Open Agenda

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 1 February 2012
6.30 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Membership

Councillor Mark Williams (Chair)
Councillor David Noakes (Vice-Chair)
Councillor Denise Capstick
Councillor Patrick Diamond
Councillor Norma Gibbes
Councillor Eliza Mann
Councillor the Right Revd Emmanuel Oyewole

Reserves

Councillor Poddy Clark
Councillor Neil Coyle
Councillor Mark Glover
Councillor Jonathan Mitchell
Councillor Helen Morrissey

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Contact Julie Timbrell on 020 7525 0514 or email: julie.timbrell@southwark.gov.uk

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Members of the committee are summoned to attend this meeting
Annie Shepperd
Chief Executive
Date: 24 January 2012

PRINTED ON RECYCLED PAPER

Health and Adult Social Care Scrutiny Sub-Committee

Wednesday 1 February 2012
6.30 pm
Ground Floor Meeting Room G02B - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
	PART A - OPEN BUSINESS	
1.	**APOLOGIES**	
2.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear working days of the meeting.	
3.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members to declare any personal interests and dispensation in respect of any item of business to be considered at this meeting.	
4.	**MINUTES** To approve as a correct record the Minutes of the open section of the meeting held on	
5.	**REVIEW OF SOUTHERN CROSS**	1 - 43
6.	**LAY INSPECTORS**	
7.	**ANNUAL REPORT ON ADULT SAFEGUARDING**	44 - 101
8.	**REVIEW : AGEING ADULTS WITH COMPLEX NEEDS**	102 - 120
9.	**REVIEW: SOUTHWARK CLINICAL COMMISSIONING COMMITTEE (SCCC) CONFLICTS OF INTEREST**	121 - 145

Item No.	Title	Page No.

10. HIV

11. WORK PROGRAMME

DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING.

PART B - CLOSED BUSINESS

DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT.

Date: 24 January 2012

Agenda Item 5

Extracts from the Public Accounts Committee - Fifty-Seventh Report : Oversight of user choice and provider competition in care markets on Southern Cross / care markets

The following extracts focus only on Southern Cross /care markets , particularly in relation to Local Authorities and Four Seasons.

For the full report go to**:**
http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1530/153002.htm

Part one : Conclusions and recommendations on Southern Cross / care markets

Part two : Extracts from minutes

Part three : Written evidence from the Permanent Secretary, Department of Health

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Part one : Conclusions and recommendations on Southern Cross / care markets

1. There are no arrangements yet in place to oversee regional care markets, but the Department said that it was considering a range of options for overseeing the market in care. Recent trends in care markets indicate a trend towards fewer providers controlling an increasing share of the market. Care markets tend to operate at a local or regional level yet the Department looks at market dominance from a national perspective. For example, Southern Cross had a market share of around 9 % of the national care home market but held up to 30 % of the market in certain local authority areas in the North East of England. The Department has nothing in place to oversee the market at the local level to avoid certain providers becoming too dominant in a region. It must specify what market share at the local level is acceptable, what arrangements will be made to keep market shares of large-scale providers under review, and what additional powers it requires in case it needs to intervene to prevent a provider becoming dominant.

2. There is no clarity about what will happen in cases of failure of large-scale providers. The financial difficulties experienced by the then largest care home company, Southern Cross, in 2011, and the considerable level of debt held by another large-scale provider, Four Seasons Health Care, have demonstrated that the care home market is no longer the "land of milk and honey" it once was. There must be greater clarity over what will happen in cases of large-scale provider failure. The Department admitted to having insufficient powers, and must decide what pre-and-post failure regime powers it needs to put in place to protect care home residents, many of whom are frail and vulnerable, if or when large-scale providers fail.

3. The Department does not monitor the financial health of large-scale providers. The Department acknowledged that it was unaware of the financial difficulties at Southern Cross until the company approached it in March 2011. It is currently considering a range of options for overseeing the social care market and how it will gather better intelligence about providers and the market more widely. The Department has issued a discussion paper[2] to inform the Social Care White Paper. The Department must decide how it will monitor the financial health of large-scale providers so that it has early warning of difficulties and develop ways in which it might respond should problems arise, so that the interests of both social care users and the taxpayer are protected.

1 The oversight of care markets

1. Around £23 billion is spent annually by Government and private individuals on care services in the UK. Around £1.5 billion is spent by publicly-funded personal budget holders, mostly on domiciliary care. A further £6.3 billion is spent by those funding their own care. Both these groups have choice over the provision of their care. The term 'social care' covers a wide range of services from residential care homes and drop-in centres for disabled people, to help with daily routines in the home. The Department of Health is responsible for setting the overall policy framework for social care in England, and local authorities have statutory duties to provide or fund social care for those eligible for means-tested support. The Care Quality Commission is the independent regulator of all health and adult social care in England.[3]

2. Successive Governments since the 1990s have sought to diversify the provision of care services beyond direct local authority providers. Provider diversity is a necessary pre-condition for user choice.[4] The Government has a target that by April 2013 all eligible users of care services will be offered a personal budget in order to choose their care services. A vibrant market of providers that compete for and respond to the needs of users will therefore be of ever increasing importance in delivering value for money from care services.[5]

3. The Office of Fair Trading sets a benchmark of 40 % market share above which it considers there is a possibility of a particular company becoming overly dominant and harming effective competition.[6] There has been increasing consolidation in the care sector over recent years, in particular in the care home market, where a smaller number of providers now have a greater proportion of the market.[7] While Southern Cross had a market share of around 9% at a national level, it held up to 30 % of the market in parts of the North East.[8]

4. Despite the increasing risk of a single provider having a disproportionately large share of any individual local authority market, the Department does not have a clear idea of the upper limit above which there would no longer be a healthy, competitive market.[9]

5. As care markets operate at a local and regional level rather than as a national market, concentration matters a lot to individuals and their ability to choose between providers in their area.[10] The Department does not consider that it should monitor local markets and intervene if necessary, this being the responsibility of the local

authorities.[11] Furthermore, there are no mechanisms for monitoring or intervening in markets that cross local authority boundaries.[12] There are, however, examples of where authorities have worked together to commission domiciliary care.[13] The Department recognised that it had limited powers to intervene if there are problems in regional markets, and is exploring ways it can improve matters in the future, in particular whether Monitor may be given a regulatory role in this area.

6. Care homes are very reliant on their funding from local authorities.[14] The overall split of public to private funding across all care services is about 63 % to 37 %.[15] Since the financial crisis the care homes market is no longer what was once described as "a land flowing with milk and honey". Because of the constraints on local authorities, the fees paid and the numbers of individuals referred have been cut.[16] The drop in occupancy levels is part of a longer term trend, and they are now at their lowest level over the last decade.[17]

7. The failure of large care providers risks causing huge uncertainty and disruption to vulnerable individuals resident in those homes. This risk crystallised recently with the failure of Southern Cross. The Department has been working with the company, other providers, and local authorities to manage the impact. The Department issued a discussion paper in October 2011 that seeks stakeholders' views on different potential options for protecting care home residents from large-scale provider failure, including the roles and responsibilities of the different participants in the market.[18] However, the Department has not yet established a pre and or post failure regime.[19]

8. The problems created when a large provider fails were starkly illustrated with Southern Cross. This company failed because it relied on a business model that was based on low interest rates and high levels of debt, with presumed continuing certainty of revenue income. It was subsequently unable to adapt quickly enough when the financial crisis started.[20] The Department was concerned that Southern Cross was overvalued in 2007-08 and was also aware of concerns raised by various commentators about its business model. However, the Department was unaware of the true state of the financial difficulties facing Southern Cross until the company approached it in March 2011 to raise concerns about its viability and the continuity of care.[21]

9. There are signs that other providers may also be experiencing financial stress. For example, Four Seasons Health Care, a large-scale provider in the care homes market which has recently taken over 140 of the homes that were previously managed by Southern Cross, carries nearly £1 billion of debt that it is now having to re-finance for the second time.[22] However, the Department does not scrutinise levels of company debt or business models of large-scale care providers as a matter of course, and has limited powers to assess the financial health of these organisations.[23] The Department is, however, now considering a range of options for overseeing care markets.[24]

Part two : Extracts from minutes

Q22 Chair: You are changing the question that I asked. I am not talking about failure. I will come on to talk about failure. I am talking about a monopoly concentration in the market, which I think will happen because the way this market is going is that you are moving it towards larger providers. What you have just said—perhaps you want to go away and think about it again—is, "Actually, it's down to the local authorities. We'll work with them, but if they go to 41%, which is over the OFT figure, we will do nothing." Let me move on.

David Behan: I didn't say we would do nothing.

Chair: I don't think I have had a satisfactory answer.

Una O'Brien: I think it is important to explain the distinction between what we would do at the moment and the powers that are open to us at the moment, where the responsibilities of local government lie, and the relationship between the Department of Health, ADASS and the representative bodies of local government. As David has set it out, those are the tools and mechanisms that are open to us at the moment. We have recognised, through the experience of Southern Cross, that there are issues there for us that raise questions about market dominance. Ministers have gone on the record about this to say that we absolutely want to reflect on what we have learnt about this. We have gone out with what I think is a genuinely open set of questions about how we are going to get the balance right in regulating this market in the future. There are risks and trade-offs from over-reacting. Nevertheless, it is important that the Committee understands that this is a genuine intention to get this right. We want to understand what levers can have the best impact on the market.

Q23 Chair: I am really pleased, Una, that you are doing that. I am just somewhat surprised that that document is produced on the day that we take evidence, and therefore you can fluff on the re-evidence. That is the only thing that I feel slightly cross about.

Una O'Brien: If I might say, there is absolutely no intention on our part of that.

Q24 Chair: Well, I don't believe that. I will come to you, James, as I know you want to come in, but I just want to pursue these points.

We had the disaster with Southern Cross. We now have Four Seasons Health Care which, according to our report, is the second biggest player in the field. My understanding is that it has a debt at the moment. It has taken over 140 of the homes that were previously managed by Southern Cross, and has a debt of nearly £1 billion. Are you worried about it? It is currently running a debt. Not only has it got a current loss, but it is actually running a debt of nearly £1 billion. It already restructured its debt in 2009. At that point, it was £1.6 billion. What are you doing about that one? That looks really dodgy to me and could go bottom up on us too.

David Behan: I think there were press reports last week. It has begun to have discussions with its lenders in relation to refinancing its debt. At the present time, that arrangement is a very different one to Southern Cross. Yes, we are looking at that and

having discussions with Four Seasons in relation to that, but there is a commercial conversation that it will have with its lenders in relation to refinancing its debt.

Q25 Chair: Well, there is a commercial conversation, but there is also a public interest in its homes. It took over 140 homes that were formerly managed by Southern Cross. In those homes, there are a lot of people living there who are living in an organisation, the financial health of which is hugely questionable. The lenders could foreclose on it any day. What are you doing to protect that, having learned the lessons from Southern Cross? What are you doing about Four Seasons, which seems to be the next in line?

David Behan: We have no alerts, Chair, that there is any threat to continuity of care in relation to Four Seasons.

Q26 Chair: Have you got any alerts that there may be problems with Four Seasons? I mean, there are problems with Four Seasons if it has restructured its debt once, maybe only two years ago, and is having to restructure again now. Does that not give you a sense of alert and concern?

David Behan: It is an issue that we need to attend to. It successfully restructured its debt. When it restructured its debt two years ago, a restructuring date was set for the future—

Chair: That was two years ago.

David Behan: Which will take place next year. This restructuring is not borne out of a crisis; it is absolutely to be anticipated. The last time it restructured the debt—

Q27 Chair: A £1 billion debt is to be anticipated for an organisation like this?

David Behan: It always knew, when it restructured previously, that it would have to come back and restructure the debt that it was carrying. So, in that sense—

Q28 Chair: £1 billion. Did it own these Southern Cross homes? I am very unclear about this. Does it own them, or is it another of these organisations, like Southern Cross, that are just dependent on the revenue that they get from the fees?

David Behan: It owns some of them. It was the landlord for some of the Southern Cross properties—in excess of 40.

Q29 Chair: It was the landlord?

David Behan: It was the landlord.

Q30 Chair: It owns some of the Southern Cross properties?

David Behan: It owned 40 of the Southern Cross properties. Other landlords have sought Four Seasons as their operator for their homes as they go forward to give the continuity of care to the individuals in those homes.

Q31 Chair: If it owns them, why the hell has it got such a huge debt?

David Behan: That goes back to its business model and how that business was taken over back from 2006 through to 2007-08. When the financial crisis began in 2008, it needed to restructure its debt. The structure is very different from that of Southern Cross. It had not got the same degree of opco-propco separation that Southern Cross had, but it did have a debt that needed to be refinanced. It refinanced that in 2008, I think it was.

Chair: 2009.

David Behan: It has to refinance it again next year, and that was to be anticipated.

Chair: No, this year.

David Behan: It begins it this year. I think it needs to be concluded by 2012.

Q32 Chair: Is it still Qatari owned?

David Behan: My understanding is that it is not owned in the same way it was when the original debt was set, when it was largely Qatari owned at that time.

Q33 Chair: Who owns it how?

David Behan: I will have to write to you with that detail.

Part three : Written evidence from the Permanent Secretary, Department of Health

PUBLIC ACCOUNTS COMMITTEE—OVERSIGHT OF USER CHOICE AND PROVIDER COMPETITION IN CARE MARKETS

At the Public Accounts Committee on Monday 10 October, I promised to write to the Committee in response to a number of questions raised. The Department of Health response is set out at Annex A.

18 October 2011

Annex A

DEPARTMENT OF HEALTH RESPONSE TO QUESTIONS RAISED AT THE PUBLIC ACCOUNTS COMMITTEE HEARING ON MONDAY 10 OCTOBER 2011

What proportion of the market does Four Seasons Healthcare currently own? (Question 10*)*

Four Seasons had 16,700 beds for older and physically disabled people and a market share of 4.6% of the for profit sector in July 2010. This does not include the care home freeholds owned by Four Seasons and leased to other operators, nor does it include the recent transfers from Southern Cross homes.[1]

In September 2011, Four Seasons announced that it would take over the operation of 140 Southern Cross Care Homes. The total transfers include Four Seasons taking back 45 homes it owns that had been leased to Southern Cross under an historic arrangement.

Currently, Four Seasons operate in 7% of the homes in the North East Region, accounting for 12% of the places available.[2]

Who owns Four Seasons Healthcare now? (Question 33*)*

Four Seasons is owned by its former lenders, of which the Royal Bank of Scotland (RBS) is the biggest shareholder with 38%.

Background on Four Seasons from *Care of the Elderly People: UK Market Survey 2010-11*, Laing and Buisson, 2010

Four Seasons, in July 2010, operated 320 care homes for older and physically disabled people with 16,700 beds, giving it a 4.6% share of the for-profit sector. In addition, Four Seasons is an operator of 23 care homes with 759 beds for people with learning disabilities, mental health problems, alcohol addiction and brain injury, plus seven mental health hospitals with 218 beds. It is also a substantial landlord of care homes leased to other operators.

The company operates under two brands, *Four Seasons Health Care* for the bulk of the portfolio including elderly care homes, and the *Huntercombe* brand, which operates specialised care facilities and the mental health hospitals.

Four Seasons reported revenues of £460.7 million for the year ending December 2009. EBITDAR stood at 24.5% of revenue, placing Four Seasons in the second rank of performance below Barchester (29.6%).

Statutory accounts for the year ending December 2009 reported average occupancy of 87.6% (2008: 86.4%) across the Four Seasons portfolio as a whole.

History

— Four Seasons was established in the early 1980s and achieved growth both through acquisition and construction of care facilities. In terms of earlier history, Four Seasons merged with the previously quoted CrestaCare plc in July 1999 with financial backing from Alchemy Investment Plan, within the stable of venture capital company Alchemy Partners.

— In September 2002, Four Seasons Health Care Ltd purchased Omega Worldwide Inc (owner of Idun Healthcare Ltd) and Principal Healthcare Finance Ltd, the Jersey

based care home landlord. The deal value was reported at $500 million (£325 million).

— In July 2004, Four Seasons was acquired by Allianz Capital for a reported £775 million.

— In May 2005, Four Seasons acquired the BetterCare Group from management and 3i for £116 million.

— In September 2006, Four Seasons was sold to Delta Commercial Property LP, an investment vehicle for Three Delta LLP acting on behalf of the Qatar Investment Authority (QIA), for £1.4 billion, a multiple of about 14 times EBITDA.

[This a highly leveraged buyout and the point that Four Seasons incurred high levels of debt]

— The new owners found they were unable to refinance the asset following termination of the short term loans with which it had been acquired in 2006. Lenders lost substantial sums. A restructuring was agreed in September 2009 which saw a £1.55 billion debt pile reduced to £780 million via a debt-for-equity swap with RBS.

— In September 2010 a £600 million loan owed to special purpose vehicle Titan was due to mature in the wake of the 2009 restructuring. At this point, a deal was struck to extend the maturity of the loan to September 2012.

DRAFT

LINk Southwark:
A Scrutiny of Southwark Council Adult Social Care Services in respect of the issues raised by the Care Quality Commission Report 2008/09

Summer 2011

CONTENTS

Appendices:

Executive Summary

The Scrutiny Task Group was set up when the Care Quality Commission (CQC) assessed Southwark Council as performing ''adequately'' in their provision of adult social care services in 2008/09. This was in comparison to the previous assessment by CQC's predecessor, Commission for Social Care Inspection (CSCI) where Southwark Council was assessed as performing ''excellent'' in their provision of adult social services in 2007/08.

The drop in rating and its report findings caused a public disagreement from Southwark Council on the CQC's report findings. The uncertainty surrounding the report findings caused LINk to address its remit to scrutinise adult social care and hold commissioners to account should this be found to be necessary. The Scrutiny Task Group sent a letter to the Council informing them of its intent to scrutinise adult social care provision and its commissioning functions, and to note its co-operation with the Council.

During the course of the Scrutiny, the Team met with various Council and CQC officials to gain further insight behind the CQC and CSCI assessment process, in addition to understanding the care home context in Southwark. Background research was undertaken to support this. Outreach visits to local older people community groups and public advertisement were used as tools to aid the scrutiny.

During the course of our information gathering process which involved consultation with various statutory bodies, the Council was forthcoming in providing information concerning previous embargoes and issues relating to Southern Cross Care Homes and the no longer operating Southwark Park Nursing Care Home. The issues raised by the CQC report are being tackled and was reflected in the upgrading of the Southwark Council's CQC assessment to ''well'' in 2009/10 and no complaints received from the public of the quality of care homes.

PLEASE NOTE: UPDATE

While we are aware of the recent publicity surrounding the quality of care at these Homes (6th Oct 2011, Southwark News) and (28th April 2011, Southwark News) respectively, we are satisfied that Southwark Council has taken ownership in the work they are doing to improve commissioning of care services and the quality of services. With the continuity of funding available to the Lay Inspectors Scheme, we believe that these parties will endeavour to continue to tackle these issues. We will also be monitoring the situation.

Although the Scrutiny began over a year ago, Southwark residents are worth noting the report and its appendices. The research gathered will give an understanding of the:

- stages of a ***care home pathway*** ,
- how the quality of care homes can be influenced by the commissioning process
- and transparency into the commissioning process, which has previously been not been widely known.

This information is relevant to the adult social care changes that are happening now:

- including personalisation where some people can be expected to 'commission' your own services for your personal budget
- in addition to background understanding of commissioning generally.

The report is aimed at Residents, family and friends who use or know of someone who use Social Care Services which can include Care Homes and Home Care.

1. Introduction

This report deals with the issues raised by the assessment of Southwark Council's Adult Social Care Services by the Care Quality Commission (CQC) for the year 2008/09 published in December 2009.

The CQC named Southwark Council as one of the eight worst authorities in the country as failing to provide a good enough service for Older People and people with disabilities. Southwark was assessed as delivering services ''adequately'' from a scale of ''poor'', ''adequate'', ''good'' and ''excellently''. It said it wanted to know why they were using homes judged as poor or just adequate.

Southwark Council, which dropped from being rated as ''excellent'' in 2007 (by its previous regulator Commission for Social Care Inspection CSCI) informed the LINk that they had called for an urgent parliamentary review of the new regulator. The furore surrounding the CQC report and its findings regarding Southwark Health & Social Care services for older people required that LINk Southwark address its remit to scrutinise such provision and hold commissioners to account should this be found to be necessary. LINk Southwark notified the council in a letter of its intention to conduct this inquiry.

At its meeting in December 2009, the Steering Group established a Scrutiny Task Group to examine the delivery of Southwark Councils care services, in exercise of its duty to Southwark residents as given by The Public Involvement in Health & Social Care Act 2007 (The Act). The outcome of the Task Group's work was not to produce a critique of the Council but to produce a report to Southwark residents that:

- describes both the process and the conditions as they are found to be during the course of the Scrutiny
- recommends action that may help to remedy any adverse situations which were discovered
- reassures residents that there is no cause for concern should this be the outcome of the Scrutiny and, therefore, the appropriate conclusion to be drawn from it

The Report outlines our lines of inquiry and findings. We would like to extend our appreciation to the many organisations, bodies and Council Officers who worked with us to ensure that we were able to substantiate our findings. A list of these can be found in Appendix 1.

2. What we did

In early January 2010 the Scrutiny Team, following the approval of the Steering Group, published a press release to give notice to residents of the exercise of its statutory powers and sent a letter to the Council informing its intention to conduct a formal scrutiny with the above intended outcomes. (Please see Appendix 2). The Team and its remit were also approved to undergo training as required by The Act to become Authorised Representatives, if the need arose to exercise its ''Enter & View'' Authority.[1] (Appendix 3)

The Scrutiny Team arranged to meet with the Council Officers on the best way to proceed with the inquiry. It also sent a series of questions to and had meetings with both the CQC and the Council to gain further understanding on the current Care Home situation in Southwark and the CQC assessment process. An advert was placed in the Southwark News newspaper calling for information on Southwark Care Home issues. A paper was also produced to provide background information on how care home services are accessed entitled *''Access and provision of care home services – A LINk Southwark Primer''.* This outlines how an assessment occurs, the eligibility criteria and the types of care services offered. *(*Appendix 4)

Further activities of the scrutiny included holding meetings with local community and representatives groups and individuals. We looked through relevant board reports, secondary literature, local and national legislation and policies as well as compiling our own Care Home database. The Team also informed the Council's Adult

[1] A description of LINk and its powers can be found in Appendix 3

Social Care Scrutiny Sub-Committee of its intentions and invited cooperation, if they intended to examine the CQC findings.

3. What we found

The Scrutiny was delayed by a few months, partly by the initial limited cooperation from the Council, as well as the staff changeover at the CQC, both of which had data that the Scrutiny needed to progress. We found some of our formal queries on the CQC report were not met, not withstanding the statutory requirements to reply within 20 days, and similarly there was a failure to respond to timescales set by the Freedom of Information Act (FOI). The LINk understood the context within which the two parties were operating in at that time and at a later stage developed a constructive working relationship with both.

3.1 Home Care

Originally the scrutiny had planned to look at both care services at home and in care homes. However after initial scoping it was agreed that this was a much different area than care homes from the point of view of both of the Commissioning process and the service user pathway. Home Care was a substantial area within its own right, and it would not be feasible to look at both care homes and home care given limited time and resources. There were specific references to the CQC report that referred to the 'poor or adequately' rated services in Care Homes, but little about concern of care in the home, and it was decided to narrow the focus of the scrutiny on care homes.

To note, the findings of our commissioning report into care homes can provide a general understanding of the commissioning process and in some instances apply to the home care process. Given the incoming personal budget agenda and the 'commissioning' of your own services, this will be useful for future monitoring of services.

3.2 Enter & View

After much discussion with lay inspectors, the CQC, Age Concern Lewisham & Southwark and Older People Community Groups, we chose not to conduct a formal LINk visit called an 'enter and view'. It was felt that 'another inspection' would not be in the best interest of the residents.

3.3 Care Home pathway - current and new

Our research found that there was not, to date, a single document which clearly mapped the process and pathway of an Older Person Service User journey from initial access to assessment and provision of services. There was a limited understanding about the assessment process and how an individual is given a Care Home placement.[2] To the average person with no prior knowledge of the system, this added to the perception of accessing Care Homes as being complex or was not aware of the Council's duty to assess and their entitlement. Thus, we established and mapped this pathway. This can be found in Appendix 5.

When viewing the care home pathway it is worth noting that the Council receives under 6000 adult social care referrals regarding older people per year. Out of these referrals, 3400 receive a service.[3] Approximately 550 then go on to be placed in care homes.[4] This is a smaller service-user group in comparison to other service groups.[5]

[2] If the individual disagrees with the outcome of the assessment, individuals will be advised to follow the complaints procedure. Firstly raising the complaint informally with the Adult Social Care Team (or through PALs); Secondly, if unsatisfied then formally making a complaint via the Complaints department, and thirdly, if still unsatisfied contacting the independent Local Government Ombudsman.

[3] This refers to individuals who are funded, partly or in whole by Southwark Council.

[4] Exact Values cannot be calculated. This is because some people are assessed for community based services and then later assessed for care homes which can account for some double counting.

[5] This includes all service user groups such as learning disabilities, physical disabilities as well as Older People receiving other social care services

- Between October 2009 and October 2010, 5890 people contacted Southwark Council for a Needs Assessment [known as 'Community Care Assessment' (CCA)].

- 3404 were recorded as being offered a service, meeting the FACs eligibility criteria of substantial and critical. 93% were substantial and 7% were critical.

- Data 08/09 shows that Nursing Home placements had more placements of a lower rated service (Adequate and Poor) than Personal Care placements.

- The rest were signposted to other Grant Funded voluntary organisations of information and advice sources. This information is not automatically recorded but an annual survey of council funded organisations is undertaken by Southwark Council.

The age, health and economic status of residents have an effect on the type of care services needed and provided. This should be looked at in the context of the following demographic facts regarding Southwark having:

- a lower than average older people population of 27,000, a tenth of the borough population
- one of the highest socially and economically deprived communities nationally,
    - 26% of areas ranked in the most income deprived deciles (Income Deprivation Affecting Older People IDAOP)[6]. This means people aged 60+ years who are living in pension credit (guarantee) households, a means-tested social security benefit
    - over 60% of older people living in Council Homes[7]
- Older people as the biggest group receiving social care (71%) [8]

3.4 Commissioning

We wanted to find out the *current* way in which the Council commissions Care Homes and established that the two main procedures are block contracts and spot purchase. Block contracts are long term contracts with a specific provider that will guarantee a certain number of beds are reserved for a precise period of time at a specific price. Spot purchasing contracts are used when specific needs cannot be met within a block contract provision and there are no other alternatives. They are used as and when needed.

We are relatively clear on how the process for commissioning block contracts is followed but still have some outstanding questions related to spot purchasing. From the commissioning process, we were able to look into the two main care providers in Southwark and how this affected the CQC report assessment.

Main findings[9]:

- Contrary to other Councils, Southwark Council does not have an 'Approved List of Providers'. The Approved List shows Providers who have been assessed as reaching certain Council standards and therefore allowing Councils to simply choose one on the list, amongst other criteria if specified.
- National Government policy in 1991 saw a separation between the Provider and Purchaser/Commissioner. Therefore, it became common practice for Councils to outsource care homes to external Providers.
- The Council entered into a block contract with a Provider (Anchor Homes) to ensure them a guaranteed flow of income. This gave security to the Provider to invest in the care homes through rebuilding and renovating them.

[6] English Indices of Deprivation 2007, London Borough of Southwark, Southwark Analytic Hub (April 2008)
[7] This includes Council Rented and Socially rented (Older People Commissioning Strategy 2010)
[8] Needs Audit for Health & Social Care (2006) for Southwark, Physical Disabilities are the second biggest group, physical disabilities (20%)
[9] All figures relate to Older People and Older People Care Home. All care home residents mentioned in this section refer to individuals receiving council funded support.

- The block contract entered into by the Council and Anchor Homes (registered Personal Care Homes) is no longer as financially or demand effective and found to be similar across other London Councils. The Council are currently negotiating some of the contract specifications to increase its value for money while meeting the rising nursing home placements and re-addressing the Policy agendas mentioned in

Section 4.1.

  - Southern Cross is the main nursing home provider in Southwark and has many 'spot contracts' with the Council. Many of these care homes were assessed as 'adequate' care.
  - Many residents were placed in Southern Cross Care Homes due to the limited choice of Nursing Home Providers in Southwark as well as the influence of family/friends who choose Southern Cross based on how close the care homes was to them.

- As of November 2010, information received saw 312 Southwark residents placed in a Care Home in Southwark, with 53% of these placed in Anchor Homes as part of the Block Contract Agreement and 47% (148) in spot contracts. (*Appendix 5, Figure 3)*
- 77% of the Spot contracts in Southwark, were with Southern Cross Care Homes.(*Appendix 5, Figure 4)*
- The social demographics of care home residents are changing. Two trends are identified,
  - the demand for care homes without nursing is decreasing (i.e. Personal Care Homes)
  - the demand for care homes with nursing is increasing

  Upon entering a care home, most care home residents tend to get progressively physically and mentally less able. This changes the individuals care needs from when they first arrived at the care home requiring *personal care* needs to later requiring *additional nursing care needs*. Consequently, Personal Care homes will be providing additional nursing related care for some of its residents. The change in care needs means that the type of care provided at a personal care home and nursing care home can get/is blurred. Our research suggests witnessing other residents receiving mental healthcare can have a negative impact on the quality and mental well-being of those who are not at that stage.

PLEASE NOTE: Since time of writing more up to date figures have been released by the Council in relation to the transfer of ownership from Southern Cross to other Providers. However the main reasons and trends still persist. The Southern Cross Briefing (Sept 2011) presented at the Councils Health & Adult Scrutiny Sub-Committee (HASC) meeting (6th Oct 2011), which resulted in the public news announcement can be found here http://moderngov.southwarksites.com/mgConvert2PDF.aspx?ID=22612

- Care Homes were rated by CQC on a scale from 0 star (''poor'',) to 3 stars (''excellent'') to reflect the quality of care provided at that care home.
  - We could not establish a relationship between the *stars rating / quality of care provided* and the *price* of care home placements.
  - All contracts (block and spot) have a selection criterion, which included weighting the quality of care against its financial worth. Uncertainty surrounds the selection criteria for a Provider, and more specifically the weighting between quality and costs.

However, during the course of the scrutiny it has become clear that Commissioning is moving towards fulfilling the Personalisation Agenda, less of block contracts and more of spot purchasing - which will affect how both 'Homecare' and 'Care Homes' will be provided in the future. Please see Section 4.1 for more information.

A more extensive report on our findings into the commissioning of care homes can be found in Appendix 5 including the purchasing of Adult Social Care services specifically care homes in and out of the borough, who the main care home Providers are, monitoring arrangements and how the care homes are paid for.

4. Issues that influenced the conduct of the Scrutiny

The Scrutiny Team noted that a combination of delays and obstacles during the start of the Scrutiny affected its progress and the publication of the Scrutiny's activities. As our scrutiny progressed, it became clear that the

Council was making progress towards resolving the issues identified in the CQC 2008/09 report alongside the substantial work taking place regarding the national transformation of the adult social care system. The CQC was found to be working closely with Southwark Council, to improve their outcomes.

This became clear with the next publication of the CQC Assessment for 2009/10, published 29th November 2010 whereby the rating of Southwark adult social care services was upgraded by one band to the rating of ''*Well*''.

4.1 Policy Shift – Incoming Personalisation and its impact on commissioning and delivery of social care services

As first proposed in the 'Putting People First' Concordat (2007) and in line with the national policy, Southwark Council have had to completely transform their adult social care system. In this last year we have seen Southwark Council moving away from *just providing services* (service –oriented) to focusing on giving more choice by arranging services *around the persons preferences* (personalised services).

Part of this policy includes:

a) moving towards Care in the Community, with Care Homes as an absolute last option
b) Personal Budgets for Home Care Services and possibly in the future Care Homes.

The Council will change its approach in two ways:

a) Re-focusing services that can take place at the persons home or in a community setting i.e. GP surgeries/clinics. This can be for primary or clinical need. [10]
b) Southwark Council will no longer provide all social care support; instead individuals who meet the Councils eligibility criteria and the financial assessment will have a bigger role in picking and buying their own services through using Personal Budgets. On a commissioning level, this means the Council will buy fewer services on a long term basis i.e. 'block' contract, with the public buying more individual 'spot' services using their personal budgets.

In addition the council will be focusing more on short term intensive treatments to avoid people going into long term care, i.e. having a Personal Budget. This can refer to Intermediate Care or ''Reablement''. [11]

In summary this policy heavily emphasises Home Care in the community as the way forward rather than the use of Care Homes. There is a financial long term incentive for such a policy**,** as Care Homes (Residential and nursing homes) takes up over 40% of the Adult Social Care Budget.

4.2 Financial Constraints

Social Care provision is expensive to fund in the long term, especially as people are living longer and therefore more money is needed. Adult Health & Social Care is one of the highest costs using up to a third of the Council's *total* budget. In May 2010, the Coalition Government announced significant reductions in Government support for Council Services delivered through a Council's Area Grant. This impacted substantially on discretionary social care spending from 2011/12 onwards, and accelerated the emphasis from care homes to home care, as well as leading to the decommissioning of other social care services.

4.3 Limited care complaints received in care homes

The Team widely publicised the call for information regarding the quality of care received in care homes. This

[10] Primary need refers to services that do not require hospital admission, usually non-urgent medical care such as going to see a GP, midwives, dentists, pharmacists.
[11] Since August 2011, Southwark and Lambeth Community Services are piloting a Virtual Ward Pilot, to support the wider Admissions Avoidance Programme which involves avoiding long term admission into care homes.

included outreach meetings and presentations with local community groups, residents in community settings, lay inspectors and local branches of national organisations. Two issues were raised from this that affected the scrutiny:

- it was found that another inspection was not in the best interests of care residents
- there was difficulty in accessing current residents who were in care homes and their carers or relatives, taking into the account the sensitivities when entering a care home and those who were in care homes would be unlikely to assist due to their frail capacity.

Despite substantial advertising and appeals by the LINk, no service users, family or friends came forward on complaints of care received in care homes. Consequently we did not continue the prospect of an Enter & View.

5. Conclusions to the Scrutiny Team remit

In light of our scrutiny findings, LINk Southwark considers that the issues and concerns raised by the CQC Report 2008/09 has effectively been tackled by the Council since then, and continues to be at the forefront of Commissioners.

During the course of the scrutiny process, we found that:

- People we spoke to were not clear about the pathway
- Substantial work was going on to improve the Councils commissioning of Adult Social care services and specifically care home services, informed by recent financial constraints. This included the Councils intervention to a Southern Cross Care Homes and working with them to improve the quality of services.
- Practices observed in commissioning services is changing.
- The purpose of the scrutiny – the 08/09 CQC assessment of ''adequate'' – was overtaken by the subsequent CQC assessment in 2009/10 of ''well''.

On the basis of the above, the remit for the Scrutiny Team as outlined in the letter to Southwark Council (Appendix 3) has been fulfilled. However, given the accelerated progress of the transformation of the Adult Social Care System as well as the added financial cuts, the Adult Social Care system is still in its early stages in establishing a robust Adult Social Care system, but this is outside the remit of this Scrutiny Team.

After its initial shock, the Council acted strongly to address the adverse Report from the CQC and succeeded in increasing the Regulator's rating suggesting that sufficient progress had taken place. The Scrutiny Team's own observation confirmed this and so we are satisfied that we are able to provide that reassurance to residents to which we referred at the onset in Section 1.

We would also like to note that while the original intention of the scrutiny team was to provide an evidence-based report on the quality of older people care homes leading to a possible Enter & View, influences noted earlier redirected our focus onto the quality of commissioning of care homes which can affect the quality of care homes, and the care home pathway.

In particularly, we would like to draw attention to Appendices to 4, 5 and 6 to Southwark residents. Southwark residents will find these sections useful during this period where the adult social care system is changing. It helps to get a vital understanding on what happens when you or a relative may be in need of a care home placement. Understanding the way the care pathway and system works, helps in finding what you or your relative/friend need to get the best help for them.

Appendix 6 gives an general understanding to Southwark residents on commonly used terms that are not always clear to understand such as 'Commissioning, Providers, block contracts', and what this means for Southwark, especially given the recent media publicity on care homes.

6. Future Considerations:

During our scrutiny there have been no adverse situations found, however certain matters and issues need to be highlighted relating to the commissioning of Care Homes for Older People:

- the low level of awareness of the Care Home pathway by residents,
- there is not a commissioning related 'Approved List' for Providers, how do carers begin to choose care homes?

Some concerns do not directly relate to this remit, but are of importance to Southwark Residents and are noted below.

Care Home Pathway

- **Clarity on why a Care Home Placement is given and what social care they offer.**
  Clear criteria and information on *when, why and in what situation* a care home placement is needed and given. This should be provided freely to *promote understanding* of the reasons for a care home. It would also correct misperceptions especially in the older community.

- **Publicity and wider awareness in the community**, especially older people, of the central contact point for social services. Not everyone can access the internet, or know who to telephone. The most vulnerable being those who are isolated.
  - ***The Team has noted that the Council has since established a central contact point for all social care services***

Commissioning

- To develop a system of a 'select or approved list' where providers are only included on the list after being vetted/examined to a certain criteria. This will help when short listing providers for services. This should incorporate strong specification criteria with effective monitoring mechanisms and evaluation tool in place to encounter risks to quality of service. Such assurances will help Personal Budget Holders. [10] It will also help Carers to begin to select care homes, while some appreciate reliance on Social Workers helping, choosing a care home can bewildering.
  - ***The Council are setting up a Social Care Directory online, but at time of publication there has been no confirmed vetting criterion for providers.***

7. The Way Forward

LINk Southwark notes that the meeting of the Council's Health & Adult Social Care Scrutiny Sub-Committee (HASC) on 4th May 2011, records the concerns both for the past and for the future similar to its own.

In order to continue to develop the LINk's scrutiny function and practice, as the Scrutiny Team completed its remit, an Adult Social Care Scrutiny Task Group is being established, to report to the soon-to-established new Leadership Group. Its approach will be scrutiny-based, however its specific work plan has yet to be confirmed. The task group will monitor and report to residents the changes that are taking place in Southwark's Adult Social Care System, with a focus on the commissioning and delivery of social care in a rapidly changing and financially challenging environment.

The LINk hopes that in accordance with best practice, it can jointly work with the HASC in exploring our common concerns and remit. It hopes its action will provide the basis for the future system of scrutiny by the emerging

[12] The Scrutiny did not look at Southwark practices in comparison against other local Councils; however this may be a future consideration for the Adult Social Care Task Group.

local HealthWatch as proposed in the Health and Social Care Bill being considered by Parliament at the time of this report's publication.

Glossary

Below are commonly used terms throughout the report. We have described the meaning and context in which we use these terms.

- ''**Older People''**: This refers to people aged 65 and above.

- **''Service Users'':** refers to individuals who use or receive social care services.

- **''Council Support''**: refers to individuals who receives funding either in part or in full by Southwark Council. This report refers only to these individuals, unless explicitly stated.

- **''Care Homes''**: refers to Residential Care Homes of both Personal Care Homes and Nursing Care Homes. Care Homes are registered as providing Personal Care or Nursing care, and can be registered for a specific care need, e.g. dementia or terminal illness.
    - **Personal Care Homes**: provides accommodation, meals and personal care for older people. Personal Care can include help with bathing, dressing and preparing meals, to those who are unable to do so without help.
    - **Nursing Care Homes**: provides the same services as personal care and will also have a qualified nurse on duty twenty-four hours a day to carry out clinical/nursing care. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse. They will only accept people with nursing needs or in certain circumstances people with personal care needs at present but will need nursing care later.

- **''Fair Access to Care services (FACs)'' / ''Eligibility'':** This refers to the national governments eligibility criteria for Adult Social Care, known as FACs. There are 4 bandings: from low, moderate, substantial and critical needs. Each Council sets its own criteria based on this. The Council will assess the individual's level of need, and if it meets the Council's criteria, they will *eligible* or entitled to support. Southwark Councils criteria are individuals with needs of a substantial or critical nature. (For more information, please see Appendix 4.)

- **''Reablement'':** is a free and short term (usually 6-weeks) intensive treatment to help individuals re-gain the ability to carry everyday tasks they previously were able to do. They work with the individual to help regain mobility, confidence and life skills such as preparing a meal. This is designed to avoid individuals being re-admitted into hospital, help with recovery after an illness and/or to avoid entering into a care home or long term home care package.

- **Care Quality Commission (CQC):** is the Independent Regulator for all health and social care services in England. Each Provider/service must be registered by the CQC.

- **Commission for Social Care Inspection (CSCI)** was the CQC's predecessor.

- **Star Quality Rating:** shows the quality of care at the care home following assessment by the CSCI (CQC predecessor). From lowest to the highest rating:
    - 0 Star = Poor
    - 1 Star = Adequate
    - 2 Star = Well
    - 3 Star = Excellent

List of Appendices

Appendix 1: Sources of Information

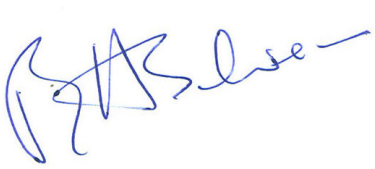
We would like to show our appreciation and extend our thanks to the organisations below that assisted with our scrutiny:

- Age Concern
- Alzheimer's Society & Dementia Cafe
- Care Home Advocates / IMCA
- Care Home Representatives
- CQC – Southwark / CQC service Inspector
- Lay Inspector Schemes
- Oxfam
- Southwark Council – Procurement & Commissioning
- SPC Advert
- various Older People Community Groups including
    - Dulwich Library Older People meeting
    - Over 60+ Garden Party
    - SMWA – Older People BME Groups

We would also like to make a particular mention to the Lead Commissioning Manager for Older People and his team for giving us his time, frankness/transparency and consideration during the conduct of our work.

The Members of the Scrutiny Team include:

From the Steering Group:



Barry Silverman
(Lead of Scrutiny Team, Chair of LINk Southwark at the inception of the Scrutiny Team),

Felicia Boshorin
(Vice-Chair of Social Care)

Martin Saunders
(Vice-Chair of Health)

From the Host:

Alvin Kinch (Host Team Leader)

Sec-Chan Hoong (Host Researcher)

Kris Hall (Host Community Services Manager)

Appendix 2: Letter to Annie Shepperd, Chief Executive of Southwark Council.

Cambridge House
131 Camberwell Road
London
SE5 0HF
Tel: 020 7358 7005
Fax: 020 7703 2903
E mail: link@ch1889.org

4th January 2010

Annie Shepperd
Chief Executive
Southwark Council
160 Tooley Street
London
SE1 2TZ

Dear M/s Shepperd,

In the light of the findings of the CQC, you will not be surprised to learn that it is the intention of **LINk Southwark** to scrutinise Southwark Council's Commissioning and provision of Care Services for Older People in Care Homes and in their own homes. Scrutiny will be undertaken using the powers given to The LINk by The Local Government and Public Involvement in Health Act, 2007.

In the first instance, The LINk would like to meet with you and/or The Strategic Director of Health and Community Services, if you think the latter to be the more appropriate. The purpose of this Meeting would be, solely, to explore how the Scrutiny can best be conducted, and the facility that you will provide to the LINk Scrutiny Team, so that the Report, that The LINk will make to the Residents of Southwark, in pursuance of its Statutory Duty, is **Evidence Based.**

The LINk anticipates that it will:

- wish to meet with Council Personnel engaged in the Commissioning of these services as well as those engaged in Provision, at both Management and front - line levels
- need to have access to all relevant papers of which it will give Statutory Notice, in accordance with The Act
- use its **Enter & View powers,** according to The LINk Regulations, as a tool of scrutiny if it deems that this would be helpful to the Scrutiny process

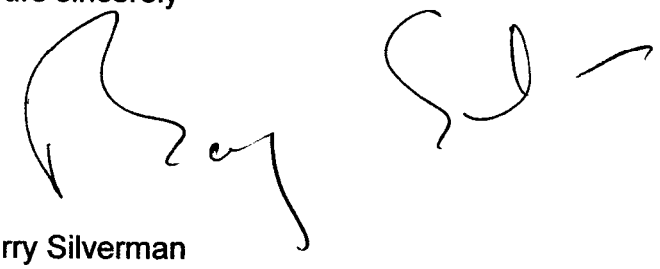
The LINk has as its objective the production of an 'Evidence-Based Report' to Southwark Residents that:

- describes both the process and the conditions as they are found to be in the course of Scrutiny
- recommends the action that is thought would be likely to help remedy any discovered adverse situations
- reassures residents that there is no cause for concern should this be the outcome of the Scrutiny and, therefore, the appropriate conclusion to be drawn from it

The LINk will be liaising with the **Adult Health & Social Care Oversight & Scrutiny sub - Committee** in accordance with suggested Best Practice.

The LINk now looks forward to hearing from you with a view to an early commencement .

Yours sincerely



Barry Silverman
Chair of LINk Southwark

Copy :

Susanna White, Strategic Director of Health and Community Services

Councillor David Noakes, Executive Member for Health and Adult Care.

Appendix 3: LINk description and powers

LINk Southwark is the Local Involvement Network which consists of local people, organisations and community groups. LINks give these people the opportunity to improve health and social care services in Southwark such as GPs, dentists, care homes and hospitals.

The Local Government & Public Involvement in Health Act 2007 section 221 states the current activities of the LINk as

(A) Promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;

(b)enabling people to monitor for the purposes of their consideration of matters mentioned in subsection (3), and to review for those purposes, the commissioning and provision of local care services;

(c) Obtaining the views of people about their needs for, and their experiences of, local care services; and

(D) Making—

(I) views such as are mentioned in paragraph (c) known, and
(ii) Reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services.

LINks were developed to look at:

- The quality of a health or adult social care service
- Access to services
- Proposed changes to health and social care services
- The care needs of different parts of a community
- The priorities of Southwark residents

LINks have statutory powers to:

- Visit care services to see how they are running (This is known as an ''Enter and View'')[13]
- Ask for information from the commissioners of services and get a response, by law, in 20 working days
- Make recommendations and get a response from commissioners
- Refer matters to the Southwark Council Health and Adult Social Care Scrutiny Sub-Committee

LINk Southwark is independent of the Southwark Local Authority and the NHS. LINk Southwark is supported by the 'host' organisation Cambridge House.

[13] This is a power unique to LINk and is not shared with Southwark Council.

Appendix 4:

Access and provision of care home services
– A LINk Southwark primer.

Initially, there are three stages process that need to be understood.

- Assessment
- 'Needs' and 'Eligibility'
- Care planning and Service Provision

1. Assessment

What triggers the 'duty to assess'?

There is *a duty* on all local authorities to carry out an assessment on an individuals need for community care services – even where the individual has made no request for one – once:

A) The individual has '*come to the attention'* of the authority
B) He/she appears to belong to one of the client groups for whom community care services can be provided
C) He/she might benefit form the provision of services

What happens in an assessment?

Unlike for children's services, there's no 'Common Assessment Framework'. There is no statutory definition of what the assessment process *should* consist of.

Section 47 (4) of the 'National Health Service and Community Care Act (NHSCCA*) of 1990', leaves it to the local authorities discretion of *how* exactly it carries out an assessment.

'Principles' of assessment are set out in the NHSCCA. '*Guidance'* exists (e.g. 'Fair Access to Care Services' – FACS) which directs 'Good Practice' – for example, to involve fully the individual and the carer of the individual in the assessment process. These principles and guidance have been further developed by case law. Obviously, 'case law' exists because people have challenged their assessments as being flawed and have achieved concessions on various grounds.

Timescales for assessment:

There is no specific time limit for carrying out assessments and chronic delay is therefore a feature of many authorities' assessment processes. A problem for 'advisers' (i.e. carers, advocates) is deciding when a 'delay' amounts to a 'refusal to assess'. In practice raising legal arguments about delay in assessment generally leads to an assessment being carried out!

Identifying a need during assessment:

Section 47 (1) of the NHSCCA* 1990 requires authorities to 'identify those needs that *can* be met by the provision of a community care service'. For example, if the assessment identifies a health or housing need, Social Services has *a duty* (under Section 47 of NHSCCA) to refer the individual to the Health or Housing Authority.

Carers Assessments

The Carers and Disabled Children Act 2000 gives carers an independent right to have *their own* needs assessed – regardless of whether the person they are caring for is also having an assessment. The 'Carers Assessment' may therefore identify needs that may impact on any assessment of the person that they are caring for.

2. 'Needs' and 'Eligibility'

How is 'Need' defined?

There is no statutory definition of 'Need'. Policy, practice and case law give only some helpful guidance.

The 1991 Practice Guidance subdivides 'Need' into 6 broad categories:

1. Personal/Social Care
2. Health
3. Accommodation
4. Finance
5. Education/Employment/Leisure
6. Transport/Access

Each of which should be covered in any comprehensive 'Assessment'.

(NB: Case law has also recognised 'psychological', 'emotional' and 'cultural' needs – presumably when these have judged not to have adequately been recognised during the assessment under any of the existing 6 headings)

Meeting 'Need'

Not all needs are capable of being met by service provision. Need identified during assessment that cannot be met through service provision is called 'Unmet Need'. The Practice Guidance advises that 'Unmet Need' be recorded in a care plan.

However, there is no guarantee that even when an identified 'Need' *can* be met by service provision it *will* be met by service provision. This is because there is a conflict between balancing an individuals needs with the availability of limited resources.

Eligibility Criteria

In deciding whether services will be provided to an individual, the Local Authority will determine whether the individual is 'eligible'. It will do this by referring to its own 'Eligibility Criteria'. If an individual does not meet the Local Authorities 'Eligibility Criteria' they may not be provided services by the Local Authority. For example, Southwark only provides services for individuals whose 'Need' is defined as being 'Critical' or 'Substantial' (see section 4 for FACS 'superseded 2010' definition).

What happens to those not eligible?

If services are not offered then the individual must be presented with a written explanation of the reasons for this. A Council must have satisfied itself that an individual not eligible for services needs will not significantly worsen or increase in the foreseeable future and compromise key aspects of independence. The individual will then be signposted to alternative providers.

3. Care Planning and Service Provision

Care Plans

There is no statutory duty to provide a care plan. However, Policy Guidance and case law support care plans. FACS guidance states that if a person is assessed as having a need and is eligible for services, then a council should develop a care plan involving the individual in the process. The guidance sets out the minimum criteria:

1. Note of Eligible Needs
2. Preferred outcomes of service provision
3. Contingency plans for emergency changes
4. Details of services to be provided, any charges the individual is assessed to pay, of if direct payments have been agreed.
5. Contributions of carers and others who are willing and able to make
6. A review date

Does the service user have any options about choice of alternative care packages?

First and foremost, the proposed package must meet assessed needs. The Local Authority is obliged to take into account the views, wishes and preferences of the service user and his/her carer. However, the decision of how to provide for assessed needs ultimately rests with the Local Authority.

What kind of services could be provided?

Non-accommodation:
The objective of Community Care Provision is to ensure that people are enabled to achieve maximum control and independence over their lives and to live in their own homes wherever possible. The Policy Guidance 1990 stresses that in order to obtain the objective of ensuring service provision as far as possible preserves normal living, there should be an order of preference in constructing a care package. The first preference should be to provide support for the user in his or her home. This may include provision of radio, TV, mobile library service, travel and other assistance, home adaptation and disabled facility, meals, holidays, telephones and ancillary equipment.

Residential accommodation:
A residential setting where a number of older people live, usually in single rooms, and have access to on-site care services. Since April 2002 all homes in England, Scotland and Wales are known as 'care homes', but are registered to provide different levels of care. A home registered simply as a care home providing personal care will provide personal care only - help with washing, dressing and giving medication.

A home registered as a care home providing nursing care will provide the same personal care but also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.
Some homes, registered either for personal care or nursing care, can be registered for a specific care need, for example dementia or terminal illness. Clients will either remain in the borough, or, be placed in accommodation outside of the borough (NB: In this case, the 'placing authority' will in most circumstances remain responsible for the provision of that care).

Preferred Accommodation:
A preference for a particular accommodation over another can be expressed; however, there is no obligation for the authority to provide this if it is more expensive than what the council would normally pay. The accommodation must also be suitable to the persons needs as defined in the assessment

4. Eligibility Criteria

The Eligibility Criteria refers to the Fair Access to Care Criteria (FACS). This supersedes February 2010 version):

Critical – when

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or vital involvement in work, education or learning cannot or will not be sustained; and/or vital social support systems and relationships cannot or will not be sustained; and/or vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial - when

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate - when

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

Low – when

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not be sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

Appendix 5 – What happens in a Care Home pathway?

People go into care homes usually when they are unable to appropriately care for themselves or do not have someone to provide that care. This will affect their health and well-being and is commonly referred to as 'social care'. It is triggered by a referral from any health professional, family or friend, to the Southwark Council Social Care Services.

An assessment of Social Care needs has to take place before services can be provided. The outcome of the assessment will decide whether a care home place is the best option for that individual. It can be on a temporary basis or permanent basis.

The pathway highlights various important checkpoints in the Care Home pathway. This includes the quality of the individual's first contact with social care services, and the limited understanding of why care homes are a care option and alternative care options. It also brings to attention, the importance of universal services in terms of public awareness and accessibility, as well as changes to care planning via the Personalisation Agenda bearing in mind that the Agenda only applies to those who qualify for Council Support.

The pathway to a care home will generally incur 6 stages. (Figure 1) provides a flowchart diagram of this pathway.

Summary of Care Pathway

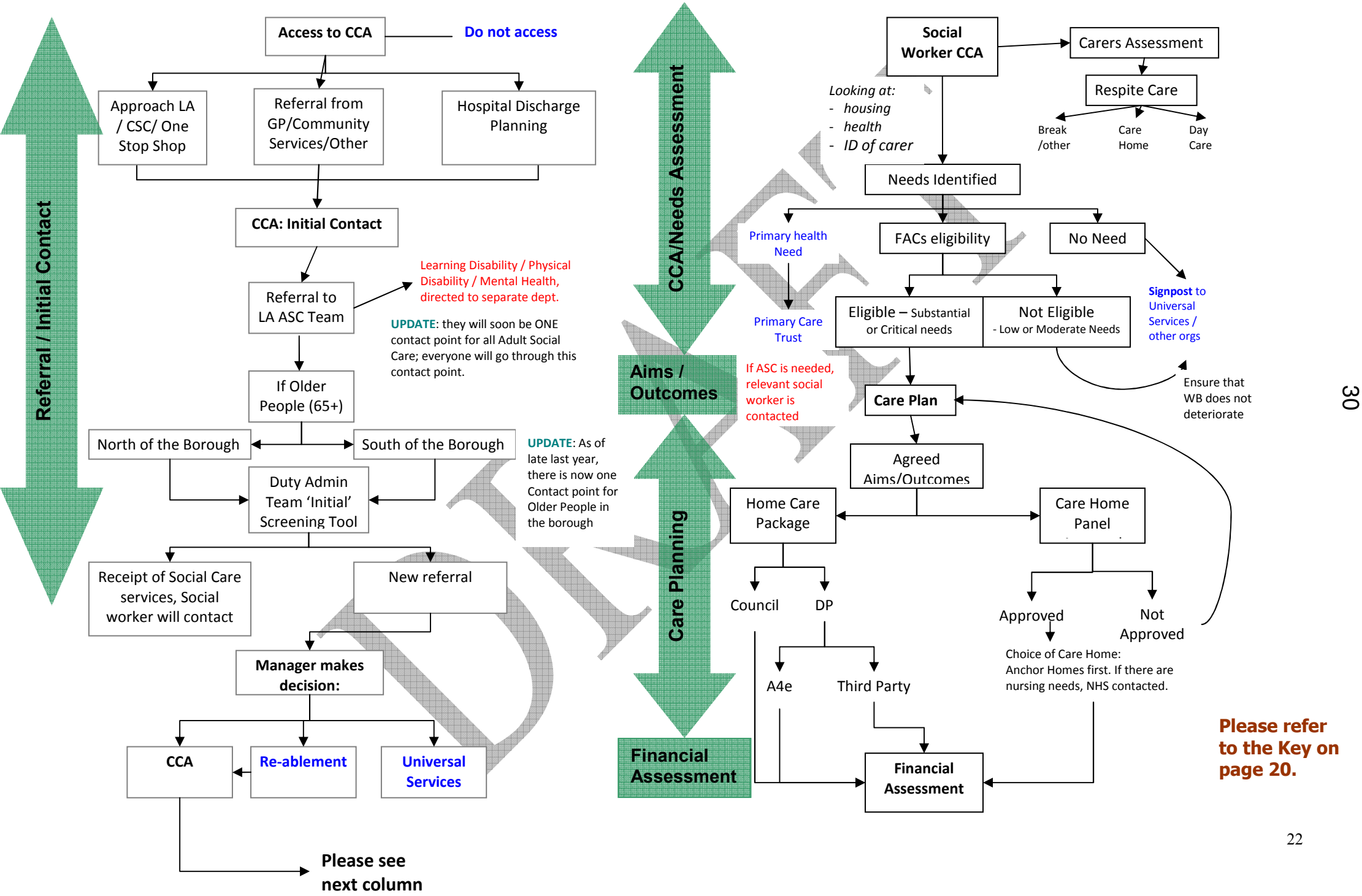
Stage 1:	Referral
Stage 2:	CCA / Needs Assessment
Stage 3:	Needs Identified
Stage 4:	Eligibility
Stage 5:	Care Planning and Outcome
	Residential Care Home Panel Procedure
Stage 6:	Financial Assessment

Key to the Care Home Pathway flowchart (Figure 1)

ASC – Adult Social Care
CCA – Community Care Assessment (also known as a 'Needs Assessment')
CSC – Customer Service Centre
DP – Direct Payments
FACs Eligibility – Fair Access to Care Guidance
ID - Identification
LA – Local Authority
WB – Well Being
Blue Text – indicates an individual not receiving care from the ASC system

Please refer to Figure 1 on the next page.

Appendix 5: Figure 1: What happens in a Care Home pathway?



Please refer to the Key on page 20.

Appendix 6: Commissioning Process

In order to understand the CQC's 2008/09 assessment of Southwark Council as providing Care Homes assessed as ''adequate'' or ''poor'' we need to understand how Care Homes are commissioned. Therefore this Report summarises how Care Homes for Older People are commissioned by the Council; firstly it provides the definition of commissioning, outlines the process, shares who the main Providers are, the monitoring arrangements and how it is paid for.

1. What is Adult Social Care Commissioning?

- **Commissioning** relates to buying services for a specific need or aim. Commissioning involves finding out what is needed, looking at the options available, choosing the best solution and then seeing if that service or organisation can be improved at the same time as balancing the cost and the quality.

- The council **currently commission adult social care services on behalf of Southwark residents**. This means that the Council do not directly provide the service but pays someone or an organisation to carry out that service based on the Councils rules (specification criteria). A contract document states the rules and agreement for both the Council and the organisation.

- When the Council is going through the commissioning stages for a service, they have to follow the Councils Contract Standing Orders (CSO). Adult Social Care Commissioning also has its own internal social care guideline which they must follow on top of all the CSOs. All decisions follow the CSO pathway.

- In Adult Social Care, commissioning occurs in **Block or Spot contracts**. *Block contracts* are long term agreements with a Provider to give a continued and consistent service, whereas *spot contracts* are a one-off agreement for a specific purpose or need that cannot be met by the block contract. This applies to all home care, day care and care home services.

- In early 2010, the Council acknowledged the need for clearly defined roles in Commissioning by putting in place a Commissioner for each service user group: *older people, learning disabilities, mental health and physical disabilities.*

2. How are Care Homes commissioned?

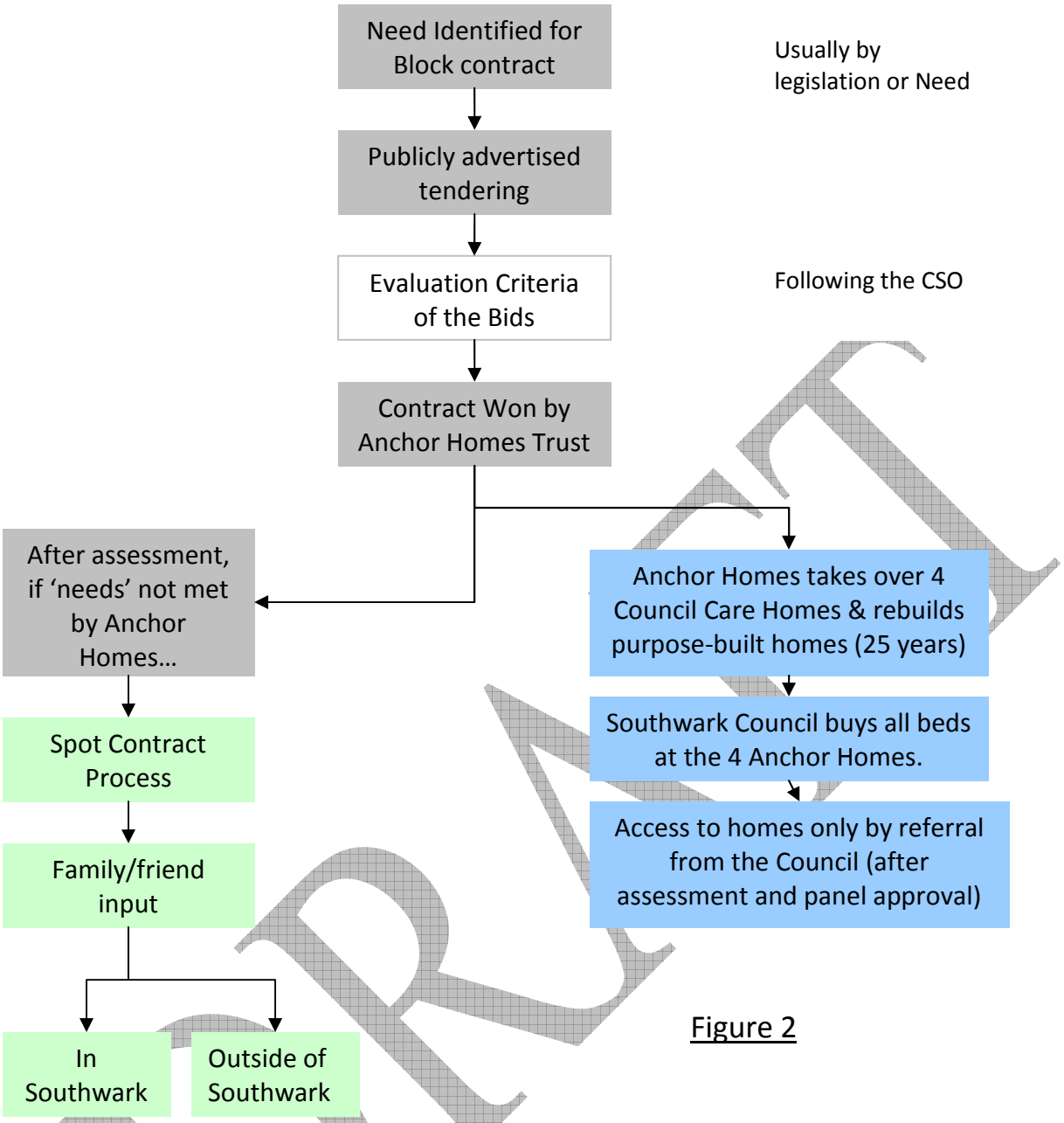


Figure 2

During the 1990s, Southwark Council stopped directly providing Care Home services. Instead they paid an external organisation to run their care homes. This was because of the national policy introduced in 1991 to separate the Provider and Purchaser function, as part of the wider context in trying to establish an internal NHS market.

The Main Providers

a) Anchor Homes (Block Contract)

Following the flow chart above (figure 2), Anchor Homes won the big long term contract known as a block contract. This contract was agreed for 25 years. Anchor Care Homes include Blue grove House, Greenhive House, Rose Court and Waterside.

The Block Contract was based on the agreement that Anchor Homes would be guaranteed an income during the years of contract, in order for them to re-build and invest in the four care homes it was taking over. This meant:

- That Southwark Council would buy all their beds at their homes – regardless whether the beds were occupied or not – at an allocated fee per bed. At the time, it was deemed to be cheaper in the long term than buying single beds when needed.
- Access to Anchor Homes beds is only through referral from Council Social Services
- A preference for individuals to be placed at Anchor Care Homes, if their needs could be met there.

b) Southern Cross (Spot Contracts)

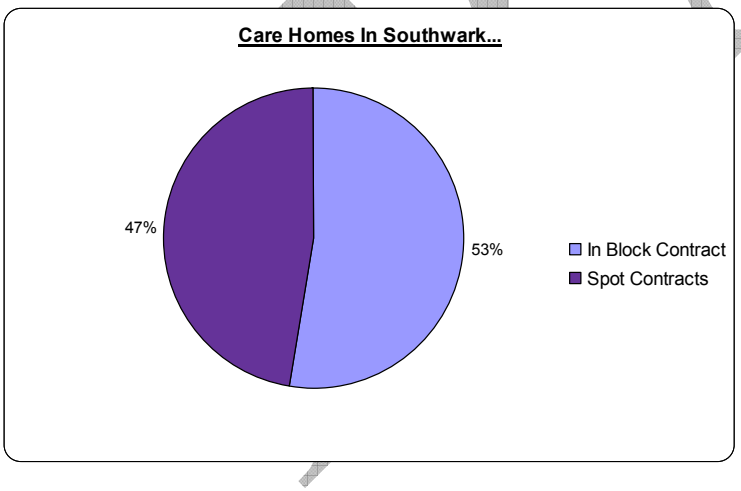
Needs that could not be met at Anchor Homes, which were mainly nursing needs as Anchor Homes lacked the appropriate registration, was met at other care homes as and when needed. This is known as 'Spot Contracts'. Exact details on spot contracts are unclear, but we know that Spot Contracts are agreed after deliberation with the social worker, individual and family. Personal and family choice can affect the Council's number of lower rated Care Homes as mentioned in the CQC Assessment 08/09. [14]

The main recipient of these spot contracts is Southern Cross. Southern Cross was receiving 'adequately'' rated reviews from CQC. During the scrutiny progress, the Council have intervened to avoid placements in these named homes as well as working with them to improve its commissioning quality.

***NB**: Southern Cross have recently moved to new operators due to financial reasons. Southwark Council have released a press statement found in the link below.*
http://www.southwark.gov.uk/news/article/453/important_update-southern_cross_care_homes

Breakdown of Placements and Main Providers

- **Inside Southwark, 53% of placements are in Block Contract and 47% of Spot Contracts.**
- **Inside Southwark**, 77% of spot contracts are in Southern Cross Homes.
- **Outside of Southwark**, all placements are spot contracts and make up approx. 42% of all care home placements.



***Note**: based on figures received in Oct 2010. There are a total of 312 residents in Southwark-based Care Homes, 164 in Anchor Homes, and 148 in spot contracts.*

Figure 3

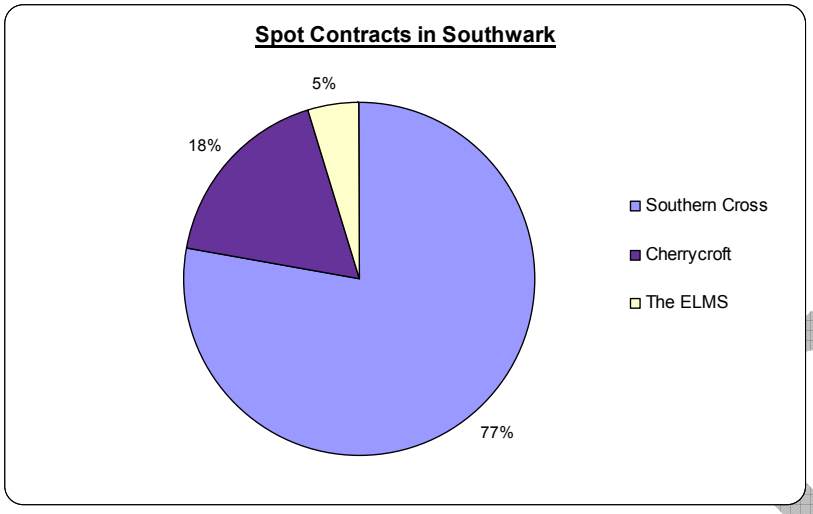
Context[15]
The Council's temporary embargo on some Southern Cross care homes and its quality concerns, combined with the limited nursing care homes in Southwark, meant that the Council had to look outside of the borough to find nursing home placements. In addition, a substantial influence of out of borough placements was due to family connections.

[14] Recognised by CQC ('The Quality of Care Services Purchased by Councils'' Nov 2010) and Southwark Council, but we are not clear how big a factor this is.
[15] 2005 Contract Variation between Anchor Homes and Southwark Council saw Southwark Council decrease its purchase of beds from 100% to 80%.

The increase in Care Home reliance as a means of providing council support also contributed to the Councils assessment.

Figure 4

Breakdown of Spot Contracts In Southwark



Note: Southern Cross and Cherrycroft are run by private sector providers and The ELMS is run by a charity provider.

Figures are out of a total of 148.

3. Monitoring Care Homes

Who monitors Southwark Care Homes?

- Southwark Care Homes are monitored by the CQC, Southwark Council and the voluntary Lay Inspectors Scheme, run by Age Concern Lewisham & Southwark.
- All care homes must be registered with the CQC and undergo periodic inspection and monitoring. The Council also separately monitors care homes where they have purchased placements.

Within the Council's ASC department, under the commissioning side, there is a **Contracts Monitoring Team** (CMOfficers) who monitor all spot contracts and Anchor Homes in Southwark. The team work from a monitoring framework which includes monitoring visits; planned and unplanned, service user feedbacks and activity reports submitted by service providers. The CMO team work with both Lay Inspectors and the CQC as part of its monitoring framework.

Lay Inspectors also have the independence/authority to visit unannounced without Council officials, as well as announced with Council officials. They aim to provide a 'human perspective' away from regulations. **CQC** have designated Southwark inspectors as well as a Southwark Performance Manager.

Out of borough placements are monitored through issues raised by residents, families or issues that may become apparent during social work reviews of residents. Information on that borough, embargoes, past issues and current issues are also monitored.

There is some uncertainty regarding the exact monitoring mechanism of homes outside of the borough, as well as the auditing of this information, whether this is done in retrospect or proactively.

4. How is a Care Home placement paid for?

Once it is determined that a Care Home placement is required, it must then be determined who will pay for this. The potential resident is financially assessed by the Council following national guidelines known as CRAG

(Charging for Residential Accommodation Guide). The outcome of this assessment will determine how *much the council will contribute* and *how much the individual needing the care will have to pay through* their private means.

A care home placement can be paid: *entirely* by the local authority, in conjunction with *Council support* or entirely *self-funde*d.

In contrast, a *self –funder* will pay their full care home costs, if they choose to bypass council assessment, or, are not aware of council assessment, or, if the council financial assessment has determined that the individual is financially capable to fund the entirety of their care needs privately.

Note: there is a different funding policy for Home Care.

What is taken into account?

When calculating the resident's contribution to their care home costs, *capital* and *income* is taken into account. There is an upper threshold of £23,250 and lower threshold of £14,250. Residents with capital above the upper threshold may have to pay the full cost of the care home. Capital value below the lower threshold will be eligible for council support. Residents with capital between these two values will have part of their costs met by the council.

There are different rules concerning married couples, dependent relatives, temporary residents and property ownership issues. The Council will follow the CRAG in applying these rules. More detailed information can be available on the department of health website or at the Council link below.

http://www.southwark.gov.uk/info/200091/services_for_adults/781/residential_care

Capital refers to payments that does not relate to a specific period and not intended to form part of a series of payments. It can refer to buildings, land, national savings, premium bonds, stocks and shares, savings in building society accounts/current accounts and trust funds.

Income represents a payment that is made in relation to a period that forms part of a series of payments. They do not have to be received regularly. Income can be taken fully into account partly or fully disregarded. Income received is calculated so that the amount is equated to a weekly basis.

What happens to a resident's property during the admission to a Care Home?

Last year a consultation took place by the government to look into the sustainability of funding for social care and support. This was known as the Dilnot Commission. While the Dilnot Commission has published its findings and recommendations in July 2011, there are no firm proposals on how to take forward the reform of social care funding.

The current situation is:

- If the resident is a permanent care home resident, the resident's main property is disregarded for the first 12 weeks of stay, after this period the residents property will be taken into account during their financial assessment. If the property is occupied by a partner or relative who meet the criteria (specified in CRAGs), then it is also disregarded
- if the individual does not have adequate income or capital after excluding the property value to meet the care home fees, the individual will be offered a ''deferred payment'' option. This means the value of care home fees will be deducted from the property value after the individual has passed away.

Cllr Mark Williams
Chair, Health & Adult Social
Care Scrutiny sub-Committee
160 Tooley Street
London
SE1 2TZ

Scrutiny Team
Direct dial: 020 7525 0514

January 2012

Dear ...

Southern Cross: Call for Evidence

Southwark Council's Health and Adult Social care scrutiny committee is looking into the recent changes to your care home ownership. We would like to understand how this has affected you. We are writing to tell you about the review and to explain all the different ways you can give your views and how we will use them. We very much hope you can help as hearing about and understanding your experiences will help us improve the way we deliver council and health services in the future.

The review

The scrutiny committee is made up of locally elected councillors and one of its roles is to undertake reviews and then make recommendations to the Cabinet, who run Southwark Council. We are looking at all three of the homes that used to be run by Southern Cross. We would like to understand the how the ending of Southern Cross and transfer of the Care Homes to new owners impacted on residents and their families. We would particularly like to understand how the care homes, Council and NHS Southwark communicated with residents and families during the recent changes. We are also looking at a number of other wider questions which are detailed overleaf, and you are welcome to make comment on these too.

How to give evidence

There are a number of ways you can give evidence. There is a short questionnaire enclosed with a free post address to return this directly to the scrutiny team.
We will be holding a special meeting in your home on XXXX. I hope you are able to attend. Written evidence can be submitted via email to scrutiny@southwark.gov.uk, or at the address at the top of the page, and should be submitted by 2 March 2012.

Lastly you are invited to give evidence in person at our next meeting. This will be held on Wednesday 14 March at 6:30pm at 160 Tooley Street SE1 2QH. Please book a place on the contact details below. We can arrange transport if you need it, pay for care expenses and help with any access needs.

How scrutiny will hold the review and make recommendations.

The committee will consider lots of evidence from different people who use care homes or have a responsibility for running them. For example we will ask Council and NHS Southwark officers to give their views and we will consider evidence from a Central government select committee comprised of MPs. If you give evidence we will make a note of this and then publish it, but we will not use your name unless you want us too. Once we have gathered all the evidence a report will be written. We will then send it to decision makers, such as the Cabinet, who run Southwark Council, and the local health service. We will also send you a copy if you give us your address.

Further information

If you have any queries or access issues, please contact scrutiny project manager Julie Timbrell on 0207 525 0514 or julie.timbrell@southwark.gov.uk.

Yours faithfully

Cllr Mark Williams
Chair, Health and Adult Social Care Scrutiny sub-committee

The Southern Cross review

The review is looking into the ending of Southern Cross and the transfer of homes to the new owners. As well as looking at the impact on residents and families we will also be looking at a number of related issues. The review will be considering the background to the demise of Southern Cross and the role of local and central government. We also be looking at what we can do better next time.

Background

Southern Cross was the largest care home operator in the UK. It was big privately owned business which had grown over the last decade and changed ownership several times. Around 2005 it separated out the care homes operation from the buildings ownership. Southern Cross was badly affected by the financial crisis in 2008, and so were many of the properties owners. The council started using less institutional care. Southern Cross could no longer afford it rents. In 2011 Southern Cross ended because of its financial problems and new owners took charge.

In Southwark the new owners of Southern Cross homes are Four Seasons, who took over Burgess Park care home, and HC-One, who took over Tower Bridge and Camberwell Green.

Broader questions the review will be asking:

- What was the background to the financial collapse of Southern Cross
- Who had responsibility for making sure that the business model was safe enough and what did central and local government do to measure risk.
- How can Southwark Council, Central Government, monitoring bodies, residents & families better understand care home businesses and make safer choices when we choose homes.
- Lastly the review will be considering all the different types of care homes in Southwark and asking if we have enough diversity. We will also be thinking about the type of residential and nursing care given at these homes. The review will be asking if Southwark's care homes meet our needs now, and if they will continue to do so in the future, particularly give our aging population.

Giving you views on the broader questions

You are welcome to contribute your views on any of the above issues. We have some background documents and we will be taking more evidence at the next meeting on and the 14 March. You are invited to attend this meeting. If you have access to a computer and the web you can access paperwork for the Health and Adult Social Care scrutiny committee online, including background papers for this review. Contact scrutiny project manager Julie Timbrell on 0207 525 0514 or julie.timbrell@southwark.gov.uk for more details.

Scrutiny team, Southwark Council, Communities, law and governance, PO BOX 64529, SE1P 5LX
Switchboard: 020 7525 5000 **Website:** www.southwark.gov.uk
Chief executive: Annie Shepperd

Care home questionnaire

We would very much appreciate it if you could take a few minutes to fill out this questionnaire by 2 March 2012 and either email it to julie.timbrell@southwark.gov.uk, or post to:

FREEPOST RSER-TXXL-EUEE
Southwark Council
Scrutiny team
160 Tooley Street (2/2)
London SE1 2QH

If you have any questions or have more to say then please contact Julie Timbrell on 020 7525 0514.

Survey of residents and families affected by the ending of Southern Cross and the move to new care home ownership.

Introduction

Southwark Council's Health and Adult Social Care scrutiny committee is looking into the ending of Southern Cross and its impact on affected residents and their families. The scrutiny committee is comprised of locally elected councillors and one of its roles is to undertake reviews and then make recommendations to the Cabinet, which runs Southwark Council. We would particularly like to understand how the care homes, Council and NHS Southwark communicated with residents and families.

Question 1 **Are you a resident of family member?**

Care home resident	
Relative	

Question 2 **Are you aware that Southern Cross used to own this care home and now it is run by XXX?**

Yes	
No	

Question 3 **If so, how did you <u>first</u> become aware?**

Care home staff	
Social worker	
A relative	
Resident	
Media	

Any other? Please give details: .....

Question 4 **Who has kept you informed through out the changes?**

Please tick all that apple :

Care home staff	
Social worker	
A relative	
Resident	
Media	

Any other ? Please give details: .....

Question 5 **How well do you feel you were kept informed and supported throughout the changes to the Care Home's ownership?**

1 to 10 (where 10 is very satisfied and 1 very unsatisfied)

1	2	3	4	5	6	7	8	9	10

Question 6 **What was good about the communication and support you received as Southern Cross ended and the care home's ownership changed?**

Question 7 **What could have been done better?**

Question 8 **Have you noticed or felt any changes since XXX has changed its ownership?**

Yes	
No	

Question 9 **What, if anything has changed?**

Question 10 **How did you feel about the care you or your family member received when it was owned by Southern Cross?**

1 to 10 (where 10 is very satisfied and 1 very unsatisfied)

1	2	3	4	5	6	7	8	9	10

Question 11

How did you feel about the care you or your family member receive now it is owned by XXX?

1 to 10 (where 10 is very satisfied and 1 very unsatisfied)

1	2	3	4	5	6	7	8	9	10

Question 12

Please comment on anything you feel important; this could include relationships with staff, activities, relationships in the home, visiting, meals, your routine care, medical care etc

Question 13

Do you have any other comments on the ending of Southern Cross and the recent change of ownership?

Question 14

Is there any other comment you would like to make?

Thank-you for taking time to fill in this form, please use the freepost address on the front cover to return the form by **14 February 2011.**

Your information will be kept confidential.

.....cut.....cut.....cut.....

Final report request

If you would like to receive a copy of the final report please fill in your name and address below, cut along the dotted line above and post this with your questionnaire. This information will be kept separately.

Name & Address:

Agenda Item 7

Item No.	Classification: Open	Date:	Meeting: Southwark Health & Social Care Board
Report title:		Southwark Safeguarding Adults Partnership Annual report 2010-2011	
Ward(s) or groups affected:		**All**	
From:		Terry Hutt Independent Chair of the Safeguarding Adults Partnership Board	

RECOMMENDATION

1. That the Safeguarding Adults Annual Report 2010-2011 is accepted and endorsed by members. The report was presented to the Safeguarding Adults Partnership Board 13th September 2011

BACKGROUND INFORMATION

2. Year on year there has been an increase in the number of safeguarding alerts received since 2006-7 when figures were first recorded. The figures for 2010-11 are 428 alerts of which 378 or approximately became investigations this compares with 377 alerts and 332 investigations in 2009-10. As in previous years, the majority of safeguarding alerts progressing to investigation concerned elderly people - 223 investigations or 59% of the total (with 46% of alerts concerning those over the age of 75). This is consistent with previous years, and is in line with national levels (AEA Prevalence Report 2007) which highlights that people over 75 years of age were most likely to be abused.

3. There are reports from member agencies of the Southwark Safeguarding Partnership on their activity in 2010 -12. In particular, NHS partners describe their response to the safeguarding adults agenda

4. The increase in safeguarding activity in Southwark in 2010/11 has taken place in the context of organisational, practice and proposed legislative changes. Over the last year in Southwark, personalisation has become the norm rather than the exception. In 2010/11 work to meet the Putting People First (PPF) milestones and personalisation agenda have changed the way that adult social care supports and safeguards people who use and commission services. Frontline teams are now assessing people for personal budgets which has meant that a greater number of individuals in Southwark, are able to create and choose their own support packages.

RISK FACTORS

None

Background Papers	Held At	Contact

Lead Officer			
Report Author			
Version			
Dated			
Key Decision?			
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / EXECUTIVE MEMBER			
Officer Title		**Comments Sought**	**Comments included**
Borough Solicitor & Secretary			
Chief Finance Officer			
Director Social Services/ CE PCT			
Executive Member			
Date final report sent to Constitutional Support Services/ PCT dispatch			

Southwark Safeguarding Adults

Annual Report 2010-11

CONTENTS PAGE

Foreword by the Chair of the Southwark Safeguarding Adults Partnership Board

In a time of considerable change, it is essential that safeguarding services are robust, flexible and responsive in order to respond to the challenges we face. These include embedding personalisation as the norm, organisational change in the public sector, particularly in the NHS, and changes as to how services are commissioned and their quality is ensured. All of this within the context of national financial pressures and reducing budgets. It is a challenge that we all have a responsibility to meet.

It is the responsibility of the Adult Safeguarding Board to provide leadership and direction. It is very likely that the Adult Safeguarding Board will be put on the same statutory footing as the Children's Safeguarding Board. It is a recognition that adult safeguarding is an essential service that must be available when and where it is needed no matter what the setting.

The following report details the safeguarding demands in Southwark and the work being undertaken in response. We have included some anonymised case examples to illustrate and explain the safeguarding process but most importantly the impact on individuals. The report also details how the council, the NHS and other partners are responding both individually and collectively.

I hope you find this report both informative and encouraging.

Yours sincerely

Terry Hutt
Chair of Southwark Safeguarding Adults Partnership Board

Executive summary

The year of 2010/11 has been one of considerable change which has had an impact on the way that safeguarding work is carried out in Southwark. Following a rating of "performing well" for safeguarding in the Care Quality Commission's (CQC) assessment of 2009/10, there has been a continued focus on ensuring that people are safe from harm and abuse. The year has involved work to ensure that the opportunities of the personalisation of adults services, including new personal budgets and the impact on safeguarding work, are realised in Southwark. There has also been work to ensure that people are helped to remain safe within the context of a changing environment in the public and voluntary sector in light of budgets cuts and a reorganisation that is taking place in the NHS.

Southwark like other inner London Boroughs has experienced a year on year rise in the number of safeguarding alerts. Encouragingly, an increasing number of alerts are being raised by the person at risk against whom the abuse is alleged to have been committed, their friends or family. With an increased number of alerts, there is also an increased number of safeguarding investigations. In 2010/11 more people in Southwark have been kept safe.

Southwark is a borough in which over the last year personalisation has become the norm rather than the exception. In 2010/11 work to meet the Putting People First (PPF) milestones and personalisation agenda have changed the way that adult social care supports and safeguards people who use and commission services. Frontline teams are now assessing people for personal budgets which has meant that a greater number of individuals in Southwark, are able to create and choose their own support packages. The implications of personalisation on adult social care commissioning are considerable. The previous model in which the public sector largely commissions and provides is being transformed, and this has also changed the nature of the safeguarding roles of individuals, families, friends and agencies.

The establishment of the personalisation model in Southwark has taken place in the context of a changing public sector environment. The local government settlement reduced Southwark Council's grant by 11.3% in 2011/12, with a further 7.4% reduction planned in 2012/13. This resulted in the Council agreeing to budget reductions, including in adult social care. At the same time, there has been a reorganisation of NHS Southwark with the development of cluster arrangements, that is, with the development of one PCT (the NHS South East London Cluster) to work across the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. This follows a requirement for London PCTs to reduce their management costs by 54% in one year so that the whole reduction would be in place for April 2011. The increase in safeguarding activity in Southwark in 2010/11 has taken place in the context of organisational, practice and proposed legislative changes.

The majority of safeguarding alerts in Southwark relate to acts of abuse which are committed within the victim's own home, often by members of their own

family or by friends. Financial abuse is particularly prevalent. However, as with any local authority in the UK many different forms of abuse are experienced by Southwark residents and some types of abuse are more prevalent than others. Whilst this report describes the preventative actions taken by Southwark Safeguarding Adults Partnership, in the era of personalised services and greater community responsibility, abuse is now more than ever before, everybody's business.

Introduction

Southwark Adult Social Care delivers services to thousands of its residents. This group of people are those generally described as adults at risk. Fortunately, as the following pages show only a relatively small number of people suffer abuse, however, for those that do the consequences can be devastating physically, emotionally and financially. This report describes the work undertaken by Southwark Safeguarding Adults Partnership to combat such abuse.

The Care Quality Commission (CQC) assessment of performance in relation to safeguarding adults in Southwark published in November 2010 stated that the borough was "performing well''. In particular, CQC noted that safeguarding adults governance in Southwark "had improved through the streamlining of the Safeguarding Board and its subgroups, which had maximised multi agency involvement and seen the appointment of an independent chairperson." The assessment also noted that "routine safeguarding was conducted appropriately."

The rating provided by the CQC inspection team was delivered in the context of increased levels of safeguarding activity in Southwark. Year on year there has been an increase in the number of safeguarding alerts received since 2006-7 when figures were first recorded. The figures for 2010-11 are 428 alerts of which 378 or approximately 88% became investigations this compares with 377 alerts and 332 investigations in 2009-10 or 88% of alerts becoming investigations. (see Appendix 1 – Statistical Information)

This increase in safeguarding activity has taken place in the context of the transformation and personalisation of services in Southwark. The transformation agenda aims to offer people greater autonomy, independence and choice over how their services are delivered. This has included the opportunity for people to have choice and control over their care via a personal budget. Adult safeguarding and personalisation share the same underlying principles of empowerment, autonomy and independence and both require the focus of any support to be on outcomes that people value.

The promotion of choice and control, particularly through the use of personal budgets and direct payments requires a change in the way risk is understood, managed and negotiated. To this end a series of bespoke training courses have been run for managers and practitioners on safeguarding and positive risk taking. At a more strategic level the Association of Directors of Adult Social Services (ADASS) has supported such work through various seminars and events and has published a paper covering the topic of personalisation and empowering people. The paper also included a section providing "Top 20

tips to make your area safer for vulnerable adults". At a regional level the "Protecting Adults at Risk, the Pan London Multi-Agency Policy and Procedures to Safeguard Adults from Abuse" serves to improve consistency and joint working across London. This document which was launched in January 2011, represents the commitment of organisations across London to work together to safeguard adults at risk. Southwark through its Partnership Board and safeguarding adult's manager played a major role in the development of the policy and procedures.

In 2010-11 adults safeguarding activity has taken place in an environment where there have been budget cuts announced by the Council, and a reorganisation of the NHS locally. Some key individuals who have supported safeguarding work in Southwark in previous years have moved to other opportunities, whilst other organisations and agencies, including Southwark's newly-established GP consortia, have taken on new responsibilities in support of safeguarding work. It is in this changing environment that the leadership role of the Adults Safeguarding Board has become increasingly important.

This report describes the activities for adult safeguarding during 2010-11 in Southwark and highlights work to ensure that safeguarding is at the forefront of the establishment of the personalisation agenda in Southwark. The report sets out key outcomes achieved, and actions that are now being taken forward in order to ensure people in Southwark are helped to stay safe from harm and abuse.

Safeguarding and Personalisation

The transformation of services and development of personalisation in Southwark, and the consequent work towards meeting the Putting People First (PPF) milestones, is changing the relationship of individuals, families, carers and social workers to the adult social care system. Our social care environment is now one where people increasingly create and choose their own support packages and contains opportunities and challenges in order to ensure individuals are kept safe from harm and abuse.

2010-11 has seen the considerable progression of the vision of service delivery in which people are supported to live independent and fulfilling lives based on choices that are important to them. Services have had to change. There has been a focus on individuals rather than institutions, with work to shift the balance of care in Southwark away from residential homes and towards more personalised support services in community settings.

Southwark has produced a "Vision for the future of social services" and a "Charter of rights" which aims to explain the transformation of services and Southwark's commitment to ensure people receive high quality support and services (see appendices 2 and 3). The Vision explains how services will be transformed and the consequent shift towards personal budgets and co-production of care and support. The Charter specifies the rights that people will have in relation to their care and support including the right to control over their own care and to be safeguarded from abuse. Work has already taken place in Southwark to examine how, by empowering individuals through the implementation of personalised services they have more control over their

lives and are better able to safeguard themselves. However as the Charter acknowledges, Southwark still has a key role to play in safeguarding adults at risk, but national research is beginning to show the more that people are empowered through personalisation of their services, the more capacity they are likely to have to manage their own safety.

Safeguarding and Personalisation Stakeholders Event

In November 2010 almost 100 delegates representing the customers and agencies that form Southwark Safeguarding Adults Partnership attended a stakeholders' event to learn about, discuss and develop ideas about how excellent practice in safeguarding vulnerable adults can be further achieved in Southwark.

Delegates were welcomed by Councillor Dora Dixon-Fyle, the Cabinet Member for Health and Adult Social Care, who affirmed the Council's commitment to making Southwark a safer borough and its determination to safeguard vulnerable adults.

Safeguarding and personalisation were the key themes delivered in the presentations given by speakers throughout the day.

Lucy Bonnerjea from the Department of Health (DH) delivered a presentation outlining the responses provided following the "No Secrets Refresh" consultation. This had been one of the largest consultation exercises ever undertaken by the DH and involved talking with and recording the views of 12,000 people including professional groups, private and voluntary sector representatives and a large number of service users, carers and members of the public. Lucy outlined the conclusions of the consultation including that safeguarding must be built on empowerment and listening to the person at risk, and that the language used in safeguarding was often difficult to understand and sometimes patronising. For example, people with disabilities argued that it is situations that make them vulnerable and vulnerability is not innate to a disability. People who took part in the review requested the term 'adult at risk' to replace the term vulnerable Adult for those who have been abused. They also felt strongly about the term alleged perpetrator and that 'person suspected of causing harm' often gave a truer representation of the circumstances behind the abusive situation which is often caused by informal carers such as family or friends reaching the end of their tether.

The presentation also outlined findings from talking to adults at risk of abuse stated out what they ultimately wanted from the process, during and after a safeguarding intervention. Essentially they wanted to be as fully involved as possible throughout, have things clearly explained to them and be at the centre of the process. The presentation also included a discussion about the changing legislative framework, including the Law Commission Review of Adult Social Care Legislation (published April 2011), and the Social Care Bill (proposed Autumn 2011) with the possibility of a statutory duty for both the investigation of safeguarding cases, and that partners such as the NHS, Police and Local Authorities should have a duty to co-operate in a Safeguarding Adults Partnership Board.

Sam Mayne, the Head of Transformation of Care in Adult Social Care Services delivered a presentation on how the customer journey was being embedded into Southwark to empower and give more choice to individuals. Jenny Millgate, Southwark Corporate Fraud Manager, delivered a presentation entitled 'Managing Finances Safely', providing definitions of types of fraud, people who are typically targeted and approaches to prevention.

William Case, a young man with a learning disability, shared his experiences of managing his own support services with assistance from brokers, and talked about his journey through a safeguarding investigation. The local authority within which William lived initially offered him a residential placement. However he chose not to go to go into residential care and fought for his own tenancy. William recruited and employed his own personal assistants and stated that his life was immeasurably richer than it would have been if he had been living in institutional care. However one of Williams's carers stole money from him and he shared his safeguarding experience with the delegates. He explained that it was very painful to be abused by someone he trusted, but by being involved in the safeguarding process throughout, and by being supported by the Police when taking the case to court, he was able to achieve resolution and closure of the episode for himself. He said the experience has certainly not made him think twice about living independently and concluded by encouraging delegates and other people who use services to take control of their lives and to always report abuse.

Closing remarks were provided by Susanna White, Strategic Director of Adult Health and Social Care in Southwark. Feedback from delegates was extremely positive and, despite adverse weather conditions, the day was very well attended.

Fairer Future for Southwark

In June 2010 the Government set out a plan for deficit reduction in an emergency budget which included a reduction in local government funding. Following further announcements, the savings across the public sector amounted to a real terms reduction of around 25% on average over the next four financial years in government spending.

The resulting local government settlement reduced Southwark Council's grant by 11.3% in 2011/12, with a further 7.4% reduction in 2012/13. The Council agreed a budget on 22nd February 2011 which set out a plan to implement these reductions.

The reduction in Council funding will impact on the Council's adult social care service, which makes up 28% of the council's budget. This funding supports some of the most vulnerable residents in the borough, including those with learning and physical disabilities and mental health needs. The Council takes its safeguarding responsibilities extremely seriously, and as noted above has made a commitment in its "Charter of rights" to safeguard adults at risk from abuse. The budget savings that must now be implemented need to ensure that those at risk are still enabled to stay safe from harm and abuse. There are rising demands on adult social care services and the Council already has

to make year on year reductions to manage this. Robust safeguarding structures and procedures will play an important role over the coming years to ensure that the Council reduces its budget whilst ensuring that people are kept safe.

Equity and Excellence: Liberating the NHS

The publication of the NHS White Paper, Equity and Excellence: Liberating the NHS, on the 21st July 2010 was the beginning of a far-reaching programme of change in the NHS which is having an impact at a national, regional and local level. The paper and subsequent Health and Social Care Bill includes proposals to transfer public health functions to local authorities, to abolish NHS Primary Care Trusts (PCTs) and, in their place, to establish consortia of GPs, and to set up new Health and Wellbeing Boards that will join up the commissioning of local NHS services, social care and health improvement.

Since the publication of the NHS White Paper there were two significant further developments in the health system for Southwark:

In October 2010, the Strategic Health Authority, NHS London, brought forward the requirement for London Primary Care Trusts (PCTs) to reduce their management costs by 54% by one year so that the whole reduction needs to be in place for April 2011. Following this there was a reorganisation of NHS Southwark with the development of cluster arrangements, that is, with the development of one PCT (the South East London Cluster) to work across the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. Once change that has been implemented by the NHS as a result of this development has been the termination of joint management arrangements between Southwark Council and the PCT.

In December 2010, Southwark GPs were awarded early adopter status to become one of the first GP consortia in the United Kingdom under the title Southwark Health Commissioning (SHC).

These developments in the health system do not change the crucial role of the health service to support safeguarding work. With these changes there will be new organisations that will need to be involved in safeguarding, notably the new cluster organisation and GP consortia and the Safeguarding Adults Partnership Board is changing its delegate structure to reflect this. There are a number of opportunities that follow from these changes, not least the local knowledge and understanding that GPs will bring in supporting safeguarding work and in becoming more involved in work to help ensure people are safe from harm and abuse.

Statistical Overview

The following section provides a brief analysis of safeguarding activity in Southwark in 2010-11. Safeguarding data and information is available in Appendix 1. All data is based on the AVA return to the Health and Social Care Information Centre.

Number of safeguarding alerts and investigations

In 2010-11 a total of 429 safeguarding alerts were received. This represents an increase of 51 or approximately 12% in the number of safeguarding alerts raised compared with 2009-10. This continues the trend of year on year increases since data was first collected in 2006-7. 378 alerts led to safeguarding investigations in 2010-11, compared with 332 last year. This represents an increase of almost 9%.

Who is raising alerts of abuse?

In 2010-11 safeguarding alerts were most frequently raised by the adult at risk themselves, or their family, friends or informal carer. However this statistical majority has reduced from 40.8% of alerts raised through this avenue in 2009-10, to 28% (107) in 2010-11. However, 60 alerts (15.9%) are recorded as being made by other service users. These would previously have been recorded in the family and friends category in the annual report and taken together these figures represent a reporting rate of almost 44% by people using services and their immediate families and other vulnerable adults.

Who are the adults most at risk of abuse?

As in previous years, the majority of safeguarding alerts progressing to investigation concerned elderly people - 223 investigations or 59% of the total (with 46% of alerts concerning those over the age of 75). This is consistent with previous years, and is in line with national levels (AEA Prevalence Report 2007) which highlights that people over 75 years of age were most likely to be abused.

Women remain more likely to be the subject of a safeguarding investigation than men. The gap between investigations involving women and men has remained fairly constant with 58% (221) investigations involving women and 42% (157) involving men compared with 57% female (190) and 43% (142) male in 2009-10. Again these figures are in line with London-wide and national reporting.

Location of abuse

The majority of investigations relate to allegations of abuse in the person's own home (239 or 63.2%). However, a significant proportion of investigations relate to allegations of abuse in residential and nursing homes or supported living settings (91 or 24%). These investigations always involve adult social care commissioners in addition to social work and health staff and often lead to service improvement plans which may include an increase in monitoring of the provider service by commissioning officers.

Outcomes of investigations

237 cases were closed within the year. 54 (22.8%) allegations were fully substantiated, 26 (11%) were partially substantiated, 50 (21%) were not determined or inconclusive and 107 (45%) were unsubstantiated. These figures are broadly comparable with the returns for 2009-10.

Whilst these figures for case conclusions may appear low they are typical for a London borough and reflect the difficulty in fully investigating allegations of adult abuse where the victim often lacks capacity to understand that they may have been abused and is unable to provide reliable information, or may feel intimidated or reluctant to provide information because the alleged perpetrator is a friend or family member. This situation is reflected in some of the challenging case studies cited in this report.

Most common types of abuse

In line with the previous years' data, the most common type of alleged abuse has been financial with 165 or 43.7% of investigations carried out concerning this form of abuse. This is a rise of 2.8% compared with last year, where 136 or 40.9% of investigations were concerning financial abuse. As in previous years older people are the service users who experience the highest prevalence of financial abuse with 117 alerts pursued or 71% of such alerts. It is unclear whether the tougher economic climate has contributed to this rise in cases, however, as in previous years, it is noted that this form of abuse tends to occur in families where there are multiple problems and deprivation across generations.

To more effectively combat the level of financial abuse there has been an increase in work involving the Southwark anti-fraud team. The Team works closely with social workers and the police in conducting investigations, pursuing proven perpetrators and in putting effective protection plans in place. A police officer is seconded into the team to assist with this work. The Council is also involved in the National Fraud Initiative and the safeguarding and anti fraud teams have contributed to the Metropolitan Police Operation Sterling anti-fraud initiative.

It has long been recognised that isolation can lead to people being more vulnerable to abuse and Southwark in its Vision for adult social care recognises that community engagement is one of the major components of ageing well and staying safe. Key to remaining actively engaged in the community is making full use of financial and other benefit entitlements. Southwark is seeking to ensure that older people receive all the benefits to which they are entitled. The Pension Service Joint Team is one of the most successful services across London with Southwark having higher levels of benefit payments for over 60's than any other London borough..

Physical abuse was the next most prevalent type of abuse with 128 investigations carried out represents 33.8% of all cases investigated. Compared with 2009-10 this is an increase from last year, when there were 90 alleged cases of physical abuse, totalling 27.1% of all allegations investigated. The majority of allegations of physical abuse are made against

family or informal carers, and whilst a minority of cases such as that in case study 1 are characterised by deliberate sustained cruelty, the majority such as in case study 2 come about because of carer ignorance or are one off events when a carer reaches the end of their tether. In these latter cases more help for carers is often provided, as in Mr B's case, through multi-agency intervention.

Allegations of neglect were the next most common form of abuse reported with 85 investigations carried out. There were 31 investigations into allegations of sexual abuse in 2010-11 totalling 8.2% of safeguarding investigations. This is a relative percentile increase of 3.7% on the previous year's 15 cases. The majority of allegations of sexual abuse allegations (12 or 38.7%) were reported by younger women with mental health problems, and could largely be categorised as domestic violence type issues in that allegations were made against current or former partners. These cases were very difficult to satisfactorily investigate as often the person at risk would withdraw their co-operation with the safeguarding process as the nature of their relationship with the alleged perpetrator changed. Whilst this does not mean that the alleged abuse was not real, research shows that this is often a common feature of such cases which makes them very difficult to satisfactorily resolve.

In 2010–2011 there were 6 investigations of institutional abuse carried out and no incidents of discriminatory abuse.

Below are two case examples of financial and physical abuse investigations which took place in Southwark, and the resulting outcome for the person at risk.

Case Study 1

Mrs A is an elderly lady who was referred to Southwark via Accident and Emergency in June 2010. Her needs included supervision when moving, and she had several serious health conditions. A safeguarding alert was raised after she informed staff that she did not wish to return to her family home as she felt unsafe to do so. Mrs A disclosed that she was being abused physically, financially and mentally by multiple members of her family; hospital staff observed bruising. A safeguarding investigation resulted in Mrs A choosing to move to a temporary placement within a care home, which could meet her physical and personal care needs. The placement subsequently become longer term at her request. Since being placed Mrs A's quality of life has improved, she has noticeably thrived, appearing more alert, is interacting well with staff and other residents and participating with all activities taking place in the home. Mrs A's finances are now managed by appointeeship. Mr. B is unable to express his opinion about the SA intervention. However his family have acknowledged the benefits of the intervention and an improvement to their son's well being now that they fully understand how to implement the guidelines.

Case Study 2

Mr. B is a 32 year old man with severe learning disabilities, suffering from cerebral palsy and dysphasia (a swallowing disorder). He lives with his two elderly parents and his brother's family. Mr. B's parents have a very limited understanding of English as it is their second language.. Mr. B was funded to attend a day service five days per week but his attendance was poor. During a review of Mr. B's support package his social worker became concerned about weight loss and a lack of compliance with recommended feeding practices. A referral was made for an assessment of Mr. B's eating and drinking to be undertaken.

During the assessment health professionals noticed that Mr. B appeared to be lethargic and had lost considerable weight since his last assessment. Due to the language barrier it was hard to establish why Mr. B's family appeared unwilling and unable to implement previous Speech and Language Therapy guidance regarding safe feeding positions; they were feeding Mr. B lying on his back on the floor. The family also expressed that they had concerns about Mr. B's weight loss and frequent bouts of ill health. It was observed that manual handling techniques were utilised which could pose significant risk of injury to Mr X. and that his family seemed unsure of how frequently they were required to administer their sons prescribed antibiotics.

As part of the safeguarding process a multi-disciplinary risk assessment was undertaken and identified that Mr. B was at high risk of malnutrition, dehydration, aspiration, asphyxiation and injury due to his situation. Mr. B's protection plan was complex and involved the close collaborative working of several professionals. He received improved access to generic and specialist healthcare, which included a referral for Video-fluoroscopic Swallowing Study (VFSS) and to the Home Enteral Nutrition (HEN) team.

It was noted that as English was a second language to Mr. B's family there was the need provide clearly translated information in order to explain the serious risks posed to their son's health and wellbeing, and to explain that their management of his needs was placing him at risk. His family responded well to advice and guidance and Mr. B's physical health has noticeably improved; he has put on weight and has regained function (e.g. he is now able to eat without his head being supported). He regularly attends day services where as well as enhancing his quality of life, his well being can be monitored, and he receives homecare support provided by culturally appropriate workers from the same linguistic background as himself and family. Due to severe learning disabilities Mr. B is unable to express his opinion about the SA intervention. However his family have acknowledged the benefits of the intervention and an improvement to their son's well being now that they fully understand how to implement the guidelines.

Deprivation of Liberty Safeguards

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA/DoLS) came into effect on 1st April 2009.

This amended a breach of the European Convention on Human Rights and provided for the lawful deprivation of liberty of those people who lack the capacity to consent to arrangements made for their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests, to protect them from harm.

Primary Care Trusts (PCTs) and local authorities (designated as 'supervisory bodies' under the legislation) have the statutory responsibility for operating and overseeing the MCA/DoLS whilst hospitals and care homes ('managing authorities') have responsibility for applying to the relevant PCT or local authority for a Deprivation of Liberty authorisation.

The legislation includes a statutory requirement for all care homes and hospitals as well as local authorities and PCTs to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person's representative and the documentation related to termination of authorisation.

The Safeguarding Adults Team manages the Deprivation of Liberty Safeguards for both the local authority and Southwark PCT. In 2010-11 the team processed a total of 31 DoLS applications of which 22 were authorised and 9 refused. Available data suggests that this is an average total for a London borough.

Working Together – NHS & Southwark Council

Local NHS partners have reported their commitment to working together to safeguard adults at risk in different ways. Community services have highlighted their contribution to this work below by describing their interventions in some case examples SLaM have also included some case examples and reported a whole system overview, and Guys and St Thomas's NHS Foundation Trust, and Kings College Hospital have also provided a whole system overview of their work in this area.

Community Health Service

Case Study 3– Care Home Support Team nurses

The Care Home Support Team specialist nurse was asked by Southwark Safeguarding team to help support them with a safeguarding case that they were investigating in a care home.

It involved a resident who had been at the home less than 24 hours. The London Ambulance service raised a safeguarding alert as they felt the home had not responded promptly enough to changes in her level of consciousness.

The home had taken a blood glucose level in the morning the result of which showed a stable blood sugar level. However by lunch time the resident was so drowsy she was unable to eat or drink. The GP requested staff monitor her condition and no further blood glucose levels or observations were taken until the ambulance was called later that day.

During the safeguarding investigation strategy meeting the Care Home Support Team gave advice around what the expectations of a care home and also the responsibilities of the nurse on duty should be, which assisted the safeguarding investigation to draw their conclusions about the allegation of abuse. They were able to discuss with the home actions that needed to be put in place to avoid further incidents of a similar nature.

Case Study 4 – District Nursing

District Nurse Service was providing insulin management care to a vulnerable patient who had diabetes and who was being looked after by her husband at home. However, he was obstructing their input and consistently prevented access into the home before 11am which impacted the vulnerable persons blood sugar level and placed her at risk. She was experiencing side effects due to poor management of her diabetes because of the delay, and she was being given a poor diet by her husband. Following a joint safeguarding meeting it became apparent that her husband appeared disengaged with both health and social services. Joint visits with the social worker and nurse were arranged with the patient and her husband to explain the risks to her health. Once the patient's husband fully understood the extent of risk he was inadvertantly placing his wife in, he agreed to allow District Nurses into his home at the approproate time and also accepted additional support. As a result, the patient is well and continues to be supported at home

Guys and St Thomas's NHS Foundation Trust

Partnership working

Close working partnerships have continued between the Trust and Southwark.

The Trust is represented in the 3 of the 5 sub-groups that support the Southwark Safeguarding Partnership Board. The Trust representative chairs the Health Provider sub-group and the group has completed key pieces of work which will be launched this year.

The Trust has worked closely with NHS London in setting up and supporting the Safeguarding Adults Network for NHS leads and was also an active participant in the writing of the London wide multi-agency procedures.

Referrals

During the past year a new referral system has been introduced whereby referrals to safeguarding are made via the electronic patient record system. The referral is submitted directly to the safeguarding team and to social services within the Trust. This has simplified the referral process and improved the quality of the referral with better information and contact details of the referrer.

Throughout the past year all safeguarding adult referrals relating to patients within the Trust, have been reviewed. The table below details the number of reported cases during April 2010 - March 2011:

April 2010 – March 2011	Q 1	Q 2	Q 3	Q4	Total
Safeguarding Adults Referrals	53	51	72	77	253

Most of the referrals are from A&E and the admission wards.

The themes arising from these referrals highlighted the following:

- The largest number of referrals has been for patients who self neglect for a number of reasons such as substance misuse, cognitive impairment or mental health problems.
- A significant number of people who are neglected or suffer other forms of abuse also suffer some form of cognitive impairment
- More than half the referrals were for people over the age of 65 years

Governance Arrangements

From April 2010, health and social care providers were required to register with the Care Quality Commission in order to be able to operate. In order to register organisations were required to demonstrate that essential standards of safety and quality set out under the Heath and Social Care Act 2008 were being and will continue to be met. The Trust is subject at any time to unannounced inspection by the CQC against any of the essential standards

for quality and safety, of which safeguarding is one. As part of the CQC requirements an NHS provider compliance assessment in relation to Outcome 7 (Regulation 11) has been completed and evidence collated.

A policy on the use of restraint has been developed and is awaiting ratification. The Trust is represented on the Lambeth and Southwark Safeguarding Adults Partnership Boards. The Trust is also represented on the Safeguarding Adults at Risk Steering Group for the Metropolitan Police - a bi-monthly meeting that focuses on joint working between the police and partner agencies.

The Trust Adults at Risk governance arrangements have been reviewed and updated. An Adult at Risk Assurance Committee has been set up and is chaired by the Chief Nurse. The committee meets quarterly and reports to the Trust Assurance and Risk Committee.

Training

Month	Number trained to date	Percentage of compliant staff	Total Number to train
April 2010	998	40%	2470
May 2010	1024	40%	2535
June 2010	1063	42%	2510
July 2010	1084	44%	2455
August 2010	1131	46%	2444
Sept 2010	2484	45%	5525
Oct 2010	2653	47%	5587
Nov 2010	2768	49%	5612
Dec 2010	2719	49%	5555
Jan 2011	2962	54%	5526
Feb 2011	3292	59%	5573
March 2011	3617	65%	5568

All staff have received Level 1 training in line with the Trust 2007 – 2010 safeguarding adults training strategy.

Level 2 training is offered to all staff who provide care and treatment to patients. With effect from October 2010, this training was available via an on-line package to all junior doctors as part of their induction. This e-learning package was also accessible to senior staff who have professional and managerial responsibility for clinical activity but not directly providing clinical care to patients on a daily basis.

Level 2 classroom sessions are provided to nursing and midwifery staff on induction. This is an interactive session and also available on request to groups of staff who would prefer this form of training to an e-learning programme. The Trust compliance with Safeguarding Adult training at Level 2 in March 2011 was 65% which is a rise of 16% since December 2010.

Kings College Hospital NHS Foundation Trust

King's College Hospital NHS Foundation Trust is situated on the borders of Lambeth and Southwark and is a centre for specialist care and a world-class teaching hospital. It is one of four partners in the Academic Health Sciences Centre, Kings Health Partners, which collaborates in world-class research driving a vision to become the best medical research campus in Europe. The Trust delivers a full range of services for the local population and specialist services to patients nationally and internationally, and has approximately 7,000 staff and 960 inpatient beds. The Trust's client group is complex and challenging, combining an ethnically and culturally diverse local inner city population, from areas of high mobility and social deprivation, with a non-local cohort of patients with additional vulnerability due to chronic illness or severe injury/trauma. King's is fully committed to the provision of support for patients and continuously strives to deliver high quality care in a safe environment. Kings has a 'zero tolerance' towards abuse and will take positive action to safeguard patients wherever necessary.

Current safeguarding adults team arrangements

The team was established in July 2009 and comprises a full time Coordinator and a part-time Administrator. The team has been joined by a Learning Disability Coordinator in January 2011. The key responsibilities of the Safeguarding Adults team are as follows

- response to alerts for all adults at risk groups
- support for mental capacity and best interests decision making issues
- training for all staff groups in safeguarding and mental capacity
- interagency working
- audit activity
- policy development
- implementation of 'Healthcare for All' targets relating to the health care of people with a learning disability.

Safe Recruitment

The Trust adheres to the mandatory Employment Check Standards issued by NHS Employers and Government legislation, which supports safeguarding. In December 2009 KPMG completed an independent audit of the Trusts recruitment procedures and reported a 'substantial assurance' to the Board of compliance with its own procedures and the Employment Check Standards. In September 2010 the Trust was awarded the highest level of achievement to reduce its litigation premium. This included an analysis of pre-employment checks. The Care Quality Commission conducted a check on pre-employment checks additionally on the 3 December 2010 and were satisfied with our compliance. All contractors (including for bank/agency/locum staff) are asked to confirm that they fully comply with the NHS Employment Check Standards and that they have appropriate governance and audit procedures in place to assure compliance with their own procedures

Training

Safeguarding Adults training is mandatory for all staff and two levels of training are available in the Trust.

The Level 1 course provides basic safeguarding adults awareness training and 47% of staff having been trained through e-learning to date.

22% of clinical staff have been trained to level 2 through 'face to face' and focussed departmental training.

The Level 2 course is delivered to include the following competences:

- Understand who is an Adult at Risk
- Know and understand the different categories of abuse
- Understand your responsibilities in the Safeguarding reporting process
- Understand your responsibilities to Learning Disability patients
- Know how to complete essential and relevant paperwork
- Basic understanding of the Mental Capacity Act (2005)

Monitoring and Governance

- The Safeguarding Adults Team were recently assessed by the NHS Litigation Authority to ensure compliance with the Safeguarding Adults Policy and have achieved level 3 status which is the highest standard attainable. All alerts are logged onto a secure database for critical analysis.

- An IT system is required which interfaces with the different electronic patient records systems in use across the Trust. This is a priority within the Trust's IT work plan.

- Currently, the Safeguarding Adults Team is able to add a 'special case' alert on the Emergency Department (ED) computer system, Symphony.

- The Safeguarding Adults Team regularly audit cases. Using the information from the Safeguarding Adults secure database in conjunction with information from the King's Datix system, the Safeguarding Adults Team provide a report 3 monthly to the Quality and Governance meeting which ensures a continuous improvement process and that risks are addressed.

- The Safeguarding Adults Team initiated the development of a cross-partnership information sharing mechanism.

Identification of Vulnerable adults

- Commissioning of an electronic 'flagging' system for vulnerable adults is a priority within the Trust's IT work plan

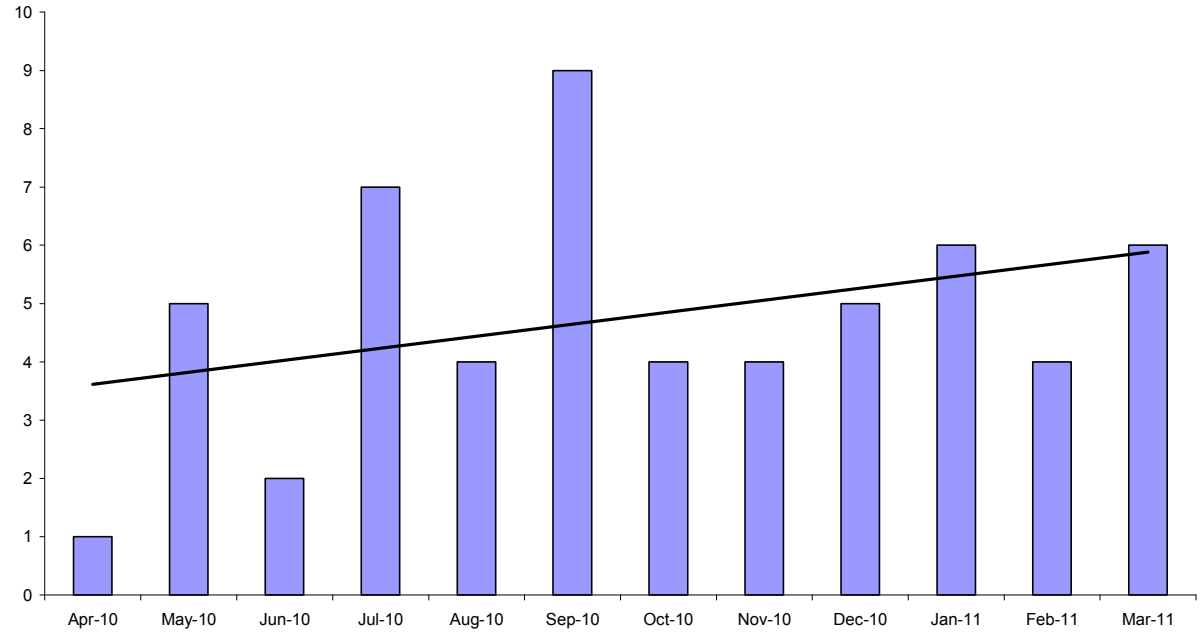
Achievements

- Multi Agency Skin Damage Launch, June 2010
- Development of a robust Learning disabilities service for King's
- Appointment of a Learning Disability Coordinator
- Stonewall Health Lives programme
- ARMS compliance August 2010 – Level 3.
- Returned CQC monitoring (pending outcome), December 2010
- Host of the **W**orld **E**lder **A**buse **A**wareness **D**ay 2011
- 'Healthy Passports'

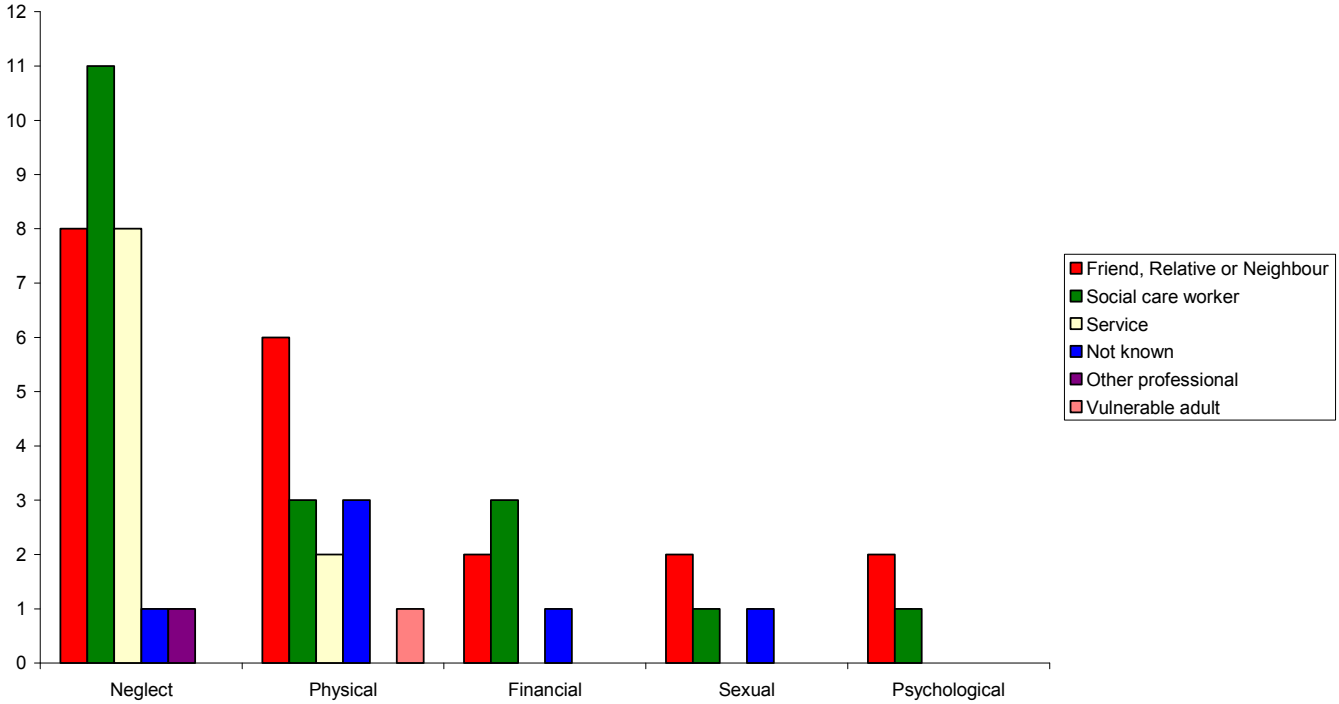
Southwark (April 2010-March 2011) Safeguarding Adults statistics

Of the 57 cases of alleged abuse, 4 (7%) relate to King's care. Of these alleged abuses, there were 2 allegations of neglect and 2 of physical abuse

Southwark referrals over last 12 months



Alleged abuse by type of perpetrator



SLaM NHS Foundation Trust

Partnership Working

During the past year the Trust has been looking at the possibility of introducing a new referral system and would like to look at this being implemented through the electronic patient journey system. Currently the referrals in Southwark are submitted directly to the safeguarding lead and they are reported to the LBS Safeguarding Team. In future they will also be reported to the Trust SUI system.

Throughout the past year all safeguarding adult referrals relating to patients within the Trust, have been reviewed. The table below details the number of reported cases during April 2010 - March 2011:

April 2010 – March 2011	Q 1	Q 2	Q 3	Q4	Total
Safeguarding Adults Referrals	13	8	12	17	50

Most of the referrals come via the LAS

Trends

The majority of referrals in Southwark over the last 12 months have come in via the London Ambulance Service, and in the main they refer to people brought in to A&E as a result of living in neglected circumstances although not directly being the victims of adult abuse. Typically a large number have alcohol dependence problems and the majority are already receiving services from the Trust.
The process currently followed for these is that the referrals are immedately forwarded to the Service Manager (for information and oversight), to the Team Manager and to the frontline worker involved (for action). They are asked to follow these up as part of their on going contact with the client, but also to initiating the safeguarding procedures where there is clear evidence of one of the seven forms of adult abuse taking place.
There have been a number of separate referrals for clients of drug and alcohol services

Audit Activity

Following a CQC visit to Lewisham and a Trust wide complaints meeting, an Audit was requested to see if any safeguarding issues were detected within complaints and followed up through individual patient care plans. The retrospective sample size used was selected from trust wide complaints from Quarter Four 2010 that reported themes relating to:-

- Property
- Assault
- Treatment and Care – Mental Health Assessment.

The sample consisted of 56 cases and from that a selection 13 (23%) were reviewed. A structured SNAP Questionnaire was used to survey the ePJS for these cases.

Number of cases from inpatient units and community

Cases	Inpatient	Community
13	9	4

Cases classified according to Clinical Academic Groups (CAGS):

CAGS	
Psychosis	9
Map	3
MHOA	1

Types of complaint

Complaints	
Lost Property	3
Assaults - verbal/physical by staff/relatives/patients	6
Treatment and Care – mental health capacity	4

Process implemented regarding complaints

Cases	13	
Safeguarding care plan	0	0%
Documentation Events	11	84.6%
Action taken	4	30.8%
Action not taken	7	53.8%
No documentation of complaint or action	2	15.4%

Conclusion

There is an insufficient awareness of safeguarding procedures where complaints are concerned. There is also a lack of standards and guidelines to support staff with safeguarding issues where complaints are concerned. Recommendation is for the Trust Lead to check that all CAGS have a Safeguarding Lead, for Policy review re: relationship to complaints and safeguarding issues and for an awareness campaign to staff of the new policy changes. The re-audit will take place once all the Safeguarding Leads are in place

In February this year SLaM's Clinical Audit and effectiveness Team also re-audited the Trust's existing Safeguarding Adults Policy, using a sample of cases on the DATIX database. There is an Action Plan in place to implement the recommendations of this Report.

Adult Safeguarding Lead Role

The Trust has an Adult Safeguarding Lead, and the Clinical Director has responsibility for implementing adult safeguarding at Trust Board level. However the structure for dealing with adult safeguarding more locally has needed to be reviewed.

We have recently been reviewing the Adult Safeguarding Lead role, in relation to the new Academic Health Sciences Structure and have developed an Adult Safeguarding Lead role for the new CAGS within the Clinical Academic Sciences Centre. This has posed issues for how local Borough reporting will work.

This role has been created with the SCIE Pan-London Guidance on Safeguarding Adults in mind. The role of the NHS in safeguarding is given greater emphasis in the Pan London guidance and it is to be more formally incorporated into the Trust's new Clinical Governance structures (thus highlighting its importance to all clinical directors, who will need to be aware of the issues involved and their responsibilities). Each Clinical Academic Group (CAG) has been asked to identify a lead person, and the following will be the main responsibilities of the role. The role needs to be held by a clinician or manager who is able to make decisions relating to the Safeguarding process.

Main tasks are to:

- Oversee implementation of the Pan-London Guidance in the CAG
- Decide on action when a safeguarding issue is raised (this can include deciding whether or not it is a safeguarding issue, especially in inpatient services)
- Ensure that the Safeguarding investigation and planning process is followed appropriately
- Keep track of recording, monitoring and actions taken in relation to safeguarding in the CAG, and report on outcomes to the trust and LA
- Receive the DATIX alerts and follow up as appropriate
- Liaise with the relevant LA safeguarding leads and systems
- Provide advice and support to the CAG staff on Safeguarding Adults issues
- Be a point of contact for CQC inspections.
- Support implementation of the MCA
- Attend the Trust Safeguarding Adults committee

The Head of Social Care for Southwark Integrated Mental Health Service has taken on the role for the Psychosis CAG, and the issue which currently needs to be worked through is how each CAG relates to the Safeguarding Board in the Boroughs, or whether there is a mechanism by which the CAG Leads report to the Trust Adult Safeguarding Board, and a different representative comes from that Board to the Borough Safeguarding Committee to represent implementation in all the CAGS in that Borough.

Case study 5

50 year old white female service user contacted the police about being harassed, and her ex-partner was called in for questioning. There is an order against him coming anywhere near her for at least the next 6 months as he is on licence for a previous offence. The Client was given a direct police officer's number to get support quickly in any future emergency and she has been advised about locking her door and not letting anyone unexpected into her flat (which is how he got into the flat the last time as she thought it was someone from British Gas who she was expecting at the time). If she feels unsafe she has been advised in future to go and stay with her brother. The client still does not feel safe in her flat, as her ex-partner lives near by. She has been supported to access housing advice regarding a move. She does not want to take up the option of a bed and breakfast or a women's refuge which was offered at the time by housing as she wants to wait and see if she can be re-banded, and then bid for another property. The worker has assessed her mental capacity to make this decision. The service user reported that she has had no further contact with the abuser since her initial report to the police. However she was given the number for domestic violence support. The worker and her team leader planned to re-assess the situation and see if they can support her in any other way with follow up in a month time to ensure no further contact form the abuser.

Case study 6

24 year old Black British male disclosed abuses against him by another patient in the same service, including physical assault, deliberately burning him with a cigarette and uninvited sexualised advances. He also alleged physical and financial abuse by another service user, from a separate service. In this case the person thought to be causing harm allegedly punched him in the stomach previously, and pressured him to use his cash card to make withdrawals to buy cannabis which they then smoked together. His mother and his tenancy support key worker strongly suspect that the latter abuser had stolen significant sums from the patient’s account in the process, but this has not been substantiated.

The client had been an inpatient at the same time as the two people who were thought to be causing harm. The patient had regular contact with one person, but only occasional contact with the other. On one occasion both alleged people thought to be causing harm were at the victim’s flat, and one had made sexual advances to him, and both had persistently punched his upper body in the context what he described as "play fighting." He denied that they caused or intended to cause him injury but acknowledged that this "play fighting" caused him significant psychological discomfort. It is unclear to what extent if any, the two individuals had ever or were continuing to collude in the deliberate exploitation (ie financial) of the person at risk

Protection Plan

The team reported the disclosed abuses to the Metropolitan Police at Camberwell Green Safer Neighbourhood Team. At the time the person at risk expressed a wish for them not to report the abuse to the police, but was informed that they had a duty do so, even against his wishes, in accordance with the 'No Secrets' policy. He was made aware that he was not personally obliged to give statements to the police, and was reassured that the matter would be dealt with sensitively in relation to his continued consensual (albeit strongly unadvised) contact with the people thought to be causing harm to him. The medium support project where the client resides was advised to seek a legal ban (or otherwise attempt to affect the equivalent outcome to force the people thought to be causing harm to stay away from the accommodation completely and permanently). This is a private/supporting people registered property - but the manager and clinical team both acknowledged an effective ban would be difficult to enforce if the client was unwilling or unable to cooperate with this, and also as a ban cannot be legally enforced (in the absence of restriction orders following prosecution) in relation to his legal rights as a tenant.

However, the staff agreed to call the police immediately if they perceive harm and/or threat to him, themselves or other tenants in any further encounters with the people thought to be causing harm. Staff know the two people by appearance and by their full names from previous encounters, and they are aware from the client of the alleged abuse he has experienced. All disclosures and concerns were formally reported to the LB Southwark Safeguarding Adult coordinator, who is jointly monitoring the progress of the plan until further notice.

With multi agency liaison and meeting between relevant professionals, client and with his agreement, his mother it is possible to establish a clear short, medium & long term safeguarding plan with for periodic review.

Wider Safeguarding Governance

From April 2010, health and social care providers were required to register with the Care Quality Commission in order to be able to operate. In order to register organisations were required to demonstrate that essential standards of safety and quality set out under the Heath and Social Care Act 2008 were being and will continue to be met. The Trust is subject at any time to unannounced inspection by the CQC against any of the essential standards for quality and safety, of which safeguarding is one. As part of the CQC requirements an NHS provider compliance assessment in relation to Outcome 7 (Regulation 11) has been completed and evidence collated.

In other areas of this year’s Compliance Assessment the Trust outlined detailed systems to safeguard patients from medication errors. The evidence for this can be found in the Medicines Management Policy (including standard operating procedures for Controlled Drug Policy, self-administration policy, unlicensed medicines policy, covert administration policy; Minimum Clinical Pharmacy Standards; the Trust Physical Healthcare Policy; Trust rapid

tranquilisation policy; Antibiotic/Anti-infective Policy. Maudsley Prescribing guidelines; medicines management bulletins, medicines management and drug and therapeutic committee minutes; CEO PMR minutes; annual medicines management report; annual medicines management programme; the Corporate risk register; results of POMH-UK audits, results of trust-wide audits and Quality Improvement programmes (eg, allergy status, medicines reconciliation, physical health monitoring, antipsychotics in dementia, rapid tranquilisation); minutes of NICE implementation group meetings

Following an audit the Trust has also implemented the use of Tabards (bibs) on in-patient wards to indicate to other patients, staff, administrative staff, when nurses are administering medication so they are not interrupted in the course of their dispensing.

Other standards in the CQC Provider Compliance Assessment demonstrate other areas in which patients are safeguarded, including suitability and safety of premises;

The Trust has a long standing policy on the use of restraint and is awaiting ratification. The Trust is represented on the Lambeth and Southwark Safeguarding Adults Partnership Boards. The Trust is also represented on the Safeguarding Adults at Risk Steering Group for the Metropolitan Police - a bi-monthly meeting that focuses on joint working between the police and partner agencies.

The Trust Adults at Risk governance arrangements have been reviewed and updated. An Adult at Risk Assurance Committee has been set up and is chaired by the Chief Nurse. The committee meets quarterly and reports to the Trust Assurance and Risk Committee.

Serious Incident

Following the death of a patient at Bethlem Hospital during a police restraint, the Trust and the Metropolitan police have undertaken a significant piece of work to review joint working in situations where the police are called on site to prevent a breach of the peace. This has focused on how nursing staff and police officers work together to manage these high intensity situations.

Domestic Violence

There is a SLaM working group, on which LB Southwark is represented, which is looking at improving systems for service users who have been victims of Domestic Violence. This policy interfaces is being developed in conjunction with staff from CAMHS and C&F services, as there are safeguarding implications for both adults and children. The work is going to be linked with Borough initiatives on Domestic Violence. The working party has met on two occasions to date and this work is still in the early development stages.

Training

The basic awareness training continues to increase steadily with 770 completions this year. A mixed method of delivery has been used, which has increased the use of e-learning and the Trust compliance rate at present is 82% (see below).

All the LBS social work staff working within the Integrated Mental Health service with SLaM have completed the alerter and investigators training (at the last complete check this was 52 staff). A considerable number of CMHT based health staff have also completed the LBS investigator's training.

The Awareness training is mandatory for all SLaM staff, and forms part of the Trust Induction programme.

There is a specific face to face awareness training course for administrative staff in the Trust.

Achievements in 2010/11

- Setting up of a work stream to promote improved processes for safeguarding those who are victims of domestic violence
- Returned CQC Monitoring data – awaiting approval
- Research grant to develop improved systems for safeguarding those who self harm, and continued programme of training to protect those at risk of suicide
- Two audits of adult safeguarding practice in the Trust

+ = increase _= decrease No indication indicates new level of monitoring are or data not available due to structural service changes	Safeguarding Adults
Addictions	91% +
Behavioural & Development	82%
CAMHS	83% +
MHOA	85% -
Mood, Anxiety & Personality	82%
Psychological medicine	90%
Psychosis	76%
HR:	91% -
Nursery:	79%
Nursing:	85% +
Education:	88% +
Hotel Services:	75% +
Social Work	100%
Finance	100%
IT	100%
Pharmacy	64%
Strategy & Business Development	89% -
Trust HQ Directors	93%
Medical Education (trainees)	20%
OT/Professional Heads	100% +

Working Together – Community Safety

At the heart of Southwark's partnership approach are the principles of identifying and reducing the risk of harm and identifying and supporting vulnerable people. To support the clear links between the work of the Council's community safety team and other safeguarding agencies, the Head of Community Safety is a member of the SAPB and the Deputy Director of Adult Social Care is a member of the Safer Southwark Partnership (SSP) which includes representation from the police and fire service, council community safety & enforcement team, and probation service along with other agencies.

The Head of Community Safety is accountable for ensuring that the Safeguarding Adult Team and the adult social work services receive early

notification of critical incidents that occur and may have impact on vulnerable adults.

All of the agencies working within the SSP are committed to these principles and the SSP recognises the strong links to both the adult and Children's Safeguarding Boards in Southwark.

The SAPB also works very closely with Community Safety Partnership Services to address domestic abuse issues, including regular and active attendance by the Safeguarding Adults co-ordinator at MARAC (Multi-Agency Risk Assessment Conferences), which ensures co-ordinated action by partner agencies to safeguard people at serious risk from domestic violence.

Working Together – Housing

Southwark Council is the largest local authority social landlord in London with approximately 45,000 tenants and homeowners. With such a high level of social housing in the borough there is an additional importance with regards to safeguarding in housing services.

Housing officers' visits to known vulnerable tenants have been a great success. Leading up to February 2011, 6,423 visits were made to check on known vulnerable tenants, as part of a "Cause For Concern" programme. The Council is also scheduled to complete a tenancy check programme this year, which helps to identify tenants whose vulnerability was previously unknown. This programme started last financial year, is ongoing and is aimed at making sure that tenants are receiving adequate help and support from either the Council or other agencies and are living free from abuse.

A programme of monthly surgeries at 20 sheltered housing units by housing and income officers provide general advice and assistance to those in need. Visits to all vulnerable residents are arranged when the council is advised of estate outages. Eviction reports also ask specific questions about vulnerability before authorisation by a senior manager.

A series of Fire Safety visits were carried out at sheltered units in conjunction with the London Fire Brigade and Safer Southwark Partnership.148 properties, out of a total of 197 which equates to 75% of residents benefited from London Fire Brigade home fire safety advice. This programme was postponed due to the LFB dispute, but has since resumed.

The Metropolitan Police were invited to give talks to tenants at each sheltered scheme in the South of the borough and raise awareness around the issue of tenant safety, bogus callers, and elder abuse. Work with SASBU (Southwark Anti Social Behaviour Unit) and Bede House has also been undertaken to identify and assess possible risks to adults who have been victims of domestic violence and support tenants with their housing needs (e.g. placements in temporary accommodation).

Within Area Housing Management, awareness of Safeguarding and Personalisation was raised by organising a briefing for housing managers in September 2010 and inviting housing lead officers to attend a joint conference

with Health & Social Care in November 2010. The portfolio lead for safeguarding in Housing has enlisted the support of lead officers within each of the eight area offices to ensure information about Safeguarding Adults is disseminated appropriately. Housing rolled out mandatory e-learning on basic safeguarding awareness training to all area housing staff in the Summer, and the majority of staff have now undergone this training. Since December 2010 alerter training has been rolled out to housing and income staff, and is scheduled to be completed in Summer 2011.

Case Study 7

Mr. E is an elderly man living in Peckham who was admitted to hospital by the local Police after he reported that his home had been ransacked and that he had been beaten up by intruders during the night. He had incurred bruising, and was so scared that he did not feel able to return to his home of 60 years. During the safeguarding investigation it became apparent that Mr. E had been struggling with the hygiene of his home, it had fallen into a state of severe disrepair was uninhabitable and attracted squatters who believed the property to be vacant. The safeguarding process involved close collaboration between the Housing department, local police and victim support. It was initially hoped to repair and clean Mr. E's house, however he chose to sell his property and move to a more manageable flat. Mr. E's protection plan included receiving support from mental health services and Season support worker who helped him to find his new property. Mr. E chose not to take active part in the safeguarding process directly but was happy to accepted the support that was offered. He has returned to living independently in the community and is happy with his outcome.

Case Study 8

Mr. X arrived at the housing area office reception having received a "Notice Seeking Possession" letter. He presented as having mental health issues, stated that he was taking anti-depressant medication and that he spent most days sleeping. Mr X stated that he was currently on 6 weeks' sick leave from his work as a driver, but was not in a fit state to return at the moment as he felt he would be putting himself and others at risk. It was the interviewing officers view that Mr X appeared to be suffering from impaired reasoning During the interview Mr X reported that he had been attacked with a bladed weapon by his neighbour, resulting in him being hospitalised for 18 months. Upon his return from hospital, his wife had left him and taken their children with her, his housing benefit had been stopped and he was struggling to pay rent. The safeguarding protection plan included support with housing benefit and job seekers allowance.
Intervention has resolved his housing issues and Mr X is now managing much better.

Building Safeguarding Capacity within Southwark Council

In light of recent local and national changes the current training strategy across Southwark Safeguarding Adults Partnership is being revised. Bournemouth University has published a competency framework for safeguarding adults in response to recommendations from the Care Quality Commission's inspection reports and lessons learnt from serious case reviews which has been endorsed by the Social Care Institute of Excellence, Skills for Care and Learn to Care. In response to this, a new competency based training programme is being developed together by all partner agencies.

Currently a range of Safeguarding Adults training courses are incorporated into the Learning & Development plan, commissioned and co-ordinated by Southwark Council and are advertised on the Southwark intranet for council staff and through My Learning Source via Southwark's website for staff from partner organisations. The Alerter and Investigation Officer courses are provided frequently. More specific courses are provided in response to service need and include courses on chairing safeguarding meetings, Safeguarding Adults Managers training (SAM), case conference minute takers and enabling positive risk taking. In 2010-11, a total of 435 social care staff (143 non Southwark 292 Southwark) received formal adult safeguarding training. Additionally on site alerter training has been delivered to approximately thirty staff from day centres and Learning & Development are extending their reach to offer training to organisations that support people with English as a second language. For example alerter training was delivered via interpreters to a Turkish Cypriot centre in Peckham.

In addition to the basic safeguarding awareness e-learning course introduced by the Housing Department, Southwark has introduced a general safeguarding adults and children e-learning induction course that is mandatory for all new members of staff and is available to all partner agencies should they wish to use it.

Whilst NHS Health Foundation Trusts do take advantage of some specialist safeguarding training offered by Southwark, in the main they take responsibility for training their own staff as this more effective in terms of efficiency and relevance to in-patient settings.

Commissioning

There are five teams within Southwark's Commissioning division. These teams provide services for older people; people with learning disabilities; physical disabilities and complex needs; supported housing and social inclusion; and an integrated contract monitoring team. Contract and performance monitoring is utilised as an important tool in improving the standard of care and practice and helping to prevent safeguarding incidents. Commissioners, Contract Monitoring staff, the Safeguarding Team, Operational Teams and the Police all work in partnership to resolve serious service concerns and to learn lessons for the future.

Commissioning has the lead for incorporating safeguarding in to service contracts and they take into account the comparative safeguarding arrangements of prospective new providers. The contract monitoring team use the key performance indicators in the contracts to measure the performance of providers and use safeguarding monitoring tools.

Contract monitoring staff are often involved in safeguarding meetings when incidents have been reported in commissioned services and they provide information for the investigation. When an action plan is devised to improve services monitoring staff check that it is being implemented.

In the past year the Council had to place embargoes on two providers of residential care homes to stop new placements until each service provided evidence of improvements and compliance with action plans. Intensive joint working was carried out internally at both strategic and practice levels, and with the senior management of embargoed homes. This resulted in an improved focus on, for example, aspects of staff training, strengthened staff and management structures and the development of quality indicators and early warning signs.

In the case of domiciliary care services there is an effective system of quality risk alerts so that professional staff can report issues that require investigation. This is followed by joint working with service providers to improve the practice of individual care staff and the organisation's systems and to reduce the frequency of problems. Disciplinary action is sometimes required by providers. The Council has introduced new contracts in 2011 with additional monitoring requirements, and electronic monitoring of all visits will be introduced to pick up problems quickly, such as missed or late visits.

The Care Quality Commission requires registered services to report on serious incidents such as falls, serious injuries and illnesses, accidents, thefts, staff misconduct etc. The Contract Monitoring staff collect and examine this information, which informs the content and frequency of their monitoring visits to improve services and prevent the recurrence of serious incidents.

In the current climate of cost savings Commissioning has an important focus to maintain quality while also delivering savings, and ensuring that vulnerable adults are safeguarded is an important aspect of this.

Quality Risk Alerts for Domiciliary Care Services 2010/11

There were 156 Quality Risk Alerts for 23 domiciliary care services during the year. It was found that 93 alerts (60%) were fully upheld and 59 (40%) were partially upheld.

The most common issues were as follows:

Tasks not completed	44.2%
Carer arrived late or left early	43.6%
Carer did not visit	42.9%
Care provider not notified of care plan changes	39.1%

Quality Assurance

Southwark recognises the importance of quality assurance and in 2010-11 took actions to make improvements. A Quality Assurance Framework has been written and is in the process of being implemented, and a more robust case file auditing system has been introduced. Safeguarding audits consist of targeted and non-targeted audits. Non-targeted audits are carried out on a monthly basis by Senior Practitioners and Service Managers whilst targeted audits which concentrate on complex safeguarding cases, and cases of concern are carried out quarterly by the safeguarding team and senior managers. Qualitative and quantitative data reports are presented to the Practice Audit, Quality and Performance sub-group identifying trends and themes and further actions required to improve and standardise good practice, inform training need and to recognise good work and outcomes which are used to celebrate excellent practice.

The final quarter audits for 2010-11 showed several areas of practice improvement namely evidence of a more person centred approach to safeguarding investigations with more involvement from the vulnerable person, when they were able to participate. There was also clear evidence in practice improvement, for example audits highlighted a greater use of the formal risk assessment tool and the vast majority of safeguarding meetings included strong collaborative multi-agency engagement.

Feedback from Managers and practitioners is that they value the audit process and that it enables them to measure improvement in practice, identify team and individual development, and learning needs.

Some other measures that have taken place to improve quality of the intervention we provide includes:
A review and update of the safeguarding forms and their incorporation into the Carefirst system. The AP1 form now includes a risk assessment and more comprehensive capture of initial information. The AP2 has been redesigned to reduce repetition and the time taken to complete, and the outcomes recorded in the AP3 are clearer and there is less opportunity for error or misinterpretation ensuring a more robust capture of data. A review document has been written and is the process of being introduced.

All operational teams continue to hold monthly safeguarding group supervision meetings which, as well as being a forum for advice an guidance on individual case discussion, enables peer learning and support, and enables management to keep staff up to date of changes.

Managers have access to a ‘partition’ of the safeguarding drive where they will find news and useful safeguarding information that will help to inform them of changes as and when they take place.

Future Developments

The Pan-London multi- agency policy and procedures to safeguard adults from abuse will be adopted across the Southwark Safeguarding Adults Partnership Board.

The Partnership will develop a competence based training strategy based on safeguarding competences developed by Bournemouth University

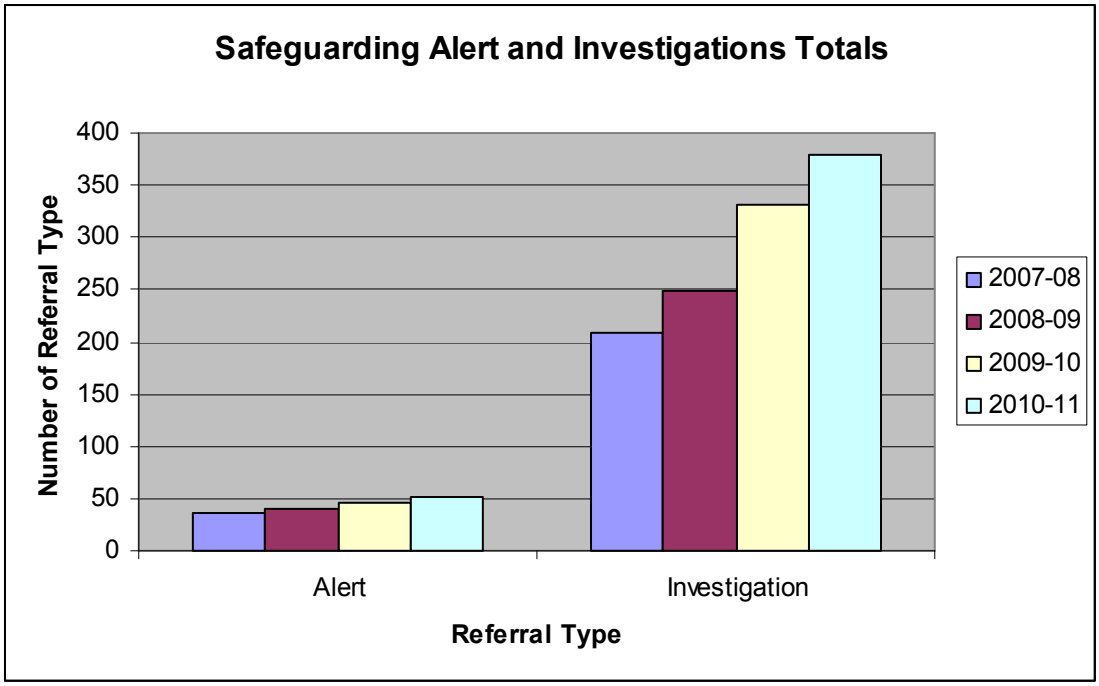
In line with Southwark's vision of for the future of adult social care (Appendix 3) the quality assurance framework for safeguarding adults activity will be further developed and expanded in 2010-11.

In order to more effectively carry out the Management Supervisory Body responsibilities for Deprivation of Liberty safeguards further Best Interest Assessors will be trained to ensure all DoLS assessments will be completed within the required timeframes.

The Government has stated its intention to place Safeguarding Adults Partnership Boards on a statutory footing. Southwark Safeguarding Partnership Board will actively plan to ensure it meets any future statutory obligations required by ensuring all its members are kept aware of Government guidance and planning milestones.

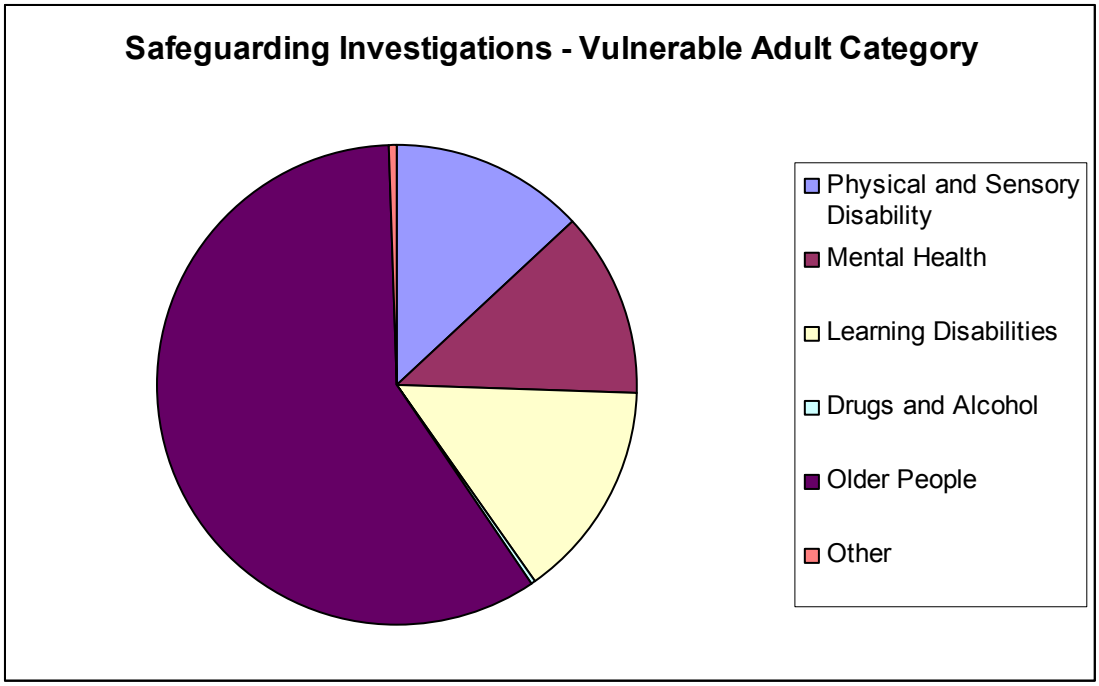
Appendix 1

Safeguarding Adults statistical Data

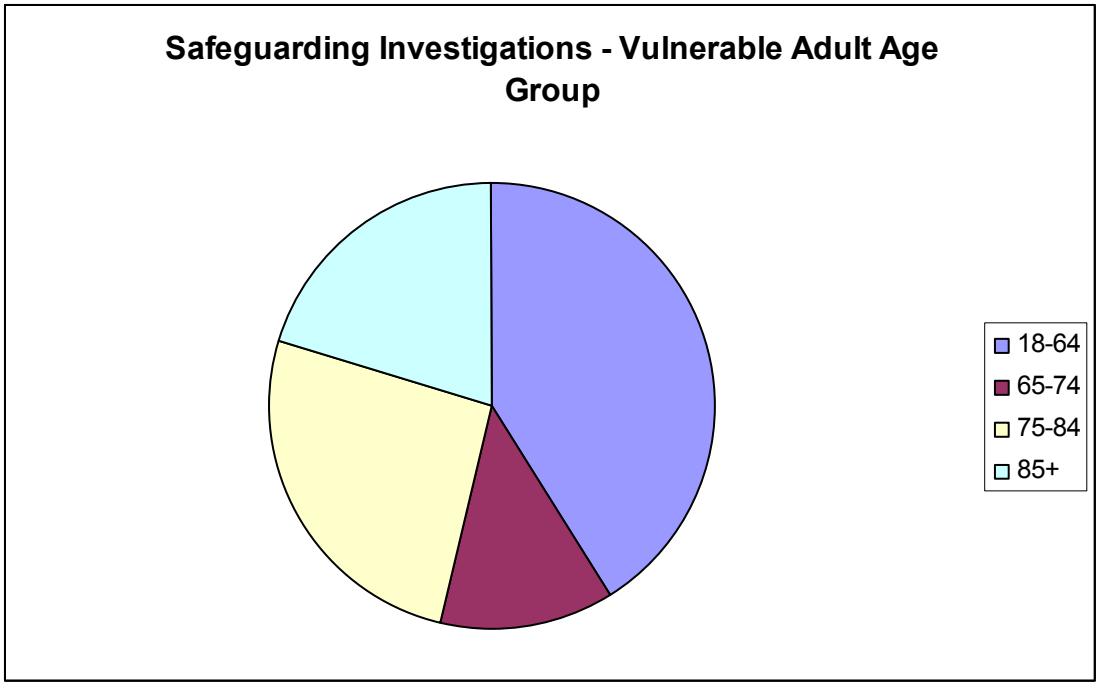


Safeguarding Alert and Investigation Totals				
	2007-08	**2008-09**	**2009-10**	**2010-11**
Alert for which a safeguarding investigation is not required	36	40	45	51
Investigation	208	248	332	378
Total	**244**	**288**	**377**	**429**

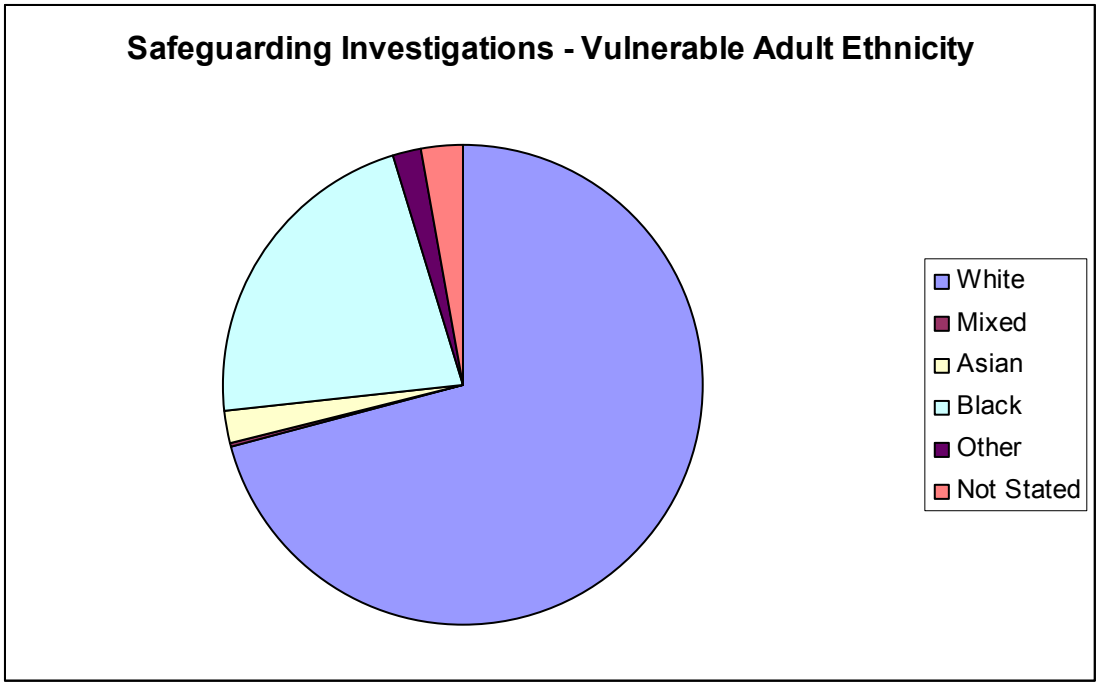
Safeguarding Alert Sources – Investigations Only		
Social Care Staff Total		97
	Of which	
Social Care Staff	Domiciliary Staff	2
	Residential Care Staff	4
	Day Care Staff	1
	Social Worker/Care Manager	90
	Self-Directed Care Staff	0
	Other	0
Health Staff Total		37
	Of which	
Health Staff	Primary/Community Health Staff	2
	Secondary Health Staff	35
	Mental Health Staff	0
Other Sources of Referral	Self Referral	57
	Family Member	41
	Friend/Neighbour	9
	Other Service User	60
	Care Quality Commission	2
	Housing	6
	Education/Training/Workplace Establishment	0
	Police	7
	Other – eg anonymous, probation, contract staff etc.	62
Total	Overall Total	378



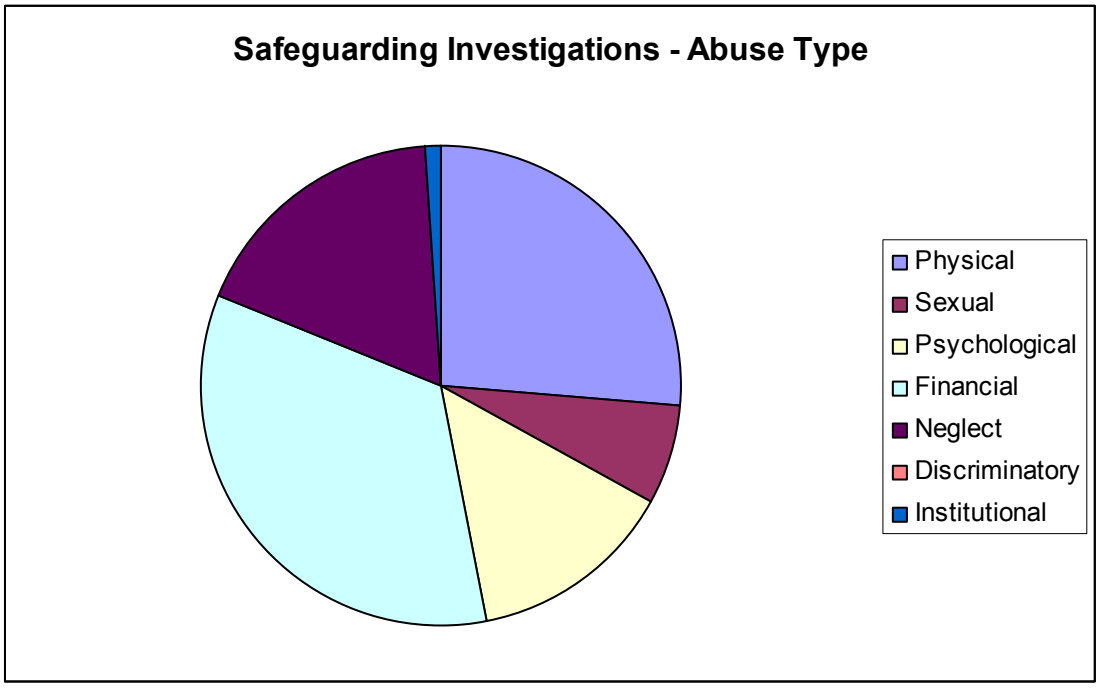
Safeguarding Investigations by Vulnerable Adult Category	
	2010-2011
Physical and Sensory Disability	49
Mental Health	48
Learning Disabilities	55
Drugs and Alcohol	1
Older People	223
Other	2
Total	**378**



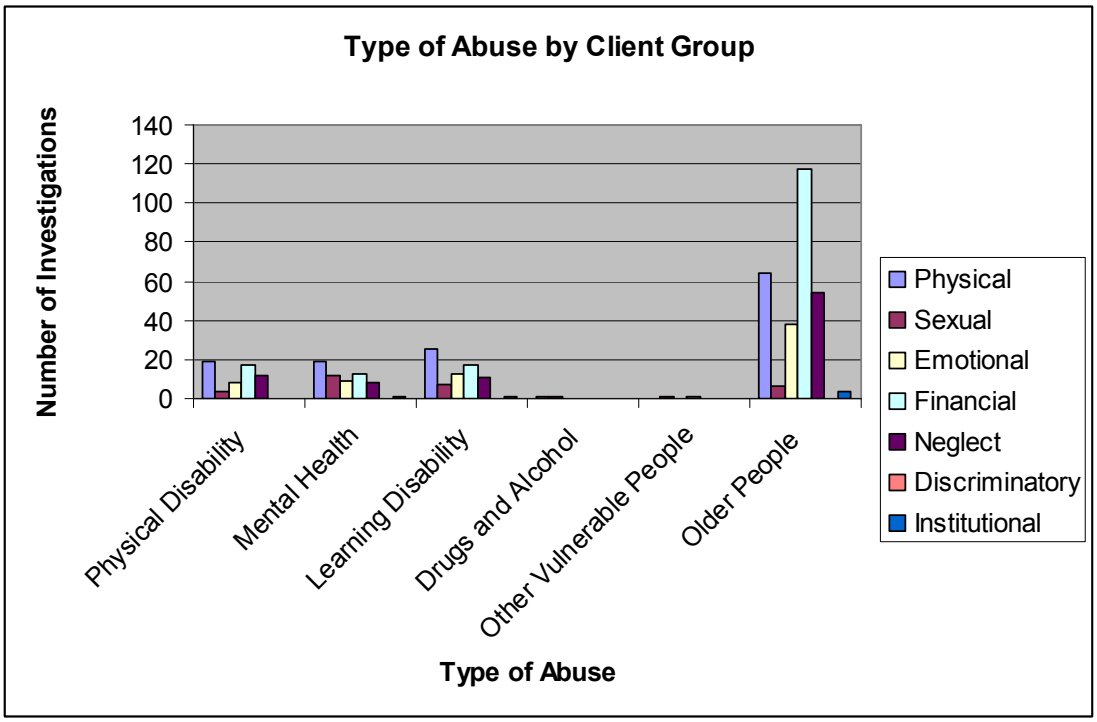
Safeguarding Investigations by Age Groups	
	2010-2011
18-64	155
65-74	48
75-84	98
85+	77
Total	**378**



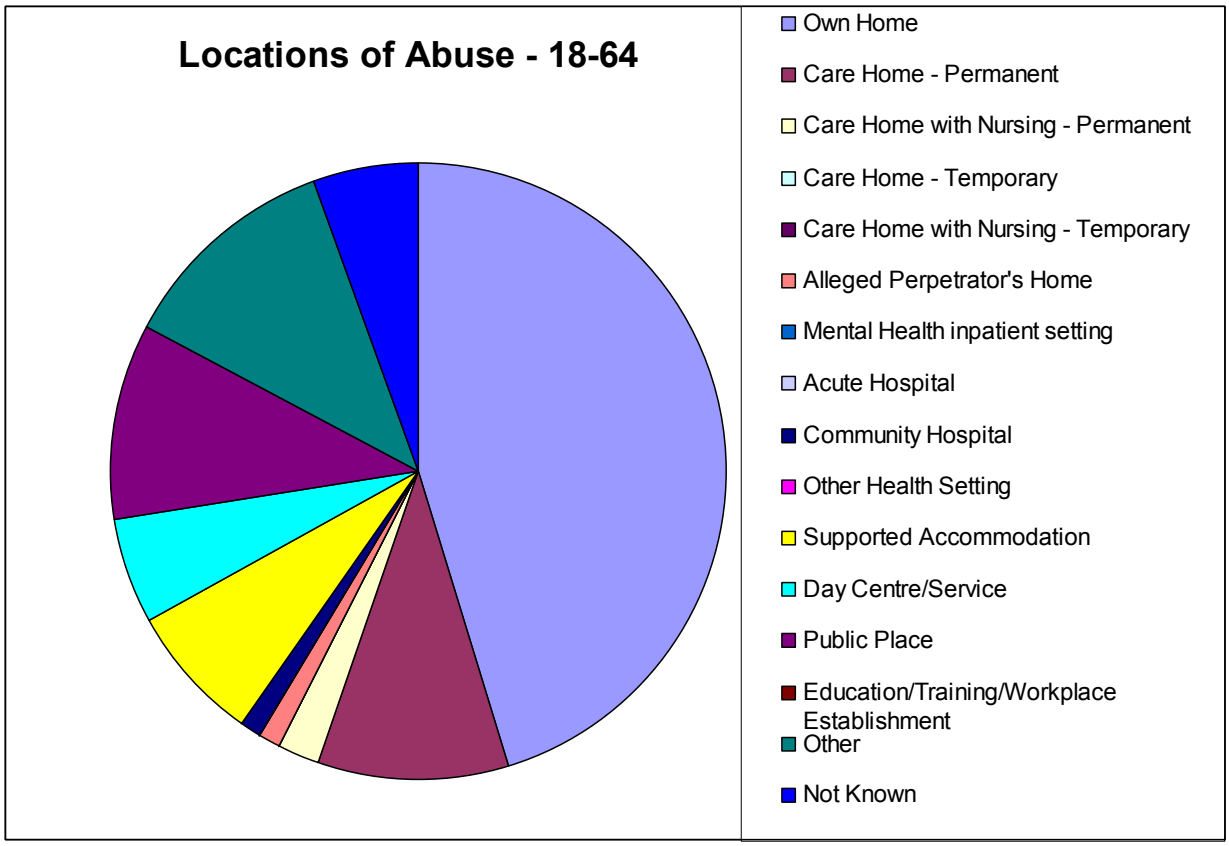
Safeguarding Investigations by Vulnerable Adult Ethnicity	
	2010-2011
White	268
Mixed	1
Asian	8
Black	83
Other	7
Not Stated	11
Total	**378**



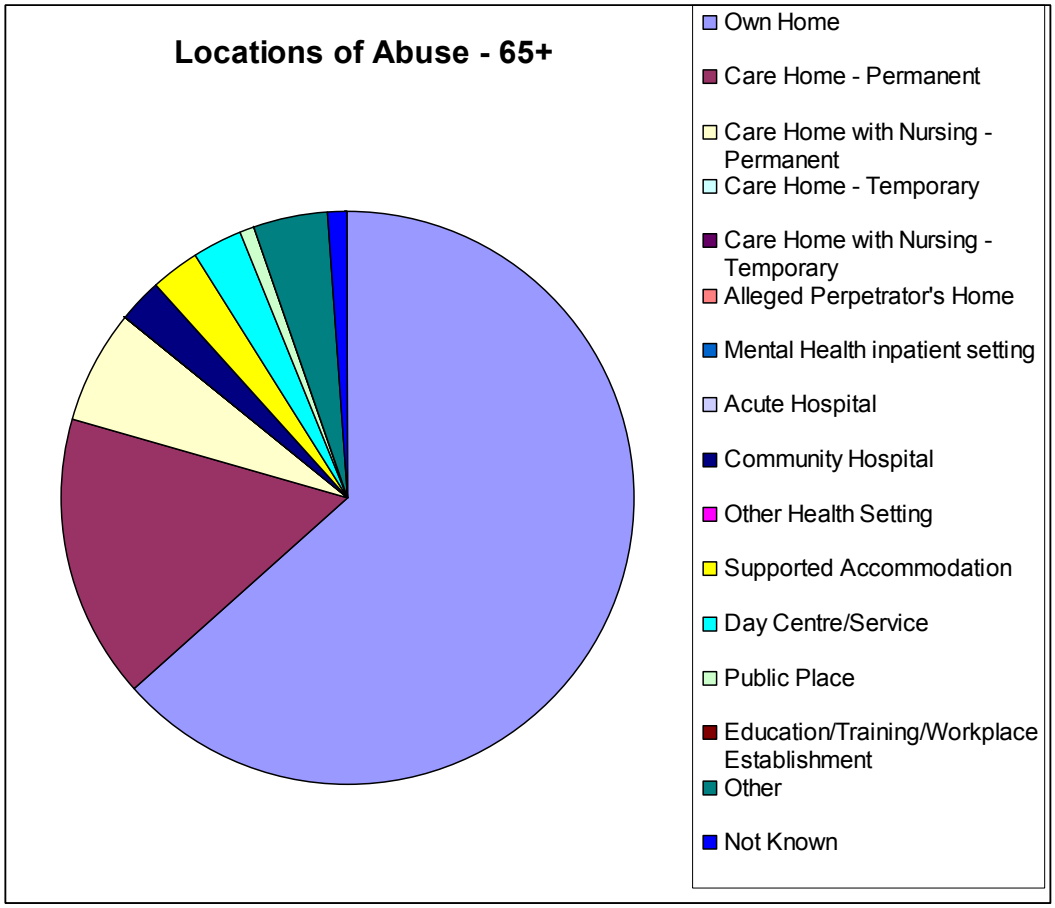
Safeguarding Investigations by Abuse Type	
	2010-2011
Physical	128
Sexual	31
Psychological	68
Financial	165
Neglect	85
Discriminatory	0
Institutional	6
Total	**378**



Type of Abuse by Client Group						
	Physical Disability	**Mental Health**	**Learning Disability**	**Drugs and Alcohol**	**Other Vulnerable People**	**Older People**
Physical	19	19	25	1	0	64
Sexual	4	12	7	1	1	6
Emotional	8	9	13	0	0	38
Financial	17	13	17	0	1	117
Neglect	12	8	11	0	0	54
Discriminatory	0	0	0	0	0	0
Institutional	0	1	1	0	0	4
Total	60	62	74	2	2	283



Location of Abuse – 18-64	
Own Home	82
Care Home – Permanent	18
Care Home with Nursing - Permanent	4
Care Home - Temporary	0
Care Home with Nursing - Temporary	0
Alleged Perpetrator's Home	2
Mental Health Inpatient Setting	0
Acute Hospital	0
Community Hospital	2
Other Health Setting	0
Supported Accommodation	13
Day Centre/Service	10
Public Place	19
Education/Training/Workplace Establishment	0
Other	21
Not Known	10



Location of Abuse – 65+	
Own Home	157
Care Home – Permanent	40
Care Home with Nursing - Permanent	16
Care Home - Temporary	0
Care Home with Nursing - Temporary	0
Alleged Perpetrator's Home	0
Mental Health Inpatient Setting	0
Acute Hospital	0
Community Hospital	6
Other Health Setting	0
Supported Accommodation	7
Day Centre/Service	7
Public Place	2
Education/Training/Workplace Establishment	0
Other	10
Not Known	3

Safeguarding outcomes for vulnerable adult following investigation	
	2010-2011
Increased Monitoring	69
Vulnerable Adult Removed from Property or Service	2
Community Care Assessment or Services	39
Civil Action	0
Application to Court of Protection	0
Application to Change Appointeeship	5
Referral to Advocacy Scheme	3
Referral to Counselling/Training	8
Moved to Increase/Different Care	1
Management of Access to Finances	12
Guardianship/Use of Mental Health Act	3
Review of Self-Directed Support	0
Restriction/Management of access to alleged perpetrator	2
Referral to MARAC	2
Other	13
No Further Action*	155

Safeguarding outcomes for alleged perpetrator following investigation	
	2010-2011
Criminal Prosecution/Formal Caution	3
Police Action	18
Community Care Assessment	12
Removal from Property or Service	7
Management of Access to the Vulnerable Adult	9
Referred to PoVA list/ISA	1
Referral to Registration Body	0
Disciplinary Action	2
Action by Care Quality Commission	2
Continued Monitoring	18
Counselling/Training/Treatment	11
Referral to Court Mandated Treatment	0
Referral to MAPPA	0
Action Under Mental Health Act	4
Action by Contract Compliance	0
Exoneration	0
No Further Action*	147
Not Known	17

Note:
The 'No Further Action' outcome may have been misinterpreted by some practitioners with the result of an inaccuracy in the statistical data. The ambiguity of this outcome has been rectified to ensure a more robust set of outcomes for the vulnerable adult and alleged perpetrator.

Appendix 2

Charter of rights

We have compiled a charter of rights for people in Southwark who may need social care support.

We asked people what they thought about the Charter of Rights and took their responses into account. Many of the comments made in response to the Charter of Rights have been considered as part of the next steps for planning and implementing the vision for adult social care in Southwark.

We know you are the best person to say what is right for you and what you need to live your life to its fullest. We want you to enjoy living your life as independently as possible. We aim to give you choice and control over any support you require and promote independence, health and wellbeing and dignity.

The Charter of Rights was agreed by cabinet on 19 April 2011.

The charter

The charter is designed to highlight broadly what the council aims to achieve for adult social care services, along with the type of service that people should be able to expect when they approach us about adult social care and accessing support.

The council is clear on its national legal duties and operates within the national legislative framework. This includes a range of duties, for example in the Equality Act and community care legislation. It also includes areas such as obligations in safeguarding and statutory rights for individuals around access to records, confidentiality and sharing information about individuals.

We will provide you with good information and advice about all the support and services that are available in Southwark

You should be treated with dignity and respect and be treated fairly

Vulnerable people, those who are at risk due to disability or frailty, have the right to be safeguarded from abuse

You are entitled to request an assessment of your social care needs to help you maintain your health and wellbeing and you will be encouraged to complete this yourself

Carers are entitled to a separate assessment of their needs to identify what support would enable them to continue in that role

Our aim is to assist you to regain your independence so that you do not need long-term support

If you have longer term eligible needs we aim to give you control over your social care support so that you can make choices about what works for you

We will let you know who to contact in the council if required.

We aim to have skilled and trained staff to provide timely, clear, high quality responses

You will be given information about your statutory rights (for example access to your records, confidentiality, how information about you is shared with other organisations and how to feedback comments during your assessment)

If you need to contact our adult social care services, you can call us on **0845 600 1287.**

Appendix 3

Southwark's vision for the future of social services

Why the future of services needs to be different from today

Southwark Council wants people to live independent and fulfilling lives, based on choices that are important to them. We want care and support services to be more effective and focused on individuals so that they can be independent and get involved in their local communities.

We need to consider this alongside the long-term impact for services. Demand for adult social care has been growing year on year and this is also the case in Southwark.

People are living longer (we expect to see an increase of 17 percent in the number of people over eighty five living in Southwark over the next 10 years) and we are finding that there is an increase in the number of people with long-term conditions, including dementia.

People are also living longer with very disabling conditions. We have particular pressures here with a high level of mental health and substance misuse needs.

As in other London boroughs, we also have pressures from younger disabled people coming through transition with very long term needs.

Adult social care represents around one third of the council's total budget. The Coalition Government's finance settlement for Southwark means there will be large cuts to the council's budget over the next 3 years. Almost £34m will be removed in 2011/12. This could be followed by £17m in 2012/13 and further cuts, not yet quantified, in 2013/14.

We need to balance all of these elements to make sure that we have a sustainable system that puts people in control of their own care and support, makes sure that the most vulnerable people are supported and also delivers value for money for local residents.

To try and achieve this, we need to create a very different set of expectations and radically change the way we do things.

We need to minimise what we spend on administrative costs and find more innovative ways of helping our residents to support themselves with fewer formal council services.

A key part of this is shifting the balance of care away from costly residential homes and towards more personalised services in community settings.

This vision sets out how we propose to work towards this model in the coming years.

We recognise that this is a very challenging task and we want to work with all groups locally to harness good ideas and maintain good quality services for people who access care andsupport.

Several measures have been taken over recent years to manage rising demand, including raising the Fairer Access to Care Services (FACS) eligibility criteria to substantial and critical needs only. It is an option to raise eligibility further to critical need only. However, some evidence suggests that this may not deliver the required level of savings as people with substantial needs who do not get support may deteriorate, leading to a spiral of higher costs. However, this may need to be revisited if the level of savings required is not delivered.

A Fairer future for older and disabled people

To create the system described above we need to develop a different relationship between the council and the community. We need to move from a model of dependency to one where older and disabled people are seen as people who can contribute and exercise control over their own lives, improving their own health and well-being. If we want to maintain the level of access that we currently have for adult social care we need to signal a different, and smaller, offer to everyone. This is within the boundaries that we do have to meet the needs of people who fulfil the eligibility criteria for access to care and support.

What the council provides also needs to be of excellent quality.

We will offer people high quality, useful information that can help them to make informed choices about care and support, including what services are available locally and how to access them. This will be for everyone, including people who self-fund their care and support.

More people across the whole spectrum of support needs will be helped to live as independently as possible, through prevention, signposting and ‘re-ablement’ – short term interventions to help people recover skills and confidence following a period of poor health or admission to hospital.

Overall, fewer people will be dependent on long-term council support and more interventions will be time-limited.

This support will be aimed at enabling people to access mainstream services rather than relying on specialist services.

We will continue to develop the offer of personal budgets for those people who do require ongoing care and support, including direct payments in cash.

People will need information on the amount of money to be spent on their care and support needs so they can make choices on how it is spent.

We recognise there is a role for the council in supporting the development of a care and support market that provides the sort of services that people want to access. This includes the availability of support for people in making those decisions and the implications of choosing to employ their own staff, for example.

We recognise the vital role that carers play both in delivering care and in helping prevent people from getting worse or needing more intensive packages of support over time. This means we must carefully consider interventions that can have a demonstrable impact in improving outcomes for people and supporting carers.

Care and support is about partnership – involving individuals, communities, voluntary and private sectors, the NHS and the council's wider services, particularly employment and housing.

We will need to work closely with the NHS in addressing individuals' and carers' needs and supporting seamless pathways for care. We also need to take account of the proposals for reform of the NHS, particularly the enhanced role for GPs in terms of commissioning services, and for the council in terms of joining up commissioning across health, social care and health improvement.

Voluntary and community services have a key role to play in helping to build strong community engagement. The experience of the sector is also invaluable in thinking of new ways of doing things and helping people understand the need for change. We know that voluntary and community organisations will experience challenges in the future as the overall amount of funding available is reducing. It is important for us to work together with people using services and carers to make the best use of available resources.

Some key aspects of how the service will be different

The focus for the system is about enabling people to live independently and well for as long as possible, and not feeling restricted to traditional support options. Partnership is key here – self help, helping yourself and others as an active citizen, working with the wider community and voluntary sectors to develop social capital are all vital components of a system that provides effective care and support, and which goes beyond the traditional sense of statutory services.

This means that the council also has to think differently about the wider services available to support people to make the most of these opportunities.

We recognise that many people need some intensive support at the end of their lives. What we want is to have a good balance of services in place to promote health and wellbeing and make that period as short as possible for everyone.

1. With this in mind, we are looking to re-shape our **universal offer** (open access discretionary services) that cover areas such as lunch clubs and day care services as well as befriending, information and advice. These are available to people who may not have eligible social care needs.
Services will need to think differently about how they may want to provide social and practical support to people but with a reduced level of council funding available.
We are considering re-shaping the offer within the wider voluntary sector to provide a model with fewer buildings but from which services could reach out and deliver services in different ways. People could get together, have meals, access advice, signposting and support planning from buildings but there could also be more reaching out, with organisations potentially delivering services that people choose to purchase through their own resources or personal budgets, for example hot meals in the home or practical help.
There will continue to be a role for the voluntary sector but different kinds of services will be needed in future, which will need to be financially self-sustaining.
Current examples of this self-sustaining approach in Southwark include the SE Village, HOurBank and Southwark Circle. Services are offered in a way that also enables people to contribute time and skills, rather than being seen as passive recipients of care.

2. We will create **a single point of informed contact** so that people can access high quality information and advice about social care services and be signposted to resources outside the council. This will be for everyone regardless of whether or not they receive support from the council for their care.
There will be an expectation that practical help is funded by the individuals themselves (through benefits if eligible).

3. **Prevention** work needs to consider ways of stopping people's care and support needs from getting worse and of helping people minimise the risk of them entering the adult social care system as far as possible. It is important that we target this work based on available evidence, particularly around how investment early on can support a reduced demand for longer-term social care support. This may include help for carers and the development of telecare, enabling people to live independently at home with the use of technology and equipment, for example personal alarms, fall detectors or temperature extreme sensors. Health services also have a key role to play in helping us become more aware of the groups of people who are more likely to enter the social care system, particularly when they have long-term conditions so that we can target interventions effectively. The biggest impact of

preventative action is often on health provision. We will look to engage with GP commissioners and work as part of the proposed new Health and Wellbeing Board to support this.

4. We want to focus on opportunities that support people to retain their independence for as long as possible. This may include short-term home care or **re-ablement** to help people get back on their feet, making use of technology and providing effective equipment for the home. Over time, our ambition is for this to be expanded to become the initial offer to everyone with eligible needs, either as new entrants to the system (obviously taking into account certain circumstances, for example people requiring end of life care) or, for existing clients, at the point of review where appropriate. This includes thinking about intermediate or step down care for people coming out of hospital.

5. Once a person has been through re-ablement and a longer term need is established, a **personal budget** will be the offer. People will plan ways in which their agreed goals can best be met in the most cost-effective way. They will be encouraged to plan and to manage their own budget through a direct payment and to creatively make use of existing resources within their family and community to support their plan.

6. There will be help with **support planning** only for those who need it – including local support planners, council-based social workers and, in the future web-based self service. We hope that creative support planning and smarter brokerage will lead to greater use of mainstream services and a significant shift in the balance of care so that people are better able to achieve the outcomes they want for themselves. This may include fewer people requiring high cost residential and nursing provision where this does not most effectively contribute to their identified goals.

7. We are looking to re-shape day services for people with eligible needs in support of the vision and for people who continue to choose this model. Services will be focused on offering respite and support for a smaller number of people with the most complex needs but also providing opportunities for people to gain the skills they need to live **independent lives**, including access to employment.

8. **Transitions** from children's to adults' services will be re-shaped to minimise duplication across services and further promote the concept of whole life planning. This aims to support people to maintain independence throughout their lives and seek creative ways of making best use of resources over the long term.

9. A set of triggers and alerts will be embedded in the system with the aim of ensuring that people who are at risk are **safeguarded**. The culture will support positive risk-taking and the whole community will be responsible for picking up warning signals and will need to be part of an effective response.

10. All people receiving support through the council will benefit from regular **review** of their needs and circumstances, proportionate to the level of risk. The review process needs to be supportive of the overall direction of services, particularly in terms of supporting people to live independently and well and make the most of their own capabilities, not just passively receiving services.

11. The system as a whole will be underpinned by the ethos of independence and reablement. Support will be progressive and proportionate to need, **minimising bureaucracy** and duplication, and ensuring all steps along the way are timely and focused on outcomes. The resources we have for helping people arrange care and support will be increasingly focused on those who are less able to help themselves, including people without family or networks, people with cognitive impairment or a lack of mental capacity.

12. The **workforce** has a key role to play in supporting and delivering this vision and transformational change. It will be important for us to review our structure and skill mix to make sure that they best support the vision and continue to provide timely, clear and high quality responses. Our focus will be on reducing back office costs as far as possible and supporting frontline workers to operate effectively and efficiently. This includes a range of supporting elements including performance management and IT systems, for example mobile technology.

13. In addition, **providers** of care and support will need to **think differently** about the services they offer as individuals take control of their own care and support needs. The council will have a role to play here to help providers understand the changes that are happening and we will also be focused on the need for all care and support offers to be about high quality support that helps people to achieve the outcomes they want. Quality assurance will therefore need to be focused on understanding whether services available to people are effective in helping them achieve their goals and provide the degree of choice and control people want for themselves.

This is a long-term vision for the future of adult social care and we recognise it is a challenging one that requires us to look at the whole system. At the heart of the vision is the intention to support people to live independently and well for as long as possible while making best use of the resources that are available. We want to work together to develop a sustainable system so people can live the lives they want while delivering value for money for the residents of Southwark.

Annex – what does the vision mean for individuals?

This case study shows how our vision for adult social care is already being put into practice and the impact that this can have on people's lives.

Case study: Re-Ablement and Personalisation
Following a recent spell in hospital as a result of ongoing and long-term health problems, Mr T was referred to the re-ablement team in Southwark to look at what ongoing support in the community may be required.

Following a re-ablement review and assessment of his ongoing needs Mr T began the process of support planning to look at the money that was to be spent on his care and support and how he wished to use that money to achieve the outcomes he agreed in three key areas:

- personal care
- practical care
- social needs.

Although he had not had a care package before Mr T had a lot of ideas of how he wanted to organise and manage his support and was very keen to manage things himself, including his money. He had a network of friends and neighbours who he wanted to help him with personal care, doing laundry and cleaning his house, paying expenses as appropriate.

He also chose to arrange for one of his friends to come and make home cooked African food for him that he could store in the freezer, rather than using the meals on wheels service, which he did not want. He felt that by having his friends support him more formally he would be able to organise his life in a much better way, with control over when people worked and the tasks they did for him, rather than waiting around for someone from a care organisation to arrive.

Discussion also needed to include how and whether he would require support for any help around employment issues and with payroll for people he decided to employ, and how to use money from his personal budget for this.

For social engagement and activities Mr T was keen to get back to regularly going to church and meeting up with friends through that route rather than using traditional day care services, as he felt better off with people he previously knew rather than strangers. As part of this he organised for a friend to transport him there and back, covering petrol costs.

Mr T was also very keen to learn how to use the internet so that he could be in regular contact with his family who live abroad. He chose to put his money for day care towards purchasing a laptop computer and computer lessons. Having regular contact with his family was one of the most important things for him and he felt more useful to him than attending a day centre, for example.

Through the support planning process, he was also sign-posted to a variety of voluntary organisations that could provide support and input, both relating to his interest in art and films, and for advice and support relating to his particular health conditions.

Agenda Item 8

Item No.	Classification: Open	Date: 23 January 2012	Meeting Name: Scrutiny Committee
Report title:		Transition planning for young disabled people and supporting ageing adults with complex disabilities	

INTRODUCTION AND DISCUSSION FOR SCRUTINY COMMITTEE

1. The council is transforming services for adults with learning disabilities in line with the vision for adult social care and national policy. The purpose of adult social care is shifting from the historic role as provider of care and activities to a facilitative role that supports every disabled adult to live, work, learn and socialise like their non-disabled peers, accessing mainstream accommodation, leisure, education and paid employment, and supporting adults with learning disabilities and their carers to maintain their independence and wellbeing in their own homes. This means phasing out institutional, building-based nursing, residential and day centre services, and developing a greater range of community services which offer choice, control, and self directed support.

2. Whilst transforming services to improve outcomes for people the council is faced with a significant reduction in funding from central government. At the same time, the number of people born with or diagnosed with a learning disability is increasing, and people are surviving longer with more profound and multiple disabilities due to advances in health care. This means that a growing number of service users with learning disabilities transfer from children's to adult health and community services every year with substantial support needs. In addition, the number of adults with learning disabilities outliving their parents continues to rise, due to better healthcare and prevention of illness.

3. The transformation of services for adults with learning disabilities involves four key programmes of work, including:

   - establishing a 'Teen Team' to undertake person-centred transition planning for 14-25 year olds;
   - redesign of day opportunities services – shifting away from traditional building based day care to a greater range of community services which promote social inclusion and paid employment;
   - accommodation - helping people with learning disabilities to have their own homes and tenancies; and
   - developing open access services that are self sustaining and which enable people with eligible and non-eligible support needs to live independently in their own homes, reducing isolation and accessing the community.

4. These projects are each at different stages of implementation, with the work on accommodation significantly progressed with several local care homes deregistered and a greater proportion of people with learning disabilities now living in supported accommodation with their own tenancies. The 'Teen Team' will be

launched in April 2012, and young people are already offered a personal budget and help with planning community support as they turn 18. The three month consultation on LD Day Opportunities is due to begin in February.

5. A principle underpinning the projects concerns how the council can offer person-centred services that promote social inclusion by helping people to access mainstream education, housing, leisure, and paid employment. This will be a critical theme within the consultation and engagement process with service users, carers, providers and other stakeholders. To strengthen this process, the council is keen to understand from the scrutiny committee how it thinks the council can adopt a whole council approach to improving social inclusion for adults with learning disabilities and to the development of true community based services and supports. This can then be used to inform future recommendations to Cabinet.

6. This paper is designed to provide background information on the context in which the learning disabilities service transformation is being considered. It highlights the process and work to develop proposals for the future of LD day opportunities services, as these services are strategically critical to achieving better outcomes particularly for young disabled people in transition from children's services to adulthood, whilst these services are also subject to an unprecedented level of savings.

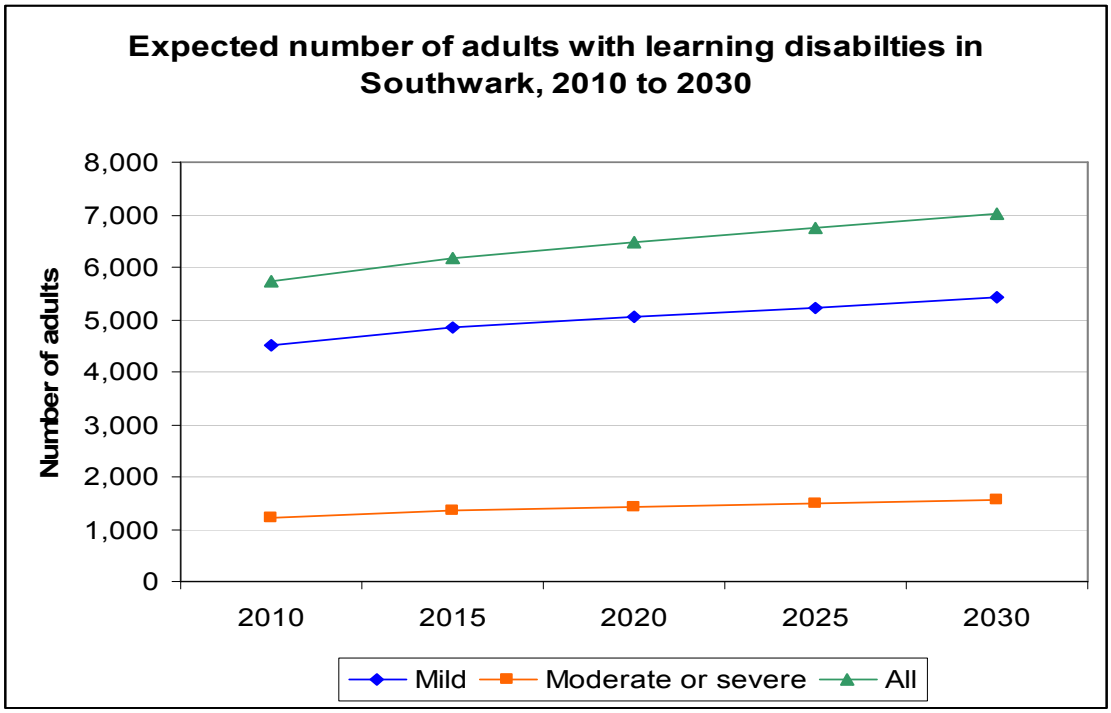
BACKGROUND INFORMATION

Demographics – learning disability population

7. The trend is of an increasing population of people with learning disabilities, nationally, and in Southwark. Advances in medicine mean that more babies survive trauma and fewer succumb to acute illnesses or long term conditions. This means the population grows year on year, with more children transferring to adult services at 18 years with complex and multiple disabilities. Figure 1 shows the expected rise in the number of adults with learning disabilities in Southwark over the next 20 years, and figure 2 gives an estimate of the learning disabled population by Borough over the same period.

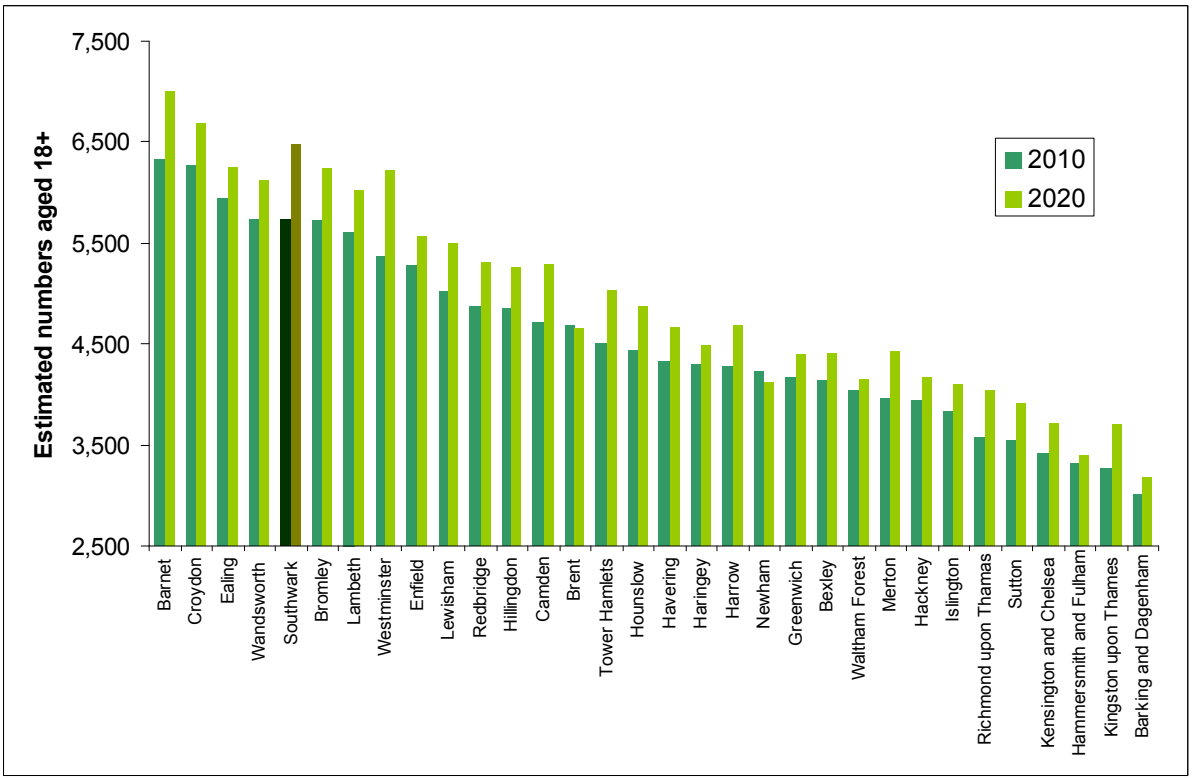
8. There are about 5,740 people with learning disabilities in Southwark, of whom about 1230 (21%) have moderate or severe learning disabilities. The number of people in the borough with learning disabilities is projected to increase by 22% to 7000 by 2030. Recent data suggests that there are 599 people with learning disabilities known to social services and 623 people on primary care learning disabilities registers. There are an estimated 495 people with moderate or severe learning disabilities aged 18-64 living with one or more parents in Southwark. This is expected to rise by 13% to 559 in 2020.

   Figure 1:



Source: PANSI 2011

Figure 2: Estimated number of adults with learning disabilities by borough, 2010 and 2020



9. People with learning disabilities receiving social care services are likely to be people who have a moderate or severe learning disability. During 2010/11 there were 599 adults with learning disabilities receiving services provided or commissioned by Southwark adult social care.

10. Recent work has indicated that nearly a third (31%) of people with learning disabilities known to services have additional needs as well as learning disabilities. These may include physical disabilities, dementia or other health conditions. Co-ordination across agencies (including information sharing), person-centred care and support for carers are particularly important when people have complex needs.

11. Just under 10% of adults with learning disabilities known to Southwark services also have a diagnosis of autism. This is normally diagnosed in childhood and underlines the importance of effective processes for the transition from children's to adult services.

12. Some people with learning disabilities are identified by services as having challenging behaviour. This can take a number of different forms and can stem from a variety of causes including the way in which people are supported by services. Southwark has reviewed its approach to challenging behaviour including the adoption of a more person-centred approach as a key part of its strategy.

13. The proportion of people with learning disabilities known to services who are aged 65 years and over is 7.5%, which compares with 10.2% in Southwark's overall population. However more people with learning disabilities are living into older age groups, with a projected 40% increase in the borough by 2030.

14. The ethnic group profile of people with learning disabilities known to services is broadly comparable to the profile of Southwark's overall population.

15. Southwark will see a large increase in the number of people with learning disability at a time when public sector spending is being curtailed. There must be clear priorities, realistic expectations and creative solutions while pursuing the personalisation agenda.

16. A clear priority is to address the needs of young disabled adults making the transition from children's to adults services, to meet need in a sustainable way, without engaging people in traditional and high cost services.

17. Further along the age spectrum, the priority is to identify and support adults with learning disabilities living at home with ageing parents, to plan support after family carers die.

Financial context for learning disability services

18. Adult social care represents around one third of the council's total budget. The Council's three year savings plan means almost £34 million is being removed in 2011/12.

19. Learning disabilities represents £42m expenditure of the total £140m annual expenditure in health and adult social care. The three year savings plan for learning disabilities is set out below with a target of £4.6m to be taken out of the budget in total, which represents a reduction of around one third of the budget for people with learning disabilities. The 2011/12 savings have been achieved.

	2011/12	2012/13	2013/14	Total
Transitions	95,000	150,000	68,000	313,000
LD Day Services	-	1,000,000	1,700,000	2,700,000
Residential care	700,000	300,000	606,000	1,606,000
Total	**795,000**	**1,450,000**	**2,374,000**	**4,619,000**

20. Notwithstanding the duty to deliver better outcomes for people, the quantum of savings requires radical change to the model of learning disability services. The implementation of personal budgets means all individuals are assessed via an Outcome Based Assessment and given an indicative budget, creating transparency about the resource allocated to each person so that service users and families can make choices and plan support.

21. Planning transition earlier with young people (aged 14-18) and their parents, and agreeing support plans in consultation with older carers so that there is support for their learning disabled son or daughter when they die, will be key to helping people make the most of their personal budget. Ending block contracted residential and day services with providers and stimulating the development of the market so that there is a wide range of local providers available to respond to diverse need, means that service users and carers will have real choice and control over how they choose to spend their personal budget, and money will not be tied up with building based services.

22. It is in the context of this overall vision and current financial position that the transformation projects for learning disabilities in the borough are taking place.

The vision for adult social care in Southwark

23. The strategic direction for learning disability services is based on a developing a new relationship between the Local Authority and learning disabled service users and their family carers, moving from a model of dependency to one where disabled people are seen as people who can contribute and exercise control over their lives, improving their own health and wellbeing.

24. The implementation taking place involves a new offer, which consists of:
    - enabling people to live as independently as possible in their own home
    - supporting people to work (or pursue a meaningful occupation), learn, follow their interests and maintain their social relationships in the same places and at the same times as the rest of the community.

25. There will be a need for clarity and honesty about this offer. It will be no more than it states and support will be focused on reducing dependence on social care rather

than fostering a lifetime of isolation in an expensive 'parallel world' of residential and day care, which offers no entry into the mainstream community. The job of social workers will be to reduce or minimise people's dependence on social care intervention rather than intensifying it. An important part of this will be to manage the expectations of young people (and their families) as they make the transition from children's to adult's services.

26. This will involve a whole local authority approach where the first assumption is that people with learning disabilities will make use of and be welcomed into the universal services and activities – including housing, adult learning, leisure, health, community development, social networks and employment. The job of social care will be to provide the support around a person's disability that enables them to be part of the wider world, rather than creating and funding a separate world.

TRANSITION FOR YOUNG PEOPLE WITH LEARNING DISABILITIES – CONTEXT AND FUTURE DIRECTION

27. The Director of Children's Services and the Director of Health and Community Services recently approved the proposal to establish a 'Teen Team', bringing together social workers from children's and adult services to work with people aged 14-25 years with a learning disabilities. The team proposal was based on financial benefits and improved outcomes and life chances for young disabled people going through transition from childhood to adulthood. The purpose of the Teen Team will be to re-shape the current offer to young people in Southwark and introduce whole life planning to seek creative ways of reducing long term costs. This will involve the Teen Team engaging with young people and families in life planning following year 9 reviews.

28. Crucial to the ongoing success of the LD transformation programme will be young people moving through transitions and into work and wider community lives. The Teen Team will lead in delivering radical change through encouraging young people to develop independence through innovative ways of supporting them. In doing so this will in turn reduce the reliance on the Council. The default expectation will be that young people and families will have a personal budget prior to turning 18, and that they will take responsibility for managing the budget and self directing their support.

29. Currently within the Children's Disabilities Service there are 18 young people aged 14 years and above that receive a package of support ranging from residential, direct payments, or other care package which are in excess of £20,000. The total cost of this is £1,546,811.80**.** There is a savings target for the Teen Team which is £95,000 in 2011/12 and this has already been met due to the changes in practice taking place.

30. The following outlines the number of children and young people who have been referred to the adult health and social care Transition Panel:

- 2008 53 individuals, 6 of which only required signposting.
- 2009 41 individuals, 2 of which only required signposting

- 2010 46 individuals, 4 of which only required signposting

31. From November 2010 to July 2011 there were approximately 140 pupils highlighted by the SEN Team who entered year 9 transition, 49 of whom are likely to be referred to the Transition Panel. 32 are on the Children's Disability Register. The remaining 17 are young people at special school provision who are not on the Children with Disability Register and are likely to be referred.

32. Education costs: Out of the 18 young people mentioned above, 16 attend local maintained special schools whether in or out of borough. These are places that would be in the severe learning range so costs would range from £25,000 to £32,000 approximately per annum.

33. The 2 pupils that are placed outside of the above, 1 is joint funded and attends a 52 week residential provision. The other SEN has agreed as part of the personalisation agenda a personal budget prior to transfer into adult services, the costs are as follows:

- Pupil in 52 week residential education costs are £94,198
- Pupil on individual programme and budget education costs are £81,798
- The estimated spend to SEN placing young people in the independent sector for 2010/2011 financial year equates to £2,908,042.
- Out of the 81 pupils at least 34 will be referred to Transition Panel and will require services in the future. SEN leads in this area.

AIMS OF THE TEEN TEAM

34. The aims of the teen team to be implemented with children's and adults social workers in April 2012 are as follows, and the outcomes are listed in appendix A.

- To provide a transition service that provides one point of contact and supports young people and their families from ages 14-25 into adulthood;

- To be a multi-agency team that all work together, use the same systems and streamline the paperwork and bureaucracy;

- To make the young person and their parents/carers central to the process and avoid duplication of work and roles by all using the same working practice;

- To actively involve, inform and support the young person and parents/carers in the transition planning process;

- To assess each young person holistically and share information and assessments across organisational boundaries;

- To identify eligibility for NHS continuing care funding at 14 years of age;

- To allocate a lead professional for each young person;

- To devise a transition plan and oversee, monitor and review this plan;
- To complete any assessments, reports and funding applications required within deadlines and to quality standards;
- To decide, and ensure implementation of, continuing support required by the young person up to age 25;
- To work in close partnership with key partners such as schools, Children & Young People's Trust, adult services, specialist health services and service providers;
- To ensure that the young person's needs are met in the most cost effective way within the legislative framework;
- Ensure early identification of high costs placements currently placed in Children's Services and work to reduce costs as early as possible to achieve best value;
- To manage within budgets allocated;
- To inform for planning and budget commitments in Adult Services and support achievement of any identified savings targets;
- The S139A assessment by the LDD Connexions Advisor is key in identifying those young people seeking placement in high cost specialist provision;
- The Connexions Advisor will have close links with local Further Education Colleges and have an up to date understanding of the provision available;
- Provide support to young people, their families, schools and professionals and distribute transition guidance, this will require updating as legislation changes;
- The Teen Team will have responsibility for liaising with transition leads that already exist in Health (learning disabilities) for: speech and language therapy, occupational therapy, nursing, physiotherapy and audiology;
- The Teen Team will need to consider the important input that these teams would have, as well as input from: Connexions, Education, and Children's Specialist Health Services etc;
- The Health Team in adult services will have the responsibility for drawing up the Health Action Plan to ensure that there is continuity of services and access to ensure that young people stay healthy and do not 'fall between' services;
- To ensure that individual cases and provision are reviewed and monitored on a regular basis including evaluating outcomes for individuals in transition from 18 to 25; and

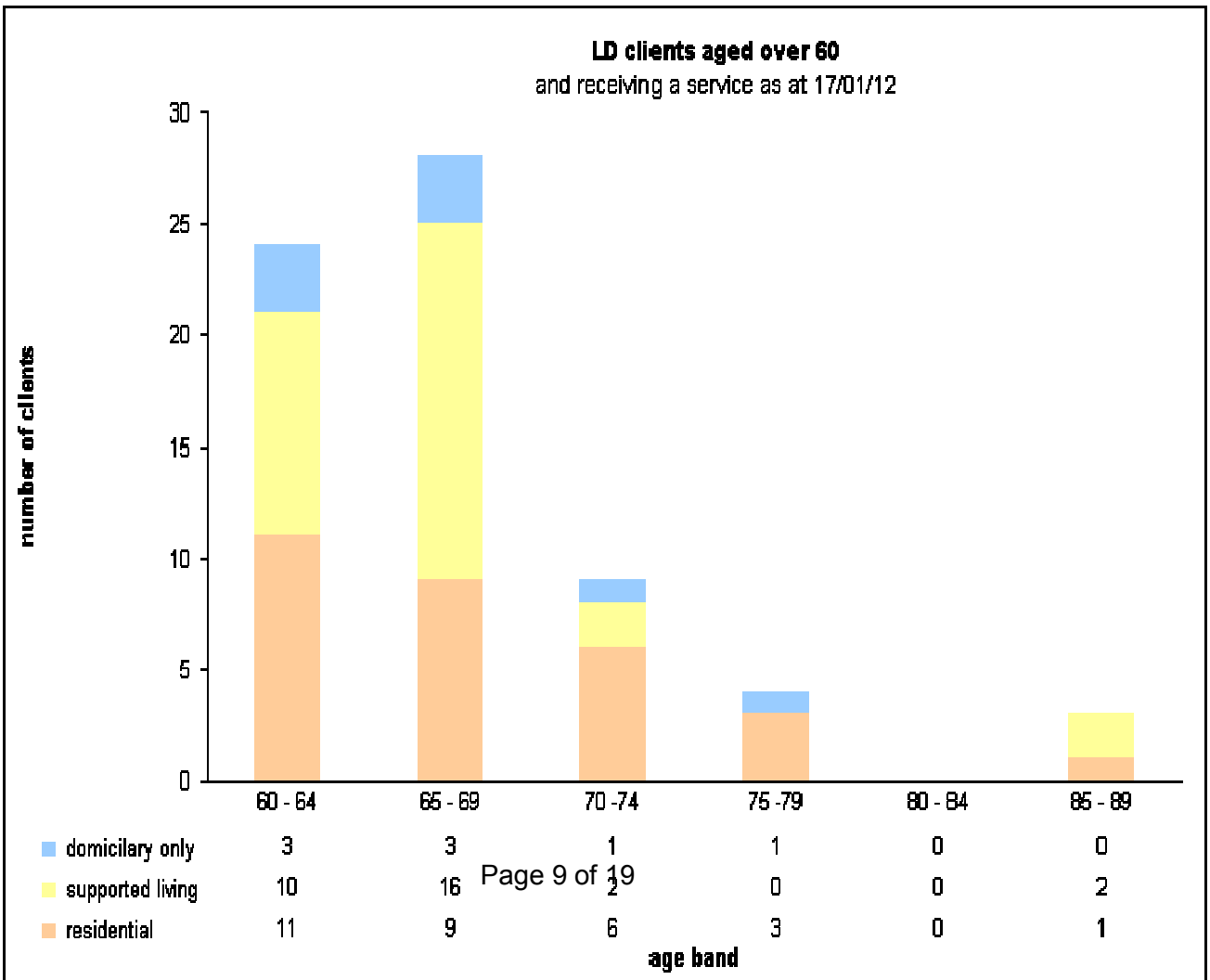
- To oversee that the young person has a transition plan that includes 'whole life' planning and creative ways of meeting long term needs.

ADULTS WITH LEARNING DISABILITIES AND AGEING NEEDS AND OLDER CARERS

35. As of January 2012, there are 68 people with learning disability over 60 years old who are receiving social care services. The breakdown in relation to age-band is below:

age band	total
60 - 64	24
65 - 69	28
70 -74	9
75 -79	4
80 - 84	0
85 - 89	3
	68

36. Of the total number of 60+ years service users, only 7 people receive some form of day care. This figure does not include people whose needs do not meet current eligibility criteria but who may make use of some of the open access services and lunch clubs for which council funding has been available. The breakdown in the type of services that people aged 60+ are receiving is highlighted below:



37. Southwark has a Dementia Care Pathway, which is a protocol agreed by adult social care with health professionals from Guys and St Thomas' Trust learning disability services and SLaM (see Appendix C). This is in line with national good practice produced by the National Institute for Clinical Excellence. National statistics show that people with learning disability who do not have Down's Syndrome are 4 times as likely to have a diagnosis of dementia than the general population. For people with Down's Syndrome the prevalence rate is even higher, with 10 in every 100 people age 40+ having dementia. This figure rises to 36 in every 100 age 50+ and as high as 50-65 in 100 over 60+ years.

38. In Southwark there are currently 15 people with learning disabilities between the ages of 41-64 who are on the dementia pathway. Within the multi-disciplinary team, a care co-ordinator is agreed and acts as the named point of contact for the person and the professionals involved in their care.

39. Health conditions normally associated with the general older population are common in younger adults (ie under 60 years old) with learning disabilities, for example sensory impairments, visual impairment, hearing loss, physical frailty, mobility problems. The multi-disciplinary nursing and therapy team, who are part of the joint learning disability community team work closely with social care providers and GPs to offer training and clinical support to recognise deterioration in health conditions and the necessary intervention required.

40. Due to the fact that complex physical health problems are more common for adults with learning disability than in the general population, there are not specific care providers for the older LD population. There are some providers in Southwark that are seen to have a more skilled approach to support for those with complex needs.

41. One of the local care homes that does cater for older adults with LD who have dementia and physical frailty is Gaywood Street, a 5 bedded residential home, managed by PLUS. This service has evolved in response to a growing need for expertise and skilled support for adults with LD who have dementia. Currently there are older adults living at Gaywood Street, with close input from the MDT and social work team to monitor and provide clinical intervention.

THE FUTURE – SUMMARY OF KEY CONSIDERATIONS

42. The key focus is on offering personalised support for people so that they can maintain or regain their independence, linked to effective transition planning for young people.

43. Services will focus on supporting people to achieve specific outcomes, particularly around independent living, employment opportunities and access to education and leisure. Integrated working with health is essential to maintaining health and wellbeing, managing physical and sensory disabilities and long term conditions, including supporting adults with LD and dementia. It will be vital to address the respite needs of family carers to enable them to sustain people with LD remaining in family homes, with options for people to move out and live alone or with peers

who have similar needs.

44. The future landscape will need to comprise a broader range of services with less focus on traditional models of in-house or externally commissioned day centre care. User-led organisations and the voluntary sector also have a key role to play in supporting an effective and varied model of provision for the borough, making more of the opportunities around outreach and community support. Accessing mainstream services that support people to connect with their local communities is an important element.

RE-SHAPING LEARNING DISABILITY DAY SERVICES – PROPOSALS AND PROCESS FOR ENGAGEMENT

45. As outlined previously the council's approach to re-shaping LD day services is considered within the context of wider service transformation across adult social care and the financial position of the council over the next few years. It is also aligned with the suggested approach to other day services, considering fewer buildings-based services and a focus on people coming together to access support in one place, as well as outreach and people using creative ways of meeting their assessed needs within available resources. The focus is on supporting a more self-sustaining set of open access services that can deliver the council's vision for personalisation and promoting health, wellbeing and independence for people at risk of needing adult social care support.

46. The implementation of the redesign of LD day services will take place via a phased approach over the next two years, with a focus in 2012/13 on adults in residential care and supported living, and young adults coming through transition.

47. The National Development Team for Inclusion[1] have been engaged to support the LD day opportunities review, to support the council to understand and integrate best practice in the 'vision for day support/services'.

48. The NDTi have been working with health and social care managers and providers to agree a vision for LD day support that will be consulted upon over three months from February. The vision statement will reflect the core belief that people should, where possible, be accessing the community. It is not about how each person will spend their day, it is about the overall structure and will include individual

[1] The National Development Team for Inclusion (NDTi, www.ndti.org.uk) is a not for profit organisation[1] concerned with promoting inclusion and equality for people who are at risk of exclusion and who need support to lead a full live. We have a particular interest in issues around age, disability and health. Our roots are in the learning disability field and 40% of our work continues to be in that sector. In undertaking our work, we particularly aim to:

- Shape and influence policy and public debate
- Enable a stronger voice of people to be heard
- Support services to work differently so that they promote inclusive lives
- Support communities to be welcoming and inclusive.

planning, funding methods and developing the market. This will also include the identification of some guiding targets for example that the percentage of people in employment matches the wider percentage of disabled people in employment and that young people move through transitions into ordinary patterns of life.

49. The purpose of the NDTi work with the council is to:-

- Support the development of a day services strategy and delivery plan
- Support consultation with people using services and families
- Provide best practice information to elected officers
- Build a shared understanding of better/best practice
- Support the development of a range of day services choices (the market place) to include existing and new providers
- Support the implementation of the strategy and delivery plan
- Support transitions from education to community based day services (this has been added by the NDTi on reflection of local issues)

50. The key concern for service users, family carers, and providers engaged in the consultation process will be about cuts and anxiety about losing current services. We cannot deny that cuts will mean a reduction in some services. However, from our work locally and from best practice examples elsewhere cited by NDTi, we know of practical examples of austerity with integrity, for example:

- where an investment in supported employment (as opposed to day care activities) delivers long term individual support savings,
- where supporting people/families to do some shared interest pooling of personal budgets means people can make more efficient use of the money available,
- an expectation that all services will make greater us of planned 'natural supports' (the integrity bit here being the goal of greater community participation/engagement).
- outcomes based commissioning for which providers will be rewarded, with ongoing work, for delivering key objectives of more individual independence.

51. Initial feedback from engagement with health and social care front line staff and providers is that we need to do much more to make education, employment, and leisure accessible. For example, a lack of equipment in leisure and library facilities and a lack of skilled customer support prevents people from accessing sports and leisure and information. This is a theme that the scrutiny committee may be interested in exploring.

52. Another strategic priority is the need to stimulate market development. The LD innovation fund enables local groups to bid for money to support providers to

develop new business models to facilitate the introduction of self directed support to people with learning disabilities in Southwark, and to enable service users to have more choice and control over how they live their lives and participate in community life. The innovation fund is a one off opportunity available for 2011/12 and the funding will be awarded in March 2012. It is hoped this fund will attract new providers as well as facilitate existing providers to change.

53. The formal consultation process will be an opportunity to understand what service users and family carers think about LD services and the future direction, and the following questions are likely to be central to our conversations:-

- What about day services do you like?
- What about day services should we change?
- We think that day services in Southwark should focus on friendship & community, jobs, educations and social and leisure activities. Is this right?
- We would like people to have more say in choosing their day services, including using personal budgets, Is there anything that we can do to give you more control of day services?

54. The outcome of the consultation and engagement process will help to inform future recommendations to cabinet. In the meantime the committee may wish to bear in mind that although wider population awareness and national policy may be improving, people with LD are still subjected to hate crime, lower access to some services and low employment levels. Work will need to continue to ensure that equity is achieved and discrimination opposed and this requires a whole system approach where all council departments and community resources provide accessible services and seek to overcome the barriers to true social inclusion.

APPENDICES

No.	Title
Appendix A	EXPECTED OUTCOMES: TEEN TEAM FOR INDIVIDUALS IN TRANSITION
Appendix B	LD DEMENTIA CARE PATHWAY

Appendix A

EXPECTED OUTCOMES: TEEN TEAM FOR INDIVIDUALS IN TRANSITION

The National Transition Support Programme's report *TransMap: From theory into practice* (2009) identifies a number of underlying principles that, when applied can lead to a high quality service for young people in transition:

Comprehensive multi-agency engagement:

The Teen Team will ensure effective multi-agency engagement, which is a key way to ensure a smooth transition for young people with disabilities. The transition pathway outlined in the *Good Practice Guides for Young People and Families in Southwark* gives a clear and accessible format to raise awareness of who is responsible for supporting the person at each stage of transition, and to enable them to hold professionals accountable for delivering the service. The Teen Team will be co-located and will also be part of a virtual team, with wider links to Health, Education, Housing, Employment and Leisure. Key workers or lead professionals play an important part in coordinating the transition planning for young people and staff in the Teen Team will take on the role of key worker or lead professional for individuals going through transition.

The full participation of young people and their families

The Teen Team will involve young people and their families from the start of the development of comprehensive transition plan. Advice will be sought from children's services about the most effective ways that Southwark can engage with parents early in a child's life to ensure that they develop skills to work in partnership with professionals, who in turn support them to develop the skills that they need to advocate on behalf of their child. It will be for the Teen Team to lead on discussions with young people and their families after Year 9 Transition Reviews about the principles of self directed support and developing the skills of the young person to lead an independent and fulfilling life.

The provision of high quality information

Southwark has an *Information Guide on Transition for Young People and Families* that is aimed at empowering both young people and their parents throughout the transition process. This gives information about what can be expected from the transition process and it is hoped that through the guides young people are enabled to participate more effectively in the process. The Teen Team would bridge this gap, providing accessible information tailored to the individual and their families. The Teen Team will have a role in signposting young people not eligible for social care support to tap into open access services. Invaluable support and information on options for education, training and employment opportunities, as well as for social and recreational opportunities can be passed on to young people not eligible for adult services.

Effective transition planning.

The expectation is that the Teen Team would be involved in person-centred approaches to transition planning and close liaison with schools, who would have the lead in this area. There is a drive towards person centred planning in Southwark, placing the young person is at the centre of the process, with plans that are made based on the needs and aspirations of the young person. A multi-agency approach to transition supports person-centred approaches, as it means that all professionals are

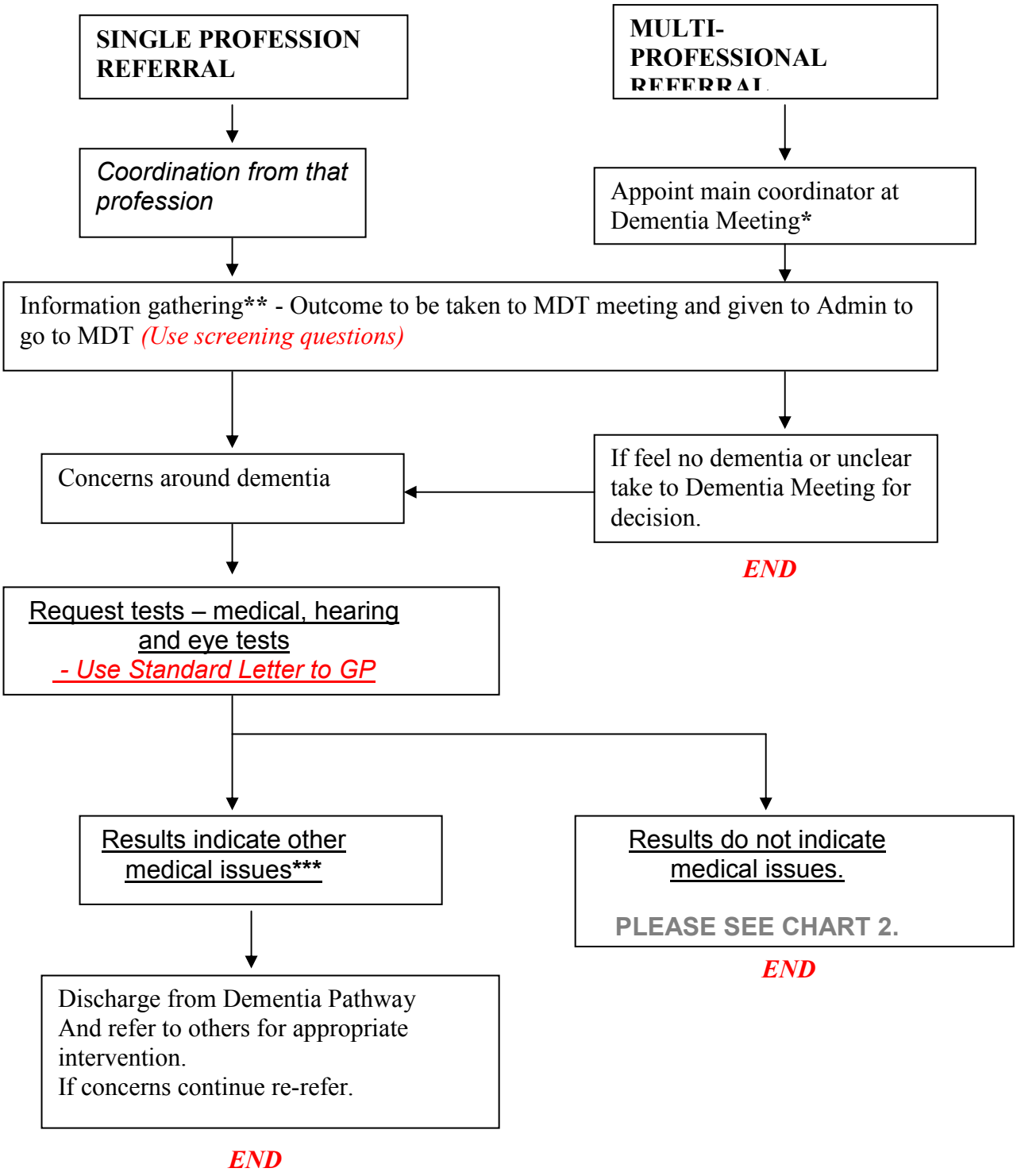
working together to support the young person. Schools have a duty to ensure that in Year 9 young people with a statement of special educational needs have a transition review. This review gives the young person and their family the opportunity to think about and plan for their future, with the support of professionals. The transition plan should be reviewed at least annually, and should be a live document. It should also be presented in a format that is accessible to the young person and their family. The aim of the Teen Team will be to advise and input to ensure high quality transition plans are produced that reflect the voice of the individual and their wishes for their future.

An array of opportunities for living life.

It is recognised locally and nationally that young people with disabilities must have the chance to live a fulfilled life, with the same opportunities offered to them as their non-disabled peers. In Southwark there is further work to do in ensuring that there are a range of opportunities for young people to access, including opportunities in education, employment, youth and leisure services, and this is the central theme of the LD Day Opportunities redesign. Personalised approaches, as mentioned above enable young people to have an individualised plan that takes into account all of these areas and the Teen Team will lead in developing Transition Plans that make these aspirations a reality. The Teen Team will play a key role in implementing the redesign of day opportunities services, by supporting young people to move through transitions into a range of day opportunities. There is a programme of work well-underway in Adult Social Care to encourage vulnerable people to be supported to take control of what they do, through the use of self-directed support and personal budgets.

APPENDIX C

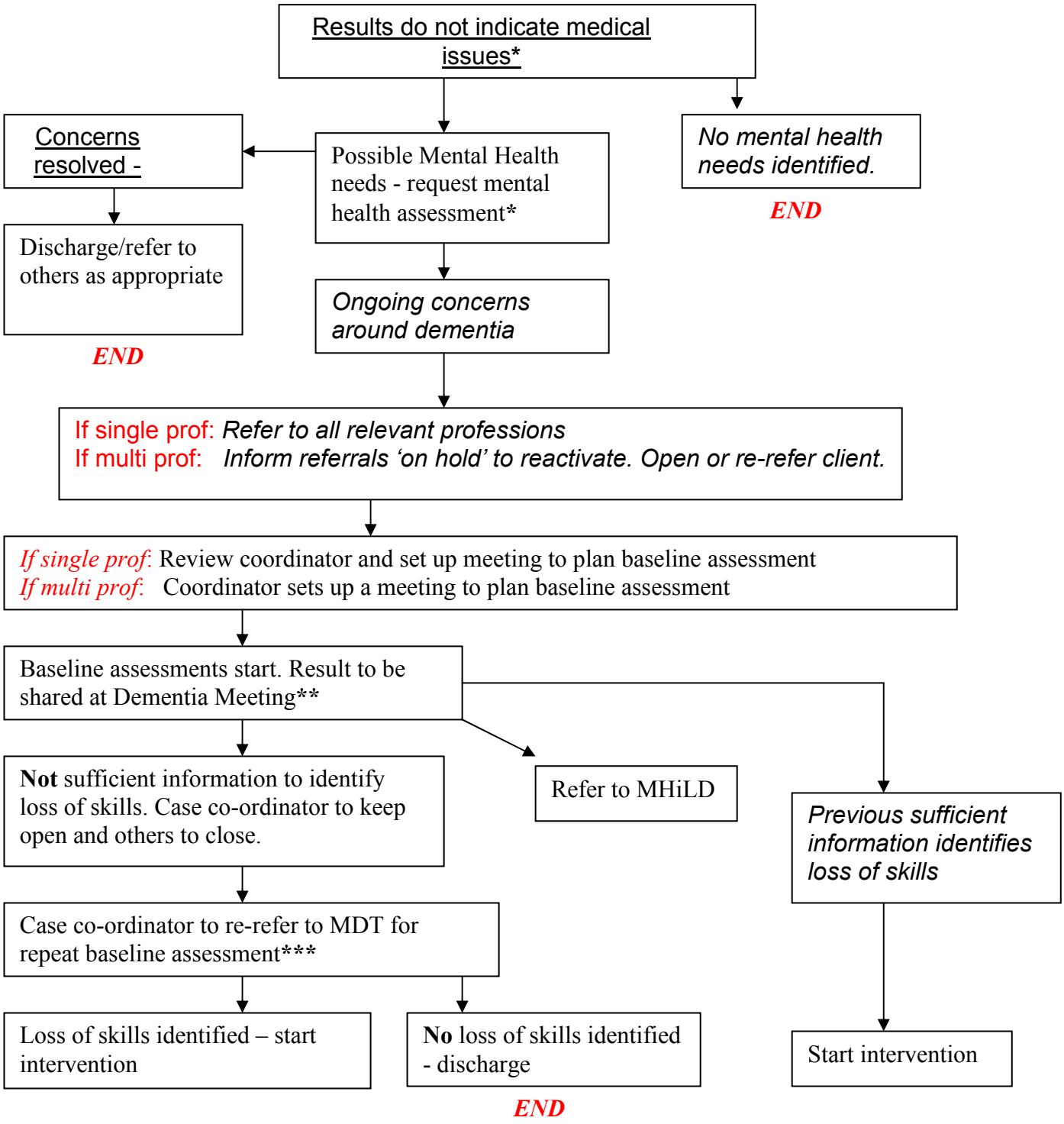
Down's Syndrome and Dementia Screening Pathway – Chart 1



* Best practice 4 weeks.
** Best practice 6 weeks from date of referral for SouthwarkPCT.
4 weeks for SLAM.
*** Best practice 6-8 weeks from date of GP referral

PILOT

Down's Syndrome and Dementia Screening Pathway – Chart 2



* If referral from MHiLD team originally, go to *Ongoing concerns around dementia*.
** Best practice within 2 weeks after coordination meeting
*** Best practice 6 months from previous assessment

Agenda Item 9

Southwark Health and Adult Social Care Scrutiny sub-Committee – November 2011

Interim Report into Southwark Clinical Commissioning Consortia

Part 1: Introduction

This report seeks to review, and make recommendations to improve, the transition to and operation of the clinical commissioning consortia that is being established in Southwark as part of the national government's changes to the National Health Service (NHS) in England. These changes will be enacted under the Health and Social Care Bill which is currently before the House of Lords at Committee Stage.

Whilst HASC committee members have some reservations about the fundamental proposals contained within the bill and the potential detrimental impact on NHS services in Southwark it is beyond the remit of this committee, or Southwark Council, to stop them. Therefore this report seeks to investigate and make recommendations to enable the changes to work as well as they can in Southwark. The overriding concern of HASC Committee members is the provision of high quality healthcare provision that meets the needs of Southwark's population and continual improves

Importance (COMPLETE)
Importance of NHS to local population
Importance of existing work being undertaken (e.g paediatric liver unit at KCH)
Importance of maintaining viable health economy

Scope of the Review
Review into the establishment, transition to and operation of a Clinical Commissioning Consortia in Southwark following changes to the NHS brought about by the government's Health & Adult Social Care Bill which is currently before Parliament.

The review will focus on:

i) Transition to the Consortia;
ii) Impact of Cost Savings on Patient Care;
iii) Conflicts of Interest and;
iv) Contract Management

This review seeks to influence Southwark Council, the Southwark Clinical Commissioning Consortia, the SE London PCT Cluster, the (to be created) Health & Wellbeing Board, NHS London and central Government.

Achievable outcomes: influence Consortia's internal procedures; influence the transition to/setting of Consortia policies; draw attention to potential risks so that these can be mitigated by the council and consortia.

Part 2: Scrutiny of Establishment of Southwark Clinical Commissioning Consortia

Southwark Clinical Commissioning Consortia (SCCC)

The SCCC gave evidence to the committee on 29th June and 5th October 2011, in addition the HASC Chair attended a SCCC public meeting in July and the NHS Southwark AGM September The HASC Committee welcomes the open approach taken by SHC towards the scrutiny process and hopes that the recommendations contained within this report are received with the same openness.

Dr Amr Zeineldine (Chair SHC) and Andrew Bland (Managing Director Southwark Business Support Unit) gave evidence to the committee to explain the transition to the consortia, the impact of cost savings (QIPP) on patient care and at the committee's request the SCCC provided further clarification of it's conflict of interest policies.

Consortia Background:
Southwark Health Commissioning was granted Pathfinder status in the first wave of GPs in England to have been selected to take on commissioning responsibilities. Pathfinders are working to manage their local budgets and commission services for patients alongside NHS colleagues and local authorities. The new commissioning system has been designed around local decision making and Southwark Health Commissioning believe that this will lead to more effective outcomes for patients and more efficient use of services for the NHS. GP Commissioning is not new in Southwark. Southwark's General Practices have worked together as a commissioning group since the beginning of 2007 when the Southwark Practice Based Commissioning Leads Committee was established. Local GPs have a record in commissioning and service redesign. Under existing arrangements GPs have been involved in the planning of several major areas of patient care such as outpatients, walk-in centres, and local community services. Southwark Health Commissioning has the support of local GPs and doctors' representatives and the Local Authority and will begin testing the new commissioning arrangements to ensure they are working well before formal delegation in April 2013.

Southwark Health Commissioning consists of a Board of eight GP members, four from the South of the Borough and four from the North. The SCCC is chaired by Dr Zeineldine who is also a member of the PCT Board. The current SCCC membership brings together the senior management team of the Southwark Business Support Unit, the Non Executive Directors (NEDs) of the Board with responsibility for Southwark and the consortium leadership team who represent their constituent practices. All of the above constitute the voting members of the SCCC, in which the eight clinical leads hold a majority. Other non-voting members include Adult Social Care, King's Health Partners, a nurse member, a Southwark LINk representative and a representative of the Southwark Local Medical Committee.

Whilst the previous Primary Care Trust structure was not perfect and did have a democratic deficit, the committee is concerned by the closed nature of commissioning consortia as set out by government, as the only people who can be guaranteed to sit on the board are local GPs. Whilst this may bring benefits it is also worrying that there is only a relatively small pool of people from which lead GPs can be elected (and indeed take part in election). This is not a criticism of existing GP leads but is made to highlight potential problems that could develop in the future and to try and mitigate against these. It is understood that Southwark Health Commissioning has co-opted members onto its board which is a welcome step. The committee recommends that this practice of co-opting members onto its board continues in the future to broaden the range of experiences available when making commissioning decisions.

Due to the controversial nature of the changes being made by national government it is vital the consortia builds trust with the resident population, council and other local providers and organisations. It is also important for patients to feel that they are being listened to, as David Cameron has said “no decision about me, without me”. Therefore the committee urges that a culture of listening and consultation with patients is developed and built upon to ensure that they remain front and centre in commissioners minds. Initial steps have already been taken by SHC, which are to be welcomed, however this must continue.

Southwark Health Commissioning 2011/12 business plan outlines the trajectory for delegation, whereby SHC takes on responsibility for commissioning (i.e. spending taxpayer’s money). The timetable for delegation can be found at appendix 1, essentially by January 2012 SHC will be responsible for a budget of £421million which is c.80% of total NHS spend in Southwark. Nationally GP-led consortia will be responsible for spending £80billion on an annual basis, this represents 80% of total NHS spending. It is critical the people responsible for spending this money have comprehensive structures to deal with conflicts of interest and prevent possible misappropriation of tax-payers money.

Conflict of Interest

The committee agreed to look at SCCC’s conflict of interest policy and their contract management arrangements. SCCC’s current conflict of interest policy can be found at appendix 2. HASC committee members feel that while these measures are a good starting point they are not rigorous enough. There are potential conflicts of interests that will arise for GPs in their new role as commissioners. GPs bidding as providers who are also commissioners is a key tension in the new arrangements set out by national government. As mentioned above the SCCC and NHS SE London are already looking at how conflicts of interest could be managed locally, but guidance should be set out nationally on how such conflicts are managed.

It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that such training continues and a programme of ‘refresher’ training and sharing experiences and best practice from other public bodies and clinical commissioning groups takes place.

In addition, given the importance of the SCCC’s work and the vital need for transparency to build public confidence in the new arrangements and to allow proper accountability the committee recommends the following:

a) All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.
b) Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted where by any ‘closed items’ can be discussed in private, but minutes of the non-public part of the meeting should be published.

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c) Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.
d) The register of interests should be updated within 28 days, of a change occuring.

e) Southwark's HASC committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark HealthWatch, SHC Chair and the local press.
f) If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.
g) Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.
h) In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material none public information that could affect the value of an investment must not act or cause others to act upon that information".

King's Health Partners

On 5th October 2011 the committee took evidence from Professor John Moxham, Director of Clinical Strategy for King's Health Partners (KHP). KHP is an Academic Health Sciences Centre (AHSC), which delivers health care to patients and undertakes health-related science and research. This type of organisation is fairly common amongst the leading hospitals and universities around the world. KHP is one of the UK's five AHSCs. It brings together a world leading research led university (King's College London) and three NHS Foundation Trusts (Guy's and St Thomas', King's College Hospital and South London and Maudsley).

Their aim is to create a centre where world-class research, teaching and clinical practice are brought together for the benefit of patients. They aim to make sure that the lessons from research are used more swiftly, effectively and systematically to improve healthcare services for people with physical and mental health care problems. At the same time as competing on the international stage, their focus remains on providing local people with the very best that the NHS has to offer. The aim is for local people to benefit from access to world-leading healthcare experts and clinical services which are underpinned by the latest research knowledge. There will also be benefits for the local area in regeneration, education, jobs and economic growth.

Professor Moxham explained to the committee the importance of integration and collaboration for KHP to improve patient outcomes. Within KHP there are 21 'Clinical Academic Groups' (see appendix 3) that integrate services across the partners, this pulls together knowledge, experience and expertise across the different hospitals and leads to better patient outcomes. There are four main streams to this integration:

1) Integrating Services across the partners
2) Integration of clinical service with academic activity
3) Integrating mental and physical health
4) Integration of core patient pathways

He explained to the committee that this level of integration, to improve patient outcomes, is reliant on collaboration between all parts of the local health system, and indeed the local authority. Committee members have concerns that the introduction of private providers into this system through 'Any Qualified Provider' could have a detrimental impact to the development of KHP and the continual improvement of health outcomes for our residents. This concern is based on the reality that private providers' are in part motivated by profit (which is wholly understandable) and that if collaboration was not deemed to be in their business interests then further integration and improvement of patient outcomes could be jeopardised. Therefore the committee recommends that the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and

integration continue to take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority.

King's College Hospital and Guy's and St Thomas' Hospital Trusts

Committee members visited both hospitals (a visit to SLaM is being organised) and met with the Chief Executive and Chair of KCH and the Chief Executive of GST. Members also saw the Specialist Stroke Unit and A&E at KCH and the A&E at GST. The committee would like to thank both hospitals for hosting members and shining a light on the work that they do.

At KCH it was clear the hospital excels in certain types of treatment and care, for example Paediatric Liver Transplants, Neuro-Sciences and Stroke Care. At GST it was also clear that the size of the trust allows cross-working between types of clinician that leads to innovative forms of treatment for patients. As discussed in more detail above King's Health Partners is driving such integration and collaboration even further which is to be commended.

At KCH concerns were raised by management that if income streams were removed (i.e. other providers were commissioned by the SHC) then the financial viability of KCH would be put at serious risk. This is a serious concern of the committee, as it would be unacceptable for the specialism's and work of any acute trust and KHP to be put at risk as this would be detrimental to serving the health needs of the local population. This is not to say KCH (and GST and SLaM) should not be challenged to deliver more cost efficient forms of care, but that the viability of the institutions should not be put at risk. Therefore the committee recommends to the SCCC that they:

a) That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers.
b) That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASSC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC Ctte for scrutiny, including outsourcing
c) The committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'
d) The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision.
e) As a contractural obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are.

Impact of Cost Savings on Patient Care

In addition to the changes to NHS Commissioning described above the government has also required the NHS to make total savings in England of £20billion,at a time when Southwark's population is increasing by 2% per annum. The impact of these savings on patient care in Southwark has been included in this report to highlight potential problems and areas of pressure within the system..

NHS Southwark Performance:
A full breakdown of performance data for Southwark can be found at Appendix 4 (taken from Southwark NHS' Annual Report 2010/11. This shows an underperformance for the 18 week waiting time target, it also shows worryingly high failures to meet targets for Breast Screening, Cervical Screening, Smoking Quitters and immunisation of children – particularly those aged 5. Additional areas of concern are alcohol consumption, sexual health and childhood obesity, currently at 25.7% of year 6 pupils (age 11-12). We will have to await next year's report to assess performance for the current financial year. Failure to improve on these targets would be of deep concern to the committee.

Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health.

Contract Management
With delegation of budgets to the SCCC comes responsibility for making commissioning decisions and tendering contracts. This may be self-evident but is worth highlighting and dwelling upon. The SCCC currently uses the expertise of Southwark PCT's Business Support Unit (BSU) who provide them with commissioning support . In April 2013 SCCC will be able to decide who provides this commissioning support in the future.

One of the unfortunate consequences of central government's changes has been the breaking of the very close working between Southwark PCT and Southwark Council. In the immediate future the working relations developed between BSU and SC staff will almost certainly remain, however, in the future these working relationships may erode as they are not formally codified as they were in the past. This could lead to a lack of integration at all levels of both organisations which could impede improvement in health outcomes for Southwark's residents. The committee therefore recommends SHC and it's BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing).

As part of the move to 'Any Qualified Provider' it is more than likely that at some stage a private provider will be commissioned to deliver health services in some form in Southwark. Given the mixed experience that parts of the public sector have had with private providers (e.g. Southwark's Housing repairs service and call centre) it is imperative that SCCC take a robust approach to contract management, both in drawing contracts up and in monitoring them when signed.

The recent experience and problems caused by the collapse of Southern Cross care homes and the levels of poor care provided at other privately run homes should act as stark warnings to health care commissioners. It took several years for their flawed business model to be exposed (when market conditions changed). To avoid any repeats of this in the health care system the committee urges the SCCC to introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis and that robust monitoring of satisfaction amongst patients placed with those providers takes place.

There have been previous instances of tendering out NHS services, for example in April 2004 it became possible to outsource primary care out of hours services to independent commercial providers. John Whitting QC, a specialist barrister in clinical and general professional negligence, has reviewed the subsequent CQC and DH reports and inquiries into this and in June 2011 stated that:

"It identified staffing levels that were potentially unsafe, significant failures of clinical governance caused directly by overly ambitious business growth and failures to investigate or act upon serious adverse incidents. The CQC chairman concluded that 'the lessons of these failures must resonate across the health service'." *(John Whitting QC, New Statesman, 23/06/2011)*

The committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational abilities. The details of this arrangement should be for the SCCC to decide, but contract management and effective monitoring must not be an afterthought in any potential tendering process but at the centre.

Further info required: TUPE – If a service is tendered out to a private or other provider will the staff currently providing the service be covered by Transfer of Undertakings (Protection of Employment) TUPE legislation?

Part 3: Conclusions and Recommendations

In summary, the committee's recommendations are listed below, the body which the committee is seeking to adopt the recommendation are italicised in square-brackets at the end of each one.

Recommendation 1
The committee recommends that the practice of co-opting members onto the SCCC's board continues in the future to broaden the range of experiences available when making commissioning decisions. *[SCCC, NHS SE London]*

Recommendation 2
Given the importance of SCCC's work and of the vital need for transparency to build public confidence in the new arrangements the committee recommends the following:

a) All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.
b) Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted where by any 'closed items' can be discussed in private, but minutes of the non-public part of the meeting should be published.
c) Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.
d) Declarations of Interest are recorded at the beginning of meetings and recorded in sufficient detail in the minutes.
e) The register of interests should be made public by being published online, in an easy to find location. To avoid confusion the SCCC should use consistent terminology when referring to *declarations* of interest and *the register* of interests.
f) Southwark's HASC committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark LINk/HealthWatch, SCCC Chair and the local press.
g) If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.
h) Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.
i) The SCCC ensures there is a non-executive non-GP 'Conflict of Interest Lead/Tsar' on its board and amends it's constitution accordingly.
j) In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material none public information that could affect the value of an investment must not act or cause others to act upon that information".
k) The SCCC should develop a comprehensive policy for handling and discussing confidential information.
l) In the interests of transparency, the SCCC should publish the results of election ballots for the 8 lead GPs, in addition they should publish full details of the ballot process and who conducts the ballot.

[All of the above – SCCC/NHS SE London]

Recommendation 3
The committee recommends that the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and integration continue to

take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority. *[SCCC, NHS SE London and Southwark Council]*

Recommendation 4
That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers. *[SCCC, NHS SE London and Southwark Council]*

Recommendation 5
That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC Committee for scrutiny, including outsourcing

Recommendation 6
The committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'. *[DH, via HASC Ctte]*

Recommendation 7
The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision. *[HWB and Monitor through HASC Ctte].*

Recommendation 8
As a contractual obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are. *[SCCC, NHS SE London, Southwark OSC].*

Recommendation 9
Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health. *[HASC Ctte].*

Recommendation 10
The committee recommends SCCC and it's BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing). *[SCCC, NHS SE London, Southwark Council].*

Recommendation 11
The committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational capabilities. The details of this arrangement should be for the SCCC to decide, but contract management must not be an afterthought in any potential tendering process but at the centre. *[SCCC, NHS SE London and Southwark Council].*

Recommendation 12
That the Health and Wellbeing Board has as a central aim of stimulating integration and collaboration between local health care providers to improve patient outcomes. *[HWB].*

Recommendation 13
Patient views and perceptions of the level of care they receive are vitally important to improve services. It is therefore recommended that the Acute Trusts continue to conduct patient surveys, and the SCCC drives patient surveys at GP practices across the borough to capture patients' views and perceptions of their care to help understand what can be improved. *[Acute Trusts x 3 and SCCC]*

Recommendation 14
It is recommended that the SCCC introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis. *[SCCC, NHS SE London]*

Recommendation 15
It is recommended that robust monitoring of satisfaction amongst patients placed with all providers takes place as a matter of course.

Recommendation 16
In addition to clinical standards, set out by government, it is recommended that minimum levels of patient satisfaction are included in any contracts signed by the SCCC with financial penalties if these are not met, the exact levels, and how they are measured, should be a matter for the SCCC. *[SCCC, NHS SE London]*

Recommendation 17
Guidance on managing conflict of interest for GP commissioners should be set out nationally. It is recommended that the HASC writes to the Dept of Health requesting this to take place. *[HASC]*

Recommendation 18
It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that governance training continue for GP commissioners and a programme of 'refresher' training, sharing experiences and best practice from other public bodies and clinical commissioning groups takes place. *[NHS SE London, HASC]*

Recommendation 19
It is recommended that the SCCC consider their capacity for developing contracts and build this into their development plan, in particular where they will access expertise in drawing contracts up and monitoring them when signed.

Recommendation 20
It is recommended that the SCCC works closely with and pays close regard to the priorities of the local authority and health and wellbeing board to foster cooperation and meet the mutual goal of improving health outcomes of Southwark's residents.

Recommendation 21
It is recommended that that the SCCC monitors clinical outcomes, including measures such as mortality rates, and that these are related to contracts signed with all providers, with financial penalties attached.

Recommendation 22
It is recommended that the SCCC appoints external auditors

Appendix 1 - timetable for delegation to SCCC

2011/12 Budget Delegation

Delegation Phase / Date	Budget Area	Budget (£m)	QIPP Gross (£m)	Detail / Complexity* (column consider the complexity of the commissioning area to inform phase)	
One – Jul 2011	Emergency PbR	49	4.8	This phase includes the following areas:	
	A&E PbR	12	0.1		
	New Outpatients	19	2.4		
	F-up Outpatients	22	1.5	Outpatient (GP referrals)	Low
	Drugs and Devices	11	0.5	Prescribing	Low
	Pri Care Prescribing	33	1.0	Urgent care (A&E / UCCs)	Med
	Corporate	17	2.0	Urgent care (Admissions)	Med
				Non GP referred outpatients	Med
				Intermediate Care / Reablement	Med
				Non-PbR Drugs and Devices	Med
Total		163	12.3	(6.3 delivered prior to delegation)***	
Two – Oct 2011	Community Services	33	1.5	This phase includes the following areas:	
	Other Acute**	166	2.6		
				Community Health	Low
				Direct Access Diagnostics	Low
				Sexual Health	Med
				Elective Care	Med
				Maternity	Med
				End of Life Care	Med
				Critical Care	High
				Specialist Acute Commissioning	High
Total		199	4.1	(3.6 delivered prior to delegation)	
Three – Jan	Client Groups	22	-	This phase includes the following	

2012	Mental Health	67	2.6	areas:	
				Community Mental Health	Med
				Voluntary Sector	Med
				CAMHS	Med
				Inpatient Mental Health	Med
				Physical Disability	Med
				Specialist Mental Health	High
				Continuing Care (inc. LD)	High
Total		89	2.6	(4.6 delivered prior to delegation)	
Other	Non-recurrent 2%	10	-		
	Reserves / Surplus	11	-		
Total		21	-		
Non-Delegated	Primary Care	68	1.2		
Total		68	1.2	(0.8 delivered - no delegation)	
Budget Total		**540**	**20.2**		

Notes:

***** SHC has sought to take early delegation for those areas that fall in areas of low or medium complexity. Complexity refers to the commissioning activity itself and SHC are equally aware of the different levels of control that can be secured over performance in these areas.

** Includes £30m budget for Specialised Commissioning which will continue to be led through the LSCG.

******* Clearly delegation is being made in-year and the figures provided above also seek to reflect the level of QIPP delivery undertaken ahead of delegation in the context of the overall QIPP challenge.

Appendix 2 - SHC's current conflict of interest policy

SCCC approach to Conflicts of Interest

1.1. A register of interests of members of the SCCC will be systematically maintained and will be made publically available. These details will be published in the PCT Annual Report. Members will also be asked to declare any interests at the start of each SCCC meeting.

1.2. To ensure that no commercial advantage could be gained, a GP lead who declares an interest in an area cannot be involved in it. If after being involved, any bids received from the lead's practice would not be accepted.

1.3. Where the business of the committee requires a decision upon an area where one GP holds a significant conflict of interest, the Chair will ensure that the individual takes no part in the discussion or subsequent decision making.

1.4. Where more than two GP leads holds a significant conflict of interest the committee will require consideration of the proposal / issue to be made by a separate evaluation panel. The evaluation panel would evaluate the proposal for quality and cost-effectiveness and if satisfied it would then make a recommendation to the Clinical Commissioning Committee, excluding the interested GP members, for decision.

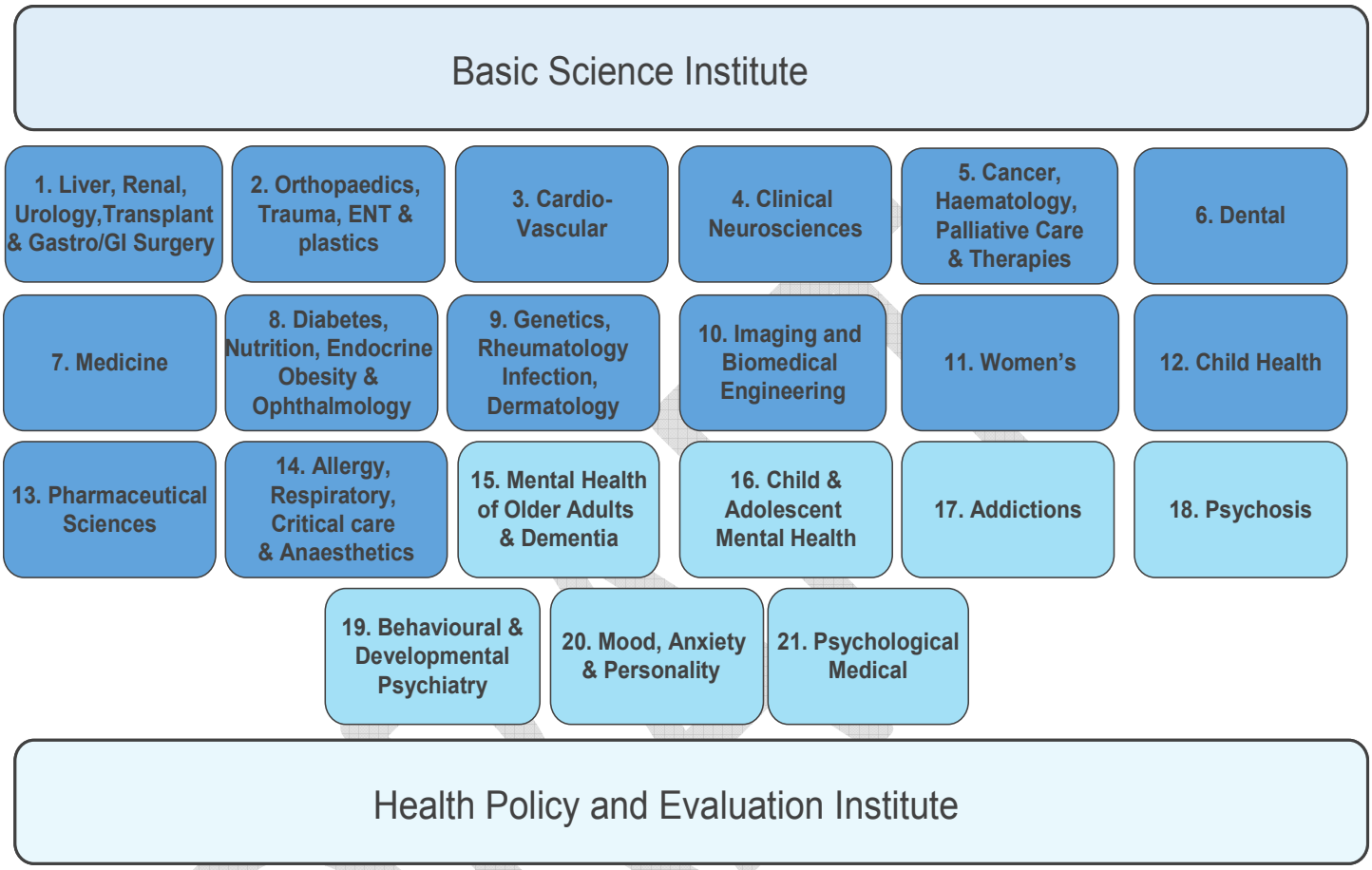
1.5. The Evaluation Panel, when called upon, will provide neutrality in the evaluation process and will have the following membership:

- One Non-Executive Director of the PCT Board
- Managing Director, Southwark BSU
- Southwark Director of Public Health (and Health & Well Being Board representative)
- Co-Opted clinical expertise if necessary at discretion of the MD

1.6. In the rare occasion where the Clinical Commissioning Committee is unable to reach a decision under these circumstances the decision maybe referred to the PCT Board.

Appendix 3 - King's Health Partner's Clinical Academic Groups

CAG and Research Group Structure



Appendix 4 – 2010/11 Performance data for NHS Southwark (from Annual Report)

To be copied in, see **http://www.southwarkpct.nhs.uk/documents/6930.pdf** page 6 for relevant info

South East London

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NHS South East London
PO Box 64529
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Email: andrewbland@nhs.net
Website: www.southwarkpct.nhs.uk
Telephone: 020 7 525 0401
Fax: 020 7 525 0450

12 January 2012

Dear Mark

Response to the recommendations of the Interim Report into Southwark Clinical Commissioning Consortia – November 2011

I am writing on behalf of the Southwark Clinical Commissioning Committee (SCCC) to acknowledge the recommendations of the Southwark Health and Adult Social Care Scrutiny sub-committee (HASC) report above and to provide a formal response to each of the recommendations provided. It is our understanding that the interim report will be considered again at the upcoming HASC meeting and that our responses will contribute to this review.

I would like to place on record the SCCC's thanks to the committee for the in depth consideration that members have given these issues and for the recommendations that are not only helpful but are also extremely timely, given that the SCCC is currently engaged in development work to shape the way it conducts commissioning activities in future. The SCCC welcomes the constructive challenge that has been present throughout our engagement with the committee and for the thorough nature of the report and its recommendations.

The interim report has been considered by Dr Amr Zeineldine, Chair of the SCCC, Dr Richard Gibbs, the Non-Executive Director of the PCT and member of the SCCC with responsibility for governance, and myself as the Managing Director of the Southwark Business Support Unit. The report will also be received by the full SCCC before the end of this financial year (the clinical leads of the SCCC are copied to this letter).

In reviewing the recommendations of the report the SCCC representatives have provided a short response to each recommendation in the attached document. These responses are provided in summary and we would be happy to provide further detail on any part of the response as required.

In general terms the SCCC welcome the recommendations of the report and our responses fall into four categories:

NHS

South East London

- Those that the SCCC welcomes in full and have already taken steps to address them
- Those that the SCCC welcomes in full and have now established plans to address them in the coming months
- Those recommendations that suggest actions from a party other than the SCCC, but that the committee would wish to receive the outcome of those requests (or contribute to them as appropriate)
- Those that the SCCC would welcome a further discussion with the HASC prior to progressing work on these areas

At the bottom of the response document we have included an action plan to address or further explore the recommendations and we have identified the lead BSU officer that would take these actions forward and the timescale that we would propose for each action. We would welcome your feedback on our responses and on these proposed actions specifically.

We hope the detail of our response will assist the HASC in its ongoing review in this area and we would reiterate the importance we place upon this work and the value we believe it has added. We look forward to working with the HASC on this and related areas of commissioning in future.

Should you have any immediate questions or you require any further information, please do not hesitate to contact me.

Yours sincerely

Andrew Bland
Managing Director
Southwark Business Support Unit

For and on behalf of the Southwark Clinical Commissioning Committee

C.C.

Dr Amr Zeineldine	Chair / GP Lead
Dr Simon Fradd	Vice Chair / GP Lead
Dr Patrick Holden	GP Lead
Dr Mark Ashworth	GP Lead
Dr Jonty Heaversedge	GP Lead
Dr Jane Cliffe	GP Lead
Dr Adam Bradford	GP Lead
Dr Roger Durston	GP Lead
Dr Richard Gibbs	PCT Non Executive Director
Robert Park	PCT Non Executive Director
Malcolm Hines	BSU Chief Financial Officer
Tamsin Hooton	BSU Director of Acute and Community Commissioning

NHS
South East London

Attachment 1

Southwark Clinical Commissioning Committee response – January 2012

Recommendations of the Southwark HASC in November 2011:
Recommendations have been made as part of the HASC Interim Report into Southwark Clinical Commissioning Consortia

Please note that any actions or points of clarification have been highlighted in **bold** and are included in a summary actions table at the bottom of this document.

No.	HASC Recommendation	SCCC Response
1	The committee recommends that the practice of co-opting members onto the SCCC's board continues in the future to broaden the range of experiences available when making commissioning decisions. *[SCCC, NHS SE London]*	The SCCC welcomes this recommendation in full. This practice will be continued throughout 2011/12 and 2012/13. In Quarter four 2011/12 the SCCC expects further guidance from the Department of Health upon the composition of the governing body of a CCG and we will update the sub-committee as this becomes available.
2	Given the importance of SCCC's work and of the vital need for transparency to build public confidence in the new arrangements the committee recommends the following:	
2a	All interests are declared at the beginning of each meeting (either SHC, SCCC or sub-committees), as opposed to the current practice of simply noting the register of interests and declaring new interests.	The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings

2b	Meetings of the SCCC where commissioning decisions are discussed or taken should be held in public, as opposed to the current system whereby every other meeting is held in private. A similar model to the council should be adopted where by any 'closed items' can be discussed in private, but minutes of the non-public part of the meeting should be published.	The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings
2c	Minutes of such meetings should be made available within two weeks of the meeting and be published online in an easy to find location.	The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings. **The SCCC is not currently meeting the two week standard recommended here and will take action to achieve this by March 2012**
2d	Declarations of Interest are recorded at the beginning of meetings and recorded in sufficient detail in the minutes.	The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings.
2e	The register of interests should be made public by being published online, in an easy to find location. To avoid confusion the SCCC should use consistent terminology when referring to *declarations* of interest and *the register* of interests.	The SCCC welcomes this recommendation in full and has already implemented this for all relevant meetings.
2f	Southwark's HASC committee should review the register of interests on an annual basis as part of its regular work plan and a report be submitted to the Health and Wellbeing Board, Southwark LINk/HealthWatch, SCCC Chair and the local press.	The SCCC welcomes this recommendation in full. **We would request that the HASC committee outline the process by which they wish to undertake this action.**
2g	If a member declares a material conflict of interest they should absent themselves from that part of the meeting and remove themselves from the room.	The SCCC welcomes this recommendation. However our current process requires the member to absent themselves from the meeting only. Given that it is a public meeting we have agreed that they may sit with the public. **We would welcome a further discussion with representatives of the HASC committee on this issue.**

2h	Under the SHC's existing conflicts of interest policy under 'Related Parties' a new category be added of 'close friend'.	The SCCC welcomes this recommendation in full. **We will take action to amend this policy by March 2012.**
2i	The SCCC ensures there is a non-executive non-GP 'Conflict of Interest Lead/Tsar' on its board and amends it's constitution accordingly.	The SCCC welcomes this recommendation in full. This position has been established for some time in our arrangements and will continue to feature in any future constitution.
2j	In line with best practice a new clause be added to the SHC/SCCC's conflict of interest policy to emphasise: "That a member in possession of material none public information that could affect the value of an investment must not act or cause others to act upon that information".	The SCCC welcomes this recommendation in full. **We will take action to amend this policy by March 2012.**
2k	The SCCC should develop a comprehensive policy for handling and discussing confidential information.	The SCCC welcomes this recommendation in full. **We will take action to establish this by April 2012.**
2l	In the interests of transparency, the SCCC should publish the results of election ballots for the 8 lead GPs, in addition they should publish full details of the ballot process and who conducts the ballot.	The SCCC welcomes this recommendation in full. **The SCCC will be outlining its processes for future 'Selection / Election' in April 2012 and will ensure that this recommendation is reflected.**
3	The committee recommends that the SCCC's tendering process for any service includes standard clauses in the contract to ensure collaborative working and integration continue to take place. It is further recommended that the SCCC develops such clauses with KHP and the local authority. *[SCCC, NHS SE London and Southwark Council]*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**
4	That all publically funded commissioners of healthcare including the CCG and local authority consider the wider effect of commissioning outside the NHS on the long-term viability of public providers. *[SCCC, NHS SE London and Southwark Council]*	The SCCC welcomes this recommendation in full.

5	That anything other than minor commissions outside the NHS are referred to the Health and Wellbeing Board (HWB) and the Health and Adult Social Services Scrutiny Sub-Committee (HASC) for consideration and should be deemed a 'substantial variation' and be submitted to the HASC Committee for scrutiny, including outsourcing	**The SCCC welcomes this recommendation in principle but would wish to work with the HASC committee to define the terms referred to and to ensure they can be applied adequately.**
6	The committee requests further clarification from the Department of Health (DH) relating to the legal issues around 'substantial variation' raised by these changes. As legally this appears to be a 'grey area'. *[DH, via HASC Ctte]*	The SCCC would welcome feedback from the Committee as and when detailed responses are received.
7	The HWB and Monitor should maintain a close watching brief on private providers to note and respond to any trends that suggest that private contractors are 'cherry-picking' particular contracts. Such activities may lead to disparity between groups of patients and undermine public provision. *[HWB and Monitor through HASC Ctte].*	The SCCC would welcome feedback from the Committee as and when detailed responses are received.
8	As a contractual obligation all providers should be subject to scrutiny by the HASC Ctte just as NHS ones currently are. *[SCCC, NHS SE London, Southwark OSC].*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**
9	Given the importance of integration and collaboration across the local health system and the importance of preventative public health, and the fact that those duties are moving across to the local authority, it is recommended that the HASC committee in the next municipal year (i.e. from May 2012) conducts a review into Public Health. *[HASC Ctte].*	The SCCC would welcome this action and is happy to participate in any work as appropriate.
10	The committee recommends SCCC and it's BSU (whoever that may be in the future) work closely with the local authority to integrate their work as closely as possible across public health, adult social care and the council's other services (in particular housing). *[SCCC, NHS SE London, Southwark Council].*	The SCCC welcomes this recommendation in full.

11	The committee recommends that SCCC works closely with Southwark Council, NHS London and other Clinical Consortia to learn lessons from past experiences and develop a strong contract management function as part of their organisational capabilities. The details of this arrangement should be for the SCCC to decide, but contract management must not be an afterthought in any potential tendering process but at the centre. *[SCCC, NHS SE London and Southwark Council].*	The SCCC welcomes this recommendation in full.
12	That the Health and Wellbeing Board has as a central aim of stimulating integration and collaboration between local health care providers to improve patient outcomes. *[HWB].*	N/A
13	Patient views and perceptions of the level of care they receive are vitally important to improve services. It is therefore recommended that the Acute Trusts continue to conduct patient surveys, and the SCCC drives patient surveys at GP practices across the borough to capture patients' views and perceptions of their care to help understand what can be improved. *[Acute Trusts x 3 and SCCC]*	The SCCC welcomes this recommendation in full.
14	It is recommended that the SCCC introduce and use as a matter of course standard clauses, in any contracts it signs with providers, that ensure information is provided on the financial position of the provider on a quarterly basis. *[SCCC, NHS SE London]*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**
15	It is recommended that robust monitoring of satisfaction amongst patients placed with all providers takes place as a matter of course.	The SCCC welcomes this recommendation in full.
16	In addition to clinical standards, set out by government, it is recommended that minimum levels of patient satisfaction are included in any contracts signed by the SCCC with financial penalties if these are not met, the exact levels, and how they are measured, should be a matter for the SCCC. *[SCCC, NHS SE London]*	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**

17	Guidance on managing conflict of interest for GP commissioners should be set out nationally. It is recommended that the HASC writes to the Dept of Health requesting this to take place. *[HASC]*	The SCCC welcomes this recommendation in full. Draft guidance has started to emerge and we expect this documentation to be finalised in the coming months.
18	It is important that GP commissioners are trained in governance - understanding that role and the distinct functions of governance are part of the development work being undertaken by NHS SE London and the SCCC. From 2013 GPs will be managing the dual role of running small businesses and being an officer on a commissioning body. It is recommended that governance training continue for GP commissioners and a programme of 'refresher' training, sharing experiences and best practice from other public bodies and clinical commissioning groups takes place. *[NHS SE London, HASC]*	The SCCC welcomes this recommendation in full. The SCCC and will take action to ensure that this training is established.
19	It is recommended that the SCCC consider their capacity for developing contracts and build this into their development plan, in particular where they will access expertise in drawing contracts up and monitoring them when signed.	The SCCC welcomes this recommendation in full. **The SCCC will be updating its development plan as part of the CCG authorisation process and will ensure this is built into that work.**
20	It is recommended that the SCCC works closely with and pays close regard to the priorities of the local authority and health and wellbeing board to foster cooperation and meet the mutual goal of improving health outcomes of Southwark's residents.	The SCCC welcomes this recommendation in full. This reflects the current working practice and priorities of the SCCC and will continue into the future. It will also be a requirement of our Authorisation process in 2012/13.
21	It is recommended that that the SCCC monitors clinical outcomes, including measures such as mortality rates, and that these are related to contracts signed with all providers, with financial penalties attached.	The SCCC welcomes this recommendations and will endeavor to comply with it provided actions do not fall outside of national contract requirements.

22	It is recommended that the SCCC appoints external auditors	At the current time (and until April 2013) the SCCC is a committee of the PCT Board with delegated responsibility for commissioning. The PCT Board has appointed external auditors. This requirement will be addressed, post April 2013, as part of the Authorisation process.

Summary Actions:

No.	Action	Timescale	Lead
2c	**The SCCC is not currently meeting the two week standard recommended here and will take action to achieve this by March 2012**	March 2012	Malcolm Hines BSU Chief Financial Officer
2f	**We would request that the HASC committee outline the process by which they wish to undertake this action.**	March 2012	Andrew Bland BSU Managing Director
2g	**We would welcome a further discussion with representatives of the HASC committee on this issue.**	February 2012	Andrew Bland BSU Managing Director
2h	**We will take action to amend this policy by March 2012.**	March 2012	Malcolm Hines BSU Chief Financial Officer
2j	**We will take action to amend this policy by March 2012.**	March 2012	Malcolm Hines BSU Chief Financial Officer
2k	**We will take action to establish this by April 2012.**	April 2012	Malcolm Hines BSU Chief Financial Officer
2l	**The SCCC will be outlining its processes for future 'Selection / Election' in April 2012 and will ensure that this recommendation is reflected.**	April / May 2012	Andrew Bland BSU Managing Director

3	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**	April 2012	Tamsin Hooton BSU Director of Acute and Community Commissioning
5	**The SCCC welcomes this recommendation in principle but would wish to work with the HASC committee to define the terms referred to and to ensure they can be applied adequately.**	March 2012	Malcolm Hines BSU Chief Financial Officer
8	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**	April 2012	Tamsin Hooton BSU Director of Acute and Community Commissioning
14	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**	April 2012	Tamsin Hooton BSU Director of Acute and Community Commissioning
16	**The SCCC will consider this recommendation within the context of national procurement and contracting rules and procedures. We will update the HASC committee on the outcome of this work.**	April 2012	Tamsin Hooton BSU Director of Acute and Community Commissioning
19	**The SCCC will be updating its development plan as part of the CCG authorisation process and will ensure this is built into that work.**	Ongoing	Andrew Bland BSU Managing Director

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HEALTH & ADULT CARE SCRUTINY SUB-COMMITTEE

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