MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Wednesday 4 September 2019 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Afzal, Ethapemi, Hector, Shahzad, and Thakkar, and co-opted members Rev Helen Askwith, Mr Alloysius Frederick and Mr Simon Goulden

Also Present: Councillors Farah, McLennan and Colacicco

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

Apologies for absence were received as follows:

- Councillor Knight
- Councillor Stephens (Councillor Kabir attending as substitute)
- Teachers Union observers.

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Ketan Sheth – Lead Governor, Central and North West London NHS Foundation Trust
- Councillor Ethapemi – Spouse employed by the NHS.
- Councillor Shahzad – Spouse employed by the NHS.
- Councillor Thakkar – Employed as Care Negotiator.

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 9 July 2019 be approved as an accurate record of the meeting, subject to following amendments to the attendance list:

- Rev Helen Askwith – delete Councillor.
- Mr Alloysius Frederick – Name misspelt as Fredericks.

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

There were no matters arising.

6. **Order of Business**

RESOLVED: that the order of business be amended as recorded below:

- Agenda item 7, **Cricklewood Health Centre** taken before **Agenda item 6, Home Care Recommissioning**

7. **Cricklewood Health Centre**

Dr Jahan Mahmoodi (Clinical Director, Brent CCG) introduced the report, setting out the context of the paper and explaining proposed changes. Dr Mahmoodi said that evidence suggested that far fewer patients were seeking walk-in access to primary care. He went on to highlight the stated benefits of a joined up approach being developed by Primary Care Networks where all clinicians seen by a patient have access to that patient's notes digitally, therefore ensuring the best possible care for the patient. Rather than the patient potentially seeing a number of different clinicians when making multiple visits to the walk-in centre, it was preferable for the patient to be treated in a facility where their notes were available to whomever they saw or had been referred to, so that clinical decisions could be made with all the information to hand. The CCG aimed to provide a seamless service with efficiency, choice and accessibility being the presiding ambitions.

Dr Mahmoodi confirmed that the CCG was working towards consolidating services over the next few months and was influenced by the evidence of patients preferring alternative methods of accessing primary care such as online consultations. The lease on the Cricklewood premises was due for renewal next year and there were restrictions on the re-procurement process which would be taken into account.

Andrew Pike (Assistant Director of Communications and Engagement NHS North West London CCGs) spoke about the 14-week Consultation which started on 12 August 2019 engaging the walk-in patients and nearby GP practices. Documentation in respect of the Consultation was available in libraries and other public places and its aim was to explore thoroughly with walk-in users why they used the service and what factors needed to be taken into consideration. Stakeholders, including the Committee were strongly encouraged to participate. Dr Mahmoodi added that the consultation would illustrate how the CCG planned to seek the engagement of users and stakeholders in creating a joined up non-fragmented service.

The Chair thanked the CCG representatives for the introduction and invited questions from the committee.

In the subsequent discussion, the committee queried the validity of evidence that walk-in centres were dated and under-used and asked what risks there were for residents and how they would be mitigated. They asked what would happen to people who were not currently registered with a GP and how the closure of the walk-in centre would affect those patients needing an emergency provision. In relation to other available healthcare resources, they queried if there would be adequate and improved provision going forward with enough GPs available and ease of registration. Further questions were raised about the engagement with the current users of the walk-in service, how it was being promoted, how would elderly people and those with language barriers be included and if there was sufficient time before the proposed closure date to let patients know about the alternative

provisions so that there would be no gap in service or health implications. It was also asked if feedback had been received as part of the engagement so far and whether there were any processes in place to measure the effectiveness of alternative services.

The Committee raised the question of why the technology for universal access to medical notes could not be installed at the walk-in centres and expressed concerns that the deprivation of readily accessible health services damaged community cohesion. They confirmed that Barnet councillors also wanted to save this service.

With the permission of the Chair, Councillor Colacicco (Deputy Mayor) spoke on behalf of the Mapesbury ward residents whom she said hadn't been consulted. She went on to say that, while she understood the sentiments of the proposal, she questioned why people were attending the Walk-in centre if there were alternative services available. Councillor Colacicco went on the say that local people had said there were no GP appointments and, Cricklewood being a poor area, they couldn't travel easily. She wondered if the residents knew about the proposal and whether there was enough provision for the increasing population in Cricklewood.

In response to the committee's queries Sarah D'Souza (Director of Commissioning, Barnet CCG) reported that there were just under 20k attendances at the walk-in service, 58% of which related to patients registered in Brent. This represented a 10k drop on the previous year and an on-going decline of 21% over the last twelve months. Ms D'Souza could not confirm how many of the 20k were GP referred as the walk-in centre had no access to medical records and could not therefore refer patients on. Dr Mahmoodi advised that the general direction of travel within the NHS was the closure of walk-in units or non-renewal of contracts. In promoting a seamless service, Dr Mahmoodi went on to explain that a patient's notes which contained details of any allergies, medication and their medical history were solely held by their GP and, if that patient presented, for example, to hospital, this information was not available to the hospital team. A seamless service meant that a data sharing agreement would be in place to ensure that wherever the patient went for medical care, whomever treated them was fully informed of all the factors that would enable them to make the best clinical judgement.

Dr Mahmoodi went on to explain that there were always risks with change. Initially patients may go to the walk-in centre, unaware that it was closed, but the aim was to mitigate risks and he reported that a comprehensive quality impact and inequality assessment would be undertaken by the health commissioning service to consider any impact on residents. He advised that the result of the reinvestment of resources would give patients better access to their own clinicians and would meet the terms of the Government's plans to move away from a fragmented service. He continued that it was likely that the Government would invest additional funding to implement its plans, resulting in more choice for patients and better access to primary care. Fana Hussain (Assistant Director for Primary Care, Brent CCG) added that the report outlined how the guaranteed funding and Primary Care Networks' investment planned to support identified local patient population needs.

Members also wanted to know about why there was a Consultation taking place about the walk-in centre if the CCG was saying that they were acting according to NHS England guidance.

In response to the Committee's questions, Rashesh Mehta (Assistant Director, Integrated Urgent Care, CCG) reiterated that there was a national directive to close walk-in centres and replace them with extended hours hubs which Cricklewood already had onsite. She advised that Brent GPs conducted more than 80k appointments over 56 practices and patients additionally had 24-hour access to the NHS 111 line for out of hours advice. Fana Hussain advised that within her remit she led on workforce development and recruitment which was looking at the utilisation of other clinicians with specialist skills (such as diabetes nurses, paramedics and pharmacists) to alleviate GP time and proactively manage patient care. For example, the introduction of ten clinical pharmacists every year for next four years. Ms Hussain confirmed that they were working towards having all people registered and the GP hub was providing help in this respect. She advised that utilisation was currently about 76% for GPs and 56% for nurses with the expansion of the Brent hubs meeting capacity. Additionally, Brent was at the forefront of digital access to healthcare. Dr Mahmoodi advised that all GP practices had open lists at all times and there were no obstacles to registration. He confirmed that telephone and in-person language services were available at all GP practices.

Fana Hussain advised that a pre-engagement event identified that walk-in users were not aware of the 8-8 extended hours primary care service and the on-going communications would promote the expanding services. She said the engagement process surrounding the walk-in centre aimed to share information and to develop access not only via face to face appointments but through video and online consultation. The goal was concerned with improving access not reducing it. Sarah D'Souza added that the contractual requirement to give three months' notice of the closure would allow sufficient time to complete a consultation and distribute information leaflets. Andrew Pike confirmed that they had previous successful experience in this area and were proposing a comprehensive engagement process and marketing campaign, utilising GP staff and libraries, targeting users of the walk-in centre in the run up to its closure.

The Committee was informed that a final decision would not be made until the consultation was completed and that the CCG wanted to take the views of all stakeholders into consideration. It was advised that it would technically be possible to recommission a walk-in service but in a national context it was against the trend and the main goal was to take this opportunity to invest in improving fundamental primary care and redistribute the resources across the Borough. Academic research findings and statistical information would be provided to the Committee in support of the increased demand for online services, particularly among students and people with no fixed abode.

The Chair brought the item to a close and thanked the NHS officers for their contributions. There were NO RECOMMENDATIONS on this item.

8. **Home Care Recommissioning**

Councillor Farah (Lead Member for Adult Social Care) introduced the report which sought the Committee's input into the recommissioning the Homecare Contract. Councillor Farah said it was hoped to incorporate the London Living Wage and reduce the number of zero hour contracts while improving the Homecare Provider Network.

Andrew Davies (Head of Commissioning, Contracting and Market Management) explained the reasons behind the recommissioning and the current position following the closure of the West London Alliance Homecare Framework. He highlighted the current issues which focussed around the high number of providers and the Council's ability to monitor the quality of delivery and the employment terms of the employees. The Committee's attention was drawn to the paragraphs in the report (5.1 onwards) describing the new Homecare model and the intention to move away from geographical commissioning to a patch based system aligned to the 13 primary care networks. In addition, there would be larger patches where specialist services that didn't fit into the 13 patches would be commissioned. The overall provider numbers would reduce to between 13 and 25 enabling closer monitoring and greater consistency of care workers.

The Chair thanked Councillor Farah and Andrew Davies for the introduction and invited questions from the committee.

In the subsequent discussion, the Committee queried how the new model would fit in with the Borough Plan and how it would work robustly to improve performance from the existing commissioning and went on to ask questions around how the new model would enable closer monitoring of providers, how eliminating zero hour contracts would meet the increasing demand for services and would there be enough care workers with relevant skills. Additional questions were raised concerning the diverse range of needs in the Borough and how the smaller number of providers would meet these and what level of research had been carried out with service users in the light of frequent complaints and the needs of vulnerable people.

Further questions from the Committee covered the issue of workforce training, risk assessment, the idea of a holistic approach where carers linked their clients with other services, the option and benefits of bringing services in-house and the potential of partnerships and outsourcing.

Councillor Farah explained that the issues of the London Living Wage and zero hour contracts closely affected the residents of Brent, particularly women, and therefore a minimum of 16 hour contracts would be offered. He said the new system would be an improvement on the current model as the Council would have more control, ensuring contracts fell in line with Borough priorities. Andrew Davies responded to the Committee's questions advising that growing demand for services and a greater complexity of user needs was envisaged year on year in the future and working with a smaller number of providers would enable better scrutiny of service quality and allow the monitoring staff to build closer relationships with the providers.

Andrew agreed that individual worker contract hours was a complicated issue and some workers liked the flexibility, but it was preferable to have as few zero hours as possible unless the worker genuinely requested it. Provider feedback showed that their own preference was for fixed hour contracts as they were better able to retain staff and plan the workforce effectively. On the question of the diverse range of skills required to meet the needs of service users, Andrew responded that staff retention was a factor here and this should improve under guaranteed hours contracts and the commitment to pay the London Living Wage. In terms of the skills needed to support the Borough's diverse population, he explained that there was already a number of specialist care providers serving the smaller communities, and

the tender process would test their suitability. Phil Porter (Strategic Director, Community Wellbeing) added that as well as the patch providers there would be an alternative choice of providers available.

Addressing the question about service user consultation, Andrew Davies said there was continuous feedback showing that the service was performing well. He acknowledged that with 1700 daily users there would always be issues and complaints but said the tender process would facilitate the opportunity to select the best quality providers and reject those falling below the desired standard. Andrew explained that training was a key challenge, particularly keeping workers up to date with constantly changing needs and the development of new equipment, and this issue would be covered in the tendering process with providers expected to present comprehensive training plans. There would also always be additional support from Council in-house training services. On the topic of linking up services, Andrew said he appreciated the sentiment but it was not within the scope of the current proposal. He would however take it on-board and look into how it might be incorporated. Phil Porter added that improved collaboration with GPs through the primary care networks aimed to link chosen providers up with GP practices looking at the Public Health Act and the 'making every contact count' initiative.

Andrew Ward (Head of Finance), responding to the Committee's question concerning the costs and benefits of bringing services in-house, reported that this had been looked at but would be too costly when taking into account staffing on-costs and pensions. Phil Porter confirmed that the costings were estimated to be £34m against £27.9m based on staffing costs but the Council's overheads and operating costs needed to be considered as well. He said there were no clear benefits to bringing the service in-house other than staff stability and terms & conditions but confirmed that the discrete small Re-enablement support planning team had been retained in house and this could be built on over time by bringing in house reablement care workers. Andrew Davies remarked that to bring a service of this scale in-house would bring significant risks and that Adult Social Care was a delivery service governed by statutory regulations. He suggested that any future move towards increasing in-house services could only safely be considered on a step by step basis and on the question of any possible external partnerships, confirmed that the new model would allow more potential collaboration with partners.

In response to the Committee's question on how robust contract management would be applied, Councillor Farah reiterated that the smaller number of providers would enable closer monitoring. Phil Porter added that the Care Quality Commission (CQC) monitored providers and the rating currently showed that Brent outperformed most other boroughs in the quality of home care and residential nursing care. He advised that quality standards for London due to be released in April 2020 would provide a benchmark to compare providers across whole of London. Dealing with the Committee's question about care criteria, Phil Porter responded that all care needs were assessed and full support to daily living activities was provided. Andrew Davies added that the care providers made care plans with the service users to ensure that all needs falling within the Care Act were met. If a service user was not happy they should report their concerns to the Council for action. Phil referred the Committee to Appendix 3 of the Report detailing the assessment criteria.

In response to a question from the Committee, Andrew Davies said that the procurement aimed to differentiate between some of the services requiring specialist skills - for example, mental health vs. older people with dementia. He acknowledged it would be a challenge for some providers in the market to meet expectations around those specialist services but the intention was to move toward a model that delivered identified specialist skills where needed. With reference to risk assessment, Andrew said that most users were elderly and disabled so the majority of providers worked within the West London Alliance framework but the aim was to move beyond this and reintroduce specialist services. Brian Grady offered an example from Children's Services explaining children needed similar types of care but in very different circumstances and the management of risk was achieved by working with smaller group of providers to enable needs were met. Phil Porter said that previous drafts of this report had included a variety of options for analysing risks and he could provide the Committee with a summary of how risk would be identified and managed during the procurement process. The Committee emphasised that risks should be explicit for Scrutiny.

Councillor Farah confirmed that there would be rigorous assessment of potential new providers and issues raised at this meeting would be followed up. Andrew Davies highlighted changes in how providers would be required to deliver services and the use of e-brokerage and electronic tracking systems would enable more efficient monitoring and closer engagement with users to process feedback.

The Chair thanked everyone for their contributions and the Committee then **RESOLVED** to approve the recommendations set out in the report that:

1. Scrutiny note the financial implications to the council of delivering a London Living Wage compliant homecare service

2. Scrutiny 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.

3. Scrutiny are further asked to confirm that the proposed model will deliver the objective of making the council fully compliant with the Unison Care Charter.

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

RESOLVED that the contents of the Update on the Committee's Work Programme 2019-20 report, be noted.

10. **Any other urgent business**

None.

The meeting closed at 8.24 pm

COUNCILLOR Ketan Sheth
Chair

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