry, optometry and audiology in prevention, working together to hardwire the principles of 'making every contact count' into more services. For example:

- on early years and children's services: working with nurseries to tackle dental caries in the under-fives and improve MMR vaccine delivery; working with school immunisation services on HPV vaccination uptake and child and adolescent mental health services; community health service teams improving diagnosis of autism and helping improve the health and life chances of children with special educational needs, as well as safeguarding
- on cancer diagnosis: community pharmacy playing a more active role in signposting eligible people to screening and supporting early diagnosis, building on a number of successful pilots such as those from the Accelerate, Coordinate, Evaluate (ACE) programme
- on positive lifestyle choices: eye checks where people are offered brief advice on alcohol and smoking and referred for smoking cessation as appropriate.

Combined with insights drawn from the community, data can empower neighbourhood teams to increase uptake of preventative interventions while also tackling health inequalities by identifying those populations and groups that may currently be underserved.

Reena Barai, a community pharmacist in Sutton, proactively attended a Director of Public Health presentation on local health and social demographics where she learned of the higher than average rates of mental health problems and suicide among young people and males in Sutton when compared to the rest of London.

Having been previously unaware of the severity of the issue locally, her pharmacy team immediately enacted a simple but crucial change in their dispensing behaviour – they endeavoured to check that any young person prescribed anti-depressants was asked how they were feeling and whether they felt the medication was helping. This opportunity to ask for help allowed many people to feel that they could talk to a pharmacist about their mental health and the pharmacy team were able to refer patients back to their GP if they felt they or the patient had concerns.

The trick for ICSs will be to normalise this sort of interaction and subsequent intervention, rather than relying on individuals going the extra mile and stumbling across crucial insights. There is also scope for efficiencies in pharmacies being able to refer onward directly, eg to mental health or other neighbourhood services.

At a place level, we have seen primary care increasingly working in partnership with local authorities (in particular public health and housing teams), local communities and other local system partners, to pool information and population health data. This means sharing expertise to understand what factors lead to poor health and wellbeing in their communities and agreeing how to work together proactively to tackle these. We have seen this type of joint working become commonplace during the pandemic, where a combination of national data tools, collaboration with local authorities and hyper-local engagement were critical success factors. This enabled teams to try different approaches to outreach and communications, get immediate feedback on what is working, and course-correct accordingly. This was essential in minimising the uptake gap by deprivation and ethnicity.

We should build on this, specifically ensuring that we have data made available to integrated neighbourhood teams on uptake of key prevention and population health measures. This will contribute to the effective co-ordination and delivery of vaccination and immunisation, screening and health checks at *place*, in line with national standards, working with NHS ICS partners, local authorities, in particular directors of public health and their teams, over the life course.

Protect Now in Norfolk and Waveney is a proactive care model which focuses on building a detailed data profile of the most deprived populations and offering tailored health interventions to meet their needs. Building on a model called Covid Protect introduced during the pandemic, it is a clinically led collaboration of more than 20 local organisations and partners including local authorities and the VCSE sector. Through the scheme, 100% of those in the top 10% most deprived areas were contacted and information about 1,764 people (49%) was collated. During COVID-19, those who engaged with Covid Protect had statistically better outcomes in terms of COVID-19 infections, mortality and admissions. This methodology has now been successfully expanded to encompass other areas such as vaccination uptake, falls prevention, pain management, diabetes prevention, cervical screening and IAPT uptake.

At a system level, ICSs, particularly through their local authority members, have the opportunity to shape and co-ordinate cross-sector efforts to support people to stay well by working with the voluntary sector, local business and education providers to provide a more consistent offer for socially excluded and most disadvantaged groups, for homeless and inclusion health services. For

example, we heard very clearly the benefit of system-level (and in some instances regional) co-ordination, and co-design of services for **inclusion health groups** will be essential to ensure equity of access and address the needs of people for whom traditional models may work less well.

This principle of equity extends to the life course approach taken through the stocktake. In particular, we heard that there is often insufficient attention and resources directed toward providing effective support for children and young people, and to people with a learning disability and autistic people. Ensuring integrated primary care models are able to effectively adapt their offer will be vital in improving health outcomes and reducing unnecessary future demands on the health service. A real measure of success for this and other ICS strategies will be whether ICSs have meaningfully improved outcomes and experience for these groups which are often not well-served by traditional models.

Creating the national environment to support locally driven change

Making the vison for integrated primary care a reality in every neighbourhood will not happen overnight, and additional workforce and resources – as much as they *are* needed – will not, on their own, get us to where we need to be.

We need a change in how national policy is designed and implemented, which pivots to enabling local teams to be supported to do the job they need to do. We encourage national partners including NHS England and DHSC to continue to consider how to create and support conditions for success and local flexibility, as determined by local leadership and delivery partners in service of local populations.

There are three major areas where we heard very clearly that with the right approach, we can make the biggest impact in creating the environment for local systems to succeed in delivering the new vision for primary care: **workforce, estates and data**.

These three policy areas are crucial to the delivery of the new model because they can enable the flexibilities on workforce that will be central to creating integrated neighbourhood teams, provide the opportunity to co-locate those teams in hubs to ensure greater accessibility for patients and a positive working environment for staff, and equip them with the information to target services where they are most needed.

It is worth noting that most of the recommendations contained in this report are by systems for systems, as well as requiring more national action on workforce, estates and data; and not all the recommendations require additional funding. It is just as important that we create an environment that *supports* local change not *dictates* it: we need to energise local ambition if the new vision for integrating primary care is to succeed.

But there is a simple reality: the pace at which we create the right environment on workforce, estates and data, both at a national and system level, directly impacts on the speed at which the model can be delivered in every neighbourhood.

Confronting workforce gaps

Primary care has never been busier, and capacity gaps lie behind most of the challenges that the NHS faces. These gaps – and the increased demand for services – were growing in the decade before COVID-19 due to workforce pressures and reduced staff satisfaction, the increasing number of people living with multiple long-term conditions, and changes in public expectations.

Layer on the demands of treating COVID-19 patients and vaccinating the nation, and we now have an extremely busy urgent care system, big backlogs of work across elective, community, mental health, social and primary care, and staff unable to offer what they think patients reasonably need. These challenges, while consistent around the country, are more pronounced in areas of greater deprivation, which risks further contributing to health inequalities.[xi]

A new care model will not magic away our workforce challenges: we need to continue to grow the MDTs in primary care and recruit and retain as many extra GPs as we can possibly get. The plain fact is that the aggregate numbers of GP full-time equivalents (FTEs) are simply growing too slowly and we will need more action at every level to address the gap.

In headline terms, the record number of trainees masks the loss of fully trained GPs, particularly experienced partners, who also on average work more hours than salaried GPs, who in turn on average work more hours than those who work solely as locum GPs.[xii] We also face a big potential retirement bulge, and as a nation we should certainly be doing all we can to encourage all our international medical graduates – who make up 40% of all our GP registrars – to settle in England as an NHS GP on a permanent basis. We also heard that looking again at the role of the GP Performers List could enable us to increase capacity if it enables other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.

Addressing the shortfall in GPs is essential and urgent. We have heard through the stocktake that there are also recruitment and retention challenges across the wider primary care workforce, particularly NHS dentistry and community pharmacy, and that there is significant variation across different parts of the country and across employers.

But the workforce picture in primary care is not all bleak. PCNs have been more successful than we all hoped in hiring extra staff in new roles. The latest data as of Q4 2021/22 shows that over 18,000 FTEs were in post by end of March 2022 – significantly ahead of the trajectory towards the 26,000 March 2024 target. This is very welcome, and progress must not stall. We welcome the clarity from NHS England that staff in post will continue to be treated as part of the core PCN cost base beyond 2023/24 when any future updates to the GMS contract are considered.[xiii]

We also heard a strong message through the stocktake that improving the supervision, development and career progression of individuals in Additional Roles Reimbursement Scheme (ARRS) roles is crucial to retain them and make the most of their skills and experience as part of integrated neighbourhood teams. We came across some great examples of practices and PCNs using additional roles to improve patient care, but we know there is variation across the country, something highlighted in the recent King's Fund report. Some local systems have not yet been able to make best use of the scheme due to a lack of local capacity for clinical and managerial supervision, inadequate space in practices, confusion around the purpose of some roles, administrative complexities, and lack of expertise on organisational development and role redesign to embed new roles.

Reforms to education and training to build our workforce pipeline will take time, and we acknowledge that there are no quick fixes when it comes to workforce supply, which is why a long-term workforce strategy is required. The forthcoming national workforce strategy should include a focus on primary care and support ICSs to deliver this report. However, what we also heard loud and clear through the stocktake is that given the right discretion and flexibility, systems can get on with building the right local teams *now*.

Systems working differently to shape their workforce

Creating the environment where we can be flexible and nimble in managing the broader workforce can provide some quick wins. Systems need the flexibility to think creatively about how they maximise the skills and experience across the current primary care workforce and elsewhere in the system. As well as working with system partners to promote education, apprenticeships and new local employment opportunities, ICSs should be supported in the process of appropriately de-medicalising 'care' to help deliver a more personalised offer for patients but also to help with immediate workforce supply issues.

Systems should also support the development and rollout of innovative employment models such as joint appointments and rotational models that promote collaboration rather than competition between employers, particularly where skills are scarce.

To support improved workforce planning, the electronic staff record or a similar integrated workforce solution, should be used throughout primary care to inform demand and capacity planning and enable team-based job planning and rostering to become the norm.

Not only will this support integrated neighbourhood teams to make more effective decisions, the aggregated data would support a greater national understanding of workforce pressures that should guide the development of future national workforce and estates strategies.

Berkshire, Oxfordshire and Buckinghamshire commissioned support to develop an online workforce planning tool for their PCNs. The aim was for general practice recruitment strategies and workforce plans to be better informed by population needs. They used quantitative and qualitative data to provide tailored insights to each PCN on how to meet population and workforce needs one, three and five years into the future. Subject matter experts, including data analysts, supported making sense of the information and identifying pragmatic solutions to current and future workforce challenges. These data packs have been used to inform targeted interventions, including maximising the use of ARRS roles. An insight paper was also provided to the ICS to inform their system-wide workforce strategy. PCNs have already requested to repeat the process next year to capture progress and develop increasingly sophisticated approaches to workforce planning.

ICSs developing system-level workforce data will also enable a better understanding of workforce pressures across primary care: for example, the impact of likely changes in GP numbers in each practice, allowing them to identify what actions they might take to improve recruitment and retention of GPs, such as GP returner and retainer schemes, GP mentors and mentorship schemes, and leadership schemes.

NHS England should work together with systems – recognising they will all have locally driven workforce plans – to identify what measures can be introduced to better *support local recruitment and training* of key community healthcare teams such as community nurses, care support, community psychiatric nurses and district nurses to work alongside primary care in integrated neighbourhood teams.

Extending the agenda beyond headcount

We do not just need to attract new staff into primary care; we need to create the backdrop that allows their roles to be reimagined and made more flexible and attractive – ultimately supporting increased participation and retention in primary care.

This was particularly evident in conversation with the next generation of primary care leaders, who are clear about the need for a sense of parity with specialist careers, a realistic work-life balance, their desire to work in MDTs, and having the ability to pursue a variety of roles to create a diverse working week and, ultimately, career.

There should be a more consistent and comprehensive training, supervision and development offer across primary care – including a focus on medical and non-medical staff and existing staff such as receptionists, practice managers and practice nurses, and retention strategies across early, mid and

late career. Systems will want to work with primary and community care training hubs to ensure 'the offer' they provide is broad enough to help integrated neighbourhood teams flourish.

We need to recognise that PCNs will only be able to meet the challenge set out in this report if they are properly supported. There should be a strong focus on supporting PCNs and GP practices with supervision of the ARRS roles and others, for example, making the most of multiprofessional and remote models of supervision where appropriate.

Birmingham and Solihull (BSoL) has a primary care 4Rs workforce strategy (Recruit, Retain, Returners and Role Allocation). This includes a PCN development plan co-designed with PCNs that complements the training hub, leadership academy and system peoples board. It supports recruitment and retention of ARRS roles across the system – for example, facilitating joint working between PCNs and Birmingham Mental Health Trust on mental health practitioner roles and integrating the community mental health transformation programme. All 29 PCNs have signed up to deliver PCN development plans for three consecutive years.

The strategy has an underpinning framework consisting of a range of joined-up and proactive workforce schemes for early, mid and late-career GPs and nurses. BSoL also has a thriving general practice Equality, Diversity and Inclusion Staff and Allies Network with over 300 members and 29 PCN health inequalities champions. In addition, there is a general practice flexible pools scheme locum bank.

These steps, taken together, will support ICSs to have a fighting chance of improving recruitment and retention in primary care going forward. But this will only get us so far.

Listening to and supporting our frontline staff

We also need to improve the experience of working in primary care for everyone by making the employment culture more compassionate and inclusive, and listening much more effectively to what primary care staff are telling us.

The NHS staff survey is already being piloted in some areas of general practice and now needs to be extended nationwide and considered for NHS-funded primary care. Identifying ways to support and listen to staff who are working as carers would also be very welcome, and primary care staff should have access to Freedom to Speak Up guardians, promoting an open and listening culture. Workforce data, staff surveys and other feedback mechanisms for staff, should be used by ICSs and local leaders across primary care to take action to improve equality, diversity and inclusion across the primary care workforce.

We must tackle racial discrimination and harassment[xiv] because it is the right thing to do, it is crucial to retain our staff, and to further strengthen how the primary care workforce reflects and strengthens its connection with the diverse communities it serves. We must value the important contribution that individuals with protected characteristics, including age, sex, religion or belief, people with disabilities, those from the LGBTQ+ community, black and minority ethnic backgrounds, and with caring responsibilities, make as part of our workforce. Ensuring flexible working and other forms of support are available to these groups and any others that experience discrimination in the workplace should be central to local, system-level and national workforce strategies.

Systems should drive a more standardised and improved employment offer for primary care in line with the NHS People Promise: for example, by ensuring parity of access to system staff health and

wellbeing hubs and occupational health services, and by encouraging employers to adopt NHS terms and conditions by sharing existing good practice and model contracts.

Investing in local leadership to drive change

The role of PCN clinical directors in the future will be essential to the leadership of integrated neighbourhood teams: and when leadership is strong and purpose is clear, retention rates improve.

More focus needs to be given to the development and support of clinical directors beyond the current basic arrangements provided through the national contract, including the local provision of sufficient protected time to be able to meet the leadership challenge in integrated neighbourhood teams.

Some systems will want to go beyond this and use even more innovative ways to support clinical directors to expand and develop their integrated neighbourhood teams, for example:

- some neighbourhood teams may offer an opportunity to develop different areas of focus and specialisation, with senior GPs serving as the 'consultant in general practice' – working across prevention, chronic and urgent care as part of wider teams
- securing the specialist input from secondary care required in neighbourhood teams, as part of job planning for consultants
- supporting community partners to operationally embed relevant teams as an integral part of existing PCN teams, recognising that the integration of community and mental health services with primary care is crucial to delivering more integrated care for patients in the community, as set out in the NHS Long Term Plan.

We also need to consider the leaders of tomorrow. Aspiring leaders already within systems and those coming though the national talent pipeline in the NHS – for example, the NHS Graduate Management Training Scheme – should, in future, be able to access development programmes that promote integrated working across systems. There should be a consistent leadership development offer accessible to primary care staff that is comparable to other NHS family providers and promotes multiprofessional leadership across the breadth of primary care. This should increase diversity across primary care and system leadership. The welcome mindset change we are seeing in the leadership of the emerging ICSs needs to be embedded and tested in what we expect of our future leaders. It is important that primary care leaders can see a career path that extends into system roles in neighbourhoods, provider collaboratives and beyond.

Suffolk and North East Essex One Clinical Community leadership development programmes aim to cross multi-organisational boundaries, support a common purpose across practitioners in the community, develop trust and improve outcomes, and build a network of effective leaders who can together address the key challenges in the wider health and social care system. Since it was commissioned in 2018, the programme has evolved to support leadership development across the eight integrated neighbourhoods teams (INTs) within the Ipswich and East Suffolk Alliance. The core members of INTs on the programme come from community services, social care and mental health, with additional participation from staff working in general practice, secondary care, charity and voluntary sectors, public health and district and borough councils. An evaluation by the University of Suffolk found that the programmes' objectives to enhance leadership skills, support personal development and for the skills and knowledge developed to be applied through the practice of integration impacting teamworking, were met.

Reimagining our approach to primary care estates

In parallel, we need to address and rethink our second capacity constraint: space.

Next steps for integrating primary care sets out a vision of integrated neighbourhood teams, providing joined up accessible care. But much of the general practice and wider primary care estate is frankly not up to scratch.

There are 8,911 premises in England, 22% of which are pre-1948 and 49% of which are owned by GPs, 35% owned by a third party, and 14% owned by NHS Property Services.[xv] Around 2,000 premises have been identified by GPs as not being fit for purpose,[xvi] and there was strong feedback throughout the stocktake that we do not start thinking about estates early enough in our planning and frequently regret it.

Estates are so much more than buildings. We must move to a model that makes estates a catalyst for integration rather than a barrier to it. This new model should focus on patient needs, create a positive working environment for staff and provide adequate space for key activities like training and team development. Creating the right environment has to start with understanding what we have got in terms of estates, something that is best undertaken locally.

In **Dorset**, the primary care estates team has undertaken an 18-month programme to pull together practice profiles for its 120 general practice sites. These profiles include ownership models, square footage, utilisation etc, and are supporting the development of a broader strategic network plan that allows PCNs and practices to take a holistic approach to estates planning.

The focus of capital investment has been weighted towards secondary care – something that now needs to change. Layered onto this is the fact that the GP owner-occupier model includes perverse incentives which can make cross-system collaboration more difficult.
As with workforce, we need to recognise that the current mindset and approach to estates need to change, and that we need to create the permissions and support for local systems to build estates models that better align with delivery of clinical, digital and workforce strategies. Despite investment constraints, there is real opportunity locally to start to deliver improvement now.

We need a detailed review of the space available in each system, service by service, to inform the ICS estates infrastructure strategies. These reviews should help us understand what we have got and what we can fix locally, as well as help us prioritise funding as and when capital becomes available.

ICSs have the reach to take a ‘one public estate’ approach and think creatively about primary care estates, considering:

- developing primary care estates plans from the perspective of access, population health and health inequalities
- making use of local authority, third sector and community assets, building on the approach to COVID-19 vaccination, including places of worship, community centres, and allotments
- making creative use of void and vacant space in the NHS Property Services and Community Health Partnerships portfolio
- opportunities for co-locating primary care when bringing forward secondary care estates plans

- pragmatic, low-cost opportunities to repurpose existing space, within local funding streams, as well as making use of the potential ability of the local authority to raise capital beyond NHS limits to fund new estates
- opportunities for locating primary care onto the high street as part of local economic regeneration.

In **Waltham Forest, north east London,** a new state-of-the-art health centre following partnership working between the borough council and local NHS has been built. The £1.4 million building, located within the Sutherland Road development in Walthamstow, is due to open in spring 2022 – providing a modern and spacious new home for GPs and other staff at the Lime Tree and Sinnott Healthcare medical practice.

The project formed part of the council's capital plan for regeneration, which included the desire to improve healthcare infrastructure across the borough, in response to demographic changes and increased local demand for primary care services.

The new purpose-built centre will enable the GP practice to relocate from its existing premises and allow it to expand its current registered list from 6,500 to 10,000 patients over the next 15 years. The new-look practice will also benefit from investment in digital technologies to facilitate self-monitoring – allowing patients to take greater control of their own care, alongside convenient access to a wider range of health services in the community.

As systems, we should already be thinking about tackling those issues that create barriers to change. 'Last partner standing' scenarios may require systems to find innovative solutions that maintain service quality and continuity when partnerships propose handing back Primary Medical Services contracts. For example, where the overall benefits to patients and avoided costs of replacing provision would justify it, there may be options such as to transfer ownership to public or commercial system partners. In scenarios such as this, NHS England needs to give permission to systems to make difficult choices, but ones which will ultimately benefit our patients and the taxpayer.

Data, data, data

Integrated neighbourhood teams can only flourish if we ensure information about patient care can be properly shared – for use in providing and improving the co-ordination of care at an individual level, and for wider planning and research. Working across the whole of primary care, PCNs should be given the tools to make routine use of population data to inform how they design care for the people they serve.
PCNs and wider neighbourhood teams need to be able to read and write seamlessly into a shared patient record that provides a single version of events for each patient with appropriate information governance arrangements in place. They also need to be able to access real-time data on demand, activity and capacity so that they are able to improve services, identify gaps and take action to redistribute resources and plan workforce accordingly.

Data sharing is often not the norm in the NHS or other public services, despite the fact that most patients expect relevant information about their care to be shared between different professionals and organisations involved in their care. A number of ICSs are already working through plans for improving data sharing in their area and working with providers collaboratively to co-produce this**,**

looking at how to best invest in the essential IT infrastructure that underpins this – including establishing IT systems that can do the difficult work of linking datasets to enable population health management.

It has always been true that if you give clinicians the data they will respond. Systems can enable this by putting in place a local transformation function which includes joined-up intelligence, improvement and other support functions with a deep understanding of primary care, organised and funded at system or place level, but wholly orientated to provide support for their neighbourhood teams.

System P in Cheshire and Merseyside utilises multiple sources of intelligence to categorise population segments, and then explore the way in which these different groups of people interact with health and care services, and whether their needs are being met in the most effective and person-centric way. The initial focus is on two priority segments: Complex Lives and Frailty & Dementia, both of which have a unique set of needs and risk factors, which must be taken into consideration if outcomes are to improve. Partnership working with the University of Liverpool and utilisation of the CIPHA (Combined Intelligence for Public Health Action) platform is putting both the data and expertise in place.

For much of the country, neither of these things exist and need to be put in place. As part of this, systems will need to consider how they can develop sufficient expertise in data analytics at the right level, including retraining existing staff and planning to increase recruitment in key roles. This means a change of mindset – from a previous focus on using data to inform commissioning and monitoring of contracts, to a two-way process of using data to drive improvement.

Systems have a role to play in articulating a clear plan for data sharing across the system to support the development of population health management approaches at neighbourhood and place level, enabled by a clear information governance framework and work closely with providers and patients to co-produce data sharing agreements where appropriate.

Creating the digital infrastructure needed to underpin integrated primary care

Digital technology has the potential to transform how people access primary care, how services are delivered and how we plan care to better meet the needs of local communities. Often, however, the underlying infrastructure to enable this transformation is lacking – with wide variation in digital maturity, knowledge of digital transformation and procurement across and within systems.

In Brent, London, 20 practices created a centralised 'eHub' for online consultation management. The eHub supports practices to manage increasing levels of patient demand; leverage economies of scale; share existing and additional workforce, resources and flex capacity; optimise additional roles by distributing work to the right person; collaboration and peer support.

The eHub enables clinicians to view patients' 'home' practice records and write to the 'community' record. Notes are shared with the 'home' practice through a 'discharge summary'.

The eHub closes around 90% of online consultations. Face-to-face appointments remain available through patients' 'home' practice and local, face-to-face extended access hub. Many patients reported that they like the improved convenience and speed of the new online access system. The eHub helps reduce pressure on 'home' practices, reduce patient waiting times and enables a faster response. Most requests sent to the eHub are 'closed' by it, increasing time for practices to focus on patients with more complex needs.

During the pandemic, digital technology played an increasingly important role in maintaining services for patients who were happy to use it. We also learned that we can roll out digital technology at pace when circumstances demand. Having created a greater appetite for digital services – both among patients and staff – we should continue to offer a greater diversity of services in this way.

ICSs have a vital role to play in developing a more coherent approach to digital transformation in primary care that focuses on improving patient experience and outcomes. Some are already conducting baseline assessments of the current state of digital infrastructure in their area and understand current needs and gaps and exploring how cloud telephony and online consultation tools, for example, can help to deliver more streamlined systems for accessing general practice.

ICSs can support the development of more interoperable IT systems by following 'what good looks like' principles and the GPIT operating model when making decisions about IT investments and products, and they can leverage their larger scale and purchasing power to improve value for money and quality of service.

Systems will also have a vital role in providing a digital training offer for clinical and non-clinical primary care staff. They will need to consider how digital expertise and leadership inform decision-making at every level. Some have already chosen to appoint a chief information officer (CIO) or chief clinical information officer (CCIO) at executive level, as well as named leads for primary care digital transformation. Digital transformation needs to be embedded as part of a more holistic approach to primary care transformation.

Critically, decisions about digital infrastructure in primary care need to be made in partnership with those who will use them – including engagement with both staff and patients. Ensuring that potential barriers to using digital tools, such as digital exclusion, are understood and addressed will be particularly important. Establishment of digitally enabled primary care hubs on a neighbourhood footprint will be a priority.

Hard-wiring the system to support change

Throughout the course of the stocktake we had a number of themed working groups with expertise from every part of the system coming together to think about the kind of changes we would need to see both to inform the new model but critically how to make it deliverable.

There are a range of near-term and longer-term actions – for systems, national organisations and government – that we can be getting on with now to directly support the delivery of the new model.

Taken together the actions outlined in this section will not just create the conditions for the new vision of integrated primary care to succeed, they will create a common sense of purpose for the ICSs to maximise the impact of new ways of working that the reforms create the opportunity for.

The recommendations in this section are by no means exhaustive and while the majority of this report places the onus on new ICSs to deliver the new model, this can only be done if national policy aligns to enable them to deliver it. To that end, we encourage national partners/DHSC and NHS England to undertake further work to consider the existing legislative, contractual, commissioning, and funding frameworks, which were out of scope for this stocktake. This work should consider what further changes could enable and incentivise this integrated model of care and new models of primary care; and how to improve equity in distribution of resource to ultimately improve health outcomes.

Workforce

The forthcoming national workforce strategy should focus on primary care and identify the wider skills and roles required for successful neighbourhood and place-based teams. This strategy should build on Health Education England's (HEE) Strategic Framework 15 and must inform any future national estates plans to ensure adequate space for training, development and service provision. NHS England should simplify guidance and address common misunderstandings regarding ARRS, as well as consider further flexibilities that could be introduced that support recruitment in the short term. NHS England should work with DHSC and HEE to consider how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it.

The NHS Staff Survey should be rolled out nationally across primary care, building on current pilots in general practice to provide parity across the NHS family – as soon as funding permits.

Estates

DHSC and NHS England should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues, and practical support to work through them, as well as building ICS estates expertise. DHSC and NHS England should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.

The estates reviews, aided by the national plan, are central to creating coherence across services and sectors, and they should drive the transition to a modern, fit-for-purpose primary care estates offering – including future development of hubs within each neighbourhood and place to co-locate

integrated neighbourhood teams, as well as linking into the wider rollout of community diagnostic hubs, for the provision of more integrated services.

Data and digital

National action is needed to help put in place the data and digital infrastructure necessary to transform primary care.

NHS England will need to work with ICSs and IT suppliers to ensure business intelligence tools and timely data are made readily available to practices and neighbourhood teams in an easy-to-use format, supported by the development of real-time data visualisation and standardisation of approaches to data to enable comparability tools.

NHS England can also support ICSs to improve data sharing for direct care, service improvement and research by publishing a revised national template data sharing agreement, making clear that practices will not be liable for General Data Protection Regulation breaches relating to data shared under the agreed terms – an issue that is proving a barrier to setting up such agreements in some areas. It will also need to provide systems with guidance on minimum standards for procurement of analytical software and ensure training, tools and a comprehensive support offer are available.

Both NHS England and systems need to work together to engage both communities and staff in why sharing data is so important and will help improve patient care.

Access

NHS England should consider the implications of a neighbourhood-based approach to urgent same-day access in future national guidance on the wider urgent and emergency care pathway, specifically NHS 111 and integrated urgent care.

NHS England should consider the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.

Pivoting to locally led investment and support

This report marks a strategic pivot to system-led approaches as a key way of driving up access experience and outcomes in primary care.

National contractual arrangements, including for PCNs, have provided essential foundations including for chronic disease management and prevention. But they can only take you so far. As already highlighted in the report, getting to integrated primary care is all about local relationships, leadership, support and system-led investment in transformation.

ICSs putting in place the right support locally will be enabled by maximising what control ICSs have over the direction of discretionary investment. This should be looked at by NHS England as part of the implementation of recommendations.

It is also generally accepted that the distribution of primary care funding to neighbourhoods is not always well aligned to system allocations and underlying population health needs – and we need a concerted local effort to try and fix this. ICS leaders have already started to review discretionary investment in primary care to address this issue, working with clinical colleagues to understand the data and make the case for alternate approaches**.**

ICBs have an opportunity to establish a firm understanding of current spending distribution across primary care weighted by deprivation and other elements of the Core20PLUS5 approach, which can then inform discussions on how discretionary investment can be more purposefully directed to address health inequalities and form the basis of work to secure collective commitment from all system partners to this redistribution.

In Leicester, Leicestershire and Rutland action has been taken to address inequalities in the existing primary care funding model, which is primarily driven by age and gender and not reflective of actual patient need at practice level. They are also tackling disparities in service provision; a population health-based model found that underfunded areas were the most deprived.

The new model calculates practice payments by setting aside the core staff components, based on the current practice core contact income. The remainder of core contract funding and other funding in the model is distributed to practices based on needs and deprivation (90:10). As a result, approximately £3 million was identified to rebalance a fairer level of baseline funding across all practices, based on need and demographics, and the model enables future investments in primary care to be transparently distributed at practice and place, based on population health need.

Beyond national contract entitlements, there are also too many small national pots of programme and system development funding money, ringfenced for particular purposes, which undermines how efficiently resources are allocated. NHS England should consider combining and simplifying central programme and transformation budgets for primary care.

Backing existing practices and new models of provision for primary care

The successful delivery of the new model can only be optimised if systems ensure they bring GP practices of all different shapes and sizes with them. We need to recognise that maintaining stability in general practice will be central to being able to deliver the new model of integrated care.

We need to ensure the right arrangements are in place to support primary care where it wants to work with other providers at scale by establishing or joining provider collaboratives, GP federations, supra-PCNs, or working with or as part of community, mental health and acute providers. Both the contract and funding arrangements were out of scope of this review. But it is clear that changes to these could support this vision. We recommend that DHSC and NHS England rapidly undertake further work to understand how changes to these could support the implementation of integrated and new models of primary care.

Where there are gaps in provision, or individual providers are rated ‘inadequate’ by CQC, ICSs should provide tailored support to practices to improve and, where appropriate, actively commission new providers of integrated list-based primary care, in particular for the least well served communities. ICSs should more generally also provide a primary care support offer for all providers, that includes a focus on quality improvement.

The role of ICSs in supporting the development of integrated primary care as part of a national support and development offer should be explicit with accountability for delivery of integrated primary care reflected in the ICS accountability framework, including the respective roles of ICS and place-based leaders.

Enabling primary care at a system level

System-level expertise on primary care should go beyond contracting to building relationships and developing capabilities within systems as they build their new teams. We heard throughout the stocktake of the importance of a core set of capabilities to support improvement and transformation, with quality improvement; digital, data and analytics; understanding local communities and user experiences; physical infrastructure; workforce planning and transformation; service design; and the development of the primary care provider landscape coming up most frequently.

These key primary care capabilities need to be in place for all systems, but not all need to be provided in-house – some may be brokered or commissioned from other providers at scale: eg GP federations, acute, community or mental health providers, or commissioning support services.

Dudley Integrated Health and Care NHS Trust (DIHC) was created in 2020 by local GPs to provide out-of-hospital care by integrating primary care with community-based services and providing strategic and operational support. Forty-one practices signed an integration agreement with DIHC, committing general practice to deliver a primary care operating model in return for DIHC providing wider workforce and support to enable the model and the Dudley Quality Outcomes Framework to be achieved.

Primary care is at the centre of all DIHC planning and development. Through a management agreement, DIHC supports the running of services and provides a turnaround team to address quality of service or management issues. DIHC produces workforce and estates plans on behalf of the PCNs each year, which PCNs tailor to their population's needs. DIHC employs, trains, supervises and operationally manages all ARRS staff on behalf of PCNs and has established a pharmacy team of 50 to support all practices.

DIHC working with primary care is improving population health outcomes, providing a consistent service offer and supporting delivery of a sustainable model of general practice by providing support though extended access, community services, care home support, and PCN Direct Enhanced Service delivery. Dedicated management capacity and clinical leadership capabilities support primary care planning and development and enable the development and expansion of the range of commissioned services.

All systems should carefully consider the breadth and level of their organisational capacity and capability to turn this framework for integrated primary care into local reality, taking account of responsibilities for commissioning NHS community dentistry, pharmacy and optical services from April 2023.

Embedding primary care leadership throughout systems

ISCs come into being on 1 July this year and have the opportunity to ensure that primary care is deeply embedded in the new governance arrangements they are designing. There are some well-established existing forums for bringing clinical leaders and professions together, in particular for general practice.

ICSs will want to ensure that primary care leadership across all four pillars is embedded across systems – this might be through the creation of a primary care forum or network with credibility and breadth of views to be able to advise the ICS. Building relationships with existing local professional

committees across all four pillars of primary care, such as *local medical, pharmaceutical, dental and optical committees and primary care audiology,* will ensure the support and collaboration of key local leaders in improving access, experience and outcomes for patients and communities.

To ensure that primary care and the views of the communities it works in are heard throughout systems, integrated neighbourhood teams should be well linked to – and represented on – all place-based boards. The connections integrated neighbourhood teams will build both with their respective communities and between them will be invaluable in the planning and decision-making that happens at a place board.

The Black Country and West Birmingham Primary Care Collaborative was established to promote the interests and sustainability of primary care services and ensure a single voice for primary care in decision-making at all levels within the ICS.

It represents grassroot primary care views, and in turn reflects patient and public needs and focuses on tacking inequalities in the planning and delivery of services.

It joins all primary care professionals at a Black Country level, including GP practices, GP federations, primary care providers, local medical committees and PCNs. The collaborative plays a leading role in the design and development of the ICS primary care transformation strategy and acts as an expert reference group to the ICB around primary care issues.

In its next phase, other independent contractors (including pharmacy, optometry and dentistry) will be included as delegation of statutory responsibility shifts to the ICS and is also intended to extend to include community services.

Conclusion

Throughout this stocktake I have been overwhelmed by the energy, hope and appetite for improvement and change that exist today in the NHS. This is all the more remarkable given what everyone has been through for the last two years in supporting patients, families and neighbourhoods through the pandemic.

There is real evidence that the experiences of individuals and teams over the last two years – alongside the enormity of challenge we face in recovery – are forging a new determination to work together to fix the issues that sometimes hold us back from delivering the best services and care.

We arrive at this moment with an opportunity – through the creation of ICSs – to be brave in embracing new ways of working: to reimagine how we might deliver care in the future. To organise ourselves differently and better. To work together, no matter what part of the NHS we're in.

We've learned through the pandemic the true value of bringing people together and working in partnership to come up with local solutions. Communities up and down the country rallied as they never have before to support the COVID-19 vaccination programme and save lives. Harnessing that energy and working with those same communities to rebuild services to be more effective in delivering what they need has to be at the heart of everything we do.

That's why shifting our focus now onto developing integrated neighbourhood teams, places and systems gives us such a great opportunity to build a new, more effective health service designed with our communities to fit their needs.

We also arrive at the point with a growing belief in how we can use digital and technology much better than ever before. The rapid development and rollout of technology-based solutions to support remote care during the pandemic helped all of us to realise the rapid opportunities this presents. More and more people want to use apps and mobile devices to support their healthcare – and this doesn't have to be at the expense of face-to-face care, indeed as this stocktake shows, providing technology-based services for those who want them can free up more time for face-to-face care for those who need it.

Our biggest challenge is creating the conditions by which local change can happen – and that's going to require pivoting away from top-down directives and creating an environment that supports local change, not dictates it from the centre.

Ensuring local systems can access the right data to support the integrated neighbourhood teams to help primary care enhance the services it can provide is a good example. We also need to change step on how investment and financial support flows through the system. More new money is always welcome, but as a minimum every effort should be made to create as much local flexibility around discretionary funding as possible. That won't just support local teams to shape services in a way their communities want them to, it will help them create the right incentives to being GP practices of all shapes and sizes with us on this journey.

The glue that holds all of this together is leadership: investing in leadership at PCN, place and system level will be the difference between success and failure in integrating primary care. The talent pool that exists in primary care is vast: supporting and nurturing that talent to be innovative, brave and collaborative in leading the changes outlined in this stocktake will help to reignite appetite for change and improvement in neighbourhoods right across the NHS.

Very little of what is outlined in this stocktake is easy to deliver: I wouldn't have been asked to undertake this work if it were. But the prize of delivering the ideas outlined in this document is greater than just improving the experience, access and outcomes of primary care: I believe that working this way we can strengthen trust within the NHS and rebuild confidence in the services it provides.

Dr Claire Fuller

26 May 2022

Annex: Framework for shared action

1	**Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices.** This should be for all patients clinically assessed as requiring urgent care, where continuity from the same team is not a priority. Same-day access for urgent care would involve care from the most clinically appropriate local service and professional and the most appropriate modality, whether a remote consultation or face to face.	ICSs
2	**Assist systems with integration of primary and urgent care access,** specifically looking at the role of NHS 111, and considering the development of new metrics and standards on urgent and routine access, and introduce as planned, the new patient-reported experience measure for access to general practice.	NHS England
3	**Enable all PCNs to evolve into integrated neighbourhood teams**, supporting better continuity and preventive healthcare as well as access, with a blended generalist and specialist workforce drawn from all sectors. Secondary care consultants – including, for example, geriatricians, respiratory consultants, paediatricians and psychiatrists – should be aligned to neighbourhood teams with commitments reflected in job plans, along with members of community and mental health teams. With teams collocated within neighbourhoods, to extend models of personalised care, embed enhanced health in care homes and develop a consistent set of diagnostic tests. At place level, bring together teams on admissions avoidance, discharge and flow – including urgent community response, virtual wards and community mental health crisis teams. Focus on community engagement and outreach, across the life course. Proactively identify and target individuals who can benefit from interventions in neighbourhoods, committing to delivering neighbourhood teams first for Core20PLUS5 populations. Co-ordinate vaccinations, screening and health checks at place level, in accordance with national standards.	ICSs
4	**Co-design and put in place the appropriate infrastructure and support for all neighbourhood teams**, across their functions including digital, data, intelligence and quality improvement, HR, finance, workforce plans and models, and estates. Specifically put in place sufficient support for all PCN clinical directors and multiprofessional leadership development, and protected time for team development. Baseline the existing organisational capacity and capacity for primary care, across system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions.	ICSs

5	**Develop a primary care forum or network at system level**, with suitable credibility and breadth of views, including professional representation. Ensure primary care is represented on all place-based boards.	ICSs
6	**Embed primary care workforce as an integral part of system thinking, planning and delivery.** Improve workforce data. Support innovative employment models and adoption of NHS terms and conditions. Support the development of training and supervision, recruitment and retention and increased participation of the workforce, including GPs.	ICSs
7	**Include primary care as a focus in the forthcoming national workforce strategy to support ICSs to deliver this report (NHS England).** Recognising this is not currently funded, commit to future rollout of the NHS Staff Survey in primary care. Examine further flexibilities, and better communicate existing flexibilities, in the Additional Roles Reimbursement Scheme. Specifically consider, with DHSC and HEE, how the scheme should operate after March 2024, including the role of ICSs in working with national colleagues and PCNs in delivering it. Review the GPs Performers List to enable other appropriately qualified clinicians to contribute more easily as part of the primary care workforce.	DHSC with NHS England and HEE
8	**Pivot to system leadership as the primary driver of primary care improvement and development of neighbourhood teams in the years ahead.** Move to greater financial flexibility for systems on primary care. Bring together existing national primary care funding wherever practicable. Beyond 2023/24, maximise system decision-making on any future discretionary investment, beyond DDRB and pay uplifts.	NHS England
9	**Improve data flows** including by (i) solving the problem of data-sharing liability, issuing a revised national template; (ii) working with system suppliers on extract functionality; (iii) improving data to support access (actions 1 and 2 above), and (iv) helping to identify population cohorts to be targeted by neighbourhood teams.	NHS England
10	**Develop a system-wide estates plan to support fit-for-purpose buildings for neighbourhood and place teams delivering integrated primary care**, taking a 'one public estate' approach and maximising the use of community assets and spaces.	ICSs
11	**DHSC and NHSE should provide additional, expert capacity and capability to help offer solutions to the most intractable estates issues,** and practical support to work through them, as well as building ICS estates expertise. DHSC and NHSE should consider what flexibilities and permissions should be afforded to systems to allow shaping and influencing of the physical primary care estate, including through reviewing the Premises Cost Directions. DHSC	DHSC and NHS England

	should ensure that primary care estate is central in the next iteration of the Health Infrastructure Plan.	
12	**Create a clear development plan to support the sustainability of primary care and translate the framework provided by *Next steps for integrated primary care* into reality, across all neighbourhoods.** Ensure a particular focus on unwarranted variation in access, experience and outcomes. Ensure understanding of current spending distribution across primary care, compared with the system allocation and health inequalities. Support primary care where it wants to work with other providers at scale, by establishing or joining provider collaboratives, GP federations, supra-PCNs or working with or as part of community mental health and acute providers. Tackle gaps in provision, including where appropriate, commissioning new providers in particular for the least well-served communities.	ICSs
13	**Work alongside local people and communities** in the planning and implementation process of the actions set out above, ensuring that these plans are appropriately tailored to local needs and preferences, taking into account demographic and cultural factors.	ICSs
14	In support of systems, **set out how the actions highlighted for NHS England will be progressed.**	NHS England
15	DHSC and NHS England should rapidly undertake further work on the **legislative, contractual, commissioning, and funding framework** to enable and support new models of integrated primary care. This work should also consider how to improve equity in distribution of resource and ultimately improve health outcomes.	DHSC and NHS England

Workstream and task and finish group chairs

This stocktake has been informed by invaluable insights from nine workstreams and four task and finish groups, the Chairs of which endorse its findings

Professor Simon Gregory
Deputy Medical Director, Primary and Integrated Care, Health Education England
Chair, Workforce, people, leadership, education and training workstream

Dr Neil Modha
GP Partner and Chair of Greater Peterborough Network GP Federation
Chair, Data, pop health data, demand & capacity, risk stratification and health inequalities workstream

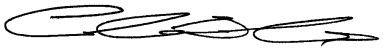
Fatima Khan Shah
Associate Director, Long Term Conditions and Personalisation, West Yorkshire and Harrogate Health and Care Partnership
Chair, Engagement with people and communities workstream

Thirza Sawtell
Managing Director/ Integrated Care, St George's, Epsom and St Helier Hospitals and Health Group
Chair, Governance & decision-making workstream

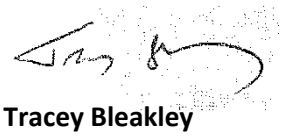
Dr Harpreet Sood
Non-Executive Director, Health Education England, and founding board member, Digital Health London
Chair, Non-physical access and digital workstream

Jan Thomas
Chief Executive Designate, Cambridge and Peterborough ICS
Chair, Physical access and estates workstream

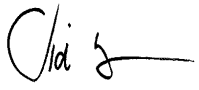
Joanna Killian
Chief Executive, Surrey County Council
Chair, Start well lifecourse workstream



Glen Burley
Chief Executive, South Warwickshire NHS FT, Wye Valley and George Eliot NHS Trusts
Chair, Live & work well lifecourse workstream



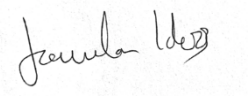
Tracey Bleakley
Chief Executive Designate, Norfolk and Waveney Integrated Care System
Chair, Ageing and dying well lifecourse workstream



Dr Nick Broughton
Chief Executive, Oxford Health NHS Foundation Trust
Chair, Mental health task and finish group

Daniel Elkeles
Chief Executive, London Ambulance Service
Chair, Urgent and episodic care task and finish group

Professor Kevin Fenton
Regional Director for the London Office of Health Improvement and Disparities
Co-Chair, prevention task and finish group



Dr Jaweeda Idoo
Clinical Champion for Personalised Care, Greater Manchester Health and Care Partnership
Co-Chair, prevention task and finish group

Rob Webster
Chief Executive, West Yorkshire Health and Care Partnership
Chair, Learning disability and autism task and finish group

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[xi] 'Levelling up' general practice in England - The Health Foundation; Build Back Fairer: The COVID-19 Marmot Review - The Health Foundation; and socio-economic inequalities in access to planned hospital care - 210513.pdf (strategyunitwm.nhs.uk)

[xii] General Practice Workforce - NHS Digital: the comparison between contracted hours can be calculated by dividing the FTE figures by headcount for each individual or for each staff role – based on the March 2022 data, GP partners work an average of 85.5% of FTE, salaried GPs an average of 64.0%, and regular GP locums an average of 40.9% in a general practice setting.

[xiii] Update to the GP Contract agreement 2020/21 – 2023/24 (2020)

[xiv] Pan-LondonDiscriminationRacismPrimaryCareSurvey_Final.pdf

[xv] Primary Care Estates Data Gathering Programme

[xvi] NHS Property and Estates (publishing.service.gov.uk)

ACCESS TO MEDICAL APPOINTMENTS

Headline report

SCOPE OF REVIEW

This review examines access to Primary Care, as well as Urgent and Emergency Care, with an emphasis on the former.

The review was conducted in order to respond to :

i. difficulties accessing doctor appointments

ii. concerns that the pandemic had precipitated a switch to greater use of online and telephone consultations, which was not always welcomed by patients, or appropriate.

iii. hospital emergency departments' waits were too long

The review took place during a period of change as the new integrated health partnership arrangements at the South East London level and borough level are formally constituted and delivered at an increasingly local level.

CONTEXT - INTEGRATED CARE SYSTEM

The review took place during a period of change as the new integrated health care partnership arrangements at the South East London level and borough level are formally constituted and delivered at an increasingly local level.

OUTCOMES

A. Residents know what to expect from the local system – where and how to be seen for their conditions whether urgent/serious or not.

B. Providers ensure that their appointment and care systems can be navigated equally by patients and residents can get timely care.

C. Residents and Providers are able to offer care in a way that best meets people's needs, including face to face, and that the right balance is found in the use of new technology.

D. Public and councillors to know how to feedback when experience is not good and that this will be taken into account and lead to improvement.

E. The health system that operates well so that needs are met as much as well as possible within available resources

F. The scrutiny review feeds into work that Partnership Southwark is doing to engage with residents in order to build trust local and use feedback to improve performance

BACKGROUND – SYSTEM PRESSURES

Health services, both Primary Care, and Urgent and Emergency services, are under pressure for a variety of reasons:

i. Winter pressures : paediatric Strep A, Covid 19 , flu
ii. Pandemic recovery – backlog of hospital care
iii. Pandemic burn out
iv. Staff shortages of GPs in particular but also social care and other health practitioners
v. More ill health; life expectancy has been stalling since 2010, while the amount of time people spend in poor health has been increasing

SYSTEM CHANGE

I. South East London Integrated Care System (ICS) and its governing body, the Integrated Care Board (ICB) was established by statute in the spring of 2022. This covers the 6 boroughs of Southwark, Lambeth, Lewisham, Greenwich, Bexley and Bromley.

II. Partnership Southwark brings partners together and commissions services , aiming to work together to improve the health and wellbeing for the people of Southwark

III. Neighbourhood multidisciplinary teams (MDT), which will bring local surgeries together with social care, the community and other partners in the localities

NHS IS CREATING MORE SPECIALIST FRONTLINE ROLES LOCATED IN PRIMARY CARE NETWORKS

Additional Roles	Current (WTE)	Prospective (WTE)	Current (WTE)	Prospective (WTE)
	North PCN		South PCN	
Clinical Pharmacist (exclude Advanced Practitioner)	6.3	0	10.1	0
Advanced Practitioner	2	0	0	0
First Contact Physiotherapist	2	0	0	0
Physician Associate	0	0	1	1
Social Prescribing Link Workers	12.6	0	9	0
Nursing Associates	4	0	0	0
Trainee Nursing Associates	6	0	0	0
Mental Health Practitioners	1	1	1	1
Care Co-ordinators	0	12	0	0
Health & Wellbeing Coach	0	5	0	4
Paramedics	0	0	1	0.8
Total	**33.9**	**18**	**22.1**	**6.8**

OUTCOME A

Residents know what to expect from the local system – where and how to be seen for their conditions whether urgent/serious or not

COMMUNICATION

The recent move to an expanded Primary Care offer, with a broader range of frontline practitioners is not widely understood by local residents.

It is also unclear if people are widely aware:

I. that it is possible to access Out of Hours appointments at two local hubs

II. that 111 can now make appointments

III. how to access the Wellbeing Hub for mental health needs, which people can self -refer and obtain assessments

IV. pharmacies now have a broader role in treating common ailments and providing health advice.

RECOMMENDATION ONE

Conduct a communication and engagement campaign explaining local integrated health services, where and when visit to Primary, Urgent and Emergency care, as well as services such as the Well-being Hub. This to include a user friendly description of the below:

- Primary Care practitioners and their roles
- South and North Primary Care Networks and move toward integrated neighbourhood teams working in partnership with social care and the community – keeping this updated and in plain English
- Out of hours GP hubs remit and how to access an appointment
- How to make best use of Pharmacies
- When to use 111 (including information on accessing a urgent doctor appointment)
- When and how to use Urgent Care Centre (Guys etc.)
- When to go to Accident and Emergency (GSTT and Kings)
- The role of the mental health Wellbeing Hub and what they can do – including assessments

Include the following in promotion methods:

- GP surgeries waiting area
- Southwark Partnership website (in part to increase understanding and transparency on how local health and integrated services are delivered)

OUTCOME B

Providers ensure that their appointment and care systems can be navigated equally by patients and residents can get timely care.

GP APPOINTMENTS

I. Complaints from residents about being stuck in 8am morning telephone queues for an hour and, and then still not being able to access an appointment , and then waiting in for a call back which might or might not happen.

I. People who are elderly, have mental health issues, young children, or where English is not the first language were of particular concern. These groups cannot necessarily make use of digital or phone systems.

II. Digital and phone options working for some and reliving pressure. Data shows a mixed picture with most people still very happy or fairly happy

RECOMMENDATION TWO

Develop a best practice appointment model that will allow equitable and safe access for all, with particular care taken to:

- ensure that patients are not repeatedly turned away
- there are alternatives to early morning telephone booking systems
- that a combination of face to face, telephone, and digital appointment systems are provided to
- flexibly meet the needs of all sections of the community, particularly those with additional needs (mental health, disability, older, parents of young children, language barriers)

RECEPTIONISTS

I. Receptionists have important role in ensuring that patients have good experience
II. Healthwatch report and Café Conversation event heard that some seem rushed, have a poor manner or are unable to explain the system adequately

RECOMMENDATION THREE

Recognise and value the importance of GP Practice receptionists and invests in guidance / training to ensure that they are appropriately guided and supported on how to screen patients, can provide an effective service and relate to patients with empathy. Attention also ought be paid to ensuring receptionists are not overworked.

TRIAGE OF PATIENTS

Primary Care Network GP leads told the commission that vulnerable people are identified as high needs, and this includes older people and those with mental health needs, however they are yet able to identify the high needs of callers.

The Fuller Stocktake report gave an example of identification and streaming patients by the Foundry Health Centre in Sussex .Patients are streamed using systematic triage and clinical judgement and identified as green (generally well – continuity less important), amber (long-term conditions – continuity important; appropriate reactive care delivered), and red (vulnerable or complex – continuity paramount; proactive care given).

RECOMMENDATION FOUR

Build on local and national good practice, particularly in triage / screening of patients by need and building this into the appointment system

OUTCOME C

Residents and Providers are able to offer care in a way that best meets people's needs, including face to face, and that the right balance is found in the use of new technology.

FACE TO FACE V TELEPHONE & VIDEO

I. Third of appointments now telephone and just under 1/20 online
II. Many people distrusted and/ or had poor experience of diagnosis over the phone – they wanted to be seen face to face
III. More acceptance of online or telephone appointments once a relationship was established or to triage
IV. Digital repeat prescriptions working for many
V. Greater use of online mental health appointments had increased capacity

RECOMMENDATION FIVE

In finding a balance between face to face, telephone and video appointments these are recommended as guides:

- Telephone and video calls are reserved for triage, situations where a relationship has already been established face to face, and/ or where it is clearly the patients preference
- Face to face is the primary and preferred method for diagnosis of new conditions

OUTCOME D

Public and councillors to know how to feedback when experience is not good and that this will be taken into account and lead to improvement.

PUBLIC COMPLAINTS

Healthwatch conducted a survey in its report and found that not all GP Surgeries websites clearly indicate how to complain.

RECOMMENDATION SIX

Ensure all local surgeries website clearly indicate how to patients can complain directly and how to escalate to commissioners if still unresolved.

COUNCILLOR FEEDBACK

In the course of the review concerns (and compliments) about named surgeries have been passed onto Commissioners

National reviews of failing services, such as the Francis Report on Mid Staffordshire, recommend that bodies with oversight of services, such as scrutiny, Healthwatch and Commissioners share intelligence and develop a template to do this

RECOMMENDATION SEVEN

Partnership Southwark, health scrutiny and Healthwatch consider drawing up a template for councillors to report concerns as part of a protocol to guide relationships and share intelligence

OUTCOME E

The health system that operates well so that needs are met as much as well as possible within available resources.

GP SUFFICIENCY

Having sufficient GPs is still important to ensure there is enough local capacity and there is concern that doctors are overstretched

Southwark has higher patient to care ratios than most, following decreases in GPs over the last few year.

Southwark GPs have increased their patient ratios by 31%, which makes them the borough with the largest increases across South East London

Despite this local GPs are delivering more appointments than most

Nationally the GP workforce capacity is reducing as there are less doctors and also more working part time as part of a portfolio career.

Southwark can usually attract more newly qualified GPs , but there are difficulties with retention as GPs leave the borough for housing when they want to start a family.

RECOMMENDATION EIGHT

Actively seek to recruit and retain more GPs to Southwark and to the new Primary Care roles by:

- Including this as an objective within SEL workforce programme.
- Undertake work with local GPs and local Primary Care to understand more on how to improve retention, with particular regard to housing and addressing the national problem with burnout and low morale, and if there are opportunities within Southwark Partnership and SEL to retain more local GPs for longer
- Redirect more resources to Primary Care , where possible

MENTAL HEALTH AND GP ACCESS

I. Concerns about links with secondary care and the difficulty of ensuring a referral to a specialist is followed up on - especially for people who cannot advocate for themselves

II. Navigating GP appointment systems , particularly early 8am appointment calls , is difficult and stressful

III. Accident and Emergency rooms are very difficult for people in crisis and good preventative care is the best way to prevent this

IV. Newly commissioned sanctuary service at the well regarded Well-Being Hub

RECOMMENDATION NINE

Increase focus on continuity of care for people with enduring Mental Health conditions and particularly ensuring that there is good links with secondary care and referrals are followed through for those people who are least able to advocate for themselves.

PROACTIVE, HOLISTIC APPROACH TO HEALTH

South East London Integrated Care System (SEL ICS) and Partnership Southwark both have a focus on proactive health care, saying that "We need to become much better at helping people to stay healthy and well" , and is seeking to reduce health inequalities.

Fuller Stocktake report spoke of making a cultural shift towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community, and residents also advocated for this.

A more proactive approach to addressing the increased loneliness and isolation that has come out of the pandemic, which has impacted older people and people with mental health conditions, could be taken by linking up with the voluntary sector.

Southwark has an active community and voluntary sector such as Southwark Pensioners Centre, Copleston Centre, Walworth Living Room, and historic initiatives such as Peckham Experiment focusing on taking a proactive approach to population health.

RECOMMENDATION TEN

Work with the local voluntary and community sector to develop a more proactive and holistic model of good health , by piloting a scheme in a neighbourhood with higher levels of deprivation and focusing on groups at particular risk of ill health , such as older people, people with mental health.

Agenda Item 11

Responses to questions from the Health and Social Care Scrutiny Commission regarding the closure of Queen's Oak Nursing and Annual Care Home Cabinet Report

1. Background

1.1. Members of the Health & Social Care Scrutiny Commission requested an 'informal briefing on Queens Oak nursing home closure' and 'broader information on Care Home quality and provision'.

1.2. The Health & Social Care Scrutiny Commission shared questions (in *italics*) to inform the requested briefing and the responses are set out below.

2. Queens Oak nursing home closure

2.1. *At what point did the Council learn of Excelcare's plans to close down Queen's Oak nursing home?*

The Council was notified of Excelcare's decision to close Queens Oak on 30 September 2022.

2.2. *In the 12 months prior to the home closing down, how many visits / inspections from any of the following external bodies took place at Queen's Oak: Council staff / CQC / Healthwatch / Age UK lay inspectors? Did any of the above bodies pick up that the home was struggling in any way in the 12 months prior to its closure?*

The CQC visited on 24 November 2020 with a rating of 'Good'. The last CQC inspection took place on 29 September 2022 with an overall rating of 'Requires Improvement'; and the same rating in two areas: 'Is the service safe?' and 'Is the service well-led?'

The CQC inspection took place due to 'concerns being raised over the management of medicines'. The CQC report was published on 23 November 2022, after the provider informed of their intention to close. The council was not informed of the inspection by CQC.

Lambeth Council held and managed a block contract with Queens Oak. Southwark Council placements were made on a spot-purchased basis, therefore our Contract Monitoring Officers did not conduct routine monitoring visits.

The Council has not been notified of Healthwatch exercising their right to 'Enter and View' at Queens Oak. The Lay Inspectors scheme has become a visiting service, however we have not been informed of any clients that were supported by the scheme in the home.

2.3. *How many residents were there at Queen's Oak at the time of its closure? How many were funded by Southwark Council and how many were self-funders? How many have now been moved to Camberwell Lodge? Have any residents moved to homes other than Camberwell Lodge?*

At the time of closure there were 69 residents at Queens Oak, funded as follows:

- 35 funded by Southwark Council
- 2 self-funders
- 32 funded by other authorities, who managed the transfers for their clients.

Of our 35 Southwark funded residents, 25 moved to Camberwell Lodge. The remaining 10 Southwark residents moved to the following accommodation:

- 2 moved to Tower Bridge Care Centre
- 2 moved to Anchor Waterside residential home
- 1 moved to Extra Care
- 5 moved to placements out of borough due to personal/family choice (4 N^{o}) or lack of suitable step-down provision in-borough (1 N^{o})

Of the 2 self-funding residents, 1 chose to move to a care home in Lambeth, and Adults' Social Care supported the transfer of the other resident to The Elms in Southwark.

2.4. *The health and wellbeing of residents can sometimes improve as a result of moving to a different (better) home and receiving better care. However, there is much evidence that the opposite can also happen i.e. that care home residents, particularly those with dementia, can die as a result of being relocated. This can be due to the stress of the move, the confusion of new surroundings, or the fact that new carers do not know the residents well and do not pick up the signs of e.g. a resident having an infection etc. Will the Council be monitoring if any of the Queen's Oak residents die within e.g. an 8 week period of being moved?*

Welfare checks on residents were done by allocated Social Workers the day after individual moves (by phone). Allocated Social Workers were scheduled to conduct follow-ups with residents at 6 weeks and 3 months after closure. As part of follow ups, Social Workers will monitor any deaths, significant changes in needs, or increased interventions from community Mental Health teams.

3. Care Home Quality and Provision

3.1. *Back in July 2020 there was a recommendation for an annual cabinet report on Care Homes and this was supported by cabinet, with the report stating this would follow after the completion of the Residential Care Charter. Could you also please provide the completed charter and annual report – or provide an update on this if still in development?*

A report was presented to Cabinet on 19 January 2021 as a response to the recommendations from the Health & Social Care Scrutiny Commission about Care Home Quality Assurance. The response related to recommendation 7 said 'The first annual report will follow the report related to the residential care charter.' The residential care charter was approved by Cabinet in February 2022 and the first report is scheduled to be presented to Cabinet in June 2023.

Agenda Item 12

Item No. 12	Classification: Open	Date: 18 April 2023	Meeting Name: Health & Social Care Scrutiny Commission
Report title:		Health & Social Care Scrutiny Commission Work Programme 2022-23	
Ward(s) or groups affected:		N/a	
From:		Julie Timbrell, Project Manager, scrutiny.	

RECOMMENDATIONS

1. That the Health & Social Care Scrutiny Commission note the work programme as at 11 April attached as Appendix 1 Work Programme, and review scopes in appendices A, B and C.

2. That the Health & Social Care Scrutiny Commission consider the addition of new items or allocation of previously identified items to specific meeting dates of the commission.

BACKGROUND INFORMATION

3. The general terms of reference of the scrutiny commissions are set out in the council's constitution (overview and scrutiny procedure rules - paragraph 5). The constitution states that:

   Within their terms of reference, all scrutiny committees/commissions will:

   a) review and scrutinise decisions made or actions taken in connection with the discharge of any of the council's functions

   b) review and scrutinise the decisions made by and performance of the cabinet and council officers both in relation to individual decisions and over time in areas covered by its terms of reference

   c) review and scrutinise the performance of the council in relation to its policy objectives, performance targets and/or particular service areas

   d) question members of the cabinet and officers about their decisions and performance, whether generally in comparison with service plans and targets over a period of time, or in relation to particular decisions, initiatives or projects and about their views on issues and proposals affecting the area

e) assist council assembly and the cabinet in the development of its budget and policy framework by in-depth analysis of policy issues

f) make reports and recommendations to the cabinet and or council assembly arising from the outcome of the scrutiny process

g) consider any matter affecting the area or its inhabitants

h) liaise with other external organisations operating in the area, whether national, regional or local, to ensure that the interests of local people are enhanced by collaborative working

i) review and scrutinise the performance of other public bodies in the area and invite reports from them by requesting them to address the scrutiny committee and local people about their activities and performance

j) conduct research and consultation on the analysis of policy issues and possible options

k) question and gather evidence from any other person (with their consent)

l) consider and implement mechanisms to encourage and enhance community participation in the scrutiny process and in the development of policy options

m) conclude inquiries promptly and normally within six months

4. The work programme document lists those items which have been or are to be considered in line with the commission's terms of reference.

KEY ISSUES FOR CONSIDERATION

5. Set out in Appendix 1 (Work Programme) are the issues the Health & Social Care Scrutiny Commission is considering in 2022- 23.

6. The work programme is a standing item on the Health & Social Care Scrutiny Commission agenda and enables the commission to consider, monitor and plan issues for consideration at each meeting.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Health & Social Care Scrutiny Commission agenda and minutes	Southwark Council Website	Julie Timbrell Project Manager
Link: https://moderngov.southwark.gov.uk/ieListMeetings.aspx?CommitteeId=518		

APPENDICES

No.	Title
Appendix 1	Work Programme 2022-23
Appendix A	Review: Access to Medical Appointments
Appendix B	Topic: Partnership Southwark and Integrated Care System (ICS)
Appendix C	Review: Health and Social Care Workforce

AUDIT TRAIL

Lead Officer	Everton Roberts, Head of Scrutiny
Report Author	Julie Timbrell, Project Manager, Scrutiny.
Version	Final
Dated	7 December 2022
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Law and Governance	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	No	No
Date final report sent to Scrutiny Team		25 January 2023

Health and Social Care Scrutiny Commission 2022/23

Work plan

Reviews and topics

- Review: Access to Medical Appointments – addressing patients timely access to frontline medical care and meeting patients' needs (GP Appointments / A& E waiting times/ face to face physiotherapy etc.) See ***Appendix A***

- Topic: Partnership Southwark and Integrated Care System (ICS) .See ***Appendix B***

- Review: Health and Social Care Workforce.. Continue and complete the review started on the impact of pandemic and Brexit on the health and social care workforce, started during the previous administrative year. Evidence from unions and Human Resources on the impact of the pandemic, particularly burnout, will be sought, along with an update on Brexit. See ***Appendix C***

Standing items

- Interview with the Independent Chair of the Southwark Safeguarding Adults Board (SSAB). The Safeguarding Adults Board is a multi-agency partnership which has statutory functions under the Care Act 2014. The main role of Southwark Safeguarding Adults Board (SSAB) is to ensure that local safeguarding arrangements work effectively so that adults at risk due to health needs, social care needs or disabilities are able to live their lives free of abuse or neglect.

Interview Cabinet member/s

- Cabinet Member for Health and Wellbeing

Meeting dates and items

Date	Item
11 July 2022 briefing and pre meet	Briefing and q & a on health scrutiny powers and responsibilities
11 July 2022	• Briefing and q & a on health scrutiny powers and responsibilities • GP Appointments • Workplan and deciding review topics
28 September 2022	Review: Access to Medical Appointments • Healthwatch Southwark update on recent work on this topic, with input from NHS • Follow up briefing arising from the last session from NHS / Partnership Southwark on workforce and appointments Topic: Partnership Southwark and the ICS Presentation and Q & A on the topic by Partnership Southwark lead including principles for working protocol Workplan – discuss and plan outreach
Outreach: October – March	Review Access to Medical Appointments : visit A & E and other frontline providers in liaison with Healthwatch
15 December 2022	Review Access to Medical Appointments : SLaM advisory members re GP access Covid and Flu vaccination programme briefing and presentation Review workforce – reports to note • Evidence from NHS Southwark / SEL Hospital workforce • Update council workforce • Update social care commissioning Workplan : Update Healthwatch meeting
2 February 2023	**Care Charges and people with Learning / Physical Disabilities** -Officers report - Mencap will facilitate the carers voice - Southwark Disablement Association have been invited to hear from people with physical disabilities

	Review Access to Medical Appointments: i) Report and presentation on Mental Health Transformation ii) Report on patient use of urgent, emergency , 111, ambulance service and primary care, including numbers, waiting times and demographics, where possible Workplan with update on • Access to Medical Appointments including outreach • Workforce • Partnership Southwark protocol • Care homes briefing
18 April 2023	Interview Cabinet Member for Health and Wellbeing Interview with the Independent Chair of the Southwark Safeguarding Adults Board (SSAB) FGM report, with a focus on adult survivors Care Contributions update briefing Care Contributions report Access to Medical Appointments – headline report Queen's Oak nursing home and Annual Care Homes report – to note
16 May 2023	Immunisation Update – presentation and Q &A Queen's Oak nursing home and Annual Care Homes report – presentation and Q & A Agree review reports: • Access to Medical Appointments Agree Partnership Southwark and health scrutiny Protocol

Scrutiny review scoping proposal

1 What is the review?

Access to Medical Appointments.

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

The review seeks to influence health providers, Partnership Southwark , and the Cabinet .

Outcomes:

A. Residents know what to expect from the local system – where and how to be seen for their conditions whether urgent/serious or not.

B. Providers ensure that their appointment and care systems can be navigated equally by patients and residents can get timely care .

C. Residents and Providers are able to offer care in a way that best meets people's , including face to face, and that the right balance is found in the use of new technology.

D. Public and councillors to know how to feedback when experience is not good and that this will be taken into account and lead to improvement.

E. The scrutiny review feeds into work that Partnership Southwark is doing to engage with residents in order to build trust local and use feedback to improve performance

F. The health system that operates well so that needs are met as much as well as possible within available resources

3 When should the review be carried out/completed?i.e. does the review need to take place before/after a certain time?

By the end of the administrative year

4 What format would suit this review? (eg full investigation, q&a with executive member/partners, public meeting, one-off session)

Full investigation

5 What are some of the key issues that you would like the review to look at?

- GP appointments – ensuring that patients can make an appointment (by visiting a practice , by phone, or online etc) and that care is timely.
- Are there sufficient GPs?
- A & E waiting times (emergency and urgent care)
- Can patient access Face to face appointments (GP, OT , physiotherapy)

6 Who would you like to receive evidence and advice from during the review?

Southwark Healthwatch

Southwark NHS / Partnership Southwark

Local Primary Care Network Directors

GP Practices

Local Medical Committee - https://www.lmc.org.uk/lmc-profiles/se-southwark/

Hospitals with Emergency and Urgent care (Guys and St Thomas and Kings College Hospital)

7 Any suggestions for background information? Are you aware of any best practice on this topic?

Southwark Healthwatch looked at access to GPs and completed a report last year. A summary is in the annual report, page 9

https://www.healthwatchsouthwark.org/report/2021-07-01/annual-report-202021

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?

e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Visits to A & E and frontline providers in collaboration with Healthwatch.

A consultation workshop in the community with older people regarding access to GPs.

Scrutiny review scoping proposal

1 What is the review?

Partnership Southwark and the Integrated Care System (ICS)

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

- Clarity on the role and remit of Partnership Southwark , relationship with South East London Integrated Care System and Boards (SEL ICS/B) , the membership, sub groups and any key pieces of work.

- Establish how scrutiny can add value to Southwark Partnership's work and vice versa.

- Develop shared understanding, principles, protocols and good practice in order to better govern the working relationship between scrutiny and Partnership Southwark- particularly between the key partners: the NHS and Social Care.

3 When should the review be carried out/completed?i.e. does the review need to take place before/after a certain time?

Completed by 2023

4 What format would suit this review? (eg full investigation, q&a with executive member/partners, public meeting, one-off session)

The review will take the form of a topic with written outcomes being an updated protocol and review of the present 'Trigger Template' – see appendix i.

5 What are some of the key issues that you would like the review to look at?

There will be a newly constituted South East London Joint Health Overview & Scrutiny Committee (SEL JHOSC) scrutinising health proposals from the ICS. The boroughs that comprise the South East London area (Southwark, Lambeth, Lewisham, Greenwich, Bexley, and Bromley) are devising a new terms of reference for the JHOSC, which will take over from the previous long standing Our Healthier South East London JHOSC, which previously covered the SEL ICS area. This new committee is being set up to respond to both proposals for substantial reconfigurations of Health Services in South East London, as well as other health issues that cross more than one borough, subject to member agreement and formal approval by respective boroughs.

Updates from government and the Centre for Governance and Scrutiny (CfGS) Regulations governing ICS and health scrutiny.

In advance of the statutory guidance on the Secretary of State's new powers in relation to service reconfigurations, this document sets out the expectations of the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities.

See: file:///G:/Scrutiny/Health%20scrutiny%20guidence/health-overview-and-scrutiny-committee-principles.htm

A Centre for Governance and Scrutiny (CfGS) blog, published September 2022 touches on health scrutiny and the anticipated changes to reconfiguration of health and social care and the role of scrutiny (particularly anticipated changes expected to the current power to refer to the Secretary of State) and also mentions joint scrutiny arrangements. This says new regulations and guidance are expected around the beginning of the new calendar year 2023.

See: https://www.cfgs.org.uk/chief-executives-update-on-health-scrutiny-and-levelling-up/

This legal blog comments on the commencement of the new statutory Integrated Care Systems (ICS) and reflects on the main themes and issues that have come from the new relationship between local government and health, over the first three months: https://www.brownejacobson.com/about-us/news-and-media/published-articles/2022/10/public-sector-integrated-care-systems-lessons?utm_source=government&utm_medium=vx-email&utm_campaign=public-matters-2022-10-25

6 Who would you like to receive evidence and advice from during the review?

Partnership Southwark members

7 Any suggestions for background information? Are you aware of any best practice on this topic?

Lewisham Council have produced a protocol

8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Discussion at meetings.

Attending conferences and events on the subject.

Scrutiny review scoping proposal

1 What is the review?

'Health & Social Care Workforce'.

The review has two themes:

- Impact of Brexit on workforce retention and recruitment
- Impact of the pandemic on morale and well being

Impact of Brexit

The review will look at how the downward turn in EU migration along with the high levels of outward migration from EU workers has affected the Health and Social Care industry.

As of 2020, of every 1000 NHS staff in England, 55 were from the EU with the Health and Social Care industry relying on this workforce.[1]

However, since Brexit a different picture has been clear with those from the EU either leaving the NHS and applications falling. In 2015/16, 11% of those joining the NHS were EU nationals. In 2017/18, this had fallen to 8%, and in 2019 to 7%. For nurses the percentage of EU joiners fell from 19% in 2015/16 to 6% in 2019. Meanwhile, the proportion of nurses joining the NHS with non-EU nationality rose from 8% in 2015/16 to 22% in 2019.[2]

In 2017/18, 12.8% of nurses leaving the NHS were EU nationals, up from 9% in 2015/16. This fell to 11% in 2019.[3]

With this in mind, the review will look at how this outward migration has impacted the workforce, along with an emphasis on how to encourage retention; increase recruitment and train the local workforce.

The review aims to assist the Council's Economic Review Plan, which aims to, "mitigate the impacts of Brexit as they become evident, with a shared emphasis on protecting our local economy and our diverse Southwark communities".

[1] https://ukandeu.ac.uk/wp-content/uploads/2018/03/Brexit-and-the-NHS-.pdf.
[2] Ibid.
[3] Ibid.

Pandemic

The impact has not only hit the health and social care workforce in terms of employment numbers, but also the well-being of the existing workers and the strain felt during the pandemic. Firstly, in terms of social workers:

- Social care workers faced among the highest mortality rates by occupation during the first phase of the pandemic and sickness absence rates more than doubled between February and October 2020, with the industry carrying increased risk of COVID-19 exposure.[4]
- Staff are also at higher risk of getting the virus and of dying from it because they are older and more ethnically diverse than the general population – a quarter are aged 55 and older and 21% are from black and minority ethnic backgrounds.[5]
- Moreover, the government was slow to implement policies (for example to ensure staff had access to enough PPE and comprehensive testing) to protect the sector.
- In a Health Foundation funded 'pulse' survey of nearly 300 social care staff in July 2020, a sobering four out of five respondents said that their job had left them feeling 'tense, uneasy or worried' more often since the onset of COVID-19.
- In July, four in five reported that their workload had risen, mainly due to covering for colleagues who had to self-isolate or having to train new volunteers.[6]

Secondly, NHS staff are feeling similar effects on wellbeing, mental health and physical burnout:

- Pre-pandemic reports indicate high levels of staff stress and burn-out. Features of burn-out include exhaustion, detachment and cynicism, which can reduce the healthcare provider's capacity for empathy and in turn negatively impact on their ability to provide high quality care. It can also increase the risk of mental ill health.
- 50% of staff felt that their mental health had declined during the first two months of the pandemic. 45% of doctors across the UK surveyed in May 2020 by the British Medical Association (BMA) reported experiencing depression, anxiety, stress, burn-out or other mental health conditions relating to or made worse by the outbreak.[7]
- Six months into the pandemic, 76% of almost 42,000 nurses surveyed by the Royal College of Nursing (RCN) reported an increase in their stress levels since the advent of the pandemic.[8]

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[4] https://www.health.org.uk/news-and-comment/blogs/how-is-covid-19-impacting-people-working-in-adult-social-care.
[5] Ibid.
[6] Ibid.
[7] https://post.parliament.uk/mental-health-impacts-of-covid-19-on-nhs-healthcare-staff/.
[8] Ibid.

The government's announcement of mandatory vaccinations for the health and social care workforce (later dropped) was predicted to have similar detrimental effects on staffing issues. The leader of Britain's biggest union – Unison - warned that tens of thousands of people could lose their jobs unless the government drops plans to enforce compulsory Covid-19 jabs for workers in adult care homes in England and, potentially, frontline NHS staff.[9] She said the government's "heavy-handed" and "counter-productive" approach could be perilous for the health sector, which is suffering from staffing shortages following post-Brexit barriers to hiring overseas workers.

2 What outcomes could realistically be achieved? Which agency does the review seek to influence?

The review will aim to influence the Council and especially Cabinet Member for Health & Wellbeing to encourage local job retention, employment and advocate training.

It will also aim to provide a forum to investigate the impacts of Brexit on our local workforce by working with external organisations, as well as examining the wider issues surrounding well-being and mental health of the workforce.

3 When should the review be carried out/completed?i.e. does the review need to take place before/after a certain time?

The review will take place across administrative year, 2021/2022 and 22/23 aiming to complete early 2023

4 What format would suit this review? (eg full investigation, q&a with executive member/partners, public meeting, one-off session)

The commission will seek to hold a Q&A with external actors such as SEL and Commission leads on initiatives such as 'Proud to Care', which will help build a larger picture for a full investigation and subsequently a report for the cabinet.

In carrying out this investing, the review will also work with local partners within the NHS and the social care industry.

[9] https://www.ft.com/content/5ab2c2de-96f2-4748-8444-480900900d2a.

5 What are some of the key issues that you would like the review to look at?

- Analysis of the impact of Brexit on health and social care provision
- Actions to encourage retention of the existing workforce
- Actions to recruit to vacancies
- Actions to train the local workforce
- The impact of work on the well-being, mental health, moral and physical burnout of the health and social care workforce, and how this has been especially exasperated by Brexit and Covid-19.
- The introduction of mandatory vaccinations for Social Care NHS workers.
- Fair pay / ethical care charter
- Precarious employment in care sector
- impact of commissioning due covid cost issues

6 Who would you like to receive evidence and advice from during the review?

- Cabinet Member for Health and Wellbeing
- Cabinet Member for Jobs, Business and Towns
- Local authority best practice (e.g. Islington, Lambeth, Hackney, Kensington and City of London)
- Mayor of London / GLA findings and work
- Proud to Care organisation
- The Nuffield Trust
- Unions
- Equality Trust

7 Any suggestions for background information? Are you aware of any best practice on this topic?

- The UK in a Changing Europe (Kings College) report: https://ukandeu.ac.uk/wp-content/uploads/2018/03/Brexit-and-the-NHS-.pdf.
- Nuffield Trust - Impact of Brexit on the UK Health Sector: https://www.nuffieldtrust.org.uk/research/understanding-the-impact-of-brexit-on-health-in-the-uk.
- The Kings Fund: Brexit and the End of the Transition Period: https://www.kingsfund.org.uk/publications/articles/brexit-end-of-transition-period-impact-health-care-system.
- Age UK - Brexit Could Worsen Broken Care System for Older People: https://www.ageuk.org.uk/our-impact/campaigning/care-in-crisis/brexit/.
- Government Website – NHS Staff from Overseas: https://commonslibrary.parliament.uk/research-briefings/cbp-7783/.
- Nuffield Trust on Statistics: https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers#1-what-kinds-of-staff-make-up-the-nhs-workforce.
- Proud to Care: https://www.proudtocarenorthlondon.org.uk/.
- London Assembly report on EU Migration Consequences: https://www.london.gov.uk/about-us/london-assembly/london-assembly-publications/eu-migration.
- How Covid is Impacting the Social Care Workforce - https://www.health.org.uk/news-and-comment/blogs/how-is-covid-19-impacting-people-working-in-adult-social-care
- Work Study https://www.hscworkforcestudy.co.uk/.
- Parliamentary Report on the Health Care of the NHS https://post.parliament.uk/mental-health-impacts-of-covid-19-on-nhs-healthcare-staff/.
- FT article on Mandatory Vaccinations https://www.ft.com/content/5ab2c2de-96f2-4748-8444-480900900d2a.
- House of Commons Health and Social Care Committee Workforce:

recruitment, training and retention in health and social care Third Report of Session 2022–23
https://committees.parliament.uk/publications/23246/documents/171671/default/

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8 What approaches could be useful for gathering evidence? What can be done outside committee meetings?
e.g. verbal or written submissions, site visits, mystery-shopping, service observation, meeting with stakeholders, survey, consultation event

Verbal and/or written submissions from external actors, NHS bodies and organisations, cabinet members and officers.
Stakeholder representation that speaks to the session and assists in framing and scoping the review.