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Isle of Wight Council

Monitoring Officer
Christopher Potter

County Hall, Newport, Isle of Wight PO30 1UD
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Agenda

Name of meeting	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date	**MONDAY 4 MARCH 2024**
Time	**5.00 PM**
Venue	**COUNCIL CHAMBER, COUNTY HALL, NEWPORT, ISLE OF WIGHT**
Members of the committee	Cllrs M Lilley (Chairman), J Nicholson (Vice-Chairman), R Downer, W Drew, J Lever, J Robertson and P Spink
Co-opted	Chris Orchin (Healthwatch Isle of Wight)
	Democratic Services Officer: Megan Tuckwell democratic.services@iow.gov.uk

1. **Apologies and Changes in Membership (If Any)**

   To note any changes in membership of the Committee made in accordance with Part 4B paragraph 5 of the Constitution.

2. **Minutes** (Pages 5 - 12)

   To confirm as a true record the Minutes of the meeting held on 4 December 2024.

3. **Declarations of Interest**

   To invite councillors to declare any interest they might have in the matters on the agenda.

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4. **Public Question Time - 15 Minutes Maximum**

Questions may be asked without notice, but to guarantee a full reply, a question must be put (including the name and address of the questioner) in writing or by email to Democratic Services democratic.services@iow.gov.uk, no later than two clear working days before the meeting. The deadline for submitting a written question is Wednesday, 28 February 2024.

5. **Progress Update** (Pages 13 - 14)

To receive an update on the progress against the outcomes arising from previous meetings, and to provide an update on any outstanding actions.

6. **Health Inequalities - Food Poverty** (Pages 15 - 24)

To review local data on food poverty by hearing from the Isle of Wight Food Bank, Healthwatch Isle of Wight, and Newport Congregational Church.

7. **Mountbatten Hospice** (Pages 25 - 46)

To consider an update from the Chief Executive of Mountbatten on the future of the hospice following concerns around funding.

8. **GP Surgeries** (Pages 47 - 70)

To review the work taking place in primary care, to monitor and improve capacity and access to services, following an Island-wide survey.

9. **Safeguarding Adults Board Annual Report** (Pages 71 - 112)

To consider the annual report of the Safeguarding Adults Board for 2022-23.

10. **Update on Community, Mental Health, and Learning Disability Services** (Pages 113 - 116)

To consider an update on Project Fusion and the Afton Ward pilot outcomes.

11. **Workplan** (Pages 117 - 120)

To consider any amendments to the current workplan.

12. **Members' Question Time**

Questions may be asked without prior notice, but to guarantee a full reply, a question must be submitted to Democratic Services no later than 5pm, Thursday, 29 February 2024.

CHRISTOPHER POTTER
Monitoring Officer
Friday, 23 February 2024

Interests

If there is a matter on this agenda which may relate to an interest you or your partner or spouse has or one you have disclosed in your register of interests, you must declare your interest before the matter is discussed or when your interest becomes apparent. If the matter relates to an interest in your register of pecuniary interests then you must take no part in its consideration and you must leave the room for that item. Should you wish to participate as a member of the public to express your views where public speaking is allowed under the Council's normal procedures, then you will need to seek a dispensation to do so. Dispensations are considered by the Monitoring Officer following the submission of a written request. Dispensations may take up to 2 weeks to be granted.

Members are reminded that it is a requirement of the Code of Conduct that they should also keep their written Register of Interests up to date. Any changes to the interests recorded on that form should be made as soon as reasonably practicable, and within 28 days of the change. A change would be necessary if, for example, your employment changes, you move house or acquire any new property or land.

If you require more guidance on the Code of Conduct or are unsure whether you need to record an interest on the written register you should take advice from the Monitoring Officer – Christopher Potter on (01983) 821000, email christopher.potter@iow.gov.uk, or Deputy Monitoring Officer - Justin Thorne on 821000, email justin.thorne@iow.gov.uk.

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If you wish to record, film or photograph the council meeting or if you believe that being filmed or recorded would pose a risk to the safety of you or others then please speak with the democratic services officer prior to that start of the meeting. Their contact details are on the agenda papers.

If the press and public are excluded for part of a meeting because confidential or exempt information is likely to be disclosed, there is no right to record that part of the meeting. All recording and filming equipment must be removed from the meeting room when the public and press are excluded.

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Isle of Wight Council

Minutes

Name of meeting	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date and Time	**MONDAY 4 DECEMBER 2023 COMMENCING AT 5.00 PM**
Venue	**COUNCIL CHAMBER, COUNTY HALL, NEWPORT, ISLE OF WIGHT**
Present	Cllrs M Lilley (Chairman), J Nicholson (Vice-Chairman), J Lever and P Spink
Co-opted (Non-Voting)	Chris Orchin (Healthwatch)
Also Present	Cllrs D Andre, C Mosdell Megan Tuckwell and Melanie White Joanna Smith (Healthwatch), Natasha Taplin (Hampshire and Isle of Wight ICB), Lesley Stevens, Juliet Pearce (IW NHS Trust) Jackie Napper and Daniel O'Neill (Tower House Surgery), Karl Hart (Men Only Isle of Wight)
Also Present (Virtual)	Simon Bryant, Laura Gaudion, Johanna Jefferies, and Wendy Perera
Apologies	Cllrs R Downer, W Drew and J Robertson

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27. Apologies and Changes in Membership (If Any)

Apologies had been received from Cllrs Warren Drew, Rodney Downer, and Joe Robertson.

28. Minutes

RESOLVED:

THAT the minutes of the meeting held on 4 September 2023 be approved.

29. Declarations of Interest

Chris Orchin (Healthwatch Isle of Wight) declared an interest as his daughter was now employed by the Isle of Wight Council.

30. Public Question Time - 15 Minutes Maximum

No written public questions were received.

31. **Progress Update**

The chairman presented the report which provided an overview of the progress against outcomes and recommendations from previous meetings.

An update was sought with regards to the request of the committee in June 2023 to receive a further breakdown of data from the 111 Service regarding abandoned calls. The IW NHS Trust agreed to follow this up and provide a response before the next meeting in March 2024.

Discussion took place regarding the questions raised at the last meeting on compliance with accessibility standards and the ability to contact staff at the Integrated Care Board. The vice-chairman reported that the issue remained ongoing, and it was agreed that specific examples would be shared outside the meeting and the Integrated Care Board would contact the providers in question.

An update was sought regarding the issue originally raised at the meeting in June 2023 regarding clinical waste collections (sharps disposals). Healthwatch Isle of Wight reported feedback which indicated that the issue remained ongoing, and it was agreed that the matter would be followed up and a response would be sought from the Service Manager for Waste.

The Director of Community, Mental Health and Learning Disabilities advised that the findings of the Afton Ward pilot scheme would be reported to the committee at it's next meeting in March 2024.

An update was sought regarding patient transport, following the committee's letter to ferry companies expressing its concerns for those travelling to-and-from the mainland to access specialist healthcare services. The Deputy Place Director (Isle of Wight) for the Hampshire and Isle of Wight ICB advised that the Patient Transport Task Force had met with all ferry providers and work was ongoing as a result of that meeting. The committee sought assurance that the Isle of Wight Council was represented on this group.

RESOLVED:

THAT the report and updates be noted.

32. **Mental Wealth**

The committee received a video presentation which provided accounts of the lived experiences of young people and their interactions with mental health services on the Isle of Wight.

The Managing Director and founder of Men Only Isle of Wight, along with a user of the service, a local mental health nurse and a GP, were in attendance to provide accounts of their experiences which evidenced how local voluntary-sector groups worked to provide positive outcomes for residents of the Isle of Wight; as a vital part of suicide prevention and acting as a bridge between primary care services and the community.

RESOLVED:

THAT the oral presentations be noted.

33. **Project Fusion Update**

The committee received an update on the progress with the development of the Hampshire and Isle of Wight Healthcare NHS Foundation Trust, ahead of the scheduled go-live date in April 2024, which had been created to deliver community, mental health and learning disability services across the Hampshire and Isle of Wight area.

Concerns were raised regarding the long-term sustainability of voluntary-sector organisations which were reliant on grant funding, and how this uncertainty could impact the various services offered within the Hampshire and Isle of Wight Healthcare NHS Foundation Trust.

Questions were raised around the ways in which residents could access mental health services (including medical interventions and voluntary-sector support groups). Comments were made regarding trauma training, prevention across all age groups including Public Health involvement, and interventions in schools. The chairman requested a journey map outlining the range of services available to Island residents.

RESOLVED:

THAT the update be received and noted.

34. **Winter Plan Implementation**

The committee received the report on the delivery and implementation of the IW NHS Trust's winter plan, which provided assurance that there were robust resilience arrangements in place to manage any risks associated with overcrowding in the emergency department, ambulance handover delays, and the associated impact on the wider community and the workforce within the acute, primary care and social care services. It was confirmed that plans were in place for all health services so that there was no unintended consequences on a different part of the system.

The committee sought assurance that improvements were being made and lessons were being learnt from previous years, and it was agreed that a further report would be provided at the end of the winter period.

RESOLVED:

THAT the update be noted.

35. **Update on Dentistry**

The committee received an update on the progress with improving access to NHS-commissioned dental services on the Isle of Wight. The Deputy Place Director (Isle of Wight) for the Hampshire and Isle of Wight ICB recognised the unstable position and the committee were advised that workforce pressures remained the biggest issue. Attention was drawn to the key actions which had been agreed in the first

instance; including a Dental Bus offering treatment from January 2024, a two-year funded pilot to increase the rates paid to dental practices, and an additional 15,000 funded units of dental activity to increase capacity on the Island. It was agreed that the draft Dental Strategy would be circulated to committee members for comment.

RESOLVED:

THAT the committee supports the efforts to move in the right direction, but the issue of dentistry on the Isle of Wight will remain on the committee's agenda as a priority issue so this can be tracked for the residents of the Island.

36. **Workplan**

Consideration was given to the future workplan, and the committee and health partners were invited to identify any key issues that should be included. Comments were made regarding the informal meeting scheduled for January 2024 to discuss the health and social care budget, and it was advised that this would only be early indicative feedback as the health budget was unlikely to be finalised before the end of March 2024.

RESOLVED:

THAT the workplan be received and noted.

37. **Members' Question Time**

Cllr Clare Mosdell submitted a written question to the committee seeking assurance that all unique Island factors were considered in decision-making by senior health administrators at a place-based Island level. A written response was provided by the Chairman (MQ 12/23) and the question would be passed to partners for their response.

Cllr Andrew Garratt submitted a written question in relation to access to NHS dental treatment on the Isle of Wight. A written response was provided (MQ 13/23).

CHAIRMAN

Appendix 1

MQ 12/23

Policy and Scrutiny Committee for Health and Social Care – 4 December 2023

Written question from Cllr Clare Mosdell to the Policy and Scrutiny Committee for Health and Social Care

The transition to ICBs over the last 18 months was intended to bring decision making closer to the point of care.

Last year at the NHS Confederation Conference, Steve Barclay highlighted how this change from CCGs would ensure there would be a place-based approach to tackling health inequalities through local commissioning. However, on the Isle of Wight the HIOW ICB move has taken decision making powers to the mainland and removed the Island's autonomy.

When coupled with the financial position of the HIOW ICB, the Island's separation by sea and additional barriers to sharing services with neighbouring areas, we are seeing a potential loss of funding for Primary Care on our Island of close to £1m this year alone.

Will the Policy & Scrutiny Committee for Health and Social Care direct Officers to make representations that encompass our unique position and hence ensure that all Island factors are taken into account in decision making by senior health administrators at a place-based Island level?

Response

I thank you for the question, which is poignant, timely and relevant.

As Chair of the Policy and Scrutiny Committee of Health and Social Care I have been deeply concerned that the restructures of the new HIOW ICB, the new Portsmouth and IW Hospital Trust, and the new mental health trust covering Southampton, Portsmouth, Hampshire, and Isle of Wight (Project Fusion), has taken away the autonomy of the Island and reduced the Island's voice in governance in NHS bodies.

The Committee has tracked these recent changes and received briefings including the financial implications of the new bodies such as HIOW ICB. This is on our workplan, and we will have a further briefing in the new year on the 2024/25 budget.

I have recently requested for a list of all the Island representatives on all the new NHS bodies relevant to the Island so the Committee can establish strong communication links and make sure the needs of Island residents are strongly represented. Healthwatch IW is also working with all the other Healthwatch organisations across the new regional bodies in this regard.

I have spoken to new senior management of all NHS bodies and raised my concerns as Chair and sought reassurance that the special needs of the Island and the additional costs (financial and welfare) attributed to the crossing of the Solent are not lost but prioritised.

I am working closely with Healthwatch IW, part of the Committee, and the Scrutiny Officer to track this NHS transformation on the Island and regularly communicate with NHS Senior Management and those Islanders who sit on the new governing bodies.

I am grateful you have raised the issue of commissioning which has always been a deep concern of mine as this is about services at grass-roots level. It is essential there is a clear IW identity within the commissioning process as certain mainland services do not fit well within an Island context.

In a recent meeting about Project Fusion and the place-plan approach in regard to mental health services on the Island, senior NHS managers praised the network of peer-support grassroot projects. They saw Isle of Wight as a beacon of excellence regarding peer support and the mental health alliance and emphasised they wish to use this model an example of good practice.

As part of my response to your question, I will put it to the whole committee on the 4 December as a way of getting a collective/committee resolution that publicly records our concerns about making sure these changes brought by National Government and NHS do not have a negative effect on our residents, which we fear.

The IW Council approved a motion at its last Full Council brought by the Liberal Democrats to consider all inequalities including health between the Island and the mainland and how best we tackle these whether through lobbying Government or seeking legislation. We have a duty as the main elected body on the Island to advocate this evidenced Island inequality.

If the committee endorses your and my own concerns through a resolution, I will write to all the NHS relevant Chairs and CEO's and in particular the HIOW ICB. As representative of these NHS bodies attend the meeting on Monday, there will be an opportunity for them to respond as well.

As a committee we also have the mechanism of being able to raise any concerns with Parliament's Health Select Committee.

As you say, the Conservative Government implemented this infrastructure restructure in commissioning in regard to HIOW ICB as part of a place-plan based approach which appears contradictory when the majority of decision making now will be from the mainland. Perhaps, in your role as the IW Conservative group leader you can write to the Health Secretary and the Island's current existing Conservative MP as well and raise your concerns.

Appendix 2

MQ 13/23

Policy and Scrutiny Committee for Health and Social Care – 4 December 2023

Written question from Cllr Andrew Garratt to the Policy and Scrutiny Committee for Health and Social Care

The committee's continuing oversight of the dire situation regarding access to NHS dentistry on the Island is welcome. The briefing to the committee comments that "evidence suggests dental access issues here are the most pronounced". My experience talking with residents is that the evidence is more than suggestive.

What advice can be given to residents on how quickly the actions will see them able to get NHS dental treatment that is both physically accessible and available on an ongoing basis so that treatment is not ad hoc?

Response

Deputy Place Director (Isle of Wight) - Hampshire and Isle of Wight Integrated Care Board:

Our first priority is to secure more NHS contracts for dentistry across Hampshire and Isle of Wight as a whole to increase the availability of appointments with dentists under the NHS. To do this, we are looking at ways in which we can make these contracts more appealing for practices.

The Integrated Care Board has recently put forward more than £6 million by the end of the 2024/25 financial year for a number of projects to improve access to dentistry on the NHS across Hampshire and Isle of Wight.

These projects are already underway with others beginning in the next few months. Due to these early stages, it is not possible to calculate the exact additional access that this will provide to the Isle of Wight. Funding will go towards a mobile dental bus that will visit the Island, explore further a centre for dental development to address local workforce issues and help to procure additional units of dental activity both for the island and the mainland.

There are two practices on the island who have agreed to complete temporary activity to see and treat patients not only for urgent care but to provide stabilisation of their dental need. This activity, although temporary, will remain until 31 March 2025 providing some stability of provision whilst another procurement exercise is undertaken.

As well as these two practices who have agreed to do temporary activity, another practice has agreed to undertake additional sessions every other Saturday, additional to their usual contracted hours. These sessions will provide urgent care and stabilisation for patients who require dental treatment prior to undergoing surgery or cancer treatment.

The practice and the 111 helpline have been liaising to ensure all appointments are filled with this priority group and then opened up to book into any remaining slots for any patient who has an urgent dental need.

I hope this goes some way to addressing your concerns while acknowledging the problems that the ICB has encountered within its first year having responsibility for dentistry. We are exploring every avenue to address both the short and longer-term issues as we seek to stabilise and improve NHS dentistry across the Isle of Wight.

Policy and Scrutiny Committee for Health & Social Care - Progress on Actions & Outcomes

Meeting Date	Agreed Action	Responsibility	Update	Actioned
Outstanding Actions				
4 September 2023	**Progress Report** An update was requested on whether a permanent solution has been agreed for 5l sharp bin collections	Scrutiny Officer	Awaiting a response from the Service Director for Waste on the progress with implementing a permanent solution	
4 December 2023	**Mental Wealth** The chairman requested a journey map of all the mental health services and pathways. Dr O'Neill from Tower House Surgery advised one was due to be completed in the next month or so.	Chairman	A journey map is currently being worked on and will be shared with the committee once completed.	
Actions Completed (Since Last Meeting)				
5 June 2023	**111 Service** Further breakdown of data regarding abandoned calls, on whether calls are abandoned before or after they have been answered, to be provided and circulated to the committee.	Director of Ambulance Service NHS Trust	A response has been circulated to the committee	Feb-24
4 September 2023	**Public Questions** A question was raised on the compliance of Accessibility Standards and the ability to contact staff at the ICB. It was advised that the matters would be looked into, and a response would be provided.	Clinical Director of the Hampshire and Isle of Wight ICB	4 December - issue was raised again by Cllr Nicholson. Natasha Taplin advised if more detailed examples were shared then they would be looked into and specific providers contacted.	Dec-23
	Dementia Strategy The findings from the Afton Ward pilot scheme be reported back to the committee at an appropriate time.	Director of Community, Mental Health and Learning Disabilities	4 December - Outcomes will be brought to the March 2024 committee meeting	Jan-24

4 December 2023	**Dentistry** The draft dental strategy to be circulated to committee members	Deputy Place Director (ICB)	The draft dental strategy was circulated to committee members	Dec-23

Purpose: For Information

Agenda Item Introduction

Committee	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date	**4 MARCH 2024**
Topic	**HEALTH INEQUALITIES – FOOD POVERTY**

Background

1. Food poverty can be defined as the condition of not having access to sufficient food, or food of an adequate quality, to meet someone's basic needs. As well as affecting those living on low incomes, food poverty can also affect people with limited access to transport, poor housing, physical or mental ill health.

2. In 2021/22 there were 4.7 million people, or 7% of the UK population, in food poverty, including 12% of children. In 2022/23, the Trussell Trust (a charity and network of foodbanks) supplied the highest recorded number of three-day emergency food parcels.

3. The rising cost of living has been increasing household food poverty. A YouGov survey by the Food Foundation, a food poverty charity, found that in June 2023, 17.0% of households in the UK were 'food insecure' (ate less or went a day without eating because they couldn't access or afford food), up from 8.8% in January 2022 and 7.4% in January 2021.

Focus for Scrutiny

4. To understand the extent to which food poverty is affecting local residents of the Island and the contributing factors.

5. To review the current food model provisions for Island residents, it's accessibility and effectiveness.

Outcome(s)

6. To determine any areas which may assist in improving the experience of the local population.

Approach

7. To hear from Healthwatch Isle of Wight, the Isle of Wight Food Bank, and the Newport Congregational Church (that helps to run the Pyle Street Pantry).

Document(s) Attached

8. Appendix 1 – Isle of Wight Foodbank Data (1 September 2023 – 20 February 2024)

9. Appendix 2 – Healthwatch Cost of Living Survey Report (November 2023)

Contact Point: Melanie White, Statutory Scrutiny Officer,
(01983) 821000 ext 8876, e-mail melanie.white@iow.gov.uk

Isle of Wight Foodbank Data 1st September 2023 – 20th February 2024

Reasons for referral	No. of vouchers fulfilled	No. of parcels distributed to		
		Adults	Children	Total
Financial - earnings related				
Change in work hours	62	97	92	189
Unemployment following permanent work	58	97	30	127
Unemployment following temporary work	23	34	8	42
Delay in or awaiting other income	59	84	62	146
Financial - benefits related				
Benefit delay	144	216	138	354
Benefit deduction due to overpayment or benefit advance	15	19	9	28
Benefit reduction due to change in eligibility	31	56	24	80
Benefit reduction due to sanction	18	30	20	50
Awaiting first benefit payment for less than a month	18	21	8	29
Awaiting first benefit payment for more than a month	6	10	3	13
Financial - debts, costs and expenses				
Priority debt	133	199	100	299
Non-priority debt	66	92	42	134
Cost of dependents has increased	78	137	158	295
Rising costs of essentials	555	845	613	1458
Other unexpected expense	102	156	112	268
Personal circumstances				
Insecurely housed	87	100	35	135
No access to financial support due to immigration status	6	11	6	17
Loss of support from friends or family	26	34	16	50

Change in relationship status	21	25	38	63
Domestic abuse	22	30	39	69
Change in dependents	25	40	44	84
Health				
New physical or mental health condition	29	43	21	64
Ongoing impact of physical or mental health condition	236	352	127	479
No answer				
None applicable	29	43	25	68
Declined to answer	7	8	0	8
Unable to ask	166	241	207	448
Health				
Change in existing physical or mental health condition	12	18	10	28

Source of income	**No. of vouchers fulfilled**	**No. of parcels distributed to**		
		Adults	**Children**	**Total**
Benefits, not earning	813	1186	654	1840
Declined to answer	6	6	0	6
Earning and benefits	158	269	281	550
Earning, no benefits	52	83	76	159
Income but no or insufficient access to it	9	12	4	16
No income	75	97	34	131
Unable to ask	193	305	284	589
Totals	**1306**	**1958**	**1333**	**3291**

Cost of Living Survey Report

Nov 2023

healthwatch
Isle of Wight

Summary

In 2023, Healthwatch England launched a national survey looking at how the cost of living crisis had affected the general population.

We decided to share their survey locally to gather information on how local people's lives have been impacted by rising costs and low incomes.

93 people completed our comprehensive survey and shared their experiences.

66% of those who responded told us that in the past 6 months, their financial situation had got a little or a lot worse.

44% admitted reducing the amount of food they buy and eat and 16% said they use a food bank.

A further 3% told us that they were anticipating having to use a food bank.

27% of people said they were having to buy less healthy foods than they would usually.

Feedback provided by people responding to the survey:

"I'm feeling depressed at times. I'm unable to travel to the mainland to see my family and they are not able to visit me as much due to the rising cost of travel. When they come to stay, I struggle to pay for food."

"I now use the ventnor community pantry every week. This helps a lot. I have cut down on having the heating on, frightened about the cost of keeping warm. I think twice now about the cost of things and can't remember the last new outfit I had. I just make do."

"I am a full time carer for 3 family members in their 80s. I have noticed a huge deterioration in my health and wellbeing recently - I have cut back everything I can and am now quite worried about the future. "

“I try not to listen to news. I am dipping into my savings hoping nothing breaks down. I will have to repair . Did work, but due to ill health I am no longer able to. Getting help us lots of forms and phone calls with delayed outcomes.”

“I gave up work 5 years ago because of a long term illness, I have now had to return to work so we can pay our bills and mortgage this has had a very negative impact on my health condition.”

“My health is deteriorating and I can't remember the last time I had a day when I felt 'just OK.' I have tried to boost my own health by taking a range of vitamins; but these can be expensive and I have been told by my GP that he is not allowed to prescribe vitamins.”

For more information

Healthwatch Isle of Wight
Riverside
The Quay
Newport
PO30 2QR

www.healthwatchisleofwight.co.uk

t: 01983 608608

e: enquiries@healthwatchisleofwight.co.uk

healthwatch
Isle of Wight

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Agenda Item 7

Isle of Wight Council

Purpose: For Information

Agenda Item Introduction

Committee	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date	**4 MARCH 2024**
Topic	**MOUNTBATTEN HOSPICE**

Background

1. The Mountbatten Group comprises of Mountbatten Isle of Wight and Mountbatten Hampshire, which are run as separate charities supported by the local communities. The annual cost to provide Mountbatten's services across the group is £21 million - £10.5million each.

2. On 25 January 2024, the Chief Executive of Mountbatten issued a statement regarding government funding for hospices. A third of Mountbatten's funding comes from the NHS and the remainder comes from fundraised income. NHS funding will be down by £800,000 in April 2024 due to no uplift.

3. Mountbatten is currently supporting around 3,500 people across Hampshire and the Isle of Wight (1,500 Hampshire and 2,000 Isle of Wight). A further 40% growth is anticipated over the coming years, mainly due to the increasing older population.

Focus for Scrutiny

4. What are the biggest challenges in relation to funding?
5. How successful is the fundraising market?
6. Is there any national guidance for ICBs on how they should be funding end of life care?
7. Are there other hospices to benchmark against in terms of a successful funding approach?
8. How can the committee support in raising awareness?

Approach

9. To receive a verbal presentation from the Chief Executive Officer of Mountbatten, Nigel Hartley MBE.

Document(s) Attached

10. Appendix 1 – AAPG Government Funding for Hospices, February 2024

Contact Point: Melanie White, Statutory Scrutiny Officer,
(01983) 821000 ext 8876, e-mail melanie.white@iow.gov.uk

All-Party Parliamentary Group
Hospice and End of Life Care

Government funding for hospices

February 2024

Supported by hospice UK

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Disclaimer

The evidence submitted to this inquiry highlighted the importance and sensitivity of relationships between hospices and their Integrated Care Boards. For this reason, we have taken the decision to anonymise evidence which relates to specific relationships and remove footnotes in these instances.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All-Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. The views expressed in this report are those of the group.

This Report was researched and funded by Hospice UK.

Executive Summary

Despite the introduction of a legal requirement for Integrated Care Boards (ICBs) to commission palliative and end of life care, ICB commissioning of hospice services is currently not fit for purpose. As a result, the services hospices provide for dying people and their families and the value they provide to the health system is at risk.

Hospices provide essential palliative and end of life to 300,000 people every year.[1] Often, they support some of the most complex deaths, experienced by people with very high need. This specialist care prevents people who are dying from the trauma of inappropriate transfers, spending hours in A+E or feeling stuck on a hospital ward. Many hospices also train care workers and NHS staff to support people who are dying in other sectors. However, the full benefits of an integrated and sustainably funded hospice sector are currently unrealised.

The UK Government must produce a national plan to ensure the right funding flows to hospices. This should include measures that support ICBs with their commissioning decisions now to ensure a level playing field and help evolve a truly sustainable hospice funding model in the longer term.

ICBs must commit to delivering their statutory requirement and start by placing hospices on multi-year contracts, paying the full cost of commissioned clinical services and offering hospices the same annual increases as NHS services.

Despite the legal requirement for ICBs to commission palliative and end of life care in the 2022 Health and Care Act, this APPG found that the funding hospices receive from ICBs varies significantly across the country. ICB adult hospice spending per head of population ranged from £10.33 to just 23p per head of population.[2] ICB children's hospice funding also varied hugely from an average of £511 to £28 per child with a life limiting condition.[3]

> *"The care provided by the hospice was very different, it helped shape our grieving of our son and ultimately was lifesaving. I cannot imagine a different scenario where we did not have that time with our son as a family."*
>
> *Parent/Carer with lived experience.*[4]

Evidence also revealed that hospices are not being commissioned on a level playing field with NHS services as ICB funding often does not reflect the cost of clinical care. Over the last two years, 28% of ICBs provided annual increases to hospice contracts that were below increases offered to NHS services in their area.[5]

The need for palliative care is projected to increase by 25% by 2048.[6] The contribution of hospices is both vital to meeting this need and to ensure the NHS and social care have the capacity to prevent and treat disease. We hope that our recommendations will support both national Government and ICBs to make the necessary reforms to fully realise the benefits of the hospice sector and maintain the vital role they play in our wider healthcare system.

The value of the hospice sector

Hospices have an important role within the health and care system and in their local communities. They provide essential care to those at the end of their lives and provide their loved ones with crucial support through such hard times.

The core clinical services that hospices provide, both in their inpatient units and the community, are an indispensable part of palliative and end-of-life care in the UK. These services reduce pressures on the wider health and care system and keep people out of A&E or hospital when it is not best for them to be there. Without hospices, the complex care they provide would have to be provided by the NHS, at high cost.

Specialist hospice teams also provide support to NHS and social care colleagues across the system. For example, by training care home workers in how to support people who are dying or offering advice and guidance to hospital teams.

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> *"He wanted to stay at home, so we spoke to Douglas Macmillan Hospice and they were just amazing. Words can't express how grateful I am to them. They said, 'the hospice has got a bed for you - if you want it, it's yours.' After hearing his wishes, they set it all up: they got us a hospital bed downstairs, they put everything in place. Within 48 hours, my front room had been transformed... It was absolutely phenomenal. They were just brilliant."*
>
> *Lived experience shared with Hospice UK.*[7]

Hospices are pillars of their local community, bringing people together in order to support each other and raise money for services that have helped them and so many of their neighbours. Charitable fundraising also allows hospices to raise money to deliver enhanced services, such as counselling, bereavement support and activities, that are hugely appreciated by the people they serve and benefit the wider system.

Recommendations

For the UK Government to:

- produce a national plan to ensure the right funding flows to hospices. This should include measures that support ICBs with their commissioning decisions now and help evolve a truly sustainable hospice funding model in the longer term.
- conduct or commission a piece of work to understand the costs of providing different models of palliative and end of life care with the long-term aim of developing reference costs on palliative and end of life care that can be used by commissioners.
- develop national quality standards and agreed outcome measures, which commissioners can use to assess the quality of the services they are commissioning.
- set out a national minimum standard for the level of provision of palliative and end of life care that must be provided within all ICBs.
- address the immediate pressures of paying increased staffing costs for hospices by providing emergency funding and thoroughly consider the impacts on the hospice sector within the NHS pay review process each year.
- ringfence the £25 million provided by the Children's Hospice Grant to ensure it reaches its intended destination and commit to maintaining this grant for the next five years.

For NHSE to:

- undertake a proactive programme of support to ICBs on how to interpret the NHSE guidance on commissioning palliative and end of life care and what they are required to commission in their area.
- hold ICBs accountable for their commissioning of palliative and end of life care by ensuring Joint Forward Plans deliver the priorities of Integrated Care Strategies based on local need assessments.
- provide guidance to ICBs on how to commission VCSEs (Voluntary, Community and Social Enterprise), including a timeline for commissioning decisions to ensure negotiations are timely, transparent and proportionate.

For ICBs to:

- ensure the prominence of palliative and end of life care in the Integrated Care Partnership's joint strategic needs assessment and that this informs their commissioning decisions.
- ensure that hospices are on multi-year contracts.
- ensure uplifts to hospice contracts are equitable with uplifts received by NHS-run services and other hospices in the area.
- ensure voluntary sector partners have a named senior contact within the ICB who has responsibility for commissioning in their area.

Introduction

Hospices are a critical part of the health and care system. They provide care and support to 300,000 people a year across the UK and work across the system to train and support health and care workers.[8]

There has long been concern over the sustainability of the hospice funding model. On average, two thirds of hospice income is charitable, raised through fundraising such as charity shops and marathons.[9] This often leaves hospices in a precarious position, never knowing whether they will have enough funding to continue to deliver their services.

For hospices and other providers of palliative and end of life care, the introduction of a new statutory requirement to commission palliative care in the 2022 Health and Care Act is a welcome opportunity to address unequal and unsustainable hospice funding.[10] The Act specified that;

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> *"An integrated care board must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility…services or facilities for palliative care as the board considers are appropriate."[11]*

The APPG launched this inquiry into government funding for hospices in order to understand what impact the statutory requirement has had on hospice funding in England, whether ICBs are fulfilling their new statutory obligations, and what needs to change to build a health and care system fit for the future.

After launching this inquiry in August 2023, the APPG received over 80 pieces of written evidence from hospices across England, Integrated Care Boards, NHSE and national organisations with perspectives on palliative and end of life care. The APPG also received evidence from hospices in Scotland, Wales and Northern Ireland about the funding models in their countries.

The APPG held two oral evidence sessions in Parliament to dig deeper into the key questions surrounding the sustainability of hospice funding. The evidence received provided vital insight into funding for the hospice sector and its impact on the support people receive at the end of their lives.

This report includes the inquiry's key findings and recommendations to National Government, NHSE and local authorities to ensure hospices can contribute to a system where everyone who needs palliative and end of life care receives it.

1. The hospice funding model in England

1.1: The funding model

Hospices sit at the intersection between health and social care and provide a variety of services depending on the needs of their local community.

The majority of care hospices provide is in the community. This includes work by specialist teams of doctors, nurses and allied health professionals.[12] Community support allows people to stay at home when this is their wish, prevents unnecessary admissions to hospital and supports timely and safe discharge. Many hospices also have in patient units (IPUs), which typically support patients with the most complex care needs who require focused and specialist support.[13]

Many hospices will also provide outpatient clinical support and advice, such as fatigue management and breathlessness clinics, and other support services such as counselling, respite care and bereavement support.[14]

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Hospice teams also share their specialist knowledge with NHS and social care workers to support them to provide care to patients with palliative and end of life care needs.

> *"Our palliative care team could not do their jobs effectively and support people in our communities without our local hospices."*
>
> *Mid Yorkshire Teaching NHS Trust.[15]*

The hospice funding model is unique in the health and care system. Hospices provide essential health and care services to people with terminal and life limiting conditions, yet this is only partly funded by Government.

Hospice UK has found that hospices receive roughly one third of their income through government.[16] The rest of their income is charitably fundraised.

In evidence submitted to this inquiry, hospices describe the funding system as 'an anomaly', and argue that no other area of the healthcare system relies so heavily on charity.[17] Hospices and end of life care charities state that this funding model is not sufficient, resilient or sustainable.[18]

One respondent to this inquiry shared that in their experience,this funding situation was not fully understood by the public, who expect the essential clinical care that hospices provide would be NHS funded in full.[19]

1.2: Funding streams

Government funding for hospices comes from multiple sources but the most common route for adult hospices is funding delivered via Integrated Care Boards. Integrated Case Systems (ICSs), local health and care partnerships for 42 geographical areas across England, were established in the 2022 Health and Care Act.[20] Within each ICS, an Integrated Care Board (ICB) is responsible for commissioning health and care services, including palliative and end of life care. The majority of government hospice funding is provided by ICBs, which are now required by law to commission sufficient palliative care services for their population.

NHSE also produced statutory and non-statutory guidance to support ICBs in delivering the new requirement. This guidance advises ICBs to take a whole system approach and assess how they deliver against the Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026. It also specifies that ICBs 'should' implement a service specification for end of life care, and ensure there is sufficient provision of end of life care to meet population need.[21]

Alongside the money they receive through contracts with their ICB, some hospices receive funding from local authorities, for example at borough level.[22] This is often funding for a specific service, for example, where hospices provide domiciliary care services, funding will come from the local authority.

Historically low funding for children's hospices, led to the introduction of the NHSE Children's Hospice Grant, which was originally introduced as a Department of Health grant in 2006/7. Children's hospices in England receive this money directly from the NHSE, rather than from local ICBs. For children's hospices, it is a vital source of funding within a 'patchy' system.[23]

The grant makes up a significant portion of government funding for children's hospices, one hospice reported that the grant they receive makes up 50% of their government funding. In early 2023, NHSE told children's hospices in England that grant would come to an end that year. This was a significant concern for the hospice sector, until NHSE confirmed the grant will be extended for the year 2024/25 with children's hospices receiving a collective £25 million.[24] The future of the grant beyond April 2025 is unknown and the impact of not receiving this funding for children's services would be serious.[25]

Funding also varies depending on the type of service. The Childhood Bereavement Network and National Bereavement Alliance submitted evidence on the bereavement services provided by hospices, which is a significant proportion. Some hospice bereavement services are restricted, for example only available to those who have been bereaved of someone who died in their care. However, increasingly following the pandemic, hospice bereavement services are becoming open to anyone in their area. These services are a vital part of mental health support in the community and can help to prevent people developing complex grief disorder and requiring more acute and ongoing mental health support.[26]

Under CCGs, hospices received funding for bereavement services from a range of sources. Some had funding from the CCG or local authorities, while some were entirely charitably funded.[27]

Following the 2022 Health and Care Act, there was debate over the extent that bereavement services were included in the statutory requirement to commission palliative and end of life care. The Commissioning and Investment Framework for Palliative and End of Life Care, which aims to support the requirement states that it is a core requirement to provide assessment of bereaved people and to have referral pathways to sufficient support.[28] Emotional and psychological bereavement support services, however, are considered an enhanced service and the framework specifies they should be charitably funded. However, as stated above, bereavement support is often a core part of local mental health support and therefore also requires sustainable funding.[29]

1.3: Reliance on charitable donations

The hospice sector's reliance on fundraising for the majority of its income carries huge risk. For example, during the COVID-19 pandemic, many charity shops had to be closed and sporting events cancelled, with serious consequences for hospice finances.[30] Other, more common factors that impact funding streams include rises in the cost of living that reduce communities' ability to give, or unpredictable legacy droughts.[31] The volatility of this income makes it hard to plan for the future and puts services perpetually at risk.[32]

Evidence to the APPG also emphasised how this reliance on donations deepens socio-economic inequalities. Communities in the most economically deprived areas are least likely to be able to donate to their local hospice. As a result, their local hospice may have a lower income than hospices in more affluent areas and its community may have poorer access to services.[33]

> *"The reliance on charitable funding to sustainably deliver services that form core components of clinical pathways reflects poorly on how this area of care is valued and prioritised."*
>
> *St Rocco's Hospice.*[34]

Many hospices feel that their reliance on charitable fundraising is symbolic of the lack of value the NHS and Government places on palliative and end of life care. One hospice argued that the current funding system 'undermines the specialism of the clinical staff' as staff in the same roles in other settings would be fully NHS funded.[35]

There is value to having a charitable element to hospice services, as it fosters a deeper connection with the community and allows flexibility in the enhanced services they can offer. It also enables hospices to fundraise for services that have great value to their community but are not within the remit of Government or NHS funding.

However, evidence to this APPG demonstrates the risks and harms of what has become an overreliance on these funding streams. Government should readjust the balance between statutory and charitable hospice funding and ensure local commissioning is fulfilling the intentions of the statutory requirement. The starting point for this should be developing a national plan to ensure the right funding flows to hospices, which includes many of the measures set out in this report's recommendations.

2. Impact of the new ICS system and statutory requirement

2.1: Changing system, changing relationships

The 2022 Health and Care Act put into place a shift from CCGs to ICSs. While in the previous system, there were over 200 CCGs when established, there are now 42 ICSs, meaning most ICBs cover a larger footprint than the previous CCGs.[36]

In their evidence, some hospices speak fondly of the 'healthy and positive' relationships and mutual understanding they built with their previous commissioners at CCGs. When ICBs were introduced, these established relationships disappeared and hospices moved into the scope of one, or several, new systems, with new commissioning teams managing complicated new responsibilities. This requires significant investment of time and resources by hospices to rebuild relationships with ICB commissioners, as they have the majority of responsibility for hospice funding in England. This is particularly difficult for children's hospices, which typically provide services to greater geographical areas and therefore have more relationships to maintain. One hospice explained that while they have generally good relations with their ICB, the ICB has had to cut staffing costs and is experiencing increased turnover, forcing the hospice to continuously build new relationships.

Some hospices have been able to build or maintain excellent relationships with their local ICBs. One hospice told us that their ICB are 'amazing' to work with and provide great support. Unfortunately for many, there has been a marked decline in the quality of these relationships despite the efforts of hospice teams. One hospice, which spoke of previous success when discussing inflationary uplifts, had experienced a reduction in funding since the Health and Care Act came into effect as 'dialogue was avoided and negotiations protracted'.

It is clear that this heavy reliance of government funding for essential services on local relationships carries risks. There needs to be an agreed national minimum standard for the level of provision of palliative and end of life care the ICBs must ensure is provided for and funded. There must also be national quality standards, which commissioners can use to assess the quality of the services they are commissioning and ensure they are getting value for money.

Additionally, NHSE should provide guidance to ICBs on how to commission VCSEs, including a timeline for commissioning decisions to ensure negotiations are timely, transparent and proportionate.

2.2: Profile of hospices and end of life care

The profile of palliative and end of life care and the services delivered by hospices have also been impacted by the new systems. Several respondents to our call for evidence argued that the statutory requirement improved the prominence and prioritisation of palliative and end of life care in discussions and in the minds of ICB members.

Research by Hospice UK in late 2023 found that 23 of 42 ICBs prioritised adult palliative and end of life care in their Integrated Care Strategy (which is held by the Integrated Care Partnership) and/or Joint Forward Plan (JFP) (held at ICB level).[37] In previous research, the National Bereavement Alliance found that only 9 of the 36 Integrated Care Strategies published at the time mentioned bereavement, although this may be addressed within other plans.[38]

The APPG heard from representatives of ICBs across England about their priorities for end of life care within their JFP. For one ICB, this included access to co-ordinated 24/7 care, and fair access driven by early identification and reduction in inequalities.[39]

However, there was no correlation between those who highlighted palliative and end of life

care in their plans, and those who provide better funding for hospice care.[40] This is evidenced in hospice submissions to this inquiry, which highlight that, even where there have been positive conversations about end of life care at ICB level, this has not resulted in material improvements in commissioning. Recent Freedom of Information requests by Together for Short Lives also found that, despite the legal duty, only 31% of ICBs were able to say how many children and young people with life-limiting or life-threatening conditions who live in the areas they serve accessed hospice care in 2022/23. 14% were unable to say how much money they spent on children's hospice care at all in 2022/23.[41]

> *"Senior hospice clinical leaders do actively participate in the overall [End of Life] planning infrastructure which has been established under the ICS structure. However, this engagement has yet to yield any material improvements to service provision."*
>
> *Anonymised hospice.*

To begin to address this need for consideration of palliative and end of life care to follow through to material change for these services, ICBs must ensure the prominence of palliative and end of life care in the Integrated Care Partnership's joint strategic needs assessment and that this needs assessment informs their own commissioning decisions.

Further many hospices are finding it difficult to get their voices heard. ICBs are responsible for a larger geographical footprint and number of providers than CCGs previously were. Hospices have found that under this new system, they are a smaller player than previously and are not given a platform to share their perspectives.

> *"It has been a struggle to ensure services for Palliative and End of Life Care for both Adults and Children are included in Forward Plans and Strategic Plans as PEOLC is frequently overlooked."*
>
> *Anonymised hospice collaborative.*

In some areas, hospices have sought to address this by forming collaboratives, which provide a single clear voice for local hospices, share learning and seek opportunities to build partnerships with the ICB.[42] A national palliative care provider shared that many of its hospices across the UK have joined collaboratives, and that several of these have been successful in amplifying the concerns of hospices and addressing short term pressures. One collaborative secured a £1.8m grant between its 10 members in March 2023, to help with sustainability.

However, despite some evidence of success, many hospice collaboratives have been unable to secure improvements to their funding and long-term sustainability. Another hospice shared that through working with local hospices, they have produced collaborative plans on key issues such as virtual wards and 24/7 access to advice, but have so far not secured funding. Further, while being represented as a collaborative is efficient, this still equates to less influence than many hospices were used to in the previous system, when they would each be able to represent their hospice in its own right.[43]

> *"Hospice Collaboratives have been successful in some instances in using their collective voice to address short term pressures but are not yet able to fully replicate previous strategic relationships."*
>
> *National palliative care provider.*

Others have found that the variation in situation between hospices is a barrier to collaboration. Even neighbouring hospices may have very different funding from the local ICB, different levels of donations and different costs. This inequality in experience, with some hospices in a sustainable position and others reducing services, makes it difficult for hospices to work together on an equal basis. Therefore, for hospice collaboratives to be more widespread and facilitate better communication between commissioners and end of life care providers, ICBs need to take a more consistent approach to commissioning. The UK Government must start work to develop reference costs and quality standards that can be used by commissioners to better understand what they should be paying for different hospice services.

2.3: Understanding of hospices and end of life care

Another impact hospices have experienced following the introduction of Integrated Care Systems is the loss of end of life care knowledge and understanding at this level. As mentioned, hospices lost commissioners they spent years building relationships with, and many of the teams who replaced them are unfamiliar with end of life care and having to understand multiple new commissioning areas at once.

Hospices are finding that these new commissioning teams do not have detailed understanding of the services hospices can and do offer, or the care people will need at the end of their life. A children's hospice feel that commissioners lack understanding of the role of the short breaks service they provide, and that planned short breaks form 'the essential foundations of the child's journey to end of life'. In its evidence, an adult hospice identifies a lack of understanding of the role hospices play, in managing symptoms and preventing emergency hospital admissions or ambulance call outs.[44] Another hospice argued the need for hands-on care for people at the end of their life is not understood or reflected in funding for end of life care services.

This lack of understanding concerns hospices, as it means that the funding provided, and the services this funding is earmarked for, does not always match up with the demand for services and the ways they are used. Furthermore, this lack of insight into hospice services can make it easier for commissioners to stop or suddenly change funding as they did not have a good enough understanding of the consequences of such a decision on the local population.

Along with the lack of understanding of service delivery, hospices have also noticed a lack of understanding of the costs involved in hospice provision. This problem does not only arise at ICB level but is also reflected in the guidance provided to ICBs by NHSE, which does not reflect the varied reality of hospice funding.[45] This is compounded by a lack of understanding of the variation in hospice costs and commissioning needs due to the different kinds of hospices, for example, hospices without an inpatient ward or physical building have very different overhead costs to hospices with large buildings.[46]

The Speciality Advisory Committee for Palliative Medicine Higher Specialty Training submitted evidence to this inquiry highlighting its concern over a lack of understanding at ICB level of the training and workforce needs in hospices, and the funding needed to address them.[47]

> *"While hospices are working to broaden the range of multidisciplinary workforce and therefore build resilience, this is not being acknowledged or matched with funding from their NHS partners or investment by ICBs."*
>
> *The Speciality Advisory Committee for Palliative Medicine Higher Specialty Training.[48]*

Due to this lack of understanding of hospices, palliative and end of life care need and the role of end of life care commissioning, hospices express that they are having to take the lead in relationships and negotiations with ICBs. One shares that they brought the statutory guidance produced by NHSE to the attention of their ICB, as they had not been aware of it. This demonstrates the need for more support from the centre to ensure ICBs understand and are properly implementing the NHSE guidance and their requirements.

NHSE must undertake a proactive programme of support to ICBs on how to interpret the NHSE guidance on commissioning palliative and end of life care and what they are required to commission in their area. It must also hold ICBs accountable by ensuring Joint Forward Plans deliver the priorities of Integrated Care Strategies based on local need assessments.

2.4: Lack of clarity on ICB decision making

The new ICS system has also led to a lack of clarity regarding where decisions are made, or contacts are held. ICBs often do not properly communicate who has decision making authority for hospice funding or holds responsibility for end of life care. This lack of clarity on where decisions are made means hospices do not know how to build relationships that support the commissioning of their services. Some hospices are particularly unclear on what role, if any, place level has in commissioning and how funding can flow from discussions at this level.

> *"The lack of identifiable individuals with clear commissioning and decision-making powers has left commissioning in a challenging state of paralysis."*
>
> *Anonymised hospice collaborative.*

This lack of clarity has slowed contract negotiations for some hospices. There is not only a lack of contact with decision makers, but also a lack of transparency and clarity on how decisions are made and the processes. This appears to have impacted trust between hospices and commissioners, particularly when there is not a clear visible process behind changes to funding.

These challenges are likely related to the 'immaturity' of these new systems, and the amount they are grappling with. Many of these barriers may be addressed as the system grows to understand how they work in practice and what support their providers need. In the meantime, ICBs can help by ensuring hospices have a named senior contact within the ICB who has responsibility for commissioning in their area.

The Children's Hospice Grant, which previously has been allocated centrally by NHSE, could be delivered via ICBs in 2024-5. There are concerns about whether ICBs can manage this at this point in time and whether the money will flow through from central Government to ICBs and then to children's hospices as needed.[49] It is clear that, at least for the next few years, the Children's Hospice Grant funding must be ringfenced to ensure that it reaches intended services.

3. Shortcomings of the hospice funding model

3.1: Funding for hospices and ICBs

The overwhelming majority of those who submitted evidence to this inquiry made clear that funding for hospices, and for palliative and end of life care as a whole, is not meeting the need for care. The core clinical costs of hospice services are not covered by NHS funding, and so are precariously propped up by charitable donations.[50] This disparity is also worsening in the cost of living crisis, with the cost of providing their services increases while donations are under strain and NHS funding falls in real terms.

Hospices reflected that ICB expectations of hospice services and their contribution to palliative and end of life care were not in line with commissioning decisions, with some hospices feeling they are plugging gaps in the NHS end of life care service provision, and yet local contracts are not covering the costs of core clinical services.[51]

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> *"The role of our hospices is crucial to how we operate and for ensuring there is the ongoing and effective support of patients, residents and their families who are dealing with end of life and life limiting conditions, and for supporting end of life in the most appropriate place, ideally home. The role and contribution of Hospices in all their forms is crucial to meeting the needs of those at the end of life or with life limiting conditions."*
>
> *Mid Yorkshire Teaching NHS Trust.*[52]

This lack of funding is resulting in a reduction in service provision and hospices having serious conversations about reducing their offer. For example, one shared they were unable to use 4 out of their 20 beds due to the lack of funding.[53]

Historically, funding for hospices has been consistently low, made available from different sources with different requirements and run on a short-term basis. The majority of hospices have received government funding through rolling grants that require yearly renegotiation.[54] Sue Ryder argues that the government funding hospices receive was 'patchy, insufficient and short term, and made of non-recurrent funding pots'.[55]

This makes it difficult for hospices to plan for the future, expand their services, or even offer permanent employment contracts to staff.[55] It also means hospices must use significant resources to 'refresh and update financial forecasts' and bid for small pots of money.[57]

> *"I have yet to meet a hospice colleague who can explain the funding formula by which their org receives funding, but all tell of time-consuming bids to access pots of money."*
>
> *Individual with lived experience working in the hospice sector.*[58]

Despite the new requirement for Integrated Care Boards to commission palliative care to meet their population's needs and additional statutory guidance, commissioning has not improved. Many previous grants and models established by CCGs have simply been rolled over. As a result, hospices are funded on historic block contracts based on previous calculations that do not relate to current activity, cost and need.[59]

One hospice shared that they receive their government funding through the Model Agreement of the NHS, which is not a commissioning document but functions similar to a donation, and provides no room for negotiation or leverage for more money based on service needs.

Hospices describe their funding as 'stubbornly insufficient' and 'flat', while costs rise.[60] Where hospices had seen a change in their funding following the amendment, this had been for the worse, with some reporting a 'deterioration' in the funding they receive from commissioners.

Many stakeholders who submitted evidence to this inquiry suggested that the worsening of matters since the Health and Care Act is due in part to the requirement to commission palliative care being issued with no funding behind it.[61] Newly established ICBs are facing severe financial pressures and are having to balance many underfunded areas of care.[62] Many ICBs do want to meet their population's end of life care needs and support hospices, as evidenced by actions such a system plans, but do not feel they have the funds to do so. A hospice collaborative shared with this APPG that a local ICB committed to putting in place a 5 year funding agreement with the local hospices but had to put this on hold due to pressures to cut costs.

Hospices with positive relationships with commissioners, who they describe as 'forward thinking and collaborative', are told their ICB's colleagues' hands are tied by a lack of resource. These financial pressures are then being passed on to hospices and other system partners. A national provider of hospice care told this APPG that many of their hospices have been told by ICBs that there is 'no money' and to expect further cuts to their funding. An ICB that submitted evidence to this inquiry highlighted that, while they are being told by hospices that they are having to consider reducing their services, they are simply unable to allocate any additional budget to them.

In times of stretched resources, well integrated hospice services delivering quality services can alleviate pressures on the wider system and help the NHS and social care meet their broader goals. To support commissioning that maximises the offer of local hospices, national government must work to develop reference costs for different models of palliative and end of life care that accurately reflect the value of these services. NHSE must also undertake a proactive programme of support to ICBs focused on the NHSE guidance on commissioning palliative and end of life care. This support should cover how to assess the wider value of services to system priorities and pressures.

Children's hospices are concerned that the 2024-5 Children's Hospice Grant will be added to the existing ICB budgets, without clear safeguards and ring-fencing, and therefore will not make it in full to the charities that it is allocated to.[63] Other hospices for children and young people have shared concerns that ICBs may use the grant as their full commissioning budget for children's palliative care, removing any existing local ICB funding, which would effectively result in a 50% drop in statutory income for some services.[64] It is essential that the 2023-4 children's hospice grant funding is ringfenced and that Government commits to maintaining this grant for the next five years to prevent this becoming the case.

> *"Safeguards are needed to guarantee that, as a minimum, children's hospices continue to receive their current levels of NHS funding, including their Children's Hospice Grant allocations. Without these safeguards, we are concerned that distributing the grant to ICBs to allocate could have serious consequences for the sustainability of children's hospices and undermine support for children and young people with life-limiting conditions."*
>
> *Together for Short Lives.*[65]

3.2: Unjustified variation

Levels of funding for hospices vary significantly across the country and even between neighbouring hospices. This has long been the case, in large part due the lack of a standardised approach to commissioning and contracting.[66] Previously, CCGs determined funding for local hospices on an ad hoc basis, and the introduction of Integrated Care Systems has not yet addressed this.[67] Evidence submitted to this inquiry demonstrates this variation, with hospices sharing how they receive less funding per capita than other hospices in their area.[68]

There is also significant variation in the total amount that each ICB spends on palliative and end of life care in their patch. Hospice UK submitted to this inquiry findings from a series of Freedom of Information (FOI) requests to ICBs made in mid-2023. This research found significant variation in the adult hospice spending of each ICB, ranging from £10.33 per head to just 23p per head.[69] A similar exercise undertaken by Together for Short Lives found variation in the spending on children's hospice care per child with a life limiting condition varying from an average of £511 in Norfolk and Waveney ICB to £28 in South Yorkshire ICB.[70]

Not only is there variation in the amount of funding, but also what types of services are funded. This inequity in funding creates a 'postcode lottery' in the palliative and end of life care services populations can access.[71]

For example, the Association of Chartered Physiotherapists in Oncology and Palliative Care shared with the APPG that the majority of hospices do not receive specific commissioning for physiotherapy.[72] This leads to serious variation in who is able to access this important service. They have heard from members working in hospitals covered by more than one ICB that the specific area a patient lives in determines whether they can refer them to physiotherapist at all upon discharge. In one area, the NHS community physiotherapy service specifically excludes those with a palliative diagnosis, and the local hospice is not commissioned for physiotherapy. This means there is no commissioned physiotherapy for palliative and end of life care patients in this area. Similarly, one hospice shared they have had to delay discharges from their inpatient unit due to a lack of Occupational Therapy.[73]

The Association for Palliative Medicine of Great Britain and Ireland demonstrated that the case is similar for out of hours care, which is also predominantly charitably funded. As a result, only 1 in 4 areas in the UK have access to designated palliative care phone lines.[74]

In their response to this inquiry, NHSE state that 'variation is to be expected as variation between population need exists'.[75] The Health and Care Act states that ICBs must commission palliative care 'necessary to meet the reasonable requirements' of the ICBs population, and therefore it is reasonable to expect funding to vary along with the complex needs of each community.[76] However, Hospice UK compared adult hospice care spending with the proportion of people over the age of 65 in each ICS, and found the region receiving the lowest hospice funding per head of the population, Cornwall and Isles of Scilly, has the highest percentage of residents over 65. Similarly, Norfolk and Waveney ICB, which provided a high level of children's hospice funding, provided just 74p of adult hospice funding per head of the population, despite having the 4th highest percentage of residents over 65.[77]

Many stakeholders responding to this inquiry felt that the statutory guidance produced alongside the statutory requirement does not address this variation as it is too vague and allows commissioners to interpret the guidance at their own discretion.[78] As the Association of Palliative Medicine highlighted in their evidence, there is not a detailed description of what adequate specialist palliative care is to guide commissioning decisions.[79]

> *"The lack of mandate or prescriptiveness within the NHS England guidance for ICBs has meant that we have seen radically different approaches being taken by the three Integrated Care Boards that we are commissioned by, and ultimately no changes have been made to how [the hospice] is funded or contracted."*
>
> *Anonymised hospice.*

National government must set out a national minimum standard for the level of palliative and end of life care that should be provided within all systems. NHSE should also undertake a proactive programme of support to ICBs on how to interpret the NHSE guidance on palliative care commissioning and what ICBs are required to commission.

3.3: Depreciation in the value of contracts

Hospices have seen variation in approaches to commissioning most clearly demonstrated in the annual increases, or lack thereof, applied to their contracts. Hospices are increasingly expected to deliver more with less and having their contracts reduce in real terms. Across the board, annual uplifts have not kept up with inflation, resulting in a £47 million real terms funding cut to hospices over the last 2 years.[80]

As they provide essential services that would otherwise need to be provided by the NHS, hospices should at least be eligible for the same annual increases (or uplifts) to their contracts as NHS services. However, in 2022-24, 28% of ICBs provided uplifts that were below the basic NHS uplift to contracts with hospices in their area and 5% gave no uplift at all.[81] One hospice shared with the APPG that they went 7 years without any uplift to their contract. As a result of a low uplift offer for 2023-4, at the time of submitting evidence, one hospice was still in contract disputes with their ICB and did not have a signed contract.

In 2022-23, NHS England released £1.5 billion of additional funding to ICBs to provide support for inflation and allowed ICBs to decide how best to distribute this funding within their systems. It is hugely concerning that, despite this additional funding, there is such significant variation and hospice contracts not receiving the minimum of annual increases.[82]

The significant variation in the percentage uplifts hospices are receiving to their contracts contributes to the inequality and postcode lottery in funding for palliative and end of life care across the country. Several hospices shared that they received minimal uplifts and noticeably less than their local colleagues. One hospice shared that its ICB said the hospice would receive no uplift to its contract this year. The hospice then highlighted to the ICB that, with its funding and finances already vulnerable, not having an uplift would force a reduction in services. In response, the hospice was offered a 2.45% uplift. While this is a welcome improvement, it is a concerning demonstration of the lack of standardisation or clear process for deciding uplifts.

Hospices are managing serious long-term and short-term pressures on their finances, and while many are currently able to continue to provide services by using any existing reserves, they are rapidly approaching a time when this will not be possible. If we are to avoid hospice closures and the loss of essential services in a few years, increasing pressure on NHS services, ICBs must ensure uplifts to hospice contracts are equitable with uplifts received by NHS-run services and other hospices in the area. National government must also pursue a plan to ensure the right funding flows to hospices, which includes commitments to develop nationally agreed reference costs for palliative and end of life care and quality standards that services need to meet to be contracted.

4. External pressures on funding

The flaws of the current hospice funding model have been made more acute by external pressures and the changing need for palliative and end of life care.

During the pandemic, the need for the hospice sector to support the health and care system with increased mortality and provide complex care to patients skyrocketed, while their ability to fundraise was decimated by lockdowns.[83] At this time, Government took quick action, purchasing extra capacity from the sector to help protect the NHS, with a total value of almost £400 million across the UK over the course of the pandemic. Analysis by Hospice UK showed that the first £155 million in additional funding to hospices delivered £323 million of value to the NHS in England.[84]

> *"The additional funding provided from NHS England…during the pandemic was essential to sustain service delivery and organisational viability during a time when our retail and fundraising services were forced to close and be suspended. This provides an illustration of the effective mechanisms that can be deployed by Government…ensuring the charities can be sustained through challenging financial times and supported to deliver essential patient care."*
>
> *The Kirkwood.*[85]

Many hospices responding to the inquiry emphasised their gratitude to national Government for this funding. In a previous inquiry, this APPG highlighted ways hospices used this money to maximise their value to the system. However, this demonstrates the fragility of the funding model and the need for a long-term plan to ensure hospices and local communities can rely on the local commissioning system.[86]

4.1: Cost of living crisis

Rising costs, from energy and food prices to staff costs required to meet NHS pay rises, mean hospices across the UK are collectively budgeting for a deficit of £100 million in 2023-4.[87] As discussed above, uplifts in hospice NHS contracts have not followed inflation, and so these costs are rising without a matched rise in funding, both long-term and in the short-term emergency circumstances.[88]

The cost of living crisis has also had an impact on the community's ability to donate to charities, such as hospices, and therefore, as hospices struggle, and receive no improved support from government, the charitable fundraising they rely on is dropping.[89]

The most troubling rising cost facing the majority of hospice services in England is staffing costs. Whilst pay rises for NHS staff are welcome and richly deserved, hospices have to keep pace with these increases without additional funding from Government.

69% of hospice expenditure is spent on staff.[90] Hospices employ clinical staff in many of the same roles as within the NHS, however, hospices are not provided with the necessary government funding to meet these new pay levels and charitable fundraising alone cannot make up the difference. Hospices pay what they can to their staff to try and keep pace with what they would receive if they worked in the NHS, but many fall short of matching Agenda for Change.

As a result, many hospice staff are doing the same job as their NHS colleagues but are being paid less for it. Hospice leaders shared with us how this seems to devalue their amazing staff, and how not being able to pay staff what they deserve, particularly during a cost of living crisis, is impacting morale across the organisation.[91] This inequality of pay also impacts recruitment and retention of clinical staff for hospices.[92]

> *"Government funding for hospices has not kept pace with inflation recently nor has it kept pace with the NHS Agenda for Change wage increases agreed on a national level. Given staffing costs are the biggest component in our expenditure, the current government funding system makes it difficult to recruit and retain staff."*
>
> *St Barnabus Hospice.*[93]

Lack of funding and increased staffing costs are already having an impact on hospice services. One hospice describes how they are having to go without key roles on Multi-Disciplinary Teams as they cannot afford to replace them.[94] For another hospice, workforce costs mean they will be forced to reduce services by the start of the next financial year, despite knowing there is a clear need to expand to meet demand.[95]

Between February and March 2023, Hospice UK conducted a survey of 101 UK hospices and found that 7 in 10 felt that cost of living pressures were highly likely to result in having to reduce the volume of certain services. 7 in 10 also agreed that these pressures are highly likely to result in reduced support being available to the wider system. Hospice UK informed the inquiry that collectively hospices are budgeting for a deficit of over £100 million for 2023.[96] In their individual evidence to this APPG, hospices detail significant deficits and emphasise that, while financial buffers will help them survive a deficit year, this will eat into their reserves and very soon they will be out of options.[97]

> *"The deficit budget will inevitably impact our reserves which through due diligence over the years by our Trustees has given us a small buffer for tough times. The reserves will only last for so long and without a significant increase in income our financial situation will become fragile."*
>
> *Beaumond House Hospice Care.*[98]

There is a need for national government to address the issue of staffing costs by providing emergency funding and thoroughly consider the impacts on the hospice sector within the NHS pay review process each year.

4.2: Changes in population need

A long term challenge facing the end of life care sector and the health and care system more widely, is the aging population and changes to what is needed and expected from care. The impact of this will be more severe in some areas than others, for example St Wilfred's Hospice's local population is already skewed to the 65+ demographic and is increasing.[99] It is clear, however, that this will impact every hospice in the UK, and the demands and complexities of their care.

According to sector projections, the number of people in the UK needing palliative care will increase by at least 25% by 2048 and the care needed will become increasingly complex, as people live longer with life limiting conditions and experience multiple co-morbidities.[100] 57.1% of hospice bereavement service managers also said demand for their services was much higher following the pandemic.[101] There is also an increasing need for children's palliative and end of life care, as due to advances in care babies, children and young people with terminal and life limiting conditions are able to live longer than before. This is fantastic, but it is vital that children's palliative care services are properly funded and able to plan for this continued increase in demand to provide the needed support.[102]

> *"We should expect increasing numbers of people coming to the end of their lives over the next 10 years, forecast by the ONS projections, therefore we should be planning for this."*
>
> *ICB End of Life Clinical Lead for Nottinghamshire.*[103]

It is evident that this is something hospices are very aware of, and many are already struggling to meet demand. [104]

> *"There is an increasing demand for specialist end of life care with people living longer and with more complex healthcare needs. Referrals for our inpatient unit (IPU) and community services increased by 4% during 2022-23 compared to the prior year, and these were also 23% higher compared to four years ago."*
>
> *St Christophers Hospice.*[105]

Some ICBs and NHS services are undertaking population needs assessments, for both now and in the future to better understand if there is enough capacity in the right places to meet growing complexity and demand.[106] One ICB very clearly identifies that 'hospices are struggling to meet the current levels of demand with existing levels of funding and capacity' and will continue to struggle in future, however, due to the intense financial pressures on the ICB itself, despite understanding this need they do not have the money to support hospices to grow or innovate.

Care will need to innovate and adapt in order to meet this change in demand, but national charities that provide palliative and end of life care services across the country have found hospices ability to innovate and integrate into the system, and to plan for the future, is compromised by their funding model.[107] The current approach to commissioning hospice services restricts the work they can do in collaboration with system colleagues and prevents them from establishing or expanding services for changing need as they cannot be sure they have the funding to maintain them.

In its evidence to the inquiry, Marie Curie highlighted that, increasingly, the need for care is shifting to the community as more and more people wish to die in their own home. This needs to be reflected in funding for palliative and end of life care services.[108]

As NHSE identify in its evidence to the APPG, the majority of end of life care is provided in NHS hospitals, however, we know that a large proportion of people do not want to die in hospital.[109] To support people to die where they would prefer and allow timely discharge for those not best served in hospital, sufficient community palliative and end of life care services must be sustainably commissioned. The Nuffield Trust found that 66% of hospice patients are seen in the community, hospice services will remain essential as demand in the community grows.[110] As St Christopher's Hospice illustrated, not everyone needs specialist care at the end of their life, many at home and in care homes are supported by community nursing teams and social care teams, and so this must also be considered when ICBs and central government are planning the funding allocation for the future of palliative and and end of life care.[111]

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5. Alternatives to the current model

In all, it is clear that the hospice funding model is no longer fit for purpose and does not maximise the value these services can bring to the system. Many of those submitting evidence to this inquiry suggested changes to the funding model that would offer more sustainable support to the hospice sector to ensure their vital services can continue.

Many hospices would not want 100% of their funding to come from Government sources. Having a charitable arm means hospices can be flexible with the services they offer and raise money for additional, enhanced services. Alternatively, 100% NHS funding would force hospices to drop 'added value' services.[112] The charitable aspect to hospices also strengthens their connection with their local community, providing an opportunity for people to come together to support a good cause in their community.

However, core clinical services that would otherwise need to be provided by the NHS should not be subsidised by local communities. This is the intent behind the statutory requirement for ICBs to commission palliative and end of life care but is not being fulfilled on the ground.

Hospices have differing views on the percentage of their total income that should provided by government sources.[113] However, many agree that the full costs of core clinical services that would otherwise need to be provided by the NHS should be met by commissioners. For one hospice, this includes pharmacy, pathology, patient community equipment, all CHC funded activity, palliative consultant costs, clinical nurse specialist and advance care planning.[114]

NHSE have provided guidance on core and specialist services ICBs should commission in their area, however this is not consistently applied on the ground. National government must develop a national minimum standard for the level of provision of palliative and end of life care that must be provided within all ICBs to make it clear what should and should not be commissioned by ICBs. NHSE must also provide more proactive support to ensure ICBs understand and are able to follow this guidance, as well as developing further guidance on how to commission services from VCSEs more broadly.

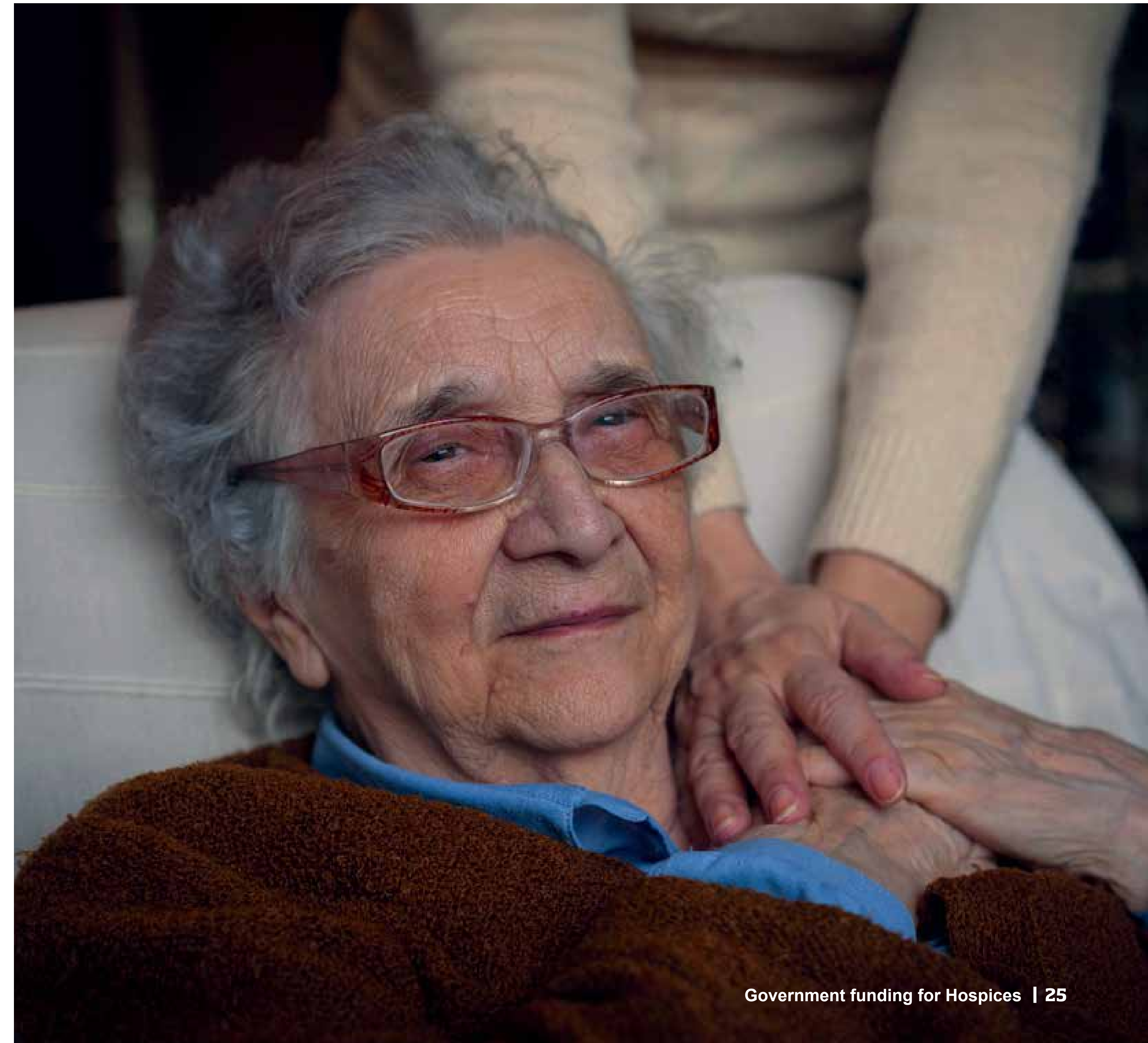
There have been calls for standardised and nationally recognised reference costs for end of life care, to facilitate a more equal and logical funding model. Providers have attempted to use comparable NHS reference costs as proxy indicators for the costs of their services, however this has not been supported by their ICB as they argued 'there is no nationally mandated tariff or price that can reliably used for presentation of any conclusive evidence with regards to value for money of provision'.

It is clear that a better understanding of the costs and benefits of different models of hospice care is needed. UK Government must conduct or commission a piece of work to understand the costs of providing different models of palliative and end of life care with the long-term aim of developing agreed reference costs that can be used by commissioners to provide a basis for the levels of funding they provide. UK Government must also develop national quality standards and outcome measures. All of this data will equip commissioners to benchmark hospice services and their value to the system.

> *"Hospices will rightly continue to fund raise and seek the support of local communities and this will continue to be critical to their success. However, ensuring there is reliable core central funding year on year would help provide more certainly about service delivery and development."*
>
> *Mid Yorkshire Teaching NHS Trust.*[115]

When making changes to the hospice funding model, it is important that the postcode lottery of services is ended and any new model is consistent. That is why we are calling on the Government to set out a national minimum standard for the level of provision of palliative and end of life care that must be provided within all ICBs. ICBs must also work to provide consistent and fair funding to the services they commission, through ensuring uplifts to hospice contracts are equitable with NHS services and contracts are multi-year.

To adapt the hospice funding model to the needs of the population and the roles hospices play in the current system, action must be taking at the government, NHSE and ICB level. Key to making fair funding for hospices a reality is a plan from UK Government to adapt the funding model in order to realise the full potential of the hospice sector. This should include interim measures to support ICBs. However, its core function will be to set out a plan for how the funding model will change as a better understanding of the cost of delivery different models of hospice care is developed and data is improved.



6. Reflections on the hospice funding model in Scotland, Wales and Northern Ireland

As health and social care is a devolved issue, this inquiry only makes specific recommendations with regard to hospice funding in England. However, it is important to understand hospice funding in Scotland, Wales and Northern Ireland, learn from these models and advocate for sustainable funding across the UK.

Hospices provide essential care across the UK. In Northern Ireland, sources indicated that the 4 charitable hospices provided care to 11,000 adults and 300 children in 2020/21.[116] There are 14 independent hospice care charities in Scotland, providing support to 21,000 adults and children in 2022-23 and in Wales, 14 hospices provide essential care to more than 20,000 children and adults.[117]

Hospice funding models vary across the 4 nations, however hospices in each nation are funded by a combination of statutory funding and charitable donations.

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In Scotland, the responsibility for commissioning palliative and end of life care sits with local integration authorities. On average just over a third of hospice' income in Scotland comes from statutory funding with hospices having to fundraise the remainder.[118] The majority of statutory funding Welsh hospices receive comes via the seven Health Boards, with a small percentage funded centrally by Welsh Government. Wales developed a funding formula in 2008 in order to guide the delivery of ring-fenced government funding to ensure equality of evidence-based care provision.[119] This defined the 'core' services government would fund hospices to deliver. This funding is delivered through Service Level Agreements and additional costs are met by the voluntary hospices.[120]

In Northern Ireland, the funding system for hospices is in a particularly difficult position due to the Northern Ireland Assembly not being operational since early 2022. All hospices in Northern Ireland receive statutory funding, however several are managing relationships with multiple commissioners, and all have complicated commissioning arrangements. National palliative and end of life care strategies are out of date and no new strategy is being developed due to a lack of funding.[121]

Despite the variations in their statutory funding models, many of the same challenges and concerns are shared by hospices across the UK. Health boards and local statutory partners in each of the devolved nations are under financial pressure and this has had an impact on hospice funding. Many Hospices Cymru members have received no uplifts from Health Boards this year and, as a result, many are considering making cuts to their services.[122] The annual uplifts that hospices in Scotland receive varied widely, with an audit in April 2023 showing uplifts typically ranging from between 4% to no uplift at all.[123]

> *"There is growing evidence and concern that rising staff and energy costs, workforce pressures, and increased demand and complexity of care pose an existential threat to the short and medium-term sustainability of children and adult hospice services in Wales."*
>
> *Hospices Cymru.*[124]

In Wales, NHS pay increases over the last two years have raised total hospice staffing costs up by approximately £5.4 million. Welsh hospices are committed to paying a fair and competitive wage to their staff but, as with hospices in England, cannot keep pace with these pay rises. Hospices Cymru shared that all Welsh hospices are drawing on their reserves. This is not a long term solution, on average Welsh hospices have just 10 months in reserve, with some having only 3 months.

In July 2023, Hospices Cymru and Hospice UK found that every hospice in Wales is projecting a deficit for this financial year, representing a total deficit of £9.5m. Similarly, Scottish hospices are facing an expected deficit of £16 million for 2023 because of statutory funding not keeping pace with spiralling costs.[125]

In Northern Ireland, the Strategic Planning and Partnership Group (SPPG) recognised the scale of cost pressures facing hospices and provided some additional funding, however this did not match the financial impact of cost pressures and there was little transparency on how allocations were made.

The variation in hospice funding seen in England is also a challenge in Wales, Scotland and Northern Ireland. Statutory funding for voluntary hospices varies significantly in Wales, particularly as Health Board funding for hospices is not ringfenced by Welsh Government. This results in some hospices receiving no funding, while others receive up to 50%. Hospice Alliance NI shared that almost every hospice contract in Northern Ireland is different, showing no consistency in approaches to commissioning. Hospice funding also varies between nations, with hospices in Wales receiving less overall government funding as a proportion of expenditure than those England, Scotland and Northern Ireland.[126]

In Scotland, Scottish Government has made some progress towards a new national funding framework for hospice care, with a draft framework currently under development. However, the underlying issue of the £16 million deficit facing Scottish hospices has not been addressed. In addition, there needs to be longer-term assurances that the hospice funding model will support future growth and demand, and that future NHS pay awards will consider and factor in the impact on the hospice sector.

It would be inappropriate for this APPG to make recommendations to address the funding challenges in Scotland, Wales and Northern Ireland. However, it is clear that something must be done to offer urgent support to these hospices and address their deficits. A long term funding framework for hospices in each nation should be developed that funds these services sustainably and recognises their role as equal partners in the system.

In Wales, the Minister for Health and Social Services has agreed that the final phase of their Palliative and End of Life Care funding review will consider the ongoing support that hospices need in more detail. Alongside this, Welsh hospices have requested financial support of £4m to meet the significant increases they are experiencing for their wage bills of core and relevant support staff delivering palliative care. Scottish government have also committed to producing a palliative care strategy and are working on its development. This is a welcome step, and this APPG would welcome reviews of hospice funding in each of the four nations.

Conclusion

This APPG received evidence from across the health and social care sector demonstrating significant variation and unsustainability in the commissioning of hospice services in England. This inquiry found that while the statutory requirement to commission palliative care was a welcome step and increased the profile of palliative and end of life care, this has not yet resulted in a more logical and consistent approach to funding of charitable hospices.

There have been drastic real terms cuts in the funding hospices receive from ICBs, as this has not kept pace with inflation. Additionally, the funding hospices receive varies significantly between services, without following a logical pattern of population need or service type.

Across the sector, there is a keen awareness that ICBs are not meeting the statutory requirement. To ensure hospices can provide their full benefit to the system, ICBs must commit to delivering their statutory requirement and start by placing hospices on multi-year contracts, paying the full cost of commissioned clinical services and offering hospices the same annual increases as NHS services.

The evidence also demonstrates the need for national leadership from the UK Government. ICBs are new and have been handed a range of commissioning responsibilities with little detail on the services needed and severe financial pressures. It is vital that NHSE provides further support to ICBs to interpret their responsibilities, while the UK government produces a plan to adapt the hospice funding model over time.

The findings and recommendations in this report are intended to support national government and ICBs to reform commissioning of hospice services. Hospices are a vital part of the palliative and end of life care system in this country, and through suitable commissioning, they can be strengthened to fully realise the benefits of a sustainable and integrated hospice sector.

The APPG on Hospice and End of Life Care would like to thank all those who submitted evidence to this inquiry

Acorns Children's Hospice
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The Association of Chartered Physiotherapists in Oncology and Palliative Care
The Association for Palliative Medicine of Great Britain and Ireland
Beaumond House Hospice Care
Blythe House Hospicecare and Helen's Trust
Blythe House Hospicecare, Hospice Clinical Services Manager
Cheshire and Merseyside Hospice Provider Collaborative
Claire House Children's Hospice
Compton Care Hospice
Cornwall Hospice Care
Coventry and Warwickshire ICB
Demelza
Derby and Derbyshire ICB
Dignity in Dying
Dorothy House, Prospect and Salisbury hospices joint evidence
Eden Valley Hospice and Jigsaw Children's Hospice
Florence Nightingale Hospice Charity
Forget Me Not Childrens Hospice
Greater Manchester Hospices Collaborative
Hospice Alliance NI
Hospices Cymru
Hospiscare
Humber and North Yorkshire Hospice Collaboration
Ian Byrne MP on behalf of Zoe's Place Baby Hospice
ICB End of Life Clinical Lead for Nottinghamshire
Individual with lived experience
Individual with lived experience (NHS and Hospice Career)
Individual with lived experience (Medical Director)
Individual with lived experience (Patient and carer)
Individual with lived experience (Frontline)
Isabel Hospice
Surrey Adult Hospice Chief Executives
The Kirkwood
Lancashire South Cumbria Hospices Together
Leeds Palliative Care Network
Lindsey Lodge Hospice
Macmillan Cancer Support
Marie Curie
Martin House Children's Hospice
Mid Yorkshire teaching Hospitals NHS Trust
Mountbatten Hospice
MSA Trust
National Bereavement Alliance and Childhood Bereavement Network
NHSE
North Devon Hospice
North Devon ICB
North East and North Cumbria ICB
North London Hospice
Nottinghamshire Hospice
Overgate Hospice
Prince of Wales Hospice
Queenscourt Hospice
Rennie Grove
Royal College of Speech and Language Therapists
Royal Trinity Hospice
Scottish Hospice Leadership Group
Severn Hospice
The Shakespeare Hospice
Shooting Star Children's Hospice
Shooting Star Children's Hospice, Parents + Carers
South West London Hospices
The Speciality Advisory Committee for Palliative Medicine Higher Specialty Training
St Barnabas Hospice
St Catherine's Hospice
St Christopher's Hospice
St Gemma's Hospice
St Giles Hospice
St Helena Hospice
St Leonard's Hospice
St Michael's Hospice
St Raphael's Hospice
St Rocco's Hospice
St Wilfrid's Hospice (Chichester)
Sue Ryder
Surrey Heartlands ICB
Together for Short Lives
Treetops Hospice
University of Surrey
Wakefield Hospice
West Yorkshire Hospices collaborative
West Yorkshire Integrated Care Board
Wigan and Leigh Hospice
Wirral Hospice

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36. The King's Fund. The new NHS: clinical commissioning groups. [Internet] [cited Jan 2024] Available from: https://www.kingsfund.org.uk/projects/new-nhs/clinical-commissioning-groups [last accessed January 2024].
37. Evidence submitted to the APPG by Hospice UK.
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39. Evidence submitted to the APPG by West Yorkshire Health and Care Partnership.
40. Evidence submitted to the APPG by Hospice UK.
41. Together for Short Lives. The deep disparity in NHS funding for children who need hospice care. December 2023 [last accessed January 2024].
42. Evidence submitted to the APPG by the West Yorkshire Hospice Collaborative.
43. Evidence submitted to the APPG by Mountbatten.
44. Evidence submitted to the APPG jointly by Dorothy House Hospice Care, Prospect Hospice and Salisbury Hospice.
45. Evidence submitted to the APPG by the West Yorkshire Hospice Collaborative.
46. Evidence submitted to the APPG jointly by Dorothy House Hospice Care, Prospect Hospice and Salisbury Hospice. Evidence submitted to the APPG by Treetops Hospice.
47. Evidence submitted to the APPG by The Speciality Advisory Committee for Palliative Medicine Higher Specialty Training.
48. Ibid.
49. Evidence submitted to the APPG by Together for Short Lives.
50. Evidence submitted to the APPG by St Christopher's Hospice.
51. Evidence submitted to the APPG by Demelza. Evidence submitted to the APPG by an Individual with lived experience (NHS and Hospice Career).
52. Evidence submitted to the APPG by the Mid Yorkshire Teaching NHS Trust.
53. Evidence submitted to the APPG by St Michael's Hospice.
54. Evidence submitted to the APPG by Blythe House Hospicecare & Helen's Trust.
55. Evidence submitted to the APPG by Sue Ryder.
56. Evidence submitted to the APPG by St Wilfrid's Hospice.
57. Evidence submitted to the APPG by St Rocco's Hospice.
58. Evidence submitted to the APPG by an Individual with lived experience (NHS and Hospice Career).
59. Evidence submitted to the APPG by The Prince of Wales Hospice. Evidence submitted to the APPG by Rennie Grove Peace Hospice Care. Evidence submitted to the APPG by Lindsey Lodge Hospice. Evidence submitted to the APPG by Royal Trinity Hospice.
60. Evidence submitted to the APPG by The Prince of Wales Hospice. Evidence submitted to the APPG by Pendleside Hospice.
61. Evidence submitted to the APPG by Martin House Children's Hospice. Evidence submitted to the APPG by West Yorkshire Hospice Collaborative. Evidence submitted to the APPG by Eden Valley Hospice and Jigsaw Cumbria's Children's Hospice.
62. Evidence submitted to the APPG by Martin House Children's Hospice. Evidence submitted to the APPG by Cheshire & Merseyside Hospice Provider Collaborative. Evidence submitted to the APPG by Sue Ryder. Evidence submitted to the APPG by Marie Curie.
63. Evidence submitted to the APPG by Together for Short Lives.
64. Evidence submitted to the APPG by Demelza.
65. Evidence submitted to the APPG by Together for Short Lives.
66. Evidence submitted to the APPG by The Kirkwood.
67. Evidence submitted to the APPG by an Individual with lived experience (NHS and Hospice Career).
68. Evidence submitted to the APPG by The Kirkwood.
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72. Evidence submitted to the APPG by the Association of Chartered Physiotherapists in Oncology and Palliative Care.
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81. Evidence submitted to the APPG by Hospice UK.
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86. Evidence submitted to the APPG by Surrey Adult Hospice Chief Executives.
87. Evidence submitted to the APPG by Hospice UK.
88. Evidence submitted to the APPG by Lancashire South Cumbria Hospices Together. Evidence submitted to the APPG by Queenscourt Hospice. Evidence submitted to the APPG by Greater Manchester Hospices Collaborative.

89. Evidence submitted to the APPG by Treetops Hospice. Evidence submitted to the APPG by Cheshire and Merseyside Hospice Provider Collaborative.

90. Keeble E, Scobie S, Hutchings R. Support at the end of life: The role of hospice services across the UK. London: Nuffield Trust; 2022 [last accessed January 2024].

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92. Evidence submitted to the APPG by Treetops Hospice. Evidence submitted to the APPG by Shooting Star Hospice. Evidence submitted to the APPG by St Barnabas Hospice.

93. Evidence submitted to the APPG by St Barnabas Hospice.

94. Evidence submitted to the APPG by The Prince of Wales Hospice.

95. Evidence submitted to the APPG by Wigan and Leigh Hospice.

96. Evidence submitted to the APPG by Hospice UK.

97. Evidence submitted to the APPG by St Helena Hospice. Evidence submitted to the APPG by St Gemma's Hospice. Evidence submitted to the APPG by St Wilfrid's Hospice.

98. Evidence submitted to the APPG by Beaumond House Hospice Care.

99. Evidence submitted to the APPG by St Wilfrid's Hospice.

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104. Evidence submitted to the APPG by Royal Trinity Hospice.

105. Evidence submitted to the APPG by St Christopher's Hospice.

106. Evidence submitted to the APPG by Derby and Derbyshire ICB.

107. Evidence submitted to the APPG by Marie Curie. Evidence submitted to the APPG by Sue Ryder.

108. Evidence submitted to the APPG by Marie Curie.

109. Evidence submitted to the APPG by NHSE.

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111. Evidence submitted to the APPG by St Christopher's Hospice.

112. Evidence submitted to the APPG by St Christopher's Hospice. Evidence submitted to the APPG by Hospiscare.

113. Evidence submitted to the APPG jointly by Dorothy House Hospice Care, Prospect Hospice and Salisbury Hospice.

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115. Evidence submitted to the APPG by Mid Yorkshire Teaching NHS Trust.

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118. Evidence submitted to the APPG by the Scottish Hospice Leadership Group.

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121. Evidence submitted to the APPG by Hospice Alliance NI.

122. Evidence submitted to the APPG by Hospices Cymru.

123. Evidence submitted to the APPG by the Scottish Hospice Leadership Group.

124. Evidence submitted to the APPG by Hospices Cymru.

125. Evidence submitted to the APPG by the Scottish Hospice Leadership Group.

126. Evidence submitted to the APPG by Hospices Cymru.

All-Party Parliamentary Group
Hospice and End of Life Care

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Isle of Wight Council

Purpose: For Information

Agenda Item Introduction

Committee	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date	**4 MARCH 2024**
Topic	**GP SURGERIES**

Background

1. The General Practice survey that was undertaken by NHSE in 2023 resulted in some concern for residents and the media about the state of general practice.

2. The Island's healthcare system wanted to better understand the views of Island patients and therefore have introduced an Island-wide survey, which is now sent out after each appropriate appointment.

3. Since the beginning of the roll-out in October 2023, there have been 6000 responses, and the data paints a very different picture from the national survey.

Focus for Scrutiny

4. What are the key learning outcomes from the survey responses so far?

5. What work is taking place to monitor and improve capacity and access, as a result of the survey?

6. What areas need improvement but are unable to be actioned at this current time?

7. Is a long-term action plan being created as a result of the Island survey findings?

Outcome(s)

8. To determine any areas which may assist in improving the experience of the local population.

Approach

9. Set out the approach for the committee.

Document(s) Attached

10. Please ensure that any appendices are listed here in number order.

Contact Point: Melanie White, Statutory Scrutiny Officer,
(01983) 821000 ext 8876, e-mail melanie.white@iow.gov.uk

IOW Primary Care Access & Patient Survey 2023/24

Health Overview and Scrutiny Committee – 4th March 2023

Appendix 1

Content Outline

- **Primary Care Access**
  - Priorities
  - Recovery plans
  - Appointment data
- **Patient Survey**
- **Summary of key messages**

Practices & PCNs have been focusing on 3 key areas during 2023

Hampshire and Isle of Wight

PCN Improvements in 3 key areas
Baseline data for:

Patient experience of contact:
- ❑ GPPS
- ❑ F&F
- ❑ PPG activity levels (local)

Ease of access & demand management:
- ❑ CBT & functionality
- ❑ Online consultations
- ❑ DNAs (local)
- ❑ Appointment reminders (local)

Accuracy of recording in appointment books:
- ❑ National GPAD data

Plans

1 Patient Experience of Contact

- Local survey of patient experience (Island-wide survey)

2 Ease of access & demand management

- Review of cloud-based telephony (CBT) functionality and opportunities across the PCN
- Review of triage and signposting processes across the PCN, share learning and implement improvements where possible
- All practices to have mapped their appointments to the 3 main Apex categories

3 Accuracy of recording in appointment books

- All practices to have access to regular GPAD data
- Review recording of appointments in books in line with 2021 GPAD guidance with support from ICB and regional team

Progress against recovery plans

Hampshire and Isle of Wight

- cloud-based telephony
- island-wide website audit programme
- local patient experience survey
- recruitment of additional roles to multi-disciplinary teams
- GP Practices are offering more appointments year on year
- Data analytic software (APEX)

IOW Appointment Data – last month

Data obtained from Apex for January 2024

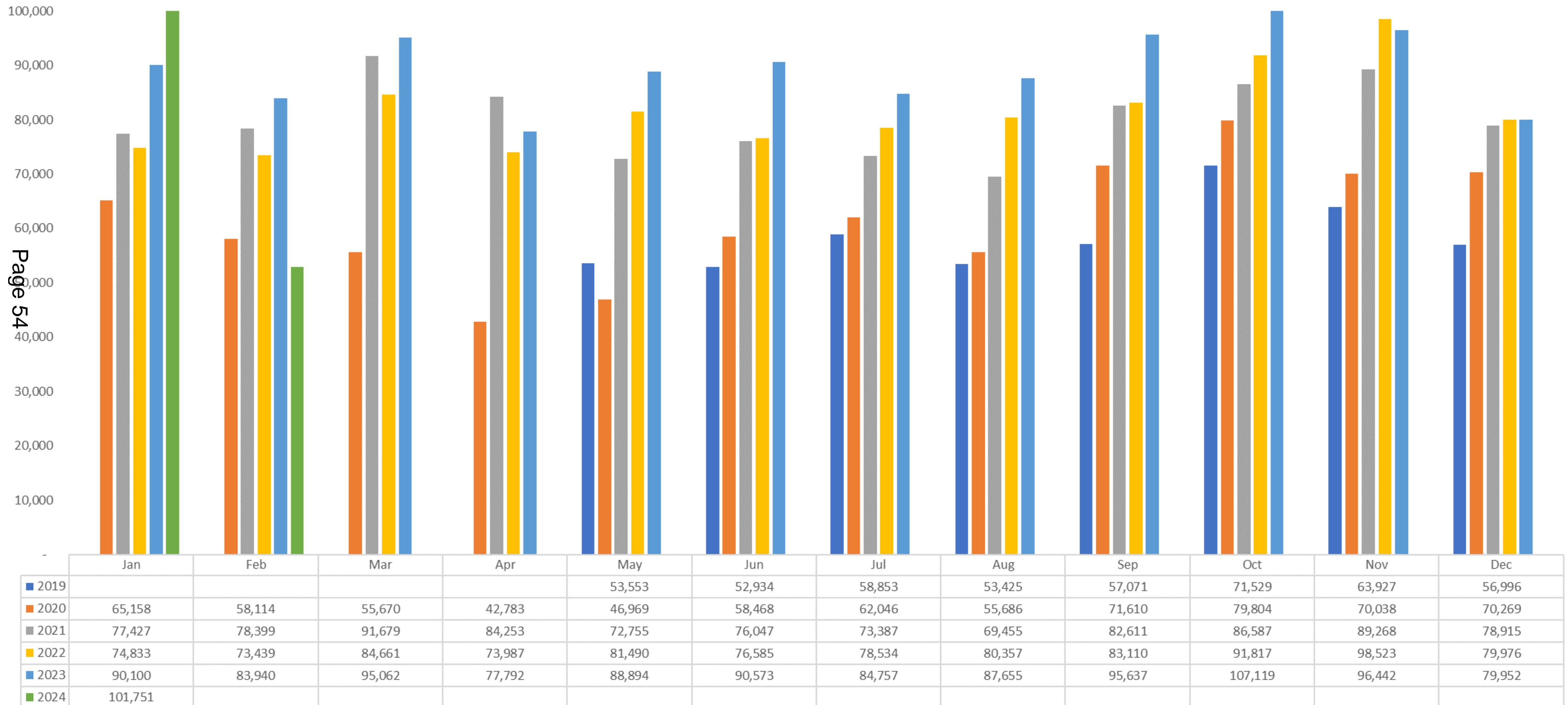
Includes all data that is mapped through to Apex

AVAILABILITY

35% booked on the day (urgent)

- **103,302** appointments in primary care – this equates to 70% of our population being seen once
- **58,882** patients had a face-to-face appointment – this equates to 40% of our population being seen
- **36,155** appointments were booked on the day as urgent – this equates to 25% (one in four) of our population being seen urgently

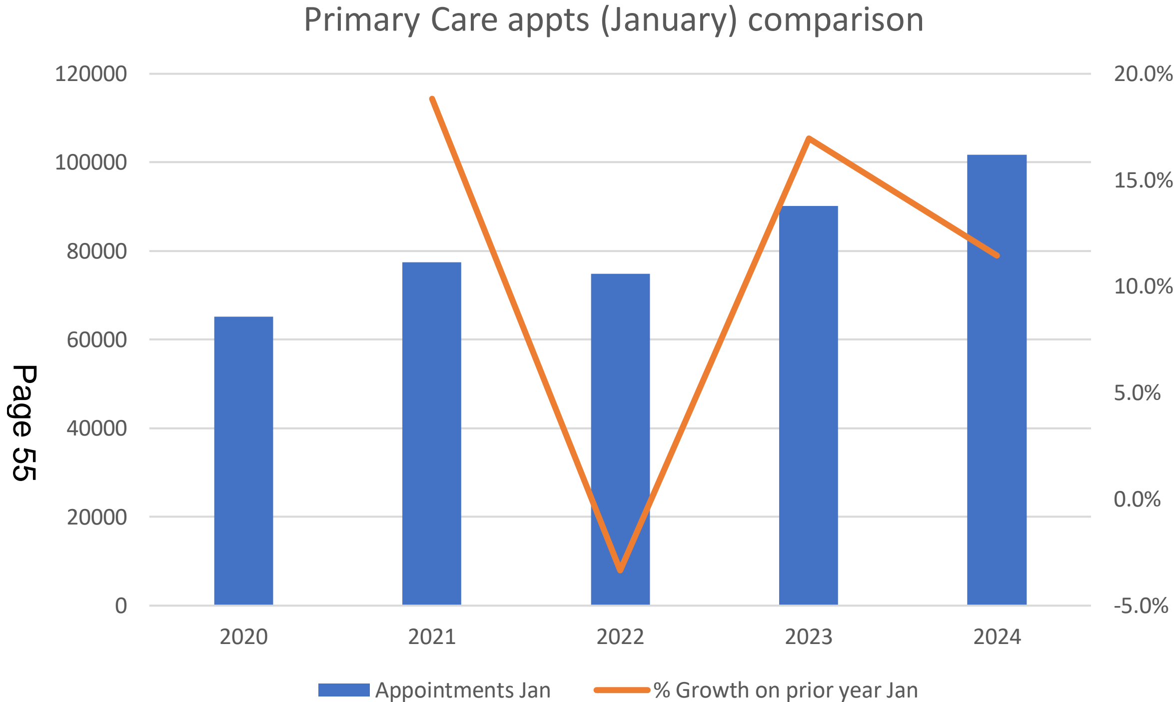
IOW Appointment Data – last five years



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019					53,553	52,934	58,853	53,425	57,071	71,529	63,927	56,996
2020	65,158	58,114	55,670	42,783	46,969	58,468	62,046	55,686	71,610	79,804	70,038	70,269
2021	77,427	78,399	91,679	84,253	72,755	76,047	73,387	69,455	82,611	86,587	89,268	78,915
2022	74,833	73,439	84,661	73,987	81,490	76,585	78,534	80,357	83,110	91,817	98,523	79,976
2023	90,100	83,940	95,062	77,792	88,894	90,573	84,757	87,655	95,637	107,119	96,442	79,952
2024	101,751											

June and September 2022 include extra Bank Holidays, May 2023 includes an extra Bank Holiday, February 2024 data incomplete

IOW Appointment Data – last five years



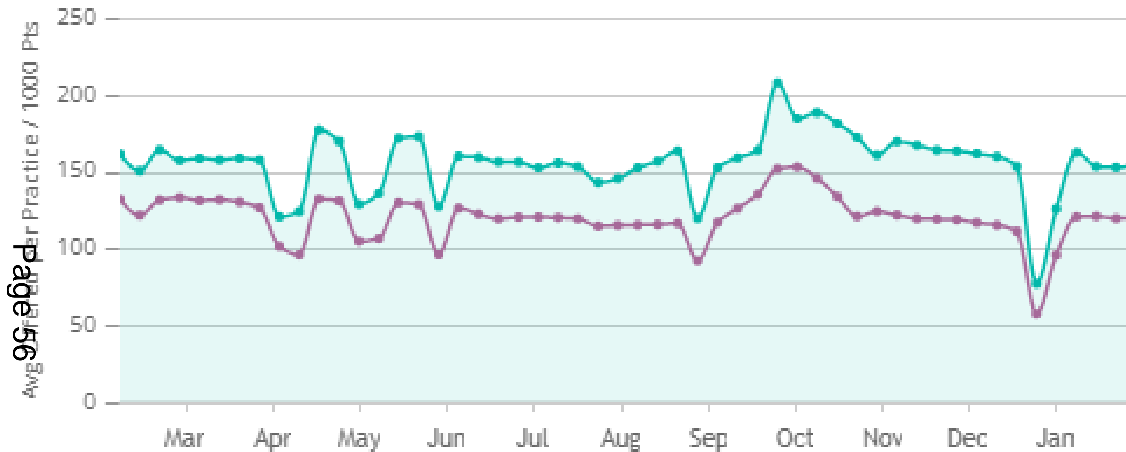
Year	Appointments Jan	% Growth on prior year Jan
2020	65158	
2021	77427	18.8%
2022	74833	-3.4%
2023	90100	16.9%
2024	101751	11.5%

Taking January as a representative month (trend is in line with full year growth), total growth across the 5-year period shows an increase of 56% more appointments being offered

Workforce has diversified into more multi-disciplinary roles over the period, in recognition of the challenging nature of workforce capacity within GP and nursing roles.

During this period, GP and nurse numbers have remained flat whilst direct patient care roles have increased by c65%

Appointments offered and booked – IOW vs HIOW ICB



Overall

Total
1,190,765

Avg / Week
22,899

Per Practice

Per 1000 Pts
8,099

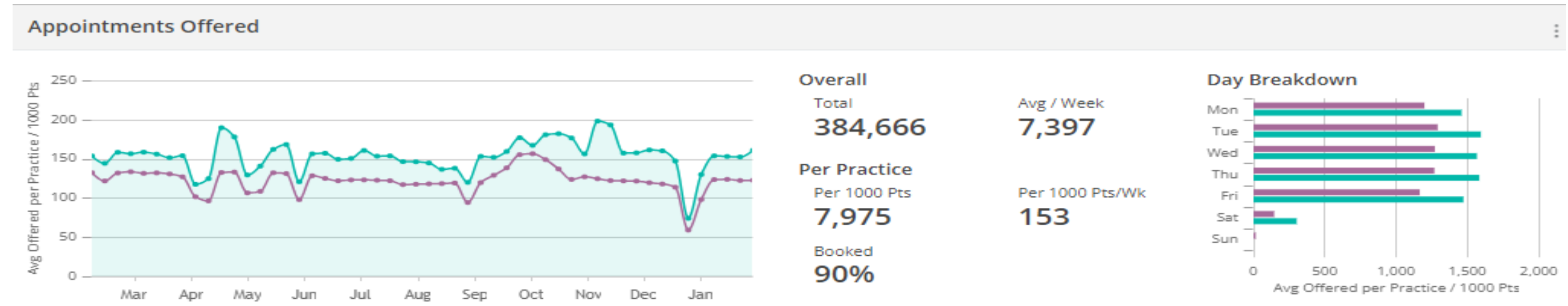
Per 1000 Pts/Wk
156

Booked
87%

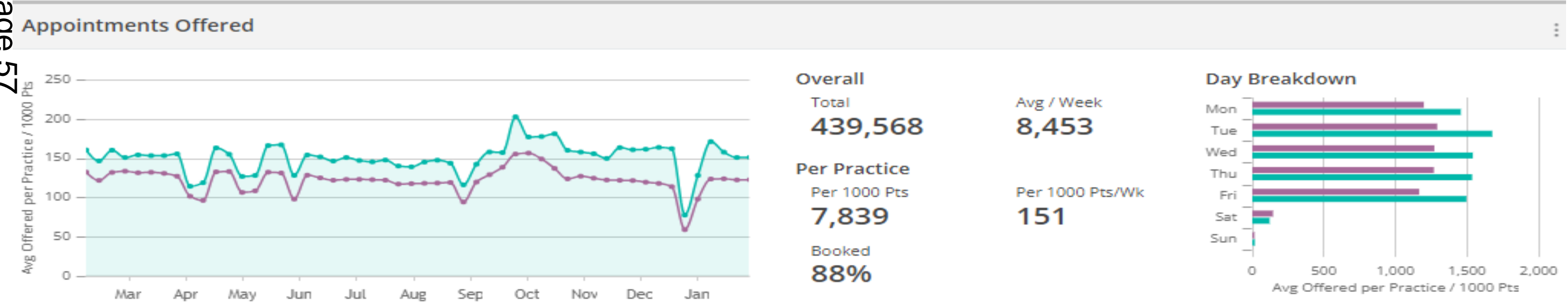
- As a place the IOW is offering its population a higher proportion of weekly appointments per 1000 patients than the ICB average (**156** per 1000 patients vs **120** per 1000 patients)
- Between 6th Feb 2023 and 4th Feb 2024 over **1.1 million appointments** were made available to Island residents across the 3 PCNs.
- 87% of these appointments were booked equating to 1.03 million appointments

Appointments offered by PCN

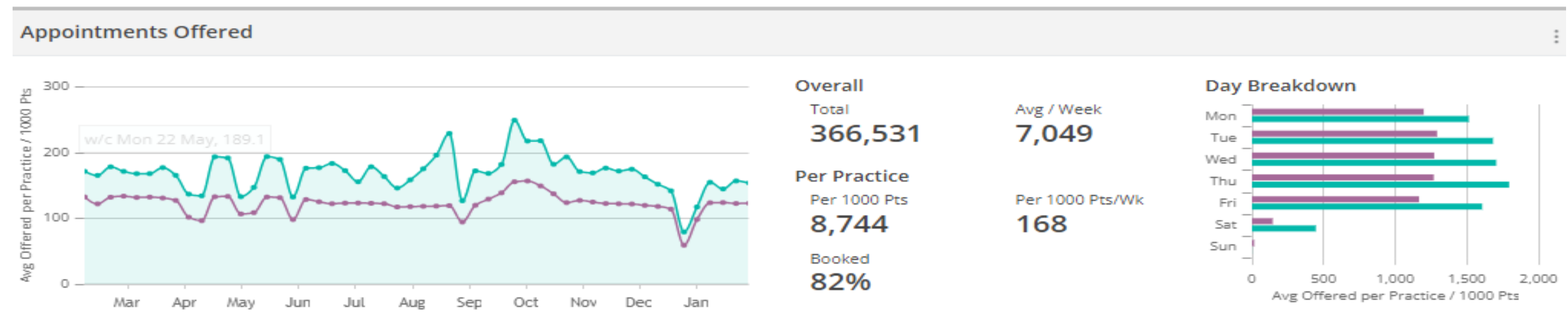
Central and West PCN vs HIOW ICB



North and East PCN vs HIOW ICB



South PCN vs HIOW ICB



- All PCNs on the Isle of Wight are offering the population a higher proportion of appointments than the HIOW ICB average.
- This also includes a higher proportion of Saturday appointments through enhanced access service

Data taken from Apex for a 52-week period between 6th Feb 2023 – 4th Feb 2024

IOW Patient Survey 2023/24

Hampshire and Isle of Wight

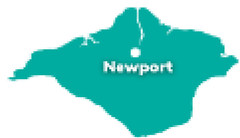
As part of their Capacity & access improvement plans….

- All 12 practices are phasing in the survey across their clinics and appointment types
- A survey gets sent to a patient following their appointment
- Over 12,000 responses (c8% of island population) have been received between October 2023 and end of Jan 2024
- Practices and PCNs are actively reviewing their data on a regular basis to enable quality improvement actions to be identified.
- In the 2023 National GP Patient Survey, 3528 surveys were sent out across the island, with 1,443 responses ~ 40.9% response rate but only equating to 0.99% of our population

In summary…

1.1 million appointments offered to the Island population over a 52-week period

56% more appointments than five years ago, despite roughly the same GP & nurse numbers



156 appointments offered per 1000 population weekly on the IOW

120 appointments offered per 1000 population across the HIOW ICB

90% of those that accessed their practice felt it was easy to do so

93% were satisfied with their last contact with the practice

92% would recommend their practice to their family and friends

Appendix

- National Context
- Our multi-disciplinary teams
- Patient Survey question results

Hampshire and Isle of Wight

National Context

In May 2022, Dr Claire Fuller, published her stocktake report of how primary care can best be supported within the emergent integrated care systems (ICSs) to meet the health needs of people in their local areas. The vision for integrating primary care, improving access experience and outcomes for communities was centred around:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

National Context

Hampshire and Isle of Wight

In May 2023, the government published its recovery plan for primary care. The plan sets out four key areas to support recovery:

- **Empower patients to manage their own health** including using the NHS App, self-referral pathways and through more services offered from community pharmacy.
- **Implement modern general practice access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.
- **Build capacity to deliver more appointments** from more staff than ever before and add flexibility to the **types of staff recruited** and how they are deployed.
- Cut bureaucracy and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

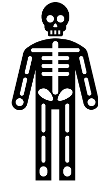
Our Multi-disciplinary teams

Hampshire and Isle of Wight

Overall Objectives

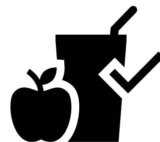
- **Maximise recruitment** of the ARRS roles
- **Expand the skillset and specialist experience** across General Practice
- **Increase efficiency and effectiveness of care and support** provided to practice population by ensuring they are seen by the **most appropriate** member of the workforce
- **Promote integrated and multi-disciplinary working** across the local delivery system

12.5 WTE Clinical Pharmacist &4.5 WTE Pharmacy Technicians



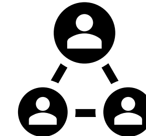
5.9 WTE Musculoskeletal First Contact Practitioners

7.6 WTE Health and Wellbeing Coaches

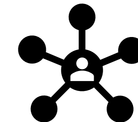


1 WTE Dietician

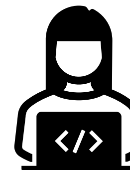
4.76 WTE Physicians Associate



9.6 WTE Social Prescribers



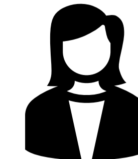
23.85 WTE Care Coordinators



15.2 WTE GP Assistants

1 WTE Podiatrist

4.2 WTE Nurse Associate and Trainee Nurse Associate

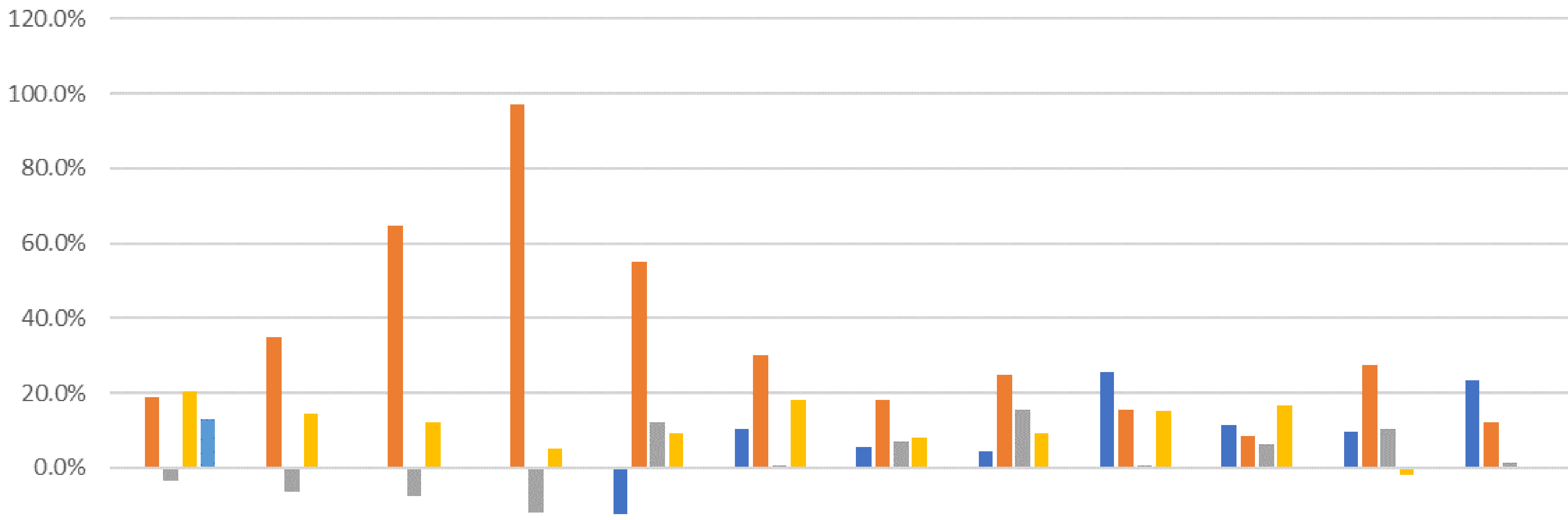


10.8 WTE Advanced nurse Practitioners

19.5 WTE Paramedics

Monthly Appointments Growth

% Growth compared to previous year by month

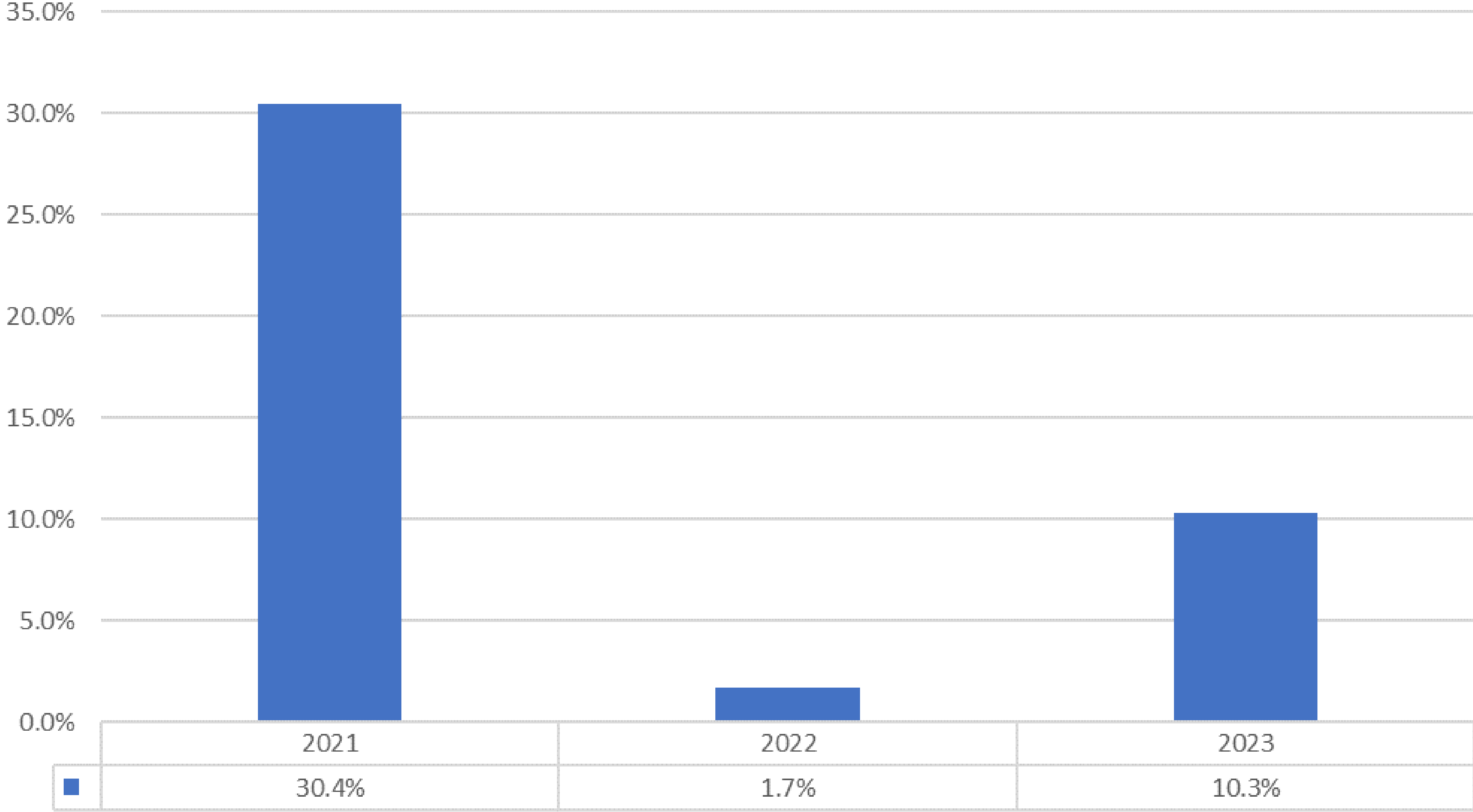


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020					-12.3%	10.5%	5.4%	4.2%	25.5%	11.6%	9.6%	23.3%
2021	18.8%	34.9%	64.7%	96.9%	54.9%	30.1%	18.3%	24.7%	15.4%	8.5%	27.5%	12.3%
2022	-3.4%	-6.3%	-7.7%	-12.2%	12.0%	0.7%	7.0%	15.7%	0.6%	6.0%	10.4%	1.3%
2023	20.4%	14.3%	12.3%	5.1%	9.1%	18.3%	7.9%	9.1%	15.1%	16.7%	-2.1%	0.0%
2024	12.9%											

2020 2021 2022 2023 2024

June and September 2022 include extra Bank Holidays, May 2023 includes an extra Bank Holiday

Annual Appointments Growth



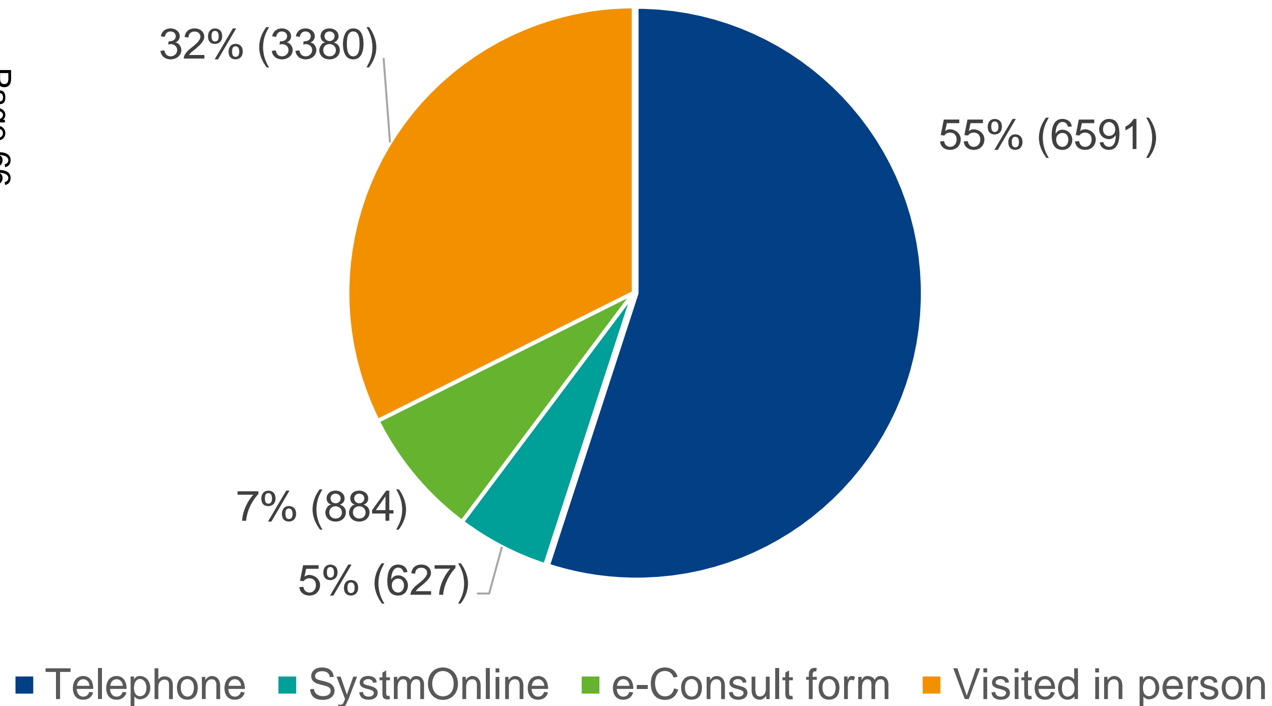
	2021	2022	2023
■	30.4%	1.7%	10.3%

June and September 2022 include extra Bank Holidays, May 2023 includes an extra Bank Holiday

Hampshire and Isle of Wight

IOW Patient Survey 2023/24

How did you make your appointment?

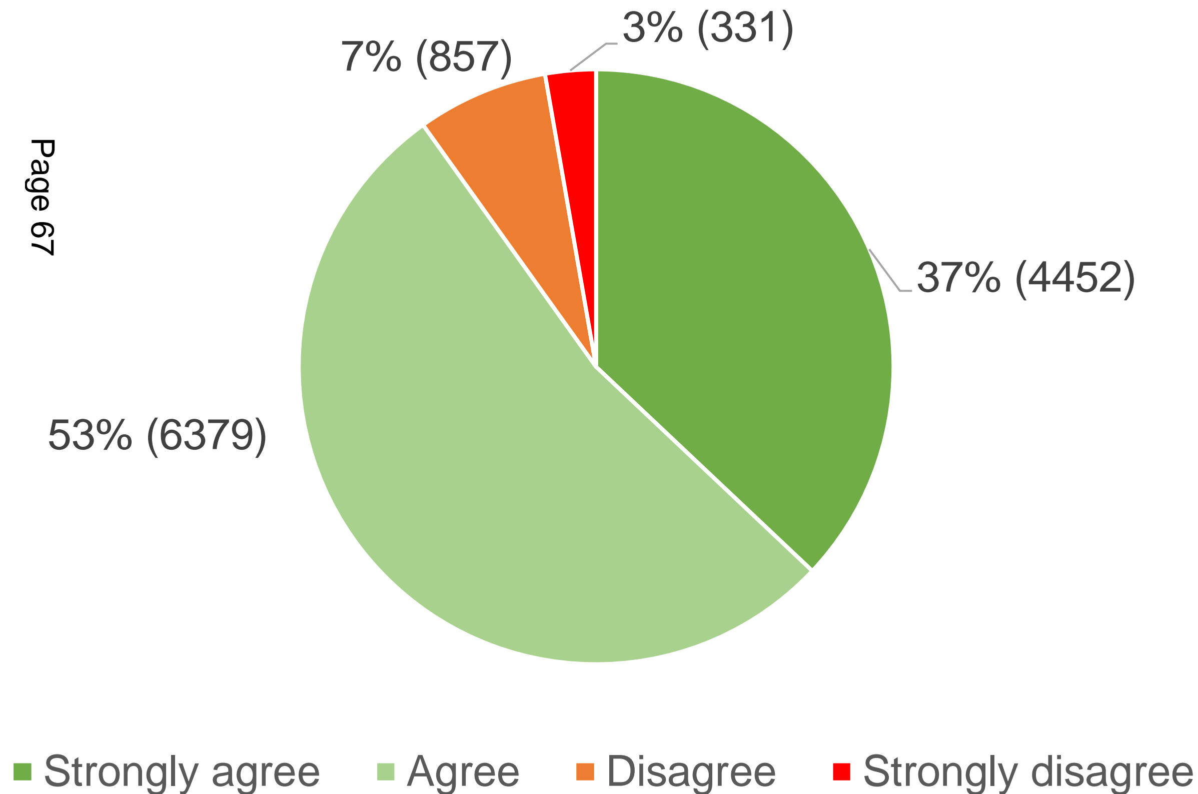


- A majority of those that completed the survey made their appointment over the phone or by visiting the practice.
- Total responses: 11,982

Hampshire and Isle of Wight

IOW Patient Survey 2023/24

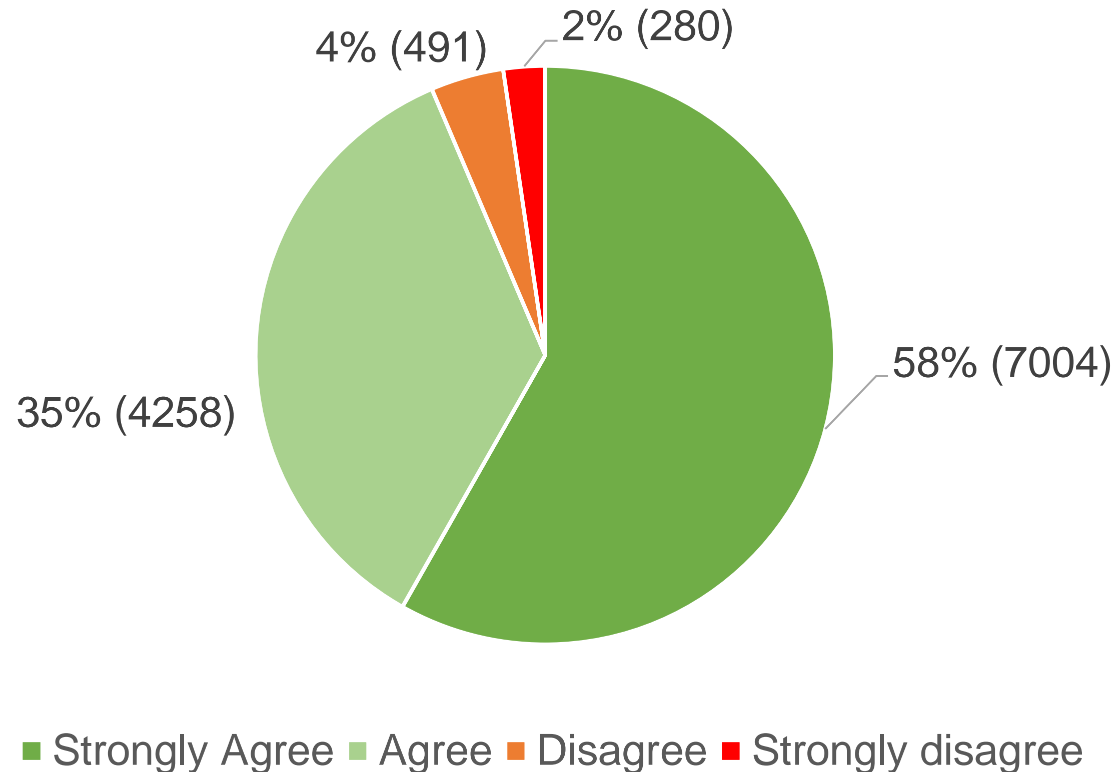
It was easy to access the service?



- 90% of those that completed the survey found it easy to access the service
- Total responses: 12,019

IOW Patient Survey 2023/24

I am happy with the outcome because it met my needs?

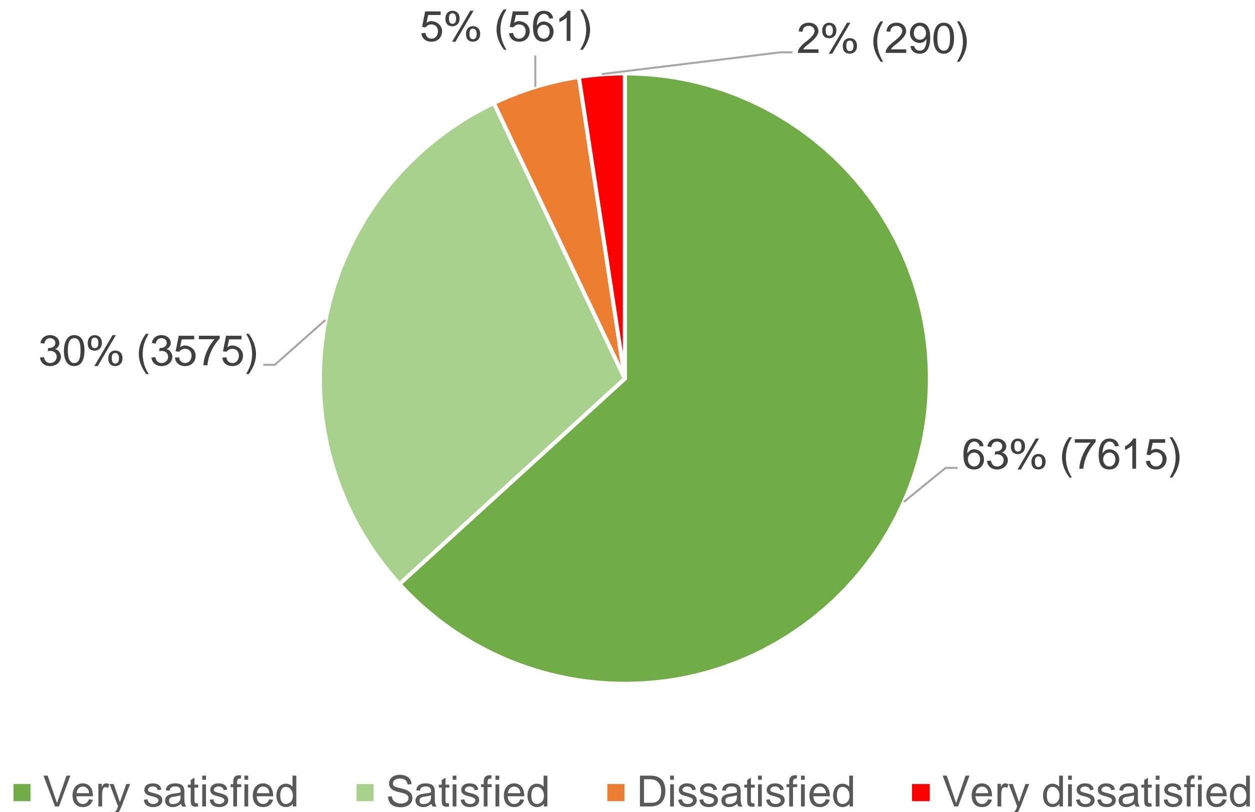


- 92% of those that completed the survey were happy with their outcome and felt it met their needs
- Total responses: 12,033

IOW Patient Survey 2023/24

Hampshire and Isle of Wight

How satisfied are you with your last contact with your practice?

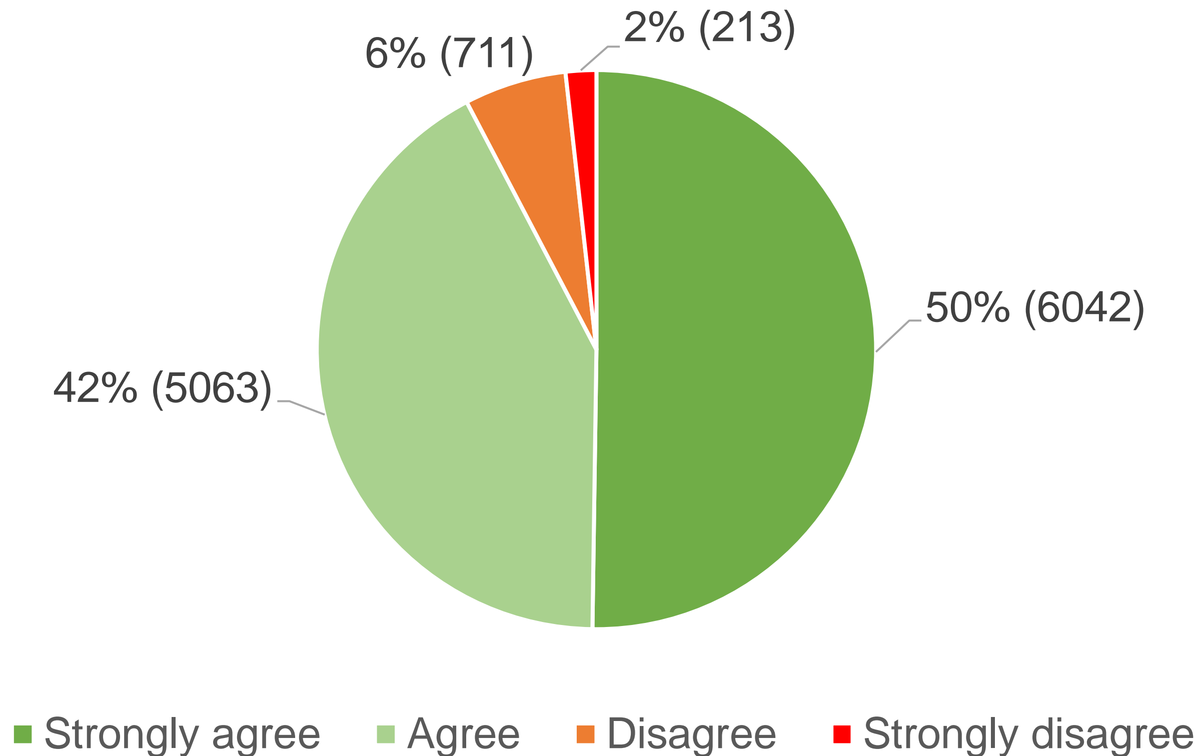


- 93% of those that completed the survey said they were satisfied with their last contact with the practice
- Total responses: 12,041

IOW Patient Survey 2023/24

Hampshire and Isle of Wight

I would be happy to recommend my practice to my family and friends?



- 92% of those that completed the survey said they would be happy to recommend their practice to family and friends
- Total responses: 12,029

Purpose: For Information

Agenda Item Introduction

Committee	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date	**4 MARCH 2024**
Topic	**SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2022-23**

Background

1. The Policy and Scrutiny Committee for Health and Social Care receive the Adult Safeguarding Board Report on an annual basis to help strengthen the way in which the views and concerns of local communities are represented.

Focus for Scrutiny

2. Is the Safeguarding Adults Board (SAB) effective in leading and holding individual agencies to account and ensuring effective multi-agency working?

3. Is there a clear overall vision for adult safeguarding?

4. What policies and procedures are in place to ensure that safeguarding is central to services and that concerns about safeguarding are addressed effectively?

5. What are the experiences of, and outcomes for, people who use safeguarding services?

6. Are people who need safeguarding services fully involved in and in control of safeguarding processes?

Document(s) Attached

7. Appendix 1 – Isle of Wight Safeguarding Adults Board Annual Report 2022-2023

Contact Point: Melanie White, Statutory Scrutiny Officer,
(01983) 821000 ext 8876, e-mail melanie.white@iow.gov.uk

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Annual Report

2022-2023

Foreword from Teresa Bell, Independent Chair

- Welcome to the IOWSAB annual report for 2022/23. Our annual report shows what the Board aimed to achieve during 2022 to 2023 and what we have been able to achieve. It provides a summary of who is safeguarded on the Isle of Wight, in what circumstances and why. This helps us to know what we should be focussing on for the future in terms of who might be most at risk of abuse and neglect and how we might work together to support people who are most vulnerable to those risks.

- I am very grateful to our partners for their continued commitment to the work of the IOWSAB, despite the wider pressures on their time and resources. In particular I would like to thank the chairs of the Board's sub groups, who work tirelessly to progress our shared priorities for adult safeguarding.

- This report of our work together over the last year evidences a commitment to effective partnership working, which provides a sound basis to approach our priorities for reducing the risks of abuse and neglect on the Island.

Contents

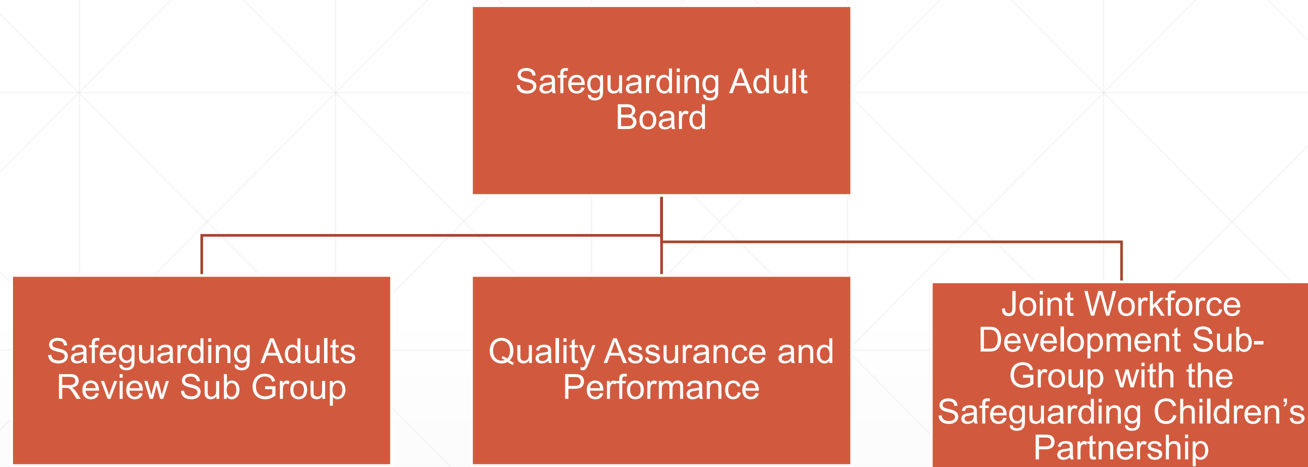
1. Board Membership
2. Board Structure
3. Safeguarding Adults Review Sub Group activity
4. Quality Assurance and Performance Sub Group
5. Workforce Development Sub Group
6. Policy and Procedure Updates
7. 4SLAB Fire Safety Development Group
8. 2022- 2024 Business Plan
9. Safeguarding Adults Collection 2022-23 IWC Govt. Return

1. Board Membership

The Isle of Wight Safeguarding Adults Board (IWSAB) is a statutory, multi-agency partnership committee, coordinated by the local authority, which gives strategic leadership for adult safeguarding across the Isle of Wight. The Board meets quarterly, and these meetings have all been virtual in 2021-2022. The board has three statutory partners namely the **Isle of Wight Adult Social Care, Hampshire Constabulary, and the Isle of Wight Clinical Commissioning Group**. However the statutory partners are joined by a range of agencies, providers, and voluntary sector representatives who work with adults all across the Island:

2. Board Structure

The IOW board has sub groups:



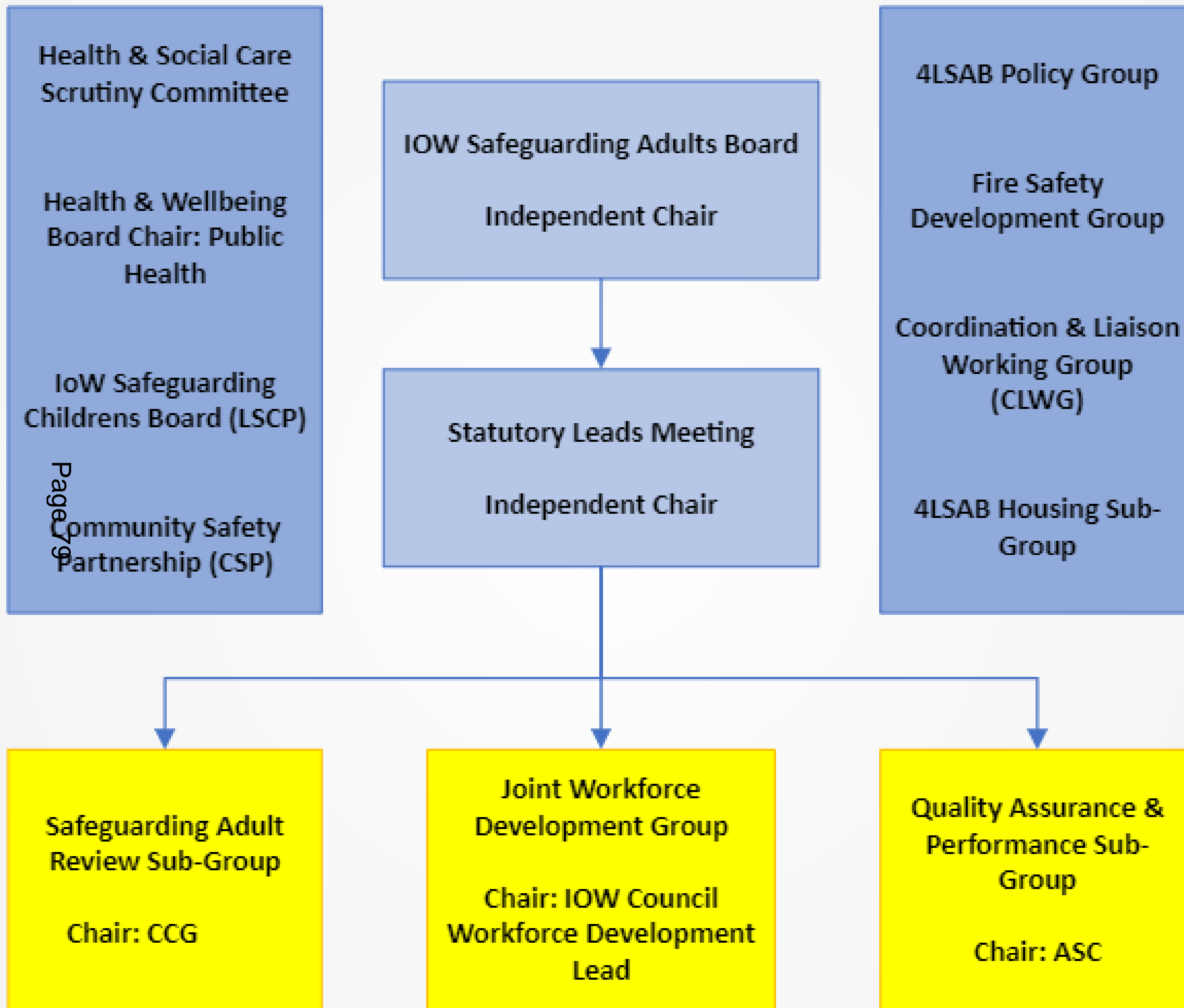
Much of the work of the Board is undertaken by members of the three sub-groups, in collaboration with the Board Manager and their administrative support.

2. Board Structure

- The Board maintains close links with the Local Safeguarding Children's Partnership and the Community Safety Partnership

- The Isle of Wight Board is also a core member of a range of 4LSAB Sub-groups, which have membership from the 4 Safeguarding Adults Boards across Hampshire, Isle of Wight, Portsmouth and Southampton.

- The Board has a Statutory Leads group, which meets a few weeks before Board meetings to check on progress against some key actions, raise and discuss any concerns, and agree how best to put forward proposals to the Board to address those concerns. This group involves the Director of Adult Social Services, the District Commander for the Isle of Wight, the Clinical Commissioning Groups Deputy Director of Quality, and the Chair and Board Manager of the Safeguarding Adults Board.



Isle of Wight Safeguarding Adults Board Governance 2022-2023

3. Safeguarding Adult Review Sub Group Activity

As part of its statutory responsibilities, the Board is required to undertake Safeguarding Adult Reviews (SARS). The purpose of a Safeguarding Adults Review is not to hold individual organisations or practitioners to account, nor to apportion blame, but specifically to identify areas of learning. SARs ensure that Boards have a full picture of what happened, so that all organisations involved can improve as a result. The goal is to move beyond the specifics of a case – what happened and why –to identify deeper underlying issues that are influencing practice more widely.

The Safeguarding Adults Review Group is one of the sub-groups of the Board with a multi-agency membership of agencies represented on the Board. The role of this group is to manage SARs. The group will receive referrals for reviews, collect appropriate information and make decisions about whether case meet the statutory criteria. The group will then determine the most appropriate method for identifying learning, which ranges from full written reviews with a commissioned independent reviewer, thematic reviews where several cases with similar themes are grouped together, to locally facilitated learning workshops.

The chair for the sub-group is a member from health, in April 2022, the chair changed from the interim designated nurse for adult safeguarding to the current chair who was new into post in the CCG/ICB.

Current mandatory Safeguarding Adult Review activity

- Ms L involves an individual with a long-term health condition who relocated from the mainland to the Isle of Wight and involves alleged abuse and neglect by a professionally registered carer. This case was agreed to meet the criteria for a mandatory Safeguarding Adults Review in June 2021.
- A joint review with Southampton Safeguarding Partnership is underway.

Referrals to the SAR Sub Group 2022-2023

- During 2022/2023, the Safeguarding Adults Review (SAR) sub-group on the Isle of Wight scoped 8 cases, none of which met the criteria for a mandatory Safeguarding Adults Review (SAR), however local learning was identified in 4 the cases, with scoping on 1 case being paused at the request of the Police whilst they further investigated.

- Scoping took place for 4 other cases that did not meet the criteria for a mandatory SAR with feed-back given to referrers of the outcome and rationale for the decision made. In one case referred by the Fire Safety Development Group feedback was provided for the 4 LSAB to gain assurance that the Fire-Safety Framework is embedded in practice, this a business priority for 2023-2024.

- Following a case referred in January 2022 which related to a victim of homicide, it was identified that they were open to several agencies. On scoping, the case did not identify any multi-agency system failings relating to the victim. They received support sporadically and were well at the time of the event. There was a criminal investigation in this case, and the potential for a Mental Health Homicide Review (MHHR). However, following a Not Guilty verdict at the criminal trial, the criteria for a MHHR was not met.

- A further case involves an individual who suffered serious harm during a domestic abuse incident. The case was referred in January 2022, as the individual has care & support needs and was known to several services. Following a criminal investigation and prosecution, a 'near miss DHR' is taking place under the discretionary SAR criteria, as scoping identified some potential points for intervention. This is an opportunity to gain the voice of both victim and perpetrator in a high-risk domestic abuse case.

- A health review took place involving an individual who was discharged from hospital with a package of care that they later declined. They sadly passed away shortly afterwards. The case had been referred in January 2022. This did not identify multi-agency system failure. The gentleman had been resident on the IOW for 16 days prior to hospital admission with positive work evidenced. A review of the health interventions post discharge took place by the Named GP for Adult Safeguarding, Lead professional for Adult Safeguarding for the IOW Trust and Designated Nurse. The health review identified good use of the mental capacity act and follow up on his reluctancy to engage. These are both board priorities.

SAR Sub Group Activity

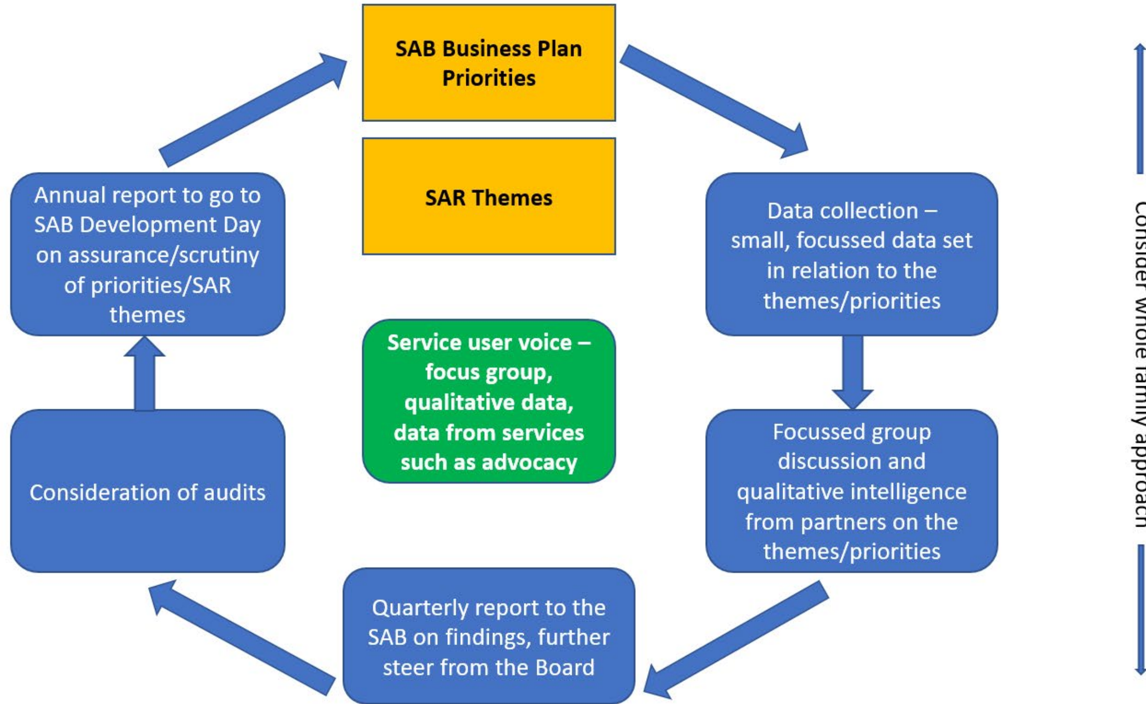
Update on previous work

In early 2022, a Thematic Review into 5 cases with common themes was completed. The themes identified were:

- Homelessness
- Mental health
- Alcohol/substance misuse
- Suicide/overdose

The review offered us an analysis of the cases and systemwide themes. A multi-agency workshop with the reviewer was held in May 2022 and the Board is implementing improvements and learning with a particular focus on application of the Mental Capacity Act in circumstances where people at risk may be resistant to accepting care and support.

A second Thematic Review into 4 cases with similarities, and an overall theme of neglect was completed. Two of the individuals included in the review are still alive and an executive summary has been published in August 2023.



4. Quality Assurance and Performance

As a sub group of the board, the Quality Assurance and Performance Group has membership from a number of agencies represented on the Board. This year new members from IOW Care Partnership, Inclusion and Public Health have been welcomed. The purpose of this group is to provide the Board with appropriate information so that it can assure itself that all partners are consistently safeguarding adults across the Island and are working is accordance with the Care Act (2014), Statutory Guidance and the 4LSAB Multi-agency Safeguarding Procedures and additional guidance.

Quality Assurance and Performance activity

The Quality Assurance and Performance group have held meetings every three months throughout the annual review period. A new workstream concentrating on individuals who find it difficult to engage with statutory services (Refusal to engage) has been commenced and this is in the planning stages, a terms of reference has been drafted and a workshop is being planned for January 2024.

This workstream will be accompanied by an anonymous staff survey which will be shared across all of the partner agencies. We will be exploring the best way as to how to capture the voice of the people with lived experiences throughout.

Our aim is to understand the decision making of all partner agencies in relation to the engagement of service users, with their services and the support provided for people who find it difficult to respond to appointments, have no reliable means of contact or have no fixed address.

Our staff survey will be asking questions around experiences working with people who are difficult to engage, the process of supporting decisions making related to ending or not ending involvement and understanding of Mental Capacity Act.

5. Workforce Development Sub-group

The joint Safeguarding Adults Board (SAB) and IOWSCP Workforce Development subgroup (WFD) is well established and there is synergy between the two workforce development agendas in terms of pooled budgets for areas of joint interest as well as separate courses that are relevant for the individual Board / Partnership. A cyclical process is in place for ensuring training meets the needs of the workforce. Learning Needs Analysis is undertaken annually, with feedback from a staff survey of workforce development needs considered alongside course evaluations, attendance numbers and observations of learning delivered. Learning needs are also identified through the Board's scrutiny and assurance programmes and learning reviews. Learning and development is delivered face-to-face, online or in an e-learning / briefing format. Some IOWSAB learning and development is shared with 4LSAB colleagues.

A range of training opportunities were offered throughout 2022/2023 which reflected the themes from the previous year's Learning Needs Analysis.

Themes identified as part of learning needs analysis and / or arising from learning taken from SAR's will be taken forward in a mixture of training, webinars, e-learning and resources which will be widely available through the Learning Hub

How have we progressed?

Learning from Covid (Safeguarding in a pandemic): executive summary report has been published and partners continue to monitor the impact of improvements .

A Learning Needs Analysis has been completed to ensure that the Board's training provision is based on analysis of need and links to SARS. All learning has been incorporated into proposed new training plan.

The SAR Sub Group have arranged a local training programme to be delivered by SCIE which will ensure a local pool of professionals are trained to carry out reviews ensuring a good basic understanding of local systems and processes

The Board committed to provide a comprehensive training package for multi-agency staff which took forward the learning for front line staff from the Alcohol Change UK workstream.

Between 2022 and 2023 a full programme of training with 3 separate courses was delivered. All of which were well received.

Consideration is now being given to a single amalgamated course in 2023/2024

6. Policy and Procedure updates

- One important duty of the Safeguarding Adults Board team is to ensure local and regional policies, procedures and guidance are fit for purpose.
- Most Board guidance used on the Island is applicable to the 4 Boards in Southampton, Hampshire, Isle of Wight and Portsmouth. Having all 4 Boards producing and embedding joint guidance is important for effective multi-agency working, with many partner agencies spanning more than one local authority area.
- The 4LSAB Policy Sub-group manages the updating of current guidance, as well as identifying gaps and overseeing the development of any new guidance. This group is currently chaired by Portsmouth. In 2021/2022, the following Policy work was undertaken

New Guidance and Revisions undertaken in 2022-2023

Key Policy and Guidance Documents developed or updated this year:

- Large Scale S42 Safeguarding Enquiry Protocol
- Homelessness Guidance
- Framework for Managing Risk and Safeguarding People Moving into Adulthood
- Revised Hoarding Guidance

What are the recognised challenges?

Learning identified through national and local case reviews often result in the need for new guidance or revisions to existing guidance, partners are committed to prioritising this work and supporting practice but acknowledge this work can take time.

What is the groups future focus?

- Finalising the review of Multi Agency Risk Management Framework.
- Development of Family Approach Toolkit.
- Engagement policy

7. 4LSAB Fire Safety Development Group

The four LSAB Fire Safety Development sub-group continues to review and share learning from serious fire incidents to ensure effective inter-agency processes, procedures and preventative practices are in place.

Key Achievements of the 4LSAB Fire Safety Development Group in 2022-2023:

- Publication of the Fire Safety Development Group Thematic review 2019-21 and Learning briefing
- Between April 22 and March 23 the Fire Safety Development Group conducted 15 case reviews for fire incidents where a serious injury or fatality occurred. 75% of incidents reviewed involved an individual who was living alone and 88% were male. 25% of cases were known to Adults Health and Care.
- Training from Hampshire and Isle of Wight Fire and Rescue Service through the 4LSAB's and to individual partner organisations raises professional awareness and knowledge to identify, assess and manage fire risk.

What are the challenges?
Learning identified in Fire Safety Development Group case reviews can identify themes of a similar nature. There is a challenge regarding the confidence and assurance that partners are reviewing the learning and embedding positive changes in practice

Priorities for the group in 2023-2025

- To provide assurance that the Fire Safety Framework and case review learning, has been embedded in practice within agencies across the 4LSAB
- To engage with the Care Quality Commission across the 4LSAB area to seek assurance of fire risk management within domiciliary care providers and the promotion of the 4LSAB Fire Safety Framework

8. 2022-2024 Business Plan

The areas of focus for 22-24 are:

- Preparation for Liberty Protection Safeguards (LPS)
- Service User Voice (building on Making Safeguarding Personal)
- Safeguarding in Transition
- Learning from Safeguarding in a Pandemic Report
- Safeguarding Concerns – complexity of referrals, abuse types, referral rates, identify underreporting, appropriate use of criteria
- Quality Assurance Framework
- Using the Homelessness, Mental Health, Substance Misuse and Suicide/Overdose Thematic Review to shape better multi-agency working and support people who are accessing multiple services. Consideration of SAR outcomes in the commissioning process.
- Managing the interface between SARs and Coronial Processes – National Workstream
- Alcohol Change UK – taking forward the learning
- MARM (Multi-agency Risk Management) and Safeguarding
- Impact of workforce capacity

Our strategic aims 2022-2024

- Prevent abuse
- Protect adults at risk
- Learn from experience
- Improve services

9. Safeguarding Adults Collection (SAC) 2022-2023 IWC Govt. Return

Introduction

- Records details about safeguarding activity for adults 18 and over
- Includes activity reported to or identified by Councils with Adult Social Services Responsibilities (CASSRs)
- Includes demographic information about the adults at risk & details of the alleged incidents
- Return is split into 5 sections covering: Demographics, Case details, Mental Capacity, Making Safeguarding Personal (MSP) and Safeguarding Adult Reviews (SARs)

Terminology

- **Safeguarding concern**
  Sign of suspected abuse or neglect that is reported to the council or identified by the council .
- **Safeguarding enquiries**
  The action taken or instigated by the LA in response to a concern that abuse or neglect may be taking place. Can range from a conversation with the adult to a more formal multi-agency plan or action.

  Two types of Enquiry:
  - **Section 42:** Where adult meets all of the section 42 criteria
  - **Other:** where adult does not meet all of section 42 criteria but the council considers it necessary & proportionate to have a safeguarding enquiry

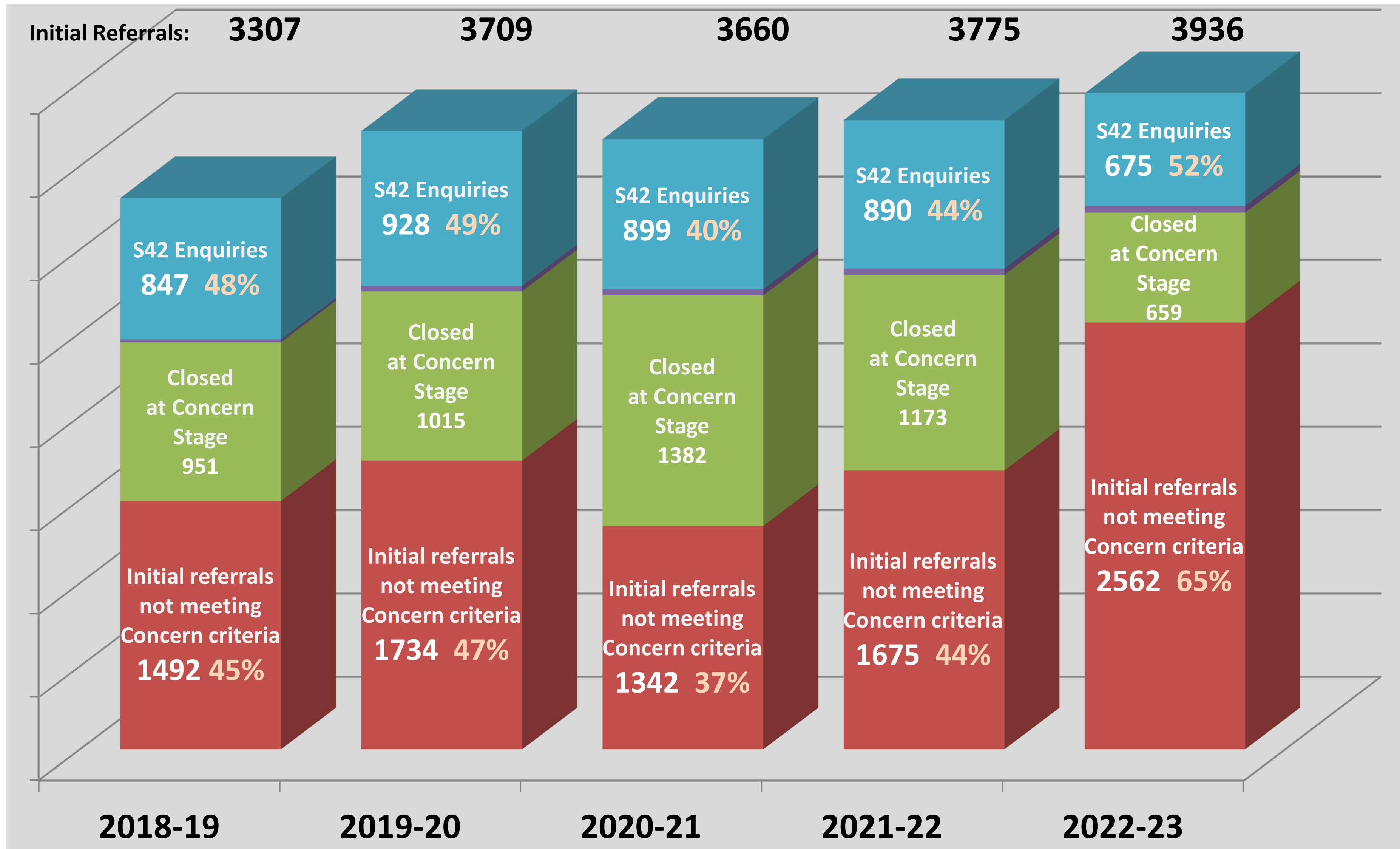
CIPFA comparators (Chartered Institute of Public Finance and Accountancy)

Comparator groups are a selection of 15 CASSRS considered to be similar to the chosen council. They are selected according to the CIPFA Nearest Neighbour Model, which identifies similarities between councils based on a range of socio-economic indicators

CASSR Name	Region
Cheshire East Council	North West
Cheshire West and Chester Council	North West
Cornwall Council	South West
Dorset Council	South West
East Riding of Yorkshire Council	Yorkshire and The Humber
Herefordshire Council	West Midlands
Isle of Wight Council	South East
North Somerset District Council	South West
North Tyneside Council	North East
Redcar & Cleveland Borough Council	North East
Sefton Council	North West
Shropshire Council	West Midlands
Stockport Metropolitan Borough Council	North West
Torbay Council	South West
Wirral Metropolitan Borough Council	North West

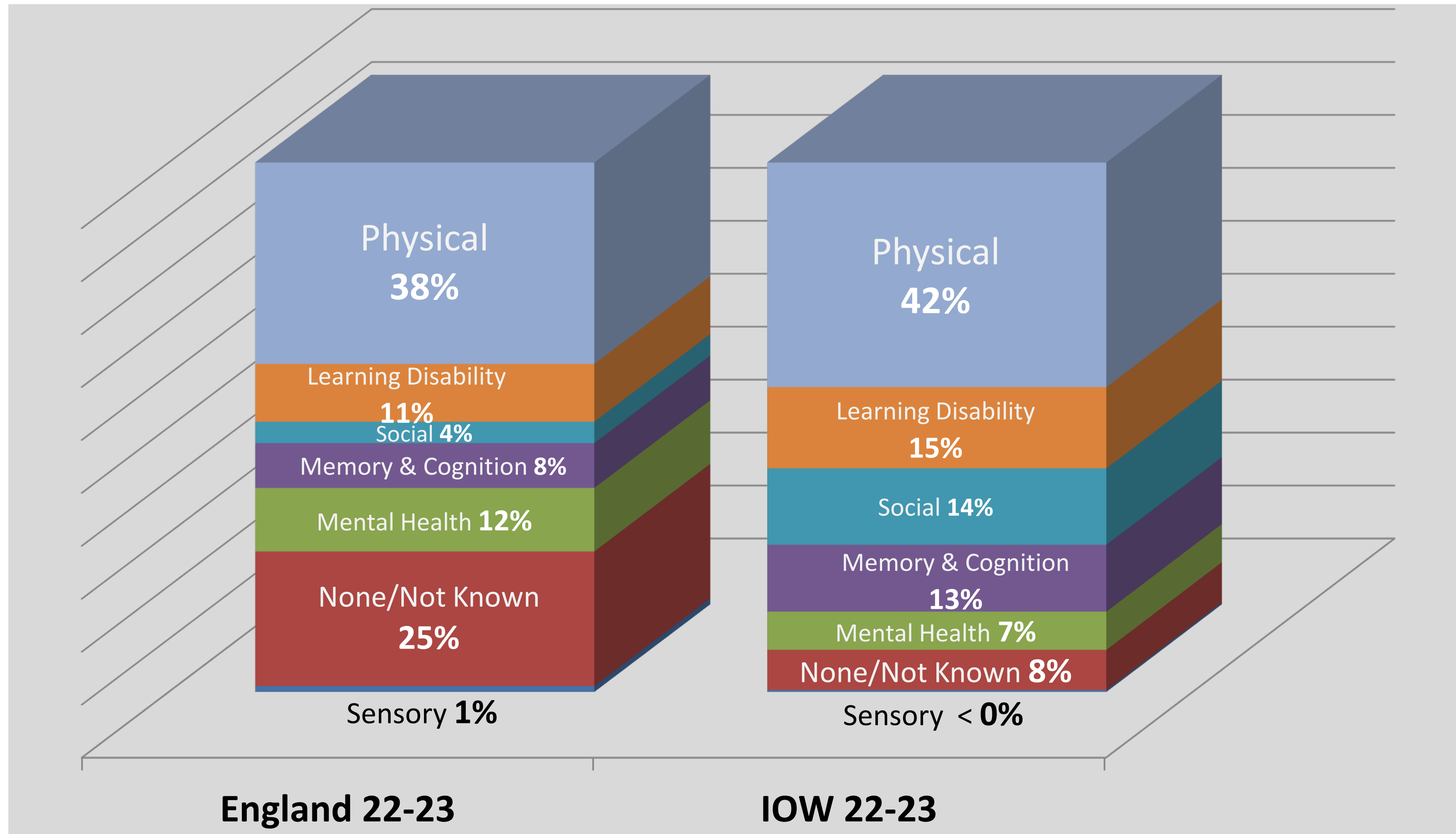
Overall Referrals Analysis

IWC Comparison with previous years



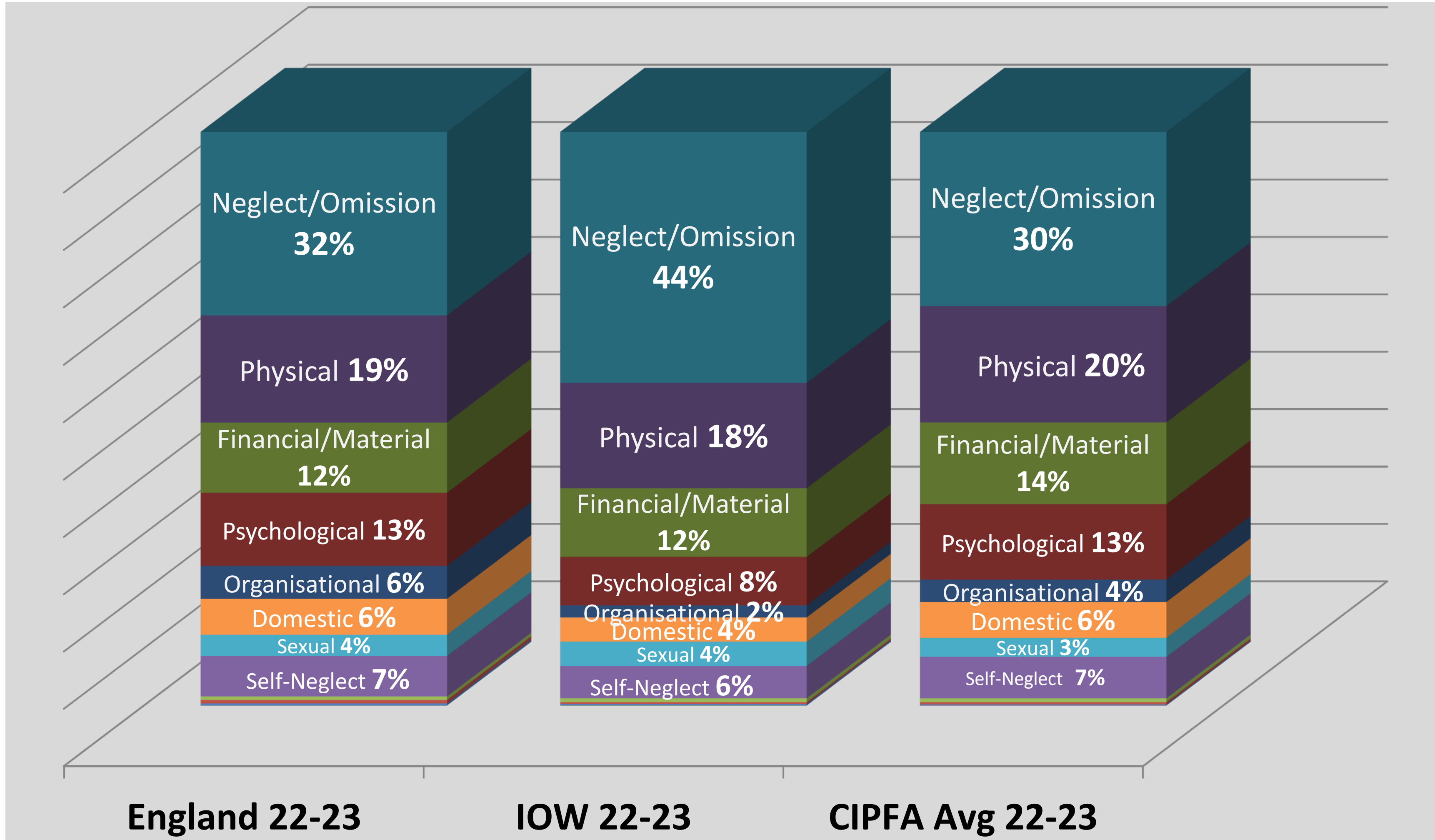
SAC return – Section 1

Individuals involved in S42 Enquiries - by Primary Support Reason



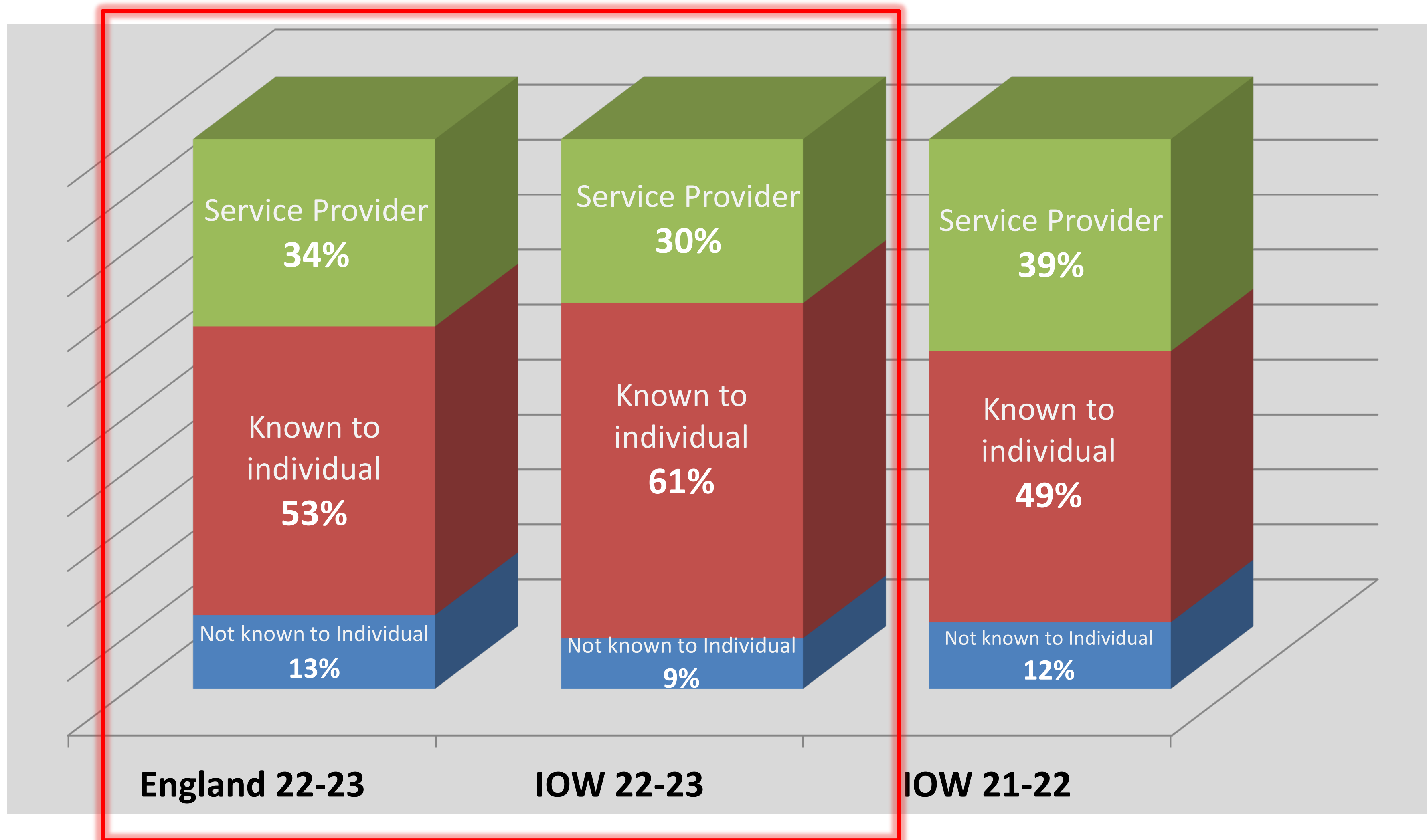
SAC return – Section 2

Section-42 Enquiries: Type of risk

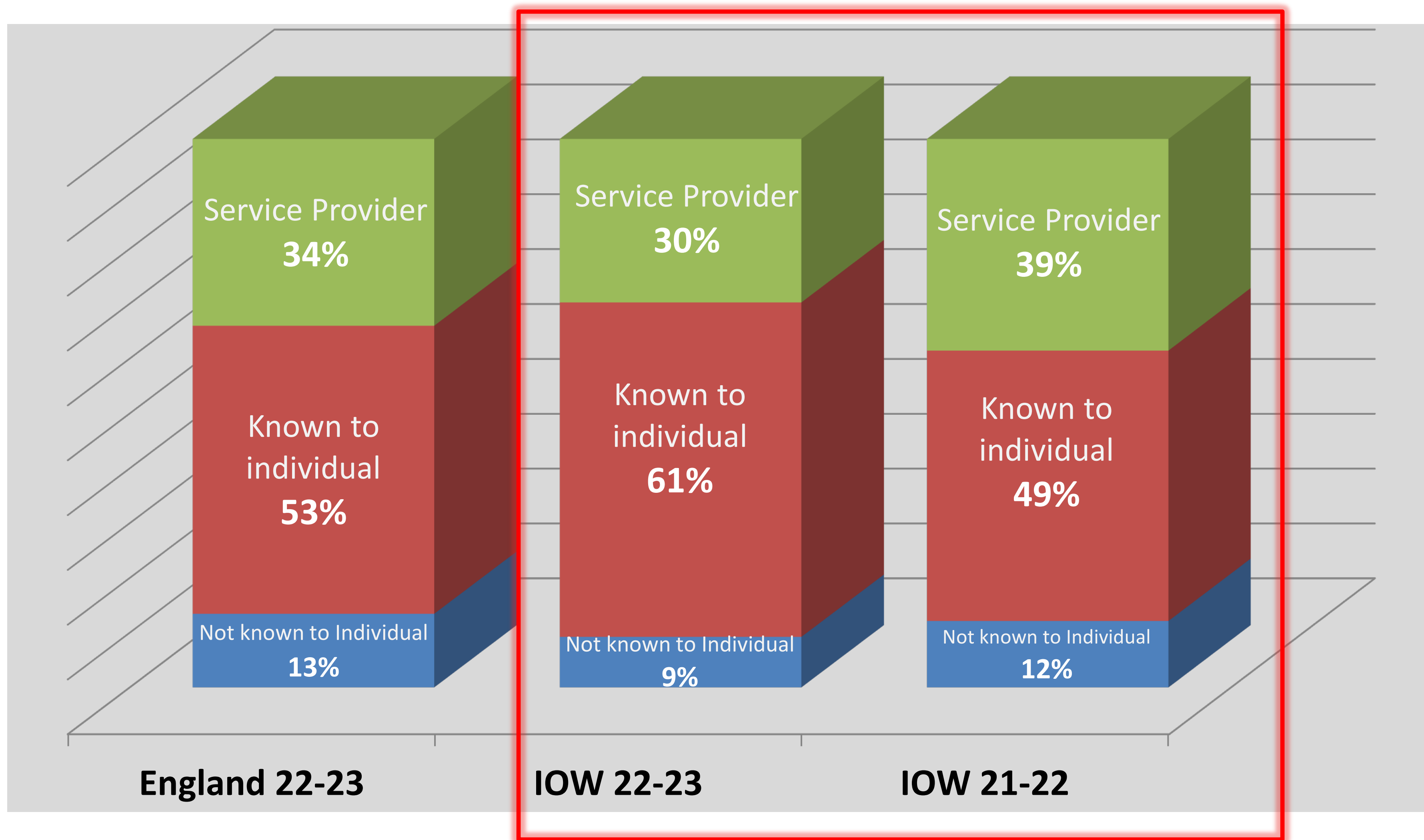


SAC return – Section 2

Section-42 Enquiries: Source of risk

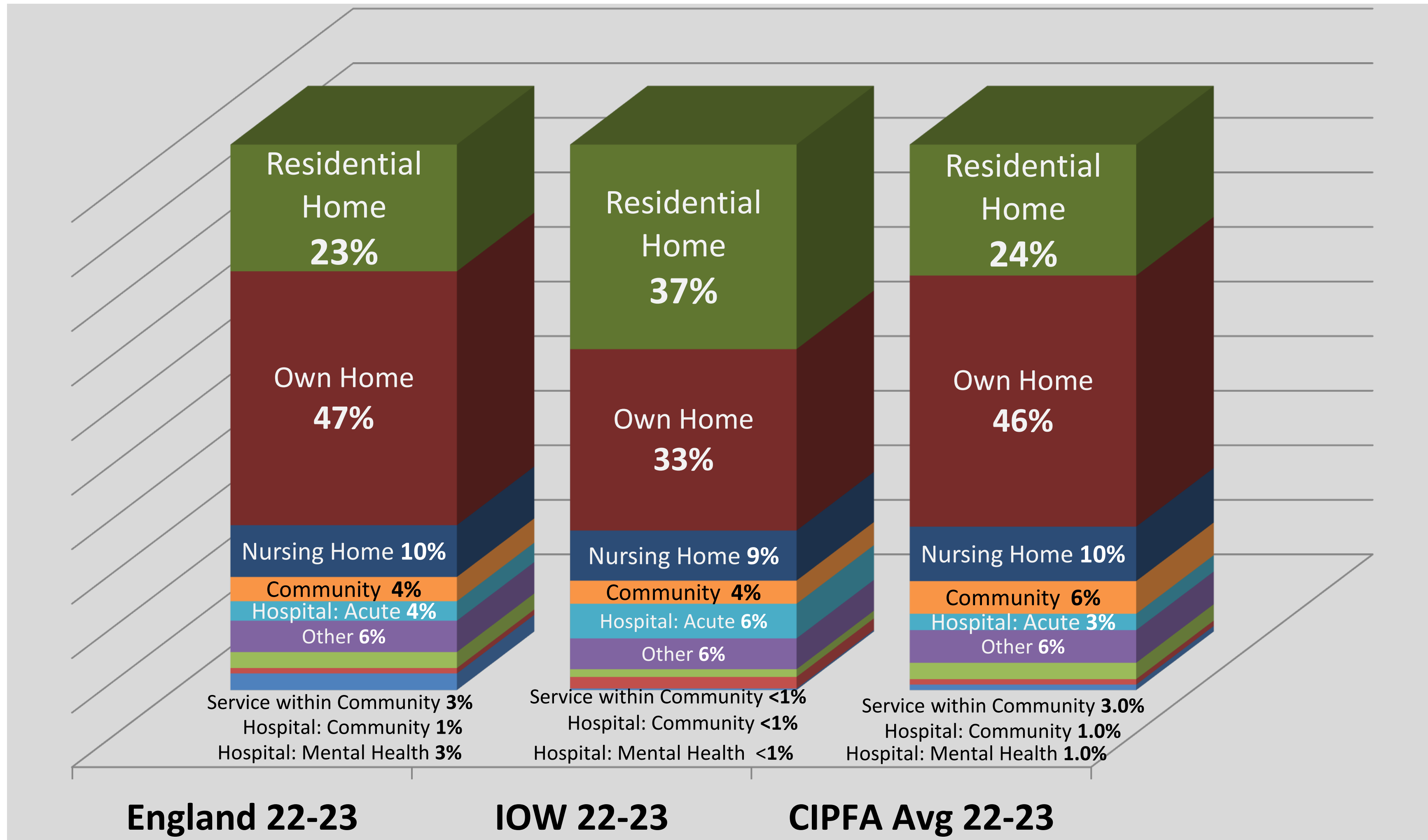


SAC return – Section 2



SAC return – Section 2

Section-42 Enquiries: Location of risk



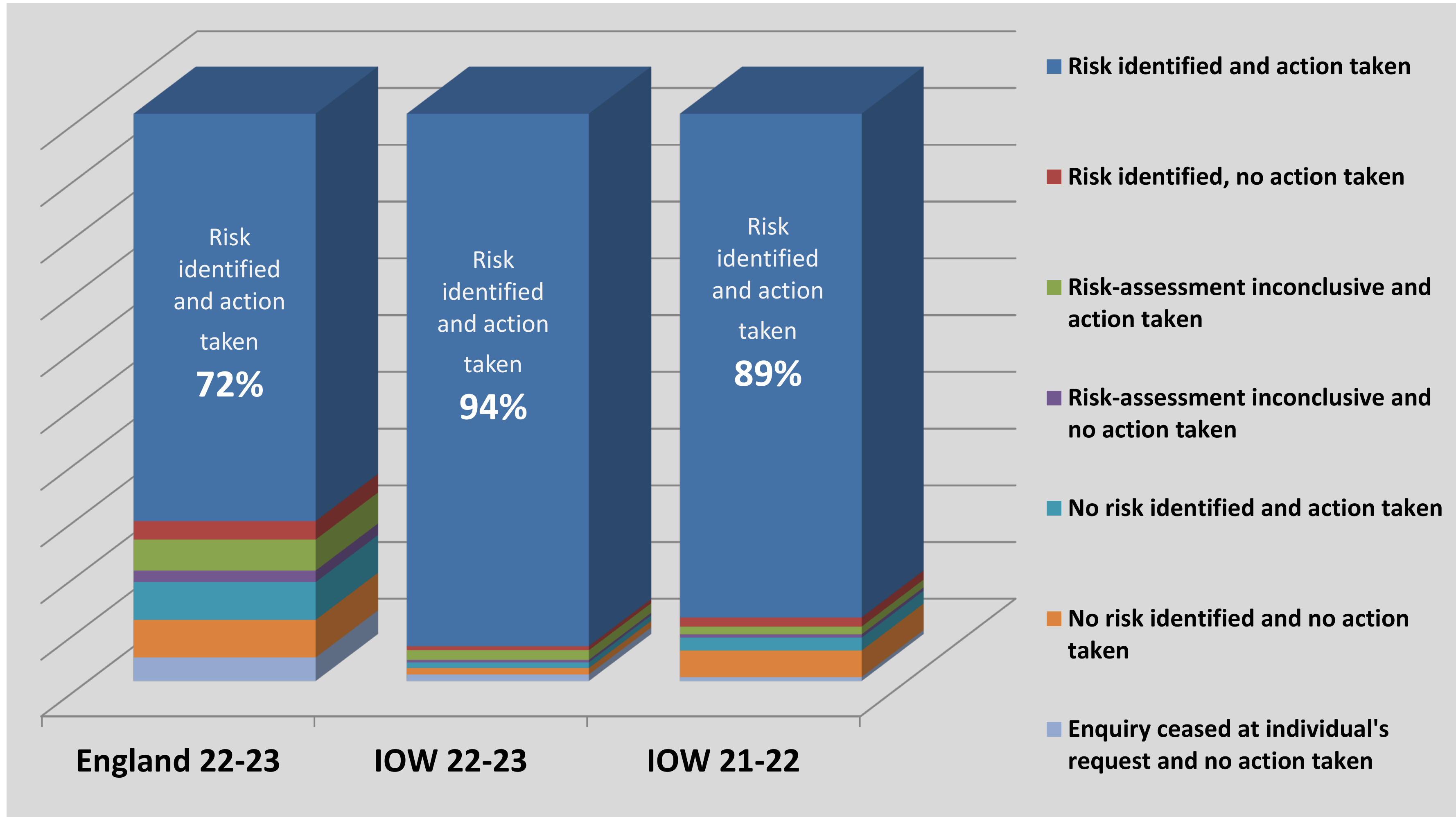
SAC return – Section 2

Section-42 Enquiries: Type and Location of Risk. **IWC 2022-23**

SAC return – Section 2

Section-42 Enquiries: Risk Assessment Outcomes

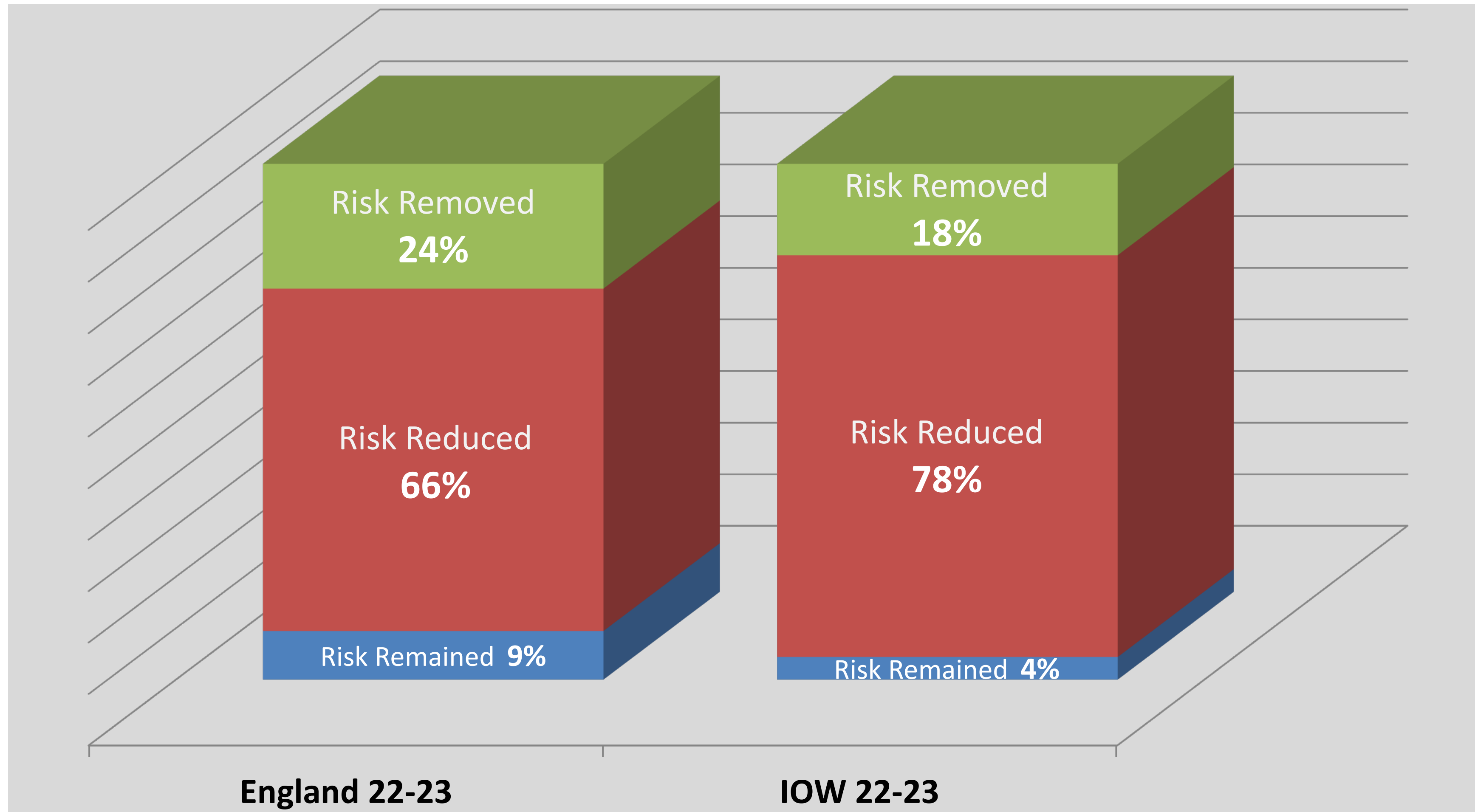
Was a risk identified and was any action taken / planned to be taken?



SAC return – Section 2

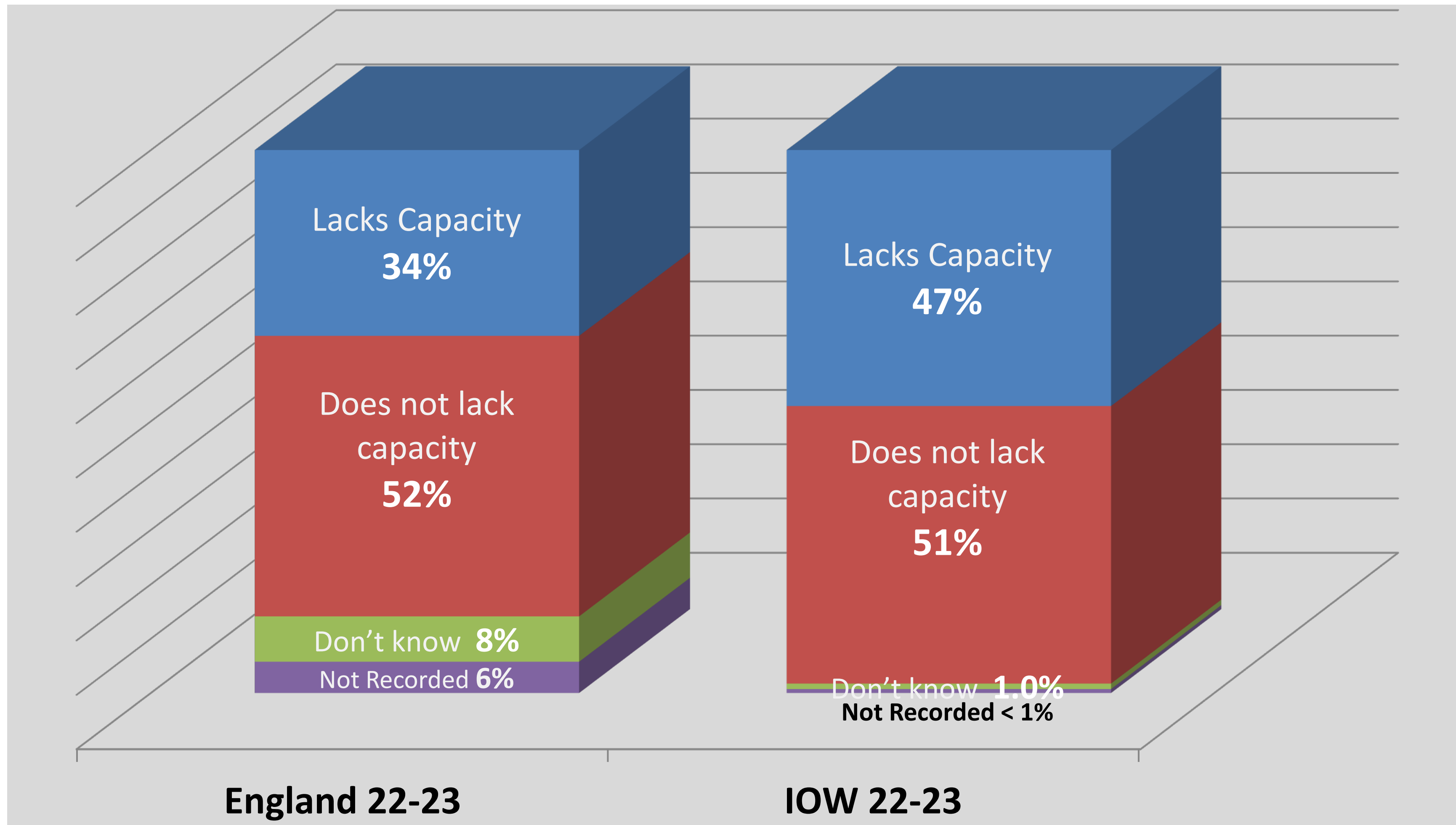
Section-42 Enquiries: Risk Assessment Outcomes

Where risk was identified (in previous slide), what was the outcome when the case was concluded?



SAC return – Section 3

Section-42 Enquiries: By mental capacity of adult at risk.



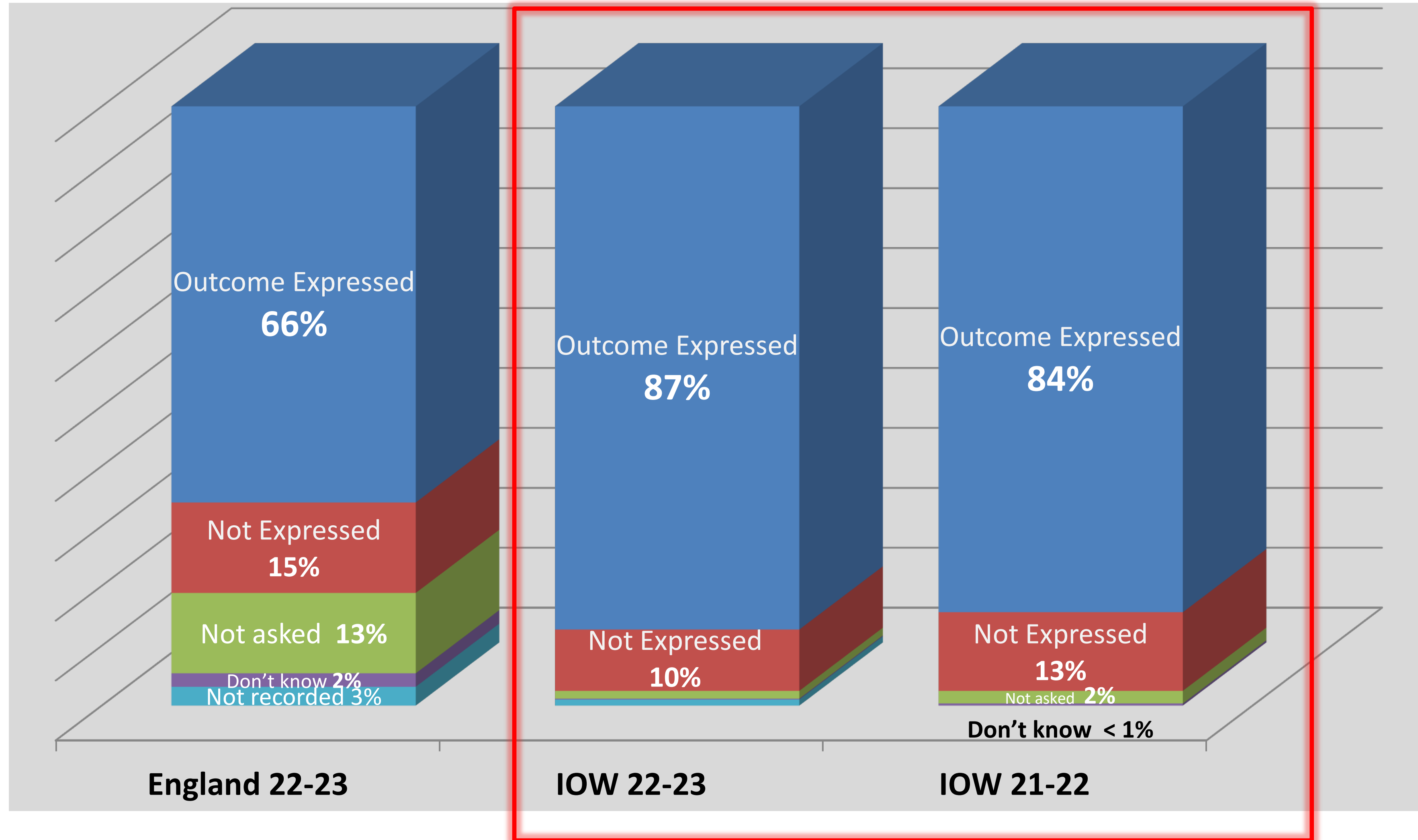
SAC return – Section 3

Section-42 Enquiries: Mental capacity of adult at risk

Those that lacked capacity were supported by advocate, family or friend?

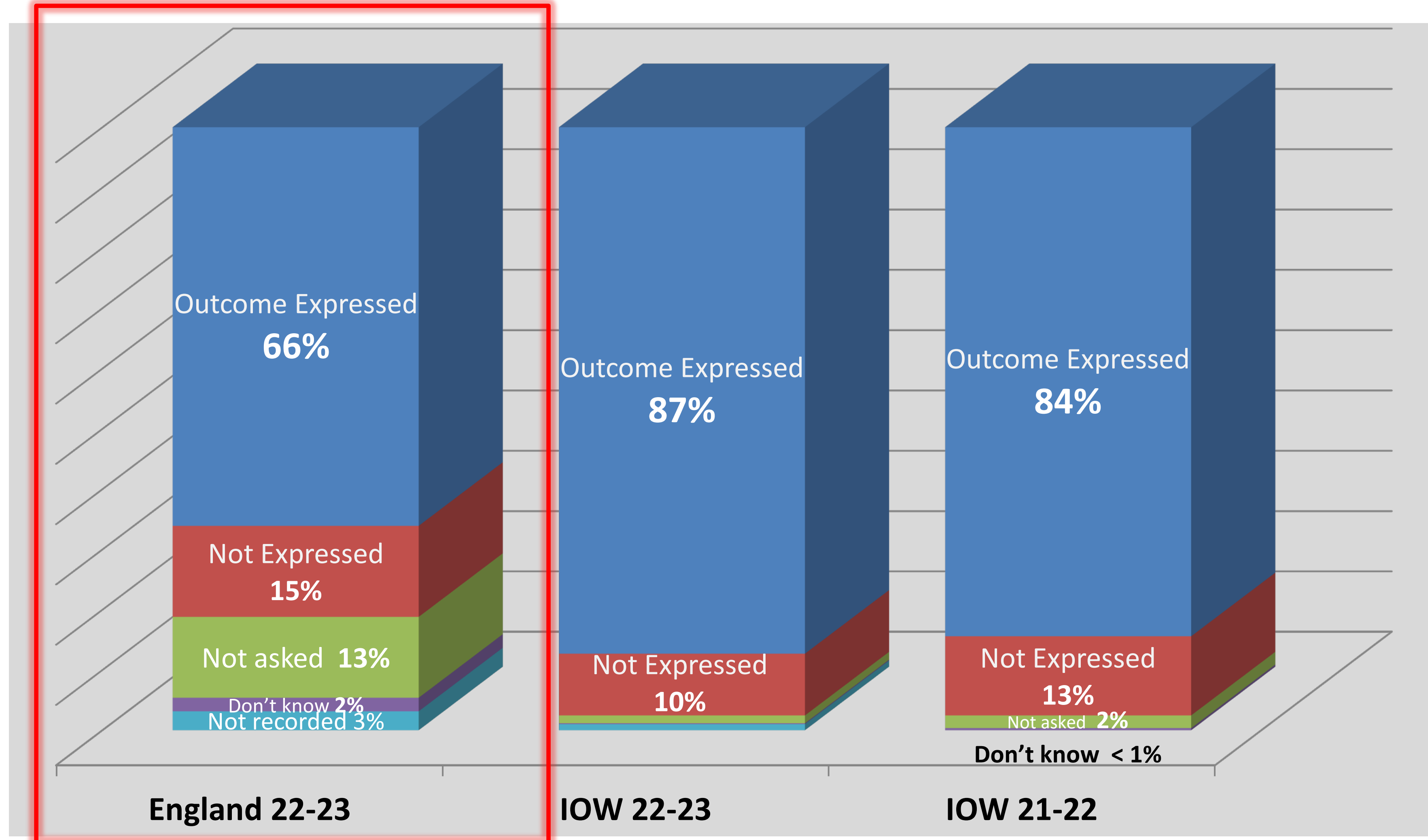
SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)



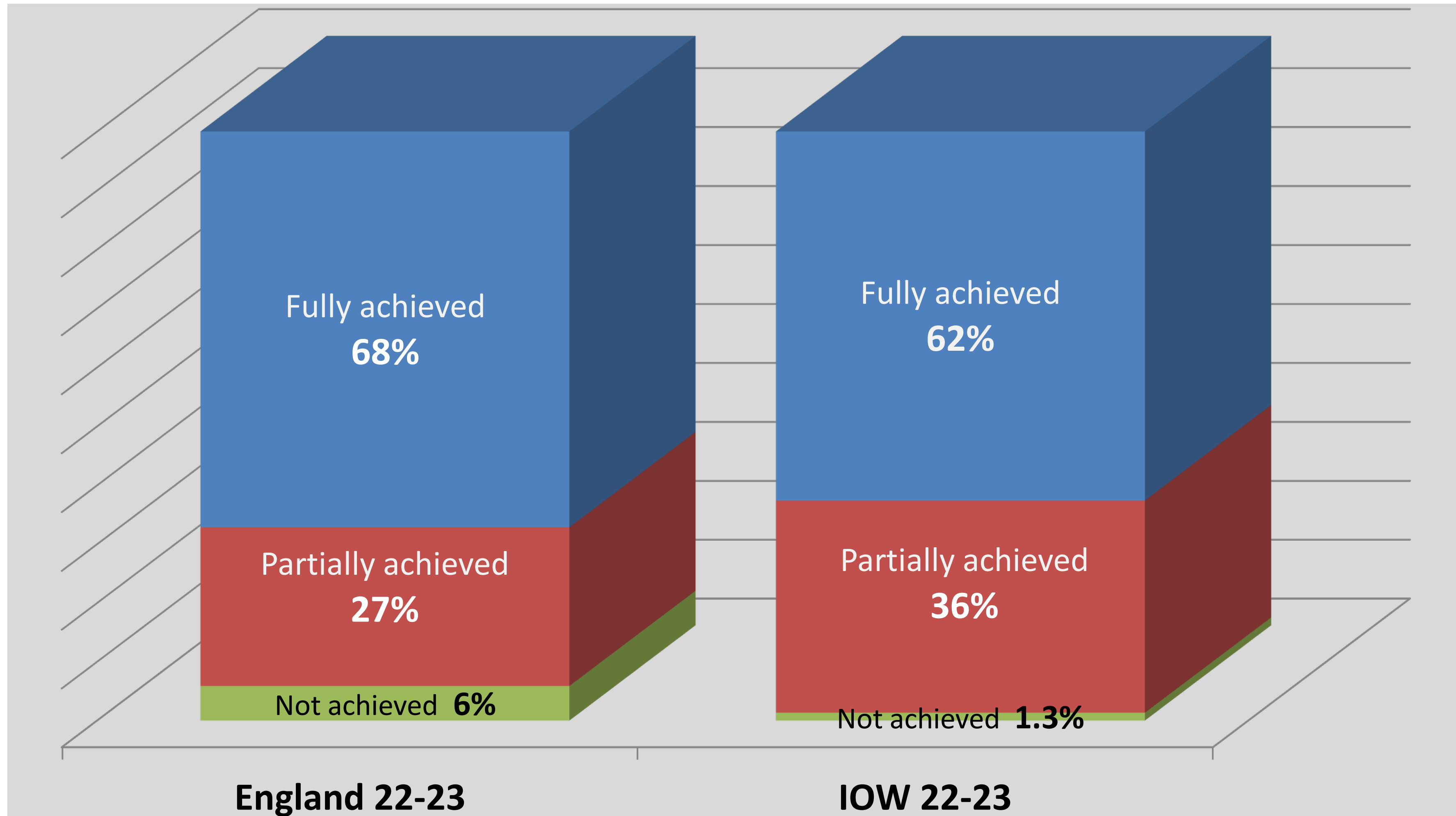
SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)



SAC return – Section 4

Section-42 Enquiries: Making Safeguarding Personal (MSP)



SAR – Safeguarding Adult Reviews

0 SARs reported this year IOW 22-23

Table SG5a	
Counts of Safeguarding Adult Reviews	Count
Count of SARs where one or more individual died	0
Count of SARs where no individuals died	0

Table SG5b	Age Group						
Counts of Individuals Involved in Safeguarding Adult Reviews	18-64	65-74	75-84	85-94	95+	Not Known	Total
Count of individuals involved in SARs who suffered serious harm and died	0	0	0	0	0	0	**0**
Count of individuals involved in SARs who suffered serious harm and survived	0	0	0	0	0	0	**0**

Purpose: For Information

Agenda Item Introduction

Committee	**POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE**
Date	**4 MARCH 2024**
Topic	**COMMUNITY, MENTAL HEALTH, AND LEARNING DISABILITY SERVICES**

Background

1. Project Fusion is the programme taking place to create a new, combined NHS Foundation Trust to deliver community, mental health and learning disability services across Hampshire and the Isle of Wight. The aim is for the new Trust to be formed by April 2024.

2. A six-month pilot scheme took place on Afton Ward at St Mary's Hospital in 2023. The new mental health ward for dementia patients was opened, four years after a specialist ward closed over care concerns, with fewer beds to give staff space and to accommodate specialist nursing provision.

Focus for Scrutiny

3. Is the creation of the new NHS Trust on track to be completed by 1 April 2024?

4. What is being done to ensure maximum communication with Island residents ahead of 1 April 2024?

5. How can the committee support health partners in the lead up to the establishment of the new NHS Trust?

6. What direction of travel will the new NHS Trust be taking following the outcome of the Afton Ward dementia bed pilot scheme?

7. Is there going to be a permanent solution in place on the Isle of Wight?

Approach

8. To receive an update report on the Project Fusion, and to receive a verbal update and presentation on the outcomes of the Afton Ward pilot.

Document(s) Attached

9. Appendix 1 - Project Fusion Update

Contact Point: Melanie White, Statutory Scrutiny Officer,
(01983) 821000 ext 8876, e-mail melanie.white@iow.gov.uk

Appendix 1

Policy and Scrutiny Committee for Health and Social Care - Monday 4 March 2024

Project Fusion Update

1. The work to bring together community, mental health and learning disability services across Hampshire and the Isle of Wight into a new, combined NHS Foundation Trust is on track and continuing to make good progress. Bringing services into a single organisation will result in more consistent care, reduce unwarranted variation, provide equal access to services irrespective of where people live across the area and create a more sustainable workforce and services.

2. A new name has been identified for the Trust – Hampshire and Isle of Wight Healthcare NHS Foundation Trust, which concurs with feedback from our local communities who were keen to see Isle of Wight incorporated into the name of the new trust.

3. A considerable amount of progress has been made in recent months:

   - A new designate executive and non-executive leadership team have been appointed. Community partners and service users from across the area were involved in their appointment. The new executive team includes directors from Southern Health, Solent and Isle of Wight Trusts, and two new appointments from outside the system.

   - A high level Clinical Strategy for the new trust has also been developed, setting out the overarching clinical aims and principles. This strategy aligns with the existing healthcare system priorities and strategies and has been developed in collaboration with clinicians from provider NHS Trusts, other partners and people with lived experience.

   - The majority of Child and Adolescent Mental Health Services (CAMHS), provided by Sussex Partnership in Hampshire, moved into Southern Health at the beginning of February in preparation to transfer to the new trust, and this transition has gone well.

   - Ongoing collaborative working has continued across all clinical teams to identify best practice and opportunities to develop and improve services in the new organisation. Updates on this work have been shared with our community partners along with opportunities for them to get more closely involved with this work.

- Detailed and ongoing integration planning has continued to prepare for the organisations to come together. Our ongoing focus is on the safe transition of services so that our service users and communities remain unaffected as the new organisations come together.

- We have completed TUPE consultation processes with our IW NHS Trust staff who will transfer into the new trust in their existing roles.

- We have developed our corporate values in consultation with our staff and community partners. As a Trust we CARE; Compassionate, Accountable, Respectful, Excellence.

- We have held a roundtable discussion with our island partners to explore how we can improve our collaboration under a place-based leadership model on the Isle of Wight; to integrate and deliver services to reflect local needs and resources.

- We have continued to communicate and engage with our staff, service users, community partners and the wider VCSE sector on the Island.

4. We are preparing now to recruit new members and governors who will form part of the new Trust's constituency. This will include a new service user and carer constituency comprising six members; ensuring the voice of lived experience is at the heart of the new Trust. There will also be additional public (2) and staff (1) constituency members for the Isle of Wight along with an expanded list of appointed governors from the local authority and designated partner organisations.

5. The transaction that will create the new trust is subject to an assurance process by NHS England. As part of that process NHS England are currently reviewing a full business case agreed and submitted by the trusts involved. This is a detailed plan describing the case for change, the benefits and the work to bring the Trusts together. As part of that assurance process NHSE undertook visits to the Isle of Wight in January. Their decision around the timescales for when the new organisation can be formed is expected in early March.

6. There will be minimal change to services when the new trust is formed. Clinical services will continue to be delivered on the Island in the same locations, by the same teams working in close partnership with the IW NHS Trust, voluntary sector and other health and care partners on the Island. Once the new trust is formed, we will continue to work closely with service users, local communities and our staff to implement the improvements we all want to see at a pace that is right for everyone.

7. You can read more about Project Fusion, the name of this programme of work here: https://fusion.hiow.nhs.uk/

Policy and Scrutiny Committee for Health & Social Care - Workplan 2022/25

The committee assists Cabinet in the development and implementation of key plans, policies and activities set out in the Corporate Plan relating to the delivery of relevant services, including:

Adult social care (including safeguarding)

All health services commissioned or delivered for the benefit of island residents

Health and Wellbeing Board, the delivery of the Health and Wellbeing Strategy and Joint Strategic Needs Assessment

Health and social care Integration

Future local delivery model and strategic commissioning

Public health

Date	Agenda Items	Description & Background	Lead Officer/Cabinet Member
4 March 2024	**Health Inequalities - Food Poverty**	To review local data on food poverty by hearing from IW Food Bank, Healthwatch and Newport Congregational Church	
	Earl Mountbatten Hospice	To consider an update from Mountbatten’s Chief Executive Nigel Hartley on the future of the hospice following concerns around funding.	
	GP Surgeries	The committee to review the work taking place in primary care to monitor and improve capacity and access to services following on from an island wide survey	ICB
	Adult Safeguarding Board Annual Report	To consider the annual report of the Adult Safeguarding Board	Chairman of the Board/ Board Manager
	Community, Mental Health, and Learning Disability Services	To consider an update on Project Fusion and the Afton Ward pilot outcomes.	Group Executive Director of Community, Mental Health and Learning Disabilities Services

24 April 2024 - **INFORMAL**	**Health and Social Care Budget**	To review the impact of funding of Adult Social Care and Health across IWC and NHS and how budgets/services interact and impact on each other.	ASC, ICB and NHS Trust Representatives
13 May 2024 - **INFORMAL**	**CQC Inspection Framework**	To consider the national picture of the new CQC inspection framework	
3 June 2024	**Dentistry**	To monitor the progress of improving dentistry services on the Island.	ICB
	Home Support	To review how quality of service is maintained and how feedback from those who draw on care and support is utilised to make improvements by hearing from the Islands three prime providers	Cabinet Member for Adult Social Care and Public Health
	Wightcare Business Model	To review the implementation of the two-year cost recovery model.	Cabinet Member for Adult Social Care and Public Health
	Recruitment & Retention	To review the progress made in the last year regarding recruitment and retention across the Island workforce system	Cabinet Member for Adult Social Care and Public Health
8 July 2024 - **INFORMAL**	**TBC**		
2 September 2024	**Adult Social Care Annual Complaints Report**	To consider the statutory annual complaints report relating to adult social care	Cabinet Member for Adult Social Care and Public Health
	Project Fusion	To monitor the progress of implementation following go live in April 2024	Isle of Wight NHS Trust
7 October 2024 - **INFORMAL**	**TBC**		
2 December 2024	**Adult Safeguarding Board Annual Report**	To consider the annual report of the Adult Safeguarding Board	Chairman of the Board/ Board Manager
6 January 2025 - **INFORMAL**	**TBC**		

3 March 2025	Carers Strategy 2023-28	To monitor the progress and implementation of the strategy, in line with the delivery plan, two year's after approval	Cabinet Member for Adult Social Care and Public Health
	Independent Living Strategy	To review the progress with the strategy following the refresh that took place in January 2024	Cabinet Member for Adult Social Care and Public Health
7 April 2025 - **INFORMAL**	**TBC**		

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