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Community and Wellbeing Scrutiny Committee

Tuesday 5 July 2022 at 6.00 pm

Conference Hall – Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

The meeting will be held as an in person physical meeting with all Scrutiny Committee members required to attend in person.

The meeting will be open for the press and public to attend. Alternatively the link to follow the webcast is available here.

Membership:

Members	**Substitute Members**
Councillors:	Councillors:
Ketan Sheth (Chair)	Moghaddam, Akram, Bajwa, S Butt, Conneely, Long, Miller, Mitchell and Shah
Collymore (Vice-Chair)	
Afzal	
Begum	Councillors:
Ethapemi	Kansagra and Maurice
Fraser	
Moeen	Councillors:
Seelan	Georgiou and Lorber
Smith	
Matin	
Mistry	

Co-opted Members
Vacancy, 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

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit: **www.brent.gov.uk/democracy**

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 - 16

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

4i. 9 March 2022
4ii. 14 March 2022

5 Matters arising (if any)

6 End of Life Care *(Approx. 40 minutes)* 17 - 64

For the Community and Wellbeing Scrutiny Committee to receive an outline of the community based specialist palliative care improvement programme.

7 Update on Adult Day Services *(Approx. 15 minutes)* 65 - 74

For the Community and Wellbeing Scrutiny Committee to receive an update on Adult Day Care Services.

8 Update on Shared Lives Scheme and Tudor Gardens *(Approx. 15 minutes)* 75 - 80

For the Community and Wellbeing Scrutiny Committee to receive an update on the Shared Lives Scheme and Tudor Gardens.

9 **Adult Carers** (*Approx. 40 minutes)* 81 - 86

For the Community and Wellbeing Scrutiny Committee to receive a report about how carers access services in Brent.

10 **Community and Wellbeing Scrutiny Committee Work Programme 2022-23** *(Approx 10 minutes)* 87 - 96

The report updates Members on the Committee's Work Programme for 2022/23.

11 **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 her representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: **Thursday 22 September 2022**

Please remember to set your mobile phone to silent during the meeting.

The meeting room is accessible by lift and limited seats will be available for members of the public. Alternatively it will be possible to follow proceedings via the live webcast here

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MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Monday 9 March 2022 at 6.00 pm
Held as a hybrid meeting

PRESENT: Councillor Ketan Sheth (Chair), and Councillors Afzal, Sangani and Thakkar.

Members in attendance remotely: Councillor Daly, Mr Alloysius Frederick

In attendance: Councillor Knight (in remote attendance), Councillor Nerva (in remote attendance), Councillor McLennan (in remote attendance), Councillor M Butt, Councillor Krupa Sheth, and Councillor Tatler

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

Apologies were received as follows:

- Councillor Colwill
- Councillor Aden
- Councillor Ethapemi
- Mr Simon Goulden
- Rev. Helen Askwith

2. **Declarations of interests**

None.

3. **Deputations (if any)**

There were no deputations received.

6. **Casey Review**

A presentation from the Football Association (FA) was presented by Tom Legg (Head of External Operations, FA) and Chris Bryant (Head of Tournament Delivery, FA).The presentation covered the process of the independent review of events at the Euro 2020 Final, which had been done by Baroness Casey. It was highlighted that the review had involved interviews with numerous stakeholders representing all key delivery partners, analysis of substantial documentation and CCTV footage, a survey of ticket holders, and independent reports from experts and academics across the field. The presentation detailed that the review had made 4 recommendations in relation to FA governance, including changes to the categorisation of matches of a certain scale, a review of stewarding, a national campaign regarding attitudes and supporter behaviour, and the strengthening of penalties for disorder. Those recommendations would involve the FA working closely with the government and police, supporting the Sports Grounds Safety Authority (SGSA) with the review of stewarding, working with the Premier League, English Football League and 'Kick It Out' on behavioural change campaigning, and developing a proposal for legislative and football banning order changes. Two recommendations for Wembley operational matters were made to strengthen plans for safety ahead of events and matches of significance.

The Committee wanted an understanding of the planning and preparation that had gone into the organisation of the Final. Chris Bryant advised that the event was very thoroughly planned and all mitigating actions were taken where possible. He highlighted that the planning that went into delivering the event was greater than any event he had been a part of and there was stakeholder buy in from everyone. The events of the Final had been what was referred to as a 'perfect storm' and brought about by events that stakeholders had never seen previously. Councillor Muhammed Butt (Leader, Brent Council) agreed that the preparations that went in to making the event happen were incomparable. Many meetings took place, and the situation regarding Covid-19 had meant things had to be changed several times. Conversations were taking place with central government, UEFA and all relevant stakeholders and the Covid-19 regulations were changing constantly. The FA, Stadium and Council all had to respond appropriately to those changing regulations and work within the constraints they were given. Councillor Butt highlighted that the recommendations made in the review had strengthened the conversations that had happened since, and all stakeholders were taking into account everything in the review to make sure partnerships were strengthened and the Stadium continued to work effectively for the residents and visitors.

In relation to the Covid-19 national research programme, the Committee queried how the findings from those programmes contributed to the planning and preparation for the event. Dr Melanie Smith (Director of Public Health, Brent Council) highlighted that the national research programme had been answerable to central government, which had determined that, on the advice of Public Health England and the Science Board, the dispensation would be given to allow the Euros to take place. Phase 1 of the event research programme was not designed to show and would not have shown any impact on transmission but instead explored the feasibility of the mitigations that had been put in place and allowed observational studies to be done around behaviour. It also allowed measurements around air circulation in specific areas. Carolyn Downs (Chief Executive, Brent Council), Chris Bryant and Melanie Smith had been involved in daily meetings about Covid-19 infection control, which was led by central government, and they had not been prepared to sign off infection control measures related to the event and insisted that Public Health England be the main sign off for the event, as they were not satisfied with the home testing regime. They were happy with the testing regime in place in Brent and the control measures of the Stadium, but did not accept that the home testing regime was robust, and Carolyn Downs continually raised the issue throughout the whole programme.

The Committee considered safety away from Wembley and Wembley Stadium, and asked what role the GLA and TfL had in relation to the control of alcohol on trains and stations heading towards Wembley. The Committee were advised that Baroness Casey had interviewed the GLA, TfL, and British Transport Police (BTP) as part of the review, the outcome of those being in the report, and it was acknowledged that there was a need to greater enforce the bringing of alcohol on to the public transport system. The relationship with TfL was important at the Stadium, and they had a good working relationship which was clear on how to work together and requirements ahead of each fixture. The FA shared the Committee's concerns about the ability to consume and transport alcohol on the public transport network and were talking to TfL and BTP about this in detailed planning meetings. Chris Whyte (Operational Director Environment, Brent Council) added that the new approach the Council had to

restricting the consumption and sale of alcohol on event days, which had been introduced for the Caraboa Cup Final, had required significant buy-in from BTP and TfL in helping to administrate that on trains and they had seen a very significant improvement on that day. He felt this demonstrated they had a solution that they would continue to work towards alongside partners and uphold that effort for future games. Jim Brockway (Chief Inspector, Metropolitan Police) advised that the police were in regular contact with the BTP who were a good and valued part of the system. He believed that the response they provided was a very valuable service to the wider operations which were delivered in the capital, but he could not speak on their behalf as they were a separate entity. He advised the Committee that BTP would be involved within the partnership approach as the police moved forward.

In relation to how ticketless fans were managed, the Committee were advised that there was clear signage pointing ticketed and ticketless fans to the correct areas. The system needed to work in the best way possible for all people coming through Wembley. Moving forward, the FA wanted to limit the number of ticketless fans coming to Wembley Stadium, and in mega event capacity deploy fanzones across greater London, which had not been an available option during the Final due to Covid-19. One of Tom Legg's responsibilities was to work with transport operators to ensure there was enough capacity to get people safely in and out of Wembley Stadium, and as the requirements of the operation changed and the FA got closer to the Euros the capacity conversations with TfL became a significant piece of work. The FA had a very detailed demand forecast model where they assigned postcode data from ticket sales to enable them to understand where people were travelling from and what the capacity of those networks were. The FA then worked with operators to increase capacity or maintain existing timetable commitments. In relation to how the police managed ticketless fans, Jim Brockway advised that this was not an issue bespoke to the police but rather an issue for the wider partnership. The police had looked at how they would potentially deal with that issue, as they could only operate within the laws available. Ultimately, there was no ability to move anybody without a ticket from any venue other than through powers of persuasion by partners. The police were willing to take a partnership approach to the issue and do what they could to deal with the problem, but had no law to deal with ticketless fans.

The Committee queried what work had already been done and what was in the pipeline to address the attitudes and behaviour of fans. In particular the Committee highlighted the issues which had manifested themselves during the Final which they described as hooliganism, racism and domestic abuse, and wanted to know what the FA were doing, or planning to do, to tackle these issues. Chris Bryant felt that the FA had been leading on those issues for many years, and the review highlighted that more needed to be done. He was happy to follow up with colleagues who did that behaviour change work, but highlighted some of the work the FA did in those spaces. For example, they worked closely with 'Kick It Out' and other organisations to remove and eradicate discrimination and racism in football. The FA appreciated and understood that some of the incidents raised by the Committee were linked to football fans and they had a responsibility to do what they could, as did everybody, to resolve those issues.

The Committee asked about the impact the events of the Final had on residents and how impact on residents would be reduced in future, to ensure a positive experience for all. The FA wanted local residents not to be negatively impacted by the delivery of

events, and believed there had been great strides across the past 4-5 years to better engage with residents to understand their issues and improve their experience. For example, there were resident Committees the FA engaged with, and they engaged with the Council on issues affecting residents also. They were always open to suggestions for the future in relation to engagement with residents and improving resident experience. Councillor Butt agreed that there had been a lot of resident engagement and residents were active in making sure their views were heard. He highlighted that the employment opportunities that had arisen since the Stadium and LDO had been in place were tenfold.

In response to whether there was any adherence to monitoring the levels of Covid-19 infection following the event, Dr Melanie Smith advised that the events research programme had looked at transmission associated with the events which showed that, for the Final, it was probable that a couple of thousand people may have attended while being infectious, and over 3,000 people may have acquired infection following the event. It was not possible to confirm that those infections were acquired in the stadium, as it could have been transmitted travelling to or outside the stadium. At the time of the Euros and before the Final there had been a rise in infection in the country as a whole, which has since been attributed to the Euros, but she highlighted that this was not attributable to Wembley. A very thorough research study by Imperial College London had concluded that it was likely that the increase in COVID rates in the country associated with the Euros was likely to be due to people mixing socially in front rooms and gardens across the Country rather than with attendance at Wembley. The infection levels in Brent as a community did not increase during this period of the event research programme.

In relation to stewarding, the FA agreed with the review which recognised that stewarding quality was potentially not where it needed to be, and the industry of stewarding had taken a hit on the back of the pandemic as the workforce had moved on. The FA had took many steps to ensure the stewarding for the Euros was in the best possible position in multiple ways, such as bringing in more stewards for the research programme and building up numbers so they were in a better place of readiness than they would have been otherwise. For the Final alone the FA had brought in more stewards than had ever worked for Wembley Stadium for any event previously. They had paid for the extra resource with no financial constraints, and in the delivery of the Final there was nothing that was not delivered due to financial constraints.

The Committee queried whether partners felt the Council should have been more robust with licensing and escalated the matter higher. Chris Whyte advised that all partners who had been involved in the SAG meetings between the Denmark game, Germany game and the Final had discussed the licensing issues. The opportunity to review the licensing arrangements was not there as the process to change licensing arrangements would not allow it to happen in time for the Final, and therefore the Council could not issue a blanket ban on the sale of alcohol in off-licenses in the local area. The process to do so required a premises by premises review, with evidence to support that ban in advance of the Final. The mitigating factor was for the police on the day to close any premises creating a problem at any given time, a process that was applied on occasion during the Final. Since the Final, there was now work being

done on licensing arrangements in the area to limit the sale and consumption of alcohol on event days.

The Committee queried whether there was a document setting out the strategic responsibility of the key partners. They were advised that the SGSA was the leading partner on developing the responsibilities for how Zone X worked and who would be responsible for the deployment of all the different types of arrangements outlined during the meeting. Brent wanted to push forward and create some of those new Zone initiatives for the benefit of the local community, but were waiting for some guidance from the SGSA for a national approach to delivery. Since the Final the FA had delivered a number of successful events and the Carabao cup final had demonstrated the operating model outside of Covid-19 restraints. The application of new arrangements would be scrutinised and supervised by the Safety Advisory Group (SAG) and the Council would have its own assurance about the value of these new interventions.

Carolyn Downs advised that the three local partners – the FA, the Council and Quintain – had committed to putting additional resource into arrangements known as 'best in class'.

The Chair thanked those present for their contributions and drew the discussion to a close, asking for recommendations from the Committee.

The following recommendations for areas of improvement were made:

i) For Brent Council, the FA / Wembley, the Metropolitan Police and key partners to commit to enforcing any restrictions on alcohol consumption related to events at Wembley Stadium, for supporters travelling to the stadium and those in the Wembley Stadium area.

ii) For Brent Council to review the event day parking zone and enforcement measures in place for events at Wembley Stadium.

iii) For the FA to commission and share a report reviewing their campaigns to date to remove hooliganism, racism and domestic abuse from football (including that related to Euro Sunday and England matches). This should include a list of all campaigns with an evaluation and monitoring information.

iv) For the FA / Wembley to ensure better engagement and communication with local health partners, including London Ambulance Service and Brent Council's Public Health Team to ensure that health and wellbeing is a key focus at events.

v) For Brent Council, the FA / Wembley and key partners to ensure better engagement and communication with elected members in regard to high-profile events at Wembley Stadium.

vi) For the FA / Wembley and key partners to produce and share a memorandum of the strategic responsibilities of those agencies involved in logistical and operational planning for events at Wembley Stadium,

including an overview of the governance, roles, and responsibilities of the Safety Advisory Group (SAG).

vii) For the FA / Wembley to consider introducing a levy on the price of tickets for events at Wembley Stadium, with the additional funds raised by this levy to be used to support efforts to minimise and mitigate disruption to the local area.

During the discussion, a number of information requests were also made, recorded as follows:

i) For the Community and Wellbeing Scrutiny Committee to receive an update report on the progress made by Brent Council, the FA and key partners in implementing the recommendations made in the Casey Review in the next municipal year.

ii) To receive information on the FA's plans to remove hooliganism, racism and domestic abuse from football, including information on campaigns, resourcing and collaboration with partner organisations.

The meeting ended at 20:05 pm

COUNCILLOR KETAN SHETH

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Monday 14 March 2022 at 6.00 pm
Held as a hybrid meeting

PRESENT: Councillor Ketan Sheth (Chair), Councillor Kansagra (substituting for Councillor Colwill), and Councillors Aden, Afzal, Daly, Sangani and Thakkar.

Members in attendance remotely: Councillor Daly, Mr Simon Goulden

In attendance: Councillor Southwood (in remote attendance), Councillor McLennan (in remote attendance)

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

Apologies were received as follows:

- Councillor Colwill, substituted by Councillor Kansagra
- Councillor Shahzad
- Councillor Hector
- Councillor Ethapemi
- Mr Alloysius Frederick
- Rev. Helen Askwith

2. **Declarations of interests**

Personal interests were declared as follows:

- Councillor Sheth – Lead Governor of Central and NWL NHS Foundation Trust
- Councillor Thakkar – employed as a care navigator
- Councillor Sangani – employed by NHS

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

The minutes of the meeting on 22 February 2022 were approved as an accurate record of the meeting.

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

There were no matters arising.

6. **Care Home Provision and Commissioning**

Andrew Davies (Head of Commissioning, Contracting and Market Management, Brent Council) introduced the report, which summarised residential and nursing home care in the borough, and provided an overview of the work being done on quality assurance, price setting, and the support the Council had given to the sector over the past 18 months. He advised that, of 57 residential and nursing homes in Brent, 45 were rated 'good' and 1 was rated 'outstanding' by the Care Quality Commission (CQC). Of the placements Brent made, over

83.5% were in a nursing or residential home rated as good or outstanding, which was slightly better than the London average. Where possible, the Council looked to commission within the borough, but this was not always possible due to pressure from other boroughs for placing residents. As a result, around 50% of placements were made in borough and 50% outside, which was in line with the London average. The number of placements particularly fell during 2020 following deaths due to Covid-19. The NHS took on commissioning of nursing placements for people leaving hospitals, and now the sector was seeing numbers increase to pre-pandemic levels. As a result, it was expected that the Council would spend slightly more than in previous years.

In offering care and support, the Council felt that, wherever possible, it was best to look to support people at home, with residential and nursing home care being the last resort. It was crucial there was a vibrant residential and nursing sector, and the Council spent a lot of time on quality assurance. The Residential and Nursing Team were responsible for quality assuring services, carrying out placement reviews, and taking a lead on safeguarding enquiries in Brent based homes. Each care home had a Placement Relationship Officer managing the close relationship between the Council and the home. They used a quality dashboard and there was good intelligence on the position of all homes in Brent, including those that the Council did not commission services in. The Council also continued to regularly share information with the CQC through quarterly meetings.

In relation to the 9 nursing or residential homes not rated as good or outstanding, an enhanced health and care home improvement programme was running, jointly with the CCG. This focused on medication management, improving links between primary care networks and care homes, and included a peer support programme which ten providers had been through and seen an improvement in their services. Three of the homes that were part of the improvement programme had subsequently been re-inspected by the CQC and had their rating increased.

The current challenge was the impact the vaccination mandate had on staffing levels. Although the mandate was being abolished the day following the meeting, since November 2021 it had been a legal requirement for anyone working in the care home sector to be vaccinated against Covid-19 and staff had left the sector as a result of that. This had not impacted the number of care home beds, and the Council were optimistic they could recover. The guidance from the Director of Public Health was that care homes needed to take precautions around infection control and visiting, and encourage testing for visitors to protect the vulnerable residents living in care homes in Brent.

The Chair thanked councillors for their introduction and invited the Committee to raise comments and questions, with the following issues raised:

The Committee queried whether there were any commissioning policies in relation to diversity, and the different cultural and religious needs of the Brent community. They were advised that Brent's care homes reflected Brent's communities, and there were several care homes in the borough that catered for specific ethnic and national groups, set up by people in those communities to care for their elders. The activities in those care homes reflected the client groups within those homes. The Council tried to place people into homes that could provide culturally specific and sensitive support, although that was not always possible and the Council would address that person's care needs first and foremost. Andrew Davies felt that Brent care homes had become very good at providing culturally specific and sensitive support and providing an environment within homes that took into consideration the range of nationalities and ethnicities of people from Brent.

The Committee queried how this approach factored into assessments. Andrew Davies advised that the assessment process started at the point someone approached the Council for support,

or was in hospital or waiting for a hospital discharge, and a view had been taken by a Social Worker that their needs could only be met in a care home. The assessment took into account a person's entire need including care, culture, religion and food, which helped to determine the home they were placed in. Placement Relationship Officers carried out placement reviews and reassessed people throughout their journey, including with their families, carers and friends, to determine that the placement remained suitable. If a person's food was not appropriate for them the Placement Relationship Officer would address that with the care home, and remained conscious of any feedback. Often, those placed were not in a capacity to give feedback themselves due to cognitive impairments and Placement Relationship Officers attempted to hear what their family or friends, as advocates of the person in the care home, had to say in that respect, to ensure the placement was meeting the need. If there were specific examples where the Council was falling short of supporting a person's entire need, members were asked to let officers know.

Continuing to consider diversity within caring, the Chair invited representatives of Brent Youth Parliament to address the Committee. Brent Youth Parliament highlighted staffing challenges, and asked what action the Council were taking to promote and encourage employment of youth into caring careers. Brent Youth Parliament were happy to encourage this as much as possible such as through employment talks and development hubs in order to increase diversity within caring. In relation to staff, Brent Youth Parliament felt that a more robust anti-racism programme to reduce stigma and stereotypes within staff would help patients feel comfortable within their care home setting and take away the need to place people in homes according to their cultural need. Andrew Davies agreed that it was important to encourage young people to work in the care sector as they wanted to grow the workforce with passionate individuals, and the Council were currently working with Brent Works on a programme connecting those who wanted to work in care with job vacancies in the sector. He welcomed working with Brent Youth Parliament and encouraging care providers to speak with Brent Youth Parliament. Work experience within the local authority was also available, and a 'proud to care' scheme, where carers received a rewards scheme with discounts and shopping vouchers as an incentive for anyone who worked within the health and social care sector.

Brent Youth Parliament also wanted to know what measures were being used to assess the programmes put in place to raise the ratings in those homes not rated good or outstanding. They were advised that the Enhanced Health and Care Home Peer Support Programme focused on those care homes requiring improvement, as well as care homes trying to make a step change from good to outstanding. The Council were working with providers to support them in the lead-up to inspection so that the registered managers could work together on areas they could jointly tackle to demonstrate their quality to the CQC. Business as usual quality assurance took place regularly through the Residential and Nursing Team, and it was an area the team focused on daily.

The Committee queried the role of the adult fostering service as a way of keeping people in the community. Andrew Davies advised that the adult fostering service focused particularly on respite placements and the importance of giving those caring for people who still lived at home a rest. The service had been rated by CQC as good and was due another inspection in 2022. There were 20 placements currently in the Shared Lives adult fostering service, and there were tentative plans to expand those numbers. There had been various attempts across the past 5 years to recruit carers to the service which had not been successful, which had meant the numbers had remained lower than usual. The Council had spent time and resource developing the Brent Supported Living Service which brought on approximately 70-80 learning disability and disability specialists, reducing the number of people with a learning disability living in residential care from 180 to around 120, and that was the strategic direction the Council had

decided to go in. The Shared Lives service was being reviewed to see where it could grow and develop in relation to the strategic direction.

Continuing to discuss respite care, the Committee were advised that respite placements would not be included in the report data as they were temporary. Most of the respite offered in Brent would be part of a care plan when a person's care was first put in place. For those carers where respite had not been included in the initial assessment who needed respite, the carer would be required to contact the Adult Social Care Front Door and have a separate Care Act assessment with a specific focus on the service user and carers needs. As long as they demonstrated that they did need that support in order to continue to care for a person the Council would offer that respite.

In relation to day centres, the Committee were advised that these had all now reopened. There had been a turnover of service users due to the pandemic. The Council were working with day centres on transforming their models of care to do more outreach work in the community and trying to orient them away from being focused on only delivering services from their respective buildings. The focus was on a more modern and dynamic way of delivering day care in line with what was happening across London, sharing models of good practice with other boroughs. Andrew Davies offered to bring a separate report regarding day care to the Committee.

The Committee queried how assessors concluded what sort of placement was suitable for an individual. For example, the Committee asked what assessment was done to determine if someone was more appropriate for Supported Living. Claudia Brown (Operational Director Adult Social Care, Brent Council) explained that specialist social workers were trained to do a generic, comprehensive assessment of an individual's needs. A placement would be identified once those needs were assessed. Another scenario was raised, where an elderly widower could no longer be looked after by their family, and the Committee asked whether there was a different approach if a family member approached the Council for their relative to be placed if the relative consented. In the scenario, the widower had deteriorated and were lonely and becoming forgetful. Andrew Davies advised that this was a scenario the Team dealt with on a daily basis. The approach would be the same in terms of social care assessment where the elderly person would be met and their needs assessed. The assessor may determine that their needs could be met at home alongside a care package, or that their level of need was not sufficient to place them in residential or nursing care. If that person chose to fund their own placement or sell their property to move into residential or nursing care then they were free to do that. It was important that the individual remembered that they had a choice, and often the assessor may do a Mental Capacity Assessment to see if they had the capacity to make that choice. They could chose to stay at home with support services provided, or the Council could offer Extra Care, among other options.

The Committee noted the general trend to move towards supported living and asked what the impact of that had been. They were advised that the rationale behind this was that it was felt younger people under the age of 65 were better served with people of a similar age or disability, and that creating those homes where individuals had a community, friendships and relationships developed better ways for young people to live their lives. The savings of the programme had also been a key driver. In terms of satisfaction and soft measures of success, it was felt the Council could do better at asking people about their views of the service and gathering constant feedback. Phil Porter (Strategic Director Community Wellbeing, Brent Council) advised that all service users had an annual review which was person centred and engaged their family and carers, in order to understand the extent their placement continued to meet their need. He felt more could be done to aggregate that data to understand its impact, and the Performance Insight Team were looking into how that might happen. The Council had also begun the design of a service user survey so that every visit a care worker conducted would receive feedback. Co-production was also a focus, getting service users involved when care provision was retendered,

and that happened on a regular basis. A post had been created for someone to work specifically on co-production and service user led design which would take into account the views of service users and demonstrate the impact of the service. In terms of how the increased level of independence was measured, Phil Porter highlighted that, because service users had different situations and needs, this was measured for individual cases and not currently aggregated into larger numbers. The Committee considered that this might add value as it would be a holistic view of service performance.

The Committee understood the lack of resources in the care sector, particularly following the pandemic, and asked how many care staff Brent had lost as a result of the mandatory vaccination and what the impact of that was. Andrew Davies would find out the exact figures, but it was noted that it was a much smaller number than was expected and not significant in Brent. Brent Works and providers had worked hard to backfill those posts, but there was now a wider issue about morale in the service now that the mandate had been reneged upon. In order to maximise the vaccination of staff, the Enhanced Health and Care Homes Team had delivered the vaccination in care homes to all residents and staff throughout the various phases. There were also weekly online forums led by public health consultants and NHS colleagues to promote the uptake of the vaccine. The Council had also encouraged GPs to open up their practices to allow staff to be vaccinated closer to their homes.

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

To recommend the following key areas for improvement:

i) For the Council to work with providers to fund and commission key areas of training and development for care home staff, including conflict resolution training.
ii) For the Council to consider the use of high-level metrics, such as key performance indicators, to monitor and evaluate the performance of the care home sector in Brent.
iii) For the Council to ensure that the wider wellbeing needs of service users, such as social, religious and cultural needs, are considered when commissioning nursing and residential placements.

An information request had also been made during the course of the discussion, recorded as follows:

i) For the Community and Wellbeing Scrutiny Committee to receive further information on the Shared Lives scheme and Day Care services, including any future plans for the development of these services.

7. Transformation of Community Services

Steve Vo (Assistant Director Integration and Delivery, NWL CCG – Brent Borough) introduced the report, which focused on waiting times, priorities, the monitoring and measuring of success, and comparatives with other boroughs. The report detailed the Central London Community Healthcare NHS Trust (CLCH) Covid-19 recovery plan in relation to waiting times, with clinical triaging and weekly waiting lists reviewed by clinicians. The report also detailed the transformation programme and key measures of that programme. One of the key projects to help in the transformation work was the change to the EMIS patient record system to align with the system used by GPs, which would alleviate the need to double check data, and increase transparency and fluidity. In relation to Ageing Well, CLCH were working with Central and North West London Foundation Trust (CNWL) to recruit to key posts, although there were

recruitment challenges across the sector. The paper also noted the work on patient engagement, which was key for Brent Health Matters (BHM).

The Chair thanked officers for the introduction and invited comments and questions from those present, with the following issues raised:

The Committee were concerned about the number of people on waiting lists, and asked several questions in relation to some specific waiting lists:

- In relation to those waiting for Brent Integrated Diabetes Services, the Committee were advised that this referred to an education programme, meaning that those patients' care needs were met and no-one was suffering harm, but they were recommended to go through an education programme. The programme had previously been a group learning exercise but it was no longer possible to do that. Some group sessions went ahead virtually but not every patient was able to do that through digital platforms.
- The Pulmonary Respiratory Service waiting list was also backlogged due to patients doing one-to-one rehabilitation where previously this would have been a group class setting. The service supported patients to manage their own condition and had been clinically evidenced to be effective, however there was a very small group of staff running that rehabilitation and this was something that most trusts across the whole of North West London (NWL) had built up a waiting list for. CLCH had looked to buy educational materials for patients to help themselves.
- There were very few waiting for Bladder and Bowel Services but there was a data problem with the waiting lists requiring validation. There was a growing number of patients waiting for reassessment of continence, but there was no risk that their continence pads would cease while they waited for reassessment. Those who may no longer be receiving enough continence pads could contact the service to be prioritised.
- It was confirmed that the NHS still had Covid-19 control guidance issued, which was why many services were not able to deliver group therapies. Despite this, CLCH were still doing one to one service and face to face for the vast majority of services.

In relation to the Brent Health Matters programme, the Committee queried how CLCH would measure the performance. Steve Vo advised the Committee that there were a number of key measures, and was happy to bring back what those were to the Committee. He advised that the work was front and centre in terms of strategic direction, and there were several more clinical measures he could bring back to the Committee. In relation to BHM's overall aim to reduce health inequalities in Brent, the Committee queried whether Covid-19 had set CLCH back in attaining that goal. Janet Lewis (Director of Operations, CLCH) advised that the team had been affected by Covid-19 in the same way as others. They had benefited from the learning of Covid-19 as they had been very much involved in the vaccination programme, and through that work, liaison with the Brent population had enabled a large amount of learning about what the individual health requirements of different client groups were. CLCH had now fully recruited to that team, which would be a full team the following month.

The Committee asked if the public understood the transformation journey that CLCH and the CCG were trying to take forward. Janet Lewis (Director of Operations, CLCH) felt that they had more to do on engagement. The Integrated Care Partnership (ICP) were working with BHM and the clinical forums they had established as well as through GP forums to engage fully. New forums were not being set up, instead existing forums were being put to use. As a group, it was felt the ICP needed to look at the existing engagement forums and ask what they did well and what they could be better at. Brent Youth Parliament asked how engagement would focus on the final recommendation of the GP Access Task Group – to have more young people involved in patient participation groups. The ICP were working with the Brent Children's

Trust (BCT) in relation to how, as partners, they could work together to encourage each other to get the voice of young people heard.

In relation to referrals for housebound patients and whether there was a backlog, the Committee were advised that CLCH had not seen a decrease in referrals for District Nursing or Rapid Response services and those core services were maintained throughout the pandemic. There was no cause for concern that patients were not being referred appropriately by primary care. Continuing to discuss primary care referrals, the Committee highlighted a common complaint councillors received about receiving no feedback or updates in relation to a patient's referral and where they stood along the pathway. The Committee were advised that for clinic based services, CLCH could do better communications and were currently trying to contact all patients on waiting lists. CLCH recognised the anxiety a patient might feel if they were unsure where their referral had ended up. Janet Lewis highlighted that the waiting lists were longer than CLCH would want, and CLCH were working with all services to contact people to find out their current needs and whether their situation had changed. The focus would then be on seeing patients as quickly as possible. The reality for some patients would be that their needs were clinically low priority, so it could be some time before they received an appointment. In the meantime, patients would be contacted and supported as best as possible.

Continuing to discuss waiting lists, the Committee queried what work streams currently existed to focus on reducing waiting lists in a tangible, evidenced based way. Steve Vo assured the Committee that his team worked closely with the team at CLCH, with monthly meetings looking at Key Performance Indicators in relation to waiting lists.

The Chair thanked those present for their contributions and brought the discussion to an end. The Committee RESOLVED:

To recommend the following key areas for improvement:

i) For CLCH, alongside the ICP, to review the community engagement plan for the transformation programmes in order to ensure patients and the public understand and support them, and have a clear understanding of how the changes would address local priorities and achieve better health outcomes for patients.
ii) For CLCH, alongside the ICP, to review the communication strategy for patients requiring an appointment with a long wait, ensuring that patients' care is reviewed and discussed with them on a regular basis.
iii) For CLCH, alongside the ICP, to review the communication mechanisms in place between different NHS organisations and services across Brent when making patient referrals, in order to avoid fragmentation of care.

An information request had also been made during the course of the discussion, recorded as follows:

i) For the Community and Wellbeing Scrutiny Committee to receive further information on how Brent Health Matters monitors and evaluates outcome for patients.

8. **Community Engagement for Homeless Families Service**

Councillor Southwood (Lead Member for Housing and Welfare Reform) introduced the report, which highlighted how the homelessness team wanted to develop services tailored around individuals, using a philosophy that no two homeless families were the same. The focus was on prevention, as it was believed that services that stopped someone becoming homeless in

the first place were infinitely more valuable. The report included key statistics for the service and detailed how the service reached out so that people knew what they offered. Councillor Southwood highlighted the importance of gathering data on what people thought about the service and how it could adapt on an ongoing basis to respond to feedback. The Council were eager to be involved in the Customer Service Pilot, which would allow video link up in the Civic Centre.

The Chair thanked Councillor Southwood for her introduction and invited comments and questions from those present, with the following issues raised:

The Committee queried what targeted approaches were in place to tackle different demographic challenges when it came to homelessness, to reassure residents it was not a 'one size fits all' approach. Councillor Southwood advised that one of the most important ways the service could outreach was through voluntary and community organisations. She was aware some communities and individuals were hesitant to contact the Council as they believed the Council would not help them in good faith. People were reluctant to speak with the Home Office due to the perceived hostile environment for people with pending immigration status. Going out to the community groups those people were a part of in order to reach out was an important way to raise awareness of services. Laurence Coaker (Head of Housing Need, Brent Council) added that the Council took a proactive approach. There was a team set up to review applications made during Covid-19 lockdowns for the support grants available for people in financial difficulty, and make contact where it was felt those people might be threatened with homelessness, instead of waiting for them to reach a crisis point. Home visits were not currently taking place but this was being looked at for the Council's housing subsidiary Company, i4B, contacting tenants in arrears at risk of losing their home.

Another way of reaching out was through the homelessness forum which met bi-monthly, where all the voluntary and community groups represented at that forum were informed of the service and upcoming projects. The forum included larger organisation such as Crisis, as well as organisations with specialist skills such as those working with migrants at risk of homelessness or women fleeing domestic abuse. Through those regular meetings the Council ensured organisations were clear exactly what the homelessness service was and what they needed to do to help the people they worked with get services as quickly as possible. The Council also worked with people on an individual basis via email and telephone when they were identified as at risk. For example, those who had made applications for universal credit were offered the resident support fund.

The Chair invited Brent Youth Parliament to contribute to the discussion. Representatives of Brent Youth Parliament highlighted that the report and statistics relating to youth homelessness for ages 18-25 lacked data. They highlighted the grey area for that age group which was technically adulthood but still very young, and wanted to know where the community outreach for those age groups was happening, including how homelessness in those age groups could be reduced. In addition, the Brent Youth Parliament's 'Make your Mark' ballot results showed that the biggest concern amongst young people was homelessness and opportunities. They also asked what Brent Youth Parliament could do to promote different services and youth engagement in those services. Councillor Southwood highlighted that young people were experiencing multiple challenges including difficulty with affording their own homes, economic recovery from Covid-19, less secure jobs and starts to their careers, and less financial security. This was where links with Brent Starts were really important, so that when young people known to the Council were struggling the Council could work closely with employment and skills colleagues to see what could be offered. Supported Housing Schemes targeted this cohort of younger people to support their independent living. There were other targeted services for younger people, such as wraparound services, including mental health services, to sustain tenancies for young people who may not have

previously experienced debt, controlling finances and paying bills. Awareness of services was raised through local radio stations in Harlesden.

In relation to the 3.9 of the report which detailed the free tenancy sustainment solicitor, the Committee queried how someone could access that service. Laurence Coaker advised that the tenant could self-refer to that service, or the Council could refer them on their behalf if they had knowledge of the issues being experienced.

There were approximately 250 people in emergency (i.e. nightly paid) accommodation. How long they stayed depended on their individual circumstances, but the most entrenched larger families, or families needing specially adapted accommodation, might have been in nightly paid accommodation for over 12 months. All emergency accommodation was self-contained.

The Committee asked how the Council dealt with the issue of people being made intentionally homeless, or where a family refused a suitable offer and therefore the Council ended their duty. This was where the Council had accepted the main homelessness duty and made an offer of accommodation to end the duty, but the family refused the offer and therefore ended their duty. The Council worked hard to ensure that did not happen, as the family were then still homeless but their duty had ended under Housing law. The Council made it clear what the law stated, and encouraged people to accept the offer. It was highlighted that this was an offer of accommodation judged suitable, not necessarily the ideal offer. Families were advised that they would have a statutory review of their accommodation to check it was still suitable, and that a family had the option for an independent County Court Appeal if they felt it unsuitable.

The Committee queried how the homelessness service used Brent's key strategies, such as the poverty commission and Black Community Action Plan, in its learning and moving forward. One of the big focuses in the poverty commission had been overcrowding in homes, and Laurence Coaker reiterated that if a property was not suitable then that person was considered homeless, and a place that was overcrowded was not considered suitable. This was being addressed through the maximisation of stock to move people into larger properties. In relation to the Council's strategy on the Black Community Action Plan, Councillor McLennan (Deputy Leader) advised that the Youth Advisory Group had 50 young people advising on priorities and objectives who were a very useful source of how homelessness had impacted them. One of their main priorities going forward over the action plan was housing and homelessness. She also highlighted the customer service promise, advising the Committee that customer services had now took on some housing queries so that staff were aware at the point of source where a caller could be sent on to. The Civic Centre had also became a Hub so that the most complex cases could be seen straight away. Councillor Southwood added that the more the homelessness service knew about the experiences of different groups within the community, the better it could tailor services.

The Committee asked how people with complex needs living in unsuitable accommodation were catered for within the structure. For example, a person living with mental health issues. Phil Porter (Strategic Director Community Wellbeing, Brent Council) advised that a project on mental health and homelessness had been running for 5 months in the Housing Department working closely with Asher Place and Crisis. This was an outcome based review methodology based on the experience of homeless people with mental health issues. The project was due to report at the end of March 2022, and the Committee could be informed on the outcomes.

In relation to the Private Rented Sector, the Committee queried what incentives the Council could provide to landlords to continue to house tenants rather than evict, including non-financial incentives such as ratings and accreditation schemes. Hakeem Osinaike (Operational Director Housing, Brent Council) highlighted that Brent had a very vibrant landlord forum, and the private housing service worked closely with landlords to understand the issues they had and how the Council could intervene with support, advice, training and

financial support. For example, the Council could pay for adaptations to properties for disabled residents. Brent utilised all options available to support a household to continue where they were. Housing officers had complete flexibility to tailor what that took, such as if a garden was not maintained properly, buying the tenant a lawnmower. In addition, the Council kept a list of what they considered 'accredited' good landlords in the private sector.

The Chair thanked housing colleagues for their responses, and drew the item to a close. He invited members of the Committee to make recommendations, with the following RESOLVED:

To recommend the following key areas for improvement:

i) For the Council to consider expanding the Housing Needs Service mental health, homelessness and housing project to other vulnerabilities such as old age, physical or learning disability, or those at risk of extra-familial harm.

An information request had also been made during the course of the discussion, recorded as follows:

i) To receive a breakdown of the number of people in temporary accommodation as a proportion of the population, including comparative data with other London boroughs.

9. **Any Other Urgent Business**

The Chair announced that Brian Grady, Operational Director Safeguarding Performance and Strategy, would be leaving the Council and offered thanks to Brian for all his work with the Committee.

The Chair also announced that Jackie Barry-Purssell (Senior Policy and Scrutiny Officer, Brent Council) was leaving the Council, and thanked her for the support she had given since she started in Brent.

The meeting closed at 8:12pm
COUNCILLOR KETAN SHETH, Chair

Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2022
	Report from NW London Integrated Care System

End of Life Care

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Andrew Pike ICS Communications Programmes Lead, NWL CCG and NWL ICS a.pike@nhs.net

1. Purpose of the Report

1.1 The report provides the Community and Wellbeing Scrutiny Committee with an outline of the community based specialist palliative care improvement programme.

2. Recommendations

2.1 The Committee are asked to note the content of the report.

3. Detail

3.1 Detail outlined in the main body of the report below.

North West London Integrated Care System
Working together for better health and care

Community-based specialist palliative care improvement programme

Brent Council Community and Wellbeing Scrutiny Committee 5 July 2022

www.nwlondonics.nhs.uk/get-involved/cspc

Contents

1 Introduction

Working together with residents, the London Borough of Brent and other councils across North West London (NW London) it is going to be critical to ensure we best meet the needs of those who require community-based specialist palliative care.

The North West London Integrated Care System (NW London ICS) is acutely aware that the ambiguity on the Pembridge Palliative Care Centre inpatient unit is problematic and we need to ensure we reach a clear and sustainable future for services in Brent and NW London, whilst developing a new model of care that delivers a safe and clinically high standard service that meets the needs of patients and at the same time and addresses inequalities across NW London.

We are undertaking a NW London exercise so we can learn good practice across our eight boroughs and meet the ICS objectives around equality of access, experience and outcomes, however within that the specific concerns and needs in each borough are important.

This paper describes the overall NW London approach but seeks to draw out for Brent specifically

- Outputs of local engagement sessions - see page 25.
- Data relevant specifically to Brent and your services/residents – see page 20.
  Details on the area we know to be of most ongoing concern – and our efforts to address this – see page 16.
- See page 10 for information on the suspension of Pembridge services and work to address the workforce challenge.

We will continue to engage with Brent residents, stakeholders and teams to ensure the outputs of this review work for Brent, and will deliver improvements in the experience of your residents, their family and carers.

We welcome the chance for a discussion today on the balancing of these issues. When we come to mutual decisions we need to know they are backed up by robust engagement and that we have worked through the pros and cons transparently.

Key points for Brent and NW London

- The NW London ICS wants to work with patients, carer and families and other stakeholders to understand how we can improve the experience for all adults who use community specialist palliative care services in North West London.
- A North West London wide steering group has been established that consists of NHS providers, hospices, local authority and resident representatives. Our Issues Paper sets out the key reasons why we are looking at community-based specialist palliative care and helps us have a conversation on what future care could look like.
- An engagement period started on 18 November 2022 and was extended to mid-March due to Omicron – during the winter key partners were largely deployed to the immediate response and as such the pause in work was regrettable but unavoidable. Further engagement has/is occurring to ensure

that all boroughs have the opportunity to have discussions including the Brent, Harrow and Hillingdon event that took place on the 17 March 2022 and the Brent engagement event that took place on 15 June 2022.

- An interim engagement outcome report was published on Thursday 9 June 2022 which contained all the feedback given following discussions with local residents and those who have first-hand experience of palliative and end of life care received in NW London. We would like to thank all those who have taken part. The report will be revised as further feedback is received with a final report published at the end of July 2022.
- The outcome report was sent to stakeholders across NW London including council and NHS leadership, MPs and Healthwatch. We also used our established channels to communicate with other stakeholders and North West London residents. We also produced a short video to accompany the launch and a newsletter that has been distributed widely as well.
- All the public feedback received will be used by our model of care working group, which is responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.
- Membership of this group consists of local residents, clinicians and other palliative and end of life care stakeholders. The group will be asked to:
    - agree a common specification / common core offer for community-based specialist palliative care.
    - develop a new model of care to deliver the specification / common core offer.
    - map out how this can be implemented in each borough.
- The work will draw on the national service specification for adult palliative and end of life care, the previous NW London palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.
- The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.
- We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.
- Moving forward, our expectation is that there will be wide ranging resident and stakeholder involvement throughout this process. If significant service change is proposed, we would undertake a formal consultation.
- The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support

service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate.

- Along with a number of unsuccessful attempts to recruit consultants, we have sought to work across the system to 'network' consultants in hospitals and hospices to support reopening Pembridge beds, but have not been able to develop a clinically supported model to do that – this challenge is underpinned by a national workforce shortage.
- In April 2020, the inpatient beds at Pembridge were temporarily re-designated for the for rehabilitation of Covid positive patients. We were able to staff the service – which was not consultant led- because we had national guidance to pause many other services. It is unlikely that Pembridge will be required to fulfil this function again due to the knock on impact on those other services.
- We do recognise that local residents are disappointed with the need to suspend this inpatient service and confirm that a decision on the future of the unit will only take place following the completion of the community-based specialist palliative care review that the North West London Integrated Care System is leading and is currently underway.
- We confirm that qualitative factors such as local accessibility and stakeholder views will be an important consideration alongside quantitative factors such as capacity and referrals when making any decisions regarding future provision of community-based specialist palliative care service in NW London including the future of the Pembridge in-patient beds.

We share with Brent Council and residents a focus on palliative care because of the importance of getting care and service provision right

> ""We have seen what a difference specialist palliative care services can make to a patient and their families and carers as they come to the end of their life but unfortunately we have seen what can happen if the care and support is not there and the damaging legacy for those left behind. That is why it's important that we work together to develop services that are clinically to a high standard but also meet what patients and family's need."
>
> **Dr Lyndsey Williams,**
> **NW London GP Clinical Lead for End of Life and Care Homes**

It is widely recognised that when caring for someone in the last year of their life, we have only one chance to get it right.

Anyone at the end of their life should be able to live and be cared for where they want to be and be with the people they want to be with. They (and their family, loved ones and carers) deserve the best quality care and support, regardless of their circumstances. We live in a rapidly ageing society, where people are living longer but are more likely to live with multiple complex long term conditions. As a result, the need for high-quality palliative and end-of-life care is expected to increase dramatically by 2040.

> "We need to remember how scattered families can be and how people in theory would often like to think of dying at home, and so would their families. But the reality and the lack of properly seamless care means that it becomes an impossibility or can lead to a very, very negative death. The repercussions upon individuals of experiencing negative death of somebody they care about go on to have psychological and other repercussions throughout their lives."
>
> **Quote from member of the public attending the engagement event on 13 December 2021**

Too many people experience poor care as they approach the end of their life, with many people spending their last months and weeks in hospital, often dying there, which may not be what they want. Not only can this be distressing for the patient and their loved ones, but it also adds more pressure on acute hospitals.

Palliative and end-of-life care is a national priority, as well as a priority for health and social care partners across North West London. In North West London we have some excellent palliative and end-of-life care services for adults (aged 18 and over), provided by very committed partner organisations, but we know that we need to improve the care we provide in hospitals, community settings (such as hospices and day centres), primary-care settings and patients' own homes. We want to make sure all patients have equal access to accessible, consistent, high-quality care across all palliative and end-of-life care services.

More also needs to be done to make sure the care provided by different organisations is more joined up. This includes looking at the IT challenge of not all services having appropriate access to clinical information held electronically by partner providers for patients under their care; and making sure all patients have a personalised care plan that has been agreed with them, and that the plan is available to the different care sectors supporting them and their family.

2 Our focus on community-based specialist palliative care

We are focused on community based specialist care for adults at this stage because of the fragility of those services.

In North West London we have eight community-based specialist palliative care providers providing services. These include seven hospices with inpatient units, as well as separate community specialist palliative care nursing services.

The providers deliver a wide range of services (including inpatient and community-based specialist palliative care nursing, day hospices and outpatient services) as well as some additional specialist services (including lymphedema, well-being services and complementary therapies).

Three providers – Central London Community Healthcare NHS Trust, London North West University Healthcare NHS Trust and Central and North West London NHS Foundation Trust – receive all their funding from the NHS. The other five providers are charitable hospices and receive their funding from a combination of NHS and charitable income.

- Royal Trinity Hospice is based in South London. It provides services to parts of Hammersmith & Fulham, Westminster and Kensington & Chelsea.
- St John's Hospice is based in Westminster. It provides services to Brent,
- Hammersmith & Fulham, Westminster and Kensington & Chelsea. It is located in St John's Wood on the St John and St Elizabeth's Hospital site.
- Marie Curie Hospice is based in Hampstead and provides services to Brent.
- Marie Curie's London Nursing Service provides end-of-life rapid response and nursing services to Ealing and Hounslow.
- St Luke's Hospice is based in Harrow. It provides inpatient and other hospice services to Harrow and Brent, with their community specialist palliative care nursing team only providing cover to North Brent.
- Harlington Hospice is based in Hillingdon. It also provides the Michael Sobell hospice inpatient unit which is located at the Mount Vernon Hospital in Hillingdon. Both services serve Hillingdon.
- Meadow House Hospice is based at Ealing Hospital, and is run by London North West University Hospital Trust. It provides services to Ealing and Hounslow.
- Pembridge Palliative Care Service is in North Kensington. It provides services to Hammersmith & Fulham, Westminster, Brent (South) and Kensington & Chelsea (please note, the inpatient bed part of this service is currently suspended).
- Harrow Community Specialist Palliative Care Team is also provided by Central London Community Healthcare NHS Trust, and provides services in Harrow only.
- The Hillingdon Community Palliative Care Team and Your Life Line Service are provided by Central and North West London NHS Foundation Trust. These services are provided in Hillingdon.

The NHS and its partners are committed to making improvements in community-based specialist palliative care for adults within this review process, but will continue

to seek to improve other areas of palliative and end-of-life care where possible in parallel.

Beyond this review there are opportunities for improvement across the wider palliative care landscape

We also want to raise awareness of the importance of palliative and end-of-life care in general, and discuss what we want to see in the future from high-quality, safe, community-based specialist palliative care for adults, which also delivers an excellent patient experience. We want to:

- Make sure everyone receives the care they need, when they need it, regardless personal characteristics such as their gender, ethnicity, social standing or where they live (this is known as equity of access), and improve the quality of care our residents and their families and carers receive.
- Improve the experience for our patients, and their families and carers, by developing services that reflect what is important to them at the end of their lives, from diagnosis through to death.

We are not reviewing children's and young people's palliative and end-of-life care services, community nursing which provides generalist palliative and end-of-life care services, or acute hospital services which provide specialist palliative care services.

However, we will be working hard to make sure that our work links closely and joins up with hospital specialist palliative care and all other generalist palliative and end-of-life care services in North West London. We will also work with a number of NW London ICS's other service-improvement initiatives that are already looking to reduce differences in and improve the quality of non-specialist (generalist) palliative and end-of-life care services. This includes the NW London Community Nursing Review and NW London Enhanced Health in Care Homes programme.

Difference between generalist and specialist

Palliative and end-of-life care can be generalist or specialist. By community-based specialist palliative care services, we mean care and support services that are not provided in an acute hospital, GP surgery or by district nurses or community matrons. Instead, they are provided in a patient's own home, a care home, a hospice, a community hospital or health centre by specially trained multi-disciplinary teams.

Specialist palliative care professionals, such as palliative care doctors, nurse specialists, therapists and psychologists, are experts in providing palliative and end-of-life care and have specific training and experience. They usually become involved in a patient's care to help manage more complex care problems that go beyond the expertise and knowledge of a patient's generalist and usual care team (for example, their GP and district nurses). They work closely with the patient's GP and district nurse to offer advice on controlling pain and managing symptoms, provide emotional and practical support for patients, their loved ones and carers in preparing for the end of their life and, after the patient dies, offer bereavement support to their loved ones.

Generalist palliative and end-of-life care is provided on a day-to-day basis by many health and social care professionals such as GPs, district nurses, social

workers and care home staff. A patient's family and carers can also provide generalist palliative and end-of-life care in the patient's home.

We are starting by ensuring a shared view of the different issues that we are trying to solve

There are eight broad reasons why we need to improve the way we deliver our community-based specialist services to ensure everyone receives the same level of high-quality care, regardless of their circumstances.

1. To build on the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, and the further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.
2. To bring services in line with national policy such as the national Six Ambitions for Palliative and End of Life Care and the NHS triple aim of improving access, quality and sustainability, and to make sure providers our aligned to the National institute of Care and Excellence (NICE) guidelines for palliative and end-of-life care services.
3. To meet patients' changing needs arising from changes in the population. By 2040, the number of deaths within England and Wales is expected to rise by 130,000 each year. More than half of the additional deaths will be people aged 85 or older, so there will be an increased need for palliative and end-of-life care services.
4. To reduce health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.
5. To make sure that everyone receives the same level of care, regardless of where they live. At the moment there are differences in the quality and level of community-based specialist care that patients, families and carers across North West London receive. This means that depending on where a patient life, they and their family and carers may not get the support they need, and may not be able to have their wishes supported at the end of their life. We want to do all we can to make sure this is not the case.
6. To make it easier for people to access services, particularly across our more diverse communities. Some of our services are not joined up and do not work well together, and we need to change this.
7. To cope with the increasing financial challenge, the NHS is facing and the effect this has on community-based specialist palliative care.
8. To reduce the difficulty, we are having finding, recruiting and keeping suitably qualified staff, and the knock-on effect this has on our ability to provide services.

3 Pembridge Palliative Care Service

Whilst the eight issues above are relevant to all boroughs, in Brent there is particular interest in the future of Pembridge Palliative Care Service provided by CLCH

When Pembridge inpatient unit was suspended in 2019 we committed to completion of the review prior to any decisions were made on the future of this unit. It is regrettable that the period of time where we have focused on Covid response and recovery has impacted on the timeline for completing this work. Whilst acknowledging the local frustrations on the lack of clarity for the future, we remain committed to do this review properly so there is a clear process and transparency on next steps.

Pembridge Palliative Care services during Covid pandemic waves one and two

As part of a system response to support Covid-19 patients the Pembridge inpatient beds were designated to support the rehabilitation and care of Covid positive patients.

- During the first wave the inpatient unit was opened on 20 April 2020 and closed again on 30 July 2020.
- During the second wave the inpatient unit was opened on 16 November 2020 and closed on 26 March 2021.

Other service elements of the Pembridge Palliative Care Services were operating as follows:

- The community specialist palliative care team continued to offer a 7 day a week service running 8.30am to 5pm Monday to Friday, 9am to 5pm Saturday, Sunday and Bank holidays. The community team were prioritising patients with uncontrolled complex symptoms that have not responded to previous treatments, and actively dying patients with no previous plan of care in place.
- 24/7 advice line including specialist palliative care consultant support.
- Day hospice and patient attendances to the hospice were suspended. Patients known to the service were receiving telephone advice and support from the clinical team.
- The social work and bereavement team suspended visiting and outpatient sessions, but continued to operate, receiving new referrals and providing telephone advice and support.
- The Pembridge teams moved to video conferencing services where possible to further support patient care.

Pembridge Palliative Care service now

The Pembridge Palliative Care Services inpatient unit remains suspended, but the following other services elements continue to be provided:

- Community specialist palliative care nursing team, seven days a week visiting service 8.30am - 5pm Monday to Friday, 9-5 weekends (Saturday and Sunday) and Bank Holidays.
- 24/7 advice line including palliative care consultant support.

- Rehabilitation team support -visiting and virtual from Occupational Therapist (OT), Physiotherapist (PT) and Rehabilitation Assistant five days a week (Monday – Friday).
- Social work and bereavement support, five days' week (Monday –Friday);
- Day Hospice Services Monday – Friday during Covid as many of these services as possible were offered virtually.

NW London ICS End of Life programme team monitors the number of patients who would have been eligible for inpatient care at Pembridge and instead are supported in a different unit. During 21/22 (extrapolated from nine month's data) this was 25 patients. Largely, these patients receive care at St John's Hospice which is part of the St John and St Elizabeth's Hospital and located in St Johns Wood, with a much smaller number at Royal Trinity Hospice. Further work needs to be undertaken to understand if the service closure has resulted in a fall in the number of patients accessing inpatient beds, as well as the impact of Covid-19 across all hospices as a whole.

Over the recent Covid outbreaks our NW London hospices and other community specialist palliative care services have shown considerable flexibility and joint working to provide system support, such as flexing criteria to support discharges. We have consistently had spare bed capacity in NW London hospices (with the exception of a short period during the recent Omicron variant where staff sickness impacted across health and social care services).

In July 2021 prior to relaunching this North West London wide review of community – based specialist palliative care, a number of palliative medicine consultant vacancies arose across three of our palliative care providers, including Pembridge Palliative Care Service, St John's Hospice and Imperial College Healthcare NHS Trust (ICHT). We undertook project work with these providers to review the service requirements for their consultants and how these might be met through new models of consultant service delivery for specialist palliative medicine within community, hospice and hospital domains to ensure a more resilient and sustainable workforce collaboratively. As part of this work we looked to identify if there was, two years on any other potential solutions to the Pembridge consultant workforce challenge to support safe running of the inpatient unit.

Through this work we engaged with a number of NHS Trusts and hospices, both inside and outside of North West London on their consultant models. We learnt that flexibility, rotation between care domains, career progression, being part of clinical network and organizational culture are all important in attracting and retaining consultants. It was also noted that across London and nationally there are palliative care consultant workforce vacancies and shortages, with many organisation struggling to fill and retain these posts.

Despite substantial input from all partners on this work, at that time we could not identify any collaborative solutions that did not destabilise one service to stabilise another. The outcome was that each organisations proceeds to recruit independently to the posts, as the solution would need more dynamic transformation work to address the palliative care workforce challenge, which is not just synonymous to these three organisations. This issue would therefore best be addressed within the North West London wide Community-based specialist palliative care review programme and development of a new model of care, including palliative care workforce.

We reiterate that no decision has been taken on the long-term role of Pembridge and as part of this review the important function that is inpatient palliative care will be addressed. We also recognise the impact this has on individuals and families of those who need to use alternative services elsewhere.

4 Building on feedback previous done

We must build on feedback previously given – valuing people's time and views, by showing progress where ever possible

When we talked to people about community-based specialist palliative care services previously, we heard what a crucial role the services play. The feedback confirmed that people really value their local specialist services and people with experience of these services are very positive about the care they have received.

We have also heard that services need to be made available to more people 24 hours a day, particularly that out-of-hours services (those provided between 5pm and 9am) need improving to make them more inclusive and adaptable, and to offer more choice and be more co-ordinated. People told us it is important to improve access to these services so more people receive care and are supported to die in their preferred setting, whether this is at home, in a hospice or in hospital. It is also important that people don't have to travel too far to access service.

> Mum wanted to die at home and was told that there were drugs that would be needed and they'd arrange for these to be prescribed. I then got a call from the palliative care team the next day to tell me they'd sent the prescription to mums nominated chemist. When I got there, I was told one item wasn't in stock and they'd order it. When I got outside I realised it was the pain relief which is what I needed the most and I had to run around trying to get it."
>
> **Example from a bereaved resident on the challenges of integrated care**

The feedback showed that people have different views on how we should make these improvements. We want to build on the feedback and what we have learnt from it. We also want to fully understand the role culture and religion can play in influencing the way people relate to their health, the support they want to receive and the way they experience loss and grief. We will then use this insight to develop services that can take this into account.

5 Next steps

We cannot resolve the current situation and issues unless we work in partnership with residents and other stakeholders –we welcome Brent support to do this

We want to work with local residents, clinicians and partners from volunteer, community and faith organisations to jointly identify and decide what high-quality community-based specialist palliative care looks like. We will then develop a new model of care for our community-based specialist palliative care prvoision that broadly defines the way that services are delivered, in a way that can be maintained, is culturally sensitive and better meets our diverse population's needs. The new model of care must be affordable and financially sustainable in the short and long term and will be delivered across the whole of North West London to make sure that everyone receives the same consistent high standard of care.

This involves a respectful and responsive approach to the health beliefs and practices, and cultural and linguistic needs, of diverse population groups. However, it goes beyond just race or ethnicity and can also refer to characteristics that are protected by the Equality Act, such as a person's age, gender, sexual orientation, disability and religion, and also social exclusion and socio-economic deprivation (deprivation caused by factors such as being unemployed or on a low income, or living in a deprived area), education and geographical location. (For more information, visit www.equalityhumanrights.com/en/equality-act)

When we have completed our research and received everyone's feedback, we will look to develop the model of care that will deliver the high-quality safe and fair care that people deserve. Our next step will be to look at what services are needed in the future to deliver this new high-quality model of care, that is not only affordable, but sustainable in in the long term, and to bring forward proposals that set this out.

So, for now, we are not looking at or discussing what current community-based specialist palliative care services look like or what their future should be, or how many beds we need in a community setting. That will come in due course when we have agreed what good-quality care looks like and the model of care we need to develop in order to provide it.

In summary, we are having a conversation about what we need to do to improve the quality of care our residents and their families and carers receive when they need community-based specialist palliative care.

From this starting position, we want to work with patients, clinicians and the wider community to develop and introduce a new model of care which is fairer, more joined up, high quality and can be maintained in the long term. It must also meet the clinical and individual needs of patients from diagnosis through to the end of their life, and reflect the choices that people want to make on the care they receive and where they receive it.

6 Insight report

We understand it is really frustrating for people to provide feedback, not see any action, and then be asked again for their views

We have received a tremendous amount of feedback which we are responding to and have taken to date. There are also some areas we are currently developing and implementing or propose to do in partnership, to address the issues raised to support improved care and support for patients, families and carers in the last phase of life. We also detail feedback received where we do not feel able to take action, with the reason for that given.

Our aim is to continue to work collaboratively with our public, patients, clinicians and other system partners to build on this work as it is a key part of the next phase of this programme when we look to explore the model of care and service design options to meet our NW London population's community-based specialist palliative care service's needs.

Feedback	Action taken
• Align GPs more closely with individual care homes and develop enhanced care service for care home residents. • This needs to include the development of personalised care plans to support their care needs and expressed wishes and involve relevant health professionals and the families and carers in these care planning conversations in as much as possible.	• As part of the PCN Direct Enhanced Service (DES) all care homes in NW London have a named GP and where possible are aligned to a single PCN. We are currently working on developing a NW London wide common core standard that will provide enhanced support to care homes and cover the provision of Multi-Disciplinary Team (MDT) working and personalised care and support planning. This includes advance care planning and use of Coordinate my Care/Urgent Care Plan.
• Increased access to end of life and anticipatory medication in the community. Community Pharmacists should be included in the engagement and review process to understand the issue of availability and timely access to end of life medication for patients, families / carers and clinicians in the community.	• Not all boroughs had the same level of in and out of hours' access to end of life care and anticipatory medication. The gap in West London, Central London and Hammersmith & Fulham boroughs was closed by commissioning an equivalent service meaning that during the pandemic all NW London residents have equal access to these medications 24 hours a day. The NW London Medicines Management Team have recently reviewed the service contracts and are putting plans in place to ensure ongoing 24-hour access to end of

	life and anticipatory medications in the community. • NW London has implemented the Pan-London Symptom Control Medicines Authorisation and Administration (MAAR) Chart, developed by the End of Life Care Clinical Network . This MAAR chart supports safe administration of complex injectable regimens.
Feedback	**Action being take**
• Include clinicians in public engagement meetings and patients in programme working groups for the purpose of transparency and trust.	• During the previous review of palliative care that took place in Brent, Hammersmith & Fulham, Kensington & Chelsea's and Westminster in 2020, we had a clinical reference group who worked on development of the new model of care and options. We did not have any public and patient representation on this group. For this programme we have developed a model of care working group that will have public, clinical and operational lead representatives.
• Access to 24/7 end of life care advice and support for patients, families, carers and clinicians, which includes a single point of access and co-ordination service. This is of particular importance during the out of hours period between 5pm and 8am when the patient may be experiencing a lot of pain and the family and carer may not be able to contact the usual care team or know which services to contact for support.	• All of the hospices that provide services in NW London now provide 24/7 nurse led advice lines that have 24/7 palliative care consultant support. • A further gap was identified for the Harrow Community Specialist Palliative Care team who did not have seven day working and visiting available. We have secured funding to support the development of this service and work is underway to mobilise this as soon as possible.
Feedback	**Action we propose to take**
• Having hospice inpatient services locally is very important, particularly for residents where the spouse, carer and family of the patient requiring hospice inpatient care is elderly or has family and work commitments and are negatively impacted by increased travelling time. Consideration should be given to re-opening the Pembridge inpatient service as part of the service review.	• This programme will be reviewing the role specialist palliative care inpatient beds play in community-based specialist palliative care provision so that we understand the level of need and capacity required across NW London using data to support this work. Discussions about the level of need and sites will happen at a later stage in the review once the new model of care has been developed.
• Not enough support available or consistent offer of bereavement	• Bereavement care and support really came to the fore as a gap

support (pre and post death) available to patients, families and carers. Could this reviewed as part of the latest programme of work to understand current provision and what more could be done to improve this offer.	nationally, regionally and locally during the Covid-pandemic. Through the community-based specialist palliative care review programme we will be scoping current provision and gaps for NW London which will then be considered as part of the new model of care development work.
Feedback	**Reason why we are not able to take action at this stage**
• We have heard from local residents and stakeholders that they would like the NHS to reopen the Pembridge Palliative Care Unit in-patient beds.	• The inpatient unit at Central London Community Healthcare NHS Trust's (CLCH) Pembridge Palliative Care Centre continues to remain suspended until further notice following its closure due to a lack of specialist palliative care consultant cover and being unable to recruit due to that national shortage of trained personnel. • It takes significant consultant resource to run and oversee an inpatient unit and based on current capacity CLCH would not be able to run this safely. All other services (24/7 advice line including palliative care consultant support, community specialist palliative care nursing service, rehabilitation team support service, social work and bereavement support service, and day hospice services at the Pembridge Palliative Care Centre are unaffected and continue to operate. • In April 2020, the inpatient beds at Pembridge were temporarily re-designated for the for rehabilitation of Covid positive patients. We were able to staff the service – which was not consultant led- because we had national guidance to pause many other services. It is unlikely that Pembridge will be required to fulfil this function again due to the knock on impact on those other services. • We do recognise that local residents are disappointed with the need to suspend this inpatient service and confirm that a decision on the future of the unit will only take place following the completion of the

	community-based specialist palliative care review that the North West London Integrated Care System is leading and is currently underway. • We confirm that qualitative factors such as local accessibility and stakeholder views will be an important consideration alongside quantitative factors such as capacity and referrals when making any decisions regarding future provision of community-based specialist palliative care service in NW London including the future of the Pembridge in-patient beds.

Moving forward, we will continue to update the Insight Report and the actions we have taken as a result. You can find the most up to date Insight Report here.

7 Overview of data for Brent for past 5 years (2017 – 2022)

From the outset it is important to articulate transparently that data availability and reliability are a challenge in terms of end of life data. The data we have used necessarily comes from multiple sources as we work towards a longer goal of having the data joined up in one place.

We are currently developing our future model of care, looking at current service activity data across all care domains, the data available on numbers of deaths and the workforce we currently have in our community specialist teams. We anticipate this will also involve review of demographic data available. In conjunction with a review of the literature around capacity and ultimately the agreed specification this work will allow us to articulate what our future capacity needs to be and see where our resource needs are greatest across NW London.

We will be fully transparent with this work and share our outputs and recommendations with borough partnerships to support decision making.

Mortality Data & Demographics

We have utilised the mortality data from 2021 to give an indication of where residents who have died by setting of care and the current demographic data that is also available around this.

Figure 1 shows a breakdown of all deaths in North West London by setting. Clearly the majority of people died at hospital, whilst a secondarily large number died at home.

Figure 1: Deaths in NW London

	Deaths					
Commissioner	Care Home	Home	Hospice	Hospital	Other	Total
Brent	209	622	117	1,141	66	**2,155**
Ealing	300	702	132	1,251	72	**2,457**
Hammersmith and Fulham	119	357	41	496	52	**1,065**
Harrow	197	569	89	921	40	**1,816**
Hillingdon	423	591	110	1,028	58	**2,210**
Hounslow	153	503	69	941	103	**1,769**
West London	107	398	44	606	55	**1,210**
Central London	94	217	64	426	101	**902**
NWL	**1,602**	**3,959**	**666**	**6,810**	**547**	**13,584**

Figure 2: Deaths in NW London, by age, gender and deprivation

	Brent	Central London	Ealing	Hammersmith and Fulham	Harrow	Hillingdon	Hounslow	West London	NWL
Age									
<65	**23.4%**	19.1%	**22.1%**	**24.5%**	15.9%	16.8%	**21.9%**	18.0%	**20.2%**
65-74	16.6%	16.7%	16.7%	**17.4%**	15.1%	**17.6%**	**19.2%**	16.2%	**17.0%**
75-84	25.5%	26.4%	**28.6%**	27.3%	**28.0%**	27.1%	27.1%	**30.4%**	**27.5%**
85+	34.6%	**37.8%**	32.6%	30.8%	**41.0%**	**38.5%**	31.8%	**35.4%**	**35.3%**
Gender									
Female	44.6%	**47.8%**	45.3%	46.7%	**49.9%**	**49.3%**	**47.3%**	44.9%	**46.9%**
Male	**55.4%**	52.2%	**54.7%**	**53.3%**	50.1%	50.7%	52.7%	**55.1%**	**53.1%**
Deprivation									
1	**8.6%**	**19.3%**	4.4%	**7.5%**	0.1%	0.1%	1.0%	**15.5%**	**5.6%**
2	**14.5%**	**13.4%**	**14.8%**	**13.3%**	2.0%	2.7%	10.2%	**21.4%**	**10.9%**
3	16.4%	**17.5%**	**19.6%**	**25.3%**	5.5%	**21.5%**	**18.9%**	13.5%	**17.2%**
4	**22.5%**	11.1%	13.7%	13.8%	6.6%	12.4%	**19.0%**	10.6%	**14.2%**
5	**15.9%**	11.1%	**14.9%**	13.5%	**15.6%**	9.2%	**19.9%**	7.7%	**13.9%**
6	13.5%	**14.6%**	**14.7%**	11.3%	**16.4%**	12.0%	**17.6%**	13.2%	**14.3%**
7	5.3%	9.6%	7.8%	7.8%	**19.6%**	**10.2%**	9.7%	**11.2%**	**10.0%**
8	2.2%	3.1%	3.6%	4.3%	**13.3%**	**10.2%**	3.2%	**6.4%**	**6.0%**
9	0.7%	0.2%	**6.4%**	3.2%	**10.2%**	**13.9%**	0.6%	0.6%	**5.3%**
10	0.2%	0.0%	0.0%	0.0%	**10.7%**	**7.7%**	0.0%	0.0%	**2.7%**

The deprivation score= 1 is most deprived and 10 least deprived

Figure 2 (above) shows deaths by borough and NW London average split by age, gender and deprivation. Where highlighted red this indicates that the proportion is above the NW London average. In Brent death rates amongst the most deprived residents are generally higher, and has a higher level of deaths amongst deprived residents compared to other boroughs in North West London. Interestingly Brent also has the highest rate of death amongst the under 65s and a higher proportion of deaths are men, compared to other North West London boroughs.

Figure 3 (next page, below) shows the top 20 countries of birth for those that died in Brent in 2021. This has limitations as there is significant ethnic diversity amongst those born in the UK, however, it does give a level of insight, for example a significant proportion of deaths were amongst the Indian community and also fairly high amongst the Irish and Jamaican community.

Figure 3: top 20 countries of birth

Community-based Specialist Palliative Care Services provided in Brent:

There are 4 providers of community-based palliative care services that care for Brent residents. Some patients may also attend Meadow House Hospice in Ealing but this is infrequently as data below shows.

These are specialist providers who for palliative and end of life care, particularly where expert input is required. Please note care in the community patient's receiving these services can also be supported by community nursing (for health needs) and social care (domiciliary care/re-ablement & rehab, housing etc.).

Provider	Location of provider site	Area covered
St. Luke's Hospice	St. Luke's Hospice in Harrow	All of Brent
St John's Hospice which is part of St. John's and St Elizabeth's hospitals	St. John's hospice in St John's Wood	All of Brent
Pembridge Palliative Care Services provided by Central London Community Healthcare NHS Trust (CLCH)	St Charles Hospital in North Kensington	South of Brent
Marie Curie London	Marie Curie Hampstead Hospice in Hampstead	All of Brent

London North West NHS Trust	Meadow House	Considered an out of borough hospice as services for Brent residents are not specifically commissioned from Meadow House Hospice

Trends (see figures 4-8), clearly 20/21 there was a rinse in patient use within hospices. This will be due to COVID for two reasons 1) increase in people dying 2) use of hospices as part of our regional bed capacity to support the Covid response. Another trend is that outpatient and day time service activity decreased or even dropped, this will be in line with guidance around infection prevention control measures at the time. **Please note the way the way the data has been captured is slightly different provider to provider so a direct comparison is not advised.**

Figure 4: St Luke's Hospice Activity data (based on number of patients accepted into the services)

	17/18	18/19	19/20	20/21	21/22
Inpatient	55	72	88	104	98
Outpatient	2	3	3	6	21
Day services	91	55	57	18	0
Hospice @ home	186	184	72	67	81
Brent Specialist Palliative Care team	523	434	455	461	584

Figure 5: St. John's Hospice Activity data (based on number of appointments, bed days and care episodes)

	17/18	18/19	19/20	20/21	21/22	22/23 (April / May)
Inpatient	154	275	403	619	439	30
Lymphodeoma	488	613	499	222	459	83
Day services	830	711	656	0	233	56
Hospice @ home	782	1292	2632.5	2427.5	2547.65	0

Figure 6: Marie Curie Hampstead hospice Activity

	18/19	19/20	20/21	21/22	22/23 (to date)
Inpatient	11	17	24	10	0
Outpatient (admissions)	12	9	4	3	0
Outpatient (Patients Seen)	22	19	22	13	4
Day services	2	2	0	0	0

Figure 7: Meadow house Activity data (based on number of patients accepted into service)

	17/18	18/19	19/20	20/21	21/22	22/23 (to date)
Inpatient	0	1	0	1	1	0
Community	2	4	1	0	2	0
Day services	0	0	0	0	0	
Lymphoedema	0	0	0	0	2	

Figure 8: Pembridge Palliative Care Services (provided by Central London Community Healthcare NHS Trust – CLCH) activity data. This is based on number of patient contacts – Source: CLCH Monthly activity data reports

Years	**18/9**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23 (Apr-May only)**
Inpatient (Bed days)	1118	496	N/A as IPU suspended	N/A as IPU suspended	N/A as IPU suspended	N/A as IPU suspended
Community SPC team (multidisciplinary)	5415	6866	7126	8041	7727	1346
Outpatient						
Day services	615	2691	2942	1751	887	89
Hospice @ home						
Bereavement service	954	1127	890	715	320	89

8 Engagement in Brent

We held two public involvement events with a Brent focus. The first was held on 17 March 2022 and included Brent and Hillingdon residents. The second event was held together with the Brent Integrated Care Partnership on the 15 March 2022. The presentations and recordings of both events can be found online at www.nwlondonics.nhs.uk/get-involved/cspc/how-get-involved.

Engagement with Brent residents will continue as we move forward and we would welcome Brent Council's support and suggestions as we move forward.

Public involvement event 17 March 2022 aimed at ethnic minorities Brent, Harrow & Hillingdon

The need for improved communication both between different parts of the health service and between the different service providers and patients/families/carers was consistently raised. As part of this, improved information sharing, particularly in relation to EOL plans (e.g. CMC) was highlighted on a number of occasions.

Challenges around language, faith and culture were raised in the discussion and highlighted by specific examples participants gave.

Dying at home vs hospital vs hospice

- Dying at home can cause logistical challenges for different faith groups, such as receiving death certification when a GP is not available. For example, a Muslim family, known to a participant had to travel to get a death certificate signed by the GP in a car park so as to bury their family member the next day.
- Therefore, seen as better/easier to die in a hospital environment for some faith groups as they (the hospitals) have the infrastructure and cultural competence to better serve their needs (although there are also issues where you may have multiple family members trying to visit the hospital to pay last respects).
- Many patients may say they wish to die at home but even with 3x nurse visits a day and night support it can be exhausting for the family member(s)/carer who get little sleep or rest. Also, at home it can be very difficult with, for example, pain relief when it's urgently needed out of hours (e.g. 2 am).
- We should note that home environments can differ massively across NW London – some people have small flats not large houses that are not suitable for home care and the hospice environment can be better.
- Caring for a patient at home can be very difficult – people can lack the proper support or facilities (e.g. appropriate bathroom/toilet) at home and struggle to accommodate family visitors.
- Hospices are not tailor made for large visiting groups and can lack the religious aspects certain communities require (e.g. an Imam or Priest who can counsel the patient in final hours and help people/families accept the death of a loved one).
- Carers/families looking after a patient at home can really struggle with a lack of support in out of hours' care.
- In terms of administering drugs at home, and no-one being there when the patient subsequently dies, an attendee pointed to the problem that the police can then end up getting involved.

- What happens to people in hospices that lack family/friends – who sits with them in their final hours and speaks to them / holds their hand?

Help, advice, guidance and information sharing

- The help and information from social workers needs to be improved – with factual advice on what peoples' rights are around death.
- Patients/carers/families need a very simple information sheet saying who to contact and how at different points (e.g. GP, DN service, hospice specialist palliative care service). Importantly, we need to recognise that patients are not just Mon-Fri 9-5. What about outside of that and at weekends and bank holidays?
- We need to improve the links and information sharing between GPs and hospitals.
- There is a lack of consistency in record keeping around preferences, treatment etc.
- The demarcation between health and social care is significant and is not properly understood in the community.
- The most important point is that, in the final hours of someone's life, agreement and coordination with the family is very important – when you are in the grieving process it can be easier if everyone does their job properly and well.
- All patients and families/carers need an up-to-date and fully completed care plan – that they have full access to – this can't be a static document, it has to change as the situation with patient changes.
- The care plan needs to be a living document that the care team, ambulance staff, DNs etc. should all be able to easily access.
- Will the patient and carer/family be able to access the new care planning tool and what is the process for input into it?
- The care plan should be partnership, not just a clinical process. It requires multiple levels of input – from community services, carers etc.
- The carer/friend/family member needs to feel more involved in the process – there needs to be better communication with them.
- There needs to be better post-death bereavement support for carer/family/friends.
- We need a clear final days/hours plan which lists the support available to patients/ carers/families and what they can/should expect (note the additional challenges where the patient has dementia).
- They need information/leaflets etc. – something which clearly breaks down what is available, including exactly what to do out of hours.
- We need to be aware that many patients/families/carers are not compute literature and that people need help with this (in terms of filling in an EOL plan/document but also using email and text).
- The link between the ambulance service and A&E (and other parts of those providing care services) and access to (and use of) existing Coordinate My Care Plan(s) need addressing – the info they need or request should be in these plans and it's shocking that the communications and information sharing are so bad.
- GPs need to have a role in coordinating completion of CMC or the new Urgent Care Plan, this can be complicated by patients rarely seeing the same GP and having chance to build a consistent relationship.
- It would help if families had a single point of contact for their relatives' care.

- System issues

We need a more person-centered approach.

- Hospice success is in consistency and 24-hour approach to patient care.
- We need better collaborative working, training and structures – consistency is paramount and means individual needs will be better understood.
- We need more specialist teams with specialist resources.
- Time is of the essence in terms of making system changes to improve the situation and current experiences.

Specific needs of different groups

- It's felt it's easier to deal with the more established faiths (suggestion that there are at least 15 different religious groupings across NW London).
- Younger members of faith groups can be less aware of the faith's requirements around death (e.g. next day cremation) – they need social care professionals to help them with this as well.
- There are questions over when palliative care begins when dealing with frailty in some patients.
- Some communities come from countries without palliative care so find the service a welcome and positive thing – they may not know it exists though and the communications issues are further complicated by language and needing someone or something to explain it to them so they can understand what is available and how to access it.
- Different groups can struggle to access palliative care services – it can be unclear if this is through the GP or social services and then where do different service providers fit within care services provided (e.g. district nurses).

Specific examples given by participants

- Participant experienced EOL care in last year. Their mother died at home (as she wished). The GP Service was good and correct equipment was delivered (e.g. hospital bed). However, it was extremely confusing who to phone/contact at different times, particularly out of hours. They knew the District Nurses would be attending the house but not always when. Following her mother dying and before a doctor had attended to certify, a team arrived (at 3am) to collect the equipment from the house. This was not due to an emergency but because it was a quiet time when they could get such equipment runs done. This displayed an awful lack of sensitivity.
- Participant currently cares for her father at home (where he wishes to stay as long as possible). He ended up being taken into hospital, where it took two days for them to contact her and enquire as to what medication he was on. She had to try and find out via GP and hospice advice line. Very distressing as she didn't know. He also wasn't eating at the hospital because his menu/diet was not appropriate. He didn't recognise what was served as food (and the hospital seemed unaware of its own specialist menu or why it existed, i.e. for patients like this). She ended up cooking three meals per day at home to then take into the hospital for him. She eventually forced his discharge to bring him back home so she could care for him better there. St Luke's provided very helpful information and a booklet (through Dementia Cares) helped her list out some key facts about her father's likes/dislikes/ daily schedule (e.g. what he will eat, when he wakes, when he goes to bed

etc.). Her biggest anxiety as a family carer is that they will be put her father into hospital again – she stated that she should see hospital as a safe place but it feels like the worst place possible – he'll go in and it will be like a black hole with her having no idea who will be caring for him and a complete information blackout. This places huge anxiety on carers and families.

- Participant lost their 97-year-old mother two years ago. She was originally admitted to hospital after a heart attack and had a pace maker fitted. Whilst at the hospital, the family received different information from different clinicians and eventually found out she was to be discharged home, even though she "couldn't lift a glass of water". The family were informed that carers would be put in place to assist. After equipment was delivered to the home, her mother suffered organ failure and was instead kept in hospital (although her desire was to die at home). The family asked about hospice care and was told this would be no different to that provided in the hospital. In General, family wishes were not respected. She was kept on a general ward though she was eventually moved to a separate room (after 2 days of family requests). Whilst in the separate room, there were not enough staff to clean her, so her daughter had to do this herself. The way she died and was treated still hurts terribly three years later.

Further issues raised

- One participant noted that the area (NW London) has a very limited number of hospice beds for the 500000+ people it covers.
- Pembridge Palliative Care Unit – a participant asked what the plans were for Pembridge. The review team said that no decisions had been made but that if it's closure were to be part of the review then it would go to full public consultation.

Brent palliative care and end of life webinar Wednesday 15 June 2022

We would like to say thank you to everyone who attended the event. Their thoughts and feedback will be used as evidence as we move forward to develop the future model of care.

Key points/questions raised

Whether palliative care services are free of cost at the point of delivery – they are.

Do Palliative care services take into account ethnic background and the needs of Brent's diverse communities – the current review work is actively seeking to understand where the gaps are in terms of cultural and faith needs from palliative care and ensure services are culturally aware, sensitive and diverse and that there are no barriers to accessing them.

Lack of hospice facilities in the south of Brent and the difficulties in travelling to hospices further away – these considerations are very much part of the current review and we would encourage people to come forward and tell us more about their experiences as we seek to develop solutions as close to homes as possible.

Lack of clear information on the options available to people and linked to this the lack of fluency in English amongst some communities – the voluntary sector, with its existing strong links into different communities, have an important role to play here. Also the district nursing service, for example, have access to interpreters and interpreting services. We need to ensure these services are being utilised effectively. Information needs to be better shared with the voluntary sector so they are equipped to inform people. NW London has a programme focused on improving working with the voluntary sector and Brent is also improving the links between its service providers and the voluntary sector / outreach workers.

Accommodation and family situation – many in Brent live in one bedroom homes with no family and It's unclear how these people are being addressed through the review. Whilst the review is considering how best to provide the services that people need, part of the challenge outlined is around how health and social care services work better together (e.g. through things like the Brent Health matters team) and another part (overcrowding and cramped accommodation) is a challenge beyond this reviews/the NHS's remit.

Draft resource pack on palliative care services – this needs further work and in particular needs more on what can be done before the end of life to access services and equipment. It's recognised as a good start but will need to be improved and kept up-to-date so it is accurate.

Communication between service providers and specialists was raised as an issue - particularly when the family/carer is dealing with a sudden downturn in the patients' health and feels stuck in between services and conflicting advice. This point has come up during other engagement events and the final resource pack should make clear at all times who the point of contact should be for the family/carer.
Rapid response and provision of mutual aid – the pandemic and responses to it showed that support can be provided quickly if we ignore silos and sidestep red tape to focus on outcomes. We need to take note of this within the review.

Pain relief at home – pain management and the in-home service is actively being looked at through the review and through additional work in Brent. Particularly issues around administering stronger forms of pain relief in the home.

9 Interim engagement outcome report

During the involvement period, we arranged a number of events and webinars, attended external meetings and arranged numerous one on one interviews with local residents and representatives of the voluntary, community and faith sectors. This engagement will continue throughout the length of the review.

The table below detail the engagement activity that has taken place or is planned.

Event	Boroughs	Date	Link to meeting/ outcome
Hounslow Integrated Care Patient & Public Engagement (ICPPE) Committee	Hounslow	07 December 2021	Find out more
Public involvement event	NW London wide	13 December 2021	Find out more
NW London Joint Health and Overview Scrutiny Committee	NW London wide	14 December 2021	Find out more
Older people's Engagement at the Pavilions Shopping Centre in Uxbridge	Hillingdon	28 January 2022	Find our more
BME Health Forum Director interview	Hammersmith & Fulham, Kensington & Chelsea and Westminster	08 February 2022	Find out more
SOBUS Community Lead interview	Hammersmith & Fulham	10 February 2022	Find our more
BME Stakeholder Event	Kensington & Chelsea	22 February 2022	Find our more

	and Westminster		
North Kensington Health Partners	Kensington & Chelsea	03 March 2022	Find out more
RBKC Adult Social Care and Health Select Committee	Royal Borough of Kensington and Chelsea	03 March 2022	Find out more
Trustee, Kosher Dementia UK	NW London wide	04 March 2022	Find out more
Public involvement event with a focus on ethnic minorities	Hounslow and Ealing	Thursday 10 March 2022	Find out more
Public involvement event with a focus on ethnic minorities	Westminster, Kensington & Chelsea, Hammersmith & Fulham	Tuesday 15 March 2022	Find out more
Hounslow and Ealing Integrated Care Partnership Engagement Event	Hounslow and Ealing	Thursday 17 March 2022	Find out more
Public involvement event with a focus on ethnic minorities	Brent, Harrow and Hillingdon	Thursday 17 March 2022	Find out more
Public involvement event feeding back what we have heard so far and actions we have taken as a result	NW London wide	Friday 18 March 2022	Find out more
Hammersmith and Fulham Integrated Care Partnership end of life meeting 08 March & 03 May 2022	Hammersmith & Fulham	08 March and 03 May 2022	Find out more

Hammersmith and Fulham Integrated Care Partnership Event	Hammersmith & Fulham	Wednesday 11 May 2022	**Find out more**
Harrow Palliative Care and End of Life Webinar	Harrow	Wednesday 11 May 2022	**Find out more**
Come and help us shape the end-of-life care in Brent	Brent	Wednesday 15 June 2022	**Find out more**

We have committed to transparent and meaningful engagement at every stage of the work

We also linked in with experts both locally and nationally in certain areas including learning disabilities and homelessness. Their advice led us to carry out two literature reviews which have been published and used as evidence in the review.

We received a large amount of feedback which we are responding to and some actions have already been addressed as a result. There are also areas we are currently developing and implementing, or propose to do so, in order to address the issues raised. Some local residents have been kind enough to share their stories so we could use them as case studies to illustrate the good experiences and the challenges that people face when using community-based specialist palliative care services, so that we can learn from their experiences.

In addition to these meetings, we developed a number of online surveys through which local residents and health and social care professionals could give their views. Open-ended questions were also included to give respondents the opportunity to express their opinions in their own words. We also received a number of written submissions which were responded to.

It is our expectation that engagement with local residents will continue as we move forward. All boroughs have had the opportunity to be involved in a webinar or complete a survey.

Further webinars are already planned or being planned for Kensington and Chelsea and Westminster. The output of the webinars will be used to support the final report and new model of care working group.

All the public feedback received will be used by our model of care working group, which will be responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.

Membership of this group will consist of local residents, clinicians and other palliative and end of life care stakeholders. The group will be asked to:

- agree a common specification / common core offer for community-based specialist palliative care
- develop a new model of care to deliver the specification / common core offer
- map out how this can be implemented in each borough.

The work will draw on the national service specification for adult palliative and end of life care, the previous NW London palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.

The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.

We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.

We understand and share local residents' feedback that having good community-based specialist palliative care services is really important. In some cases, the feedback that has been provided has led us to make changes to services where possible and have plans to do some more of this via this review programme. This is detailed in an insight report where we also detail areas where we are not able to make changes.

We would like to reiterate our commitment to work collaboratively with our public, patients, clinicians and other system partners as we move forward to develop the future model of community-based specialist palliative care for adults, which includes consideration of current services and where the locations we need our services in

1.1 Key findings from the feedback received

As laid out in the Issues Paper, there are eight broad reasons why we need to improve the way we deliver our community-based specialist services to make sure everyone receives the same level of high-quality care, regardless of their circumstances.

We have carried out an analysis of all the feedback received through the webinars, surveys, one to one conversations, meetings attended and literature reviews and grouped the feedback received against the eight broad reasons.

1. **To review the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, and the further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.**

In the previous review of community-based palliative care provision in in 2019 and 2020 we talked to people about community-based specialist palliative care services

and heard what a crucial role the services play. The feedback confirmed that people value their local specialist services and would like to receive them as close to home as possible, and people with experience of these services are very positive about the care they have received. Local residents and stakeholders said they would like the NHS to reopen the Pembridge Palliative Care Unit in-patient beds following their temporary closure in October 2018 due to a lack of specialist care consultant cover and being unable to recruit due to the national shortage of trained personnel (see Section 1.2 Insight report and actions taken for further details).

We also heard that services need to be made available to more people 24 hours a day, availability of care needs to be improved during the out-of-hours periods (between 5pm and 9am) particularly, services need to be more inclusive and adaptable, offer more choice and more be more joined up. People told us it is important to improve access to these services so more people receive care and are supported to die in their preferred setting, whether this is at home, in a hospice, or in hospital. It is also important that people don't have to travel too far to access services.

The feedback showed that people have different views on how we should make these improvements. We want to build on the feedback and what we have learnt from it.

See the Palliative care services Independent review - full report Review of provision in Kensington & Chelsea, Hammersmith & Fulham and Westminster.

See the Palliative Care Services Public Engagement Report July 2020 In the boroughs of Brent, Hammersmith & Fulham, Kensington & Chelsea and Westminster.

In January 2020, Hillingdon Commissioning Group (HCCG) performed a review of End of Life Services looking at the views of general practitioners (GPs) and the lesbian, gay, bisexual, and transgender community (LGBT).

See the Review carried out on End of Life Services in Hillingdon in January 2020.

2. **To bring services in line with national policy. Such as**
    a. **the national Six Ambitions for Palliative and End of Life Car**
    b. **the NHS triple aim of improving access, quality and sustainability**
    c. **Ensure providers follow the National institute of Care and Excellence (NICE) guidelines for palliative and end-of-life care services.**

- We will utilise the learning and gaps in improvements taken from the borough and ICS level self-assessments against the six national ambitions for palliative and end of life care.
- Future community-based specialist palliative care services will need to align with national standards and guidelines.
- This includes adhering to the national service specification for community-based specialist palliative care.

3. **To meet patients' changing needs arising from changes in the population.** ***By 2040, the number of deaths within England and Wales is expected to rise by 130,000 each year. More than half of the additional deaths will be people aged 85 or older, so there will be an increased need for palliative and end-of-life care services.***

- We will need to take into account aging population with likely increased demand on community-based specialist palliative care.
- The number of people living with dementia is increasing which brings increased complexity of care needs.
- The number of elderly people living on their own is increasing with no one to care for them. Often they can live away from their family leading to social isolation.
- This includes support for the family and carer supporting them.

4. **To reduce health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.**

- Review should look at ways of tackling the widening Health Inequalities for people who require palliative and end of life care and support service.
- Attention should be given to isolated people, those with family outside the country or in different regions, elderly couples that are physically or mentally unable to care for each other, the large number of disabled people that require specialist care and those who experience homelessness.

5. **To make sure that everyone receives the same level of care, regardless of where they live. At the moment there are differences in the quality and level of community-based specialist care services that patients, families and carers across North West London receive. This means that depending on where a patient lives, they and their family and carers may always be able to get the support they need, and may not be able to have their wishes supported at the end of their life. We want to do all we can to make sure this is not the case.**

- Implement a 24/7 telemedicine co-ordination, advice and support service for care home staff to better support their residents at end of life.
- To improve co-ordination and navigation of care and support available, implement a single point of access (preferably a single telephone line) for patients, family, carers and clinicians to contact to obtain information about what palliative and end of life care services are available, how to access them, support with getting medication and equipment etc.
- To build flexibility into the service model that supports a person and their family to change their mind about place of care and place of death even if it is at the last minute. This could be where a person has always said they wanted to die at home but change their mind as they and the family are scared or believe it is too hard on the family who initially thought they could cope. Instead they want to go to a hospice or a hospital.
- Align GPs more closely with individual care homes and develop enhanced care services.
- Pembridge in-patient service should be reopened.
- A review of the number of hospice inpatient beds should take place.

- The number of and quality of care plans need to be improved. Patients and families need to be given access. More needs to be done to ensure health professional access the care plan routinely when seeing patients.
- There needs to be improved record keeping around preferences, treatment etc. and more needs to be done to make sure they are automatically accessed by the people providing care.
- The need to identify that someone is dying and recognise this earlier was identified as an important point that feeds directly into the patient and families choices about appropriate treatment etc.
- We need to make sure that there are wrap around care to provide support to the patient if they are to stay at home.
- Care needs to be holistic, and include clinical and non-clinical support e.g. Home adaptations, advice and support on what to do when a patient passes away.
- There is a lack of bereavement support across NW London for families and carer. A review of current provision is needed to understand what type of support is needed and how it could be delivered.
- We need to ensure we consider the impact of caring for someone who is dying on family and carers. Concerns were raised about impact on:
    - unpaid carers and those who are older
    - Those who have their own health issues and are struggling
    - Are trying to hold down employment or have kids and are busy and what that means for them trying to undertake a caring role.
- The way someone dies can have a big impact on the person caring for them and we need to ensure that support for relatives and carers continues after the person has died.
- Palliative and end of life care needs to be patient centred and the importance of family/carers/those of importance to the person being involved in decision making and kept informed.
- We need to think about how we design more integrated services, between the patient and family, the community, social care and clinical services.
- Care and support needs to be available 24/7 365 days a year (including pain relief). out-of-hours service (OOH), consider including an OOH service to impatient services to enable carers and patient seek help when needed.
- Lack of clarity for carers/family around medication. Medication for EoLC patients should be thoroughly explained to carers/family members so they are able to identify which medications are missing and act quickly.
- Family members and carers should be kept informed at every point during a patient's care pathway.
- Professionalism, Confidentiality and Compassion - Clinicians visiting family homes to see EoLC patients should be briefed fully on the patient's condition/situation and maintain the highest level of confidentiality when they are communicating with other clinicians in the presence of the patient and other family members.

6. To make it easier for people to access services, particularly across our more diverse communities. Some of our services are not joined up and do not work well together, and we need to change this.

- More needs to be done to create culturally competent services that take into account cultural and faith beliefs.
- We need services that are able to care for people from ethnic minorities who may not speak or have difficulty speaking and understanding English.

- Participants identified a need for existing care and support services to do more in reach into different communities in a culturally sensitive way.
- More needs to be done to promote community-based specialist palliative care, encouraging people to think, talk and plan about end of life care.
- The importance of having local services was stressed with reference to the cost, time and difficulty of using public transport.
- Need to design services that take into account people cultural and faith needs.
- Creating seamless service provision with services properly integrated with other ancillary services like 111 would make them easier to access and improve patient experience of care.

7. To cope with the increasing financial challenge, the NHS is facing and the effect this has on community-based specialist palliative care.

- Consider a proper financial settlement for hospices as their financial situation has been exacerbated by Covid.
- Local residents wanted to know more factual information on finance, demography and the help available locally.
- Look at ways of clawing back some funding from the NHS service providers when patients with intensive clinical needs decide to die at home.

8. To reduce the difficulty, we are having finding, recruiting and keeping suitably qualified staff, and the knock-on effect this has on our ability to provide services.

- A comprehensive workforce plan is needed to address the workforce challenges mentioned in the report.
- More needs to be done to educate and train all workforce to identify need. This should be NHS, Local Authority (social care) and voluntary groups so they can capture and signpost potential need.
- Need to build extra capacity and extra staff to meet growing demand.

The full interim engagement outcome report is available here.

10 The model of care working group

The model of care working group was set up by the NW London ICS to develop a framework and action plan to ensure that high quality community based specialist palliative care is delivered equitably and sustainably across NW London, and that all residents are able to access the service if it is needed.

Membership of the group which meets on a weekly basis consists of local residents, clinicians and other palliative and end of life care stakeholders. Patient/carer members contribute and provide feedback on the group's work, which reflects the voice of patients, carers and their families. They also work on projects which, have been identified as an area of focus by the membership group. Minutes of the meeting and presentations are available online.

This is not a plan to replace work that is already going on. It is a plan to build on the great stuff already happening and recognise where there are gaps and opportunities.

The work draw on the national service specification for adult palliative and end of life care, the previous NW London palliative care review programme work and qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement. We will also utilise activity trend data obtained through the programme's data working group and undertake further work looking at the structure of our services workforce.

Objectives

- Agree a set of key 'ingredient' standards/ common core offer / single service specification for NW London
- Develop new model of care for community-based specialist palliative care
- Develop options for delivery of model of care
- Develop action plan for implementation

The expected output is a set of core service standards, requirements and service functions that will need to be delivered across NW London. There will also be a number of additional localised requirements that the local Borough Based Partnerships will have responsibility for implementing these in view of their local context and population needs.

We will work with the Integrated Care Partnerships, local residents and stakeholders to decide whether the new service standards can be delivered by existing service structures or whether a service change is needed. If substantial service change is needed, we will then need to consider if a public consultation is needed.

Who are the members of the model of care working group?

Members of the group included representatives from:

- NW London NHS community SPC providers
- NW London Hospice SPC providers
- Patients

- Primary Care
- Acute SPC
- Discharge teams
- Care homes
- Local Authority and social care
- Voluntary sector
- Meds management
- 111/OOH GP
- LAS
- Community nursing
- Continuing health care (CHC)
- Cancer programme

Model of Care – what do we mean?

There are many, many definitions of what constitutes a 'Model of Care'. We have set out below what we think the scope of this stage of work is:

Defining what the core elements of delivery are	Yes	This is the kind of detail within the national service specification and the starting point
Defining how much of these key elements we need	Yes	This isn't covered in the national spec but is critical to be able to ensure common approach across NW London how much" could include hours, staffing, capacity etc.
Defining how services should be delivered	Partially	For example, we may want to define elements such as access (including geographical availability) but not how services are integrated at place.
Who delivers elements	No	But substantial change not anticipated
How much costs	No	Not at this stage

The work will draw on the national specification for adult palliative and end of life care, the previous NW London palliative care review programme work, qualitative and quantitative feedback from residents and healthcare professionals obtained through our engagement and further data obtained through the programme's data working group.

11 Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

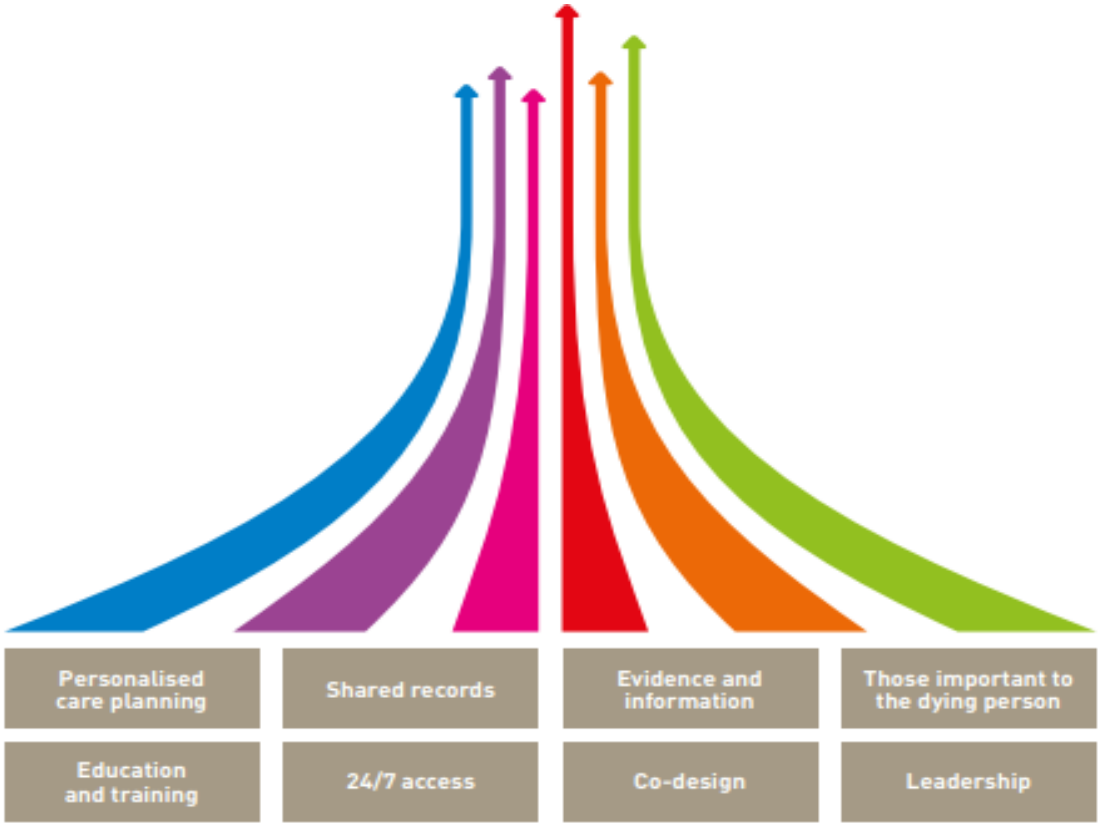
In 2015 The National Palliative and End of Life Care Partnership published the **Ambitions for Palliative and End of Life Care: A national framework for local action (2015-2020)** to improve palliative and end of life care (PEoLC), building on the 2008 Strategy for End of Life Care and other strategies and reports.

It describes what is needed to realise that ambitions, and calls for local health and social care leaders to use these foundations and building blocks to collaboratively build the accessible, responsive, effective, and personal care needed, via a process that is open, transparent and effective.

A refresh of the Ambitions Framework (2021-2026) was published in May 2021, with a reminder that more must be done, building on the learning from COVID-19 pandemic to focus more efforts on personalised palliative and end of life care, to improve support for people of all ages including those bereaved, and to drive down health inequalities.

Each ambition includes a statement to describe the ambition in practice, primarily from the point of view of a person nearing the end of life. Each statement should also be read as our ambition for carers, families, those important to the dying person, and where appropriate for people who have been bereaved.

The eight foundations that underpin the ambitions and are required to bring about this improvement. Different individuals and organisations can lay these foundations, either on their own or collectively.



Foundations for the ambitions

To support delivery of the six ambitions, the NHS England & NHS Improvement Palliative and End of Life Care Team worked alongside stakeholders to further develop the Ambitions for Palliative and End of Life Care self-assessment tool as a national resource.

This tool provides a self-assessment framework and process to support localities/ boroughs to

- Support a more coordinated response for localities to determine their current level of delivery of services against the Ambitions for Palliative and End of Life Care - A National Framework for local action (2021-2026).
- To understand where there are strengths and opportunities for improvement and growth that need prioritising within future strategy for palliative and end of life care.

In order for this self-assessment process to become a meaningful and useful exercise, localities are encouraged to be as honest as possible, with cross-organisational collaboration to complete the tool and achieve the improvements being vital. Localities are strongly encouraged to ensure health and social care are equal partners in this assessment process.

All eight Borough Based Partnerships (BBP) were asked to complete the self-assessment tool and came together in two workshops facilitated by the NW London last phase of life programme to facilitate its completion. Participants included representatives of Brent Council and local residents.

All BBP's have now completed the self-assessment tool. The rich discussions that took place in each BBP breakouts, and feedback from multiple workshop stakeholders, that completing the self-assessment tools with multiple stakeholders locally for each BBP was really beneficial:

- To ensure the information on the tool is as accurate as possible for each BBP and ultimately for completion of the NW London self-assessment.
- To raise the profile of PEoLC locally and regionally.
- To identify the relevant PEoLC stakeholders and building place-based links.
- To start the basis for driving PEoLC improvement work forward at place and within other programme areas.

An analysis has now taken place and a NW London level and this will be used to inform the new CSPC model of care (MOC) in development by the CSPC MOC working group. In addition:

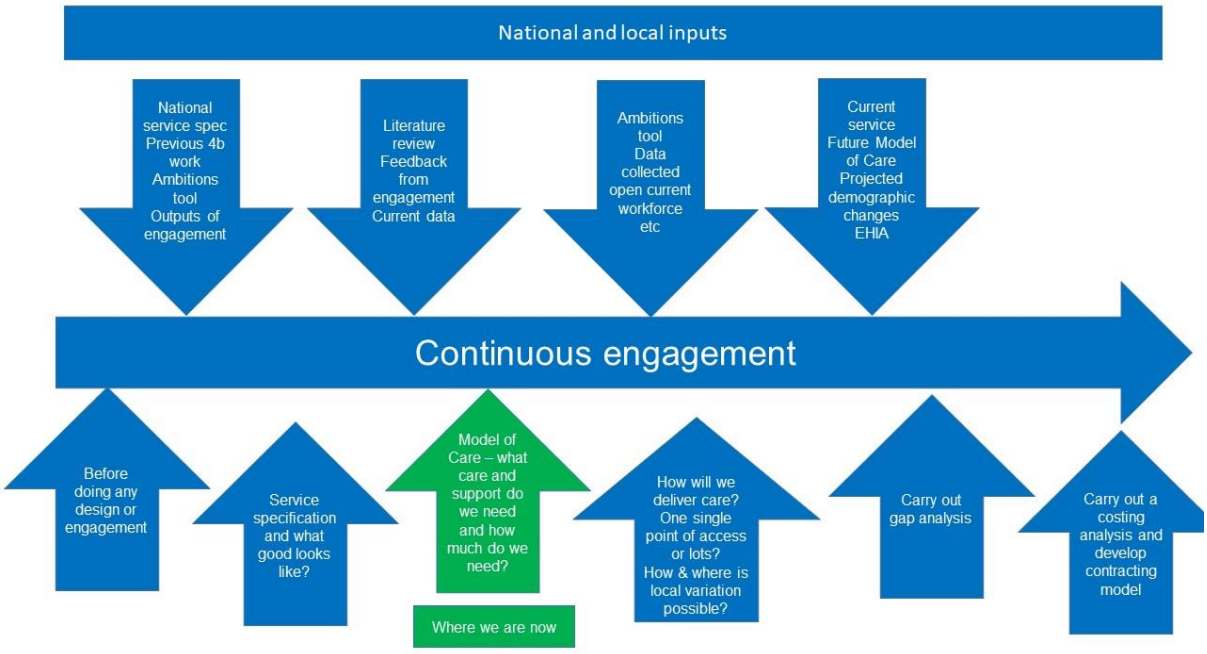
- Key gaps/ areas of improvement identified for other parts of the end of life pathway will be shared with other NW London programme areas.
- BBP self-assessments will be shared with BBP and borough directors with an ask to support any local PEoLC improvements using the findings to inform this work.
- NW London Last phase of life programme will host a 3rd workshop later in the year for all PEoLC stakeholders across the system to share the outcome of the NW London self-assessment, learning and areas of good practice identified.

We would like to thank partners and local residents for taking part in the workshops and contributing to their success.

12. Timeline

We are taking a flexible approach to the timeline to make sure that we can carry out good conversations with local residents and our partners within the Integrated Care System.

The diagram below shows the national and local inputs into the development of the model of care and immediate next steps.



It is anticipated that the model of care working group will complete its work in Autumn 2022. We will then move into a development phase where we will carry out a gap analysis, costing exercise and develop the costing model. This will be accompanied by the commencement of an assurance process with NHS England/NHS Improvement and the London Clinical Senate.

13 Conclusion

- We are undertaking a wide range of engagement and events to understand the improvements residents and health care professionals want in terms of community-based specialist palliative care.
- We have reviewed the feedback and published an interim engagement outcome report that is being used by the model of care working group which is responsible for designing, planning and mobilising the future model of care for adult community-based specialist palliative care.
- The inpatient unit at the Pembridge remains closed, however, we are currently providing alternative provision through neighbouring local hospices.
- We recognise that services need to be accessible locally and will review inpatient provision as a key part of the review, but cannot pre-empt what this means at present.

We welcome further feedback and suggestions from Brent Council. Please let us know by emailing nhsnwlccg.endoflife@nhs.net

Appendix 1 – Detail on the Palliative care services improvement programme in the London Boroughs of Brent, Hammersmith & Fulham, Kensington and Chelsea and Westminster. Note this review has been superseded by the current NW London wide process and as such the outcomes will feed in to that process but the options are not recommendations that we are actively progressing

In November 2018 Central London CCG, on behalf of West London CCG and Hammersmith & Fulham CCG, commissioned Penny Hansford, former Director of Nursing at St Christopher's Hospice, South East London; to independently review provision of community-based specialist palliative care services in the three boroughs following suspension of the in-patient unit at The Pembridge Hospice following that failure to recruit a consultant registered on the specialist register for palliative care which is required to cover inpatient care.

This event, combined with commissioner's desire to ensure palliative care services are fit for the future, meant the tri-borough CCGs decided to review the current provision of specialist palliative care. The independent review of palliative care services published with the aim of developing recommendations for an improved commissioning model that would deliver high quality services for patients, families and carers across the three boroughs.

A 'Call for Evidence' was launched on 14 December 2018 and a clinical steering group was created, with representatives from GPs, acute trusts, community trusts and hospice providers, all with an interest in specialist palliative care, with the final review published in June 2019.

The report provided a comprehensive assessment of the current local service provision, a review of best practice and made a number of recommendations for commissioners to consider for the future model of service.

Findings and future options

The review of services offered to patients identified the following three overarching challenges to be addressed:

- inequity of specialist palliative care services in the three boroughs
- inequity of access to the services, with only 48% of people who have an expected death having any contact with community palliative care services; and
- inequity of funding arrangements for the services from the CCGs.

The review put forwards three options in order to address these challenges whilst providing a sustainable local system, which ensures all patients receive care in their preferred place at the right time:

Option one (recommended option)

Tender a new community service with one lead provider for the specialist palliative care services, to provide an 8am-8pm co-ordination/case management centre. Out-patient, rehabilitation and well-being services should be easily accessible to patients and be located within the boroughs

Option two

Tender a new service and rationalise and reduce the number of specialist providers to two, with the same service specification and contracts and

Option three

Tender the services based on one community service per borough with the same service specification with one co-ordination centre/case management centre per borough.

Read the review in full here.

In Autumn 2019, the three CCGs were joined by Brent CCG as a commissioner of services at the Pembridge Hospice in holding a number of workshops to understand the experience of the end to end pathway.

Workshops were on held on ‘Access’, ‘Care’ and ‘Bereavement / aftercare’ with the purpose of having some in-depth conversations on the whole end to end pathway and use the information to feed into future potential scenarios for service delivery.

After listening to feedback from the public and stakeholders following the public workshops, we launched our ‘potential scenarios’ to the public for discussion and feedback and work in partnership with the public to design future potential options for service delivery.

This led to the development of four scenarios that set out how we might organise palliative care services in the future and in February 2020 we asked the public for their feedback on them.

Scenario 1—Services remain the same.

This scenario would keep all palliative care services as they are including the re-opening of the inpatient unit at the Pembridge, subject to the appointment of a palliative care consultant. In-patient, day and community care services would continue as they are.

Scenario 2- Some improvements to day and community services with in-patient services remaining the same.

This scenario would keep in-patient services as they are now, including the re-opening of the inpatient unit at the Pembridge subject to the appointment of a palliative care consultant.

Community services would also be standardised to 5 days’ week. This scenario would also lead to some improvements in the co-ordination of out of hours’ advice.

Scenario 3—A re-design of all elements of palliative care services.

This scenario would see in-patient services delivered from four rather than five sites but without reducing the number of beds that the NHS funds.

This would enable CCGs to fund enhanced community services 7 days a week, with 24/7 admissions for patients. It would also provide an out of-hours nurse visiting service and Hospice@Home available to all.

Scenario 4—A re-design of all elements of palliative care services including access to a new nurse-led inpatient service.

This scenario would see in-patient services delivered from four rather than five hospices but without reducing the number of beds that the NHS funds. CCGs would then fund enhanced community services.

Patients who do not have complex medical needs, but whose preference is to die in a hospice environment could receive nurse-led care at a bed in North Kensington provided by the Pembridge Palliative Care.

There followed a period of further engagement on the options with the public and a wide range of stakeholders which brought forward a number of themes and feedback on the scenarios.

- Dying in dignity and agreement on the importance of palliative care and local services
- Communication and awareness of death and dying, palliative care and the need to plan for it
- Capacity of service provision now and in the future
- Review process – residents wanted more information on the evidence being used to inform the process
- A strong desire to keep inpatient services at Pembridge and opposition to closure
- Agreement on the need to improve access to services
- Better and more clear engagement
- More information on the staffing issues
- More information on the finance issues
- To consider the impact of travel and transport when making decisions
- Recognition that there was a need for change

In summary we heard throughout the engagement period, that specialist palliative and end of life care services play a crucial role for people. The feedback confirmed that people really value their local specialist services and people with experience of these services are very positive about the care they have received.

We also heard that we could improve and that these services could be available to more people, be more inclusive, adaptable and offer more choice. The feed-back indicates however that there are differing views about how we make these improvements, and create a more equitable service for all.

View the full public engagement report

The decision was then taken to pause the programme of work due to the current coronavirus outbreak and the subsequent decision by the NW London ICS to look at community-based specialist palliative care services across the eight boroughs in NW London.

Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2022
	Report from Strategic Director Community Wellbeing

Day Opportunities in Brent

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Andrew Davies Head of Commissioning, Contracting and Market Management – Adult Social Care Andrew.Davies@brent.gov.uk

1. Summary

1.1 Members of the Community and Wellbeing Overview and Scrutiny Committee have requested a report on day opportunities in Brent. This report covers –

- A summary of day opportunities provided for residents in Brent
- The commissioning responsibilities of the Council under the Care Act 2014, and the strategies in place to shape the marketplace and commission the right services
- An overview of the financial position of day services in Brent
- How the Council measures and monitors the quality of day services
- The Council's response to the Covid-19 pandemic, including the key challenges and support provided
- The post Covid position for day opportunities in Brent, including how the Council will work with providers to make services better and easier to access

2. Recommendations

2.1 The Community and Wellbeing Overview and Scrutiny Committee are recommended to note the report and ask questions to the Lead Member for Adult Social Care and officers on the issues raised.

3. Background

Overview of Day Opportunities in Brent

3.1 The Care Act 2014 focuses on improving people's independence and well-being. As part of its duties under the Care Act 2014, the Council must meet the assessed needs of residents in the London Borough of Brent to provide or arrange services that help prevent, reduce or delay people from needing care and support. All day opportunities services commissioned by Brent Council are for people eligible for support under the Care Act – day opportunities are not a universal service.

3.2 A core aim of day services is providing support that helps people achieve the outcomes that matter to them in their lives, known under the Care Act as the "well-being principle". This is a guiding principle that puts well-being at the heart of care and support. Day opportunities are a valuable provision that enables Brent residents with care and support needs living at home to seek social stimulation, and enjoy the company of others whilst receiving support from trained staff. Day services target different service user groups, for example, people with learning or physical disabilities, mental illness and older people. Day services provisions specialise in specific support needs, enabling access to skilled and tailored support for Brent residents. Day services in Brent are in the main building based varying in size, needs of service users, and the services offered.

3.3 Day services play an important role in the delivery of social care support to people in Brent. Brent has thirteen-day centres in the borough employing over 150 people. Five day centres support older people and those with physical disabilities. The remaining eight day centres support adults with Learning Disabilities, Autism, Mental Health, dual diagnosis and complex needs. In total, 314 Brent residents receive support through day services commissioned by Adult Social Care. Of those 314, people 65% of residents attend day opportunities in Brent, and 35% attend day services in other boroughs. People attend day centres based on their assessed needs.

Support Need	**Numbers Registered**
Learning Disability / Mental Health	199
Physical Disabilities	56
Older People / Dementia	59
TOTAL	**314**

3.4 Of the thirteen Brent day services, eleven are managed by independent organisations. Brent runs two in-house day centres, John Billam Resource Centre and New Millennium Day Centre. Large organisations manage 38% of day provision in Brent and have a number of other commissioned services such as home care and residential care. A further 15% are charity organisations. The remaining 53% are smaller organisations with a single day centre.

3.5 The current Brent day services are longstanding organisations providing services for Brent residents and working with Brent Adult Social Care for many years. The longest day care provider established services in Brent over 30 years ago, with the most recent service providing services locally for eight years. Brent day care providers have developed strong relationships with the local community and utilise this to access community resources as part of their day opportunities offer for Brent residents.

3.6 Fifteen percent of Brent's day services provide culturally specific services for the Asian and black African-Caribbean community. These day services enable residents to access culturally appropriate services inclusive of religious and cultural needs. Brent residents attending these centres have the option of cultural meals supported by staff who speak the same language. All Brent day providers are aware of their duty and responsibility under The Equality Act 2010 to eliminate discrimination, advance equality of opportunity, and be inclusive of a diverse range of needs regardless of age, race, gender or disability. All building-based day service provisions in Brent have level access for wheelchair users and accessible toilets.

4.0 In House Provision - New Millennium Day Centre

4.1 New Millennium Day Centre is a Brent managed Older People and Learning Disability day opportunities service. The provision also includes a Community Outreach programme that supports our residents to access community activities such as college attendance, work experience, and other person centred related activities.

4.2 During the Covid pandemic, the service has adapted a new campus style model to of support to more effectively meet the needs of our service users. This model allows us to find creative ways to deliver support.

The service offers three pillars of support:

- Virtual Sessions
- Community Engagement
- Building based Opportunities

4.3 The focus of this model is on the strategic and person centred delivery of tailored activities that meet individually assessed needs. As a result, we are now offering a Campus style model approach to service delivery. This means our customers can chose a variety of specific activities delivered across Direct Services, which enable customers to have greater choice and control of their lives. Choosing from a menu of activities that will meet their needs and enhance their skills. Our offer consists of, Educational, Recreational, Sport, Life-skills and wellbeing sessions.

4.4 Our Traditional model supports customers Monday-Friday, 9:00-15:30. However, customers can chose to attend half day or full day sessions. In addition to this, customers can also chose virtual sessions only or engage in a mixed menu of activities.

4.5 In Direct Services, we promote customer independence and we strive to give opportunities of work experience, where possible. At New Millennium Day Centre, there is a well-equipped café facility and plans are underway to encourage service users from across Direct Services to staff this.

4.6 This enterprise project will be offering training opportunities to people with a Learning Disability who have an interest in catering, money management, and customer service and community engagement. As part of our Enablement initiative, this project will also give choices to customers from Adult Social Care and customers moving into adulthood who wish to engage in work experience and learn new skills. The project will start by selling teas and coffees to the day centre customers and wider community. This will be a fantastic training opportunity for customers who would like to work in catering field in the future. This would also help to empower service users and build their confidence when dealing with members of the public.

4.7 There is a significant amount of partnership working at New Millennium, and we are proud to be actively working with other community providers as follows:

- TFL and Met Police (Travel training and Autism training)
- Mencap
- Positive about Autism
- Autism training
- ProAct Training: person first" approach, using proactive strategies to support personal development and minimise crisis intervention.
- National Autistic Society
- Middlesex Cricket association for sports and wellbeing
- Boom-Wow theatre group
- My Health my Choice

4.8 As a service, we are constantly seeking new innovative ways to collaborate with partners and stakeholders. This will enhance the support available for our residents.

4.9 New Millennium Day Centre is in the process of embarking on the new community project and creating a sensory garden. We intend to open it out to all vulnerable adults in need of a safe space who live within the local community. This will include people who are receiving services from the Rehabilitation Team, Older People Service, Integrated Learning Disabilities Service, as well as those who receive a direct payment.

4.10 The proposal is for the garden to be divided into four sections as follows:

Sensory*:* Sensory garden will include features such as, surfaces, objects and plants that stimulate senses through touch, sight, scent, taste and hearing. The aim of that part of the garden is to stimulate senses of service users who will benefit through that therapeutic addition to the service.

Meditation and relaxation section: this section of the garden is aimed to provide relaxation and promote wellbeing for calm and relaxed mind aiding mindfulness. That will consist of water feature, wind chimes and ornaments that will help service users to unwind and drown out the outside world and add the peaceful sense of enclosure for those who would benefit from relaxation.

Performance stage: this feature will enable talented service user to show case this skills and improve their performance. Many service users have already been involved in art and performance projects and this feature will enable us to provide a stage to offer and promote performance opportunities and enhance cultural diversity. This will also open further opportunities for outdoor activities such as, drama group, dance group, sing along and many more.

Green house and gardening: this garden feature will include green house for vegetable plantation, this will give service users a sense of being involved in the process from planting and using the grown produce at the skills kitchen.

4.11 **In House Provision - John Billam Day Centre**

4.12 John Billam Resource Centre is a Specialist Autism service with an Advance Accreditation with the National Autistic Society. The centre offers specialist Autism training to colleagues in Brent and other Stakeholders such as Brent Shared Lives

Carers, London Transport and Local police services our client group have very complex needs and may occasionally display behaviour that can challenge.

4.13 Staff are specially trained in positive behaviour management PROACT-SCIPr-UK® (Positive Range of Options to Avoid Crisis and use Therapy – Strategies for Crisis Intervention) in order to ensure our customers can lead positive and fulfilled lifestyles. Staff are also specially trained to support customers with their sensory needs and to understand the function of each client's behaviour and ultimately develop positive, holistic approaches for each individual.

4.14 Due to the nature of our customers, the service offers and promotes the following therapeutic sessions:

- Sensory and relaxation session
- Sensory story telling
- Dance and Movement
- Physio on soft mat
- Intensive Interaction
- Massage Therapy

4.15 Since 2019, John Billam Resource Centre has held an Advanced Accreditation with National Autistic Society. This is the only service in Brent accredited by NAS. The service is currently in the process of renewing the accreditation and due for a review during December 2022.

5. Commissioning Approach

5.1 The Adult Social Care Commissioning Service has a Community and Prevention Team responsible for the commissioning and quality assurance of all community contracts, including day opportunities. The team carries out quality assurance checks, responds to complaints and safeguarding enquiries about day services. The Community and Prevention team has oversight of the day services to monitor quality assurance. The Market Oversight manager in the team leads on day provision and is a first point of contact for providers ensuring forums take place once a month, and promoting regular engagement with providers over a range of topics.

5.2 The Community and Prevention Team gather intelligence from a range of sources. In addition to information gathered by social workers, taking into account the views of residents, family members, and other professionals to build a picture of the quality of Brent's services. The team utilise the Adult Social Care commissioning dashboard to obtain data on the number of people using day services and the costs of these services. Where day opportunities form part of an individual's care plan, social workers carry out frequent reviews of services monitoring the quality of provision to meet care needs through personalised support. Any concerns/safeguarding issues that arise are raised directly with commissioners to carry out further monitoring based on risk and quality of care.

5.3 Having an allocated team as the main source of contact for day service providers is an effective way of working with our local providers, giving them a route to contact the council when seeking support. This has been particularly important over the last couple of years as the council and providers have managed the Covid 19 pandemic. With over 300 Brent residents accessing day services in and out of the borough, having a good oversight of the sector is crucial.

5.4 The council and partners are engaged in various work with day providers to improve quality. Brent runs a monthly day opportunities forum, used as a mechanism to communicate and work with providers in line with government changes and good practice developments across the sector. All Brent providers regularly attend the forum. In addition, a number of information events have been held virtually and in-person at the Brent Civic Centre to encourage communication and promote joint working with Adult Social Care staff and providers in a shared approach to meet the needs of Brent residents. These events have been well attended and received positive feedback from providers and adult social care colleagues in a shared approach for Brent residents

5.5 Through joint working with London ADASS (Association of Directors of Adult Social Services), we have promoted incentives such as the Proud to Care rewards scheme specifically aimed at paid carers in day services and other care sectors. Enabling care staff to access savings through the scheme in a large number of retail shops in addition to providing training opportunities through the care sector for professionally qualified roles such as nursing and social work. These incentives focus on giving back to paid carers and encourage staff recruitment and retention for providers.

5.6 The strategic aim for day opportunities is to increase capacity and maintain and improve the day service offer to provide good quality support to people with the most complex needs. For those with lower-level needs who have previously attended day services, the aim would be to offer greater choice in the community that better reflects our population's diverse needs

6 Impact of Covid 19

6.1 The Covid 19 pandemic has had a significant impact on the day services in Brent and an impact that is still being felt today. Day centres closed for over a year due to the COVID-19 pandemic. A small number of services remained open to supporting service users in crisis or carers who are at high risk of breaking down. These providers were creative in their approach to providing alternative outreach services in parks and open spaces. Social work teams and commissioners were notified of service users attending these day care provisions.

6.2 Brent providers adapted their service to provide different strands of support, including:

- Telephone welfare calls
- Online Activities – music, drama, arts and crafts, health & wellbeing and more.
- Practical support for vulnerable residents, picking up medication/food.
- Delivering activity packs for those unable to participate online.

6.3 These different strands of day provision enabled service users to maintain some continuity of care through regular communication with familiar staff. Brent facilitated regular meetings with providers to discuss finances, health and safety issues, and risks of business sustainability caused by the closures. To support local providers, Brent agreed to continue to pay providers the same amount they were paid at the start of the lockdown period until April 2022, to help them through the pandemic. A few Brent providers also commission day services to neighbouring boroughs and lost income from other local authorities due to closures, this has had a significant financial impact on their business.

6.4 Service users and their families expressed that due to the covid-19 lockdown period, they missed the social interaction, structure and routine of attending day services. Some service users faced loneliness, boredom, anxiety, social isolation and worried as a direct result of the closure of day centres. In addition, there were significant challenges managing health needs due to missed or cancelled appointments, which saw a decline in health conditions such as dementia and increased care needs of some Brent residents.

6.5 In 2020, the impact of the first wave of the pandemic was significant, with Brent being one of the boroughs most impacted by Covid 19 in terms of community cases and deaths. The pandemic presented a considerable challenge to the care sector in Brent, balancing how to support the most vulnerable individuals with essential care needs whilst dealing with an unknown virus. The support that the council and partners provided was comprehensive and delivered early. Working closely with colleagues in Public Health, advice was given around vaccinations, infection control, PPE and testing. In addition to troubleshooting problems and offering guidance. Day providers were proactive through welfare calls and checks to determine how Brent residents who attended their centres were managing and identifying where individuals or carers were found to be struggling. Providers offered support where needed or escalated appropriate concerns to Adult Social Care staff.

6.6 Day opportunities providers have fed back to Adult Social care staff that the combined efforts of support from the council and other organisations had a positive impact in supporting them throughout the pandemic. In September 2021, day providers began to open up services with caution. The commissioning teams met with all providers individually to outline the comprehensive plans providers had put in place to re-open safely through a phased reopening.

6.7 Commissioners asked providers to put in place contingency plans in the event of an outbreak. Providers developed robust reopening, and recovery plans and Brent residents were invited back to day services through a pilot scheme. Day providers implemented bubble/zone working, and staff were trained to work in a way that would manage the safety of attendees and ensure that the buildings were Covid secure.

6.8 Staff continued to test regularly, visitors also tested before entering day services, and good infection control measures (such as wearing PPE and regular handwashing) continued. Managing the impact of the virus has become a regular facet of day provision. The support that the council and partners put in place alongside joint working with Brent organisations has ensured that providers are well equipped to manage and deal with outbreaks in their services. The high vaccination levels amongst residents and staff have also had a positive impact.

6.9 The numbers of individuals attending day opportunities has fluctuated because of the pandemic.

- In February 2020, 469 Brent residents were attending day services at the cost of £4,167,844.09 a year
- In February 2022, this number has decreased to 314 people at the cost of £3,601,965.64 a year.

6.10 There are a few reasons for this. Firstly, the reduction due to deaths during the pandemic. However, there are individuals whose physical health and mental and emotional well-being have declined significantly during the pandemic, and day provisions can no longer meet their social care needs. A number of individuals have

also refused to return to services due to concerns around infection of Covid-19 and the risks this may pose to their health.

6.11 The commissioning teams are encouraging new referrals from social work teams through a series of promotion events, raising awareness of services available locally. This promotion has been extended to colleagues in children's social care in the Children's with Disabilities Service 0-25, to encourage young people 18 and older leaving education to transition into Adult day services as future customers of Adult Social Care.

7. Moving on from Covid 19 – A sessional model of day opportunities

7.1 Commissioners are working with providers to redesign day opportunities in Brent to create a Day Opportunities "sessional model". This model will result in a significant change in approach to Day Opportunities to support adults in need of social care and deliver the optimum level of support that is flexible and responsive to a diverse range of needs. Providers have put in place alternative services based on virtual activities, outreach and community based services; they are however in the main building based services still. Post Covid-19 this offer does not address the full range of complexities faced by Brent residents and focuses on a more traditional care model.

7.2 Traditional day care models are an increasingly less attractive option for people coming into adult social care. The historical stigma of day centres portrayed in a traditional building-based model can be a barrier for those who may benefit from a day opportunity provision to maintain their well-being and promote independence. A modernisation of day opportunities will ensure the services we offer in Brent is inclusive of all residents with support needs to lead full and meaningful lives. Importantly, the sessional approach will mean people can take up day opportunities on the days and times that suit them, and not be limited to the opening hours or offer available from traditional day centres.

7.3 Post Covid-19, the changes in the way Brent day opportunities continue to provide a hybrid version of day opportunities represent a timely opportunity for innovation, inspiration and positive change to day services. That focuses on best practice in day services, demonstrating different and dynamic ways of commissioning and providing day services to meet the diverse needs of vulnerable people.

7.4 There is a need for more universal and community-based services around the borough. The redesign of day opportunities will encourage integration between day centres and community/universal services, focusing on a holistic approach to care. For example, the Gateway Social Isolation Preventative Service (SILP) has established relationships with various community, voluntary and specialist organisations to lead this collaboration.

7.5 People lack opportunities to access services in the community or different activities of choice in other locations/day services. The sessional model aims to promote and deliver choice. People can do different activities to help them achieve the outcomes in their care plan, and this can be achieved by commissioning shorter sessions across various day centres.

7.6 We are continuously reviewing our testing strategy for adult social care in light of the latest evidence and prevalence. Care Act reviews are taking place in-person through the social work teams, reviewing quality assurance in day centres as part of individual

care plans. This ensures we fulfil our oversight function and have a comprehensive picture of the quality of provision in the borough.

7.7 Collaboration with Brent's internal in-house provider, Direct Services, has explored and trialled a sessional approach to day opportunities as a cost-effective option. Engagement and partnership with service users, their carers and providers are crucial to any changes proposed in day services in Brent. Communication and engagement processes with service users and carers are underway and began with a survey to obtain feedback.

7.8 The five most important things discovered during the research project were:

- Choice was the main driver of positive feedback for changing the way day opportunities are delivered.
- Providers want to work with Brent to ensure the new approach to day opportunities is as successful as possible.
- The most optimistic group of people surveyed were Brent residents service users yet to attend a day centre trialling a sessional model approach.
- Carers had an ambivalent attitude to the changes with mixed responses to questions about specific areas of concern.
- Service users already visiting a sessional model centre (Direct Services) were the most apprehensive people surveyed.

7.9 In summary, the survey highlighted the optimism of service users attending traditional day centres means commissioners have a green light to move forward with the implementation of the sessional model alongside relevant stakeholders such as providers, carers, service users and others. The popularity of increased choice across all the groups who took part in the research further rubber stamps this. Providing a selection of activities that accurately reflects what the range of Brent residents want and need will be key to successfully implementing the sessional model.

7.10 Through the redesign of day opportunities, Brent residents will have the option to select different "sessions" of support from various providers, depending on their needs and interests. At present, it is not possible to do this in Brent because of the current offer of commissioning and providing services. Moving away from the default option for day opportunities being all-day attendance at a day centre to a model where people receive a direct payment to buy support that helps them meet their needs as set out in their care plan.

7.11 Some fundamental principles included in the model -

- Each Brent resident through a Care Act assessment will receive an outcome-focused support plan based on eligible care needs. This care plan enables residents to receive support to choose activities that support them to meet their outcomes, ensuring day opportunities tailored to the needs of the individual.
- Service users can access a 'day centre' when activities they wish to participate in are scheduled - this will reduce the previous traditional / institutionalised building based day centre model, where attendance was required from 10 am – 3 pm.
- Voluntary or paid employment and work experience will provide real opportunities that promote independence and is a priority in the sessional model to maximise the potential of individuals.

- Based on feedback from service users and carers, there is scope for weekend and evening activities through the sessional model to enable a full and flexible service provision that fully meets the needs of each individual and their carers.
- Service users will receive support in independent travel training skills and maximise accessibility to activities and services in the local community.
- Service users can purchase activities for the sessional model through Direct Payments in line with each individual's assessed personal budget.

7.12 Moving forward with the implementation of the sessional model commissioners have attended day centres in person to meet with service users and staff, sharing information on the sessional model through an easy-read format as an accessible version. Brent providers have started to implement the sessional model since the reopening of services. Feedback from providers is positive and they have expressed a keen desire to work with commissioners on different elements of the redesign. The sessional model is designed in an attempt to attract private customers to day opportunities. Residents who do not have eligible social care needs may wish to attend sessions purchasing this privately and generating business for local day care providers.

7.13 Day care providers are crucial partners in the planned redesign of day care services. The current day care forum complements the partnership work and engagement with providers. A working group will include colleagues across ASC to better connect what social workers require to meet the needs of individuals through the commissioning of day services. Plans are in place to establish a service user led group predominately made up of current users of Brent day services. Investment in communication and engagement is essential to encourage co-production and ensure the successful delivery of the sessional model redesign.

7.14 The commissioning team in partnership working with providers will continue further work, to drive improvement in the day opportunities in the borough. Reflective good practice sessions are planned by the day centre lead in commissioning as part of growth and learning amongst providers to further enhance their skill set and recognise what providers are doing well.

8. Financial Implications

8.1 Included in the main body of the report.

9. Legal Implications

9.1 Included in the main body of the report.

REPORT SIGN-OFF:
Claudia Brown
Operational Director, Adult Social Care

Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2022
	Report from Strategic Director Community Wellbeing

Brent Regulated Services – Brent Shared Lives and Tudor Gardens

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Martin Crick Team Manager Commissioning, Contracting and Market Management – Supported Living Martin.Crick@brent.gov.uk

1.0 Purpose of the Report

1.1 This report provides the Community and Wellbeing Overview and Scrutiny Committee with an overview of the Brent Shared Lives Scheme and Tudor Gardens. Both services are regulated by CQC. The overview includes the scheme's current operational responsibilities as well as an outline of the future plans for the scheme.

2.0 Recommendations

2.1 Members of the Overview and Scrutiny Committee are recommended to note the report and question officers on the plans for Brent Shared Lives and Tudor Gardens.

3. Introduction to Shared Lives

3.1 Shared Lives Schemes are similar to fostering, but with the main difference being that these schemes are for people over 16 years old. Schemes can support service users with a range of support needs such as learning disabilities and mental health. It is a real alternative to someone who does not wish to live in more traditional models of care such as residential care or supported living.

3.2 Shared Lives matches service users' needs to a registered carer and their family. The matching process takes in to consideration gender, age, ethnicity, cultural needs as well as any specific support needs. The service user will live with their carer and family and be fully integrated in to the wider community.

3.3 Carers registered with the Brent Shared Lives scheme are self-employed and 'approved' as carers by the Approval and Advisory Group (AAG). The process involves and application process including references, DBS check, property risk assessment, medical questionnaire and a successful interview with a recommendation for approval from core members of the AAG.

3.4 The Approval and Advisory Group is a board that is set up to oversee the general governance of the scheme and to support the registered manager in making decisions that are outside of general day to day operational decisions. The board consists of officers who have the following job titles:

- CQC Registered Manager and Nominated Individual
- Head of Service for Commissioning, Contracting and Market Management
- Service Manager in Children's Services
- Service Manager in Direct services
- Deputy Team Manager – Learning Disabilities Team

3.5 The following officers are part of the AAG but are non-decision makers and provide information and guidance only.

- Chief Lawyer for Adult Social Care
- Supplier Relationship Manager responsible for the schemes compliance
- Supplier Relationship Manager responsible for operational issues.

3.6 Decisions are made by the core membership but the registered manager is the ultimate decision maker. The reason for this being that they have legal responsibility for the service and the regulated activity of personal care.

3.7 Shared Lives Schemes are registered with the Care Quality Commission (CQC) for regulated activity of personal care. In line with registration requirements the scheme must have a Registered Manager and Nominated Individual. For Brent, Martin Crick, manager of the Supported Living and Extra Care Team in ASC Commissioning performs these roles. The main differences between the Registered Manager and Nominated Individual is the registered manager has legal responsibility for regulated activity whereas the nominated individual holds no legal responsibility. The nominated individual is responsible for ensuring that a suitable experienced manager is appointed and registered with CQC and also supervising the regulated activity.

3.8 Although the carers are self-employed the council has a responsibility under its CQC registration to ensure they are appropriately 'approved' and trained at all times.

4. Brent's Shared Lives

4.1 As of June 2022, the following number of carers and service users are in the Brent Shared Lives service.

Carers	
Carers Currently Providing Permanent Placements	**11**
Respite Only Carers	**8**
Total Carers	**19**
Service users	
Current number of **service users**	**18**

4.2 Table 2 provides the breakdown of the scheme's carers.

Gender	**Male**	**Female**		
	5	14		
Age	**25-64**	**64-74**	**75-84**	
	9	9	1	
Ethnicity	**Asian/Asian British**	**Black/Black British**	**White/British**	**White/Other**
	6	3	8	2

4.3 Table 3 provides the breakdown of the current service users within the scheme.

Gender	**Male**	**Female**				
	8	10				
Age	**25-64**	**64-74**	**75-84**	**85-94**		
	12	3	2	1		
Ethnicity	**Asian/Asian British**	**Black/Black British**	**White/British**	**White/Other**		
	12	3	2	1		
Support need	**LD**	**MH**	**PD**	**Sensory**	**PD&LD**	**PD & Sensory**
	10	2	1	2	2	1

4.4 Table 4 provides the three bandings and weekly fees paid to carers, depending whether service users are considered to have low, medium or high needs.

Band	**Weekly Rate**	**Number of carers**
Band 1	**£360.47**	**4**
Band 2	**£425.77**	**6**
Band 3	**£491.02**	**8**

4.5 The commissioning, contracting and market management team are responsible for the operational management of the scheme but not the annual statutory review of the service users. This function remains within the complex care teams. It is important to keep the two functions independent of each other to avoid any conflict of interest.

4.6 Placement relationship officers in the Adult Social Care Commissioning Service undertake a quarterly review with each carer to ensure the placement is meeting the needs of the service user and the carer is well supported.

5.0 Scheme governance

5.1 The scheme has a board Approval and Advisory Group (AAG) that meet at least every quarter to review the overall governance of the scheme. A supplier relationship manager, within the wider supported living commissioning team is responsible for overseeing compliance. They will present a report that updates members on all issues to do with the scheme including statutory notifications to CQC, carer compliance levels with training and any operational issues.

5.2 At least 4 board members are required at each meeting if any formal decisions are required. In line with the schemes terms of reference the CQC registered manager is the ultimate decision maker. The board is made up of representatives from different services and teams such as a head of service, team and deputy team managers as well as other colleagues in health.

5.3 Annual quality assurance surveys are sent out to service users, carers and stakeholders each year to see how the scheme has performed and where improvements can be made.

5.4 The scheme has a service improvement and CQC action plan in place to move the scheme from an overall CQC rating of 'Good' (the current rating) to 'Outstanding'. CQC requested that a provider information return (PIR) was submitted in February 2022. In the past this has normally meant an annual CQC inspection is due. However CQC are reviewing how they inspect services and given the current overall rating this inspection may not happen for some time

6.0 Future of the scheme

6.1 The scheme is able to support all service users with a permanent placement. However, due to a number of carers either retiring or being de-registered, respite for the permanent carers is becoming an issue.

6.2 Initial plans are to test the Shared Lives carer market and recruit a number of respite carers for the scheme.

6.3 Dependent on the market and how successful the recruitment of new carers goes, the scheme will look to build capacity and offer more placements. Further work is required to look at demand for the scheme but early indications suggest that there are a number of individuals with a learning disability and mental health support need that would benefit from this type of service. There is also an opportunity to build capacity to provide a wider 'respite' service across Adult Social Care.

7.0 Tudor Gardens Supported Living

7.1 Tudor Gardens is a 24 hour Supported Living Service for adults with Learning Disability and Autism. The Service was opened in April 2010 and has a Care Quality

Commission **"Good"** rating… that Tudor Gardens is, "Caring, Safe, Effective, Responsive and Well-Led". The service is currently running at full occupancy.

7.2 Tudor Gardens Supported Living is located in purpose built accommodation and consists of three separate buildings, each building having five bedrooms, self-contained units. The first two buildings are split over two storey accommodation with ground and first floors with a connecting lift service. The other unit is a single storey building which has a further five bedrooms, self-contained units.

7.3 The property is set in its own grounds and provides accommodation, Care and support for 15 adults with varied learning and physical disabilities. All bedrooms are designed as individual flat-lets and have a bedroom/living area, en suite and kitchenette facilities. All bedrooms are designed for single occupancy only.

7.4 The service is built around the individual needs and aspirations of aour residents, giving each person the opportunity to live as independently as possible with support from our qualified and caring staff team. Our service users are encouraged to make their own choices and lead their lives in the way they want to. Promoting independence is high on our agenda.Through elements of communal living, residents make new friendships, develop social networking skills and can get involved in group sessions such as cooking, gardening and film nights. Service users are supported with Educational, Recreational, Sport, Life-skills and wellbeing needs.

8.0 Management & Staffing

8.1 The service is led by qualified and experienced team of managers, consisting of:

- X1 Team Manager
- x 3 Team Leaders
- x 26 Care Support staff

All Care Support staff have a minimum of two years experience working with adults who have varied learning disabilities and autism and hold a minimum of NVQ level 3 or equivalent. The Team Manager and Team Leaders all have NVQ Level 5, or equivalent experience.

8.2 All of our staff team have undergone comprehensive training to meet the varying needs of our service users. They are trained to manage residents with challenging behaviour and complex needs. Throughout the year, staff attend a wide range of training and personal development courses to fully equip them to work effectively and professionally with our service users.

8.3 To maintain an effective and safe service, our staff team work both day and night shifts to ensure the service meets Care Quality Commission standards. There is also a waking night staff ,member per building with 24-hour management support.

9.0 Benefits of Tudor Gardens Supported Living

9.1 At Tudor Gardens Supported Living, all service users have an individual care and support plan that specifies the type of support that is needed, the support plan is outcome base to ensure Care Act assessed needs are met in a strengths based way.

9.2 The benefits that our service users receive varies depending on their level of need and abilities. We actively promote independence and choice, this enables service users to have control over their life and to maintain the things that are important to them. They have their own tenancy and are responsible for their own bills and cost of living expenses. At Tudor Gardens, Service users are supported with budgeting and money management.

9.3 Other support provided includes:

- Round the clock support provided by trained professionals
- Tailored support and care
- Enjoy greater independence
- Live in own home tailored around individual needs
- Strength base approach support
- Maintaining own home
- Managing personal finances
- Developing domestic and life skills
- Accessing employment, training or volunteering opportunities
- Developing and keeping personal relationships
- Learning new skills for independence
- Personal care and well-being
- Managing medication
- Support with social networking

10. Financial Implications

10.1 Included in the main body of the report.

11. Legal Implications.

11.1 Included in the main body of the report.

Report sign off:

Claudia Brown
Operational Director of Adult Social Care

Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2022
	Report from Strategic Director Community Wellbeing

Carers Services in Brent

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Andrew Davies Head of Commissioning, Contracting and Market Management – Adult Social Care Andrew.Davies@brent.gov.uk

1. Introduction

1.1 The Community and Wellbeing Overview and Scrutiny Committee has requested a report on carers services in Brent. The report sets out information on the council's responsibilities to carers, demographic information on carers in the borough and carers supported by Adult Social Care. The report also includes information on the carers strategy and carers forum and plans for procuring carers services in 2022/23.

1.2 Members are asked to review and comment on the proposed work to improve support for Carers in the Borough and:

- Support the development and implementation of the revised Carers Strategy 2021 – 2024
- Support the development of the Adult Carers Forum
- Support the planned Procurement Activity for 2022

2. Carers in Brent

2.1 The term "carer" is defined in the Care Act 2014. The Local Authority has a statutory duty to support local carers. For the purpose of this paper, we recognise carers in a far broader sense. Too narrow a definition risks people not getting the recognition and support they need. A carer is anyone who provides any care or support to an individual

such as a relative, partner, friend or neighbor who needs assistance in their day to day life and cannot manage without your help. Carers do this without payment, and they are not under a contractual obligation to provide care.

2.2 Many people who are caring for someone do not necessarily see themselves as carers. Carers can be:

- mothers and fathers
- sons and daughters
- young people
- husbands, wives and partners
- friends and neighbors

2.3 The Brent Carers Action plan built upon the definition of a carer as "...anyone who spends time looking after or helping a friend, family member or neighbour who, because of their health and care needs, would find it difficult to cope without this help regardless of age or whether they identify as a carer" (Carers Action Plan 2018-2020 - Supporting carers today 2018).

- The 2011 census recorded 26,600 Carers in Brent providing 1-50 hours or more care per week (this is 11% more Carers compared to 2001)
- 9% of Brent residents provide some form of unpaid care.
- Most carers are of working age between 25-49 years.
- 14% of Brent Carers are aged over 65 years.
- 12% are Young Carers under 18 years old.
- The majority of carers are women (54%). However, there is a significant number of male carers, 46%.
- 22% of carers are caring for more than 50 hours per week.
- 10% Carers care between 20-49 hours per week
- The majority of ethnic groups provide similar amounts of care.
- Some ethnic groups, including Asian/Asian British, provide slightly more care than average, while other groups notably mixed white/multiple.
- Nationally it is estimated that Carers save the economy £119 billion every year. (Brent Carers Strategy 2017-2020)

2.4 The 2011 Census identified 166,363 Young Carers in England (a 20% increase in the 2001 census). In Brent, we estimate the number of young carers to be more than 3,243. There are likely to be Young Carers in every school or college in Brent, and the BBC estimates that 1 in 12 pupils are Young Carers

2.5 This is the most current data reported by the Office of National Statistics (ONS). Data from the 2021 census results are yet to be published.

2.6 Adult Social Care in Brent has 613 registered carers. Of this number, 248 are receiving a care package from the local authority to support with their caring needs. The most common care packages are respite services (usually either residential respite for the person they are caring for, or a sitting service where a paid carer visits the home to allow the un-paid carer some time off), and day opportunities for the person being cared for. The council carried out 128 carers assessments in 2021/22.

3. Developing the Carers Strategy

3.1 The Brent Adult Carers Strategy and action plan is currently being revised. This ambitious document originally co-produced with a broad range of partners and Brent Carers, sets out a blueprint for change. The Carers Strategic Delivery Board has been re-established to oversee delivery of the Carers Strategy and action plan. Local Carers sit on the Board alongside officers to jointly lead this work stream, develop strategic objectives and implementation of local plans.

3.2 The core responsibility of the Carers Strategic Delivery Board will be on achieving the implementation of the strategic action plan. As part of the work of the strategic board, it has been identified that Carers in Brent require a separate space to raise more individual issues and concerns, regarding access to information and services as well as delivery. The Carers Forum will provide an appropriate place where carers can raise any issues, and have assurance that any concerns raised will be listened to and addressed. As a direct response to this, it is proposed that the Brent Adult Carers Forum (as detailed above) is developed initially for 12 months and then reviewed.

4. Carers Support Services

4.1 Brent Gateway

4.2 Brent Gateway is a partnership organisation that supports carers in the Borough to increase support and signposting. They have facilitated better communication with carers and developed improved resources of services for carers to access in different formats. Brent Gateway proactively identifies carers who are accessing their services and build on equality and inclusion.

4.3 Brent residents needing support from Gateway benefit from the following:

- Young carer activities, trips, and events during term time and school holidays
- Opportunities to come together and network
- Advocacy support
- Championing rights
- Early Help Assessments (EHAs)
- Carer-specific information and advice service
- Carers' assessments
- Carers' support groups
- Training programmes.

4.4 Brent Gateway has expanded the range of engagement activities they offer to include coffee shop drop-ins that have proved popular with carers and information sessions related to health issues. Regular activities are held at Bridge Park, focusing on improving well-being through dance and movement, drama workshops, relaxation, and exercise. Brent Gateway has also held more informal drop-ins whereby carers can attend on an ad hoc basis to speak to a Carer Support Officer in person.

4.5 Brent ASC recognises the importance of choice in the services available to residents and proactively encourages service user feedback in the commissioning and procurement of services. Brent Gateway's contract expires in December 2022. The ASC Commissioning team has started the retendering process, which will involve and encourage stakeholders participation and engagement. Consultation and engagement work is underway via the Carers Board and will also include engagement via the Carers

Forum to gather as many views on services required going forward. This will ensure that as many user by experience voices are captured and both carer and service user feedback will inform any subsequent specification. The procurement process was initiated on the 28th January 2022 with a targeted completion date of the of October 2022 to prepare for the implementation of the new service by December 2022.

5.0 Brent Adult Carers Forum

5.1 As part of the relaunch of the Brent Carers Strategy as detailed above, a new Brent Carers Forum is proposed to work alongside the Carers Strategic Board. This will provide an opportunity for Brent carers to have a place to voice any concerns, inform practice and to support the work of the Carers Strategic Board. It is proposed that this forum will be developed in partnership with colleagues from across the Council, Health and the voluntary sector, and most importantly with the direct involvement of Brent Carers.

5.2 The Carers Forum will provide an opportunity to make a real difference to Brent Carers, not just to Carers who are already performing the role, but also to people in the borough who may be delivering care but not receiving the support that they need. Through both the Carers Forum and the Carers Strategic Board, we want to raise the profile, collective understanding and recognition of the invaluable work that Carers do. We want to make lives easier for Carers in Brent. We want to listen and respond to what Carers want, to enable them to continue delivering crucial support whilst they can and wish to do so. It is proposed that the Carers Forum will initially run for a period of 12 months while we 'monitor' the effectiveness of the group and understand any impact it is having on the carer and customer experience.

5.3 The role of the proposed forum is to:

- Provide a regular and open forum where any adult carer in Brent can raise system related issues and/or concerns, feel that these are being listened to, and acknowledged by officers.
- Create a supportive and action focused space where solutions to ongoing operational concerns are identified and actioned.
- Create a single forum for all adult carer related systems issues and provide assurance that they will be responded to and addressed
- Help to ensure that other meetings (such as the Carers Strategic Delivery Board) can maintain their strategic focus

5.4 The group will meet quarterly between August 2022 and July 2023, and each meeting will last for 2 hours. The meeting will be a mix or virtual, face-to-face, and meeting details will be circulated to Carers during July 2022.

5.5 Carers will be encouraged to outline any issues they would like to be addressed via the a newly created Carers mail box and will be required to submit these at least 2 weeks prior to the meeting. This will allow officers time to review submissions and ensure a focused and productive meeting.

5.6 Actions and decisions reached during the meeting will be clearly captured and circulated to all attendees. The Actions and Decisions log will then be reviewed at the beginning of the next meeting to ensure a clear 'feedback loop' and transparency.

6.0 Brent Parent Carers Forum

6.1 The forum is an independent, parent-led organisation to bring together parents and carers of children and young people aged 0-25 with special educational needs and disabilities (SEND) in Brent. The forum works in partnership with Brent Council, health providers, schools and other organisations to provide information, advice and support to carers and young people with SEND

6.2 Carers have opportunities to socialise and interact with other carers. The forum promotes peer support, bringing together carers with shared experiences to support each other. The forum hosts regular coffee mornings and evening meetings where guest speakers are invited to raise awareness around local community offers for carers and their children. Carers can attend workshops and training events for parents on a wide range of SEND-related issues.

7.0 Financial Implications

7.1 There are no financial implications arising from this report.

8.0 Legal Implications

8.1 There are no legal implications arising from this report.

Report sign-off:
Claudia Brown
Operational Director Adult Social Care

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Brent	**Community and Wellbeing Scrutiny Committee** 5 July 2022
	Report from the Assistant Chief Executive

Community and Wellbeing Scrutiny Committee Work Programme 2022-2023

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	Appendix 1 - Community and Wellbeing Scrutiny Committee Work Programme 2022-23
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	George Kockelbergh Strategy Lead – Scrutiny, Strategy and Partnerships, Assistant Chief Executive's Department George.Kockelbergh@brent.gov.uk 020 8937 5477

1.0 Purpose of the Report

1.1 This report updates members on the committee's work programme for 2022/23.

2.0 Recommendation(s)

2.1 The committee to discuss and note the contents of the report and work plan in Appendix 1.

3.0 Detail

3.1 The work programme outlines the policy areas and decisions that will be reviewed by the Community and Wellbeing Scrutiny Committee during the municipal year according to its remit set out in the committee's terms of reference: Adult Social Care; statutory safeguarding boards; Children's Services; Cultural Services; education; housing; Public Health and external

NHS organisations. Reports taken to the committee are based on Cabinet decisions, annual safeguarding board reports, strategy, and policy development.

3.2 To ensure effective scrutiny members of the committee prioritised items for inclusion in the work programme based on a set of criteria. This helped to ensure items included in committee reports were either a strategic priority as set out in the Borough Plan 2019-23; of concern for a significant number of the borough's residents; a significant cabinet decision or form part of a forthcoming policy review or new strategy being developed by the Cabinet. This methodology of prioritisation is considered best practice by the Centre for Governance and Scrutiny (CfGS) and is an effective tool for a scrutiny committee to develop a coherent work plan for the year.[1]

3.3 The committee's work programme for the 2022/23 municipal year is detailed in Appendix 1. It also states details of a scrutiny task group on social prescribing which will be conducted as in-depth reviews into the topic. A scoping paper on the topic will be brought as a report to the 21 September Committee meeting.

3.4 There is scope for the scrutiny committee's work plan to change during the municipal year with capacity and flexibility to review emerging issues when they arise and as the Cabinet's Forward Plan is developed during the year. It is intended that the work programme is a living document that will evolve according to the committee's needs. It may also be necessary at times to move items to a particular committee date for practical reasons, in these cases the work programme will be updated accordingly.

3.5 As set out in the constitution, part of the Community and Wellbeing's Scrutiny Committee's remit is that it can scrutinise and make recommendations to NHS organisations. Its role is to review the provision and operation of health services in Brent and can make reports or recommendations to NHS bodies or Full Council. Areas related to external scrutiny of the NHS are set out in the work programme in Appendix 1.

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

6.1 There are no equality implications arising from this report.

7.0 Consultation with Ward Members and Stakeholders

[1] *The Good Scrutiny Guide* (Centre for Public Scrutiny, June 2019), p26

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

8.0 Human Resources/Property Implications (if appropriate)

8.1 There are no human resources or property implications arising from this report.

Report sign off:

Shazia Hussain
Assistant Chief Executive

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Appendix 1: Community and Wellbeing Scrutiny Committee Work Programme

5 July 2022

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive/Strategic Directors	External Organisations	External participants
Update on Adult Day Care Services	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing		
Update on Shared Lives Scheme & Tudor Gardens	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing		

Adult Carers	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing		
End of Life Care	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing	NHS	Carolyn Regan – Chief Executive West London NHS Trust Andrew Pike, Assistant Director of Communications NW London CCG

21 September 2022

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive/Strategic Directors	External Organisations	External Directors
Implementation of SEND Review and High Needs Block	Cllr Gwen Grahl, Lead Member for Children, Young People and Schools	Gail Tolley Strategic Director, Children and Young People Minesh Patel, Director of Finance	Health	TBC

Early Help & Family Wellbeing Centres	Cllr Gwen Grahl, Lead Member for Children, Young People and Schools	Gail Tolley Strategic Director, Children and Young People		
Scoping Paper on Social Prescribing	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing Shazia Hussain, Assistant Chief Executive Tom Shakespeare, Director of Health and Social Care Integration		Robyn Doran, Borough Director Brent Integrated Care Partnership

22 November 2022

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive/Strategic Directors	External Organisations	External Participants
Brent Safeguarding Adults Board Annual Report 2022-2023 *with a particular focus on cuckooing	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing	Brent Safeguarding Adults' Board	Independent Chair, SAB
Brent's Multi-Agency Safeguarding Arrangements for Children	Cllr Gwen Grahl, Lead Member for Children, Young People and Schools	Gail Tolley Strategic Director, Children and Young People Carolyn Downs Chief Executive, Brent Council	Metropolitan Police Health	Safeguarding Lead, North West London BCU Director of Quality, North West London CCG Independent Convenor, SCF

Transitional Safeguarding Task Group 6 Months' Update	Cllr Gwen Grahl, Lead Member for Children, Young People and Schools Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Gail Tolley Strategic Director, Children and Young People Phil Porter, Strategic Director, Community Wellbeing		

25 January 2023

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive/Strategic Directors/ Director of Public Health	External Organisations	External Participants
Brent Housing Management Update to include: Fire Safety, Resident Engagement, Housing Inspection Framework	Cllr Promise Knight, Lead Member for Housing, Homelessness and Renters Security	Phil Porter, Strategic Director, Community Wellbeing		
Mental Health	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing		Carolyn Regan, Chief Executive West London NHS Trust
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7 March 2023

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive/Strategic Directors/ Director of Public Health	External Organisations	External Participants

Children's Mental Health and Wellbeing Including CAMHS	Cllr Gwen Grahl, Lead Member for Children, Young People and Schools	Gail Tolley, Strategic Director, Children and Young People		Trish Davies, Central North West London CAMHS Service manager
Update on School Attainment including for Black British Boys of Caribbean Heritage	Cllr Gwen Grahl, Lead Member for Children, Young People and Schools	Gail Tolley, Strategic Director, Children and Young People		Head teacher from primary & secondary school in Brent
Northwick Park NHS Trust Maternity Improvement Plan Progress Update				Pippa Nightingale, Chief Executive for London North West University Healthcare NHS Trust. Lisa Knight (Chief Nurse NWL ICS)
GP Access Task Group 1 Years' Update	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing		Dr Muhammad Haider, Primary Care Lead Officer Fana Hussain, Head of Planned and Primary Care Jonathan Turner, former Borough Lead Director (Brent), CCG
Immunisation	Cllr Neil Nerva, Lead Member for Public Health and Adult Social Care	Phil Porter, Strategic Director, Community Wellbeing Melanie Smith, Director of Public Health Tom Shakespeare, Director of Health and Social Care Integration		Jonathan Turner, former Borough Lead Director (Brent), CCG

18 April 2023

Agenda Item	Leader/Deputy Leader/Cabinet Members	Chief Executive/Strategic Directors	External Organisations	External Participants
Casey Review 1 Years' Update		Carolyn Downs, Chief Executive, Brent Council Chris Whyte, Chair of Stakeholder Panel	Metropolitan Police Football Association	Tom Legg, Head of Operations, The Football Association Chris Bryant, Head of Tournament Delivery, The Football Association Jim Brockway, Metropolitan Police
Diagnostic Hubs in North West London		Phil Porter, Strategic Director, Community Wellbeing Tom Shakespeare, Director of Health and Social Care Integration		Jonathan Turner, former Borough Lead Director (Brent), CCG
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