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Community and Wellbeing Scrutiny Committee

Thursday 29 April 2021 at 6.00 pm

This will be an online virtual meeting. The link to view the meeting can be accessed HERE.

**This agenda has been republished on Thursday 22 April 2021 to include items 6, 7 and 8*

Membership:

Members	Substitute Members
Councillors:	Councillors:
Ketan Sheth (Chair) Colwill (Vice-Chair) Aden Daly Ethapemi Hector Lloyd Sangani Shahzad Thakkar	S Choudhary, Hassan, Johnson, Kabir, Long, Mahmood, Miller, Perrin and Shah Councillors: Kansagra and Maurice

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

Observers
Brent Youth Parliament
Jenny Cooper, NEU and Special School observer
John Roche, NEU and Secondary School Observer
Vacancy, NEU Primary School Observer

For further information contact: Hannah O'Brien, Governance Officer
hannah.o'brien@brent.gov.uk

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The press and public are welcome to attend this meeting. The link to view the meeting can be accessed HERE.

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 Update 11 - 22

This report provides an update to the Community and Wellbeing Scrutiny Committee on the recommissioning of home care contracts.

7 New Accommodation for Independent Living (NAIL) Update 23 - 30

This report provides the Community and Wellbeing Scrutiny Committee an update on New Accommodation for Independent Living (NAIL).

8 Day Services and COVID-19 31 - 36

This report provides information to the Community and Wellbeing Scrutiny Committee on the activities of day services including during the COVID-19 pandemic.

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.

Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Wednesday 24 March 2021 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Aden, Daly, Ethapemi, Lloyd, Sangani, Shahzad and Thakkar, and co-opted members Rev. Helen Askwith, Mr Simon Goulden and Mr Alloysius Frederick. ***All members were present in a remote capacity.***

Also Present: Councillors M Butt and McLennan

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

Apologies for absence were received as follows:

- Councillor Hector

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Sheth – Lead Governor for Central and North West London NHS Foundation Trust
- Councillor Shahzad – spouse employed by NHS
- Councillor Ethapemi – spouse employed by NHS
- Councillor Thakkar – Health and Social Care Co-ordinator for Complex Patient Management Group
- Councillor Sangani – employed by a Medical Centre
- Mr Simon Goulden – spouse governor for Sinai Jewish Primary School
- Mr Alloysius Frederick – Chair of governors for St Gregory's Catholic School and governor for Newman College

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meetings**

RESOLVED:-

that the minutes of the previous meeting held on 24 November 2020 and 19 January 2021 be approved as an accurate record of the meetings.

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

There were no matters arising.

6. **A&E Performance at Northwick Park Hospital and St Mary's Hospitals**

The Chair invited Simon Crawford (Director of Strategy and Deputy Chief Executive, London North West Healthcare NHS Trust (LNWHT) to introduce the item for discussion.

Simon Crawford began by highlighting that the past year had been unusual because of responding to COVID-19 and the challenges in the NHS and at Northwick Park in particular. He explained that 3 March 2020 was when Northwick Park had their first patient admitted with COVID-19. The hospital was under great challenge and one of the hardest hit in the early wave of the pandemic, and there was a need to respond significantly during that early wave in March and April 2020 to ensure the hospitals were not overwhelmed with presentations. This meant treating patients coming through A & E differently depending on their presentations of symptoms, learning new processes and procedures around PPE, infection control, treatment modalities and then standing down elective procedures and processes and focussing the whole response of the hospital to COVID-19. In particular, patients coming through A & E and those most critically unwell needing access to critical care beds. As part of that response beds were increased from 22 to a maximum of 50 critical care beds in Northwick Park Hospital and significantly increased High Dependency Unit (HDU) capacity from 18 beds pre-Covid to 33. This presented a logistical issue such as getting more monitors, equipment and retraining staff to support those beds. Protected pathways were also introduced such as green pathways for those without COVID-19 and red for those with COVID-19. Staff protected patients as best as possible from getting infected within the hospital. In the first wave of COVID-19 the majority of elective care was stood down, but during the second wave and using the learning from the first wave Central Middlesex Hospital and the independent sector maintained 20-30% of elective activity. Cancer patients were also seen at the Royal Marsden Clinic, London Clinic and Cromwell Hospital. Maternity services continued to be offered and there had been 4,000 births during the period.

Jon Baker (Divisional Clinical Director for Emergency and Ambulatory Care, Northwick Park Hospital) highlighted that Northwick Park Hospital was now number one in London for A & E performance and third in the country, which he noted was a huge difference to where it was when he started working there, particularly given Northwick Park was one of the busiest hospitals in London most days. He advised the Committee that Northwick Park now delivered prompt emergency care and received most ambulances, dealing with those the quickest compared to the rest of London. He felt that there was partner working end to end with the pathway starting at the front door and nurse consultants who had helped overhaul the pathways of moving ambulance patients through the system. This included what was nationally known as same day emergency care, managing patients in a more comfortable speedy environment where patients who would have in the past been admitted overnight were now seen in a large emergency floor and could leave the same day. The majority of patients presenting to A & E were medical emergencies such as heart attacks and strokes, with 6 medical consultants responding in the centre of the hospital to those. Covid patients could be seen virtually which helped with the flow to deal with the most sick patients.

Professor Frances Bowen (Interim Divisional Director of Medicine and Integrated Care, Imperial College Healthcare NHS Trust) advised that St Mary's Hospital was not able to report performance in league tables at the moment as they had been piloting new standards, but similar to Northwick Park during the first and second waves of COVID-19 had ensured rapid assessment of patients in the emergency department with a good change of pathways with Vocare and Urgent Treatment Centres to ensure potentially high risk patients were in one area. There had been a large expansion of the same day emergency care pathways and redeployment, such as surgeons who were not doing elective activity during the first wave taking on minor injury patients. In the second wave of COVID-19 therapists and neurologists were used to support the response. They had supported other hospitals who were a few weeks ahead in terms of responding to the COVID-19 waves through ambulances being diverted to who was able to take the next ambulance and enable early offloading of patients. She advised that collaborative working worked well together and there had been some good learning and now a better understanding of responding to the virus, meaning the following winter the sector would be well prepared.

The Chair thanked the health colleagues for their introductions and invited the Committee to raise comments and questions, with the following issues raised:

The Committee noted that all but time critical planned care had been cancelled and queried what was meant by time critical and how many appointments had been cancelled as a result. Simon Crawford advised that all elective procedures had been cancelled at the Northwick Park site but some activity was diverted to Central Middlesex Hospital. Northwick Park had still conducted emergency surgery for people coming through A & E and arrangements were put in place with the independent sector such as BMI The Clementine Churchill Hospital to maintain the most urgent cancer treatments in both waves of the virus. There was now more elective activity at Central Middlesex Hospital and Northwick Park had began bringing elective activity back. Frances Bowen advised that at St Mary's Hospital they only operated on the most extreme traumas and outpatients were maintained virtually during the first and second waves of the pandemic.

Simon Crawford advised that the plan for LNWHT regarding elective activity was to return to September 2020 elective activity by the end of June 2021 as part of the Integrated Care System (ICS) planning framework across NWL and to return to pre-Covid activity, dependent on any further waves, by late autumn. This was also the case for St Mary's Hospital. In relation to cancer care and treatments, Simon Crawford advised that they had focused in terms of the highest priority patients and tried to maintain access to services for cancer patients. This had not necessarily been done within the Trust as the Trust had arrangements in place with BMI The Clementine Churchill Hospital, Harrow on the Hill and The Royal Marsden to source high priority procedures, so the Trust had managed to maintain delivery of cancer services for Priority 2, 14-day, cancer patients. Frances Bowen advised that St Mary's Hospital had managed a huge amount of priority 2 work and urgent cardiac and non-cancer work. All cancer specialities had been managed equally with no particular speciality disadvantaged. Lesley Watts (Chief Executive for the North West London Integrated Care System) added that across London there was a set of emerging principles for elected programmes which would change how things were done in the future. She advised that as that work was iterated across London and North West London it would be brought back to the Committee, with the aim being to ensure equality of access across the patch particularly in Brent.

The Committee noted the improvement in performance from the first wave of the pandemic to the second wave and asked what impact the second wave had on people needing operations. Simon Crawford acknowledged that the second wave had not been easier than the first wave but they did have the benefit of the learning from the first wave, meaning the sector was better organised for treatment, modalities, PPE, systems and collaborative working. Frances Bowen added that the second wave at Imperial College London and St Mary's Hospitals was very difficult and beds increased to 150, with extremely tired staff. The hospital had continued with urgent cancer endoscopy and urgent cancer operations during the second wave. The hospital had been balancing the intensive care needs of patients with patients that were in acute respiratory units as well as doing urgent care which had been a lot to do. Some treatments trialled in the second wave had been really beneficial so outcomes for patients during the second wave were outstanding.

In response to Committee members asking if there were any teething problems from the pilot of the 111 time slots, Frances Bowen advised that the pilot had only been booking around 4-5 slots per day and it had not made much difference to the workflow through the emergency department. The pilot had not been as successful as the initial launch suggested it might be and they had not been informed of any issues around waiting times.

Discussion was held regarding the potential for digital exclusion as a result of virtual clinics. Jon Baker advised that the majority of emergency work came through the emergency

department rather than virtually, then if possible a patient could be followed up virtually. If a patient had come into hospital and was assessed as well enough to go home they could be sent home with an oximeter to measure oxygen levels and could call with any issues. If a patient was not able to use the device they would either be kept in hospital or managed in a different way to ensure there was no discrimination.

In relation to staffing, the Committee noted the recent Panorama documentary focusing on comparisons in the Coventry Hospital now and a year ago and that a number of staff had left, and asked how the hospitals in North West London were getting on in that respect. The Committee heard that Northwick Park had done a lot of work with staff since the crisis and focused a huge amount of work on wellbeing in what had been a highly stressful period. Jon Baker reflected that some staff were more used to high pressure situations such as staff within the emergency team and were therefore more ready but they had been conscious many staff had moved across the trust into different areas and therefore those staff were being provided support. Frances Bowen added that at St Mary's Hospitals a lot of staff had been redeployed and there was a focus on staff wellbeing and allowing staff some rest.

The Committee queried whether the hospitals had seen an increase in admissions to A&E due to domestic abuse or mental health issues. Jon Baker advised that sadly they did see people coming through the department due to mental health issues or domestic abuse and felt that was the case for most shifts he worked. The past few weeks had seen a heavy spike in presentations of mental health issues and there were teams to support this in the community and the Trust and a domestic abuse advisor within the department. In addition there was a youth support service at St Giles' Trust commissioned by Brent Council and psychiatric liaison nurses worked parallel with clinicians at the front door. Robyn Doran (Chief Operating Officer, Central and North West London NHS Trust) added that there had also been an increase in presentations at Central North West London NHS Foundation Trust that week in particular with a lot more children and young people presenting and more adults who were not known to the service. It was acknowledged that COVID-19 had impacted on the number of people who had never been seen in services before and the rise in children and young people presenting was suggested to be linked to young people going back to school.

The Committee asked for assurance that health partners were embedding new ways of working to ensure performance targets continued to improve going forward. Simon Crawford agreed it was important those ways of working were embedded, and across the ICS they had learnt the importance of working together in a joined up way. He assured the Committee LNWHT were embedding new practices and ensuring those were sustained and highlighted the acute medical model at Northwick Park with changes to the front door and the way patients were assessed. In response to COVID-19 a lot of attention had been given to discharge planning and consultant timings and supporting in a robust way which was becoming embedded into the normal way of doing things. Frances Bowen added that they had learnt how to flip pathways so that emergency pathways could become high, medium or low risk, could move structures and staff around and could confirm they had areas they could safely bring patients in for elective operations. She felt that COVID-19 had brought on a speed of transformation that many had never seen previously, with learnings from the first wave transferred to the second wave and consultants working together deployed to the front door and embedded in STP, pathways, discharges and communities. She advised that the process of allowing staff to recover and ensure these new processes were embedded had been hugely beneficial to people coming through the front door.

The Chair drew the item to a close and invited the Committee to make recommendations, with the following RESOLVED:

i) To note the performance report.

7. **Primary Care and GP Services in Brent and Care Quality Commission (CQC) Ratings**

Jonathan Turner (Borough Lead Director (Brent), CCG) introduced the report which provided information on standards and ratings in GP services in the Borough as rated by the CQC. The report covered the evolving landscape of primary care, the role of CQC, a summary of ratings in the Borough and how the CCG was working with practices to support them. He advised that satisfaction was generally good but there were variations and it was important as part of the work as an Integrated Care System (ICS) to address that variation. As well as GPs' core role as consultants at the start of a patient's NHS journey GPs also participated in extended primary care services such as screenings and vaccinations / immunisations, and co-ordinated with social care, the voluntary sector and the acute sector for referring and managing patients.

In relation to how the contracting mechanism worked for GPs, Jonathan Turner advised that generally the more patients a GP surgery had the more funding it would get. This was topped up through the quality and outcomes framework which had been a mainstay of general practice for 20 years. He advised that the key development in the last few years had been Primary Care Networks (PCNs) which had changed the way some practices came together as a group to support each other and consolidated some of the back office functions to standardise care. He pointed to page 44 of the report which set out the configuration of PCNs in Brent and which practices were within them, who was responsible and the clinical leads. Part of the CCGs role was to support the development of integrated care, the coming together as PCNs and the work with community nursing to ensure patients were being managed effectively as part of a whole system approach. The Committee heard that Brent was "underdoctored" in relation to GPs in the workforce with the workforce changing over time as more salaried roles become the norm and GPs took on more roles, with physios and pharmacists playing a bigger role for a more effective skills mix within practices. The additional roles and reimbursements scheme brought in by the NHS paid practices to bring in those additional roles to better support Musculoskeletal (MSK) conditions, aches and pains and those otherwise needing a referral so that they could be dealt with more quickly. A recruitment and retention programme was being introduced to ensure Brent got more qualified and experienced GPs. Jonathan Turner advised that there was a demographics challenge in Brent in relation to the number of people living in the Borough which had increased over the 20 year period and was concentrated in particular wards. As well as this the population was ageing with an increased number of people living for longer including in frail older people and people with complex comorbidities.

In relation to the CQC process, Jonathan Turner advised that every GP had an annual regulatory review which would inform how frequently that practice was reviewed depending on the rating of the annual review. Those rated inadequate or requiring improvement were therefore inspected more regularly. He advised that GPs were independent contractors not employed directly by the NHS therefore it was their responsibility to get into a better rating position but that there was a supporting role for the CCG such as running regular training workshops, conducting mock CQC inspections, supporting PCNs to provide dedicated support to individual practices and commissioning 1 to 1 support from external providers to address issues arising from CQC inspections. Part of the CCGs wider role within the ICS was addressing unwarranted variations so there was now a dashboard to look at a range of different care related metrics across practices and address unwarranted variation.

Fana Hussain (Assistant Director of Primary Care, CCG) advised the Committee that the report was a "moment in time" document and the situation changed regularly. The Committee heard that some very good practices on the list had been devastated to receive the report on CQC ratings but had taken the reports on board and made a lot of strides and changes. An area of development identified as a result of CQC ratings for PCNs in the

Borough was the requirement to have documented policies that everybody was aware of. The CCG worked closely with the CQC and this enabled the CCG to have open discussions with GPs over where their practice was going in the future.

Bethenie Woolfson (CQC) informed the Committee she had seen a positive improvement in the highest risk practices in Brent which had meant some ratings had gone up from inadequate to requires improvement. She advised that there was still a long way to go but the CQC were very pleased with that work. She mirrored comments that the CCG and CQC had a positive relationship and worked well together, engaging positively with practices. The Committee heard the CQC was moving towards a risk based approach as a regulator and at the moment were not conducting annual reviews but were using a transitional approach assessing the information held on a provider to decide whether to inspect, meaning frequency of inspection would not be used going forward.

Lesley Watts (Chief Executive for the North West London Integrated Care System) added that the ICS were trying to consolidate its oversight together with CQC in some sectors, which was already being done with major providers through oversight programs which the CQC sat on. The intention was to do that with primary care colleagues. She felt that there was a need to be more systematic within the system that assured the ICS that they were well sighted on issues which would allow for a programme of improvement.

The Chair thanked health colleagues for their introductions and invited members of the Committee to ask questions in relation to the report, with the following issues raised:

Members of the Committee highlighted that they had received complaints from constituents around changes in patient's medication to cheaper alternatives, and there was concern this would result in less effective treatment. Lesley Watts assured the Committee that any medication prescribed by GPs were approved drugs, and usually the generic cheaper alternatives were exactly the same tablet and constitution but was the recommended medication regarding price. She advised that if there was a particular reason a patient needed a particular medication rather than the generic medication then the GP could prescribe that at their discretion if they had justification. She highlighted to the Committee that every penny spent on more expensive medications that did the exact same thing was money that could not then be spent on surgery or more GPs and nurses, and advised that the prescribing of generics was incredibly carefully controlled nationally. Dr M C Patel (NWL CCG) added that there was a Prescribing Committee which looked at papers and guidance from NHSE.

The Committee highlighted Table 1 of the report, in particular section 6.1 which stated Neasden Medical Centre and Greenhill Park Surgery had ratings of 'requires improvement', and queried whether there was any correlation between deprivation or affluence and the result of a CQC rating that mitigated or complemented the result. Lesley Watts acknowledged that the aim should be to ensure there was absolutely no correlation in ratings and deprivation and that people in the most deprived areas often needed the best services and in many deprived areas did get that. Bethenie Woolfson did not believe there was a correlation. She advised there were trends across the whole system in North West London which were often related to the governance of GPs and not the area or patients of the GP. She acknowledged there may be instances where fewer GPs were available in deprived areas but usually a poorer rating was linked to the clinical leadership and governance of the practice.

In relation to national studies of patient satisfaction, the Committee queried when the surveys took place in Brent and what the outcomes were. Fana Hussain advised that the national patient survey was conducted every year and was currently underway. Satisfaction in Brent currently was at 76%, and varied across practices, for example one practice had 94% satisfaction.

Regarding screenings and immunisations, the Committee heard that the immunisation programme was conducted through a core recall system operating nationally, as was breast cancer screening. All practices would have their own systems for calling patients due for immunisation. The immunisation rates had improved in Brent, but during the pandemic there had been less uptake of cervical sitology due to patients feeling reluctant to go into practices.

The Committee asked how much locally was spent on health services. Jonathan Turner advised that there was £550m allocated for Brent which included the whole acute system and all mental health providers, not just general practice. Sheik Auladin added that the delegated budget for primary care was £110m per year which gave an idea of the level of spending in the CCG compared to other areas.

Some concern was raised regarding employment practices due to the increased number of GPs employed by one partner. Jonathan Turner highlighted that GPs were independent contractors but also part of the NHS family. He explained that employment practices had changed over the years with an expansion of salaried posts which he expressed were perfectly legitimate ways of working, which some GPs preferred as it meant they did not have the same level of responsibility for the admin and running of the practice and could concentrate on clinical work. He advised the Committee that if there were concerns or issues around general practice and employment it would be for that individual practice to resolve, with the CCG becoming involved only where necessary. Dr MC Patel added that increasingly younger GPs were doing portfolio type work where they worked as GP and did a couple of other different sessions a week and a lot of younger GPs did not want to take on that additional responsibility so practices were relying on salaried staff and those who wanted to work part time. He felt that partnerships should be encouraged.

The Committee had concerns about access to GPs, including digital access and exclusion. Fana Hussain advised that GP access was monitored on a monthly basis. The NHSE website published a number of appointments available and the data for February 2021 had been reviewed which had shown Brent practices continued to provide GP access digitally, face to face and by appointment. Sheik Auladin (NWL CCG) advised that during the first wave of the pandemic there had been a lot of e-consultation but during the second wave GPs had seen patients through a mixture of e-consultation and on a face to face basis, therefore patients without access to IT were able to see their GP. A conversation was had regarding who councillors could contact in relation issues with residents accessing GPs, with the advice being to contact the GP in the first instance through their complaints procedure and let the CCG know. CCG colleagues agreed to provide a formalised contact for the specific purpose of giving councillors a place to go for resident GP concerns. The CQC added that from April 2021 they would be looking at GP access in Brent and encouraged anyone to share their experiences of access via the CQC website which could be done anonymously.

It was highlighted that due to COVID-19 relatives were not allowed to attend hospitals with patients, and the Committee queried what support was available from GPs for patients going for hospital treatments or urgent care who may rely on relatives to help them communicate, such as those with a language barrier. Lesley Watts advised that visiting was being looked at currently in all acute hospitals across London to put something in place, but there were always exceptional circumstances to consider, so if there were specific needs or a patient was end of life visiting was allowed.

Committee members highlighted that they had received information from residents that there had been a couple of incidences of “list cleansing” where patients had expected COVID-19 vaccination calls and had not received them as they had been removed from the list for not visiting their doctor for so long. Lesley Watts confirmed that any patient in the

appropriate cohorts could be vaccinated whether they were referred by their GP or not and could book an appointment through one of the vaccination hubs. The Committee highlighted that this message could be better publicised to ensure people in the relevant cohorts were not waiting for their invitation from their GPs. Lesley Watts agreed to talk with the vaccination lead the following day regarding messaging on this and work with Council Officers for communications.

As there were no further questions, the Chair thanked Committee and invited recommendations, with the following recommendations RESOLVED:

i) To note the contents of the reports and receive assurance on the management and support structures in place to improve standards of care in GPs in Brent.

8. **GP Access Members' Scrutiny Task Group Scoping Paper**

Councillor Mary Daly introduced the report which enabled members of the Committee to commission a task group on GP and primary care accessibility in the borough of Brent. She explained that the paper had been inspired by Councillor Abdi Aden's constituent experiences in Stonebridge in relation to accessing GP services during the pandemic. Councillor Daly felt that the task group should look at comparisons of the more affluent wards in Brent and North West London and the investment precedent in those wards, including the number of GPs per head and a few other agreed indicators, which may or may not show the degree of equity within primary care. She also thought there should be comparisons of the best and worst GP surgeries in the Borough. She expressed that she looked forward to the first meeting to distil further what the group wanted to look at in the task group sessions..

The Chair thanked Councillor Daly for introducing the scoping paper and invited those present to ask questions, with the following issues raised:

Dr M C Patel (NWL CCG) agreed that looking at comparisons of deprived and affluent wards and good and bad practices would be a useful activity. He highlighted that the scoping paper was based on a paper from 2010 and some factors were relevant but others were not, therefore suggested the group worked together with primary care to look at outcomes as well as access, to develop something with significant meaning that was helpful to GPs, Brent Council, members and constituents.

Sheik Auladin (NWL CCG) reiterated that they were happy to work with the Council on the task group. He advised that a lot of work had been done by the Integrated Care System (ICS) around North West London primary care and levelling up in Brent. He informed the Committee that a lot of investment was coming to Brent as part of that process and there was a need to ensure that was reflected in any discussions on primary care going forward. Jo Ohlsen (Accountable Officer, NWL CCG) emphasised this, expressing that they wanted to be assured in North West London that they were reducing health inequalities within and across boroughs. She highlighted that as part of the merger to a single CCG they had agreed they would move investment from some more affluent parts in North West London to places like Brent, and the first area that was being done was diabetes and mental health. Jo Ohlsen would share the data the group were seeking which would influence where changes were made. In response, the Committee highlighted the importance of not creating a 2 tier set of patients, for example ensuring that if digital access tools were used for the treatment and monitoring of diabetes patients the same treatment and monitoring was available for patients without that type of access.

The Committee also wanted the task group to explore what services Primary Care Networks (PCNs) would provide and the number of doctors attributed to different areas, and consider the pre and post covid environment in their discussions.

The Chair moved on to invite Committee members to make recommendations, with the following recommendations RESOLVED:

i) To agree the scope of the scrutiny task group review including the membership and terms of reference as set out in Appendix 1 of the report.

9. **Any other urgent business**

Contract with AT Medics

The Chair advised the Committee that he would be taking an additional item under any other urgent business in accordance with Standing Order 60. The item was in relation to the APMS contracts that were held by AT Medics. The item was considered urgent as it had been discussed at the Brent CCG meeting the previous week, resulting in considerable interest amongst residents and councillors.

Jo Ohlson (Accountable Officer, NWL CCG) explained that there were 2 APMS contracts in Brent held by AT Medics. An APMS contract had more detail and KPIs than other GP contracts. AT Medics had approached the CCG at the end of the previous year to seek consent for a change of control. As a result the control had moved to Operose which was a British based company dealing with healthcare. As Accountable Officers across London it was agreed this would be looked at collectively in relation to seeking legal advice and due diligence, including looking at their financial standing and other governance measures. A number of assurance were sought from AT Medics, who the contract remained with, and they concluded there would be no change to the services being provided or to the staff providing them throughout London. Assurance was also sought that the current directors would remain involved in the service, and although they would no longer be statutory directors they would be directors on Operose and involved in the management of the practices. Jo Ohlsen advised that if there were any changes in relation to service provision or concerns about services having changed as a result of the change in control that would be picked up by Fana Hussain (Assistant Director of Primary Care, CCG) and her team who would continue to manage those contracts.

The Chair thanked Joe Ohlson for providing the background information and invited members of the Committee to ask questions, with the following issues raised:

The Committee queried why the change was taking place if nothing would change regarding the services or financially. Jo Ohlson clarified that the APMS contract had not been given up but that there had been a change in the owner of AT Medics, therefore no TUPE indications applied. In relation to the reason behind the change, Jo Ohlson advised she had met with the Chief Executive of AT Medics across London and in their view there was a benefit in coming together with Operose for the skills they had around population health management. She confirmed it was a decision for AT Medics to make regarding who they wanted to work with and the CCGs job was to be assured they would continue to provide the services to the same standard as they were currently doing and hopefully improve them. She added that AT medics was rated good by the CQC and had gone into areas that were difficult to provide services and recruit to and been able to do that.

In relation to Operose's financial standing, the Committee expressed concerns at their most recently submitted accounts records. Jo Ohlson advised that due diligence had been completed and they had been assured that they were fit to hold the contract and added that any concern in that regard would be followed up immediately. In relation to the CCGs ability to control the change of contract, the Committee were advised that the CCG were being sought their consent and there was no legal reason or basis in which they could have stopped the change in control as there had been no change to the service provided. The

ability to consult or insist on consultation was limited also as there was no substantial change of service to patients and that would leave the CCG open to questioning every practice merger. Jo Ohlson assured the Committee that the CCG would continue to ensure the services patients had received would continue and monitor in the way they would monitor any other practices in Brent to ensure services were delivered.

The Committee raised concerns about data privacy with Operose. Jo Ohhlson explained that they had requested a cast iron guarantee there would be no sharing of data outside of the UK which they had received and if there was any transgression of that it would be picked up.

The Committee acknowledged that this was a difficult and unusual situation but felt that there was not enough time or information present to understand the issue in full. As a result, the Chair drew discussions to a close and invited the Committee to make recommendations, with the following RESOLVED:

i) To request that the CCG provide a written briefing note to the Chair in relation to the matter and to respond to questions as submitted by the Committee within that note. The Committee then delegates to the Chair to take a view as to whether the matter requires a further scrutiny of the matter following that briefing note.

The meeting closed at 8:02 pm

COUNCILLOR KETAN SHETH, CHAIR

Brent	**Community and Wellbeing Scrutiny Committee** 29 April 2021
	Report from the Strategic Director of Community Wellbeing

Update on Home Care Commissioning

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	2 Appendix 1 – Patch Based Providers Appendix 2 - Appendix 2 – Unison Care Charter (both appendices can be found at the end of the report)
Background Papers:	0
Contact Officer:	Andrew Davies Head of Commissioning, Contracting and Market Management; Adult Social Care 020 8937 1609 andrew.davies@brent.gov.uk

1.0 Purpose of the report

1.1 The Community and Wellbeing Scrutiny Committee has requested an update on the implementation of the council's new homecare contracts.

1.2 The council has appointed new lead providers, which has enabled Brent to move to a patch-based model for older people and physical disabilities homecare, dividing the borough into 13 patches to align with proposed primary care networks, with a lead provider for each. For specialist homecare services (Learning Disabilities, Children and Young People with Disabilities and Mental Health), there are fewer patches because the lower number of homecare hours delivered does not allow for these services to be arranged in the same way as for older people/physical disabilities.

1.3 Officers are working with providers to begin to implement the transfer of existing care packages to the new lead providers, or if the person receiving homecare chooses, to set them up with a direct payment, so that they can commission their own homecare services. This process started on 6th April 2021. New homecare packages have been awarded to lead providers since 1st February 2021, the date that the contracts went live.

1.4 This report provides members with an overview of homecare services in Brent, an update on the homecare contract implementation and information on the homecare framework which will go out to tender later in 2021.

2.0 Recommendations

2.1 The Community and Wellbeing Scrutiny Committee is recommended to note the report and question officers on the progress of the homecare contract implementation.

3. Background

3.1 Members of the Community and Wellbeing Overview and Scrutiny Committee will be aware that the council awarded new homecare contracts in October 2020. Prior to the award of new contracts, Brent was commissioning homecare services from 68 providers for adults and 32 providers for children. In total, these providers delivered 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 was £18.5m per year.

3.2 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 and Children's Services. By far the largest group of people in receipt of homecare is older people.

3.3 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.

3.4 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 helped Brent bring down the hourly cost of care for client groups such as learning disabilities significantly, and allowed us to harmonize prices across the market to a degree. However, it had the disadvantage that some providers lost the specialisms that may have had that enabled them to manage more challenging clients at home. As the client base in Brent has become 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 was felt that when re-commissioning services the council needed to invest some effort in supporting the market to re-establish specialisms in particular areas of care.

3.5 Since the expiry of the WLA framework in Sept 2018, homecare services have been commissioned on a spot purchased basis but only from those providers who had previously been part of the WLA framework.

3.6 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 in helping Brent understand and control hourly costs, there had 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.

3.7 Monitoring so many providers is unsustainable and to have allowed the previous approach to commissioning to continue presented too many risks in terms of quality of care and value for money from commissioned services. As a result, commissioners were clear that any re-procurement needed to reduce the overall number of providers delivering homecare in Brent in order to have more control over the quality of care provided. This aligned with feedback from the providers themselves, who told 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 was for smaller patches with less providers per patch.

3.8 As a result, Cabinet agreed in October 2019 to the introduction of a patch based approach to homecare, and the commissioning of specialist lead providers for different client groups. Nationally and regionally, there has been a shift to a patch based model, where organisations are commissioned to deliver services in a defined geographical area. This approach has been adopted by most boroughs in the WLA (with Ealing being the exception) since the end of the WLA homecare framework.

3.9 Brent's homecare model has split the borough into 13 patches for older people / physical disability services, and into two smaller zones for specialist services, mental health, learning disabilities and children's services.

3.10 The new homecare contracts have been awarded to seven new lead providers for older adults and physical disabilities homecare; two new lead providers for mental health; two for learning disabilities; and three new lead providers for children's services. Of the 14 providers appointed, only two are completely new to Brent. The other 12 were already delivering packages in the borough prior to being appointed a lead provider.

3.11 The homecare model agreed by the council was informed by the Community and Wellbeing Overview and Scrutiny Committee task group into homecare services, and will also be compliant with the Unison Care Charter (see appendix 2). The recommendations from the task group were –

Recommendation	Progress
That London Living Wage is introduced incrementally as part of a new commissioning model	This has been achieved through recommissioning – providers will be paid £19.50 an hour from 1st April 2021
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.	This has been achieved through recommissioning. A training allowance is included in the homecare fee, training opportunities will be made available to providers by the council, as well as monitoring of in-house training offered by lead providers.
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 two years.

3.12 The Brent homecare contracts will deliver the following objectives once fully implemented –

- Delivery of a patch based model aligned to the 13 Primary Care Networks for the delivery of service for Older People and Physical Disabilities. Each patch would have a lead provider who would be required to deliver at least 80% of all of the hours in the patch. The remaining hours will be delivered by providers from a framework, 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.
- By giving guarantees on allocations of care to providers appointed under contracts, the council will move away from spot purchasing from providers giving greater control over spend and quality. 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. This will 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. Providers will be asked to commit to providing a small pool of named care workers for each service user, and commit to these named workers being the people who deliver care to the service user for the lifespan of the contract (wherever possible).
- Electronic Call Monitoring will allow for better real time monitoring of consistency of care worker and timeliness of calls, and will also allow contract monitoring to be evidence based.
- Providers will have to demonstrate that they will keep the use of zero hour contacts to a minimum as part of the contract monitoring process.
- The council has committed to paying an hourly rate that allows workers to be paid at the London Living Wage (LLW). This has been implemented from the start of the new contracts for all new packages. Existing packages will be paid at the LLW as new contracts are implemented on a patch by patch basis.
- Moving to a patch based model will reduce the travelling distance for care workers, because their care packages will be located in specific parts of the borough rather than having to travel across Brent to deliver care. This will

contribute to Brent's ambition to reduce the environmental impact of the council's services.

- For 'specialist' care groups, where there are a smaller number of service users it would not be possible to split the borough into 13 patches, so the following arrangements have been established. For children with disabilities services there are two patches covering the borough, with three lead providers. For learning disabilities and mental health services, there are two patches, with two lead providers for each service type.

3.13 The implementation of new homecare contracts represents a significant investment by the council. The council has a clear commitment to paying London Living Wage and the rate that will be paid to homecare providers under our new contracts will enable care workers to be paid the London Living Wage, £10.85 an hour from 1st April 2021. In order to meet the London Living Wage requirements Brent's homecare rate between 1st February 2021 (the date the new contracts went live) was £19 per hour. This increased to £19.50 an hour from 1st April 2021.

3.14 Overall the total spend on adult homecare will increase from £17.6m in 2019/20 to an estimated £29.4m by 2024/25 when spending on London Living Wage and growth in services is factored in. For Children's homecare services, spending will increase from £960,000 in 2019/20 to £1.7m in 2024/25.

4. Implementation Update

4.1 The new contracts started on the 1st February 2021, with all new homecare packages offered to lead providers from that date. All lead providers except Eleanor Nursing and Social Care and Dendera Care delivered services in Brent prior to the award of the new contracts. The remaining lead providers were already delivering some care packages in their patches on 1st February, and so these care packages immediately changed to the new contract terms on 1st February. The total number of packages that each lead provider for older people and physical disability services has in their patch, either packages that have been awarded to them or packages they already had in their patch, as of 7th April 2021 is –

Patch	Provider	Total POC in Patch at 7th April 2021
Patch 1 - Northwick Park & Preston	MiHomecare	8
Patch 2 - Sudbury	Active Care & Support Ltd	18
Patch 3 - Tokyngton	J.C. Michael Group Ltd	12
Patch 4 - Wembley Central & Alperton	J.C Michael Group Ltd	14
Patch 5 - Stonebridge	Eleanor Nursing and Social Care Limited Patch 5	12
Patch 6 - Queensbury & Kenton	MiHomecare	17
Patch 7 - Barnhill	Active Care	11
Patch 8 - Welsh Harp & Fryent	Dendera Ltd	12
Patch 9 - Dudden Hill & Dollis Hill	Eleanor Nursing and Social Care Limited	6
Patch 10 - Harlesden	Supreme Care Services Limited	3
Patch 11 - Willesden Green & Kensal Green	Supreme Care Services Limited	15
Patch 12 - Mapesbury & Brondesbury	Healthvision	15
Patch 13 - Queens Park & Kilburn	Healthvision UK Ltd	24

4.2 From Tuesday 6th April the council began transferring existing care packages to the new providers. The care package transfers will happen one patch at a time initially, so that services users are supported through the process and to limit the impact of the change, and officers can learn from this process and adapt their approach if necessary.

4.3 Before the council starts to transfer care packages, service users will be contacted in writing to let them know what is happening. The letter includes a named contact at the council who will support them through the process. Service users will have an opportunity to discuss their care package transfer with a named officer from the council and also with the new care provider. Proper handover arrangements will be made so that the quality of care isn't adversely impacted.

4.4 This is a service user led contract implementation - all service users will have the choice to move to their new provider or take a direct payment if they want to stay with their current provider or arrange for someone else to deliver their homecare service. It is important to note that nobody will be forced to change care provider as part of this process.

4.5 The order in which older adult and physical disability patches will be implemented has been chosen based on the size of the patch, the number of packages that the lead provider already has in the patch and whether the provider is already delivering care in Brent. Sudbury is the first patch to be implemented, followed by Queens Park and Kilburn and then Tokyngton. All providers will have at least one of their patches implemented before work starts to transfer care packages in their second patch. The indicative timetable for implementation is set out below.

	Patch Number	**Provider Name**	**Wards**	**Indicative Start Date**
1st	Patch 2	Active Care	Sudbury	6th April
2nd	Patch 13	Healthvision	Queens Park & Kilburn	3rd May
3rd	Patch 3	JC Michael Group	Tokyngton	24th May
4th	Patch 1	MiHomecare	Northwick Park & Preston	7th June
5th	Patch 10	Supreme Care Services	Harlesden	21st June
6th	Patch 9	Eleanor Nursing & Social Care Ltd	Dudden Hill & Dollis Hill	5th July
7th	Patch 8	Dendera Care	Welsh Harp & Fryent	12th July
8th	Patch 7	Active Care	Barnhill	19th July
9th	Patch 12	Healthvision	Mapesbury & Brondesbury	26th July
10th	Patch 4	JC Michael Group	Wembley Central & Alperton	2nd August
11th	Patch 6	MiHomecare	Queensbury & Kenton	16th August
12th	Patch 11	Supreme Care Services	Willesden Green & Kensal Green	6th September
13th	Patch 5	Eleanor Nursing & Social Care Ltd	Stonebridge	6th September

4.6 As the transfer of existing care packages has only just started at the time of writing this report, more detail on progress will be provided at the meeting to councillors.

4.7 Assuming the implementation timetable doesn't change, all older adult and physical disability care packages will have transferred to new providers, or have been switched to a direct payment by the middle of October 2021. Some service users will require more time to make up their mind as to what they wish to do – at this stage we are not forcing anyone to make up their mind, but we will revisit these service users throughout the year to help them to make a decision on their future care arrangements.

4.8 The arrangements for transferring care packages for people with learning disabilities and mental health issues are slightly different. Those service users will be transferred to the new provider in their area as part of the annual review process and will be supported through that process by a social worker. Annual reviews happen throughout the year, so the transfers will take longer, but given the complexity of some of these packages it is felt that this is the most appropriate way to manage these transfers. Again, a direct payment is available to any service user that choses this option rather than have their care package transferred.

4.9 For learning disabilities and mental health the borough is split into two zones, North and South. One provider appointed for each of the specialist services in each zone. These are:

Services	Name of Provider	Contract Start Date
Learning Disabilities North Zone	Unique Personnel (UK) Ltd	1st February
Learning Disabilities South Zone	Allfor Care Services Ltd	1st February
Mental Health North Zone	Onecare-UK Ltd	1st February
Mental Health South Zone	Bluebird Care Brent	1st February

5. Homecare Framework

5.1 In the original homecare tender proposal, the council had planned to appoint lead providers and additional providers, who would be spot purchased to deliver homecare from a Brent Homecare Framework. It was envisaged that around 8 to 10 additional providers would be appointed to the framework to deliver any homecare packages that the lead providers declined. Contractually, lead providers are required to deliver a minimum of 80% of the care packages in their patch, leaving up to 20% of provision available for other providers on the framework, that they would be able to bid for. Decisions on awarding packages using the framework would be based on quality and not price, as price is fixed in order to pay care workers the London Living Wage.

5.2 The benefit of a Homecare Framework is that it enables the council to work with a group of providers, particularly smaller companies, that would be unable to scale up to meet the demands placed on lead providers. The council is able to support smaller businesses this way, without putting at risk the implementation of the new contracts – quickly increasing the amount of work given to a provider does add additional risk to homecare services, and this can be avoided using a framework.

5.3 Due to the impact of COVID-19 it was decided not to appoint providers to the Homecare Framework, but to re-run this element of the tender in 2021. Learning from Covid-19 it is felt that a larger pool of providers is required on the framework than previously anticipated. One of the reasons that Brent has been able to sustain homecare services during the pandemic is the considerable amount of capacity we have in the homecare sector. Whilst we still want to reduce the number of providers we contract with, and we have done this through the lead provider model, there is scope to ensure a wide breadth of provision through the framework.

5.4 With colleagues in Procurement, Adult Social Care Commissioning is also working on capacity building in the homecare sector, and supporting homecare providers in the work they need to do to help with their contract bid skills. This work is happening in

April and May 2021, with a view to running the Homecare Framework tender in August and September 2021. Providers will be appointed to the framework by November 2021.

5.5 Until the Homecare Framework is established, care packages that are declined by lead providers will be spot purchased from other homecare providers. Providers will be able to bid for these packages using our e-brokerage platform Care Place, which has been in use in Brent since February 2020. Using this platform bids for care packages can be evaluated based on quality and awarded to the provider with the highest quality score.

6. Conclusions

6.1 Although the implementation of the new homecare contracts is still in its formative stages, particularly the transfer of existing packages, it is positive that this is now underway following delays caused by the pandemic. Work on implementation will be completed by October 2021, by which time providers being appointed to the Homecare Framework will also be close to confirmation. Further updates can be reported to the Community and Wellbeing Scrutiny Committee as members require.

7.0 Financial Implications

7.1 Implications are included within the main body of the report.

8.0 Legal Implications

8.1 Implications are included within the main body of the report.

9.0 Equality Implications

9.1 Implications are included within the main body of the report.

REPORT SIGN-OFF

Phil Porter
Strategic Director of Community Wellbeing

Appendix 1 – Patch Based Providers

Map 1 – Homecare Patches

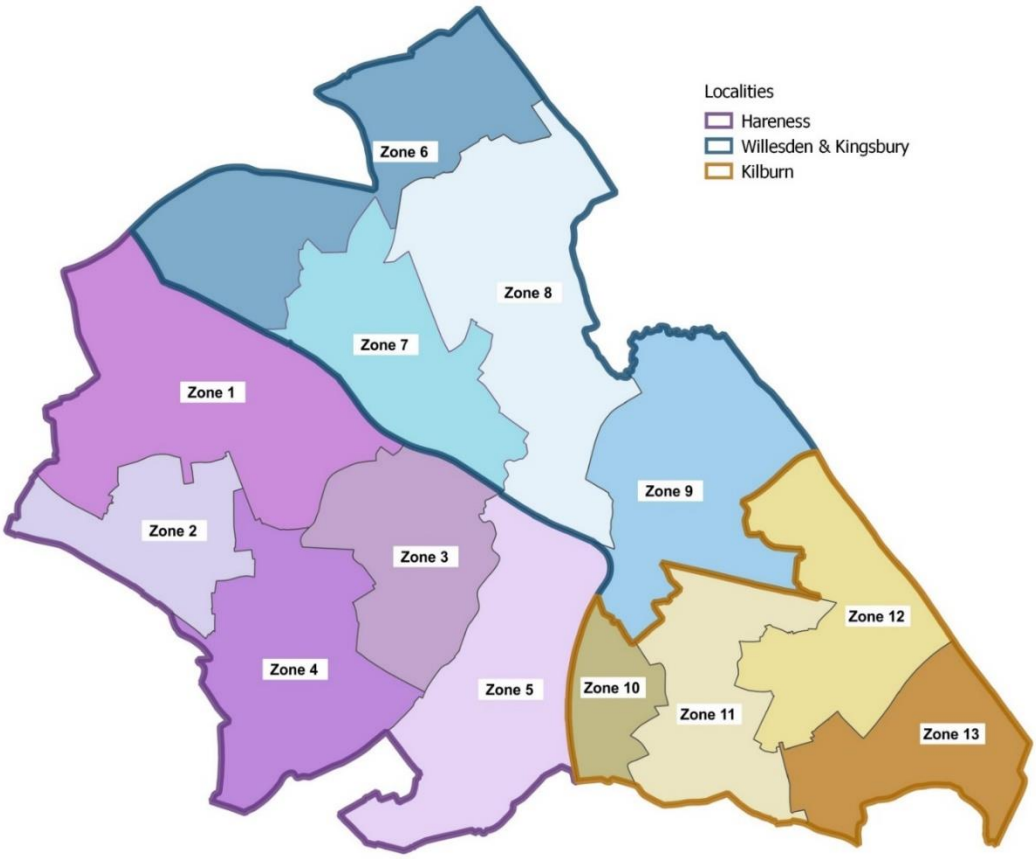

Table 1 – Older People / Physical Disability Homecare Localities

Locality	Zone		Provider
Harness	1	Northwick Park and Preston	Mi Homecare
	2	Sudbury	Active Care
	3	Tokyngton	JC Michael Group
	4	Wembley Central and Alperton	JC Michael Group
	5	Stonebridge	Eleanor Nursing & Social Care Ltd
Willesden and Kingsbury	6	Queensbury and Kenton	Mi Homecare
	7	Barnhill	Active Care
	8	Welsh Harp and Fryent	Dendera Care
	9	Dudden Hill and Dollis Hill	Eleanor Nursing & Social Care Ltd
	10	Harlesden	Supreme Care Services
	11	Willesden Green and Kensal Green	Supreme Care Services

Kilburn	12	Mapesbury and Brondesbury	Health Vision
	13	Queens Park and Kilburn	Health Vision

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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Brent	**Community and Wellbeing Scrutiny Committee** 29 April 2021
	Report from the Strategic Director of Community Wellbeing

Update on New Accommodation for Independent Living (NAIL)

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	0
Background Papers:	0
Contact Officer:	Andrew Davies Head of Commissioning, Contracting and Market Management; Adult Social Care 020 8937 1609 andrew.davies@brent.gov.uk

1. Purpose of the report

1.1 The purpose of this report is to provide members with an overview of the New Accommodation Independent Living (NAIL) scheme, including progress against targets, forecast demand and future proposed developments.

2. Recommendations

2.1 The Community and Wellbeing Overview and Scrutiny Committee is recommended to note and comment on the content of the report, particularly progress to date against targets and advise on any further information that would be useful to members.

3. Background

3.1 The NAIL Programme is a major cross-council strategic initiative to provide high quality accommodation for a range of vulnerable people. This accommodation offers a viable alternative to residential care for people with high support needs, through providing schemes, which promote wellbeing and the ability to live independently through good design.

3.2 The NAIL programme generates efficiency savings as Adult Social Care (ASC) only pays for the 'care and support' element of the service, which is our statutory obligation, leaving the individual to claim housing benefit for the accommodation costs. This also entitles service users to claim benefits (which they are not eligible for in residential care) to enable them to pay for social activities, utilities, food etc. This represents an average weekly saving of £331 per person to the Adult Social Care budget, compared to accommodation provided in a care setting.

3.3 The NAIL programme has four phases. The council is currently in phase 3, with a fourth phase to follow.

4. NAIL Programme Phase 1 and 2 (2014-20) – targets, delivery and impact

4.1 Targets

For ease, the targets agreed for the NAIL programme are set out below, with a further section setting out delivery against targets, and a final section discussing the impact.

4.1.1 The Phase 1 NAIL programme was agreed by Cabinet in 2014 with a savings target of £7.9m through the delivery of 436 units of accommodation by 2019/20.

4.1.2 The programme was reviewed in 2016 when it became clear that the savings had been front-loaded and that for a capital programme this was not realistic. The delivery profile of savings was additionally impacted by extended delays in delivering Visram House.

Table 1. Original projected and actual savings from 2014 -2020

Financial year	NAIL Units projected	NAIL units delivered	Projected savings	Actual savings
2014/15	0	6		103,272
2015/16	40	40	610,000	688,480
2016/17	152	154	4,110,000	2,650,648
2017/18	145	26	1,400,000	447,512
2018/19	128	38	1,400,000	654,056
2019/20	28	42	0	722,904
Total	**493**	**306**	**7,520,000**	**5,266,872**[1]

[1] End of year savings for 20/21 have yet to be calculated.

4.1.3 In 2018/19 the programme was extended to 2023/24 due to demographic demand. An additional £2m of savings were added to the programme bringing the revised total savings target to £9.5m

4.1.4 Although the Covid-19 pandemic has had implications for the NAIL programme, the overall savings target has not changed. However, savings have been re-profiled to reflect the delays caused by the pandemic.

4.2 Delivery against targets

4.2.1 At the start of 2020/21, £5.3m of savings has been delivered through the provision of 306 units, across 24 schemes. £1.8m was projected to be delivered in 2020/21 through full occupancy of existing schemes as well as the completion and fill of new schemes that were due to come on line in 2020/21.

4.2.2 The Covid-19 pandemic has had a considerable impact on the delivery of NAIL schemes. Schemes at Peel Road, Woodhill Crescent, Preston Road and Gladstone Park Gardens, which should all have opened in the first half of 2020/21, were delayed. Although Peel Road and Woodhill Crescent are now open, Preston Road and Gladstone Park Gardens will not open until 2021/22. Nevertheless, occupancy has increased by 9% despite three lockdowns. Moving adults into either supported living or ECH was particularly high risk and many families and individual were understandably risk adverse to moving during the pandemic.

4.2.3 Due to it being financial year-end, we are not yet in a position to know the full amount of savings achieved for NAIL for 2020/21, until budget reconciliation has been completed.

Table 2. Schemes delivered in 2020/21

Address/scheme	Client group	Units
Gladstone Park	LD	6
Preston Road	LD	6
Ruby Street	LD	6
Peel Road	LD	11
Clement Close	LD	12
Woodhill	LD	6
Oxgate	LD	5
Craven Park Road	MH	6

Table 3. Schemes to be delivered in 2021/22

Address/Scheme	Client Group	Units
127/129 Harrowdene	LD	10
4 Cranhurst	LD	6
124 Harrowdene Road	PMLD	5
Knowles House	Extra Care Housing	61

4.3 NAIL programme impact

4.3.1 NAIL also delivers a range of wider benefits other than financial. Across our Extra Care Housing(ECH) schemes over the last two years, NAIL have successfully offered 134 tenancies to individuals who would have most probably ended up in residential care. Based on an average weekly saving of £331, this equates to an average cost avoidance saving of £2.3m.

4.3.2 All NAIL care and support contracts are London Living Wage compliant that improves the terms and conditions of many of our highly skilled but generally low paid care workers.

4.3.3 The development of our larger extra care services in particular also brings wider benefits to the local community and surrounding areas. With between 40 and 60 new residents in each scheme with all of their visiting friends and family will contribute to the local economy by shopping, visiting restaurants, bars, hairdressers, barbers and other resources such as leisure centres and cinemas.

5. Phase 3 – Immediate demand

5.1 One of the significant points of learning from the first two phases of NAIL was that for smaller schemes, and those schemes for younger adults or those with specific care needs, it is better to identify properties for cohorts, rather than cohorts for properties. This means that cohorts of people with similar needs and similar interests are identified, and suitable properties for each of these cohorts are then sought.

5.2 Therefore, phase 3 of NAIL concentrates on immediate need, i.e. individuals that have been already identified as suitable for NAIL and are currently known to ASC. It had been intended that some of these individuals/cohorts would occupy existing properties purchased or developed through phase 2 of the programme. However, in some cases their needs have worsened or changed prior to suitable schemes being completed, and in some cases, it was identified that particular cohorts have specialist requirements for both the physical building and the type of care provider they need. For example, it was originally anticipated that clients with a dual diagnosis of autism and a learning disability could be supported in proposed LD schemes. However, it was found that the majority of people with this type of dual diagnosis require a specialist provider with the associated increase in cost. Therefore providing for them within a ‘generic’ LD scheme is not an efficient use of funding.

5.3 A further challenge is the increase in certain types of presenting need. For example, there are now a number of individuals being supported by ASC with Korsakoff's syndrome (alcohol-induced dementia). Due to the challenging behaviour that often accompanies a Korsakoff's diagnosis, schemes will necessarily need to be smaller to allow a provider to manage behaviours safely, and the location of the scheme is important following learning from some of the community resistance to existing mental health schemes.

5.4 Similarly, we now have a significant cohort of older individuals with a learning disability who have also been diagnosed with dementia. The original intention was that older adults with a learning disability could be supported in ECSH, however, it has become clear that older adults with dementia and a learning disability require a specialist provider to support them safely in a community setting and we have now identified enough of a demand that a smaller scheme to support them is required.

5.5 Finally, whilst a number of schemes for people with mental health issues have been developed, experience has shown that more tailored schemes are required for individuals with different types of presenting behaviours, including those with forensic MH needs.

5.6 Table 4. Proposed requirements for Phase 3 and 4 NAIL developments

Property Required	Number of units required	User group
SCMHT have identified a demand for a small forensic service.	6	Forensic Mental Health.
1 x property that has small studio units with a lounge. Property design brief in place but location important.	6	Korsakoffs Syndrome
1 x property with self-contained units and an element of communal space.	12	Physical disability
2 six-bed, purpose build units.	12	Autism/CB
6 bed unit with ample shared communal space and garden for moderate/severe LD and Autism.	6	Learning Disability/Autism
6 bed unit with ample shared communal space and garden for moderate/severe LD and Autism	6	Learning Disability/Autism

6.0 Future demand and development – Phase 4

6 bed unit, fully accessible with a lift to first floor.	6	PMLD
6 bed unit with ample shared communal space and garden for moderate/severe LD and Autism	6	Learning Disability/Autism
6 bed unit for ageing LD population.	6	Older LD
Knowles House Extra Care Housing	61	Mixed communities for over 50's
Honey Pot Lane Extra Care Housing	57	Mixed communities for over 50's
Watling Gardens – Extra Care Housing	70	Mixed communities for over 50's
Kilburn Square – Extra Care Housing	70	Mixed Communities for over 50's
Stonebridge (Hillside)	40	Mixed communities for over 50's
Mental Health Supported Living units	78	Mental health 18-65, split over a number of separate services
Total	442	

6.1 In addition to the immediate needs identified above, demand modelling suggest that in order to manage demographic pressures in the future, c. 100 units of Extra Care Housing (ECH) will be required every 5 years in Brent for older people. This modelling is based on both the increasing number of older people in Brent, evidence suggesting that older people will live longer with multiple health conditions and the desire to open ECH provision to a wider cohort of older people with less substantial needs.

6.2 That said, the impact of the Covid-19 pandemic is still unclear and so further work will be done to determine the demand for extra care services in the medium to long term. This work has only recently begun and will influence our approach to extra care in the future.

6.3 ECH is for those residents who are over 55 (although this age limit may be lowered in the future) and residents must have Care Act eligible needs. ECSH is usually purpose built and designed specifically to be able to meet the care needs of this client group. Schemes will have a registered care provider on site 24 hrs (not a warden), and will have telecare alarm systems wired into all units. Some units include additional telecare support, such as door sensors or falls monitors and all units will be able to accommodate hospital beds and be wheelchair accessible.

6.4 In the past, the eligibility criteria for ECH was set deliberately high to ensure that those residents with the most need were able to access the services, and that the highest level of savings possible was generated from the programme. However, the ideal situation for ECH is that there is a mixed community of need, allowing residents

with lower needs to support and encourage those residents with higher-level needs to remain active and social for longer. Residents with lower level needs ensure that ECH schemes can build true communities, encourage more socialisation, can offer peer support to other residents and allow us to provide people with a genuine home for life as the aim would be that as people's needs increase, they can be supported in their existing home. This is the model we are working towards in future phases of NAIL.

6.5 By moving individuals into ECH at an earlier point, individuals are likely to be more settled, better used to their surroundings and accommodation and better able to manage with a smaller package of care than if we wait to move people until they are in crisis. We are therefore working towards lowering the eligibility threshold for ECSH to 1 hrs per week of care, and putting a lower age limit of 50 yrs in place across the 6 existing Network Home Schemes (Willow House, Beechwood Court, Rosemary House, Tulsi House, Newcroft House, Tulsi House and Harrod Court). The lower age limit is required due to an increase in the number of individuals with early onset dementia the service are now seeing (an average of 5% of all individuals under 64 now placed in a residential or nursing placement are placed due to dementia).

6.6 A further challenge is that we are currently unable to accommodate individuals who own property, or who have significant funds (self-funders). The intention would be to develop some schemes to be mixed tenure, as well as mixed need, which would both support the management of demand on ASC, but would also support to reduce the demand on housing in the borough.

6.7 There is also an immediate and ongoing requirement for provision that can support people with dementia to live well in the community, both through the design of the building and through the care commissioned to support people. Each of the proposed new schemes (see below) either will be dementia specific, or will include specific dementia units.

6.8 A number of sites with potential to be developed into larger ECH schemes have been identified already, and two (Honey Pot Lane and Knowles House) are at the construction stage. Phase 3 of the NAIL purchase and adaptation programme will run parallel to the new development programme (Phase 4) which will supply approximately 298 new Extra care units across the below sites:

Table 5. Proposed Extra Care Schemes

Property/Site	Number of Units	Use	Delivery Date
Honey Pot Lane	61	Extra Care	2022
Knowles House (Includes 10 beds of EMI specialist provision)	57	Extra Care	2022
Stonebridge (Hillside)	40	Extra Care	2023/24
Watling Gardens	70	Extra Care	2023/24
Kilburn Square	70	Extra Care	2023/24

Total	**298**		

6.9 The number of extra care units supplied during phase 4 by the new programme will be during a concentrated period of time and thus requires increased resourcing to ensure the occupants of these properties are prepared and ready to move into the new property from the time its handed over.

7.0 Financial Implications

7.1 Financial implications are included in the main body of the report.

8.0 Legal Implications

8.1 Legal implications are included in the main body of the report.

9.0 Equality Implications

9.1 Equality implications are included in the main body of the report.

REPORT SIGN-OFF

Phil Porter
Strategic Director of Community Wellbeing

Brent	**Community and Wellbeing Scrutiny Committee** 29 April 2021
	Report from the Strategic Director of Community Wellbeing

Day Centre Services and COVID-19

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	0
Background Papers:	0
Contact Officer:	James Pearce, Interim Head of Service, Complex and Direct Services james.pearce@brent.gov.uk 07776665691

1.0 Purpose of the report

1.1 To update members about the impact of the Covid 19 pandemic on day centre provision, including managing any disruption for service users, and the current extent of services.

2.0 Recommendations

2.1 Members of the Community and Wellbeing Scrutiny Committee to note the report.

3.0 Detail

3.1 John Billam Resource Centre (JBRC) and New Millennium Day Centre (NMDC) are part of Brent's Direct Services provision that provide day based support for 135 Brent clients. The service offers a range of day-based activities across the sites. There is also a Supported living accommodation (Tudor Gardens) providing tenancy and support based accommodation for 15 adults with 24/7 care and support needs.

3.2 The FTE for staff in Direct Services in March 2020 comprised of 88 staff.

Staff utilisation Since March 2020

- New Millennium Day Centre and John Billam Resource Centre Closed due to COVID 19 restrictions in March 2020.
- 13 staff from the Day Centres have been supporting Tudor Gardens on shift rota basis to cover absences and the shortfall of agreed staffing levels.
- 27 staff members were medically shielding following assessment and guidance given by Occupational Health. These staff are supporting with the coordination and delivery of well-being calls and online activities.
- 13 staff members were supporting customers in the community and provided taster sessions back in December 2020.
- 9 remaining staff were Team Leaders/ Manager and administrative staff

Current Staff Numbers

- 15 staff took EVR since March 2021
- 1 Ill Health Retirement
- Leaving Direct Services with staff team of 72 FTE equivalent

3.3 The Covid-19 Pandemic has provided immense challenges in continuing to support residents with wide ranging care and support needs. In line with wider public health council guidance and planning with Brent's Commissioning arm of Adult Social Care building based activities have in the main been ceased since March 2020.

3.4 The approach taken mirrors that of the majority of London Boroughs where decisions to cease building based activities were made In the context and recognition of the vulnerability of the majority of Brent residents using the building resource were vulnerable to serious ill health or mortality as a result of Covid-19 infection. NMDC closed on 20th March 2020.

3.5 Initial support was provided through welfare calls. These were made weekly or up to 2/3 times per week depending on need. This became an essential strand of support for clients and carers, often the first point where arrangements and contact was made to provide alternative support. In the early phase of the pandemic the welfare calls identified immediate support needs and regularly supported and signposted clients, family and carers many of whom were shielding.

3.6 In June 2020 the PII Insight team with the support of library staff surveyed carers and residents who (pre-lockdown) were in receipt of day services to determine their views. Over 100 calls were made and 80 responses were received. Of these 51% indicated that they wished to return to a building-based service as soon as they could, while the remainder were split between wanting to wait for several months, until Covid was no longer a significant risk at all and a small minority who did not wish to return to building-based services at all. These findings were presented to Brent Carers Board and the ASC Departmental Management Team in order to inform their decision making around when to re-open services. Brent Carers Survey conducted a Carers

survey in November 2020 and these findings were also shared via the Carers Board in December.

3.7 In May 2020 NMDC developed a range of activity packs which were sent out To 65 clients on a monthly basis. These included diverse subject areas such as:

- Mindfulness exercise
- Word search
- Gentle exercise examples
- Numeracy and literacy
- Recipes
- Colouring booklets
- Puzzles and other mind stimulating games
- Sensory activities such as: birds listening and watching, stretching exercise in the garden, smell or taste examples of activities that could have been done at home safely

3.8 From December 2020 NMDC staff introduced a range of virtual sessions That were taken up by 45 clients. These included: Exercise and aerobic session, Mindfulness, Yoga, Art session, Drama Workshop, Virtual Café, Storytelling and creative writing, Game sessions, Dance and Sing along, Healthy Eating and Lifestyle.

3.9 JBRC like NMDC closed in March 2020. The service supports 42 clients With Care Act Assessed Needs. The service is a Specialised Autism and Complex needs service with Advanced Accreditation from National Autistic Society. All clients received weekly welfare calls for this service and 7 clients Received ongoing community support up to December 2020.

3.9.1 Out of 42 clients, 18 have been receiving virtual activities that includes: Exercise and aerobic session, Mindfulness, Yoga, Art session, Drama workshop, Virtual Café, Storytelling and creative writing, Game sessions, Dance and Sing along, Healthy Eating and Lifestyle.

4.0 Digitalisation

4.1 During the period of lockdown, we enabled our staff to be digitally connected with the teams and managers with the distribution of 65 iPhones. Staff working from home were equipped with additional devices to enable them to make wellbeing calls, log the conversations and lead the online sessions.
15 Chromebooks were distributed to customers who had no devices or connectivity. Working in partnership with Age UK on a pilot project to offer training and support to service users on digital inclusion.

5.0 Building Based Pilot Sessions in December 2020

5.1 In JBRC 12 clients attended sessions that included storytelling, dance and Movement and physio. The content reflected higher need and complexity of need and again were subject to stringent infection control measures based on

advice from public health. In NMDC 25 clients took part in a range of carefully planned sessions in Pottery, Arts and Dance Therapy.

5.2 Prior to the Covid-19 Pandemic Direct Services were beginning to apply a campus type model to day care provision. The continued challenge to move from traditional large group generic activities to sessional personal centred approaches were key to meeting desired outcomes for clients. Though the pilot was curtailed the work completed has provided a platform and knowledge base for day services staff and a springboard for the person centred model the service are striving to implement.

6.0 Future Planning /Resumption of Activities and Contingency

6.1 Regular meetings are being held with public health for advice and support and to discuss options. All customers risk assessments are being updated. A comprehensive review of buildings is underway to ensure buildings are compliant with Public Health recommendations.

6.2 The service will register for on-board testing for staff. Staff will test regularly at home so this will identify staff with no symptoms carrying COVID-19 who may pass this on to other staff members and people who use day care centres. Meetings with transport services are taking place to discuss flexibility and safety protocols. All parties except transport arrangements will be a key factor in ensuring the three pillars of support offer will continue and we are looking at scaling up activities in Building activities, Community support and Wellbeing calls. Transition back to the services - Prepare social stories, take photos of the building to reduce anxieties and help with visualisation.

6.3 The provisional timescales are :W/C: 12.04.2021 Restart of community support such as Parks, zoos and outdoor places reopens, social distancing applies, groups of support up to six people.

6.4 From W/C: 21.06.2021: Restart of building taster sessions with combination of a lower number of group activities to be reintroduced to customers with a mixture of online remote sessions. Lower number of contact hours to be considered. Virtual sessions streamlined to meet assessed Care Act needs. To give customers choices to shape their needs in a personalised manner.

7.0 Beyond Resumption/ Further planning

7.1 The management group and staff are looking to further develop Direct Services. Initial areas of development to include:

- Enablement project in partnership working with Autism Lead in children services to support transition from child to adulthood. Focus on life skills such as travel training, cooking, shopping, and money management, safety in the community, general wellbeing, employment prospects, and links with other organisations in the community.
- To further utilise the coproduction and wider partnership working with independent day care providers in the borough.

- To develop Apprenticeship programme in Health and Social Care Levels 2 and 3

8.0 Independent Day Care Providers

8.1 Approximately 220 people use independent day care services in Brent, through a combination of commissioned services and direct payments. In addition to the two in-house day centres in the borough, there are five independent older people day care providers and six learning disability providers. Brent service users also use a number of day centre providers based outside of Brent that offer provision that isn't available in-borough.

8.2 Independent day care providers closed their building based services in March 2020 due to the Covid-19 pandemic. Through this time providers have been funded, based on commissioned care packages in March 2020, to put in place alternative models of support for people who were attending day centres.

8.3 The council's ASC Commissioning Team has supported independent day care providers throughout the pandemic and worked with them to develop alternative models of care that have been delivered whilst building based services remain closed. The services have been focussed on three key areas –

- Virtual services – activities delivered virtually using programmes such as MS Teams and Zoom. The council has supported this, providing nearly 70 laptops to people without the equipment needed to access these sessions, which have been distributed by the day care providers to their service users.
- Community based services - support provided to people in small groups or 1:1 using community facilities such as parks or libraries.
- Outreach services – respite support in the home, or on a 1:1 basis with service users, to ensure continuity of care and to prevent carer breakdown.

8.4 Each provider also has their own suite of services that they have offered to their service users, including a free meals service, weekly welfare calls and activity boxes to support virtual activities. Despite the disruption to services caused by the pandemic, no service user has gone without support, and alternatives to building based care have been put in place where needed.

8.5 ASC Commissioning is supporting commissioned providers with their own pilots as service users start to return to building based services. The learning from the Direct Services pilots will be shared across the day care sector in Brent, as well as support on risk assessment, and mitigating the risk of Covid-19 with vulnerable service users. Regular forums are held with day care providers, and 1:1 meetings on service planning will take place by early May to discuss the specific service issues with each provider and to help them prepare for re-opening.

8.6 Moving forward, the ASC Commissioning is working with day care providers and people who use day care services on the future of day care provision in Brent. There is an acceptance from providers that we shouldn't revert back to delivering services in the way we were prior to the pandemic, and that a mixed model of care, including virtual, outreach and community provision needs to be an important part of the offer. There is still much to do to develop proposals, but providers are fully engaged in this and working with the council on the future of day care provision. Further updates will be brought to the Community and Wellbeing OSC as the programme of work takes shape.

9.0 Financial Implications

9.1 Implications are included within the main body of the report.

10.0 Legal Implications

10.1 Implications are included within the main body of the report.

11.0 Equality Implications

11.1 Implications are included within the main body of the report.

12.0 Consultation with Ward Members and Stakeholders

REPORT SIGN-OFF

Phil Porter
Strategic Director of Community Wellbeing