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Community and Wellbeing Scrutiny Committee

Wednesday 4 September 2019 at 6.00 pm
Boardrooms 3-5 - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members
Councillors:

Ketan Sheth (Chair)
Colwill (Vice-Chair)
Afzal
Ethapemi
Hector
Knight
Shahzad
Stephens
Thakkar

Substitute Members
Councillors:

Aden, S Butt, S Choudhary, Gbajumo, Gill, Johnson, Kabir, Kelcher, Mashari and Nerva

Councillors:

Kansagra and Maurice

Co-opted Members
Helen Askwith, Church of England Schools
Dinah Walker, Parent Governor Representative
Simon Goulden, Jewish Faith Schools
Sayed Jaffar Milani, Muslim Faith Schools
Alloysius Frederick, Roman Catholic Diocese Schools

Observers
Lesley Gouldbourne, Brent Teachers' Association
Jean Roberts, Brent Teachers' Association
Brent Youth Parliament, Brent Youth Parliament

For further information contact: Bryony Gibbs, Governance Officer
bryony.gibbs@brent.gov.uk

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The press and public are welcome to attend this meeting

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.
(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.
(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
(d) **Land -** Any beneficial interest in land which is within the council's area.
(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.
(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:
- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;

a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest

Agenda

Introductions, if appropriate.

Item Page

1 Apologies for absence and clarification of alternate members

2 Declarations of interests

Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.

3 Deputations (if any)

To hear any deputations received from members of the public in accordance with Standing Order 67.

4 Minutes of the previous meeting 1 - 10

To approve the minutes of the previous meeting as a correct record.

5 Matters arising (if any)

6 Home Care Recommissioning 11 - 34

This report provides an overview of the homecare re-procurement, including an assessment of the different factors considered as part of this process. A version of this report has previously been taken to the Policy Co-ordination Group (PCG) for comment and direction, and the outcomes of that discussion are now reflected in this report.

The report further comments on how the proposed model will meet the objectives identified as part of the CWB Homecare Task Group report of February 2018 and will make the council fully compliant with the Unison Care Charter.

7 Cricklewood Health Centre 35 - 56

This paper sets out the proposals for the Cricklewood walk in service, which is commissioned by Barnet CCG under a standard NHS contract, Brent CCG are associate to this contract and work closely with Barnet CCG as the lead commissioner.

8 Community and Wellbeing Scrutiny Committee Work Programme 2019/20 Update 57 - 64

The report updates Members on the Committee's Work Programme for 2019/20 and captures scrutiny activity which has taken place outside of its formal meetings.

9 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: Tuesday 26 November 2019

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 9 July 2019 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Ethapemi, Gill, Hector, Knight, Shahzad, Stephens and Thakkar, and co-opted members Ms Dinah Walker and Mr Simon Goulden.

Also Present: Councillors Hirani and Farah

Apologies were received from: Councillors Askwith, Mr A Frederick and Ms J Roberts

1. **Apologies for absence and clarification of alternate members**

Apologies for absence were received as follows:

- Councillor Afzal (Councillor Gill attending as substitute)
- Councillor Shahzad
- Mr Fredericks (Co-opted Member)
- Reverend Helen Askwith (Co-opted Member)
- Mrs Jean Roberts (Appointed Observer)

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Gill - employed as a Psychiatrist by Central and North West London NHS Foundation Trust.
- Councillor Sheth – Lead Governor, Central and North West London NHS Foundation Trust
- Councillor Ethapemi – spouse employed by the NHS.

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

RESOLVED: that the minutes of the previous meeting held on 17 April 2019 be approved as an accurate record of the meeting.

5. **Matters arising (if any)**

There were no matters arising.

6. **Substance Misuse Service**

Councillor Hirani (Lead Member for Public Health, Culture and Leisure) introduced the report on the Substance Misuse Service from the Director of Public Health. The report provided details of the Integrated Treatment, Recovery, Wellbeing and Substance Misuse service model; commissioning arrangements; provider performance; and, the work of B3, the service user council for Brent run by and for local residents directly affected by problematic drug and alcohol misuse. Councillor Hirani advised that the responsibility for Public Health had been transferred to local government following the Health and Care Act 2012. Despite year on year reductions to the public health grant, Brent's Substance Misuse service was considered to be an example of best practice, particularly in relation to the inclusion of peer support.

Andy Brown (Head of Substance Misuse) provided a brief overview of the key themes of the report, advising that data provided via the National Drug Treatment Monitoring System (NDTMS) estimated that there were: 2,310 opiate and/or crack users; 1,752 opiate users; 1,331 crack users; and 3,169 problem alcohol users in Brent. This data suggested that approximately only a third of active drug users and a fifth of problematic alcohol users were engaged with treatment services in Brent - this was broadly in line with national figures.

Discussing 'The New Beginnings service', Andy Brown advised that this new service model had been developed in conjunction with B3, responded to areas of local new or under met need, and rebalanced the divide between clinical services and non-clinical support such as outreach, criminal justice services and recovery support. The new service model had been fully mobilised by 1 April 2018. With the change in service provider there had been a transfer of staff, clients and case files from across five organisations into a single performance management and reporting system led by the new provider, Westminster Drugs Project (WDP). As was expected the transfer led to a temporary drop in performance, in part due to data cleansing through the bringing together of records from different organisations, but this was improving and remained higher than the national averages across a number of areas.

Radha Allen (Project Co-ordinator) and Amina Gariba (B3 Volunteer) then delivered a short presentation to the committee on the work of B3, which as previously highlighted, was an entirely peer-led service, designed and run by service users, and funded directly by Brent Council. B3 provided peer-led support and opportunities for service users and volunteers to develop new skills and qualifications. B3 also operated an out-of-hours' weekend drop-in service for people struggling with substance misuse issues. Moving forward, B3 had recently established an outreach programme to help sign-post individuals not engaging with treatment services.

The Chair thanked the Lead Member, officers and representatives of B3 for the introduction and invited questions from the committee.

In the subsequent discussion, the committee queried how the council was assured that the key objectives of the substance misuse service were being met. Members queried the strategy for engaging hard to reach cohorts and questioned what barriers existed for accessing services. Queries were raised regarding the protocol

for prescribing substitute drugs or drugs which reduced the urge to misuse substances. Further comment was sought on performance of the new service model against the previous model and members requested clarification regarding treatment completion rates. In concluding their questioning, the committee queried what the emerging challenges were for the service going forward.

In response to the committee's queries, Councillor Hirani explained that the Cabinet received quarterly performance statistics which included key indicators for the substance misuse service. Furthermore, Andy Brown measured performance as part of the contract management. Tom Sackville (Interim Head of Services WDP) advised that a monthly meeting was held between WDP, the Council and B3 to discuss performance and allow the service to be held to account by service users. With regard to engaging hard to reach cohorts, the committee was informed that WDP had an outreach service through which relationships were built with communities to help broaden awareness of the services available. WDP also worked with a range of council services and the criminal justice service to identify and engage potential service users.

Ruben Seetharamdo (Sector Manager, CNWL NHS Trust) highlighted that Central North West London NHS Foundation Trust was the clinical partner within the New Beginnings Service. Based at the Willesden Centre for Health and Care, the clinical element of the service undertook a holistic assessment of service users, encompassing physical and mental health needs. This assessment included whether there was a need for medication to be prescribed and whether in-patient services were needed to support a service user to detox. Brent had a very good community detox pathway, supported by a 12-week recovery day programme. Dr Melanie Smith (Director of Public, Brent Council) emphasised that there were no barriers in terms of policy or funding to the prescription of necessary clinical treatments. Ruben Seetharamdo advised that such treatments included campral acamprosate and antabuse (disulfiram). In response to a further query, Ruben Seetharamdo explained that the NHS was not able to prescribe implants as these were not licensed but could prescribe oral medication.

In response to members questions, Andy Brown confirmed that performance had declined when the substance misuse services were integrated under the new service model. This had been expected, in part due to the amalgamation of case-loads from the previous 5 providers which removed the potential for duplication of figures. There had been a focus on raising performance in line with key performance indicator targets. Tom Sackville confirmed that no service users had been prevented from accessing services as a result of the change of service model. Dr Melanie Smith emphasised that all parties had been acutely aware of the risks in recommissioning the service under the new model and this had therefore been monitored very closely. Public Health England had been interested to note the speed at which Brent had been able to raise performance following the implementation of the new model.

Andy Brown advised that effective treatment was usually measured as the completion of the 12-week programme, but often service users continued to access services for a longer period, reflecting the reality that this was often a longer process. The numbers of service users re-engaging with services within a six-month period was measured. Councillor Hirani advised that moving forward, outreach remained an ongoing challenge for the service.

The Chair thanked everyone for the contribution to the discussion and noted that during the discussion the committee had requested that the following be provided:

- an estimation of when service performance models would return to pre-service integration levels.

The committee subsequently **RESOLVED** to note the treatment and recovery services available to residents with problems of drug and alcohol misuse.

7. **Childhood Obesity: Members' Scrutiny Task Group**

Councillor Thakkar introduced the report proposing that the committee establish a task group on childhood obesity as per the terms of reference and membership detailed in the scoping paper attached as Appendix A to the report. The committee was reminded that levels of childhood obesity in Brent were among the worst in the country. It was intended that the task group would focus on four key areas: the NHS, local government and public services; external environment; and, home and parental engagement. With regard to membership, it was highlighted that a member of the Brent Youth Parliament would be asked to join the task group as a co-opted member.

The Chair thanked Councillor Thakkar for her introduction to the report. The committee subsequently **RESOLVED:**

i) To agree the details of the scoping paper attached as Appendix A to the report from the Assistant Chief Executive.

ii) To establish a task group as per the terms of reference and membership detailed in the scoping paper attached as Appendix A to the report from the Assistant Chief Executive.

8. **Central Middlesex Hospital - Urgent Care Centre Changes in Operating Hours**

The Chair welcomed colleagues from Brent Clinical Commissioning Group (CCG) to the meeting and noted that two members of the committee had conducted a site visit to the Urgent Care Centre at Central Middlesex Hospital to aid scrutiny of the proposals contained in the published report.

At the invitation of the Chair, Rashesh Mehta (Assistant Director, Integrated Urgent Care, CCG) introduced the report from the Brent CCG setting out a case for changing the operating hours of the Urgent Care Centre (UCC) at Central Middlesex Hospital (CMH). The committee was reminded that all CCGs had a statutory responsibility to ensure that the services they commissioned provided good value for money, were efficient and met local need. With regard to the UCC at CMH, it was explained that there were very few patients presenting between midnight and 8am. Irrespective of usage however, the provider of the UCC was required to have a full complement of staff. It was therefore considered an

inefficient use of resources to deliver UCC services overnight at CMH. Brent CCG had considered three different options for the opening hours of the UCC: closing the UCC 8pm to 8am; closing between 10pm and 8am; and, closing between midnight and 8am. The latter had been selected as the preferred option. The CCG had carried out a series of engagement activities on the proposals with the public and other stakeholders, including the Brent Equality Engagement and Self-care (BEES) committee, Healthwatch, CVS Brent, members of the Carers Board and ran a bespoke workshop to include voluntary sector organisations and patients. Summaries of feedback received were provided in the report. The Governing Body of Brent CCG had subsequently considered the proposals on 25th June and approved them, subject to receiving confirmation of approval from the LNWHT A&E Delivery Board.

Sheik Auladin (Chief Operating Officer) advised that Brent CCG was required to make savings where value for money was not being achieved. The CCG had a deficit of £9million in the current year. It was clarified that all eight North West London CCGs were in deficit and recovery plans were in place at both a North West London level and local CCG level. It was simply not justifiable to continue to invest the level of resources at the CMH UCC site given the level of usage and the clear patient preference for sites which co-located UCCs and Accident and Emergency services.

The Chair thanked Brent CCG colleagues for the introduction to the report and subsequently invited questions from the committee.

Members questioned how the identified £450k per annum savings would be better directed in primary care. Clarification was sought regarding required staffing levels and the redistribution of the staffing resource. Members questioned comparative levels of use at the other UCC sites in Northwick Park and further queried whether anticipated population growth had been considered. The committee asked what consideration was given to the impact of additional travel of those redirected to alternative UCCs. Members questioned how out of hours GP services factored into the proposed service provision for the borough. The committee sought commitment to undertake the potential mitigating actions identified in the report, should the change in opening hours go ahead, to be implemented in a transition period, including patient transport between locations and a free phone to 111. In concluding their questioning, the committee questioned what feedback had been provided by GPs on the proposals.

In response to the queries raised, Sheik Auladin advised that the savings achieved by reducing the opening hours of the CMH UCC, which is commissioned by the CCG, would form part of the aforementioned recovery plan for Brent CCG. However, the CCG had planned for increased activity at other sites accordingly. It was clarified that a certain staffing complement was required to operate a UCC, irrespective of activity at the site, and it was considered a more robust option to redeploy that staffing resource across the five North West London UCC sites. The average attendance figure for CMH UCC between the hours of midnight and 8am for 2018/19 was 1 patient per hour. Comparative figures for the UCC at the Northwick Park site were approximately 40 to 60 patients over the same period and the West Middlesex University Hospital saw averages of approximately 36 patients. Both sites were co-located with A&E departments.

Addressing the committee's query regarding population size, Sheik Auladin advised that data drawn from the census estimated Brent's population at approximately 340,000. This was expected to grow by a further 40,000 over the next five years. However, data from the Brent GP register reflected a population size of approximately 380,000. Unfortunately, the funding provided to the Brent CCG was calculated in relation to the census data. All decisions taken by the Brent CCG about the capacity of local services therefore took into consideration the fact that the population size was in fact already far in excess of the official figure.

With reference to the risks and mitigation section of the report, the committee was advised by Dr MC Patel (Chair, Brent CCG) that it was unlikely that the costs of an overnight patient transport service sited at CMH could be justified as an efficient use of resources. It was clarified that anyone too unwell to travel to an alternative site should be directed as appropriate by the 111 service. If urgent, an ambulance would be called to take the patient to A&E. The 111 service could also arrange for a home visit by a doctor if deemed necessary. The installation of a free-phone at the CMH site through which patients could contact the 111 service was considered a reasonable mitigating action and would be explored further.

Commenting on the consultation with GPs, Dr MC Patel confirmed that engagement had thus far been at a client level. GPs fully understood the proposed change and the rationale. It was confirmed that the Clinical Directors of the CCG unanimously supported the proposal detailed in the report. Ian Niven (Healthwatch) advised that the CCG had received feedback from Healthwatch on the proposals as part of the consultation and engagement activity that had already taken place. The committee was further informed that a recent piece of work had been undertaken by Healthwatch which surveyed GP practices. The results of this survey suggested a low knowledge of the range of services available and it was crucial that this was addressed.

The Chair thanked everyone for their contribution to the meeting and confirmed that as reflected in the discussion held, the committee agreed that sufficient public involvement had taken place in relation to the proposal to reduce opening hours at the Urgent Care Centre at Central Middlesex Hospital.

The committee subsequently **RECOMMENDED** that the following mitigating actions detailed at section 4.1.5 of the report for consideration be pursued:

i) The provision of overnight patient transport service based on-site between 12 midnight and 8am for a set period of time after the change of hours.

ii) Installation of a free-phone outside the UCC which goes straight through to 111 between 12 midnight and 8am.

9. Palliative and End of Life Care in Brent

At the invitation of the Chair, Rashesh Mehta (Brent CCG) introduced the report on Palliative and End of Life Care services in Brent. The report described End of Life (EOL) service provision in Brent and explained that a recent suspension of in-patient services at the Central London Community Healthcare Trust (CHCLT) Pembridge hospice provided an opportunity to review Brent's EOL strategy. This

review would encompass an evaluation of system capacity and demand for community specialist palliative care services, as well as consideration of whether the Pembridge hospice service was of sufficient quality, was clinically safe and provided good value for money.

Rashesh Mehta further explained that an independent review of the Pembridge hospice service based outside the borough as well as other local services had already been conducted by the commissioner of the service, Central London CCG. The resulting review report detailed a number of options, but recommended the procurement of one lead provider in the community for specialist palliative care services. The review also recommended that that the in-patient provision at Pembridge hospice could be reduced, given that all displaced patients had been accommodated by other hospice providers within existing capacity.

Sheik Auladin (Chief Operating Officer, Brent CCG) advised that since the suspension of services at Pembridge hospice, Brent CCG had been engaging with local providers about potential options moving forward. It was emphasised that currently, Brent CCG paid the full contract sum, despite the suspension of in-patient services at Pembridge hospice. There were three other providers of community specialist palliative care services for Brent patients in North West London, all of whom provided a high standard of service and value for money. If the Pembridge hospice service was permanently decommissioned, this would allow for re-investment in other providers. The committee was therefore asked to comment on potential options as identified in the report for the provision of EOL services in Brent to feed into the Brent CCG review and subsequent further engagement with residents and providers. As Brent CCG was moving towards a single North West London CCG structure and a new collaborative way of working between providers and commissioners, it was highlighted that due consideration needed to be given to the impact on providers across North West London of any proposed service changes in Brent.

The Chair thanked Rashesh Mehta and Sheik Auladin for the introduction to the item and invited questions from the committee.

The committee raised a number of queries regarding the circumstances leading to the suspension of in-patient services at Pembridge hospice and exploring alternative solutions to continuing these services at the site. Members sought assurance that the other three providers of hospice services for Brent patients had sufficient safeguards against similar circumstances. The committee questioned the robustness of conclusions drawn with respect to the capacity of the three remaining providers, seeking particular comment on ability to expand capacity with projected increases in demand. Clarification was sought regarding the option to pursue a tri-borough arrangement, rather than a Brent specific service. Noting the intention to expand community based palliative care services, members questioned how fragmentation would be prevented as the nature of the service developed. Further details were sought regarding consultation with service users and their families around arrangements for hospice based palliative care services. Members concluded their questioning by seeking confirmation that if Pembridge hospice were to be decommissioned, the savings by Brent CCG would be re-invested in other providers ensuring the continued provision of such services for Brent residents.

Responding to the queries raised, Sheik Auladin, advised that the specialist palliative care consultant at Pembridge hospice had resigned in late July 2018 and the provider had been unable to recruit to this position. This meant that there was not appropriate specialist palliative care clinical supervision of the in-patient unit and this service had therefore been suspended. There had been no proactive action from the provider to make arrangements for the provision of appropriate clinical supervision since this time. Brent CCG was confident in the resilience of the other three providers, who had staffing support from hospitals with which they were partnered, an arrangement that was absent from the Pembridge hospice contract. Rashesh Mehta explained that Brent CCG was content with the capacity of the existing providers and was confident that the providers would be able to accommodate additional capacity with additional resource, if and when required.

Jonathan Turner (Brent CCG) informed the committee that with the move towards a single North West London CCG and in consideration of patient flows across borough boundaries, any change to commissioned services in Brent would have an effect on service provision to patients in surrounding areas. It was therefore essential that an aligned approach be pursued with neighbouring CCGs to support connectivity in service delivery across North West London.

Dr MC Patel (Chair, Brent CCG) advised that the nature of palliative care services had changed significantly over the past few decades with more conditions treated out in the community, supporting patients to remain in their own homes when desired. However, there remained a very important role for hospices which provided a fantastic service to Brent patients and it was important that the Brent CCG invested in both forms of service delivery.

The committee further heard that there had been a degree of engagement with patients and their families with regard to hospice services in Brent. Four focus groups had been held across all providers to discuss service development and improvement and specific issues relating to Pembridge hospice. Greater engagement was planned pending the Brent review of EOL. All patients and families who had been affected by the suspension of in-patient services at Pembridge had been consulted. Patients had felt saddened at the prospect that the service would not be available going forward but had also felt that the provision of a seamless service across all competencies was an aspiration that should be worked towards.

Sheik Auladin confirmed that if Pembridge hospice were to be decommissioned, the £1.4million currently invested would be redirected to other hospice provision, whilst at the same time ensuring that services provided had appropriate clinical supervision. It was emphasised that the £1.4m was not considered a saving and did not form part of the CCG's recovery plan.

The Chair thanked everyone for their contribution to the discussion.

The committee subsequently **RECOMMENDED**:

That Brent CCG:

i) undertake engagement with Brent residents, stakeholders and existing providers (St Luke's Hospice, St John's and Elizabeth Hospice and Marie-

curie Hospice Hampstead) regarding the proposal to decommission services at Pembridge hospice and reinvest in the remaining providers, assessing whether there was sufficient capacity to meet local need and projected service demand.

ii) explore a tri-borough arrangement with the relevant CCGs if it was subsequently determined following the engagement recommended at i) that there was insufficient capacity across the three existing providers to meet local need or there was strong objection to the proposal to re-invest in the remaining providers.

That the Cabinet:

iii) review the position with regard to land adjacent to St Luke's Hospice, with a view to supporting possible expansion of the hospice at a future date.

10. **Community and Wellbeing Scrutiny Committee Work Programme 2019/20 Update**

RESOLVED that the contents of the Update on the Committee's Work Programme 2019-2020 report, be noted.

11. **Any other urgent business**

None.

The meeting closed at 8.33 pm

Councillor Ketan Sheth
Chair

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Brent	**Community and Wellbeing Scrutiny Committee** 4 September 2019
	Report from the Strategic Director of Community Wellbeing

Homecare Recommissioning: A report on the proposed model to recommission homecare services

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Three: • Appendix 1 - Patch Based Proposal • Appendix 2 – Unison Care Charter • Appendix 3 – Eligibility Criteria under the Care Act 2014
Background Papers:	n/a
Contact Officer:	Helen Woodland, Operational Director Adult Social Care; Helen.Woodland@brent.gov.uk Andrew Davies, Head of Commissioning, Contracting and Market Management, Adult Social Care Andrew.Davies@brent.gov.uk

1. Summary

1.1 This report provides an overview of the homecare re-procurement, including an assessment of the different factors considered as part of this process. A version of this report has previously been taken to the Policy Co-ordination Group (PCG) for comment and direction, and the outcomes of that discussion are now reflected in this report.

1.2 The report further comments on how the proposed model will meet the objectives identified as part of the CWB Homecare Task Group report of February 2018 and will make the council fully compliant with the Unison Care Charter.

1.3 Currently the Council spends in excess of £18m per year on homecare. Given the importance of the service, commissioners wanted to ensure that Overview and Scrutiny (OSC) were also sighted on this work and had chance to comment on the proposals before they are presented to Cabinet later in the year for formal approval. The timetable for approval is as set out below:

- Corporate Management Team 3rd October
- PCG 10th October
- Leaders Briefing 21st October
- Cabinet 11th November

1.4 Whilst Brent has good control over spend on homecare and pays a rate to providers that enables them to pay care workers above the National Living Wage (NLW), for travel time, training costs, holiday pay, overheads, as well as covering back office costs and a surplus (profit) for providers, there is a significant challenge if Brent is to pay providers at London Living Wage (LLW) levels. Following discussion at PCG the council have decided to implement LLW for homecare providers. The council has an annual £1m budget in the medium term financial strategy, which is being used to pay LLW on contracts for all of Brent's NAIL schemes. The challenge of LLW in relation to homecare is something that OSC is being asked to consider and comment on, in particular the desired timeframe for implementation of LLW.

2. Recommendations

2.1 OSC are asked to consider this report and comment on the recommendations below. A final report for decision at Cabinet will be prepared based on the views of PCG and OSC.

Recommendations:

i. OCS note the financial implications to the council of delivering a London Living Wage compliant homecare service and comments on the preferred option of delivering LLW in Year 2 (2021/22).
ii. OSC are asked to approve the proposed model and confirm that implementation of the model as set out will deliver the outstanding recommendations from the CWB Homecare Task Group report of August 2018.
iii. OSC are further asked to confirm that the proposed model will deliver the objective of making the council fully compliant with the Unison Care Charter.

3. Background – The Homecare Market in Brent

3.1 Homecare is the single biggest service in terms of volume of service users commissioned by Adult Social Care. For users to be provided with homecare services, they will first need to be assessed as having eligible care needs under the Care Act 2014. Users are assessed according to nationally prescribed criteria as set out in the Act (eligibility criteria attached as Appendix

3). An allocated worker will assess whether a person can perform certain tasks, and what degree of support is required (if any) for them to achieve these tasks. They will then work with the person concerned to devise a care and support plan, which sets out what tasks they require support with, and how much support is needed. It is worth noting that ASC are only required to fund or provide support for what is known as unmet need – this means that a person's care and support plan may identify tasks that they cannot do without support, but if that support is already being provided by a loved one, friend, neighbour or other agency, then this need would not be classified and unmet, and ASC would not be required to fund or provide support to meet it.

3.2 It is further worth noting that ASC support is not free at the point of contact in the way that health service support is. This means that anyone who is assessed as being eligible for ASC support will be required to complete a financial assessment, and that assessment will determine whether they are required to pay a contribution towards their care. Current thresholds mean that anyone with capital (savings, income, investments and property) above £23,250 would be what are classified as self-funders, or people who are required to fund and arrange their care themselves. Where people have savings or assets below these thresholds, it is still likely that they will be required to contribute financially towards their care. If a person's capital is between £14,250 and £23,250 the council will partially fund care, and if a person has less that £14,250 of capital, this will be disregarded and the council will fully fund their care. However, even in the case of an individual having less that £14,250 of capital, income (including most benefits and pensions) is taken into account as part of the financial assessment and it is likely that they will be required to make some kind of financial contribution to their care. How much they contribute will depend on their personal circumstance and the type of care they receive. Currently the government mandate that individuals in residential care must be left with £24.90 per week, which is known as the Personal Expense Allowance, and those individuals receiving care in the community must retain £189 per week (if single and over the Pension Credit qualifying age), which is known as the Minimum Income Guarantee.

3.3 Brent is currently commissioning homecare services from 68 providers for adults and 32 providers for children. In total, these providers deliver over 21,900 hours of homecare per week for adults for 1,700 service users. Children's providers deliver 900 hours per week for 77 service users. The combined cost of services is £18.5m per year.

3.4 Homecare services are delivered to a range of residents with different and distinct care needs. For reporting ease, users of the service are classified according to care need. The care need categories are; Older People, Physical Disability, Learning Disability, Mental Health, Children's Services and Reablement. By far the largest group of people in receipt of homecare is older people.

3.5 In 2014, Brent Council entered into a framework arrangement to commission homecare through the West London Alliance (WLA). At the time, the

framework arrangement allowed the participating West London councils to standardise the way that homecare was commissioned, and the cost per hour that was paid. This was important as in a relatively small geographical region, there were significant variations in both cost and quality, often with the same provider being paid vastly different hourly rates for the same service.

3.6 As part of the WLA framework, an external consultancy firm was commissioned to undertake a piece of analysis work around the hourly rate paid to providers for homecare. Using data from across North West London, and working with commissioners, Care Analytics helped the WLA to produce a dynamic and detailed cost model. This cost model helped each local authority identify the minimum sustainable hourly rate that could be paid for home care, and included a detailed breakdown of how that hourly rate should or could be allocated to allow providers to meet all their statutory requirements around such things as national insurance and pensions contributions, but also identifying allowances for things such as travel, training, uniforms and profit.

3.7 This analysis has allowed WLA participating boroughs to both meet the requirements of the Care Act (2014) to ensure that care markets are sustainable, and has allowed us to successfully defend commissioning practices and the hourly rate for homecare against two different Judicial Reviews brought by providers and by the UK Homecare Association, the national representative body of homecare providers.

3.8 Further, this model has given commissioners a framework to undertake detailed contract monitoring with providers, and a clear contractual standard to ensure providers are paying staff the rates and allowances as set out in the model. We have used the model and our contract mechanisms to successfully challenge at least two providers who were not passing on the agreed allowances for travel and training to staff.

3.9 The WLA framework did not make a distinction between care for different types of care need, i.e. it was a generic framework, meaning providers were not paid according to a specialism. This was helpful in standardizing the prices paid for home care, on the basis that the skill set required to support someone with personal care needs would be broadly similar regardless of the primary care need of the individual. This has helped Brent bring down the hourly cost of care for client groups such as learning disabilities significantly, and has allowed us to harmonize prices across the market to a degree. However, it does have the disadvantage that providers have lost some of the specialisms that may have had that enabled them to manage more challenging clients at home. As the client base in Brent becomes more complex, and with generally higher levels of need (for example, we have an increasing number of double-handed care packages requiring two carers for each care call), it is likely that we now need to invest some effort in supporting the market to re-establish specialisms in particular areas of care.

3.10 Since the expiry of the framework in Sept 2018, services have been commissioned on a spot purchased basis but only from those providers who

had previously been part of the WLA framework, and continuing to utilize the agreed framework rates.

3.11 Whilst there are a large number of providers currently delivering homecare, the majority of care packages are concentrated in a small number of providers. For ASC, twenty providers are delivering 76% of home care hours between them. The remaining 48 providers deliver 24%.

3.12 The current sustainable hourly cost of care in Brent is set at £15.43 ph. This enables providers to pay care workers just above the National Living Wage and includes travel time, training costs, holiday pay, overheads, back office costs and a surplus (profit) for providers. The highest hourly cost per hour Brent pays for a standard homecare package is £16.43, although some Transitions care packages are more expensive than this.

3.13 Within ASC we have a strong record of price control, although expenditure has increased year on year due to increases in complexity of packages and hours of homecare clients are receiving. However, both the external price analysis and intelligence from our own commissioning function has indicated that Brent now pays one of the lowest hourly rate in North West London. Other boroughs that have re-commissioned services are paying in the region of £18 per hour. The combination of a lack of available home care workers (The Institute of Public Policy Research estimates that nationally the industry will need 400,000 additional carers by 2028) and the fact that Brent is now one of the lowest paying boroughs in NW London have both contributed to the need to review our existing model to ensure the market remains sustainable in the future.

3.14 Currently adults and disabled children and young people homecare services are commissioned separately. In order to reduce duplication in commissioning activity and streamline business processes, such as brokerage activity and payments, it is intended to procure new homecare services for both groups at the same time. Discussions are also underway with Brent CCG, who commission a small amount of homecare for Continuing Health Care clients, however, as the NHS are restricted to using their own procurement frameworks, it is likely that they will not be a part of this re-procurement exercise, but may join the model at a future date.

3.15 One of the drawbacks of using a sub-regional model such as the WLA framework is that the number of providers registered on such a framework is very high. This has meant that although the framework was extremely helpful at helping Brent understand and control hourly costs, there has been less focus on quality, and on developing relationships with key providers that would allow us as a council to support better quality. Necessarily, the framework meant that there are a significant number of providers delivering homecare in Brent, and the high number of providers in turn has meant that we do not have the commissioning and contracting resources to monitor providers as closely as we would have liked.

3.16 The Community and Prevention Team in Adult Social Care Commissioning is responsible for quality monitoring homecare providers. There are four Placement Review Officers (PROs) in the team, each responsible for monitoring 15 – 18 providers. In order to effectively undertake this role, they carry out regular contract and quality monitoring visits to providers and complete service user reviews in their homes, providing an opportunity to observe care being delivered. The PROs are expected to complete three service user reviews per week, but generally focus their attention on the larger providers, with more service users to build up a complete picture on the quality of care. They are also required to carry out other duties associated with their role, such as commissioning smaller services.

3.17 Monitoring so many providers is unsustainable and to allow the current approach to commissioning to continue presents too many risks in terms of quality of care and value for money from commissioned services. As a result, commissioners are clear that any re-procurement must reduce the overall number of providers delivering homecare in Brent. This also aligns with feedback from the providers themselves, who tell us that they would prefer to have a smaller geographic area to cover, but more certainty around the number of hours they are being asked to deliver. In essence, the preference is for smaller patches with less providers per patch.

3.18 Over time, providers have developed specialisms based on their ability and willingness to work with different client groups. They have also gravitated towards working in certain parts of Brent. This has been an organic process rather than one that has happened as a result of deliberate commissioning activity. Providers have told us that they find it easier to concentrate services in particular locations that are convenient to them rather than attempt to deliver services across the borough.

3.19 Consideration has also been given to whether homecare services could be brought back in house. Analysis of this option is included in the report, including some initial thoughts on costs and implications of progressing this option.

4. CWB Scrutiny Homecare Task Group and Unison Care Charter recommendations

4.1 The proposed model will allow the Council to become complaint with both the Unison Care Charter, and will deliver the recommendations as set out in the CWB Scrutiny Homecare Task Group report of February 2018. These were:

Unison Care Charter Stage 1	No 15 min calls, no rushed calls, carers paid for travel time and sick pay	This has already been delivered as part of the current model of homecare delivery.

Unison Care Charter Stage 2	Allocate the same carer, better training and development opportunities, clear complaints process and tackle zero hours contracts.	To be achieved through re-procurement
Unison Care Charter Stage 3	Ensuring carers are paid at LLW and Occupational Sick Pay Scheme.	To be achieved through re-procurement
CWB Scrutiny Task Group recommendation 1	The London Living Wage is introduced incrementally as part of a new commissioning model	To be achieved through re-procurement
CWB Scrutiny Task Group recommendation 2	A minimum standard of training is incorporated into the new commissioning model which gives staff in Brent sufficient development opportunities to encourage homecare as a career within the social care sector.	To be achieved through re-procurement
CWB Scrutiny Task Group recommendation 3	A homecare partnership forum should be set up as part of the new commissioning model to discuss issues of strategic importance to stakeholders involved in domiciliary services in Brent	This has already been delivered and has been running successfully in Brent for over a year.

Section 6 below sets out how the proposed model will meet each of the objectives above that have not already been achieved. For ease, these have been grouped into 2 sections as the recommendations from the CWB Home Care Task Group and those required to be compliant with the Unison Care Charter are well aligned.

5. An overview of the proposed model

5.1 The proposed model has several elements to it. An overview of the changes is set out as below:

- A move away from a Brent wide, generic service to a patch based model aligned to the 13 Primary Care Networks for the delivery of service for Older People and Physical Disabilities (details of patches is set out at Appendix 1). Each patch would have a lead provider and a support provider who would be required to deliver at least 80% of all of the hours in the patch. The remaining hours would be delivered by providers from an approved provider list, allowing smaller providers who do not have the capacity to deliver the required volume of hours in any patch to also continue to deliver work for Brent and will also provide a degree of market assurance and allow us to retain enough providers to cover any market failure issues.
- For ‘specialist’ care groups, where there is not enough demand to allow for a split into 13 patches, we are proposing two patches. For reablement and children’s services the proposal is to work on two patches covering the

borough, with four lead providers for each service type. For learning disabilities and mental health services, the plan is to have two patches, with two lead providers for each service type.

- Whilst providers will be able to bid for as many services as they wish, they will only be awarded a maximum of:
  - Up to two older people / physical disability zones
  - One older people / physical disability zone and one of the children's, reablement, LD and MH or dementia zones
  - Providers will only be the lead provider for one of the children's, reablement, LD and MH zones – they will not be awarded two of these zones.
- This model has the benefit of allowing providers to develop relationships with a smaller group of GP practices, less travel time and security around the number of hours to be delivered allowing for longer term workforce planning for providers. This should also result in a smaller number of providers, allowing for better contract monitoring and better training and support for carers.
- Consistency of care worker is something that the council and care providers are committed to, and it will be included as an element in performance and contract monitoring schedules. As part of the re-procurement provider will be asked to commit to providing a small pool of named care workers for each service users, and commit to these named workers being the people who deliver care to the service user for the lifespan of the contract (wherever possible).
- The council has committed to paying an hourly rate that allows workers to be paid at London Living Wage levels.

6. Unison Care Charter Stage 2 and CWB Homecare Task group recommendation 2 - Allocate the same carer, better training and development opportunities, clear complaints process and tackle zero hours contracts.

6.1 Ensuring continuity of care workers is the key issue of importance to people who receive services and their friends, families and carers, and this has been consistently reported back to commissioners when speaking with service users. Establishing a good rapport with the people delivering care is crucial to people's satisfaction with care services, and is only possible if there is consistency and continuity of care worker.

6.2 Consistency of care worker is something that the council and care providers are committed to, and it will be included as an element in performance and contract monitoring schedules. As part of the re-procurement providers will be asked to commit to providing a small pool of named care workers for each service users, and commit to these named workers being the people who deliver care to the service user for the lifespan of the contract. We are currently in discussion with providers about what would be an achievable and appropriate number of people to be allocated into care pools, bearing in mind the fact that for service users with double handed care or very significant packages the number is likely to be larger than for those people with smaller, less complex packages.

6.3 The mandatory use of electronic call monitoring systems will assist with enforcing this, as we will be able to see which carers visit clients, and whether it is in line with the named carers on care plans. The more hours that can be guaranteed to providers, the easier it will be to achieve this as workforce planning can be done with greater certainty and the workforce should be more stable.

6.4 Currently 38% of care workers in Brent work on zero-hours contracts. To mandate that providers don't use zero-hours contracts and instead offer minimum-hours contracts would inevitably have an impact on the way that they are able to organise their staff rotas to deliver care. There are peaks in the demand for homecare services. Unsurprisingly they are in the morning, lunchtime and evenings. Providers don't want to have to pay care workers when they aren't delivering care; the council doesn't want to pay providers more than is necessary to deliver quality services.

6.5 Through discussion with providers, we are also clear that the biggest incentive for a reduction in the use of inappropriate zero-hours contracts will be being able to offer providers a guaranteed level of hours and funding. This can be achieved through reducing the number of providers and implementing a patch based model. This would give providers a clear and consistent number of hours to work with so that they can plan their workforce requirements accordingly. The more confident the council can be in guaranteeing hours of work, the easier it will be for providers to plan their rotas and not have to fill in gaps in provision with zero-hours workers.

6.6 However, it is known that in some instances, zero-hours contracts are the preferred option of homecare workers. Our aim is that where workers would prefer a standard contract and a guaranteed minimum number of hours, this is available to them, but that we allow providers the flexibility to offer other contractual mechanism such as zero-hours contracts, or casual and short term contracts where appropriate (for example for when individuals wish to work during term time only, or to cover extended leave or maternity cover).

6.7 Commissioners believe that through the up-coming tender process providers should be asked to explain how they will keep zero-hours contracts to a minimum and the guarantees that they can make on this, whilst at the same time offering flexibility to care workers who choose to work on a zero-hours contract. If guarantees are made whilst tendering contracts, commissioners would be able to monitor these to ensure that providers are delivering as expected and that zero-hours contracts are kept to a minimum and only used when requested by a care worker.

6.8 Commissioners are clear that at present there are too many providers delivering services for each of them to be closely contract and quality monitored. We are able to use other sources, such as CQC inspection reports, to keep track of the smaller providers. But, commissioning staff are seldom able to quality monitor providers delivering small numbers of care packages unless there is a specific concern raised that needs investigating.

Commissioners want to better manage the market so that 80% of packages are concentrated in our lead providers (between 13 and 25, depending on the outcome of the re-tender) and the remaining 20% delivered by the providers on the approved back up list.

6.9 It is important to see these changes in context. We'll move from a position where 20 providers deliver 76% of care (for ASC), to one where 25 providers deliver 80% and a smaller number of approved providers deliver no more than 20% of all care. What this model will end is the practice of large numbers of providers delivering very low numbers of packages. By giving guarantees on hours of care to approved providers, the council should be able to move away from spot purchasing from providers not on the back up list, giving greater control over spend and quality.

6.10 This model will also allow commissioners and social care staff to develop stronger relationships with providers, both to monitor the quality and efficacy of training that is being delivered to homecare staff, but also to provide training in more specialist areas to homecare staff as and when required.

6.11 The development of providers with particular specialisms such as reablement or learning disabilities will also support better and more targeted training and development opportunities for the workforce, which in turn the commissioning function will be better able to monitor and enforce if necessary due to the reduced number of providers and providers who have particular specialisms.

6.12 Discussions are ongoing with health colleagues to determine whether there are tasks currently being performed by District Nurses that could, with the appropriate training and support, be delivered by homecare workers. This would both allow for a more seamless service to residents, but would also give homecare workers a more technical aspect to their training and development, and may open up career pathways across both health and social care.

7. Unison Care Charter Stage 3 and CWB Homecare Task group recommendation 1 - Ensuring carers are paid at LLW.

7.1 The current cost model allows for providers to pay at or above the National Living Wage, which is £8.21 per hour, but does not enable them to pay London Living Wage, which is £10.55 per hour. Therefore, there are clear cost implications to the Council in paying at London Living Wage levels.

7.2 The Council has a clear commitment to paying LLW where possible, and no one would argue this is not the right thing to do. However, it is worth noting that there is no evidence, locally or nationally, that paying care workers above NLW has any impact on the quality of care. Regardless, discussion at PCG and at CMT has concluded that the Council will offer LLW as part of the new homecare model. The debate therefore is how quickly this can be delivered.

7.3 Home care providers are legally required to pay care workers NLW, and this is a rate that is already subject to inflation. Therefore, the Council has

budgeted an additional £4.4m for adult homecare up to 2023/24 to cover both the cost of inflation and the likely demographic growth we are predicting - £2.4m relates to demographic growth. Regardless of any decision made to fund the LLW, the total spend on adult homecare would increase from £17.5m in 2019/20 to £21.9m by 2023/24 (see table 1 for full breakdown). This is already factored into the council's medium term financial strategy.

7.4 Likewise, to continue to pay children's providers at NMW levels would require an additional £0.4m by 2023/24, bringing total spend on children's homecare to £1.2m per year.

7.5 Cost modelling on the impact of paying LLW is challenging, as the modelling must take a view on whether or not the re-procured provider will be able to keep any increases in back office or due to inflation to a minimum. Working on the assumption that providers control their costs well, then the likely additional cost to the Council would be £4.6m, bringing the total spend to £26.5m per year. If they do not then LLW will cost the Council an additional £5.9m for adult homecare by 2023/24, bringing the total spend on adults homecare to £27.9m per year (see table 1 for full breakdown).

Table 1 – Homecare costs, paying at London Living Wage (overheads at London Living Wage Levels)

Total Homecare Cost	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Adults						
Implement NLW in 19/20 (do nothing option)	£17,078,408	£17,596,059	£18,777,319	£19,751,867	£20,797,650	£21,900,617
Implement LLW in 20/21	£17,078,408	£17,820,636	£23,737,141	£25,039,412	£26,414,413	£27,866,260
Implement LLW in 23/24	£17,078,408	£17,820,636	£20,180,047	£22,638,565	£25,199,499	£27,866,260
Children's						
Implement NLW in 19/20	£963,527	£963,527	£1,022,280	£1,075,337	£1,132,271	£1,192,319
Implement LLW in 20/21	£963,527	£1,005,401	£1,292,304	£1,363,203	£1,438,061	£1,517,103
Implement LLW in 23/24	£963,527	£1,005,401	£1,125,659	£1,250,917	£1,381,341	£1,517,103

7.6 Negotiations with providers currently take place annually to agree a fee uplift, which considers factors such as real term increases in National Minimum Wage, which have an impact on providers' costs. Through a process of negotiation commissioners will look to control homecare price increases and adopt a similar approach to the one that has been taken with extra care, in giving an uplift for increases in wage inflation for carers, but expecting the provider to find other cost increases through efficiencies or a reduction in surplus.

7.7 The impact of paying LLW could be eased if it was agreed to increase the amount paid to providers to reach LLW levels by 2023/24 rather than from the start of the new contracts, essentially a tiered increase in rates over 4 years until full LLW is achieved. The overall impact on the budget remains the same, but the impact is spread across four financial years. By paying at LLW

levels from year one of the new contracts, the impact on the budget in 2020/21 is significant, as the majority of the increase in spending has to be found for that financial year. In subsequent years the annual increases are smaller. The impact of implementing LLW immediately or implementing it incrementally is set out below for illustration.

- Pay LLW at the outset from Year 1(20/21) - £9.3m
- Pay LLW from Year 2 (21/22); - £5.3m
- Pay LLW from Year 3 (22/23); or - £2.5m
- Pay LLW from Year 4 (23/24) - £0.7m

7.8 Recommendations from PCG suggest that the preferred option is to deliver LLW in Year 2 (21/22) as this level of drawdown from reserves is most achievable whilst also balancing the preference to implement LLW as soon as possible.

8. Bringing Homecare Services In-House

8.1 Consideration has been given as to whether homecare services could be brought back in house. The challenges of doing this would be considerable. Firstly, the cost of an in-house service has been modelled, focusing on staff costs alone (not including other overheads, such as premises, equipment, etc). Officers estimate than the annual cost of an in-house homecare service for Adult Social Care only would be £34.4m per year by 2023/24, compared to £27.9m, which is the modelled cost of a commissioned service including LLW. More work would need to be done to model the costs of a Children's service, but it is likely to be more expensive than a commissioned service.

8.2 The modelling is based on needing 750 carers, 50 supervisors and 14 additional managers (Team Leaders up to a Head of Service) which is an extremely conservative estimate of the staffing required. Staffing ratios would need to be considered – the service has been modelled on the basis of 1 supervisor to 15 staff. Officers have also assumed that staff would be working on permanent contracts, and there would be no use of zero hours' contracts.

8.3 There are a number of factors that make in-house homecare services more expensive than services commissioned from external providers. It needs to be recognised that many homecare providers are working with few overheads and little organisational infrastructure. It is not uncommon for smaller providers to be led by a manager / owner, who will perform a number of roles within the organisation, and also directly deliver care when needed. The flexibility that this gives providers can't be replicated if the service was to be brought back in-house.

8.4 Providers are also able to manage their workforce so that they are not working during parts of the day when demand for homecare is much lower. There are peaks in demand in the morning, lunchtime and evening, with little demand between times. Whilst providers use zero-hours' contracts to help manage this (and it's agreed we want to reduce their use), the council would not have this option. Therefore, an in-house service would be paying for staff

at times when they would not be working to full capacity, adding to the cost of services.

8.5 Brent is working to bring in-house estate cleaning services. Whilst comparisons could be drawn between the two services, there are some important differences that make the in-sourcing of estates cleaning financially viable, particularly the fact that the workforce can be organised to work to full capacity throughout the working day. There is also a fixed area that requires cleaning by the estates cleaning service, with no variations in demand. Even taking into account different shift patterns for homecare workers, arranging staff rotas to work to as close to full capacity as possible will be challenging. Additional staff will also be required for a homecare service to take account of spikes in demand at short notice, and to ensure that every homecare call is always made.

8.6 There are other factors that would also make this challenging. Market sustainability would be an issue if Brent was reliant on one, in-house provider and would bring into question our ability to meet our Care Act requirements with regard to market sustainability and choice. There would also be considerable risk in having one provider, and whether we could ensure we could manage the various issues that arise when delivering homecare, such as safeguarding issues, quality management and workforce considerations and customer satisfaction.

8.7 Given that homecare services have been commissioned from other providers in recent years, the council has no experience in managing a homecare service. This expertise would need to be brought in to ensure that services were run in line with rules and regulations, (for instance, the service would need to be CQC registered before care could be delivered) as well as ensuring it was as efficient as possible, making best use of staff time and resources. At this stage, progressing this option is not recommended.

8.8 At the request of PCG, officers are working with finance colleagues to determine whether it would be feasible and/or desirable to in-source the specialist reablement element of homecare. Further work needs to be done to finalise the financial modelling, but early indications are that this would cost a minimum of £2.3m based on 61 staff which is significantly more that the £1.2 per annum currently spent on the reablement service, and does not take into account property, infrastructure and management costs. Officers will continue to work with finance to refine the model in order to present the detail to PCG in October.

9. Risks and Mitigations

9.1 The biggest risk period will be as new contracts are implemented, working through the transfer of care provision from old providers to new. This is something that commissioners are still working on to plan to try to limit disruption and ensure continuity of care where possible. Where TUPE applies we will facilitate the transfer of staff between organisations; if continuity of care worker can’t be maintained during implementation the council and

provider will need to work with service users to explain why, and help to build relationships with new carers as quickly as possible; if service users wish to switch to a direct payment to give them more choice and control over their care they will be able to do so. Through these actions we will try to ensure there is as much continuity as possible.

9.2 Whilst a number of our existing providers will no longer provide services for the council under the new patch based model, some will still retain work from individuals choosing to remain with them via a direct payment. The council would not quality monitor DP providers (unless they were on our approved provider list), as in this scenario the service user chooses to employ a carer or agency directly, and they will manage their care. We would investigate if there were safeguarding concerns and we retain this responsibility.

9.3 There is a concern that small Brent based providers won't have the ability to deliver the number of hours expected from the patch based approach. The 13 patches that have been developed for older people/physical disabilities have been designed to make them attractive to providers - not so large that providers wouldn't be able to deliver the hours, but not so small that Brent ends up with too many providers, as is the case now. This is a delicate balancing act.

9.4 Whilst there will be challenges for some local providers to build capacity to become lead providers, the approved list will give opportunities to smaller providers to take on local authority work. Indeed, given the hours that will be commissioned from the approved list, this may appeal to some local providers more than the geographical patches, because this will enable them to pick up work at a level that they are used to. Commissioners will consider ways that we can work to support local providers, to help build capacity ahead of beginning the tender process.

10. Financial Implications

10.1 To pay providers at a level where they can pay the London Living Wage will cost the council an additional £5.9m for adults homecare by 2023/24, bringing the total spend on adults homecare to £27.9m per year. The implications for the Disabled Children and Young People Service (0-25) of paying the London Living Wage will be an additional £0.3m pressure on the budget, increasing spending on children's homecare to £1.5m by 2023/24.

10.2 Total spend on homecare for adults and children's services would increase from £18.5m in 2019/20 to £29.4m by 2023/24 if London Living Wage is paid.

10.3 The impact of paying LLW could be eased if members agreed to increase the amount paid to providers to reach LLW levels by 2023/24 rather than earlier in the contracts. The overall impact on the budget remains at £5m - £6m, but this cost impact is spread over a number of financial years rather than there being a significant budget pressure from the outset of the new contracts.

11. Conclusions

11.1 The re-procurement of homecare services is schedule to start in November 2019. Further engagement work will be carried out before going out to tender. There will be another set of events with providers to ensure they are clear on the proposals that we will be making, and they have a final opportunity to contribute to the development of the model; likewise, there will be service user engagement so that the views of people using services are captured. This work will build on previous engagement that has taken place over the last 12-18 months.

11.2 Before finalising the model which forms the basis of the service specification it is important that the Overview and Scrutiny Committee is able to consider the key issues presented in this report and express a view on whether these proposals will deliver both compliance with the Unison Care Charter and deliver the remaining outstanding recommendations from the Community and Wellbeing Scrutiny Homecare Task group report.

12. Legal Implications

12.1 There are no legal implications arising from this report.

13. Equality Implications

13.1 An Equality Impact Assessment will be completed as part of the procurement process.

14. Consultation with Ward Members and Stakeholders

14.1 Ward members who are members of the Community and Wellbeing Scrutiny Committee will be involved in scrutinising this report at committee.

Related documents: Community and Wellbeing Scrutiny Committee Homecare Task Group report

REPORT SIGN-OFF:

PHIL PORTER
Strategic Director, Community Wellbeing

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Appendix 1 – Patch Based Proposal

Map 1 – Proposed Homecare Localities

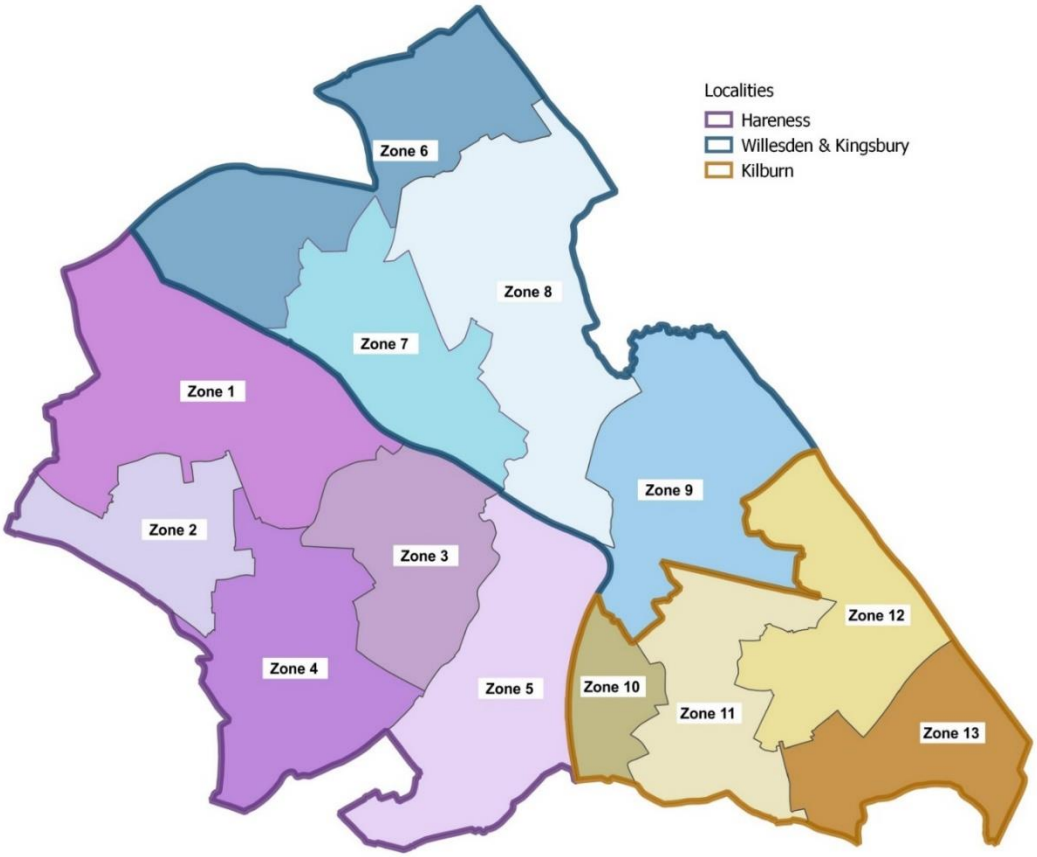

Table 1 – Older People / Physical Disability Homecare Localities

Locality	Zone		Average number of hours per week	Monthly snapshot of service users (March 2019)	Total number of service users over 12 month period
Harness	1	Northwick Park and Preston	1956	124	187
	2	Sudbury	1432	88	120
	3	Tokyngton	1440	88	128
	4	Wembley Central and Alperton	2194	151	212
	5	Stonebridge	1359	110	165
Willesden and Kingsbury	6	Queensbury and Kenton	1749	120	194
	7	Barnhill	1366	88	128
	8	Welsh Harp and Fryent	1900	135	200
	9	Dudden Hill and Dollis Hill	1988	138	191
Kilburn	10	Harlesden	1539	100	128
	11	Willesden Green and Kensal Green	2300	156	224
	12	Mapesbury and Brondesbury	1700	123	187
	13	Queens Park	1950	132	201

Table 2 – Reablement and Children's Homecare Localities

			Average number of hours per week (snapshot)	Monthly snapshot (March 2019)	Number of service users over 12 month period
Reablement Service	2 zones – North and South (based on ASC teams)	4 lead providers (2 for each zone)	1500	118	1098
Children's homecare	2 zones – East and West (based on Children's teams)	4 lead providers (2 for each zone)	900	77	77

Table 3 – Learning Disabilities and Mental Health

			Average number of hours (snapshot)	Monthly snapshot (March 2019)	Number of service users over 12 month period
Learning disabilities and mental health	2 zones – North and South (based on ASC Teams)	4 lead providers (2 for LD and 2 for MH)	1988	122	151

Appendix 2 – Unison Care Charter

Ethical care charter for the commissioning of homecare services

Stage 1	Stage 2	Stage 3
The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time Those homecare workers who are eligible must be paid statutory sick pay	Clients will be allocated the same homecare worker(s) wherever possible Zero hour contracts will not be used in place of permanent contracts Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time) Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation	All homecare workers will be paid at least the Living Wage (as of November 2013 it is currently £7.65 an hour for the whole of the UK apart from London. For London it is £8.80 an hour. The Living Wage will be calculated again in November 2014 and in each subsequent November). If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

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Eligibility

Introduction

The Care Act 2014 introduces a national eligibility threshold[1], which consists of three criteria, all of which must be met for a person's needs to be eligible. The eligibility threshold is based on identifying:

- whether a person's needs are due to a physical or mental impairment or illness
- to what extent a person's needs affect their ability to achieve two or more specified outcomes
- and whether and to what extent this impacts on their wellbeing.

Local authorities can decide to meet needs that do not meet the eligibility criteria. Where they decide to do this, the same steps must be taken as would be if the person did have eligible needs (for example, the preparation of a care and support plan). Where local authorities choose to exercise this power to meet other needs, they must inform the person that they are doing so.

Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) is experiencing, or is at risk of, abuse or neglect, then under section 42 of the Act the authority must make enquiries. Where this is the case, a local authority must carry out (or request others to carry out) whatever enquiries it thinks are necessary in order to decide whether any further action is necessary. The decision to carry out a safeguarding enquiry does not depend on the person's eligibility, but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect.

National eligibility threshold

Firstly, in considering whether a person's needs are eligible for care and support, local authorities must consider whether the person's needs are due to a **physical or mental impairment or illness**. This includes conditions such as physical, mental, sensory, learning or cognitive disabilities or illnesses, brain injuries and substance misuse.

If they do have needs caused by physical or mental impairment or illness, the local authority must consider whether the effect of the adult's needs is that they are unable to achieve two or more of the following specified **outcomes**:

[1] This replaces 'Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care: Guidance on Eligibility Criteria for Adult Social Care, England 2010' - usually referred to as the Fair Access to Care (FACS) guidance

a) Managing and maintaining nutrition

Local authorities should consider whether the adult has access to food and drink to maintain nutrition, and that the adult is able to prepare and consume the food and drink.

b) Maintaining personal hygiene

Local authorities should, for example, consider the adult's ability to wash themselves and launder their clothes.

c) Managing toilet needs

Local authorities should consider the adult's ability to access and use a toilet and manage their toilet needs.

d) Being appropriately clothed

Local authorities should consider the adult's ability to dress themselves and to be appropriately dressed, for instance in relation to the weather to maintain their health.

e) Being able to make use of the adult's home safely

Local authorities should consider the adult's ability to move around the home safely, which could for example include getting up steps, using kitchen facilities or accessing the bathroom. This should also include the immediate environment around the home such as access to the property, for example steps leading up to the home.

f) Maintaining a habitable home environment

Local authorities should consider whether the condition of the adult's home is sufficiently clean and maintained to be safe. A habitable home is safe and has essential amenities. An adult may require support to sustain their occupancy of the home and to maintain amenities, such as water, electricity and gas.

g) Developing and maintaining family or other personal relationships

Local authorities should consider whether the adult is lonely or isolated, either because their needs prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships.

h) Accessing and engaging in work, training, education or volunteering

Local authorities should consider whether the adult has an opportunity to apply themselves and contribute to society through work, training, education or volunteering, subject to their own wishes in this regard. This includes the physical access to any facility and support with the participation in the relevant activity.

i) Making use of necessary facilities or services in the local community including public transport and recreational facilities or services

Local authorities should consider the adult's ability to get around in the community safely and consider their ability to use such facilities as public transport, shops or recreational facilities when considering the impact on their wellbeing. Local authorities do not have responsibility for the provision of NHS services such as patient transport, however they should consider needs for support when the adult is attending healthcare appointments.

j) Carrying out any caring responsibilities the adult has for a child

Local authorities should consider any parenting or other caring responsibilities the person has. The adult may for example be a step-parent with caring responsibilities for their spouse's children.
The regulations provide that 'being **unable to achieve'** specified outcomes includes circumstances where the person:

- is unable to achieve the outcome without assistance. This includes where the person may need prompting, for example some adults may be physically able to wash but need reminding of the importance of personal hygiene.
- is able to achieve the outcome without assistance but doing so causes the adult significant pain, distress or anxiety. For example, an elderly person with severe arthritis may be able to prepare a meal, but this leaves them in severe pain and unable to eat the meal;
- is able to achieve the outcome without assistance, but doing so endangers or is likely to endanger the health or safety of the adult, or of others. For example, if the health or safety of another member of the family, including any child could be endangered when an adult attempts to complete a task or an activity without relevant support; or
- is able to achieve the outcome without assistance but takes significantly longer than would normally be expected. For example, a young adult with a physical disability is able to dress themselves in the morning, but it takes them a long time to do this and exhausted and taking the remainder of the morning to recover.

Finally, and crucially, local authorities must consider whether, as a consequence of the person being unable to achieve two or more of the specified outcomes there is, or is likely to be, a **significant impact** on the person's **wellbeing**. Local authorities should determine whether:

- the adult's needs impact on an area of wellbeing in a significant way; or,
- the cumulative effect of the impact on a number of the areas of wellbeing mean that they have a significant impact on the adult's overall wellbeing.

To do this, local authorities should consider how the adult's needs impact on the following nine areas of wellbeing in particular (but note that there is no hierarchy of needs or of the constituent parts of wellbeing):

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support provided and the way it is provided);

- participation in work, education, training or recreation;
- social and economic wellbeing;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

In making this judgement, the local authority should look to understand the adult's needs in the context of what is important to him or her. The **impact** of needs may be **different** for different individuals, because **what is important for the individual's wellbeing** may not be the same in all cases. Circumstances which create a significant impact on the wellbeing of one individual may not have the same effect on another.

Brent	**Community Wellbeing Scrutiny Committee** 4 September 2019
	Report from the Brent Clinical Commissioning Group

Urgent Care Developments and Cricklewood Walk in Service

Wards Affected:	Queensbury, Kenton, Fryent, Barnhill, Welsh Harp, Dudden Hill, Dollis Hill, Mapesbury, Willesden Green, Brondesbury Park, Kilburn
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	One: • Appendix A Cricklewood_Engagement 6pp 4pp insert
Background Papers:	n/a
Contact Officer(s): (Name, Title, Contact Details)	Fana Hussain, Assistant Director of Primary Care fana.hussain@nhs.net

1.0 Background

1.1 This paper sets out the proposals for the Cricklewood walk in service, which is commissioned by Barnet CCG under a standard NHS contract, Brent CCG are associate to this contract and work closely with Barnet CCG as the lead commissioner.

1.2 The Cricklewood GP Health Centre comprises a GP practice and walk-in service, both provided by Barndoc Healthcare Ltd. It is located in the south of the borough in Barnet; it is a member practice of Barnet CCG and borders the boroughs of Brent and Camden.

1.3 The walk-in service is open to all patients, not just those from Barnet, its close proximity to the borough of Brent, a distance of approximately 338 feet results in a number of Brent patients accessing the service for routine primary medical services.

1.4 The North Central London Commissioning Team, in conjunction with Barnet CCG, leads on commissioning the GP practice element of this contract. The Cricklewood Health Centre registered patient list totals approximately 5059 patients, with 2,180 patients residing in the Brent area and registered with the Barnet practice. The contract is held under an APMS (Alternate Provider of Medical Services), this means the contract is time limited and would require re-procurement after the expiry of the contract term. A separate consultation period with regards to the registered list has been undertaken. This consultation was completed on 19 July 2019. Due to the location of the practice, within the Barnet area, the Barnet CCG has lead on the consultation for the practice list**.** Registered patients and stakeholders were informed in writing of the consultation and provided with an opportunity to respond

1.5 The outcome of the consultation for the registered patient list was discussed at the North Central Joint Primary Care Commissioning Committee on 22 August 2019. A decision was made to re-procure the APMS practice for a further 5 years as is standard practice. That process will start immediately with the aim of completing in March 2020.

2.0 Walk in Service services

2.1 The walk-in service is utilised by residents living in Barnet, Brent, Camden and Harrow, and attracts approximately 19,000 people per year with the majority of visits during GP daytime hours. The majority of patients who use the walk-in service are also registered with a local GP. Approximately 58% of the attendances are from patients residing and registered with a Brent GP practice, 21% Barnet and the remainder in Camden and other boroughs in smaller numbers. Cricklewood walk-in service does not offer diagnostics or minor injury services

2.2 The walk-in service provides services from 8am to 8pm every day, staffed by a mix of GPs and nurses. The contract for the walk-in service is due to come to the end of its term on 31 March 2020. No changes to services are planned until the end March 2020.

2.3 Pre-engagement events have been held both at the walk in service and at local GP surgeries to obtain a fuller understanding of patients views, including barriers to accessing mainstream primary medical services, knowledge of availability of in hours and out of hours' services and the view on on-line access. The main learning from this engagement has been the lack of knowledge of local services, especially the Access Hubs.

2.4 On 12 August 2019, Brent launched a 12-week engagement exercise on the future of the walk in service, in tandem with the Barnet CCG process. An important factor that affects the future of all walk-in service is NHS England's principles and standards for urgent treatment centres (UTCs) set out in the document entitled 'Commissioning Standards Integrated Urgent

Care[1]' which places a requirement on CCGs to align locally commissioned services to an Integrated Urgent care model, with patients being triaged and directed to appropriate services and for providers having access to patient notes to ensure continuity of care. The review of the Cricklewood walk in service will ensure national directives are adhered to while ensuring patients are able to access services in the right setting, first time. Moving away from the commissioning of 'duplicate services' and working towards a more integrated approach to managing urgent and emergency care.

2.5 Given the national focus on integration of services around networks, the development of Primary Care Networks (PCN) is also important, presenting opportunities to provide better joined up care to keep people well and associated investment streams into the networks.

2.6 **The Brent Primary Care Strategy[2]**, which has been supported by the Local Authority and Councillors on the Primary Care Commissioning Committee, empowers the development of primary care with practices working at scale with each other and with other sectors such as social care, acute care, voluntary and community providers to deliver integrated seamless care to patients. The primary care strategy sets out the direction of travel for delivery of primary medical care in Brent and links to the wider NW London strategy, which places the patient at the centre of care.

2.7 The Community Wellbeing Scrutiny Committee is a key stakeholder in respect of local health services. The CCG would like to engage the Community Wellbeing Scrutiny Committee on the proposal to decommission the walk in service based at Cricklewood GP Health Centre and on the wider strategic direction for urgent care locally and how this informs the decision making on Cricklewood.

3.0 Reasons for Recommendation

3.1 Registered patient list

The decision to re-procure a GP practice list has agreed by the North Central Joint Primary Care Commissioning Committee on 22 August 2019. While the patient registered at the Cricklewood Health Centre will continue to be registered at this practice, due to the expiry of the current lease in December 2020, it is however unlikely that the practice will remain at this location.

3.2 If the practice premises re-locate further into the Barnet area, the patients from the Brent will be offered the opportunity to register with local practices, should they wish to do so. There are eight Brent GP practices within a mile

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[1] Commissioning Standards Integrated Urgent Care www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

[2] http://brentccg.nhs.uk/en/publications/doc_download/3420-item-5-2-i-brent-primary-care-strategy- template-v13&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjCmvi_iJnkAhXPalAKHYdTA_UQFggWMAA&usg=AOvVaw3z_aL1IOv40SQ48pGHlQXd

of the Health Centre, and the majority of people who use the service live within this radius. All of these practices are open to registering new patients.

3.3 List of Brent GP practices within one-mile radius of the Cricklewood Health Centre

Practice name	Distance
The Jai Medical Centre (formerly The Sheldon Practice)	0.1m
Burnley Practice	0.2m
Chichele Road Surgery	0.2m
Willesden Green Surgery	0.3m
Maplesbury Practice	0.5m
Walm Lane Surgery	0.5m
Oxgate Road Surgery	0.7m
Staverton Surgery	1 mile

3.4 The walk in service is commissioned from Barndoc Healthcare Ltd and provides consultation for primary care conditions on an episodic basis for approximately 20,700 Brent patients per annum. Episodic care refers to a single encounter with a patient focused on a presenting concern(s), identified medical condition(s), where neither the provider nor patient have the expectation of an on-going care relationship. Brent commissions GP extended access through three routes:

- GP Access Hubs – over 63,000 GP and nurse appointments commissioned per year. Brent commissions the most Access Hub appointments in North West London[3]
- GP Extended Hours – outside of GP core hours of Mon-Fri 8.00-6.30pm. Approximately 11,700 appointments per annum (30 mins/per 1,000 patients) 32 appointments per day
- E-consultation Hub appointments: Over 5,980 appointments commissioned per annum

3.5 In summary, we have set out below the current provision within Brent for patients to access advice, guidance or direct treatment.

4.0 Current provision in Brent

4.1 There are 55 GP practices in the borough of Brent which are required to provide as a minimum 72 appointments per 1,000 patients per week. For a list of 5,000 patients this equates to over 18.700 per annum, this would not include additional services commissioned by the CCG (Whole System Integrated Care, phlebotomy etc). As outlined above, Brent CCG has

[3] https://www.healthiernorthwestlondon.nhs.uk/sites/nhsnwlondon/files/documents/7._health_and_care_partnership_progress_report_1.pdf

commissioned additional GP appointments both in and outside of normal working hours to meet patient demand and improve access to a GP. Brent currently commission over one hour extended hours provision per 1,000 patients per week, between the Access Hubs and Extended Hours at GP surgeries.

4.2 In addition, there are the following services that can support patients with their health needs:

- 60 community pharmacies
- Five GP extended access hubs:
    - Wembley Centre for Health and Care Mon-Sun 8am-8pm
    - Roundwood Park Medical Centre, Willesden Centre for Health and Care, Mon-Fri 4pm-8pm and Sat 12pm-4pm
    - The Jai Medical Centre (formerly Stag Hollyrood Surgery), Edgware, Mon-Fri 4pm-8pm
    - Staverton Surgery, Kilburn Mon-Fri 4pm-8pm and 10am-2pm Saturday
    - Park Royal Medical Centre, Central Middlesex 4pm-8pm Mon- Fri and 10am-2pm Saturday

- At the GP Access Hubs, clinicians can access all GP-registered Brent patient records, enabling better treatment to be given. In 2018/19 there were over 63,000 appointments provided through access hubs.
- All GPs (Primary Care Networks) received funding to deliver 30 minutes of extended hours provision per 1,000 patients per week (outside core hours of Mon-Fri: 8.00-6.30pm)
- GP out-of-hours accessed via NHS 111 will direct patients to the most appropriate healthcare need, and includes ability to directly book patients into GP Access Hubs.
- Urgent Care Centres at Central Middlesex Hospital and Northwick Park are currently open seven days-a-week, 24 hours a day.

4.3 The three nearest GP Access Hubs to the Cricklewood walk in service are located at the Jai Medical Centre, Staverton Surgery and the Willesden Centre for Health, these three sites will provide access to extended hours appointments for patients who have previously attended the Cricklewood walk in service

4.4 In addition to existing services commissioned to support our local patient population, set out below are the most recent investment and development in primary care, together with our plan to increase capacity in general practice through additional staffing roles, the development of Primary Care Networks (PCN) and the focus on population health.

5.0 The NHS Plan[4]

5.1 Additional investment in primary care was set out in the NHS Plan, with substantial investment being made to increase the workforce and funding to develop and further build on the primary care infrastructure. The forthcoming changes outlined in the NHS Plan will focus on:

- Securing and guarantying the necessary extra investment;
- Make practical changes to help solve the big challenges facing general practice, not least workforce and workload;
- Deliver the expansion in services and improvements in care quality and outcomes set out in The NHS Long Term Plan, phased over a realistic timeframe;
- Ensure and show value for money for taxpayers and the rest of the NHS, bearing in mind the scale of investment;
- Get better at developing, testing and costing future potential changes before rolling them out nationwide.

5.2 Brent GPs have come together to form Primary Care Networks (PCN), these are groups of like-minded GPs working together with particular focus on the needs of their population. The characteristics of a PCN are set out below.

The core characteristics of a Primary Care Network (PCN) are:

- **Practices working together and with other local health and care providers,** around natural local communities that geographically make sense, to provide coordinated care through integrated teams
- **A defined patient population in the region of 30,000-50,000**
- **Providing care in different ways to match different people's needs**, including flexible access to advice and support for 'healthier' sections of the population, and joined up care for those with complex conditions
- **Focus on prevention and personalised care,** supporting patients to make **informed decisions** about their care and look after their own health, by connecting them with the full range of statutory and voluntary services
- **Use of data and technology** to assess population health needs and health inequalities, to inform, design and deliver practice and population scale care models; support clinical decision making, and monitor performance and variation to inform continuous service improvement
- **Making best use of collective resources across practices** and other local health and care providers to allow greater resilience, more sustainable workload and access to a larger range of professional groups

6.0 Additional roles

6.1 The CCG has supported the development of each PCN through direct and indirect, including funding for additional staff. The investment of circa £1.9m within the current financial year has focused on increasing capacity in general practice, freeing up lead GPs to take a strategic role within their PCN and funding for extended access at PCN level.

[4] Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long TermPlan https://www.england.nhs.uk/publication/gp-contract-five-year-framework/

6.2 Through a new Additional Roles Reimbursement Scheme, Networks will be guaranteed funding for an up to estimate 20,000+ additional staff (nationally) by 2023/24. The table below set out the additional roles which will be funded by the CCG over the next four years.

Year	Professional	Funding
Year 1	Clinical pharmacists and & Social prescribing link workers	£92K
Year 2	Physician associates & first contact Physiotherapists	£213K
Year 3	Paramedics	£342K
Year 4	From 2022, all of the above workforce will be increased, by 2024 a typical network will receive 5 clinical pharmacists (equivalent of one per practice), 3 social prescribers, 3 first contact physiotherapists, 2 physicians associates and 1 community paramedic.	£726K

6.3 The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, physiotherapists, and community paramedics; and 100% of the costs of additional social prescribing link workers.

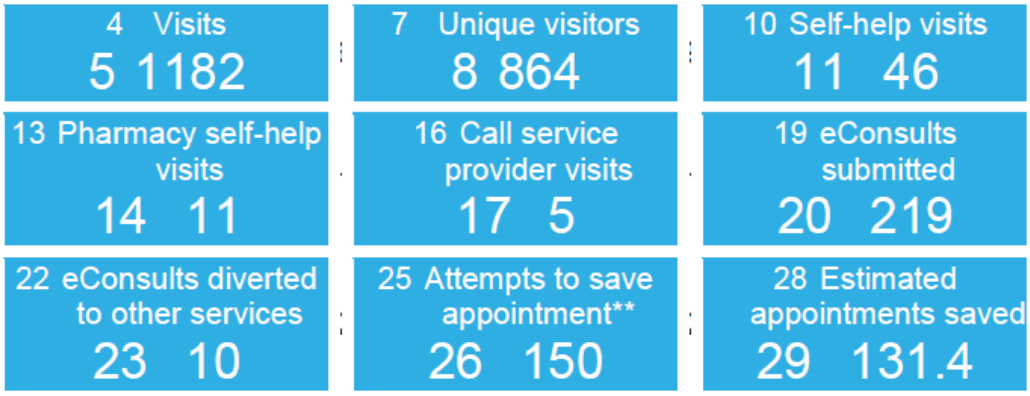
6.4 The aim of the additional roles will be to provide additional and increased capacity in general practice with patients being seen by the right clinician in the right setting. For Brent this means an **additional 10 Clinical Pharmacists and social prescribers** treating and supporting patients, in the current financial year. For 2020 **a further 10** pharmacists, physician's associates and physiotherapists will be funded by the CCG. This increase capacity in workforce will increase access to primary care.

7.0 Digital Innovation

7.1 The NHS recognises the increase demand on patient's time and the demand for a more accessible primary care, particularly for those patients who are deemed 'time poor'. It is also recognised that accessibility primary care may result in patients neglecting their health. The increase in registration with digital providers has demonstrated the demand for on-line access. In Brent we have recognised this demand and our Brent GPs have embraced the digital era, with Brent GPs being the first and only CCG to provide electronic consultation through an E-hub. Patients are able to access an on-line platform for their medical condition 24 hours a day over 7 days a week. The practice receives and reviews the e-consult and liaises with the patient remotely or if necessary, by booking a face to face consultation.

7.2 The E-consultation platform enables a patient to contact a clinician for specific advice relating to their condition. This digital work has **improved access to**

primary care while increasing GP capacity, on average an E-consult takes 7 minutes as the patient history has been made available prior to the consultation. An extract of the e-consult report for 18 August 2019 shows 219 e-consults being submitted on a weekly basis across 31 of the 55 Brent practices. August is normally deemed a quiet month for primary care access, therefore the activity for the week is lower than normal.



8.0 Pharmacy appointments

8.1 From April 2020 patients will be able to book appointments with Community Pharmacists for Minor Illnesses. Pharmacists will be funded for treating patients who require advice, guidance, medication or even a second opinion for conditions that they are qualified to provide advice on. This scheme draws upon previous Minor Ailments schemes which have been successful in certain areas. Patients will be able to self book, be referred by NHS 111, their GP practice or Urgent Care Centres. This national scheme aims to increase access to primary care services.

9.0 Population health needs

9.1 The focus of the NHS Plan is on prevention and personalised care, providing care in a different way to meet patient's needs. The CCG is working closely with each PCN Clinical Director to support the mapping of local patient population needs and develop services aimed at addressing these needs. A more integrated approach to managing patient care is encouraged with PCN's working closely with their social care colleagues, community, mental health, voluntary and acute providers to provide a seamless service. Additional funding for this work will be released shortly to implement this approach as well as supporting the development of our PCNs.

10.0 Integrated approach

10.1 It is important that patients are seen within their own group of practices which make up the PCN to enable joint up care, continuity of care and for practices to understand the needs of their patients better. The fragmentation of services and duplication that currently exists prevents this continuity of care with patients continually being confused by the different avenues for

accessing services.

10.2 The ultimate aim, as set out in the national NHS England documents is to ensure an integrated approach to urgent and emergency with one point of access for patients during this time. We aim to empower our PCNs to manage their patients care and will work with them to deliver care which meets their population needs.

11.0 Alternative Options Considered and not Recommended for the walk in service

11.1 The current walk in service contract with Barndoc Healthcare Ltd comes to a natural end and therefore cannot be extended in its current form. The current service provides episodic care with limited access to patient history and their care plans. It is deemed a duplication of existing services provided by GP practices and Access Hubs.

11.2 The Commissioning Standards Integrated Urgent Care places a responsibility on the CCG to commission services aligned to the new model of integrated primary and unscheduled care and ensure

'any savings realised from the newly commissioned services are not offset through commissioning of unnecessarily duplicated services elsewhere in the urgent and emergency care system (for example through ambulance services, urgent care centres or locally commissioned general practice enhanced services).' (page 16)

11.3 The NHS Plan focuses on population health management and working in a more integrated approach with partner organisations. The direction of travel proposed by Barnet and Brent CCG embraces and seeks to drawn upon the opportunities presented by the national directive and aims to ensure the development of primary care to better meet the needs of its population.

12. Post Decision Implementation

12.1 As our partner organisation, the CCGs seeks the backing of the Community Wellbeing Scrutiny Committee to support the changing primary care landscape and empower our local Primary Care Networks (PCN).

12.2 The CCG will continue to work closely with PCNs to ensure patients accessing the current service are aware of the availability of services locally for routine and emergency care. We are currently reviewing the three funding streams for GP access (Extended hours, Access Hub and Digital) to provide a joint up and integrated approach for patients.

12.3 A detailed engagement programme has been agreed between Brent and Barnet CCG which includes weekly drop in sessions at the Cricklewood Health Centre, local GP surgeries and places frequented by members of the public including shopping centres, tube stations etc

12.4 The outcome of the engagement will be presented to the Brent Primary Care Commissioning Committee in December (meeting in public). A similar process will occur in Barnet CCG. Members of the Committee would take into account views of residents and stakeholders as well as range of other information – including quality/equalities impact, demographic information, strategic directives, value for money etc the report will be published on the Barnet and Brent CCG websites.

12.5 If the decision taken in December is not to re-commission the walk-in service, then notice would be given to the current provider with the service coming to an end in March 2020. Barnet and Brent CCGs will work together and with their respective PCNs to support patients during and after the transition period.

13. Implications of decision

13. Corporate Priorities and Performance

The engagement proposal and rationale are in line with the corporate priorities set out in the Health and Wellbeing Delivery Plan, which includes care closer to home as a key vehicle for the delivery of better outcomes for local people and the Commissioning Standards Integrated Urgent Care which places a requirement on CCGs to develop an integrated model of care

14. Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

The rationale for the engagement proposal is based on value for money given that the walk-in service duplicates other local services and does not provide as integrated or effective provision of care. The current attendance at the Cricklewood walk in service from Brent patients equates to 11,000 attendances per annum.

15. Social Value

Primary care and associated network provision including social prescribers is the key vehicle for population health management as part of an integrated care system.

16. Legal and Constitutional References

NHS Act 2006 as amended by S14 of the Health and Social Care Act 2012 Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan Commissioning Standards Integrated Urgent Care CCG Primary Care Strategy

17. Risk Management

Risks associated with the engagement process are focused on ensuring patients using the walk-in service are able to feed in views.

18. Equalities and Diversity

A full Equalities Impact Assessment is being developed which will be available during the engagement period.

19. Corporate Parenting

N/A

20. Engagement

The draft engagement materials are attachments to this paper.

21. Insight

N/A

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Have your say on the future of Cricklewood walk-in service

NHS Barnet Clinical Commissioning Group
NHS Brent Clinical Commissioning Group

Introduction

We understand from patients and residents that choosing the right place to get care when you are feeling unwell can be confusing, with a range of services providing urgent care at different times and for different needs.

Barnet and Brent Clinical Commissioning Groups (CCGs) are keen to ensure that people understand what is available locally and to simplify the system.

The contract for Cricklewood walk-in service is coming to an end. Over the next few months, Barnet and Brent CCGs want to hear the views of local residents and stakeholders on a proposal to close the walk-in service based at Cricklewood GP Health Centre when the contract comes to an end on 31 March 2020. The local area is well-served by other primary care services such as extra GP appointments in the evening and at weekends, community based services and NHS 111. The CCGs intend to step-up promotion of these services so people know the most appropriate places to go. Further information about the proposal and ways to give your views are contained in this document.

Background

The walk-in service based at Cricklewood GP Health Centre is commissioned by Barnet Clinical Commissioning Group (CCG). Patients who use the service come from both Barnet and Brent, with a smaller number coming from Camden. The number of people from all boroughs using Cricklewood walk-in service has reduced by 21% since 2016. Although the walk-in service provides an extra place where people can access urgent care, both Barnet and Brent CCGs think that the Cricklewood walk-in service:

1. **Duplicates services that are already available within both boroughs**

- It provides a similar range of treatments to a GP surgery and the majority of patients who access the service are already registered with a GP. Both Barnet and Brent CCGs now offer extra GP appointments in the evening and at weekends in practices across both boroughs.

  There are 48,000 appointments per year for Barnet and 64,688 for Brent. Brent is currently expanding electronic consultations (e-consultations) to all patients. Barnet is currently piloting e-consultations with a small number of GP practices.

- There are GP appointments available when the Cricklewood walk-in service is open which means the CCGs are paying twice for the same service.

- There are two other walk-in centres in Barnet that are open seven days-a-week which, unlike Cricklewood, provide x-ray facilities and minor injury services. Brent also has two urgent care centres at Central Middlesex Hospital and Northwick Park Hospital.

2. Offers a limited service to local people

- The walk-in service does not provide continuity of care for long-term diseases. For most conditions, it is better for patients to attend their own GP surgery because unlike the walk-in service a patient's GP will have access to their records and can ensure continuity of care.
- The walk-in service does not provide emergency services, referral on to secondary care or services that help prevent ill health, such as immunisations, health checks and cancer screening.

3. Does not help the CCGs to achieve local urgent care priorities

- The CCGs believe that they should simplify urgent care, making it easier for patients to know where to go and focus resources on improving primary care so that more people can be seen quickly and in the most appropriate setting close to home.
- The CCGs have invested in increasing GP appointments with more primary care investment to come this year and in the future as part of the NHS Long Term Plan. This will mean more primary care staff and better outcomes for patients as health, care and voluntary services join up around patient needs and provide early help to avoid urgent attendances, where possible.
- There are alternative urgent care and and GP services in the boroughs, all of which provide the same range of services as the Cricklewood walk-in service and more.

Given these developments, continuing to pay for Cricklewood walk-in service may not be the best way to deliver the most effective care for local patients as well as not being a good use of public money given alternative services that are available.

North Central London Commissioning and Contracting ran a recent consultation on the future of the GP practice at Cricklewood GP Health Centre. Patients who are registered with the Cricklewood practice received individual letters as part of that consultation. On 22 August 2019, the North Central London Primary Care Committee in Common agreed to recommission the GP practice.

Urgent and GP services in Barnet and Brent

1.1 Cricklewood GP Health Centre

Cricklewood GP Health Centre comprises a GP practice and walk-in service. The GP practice is commissioned by North Central London Commissioning and Contracting and the walk-in service is commissioned by Barnet CCG. A consultation on the future of the practice has recently concluded and on 22 August 2019, the North Central London Primary Care Committee in Common agreed to recommission the GP practice. The centre is in the south of the borough of Barnet, on the border with Brent and Camden.

The walk-in service is open from 8am to 8pm every day, staffed by a mix of GPs and nurses. It treats patients mainly registered with GP practices in Barnet and Brent, but is open to all registered and unregistered patients regardless of where they are from.

All unregistered patients who attend are encouraged and supported to register with a GP. There are 13 practices within a mile radius, all accepting new patients. Details below.

It treats approximately 54 people per day (of which 31 Brent/13 Barnet), most of whom visit during daytime hours 8am–6:30pm Monday to Friday.

1.2 Urgent and primary care provision in Barnet

On 12 August 2019 there were 52 GP practices in the borough. Barnet CCG has recently commissioned more GP appointments to meet patient demand and improve access to a GP.

In addition, there are the following services to support patients with their health needs:

- 76 pharmacies across the borough.
- Ten GP extended access hubs* where 48,000 additional GP appointments are provided in the evenings and at weekends. GPs can access the medical records of patients, enabling better treatment.
- Two other walk-in services, at Edgware Community Hospital and Finchley Memorial Hospital, offering services from 8am (Edgware 7am) until 10pm, seven days a week.
- The GP out-of-hours service accessed via NHS 111 offers face-to-face consultations from 6.30pm to 8am seven days a week. The service includes home visits. At weekends, home visits can be offered 24 hours a day.
- An urgent care centre at Barnet Hospital is open until 11pm, seven days a week.

**A hub is a practice that offers GP appointments at evenings and on weekends to all registered patients.*

GP practices within one mile radius of Cricklewood walk-in service

Cricklewood Health Centre – Barnet

Greenfield Medical Centre – Barnet

Pennine Drive Practice – Barnet

Chichele Road Surgery – Brent

Oxgate Gardens Surgery – Brent

Walm Lane Surgery – Brent

The Windmill Medical Practice – Brent

Willesden Green Surgery – Brent

The Jai Medical Centre (Brent) – (formerly known as The Sheldon Practice) – Brent

Mapesbury Medical Centre – Brent

West Hampstead Medical Centre – Camden

Cholmley Gardens Surgery – Camden

Fortune Green Road Surgery – Camden

1.3 Urgent and primary care provision in Brent

On 12 August 2019 there were 55 GP practices in the borough and Brent CCG has commissioned more GP appointments both in and outside of normal working hours to meet patient demand and improve access to a GP.

In addition, there are the following services that can support patients with their health needs:

- 60 community pharmacies.
- Five GP extended access hubs across the borough where 64,688 additional GP appointments are provided in the evenings and at weekends. Doctors can access patient records, enabling better treatment to be given and ensure continuity of care.
- GP out-of-hours accessed via NHS 111 offers face-to-face consultations provided by London Central & West Unscheduled Care Collaborative and Care UK after 6.30pm seven days-a-week.
- An urgent care centre at Central Middlesex Hospital is also open seven days-a-week.

1.4 Other local urgent care services

Because of the location of the Cricklewood walk-in service, patients from both boroughs may also be closer to other urgent care facilities outside of their own boroughs which they can use. These include the urgent care centres at Royal Free Hospital, Northwick Park Hospital and St Mary's Hospital.

Extra GP Appointments Information
Available to all GP patients in respective boroughs through own GP or in Barnet direct on 020 3948 6809

Barnet – nearest to Cricklewood indicated with asterisk	
Location	**Opening times**
Oaklodge Medical Centre	Mon-Fri 18:30-21:00 – Sat and Sun 08:00-20:00
Millway Medical Practice	Mon/Wed/Thurs 18:30-21:00 – Sat 08:00-12:00
Greenfield Medical Centre*	Mon/Wed/Fri 18:30-21:00 – Sat 08:00-12:00
PHGH*	Tue/Wed/Thurs 18:30-20:00 – Sun 08:00-12:00
Wentworth Medical Practice	Mon/Wed/Fri 18:30-21:00 – Sat 08:00-12:00
Longrove Surgery	Mon/Wed/Fri 18:30-21:00 – Sat 08:00-12:00
St Andrew's Medical Practice	Mon/Wed/Fri 18:30-21:00 – Sat 08:00-18:00
East Barnet Health Centre	Tues/Wed/Thurs 18:30-20:00 – Sat 08:00-12:00
Dr Azim and Partners*	Mon/Tue/Thurs 18:30-20:00 – Sat 08:00-12:00
Woodlands Medical Practice	Tues and Thurs 18:30-21:00 – Sat 08:00-12:00
Brent – nearest to Cricklewood indicated with asterisk	
Wembley Centre for Health and Care Clinic	Mon-Sun 08:00-20:00
Roundwood Park Medical Centre*	Mon-Fri 16:00-20:00 – Sat 12:00-16:00
Jai Medical Centre (Brent) formerly known as The Stag Holyrood Surgery*	Mon-Fri 16:00-20:00
Staverton Medical Centre Kilburn*	Mon-Fri 16:00-20:00 – Sat 10:00-14:00
Park Royal Medical Centre	Mon-Fri 16:00-20:00 – Sat 10:00-14:00

Frequently Asked Questions

I use Cricklewood walk-in service when I can't get an appointment with my GP. What would I do if it closes?

If you can't get a same-day appointment with your own GP you can arrange to see another GP close to home. Appointments are available at practices across Barnet and Brent as set out on page 5. In Barnet the receptionist at your own practice can arrange an appointment or you can call the service directly on 020 3948 6809 from 6.30pm to 9pm seven days-a-week. In Brent you can contact your own GP or NHS 111. You can also seek urgent medical advice by dialling 111 or get an opinion on non-urgent conditions by visiting your local pharmacist. If you would prefer to use a walk-in service, you can visit Finchley Memorial Hospital or Edgware Community Hospital. You can find directions, transport links and opening times online at www.barnetccg.nhs.uk

Urgent care is also available to Brent patients at Central Middlesex Hospital, Northwick Park Hospital and St Mary's Hospital. For a full list, see www.brentccg.nhs.uk

My children are prone to cuts and bruises. If Cricklewood walk-in service closes, where should I take them?

If your child is hurt but you don't think it is serious you can treat them at home or call your own GP for advice or an appointment. If you still need advice from a healthcare professional, you can take your child to your local pharmacist who will give you clinical advice and over-the-counter remedies. If you think your child's condition is serious and you are not sure what to do you can dial NHS 111 and a trained adviser can help you. If your child's condition is serious or life threatening, dial 999 immediately.

What about people who are not registered or can't register with a GP?

It is important that everyone who is eligible to register with a GP does so, as this is where they can access the best care for most conditions and also preventive care and referrals to other services. You can find details of your nearest GP on the NHS website at: www.nhs.uk. There are 13 GP practices within a mile of Cricklewood walk-in service You can see the full list online at www.barnetccg.nhs.uk or www.brentccg.nhs.uk.

All GP practices in Barnet and Brent are open to register new NHS patients. However, if someone can't register, the walk-in services at Finchley Memorial Community Hospital and Edgware Community Hospital, are able to treat them. The NHS 111 service will also respond to anyone in need.

There are plans for re-development in Cricklewood and surrounding areas. With more people arriving is there not now a greater need for the walk-in service?

Clinical Commissioning Groups (CCGs) work closely with their local authorities in planning for future population growth. Barnet and Brent CCGs will ensure that there is sufficient primary care in both boroughs to cover any forthcoming increases in population and developers are required to contribute to local infrastructure to secure this.

I'm registered with the GP practice at Cricklewood Health Centre and received a letter about a consultation on the future of that service. Is this separate to that?

Yes, our colleagues at North Central London Commissioning and Contracting ran a consultation on the future of the GP practice at Cricklewood GP Health Centre. All patients of that practice received a letter inviting them to have their say. On 22 August 2019, the North Central London Primary Care Committee in Common agreed to recommission the GP practice.

Won't closing the walk-in service put pressure on A&Es and GPs?

All patients who are treated at Cricklewood walk-in service could be treated at their registered GP practice or by visiting a local pharmacist or through self-care.

Both Barnet and Brent CCGs have commissioned extra GP appointments at a range of locations for any patient registered with a GP in their borough.

Cricklewood walk-in service is not like an A&E. Patients using Cricklewood would not have the sort of serious conditions that would put additional pressure on A&E and their needs could be met in a range of other ways set out above. However, we recognise we need to do more work to inform patients of the choices in the community and give them confidence in using these services, rather than going to A&E for less-serious conditions.

If patients are unsure where to go when they are ill, they can call NHS 111 for advice, which will direct them to the most appropriate service to manage their health needs.

Is this proposal just about saving money?

No. In the Cricklewood area there are a number of services providing very similar care, particularly in the evening. Many patients are not clear of the choices available to them, what each service does, or that some services duplicate others. Whenever possible general practice is the best place for patients to get care. CCGs are effectively spending limited resources twice. We need to make the best use of public money and develop services that are easier for patients to access and understand.

How long do we have to share our views?

You can give your views on the proposal between 12 August to 4 November 2019.

When will you be making a decision on the future of Cricklewood walk-in service?

We will make a decision when all views have been considered and all other information gathered (such as financial data, quality and equality reports). We expect that to be in December 2019.

How to get involved

We would like to know the views of service users and carers, staff, representative groups, community organisations and local residents.

To share your views you can fill in the questionnaire attached to this document or complete it online at: **www.surveymonkey.co.uk/r/3GF53VNcricklewood**

All of this information and the survey are also available on the Barnet CCG website: **www.barnetccg.nhs.uk** Brent CCG website: **www.brentccg.nhs.uk** or you can contact either CCG for a copy. The document is available on request in other formats and languages.

If you require further information:

Email: **barccg.wic@nhs.net**

Phone: **020 3688 2822**

Post: Send your letter to: Barnet Clinical Commissioning Group, North London Business Park, Oakleigh Road South. N111NP marked 'Cricklewood walk-in service' or visit the walk-in service.

All comments must be received by 4 November 2019

Completed questionnaires should be returned to:
barccg.wic@nhs.net

Barnet Clinical Commissioning Group, North London Business Park, Oakleigh Road South. N11 1NP marked 'Cricklewood walk-in centre - Have your say'

Questionnaire

We welcome any feedback or ideas you have, but we are particularly interested in your answers to the following questions. You do not have to answer all questions and are welcome to use extra paper if necessary.

Confidentiality
If you are responding in a personal capacity, your response, **but not your personal details** may be shared with decision-makers to enable them to fully consider your views.
Unidentifiable parts of your response may also be published to illustrate comments made.

1. Are you registered with a GP? (Tick only one):

- ☐ Yes, at Cricklewood GP health centre
- ☐ Yes, with a different Barnet GP practice
- ☐ Yes, with a Brent GP practice
- ☐ Yes, with a GP elsewhere
- ☐ No

2. How many times have you visited Cricklewood walk-in service in the last 12 months?

- ☐ **0**
- ☐ **1**
- ☐ **2**
- ☐ **3**
- ☐ **4**
- ☐ **or more**

3. Why did you choose Cricklewood walk-in service on your most recent visit? (Tick only one):

- ☐ Not applicable
- ☐ It was convenient
- ☐ I didn't think my GP could deal with my health needs
- ☐ I couldn't get an appointment with my own GP and couldn't wait for the next available appointment

Other (please state)

4. When making our decision what else should we consider? Please specify:

5. If the walk-in centre was not available, would you have (tick those that apply):

- ☐ Looked after the problem yourself
- ☐ Gone to your GP practice
- ☐ Gone to see a pharmacist
- ☐ Gone to see a Dentist
- ☐ Called your GP out to you
- ☐ Gone to an Urgent Care Centre
- ☐ Gone to A&E
- ☐ Contacted NHS 111
- ☐ Done nothing

Other please specify

Some questions about you

The following questions will help us to see how opinions vary between different groups of the population. We will keep your answers completely confidential.

1. To which gender identity do you most identify

☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

2. How old are you?

☐ 0-16 ☐ 17-30 ☐ 31-45 ☐ 46-60 ☐ 61-70 ☐ 70+

3. What is your ethnic group

☐ White English/Welsh/Scottish/Northern Irish

☐ Irish ☐ Gypsy or Irish Traveller ☐ Other White background

Mixed/multiple ethnic groups

☐ White and Black Caribbean ☐ White and Black African

☐ White and Asian ☐ Other mixed/multiple ethnic background

Asian/Asian British

☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese

☐ Other mixed/Asian background

Black/African/Caribbean/Black British

☐ African ☐ Caribbean ☐ Any other Black background

Other ethnic group

☐ Arab ☐ Any other ethnic group ☐ Prefer not to say

4. Which of the following best describes your sexuality?

☐ Heterosexual or straight ☐ Gay or lesbian ☐ Other

☐ Bisexual ☐ Prefer not to say

5. Which if any of the following best describes your religion

☐ No religion ☐ Buddhist ☐ Hindu ☐ Jewish ☐ Muslim ☐ Sikh ☐

☐ Other ☐ Prefer not to say

☐ **Christian** (including Church of England, Catholic, Protestant and other Christian denominations)

6. Do you consider yourself to have a disability or long term condition?

☐ Yes ☐ No ☐ Prefer not to say

7. What is your full postcode ☐

NHS Barnet Clinical Commissioning Group
Ground Floor, Building 2
North London Business Park
Oakleigh Road South
New Southgate
N11 1NP
Telephone: 020 3688 2299

NHS Brent Clinical Commissioning Group
Wembley Centre for Health and Care
116 Chaplin Road
Wembley
HA0 4UZ
Telephone: 020 8900 5300

If you have any queries, questions or comments about Barnet and Brent CCGs, please contact us using the details on this form, and we will respond as quickly as possible.

Brent	**Community and Wellbeing Scrutiny Committee** 4 September 2019
	Report from the Assistant Chief Executive

Update: Scrutiny Committee Work Programme 2019-2020

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	One: • Appendix 1: Community and Wellbeing Scrutiny Committee Work Programme 2019-20
Background Papers:	None
Contact Officer:	James Diamond, Scrutiny Officer, Strategy and Partnerships james.diamond@brent.gov.uk 020 8937 1068

1.0 Purpose of the Report

1.1 This report updates members on the committee's work programme for 2019/20 and captures scrutiny activity which has taken place outside of its meetings.

2.0 Recommendation(s)

2.1 Committee to discuss and agree the contents of the report.

3.0 Detail

3.1 The scrutiny committee's work programme sets out the policy areas and decision-making, which are the responsibilities of the Cabinet, that the committee will review and scrutinise during the municipal year. It also states the scrutiny task groups which it will set up as in-depth reviews. The committee's work plan for 2019/2020 is set out in Appendix 1. A scrutiny committee's work plan may change during the municipal year as new issues arise and items are added. An assumption of the work programme is that it will evolve according to the needs of the committee, and spare capacity would be left to look at new issues. In addition, for practical reasons it may be necessary to move items to be heard at a particular committee date.

3.2 As part of its remit set out in the constitution, the Community and Wellbeing Scrutiny Committee can scrutinise, and make recommendations, to NHS organisations. It reviews the provision and operation of health services in the borough and can make reports or recommendations to NHS bodies or Full Council.

3.3 On 22 July there was a meeting of the North West London Joint Health Overview and Scrutiny Committee which was attended by Cllr Ketan Sheth as Brent Council's representative on the joint committee. The meeting reviewed an iteration of the document produced by the North West London Collaboration of Clinical Commissioning Groups, which proposes the merger of the eight clinical commissioning groups in North West London by April 2020, and creating a single clinical commissioning group for north-west London.

3.4 The childhood obesity scrutiny task group. There have been evidence session meetings of the task group on 16 July, 23 July and 3 September. There was also an open evidence session for parents and those involved in early years organisations scheduled for 10 September. The task group will now start to write its report based on the information it gathered at the evidence sessions. It is proposed that this report will be presented to the next scrutiny committee meeting in November for agreement. So far, the task group has covered all the themes set out in the scoping paper of health and public services, environment and the home environment and collected a significant amount of information for its report. Cllr Ketan Sheth has now joined the task group and the committee is asked to note this change to the membership agreed at the last meeting.

3.5 Members will be aware that a report on changes to Cricklewood Walk-In Service has been added to the agenda for 4 September. This issue was raised by a non-executive member at the last Council meeting in July this year.

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

6.1 There are no equality implications arising from this report.

7.0 Consultation with Ward Members and Stakeholders

7.1 Ward members who are committee members will review this report.

REPORT SIGN-OFF

PETER GADSDON
Assistant Chief Executive

Appendix 1: Community and Wellbeing Scrutiny Committee Work Programme 2019-20

Tuesday 9 July 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Substance Misuse: Treatment, Recovery and Wellbeing Service	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	No
2. Palliative and End of Life Care	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes
3. Urgent Care Centre, Central Middlesex Hospital	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes
4. Childhood Obesity: Members' Task Group Scoping Paper	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 4 September 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Home Care Recommissioning	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing		Yes	No	No
2. Cricklewood Walk In Service	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group/ Barnet Clinical Commissioning Group	No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 27 November 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Brent Safeguarding Adults' Board Annual Report	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing	Independent Chair, Brent Safeguarding Adults' Board	No	No	No
2.Peer Review: Adult Safeguarding	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing	Independent Chair, Brent Safeguarding Adults' Board	No	No	No
3. Brent Local Safeguarding Children Board Annual Report	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	Independent Chair, Brent Local Safeguarding Children Board	No	No	No
4. Overview and Scrutiny Task Group Report: Childhood Obesity	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Tuesday 4 February 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Single Homeless Prevention Service	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No
2. Brent Council Housing Management Services	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No
3. Brent Council Housing Repairs	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

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Monday 16 March 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Early Intervention to Reduce Youth Crime	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People		No	No	No
2.Contextual Safeguarding Task Group: One-Year Update	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	Independent Chair, Brent Local Safeguarding Children Board	No	No	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 22 April 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. School Standards and Achievement Report 2018-19, including Achievement of Boys of Black Caribbean Heritage	Cllr Amer Agha, Lead Member for Schools, Employment and Skills	Gail Tolley, Strategic Director Children and Young People		No	Yes	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013