London Borough of Southwark: local authority assessment

How we assess local authorities

Assessment published: 27 February 2026

About London Borough of Southwark

Demographics

The London Borough of Southwark is in Greater London, with Lambeth to the west and Lewisham to the east. It is densely populated and approximately 315,500 people live there, making it the fifth largest London borough by population. The population increased by 7% between 2011 and 2021. Southwark is made up of a patchwork of communities. The north of the borough includes the South Bank, Borough and Bermondsey. The south includes areas such as Peckham, Camberwell and Dulwich. Southwark is a borough of contrasts, with high levels of wealth in parts of the Southbank and Dulwich Village, and areas of socio-economic disadvantage in Faraday ward and Peckham. 40% of Southwark residents live in social housing.

Southwark has a much higher working age population than the England average, at 73.32% compared to 60.51% nationally. 8.77% of people are aged 65+, much lower than the England Average of 18.69%. The borough is very diverse, with 48.56% of people from Black, Asian and minority ethnicity backgrounds. Southwark is home to the biggest Latin American community in the UK. There is a large LGBTQ+ population of over 8% of adults compared to 4% in London and 3% nationally.

Southwark's Index of Multiple Deprivation decile is 8 (1 being the least deprived and 10 being the most deprived), and it is ranked 35 of 153 local authorities (1 being the most deprived and 153 being the least deprived). Male life expectancy in the most deprived wards of Southwark is up to 12.2 years lower than in the least deprived wards. Female life expectancy in the most deprived wards is up to 9.4 years lower than the least deprived.

Southwark is part of the NHS South East London Integrated Care System along with 5 other local authorities. At the time of our assessment the Labour Party had majority control of the council.

Financial facts

- The local authority estimated its total budget in 2023/24 would be **£632,056,000**. Its actual spend for that year was **£588,250,000**, which was **£43,806,000** less than estimated.

- The local authority estimated it would spend **£99,769,000** of its total budget on adult social care in 2023/24. Its actual spend was **£107,902,999**, which was **£8,133,000** more than estimated.

- In 2023/24 **18.34%** of the budget was spent on adult social care.

- The local authority has raised the full adult social care precept for 2023/24 with a value of **2%**. Please note that the amount raised through Adult Social Care precept varies from local authority to local authority.

- Approximately **4055** people were accessing long-term adult social care support, and approximately **455** people were accessing short-term adult social care support in 2023/24.

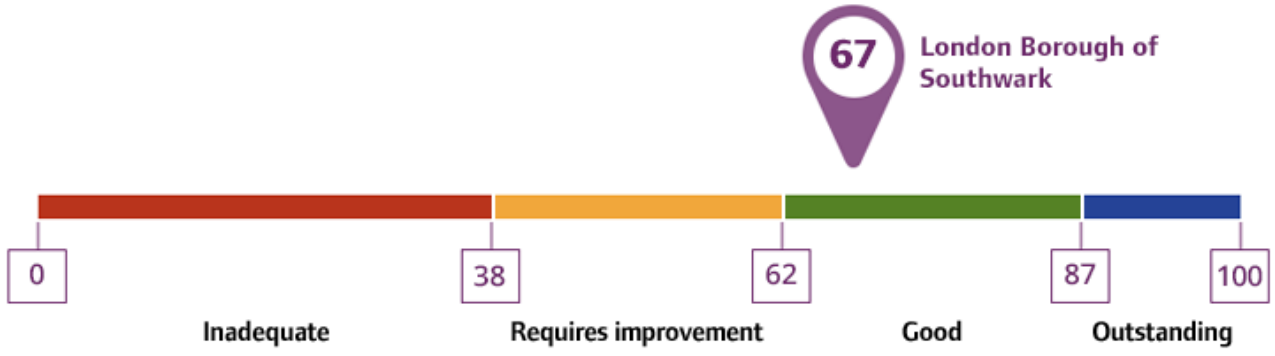
This data is reproduced at the request of the Department of Health and Social Care. It has not been factored into our assessment and is presented for information purposes only.

Overall summary

Local authority rating and score

London Borough of Southwark

Good



Quality statement scores

Assessing needs
Score: 2

Supporting people to lead healthier lives
Score: 3

Equity in experience and outcomes
Score: 3

Care provision, integration and continuity
Score: 3

Partnerships and communities
Score: 3

Safe pathways, systems and transitions
Score: 2

Safeguarding
Score: 2

Governance, management and sustainability
Score: 3

Learning, improvement and innovation
Score: 3

Summary of people's experiences

People were assessed and supported by committed and compassionate staff. Strength-based assessments and practice were well embedded. People’s right to choose was respected. Their aspirations and abilities were recognised. People were supported with the least restrictive options to promote their independence.

Most people were assessed in good time with limited waits for most services, although there were some longer waits, particularly for occupational therapy assessment. There was good multidisciplinary and multi-agency working to ensure people's needs were met in assessment and care planning. People had good access to advocacy and translation.

Most people and their carers told us their assessments were positive interactions, although survey data and feedback indicated this was not universal. Most people said they were listened to, could express their wishes, and had choice over their care and support, with good involvement by different teams.

Most people gave positive feedback about preventative support they received, which helped them to be more independent and in control of their health and care needs, although survey data and feedback indicated some people were not sufficiently supported to autonomously manage their care.

Most people told us the local authority supported them to stay well by. For example, they were signposted to local community organisations for assistance. However, few people were supported to access direct payments to independently manage their care needs.

Many people were placed out of area in other local authorities, mostly in nearby London boroughs. The number of new out-of-area placements was decreasing.

The local authority had a targeted approach to drive awareness of carer support and data showed the local authority's improved outreach and uptake of support for carers. Although some unpaid carers were not aware of what support was available to them or how to access it and some reported mixed experiences about understanding carer assessments and accessing support such as respite, direct payments and short breaks.

Summary of strengths, areas for development and next steps

The local authority's assessment and care planning approach was person-centred and strength based. Assessments were carried out in different ways to meet people's needs and staff signposted people to non-statutory services for their non-eligible care and support needs. Most of the local authority's national data indicators were in line with the England average, for example the proportion of people satisfied with their care and support. Assessments and care planning arrangements were mostly completed in a timely way. Some progress was being made to reduce the backlog of people waiting and there was a reduction in the number of people waiting for assessments and reviews in the 6 months up to our assessment.

The local authority provided many prevention-based activities and early support interventions to improve the health and wellbeing of residents. The local authority used demographic data to inform decision making and target specific needs. However, some of the local authority's national data indicators for prevention were worse than England averages, including uptake of direct payments and people's and carers' sense of wellbeing. The local authority had mixed performance in carer support indicators.

The local authority worked with NHS partners to deliver intermediate care and reablement services to support people to return to their optimal level of independence. There was very good performance in short-term reablement. The local authority managed community hubs across the borough to deliver prevention services and support people to access care, including peer support and self-management groups.

People could access equipment and minor home adaptations to maintain their independence. Occupational therapists were integrated into the local authority's front door contact team for equipment, minor adaptations and preventative support early in people's contact with ASC. However, there were long waits for Occupational Therapy (OT) assessments.

The local authority had a comprehensive understanding of local inequalities and clear equality objectives to improve people's experiences and outcomes. The local authority understood the local population profile and different inequalities faced by residents. There were specific joint strategic needs assessments to tackle inequalities in target populations. The adult social care (ASC) workforce was reflective of the diverse local community. The local authority invested to become an anti-racist organisation and had a zero-tolerance approach to discrimination. The local authority worked with people with lived experience to understand and address the impact of structural barriers to accessing care. The local authority's inclusion and accessibility arrangements considered people's diverse communication needs and supported them to engage in ways that worked for them.

Commissioning priorities followed a life course approach with integrated health and social care goals and joint commissioning. The local authority engaged local people in commissioning decision making. However, there was a relatively small care market in Southwark and a high proportion of people were placed out of area, mostly in neighbouring boroughs but some further away. The local authority was taking action to grow and develop additional care capacity.

There were robust, established provider quality assurance processes and these worked well. Providers told us the local authority had a proactive and supportive approach. The local authority supported a sustainable care market, including the Southwark Council Ethical Care Charter and Residential Care Charter to support staff recruitment and retention. Local workforce data demonstrated a relatively stable, experienced provider workforce. Although there were some challenges in recruitment and retention of local authority staff. The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping with them.

The integration agenda was developing well in Southwark and the local authority worked collaboratively with system partners to align strategic priorities. Partners reported good relations with the local authority. There were some integrated services which resulted in very good outcomes, for example in reablement and preventing readmission. The local authority worked with some partner organisations to pool budgets and jointly fund services where this meant it would achieve better outcomes. Frontline staff reported good MDT working and provided examples of collaborative working. There were examples of effective internal partnerships with other local authority services which supported a 'whole lifetime approach' to people's care and support needs and aligned priorities. Most VCSE groups reported improved relationships and involvement in strategic boards and decision making, but some local groups were under-resourced, which impacted on their sustainability.

Systems were in place to support staff to keep people safe with timely interventions, and the local authority prioritised people's care based on risk, and these mostly worked well. There was a good multi-disciplinary approach to sharing and managing risk between internal teams and external partners. However, we received mixed feedback from people and unpaid carers about the quality and consistency of their care.

There was a structured preparing for adulthood process to support young people's transition from children to adult social care services. However, some families told us transitions from children's to adult services was not seamless and some had experienced delayed assessments. In some instances, this created anxiety and frustration for young people and their families about what support they could expect.

Most feedback from people discharged from hospital highlighted good coordination of care and consistency of support, although managing pressures around hospital discharge was an identified area for improvement. Some staff reported delays accessing and sharing information.

Safeguarding systems were in place to support people at risk of abuse or neglect. We heard examples of making safeguarding personal and involving people in their support and protection plans following referrals. The local authority's safeguarding indicators were in line with England averages, but there were several areas for improvement to make safeguarding more effective, including uptake of safeguarding training. Providers gave mixed feedback on safeguarding investigation responsiveness. The local safeguarding adults board had insufficient oversight of day-to-day safeguarding performance and was disconnected from frontline practice. There was a need to improve the coherence and dissemination of Safeguarding Adult Review (SAR) learning. There was a backlog of Deprivation of Liberty Safeguards (DoLS) cases, and many people were waiting too long for an assessment.

The local authority had governance, management and accountability arrangements which provided visibility and assurance on delivery of its Care Act duties. There was a well-established, focused and capable leadership team that understood community needs. Local authority leaders engaged partners in difficult discussions about challenges. Staff were committed to the local authority and felt motivated to do their jobs to the best of their abilities. We met many well-established staff with many combined years of experience and in-depth understanding of the needs of Southwark residents.

There were established scrutiny and oversight processes, with clear lines of reporting and escalation. Local political relationships were mature and scrutiny of adult social care was effective, both internally and with key partners within Partnership Southwark. Political and executive leaders were very well engaged and informed about adult social care performance and risk. Leaders worked together for meaningful outcomes for local people.

The local authority used information about performance, inequalities and outcomes to inform adult social care strategy and allocate resources. Leaders used data to review service performance monitor and identify risks. The local authority had robust financial governance arrangements.

Most frontline staff spoke positively about the learning and training offer and opportunities for development. There was a clear learning and reflective culture. Staff reported good relationships between teams. Change was managed well and staff were supported to be innovative. There were opportunities for staff to learn and progress. There were some discrete examples of good, meaningful co-production, for example recommissioning of the carers support service and development of mental health pledges. However, some people told us the service needed to do more to seek and listen to people's views, involve them in early decision making, and ensure feedback is used to make improvements.

Theme 1: How London Borough of Southwark works with people

This theme includes these quality statements:

- Assessing needs
- Supporting people to live healthier lives
- Equity in experience and outcomes

We may not always review all quality statements during every assessment.

Assessing needs

Score: 2

2 - Evidence shows some shortfalls

What people expect

I have care and support that is coordinated, and everyone works well together and with me.

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Key findings for this quality statement

Assessment, care planning and review arrangements

The local authority's approach to assessment and care planning was person-centred and strength based. It reflected people's right to choice, built on their strengths and assets and reflected what they want to achieve and how they wish to live their lives.

We received somewhat mixed feedback from people and unpaid carers about the quality of their care. Most people and their carers told us their assessments were positive interactions by caring and efficient staff. They felt involved, listened to and could express their wishes. Staff demonstrated a person-centred, empathetic approach to help them get the support they needed. They promoted choice and offered people a range of options to meet their needs, for example with a home first approach to maintain their independence for as long as possible. Some people told us they had consistency from the local authority in terms of the people who supported them, from assessment to ongoing contact. This helped them build rapport and understanding with staff and supported staff to develop a good understanding of any progress or deterioration. However, this was not universal, and some people and unpaid carers reported poor communication and delays, difficulties contacting the local authority, difficulties accessing information, and a feeling of being overlooked and unsupported. This highlighted inconsistencies in people's experiences.

Most of the local authority's national data indicators were in line with the England average. A 2024-25 Adult Social Care Survey (ASCS, October 2025) showed 61.93% of people in Southwark were satisfied with their care and support, similar to the England average of 65.39%. But 69.03% of people felt they had control of their daily lives, worse than the England average of 77.31%. This indicated people's assessments did not always result in what people wanted to achieve from their support and how they wished to live their lives.

Assessments and reviews were carried out in different ways to meet people's needs, including face-to-face, video call and telephone assessments, joint assessments with partner agencies, or combined assessments for an unpaid carer and person with care and support needs. People's records showed staff tailored assessments to the individual and considered the most appropriate assessment environment. They recognised the different ways people understood, retained and weighed up information and communicated their needs and wishes. There was consideration of people's mental capacity and use of advocates, translators and other support to enable people's active participation.

People could access the local authority's care and support services through multiple channels, including online, telephone and in-person. In 2024 the local authority redeveloped its telephony system which had reduced wait times for callers. The local authority also introduced an online assessment form which had reduced wait times and automatically recorded information on the electronic record system.

All incoming referrals were initially processed and triaged by the front door contact team. Approximately 70% of contacts were resolved by the front door or duty team, usually with information, advice and guidance, or provision of low-level equipment following a light touch assessment by a trusted assessor. People's immediate support needs were dealt with by the contact team or urgent response team. The urgent response team was a jointly managed health and social care team providing medical, functional and social care assessments. People requiring a Care Act assessment were referred to the relevant team.

We reviewed a sample of people's records which showed consideration of people's holistic needs, for example, physical and mental health, communication, mental capacity and support needs. Assessments were generally recorded thoroughly. We saw positive practical examples of strength-based practice. Most assessments focused on people's right to choose, their aspirations and abilities and ensured the least restrictive support options to promote independence. Care and support planning focused on what people could do and positive risk taking, in line with recognised good practice. There was a clear sense of people's wishes, interests and aspirations, and their cultural and religious needs. This showed staff considered core parts of a person's identity and what was important to them. There was evidence of direct conversations with people and their support networks, and multidisciplinary collaboration with relevant professionals.

Providers told us people's care plans were detailed and included relevant documentation such as risk assessments and background information. Staff prepared a 'pen picture' of the person which was securely shared with providers to identify if they could meet that person's needs. This supported person-centred care and enabled providers to prepare resources effectively from the outset.

Frontline teams were competent to carry out assessments, including specialist assessments. There was a comprehensive staff induction and training programme. This included strength-based practice and its application in practice. Senior leaders articulated a renewed focus on professional curiosity and executive function because more people in Southwark were presenting with increased complexity and life challenges.

Timeliness of assessments, care planning and reviews

Assessments and care planning arrangements were mostly completed in a timely way. Some progress was being made to reducing the backlog of people waiting for assessments, but many people were still waiting too long, which presented risks to their safety and wellbeing. Some waiting lists were negligible, such as for the learning disability team, however there were longer waits for occupational therapy (OT) assessments.

Local authority data at the time of our assessment showed there were no waits for Care Act assessments in the mental health team and only 1 person waiting for an assessment by the learning disability team. 387 people were waiting for an assessment by the older people and people with physical disability (OPPD) team. The OPPD median waiting time was 89 days, and the maximum wait was 157 days, beyond the internal target of 28 days. The longest wait was at the request of a resident who was abroad for a prolonged period but remained on the waiting list as they expected to return to the UK. Wait times had reduced in the 6 months up to our assessment.

At the time of our assessment 321 people were waiting for an OT assessment, with a median wait time of 49 days and a maximum wait of 154 days. 27 people were waiting for a sensory assessment, with a median wait of 64 days and maximum of 189 days. Senior leaders attributed this to increased OT caseload complexity, vacant posts (which were recently filled) and the local authority's' transformational change taking place simultaneously (improvements at front door had resulted in faster passage of cases). Wait times reduced in both teams in the 6 months up to our assessment.

For people receiving long-term care, the local authority applied a proportionate approach with established support plans reviewed annually. If a person's circumstances changed, or an early review was required, this was prioritised and allocated to a social worker to reassess. Local authority data showed 74% of people receiving long-term support were reviewed in 2024. At the time of our assessment 965 people were awaiting a review, 84% of which were in the OPPD team. There was a median wait of 135 days and maximum wait of 524 days. The longest wait was at the request of the person receiving care, whose needs were reported as unchanged. National Adult Social Care Finance Report (ASCFR) data for 2024-25 showed the local authority had reviewed (planned or unplanned) 58.96% of long-term support clients, similar to the England average of 59.13% (Short and Long-Term Support, October 2025).

Providers told us the local authority was responsive to requests for reviews and reassessments and ASC staff acted promptly to implement changes and update people's care plans and assessments. Staff proactively liaised with providers and undertook joint reviews. Providers appreciated the flexibility of ASC staff in scheduling reviews and assessments to ensure all relevant individuals could be present.

The local authority took action to reduce waiting times for assessments and reduce risks to people's wellbeing while they waited for an assessment. Senior leaders recognised wait times as an area for improvement. Waiting lists were regularly reviewed to ensure routine oversight and work allocation. The increasing complexity of need and volume of referrals was being mitigated by the local authority's 'front door transformation plan' with revised initial screening and referral forms to improve triage and management of risk. Data dashboards evidenced improvements in the previous 6 months with a reduction in the number of people waiting for assessments and reviews.

There was a risk-based approach to screening incoming referrals and consideration of people's immediate support needs to manage risk at initial contact. Priority was indicated through a risk matrix system used to escalate cases according to perceived level of risk and urgency. The local authority had systems to mitigate risks while people waited for assessments. All referrals were triaged, risk assessed and prioritised. Staff applied a risk-based approach to caseload management to ensure people with urgent needs were responded to promptly and interventions were put in place to keep them safe. The local authority supported people to wait safely with 'waiting well' initiatives such as active provision of advice, guidance about who to contact should their needs change. Staff regularly re-assessed people's risks while they waited, to check if their needs had changed. This provided opportunities for signposting to other services, prevention and enablement support. The front door team also provided low level equipment and aids, which in some cases removed the need for further assessment or intervention.

Assessment and care planning for unpaid carers, child's carers and child carers

The local authority recognised the needs of unpaid carers as distinct from the person they cared for. Assessments, support plans and reviews for unpaid carers were undertaken separately, but many unpaid carers reported mixed experiences. The 2021 Census showed approximately 18,000 Southwark residents (6% of the population) provided some form of unpaid care, of which 25% provided more than 50 hours of care per week. In 2025 approximately 2,300 adult carers were registered with the local authority's commissioned carer service.

The local authority had mixed performance in carer support indicators from the Survey of Adult Carers (SACE) 2023-24, with some positive and negative outliers to the England averages. For example, 10.47% of carers accessed support to keep them in employment, which was significantly better than the England average of 2.79% and the highest reported performance nationally. But 41.07% of carers were not in paid employment because of caring responsibilities, significantly worse than the England average of 26.70%. 56.18% of carers experienced financial difficulties because of caring responsibilities, worse than the England average of 46.55%. 33.33% of carers with satisfied with social services, similar to the England average. This indicated not all carers were well supported in their care responsibilities, although variation to national averages reflected the deep inequalities in the local authority's central London location. The local authority stated 36.30% of unpaid carers were retired, which accounted for higher levels of unpaid carers not in paid employment. Additionally, Southwark was in the 98% percentile nationally for income deprivation affecting older people, and Southwark residents experienced disproportionate costs of living in inner London.

In April 2025 2 people were waiting for a carer assessment, with a median wait time of 25 days and maximum wait of 38 days. At the time of our assessment there were no people waiting for a carer assessment. However, some unpaid carers we spoke with said they had not received a carer assessment despite some providing unpaid care for a long time. Unpaid carers also reported mixed experiences about understanding carer assessments and accessing available support such as respite care, direct payments and short breaks. Some unpaid carers also highlighted concerns with delays to carer assessments, for which they had to submit follow-up applications. This indicated divergent unpaid carer experiences compared to the local authority's wait time data.

There were multiple access points for unpaid carers to seek support, including an online referral form, telephone and email to different teams. Carer assessments were completed by local authority staff, not the commissioned provider. The local authority's website published the referral routes to different teams, but this was potentially confusing as the carer would need to know which service was responsible for the person they cared for.

Staff told us unpaid carers' needs were assessed in a way that ensured a person-centred and supportive process. Carer assessments were completed according to people's needs, by telephone or in-person. There was an option to complete it separately to the cared for person's assessment. The local authority funded and supported local organisations to provide support to unpaid carers and offered equipment and training to help them carry out their caring roles safely and effectively.

Some unpaid carers told us staff were kind and empathetic towards them, although some unpaid carers told us they often felt unheard, the local authority did not sufficiently understand their caring role and support needs, and it was difficult to reach the right team. Many were unaware what services were available to them, and some did not know how to access support. However, local authority data showed since July 2024 its approach to improving awareness of carer support and information advice and guidance (IAG) reached 22,766 residents with caring responsibilities through targeted advertising campaigns. This exceeded the 2021 census data which showed approximately 18,000 residents provided some form of care. Local authority data also showed 977 unpaid carers received weekly online support including e-courses and the peer online community hub through a mobile app and website. The targeted advertising resulted in an 119% over achievement of the expected rate of unique new users accessing IAG online pages and an estimated 2555 new users as of July 2025. There was a 28% overachievement of expected targets for residents accessing full support, such as coaching programmes and e-learning modules.

The local authority had an unpaid carers policy and a dedicated joint strategic needs assessment (JSNA) for unpaid carers which documented current and future demand for unpaid carers including unmet needs. These were co-produced with local unpaid carers and representative organisations. The local authority acknowledged the need to increase the volume of carer assessments, improve mental wellbeing of carers, integrated support plans between NHS and ASC for the cared-for person, and publish an inventory of local carer support. The local authority worked with health partners to develop a carers' charter and carer passport to improve the pathways and experiences of unpaid carers navigation the healthcare system. The local authority had also worked with partners and to develop a more inclusive and accessible preventative offer for families to avoid the need for statutory intervention and more specialist services. The local authority's targeted short break offer increased significantly from 2021-2024 with a 300% increase in the number of individuals accessing targeted short breaks support. This demonstrated the local authority was aware of challenges carers faced and had strategic plans and actions to address them.

Help for people to meet their non-eligible care and support needs

People were given help, advice and information about how to access services, facilities and other agencies for help with non-eligible care and support needs. The local authority identified people with care and support needs that were not being met. As part of the assessment process, people whose needs did not meet eligibility criteria for formal support were signposted to information and advice to support their needs and prevent, reduce, or delay the risk of requiring further specialised support.

The local authority signposted people to non-statutory services for help with their non-eligible care and support needs, including commissioned VCSE organisations which bridged the gap for people who were not eligible for a funded package of care. They provided low level support such as information, advice and guidance, befriending and companionship, warmer homes support and income maximisation advice. Staff were confident in their knowledge of available services in Southwark, which enabled them to signpost people to appropriate support. Staff accessed a shared document which contained an up-to-date list of local services and contact details.

The local authority published an online advice booklet for people about cost-of-living support. This included information about a wide range of local financial support and advice organisations and grants to help people struggling financially. It included money advice, local food and clothes banks, community warm spaces, and help with energy bills and household costs, and links for support with mental health and finding employment. It also included eligibility criteria information for accessing support. These services were offered in partnership with voluntary and community organisations.

Eligibility decisions for care and support

The local authority applied documented eligibility criteria to decide whether people and unpaid carers were eligible for care and support. Eligibility criteria were in line with national legislation and guidance and accounted for people's fluctuating needs. Eligibility did not require formal diagnosis. People with urgent needs prior to assessment were referred to preventative interventions such as universal services, reablement, equipment or minor adaptations, which did not require eligibility decisions until the outcome of the intervention.

The local authority had a right of appeal process for people who wished to challenge eligibility decisions, aligned with its complaints procedure. In the year up to August 2025 the local authority received 14 appeals relating to a range of concerns including charging disputes, eligibility decisions, and dissatisfaction with the services provided. Of these appeals, 5 were not upheld, 3 were partially upheld, 2 were withdrawn, and 1 was fully upheld. The remaining 3 cases were still under review at the time of our assessment.

National data from the Adult Social Care Survey June 2024 indicated 69.34% of people did not buy any additional care or support privately or pay more to 'top up' their care and support, slightly better than the England average of 64.39%.

Frontline staff told us they always provided people with an explanation of eligibility decisions and referred people to community resources such as wellbeing and disability hubs if they were not eligible for local authority support.

Financial assessment and charging policy for care and support

The local authority's framework for assessing and charging adults for care and support was clear, transparent and consistently applied. Decisions and outcomes were transparent and most financial assessments were completed in a timely way.

The local authority charging policy was in line with relevant legislation and financial regulations. It included definitions, charging principles and an online care charge calculator to help people understand their potential contributions. It included clear information about the financial assessment process, thresholds for financial assistance, and contact details for external organisations to direct people to financial support and advice. The local authority also provided an easy-read leaflet to support people's understanding.

The local authority's financial assessment team visited people in their homes and held drop-in clinics to explain the assessment process and answer questions about charges and contributions towards care and support. Staff applied the local authority's 'rightfully yours' approach to support people to maximise their eligible welfare benefits. The local authority provided people with a copy of their financial assessment within 10 working days of completion. The local authority also conducted annual financial assessment reviews to ensure people paid the correct contributions. People gave positive feedback that the financial assessment team was understanding, helpful and acted with kindness.

At the time of our assessment 16 people were waiting for a financial assessment, with a median wait time 84 days and a maximum of 134 days, against a local target of 28 days. Senior leaders attributed the longest delays to people not engaging in the financial assessment process, as was the case with the longest wait.

The local authority's fairer contributions policy recognised its responsibility to support vulnerable people and assess how much they could afford to contribute towards the costs of their care and support needs. Where a financial assessment was not possible or disproportionate, staff completed a 'light touch' financial assessment. Staff worked with advocates and individuals with legal authority to make financial decisions on behalf of people without capacity to make an informed decision.

The local authority's personal budget policy provided comprehensive guidance to meet people's eligible Care Act needs. It outlined what people can expect after they have been assessed as eligible for care and/or support, the different ways they can choose to organise their care, an overview of financial contributions, and a list of related local documents and national policies that a person, carer, or practitioner might also find helpful. The local authority had a right of appeal process for people who wished to challenge the amount they were expected to contribute.

Provision of independent advocacy

An advocate can help a person express their needs and wishes and weigh up and make decisions about the options available to them. They can help them find services, make sure correct procedures are followed and challenge decisions made by local authorities or other organisations. The local authority had a commissioned advocacy provider in place which supported people to access statutory and non-statutory advocacy and independent advice and guidance. Statutory advocacy covered Care Act assessments, Independent Mental Capacity (IMCA), Independent Mental Health and NHS/social care complaints to support people to be as fully involved as possible in decisions about their care.

Timely, independent advocacy support was available to help people participate fully in care assessments and care planning processes. Staff reported good access to advocacy which they used as and when people needed this. They told us the advocacy service was accessible and responsive and there were no challenges ensuring advocates were available when needed. Staff had a good understanding of the importance of advocacy services and told us having an advocate present ensured assessments were person-centred and the views and wishes of the person were heard. For example, staff involved advocates to support best interest decisions for people with cognitive decline.

People's records showed advocates involved in care planning and best interest decisions. There was evidence of good partnership working between adult social care, health, support workers and advocates to achieve the best outcomes for the person. Advocates supported people to express their needs and wants and what they would like their care and support to look like. Feedback was sought from people, their families and carers about whether the advocacy service was appropriate and achieved the desired outcomes.

The commissioned advocacy provider described a good working relationship with the local authority which had led to increased referrals for support. The provider shared that local authority staff understanding of advocacy was variable but improving. For example, there were instances of confusion between Care Act advocacy and IMCA referrals. There was improvement in timeliness of referrals and there were no delays for Care Act or IMCA advocacy. The advocacy provider held awareness raising sessions with local teams to improve staff understanding of advocacy processes and responsibilities.

Supporting people to live healthier lives

Score: 3

3 - Evidence shows a good standard

What people expect

I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.

I am supported to plan ahead for important changes in my life that I can anticipate.

The local authority commitment

We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives and where possible, reduce future needs for care and support.

Key findings for this quality statement

Arrangements to prevent, delay or reduce needs for care and support

Arrangements to prevent delay or reduce the need for care and support were set out in the local authority's Adult Social Care Plan, and aligned with the Southwark Joint Health and Wellbeing 2022-27 Strategy and Southwark 2030 vision. Prevention priorities were tracked through performance indicators and outcomes outlined in the JSNA. There was ongoing work with system partners to develop effective shared outcome measures to demonstrate impact. Although this activity was not always supporting early intervention and prevention.

The local authority provided several prevention-based activities and interventions and ASC worked closely with the Public Health team and other partners to improve the health and wellbeing of residents. The local authority had taken steps to identify people with care and support needs that were not being met. Neighbourhood teams used a range of population health tools including ASC and health data to identify vulnerable people and communities, and worked with the voluntary sector to reach into different communities to understand their specific needs.

The Partnership Southwark health and care plan 2023-28 included priorities that spanned people's lives, including 'start well', 'live well', 'age well' and 'being cared for well'. Priorities supporting Live Well included access to support for mental health, smoking cessation, alcohol intake, and healthy weight. Priorities supporting Age Well and Being Cared for Well included a coordinated and integrated frailty pathway to maximise mobility and reduce crisis support and hospital admissions.

Public Health commissioned and funded a variety of services aimed at prevention and early support. For example, 160 volunteer Community Health Ambassadors outreach, advice and signposting service supported communities to address health inequalities such as cancer prevention, cost of living information and mental health support. Public Health also delivered prevention programmes including vaccinations, health screening and healthy living initiatives. The Public Health team delivered staff training sessions on making every contact count, suicide prevention, and mental health first aid, specifically targeted at front line staff. This was based on learning needs identified by ASC.

The local authority managed community hubs across the borough to deliver prevention services and support people to access care. A dedicated wellbeing hub provided mental health support to prevent and reduce people's needs for care and support, including signposting to statutory services, digital inclusion initiatives, drop-in sessions, therapeutic activities, group meetings and peer support. People told us they were grateful for the wellbeing hub because it provided a space to connect with people with similar lived experiences. Support was tailored to each person’s needs for up to 12 weeks, after which people could continue to access services within the hub. The wellbeing hub provided ‘pop-up’ outreach sessions targeting specific communities to promote mental health services.

The local authority provided 21 'warm spaces' across the borough. Warm spaces were free places to keep warm in the community, with some also offering cost-of-living advice, free hot drinks and food. The local authority also partnered with Southwark Community Support Alliance to help vulnerable people experiencing hardship with food and basic needs and promote healthy living. The service could be accessed via the local authority's website, completing an online referral form, or by telephone.

The local authority supported several peer support schemes and self-management groups including the Southwark Disabled People's Action Forum and Together for Mental Wellbeing. Social prescribers were embedded in primary care teams and provided advice and signposting to services provided by VCSE and other local organisations. The local authority had a loneliness strategy and worked with VCSE groups in Southwark that provided community choirs, exercise groups and befriending to reduce social isolation.

The local authority supported vulnerable people to access paid employment and voluntary work. Staff with specialist knowledge and local connections supported people to access education, training and work opportunities. People spoke of the positive impact of this support in providing them with a sense of purpose and routine.

There was particular focus on supporting vulnerable families to stay together, with family early help and holistic support. The Positive Behaviour Support Team led on early intervention and preventative measures, crisis support and training for young people with behaviours that may challenge. People provided positive feedback about the service, reporting the positive impact it had on reducing family and carer relationship breakdown. The local authority had an extensive team of psychologists, which supported initiatives such as PAUSE – a family support programme for women who have had, or are at risk of having, more than one child removed from their care. Senior leaders explained this had transformed many families' lives locally, helped them take control of their lives, and reduced the need for more intensive interventions.

The local authority considered the specific needs of unpaid carers and recognised the need to maintain carer health and wellbeing and prevent isolation. This included outreach events to support carers in recognition they were less likely to come forward for support. There were carer peer support groups and online 'cuppa' mornings to seek advice. Although many carers were not aware of all available support.

The local authority worked with a dedicated GP service for care homes focused on prevention of hospital admissions. There was also a joint ASC-health funded 'mini therapy' team placed in care homes to support admissions and reduce stays in hospital. However, NHS partners highlighted that health and social care needed more enhanced pathways to support people on the frailty pathway in the community to enable earlier and quicker identification of deterioration to enable more preventative support to be put in place.

Some of the local authority's national data indicators for prevention were worse than England averages. Data from Adult Social Care Outcomes Framework (ASCOF, December 2025) showed 56.80% of people reported they spend their time doing things they value or enjoy, lower than the England average of 68.80%. 91.90% of people who used services described their home as clean and comfortable, also lower than the England average of 94.05%. 69.85% of people who received short term support no longer required support, worse than the England average of 79.39%. This indicated the local authority's preventative services were not having a positive impact on wellbeing outcomes for all people, although there were significant improvements in performance over 2023-24 data and the local authority recognised this as a continued area of focus. For example, data provided by the local authority showed the proportion of people needing no or less support after reablement had risen from 69.85% in 2023-24 to 77.00% in 2024-25. This meant more people regained independence, reducing demand on long-term support, and showed how the local authority had responded to areas needing improvement and taken action to improve people's outcomes. Better Care Fund (BCF) data submitted to the local health and wellbeing board highlighted the role of the local authority's prevention activities in a 15% reduction in the number of unplanned emergency hospital admissions locally in 2024-25.

The local authority was a housing authority and had statutory responsibility under the Housing Act to provide suitable housing for people. However, we received consistent feedback that current housing stock did not always meet people's expected standards or needs, including safety risks such as damp and mould, and the negative impact this had on people's health. The local authority provided funding to address these issues and there was an audit of housing stock condition. OTs worked to manage risks, stabilise people's living conditions and make people's homes more accessible and safer. There was a Health and Housing Care Board for public health, adult social care, and housing leaders to address shared challenges and find solutions. Local authority data showed a significant reduction in the number of overdue damp and mould cases from 673 in March 2025 to 223 in October 2025. The local authority had invested £2m from the Public Health team to support this priority work. The data also showed 93% resident satisfaction rate with housing repairs and responsiveness.

Provision and impact of intermediate care and reablement services

The local authority worked with NHS partners to deliver intermediate care and reablement services to support people to return to their optimal level of independence, after a hospital stay for example. It helped prevent, reduce and delay the need for long-term care. The local authority had 6 reablement beds in local care homes and 5 extra care housing schemes for step-down care. There were also 8 discharge-to-assess beds for people awaiting further assessments, such as those needing a CHC assessment. This facilitated discharge flow, ensured people were placed in safe environments, and prevented further deterioration. The local authority's outcomes data for older people completing reablement during 2024-25 showed 77% required no ongoing support, 10% required reduced support and 13% required the same of greater support. This indicated the local authority's investment of £1.8 million in the service successfully supported more 85% of people achieve outcomes of reduced or no on-going packages of care.

National ASCOF data (December 2024) showed 7.12% of people aged 65+ received reablement or rehabilitation services after discharge from hospital, significantly better than the England average of 3.00%. National data from Short and Long Term Support (SALT, October 2024) showed 87.23% of people aged 65+ were still at home 91 days after discharge from hospital into reablement or rehabilitation care, in line with the 83.70% England average.

The integrated reablement service included nursing, occupational therapy, and physiotherapy to support people to remain out of the hospital. Practitioners applied nationally recognised reablement goals to support people's recovery. The service provided reablement support for six weeks, with options to extend this where needed. Some people received reablement support for longer than six weeks, partly due to delays completing Care Act assessments by the local authority. Social workers made additional referrals, for example to the community falls service, if needed. There were trusted assessors in local residential and nursing care homes where the local authority commissioned 'block beds' to support intermediate care capacity. The trusted assessor approach supported direct discharge of people to any of the block beds for an assessment. This had reduced delays.

There was an urgent community response multi-disciplinary team to support people in crisis and prevent avoidable admissions to hospital or emergency nursing care. A duty worker undertook face-to-face assessments and liaised with relevant professionals such as mental health and learning disabilities to ensure that the person receives a holistic assessment and received suitable support. There was also dedicated intermediate care for people who have had a stroke and needed a period of rehabilitation. The commissioned service provided 24-hour care placements for specialist stroke rehabilitation assessment within a suitable care environment.

There was specific mental health reablement provision, which staff praised for reducing the need for long-term care. The local authority provided people with up to 10-weeks mental health reablement support. There were 10 mental health peer mentors with lived experience of mental health care. They completed joint home visits with a social worker and provided ongoing advocacy, support and guidance. In 2024-25 73% of people finished mental health reablement with no ongoing care needs. The local authority also worked with the local NHS mental health trust in a mental health 'recovery college', which was co-delivered by people with lived experience. This showed the local authority invested in preventative support by people with lived experience.

Access to equipment and home adaptations

People could access equipment and minor home adaptations to maintain their independence, continue living in their own homes and prevent, reduce or delay the need for care and support. However, there were long waits for Occupational Therapy (OT) assessments, and some people waited a long time to have their needs met.

There were no waiting lists for equipment provision, with an average delivery time of 1-5 days. Staff could access emergency and same day equipment deliveries. The local authority procured equipment through an external provider and had recently completed a rapid commissioning exercise when the previous provider ceased trading. This was managed well to ensure people could access equipment without delay. Staff could submit evidence-based requests for specialist equipment, such as robot wheelchairs to improve people's independence and quality of life. Staff gave as an example of working with a person nearing the end of their life and with young children. The person's primary goal was to be able to go down the stairs to take their children to the park. OTs worked with housing to install a stairlift within eight days, enabling the person to fulfil this important goal.

To address wait times the local authority had actively recruited OTs with a focus on development and support for innovation. The local authority hosted a national OT conference which helped promote Southwark as a place to work and demonstrate the local authority valued OTs. At the time of our assessment there was 1 OT vacancy, reduced from 17 in less than a year. The local authority also employed 3 OT apprentices to provide lower-level support and interventions. However, this was not yet showing a reduction in OT assessment waiting lists. The local authority was in the process of implementing an online portal called AskSARA for people to self-assess their equipment needs. This provided impartial advice about equipment for different needs such as mobility, pressure care and personal hygiene, and where to purchase them. People could also submit requests for OT and equipment assessment on the portal.

The local authority supported over 3500 people with technology enabled care (telecare) and assistive living devices, including personal alarms, activity monitors and home environment sensors to help people stay independent or get help in an emergency. At the time of our assessment 1 person was waiting for a telecare assessment, with a median wait time of 32 days and maximum of 32 days. The local authority had completed the transition from analogue to digital ahead of schedule to support more people to access telecare without needing a landline. Staff reported that telecare was rapidly installed, often while a person waited for a Care Act assessment. The telecare supported the assessment of their needs with real time data to help families and professionals make informed decisions about people's care and support needs.

OTs were integrated into the local authority's front door contact team to assess and approve equipment, minor adaptations and preventative support early in people's contact with ASC. Some customer support officers were trained as trusted assessors which also supported prevention activity. People on OT waiting lists were risk managed and prioritised based on level of support needed. There was support whilst people waited, including a designated person in the contact team. There was an OT in the review team and OTs were located on the same floor as other frontline teams to support joined up working.

OTs advocated a 'home first' approach to support people's independence. They carried out detailed assessments focused on preventative measures. OTs discussed people's needs and concerns with them, explored different types of equipment, and offered solutions for safely navigating and using amenities within the home. This included providing minor equipment like bath boards and steps, as well as exploring other mobility aids. OTs conducted joint assessments with other social care professionals where needed to ensure holistic review of people's needs. Some of the local authority's VCSE partners were trained as trusted assessors, which also supported more timely support.

When OTs assessed a person's home environment, they addressed the identified needs in the referral and also assessed the overall environment for safety and accessibility. For example, they suggested alternative kitchen appliances for people with mobility difficulties. They also planned for people's future needs, advising people with progressive conditions on the support and equipment they may require in future.

The OT team worked closely with the local authority housing team to support adaptations in people's homes, utilising the ring-fenced Disability Facilities Grant (DFG). In 2023 the local authority completed 123 major adaptations including level access showers, bathroom alterations, stairlift installations and building alterations. OTs liaised with housing when people's needs or risks changed and to support prioritisation of adaptation waiting lists. As well as major adaptations, the DFG also funded a handyperson service which worked closely with the hospital discharge team to enable people to return home from hospital when their home needed minor repairs. However, there was no clear process to ensure OTs were informed when adaptations were completed. This meant OTs could not easily check if adaptations were meeting people's needs and being used safely.

However, many ASC staff told us the relationship with housing needed to improve as there was a reported disconnect between ASC and housing. This resulted in work often sent from housing to ASC staff that should have been addressed by housing. Staff told us it was difficult to communicate with housing as they did not have direct contacts to seek support in a crisis. High turnover of housing staff limited opportunities for effective working relationships and hindered case management and risk management. ASC staff frequently acted as conduits between housing and residents which impacted on their capacity to support people's care needs. This indicated the systems currently in place were not adequate to support joint working between ASC and housing, resulting in silo working and delayed information sharing which negatively impact coordinated support. In response, the local authority had set up housing clinics for ASC and housing staff to find solutions to people's housing needs which were impacting on their care, for example delayed hospital discharges due to pest control issues in the person's home. There was also a multidisciplinary (MDT) housing health and care partnership board with representation from ASC, housing, public health, mental health and VCSE organisations to improve information sharing. Housing leaders attended the safeguarding board to improve shared involvement in addressing priorities such as hoarding, cuckooing, and adaptations.

Provision of accessible information and advice

People, including unpaid carers and people who fund or arrange their own care and support, could access information and advice on their rights under the Care Act and ways to meet their care and support needs, but the local authority identified this as an area for improvement and recognised it needed to make information more accessible. People could contact the local authority by telephone, online or in-person.

National data from the Adult Social Care Survey for 2024-25 showed 68.47% of people who used services found it easy to find information about support, similar to the England average of 67.09%. Although the Survey of Adult Carers in England 2024 showed 37.50% of carers found it easy to access information and advice, significantly worse than the England average of 59.06%. 73.33% of carers found information and advice helpful, also significantly worse than the England average of 85.22%. This indicated the local authority was not meeting all people's information needs.

We received mixed feedback from people about the local authority's provision of accessible information. Some people told us social care staff explained things clearly in ways they could understand. They repeated and rephrased things to support people's decision making. Although other people reported limited information and follow-up by staff, which meant they had to search for information about services and providers online, or rely on family members to contact the local authority.

People's support plans and assessments were available in different formats such as easy read, Braille and translated into community languages. Local authority documents were also available in accessible formats, for example an easy-read guide to direct payments.

The local authority's website included information and contact details for different adult social care teams, links to external support organisations and briefly outlined assessment arrangements. People could self-refer to ASC using an online form. The local authority also provided drop-in services at two community locations, with staff on hand for self-referrals and in-person Care Act assessments for people not able to access information online. The local authority's disability hub opened in 2025 for residents to seek in-person advice and support from various services in a single location. People could attend the resource centre to have a wide range of their needs met without having to travel from place to place.

Some people found the local authority website inaccessible and difficult to navigate. There was a local authority-wide programme to improve provision of clear and accessible information to help people make informed decisions. Priorities included promoting digital up-take and increasing self-service. However, some people and partners told us the local authority's online forms were not accessible for those who were digitally excluded. This resulted in some people not accessing support from appropriate services.

The local authority circulated some information in printed newsletters and posters throughout the borough, which gave people access to information about available services and support. Partner organisations told us the local authority could improve its outreach efforts to ensure everyone has access to information and to identify unmet needs. Elected members articulated a need for better information sharing and cross-referencing of council data to reach vulnerable people more effectively.

There was ongoing work to improve accessible information and advice for unpaid carers, following feedback from carers that information was not clear. The local authority's recommissioning specification for the carers service included improved information advice, guidance and outreach. The local authority had created an information booklet about universal support for unpaid carers. This was shared with local GP surgeries and health organisations to communicate the different ways unpaid carers can access support and contact details for further information and advice. It was clear and easy to understand. Unpaid carers in Southwark could access to a 24 hour helpline for confidential, professional support and advice around health and wellbeing, money worries, self-care and respite, consumer and legal issues, family, home and work issues.

Direct payments

Direct payments were available as part of the local authority's assessment and provision of care, but uptake was much lower than the England average. People eligible for direct payments were offered the option of managing the direct payment themselves or a third-party could manage it on their behalf. There was early work to support the local care market to increase opportunities for people to use direct payments, for example ensuring personal assistants (PAs) were paid London Living wage. Senior leaders attributed low uptake to complicated internal processes and systems, but there was limited evidence the local authority was actively addressing this or promoting the benefits of direct payments.

National ASCOF data (2025) showed 13.27% of people in Southwark received direct payments. This was a slightly worse than the England average of 24.51%. Similarly, 18.99% of people aged 18-64 received direct payments, which was worse than the England average (35.53%), and 6.69% of service users aged 65 years and over received direct payments, also slightly lower than the England average of 13.64%.

Staff told us some people struggled to manage their direct payments well. We heard feedback about people not utilising sufficient care hours, limited understanding of financial implications on their welfare benefits, or expected personal contributions. People with mental health needs found it difficult to manage direct payments, and some people's family members employed as PAs experienced overwhelm managing their needs.

However, frontline staff gave examples of using direct payments creatively to support people's individual care needs. For example, supporting a person to have swimming sessions, day trips, gym memberships and spa treatments for carers. People with specific cultural needs utilised direct payments to employ PAs with specific culture understanding.

The local authority commissioned multiple providers to support people to manage the administration of their direct payments. Although some staff told us improvements were needed because of frequent issues with people's understanding of the cost of care packages. There was staff training to improve understanding of direct payments, but staff reported low attendance for this.

The local authority's direct payments online guides and procedures were clear, comprehensive and easy to understand. They detailed what direct payments involve, how they may be used and the responsibilities of receiving and managing one. It provided information about having a support provider to help manage direct payments. The local authority monitored usage of direct payments and recouped any unspent budgets. There was a risk-based monitoring framework and direct payments were monitored monthly by way of a user return. The document also covered usage rules and payment methods.

There were robust process to ensure direct payments were spent on agreed things/ activities as documented in people's support plans. The direct payments team worked with people's allocated social workers to ensure issues were addressed quickly. In the year up to our assessment 22 people stopped using direct payments to meet their ongoing care needs. Of these, 8 chose a directly commissioned service, 9 stopped at the request of either the person or their next of kin. In 5 cases direct payments were stopped following monitoring, which revealed funds were not being used to pay for care or support as intended. Alternative care and support arrangements were put in place for all people.

Equity in experience and outcomes

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.

The local authority commitment

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Key findings for this quality statement

Understanding and reducing barriers to care and support and reducing inequalities

The local authority centred equity at the heart of its adult social care services, which came through consistently throughout our assessment. The local authority had regard to its Public Sector Equality Duty (Equality Act 2010) in the way it delivered its Care Act with continuous learning about its communities and helping them overcome inequalities. There were clear and well understood equality objectives and well-resourced strategies to reduce inequalities and improve the experiences and outcomes for people who were more likely to have poor care. The local authority had a thorough understanding of the Southwark population profile and inequalities faced by residents. It analysed equality data on people accessing social care and used this information to identify and reduce inequalities in people's care and target resources. There was evidence this was improving people's access and outcomes. For example, the local authority's investment in positive behavioural support for autistic younger adults and people with learning disabilities had prevented their needs increasing and reduced admissions to mental health units.

The local authority had thorough strategic plans to address local inequalities and ensure people's rights were respected. There was a published equality framework and joint health and wellbeing action plan 2025-27, with associated action plans that were routinely reviewed. These identified early help and prevention as key to reducing inequalities across the borough. As part of the Southwark 2030 vision, there was a strong emphasis on tackling inequalities in mental health care and improving life expectancy for people with mental health care needs. The local authority conducted equality impacts assessments and needs analysis to assess the impact of change on local people when developing policies, projects and service commissioning, including the Southwark health and wellbeing strategy. These assessments were mandatory and used evidence-based research and extensive community engagement to ensure positive impact on residents and mitigate any negative effects on people with protected characteristics.

Southwark was a very diverse borough and approximately 48% of people identified as being from Black, Asian or Minority Ethnicity backgrounds and 8% identifying as LGBTQ+. Almost 40% of Southwark residents were born outside of the UK and more than 80 languages were spoken in the borough. The local authority was a designated 'Borough of Sanctuary' for asylum seekers and refugees, and the public health team worked closely with other services to undertake health checks and provide advice for asylum seekers to access the support they needed and prevent their needs from escalating.

The local authority recognised disparities in different communities' access to social care and partnered with local community and voluntary groups for under-represented groups such as an Irish pensioners group and a Black and African support group to support different cohorts of people get the support they needed. This focused on prevention, stigma reduction, and helping people to know how to access services. The local authority used people's feedback to develop new culturally competent health interventions, including targeted mental health outreach for Black residents and minority ethnicity groups.

Local authority leaders and staff demonstrated a commitment to understanding and reducing barriers to care and reducing inequalities in people's experience and outcomes. They had a comprehensive understanding of local inequalities and equality, diversity and good understanding of strengths, gaps, actions and outcomes to improve equity. The local authority prioritised six population groups to tackle entrenched health inequalities, which aligned with its Joint Health and Wellbeing Strategy: carers, residents with disabilities, LGBTQ+ people, asylum seekers and refugees, rough sleepers and Black, Latin American and minoritised ethnic groups.

The local authority proactively engaged with the people and groups where inequalities were identified, to understand and address specific risks and issues experienced by them. This included comprehensive use of data to identify and understand where inequalities were. For example, in additional to its main joint strategic needs assessment (JSNA), the local authority had developed specific JSNAs for different local communities, including Latin American and LGBTQ+ communities, and a needs assessment for the Gypsy, Roma, and Traveller community. The JSNAs identified specific inequalities and needs for those most at risk of discrimination. The local authority worked with these communities directly to understand their challenges and the JSNAs were co-produced with them and VCSE partners. The JSNAs informed commissioning plans and service specification revision, for example to improve support for LGBTQ+ unpaid carers. This demonstrated the local authority considered the needs of different communities with targeted health and care interventions, and led to actions such as mandatory LGBTQ+ led awareness training for staff to improve understanding of inequalities. This had reduced underreporting in case management data.

The local authority had a place-based approach to direct resources to areas of highest deprivation and respond to local disparities. This supported the delivery of services such as a resident health and wellbeing programme closer to people's homes to support easier access for local people. Through various commissioning projects and funding streams, the local authority supported many local services that catered to the diverse population. For example, the local authority offered several resources for LGBTQ+ unpaid carers through local and London-wide organisations. The local authority commissioned a London LGBTQ+ community centre and provided funding for a new cultural centre. It gave grants to local events through its Southwark Pride Fund. The local authority worked with local NHS partners to support access to a dedicated Southwark LGBTQ+ talking therapies wellbeing group. These interventions reduced and delayed people's care needs.

There was a commitment amongst leaders to represent their communities. Staff and leaders were proud that the demographics of the leadership team reflected the diversity of the borough. The frontline adult social care workforce was also reflective of local communities, with approximately 46% of staff from Black, Asian and minority ethnicity backgrounds. Some staff reflected other local populations, for example the Traveller community. They worked with those communities, supported good cultural competency and understanding of different needs, and reduced cultural barriers to accessing care. The local authority applied Workforce Race Equality Standards (WRES), and there was anti-discriminatory practice and anti-racism training for all staff, as well as cultural competency counselling to improve staff awareness and knowledge of different community needs. This improved staff cultural empathy, insight and competencies in practice.

The local authority invested heavily to become an anti-racist organisation and had a zero-tolerance approach to discrimination, with clear priorities to address inequalities in initiatives like Southwark Stands Together (SST), launched in May 2025. More than 5,000 Southwark residents shared their lived experiences of racism and inequality to shape the first SST action plan. This work was collaborative, inclusive, and designed to improve people's experiences. The local authority continued to convene listening forums and accountability panels to ensure transparency and resident challenge for SST, with annual progress reports and community updates. SST was embedded in the Southwark Health and Wellbeing Strategy as a driver of equity.

There was good evidence of work with the VCSE sector to reach into communities and work with people with lived experience to understand and address different inequalities and impact of structural barriers to accessing care. The local authority provided £28m in funding annually to Southwark charities and had introduced new services for specific communities and cohorts, including funding culturally competent local voluntary sector groups. There were funding streams specifically for black and minority ethnicity-led VCSE organisations, to build capacity and sustainability, following feedback from community groups about unequal access. The local authority worked with local VCSE groups to co-produce a dedicated Black Carers Project with targeted support, in recognition that black carers were less likely to access mainstream carers' support. This had a positive impact of greater reach into underrepresented communities, and the local authority used feedback from the project to inform wider carers' service commissioning. There was some evidence of increased carer support uptake from within black communities.

Leaders recognised some communities were mistrustful of statutory services so the local authority was conducting 'deep dives' to improve trust and hear from seldom-heard voices in the community. For example, the local authority was reaching into local Somali community groups to improve awareness and understanding of local support services. The local authority co-developed the Black Elders Centre with local volunteers with culturally relevant spaces and programmes tailored to older black residents. Feedback from people showed this helped reduce isolation and promoted wellbeing in a trusted environment.

The local authority had an outreach health promotion van which visited communities to support people to access regular health checks, smoking cessation and alcohol dependency support, and diabetes support. The aim was to empower people to access health and social care services and live healthier lifestyles. The van visited local community festivals and roadshows to improve awareness of local authority and NHS services, particularly amongst Black, Asian and minority ethnicity populations. In 2024 the outreach team conducted over 3,500 'Vital 5' checks and signposted people to urgent health support to manage their health risks. Feedback from people accessing the health promotion van was very positive. NHS partners told us the local authority supported people from marginalised groups well with competent practice and commitment to equality. The local authority and NHS partners jointly commissioned 'health and wellbeing hubs' to improve access to community support and mental health services for disadvantaged people.

The local authority also participated in a tenant health and wellbeing programme, which brought together teams across ASC and NHS to address social and health inequalities with appropriate housing. The local authority's 'Community Ambassadors' programme targeted vaccinations uptake in particular communities. Ambassadors were volunteers who represented their communities and supported awareness raising. Data showed this resulted in short-term increases for specific prevention campaigns, such as certain maternal and seasonal vaccinations.

The local authority supported work to overcome barriers for vulnerable people. Staff worked with a local care provider to provide 3-month social care work placements for care leavers. The work placements were created to support care leavers develop skills and confidence to improve their career opportunities. As a result of this project 2 care leavers had secured employment with the care provider involved in the project. This demonstrated a proactive approach to improving equity as care leavers often face greater challenges and poorer outcomes in comparison to those who do not have care experience.

Southwark was awarded 'Dementia Friendly' borough status in 2023, which recognised the local authority actively worked to include and support people with dementia to improve their quality of life and independence. The local authority continued to embed good practice and support for people living with dementia, including supplementary dementia awareness training for home care staff, new extra care housing schemes, staff learning networks, 'dementia cafes' for people to access support, and closer partnership working with health to support early diagnosis. The local authority had allocated £300,000 to local charities to ensure their offer included dementia support.

Local political leaders recognised higher prevalence of safeguarding concerns in some local communities, but such concerns were often hidden or not reported. A cross-partnership committee was created to specifically address domestic violence, which had established 'safe spaces' in the community for people to confidentially discuss their concerns with a professional. However, elected members recognised more work was required to identify and support people experiencing domestic violence promptly, particularly in the Latin American community as interpreters often did not speak the specific Latin American Spanish dialect, which risked misinterpretation.

Inclusion and accessibility arrangements

The local authority had inclusion and accessibility arrangements which considered people's diverse communication needs and supported them to engage in ways that worked for them. Staff asked people about their communication preferences and requirements, and they were trained and supported to use different methods to meet people's diverse communication needs. They had access to visual aids to support communication and understanding, for example, information in large print or translated into other languages. The local authority introduced webtools to translate and print website information into other languages. Tracking data indicated the tool was well utilised.

The local authority commissioned external translation and interpretation support, including face-to-face translation and technology to support deaf people to contact local authority departments by telephone. This included people whose first language was British Sign Language (BSL). Frontline staff also highlighted a diverse workforce that spoke different community languages, which supported people to articulate and advocate for their needs at the first point of contact. Specialist support workers helped people with learning disabilities to communicate their needs using techniques from their speech and language assessment and Makaton. NHS partners shared an example of a social worker using an amplifier to communicate with a patient, to ensure they could participate fully in their Care Act and mental capacity assessments.

Frontline staff sensitively asked people about their accessibility and sensory needs and language preferences in early conversations about their care and this was captured on the electronic record system. Staff recognised different cultural communication needs and that some cultures preferred oral communication to written. They had cultural competency training and tailored their approach according to people's needs. The local authority's accessible materials included Braille, audio format, easy read and enlarged font size documents. The local authority developed colour schemes for all official documents to support colour blind people access information. There was ongoing work to improve local authority website accessibility. Including co-production with people with physical and learning disabilities to ensure it met different accessibility needs.

Staff described many examples of supporting inclusion in practice. For example, staff had liaised with the local leisure centre to improve support for people with disabilities to access the facilities. As a result, the leisure centre changed its lighting to make the environment more inclusive for people with sensory needs and ensure universal services were as accessible as possible for all residents. This demonstrated staff advocating for people.

Theme 2: Providing support

This theme includes these quality statements:

- Care provision, integration and continuity
- Partnerships and communities

We may not always review all quality statements during every assessment.

Care provision, integration and continuity

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Key findings for this quality statement

Understanding local needs for care and support

The local authority worked with local people and stakeholders and used available data to understand the care and support needs of people and communities. The local authority had a good understanding of its diverse local population, its needs and challenges. There was an overarching Joint Strategic Needs Assessment (JSNA) for the borough, with specific JSNAs for different communities, which provided detailed assessments of current and projected health and social care needs. The local authority faced similar challenges to other London boroughs with projections for an ageing population and people with complex needs and more people needing care. The local authority's priorities included tackling inequalities through initiatives such as Southwark Stands Together, prevention, closing access and outcome gaps and Partnership Southwark programmes to improve health and social care integration. The local authority's integrated commissioning strategy reflected these priorities, with good use of JSNA, activity data, co-production with residents, research into national good practice, and engagement with providers and frontline staff to inform commissioning intentions. An integrated commissioning team operated across the local authority and NHS partners.

The local authority's market position statement 2024-26 informed its future commissioning needs to ensure sufficient market capacity, quality and sustainability. It focused on ethical, equitable and excellent care. Commissioning followed a life course approach with universal, targeted (such as flexicare – care at home and extra care) and specialist (such as nursing care) services.

The local authority was increasingly working with health partners towards integrated health and social care goals and joint commissioning specifications, for example in autism support services, advocacy, the Southwark Wellbeing Hub mental health support, accommodation for adults with multiple complex needs and equipment service procured via a pan-London consortium of 18 London boroughs.

The local authority engaged local people in the commissioning process to ensure people's views were included in decision making. This included working with VCSE organisations for consultation opportunities to ask what is important to people. The local authority worked closely with its parent carer forum, disability forum, group events and mailshot consultations. There were open forums and peer support groups for people with lived experience to provide feedback on using services. The local authority was expanding work with Southwark Independent Voice to bring in more diverse views. People and unpaid carers were invited to participate in procurement interview panels, for example in home care and disability hub commissioning. The local authority liaised with providers to develop provision by utilising existing resources and expanding capacity where needed. Providers reported a strong sense of partnership in commissioning, with regular meetings to discuss specific priorities. Commissioners worked with providers to achieve shared goals.

The local authority made efforts to improve its commissioning approach for local VCSE organisations, including shifting from contracts to grants in some areas and engaging earlier with VCS networks. Local VCSE partners described a more collaborative approach, for example in procurement of the mental health wellbeing hub.

Market shaping and commissioning to meet local needs

National data showed 62.95% of people who used services felt they had choice over services, slightly lower than the England average of 70.69% (ASCS 2024-25). 18.60% of unpaid carers accessed support or services allowing them to take a break from caring for >24hrs, similar to the 16.14% England average (SACE June 2024). The local authority was taking action to improve choice and availability of a range of local support that met people's care and support needs.

Commissioning priorities included supported living for people with learning disabilities, reablement and home care, shared lives service, carer support, mental health accommodation and wellbeing hub retendering. The local authority had established some 5-7 year contracts to provide market stability. In recognition of ageing population projections, commissioners were seeking to develop more nursing care home capacity. The local authority recognised the benefits of in-house and local authority owned properties, and funds were allocated to progress this.

Commissioning strategies were aligned with strategic objectives of partner agencies such as health, housing and public health. The local authority worked with system partners to agree strategic priorities for frailty, multiple long-term conditions, and children and young people with complex needs. There was a shared focus on improving quality of placements and supporting people to maximise their independence and recovery. System partners were working together to make improvements and bring people back into borough.

The local authority commissioned for outcomes rather than commissioning 'tasks', and providers were required to deliver services in ways that meet people's preferences. The Southwark Council Ethical Care Charter and Residential Care Charter, which applied to homecare and residential care services set out expectations for providers to allocate care worker visits to match the needs of person, with no minute-by-minute task-based commissioning or provision of care.

Commissioning staff supported some new and innovative approaches to care provision, where this led to better outcomes for people. For example, there was a significant drive towards positive behaviour support (PBS) and building a community of practice to ensure consistency across education, adult social care, and health. This included training a range of professionals and over 150 parents/carers to support young people demonstrating behaviours that may challenge.

There was specific consideration for the provision of services to meet the needs of unpaid carers. The local authority commissioned an external provider for information and advice to carers, provision of a 'carers café' and online support resources including online carer support groups, counselling and therapy sessions. The local authority was utilising the recommissioning of the carers service as an opportunity to build in flexibility to meet emerging needs, including more online support and a new carers centre. At the time of our assessment there was an ongoing review of the carers JSNA and the carers strategy to better understand and meet carer needs from the borough's diverse communities. This had identified 4 recommissioning priority areas around respite, employment, mental health and financial support. The local authority sought unpaid carer feedback in surveys, carer events and development of the service specification.

Senior leaders attend the carers forum to meet and gather views of unpaid carers, which had highlighted a need for greater respite capacity and better signposting to support resources. The local authority had developed an inventory of local support for unpaid carers including employment support, short breaks and residential respite. Some unpaid carers reported limited access to respite and they were frustrated at having set times and dates imposed on them, rather than being able to choose when to take their respite breaks. This was a gap in support. The local authority worked with other local authorities to identify how to provide more support for carers and expand the respite offer, including expansion of the Shared Lives Scheme, but current capacity did not meet local needs.

Ensuring sufficient capacity in local services to meet demand

Like other inner London boroughs, there was a relatively small care and support market in Southwark and the local authority commissioned provision in and from providers across south London and in neighbouring boroughs to meet demand and support residents as close to home as possible. Many staff reported challenges with local capacity to support people's needs, including people with complex urgent needs. The local authority had sufficient supply of domiciliary care, but undersupply of nursing care and complex needs placements, which it was taking address to address. Frontline staff highlighted the need for greater capacity in 24-hour emergency care placements, mental health placements, peer support, and supported living. Many people were placed out of area in other local authorities, but this was reducing.

Local authority data at the time of our assessment showed 38% of people were placed out of borough. Many were in settled in long-term placements, where they had been out-of-borough for a long period of time. Most people (60%) were placed in neighbouring London boroughs, close to Southwark. The specific geography of Southwark and local transport arrangements meant that for a large proportion of placements, an out of borough option was more accessible than some in-borough options and supported people's access to family and friendship networks. The local authority's analysis showed out of borough placements were the result of insufficient availability within Southwark, providers unable to meet people's specific needs, individuals declining in-borough placement and family preference. However, local authority data indicated a year-on-year reduction in out of area placements.

Some frontline staff told us some people were placed inappropriately out of borough due to a lack of suitable provision. For example, mental health staff sometimes had to place people far away due to lack of 24-hour care placements in the area. This resulted in some people having to rebuild their support networks when they returned to Southwark.

The local authority had plans to grow and develop additional in-borough care capacity so more residents could stay locally rather than being placed out of borough. This included expanding provision for specialist learning disability supported living, culturally specific and need-specialist home care and services for individuals with behaviours that challenge. Plans were also in place to increase nursing care provision and additional extra care housing with widened eligibility criteria. In the year up to our assessment the local authority had facilitated an 22% increase in bed days in local care homes and reduced the number of void bed days, to increase and sustain local sufficiency.

At the time of our assessment the local authority approved a planning application for a new dementia care nursing home and a land transaction for another new nursing care home in Peckham. Senior leaders acknowledged this additional capacity would take time to materialise and had decided to convert some residential care capacity to nursing care as an interim measure. In 2025 the local authority expanded its 'FlexiCare' extra care housing with on-site 24/7 care and support for adults with physical disabilities, learning disabilities or mental health needs. This expansion borough mitigated demand for residential care and created additional capacity to re-purpose some residential care to nursing care.

Staff reported a good range of tailored services to meet specific needs for people with learning disabilities, including the disability hub, Southwark community centre and day centres which supported people in the community with education and employment opportunities. The local authority encouraged provision of services that promoted people's independence rather than generic day services.

The local authority commissioned home care packages largely from 10 providers with 5 core providers operating across 4 neighbourhoods. Spot purchasing was used to address capacity challenges. The local authority was working with providers to develop culturally specific provision and enhance cultural competence to reflect the needs of the residents.

There were few instances of delayed care. In the 3 months up to our assessment 41 people waited for a service to start due to insufficient provider capacity. These delays affected a range of people, including those in hospital awaiting discharge and requiring complex care packages. People waited an average of 4 days before home care services commenced. In the 12 months up to our assessment, there were 14 hospital discharge delays due to lack of service capacity. These delays were due to the complexity of people's care needs. Emerging trends were around specialist services for people with a neurodiverse condition and people with multiple complex conditions, including dementia and substance misuse.

Local NHS partners reported sufficient packages of care to support people's discharge from hospital and the local authority was usually able to commission care within 24 hours, depending on the level of care required. Although they highlighted shortage of care homes, along with people's/families' specific preferences, contributed to delayed discharges.

Ensuring quality of local services

The local authority had proactive arrangements to monitor the quality and impact of commissioned care and support services, and it supported local care providers to improve where needed. The local authority had a provider quality assurance framework based on risk, with safeguarding concerns, complaints, and feedback used to measure safety. Staff carried out regular quality visits to observe care practice and environment safety such as safe medicines administration and infection prevention and control practices.

At the time of our assessment there were 71 regulated adult social care services in Southwark registered with the Care Quality Commission (CQC). The local authority worked with many providers across south London and other neighbouring local authorities, given geographical proximity to Southwark. Approximately 65% of the local authority's commissioned locations were rated 'good', 25% rated ‘requires improvement’ and 10% not yet rated. The local authority directly managed 1 CQC registered location - Orient St Adult Respite Unit in Kennington, which was rated ‘good’ across all domains. This demonstrated the local authority invested in the quality of if its own in-house provision.

The local authority was in the process of launching its ‘quality challenge’, working with Partnership Southwark and local providers to support ‘good’ services to move to ‘outstanding’ and ensure services do not fall below ‘good’. The local authority did not commission providers with reported safety or leadership concerns. Contract officers worked with the brokerage team to move people to alternative providers where there were safety concerns. Between August 2024 and August 2025, there were no out-of-area provider suspensions due to safety and quality concerns or contract non-compliance. 8 registered locations were deactivated in the 12 months up to our assessment.

There were robust provider quality assurance processes in place, and these were established and worked well. The local authority had a dedicated quality team to monitor quality of the regulated care market. The local Authority's quality and risk framework aligned with its market position statement vision to provide ethical, equitable and excellent care with governance oversight. The local authority used data to monitor contract performance with key performance indicators (KPI) relating to quality and safeguarding alerts, people's feedback, complaints, serious incidents and CQC ratings. The local authority actively maintained a market risk register, with action plans and monitoring controls in place to address quality concerns. Senior leaders, quality officers and commissioners attended a quarterly strategic quality review board to review quality information across services. This supported good management oversight and enabled the local authority to identify emerging trends and support opportunities for providers. Provider risk and quality information was shared with neighbouring local authorities and system partners. The local authority allocated sufficient resources to enable quick and robust responses to concerns including enhanced contract monitoring.

The local authority developed a new provider quality alert form to provide better insights into provider risks and concerns and capture quality themes. There was also a contract and quality handbook designed to standardise practice and ensure consistent quality across providers.

The local authority facilitated monthly provider forums for information sharing and networking, alongside newsletters and webinars to share learning, good practice and success stories. Contract officers and commissioners used the forum to deliver professionally led training on topics like pressure sore prevention and end of life care. Providers told us the local authority offered a wide range of training for care staff on topics such as prevention, mental health, and substance misuse.

Providers told us the local authority had a proactive and supportive approach and worked with them to find solutions. Each provider had an assigned quality monitor officer for routine information sharing. Quality monitoring officers carried out quarterly visits aligned with CQC regulations and standards. They observed people's care and sought feedback from them and their family members, including people who could not communicate their needs. Providers said this thoroughness helped them to be inspection ready. Contract officers also worked with providers to improve their services, which they found beneficial. They held quarterly KPI meetings to review provider performance and risk relating to safeguarding, staff vacancies, incidents and complaints. Providers told us they knew who to contact and they received timely responses from different teams. Quality officers shared examples of supporting providers with improvement plans where there were quality concerns, for example, providing medications compliance training and monitoring.

Ensuring local services are sustainable

The local authority was aware of the need for a sustainable care market and understood its current and future social care workforce needs. Although there were some challenges in recruitment and retention of local authority staff. The local authority used a range of methods to understand the local market and ensure it was diverse, sustainable and delivered high quality care and support. This was underpinned by the local authority's 'Visible Leadership, Evidence, Relationships, and Quality' (VERQ) commissioning approach. The commissioning cycle supported market sustainability including benchmarking prices with other commissioning authorities and the provider market to procure at sustainable prices, and undertaking a structured annual price review programme to ensure rates were sustainable over the course of contract lifetimes.

The local authority's market sustainability plan outlined its strategic focus on both short and long-term market sustainability. For example, the local authority adopted a range of procurement strategies to support provider sustainability, including block contracts in flexi-care, and market diversification in home care tenders. These were intended to ensure a balanced, resilient care market that meets the needs of Southwark residents.

The local authority's integrated commissioning strategy focused on deeper relationships with a smaller number of social care providers and support for improved workforce pay and conditions. This was underpinned by the Southwark Council Ethical Care Charter and Residential Care Charter, which applied to homecare and residential care services. The charters codified the local authority's support for the local social care workforce, including financial security measures such as payment of the London Living Wage, travel expenses, and occupational sick pay. Combined, these commitments were designed to improve recruitment, retention, and overall wellbeing of the care workforce, resulting in improved continuity and quality of care. Providers were expected to have adequate staffing levels and ensure staff were appropriately trained to ensure the delivery of safe and ethical care. Providers told us the Ethical Care Charter had helped their staff retention and 6 out of 7 local care homes that had signed up to the charter were fully established. Local authority data also showed the impact of the Ethical Care Charter in homecare had improved resident satisfaction from 55% in 2016 to mid-95% consistently since 2018. This indicated the charter had a positive effect on people's experiences.

Local workforce data demonstrated a relatively stable, experienced provider workforce. Skills for Care Adult Social Care 2024 workforce estimates indicated a 0.16 ASC staff turnover rate, better than the 0.25 England average. Staff sickness absence rates were 3.07%, also better than the England average of 5.33%. There was a vacancy rate of 8.52%, similar to the 8.06% England average. 49.09% of ASC staff had Care Certificate in progress, partially completed, or completed, which was slightly worse than the 55.53% England average.

Many local authority staff had trained, stayed and developed their careers in Southwark from apprenticeship to fully qualified. The local authority supported social workers and occupational therapists (OTs) to train as AMHPs in 2 cohorts each year. This indicated a 'grow your own' culture to support workforce recruitment and retention. However, approximately 30% of the local authority's ASC workforce was agency staff, 50% of whom were in post for 1-2 years. Senior leaders were addressing this with action to recruit a more permanent workforce, including apprenticeships, recruitment and retention bonuses, and a dedicated recruitment microsite and social media outreach to attract potential candidates. This had proven particularly successful in recruiting OTs. The local authority was committed to establish 500 key worker homes in the borough and social care professionals were a priority group for these to improve workforce recruitment and retention. Local authority data showed agency usage had decreased by 22% in the previous year and retention rates were improving.

The local authority collaborated with care providers to ensure that cost of care was transparent and fair. The commissioning team reviewed annual care costs with providers to inform care fee proposals. This included benchmarking across providers and other local authorities. Providers could also submit business cases to seek additional funding based on need. However, some providers told us discussions about price uplifts were not always detailed, they normally received a letter notifying them of any uplifts, which was then discussed afterwards.

The local authority worked with providers and stakeholders to understand current trading conditions and how providers were coping with them. Engagement and monitoring arrangements enabled the local authority to get early warnings of potential service disruptions or provider failure. There was a robust provider failure protocol to ensure people had continuity of care in the event of provider failure. Contract managers held regular conversations with providers about sustainability and the commissioning team reviewed information about providers' financial stability and risk. Providers were required to submit sustainability information as part of contract monitoring. These processes enabled early identification of concerns. In the 12 months up to our assessment, no care provider contracts were handed back from supported living, care home, and home care services. In the same period, one care provider exited the market. The local authority gave an example of a local care home that planned to close, which it purchased from the provider and conducted a rapid commissioning exercise to maintain the service provision and sustain local capacity. This resulted in 120 residents remaining in their settled placements and saving the jobs of care workers.

The local authority owned and invested in 5 local care home buildings, which provided a strong basis for close partnership working with care providers. Senior leaders highlighted this as evidence of the local authority's willingness to invest in capacity to ensure long-term sustainability by supporting providers who wish to enter the market but cannot afford to purchase property in the area. The local authority provided targeted support to providers, enabling them to develop existing properties or new sites for nursing care. This approach went beyond the traditional commissioner–provider relationship by fostering close collaboration with local providers.

Partnerships and communities

Score: 3

3 - Evidence shows a good standard

What people expect

I have care and support that is co-ordinated, and everyone works well together and with me.

The local authority commitment

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key findings for this quality statement

Partnership working to deliver shared local and national objectives

The local authority worked collaboratively with partners to agree and align strategic priorities, plans and responsibilities for people in the area. The local authority was a member of Partnership Southwark, which was set up in 2017 to join up services, tackle inequalities, and improve the health and wellbeing of Southwark residents. The Partnership Southwark Board approved the health and care plan and priorities for the borough. It included the local authority, health partners, VCSE representatives, care providers, and primary care services. The Partnership Southwark Health and Care Plan 2023-28 included principles for partnership working including asset-based community development, neighbourhood working, and shared learning. There were shared programmes such as Ageing Well, which focused on falls prevention and frailty, and help for older people and their carers to access financial, social and practical support.

The local authority integrated aspects of its care and support functions with partner agencies where it would support better outcomes for people. NHS partners and the local authority had a range of integrated services including urgent care and intermediate care. This resulted in very good outcomes for reablement and preventing readmission. Staff said it supported people to receive joined up health and social care, removed duplication, and people did not have to re-tell their needs multiple times.

Staff articulated many examples of joint and multidisciplinary (MDT) working, for example OTs attended weekly MDT meetings with other professionals including social workers. This allowed them to track people's progress and ensure relevant professionals were involved in people's care and support. The Transfer of Care team was based at a local hospital and was co-located in a shared office with health staff, which supported close working with discharge coordinators and the internal flow hub. This made information sharing much easier when reviewing patients who were experiencing delays or who did not have a clear discharge pathway. Weekly MDT meetings with ASC staff, therapists, nurses and medical staff enabled holistic support for people's needs.

Mental health services were jointly commissioned by the local authority and Integrated Care Board (ICB). NHS partners told us the local authority was supportive and they worked together to restructure community mental health services. The local authority shared ASC data and insights to help NHS partners plan services to meet the needs of Southwark residents. There were examples of joint ASC-NHS events and shared health promotion initiatives. NHS partners reported well-aligned strategies and goals with ASC and joint work to streamline efforts and maximise resources.

Arrangements to support effective partnership working

The local authority worked in partnership with other agencies and there were arrangements for governance, accountability, monitoring, quality assurance and information sharing. There were documented governance agreements and contracts in place that supported integrated working and set out how organisations worked together. The joint health and wellbeing action plan 2025-27 set out the partnerships between local authority, NHS and VCSE organisations to facilitate delivery of priorities to prevent ill health, promote wellbeing and reduce health inequalities.

The local authority worked with partner organisations to pool budgets and jointly fund services, including the Better Care Fund (BCF), where this meant it would achieve better outcomes. There was formal delegation of budgets to Place level in the integrated commissioning team. The BCF pooled budget arrangements were governed by a Section 75 (s75) agreement between the local authority and ICB, with shared responsibilities to implement the planned spending. A s75 agreement is a partnership arrangement between local authorities and NHS bodies that allows them to share resources and work together to improve health and social care services. The local priorities of the Southwark BCF focused on development of more specialist bed-based intermediate care services. Southwark had one of the highest rates of discharge to normal place of residence in London, reflecting a strong 'home first' approach supported by a range of intensive community-based health and care services, funded by the BCF.

However, there were few instances of pooled budgets or s75 agreements with other local health partners. Most commissioning budgets were held separately. In most cases this worked sufficiently well, but NHS partners highlighted limited shared financial resources as a barrier to efforts to improve waiting times and services for people, particularly in mental health services. Multiple governance routes for commissioning and joint funding decisions also added to complexity and required streamlining.

Senior leaders across local organisations highlighted aligned priorities and mutual commitment to make partnerships work. Partners convened in multiple forums including regular partnership meetings, bi-monthly development sessions, the health and wellbeing board and Partnership Southwark. There were shared priorities for ageing well, frailty, and long-term conditions. Partners had started neighbourhood work to align health and care provision across the borough. A strategic neighbourhood director was jointly employed by health and care partners. NHS partners reported good relationships and partnership working with the local authority. There was an established escalation framework in place, and leaders were accessible and responsive to each other. Senior leaders told us relationships were built on mutual respect and trust to tackle challenges together, particularly around funding and delegation of responsibilities. Although frontline staff reported ongoing challenges with Continuing Healthcare (CHC) assessments and resistance to agree CHC funding which they had escalated to senior leaders. There were ongoing conversations with health partners about this. ASC staff had undertaken specialist CHC training, and the local authority commissioned a medical advocate to assist residents with CHC applications and appeals. Senior ASC staff attended NHS appeals panels. This deepened their knowledge and insights in this area which strengthened their efforts to ensure CHC was more accessible to residents entitled to it.

System partners articulated a neighbourhood health and wellbeing focus, and they recognised ASC as an integral, critical partner. Local partners reported open communication and routine access to local authority senior leaders, which supported shared decision making. The Partnership Southwark board provided a forum for coordinated system planning and jointly find solutions to local challenges. This board was well integrated in local governance arrangements and reported to the Health and Wellbeing Board and Integrated Care Board to ensure effective oversight.

There were examples of effective internal partnerships with other local authority services and operational relationships were stable. Adult social care, children's services and public health were in the same local authority directorate, which supported a 'whole lifetime approach' to people's care and support needs and aligned priorities. There was evidence of partnership working across the local authority and adult social care was well respected in the council. There was alignment in vision and strategy between adult social care and other local authority teams which had some impact. For example, adult social care worked closely with public health on the prevention agenda. Together they jointly funded substance misuse and treatment services. The local authority had an integrated commissioning team for health and social care. Senior leaders described strong internal working relationships as open and transparent, which supported opportunities to share information, reduce organisational barriers and co-design services together.

Impact of partnership working

The local authority monitored and evaluated the impact of its partnership working on the costs of social care and the outcomes for people. This informed ongoing development and continuous improvement.

Staff reported a strong emphasis on collaborating with partners and colleagues. For example, a sensory worker told us how they supported a person with difficulties ascending/descending stairs to their apartment. The OT, social worker, and sensory team worked together to ensure the person was safe and had relevant care and support in place. Their joint problem solving allowed the person to stay in their home.

Public Health facilitated an 'accommodation cell' forum for system partners including adult social care, care home providers, and VCSE organisations to work together to share information on infection outbreaks and support providers with practical solutions to keep people safe. The group developed various protocols, such as catheter protocols and norovirus responses.

Intermediate care and social care staff attended local GP MDT meetings to support GPs to care for people with complex needs. This helped to reduce the number of people being referred to services multiple times, failed referrals and ensured people received the support they needed. NHS partners reported a subsequent reduction in the number of inappropriate referrals. The local authority worked with NHS partners to improve discharge pathways, including implementation of the trusted assessor model. The transfer of care hub also accepted transfer of care passports to reduce the need for social workers to return to a ward for people's assessments. Local data indicated approximately 85% of people were discharged in a timely way.

In 2024 the local authority and health partners redesigned intermediate care in Southwark to improve capacity and reduce delays for people using the service. Changes to the service saw geographical working along neighbourhood lines, shared caseloads across smaller teams, and decentralised processes to allow greater staff control. Local authority data showed significant reductions in waiting lists for intermediate care support from a peak of 80 days previously, to 30 days after the changes were made. Following this success the local authority and health partners expanded to project to a further 5 patches to integrate the new ways of working to support locally targeted health inequalities work.

The local authority worked with a local NHS partner to develop an integrated health and social care urgent response, and short term rehabilitation and reablement pathway. An external review singled out Intermediate Care Southwark for the high-quality service it provided. The service was proactive in ensuring people had access to the right care within the community, supported them to remain independent and safe at home and prevented the need for hospital admission or long-term care.

Working with voluntary and charity sector groups

The local authority worked collaboratively with voluntary and charity organisations to understand and meet local social care needs. The local authority invested in community, faith, and voluntary assets to meet the needs of the local people and promote and support prevention and wellbeing. Senior leaders reported close partnership working with the VCSE sector and the local authority provided funding and other support opportunities to encourage growth and innovation in these organisations. Local partners told us the partnership between the local authority and VCSE partners was strong to address and reduce inequalities and organisations worked together to resolve issues.

Staff and NHS partners told us the local authority worked well with the VCSE sector to improve support for people. There were some jointly commissioned services with local and national charity organisations, for example to support people with mental health conditions. The local authority worked with NHS partners to commission various lived experience services in Southwark to improve access, experience, and care outcomes for residents.

The local authority had established formal mechanisms to engage with the voluntary and community sector. This included VCSE representation on the health and wellbeing board and the Partnership Southwark strategic board. Local VCSE partners said this reflected a level of respect and recognition for the sector and showed the local authority actively involved VCSE partners in strategic decision making. Community Southwark was also an umbrella body that supported and coordinated voluntary sector organisations.

The local authority provided VCSE funding through contracts and grants, but some groups told us they were struggling financially, under-resourced and not sustainable because of financial precarity. This impacted on the sector's ability to support preventative and community-based approaches to care provision.

Some VCSE organisations reported that local authority departments were siloed and engagement was uncoordinated. Some VCSE organisations also explained the local authority's communications were often inaccessible due to technical language. For example, some VCSE organisations noted the language used in commissioning was very technical, which presented barriers for smaller organisations. The local authority had made some progress to address this, but further work was needed to improve how it communicated, consulted and engaged with community organisations.

Theme 3: How London Borough of Southwark ensures safety within the system

This theme includes these quality statements:

- Safe pathways, systems and transitions
- Safeguarding

We may not always review all quality statements during every assessment.

Safe pathways, systems and transitions

Score: 2

2 - Evidence shows some shortfalls

What people expect

When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place. I feel safe and am supported to understand and manage any risks.

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Key findings for this quality statement

Safety management

Systems were in place to support staff to keep people safe with timely interventions, and the local authority prioritised people's care based on risk, and these mostly worked well. Staff used a risk rating system to prioritise interventions and mitigate concerns to maintain people's health and wellbeing. There was a good multi-disciplinary approach to sharing and managing risk between internal teams and external partners. Practitioners described that risk was shared and they had good peer support in emergencies. The local authority was in the process of developing alerts on the electronic record system to help staff manage risk if there were particular dangers or sensitivities. Managers used live data dashboards to inform decisions and allocate resources according to need and risk. The local authority had an inventory of multi-disciplinary panels, such a hoarding panel, to support front line staff with decision making and proportionate risk management. These additional safeguards helped ensure people with complex needs received appropriate interventions, including mitigation plans for people who declined support.

We reviewed a sample of people's records which showed potential safety risks were considered and mitigated in assessments and reviews. Risks were well-balanced with people's right to independence, and there was acknowledgement of positive risk taking to maximise independence.

Some staff reported delays in sharing information with social workers and missed joint visits – including for cases involving identified risks. Staff also told us information sharing was a challenge and needed to improve as information was not always easily available. Some staff reported the local authority's electronic records system was not user friendly as it took a long time to complete assessment and safeguarding forms. Staff also told us it took a long time for changes to be made to the system. However, many staff mentioned new AI support tools had helped to streamline and reduce the time it took to complete forms and assessments on the system.

There were processes to safely share information with local partners and providers, including the London Care Record. This collated people's health and social care information from across the system into one place. The local authority had access to some parts of the shared care record system where information governance, training and processes were agreed and in place, for example mental health, and hospital discharge.

Some staff who worked between health and adult social care used two separate records systems. For example, the integrated discharge team primarily used a health case management system managed by a local NHS trust partner. There were systems in place to ensure all Care Act related activity was recorded on the local authority system to help maintain oversight of service provision. However, there were some practical challenges with the interoperability of different systems, and a recognised need for more consistent record keeping across both records systems. NHS partners highlighted a need for improved record keeping by social care staff on the NHS electronic record system to make it easier for all professionals in the MDT to stay informed about actions taken by social care, both for holistic care and targeted interventions. This sometimes impacted their ability to fully assess risks, for example when planning to discharge patients. There was ongoing training to ensure all local authority workers could access NHS systems, and team managers discussed the importance of recording on both systems during supervision and team meetings.

The out-of-hours emergency duty team (EDT) operated from 5pm to 9am the following day. A manager was accessible at all times for support and senior managers were on call for funding approvals or support with complex situations. The team had sufficient capacity to manage the workload, but they described it as busy and high pressured, with only 1 social worker covering children's and adults calls from 4am-9am. In situations requiring a home visit the EDT team manager acted as an EDT worker to respond to calls while the worker was unavailable.

There were clear handover procedures to the EDT, which ensured staff were kept fully informed of risks. EDT staff were included in MDT meeting to ensure they were informed of people's support plans. However, EDT sometimes received inappropriate referrals from the day teams, including referrals for tasks staff had not been able to complete during their working hours. EDT staff articulated their role to manage out-of-hours crisis situations, not as an extension of day teams. Managers were aware of this and were exploring joint EDT and day team meetings to improve communication.

The EDT did not have access to emergency funds and there were examples of staff using their own money in emergencies, for example to provide food to people in crisis. The EDT could authorise care agencies to purchase food and had access to food vouchers for a local supermarket, but not all people could get there.

Safety during transitions

There was a structured preparing for adulthood process to support young people's transition from children to adult social care services. There were clear referral and joint working pathways between the local authority's All Age Disability team and multi-agency partners such as children's social care, education and health which supported staff to understand expectations and provide the support required. There was a focus on maximising young people's choice, voice and independence during the process to ensure their views and wishes were central to all decisions. There were specific pathways for looked after children as part of the preparation to adulthood process. The transitions process started at 14 years old, within a single All ages Disability Service (AAD) pathway.

The AAD team provided specialist support for children and young people with severe, enduring and permanent disabilities. The local authority's 0-25 single care pathway mapped out the child's/young person's journey from infancy, adolescence, transition to adulthood up to 25 years old when the young person was transferred to the 25+ learning disability team or adult physical disability team. The AAD single care pathway removed the need for case transfers to different teams at 14 and 18 years.

The assessment process identified how the young person's needs might impact on their wellbeing as they transitioned into adulthood, outcomes they wanted to achieve, and what support was required to enable them. The Care Act assessment was initiated at 17.5 years old, which supported exploring plans for independent living, participating in society, employment and leading a healthy adult life. Assessments were completed over a few sessions to ensure all needs were considered and the assessment was not rushed, but this did not always provide sufficient time for planning after assessment before the young person turned 18.

The local authority provided some innovative support such as grief counselling for parents to help manage their expectations during transitions. This supported good conversations with young people and families to plan their care needs. However, we heard mixed feedback from families about the transitions process. Some highlighted good continuity of care and a consistent social worker allocated to support them. They described seamless and straightforward transition in good time and were kept informed. Others spoke about delayed assessments and limited discussion of transition or future care planning. In some cases it created anxiety and frustration for young people and their families about what support they could expect. There was ongoing outreach work to engage young people aged 15-17 on their perspective of transition and how they want the local authority to engage with them. The local authority was developing resources like video diaries and open days to amplify young people's voices. This work was new and in progress.

Local VCSE organisations also highlighted a need for improved 'waiting well' support for young people waiting for mental health care support whilst they transitioned from CAMHS to adult mental health services.

Most feedback from people discharged from hospital highlighted good coordination of care and consistency of support. Although we heard mixed feedback about people's care journeys and experience of support once they were home. We heard examples of people waiting for home care support and some families had made their own arrangements until appropriate care was provided by the local authority. Some providers also reported challenges with hospital discharges, with some inappropriate discharges for people not well enough or ready to leave hospital. Providers knew how to escalate such concerns, which the local authority had addressed promptly. Managers told us managing demand and pressures around hospital discharge was an area for improvement. The local authority applied discharge to assess processes and had increased resources in integrated discharge teams to better support people in their journey from hospital to home.

NHS partners also explained challenges in the discharge process for people with mental health conditions or learning disabilities. The learning disabilities and mental health teams were responsible for undertaking hospital assessments and managing discharges, but the transfer of care hub only worked with those people eligible for the older people and people with physical disability OPPD team. Each team operated differently and had different priorities, which sometimes delayed people's discharge. Partners had raised this directly and the local authority recently started work to transform the referral management system and front door to the OPPD team. At the time of our assessment this was in very early-stage scoping.

The local authority participated in a cross-southeast London returning home from hospital project to support people during hospital discharge. This included provision of information in accessible and audio-visual formats, and volunteers conducted follow up calls with people for 6-8 weeks to provide post discharge support. The local authority was exploring how this could be expanded across other south east London boroughs.

The local authority had a process for permanent moves to and from other local authorities to ensure people's continuity of care. When a person requiring support moved to Southwark from another local authority (moving of their own volition) staff would assess their eligibility and work with the other local authority to review the person's needs, including current and interim arrangements. For people moving out of Southwark, the local authority would assess capacity and then work with the destination local authority to support the move. The local authority worked with providers when a transition is needed from one service to another, and providers gave examples of working together to ensure a seamless transition. This showed the local authority had arrangements to support people's transfer of care.

Local nursing and care home providers highlighted good support and communication from social work teams when a new resident was admitted, with extensive 'pre-mobilisation' leading up to the admission to ensure a seamless transition. They monitored how residents were settling in, with regular contact and input. Providers told us social workers were invested and supportive, they brought residents to the new home and helped them settle in without any delays or issues. The local authority ensured relevant professionals, including the provider, were involved in MDT meetings.

Contingency planning

The service had documented processes for contingency planning in the event of disruption to people's care. This sat alongside emergency and business continuity planning mechanisms to prevent service disruptions, such as provider failure. The local authority had clear guidelines to ensure providers were offered support, risk was managed and people affected were not negatively affected by any changes.

Partner organisations told us the local authority's care sector management and oversight worked well, and there was a robust approach to joint funding and information sharing. There were processes for provider failure led by the local authority with support from the ICB. The local authority demonstrated its management of a recent care home closure, which would have impacted 128 residents. The local authority offered to buy the care home, which it managed for 5 months while a fast-track procurement exercise was completed to find a new provider to manage the home. Residents and their families were involved in the decision, and the local authority's approach ensured continuity and stability of people's care and maintained local capacity.

The local authority had a clear business continuity plan for adult social care and health services, and specific planning for seasonal pressures. The local authority's emergency planning and resilience team coordinated the response to major incidents and tested and validated contingency plans to ensure they worked. There were assigned roles in the event of a serious incident or provider failure.

Front line staff were supported to set up immediate care packages in crisis situations where a person's assessment was not yet completed. Staff attended emergency same day panels with managers to ensure suitable packages of care were in place in a timely way.

Many people we spoke with had good support from family and friends, which supported them in the event of an emergency or crisis. In our case tracking exercise, the people's records we reviewed showed contingency planning had been discussed and explored. In most cases support plans were detailed and had contingency plans in place to protect the person and public, including a list of professionals involved in the person's care, such as advocates and health professionals. For example, mental health practitioners mitigated risks with detailed care plan contingencies and contact details for the local psychiatry liaison team to reduce possible further distress to the person. They ensured people had contact details for the Samaritans and referred them to community-based support while they waited for a Mental Health Act assessment.

There was emergency provision for unpaid carers which could be accessed in crisis situations out of hours. The local authority brokerage team was responsible for sourcing emergency care and respite placements. 24-hour care in people's homes was available as an interim measure until a suitable care placement was found to meet the person's needs. However, some carers we spoke with were not aware of contingency planning for the person they cared for should they not be available or if they could not continue caring for them. Some unpaid carers told us they relied on family members to bridge care gaps because they were not unaware of what support was available.

Safeguarding

Score: 2

2 - Evidence shows some shortfalls

What people expect

I feel safe and am supported to understand and manage any risks.

The local authority commitment

We work with people to understand what being safe means to them and work with our partners to develop the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Key findings for this quality statement

Safeguarding systems, processes and practices

There were safeguarding systems, processes, practices to make sure people were protected from abuse and neglect. The local authority had safeguarding management and leadership structures in place, and local processes were in line with the Care Act 2014. Safeguarding roles and responsibilities were clearly defined with guiding principles of strength-based and person-centred practice, with clear risk assessments to support practitioners managing safeguarding concerns. Safeguarding responsibilities were delegated to frontline teams, rather than a centralised team. Safeguarding was seen as everybody's business and there was overarching advisory support.

The local authority's safeguarding indicators were in line with England averages. 63.35% of people who used services in Southwark felt safe, slightly lower than the 71.16% England average (ASCS 2024-25). 87.50% of people who used services said those services made them feel safe and secure, similar to the England average of 87.81% (ASCS 202425). The Survey of Adult Carers in England (SACE, June 2024) also found 74.16% of unpaid carers felt safe, slightly worse than the 80.93% England average.

National data also showed not all staff involved in safeguarding work were suitably skilled and supported to undertake safeguarding duties effectively. Skills for Care Adult Social Care Workforce Estimates showed 1.21% of independent/LA staff had completed MCA DoLS training, which was significantly lower that the England average of 46.27%. Similarly, only 20.00% of independent/LA staff had completed safeguarding adults training, also significantly lower than the England average of 60.68%. There was limited awareness of training completion gaps in the local Safeguarding Adults Board (SAB), which had not identified training uptake as a local concern.

The local authority provided free safeguarding training for staff and partners, including local VCSE organisations. This included safeguarding legal literacy and domestic violence awareness. There were safeguarding 'champions' in social work teams which supported safeguarding improvement work. 'Lunch and learn' sessions and '7-minute briefings' were used to support learning from Safeguarding Adult Reviews (SARs), and learning from specific cases was shared in team meetings, reflective practice and peer group sessions. Senior leaders recognised some learning methods were not effective and staff were not accessing them. There were plans to investigate more innovative learning materials such as video interviews and resident stories, aligned with thematic reviews. Additionally, some staff were not clear where these learning needs had come from or why they were doing the training. There was scope to improve learning from SARs to proactively reduce the risk of further incidents and concerns.

The local authority published online information about its safeguarding duties, types of abuse and how to report alleged abuse, including contact details with telephone numbers and email addresses for each team supporting different types of people accessing adult social care. The local authority did not have an online reporting system or proforma. At the time of our assessment user-testing of an online safeguarding reporting form was ongoing. To report a concern, the public had to telephone or email the relevant team. There were risks associated with this process as it did not support sufficient formal audit trail in comparison to an online portal form, and was contingent on the immediacy of the duty worker response. There was limited consideration as to how digitally excluded people would find this contact information to raise a safeguarding concern.

The local authority had a safeguarding adults improvement plan and improving safeguarding pathways was a key priorities to improve safeguarding pathways and workflows. However, a number of actions were marked as deferred, pending or incomplete, including quality audits of the local authority's safeguarding process and completion of the safeguarding adults partnership tool as a form of peer review.

The local authority worked with the local SAB and partners to deliver a co-ordinated approach to safeguarding adults in the area. There was a multi-agency safeguarding partnership, and roles and responsibilities for identifying and responding to concerns were clear. Information sharing arrangements were in place for concerns to be raised and investigated quickly. Staff told us local multi-agency risk assessment conference (MARAC) and multi-agency public protection arrangement (MAPPA) were strong in Southwark and shared information on dangerous offenders and high-risk domestic violence cases. The local authority used an electronic recording system to communicate safeguarding concerns with the police, with protocols for response within 1 day.

Frontline staff worked with other professionals to safeguard people and they gave examples of keeping vulnerable people safe. However, some staff experienced challenges with external partners, particularly the police service. There were reports of frequent turnover of local police representatives which impacted on information sharing and effective partnership working. It was sometimes difficult for staff to get the information they needed from the police to conclude safeguarding investigations. Staff explained reporting a missing person also took a significant amount of time to do. Police frequently did not attend joint visits, which caused delays and acted as a barrier to keeping people safe. There was a need for better joint working with the police around safeguarding, for which managers aware and taking action. Safeguarding managers were liaising with the local police force to get a named officer to contact for information and updates.

Staff in other council departments such as housing were required to complete safeguarding training. There was an annual joint conference between housing and ASC to share safeguarding updates and learning, for example relating to hoarding and cuckooing. Formalised arrangements with police, fire, housing, public health and ASC, such as a cuckooing panel and hoarding panel, supported joined up working to safeguard people with complex vulnerabilities. There were examples where people with hoarding issues had received support to resolve it, and people at risk of cuckooing had been re-housed.

Work was ongoing to embed new safeguarding practices to improve consistency of practice across teams. This included new forms of the electronic record system, and training on trauma-informed practice. Managers conducted monthly case file audits of previous assessments to check for clear recording of chronology and strength-based language. However, beyond this there was limited evidence of quality audits of practice or peer reviews to govern the efficacy of safeguarding practice at the local authority.

Responding to local safeguarding risks and issues

There was a clear understanding of the safeguarding risks and issues in the area. The local authority worked with safeguarding partners to reduce risks and to prevent abuse and neglect from occurring. Work was ongoing to ensure lessons were learned when people had experienced serious abuse or neglect and action taken to reduce future risks and drive best practice.

The local SAB was well attended by the local authority and other statutory and non-statutory organisations and there was clear senior management representation with clear governance structures. Substantial development work had been carried out to improve multi-agency safeguarding partnerships, develop local capacity to respond to safeguarding risks and concerns, and align strategic priorities. There was an ongoing review of SAB processes and an improvement plan. The SAB was supported to deliver its strategic objectives by a range of subgroups and forums. There was an interface between the Safeguarding Partnership Board, SAB executive board and SAB sub-groups and a learning network with a feedback loop from strategic priorities to operational practice. There was good VCS sector representation on the SAB and partners reported good intelligence sharing and constructive working relationships. The local authority was seen as a very active and engaged partner in the SAB.

The SAB indicated some concerns from people about the safeguarding support they had received, with patterns of dissatisfied outcomes, particularly for people with mental capacity issues. The SAB was also reviewing the quality of safeguarding investigations and people's voice within them. Although the SAB received quarterly performance reports, there was scope to improve SAB oversight of safeguarding performance and improve its connection with frontline practice as this was not sufficiently scrutinised. For example, review of safeguarding training uptake. Most information presented to the SAB was from the local authority, rather than other partners, which limited opportunities for wider oversight and scrutiny across the system.

The SAB identified system-wide concerns around lower-level safeguarding concerns not meeting the threshold for support. There was a thematic priority to understand how partner agencies were addressing this. The local authority's community outreach with community safety partnership staff supported safeguarding prevention and intelligence gathering on cross-cutting issues such as self-neglect, serious youth violence and how safe people feel.

In the 2 years up to our assessment the SAB received 11 referrals meeting the criteria for a SAR. At the time of our assessment there were 2 ongoing SARs, one near publication, 2 commissioned and 2 awaiting commissioning. There were commonalities within SAR themes, which included suicide and mental health support, self-neglect, dementia, and transfers of care. The local authority identified these trends were consistent with other nearby local authorities and had responded to them with a focus on transitional safeguarding, improving staff training in professional curiosity, reviewing case chronologies and accumulative risk. The local authority had created a dedicated post within mental health services following an increase in cases relating to hoarding, which was anticipated to improve the response to this issue. However, providers told us the local authority did not routinely share learning outcomes from safeguarding adult reviews with them.

There was some community outreach activity to engage different populations in safeguarding awareness. This included an ASC stall at Southwark LGBT Pride in summer 2025. There was also a supporting vulnerable adults learning day with local VCSE organisations to improve community awareness of safeguarding and how to make a referral. The SAB independent chair attended a Community Southwark (our local umbrella CVS organisation) learning event in 2025 for charities working across the borough to present on safeguarding themes, processes, policies and training. This showed the local authority was engaging different communities to support people to access safeguarding. Feedback from local people and VCSE groups at these events was used to update to the local authority's safeguarding referral process.

Responding to concerns and undertaking Section 42 enquiries

A Section 42 (s42) enquiry refers to the action taken by a local authority in response to a concern that a person with care and support needs may be at risk of or experiencing abuse or neglect. Local authority staff were supported by local and national guidance to inform their decision making, and there was clarity on what constituted a s42 safeguarding concern and when s42 safeguarding enquiries are required.

Local authority data from 2023-24 showed 1102 safeguarding concerns were received, of which 295 were converted to a s42 enquiry, representing a 27% conversion rate. This was a 5% increase from the previous year and a 2.5% deviation from the national average (presently 29.5% - NHS digital). Reported safeguarding concerns had continued to fall from a peak in 2020-21. At the time of our assessment the local authority did not have a waiting list for s42 enquiry initial review and immediate risks were mitigated to ensure the person was safe. There were 18 safeguarding enquiries awaiting allocation, with a median wait time of 22 days and a maximum wait of 58 days (the person waiting the longest was because they were currently in hospital receiving treatment). The local target timeframe was 2 days. Service managers had access to a data dashboard of all incoming safeguarding referrals that were not completed, started or allocated in one day, which supported management and oversight.

When safeguarding enquiries were conducted by another agency, such as a care or health provider, the local authority retained responsibility for the enquiries and the outcome for the person(s) concerned. Partner organisations could make direct contact with the allocated social worker to discuss any safeguarding issues. Local NHS partners told us the local authority was responsive to safeguarding referrals, and there were monthly joint oversight meetings to discuss safeguarding cases. The local authority provided safeguarding training for NHS staff and was in the process of introducing an online form to make referrals easier.

Relevant agencies were informed of the outcomes of safeguarding enquiries when it was necessary for the ongoing safety of the person concerned. Most local providers told us the local authority was responsive to safeguarding concerns and were kept informed about outcomes and learning from the safeguarding enquiry. Providers were assigned a safeguarding lead to support them through the safeguarding process, which they found beneficial. Providers told us it was sometimes challenging to reach a social worker by telephone to discuss safeguarding concerns, and they usually received quicker responses via email. Quality assurance officers discussed safeguarding concerns in quarterly assurance meetings with providers. The local authority also provided guidance on what constitutes a safeguarding concern and what information to include when raising a safeguarding concern. However, some partners told us enquiry outcomes were not always shared in a timely way, and they often had to chase social workers for updates regarding investigation progress.

Frontline staff told us they sometimes got inappropriate or repeat safeguarding enquiries from providers and partners, which took up valuable time, so the local authority had assigned social workers in the contact team to help address inappropriate referrals.

The local authority had structures in place to ensure oversight and risk management of safeguarding relating to the Mental Capacity Act (2008) Deprivation of Liberty Safeguards (DoLS), but there was a backlog of DoLS assessments. There was a dedicated team and tools to assist with prioritising applications and managing waiting times in a safe way. At the time of our assessment there were 146 people waiting for a DoLS assessment (this did not include community DoLS), with a median wait time of 70 days. The local target was 21 days. The DoLS coordinator reviewed all people on the waiting list, which was prioritised based on the amount of time the person has been waiting and other factors. Providers told us DoLS officers were responsive and quick to complete the initial DoLS assessment, but the authorisation process was slow and there was a need for improved prioritisation of DoLS applications.

Local authority data showed a trend over time of a significant increase in applications. Frontline staff reported an increase in the number of DoLS applications, including many people in supported living requiring community DoLS. Staff told us there were delays completing community DoLS applications caused by delays obtaining Court of Protection and GP information.

There was a DoLS action plan in response to a backlog of cases. The response focused on a light touch virtual assessments for non-complex DoLS referrals, and introducing a RAG rating and prioritisation of DOLS cases. The local authority had increased internal capacity by training more staff to undertake best interest assessments (BIA), increasing the number of authorising signatories, and working with external BIAs. Improvement work also resulted in DoLS assessments being recorded on the electronic records system. Senior leaders explained system and process changes introduced in 2025 were already making a positive difference and had reduced the number of people waiting.

Making safeguarding personal

Making safeguarding personal was a strategic priority for the local authority. Safeguarding enquiries were carried out sensitively, keeping the wishes and best interests of the person concerned at the centre. Although some people had to wait for investigations. All people waiting had an initial review and immediate risks were mitigated to ensure they were safe. Most people had the information they needed to understand safeguarding, what being safe meant to them, and how to raise concerns when they didn't feel safe or they had concerns about the safety of other people. Local authority data showed 67% of people were asked about their desired outcomes for safeguarding investigations and in 95% of cases these were achieved.

Staff told us they made safeguarding personal by visiting at-risk people to ascertain their views and wishes (including an assessment of mental capacity if necessary), give them sufficient control of the process, support them to identify their preferred outcomes from safeguarding investigations, and seek their views about the process. People could participate in the safeguarding process as much as they wanted to.

Timely, independent advocacy support was available to help people participate fully in safeguarding processes. The local authority supported people to access an advocate to help them understand their rights and make choices that balanced risks with positive choice and control in their lives. Staff told us the referral process for paid advocacy was simple and effective and advocates were in place quickly when required. However, the local authority previously recorded incomplete data on advocacy usage which reduced its performance in national data sets. National data showed 33.33% of individuals lacking capacity were supported by an advocate, family or friend, a significantly negative variation to the England average of 83.30% (Safeguarding Adults Collection, August 2025). The local authority acknowledged it only recorded advocacy support by commissioned and independent advocacy and did not include family or friend involvement. The local authority was adapting its case management system to ensure accurate and full reporting. The commissioned advocacy service indicated they had received increased referrals for safeguarding, but this remained lower than they expected. The commissioned provider had introduced a waiting list for relevant person's representation advocacy, and there were only 5 people waiting.

Local authority audits indicated people's voices were heard in safeguarding investigations. However, there were no formal opportunities for people's involvement in the SAB or for local people to co-produce or influence the work of the SAB and share their views on safeguarding pathways. Senior leaders told us the voice of people using services has weakened in recent years partly because there were different forums to people to speak with the local authority. This was acknowledged in the SAB risk register and it was part of the SAB business plan 2026 to seek resident stories.

Theme 4: Leadership

This theme includes these quality statements:

- Governance, management and sustainability

- Learning, improvement and innovation

We may not always review all quality statements during every assessment.

Governance, management and sustainability

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Key findings for this quality statement

Governance, accountability and risk management

The local authority had clear and effective governance, management and accountability arrangements which provided visibility and assurance on delivery of its Care Act duties, quality, sustainability and risks to people's care and support experiences and outcomes.

There was a stable adult social care leadership team with clear roles, responsibilities and accountabilities. Staff and elected members described a well-established, focused, capable leadership team that understood community needs and the services needed to support them. The Director of Adult Social Care and Strategic Director of Children's and Adults' Services (statutory DASS) had both worked at the local authority for many years and were well regarded by staff and local partners. Partners told us ASC was a well-run and respected department, local authority leaders were proactive in addressing local concerns and they engaged partners in difficult discussions about challenges.

Service leaders were experienced adult social care professionals which enabled them to support staff effectively in their roles. Leaders were determined to be visible, accessible, and communicated decisions clearly to staff. Leaders described a 'high challenge high support' culture within the organisation.

The staff we met were committed to the local authority and felt motivated to do their jobs to the best of their abilities. Staff consistently told us they had good access to managers. Several highlighted a good balance between support and autonomy in the management approach, which enabled them to perform better, and they felt managers listened to them. They consistently highlighted a clear leadership structure with good accountability, which enabled honest and open conversations.

Frontline staff told us senior managers were visible and approachable and they knew who to contact if their direct line manager was unavailable. Managers completed joint visits with frontline staff in urgent/critical situations, which evidenced a supportive culture in practice. They supported staff learning and progression and many staff described them as 'role models'. Staff mentioned managers were connected to the realities of frontline work, with clear levels of authority and escalation. Senior leaders recognised the good work of staff through awards and acknowledgement in newsletters, which made staff feel valued.

The local authority had established risk management and assurance processes to support management oversight. Risk registers were completed thoroughly and included control measures to mitigate future concerns. Although there were no timescales to indicate how often risks were reviewed. The local authority's risk register published in April 2025 considered significant risks across the local adult social landscape, including budgetary pressure, increasing demand for adult social care and waiting lists. Each risk was scored for likelihood and impact, with clear accountable leads assigned to directors of the ASC leadership team.

There were documented and established governance escalation and oversight processes, with clear lines of reporting and escalation. This included a planned programme of meetings for cabinet, corporate management team, children's and adults board, directorate management team, and individual teams for oversight of ASC quality and risk.

Local political relationships were mature and scrutiny of adult social care was effective, both internally and with key partners within Partnership Southwark. The health and wellbeing board maintained scrutiny and oversight and regular meetings were held with the Place Director, Director of Public Health and Director of Adult Social Care to maintain alignment and connection. The remit of the health and wellbeing board was expanded in the year prior to assessment to include wider determinates of health and the strategic lead for housing was added as a standing member in acknowledgement of the importance of housing and place-making in the health and wellbeing agenda.

The local authority's political and executive leaders were well engaged and informed about adult social care performance and risk. They had a holistic view of Southwark and in-depth understanding of local challenges, and they worked with officers to find solutions. This included opposition members, who were well briefed, engaged and supported a collaborative approach to social care. Elected members felt staff and leaders were all working towards a cohesive vision, with good internal challenge and a culture where staff, elected members and residents could raise concerns.

Elected members reported timely support and response to enquiries. They received regular performance updates from adult social care, including details about waiting lists. Councillors collectively agreed items for scrutiny each year based on feedback from their constituents. Senior leaders reported good political support from the full-time paid cabinet lead for adult social care. The lead member for ASC was also the chair of Partnership Southwark and chair of the health and wellbeing board, which facilitated good oversight, leadership and advocacy for residents. The ASC service was well-represented and prioritised in council decision making. Elected members were very active in their communities and shared information with officers, including individual cases and complaints, which often solved problems for residents at source.

Strategic planning

The local authority used information about risks, performance, inequalities and outcomes to inform its adult social care strategy and plans and allocate resources to deliver actions needed to improve care and support outcomes for people and local communities.

The local authority used data to review service performance monitor and identify risks. There were core measures and key performance indicators for each local authority department, and data dashboards to review all performance to scrutinise, challenge and support. A monthly data and insights group met quarterly, strategic commissioning boards every 6 weeks, and the senior management team met monthly to share learning, performance, trends and insights about budgets, standards audits, recruitment and retention, safeguarding, complaints and assessment waiting lists. Narrative reports provided more detail with operational input to provide broader picture insights. Managers had access to service performance data dashboards, with capability to review granular, person-level information to help manage individual and service-level risks. Data was validated with frontline staff to ensure it was accurate. Performance data were shared with frontline staff to support an open culture where discussions about performance were encouraged. There were monthly Partnership Southwark meetings with NHS partners to share learning, analyse borough performance data and identify needs for pool resources or service investment. The local authority also benchmarked itself against other southeast London boroughs. This ensured local authority leaders had assurance of service performance and supported strategic planning.

The local authority worked with a wide range of stakeholders including people with lived experience, partners, carers and family members to co-produce its strategies and plans, including the Southwark strategy 2030, joint health and wellbeing strategy 2022-27 and adult social care business plan 2023-28. The local authority vision for social care was ‘delivering a better quality of life in Southwark together’ guided by three core principles to reduce inequality, empower people and invest in prevention. The local authority’s strategic priorities were clearly set out, but there were no timescales for when these priorities were to be achieved.

The local authority's business plan included priorities to improve safeguarding pathways, improve the local authority's carers offer, improve health and wellbeing of staff and improve the short breaks offer for young people with learning disabilities. There was a corresponding action plan which indicated progress against these priorities. Examples included short breaks provision delegated to the disability hub for more timely support, and an unpaid carers hospital discharge project to improve carer support during people's transition from hospital to home.

The local authority had arrangements in place for robust financial governance, planning and management with a recently published 3-year budget plan and comprehensive financial strategy. Local authority leaders and elected members reported Adult Social Care had consistently operated within its budget for the past decade and was in a stable financial position. Although recent increases in demand put pressure on department budgets and required use of reserve funds. Senior leaders articulated a clear approach to spending, saving and investment, which balanced immediate and longer-term needs.

Information security

The local authority had arrangements to maintain the security, availability, integrity and confidentiality of data, records and data management systems. There was a data protection policy and safeguards such as data privacy notices on the electronic records system which supported staff to keep people's personal information safe. Staff had access only to their own service level data to ensure data integrity and confidentiality. All staff had to complete mandatory data protection training. There was a data protection officer and senior information risk owner which supported governance of data sharing. There were clear arrangements for when staff shared information with external organisations.

The local authority used secure electronic records and data management systems to store people's information. Staff received training in using these systems and in-house IT support was available. Some frontline teams, mostly those working in integrated teams with health partners, used two separate recording systems, which staff explained improved their access to timely information, but there were some challenges with integration of data and ensuring all information was recorded on both systems equitably.

The local authority was a partner in the South East London Care Record system. Users included local NHS trusts, other local authorities in the area, the local hospice, and several care homes and pharmacies. A March 2025 usage report showed a general upward trend of use over the previous 12 months across all partners, and the local authority was one of the most prolific users accessing the system. Local authority staff also had access to the London Care Record system, which allowed for some data sharing, but staff told us the information available was limited and did not have information about people's ongoing safeguarding concerns.

Learning, improvement and innovation

Score: 3

3 - Evidence shows a good standard

The local authority commitment

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Key findings for this quality statement

Continuous learning, improvement and professional development

There was an inclusive and positive culture of continuous learning and improvement and staff felt valued and supported. Staff had access to learning to ensure Care Act duties were delivered safely and effectively. Most staff felt well supported in their training and development with good induction, peer support, supervision, training and career progression opportunities. Staff consistently highlighted a flat leadership hierarchy and stable, well-established teams. Many teams were co-located in the same local authority offices, which supported collaborative working and information sharing. Staff told us they were trusted to use their initiative and find solutions, although some teams experienced heavy caseloads, which managers were aware of. Staff reported accessible managers who showed concern about their wellbeing and supported their progression. Managers supported staff on joint visits, for example to complete complex mental capacity assessments. The Strategic Director (DASS) and the Director of Adult Social Care met monthly with different teams.

There was a clear staff support framework with policies and guidance, with multiple avenues for staff to access support from line managers, supervisors and colleagues. There was culture of reflective practice with well-embedded mechanisms to support this in team meetings, supervision and monthly reflective practice sessions. Most staff had regular one-to-one supervision every 4 to 6 weeks. Casework was randomly audited and staff said useful learning was shared with the wider team. Practice audits based on clear guidance were used to ensure consistent practice. Senior leaders had good oversight and assurance of frontline practice and conducted monthly case audits and case discussions with practitioners and their managers. Senior leaders highlighted the compassionate and respectful approach of staff.

The Principal Social Worker (PSW) and Strategic Lead for Workforce and Service Development led on workforce training needs to influence practice. At the time of our assessment the PSW was an interim while a permanent staff member was recruited. Quality and performance management arrangements included quality audits of practice, key performance data, customer feedback and learning from thematic reviews.

Newly qualified social workers received regular planned supervision, which included review of caseload and workload allocation, critical reflection, addressing strengths and development needs and achievement towards milestones. Assessed and Supported Year of Employment (ASYE) social workers had a reduced caseload and protected professional development time.

There was support for practice-led continuous professional development in relation to Care Act duties. The local authority had a comprehensive learning and development plan to support staff development, aligned to the workforce strategy. This included formal and informal training to develop staff skills to provide a quality service to people. Staff could request bespoke training to support their knowledge and development. New starters had buddies to support their orientation and learning. There were weekly learning hubs where practitioners could seek multi-professional advice and guidance on complex cases. This promoted a culture of shared knowledge and continuous learning.

Staff and providers accessed an online training platform, including modules on the Care Act, strength-based assessment principles, safeguarding, and other mandatory training. Staff could access in-person training on subjects such as Best Interest Assessments, and support for autistic people and people with personality disorders. Staff could access specific training for different roles, for example commissioning staff could access a commissioning for wellbeing L5 course and brokerage staff had access to the national brokerage accreditation programme.

Staff were encouraged and given protected time to complete training, but some staff found it difficult to complete training because of limited capacity and busy roles. For example, some social workers told us urgent safeguarding enquiries took priority and this sometimes resulted in training being delayed. This indicated workload in some teams was not always manageable to allow staff to maintain their learning and development.

There were some examples of the local authority sharing learning, best practice and innovation with peers and system partners to influence and improve how care and support is provided, including contributions to national policy and national good practice examples. Senior leaders participated in regional and national networks to learn and gain insights from other local authorities. Team managers participated in peer reviews and external social care networks.

There was evidence the local authority worked collaboratively with partners to promote innovative working and improve people's social care experiences and outcomes. For example, the local authority worked with a local NHS partner to develop qualitative person-centred outcomes to measure if a person's quality of life had improved after an intervention/hospital admission, for example was the person able to go out independently or was the person happier after. As a result, such feedback was being collected through individual narratives. The local authority provided evidence of other joint transformation work being undertaken to improve services for people, for example updating process maps, referral routes and safeguarding reporting processes.

There was a clear commitment to resident empowerment and co-production in the local authority's Southwark 2030 strategy, which was developed with and by local people. Leaders and elected members illustrated co-production in practice with multiple examples of community engagement and resident forums such as the Southwark Disabled People's Action Forum, to bring local voices into decision making and make co-production routine for commissioning and policy and strategy development. In the year up to our assessment the local authority involved residents in commissioning the disabilities hub provider, homecare provision, short-term respite care for adults with learning disabilities and autism, a new extra care housing scheme, a new carers' centre and mental health supported living services. Co-production with local LGBTQ+ people resulted in development of new cultural competency awareness training for staff. Co-design activity with people with lived experience of mental health services resulted in the development of 7 pledges for staff on good mental health support such as use of plain language, asking people what they need and not making assumptions. Senior leaders articulated a respectful approach to co-production, with people reimbursed for their time and input, updates on progress, and several sessions held at times to make it accessible.

There were many examples of co-production and local people involved told us they valued the opportunity to inform and lead decisions. Some described the sessions as a 'lifeline' as they felt heard and connected. In 2025 the local authority established a co-production board with representatives from each area of care and support to deepen co-production efforts. In 2025 the local authority was also nominated in the Great British Care Awards in the co-production category for its work to develop the Harriet Hardy House FlexiCare scheme. However, we heard feedback that the local authority needed to do more to engage unpaid carers in the co-design of services and ensure their feedback was used to make meaningful improvements. It was clear that people's views were incorporated in recent service specifications for the new carers centre, but some unpaid carers were not familiar with co-production or the carer forum.

Learning from feedback

There were mechanisms for feedback from staff, local residents and people who used services. Staff told us the local authority actively sought and welcomed feedback. Staff gathered feedback from people before, during and after interventions to assess the effectiveness of support. Feedback and experiences of ASC services were gathered from people through compliments and complaints to feed into areas of improvement.

The local authority listened to and acted on feedback from local people and used this to develop services. The local authority introduced an updated online booking platform to improve ease of access as part of changes to the short-breaks and preventative support offer for young people. A survey of people using the new online registration and booking platform gave an average score of 4 out of 5. There was an active 'Thrive' programme for young people transitioning to adult services as part of the short breaks service. Staff researched what activities residents wanted and in response set up an inclusive computer coding group for people who were non-verbal.

VCSE partners highlighted the local authority's willingness to learn and adapt and engage them in improvement and development. They told us the local authority was responsive and adaptable to feedback. Examples included revising the lead provider model in contracts, and changes to forms to request a care and support assessment. The local authority made changes to ensure information on the form was not duplicated so people did not have to repeat themselves. Some VCSE organisations leveraged their very good relations with the local authority to provide direct feedback about people's experiences and seek resolution to people's concerns.

The local authority met its statutory duties when responding to complaints and enquiries. In 2024-25 the local authority dealt with 145 stage 1 complaints. In the same period there were 30 internal reviews where a person or representative was dissatisfied with a stage 1 complaint response. 72% of stage 1 complaints were responded to on time and 50% were upheld or partially upheld. The local authority's complaints analysis identified a need to provide clarity about assessed charges, for which action was being taken. Senior leaders often met with residents to resolve complaints. The local authority was informed of 1 Local Government Social Care Ombudsman notifications (which was upheld) in the 12 months prior to our assessment.

There were processes to ensure learning happens when things go wrong and from examples of good practice. The learning disabilities team had shared good practice about its family support offer with the local authority's adoption team to make improvements to family aftercare when adoptions fail. The adoption service subsequently achieved an 'outstanding' rating by the regulator and the approach was modelled by 11 other local authorities and the London-wide adoption agency. The local authority shared another example of thematic learning following a serious incident involving a premises fire in September 2024 that include better emergency situation management, better communication and support to residents particularly where individuals with care and support needs are involved.

The local authority gathered feedback from staff in various ways, including staff surveys, staff forums, and through the PSW and POT. Staff told us they were encouraged to suggest new ideas and improvements with senior leaders. There were reflective forums where they could discuss situations and share ideas about how to effectively support people. Staff spoke about these processes positively and detailed how they facilitated creative, strength-based and least restrictive support plans for people. Staff told us panels to request funding were collaborative discussions. This approach indicated effective arrangements for peer support and problem solving.

In the local authority's 2024 staff survey 68% of adult social care staff respondents reported confidence in senior managers to manage and lead Southwark Council well, which was 16% higher than the rest of the local authority. 65% believed senior managers provided clear vision of the overall direction, 13% higher than other departments.

The local authority's results from the Local Government Association Employer Standards 'health check' survey in 2025 indicated the local authority's social workers were more positive about workplace standards (86%) than the London (81%) and national (78%) averages. They also reported their workforce experiences to be more positive (76%) than the London (71%) and national (67%) averages. At 81%, the overall satisfaction level of the local authority's social workers was higher than the London (75%) and national (74%) averages.

Staff told us the local authority was innovative, not afraid to change and embraced opportunities to improve. The local authority implemented some digital innovations such as AI tools to support practice and increase productivity. These tools supported staff to complete assessment forms and meeting notes more easily, allowing them to spend more time with people and reduce waiting lists. There were control measures to ensure the tools were used effectively and accurately. There was also a 'robotic process automation' at the front door to ensure recording of consistent information. There was collaboration between the reablement team and health partners on innovative digital alarms to support falls prevention in the home. The local authority was working towards implementing AskSara, an online resource to support people to access equipment to support them to remain independent at home.