ISLINGTON

Resources Department
Town Hall, Upper Street, London, N1 2UD

AGENDA FOR THE HEALTH AND CARE SCRUTINY COMMITTEE

Members of the Health and Care Scrutiny Committee are summoned to a Virtual meeting, which will be held on **16 July 2020 at 7.30 pm.**

Link to meeting: https://weareislington.zoom.us/j/93157916035

Enquiries to : Peter Moore
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Despatched : 8 July 2020

Membership

Councillors:
Councillor Osh Gantly (Chair)
Councillor Nurullah Turan (Vice-Chair)
Councillor Joe Caluori
Councillor Jilani Chowdhury
Councillor Tricia Clarke
Councillor Sara Hyde
Councillor Roulin Khondoker
Councillor Martin Klute

Substitute Members

Substitutes:
Councillor Mouna Hamitouche MBE
Councillor Anjna Khurana

Co-opted Member:

Vacant

Substitutes:

Quorum: is 4 Councillors

A.	**Formal Matters**	**Page**
1.	Introductions	
2.	Apologies for Absence	
3.	Declaration of Substitute Members	
4.	Declarations of Interest	

If you have a **Disclosable Pecuniary Interest*** in an item of business:

- if it is not yet on the council's register, you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent;
- you may **choose** to declare a Disclosable Pecuniary Interest that is already in the register in the interests of openness and transparency.

In both the above cases, you **must** leave the room without participating in discussion of the item.
If you have a **personal** interest in an item of business **and** you intend to speak or vote on the item you **must** declare both the existence and details of it at the start of the meeting or when it becomes apparent but you **may** participate in the discussion and vote on the item.

***(a)Employment, etc -** Any employment, office, trade, profession or vocation carried on for profit or gain.
(b)Sponsorship - Any payment or other financial benefit in respect of your expenses in carrying out
duties as a member, or of your election; including from a trade union.
(c)Contracts - Any current contract for goods, services or works, between you or your partner (or a body
in which one of you 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 you or your 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.

This applies to **all** members present at the meeting.

5.	Minutes of the previous meeting	1 - 6
6.	Chair's Report	

7.	Public Questions For members of the public to ask questions relating to any subject on the meeting agenda under Procedure Rule 70.5. Alternatively, the Chair may opt to accept questions from the public during the discussion on each agenda item.	
8.	Health and Wellbeing Board Update	7 - 10
B.	**Items for Decision/Discussion**	**Page**
9.	Moorfields Performance Report - Presentation	11 - 20
10.	Scrutiny Review - Carers Adult Carers - Consideration of Review	21 - 76
11.	COVID Update	77 - 118
12.	Performance Report	119 - 124
13.	Draft Work Programme 2020/21	125 - 126

C. Urgent non-exempt items (if any)

Any non-exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

D. Exclusion of Press and Public

To consider whether, in view of the nature of the remaining items on the agenda, it is likely to involve the disclosure of exempt or confidential information within the terms of the Access to Information Procedure Rules in the Constitution and, if so, whether to exclude the press and public during discussion thereof.

E. Confidential / Exempt Items **Page**

F. Urgent Exempt Items (if any)

Any exempt items which the Chair agrees should be considered urgently by reason of special circumstances. The reasons for urgency will be agreed by the Chair and recorded in the minutes.

The next meeting of the Health and Care Scrutiny Committee will be on 10 September 2020

Please note all committee agendas, reports and minutes are available on the council's website:

www.democracy.islington.gov.uk

London Borough of Islington

Health and Care Scrutiny Committee - Tuesday, 10 March 2020

Minutes of the meeting of the Health and Care Scrutiny Committee held on Tuesday, 10 March 2020 at 7.30 pm.

Present: **Councillors:** Gantly (Chair), Turan (Vice-Chair), Chowdhury, Clarke and Hyde

Councillor Osh Gantly in the Chair

142 INTRODUCTIONS (ITEM NO. 1)

The Chair introduced Members and officers to the meeting

143 APOLOGIES FOR ABSENCE (ITEM NO. 2)

Councillors Klute, Khondoker and Calouri

144 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

None

145 DECLARATIONS OF INTEREST (ITEM NO. 4)

None

146 MINUTES OF THE PREVIOUS MEETING (ITEM NO. 5)

RESOLVED:

That the minutes of the meeting of the Committee held on 30 January 2020 be confirmed and the Chair be authorised to sign them

147 CHAIR'S REPORT (ITEM NO. 6)

The Chair stated that the order of business would be as per the agenda

148 PUBLIC QUESTIONS (ITEM NO. 7)

The Chair outlined the procedures for Public questions and fire evacuation

A member of the public referred to a leaflet that had been circulated from the NIHE regarding patients consent. The Chair stated that this should be referred in the first instance to the JOHSC

149 HEALTH AND WELLBEING BOARD UPDATE - VERBAL (ITEM NO. 8)

It was stated that there was no report that evening as the Board has not met. The next meeting of the Health and Wellbeing Board is on 25 March

150 UCLH PERFORMANCE UPDATE - PRESENTATION (ITEM NO. 9)

Simon Knight, Director of Planning and Performance, UCLH was present for discussion of this item, and made a presentation to the Committee

During consideration of the report the following main points were made –

- Performance against key targets – Infection targets, Patient surveys, Referral to treatment times, Cancer waiting times, Waiting times in the Emergency Department, Delayed transfer of care
- Strategic Developments – In October 2019 the new £1OO m Royal National ENT and Eastman Dental Hospitals were opened. It is one of the biggest specialist centres in Europe for dental, ear, nose and throat and balancing services and will carry out more than 200,000 appointments per year
- The EPIC new electronic health record system will give a one patient single electronic patient record, there will be new end user technology and IT infrastructure, and training programmes and people readiness
- MRSA – There have been four cases of MRSA up to December this year against a threshold of one. Careful investigations has shown that there were no lapses in care identified in the first two cases. The third case was a contaminated blood culture which identified lessons for staff learning. The fourth case is awaiting a post infection review
- Closridium difficile – 57 cases of C diff as at end of December 2019, against a year to date threshold of 64. 11 of these have been successfully appealed and 33 cases are under review. There have been so far no lapses in care by the Trust. There were 13 community onset hospital acquired cases. Therefore worst case position is currently 57 cases against the year to date threshold of 64
- UCLH fared second best in the 2018 NHS Trust inpatient survey
- Referral to treatment time – UCLH did not meet the standard in 2019. Performance remained above the national average until March 2019 when the new electronic records system was launched. The new system will ultimately deliver benefits for patients. However some technical and booking issues that arose during the go-live period resulted in RTT challenges. Improvements to the RTT data quality through technical fixes, manual validations, and enhancing booking efficiency are improving performance
- Diagnostic waits within 6 weeks – UCLH paused reporting of diagnostics waiting times during April to August 2019 due to issues with data quality after going live with the new electronic health records system. Recovery plans are in place, with additional activity being carried out in imaging and endoscopy
- Referral to treatment time % of patients waiting less than 18 weeks – UCLH did not meet the standard in 2019. Performance remained above the national average until March 2019 when we launched the new electronic health records system. The new system will ultimately deliver benefits for patients, however some technical and booking issues that arose during the go live period resulted in RTT challenges. The RTT data quality has improved through technical fixes, manual validation, and enhanced booking efficiency. These actions are improving performance
- Access to timely cancer care - % of patients seen within 14 days of referral – Sustained performance against the two week standard with the exception of 2018/19 Q4 and 2029/20 Q1. Breast and gynaecology were significantly below the standard which drove performance during these quarters
- Access to timely cancer care - % of patients treated within 31 days of decision to treat – UCLH met the standards in most months of the year. Urology has continued to maintain flexible surgical capacity arrangements both in house and with the private sector to maintain short waits for robotic prostatectomy treatments

- Access to timely cancer care - % of patients treated within 62 days of referral – like other major cancer centres, UCLH has historically struggled to meet the target that 85% of patients with cancer should begin their first treatment within 62 days of an urgent GP referral. UCLH passed the standard for the first time in September, and maintained this in October and November. UCLH continues to work closely with referring hospital trusts to speed up patients movement through the healthcare system
- A&E access times – waiting times continue to be challenged, as has been the case for many Trusts. Close work is taking place between partners in Camden and Islington to address the multi-factorial issues through the A&E delivery Board. This oversees the joint system improvement plan to deliver actions that will have maximum impact on improving processes within UCLH, as well as increasing discharges an admissions avoidance in the community.
- Key actions include introducing an expanded area for Rapid Access and Treat of patients arriving via ambulance to reduce the time very sick patients wait to be seen. To improve bed availability several measures have been introduced – 12 beds made available at Queens Square for patients with neurological conditions, 6 additional flow co-ordinators in the wards to help with faster discharge, a pilot of a more efficient way of cleaning beds on the acute medical unit. UCLH has also worked closely with mental health partners on a number of measures to reduce delays and 12 hour mental health trolley breaches. A safe space for patients has been introduced by Camden and Islington with 3 beds
- Delayed transfer of care in 2019 – Camden and UCLH have improved shared understanding of demand for out of hospital services, shared with Islington. Good joint working with Camden on discharge to assess pathways and starting to replicate in other boroughs. Improved collaborative working with external partners to identify and resolve external delays. Evergreen (step down ward) will close on 27 March. CCG partners are working to provide additional step down service
- Significant financial challenges – in 2019/20 the Trust is forecasting defecit of £39.4m before sustainability and financial recovery funding of £25.2m a net deficit of £14.2m. The financial challenge for 2020/21 is unprecedented. There are costs relating to strategic programmes such as – second year of electronic records system, full year revenue costs of opening the new Royal National Ear, Nose and Throat hospital, and the costs of opening the Phase 4 building which will ultimately incorporate Proton Beam Therapy. These costs were planned but now coincide with a national requirement for all Trusts and STP's to be moving at a faster pace on a trajectory to a break even position. The Trust is working closely with the London NHSE/I team and with its STP partners to plan to close the gap between what is being required of the Trust
- In response to a question it was stated that whilst the costs of EPIC were high it was felt that this would be beneficial in the long term. The cost was estimated to be paid back in 4 years and would improve quality of care, and communication with patients. There would be a more integrated system and medical staff would have all the information in one place
- A Member enquired as to the impact of coronavirus on waiting times for operations. UCLH responded that planning is taking place to delay patient appointments or have telephone appointments. There was also the possibility of staff contracting coronavirus and not being able to come into work, and patients would not be admitted with coronavirus unless being treated for this
- In response to a question UCLH stated that they did not feel well prepared if the number of coronavirus cases increase substantially as predicted, and there may be problems with the provision of beds, particularly intensive care beds, and shortages of staff, however there is a need to see how things develop and whether beds can be opened up, however a lot depended on

staffing levels available. UCLH stated that there are no plans to restrict visiting at present

- A Member enquired whether there are contingency plans in place to recruit staff to deal with the coronavirus situation. UCLH stated that there are no plans at the moment however the spread of coronavirus will lead to staff absences, and there will be contingencies in place to use back office staff with clinical experience and recruit staff who had left/retired back into the system
- Reference was made to the projected financial deficit and that this could me made worse due to the impact of coronavirus. UCLH stated that it was rumoured that the Government were intending to fund additional costs as a result of coronavirus, however it was not clear if this would cover loss of income
- A Member enquired as to the Proton Beam installation and it was stated that at present it is scheduled for October but this could be delayed until March. UCLH stated that they would inform the Committee following the meeting if this would be a 24 hour service
- A Member also enquired as to whether UCLH were experiencing problems with hospital transport and UCLH responded that they used a company called GS4 and whilst there had initially been problems there had been a recent improvement in performance. The Patient Governors on the Trust Board were constantly reviewing the position and challenging for improvements to the service. It was not felt that there were better existing providers at present, however it is often waiting times that appeared to be the problem for patients
- In response to a question about eligibility criteria for the use of transport UCLH stated that they would send details of these to Members following the meeting

RESOLVED: That UCLH provide details of the eligibility criteria for patient transport and whether the Proton Beam would be a 24 hour service to Members

The Chair thanked Simon Knight for attending

151 SCRUTINY REVIEW - ADULT PAID CARERS - DRAFT RECOMMENDATIONS (ITEM NO. 10)

Nikki Ralph, Jon Tomlinson and Ray Murphy, Housing and Adult Social Care were present for discussion of this item

The draft recommendations were laid round, together with some proposed amendments from Councillor Hyde

RESOLVED:
That the draft recommendations be noted and that any further amendments be notified to the Scrutiny Clerk and Chair for consideration and final approval at the next meeting

152 WORK PROGRAMME 2019/20 (ITEM NO. 11)

RESOLVED:
That the report be noted

MEETING CLOSED AT 8.30p.m.

Chair

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Health and Social Care Scrutiny Committee 16 July 2020
Report by Councillor Janet Burgess, Executive Member for Health and Social Care

The health and social care sectors in Islington have been tested to the limit during the pandemic, but have coped well. LBI's Adult Social Services moved very early on to working seven days a week, 8 am to 8 pm in order to support discharge from hospital as quickly as possible. Domiciliary care was then provided to the person in their own home. People spent less time in hospital than they would normally have done, but got more support at home. Throughout this period there have been no Delays in Transfers of Care (DToCs). Domiciliary care provision has held up well; throughout there has been spare capacity in the sector, and at the same time the number of service users has increased. Capacity has been helped by more people applying to work in social care (200 across North Central London), often because their jobs in the hospitality sector ceased. There has also been an acknowledgment in the country of the importance of social care work.

Hospital capacity in our area has also been adequate. Although the Whittington and UCLH at times had over 90% occupancy rate, they always had capacity.

The incidence of Covid-19 in Islington care homes has been mixed. Initially, without testing, it was not always possible to know if people had Covid or not. It took too long to establish a testing system which was accessible in Islington, but it is now in place, and testing is to be done on a regularly basis of both residents and staff in care homes, on a national basis. Very sadly, there were two staff deaths related to Covid-19, and several resident deaths. Once testing started, it was found that some residents had the virus but were asymptomatic. If the testing had been available earlier, it is my view that several lives could have been saved.

The Government is allocating extra funding for infection control within the care sector, to go via local councils. We are getting £844,000. Councils have been funded for the care home beds in their footprint, regardless of who commissions them. It is new money and Councils will be expected to passport funding to all care homes, including those with which there is no existing contractual arrangement. 75% of this will be for infection control within care homes; the remaining 25%, we think, can be spent on other kinds of care, eg domiciliary care. The Plan can be found at https://www.islington.gov.uk/social-care-and-health/support-and-guidance-during-covid-19/useful-guidance-and-resources-covid-19/test-and-trace-for-local-organisations

In terms of PPE (Personal Protective Equipment), again supplies of these were insufficient at the start of the outbreak. Homes, and domiciliary care agencies, should access their own PPE either directly or through their wider organisations; if this isn't possible, then the Council can, and does, provide it. Even by 30th April, By 30 April, the Council had supplied them with 24,400 gloves, 34,900 aprons, 22,250 surgical masks, and 410 face shields. There are weekly, often daily, discussions between LBI Social Services and care homes. LBI's Nurse Lead for Clinical Standards, Quality & Assurance for Islington Care Homes, Tina Jegede, last month was awarded Queen's Nurse status, which reflects the outstanding work she does.

The Government has allocated extra funding for infection control within the care sector, to go via local councils. We are getting £844,000. 75% of the funding was virtually passported to care homes, which had an allocation on a per bed basis, with the remainder for domiciliary care. Our Infection Control Plan is available online.

Now the NHS is encouraging people to seek medical help when needed, as it is known that many people did not during the worst of the crisis. Whittington A&E numbers are rapidly getting back to pre-Covid levels. There is great concern that mental health has deteriorated during the crisis. Again, people are being encouraged to seek help.

Public Health has carried out some research with regard to COVID-19 and Inequalities (Islington's population 56% BAME if Irish and Other White included; 32% if Irish and Other White excluded):

- Islington and Camden are the only boroughs in North Central London where men and women equally affected;
- Local analysis of deaths by deprivation within Islington show no differences by deprivation, but this could be due to the small number of deaths when stratified by deprivation;
- An analysis by ethnicity of those tested, confirmed or suspected with COVID-19, in General Practice, shows no significant difference (neither under nor over representation) when compared to the percentage of the GP registered population that are BAME – although the cases are small in statistical terms, and may be too small to detect statistically significant differences, and not all deaths will have been recorded at practice level.
- National findings show that black males are 4.2 times more likely to die from a COVID-19 related death, and black females 4.3 times more likely, than white males and females. People of Bangladeshi Pakistani, Indian and mixed ethnicities also had statistically significant raised risk: males 1.8 times more likely, females 1.6 times more likely.

As we emerge out of lockdown, and life returns to a greater degree of normality, the risk of an increase in COVID-19 transmission inevitably increases. Rapid self isolation and testing of people with COVID-19 symptoms, and timely identification and self isolation of people who have had close contact with confirmed cases, is a critical part of how we will contain the spread of the virus, save lives and hopefully prevent the re-imposition of more stringent lockdown measures.

At the end of May 2020, the Department of Health and Social Care launched the NHS Test and Trace Service for the testing of symptomatic people, and tracing the contacts of anyone with confirmed COVID-19. The important role of local authorities in preventing, rapidly responding to and controlling COVID-19 outbreaks has also been recognised, and all upper tier Local Authorities were required to develop and publish an Outbreak Control Plan by the 30th June.

Islington Council has published its COVID-19 Outbreak Prevention and Control Plan, which sets out the systems we have established, in collaboration with our partners, to enable us to prevent and contain the spread of the virus in our borough and to investigate, manage and control local outbreaks. The plan outlines how the Council

will continue to play a key role, working in partnership with health protection colleagues at Public Health England (PHE) London, in providing advice and support to a range of settings and communities, helping them to put in place measures to prevent infection, and investigating and managing outbreaks whilst remaining connected to key partners to ensure we deploy the necessary resources and interventions needed to contain any outbreaks that occur. An Outbreak Control Board, chaired by the Leader of the Council, is also being established. This Board will be a key forum for engaging a wide range of statutory, non-statutory and VCS organisations to work together to ensure high levels of awareness and engagement with testing and contact tracing, and to ensure we can harness our strong and effective partnerships should outbreaks or clusters of COVID-19 occur.

Further detail on the Council's response is set out in the Outbreak Prevention and Control Plan, which can be accessed in full here: https://www.islington.gov.uk/social-care-and-health/support-and-guidance-during-covid-19/useful-guidance-and-resources-covid-19/test-and-trace-for-local-organisations

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Moorfields Eye Hospital NHS Foundation Trust

NHS

Islington Health and Care Scrutiny Committee Quality Review 2019/20

16 July 2020

Tracy Luckett, Director of Nursing and Allied Health Professions

Ian Tombleson, Director of Quality and Safety

Our commitment to quality excellence

Contents

- About Moorfields
- Quality Strategy progress
- Compliance with national targets and standards
- Patient Experience
- Financial performance

Moorfields Eye Hospital NHS Foundation Trust

NHS

Who we are

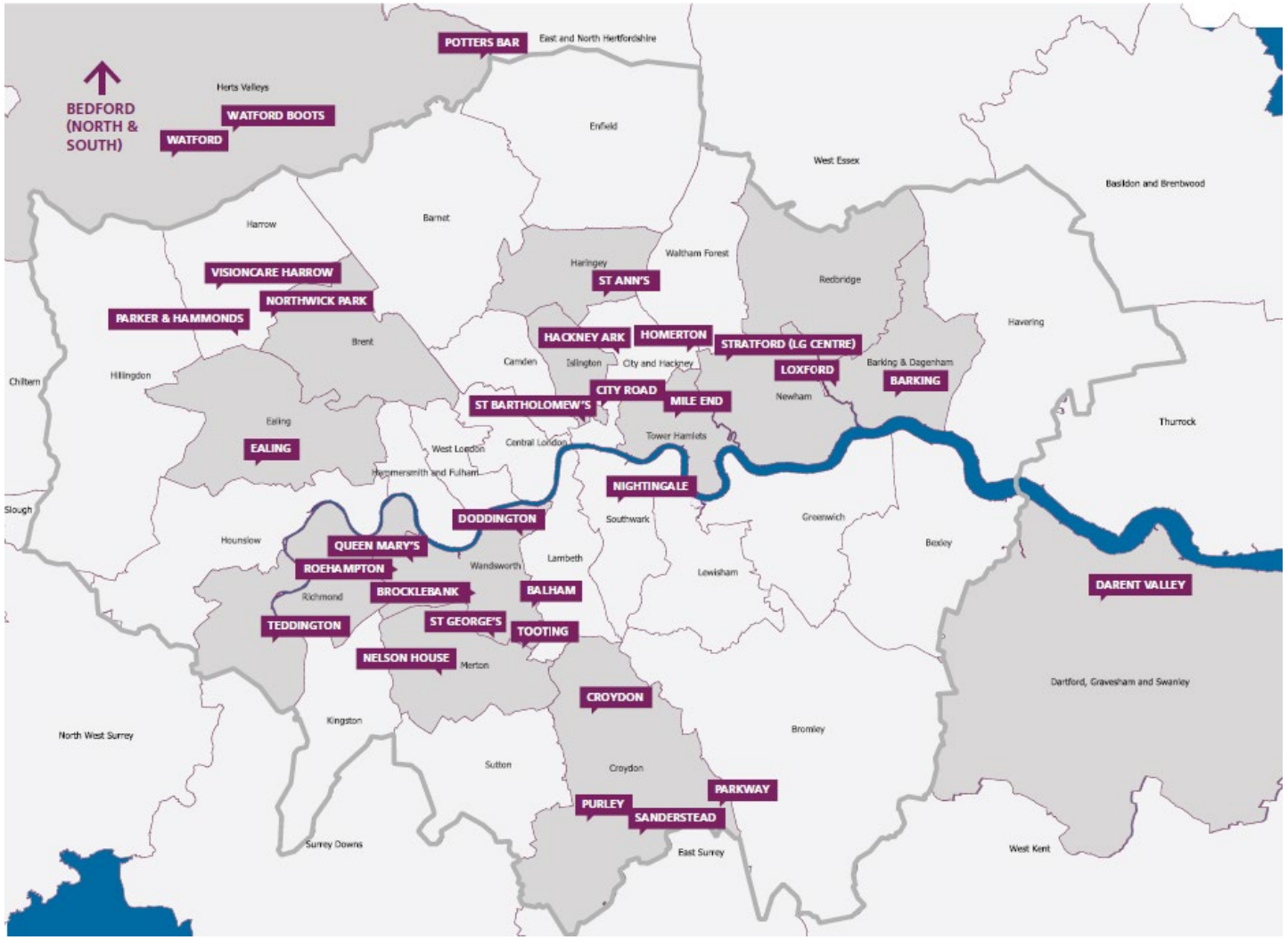
Moorfields ranks first in:

- Staff satisfaction with the quality of work and care they are able to deliver
- Staff motivation at work
- Staff satisfaction with resourcing and support

Moorfields Eye Hospital NHS Foundation Trust

NHS

Who we are



Moorfields Eye Hospital NHS Foundation Trust

NHS

Moorfields Eye Hospital NHS Foundation Trust

NHS

Year 2 progress based on our Quality Account

Six priorities

- Supporting safer care for patients undergoing invasive procedures
- Implementing and embedding our quality governance framework
- Lessons learned and changes to practice are captured, recorded and disseminated systematically
- Developing a culture and capability that supports ongoing changes to practice through quality improvement
- Involving and engaging our patients across the network in patient participation activities including service reviews and developments
- Ensuring for our patients, that appointments management is effective, efficient and responsive

Moorfields Eye Hospital NHS Foundation Trust

NHS

Compliance with national targets

Performance overview

- **A&E:** Achieved 98.5% within four hours against 95% target. Consistent year on year performance.
- **Referral to treatment 18 week pathway** (incomplete treatment pathway – patients yet to start treatment): Excellent performance against national target, achieving 94.1% against target = 92%
- **Cancer:** Meeting 3 of 3 national targets; cancer 2 week wait – first appointment from urgent GP referral; cancer 31 day wait – diagnosis to first appointment; 62 day waits from urgent GP referral to first definitive treatment
- **Six week diagnostic tests:** 99.9%
- **Infection control:** Year on year no cases of MRSA or C Diff. Low rates of other infections

Patient Experience

Overview

- **Friends and Family Test results:** Top performer nationally; overall score 95% would recommend us. Response rates increased due to new automatic texting service and continues to increase into 2020/21.

- **CQC Emergency care survey 2018** (every two years): Overall good performance compared to other trusts and similar high performance to 2016. Particularly good on information giving.

Patient Experience

Overview

- **CQC Children and Young People's inpatient and daycase survey 2018** (every two years): Excellent results performing very well compared to other trusts and similar high standard compared to 2016.

- **NHS Cancer Survey 2018** (annual): Good performance with overall patient's average rating of care 8.3 out of ten.

- **Patient participation activities:** Strategy launched in 2018 creating a culture of genuine participation in all services and activities. Numerous examples given in Quality Account. Activities overseen by Patient and Carer Forum chaired by a trust governor.

Moorfields Eye Hospital NHS Foundation Trust

NHS

Finance

Overview

- Challenging year; increased due to Corona virus in final month

Overall deficit of £0.8 million compared to £8.5 million surplus in 2018/19

Outlook for 2020/21 = very challenging due to Corona virus

Moorfields Eye Hospital NHS Foundation Trust

NHS

ISLINGTON

REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

ADULT PAID CARERS

London Borough of Islington
June 2020

CHAIR'S FOREWORD

COUNCILLOR OSH GANTLY
Chair of Health and Care Committee

Adult Paid Carers - Scrutiny Review

Evidence

The review ran from June 2019 until June 2020, and evidence received from a variety of sources:

1. Presentations from witnesses – Jess McGregor, Jon Tomlinson – Housing and Adult Social Care, L.B.Islington, Simon Bottery – Kings Fund, Sayeeda Ahmed – Snowball Care UK Ltd., Ian Haddington- MiHomecare, Caleb Atkins –City and County Healthcare, Colin Angel –UK Homecare Association, Adult Paid Carers – MiHomecare and London Care, Duncan Patterson – CQC, Stephen Day, Nicola Herrera-Martinez, Direct Payments Team, L.B.Islington, Sweet Tree Specialist Care – Nikki Bones, Denis Repard, Centre 404 – Jo Mackie, Wellbeing Teams – Helen Sanderson
2. Documentary evidence – Letter from Bob Padron – Penrose Care

Aim of the Review

To review the current position regarding paid adult domiciliary care workers in L.B. Islington including; funding, numbers, contractual arrangements, funding, numbers, delivery arrangements, and their effectiveness

To consider other models of commissioning and delivery in place of other parts of the country

To advise on any changes that need to considered/implemented to the strategic direction for providing care support to people in their own home

Objectives of the Review

To consider numbers and profile of paid Carers in Islington, and consider any benchmarking data
To examine the requirements of commissioned providers in respect of adult paid carers, in terms of: remuneration, quality assurance, and risk assessment, training, travel time, payment of LLW, and how cultural/specialist needs are being met
To examine the area of Direct Payments
To examine the effectiveness of the current arrangements
To examine the different models of commissioning and delivery of care at home currently in place elsewhere, including any in house service delivery models
To consider any actions that may need to be taken in the light of the findings of the review, to ensure that L.B.
Islington effectively supports citizens to remain independent, healthy and part of their local community
To consider how local providers can be assisted to bid for contracts for Adult Social Care

How to promote caring as a career choice
New models of care – innovative Local Authorities
Charging Policy

The Scrutiny Initiation Document (SID) is included in Appendix ‘A’ to the report

RECOMMENDATIONS:

The Committee heard evidence that there is scope for new technologies to improve the service for clients, and to reduce costs for commissioners, and providers. Such examples include electronic care plans, electronic medication charts, and the ability to meet some specific service user needs via mobile devices. The Committee noted that the Telecare system is currently under review, with the aim of increasing the use of technology, in order to improve the quality of life for those in receipt of care

(a) The Committee therefore recommend that providers and commissioners investigate, and continue to introduce new technologies, wherever available, to provide a better service to clients, and to improve co-ordination with carers

The Committee heard evidence that carers view is that information is not provided as effectively, and as quickly as possible, in relation to details of clients' needs, especially in relation to discharge from hospital. This lack of timely information impacts on the ability of carers to provide the most effective service possible to clients

(b) The Committee therefore recommend that there should be exploration of the opportunities presented by 'Fairer Together' for improved co-ordination between commissioners/NHS, (see paragraph 69) and providers, and to ensure the conveyance of the correct information to carers in relation to client's needs. This is especially in relation to discharge of clients from hospital to ensure the administration of the correct medication/assistance etc. Opportunities for introduction of new technology, as recommended in (a) above can assist in this

The Committee heard evidence that continuity of care and personalised care and support is important. Carers suffered in terms of loss of pay, from the amount of downtime that they experienced between appointments due to the client's requirements for assistance getting into bed/getting up at similar times. This affected the ability of some carers to maximise their income, and in addition created difficulties/inconvenience for client

(c) The Committee therefore recommend that commissioners and providers consider opportunities for enabling a more personalised and efficient home care system. There should be a focus on overall wellbeing outcomes for service users, rather than a list of specific tasks to be undertaken at specific times of the day. Opportunities may include better utilisation of personal budgets, and geographical zoning, whereby a provider has a set budget for each service user, based on their needs, to deliver a personalised service, which would reduce downtime/travel time for carers, and enable improved efficiency. Continuity of care is important

The Committee heard evidence that there are potential opportunities to improve the quality and speed of discharges from hospital. Providers are sometimes unable to respond quickly and flexibly to clients' changing needs, as they are limited in their ability to make changes to care plans. This should explore how commissioners, providers and social workers can work together, in order to ensure more timely and responsive changes to care packages in line with clients changing needs

(d) The Committee therefore recommend that consideration be given as to how the Council can make best use of the expertise and skills of providers and carers. In addition, consideration should also be given to consider opportunities to empower and place more trust in providers, and carers, to make decisions about the care and support clients require, from discharge from hospital to making adjustments to care packages, as needs change. This may include exploration of new roles given the need to recruit and retain more carers. The Council should also explore opportunities for more regular reviews from providers and the Council, to enable the care needs of users to be checked more frequently, in order to ensure that there is no over/under provision of care.
The Committee are also of the view that given the shortage of home carers, a situation likely to increase, commissioners and providers should investigate possible recruitment/retention measures to help alleviate shortages of carers

(e) The Committee heard evidence that there are 'untapped' opportunities to improve career pathways into home care, and career progression within health and social care. The Committee also recommend that consideration be given to career pathways and progression for carers, as part of the wider efforts of Islington's Health and Care Academy, which aims to support providers to recruit local people. Commissioners should explore which social value clauses and good employment practice stipulations, including for small/local providers, would be appropriate to include in future specifications and contracts. This would enable more local residents to also be employed who will contribute to the local economy

The Committee were impressed with the commitment, and excellent work, that carers provided for clients in Islington. The Committee heard differing evidence as to whether carers wished to be offered guaranteed hour contracts, or whether they preferred the flexibility provided by zero hour contracts. In addition, the Committee heard that carers are unpaid for the time that clients are hospitalised, if alternative work is not available. The Committee also noted concerns that carers often experienced problems when having to claim sickness pay, and that this process in their view, could sometimes be complicated

(f) The Committee therefore recommend that caring should be promoted as a profession, and that providers should offer all carers guaranteed hour contracts, rather than zero hour contracts, even if carers did not then wish ultimately wish to take up a guaranteed hour contract. There should be exploration of the benefits of a discontinuation of 'minute by minute' charging, in order to reflect the recommendations in (c) and (d) above. Please note that there is no requirement to commission on a 'minute by minute' basis and many councils have chosen not to commission in this way.

The Committee are impressed with the excellent and difficult work that carers often have to do and their commitment to their career. The Committee therefore also recommend providers consider compensating/finding alternative work for carers, in the event of clients being hospitalised. In addition, providers should ensure that the process for claiming and payment of sick is simplified

The Committee heard evidence that the introduction of Individual Service Fund payments (ISF's), into learning disability payments is working well. Direct Payments enable clients to have more flexibility/control over their care and assist in the move to an outcome based service recommended in (c) above

(g) The Committee therefore recommend that commissioners, as part of broader market development, explore the appetite and capacity for delivering personalised services through Individual Service Funds, or Direct Payments

The Committee heard evidence of the benefits of taking a relationship based approach, and a stronger enablement approach, together with integration of different types of support

(h) The Committee therefore recommend that the Council works with clients, their relatives and providers to review the Council services to people in their homes, and to explore opportunities for improvements that will better support residents to maintain independence and improve wellbeing

The Committee heard evidence that carers sometimes suffered racist/physical/verbal abuse from clients. The Committee felt that this was unacceptable, however as the Council has to continue to provide care in such cases there should be appropriate specialist advisers/training provided, in order to ensure that such instances are dealt with in an acceptable manner

(i) The Committee therefore recommend the institution of a zero tolerance approach in instances of verbal/physical/racist abuse, and commissioners/providers should take effective action. Commissioners should engage specialist providers who offer their staff appropriate specialist training, including gender/culturally appropriate training, in order to meet the needs of service users with challenging behaviours, and to minimise the effect on carers. In addition, providers should provide the most appropriate 'matching' of carers to clients as possible in respect of gender/cultural needs

The Committee recognise the excellent service that carers provide, and were concerned that carers, especially female carers, stated that they sometimes experience safety concerns, and attending clients

(j) The Committee therefore recommend that the Council explore the possibility of providing parking permits for carers working late at night that have to use their car. The Committee also support the Mayor of London's election manifesto commitment to provide concessionary London Transport fare passes for carers for the disabled, if he is re-elected

The Committee heard evidence that the increasing elderly population, who have ever more complex and multiple needs, will in the future place a growing need for additional social care resources, whilst at the same time as social care is still not being adequately funded by Central Government

(k) The Committee are concerned that that the Green Paper on Adult Social Care, scheduled for publication many months previously, has still to be published. The Committee therefore recommend that Government adequately fund social care for Local Authorities, and implements a fundamental change to its long term funding position, as soon as possible. There is an urgent need to address the implications of a growing ageing population, who will have increasing and ever more complex needs

The Committee heard evidence that the creation of integrated team work between providers/commissioners/NHS and social care can be utilised to carry out preventative work that may assist in keeping those receiving care out of hospital. This could include ensuring regular hydration, falls prevention, checking for infections etc.

(l) The Committee therefore recommend that a more integrated approach be taken to preventative care in order to reduce hospital admissions, and commissioners should work with providers, social care and NHS in this regard. An example of an integrated approach could include a combined homecare and district nursing team. There are many opportunities to integrate between health and social care and integration could take many different forms.

MAIN FINDINGS

Evidence from Jess McGregor/Jon Tomlinson – L.B. Islington, Simon Bottery, Kings Fund

1. Domiciliary/Home Care is the front line delivery covering personal care, help with washing, dressing and eating, to people with long-term care needs. It is a core service provided by most Local Authorities. Home Care can also extend to reablement services for people leaving hospital, or receiving crisis interventions to avoid hospital attendance in the first place. This can include household tasks, to help people remain independent

2. The core purpose of Adult Social Care and support is to help people to achieve the outcomes that matter to them in their life. Local Authorities must promote wellbeing when carrying out their care and support functions, in respect of a person. The wellbeing principle applies in all cases where a local authority is carrying out a care and support function, or making a decision in relation to a person. Wellbeing is a broad concept, but relates to the following areas in particular – personal dignity, physical, mental health and emotional wellbeing, protection from abuse and neglect, control by the individual over day to day life, including care and support provided, and the way it is provided. Also included are participation in work, education, training, or recreation, social and domestic wellbeing, suitability of living accommodation, and the individual contribution to society

3. Local Authorities Care Act responsibilities include market shaping, and commission of adult care/support. Local Authorities should encourage a wide range of service provision to ensure that people have a choice of appropriate services that respond to fluctuations and changes in peoples care and support needs. Local Authorities also have a range of responsibilities around the wider care and support workforce, and must have regard to ensuring sufficiency of provision

4. The estimate in England each year is that there is delivery of 249 million care hours. In 2015 it is estimated that 350,000 older people to have used the service, 25,700 of whom had their care paid for by the Local Authority. A further 76,300 younger people with learning disabilities, or mental health issues were also estimated to have publicly funded home care

5. Home Care agencies employ around 680,000 people, but more carers will be required in the future, as the number of elderly in the population increases. Currently there are around 11,000 vacancies at any one time. The average package of care commissioned is 10.8 hours in duration, and 7% of the packages of care are based on outcome focused commissioning

6. The average lowest price for a care package was £13.64 per hour, and highest £21.69. The average price of homecare across the region is £16.63. 4 Boroughs commissioned 50% or more of their homecare needs for the requested week from 2 providers

7. Adults in L.B. Islington, aged 65 or above, make up 9% of the population. In 2017, there were an estimated 20,786 older adults in Islington, and an estimated one fifth of older adults across Islington and Camden are from BAME communities. By 2035, the older adults figure is set to grow to 12%, a 605 increase in older adults. It is expected that the sharpest increase is to be amongst the very old, people aged 85 or over

8. In terms of package size, large block and spot contracts, over 14 hour or over per week, has an annual cost of £9,793,071.49, with annual hours of 564,068.39. Medium/large contracts/spot contracts of 7-14 hours weekly have an annual cost of £3,966,272.50 with

annual hours of 225,478.75, and small block and spot contracts of 7 hours per week, have an annual cost of £1,993,176.46, with annual hours of 113,276.88. This is a total annual cost of £15,752,523.45, and annual hours of 902,824

9. There are 23% small packages, 19% medium packages, and 40% of large packages placed with spot providers. The hourly rate paid for block- contracted hours is £18. A small package may typically include shopping, lunch calls, supplemented by day centre or outreach support. A large package may include 4 calls a day, meals and a bedtime call

10. Following a procurement process, there had been block contracts awarded to five homecare agencies in September 2018, for a 4-year term, with the potential to extend 2 plus 2 years. Following the failure of Allied Healthcare in December 2018, there are now 4 block contracts and these are with MiHomecare, CRG, London Care and Mayfair

11. Following the collapse of Allied Healthcare, the Council had been able to cope with the situation well, and block contracts transferred to other providers. The Council had needed to ensure that there was an adequate mix of contracts to suit resident's needs, and this is kept under review

12. The Committee noted that the Council, when letting the contracts, had only chosen to contract with 5 block providers through the procurement process

13. Quality assurance for the block contracts is provided by contract officers, who are responsible for holding providers to account, and implementing performance improvement plans, where necessary

14. There is also an LBI reablement team based in provider services within Adult Social Services. Block contractors provide support to around 800 LBI residents, with a projected spend of £9.5m. Spot purchase providers support a further 300 LBI residents, with a projected annual spend of circa £5.2m

15. There are over 17000 hours of domiciliary care commissioned across the borough every week. 1100 people receive domiciliary care packages every week. In one week in March 2019, there were around 400 carers delivering services through block contracts. Overall placements in residential/nursing care, paid for by LBI, have reduced since 2013/14 from 542 to 425 in 2018/19. The biggest reduction has been in standard residential care, where numbers over the same period, has dropped from 84 to 36

16. Islington carers are well- remunerated, in comparison to other providers, and block providers paid the LLW. Work is also taking place to investigate the payment of the provision of the LLW to spot providers, as spot provision is quite high

17. Some block providers found it difficult to meet specific needs, however there is no evidence that residents are going without care. However, it is felt that there is a need to assess care requirements at an earlier stage, when a resident is hospitalised. The Committee noted that the Telecare system is currently being reviewed, with the aim of increasing the use of technology, in order to improve the quality of life for those in receipt of care

18. Nationally, there are differences between the rural, and urban market, for care. It is often more expensive to provide care in rural areas, due to the travelling distance times. In affluent rural areas, it is more difficult to attract staff, as pay rates needed to be higher. There are currently 9,000 home care providers, but there is a high turnover, as it quite easy to set up a company,

however a large number of these new companies experience problems in operating a service, and then cease to be viable

19. In terms of commissioning and rates of pay, this varies across the country. In the North - East it is about £14 per hour, rising to £18 in the South West. Greater London is roughly £16 per hour, however Islington is the third highest payer in London, paying £17.71 per hour. The trend nationally is that hourly rates are rising faster than inflation

20. With regard to the carers' workforce, there are 50% of carers employed on zero hour contracts, and 38% of carers leave their provider within a year of starting employment. However, they often move to a different provider for an increased hourly rate. There is approximately a 10% vacancy rate across the profession. The payment rate for carers is complex, and different providers calculated pay rates in a different way. The Committee noted that in the view of providers many carers favoured zero hour contracts, as this gave them more flexibility

21. BREXIT is likely to have an impact on the workforce, at a time when the projection is that the elderly population will increase. This, combined with the 10% vacancy factor that already exists in the care service will be problematic

22. 92% of home care is provided by the independent sector, and the other 8% are mostly reablement services. In house service provision tended to be twice as expensive as private provision however, provision of reablement services may be a factor in this. In addition, Local Authorities had certain overheads that they had to incur, such as pension costs, better terms and conditions etc. than are available from private providers

Evidence from UK Homecare Association – Colin Angel Policy Director

23. The Committee also received evidence from the above.

24. The number of people affected by state funded market failures has shown a significant increase due the number of contracts 'handed back' by providers, or in instances where a provider has ceased trading. This has been a feature in both in the residential, and home care sectors

25. The current practice of the majority of Councils is to have a high usage of zero hour contracts. In order to achieve economically efficient guaranteed hours contracts for carers, Councils would need to recognise and pay the full costs of contact time, travel time and costs, as well as down time. Councils would need to pay the employer the costs of the entire span of the carer's duties, and their travel costs. Council's would also need to commission services in a way which increases workforce utilisation, e.g.by zoning areas, and moving away from framework agreements, to contracts with guaranteed purchase

26. The Committee heard evidence that flexible/zero hour contracts were popular with the majority of the workforce, even when there is an offer of the option of guaranteed hour contracts to the workforce. The reasons include that it enables workers to combine work, and other responsibilities. However, this results in carers' income being less predictable. Zero hour contracts also enable providers to respond to peaks and troughs in demand for services, and maximises the ability to recruit workers who want to work flexible/unsocial hours. However, there is a higher risk of short notice of cancellations from workers, if their contracts are not managed well

27. A guaranteed hour contract has advantages in that it gives workers a predictable income, and it is easier for them to obtain loans/mortgages/credit. However, it is often harder for them to arrange the hours to fit in with personal commitments, and there is less choice, as the worker needs to accept all the necessary arrangements within guaranteed hours. Younger workers generally prefer guaranteed hour contracts, and whilst they may increase staff loyalty, the provider bears the risk of financial loss if the purchasing pattern of the Council changes. Guaranteed hours are also generally more politically acceptable to elected Members, but there are increased costs, as the Council pays all the downtime

Evidence from City and County Healthcare – Caleb Atkins

28. City and County Healthcare are the foremost healthcare provider in the UK, providing 50,000 hours of care a day. It has 12,500 care worker staff at 170 locations, and operates in all homecare segments, home care, additional care, live in, supported living, complex care, and temporary staffing (agency). It has a diversified contract base, across more than 250 contracts, with Local Authorities and Clinical Commissioning Groups

29. There is a financially challenging environment, and there is the need to comply with the Ethical Care Charter Commitment, which is contractual. The Committee noted that it is considered that there is poor integration with health providers, and there is no local incentive for providers to invest and change delivery models. Partnership working has historically been poor, and the biggest challenge at present is to recruit, and retain, carers for the workforce

30. Care needs are rapidly growing, and the forecast is that the number of over 65's will increase from 11.8m in 2016, to 17.5m by 2036. This group will have increasingly complex medical conditions, and a reducing supply of informal care. Whilst some funding, and commissioning challenges remain however, the environment appears to be improving, and the outlook is more positive. There are still some areas of commissioning pressure, and there were issues, such as reassessments, the length of calls, and the minute by minute charging models that still needed to be addressed

31. The last 3 years have seen increased spending by Local Authorities, due to statutory care obligations. Local Authorities have redirected funding from more discretionary areas of public health funding, and there has been an additional £10 billion funding for social care, over the last 4 years

32. The supply and demand of the sector favours larger stronger suppliers, and it was stated that there is an acceptance by Local Authorities that charging rates must continue to rise. Commissioners are also struggling to secure quality care provision, and 78% of Social Care Directors are concerned about their ability to meet statutory duties, and to ensure market stability

33. The Committee noted that in terms of the price of providing care, carers wage remuneration is at the bare legal minimum, and noted that wage related costs need to be covered as well as travel for carers reimbursed. The Local Authority purchases the service at the lowest cost it can achieve, however a fair price needs to be paid, in order to attract and retain the workforce, to ensure that all costs are covered, and that a profit generated for the provider, which will support innovation, and reinvestment in services. This is needed to ensure that public money is spent on a service, which supports citizens well

34. The Committee noted that whilst carers needed basic literacy skills to read instructions for medication, residents' requirements etc., they all also had to undergo a 12 weeks training

course, and to obtain a Carers Certificate. Carers also had to be aware of users cultural needs, and it was noted that the workforce tended to be representative of the local community

35. Homecare is key to balancing overall health budgets, as there is the need to achieve break even point, when this is compared to hospital and residential care costs, and typically has better outcomes. Nearly 80% of adults prefer to live at home

36. Technology based solutions are transforming homecare, and there has been investment in digital technology and data, electronic care plans, electronic medicines management, full mobilisation of carers, digitalisation of operations, and improved data capture. The platform also uses an electronic hearing management system

37. In addition, technology to improve care has been introduced, and there are better measures of reporting from system derived data, rather than this being self-reported. There are electronic care quality plans, active tracking and alerts, and near real time data at the click of a button. This frees up time to provide care, and reduce administration and inefficiency, and reduces paperwork

38. There is also a remote audit and improved management opportunity, and daily call reconciliation. It was noted that if everyone reconciled on a daily basis, this could free up £10m of working capital to reinvest in the service

39. The Committee were of the view that there had been significant introduction of new technologies, and that there is further scope for new technologies to improve the service to clients, and reduce the cost to commissioners, and providers. Such examples include electronic care plans, electronic medication charts, and the ability to change service user needs, via mobile devices. The Committee noted the previous evidence submitted that the Telecare system is under review, with the aim of increasing the use of technology, in order to improve the quality of staff available for those in receipt of care. The Committee therefore recommend that providers and commissioners investigate, and continue to introduce new technologies, in order to improve the quality of life for those in receipt of care

40. The Committee also considered that giving the increasing elderly population, with ever more increasing complex and multiple needs, this will mean in the future a growing need for additional social care resources, whilst at the same time as social care is not being funded adequately by the Government

41. The Committee noted that the Green Paper on Adult Social Care that was due for publication a considerable time ago is still unpublished. The Committee therefore recommend that the Government adequately fund social care costs for Local Authorities, and implements a fundamental change to its long term funding position, as soon as possible. There is an urgent need to address the implications of a growing ageing population, who will have increasing and ever more complex needs

42. The Committee therefore recommend that the Government fund social care adequately, and implements a fundamental change to its long term funding policy, as soon as possible. There is an urgent need to address the implications of a growing, ageing population, who will have increasing and ever more complex needs. Whilst a long term goal would be to consider in house provision, as this would provide a better service for clients, more control for the Council and better employment for carers, the current funding levels provided by Government for funding social care does not allow this. If this situation changes the situation will be kept under review

Snowball Care UK Ltd. – Sayeeda Ahmed

43. Snowball are a care agency that provide domiciliary care and support, to people who have learning and physical disabilities, mental health problems, and also to elderly people

44. Snowball offer carers and support workers for residents who need extra support, and aim to ensure clients get the care and support that they want. Different types of care offered include waking night care, sitting service, and 24- hour care etc. Services include personal care, financial care, domestic support, social care, administrative, and nutritional care

45. Staff are criminally record checked, and recruited through a robust process, with references taken up, and full employment history. Staff have to undergo a comprehensive training schedule, and training updates are routinely given. Homecare managers and co-ordinator meetings review all carers weekly, in order to check performance, and ensure communication channels are maintained

46. Snowball works with learning disability clients, and this means a personalised service that supports and guides clients to achieve their full potential, in a friendly and safe environment, that enables them to learn new skills, increase confidence, develop life skills, and gain employment experience. In addition, attempts are made to engage clients in a wide range of different activities, that they find interesting and enjoy

MiHomecare – Ian Haddington

47. MiHomecare has delivered home care for over 20 years, and employs 3,000 staff, including 2,800 support workers. It delivers over 40,000 hours of care a week across SE England and Wales, from 15 registered branches to over 4,000 service users. It provides services in 15 London Boroughs, and has contracts with 50 Local Authorities, and CCG's/CIW. There is a consistent focus on quality, with all services rated Good/Compliant by the CQC/CIW. 61% of MiHomecare business is in London

48. In terms of the relationship with Islington, as mentioned earlier, a new 4 year contract (with the possibility to extend - 2 plus 2), was agreed in April 2018. There is a strong relationship with Islington, both at branch level and through senior management. MiHomecare successfully mobilised 3,500 hours of care delivery, to 360 residents in 9 days, following the Allied Healthcare failure in December 2018. It was pleasing to note that here has not been one missed episode of care, or of a service not delivered, following mobilisation. There are currently 211 care staff delivering c.4100 hours of care per week to Islington residents. These are 98% Local Authority funded, 1.3% CCG funded, and 0.7% privately funded

49. The Committee noted that the majority of visits to residents were usually around 30 minute duration, and that this did not always allow enough time for carers to discharge their duties effectively

50. There are a number of key challenges to the home care sector. This includes a need for further large increases in the numbers of care workers by 2022, nearly double the current number. There are other challenges, one being that the industry turnover of staff is 37.4%, and

that in addition less than 10% of the workforce is under 24 years of age. The minimum price for homecare is £18.93, and there is an increased need for specialist home provision. Partnership and collaboration are the key to a future successful approach. A recent example of this was at Cutbush House, where 3 different providers were providing care for 3 different clients

51. In terms of an operational model, care workers are the organisation's greatest asset, and there needs to be ongoing innovation and efficiency, value for money, effective leadership and experience, and a community focused approach, all underpinned by 'good' quality ratings

52. A recruitment strategy is in place targeting postcodes with the highest unemployment, and the aim is to attract staff, and reinforce care working, as a good and positive career choice. The payment of the London Living Wage (LLW) is a contractual requirement, and flexible contracts and work patterns, including guaranteed hours for all permanent care workers are available. There is a clear focus on retention of staff, and offering career progression, and the Committee were informed that MiHomecare felt that it has a strong reputation as a good employer

53. There has been investment and the introduction of the People Planner/Mobizio, (care management software), which includes the introduction of electronic care plans/risk assessment. Electronic medication charts and risk assessments has been introduced. In addition, there is now the ability to change service user needs, via mobile devices, and policies and procedures can be available at all times

54. There are a number of benefits to embracing innovation. These include increased local capacity, a valued workforce, with safer, more confident care workers, better service user visibility, real time monitoring, reduced hospital admissions, earlier intervention. In addition, there is improved prevention, fewer complaints, better safeguarding, and communication, with the ability to look after both the care user, and carer in a better way

55. In terms of partnership working, there is a need to provide ongoing involvement in future procurement, and to look at an alternative approach. This will enable a better understanding of each other's challenges, at an earlier stage, and will embed enablement into all services, where appropriate. Pilot contracts offer bespoke services to solve specific problems, and there is a benefit from increased frequency of commissioner, and provider engagement, with the ability to share technology

56. The Committee noted that one of the problems in providing care tended to be that users of the service wanted care packages at the same time, or at similar times, and this led to periods of downtime for staff. We noted however, that as Islington is a small borough, this enabled block providers to plan more easily to plan travel for carers, although spot providers found it more difficult to obtain such efficiencies

57. In terms of 'on costs' that are included in the care provider's business model, the costs for inner London, in terms of rent and rates, are obviously higher than other parts of the country. In addition, there are incorporated staff training costs. The introduction of technology could be able to reduce costs in some areas. However, 75% of costs were staff related costs. There were also other models of care that could be looked at, where costs could be reduced, whilst at the same time enabling clients to be more independent, and improving outcomes

58. MiHomecare stated that it felt that there needed to be provision of more individualised contracts, to create care plans that better met the needs of clients, and to give more autonomy to both clients and providers. There is a need to look at an 'outcomes based' approach that enables the verification of the provision of quality of service. Technology can assist in this process, as it can alert providers where an introduction of a change in care needs is required,

and independent quality assurance provided. Technology introduction will also enable carers not to have to manually complete 'log books' on visits, and information can be immediately transferred

59. In terms of improvements that are required to improve the service, providers were of the view that the most important measures that could be introduced included improving the experience of the workforce, pay rates and provision of a more effective service. In addition, there needed to be a focus on recruiting younger carers, as most carers are in the 45/50 age range). A better perception of the workforce is needed, and the 'minute by minute' charging system that is currently in use needed to be reassessed by commissioners, with more flexible methods of delivery, and a less prescriptive delivery of service

Evidence from Adult Paid Carers – (MiHomecare/London Care)

60. The Committee received evidence from a number of Adult Paid carers, who attended a meeting of the Committee

61. The Committee noted that many carers had begun working in the caring profession, after initially caring for a relative or friend. Carers informed us that they enjoyed caring for the elderly, however they did not feel adequately financially remunerated, especially for working at weekends, or after 6p.m.

62. The Committee questioned carers on whether they favoured guaranteed hour contracts or zero hour contracts, and it was stated that carers were broadly in favour of more guaranteed hours contracts, as zero hour contracts did not give security of income. It was stated that if a client went into hospital then a carer would lose their pay, as the Local Authority care package is not required when a client goes into hospital

63. The Committee were informed by MiHomecare, and London Care that they did offer guaranteed hour contracts to all carers, once they had passed their probationary period, but carers had to commit to working 30 hours per week, and this could involve late night or weekend working, which some carers did not wish to commit to. Many carers wished to work a 9-5 working pattern, and this was not always possible with a guaranteed hours contract

64. In addition, some clients did not want to go to bed until 10.00 p.m. This led to a long day for carers, as often they would also have to start early in the morning. Most of the carers' duties took place within set hours, during mornings and early evenings, and there was a lot of downtime for carers, if a client wished to put to bed late at night. This led to carers having to work a long day, however they felt that their remuneration did not reflect this

65. The Committee recommend that there should be a focus on overall wellbeing outcomes for service users, rather than a list of specific tasks conducted at specific times of the day. Commissioners and providers should consider opportunities for a more personalised, as well as an efficient home care system. Opportunities may include better utilisation of personal budgets, and geographical zoning, whereby a provider has a set budget for each service user, based on their needs, to deliver a personalised service, which would reduce downtime for carers, and enable improved efficiency. Continuity of care is important

66. Carers informed us that they also suffered from instances of abuse, violence or racist attitudes, towards them by clients, and that this should not be acceptable. The view was expressed that there should be a zero tolerance policy introduced to prevent this type of behaviour. However, the Committee noted that if clients did exhibit and persist in this behaviour, Local Authorities are in a difficult position, as they could not just withdraw care. It

was noted that present, where a client provided difficulties, it appeared the client was just passed on to another provider, without necessarily solving the problem

67. The Committee therefore recommend the institution of a zero tolerance approach in instances of verbal/physical/racial abuse, and commissioners/providers should take effective action. Commissioners should engage specialist providers who offer their staff appropriate specialist training, in order to meet the needs of service users with challenging behaviours, in order to minimise the effect on carers

68. Carers also informed us that there appeared to be long periods when there are reported concerns about clients, and action taken by Social Services. MiHomecare informed the Committee that they did report concerns relayed by carers, however whilst Social Services took action quickly in some cases, because of pressures within the system, this was not always the case. The Committee noted that carers were of the view that they were often the best placed to know the concerns, and problems of clients. Carers expressed the view that in some instances, actions are not 'put in place' within an adequate timescale by Social Services. There appeared to be no timeframe for dealing with concerns expressed and there needed to be better sharing of information processes

69. The Committee are of the view that there should be exploration of the opportunities presented by Fairer Together, which is a part of the Local Authority, NHS and for improved co-ordination between commissioners/NHS/Voluntary and Community sector partners/ stakeholders, with the aim of enabling residents to live a healthy life on their own terms. Work should also take place to ensure the conveyance of the correct information to providers/carers in relation to clients' needs. This is especially in relation to discharge of clients from hospital to ensure the administration of the correct medication/assistance. Opportunities for the introduction of new technology, as recommended in (a) above can assist in this

70. The Committee also noted that carers did not feel the travel time allocated for visits to clients and that payment for late working and weekend working is sufficient. The Committee were informed that contracts that were agreed between the Local Authority, and providers

71. The Committee heard evidence on the Trusted Assessor model and informed that there are potential opportunities to improve the quality and speed of discharges from hospital. Providers are sometimes unable to respond quickly and flexibly to clients changing needs, as they are limited in their ability to make changes to care plans. This should explore how commissioners, providers and social workers can work together, in order to ensure more timely and responsive changes to care packages, in line with clients changing needs

72. The Committee therefore recommend that consideration is given as to how the Council can make best use of the expertise and skills of providers and carers. In addition, consideration should also be given to consider opportunities to empower and place more trust in providers, and carers, to make decisions about the care and support clients require, from discharge from hospital to making adjustments to care packages as needs change. This may include an exploration of new roles. The Council should also explore opportunities for more regular reviews from providers, and the Council, to enable care needs of users to be checked more frequently, in order to ensure that there is no over/under provision of care.

73. The Committee also heard evidence that there are 'untapped' opportunities to improve career pathways into home care, and career progression, within health and social care. The Committee also recommend that consideration is given to career pathways and progression for carers, as part of the wider efforts of Islington's Health and Care Academy. Commissioners

should explore which social value clauses and good employment practice stipulations would be appropriate to include in future specifications and contracts

74. Carers also expressed their concerns that they had to visit estates, or areas, that they felt to be unsafe, often late at night. Many carers are women, and they felt especially vulnerable. The provision of parking permits for carers would assist them in being able to take their cars, if necessary, and be of minimal cost to the Council. There may be other benefits that the Council could also offer to make carers feel more valued by the Council, for the particularly difficult job that they performed

75. Some carers also expressed concern that there should be a review of the procedure for payment for sickness as it is unfair, and it is complicated to claim. MiHomecare informed the Committee that all care workers employed by MiHomecare receive statutory sick pay. A care worker will not receive any pay for the first 3 days of sickness absence, known as waiting days, but will receive pay for the fourth day of sickness onwards. Care workers are required to complete a self-certification form for the sickness pay to be processed. After a 7 day sickness absence, carers are expected to submit a sickness certificate form from their GP

76. London Care informed the Committee that all employees are entitled to receive statutory sick pay during a period of sickness, on the proviso that employees comply with sickness reporting procedures. Carers will be required to produce appropriate evidence of any period of sickness. London Care pay carers £94.25 per week for a period up to 28 weeks. A return to work interview is mandatory before staff are allowed to return to work

77. The Committee were impressed with the commitment, and excellent work, that carers provided for clients in Islington. The Committee heard differing evidence as to whether carers wished to be offered guaranteed hour contracts, rather than a zero hours contract, or whether they preferred the flexibility provided by zero hour contracts. In addition, the Committee heard that carers are unpaid for the time that clients are hospitalised, if alternative work is not available. The Committee also noted the concerns expressed above that carers often experienced problems when having to claim sickness pay, and that this in their view sometimes can be complicated

78. The Committee also recommend that given the evidence above in relation to safety, that there should be provision of parking permits for carers working late at night that have to use their car. The Committee also support the Mayor of London's election manifesto commitment to provide concessionary London Transport passes for carers for the disabled, if he is re-elected. The Committee are of the view, that given the shortage of home carers, commissioners and providers should investigate other possible recruitment/retention measures that could be put in place to help alleviate such shortages

79. The Committee therefore recommend that there should be promotion of caring as a profession, and that providers should offer all carers guaranteed hour contracts, rather than zero hour contracts, even if carers did not ultimately wish to take up guaranteed hours contracts. The Committee consider that there should be exploration of a discontinuation of 'minute by minute' charging, in order to reflect recommendations (c) and (d) above. There should also be consideration by providers to compensate/find alternative work for carers, in the event of clients being hospitalised. In addition, providers should ensure that the process for claiming and payment of sick pay by carers is simplified

Evidence from Penrose Care – Bob Padron

80. The Committee received documentary evidence from Penrose Care, who are a recognised provider of ethical home care services. The Care Quality Commission have rated Penrose Care as outstanding. Penrose Care has received a number of awards, including twice named as a Living Wage Champion, and internationally recognised for its innovations in Home Care. In July 2019, Penrose Care became one of the first 16 private businesses accredited with the Mayor of London's Good Work standard, an initiative to promote decent work in London

81. Penrose Care made a number of suggestions that they felt would be beneficial to keeping home care users healthy and improve the sustainability of services from the provider perspective. These include reforming the timing and geographic location of services to make job roles more attractive. Home Care providers struggle with attracting new social care workers to provide frontline services, and complying with their statutory obligations to their employees. Councils can alleviate the pressure on home carers by booking home care visits sequentially, and allocating users to groups of providers by small geographic regions. Currently it is the standard practice for social workers to book home care visits generally at the same times e.g. morning, lunch and evening, which can result in systematic underemployment of home care workers, as they may be without work between the standard visit times. By booking visits sequentially, providers can offer home care workers, full daily loads of work, making it easier to attract new home care workers, and reduce staff turnover, which is chronically high in home care. Users, who independently cannot have time sensitive medications administered, should have priority for visits during the peak morning, lunch and evening visit times. However, responsible bodies must assess whether it is prudent for public social care services to be supporting individuals who are unable to manage their medications independently, or whether such persons need consideration for residential social care options, such as assisted living centres, care homes or nursing homes. Furthermore, home care providers have historically struggled complying with National Minimum Wage statutory obligations, due to the need to compensate employees for travelling between clients. Social Care commissioners can alleviate this pressure by allocating users by small geographic regions to small groups of providers

82. Social Care professionals can also make easy positive impacts on users' lives in the areas of falls prevention, hydration, and early detection of infections. Falls prevention can be achieved by social workers, and ensuring the adequate allocation of an occupational therapist, and physiotherapist. Social care professionals can assist by checking if visits, by health care professionals have taken place. Social workers can improve hydration levels by encouraging users to switch to decaffeinated tea and coffee. Undetected infections can cause users' health to take steep declines. As a result, social care providers and the CCG should explore the provision of regular urine tests for users, who consent to provide the early detection of infection (See recommendation (j))

83. Furthermore, the Council can prevent adverse developments by having an in-house team check that social care workers have arrived to their visits, so that if a provider misses this it will not be missed, and then the Council can arrange a back-up social care worker to attend. This would require the Council to mandate a uniform time and attendance software across the provider base

84. The Committee, given the evidence given above on preventative action that can be taken, therefore recommend that a more integrated approach be taken to preventative care, in order to reduce hospital admissions, and commissioners should work with providers, social care and NHS in this regard

Direct Payments – Stephen Day/Nicola Herrera – Martinez –L.B.Islington Independent Living Team

85. The Committee also received evidence from the Independent Living Team in relation to Direct Payments

86. A personal budget is the amount of money the Council will pay towards any social carer and support a service user needs. Personal budgets are determined following an assessment of needs under the Care Act. The assessment will confirm what kind of care and support is needed, how much it will cost, and how much the service user is able to afford to contribute following financial assessment

87. A personal budget is payable to the service user or carer, to enable them to make decisions about how it is spent. This is a Direct Payment. Direct Payments have been in use in adult care and support since the mid 1990's. The Care Act 2014 confirms personal budgets in law for people with eligible assessed needs and carers, including the right to a Direct Payment. In order to ensure that people are supported to use and manage the payment appropriately, local authorities must provide relevant and timely information about direct payments

88. Direct Payments give individuals greater choice and control over the support that they receive, and the provision of such support. For example, a person can choose to hire care workers, or personal assistants who are always the same people and available when needed, speak the same language, have experience working with a person's care needs, or is a specific person that has been recommended

89. There are choices a service user can spend the money. The service user can make a choice, as long as the person spends the personal budget on things that meet their needs, and are detailed in the support plan

90. The benefits of direct payments include – choice and control, flexibility, empowerment, consistency, person centred, creative, enable more specialised support, savings to the Local Authority, which enables more funds to be spent on servicing clients, local job creation, improved service provision, less prescriptive care, and a variety of sources of service provision

91. Feedback from the 2018 user survey shows that the Direct Payment recipients felt that they had the most choice, and control, over their care and support services. Currently 22% of all Islington community care and support is provided through Direct Payments

92. The Council is trying to improve the offer to encourage people to move on to Direct Payments. Personalisation is a key stream of the Adult Social Care Plan 2019-22. Building on evidence from research, the aim is to improve the offer to people who choose a Direct Payment. The aim is to increase uptake to make it the default choice, and are looking at how the market can meet the needs of those who choose Direct Payments. A current review is currently taking place of processes and policies, and work is taking place across departments, and the CCG, to ensure an integrated and co-ordinated approach to personalisation, and updated policies and

procedures. The aim is to develop a new training offer for social work staff, regarding the approach to personalisation, and update policies and procedures

93. Work has already started to reintroduce the Direct Payments Forum to engage with all recipients, gather feedback, and guide plans for improvement. Feedback has been very positive. There has been an active working group established with service users, and carers, to shape future forums, work on the actions from the forums, and engage Direct Payment recipients to network and offer peer support. The working group is developing a training offer for Direct Payment employers, and PA's, engaging current providers, and building the local market

94. The Direct Payments services provide the following assistance – information, visits, and joint visits with practitioners to prospective new Direct Payment users to explain about flexibility, choice and responsibilities for Direct Payment employers. The team also provides employment set up and advice, assistance with payroll, employers' liability insurance, DBS checks, redundancy, employment contracts, etc. There is ongoing support provided to existing, and new, Direct Payment employers. There is no administration charge imposed by the Council

95. The Direct Payment team is also working with the CCG to set up personal health budgets, and service users who are on continuing care or have long- term conditions, can now access Direct Payments. They are health funded, and are called personal health budgets and they have commissioned the Social Services Direct Payment team to deliver them. The Direct Payment team complete the following tasks for the CCG – information visit, costing care plan, completing personal health budget agreements, adding the support plan and provision to LAS, support with employment, recruitment etc. Personal health budgets can be virtual budgets

96. The Committee noted that changes in the situation in the condition of a service user is usually detected either through notification from a social worker, GP, carer or family member. Although there is an annual review, vulnerable clients are visited more often, in order to check on them, and this is often done every 2 weeks

Evidence from Centre 404 – Jo Mackie

97. The Committee also received evidence from Jo Mackie of Centre 404, in relation to traditional contracted services as opposed to personal budgets, and the introduction of Individual Service Funds (ISF)

98. Traditional contracted services paid money to the provider as a lump sum to pay for support/care for more than one person, provided in terms of hours. The provider manages the overall budget to balance the needs of the clients, and the client is reliable on one provider to meet all outcomes on a long term agreement basis

99. Personal budgets enable monies to be available to the client, or a nominated person. The funds paid are for the support/care of one individual based specifically on their needs. There is support/care is provided within a financial budget, rather than hours, and a client or nominated person manages the funds for the individual. Clients can choose how to use their budget and spend on different services, activities, providers and equipment. In addition, how the personal budget is used can change over time

100. There is an assessment process for personal budgets for people with learning disabilities, where needs and desired outcomes are assessed, how best to work to establish outcomes,

agree funds required to meet these outcomes (personal budget), and then to decide how the personal budget will be managed

101. Individual service funds operate on an agreement between the client, Council and organisation, and an online bank account, and a pre-paid card made available. An annual budget is agreed and split into 4-weekly payments, and the organisation keeps all the paperwork, and is liable for the management of the account. The organisation manages all payments out and in, including invoices for support, paying payslips and tax for personal assistance, activity reimbursements for clients, travel reimbursements for support workers and course and activity fees. The Council has access to the account, and recovers surpluses and runs reports, and the organisation monitors, and follows up, the payment of assessed contributions, and this is a chargeable service

102. For clients, the benefits of individual service funds are that they are more flexible and personalised, used for different ways of meeting outcomes, relieves pressure on families/clients to manage finances, and enables payments and reimbursements to be made more quickly. It also enables changes to support and activities to be made quickly, recurring payments can be set up, smoother processes for arranging support and activities, and payments are smoother if the provider has oversight and management of Individual Service Funds, and support

103. Individual Service Funds also enable a more creative and proactive approach to be taken, with support planning, and the ability to respond to new opportunities, leads to reduced involvement with social services, the ability to review surplus and look at how unused funds can be used, and is cashless

104. For providers Individual Service Funds provide an oversight of what budget is available for a client, enables them to respond to support and activity requests more speedily, reduces face to face auditing, and the workload of having to contact social workers or finance teams. In addition, there is more joined up and person centred support, clear support plans, ability to assist a client with managing a budget and spend across the year, enables feedback to the social worker on the balance of the budget when looking at new support or activity requests. There is also the possibility of a more holistic and creative approach, with a focus on outcomes, rather than the provision of fixed hours. Networks and communities can also be built with other providers being used and be able to share information about opportunities for clients. It also assists with internal debt management, and can be followed up with the ISF manager if payments are not made

105. Individual Service Funds benefit social services, as it reduces strain on in-house services, reduces incoming day to day work and enquiries, reduces the need for meetings due to a change in circumstances, there is less face to face auditing, and a reduced risk of financial abuse. Individual Service Funds also provide the facility to upload documents, there are fewer third parties to deal with, and gives the ability to report on payments of assessed charges. In addition, it facilitates more responsive and dynamic social care provision, and can potentially find savings by identifying creative ways to meet people's needs

106. The Committee were informed that to work well, individual service funds need a good relationship between, providers, social work, and finance teams and clear support plans that are flexible, and not over prescriptive, be outcome based, provides guidance around the use of personal budgets, and are well thought through for all potential costs

107. The Committee were of the view that evidence received has shown that Individual Service Funds into learning disability payments is working well, and enables clients to have flexibility

and control over their care. This would assist in the move to an outcome based service, as recommended earlier in the report

108. The Committee therefore recommend that commissioners, as part of a broader market development, explore the appetite and capacity for delivering personalised services delivered through Individual Service Funds, or direct payments.

109. The Committee heard evidence of the benefits of taking a relationship based approach, and a stronger enablement approach, together with the integration of different types of support. The Committee recommend that the Council works with clients, their relatives and providers to review the Council's services to people in their homes, to explore opportunities for improvements that will better support residents to maintain independence and improve wellbeing

Sweet Tree Home Care Services – Nikki Bones and Denis Repard

110. Evidence was also received from Sweet Tree Home Care Services, who are rated Outstanding by the Care Quality Commission

111. Sweet Tree support all general home care needs, and have 6 specialist services, all individually led by highly experienced clinical managers providing 2 - 24 - hour care at home. This includes general home care, dementia care, end of life care, learning disability support and complex care, acquired brain injury, and neurological conditions

112. There is a clinically led circle of assessment and support to deliver Sweet Tree's vision, including early diagnosis, shared assessment, knowledge and information, care and support and regular reviews, shared with the person and their family, with input from internal and external experts

113. Sweet Tree employed 3% of all applicants in 2017, and all those employed must have 6 month minimum experience, and all team members are hired to individual services for their knowledge and skills experience

114. Sweet Tree is an accredited training academy, with a wide range of expert internal and external trainers. There is investment and recognition for the value of Learning and Development for each team member. There are Sweet Tree Manager Induction standards, a new learning management system, and mission values are taught, and reinforced and there is customer service training for all

115. Compliance and regulation is a whole team responsibility, and there is clinical expertise and specialist knowledge. The in-house teams consist of Registered General Nurses, Registered Mental Health Nurses, social workers, a clinical psychologist, physiotherapists, and qualified trainers. Each service is managed by specialists who recruit specialist teams to each service

116. Sweet Tree work with many partners, learning from and supporting each other playing a part in research projects, work on Committees, and building a national Dementia Carers Day

117. Governance provision is through an Advisory Board, which opens the company to external scrutiny and, in this way sets a precedent within the industry, and is a model available for

adoption by others. In addition, it addresses how the company is operating, and considers methods of best practice, and in this way the Board will become a catalyst for innovative thinking, enabling the company to reach new levels

118. Sweet Tree seek to provide a quality service, and support worker wages and travel, and training is initial and ongoing. There is support provided to families and clients, and there is continual improvement. Sweet Tree also works with many partners, providing learning and support for each other

119. In terms of quality assurance, Sweet Tree also commissions an external provider to do a mock inspection, has an internal and external audit process, and monitors calls for quality assurance. There is also a variety of consultants, who assist on projects, and monthly meetings of the senior leadership team, and an external audit

120. Sweet Tree informed the Committee that it has a minimum two -hour visit time for clients, and that carers allocated blocks of 6 or 12 hours. Sweet Tree were of the view that to develop a good client/provider relationship a two - hour visit is required, and this could not be provided in a 15-minute visit

121. Sweet Tree has a manager who provides support to 15/20 support workers, which allows better support for clients, support workers and families. However, there are many different models of support that providers supply, but they did not feel choice, quality of care, and flexibility could be achieved by 'minute by minute' commissioning

122. Sweet Tree stated that they had a workforce that is representative of the local community, and that clients are 'matched' to support workers, as much as possible. Where there is not a direct match, training is given

Wellbeing Teams – Helen Sanderson

123. The Committee received a video presentation from Helen Sanderson, as to a new model of care developed relating to Wellbeing teams, and that this involved the creation of self-organised teams in health and social care. There is a different way of approaching support in that plans are co-produced, there is a whole person focus, and there is capacity building and connections made

124. The support sequence involves self-care, wellbeing workers, community and services, assistive technology, and friends and family and community circles and the client

125. There is value based recruitment, and an induction process, and ongoing development and learning, with a focus on quality delivery of services. Workers for the wellbeing teams were not solely recruited from the home care sector, but also from industries such as retail, where good customer service skills were important

126. The Committee were informed that two wellbeing teams had been set up with Thurrock Council, to support the Local Authority to bring together community support, and home care, and this requires a different type of commission than the normal outcome based commissioning

Duncan Patterson – CQC

127. The Committee at its meeting on 21 November 2019 considered evidence from Duncan Patterson of the CQC

128. The CQC is the independent regulator of health and social care in England, and ensures that health and social care services provide people with safe, effective, compassionate, high quality care, and encourage care services to improve

129. In terms of Adult Care 80% of care settings were found to be good, 4% outstanding, 15% require improvement, and 1% are inadequate.

130. The Better Lives report highlighted organisations that are focus on individual drivers for success, rather than systems thinking. For people to receive a high quality service there is need for strong vision, governance, culture and leadership. There is also a need to work together to focus on the same metrics for success

131. There is a need for organisations to have a consistent, passionate, workforce and limited/structured use of agency staff. Staff need to be empowered, and there should be good leadership and strong links with the community. Common success factors include committed leaders, putting principles into action, culture of staff equality, staff being viewed as improvement partners, people who use services being at the centre, utilisation of external help, and continuous learning

132. The CQC encourages improvement by discussing best practice through an independent voice, publishing findings of inspection reports, publications, blogs, learning from incidents, etc. In the next year CQC Business Plan, there will be prioritisation of the development of a robust and consistent approach to regulating innovative, and tech enabled, care provision with complex cross sector providers. As technology and provision evolves, the CQC will work alongside people who use, and deliver services, to encourage improvement and stay abreast of technological innovation, refine the statutory approach, and welcome discussion with those who use such services and providers in the private sector. This will lead to technology improving care, whilst safety, and quality of care is ensured

CONCLUSION

The Committee received evidence from a number of witnesses, and especially found the evidence from the carers, extremely informative. Carers perform an extremely difficult job, and we are grateful for the work that they perform on behalf of both residents and the Council

The Committee are aware that social care has not been funded adequately over a significant number of years by the Government, and that this has led to Local Authorities having to seek to commission services at a cost that they can afford, whilst trying to ensure that carers at least in L.B. Islington receive the LLW

The Committee are of the view there are benefits that, in addition, the Council can offer, such as parking permits for carers, that can help carers to carry out their work more safely and efficiently, and demonstrate that the Council values greatly the work that they perform for residents

There are also technological advances that can be utilised by providers that should assist in the ability of providers to deliver a better service, whilst delivering on cost savings for commissioners.

The ‘minute by minute’ charging system is in our view a disincentive to both providing an efficient service, and penalises carers, as they are not paid for travel time, on whom the service depends. The Committee are of the view that geographical zoning would produce better outcome focused service provision for clients, and the recommendations that we have made we feel will also improve the conditions and benefits of carers.

The Committee hope that its recommendations will provide an improved work/life balance and financial reward for paid carers, whilst at the same time delivering a better service for residents

APPENDIX A

SCRUTINY INITIATION DOCUMENT (SID)
Review: Review the current arrangements for commissioning and delivering domiciliary care services within LB Islington
Scrutiny Review Committee: Health and Care
Director leading the review: Jess Mcgregor
Lead officers: Marisa Rose and Jon Tomlinson, Ray Murphy
Overall aim: To review the current position regarding paid adult domiciliary care workers in LB Islington including: funding, numbers, contractual arrangements funding, numbers, delivery arrangements and their effectiveness. To consider other models of commissioning and delivery in place in other parts of the country. To advise on any changes that need to be considered/implemented to the strategic direction for providing care support to people in their own home.
Objectives of the review: • To consider numbers and profile of paid Carers in Islington and consider any benchmarking data • To examine the requirements of commissioned providers in respect of adult paid carers in terms of: remuneration, quality assurance and risk assessment, training, travel time, payment of LLW, and how cultural /specialist needs are being met. • To examine the area of Direct Payments. • To examine the effectiveness of the current arrangements. • To examine the different models of commissioning, including best practice that can be adopted and examples of innovative Local Authorities. • Delivery of care at home currently in place elsewhere. • To consider any actions that may need to be taken in the light of the findings of the review to ensure LB Islington effectively supports citizens to remain independent, healthy and part of their local community. • To consider how local providers can be assisted to bid for contracts for Adult Social Care. • To consider how caring can be promoted as a career • To consider charging policy and comparison with other Local Authorities • In house service – is this a practical delivery model – costs, level of service provided • To consider whether joint action with Health providers on care packages can lead to reduced admissions to hospital/reablement packages that meet the needs of those in receipt of care, and if savings can be achieved through a more integrated approach
How the review is to be carried out: <u>Scope of the review</u>

The review will focus on the commissioning, delivery and effectiveness of the current arrangements for delivering home based care to support citizens in their own home. It will also focus on workforce challenges and how to encourage increased local employment of paid carers and how caring can be promoted as a career. Also, it will review the impact of staff attrition and sickness levels on the provision of care. The review will also consider other models of care successfully deployed elsewhere and its applicability to Islington – including joint arrangements with health where delayed transfers of care have been reduced. Some focus will be given to ensuring individuals who need support get it in a timely manner.
Applicability and effectiveness of the in-house service will be examined in some detail as will the Islington approach to charging.

<u>Types of evidence</u>

1. Documentary evidence including:
    a. DH guidance, advice and findings from reports published by specialist and advisory organisations
    b. Service information in relation to commissioned and directly delivered provision.
2. Witness evidence including presentations from:
    a. Commissioned (2 block, 1 spot), non- commissioned/ in-house providers.
    b. Paid carers.
    c. LBI/NHS commissioners.
    d. LBI Care Management Team.
    e. Domiciliary care national provider trade organisations – UK Homecare Association.
    f. Service users, carers and families from within Islington as appropriate.
    g. Colleagues from other areas currently delivering services through alternative models.
    h. CQC.
    i. Skills for care.
    j. Direct Payments team.

Additional information:
Timescales: (*to be confirmed*)

9 May 2019 Presentation and sign off of updated SID
June 2019 to February 2020 Witness Presentations
March 2020 compilation of report.
April 2020 Final Report

In carrying out the review the committee will consider equalities implications and resident impacts identified by witnesses. The Executive is required to have due regard to these, and any other relevant implications, when responding to the review recommendations.

MEMBERSHIP OF THE HEALTH AND CARE SCRUTINY COMMITTEE – 2019/20

Osh Gantly – Chair

Nurullah Turan – Vice Chair
Jilani Chowdhury
Tricia Clarke
Joe Calouri
Roulin Khondoker
Martin Klute
Sara Hyde

Co-opted Member

Substitutes:

Satnam Gill OBE
Anjna Khuruna
Mouna Hamitouche MBE

Co-opted Member:

Vacancy- Healthwatch

Acknowledgements: The Committee would like to thank all the witnesses who gave evidence to the review.

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Peter Moore – Democratic Services
Lead officer/s- Jess McGregor, Director of Strategy and Commissioning,- Housing and Adult Social Care

UNISON Submission to London Borough of Islington Health and Social Care Scrutiny Committee, 16th July 2020

Subject: The council's response to the government's introduction of an Infection Control Fund for care homes and domiciliary services

1. Background and National Context

1.1 Approximately a third of the 43,000 deaths directly linked to the coronavirus have been in care homes. With the total number of people living in care estimated at 330,000 in the last census, this means about one in 20 residents have died after contracting the virus.

1.2 It now seems to be widely accepted that the level of infection in care homes arose from many providers being persuaded to take people from hospital who had not been tested. This situation was further compounded by a failure to test for the virus in a timely manner within the care homes and by many residents and staff who were infected, presenting as being asymptomatic.

1.3 A BBC Newsnight report on 3rd June featured care homes run by MHA in the North West of England. When the homes were eventually able to commence testing, approximately 42 per cent of staff and 45 per cent of residents who tested positive, were asymptomatic. This underlines, not only the importance of testing, but also the absolute necessity for infected staff to self-isolate.

1.4 Although perfectly lawful, many workers in care homes and in domiciliary or home care often have poor and unsafe working conditions, all of which are allowed by law:

- Poor pay, often only the minimum wage
- No occupational sick pay (equivalent to full pay)
- No proper voice, often no trade union recognition or representation
- Lack of PPE and training
- Often, worse conditions for agency staff

1.5 Although there is a significant minority who will not be able to, most staff not receiving occupational sick pay will be able to claim Statutory Sick Pay (SSP) of £96 per week. However, this is about a quarter of a full-time worker's salary. There is usually a qualifying period of four days for receiving SSP but recently regulations were amended to allow payment from the first day of any Covid-related sickness absence.

1.6 Lack of proper provision for sick pay means that if, due to a positive test result for Covid-19 or a suspected infection, a member of staff needs to self-isolate, they will not be able to put food on the table and pay bills. The introduction of a track and trace system means it is highly possible that individuals could be advised to self-isolate several times over and clearly this could be even

more financially catastrophic for them. UNISON believes that at the very least, local authorities should be willing to encourage and financially support providers to at least pay full pay to staff who need to isolate (isolation pay). On 3rd July, UNISON senior national officer, Gavin Edwards said: "The best run homes pay employees full wages to workers off sick. In others, ill staff are effectively forced into turning up for work because they can't survive with no money coming in."

1.7 The Organisation of National Statistics (ONS) Vivaldi study, published on 3rd July and based on responses from 5,126 care homes in England, found that in homes where staff receive sick pay, residents were estimated to have lower odds of testing positive, compared with those where staff did not receive it. We believe that payment of full pay for isolating staff is a crucial measure and we do not believe that such payment should be restricted to those who have tested positive. Tests now seem to be more widely available whereas at the start of the pandemic, and particularly, in care homes, they were not. A positive test should however not be regarded as critical as there is quite significant evidence of false negative tests, particularly where a test may have been wrongly or poorly administered. It should also be clear that isolation pay can be made available to staff with a sick family member or to those who have been in contact with another infected individual or have been advised to self-isolate by the Track and Trace or Public Health service.

1.7 In April, a study undertaken by Public Health England - which has been partially suppressed – identified the issue of asymptomatic staff working across more than two or more care homes as being a significant factor in the spreading of the virus. It is reasonable to assume that most of these staff were agency or bank workers. The ONS Vivaldi report found that homes that used bank or agency staff most days or every day were 1.58 times more likely to test for Covid-19 than in homes not using such staff.

1.8 On 13th May, the government announced a £600m Infection Control Fund (ICF). The government's grant circular for the ICF stipulates that local authorities must "ensure that 75% of the grant is allocated to support six specific measures. These are set out in Appendix 1.

1.9 The ICF applies to all homes within a borough's boundary, irrespective of whether or not there is any contractual relationship between a home and the local authority.

1.10 Some ICF funding can also be channeled to those homecare providers with which a local authority may contract, again to pay isolation pay.

1.11 The Department for Health and Social Care required local authorities to submit a planning return detailing how the ICF was to be used by 29th May. It was not until that date that the Local Government Association (LGA) published its "Infection Control Fund grant conditions Briefing" online. It may be the case that the LGA's members were provided with copies of the briefing prior to this but this is not clear, and it is therefore difficult to know to what extent, any authority might have benefited from this prior to submitting its planning return to the DOHSC.

1.12 The LGA briefing rightly describes the Grant Circular for the ICF as "an unusually prescriptive document", the implication perhaps being what the government had done was to lay out a minefield which local authorities were then required to traverse without anything exploding in their faces. We believe however that the LGA is wrong in describing the six specific measures (shown in Appendix 1) as constituting "a limited range of infection control measures". The briefing implies that these are not as important as PPE or provision of deep cleans and whilst not wishing to downplay the crucial importance of the latter measures, there seems here to be an inability to clearly see that staffing measures such as payment of full pay and preventing cross-home working are absolutely crucial in terms of infection control.

2. Care Homes in Islington

2.1 There are sixteen care homes in Islington. This submission is mainly concerned with those that provide care for older people. However, it is worth noting that eight of Islington's care homes are relatively small ones, providing care for a range of service user groups:

- The council provides directly: three homes for people with learning disabilities. Staff working in these homes are on local authority terms and conditions of service, which includes entitlement to full occupational sick pay.
- Three voluntary sector organisations provide four homes for younger service users with a range of needs: mental health; substance misuse; homelessness; physical disabilities. Whilst we have no precise details of the staff terms and conditions of these organisations, prior knowledge of the sector would suggest that staff are employed on terms and conditions which are broadly comparable to those of the local authority.

2.2 Six providers provide nine homes and 400 places for older people in Islington. Staff terms and conditions vary, and this includes entitlement to sick pay. ; we will return to this later.

2.3 The council contracts with Care UK to provide three of the homes for older people.

3. London Borough of Islington's position on the Infection Control Fund and its responses to Islington UNISON.

3.1 Exchange of correspondence between Andrew Berry (AB) and the leader of the council, Councillor Richard Watts and the Executive Member for Social Care, Councillor Janet Burgess, regarding the ICF and isolation pay, occurred over a period of more than six weeks: between 19th May and 3rd July . This correspondence is attached in Appendices 2 to 8.

3.2 Enquiries from UNISON were not always responded to in a timely manner . AB sent UNISON's first email regarding this matter on 19th May however the leader did not respond until 28th May. He stated that AB'S original email had been sent to his personal email account, but this is not correct.

3.3 A crucial point of difference emerging from the exchange of correspondence concerns how much control the council has as to how money can be spent by care home providers. Related to this, there seems to have been some difficulty in terms of the council - or at least the Executive Member for Social Care - acknowledging what the ICF is actually is and what it is for. Despite the grant circular for the ICF stating that local authorities should "ensure" it is spent on six specific measures (See para 1.8 above), both Councillor Burgess and Councillor Watts have painted a picture of the local authority having no agency in the matter and no control over how the money is spent.

3.4 In her email to AB of 28th May, Councillor Burgess stated:

"Despite the Government claiming it as extra funding for councils, the additional £600 million ring fenced infection control fund to support care homes, which you mentioned, is in effect an industry fund and not Council cash… "

On 1st June, Councillor Watts, publicly tweeted in reply to a tweet from AB that the Infection Control Fund could not be used to pay isolation pay:

"Because, as we wrote to you, it's a condition of the grant that it has to be given straight over to the care providers".

3.5 In her email of 28th May, Councillor Burgess went on to say:

"It is estimated that the fund will provide a 50 bedded care home with about £50,000 additional resources, but if the occupancy levels are down to around 30 residents, the home will be making a loss of around £10,000 per week. Islington Council has also seen income reduce sharply over the past few months as costs linked to the pandemic rise and we have no idea for how long the current situation will go on."

3.6 A letter of 22nd May, from the Minister of State for Social Care, Helen Whately, makes clear that the "funding should only pay for activity to help reduce the risk of infection and is not intended to be used to improve provider financial resilience."

3.7 Replying to Councillor Burgess on 1st June, AB stated that he did not believe it was correct to represent the fund as "in effect an industry fund and not Council cash". Although certain elements of the criteria for its use remained vague, it seemed clear that what the government wanted was for local authorities to make targeted interventions, particularly around staffing costs. Furthermore, the government's press release, issued on 15th May, contained the following statement:

"Care homes will be asked to restrict permanent and agency staff to working in only one care home wherever possible. The funding could be used to meet the additional costs of restricting staff to work in one care home and pay the wages of those self-isolating."

3.8 AB went on to say that surely it was possible for the council to demand certain measures are implemented when it comes to those providers with which it directly contracts. (i.e. the Care UK homes and domiciliary care providers.)

3.9 Helen Whately first wrote, regarding the ICF, to council leaders on 14th May. At the point at which AB wrote to Councillor Burgess on 1st June, the UNISON branch was not aware of a second letter from the minister, dated 22nd May and referred to above at paragraph 3.7. This attached further information regarding the ICF, including the grant conditions. The branch only became aware of this information several days later as a result of reading the LGA briefing which is referred to at paragraphs 1.11 & 1.12 above but was in fact published on 29th May, the day of the deadline for all local authorities to submit their planning returns regarding the ICF.

3.10 Having had no reply from Councillor Burgess to his email of 1st June and having now had sight of the information referred to in the above paragraph, AB wrote once more to Councillor Watts on 9th June. He stated he could not agree that it was simply "a condition of the grant that it has to be given straight over to the care providers". He stated that an impression of this being the case may have emanated from paragraph 12 on page 5 of the DOH Grant Circular where it was stated:

"The funding should be prioritised for care homes and passed on as quickly as possible. We expect this to take no longer than ten working days upon the receipt of the funding in a local authority".

AB pointed out however that paragraph 13 of the same document began:

"All funding must be used for COVID-19 infection control measures."

In addition, the second paragraph of Annex A of the grant circular described the purpose of the grant as being as follows:

"…to provide support to adult social care providers, including those with whom the local authority does not have a contract, to reduce the rate of COVID-19 transmission in and between care homes and support wider workforce resilience to deliver infection control. The grant must only be used to support care homes and domiciliary providers to tackle the risks of COVID-19 infections. Funding will be distributed to local authorities in England, to ensure funding reaches adult social care providers in their area. In order to ensure that the relevant infection control measures are put in place as speedily as possible, local authorities should make the relevant payments to providers as quickly as possible on receipt of these allocations. Any funds not used for the relevant infection control measures must be repaid to the local authorities by the end of September 2020 and if such repayments are not made the local authorities must take such steps as a necessary to recover them.

There was here, AB believed, a clear implication that local authorities must endeavour to ensure that any care provider will use the funding for infection control.

3.11 In her email to AB of 3rd July, Councillor Burgess appears to somewhat shift from her previous position of the ICF being an "industry fund" She says that officers "have looked again to see if the

Council does have more agency and control over the ICF than we had previously understood", and that they "are still of the opinion that the guidance stipulated that Local Authorities must ensure that 75% of the grant is allocated (to care homes) to support a range of measures (6 identified), including ensuring staff away from work due to COVID-19 related symptoms are paid their normal pay." But as has been made clear, the UNISON branch was already aware of the six specific measures. Prior to the Councillor Burgess's email of 3rd July, they had not been mentioned by either her or Councillor Watts.

3.12 In the correspondence with Councillors Burgess and Watts, AB twice pointed to the issue of the council's planning return on the ICF needing to be a publicly available document and available on the council's website. Despite first being raised on 1st June, this point was not addressed until 3rd July, in Councillor Burgess's email.

3.13 It is acknowledged that a letter dated 29th May from Linzi Roberts-Egan, Chief Executive of the London Borough of Islington, to Helen Whately, constitutes, as stated in the letter, "part of the required submission" regarding the IFC. We now know that this was posted on the website on the same date but despite this, its existence was quite hard to discover. A search within the website using the term "infection control fund" did not reveal its existence. It was only discovered through searching on the term "islington council infection control fund" through Google. This may be because the title given to the letter was "Covid-19 care home support package". This did not immediately suggest that it contained any information relating to the IFC.

3.14 On reading Ms. Roberts-Egan's letter, it became apparent that a further document was missing. The letter refers to a "Care Home Support Plan" being attached but it was not attached and nor was it posted on the council's website. The co-author of this report, Brian Gardner (BG),who is also an Islington resident, wrote to Ms. Robert's Egan on 29th June, pointing this out. The following day, the "Care Home Support Plan" – this actually being the template issued by the government which each local authority was required to complete – was posted on the website. In the last few days, the appearance of the document has been much improved and given a new title: "Islington Infection Control Support Plan" .

3.15 On 6th July, Katharine Wilmette (KW), Director Adult Social Care wrote to BG in response to his letter of 29th June. Her letter does not acknowledge that the Care Home Support plan was not in the first instance, posted on the website. However, it has now been published and she does seem to acknowledge that "the information was difficult to find on the council's website and in the light of this confirms that the title of the webpage has been changed to now say: "Infection Control Fund and additional support for adult social care providers".

3.15 The page which KW refers to above does now contain summary information of what the council is doing in relation to the ICF. Contained within this is the information that 75% of Islington's allocation of the ICF "will be passed straight to care homes on a 'per beds' basis in two instalments.

3.16 The correspondence pertaining to the website and missing information is not attached, as we consider this matter to have been resolved. We remain however disappointed that it took so long to discover the information.

3.17 Though Ms Egan's letter of 29th May is intended to be part of the required submission with regard to the IFC, the number of references made to the fund are very few. It does not explicitly reference the six infection control measures referred to at paragraph 1.8. above. Of the six, the only measure specifically referred to is that of placing returning staff or volunteers in care homes. Page 6 of the letter contains the following statement:

"Islington Council will passport the entirety of the 75% IPC [sic] grant funding to care homes in our borough, based on a flat rate per bed. This constitutes a clear fair offer to all care homes reflecting the spirit of the guidance.

3.18 The next paragraph is as follows:

"The council will use the remaining 25% of the Grant on other Covid 19 infection control measures, in response to local need. This may include support for domiciliary care providers and supported living providers"

4. Comparison with other local authorities

4.1 As has been pointed out to Councillors Watts and Burgess, a number of other local authorities have agreed to underwrite full isolation pay for staff, including a number of councils in the North-West of England. In her email to AB of 3rd July, Councillor Burgess states that Islington Council has been unable to ascertain how one of them – Salford – has funded full pay. She goes on to state:

"This area of the country has had a recent history of doing things differently, for example one authority set an hourly rate for domiciliary care fairly high (well above the UKHCA estimated minimum cost) in a bid to increase quality. "

This response appears somewhat vague.

4.2 As is made clear in the letter from Ms Roberts-Egan of 29th May, together with the boroughs of Barnet, Camden, Enfield and Haringey, Islington participates in the North Central London Clinical Commissioning Group. One might therefore think that there is a consistency or similarity of approach across these boroughs, but this is not the case. Responses from Barnet and Haringey make no mention of sick pay or isolation pay. The London Borough of Camden, which has sixteen care homes contained within its boundaries, has committed to paying staff who are self-isolating, full pay for 14 days. The Chief Executive of the London Borough of Enfield, which has seventy-nine care homes within its boundaries, states the borough is: "Supporting providers who have staff isolating in order that they receive normal wages". Both of these boroughs have clearly been able work with providers in order to achieve these outcomes. The "Islington Infection Control Support Plan", referred to at paragraph 3.14, is essentially a document which the government has required

all local authorities to complete, detailing what they are doing with regard to a range of potential actions. With regard to the potential action of "Paying staff full wages while isolating following a positive test" Islington highlights the following issue:

"The Older People's care home market in Islington is primarily made up of large national providers who set their employment terms and conditions, and this presents some challenges in influencing a local approach."

One could be forgiven for thinking however that such challenges would be at least partially replicated in both Camden and Enfield. Also, the question arises as to whether this is not in fact a red herring. Providers who do not pay full sick pay would surely not object to the council committing to fund isolation pay and the measure can be implemented without an employer needing to make any permanent alteration to its staff terms and conditions.

5. Conclusion

5.1 Paragraphs 3.15 & 3.17 above indicate that as per the grant circular for the ICF, 75% of the first portion of grant (approximately £420k) has already been passed to care homes, with no indication of any discussion having taken place as to how and on what, the money might be spent. It is correct that the fund has to be allocated on a per care home/per beds basis and it is also true that the government allowed only a limited period of time for councils to pass the money on. However, it is questionable as to whether the council has exercised due diligence and whether its interests have been safeguarded here. The government has said that it will claw back any money that has not been spent on the six specified areas referred to at paragraph 1.8 above

5.2 At paragraph 16 - "Breach of Conditions and Recovery of Grant" - of Annex C of the grant conditions issued on 22nd May, the following statement is to be found:

"If the authority fails to comply with any of these conditions, or if any overpayment is made under this grant or any amount is paid in error, the Secretary of State may reduce, suspend or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State and notified in writing to the authority. Such sum as has been notified will immediately become repayable to the Secretary of State who may set off the sum against any future amount due to the authority from central government."

5.2 Ms. Roberts-Egan's letter of 29th May points out that each provider will be required to keep records of how the money is spent in line with the national guidance but this seems to be placing the onus on providers to be responsible for appropriate use of the funding rather than acknowledge that the council should try to at least influence how the money is spent. It is hopefully quite clear by now that our position is that the council is able to influence providers and is in fact required to "ensure" (the term used by the government) that the money is spent appropriately.

5.3 At this stage, we would ask:

i. What have providers indicated they are actually spending the money on and can anything be done at this point to reverse any situation where the money is not being spent appropriately or is not been spent on staffing or pay?

ii. Can anything be done at this stage to ensure that the second tranche of money is spent more appropriately

5.4 In addition to the above, we would like to ask if the council's plans to spend 25% of the second tranche of money on domiciliary or supported living services have been developed any further?

5.5 In her email of 3rd July, Councillor Burgess provides a breakdown of what care homes are paying their staff in terms of sick or isolation pay. She states that she is pleased that most of them are paying full sick pay. This is debatable as the number who are not doing or potentially not doing so is significant.

5.6 Staff working for Forest Healthcare which provides 129 beds in the borough only receive SSP.

5.7 From April 2020, staff employed by Barchester Healthcare – which provides 52 beds - will pay staff forced to self-isolate an additional sum of £13.50 per day (effectively twice the SSP day rate). This is something but is somewhat short of being full sick pay. Any staff member who tests positive for Coronavirus and is ill will be paid 80% of their pay whilst ill. This seems to be splitting hairs.

5.8 The information regarding staff of BUPA Care Homes Ltd – providing 55 beds – is unclear.

5.9 Councillor Burgess's information also seems to indicate - despite the council's return to the DOHSC not highlighting it as a serious problem – that there are still significant numbers of bank or agency staff working across homes. This is of great concern given that the information provided by Councillor Burgess also indicates that many bank staff do not receive the same staff sickness benefits as those who are regularly employed. In addition to the issue of full isolation pay, this is something that use of the ICF is supposed to address. However, it would appear the Council has paid little attention to this.

5.10 There are increasing calls for care homes and other adult social care services to be properly resourced and funded and even calls for nationalisation of care homes and de-privatisation. UNISON wants to see social care funded properly by the government, an end to privatisation and staff paid a decent wage reflecting their skills and the importance of the work being undertaken. We believe however that in the immediate term in Islington, the council needs to do its utmost to ensure that staff are paid full isolation pay and that measures to limit the numbers of staff working across homes are implemented.

5.12 The importance of these issues should not be diminished. The virus has not gone away and whilst it may be that as community transmission has lessened, so as a corollary, has infection in care homes, it seems likely that come the autumn, we will be facing a second wave. This means that in these homes, effective measures need to be in place.

5.13 It cannot be correct that the Council has no agency. We would argue also that the council has important strategic responsibilities in terms of both social care and public health and should bring its influence to bear on providers, particularly those with which it has a direct contractual relationship.

Andrew Berry (Islington UNISON Labour Link Officer) and Brian Gardner for Islington UNISON

7th July 2020

APPENDIX 1

Infection Control Grant Circular - page 13 extract

Local Authorities must ensure that 75 per cent of the grant is allocated to support the following measures in respect of care homes:

• Ensuring that staff who are isolating in line with government guidance receive their normal wages while doing so. At the time of issuing this grant determination this included staff with suspected symptoms of COVID-19 awaiting a test, or any staff member for a period following a positive test.

• Ensuring, so far as possible, that members of staff work in only one care home. This includes staff who work for one provider across several homes or staff that work on a part time basis for multiple employers and includes agency staff (the principle being that the fewer locations that members of staff work the better;

• Limiting or cohorting staff to individual groups of residents or floors/wings, including segregation of COVID-19 positive residents;

• To support active recruitment of additional staff if they are needed to enable staff to work in only one care home or to work only with an assigned group of residents or only in specified areas of a care home, including by using and paying for staff who have chosen to temporarily return to practice, including those returning through the NHS returners programme. These staff can provide vital additional support to homes and underpin effective infection control while permanent staff are isolating or recovering from COVID-19.

• Steps to limit the use of public transport by members of staff. Where they do not have their own private vehicles, this could include encouraging walking and cycling to and from work and supporting this with the provision of changing facilities and rooms and secure bike storage or use of local taxi firms.

• Providing accommodation for staff who proactively choose to stay separately from their families in order to limit social interaction outside work. This may be provision on site or in partnership with local hotels.

APPENDIX 2

19/05/20 – email to Councillor Watts outlining UNISON's demands and requesting use of the Infection Control Fund be used to assist with paying full sick and isolation pay. .

Hi Richard

I hope you and your family are well and that you are staying safe.

I am writing to you regarding a serious concern which I'm sure you share. This is about care staff working in Islington not receiving full occupational sick pay or full pay to self-isolate.

The council has often taken the initiative in the past and we ask that it does so again to ensure that all staff working in care homes in Islington now receive this. This will include not only the staff working for Care UK, which the council contracts with, but also any other private care homes; I understand, there are a small number of these.

The contribution being made by all care staff needs to be adequately rewarded and this should include immediately giving them full pay when sick or self-isolating. However, our demand for sick pay is not simply about the value of their work. It is essential in helping contain the virus.

We also ask that the Council ensure that pay and other protections as set out in UNISON's Ethical Care Charter are applied to all staff working for domiciliary services providing home care, including spot contracts as well as the current block contracts.

Yesterday, Care UK reported that 586 of its 12,409 residents across the country had died from Covid-19. You also know that many care staff have died, this at double the rate of the general population. I am sure therefore you will agree that staff need to feel confident in remaining at home if they or a member of their family are feeling unwell; also, if in the future, they or another member of their household are asked to self-isolate after being contacted as part of contact tracing.

Care staff should not feel they have to choose between self-isolating and feeding themselves and their family. I am sure you would also agree with UNISON that SSP is not sufficient to maintain any employee or their family and not all are even eligible to receive this.

I am aware that the "infection control fund" which the government announced last week, Wednesday, is in-part available to support wages of staff who need to self-isolate. Of course, I will not be surprised if you tell me that this is not sufficient funding for the support needed. And it is not clear to what extent the fund can be used in the wider social care context. It is however our view that this is too important an issue to wait for sufficient funding; it is about life and death. The council must find the money from reserves or even be prepared to run a deficit if this is required. I pledge now that Islington UNISON would stand with you in defending action taken to protect lives.

Islington has often taken the initiative and has often been ahead of other councils on progressive policies: bringing services in-house, the fairness commission, the living wage and signing UNISON's ethnical care charter. We therefore ask you to be one of the first councils in London to guarantee full pay for sickness and isolation for all staff in contracted care homes and all contracted homecare agencies.

We propose that sick/isolation pay is based on the average days' pay over the last 3 months and we ask that this be backdated to at least the beginning of March.

I look forward to an urgent response on this. As the Labour Link Officer, I am looking at raising this issue within the local party as I am sure there is deep concern amongst members. If this needs further discussion, then please do contact me or Jane Doolan.

Yours

Andrew Berry, Islington UNISON Labour link Officer

APPENDIX 3

28/05/20 – email from Councillor Burges in response to email to Councillor Watts of 19/05/20

Dear Andrew,

Re: Sick Pay in Social Care settings

I am responding to your email to Richard as this issue falls within my portfolio responsibilities.

Your email covered a number of complex issues and I wanted to respond to all of them in my reply; my apologies that preparing a proper response has taken some time.

As you would expect, I completely agree with the principle that care staff should receive full pay whilst they are sick or self-isolation –our front line care staff deserve to be supported and protected in their day-to-day work caring for our vulnerable residents but this is only possible with adequate government funding.

You will know only too well the repeated argument about NHS/social care funding and market structure. This Government, like many before it, has paid lip service to the need to recognise the importance of social care and fully fund the service, but has not acted upon it.

I hope that given the public outcry over recent weeks and months, the Government will acknowledge how fragile the current position is and reverse the trend on local authority budget settlements by providing adequate resources. Without social care, the NHS would not have been able to play their (considerable) part in dealing with the pandemic. With proper funding we could then systematically put in place care that people deserve, delivered by well trained staff who are properly remunerated for the excellent work that they do. The daily publicity about care homes has sadly put them centre stage but has, at the same time, raised public awareness about social care and the challenges we face as a society.

There are five older people's care home providers in Islington and as private organisations they each have their own policies related to sickness, absence and sickness pay. Currently at minimum all providers pay statutory sick pay (SSP) and recent pandemic–related changes in government policy mean that this has been paid from day 1 rather than day 4 so as not to disincentivises staff from taking time off if they should be isolating. Some providers are more generous than this: one provider pays staff 100% of their salary for 2-4 weeks, depending on their length of service, before moving to SSP. Our providers also report that they have supported vulnerable staff to shield e.g. through the furlough scheme. You may be aware that I did recently intervene in a case with a domiciliary care provider where staff were subsequently furloughed. It is possible that some staff felt unable to take time off due to sick pay arrangements, however we do not have confirmed evidence of this. Sickness rates have varied in different homes, in a way that broadly appears to match to the severity of their COVID-19 outbreaks.

Islington Council block purchases some beds and spot purchases the rest, both inside Islington but also further afield, and this is true of beds for other client groups besides older adults. All of these providers will have set their bed charge (or hourly rate in the case of domiciliary care and other

support services) based on their business model and agreed set of assumptions, set before the COVID-19 crisis.

Like all local authorities, Islington Council has taken significant steps to support its providers to deliver the assumptions mentioned above. We are about to pay a 5% uplift on all of the individual care packages we currently commission for residents, both in borough and further afield. This will cover services provided during April and May this year and include all client groups. In addition to this, Islington Council has supported provider organisations by ensuring the best Public Health advice is provided and, where necessary (and it has been necessary fairly regularly) appropriate PPE to safeguard care staff caring for vulnerable people in care homes, domiciliary care and other care settings. If guidance and advice is properly adhered to, there should be no reason why staff should not be properly protected whilst carrying out their job. We regularly monitor the position in our 8 care homes and domiciliary care provider settings. Commissioners, Public Health and NHS professionals are in contact with our providers regularly, offering advice and support during this pandemic.

I am sure you will be aware that the additional emergency COVID-19 resources made available to local authorities during this pandemic initially came in two tranches of £1.6 billion each. The share for London Councils of the overall £3.2 billion was around £500 million. It is estimated that there will be a shortfall of around £1.3 billion in London alone. In Islington, we face a significant budget challenge over the next 3 years due to both COVID-19 and overall resources available for services.

Despite the Government claiming it as extra funding for councils, the additional £600 million ring fenced infection control fund to support care homes, which you mentioned, is in effect an industry fund and not Council cash – an industry that faces mounting challenges. It is estimated that the fund will provide a 50 bedded care home with about £50,000 additional resources, but if the occupancy levels are down to around 30 residents, the home will be making a loss of around £10,000 per week. Islington Council has also seen income reduce sharply over the past few months as costs linked to the pandemic rise and we have no idea for how long the current situation will go on.

I hope that you, like us, will continue to lobby the Government for adequate resources and in the meantime we will work to ensure we support providers, social care workers and residents as much as we are able within our reducing resource envelope, and in keeping with Unison's Ethical Care Charter.

We would be pleased to support any campaign to call on government, to fund proper sick pay packages for all hard working care staff. I will also shortly write Matt Hancock MP to call on him to do just that.

We will continue review our commissioning strategy for care services and take every opportunity to revise our procurement and contract expectations in collaboration with providers.

We are in very challenging times, but if you would like to discuss further or raise in discussions with the Chief Executive, please do so.

With best wishes,

Councillor Janet Burgess M.B.E

APPENDIX 4

01/06/20 – email to Councillor Burgess in response to her email of 28/05/20

Dear Janet

Thank you for your very detailed account (28th May) of the council's response to the continuing challenges which Covid-19 presents to the social care sector and in particular, care homes, this in response to my email to Richard of 19th May. This concerned the possibility of the Council underwriting the payment of full pay to all care home staff in Islington who are sick or who have to self-isolate because of coronavirus. It also pointed to the existence of the new infection control fund which the government announced on 13th May. I wish here, primarily, to address your remarks regarding the latter.

I do not recall the government "claiming" the infection control fund as "extra funding for councils" though I may have missed this. I am fully aware that the money is to be given over to care homes and perhaps to a more limited extent , also to domiciliary providers. I do not however believe that it is correct to represent the fund as "in effect an industry fund and not Council cash" and though I understand the calculation, I don't understand the point you are making when you say: "It is estimated that the fund will provide a 50 bedded care home with about £50,000 additional resources, but if the occupancy levels are down to around 30 residents, the home will be making a loss of around £10,000 a week"

The fund has not been established to provide industry or business subsidy and although certain elements of its criteria and operation remain somewhat vague, it seems clear that what the government intends is to make targeted interventions around staff welfare, training on PPE, and perhaps most critically of all, staffing costs. It is clear also that the government wants local authorities to play a central part in this.

The letter from the Care Minister, Helen Whately, to Council Leaders, dated 14th May stresses "the importance of us moving to one model with increased consistent national oversight to support locally-led responses." The letter, she says, "sets out how the government will work with local authorities to achieve this".

The government's press release, issued on 15th May contains the following statement:

"Care homes will be asked to restrict permanent and agency staff to working in only one care home wherever possible. The funding could be used to meet the additional costs of restricting staff to work in one care home and pay the wages of those self-isolating."

It therefore seems to me that any suggestion that the money is simply to be handed over to care homes to do with as they please is wrong. The money is to be distributed through local authorities with care

homes in their area and each of these was asked to submit a planning return by 29th May. I assume Islington has done this.

Although the government literature is not explicit on this, it seems reasonable to assume that local authorities will not be without influence in determining how and on what the money is spent.

At the very least, it is surely possible for the council to demand certain measures are implemented when it comes to those providers with which it directly contracts.

Islington UNISON believes however that the Council should commit to a financial offer to pay the wages of all social care staff working in the borough who need to self-isolate even if the cost of this is greater than whatever monies might be available to it from the infection control fund.

From my email to Richard, I reiterate the following:

The contribution being made by all care staff needs to be adequately rewarded and this should include immediately giving them full pay when sick or self-isolating. However, our demand for sick pay is not simply about the value of their work. It is essential in helping contain the virus.

This is not just an adult social care matter or a commissioning issue. It is also about public health. It seems clear that the government intends to make local authorities responsible for containing future local outbreaks of infection without providing them with appropriate powers or resources. But if the Council were to commit to what we are suggesting, it would be making an important public health intervention by limiting the possibility of future transmission within the community.

Finally, I note from Helen Whately's letter that local authorities should make their planning returns publicly available. Could you please therefore let us have sight of the one submitted by Islington?

I would appreciate and urgent response to this email

Many Thanks

Andrew Berry

Islington UNISON Labour Link officer

APPENDIX 5

09/06/20 – email to Councillor Watts as result of no reply form Councillor Burgess 01/06/20

Dear Richard

Infection Control Fund and payment of full pay to self-isolating staff of care homes in Islington

I am writing to you again regarding the above. I apologise for the length of this. I would in normal circumstances have sent it as a letter.

As you know, I originally emailed you regarding this on 19th May and eventually received a reply from Janet on 28th May. I replied to her on 1st June seeking clarification on some of the points she made However, I am now escalating this matter for two reasons: firstly, because I haven't had a reply and secondly because of our Twitter exchange last week. The latter began with my asking you on 3rd June "why at least some of the £845 plus allocation … [could not] be used to pay sick and isolation pay now?" You tweeted in reply: "Because, as we wrote to you, it's a condition of the grant that it has to be given straight over to the care providers. The conditions set on the grant are from central government and we can alter them". You clearly mean "cannot" rather than can and I fully appreciate that you cannot add local conditions to a grant provided by central government for specific purposes. You also seem to be imply however, as does Janet in her reply to me, that the sole role of the local authority is simply to hand over the cash.

Having now seen all relevant documentation provided by the government, a substantial amount of which was not made available until after my original email to you, I cannot agree that it is simply "a condition of the grant that it has to be given straight over to the care providers". An impression that this is the case may emanate from paragraph 12 on page 5 of the DOH Grant Circular where it is stated: "The funding should be prioritised for care homes and passed on as quickly as possible. We expect this to take no longer than ten working days upon the receipt of the funding in a local authority". Yet, later, paragraph 13 on page 4 begins: "All funding must be used for COVID-19 infection control measures." and the second paragraph of Annex A describes the purpose of the grant as being as follows:

"…to provide support to adult social care providers, including those with whom the local authority does not have a contract, to reduce the rate of COVID-19 transmission in and between care homes and support wider workforce resilience to deliver infection control. The grant must only be used to support care homes and domiciliary providers to tackle the risks of COVID-19 infections. Funding will be distributed to local authorities in England, to ensure funding reaches adult social care providers in their area. In order to ensure that the relevant infection control measures are put in place as speedily as possible, local authorities should make the relevant payments to providers as quickly as possible on receipt of these allocations. Any funds not used for the relevant infection control measures must be repaid to the local authorities by the end of September 2020 and if such repayments are not made the local authorities must take such steps as a necessary to recover them.

There is here, a clear implication that local authorities must endeavour to ensure that any care provider will use the funding for infection control.

Paragraph 6 of the grant conditions set out at Annex C make it clear that no payment can be made to a provider who does not submit a capacity tracking return to the local authority; so clearly here, the local authority has discretion to withhold payment.

Whilst I appreciate that a turnaround time of ten days may severely limit the ability of each local authority to adequately determine and ensure that providers will spend the money legitimately, it is simply not true that the money simply has to be handed over.

It concerns me that Janet's reply to me seems to contain misconceptions similar to your own and I wonder if these are also shared by those officers who may have provided advice. She refers to the Infection Control Fund (ICF)as "in effect an industry fund and not council cash". I hope I have already demonstrated that this is not the case. She provides the example of a 50-bed care home which is 40% under-occupied merely using the fund as subsidy but again, the ICF has not been established to keep care homes financially afloat. The letter of 22nd May, from the Care Minister, Helen Whateley, makes clear that the "funding should only pay for activity to help reduce the risk of infection and is not intended to be used to improve provider financial resilience."

Both Janet and you are presumably aware of the briefing on the grant conditions for the Infection Control Fund (ICF)which has been produced by the Local Government Association (LGA). This sets out what it believes to be the "key headlines" of the ICF. In summary, these are:

The allocation to each local authority to be paid in two instalments.

The funding formula and clarification that the fund also covers homes with which the authority has no contractual relationship; the timescale for disbursement of funding to providers.

The issue of the capacity tracking return referred to above.

That payment of 75% of the fund must be for what the LGA describes as a "limited range of infection control measures".

That 25 "per cent of the grant may be used on other COVID-19 infection control measures payments including domiciliary care and wider workforce measures".

The LGA describes the ICF Grant Circular as "an unusually prescriptive document". I believe that most, if not all, local authorities will struggle to comply with its rigidly bureaucratic demands and reporting requirements. It may be that the government is deliberately setting up councils to fail and this may be part of a wider strategy of shifting the blame on to local government if, and when, any second wave of infection occurs. On the other hand, after seeing many of the planning returns from local authorities, it could be that the government has blinked a bit and this may be why, at yesterday's daily press briefing,

David Pearson was introduced as the new chair of the seemingly also new, Covid-19 social care support task force. It looks like he is going to work quite closely with local authorities and care providers.

Comments are made in the LGA briefing that the infection control measures specified in paragraph two on page 13 of the Grant Circular "relate [essentially] to additional staffing costs" and constitute "a limited range of infection controls", for instance not including PPE or deep cleans. This is short-sighted of the LGA and unhelpful and even possibly demonstrates a lack of understanding.

Whilst I have no desire to defend the government, all the measures cited are potentially effective infection control measures and may in the longer term have a greater impact than a deep clean. The letter of 22nd May from the Care Minister, Helen Whateley, points to the use of the fund being "to stop transmission in and between care homes, in particular by minimising the movement of staff to reduce the risk of asymptomatic transmission of the virus". This seems in fact, very sensible. The specific measures are:

- Payment of full wages to staff required to isolate.
- Preventing staff from working across homes and thus spreading infection across them.
- Recruitment of additional staff, both to cover for absences and preventing staff from having to work across homes.
- Limiting or mitigating the use of public transport which in terms of cost might necessitate providing the use of changing facilities, accommodation for people to stay over at work - or nearby - or the use of taxis.

Recent studies and reports in the media have highlighted how, in care homes, the virus has been spread by infected but asymptomatic staff and residents and through staff working across more than one care home.

Both The Guardian on 18th May and a report by C4 News, highlighted a study undertaken by Public Health England over the Easter weekend into the behaviour of the virus in six care homes in London. This showed that bank or agency staff working in more than one care home had spread the virus across them. According to the Guardian, it found that "in some cases, workers who transmitted coronavirus had been drafted in to cover for care home staff who were self-isolating expressly to prevent the vulnerable people they look after from becoming infected." Also, advice from a 2019 PHE document on flu pandemic preparations urging operators to "try to avoid moving staff between homes and floors" seems to have been largely ignored.

On 3rd June, BBC Newsnight had an extended report on care homes run by MHA in the North West of England. When the homes were eventually able to commence testing, approximately 42 per cent of staff and 45 per cent of residents who tested positive, were asymptomatic. This appears to demonstrate not only the necessity to constantly test but also the need for infected staff to self-isolate.

A journalist from the Islington Tribune informed me yesterday that Care UK has agreed to pay full pay to staff working in the homes it provides in Islington and who have to self-isolate. UNISON's Assistant Branch Secretary has written to the provider seeking further clarification. Could you also clarify, has this change of heart come about as a result of any intervention by the council as the contractor and/or is this related to the infection control fund?

We are very pleased that Care UK appears to have made this decision though at present, we do not know the details or how long the arrangement will be for.

Since writing to you originally on 19th May, Islington UNISON has not changed its position and I would be grateful if you could provide me with a clear answer to the following questions:

- Will you ensure that staff working in non-contracted care homes and home care staff employed through block and spot contracts receive full sick and isolation pay, either via the IFC or through other funding? A number of other local authorities in England – all of them, I believe, Labour administrations - have committed to paying staff full pay.
- Will you ensure that pay and other protections as set out in UNISON's Ethical Care Charter are applied to all staff working for domiciliary services providing home care, including spot contracts as well as the current block contracts?
- Will you ensure that full isolation and sick pay is paid retrospectively to those staff who have had to isolate in the last four months?
- Will the Council please immediately publish the planning return it has submitted to the government regarding the infection control fund? Other local authorities have done so. As pointed out in my email to Janet, the 14th May letter from the Care Minister, Helen Whateley, to council leaders, states that local authorities should make their planning returns publicly available. I believe that authorities are also required to publish it on their website.

In conclusion there are clearly several challenges for local authorities in dealing with the IFC and I haven't said anything in this communication about another aspect which is the complicated situation around EU state aid rules which currently still apply.

I note that the LGA is still trying to engage with the government regarding the fund and lobby for changes and simplifications. I recently attended a UNISON National Labour Link meeting, which was also attended by Angela Rayner, and I raised some of the difficulties with her. She was unaware of any problems with the fund but I wonder if these matters have been raised with the Labour front bench by the LGA or you or Janet. If not, I feel they should be.

I look forward to hearing from you.

Andrew Berry, Islington UNISON Labour Link Officer

APPENDIX 6

13/06/20 – email Response from Councillor Burgess after AB asked a question at Leaders question time.

Dear Andrew,

I am writing again, as I wanted to send you brief email to confirm what Richard updated you on in the earlier Leader's Question Time.

As you know, we completely agree with you that this is not just an issue not just about fairly rewarding staff for the hard work they are doing, it is vital to help us contain the virus, and not risk carers having to choose between losing wages or risk spreading the virus.

We have asked Council Officers to again seriously look into what can be done with the Infection Control Funding to ensure those working in care sector in Islington receive payment of full pay if they are sick or self-isolating staff.

I will of course get back to with an substantive reply to the other points you have raised in your email, and provide a further update on the above.

Best wishes,

Janet

Councillor Janet Burgess M.B.E.

Labour Councillor for Junction Ward; Deputy Leader of the Council and Executive Member for Health & Adult Social Care

Islington Council

Town Hall

Upper Street

London N1 2UD

PA Amanda Russell: amanda.russell@islington.gov.uk

020 7527 3051

APPENDIX 7

16/06/20 - email from AB to Councillor Burgess.

Dear Janet

Thank you for your reply of the 13th June and thank you also to Richard for his response at Leader's Question Time. I appreciate that you both understand my argument and appreciate the need for full sick and isolation pay. However, as you know other councils have taken steps to ensure this and I believe we now need to see similar action in Islington.

Both Richard and you still appear to be suggesting that the Council has little agency in terms of the Infection Control Fund whereas advice and guidance I have been able to access would suggest otherwise. You state you "have asked Council Officers to again seriously look into what can be done with the Infection Control Funding…" Whilst we welcome this, it might also suggest that approximately £423k (half of Islington's total allocation) has already been handed to the care home sector without the authority expressing any views or opinions as to how it should be spent or at the very least, a discussion taking place with the relevant providers. It cannot be the case that the council has no influence with regards to companies with which it directly contracts (care homes provided by Care UK; block home care contracts) or from which it purchases on a spot basis as with some home care.

As with other local authorities, the council was required to submit a "planning return" by 29th May and has presumably done so. Why has it not, as per Helen Whateley's letter of 14th May, made this public? This is the third time we are raising this with you, having previously raised it on 2nd & 8th June.

The Infection Control Fund may not be fit for purpose; it may not be enough to pay all the isolation and sick pay that may be required. If this is the case, the council needs to find another way to fund this. I believe we are all agreed that this is a public health issue and as such, requires urgent attention

I am sure you are aware that an informal meeting of Islington North CLP is taking place tomorrow evening. I will be raising these issues there and asking for Labour Party members and other Labour councillors to support Islington UNISON in our campaign for full isolation and sick pay.

I hope that I can have a full response from both you and Richard soon.

Andrew Berry

Islington UNISON Labour Link Officer.

APPENDIX 8

03/07/20 – Email to AB from Councillor Burgess.

Dear Andrew,

I can now respond in more detail to your queries.

Officers have looked again to see if the Council does have more agency and control over the ICF than we had previously understood, and that we can mandate care providers to use a portion of this money to pay for Full Sick Pay. They are still of the opinion that the guidance stipulated that Local Authorities must ensure that 75% of the grant is allocated (to care homes) to support a range of measures (6 identified), including ensuring staff away from work due to COVID-19 related symptoms are paid their normal pay. The first months payment of the grant was required to be made by the local authority direct to care homes within their geographical area on a per beds basis including to social care providers with whom the local authority does not have existing contracts. The 2nd tranche of the 75% will be paid in the manner described above as long as the grant conditions have been met.

In regard to your point about Councils in the North West, we have been unable to ascertain how Salford have funded full pay. This area of the country has had a recent history of doing things differently, for example one authority set an hourly rate for domiciliary care fairly high (well above the UKHCA estimated minimum cost) in a bid to increase quality.

On your point about ensuring that pay and other protections as set out in UNISON's Ethical Care Charter are applied to all staff working for domiciliary services providing home care, including spot contracts as well as the current block contracts, you may be aware that the Health & Social Care Scrutiny Committee recently held a scrutiny into domiciliary care. This was welcomed by myself and officers, and gave us a deep insight into current conditions. It will also help to form the next round of commissioning of this service. As part of the evidence gathering exercise, providers met elected members. The issue of zero contract hours was flagged strongly as an issue, but an issue that staff (who also met elected members) were keen to continue with as it gave them significant freedom about when they worked. The managers of the agencies, who were at the same Scrutiny Committee meeting, offered there and then to give contracts, as they said that they would prefer the certainty of having permanent staff, but I don't know if anyone took up the offer. Much that is outlined in stages 1,2 and 3 of the charter are either place or form part of our on-going discussions with the Domiciliary Care Provider Forum. Officers met a number of providers last week to talk about C19 related issues and they commended LBI on the way they had worked with the market, and we have a number of initiatives to explore together over the coming months.

With regard to your request that full isolation and sick pay is paid retrospectively to those staff who have had to isolate in the last four months, even if we were able to mandate providers to pay full sick pay using the ICF, there would not be enough funds to cover this. An Options Paper is being prepared, based on the Camden analysis, to project the full cost of this proposal.

Notwithstanding the above, I am pleased that most of our care home providers are paying full sick pay, as follows

Care UK: staff off work for Covid-related reasons are paid COVID sick pay at the equivalent of their full hourly rate from day one. Bank staff are eligible for the same if they miss shifts to which they had been allocated. Staff who are shielding have been furloughed. Staff off for non-Covid related reasons are paid Statutory Sick Pay (SSP) from day four of absence.

Forest Healthcare: Staff off work for Covid-related reasons are paid SSP from day one, and they are exploring the possibility of payment of full pay from day one. Bank Staff are eligible for SSP, assuming they meet the SSP earnings criteria. Staff who are shielding, or otherwise categorised as vulnerable, are being furloughed at present.

Barchester: as of April 2020, any stff member forced to self-isolate due to exposure to Covid is paid an additional sum of £13.50 per day (effectively twice the SSP day rate). This is paid irrespective of contracted hours. Any staff member who tested positive for Coronavirus and was ill was paid 80% of their pay whilst ill. If any staff member who passed away as a result of Covid, their estate received £20,000 death in service benefit. Shielded staff have been furloughed, with Barchester topping up the 20%.

BUPA: levels of sick pay are contract specific and depend on role and length of service. If staff are off sick for Covid-related reasons, they are paid sick pay from day one.

The Charterhouse: If staff are off for Covid-related reasons, they are paid two weeks full sick pay. Other sickness payments depend on length of service. Bank staff are entitled to SSP. Shielding staff have been furloughed.

On the issue of publishing the return, this is now available at https://www.islington.gov.uk/social-care-and-health/support-and-guidance-during-covid-19/useful-guidance-and-resources-covid-19/test-and-trace-for-local-organisations.

Best wishes,

Janet

Councillor Janet Burgess M.B.E.

Labour Councillor for Junction Ward; Deputy Leader of the Council and Executive Member for Health & Adult Social Care

Islington Council

Town Hall

Upper Street

ISLINGTON

COVID-19 cases and deaths

Date: 3 July 2020

Camden and Islington Public Health

Knowledge, Intelligence, and Performance Team

Content

ISLINGTON

1. Overview of number of cases in Islington since the start of the pandemic
2. Overview of deaths
3. Inequalities

Key Messages

ISLINGTON

COVID-19 Cases in Islington

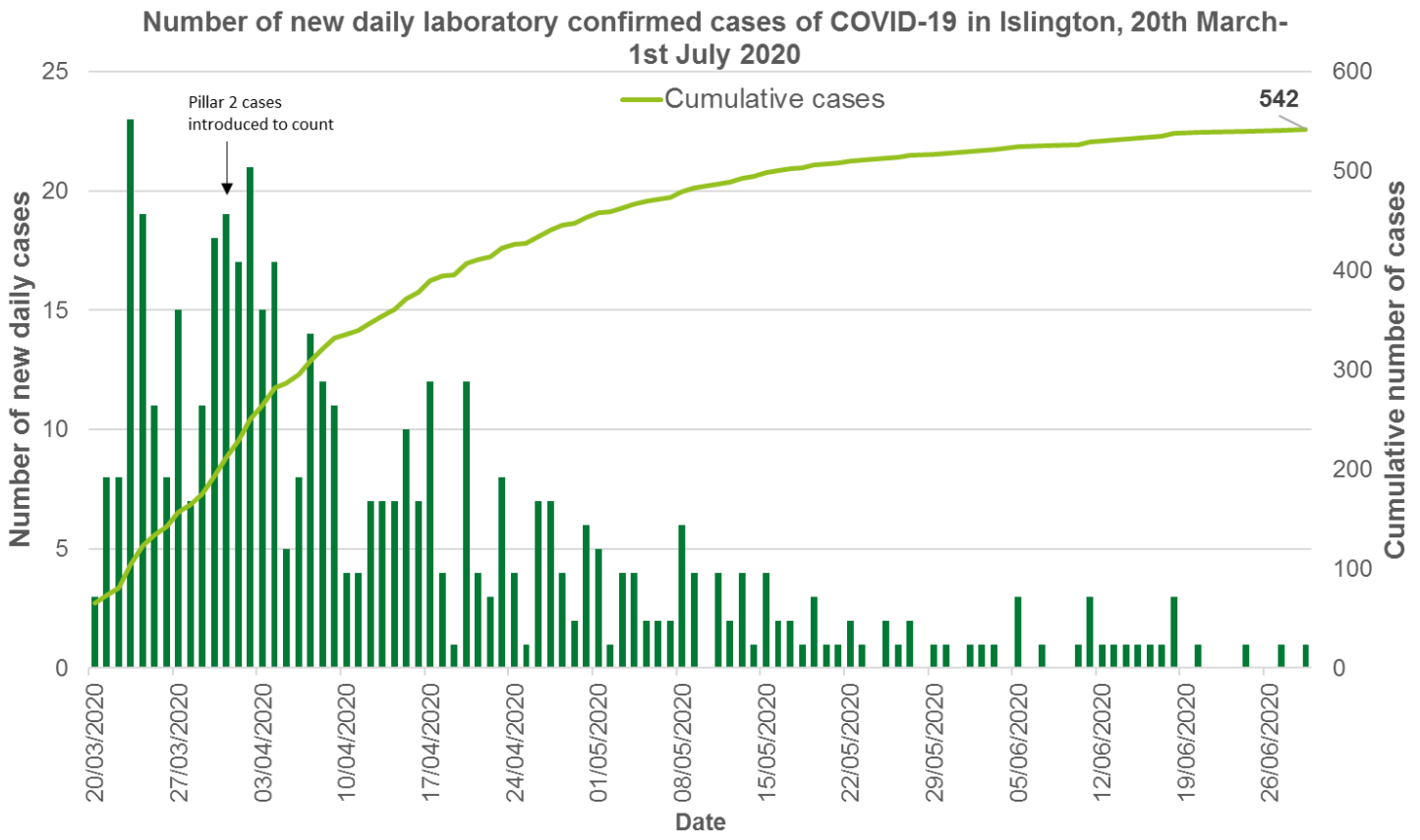
- As of 01 July 2020, a cumulative total of 542 laboratory confirmed cases in Islington have been reported since the pandemic began.
- The number of new cases per day has been on an overall declining trend since mid-April.
- Islington has had the lowest rate of cumulative COVID-19 cases in London at 227 per 100,000 population.
- The availability of testing has increased over time, therefore many suspected cases would not have been tested early on
- There were 2 new cases reported between 20 - 26 June 2020.

COVID-19 Deaths in Islington

- Between 14 March and 19 June 2020, there have been a total of 150 COVID-19 related deaths in Islington and an estimated 179 excess deaths in the borough (weekly figures minus the 2014 to 2018 average).
- There were 2 deaths related to COVID-19 reported in Islington between 13 June and 19 June 2020 (last week of data available).
- As of 31 May 2020, Islington's age standardised mortality rate due to COVID-19 was higher than the England average but similar to the London average.
- There are no statistically significant differences between the COVID-19 mortality rates in men and women in Islington.
- There are no clear trends in the rates of COVID-19 deaths across deprivation quintiles in Islington, but the crude mortality rate in the least deprived quintile is significantly lower than the borough average.

COVID-19 confirmed cases in Islington

ISLINGTON

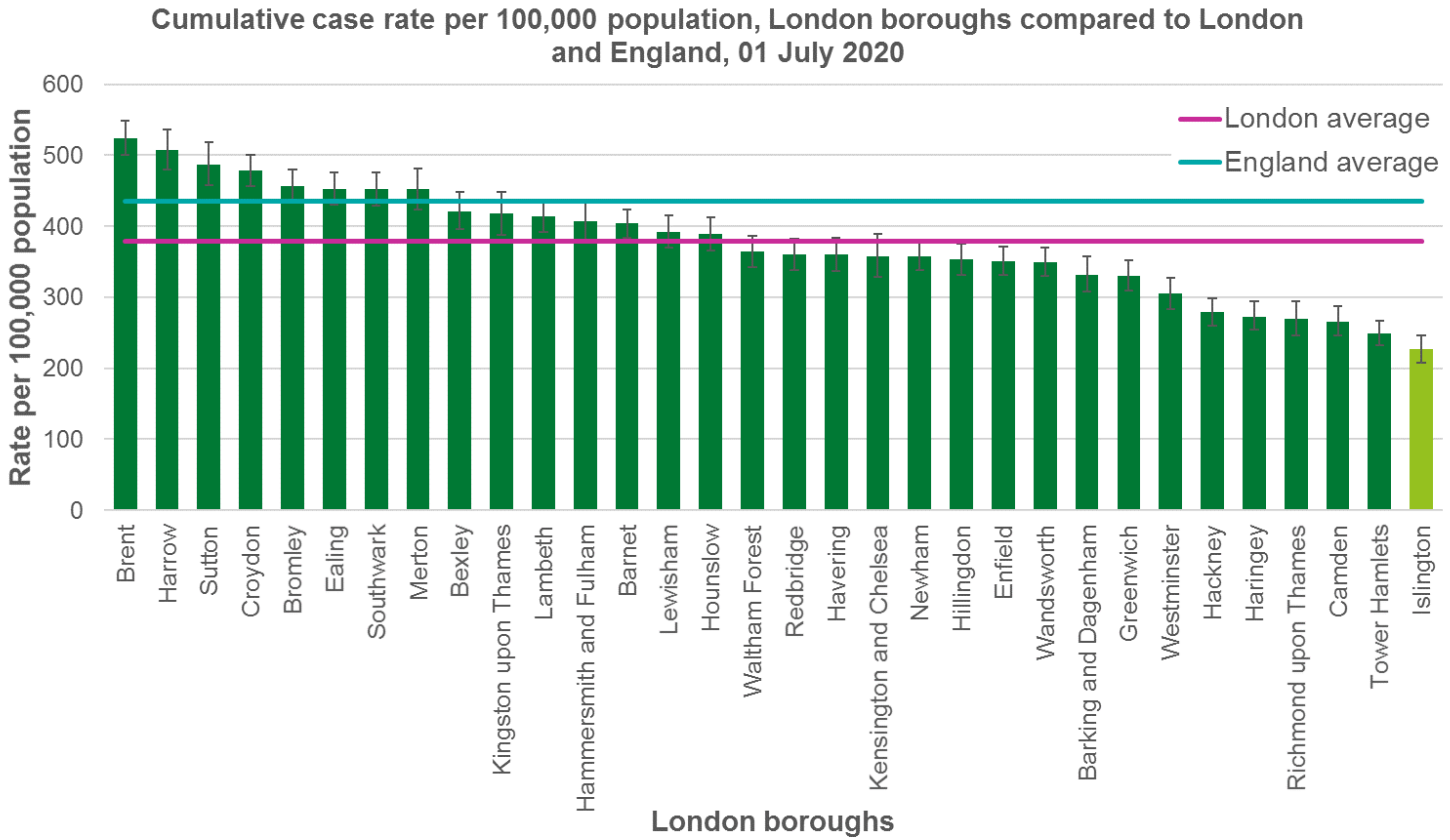


Note: Date refers to date the first specimen was taken from the person being tested. Confirmed cases are from Pillar 1 and Pillar 2 testing. Pillar 2 cases have been included since the 31st March 2020. Please note cases are added retrospectively and the last 5 days of data are likely to be incomplete.
Source: Daily report for London PHE Centre

- As of 01 July 2020, there are a total of **542** laboratory confirmed cases in Islington.
- The number of new cases per day has been on an overall declining trend since mid-April.
- 2 new cases have been confirmed between the 20 – 26 June 2020 (latest available week of complete data).

COVID-19 cumulative case rate per 100,000 by borough

ISLINGTON



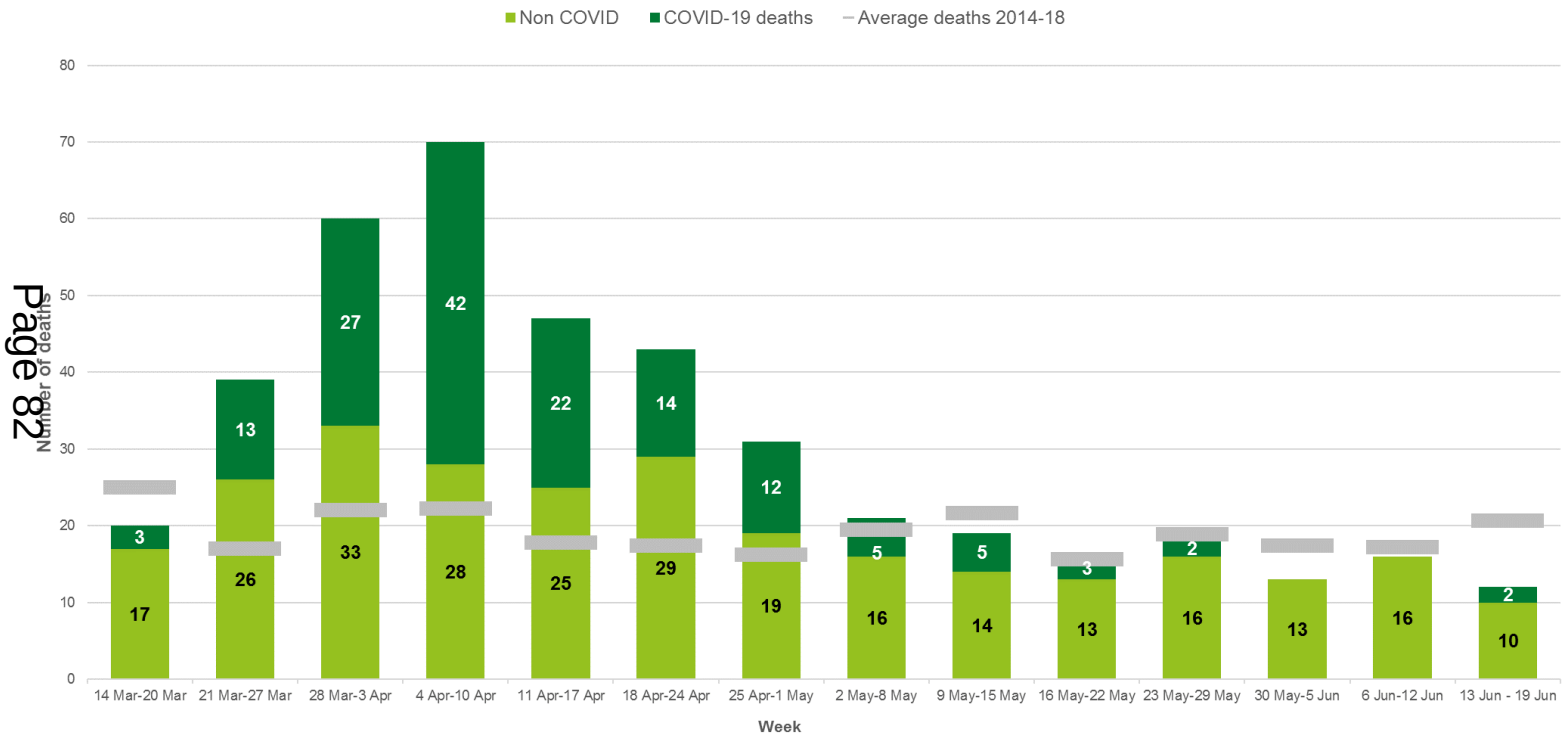
Note: Rates have been calculated using 2018 mid-year population estimates, the most up-to-date estimates when published. These are rates based off the cumulative number of Pillar 1 and Pillar 2 lab confirmed cases on the 01/07/2020. Pillar 2 cases have been included since 31/03/2020

Source: COVID-19 dashboard PHE

- Islington has had the lowest rate of cumulative COVID-19 cases in London at 227 per 100,000 population.
- This is lower than both the London and England averages (379 and 436 per 100,000 respectively)

Weekly deaths

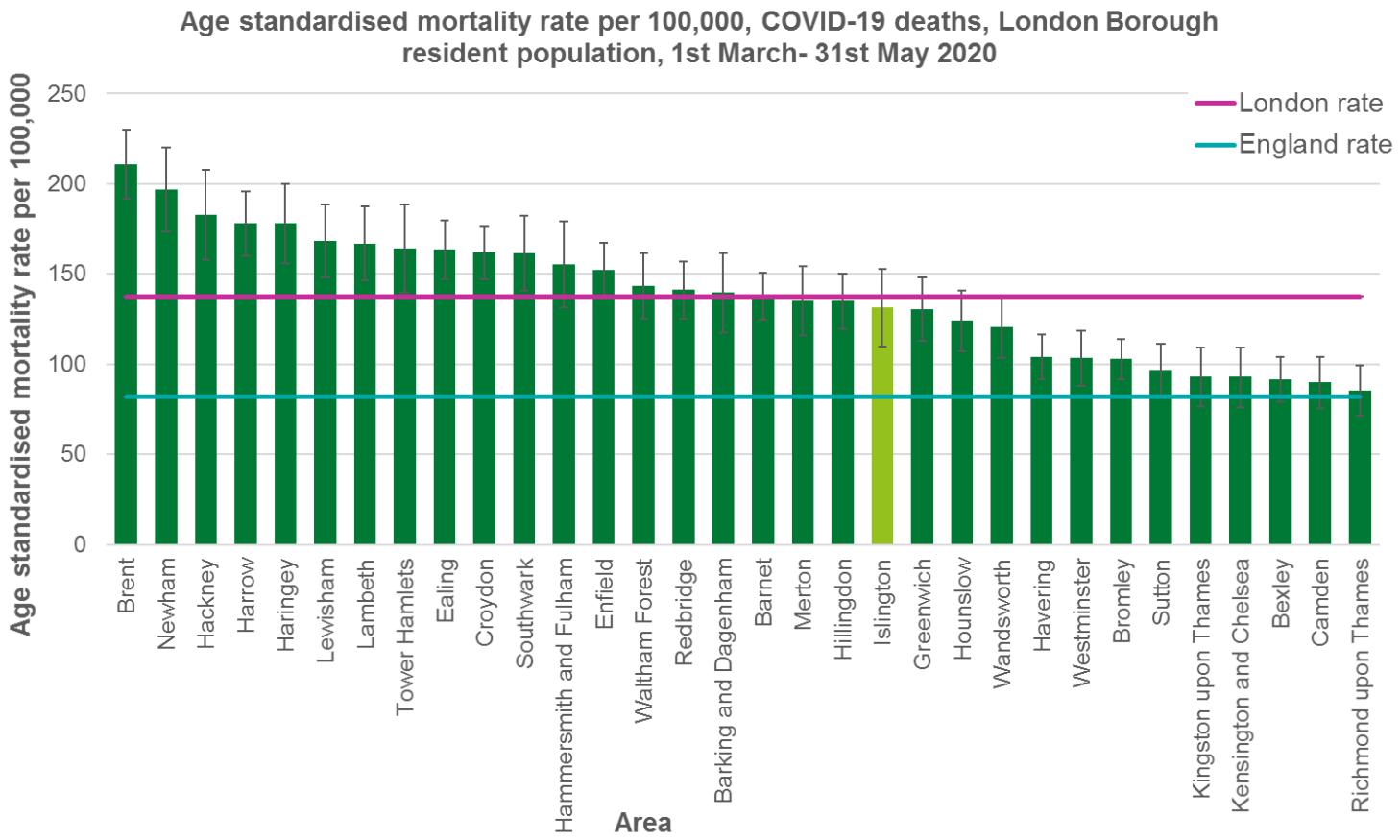
Deaths by cause of death (weekly numbers) for deaths that occurred from 14 March 2020 to 19 June 2020 (registered up to 27 June 2020)



- A total of 150 deaths in Islington have been COVID-19 related, up to 19 June 2020.
- In Islington, the number of COVID-19 related deaths peaked during the week of 4 April – 10 April at 42 deaths and has fallen steadily since.
- For the period 13 June – 19 June there has been 2 COVID19 related deaths.

COVID-19 death rate per 100,000 by borough

ISLINGTON



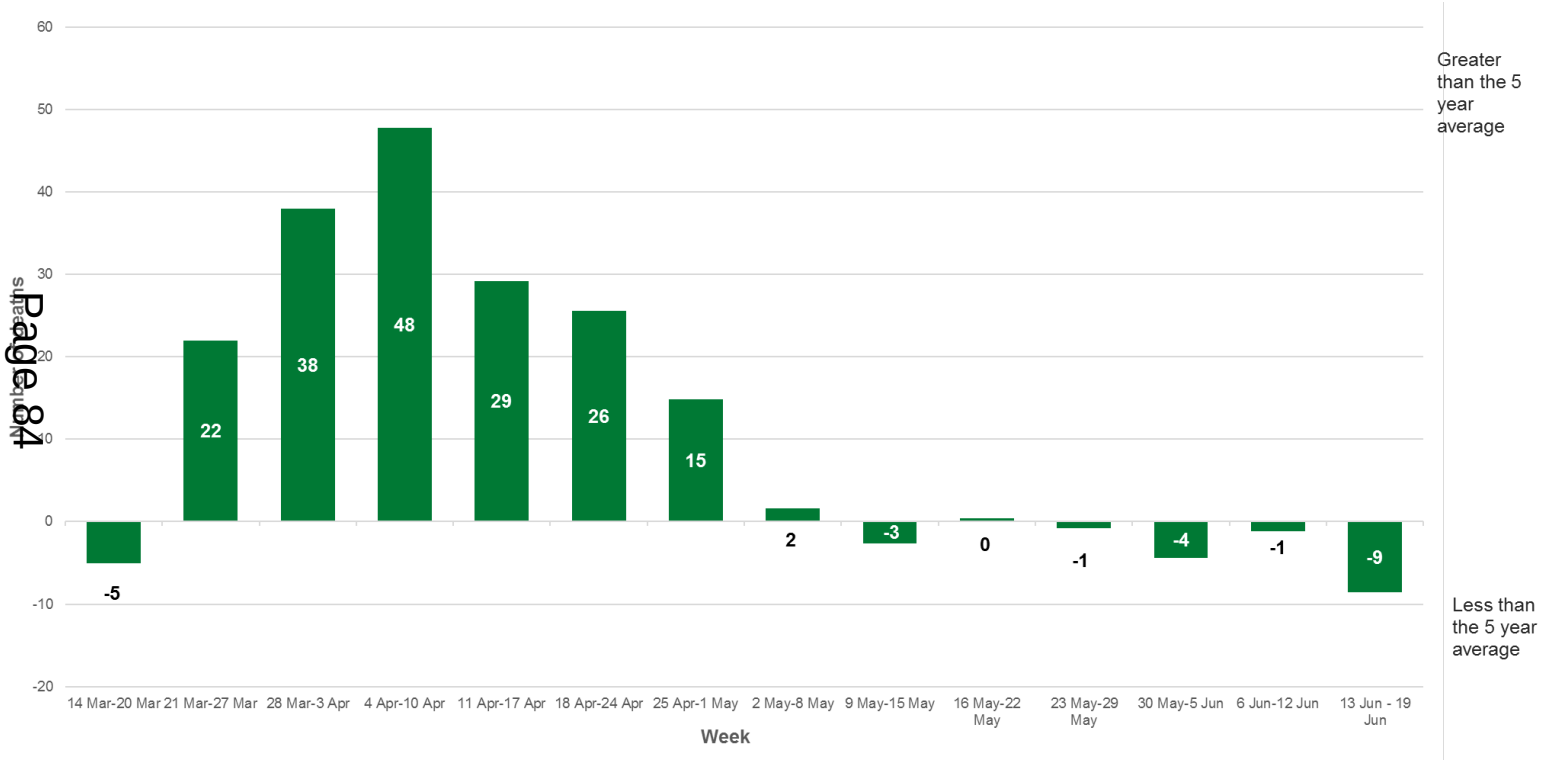
Note: Rates have been calculated using 2019 mid-year population estimates, the most up-to-date estimates when published.
Source: ONS 2020

- As of 31 May 2020, Islington's age standardised mortality rate due to COVID-19 was higher than the England average (131 deaths per 100,000 population compared to 82) but similar to the London average (138).

Excess deaths

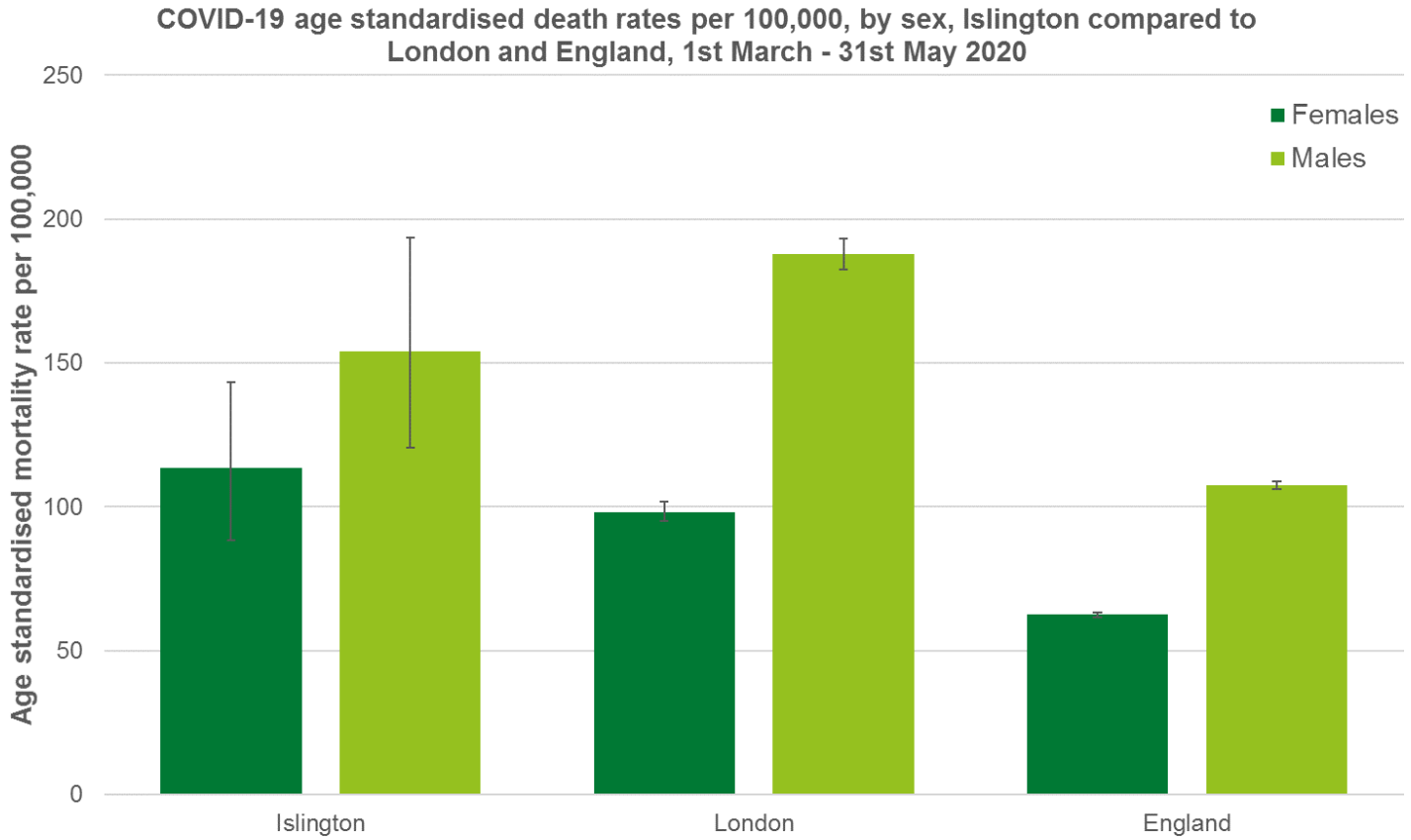
ISLINGTON

Weekly provisional figures on deaths registered minus the weekly average (2014 to 2018)



- Between the 21st March and 8th May there were a total number of **179 excess deaths** in **Islington** compared to the average number of deaths in 2014-2018.
- Of these 132 (74%) were attributed to COVID-19.
- Since the week commencing the 9th of May, there have been less deaths then the weekly 5 year average (2014-2018).

COVID-19 death rate per 100,000 by gender

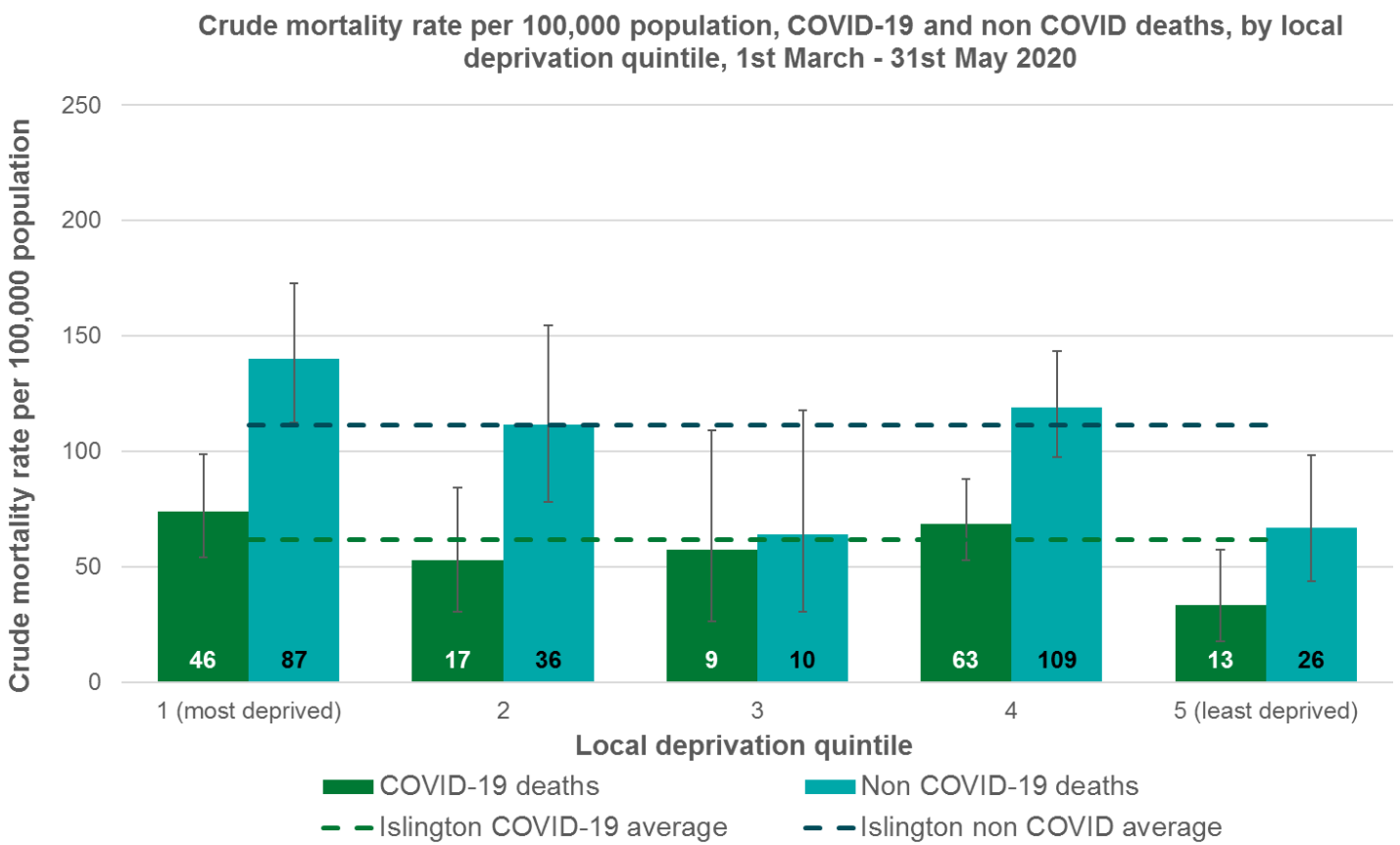


Note: Rates have been calculated using 2019 mid-year population estimates, the most up-to-date estimates when published. Figures are based on the date of death occurrence between 1 March and 31 May 2020 and registered up to (and including) 6 June 2020.
Source: ONS 2020

- Nationally, Men have been found to be disproportionately affected by COVID-19. For both England and London the COVID-19 mortality rate is approximately 2 times higher in men than women.
- In Islington, although the mortality rate is higher in men than women (154 per 100,000 compared to 113), it is not a statistically significant difference.

COVID-19 and non COVID death rate per 100,000 by deprivation

ISLINGTON

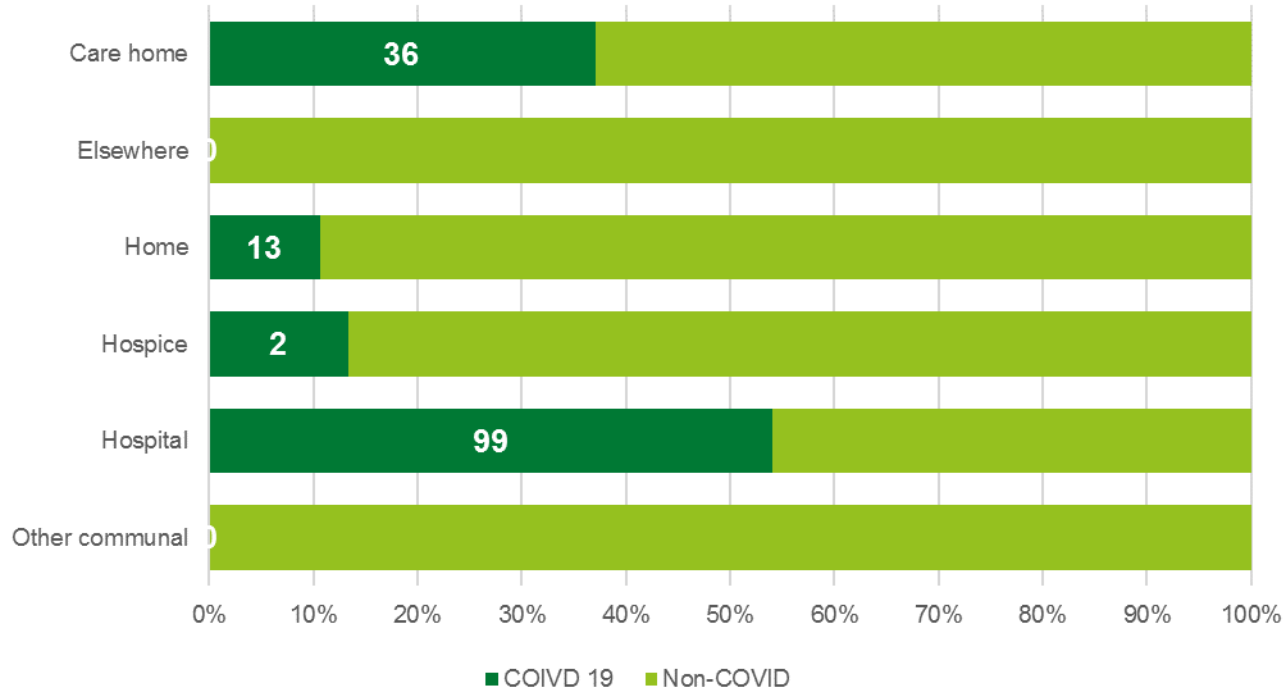


Note: Data labels show number of deaths by local deprivation qunitiles. Rates have been calculated using 2018 mid-year population estimates, the most up-to-date estimates when published. The rates in this chart have not been standardised for age.
Source: ONS 2020

- Unlike national findings, those living in the most deprived quintiles in Islington do not have a significantly higher mortality rate compared to those in the least deprived quintiles.
- The crude mortality rate of those living in the least deprived quintile is significantly lower than Islington's average (32 per 100,000 compared to 62)
- Mortality rates in non COVID and COVID-19 deaths follow a similar pattern across the local deprivation quintiles.

Deaths by place

Deaths by place of death (cumulative percentages), for deaths that occurred from 14 March to 19 June 2020 but were registered up to 27 June, by place of occurrence, cumulative



- **150** deaths in **Islington** were COVID-19 related
- Majority of COVID-19 related deaths of **Islington** residents took place in a hospital **(66%).**
- Just over **1/3** of all deaths in **Islington** care homes were related to COVID-19.
- **54%** of all hospital deaths of **Islington** residents were related to COVID-19.

Disparity in risks and outcomes in COVID-19

ISLINGTON

Category	Public Health England National Findings[1]	North Central London Local Findings[2]
Gender	Men are disproportionately affected by COVID-19. Despite making up 46% of diagnosed cases, men make up almost 60% of deaths from COVID-19 and 70% of admissions to intensive care units. Overall, age-standardised mortality rates were 74 per 100,000 males and 34 per 100,000 females.	Similar to national findings, men are disproportionately affected by COVID-19, accounting for 61% of deaths from COVID-19 in NCL, compared to 39% females. On average the age-standardised death rate was found to be 2 times higher in men than women. The age-standardised mortality rate ranged from 38 per 100,000 females in Camden to 218 per 100,000 males in Haringey.
Age	Rates of COVID-19 diagnoses increased with age. However, the majority of patients in critical care are aged 50-70. In terms of survival, those aged 80+ were 70-times more likely to die from COVID-19 than those under 40, following adjustment for demographic variables. Across all age groups, males had higher death rates than females, however, the differences decreased as age increased.	Across NCL, COVID-19 death rates also increased with age, ranging from 9 per 100,000 in those age <60 to 1,500 per 100,000 in those aged 85+. In all age groups, death rates were higher in males than in females, however this disparity narrowed with age. This is all similar to national findings.
Ethnicity	Age-standardised diagnosis rates of COVID-19 per 100,000 were highest in those of Other ethnicity (1,076 in females and 1,101 in males), followed by Black ethnicity (486 in females and 649 in males) and lowest in those of White ethnicity (220 in females and 224 in males). Disparity in death rates per 100,000 also existed, with those of Other (234 in females and 427 in males) Black (119 in females and 257 in males) and Asian (78 in females and 163 in males) ethnicity more likely to die from COVID-19 than those of White Ethnicity (36 in females and 70 in males).	Ethnicity is not listed on death certificates, however, country of birth analysis showed that those born in Africa were more likely to die of COVID-19 compared to those born in the UK and Europe. Of those born in Africa, 66% of total deaths were due to COVID-19, compared to 51% of those born in Europe/UK.

Disparity in risks and outcomes in COVID-19

ISLINGTON

Category	Public Health England National Findings[1]	North Central London Local Findings[2]
Deprivation	Those living in the most deprived quintiles were more likely to be infected with COVID-19 and have poorer outcomes (including mortality) than those in the least deprived quintiles.	Unlike national findings, there are no significant differences in the rates of COVID-19 deaths across deprivation quintiles, for each of the 5 boroughs in NCL. There is some evidence that rates are higher in those living in the middle (3rd) and second least deprived (4th) quintiles, however, due to small numbers, conclusive trends cannot be determined.
Geography	Urban areas such as London had the highest rates of COVID-19 diagnoses and deaths. For example, in London, death rates were more than three times higher than in the South West.	Barnet, Enfield and Haringey have a COVID-19 mortality rates per 100,000 population that are significantly higher than the national average (79), however Camden and Islington are below the national average. The order from highest to lowest is: Barnet (114), Enfield (113), Haringey (96), Islington (63) and Camden (59) (data to end of May – note ranking is still changing over time).
Comorbidities	The main comorbidities mentioned on COVID-19 death certificates included diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia. The most profound link was with diabetes, which was listed on 21% of death certificates.	Not currently analysed in local level data. Interpreting this within the context of inequalities will be complicated as the development of long term conditions and obesity is associated with gender, age, ethnicity and deprivation, among other things.
Occupations	Due to small numbers and limited data, clear trends were not possible to deduce, however, nursing auxiliaries and assistants have seen an increase in all cause deaths since 2014 due to COVID-19.	Due to small numbers of deaths in working aged (18-64 years) NCL residents, it was not possible to determine significant differences across occupations when comparing COVID-19 and non-COVID deaths.
Source: Local NCL data is from Local Registrar Data, 20th March 2020 to 27th April 2020. For a copy or more detail please contact Alice Wynne (Jason.doran@islington.gov.uk or Alice.wynee@islington.gov.uk). **Caveats:** there are many caveats – please speak to us if you want to understand these.		

FURTHER INFORMATION

ISLINGTON

About Public Health Knowledge, Intelligence and Performance team

Public Health KIP team is a specialist area of public health. Trained analysts use a variety of statistical and epidemiological methods to collate, analyse and interpret data to provide an evidence-base and inform decision-making at all levels. Camden and Islington's Public Health KIP team undertake epidemiological analysis on a wide range of data sources.

All of our profiles, as well as other data and outputs can be accessed on the Evidence Hub at: http://evidencehub.islington.gov.uk

About COVID-19 cases and deaths Data Pack

This data pack/profile was produced by Alice Wynne, reviewed and approved for publication by Mahnaz Shaukat

Contact: alice.wynne@Islington.gov.uk

We would also very much welcome your comments on these profiles and how they could better suit your individual or practice requirements, so please contact us with your ideas.

Update to Health & Social Care Scrutiny

Covid-19 - Adult Social Care response

Katharine Willmette

16 July 2020

Contents

Part 1: ASC response to Covid-19

Silver command established.

Critical work areas identified & resourced.

Services supported – Hospital discharge, Safeguarding, In-house services & Contracting & Brokerage.

Close working arrangements established with other LBI services and partners to ensure support for critical areas E.G. – WAI, Access Islington, Commissioned services, The NHS and the Voluntary Sector.

7 day working kicked in.

Adult Social Care response to COVID-19

4 critical service delivery areas

- Hospital discharge
- In house provision
- Contracting & brokerage
- Safeguarding residents

STAFF IN NON CRITICAL AREAS REDEPLOYED

- 7 Day service introduced to respond
- Some extra capacity into social work front line
- Brokerage service strengthened to arrange packages of care
- Care pathways strengthened
- Partnership & collaboration strengthened

WHAT HAS EMERGED

- Hospital discharges comfortably managed
- Focus on frontline delivery
- Priority groups emerged as crisis developed
- Partnerships & collaboration critical
- Extensive support to commissioned services required to support both care homes and domiciliary care providers.

Two main areas of extensive activity

- Support to commissioned services
- Emerging priority groups

Support to commissioned services – COVID-19

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- ✓ PPE 672k items at cost of £200k
- ✓ Support to access mutual aid
- ✓ Daily Provider briefings & dedicated website for updates & advice
- ✓ Co-ordination of staff testing in the early days

- ✓ Pay on planned hours for domiciliary care packages
- ✓ Discussions with providers who face ongoing financial pressures
- ✓ Collaborative commissioning approach through 1:1 discussions with individual providers

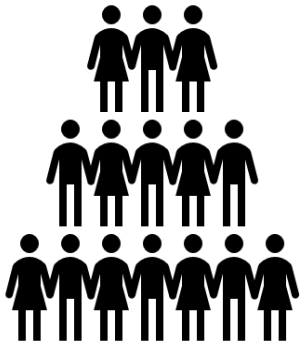
- ✓ Support to recruit
- ✓ Parking permits
- ✓ Key worker letters
- ✓ £178k hardship fund uplift on spot purchased beds (April/May 2020)

- ✓ £633,882 infection control fund for Islington bed based providers on a per bed basis.
- ✓ Further £211,294 across wider adult social care market for infection control.

Information as of 29/05/20

ISLINGTON

960 service users from both full ASC lists (including initial WAI calls)



85 identified on the Shielders list

Mobilised and **trained** staff to make Shielders calls to **1014** residents

First Shielders list **579** contacted

Second Shielders list **435** contacted

Generated referrals for support with:

Food

Finance

Personal Care

Safeguarding

Mental Health

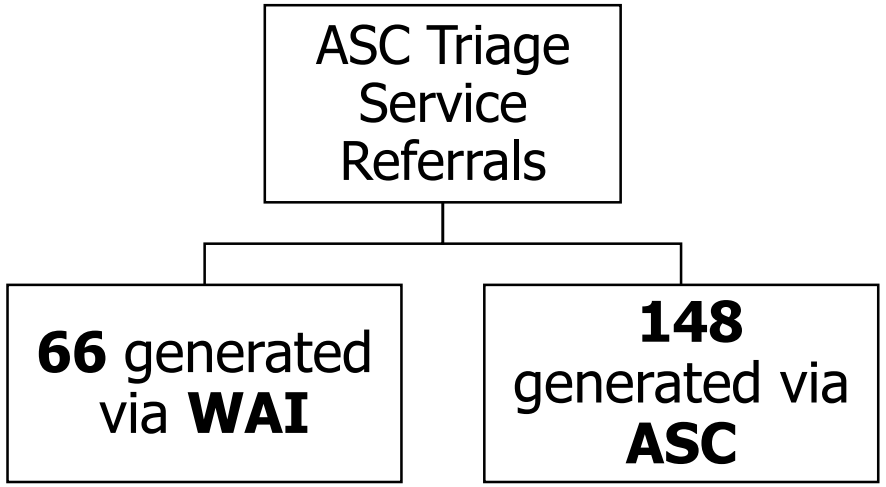
Pet care

Welfare calls

Since the beginning of COVID-19 all areas of adult social care have been making welfare calls to vulnerable residents known to ASC, some of whom are also on the shielding list.

Adult Social Care Triage Service

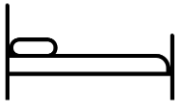
Vulnerable people who appear not to be able to understand or manage their own affairs even with support from a welfare check are referred to a new ASC Triage service.



Common actions from triage referrals include:

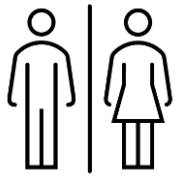

Financial Support


Direct ASC Support

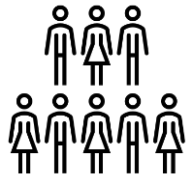

Homeless and requiring advice


Mental Health


GP or other health referral



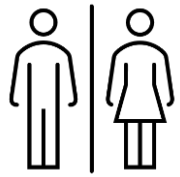
Initially **19** residents identified that required to shield.



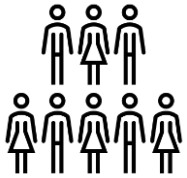
Committed to ascertain whether a further **14** required instruction to shield.

Most people cant move to self-contained accommodation due to their complex needs – bespoke protection plans put in place for all.

Through communication with GP, providers & care co-ordinators **3** further residents have been confirmed as needing shielding.



Established other **11** not required to shield.



Confirmed **71** residents previously thought required to shield no longer need to.

Shared supported accommodation

The Homelessness and Health work stream covers the needs of rough sleepers access to support and residents in shared supported housing who are required to shield. ASC and Joint Commissioning put in place a social care and health response.

Part 2: Domiciliary Care

Domiciliary care summary data

ISLINGTON

- There are currently (w/c 22th June)
  - **1231 Islington service users** receiving domiciliary care
  - **20,651 hours** of Islington domiciliary care provided **per week**
  - 57.2% of service users and 46.6% of hours were provided by our two framework providers
  - 55% of packages were with Good and Outstanding providers versus 45% with RI or unrated providers

Monthly Summary	April 2020	May 2020	June 2020
Service Users	1214	1246	1231
Weekly Hours	20,376	21,246	20,651
Weekly Cost	£370,396	£388,108	£377,576
Average Cost	£18.18	£18.27	£18.28

ISLINGTON

Market Capacity

Capacity in the market is high and recruitment is not currently an issue due to an abundance of staff who are unable to get work in other sectors such as hospitality and retail. This may change as the lockdown is eased.

London Care currently have 170 hours of capacity
Mihomecare currently have 150 hours of capacity

Across all providers in the local market there is approximately 3000 hours of capacity.

Testing

Testing of staff and service users remains low with only 5 providers indicating that they have conducted testing out of 62 who have completed the ADASS Market Insight Tool.

PPE trends – timeline

ISLINGTON

Home	W/C 23/03/20	W/C 30/03/20	W/C 06/04/20	W/C 13/04/20	W/C 20/04/20	W/C 27/04/20	W/C 04/05/20	W/C 11/05/20	W/C 18/05/20	W/C 1/6/20	W/C 8/6/20	W/C 15/6/20	W/C 22/6/20	Total Issued to provider
London Care	2300	500	4550	4950	74	0	0	16837	18200	0	1500	0	0	**63406**
Snowball	0	450	0	0	4155	0	4970	0	5612	9495	0	0	18260	**24557**
Homedotcare	0	0	0	0	9195	0	780	6205	2737	1175	0	0	6000	**26026**
Daryel Care	0	0	0	0	0	3153	2800	1168	2422	5300	0	0	3230	**22079**
Temp Exchange	0	0	0	0	0	5655	0	6410	4185	0	0	0	0	**16250**
Bright Future Care	0	0	0	0	6832	0	0	0	5869	0	0	0	0	**12701**
Mihomecare	800	500	5255	4570	4406	30000	12600	4270	17100	18550	7100	0	0	**105151**
Total	**3100**	**1450**	**9805**	**9520**	**24662**	**38808**	**21150**	**34890**	**56125**	**34520**	**22100**	**0**	**27490**	**287621**

Public Health local risk assessment – Use PPE within 2m of service users with symptoms

Public Health advice shifts to using PPE within 2m of Service Users regardless of symptoms

PPE Trends

- Providers are reporting that the costs of PPE are rising and have begun to request additional financial support.
- We can expect that the cost of delivery for homecare has increased and will need to be addressed in terms of either one-off payments to cover additional PPE costs or an increase in the providers hourly rate.
- 4C, who have been supporting the NCL throughout the pandemic, are currently estimating PPE costs of between £24 and £31 per service user, per week. Masks are assumed to be single use in homecare this leads to additional costs per interaction relative to a care home.
- Using the estimates given by 4C, we can expect an additional cost of over **£28,800 - £37,200 per week or £1.5m - £1.9m per annum.**
- This increase in cost represents an additional **£1.35 – £1.75 per hour.** Meaning the average hourly rate would move up **from just over £18p/h to nearly £20p/h**.

Part 3: Older People Care home

Overview

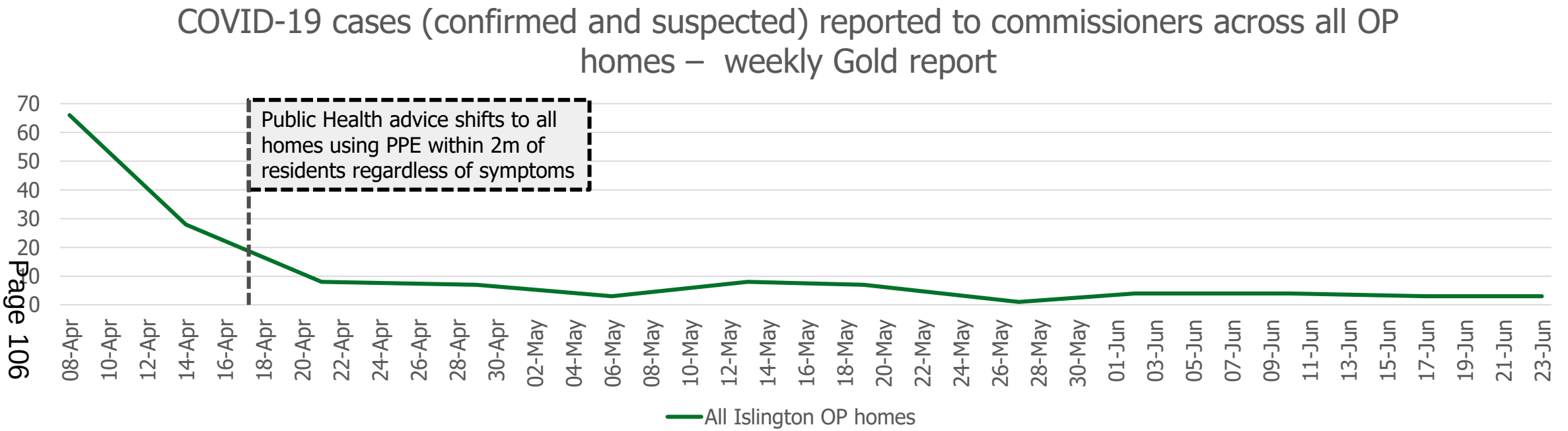
ISLINGTON

- **This week no residents presented as newly COVID positive or symptomatic – the three asymptomatic cases are those identified and reported on previously.**
- **No new COVID-related resident or staff deaths were reported this week.**
- **Staffing levels remain generally stable**.
- Care homes with vacant beds are working to fill these but constraints mean actual capacity is lower than capacity on the face of it. **Demand for placements from hospital discharges is currently limited.**

- **LBI continued to supply PPE this week, but only to two OP homes. PPE quantities supplied this week were lower than recent weeks and similar to pre April 2020 levels.**
- **Media interest in care homes has decreased compared to previous weeks as lockdown restrictions have eased – any future interest will be managed on a case by case basis in conjunction with LBI Media colleagues.**
- **All homes have confirmed they have heatwave measures in place.**

OP home sector level trends – cases reported over time

ISLINGTON

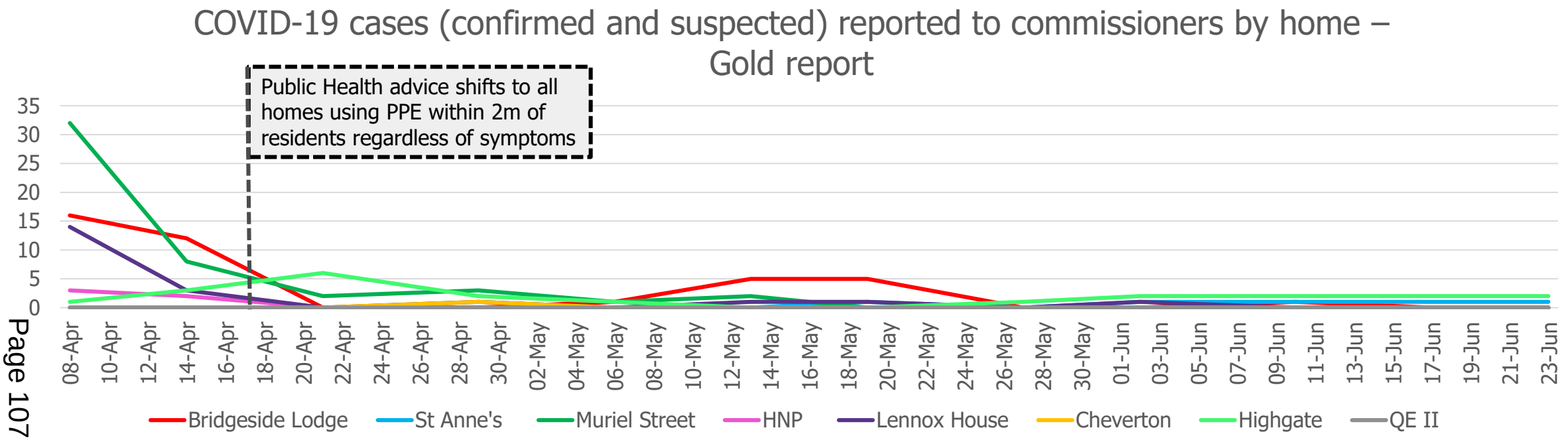


- All OP care homes have reported on the number of confirmed and suspected cases on a weekly basis to ASC commissioners since 8th April 2020. Prior to this, reporting was ad hoc, if there were cases suspected or confirmed. The above presents the total number of cases reported at weekly check ins, using the snapshot view to highlight trends. The above therefore may not accurately reflect day to day changes between value points.
- The data above includes confirmed and suspected cases – both symptomatic and asymptomatic. Changes reported week by week reflects that residents recovered, deteriorated and died, or testing clarified COVID status. It should be noted that limitations in the availability of testing and reliance on clinical judgement mean that this data, particularly earlier data, may not completely accurately reflect all COVID cases i.e. some suspected cases may not have been COVID-19 and some asymptomatic cases may not have been identified and there may variation in reporting.

There has been a considerable reduction in the overall number of COVID-19 cases reported in OP care homes from a peak of 66 suspected or confirmed cases reported in the first Gold report of the crisis to there being consistently no more than 8 cases reported in weekly snapshots since 21 April. The nature of cases reported has changed over time with a decrease in symptomatic residents presenting and an increase in asymptomatic residents identified.

Home level trends – cases reported over time

ISLINGTON



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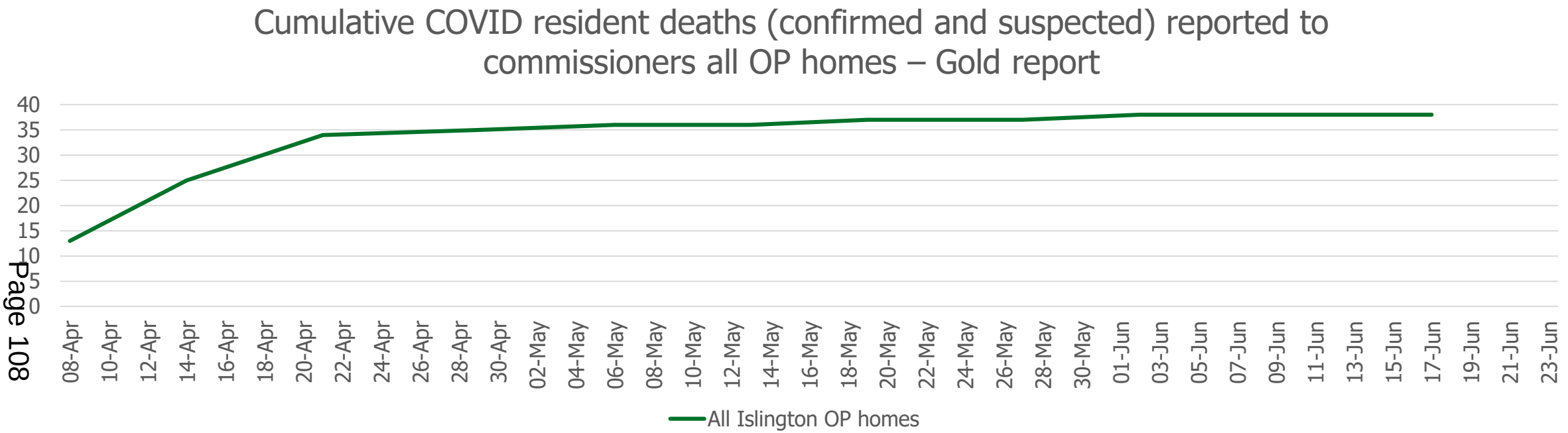
Different homes have been affected by COVID differently – Muriel Street, Bridgeside Lodge, and Lennox House had the largest outbreaks at the beginning of the crisis. Since then there have not been outbreaks on comparable scale in any home (with peaks of 6/5 compared to 33, 16, and 14 cases respectively.)

OP home sector level trends – cumulative COVID-related deaths

ISLINGTON



- All OP care homes have reported on the number of COVID-related resident deaths on a weekly basis to ASC commissioners since 8th April 2020. In the first report, commissioners asked providers to report on deaths that had occurred since 25 March 2020. The above presents the cumulative total COVID-19 deaths reported at weekly check ins, using the snapshot view to highlight trends. The above therefore may not accurately reflect day to day changes between value points.
- The data above includes both confirmed and suspected COVID-19 deaths. It should be noted that limitations in the availability of testing and reliance on clinical judgement mean that this data, particularly earlier data, may not completely accurately reflect all COVID deaths. Determining COVID's role in cause of death (e.g. where it was a secondary cause) is complex and there may be variation in reporting.

After a sharp increase in the number of confirmed and suspected COVID-related deaths early in the pandemic during wide scale outbreaks in some homes, over the last eight weeks the number of new COVID-related deaths has stabilised with relatively small numbers of new deaths reported.

Trends analysis – cases and deaths reported over time

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- In the context of COVID-19, an outbreak is now classified as one case or more in a setting (previously it had been two related cases in a setting) – by this standard, **all OP homes in Islington have experienced, in varying shapes and scales, an outbreak**.

- **It is difficult to neatly assign causality for why different homes have had such different experiences in the early weeks of the crisis.** During this time, Muriel Street and Bridgeside Lodge experienced large outbreaks that affected more than half of their residents, while other homes reported no cases.

- **Data reported does, however, show that variation of experience has reduced considerably following the large early outbreaks in some homes, with an overall reduction in the number of cases across all homes and, at home level, considerably smaller outbreaks where they have emerged.**

- **Similarly, after a sharp increase in the number of COVID-related deaths in the early phase of the pandemic, over the last eight weeks this has stabilised with relatively small numbers of new deaths reported.**

- **It is possible that a range of factors contributed to the reduction in variation and reduced number of COVID-related deaths including more consistent and widespread use of PPE,** expansion of testing to identify and isolate asymptomatic carriers, reduction in external visitors, implementation of enhanced cleaning regimes, etc.

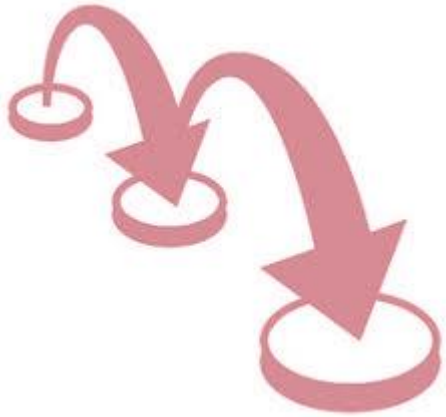
Next steps for care homes

ISLINGTON

- Nationally, regionally, and locally, work is ongoing to increase testing in care home settings – ASC commissioners will support homes to benefit from this and contribute to discussions about how mechanisms can be most effective.

- Homes will continue to receive support from ASC Commissioning, Public Health, the PPE Hub, and health-commissioned Multi-Disciplinary Team services.

- ASC Commissioning, in partnership with Public Health, will continue to monitor the situation in care homes very closely.



Part 4: ASC response and learning

ASC Response

All Teams and Services

- Proactively calling and monitoring people on case lists/service users e.g. Day Services, Learning Disability Service, Non Recent Abuse Team, Community Social Work Teams.
- The frequency of contact depends on level of need.

Welfare Checks Team

- Core team (supported by other staff in ASC) are calling shielders known to Adult Social Care,
- All staff doing this work (Housing, ASC, WAI) asking same questions, recording same info so that information is collated onto council systems.
- Potential outcomes; no further action, referral to SW Teams, provision of practical support

Triage Service

- 2 senior practitioners and community assistants, 7 days per week.
- SP's look at results from welfare checks, advisory role to We Are Islington, Urgent Response and Access Team,
- Work with/refer to Emergency Duty Team and Community Assistants for practical support

ASC Response

Hospital Discharge Service

- Integrated 3 teams (hospital, Discharge to Assess, Reablement)
- Staff working flexibly, 7 day working, making sure people have care on discharge
- More outreach into the community, assessing people after discharge, preventing admission
- Increased collaborative working, reduced bureaucracy

Extended Working Pattern (weekends/8-8)

- **Emergency Duty Team** – capacity bolstered, with a 'touch base' virtual meeting for all staff working at weekends
- **Resource Team –** supporting staff at weekends with identifying care provision
- **Urgent Response Team –** capacity bolstered
- **In House Services, Community Assistants, Triage Service, Community Social Worker Back Up and Senior Leadership Rota**

What's worked well – a lot!

Remote / flexible working

- Redeployment of staff (provider services, welfare calls team, ASC Triage)
- Integration of teams (e.g. hospital / D2A)
- Option of staff being able to work from home where previously this hasn't been allowed due to role or there might have been concerns about
- 7 day working for some staff
- Personalising working practices and hours
- Giving people opportunity to get involved with different roles / work

Fast decision making / reduced processes

- Reduction in paperwork
- More streamlined discharge processes
- Processes and pathways created quickly and fast sign-off
- Ability to tap into the support/ expertise of colleagues – maintaining team approach to cases and workload
- Singular hospital discharge / admissions form

Focus on welfare of residents

- Outreach and welfare visits/calls as preventative not just reactive
- Working closely with voluntary sector to find best solutions

Use of different technology

- Webinars
- Meetings via MS Teams or Skype
- Online learning
- DoLS assessments
- Supporting service users remotely – challenging but has been possible

WHATS WORKED WELL – A LOT!

Focus on staff wellbeing

- Offer of counselling sessions
- Wellbeing hubs on izzi and One Drive
- Team WhatsApp groups and virtual coffee breaks / lunches
- Sharing positive stories with each other
- Weekly ASC newsletter
- More regular team meetings and manager check-ins
- Managers managing staff in a more compassionate way and being more in tune with their emotional states

Giving staff professional autonomy

- Staff able to problem solve and act as 'leaders' in their role
- Trusting the professional judgement of staff
- Raising profile and understanding of team work and roles

Joint working

- Better communication across teams
- Working together
- Better understanding of roles / ways of working
- Sense of shared purpose across different teams/orgs
- Closer working relationships with operational and commissioning colleagues

Challenges

- Returning services to "normal" – increase of risks to staff and people who use our services
- Ensuring we have PPE capacity and adequate numbers of staffing
- People can become isolated when working from home for a sustained period of time and it can be hard to balance home and work
- Risk of losing the innovation and creative ways of working that have been developed during this crisis
- Maintaining quick turnaround on decisions and less bureaucracy - going back to unnecessary overly bureaucratic timeframes for change
- Inability of staff and provider to maintain social distancing/safe working practice
- Heightened staff anxiety about getting back to 'new normal' (i.e. commuting)

Achievements and Learning

Outcomes;

- Excellent collaborative working between different teams, departments and providers
- Staff willingness/ability to be flexible and take on new roles
- Residents have been appreciative of the contact and support provided
- A model of working that can combine remote and face to face working
- Processes and pathway have been streamlined

Learning that can be carried forward into the ASC recovery phase

- Continue building relationships between ASC/Providers/VCS
- Continue work in relation to prevention and early intervention
- Combine assessing people at home (hospital Discharge) with Reablement
- Emphasise people's strengths and independence

By being agile, flexible and keeping things simple, ASC can achieve great things!

Thank You for listening

Any Questions?

ISLINGTON

Corporate Performance

2019/20 Directorate Report

Health & Independence

May 2020

Performance Highlights

Our Strategic Objectives

Health and independence Ensuring our residents can lead healthy and independent lives

- Support people to live healthy lives
- Help residents to feel socially active and connected to their communities
- Safeguard and protect older and vulnerable residents
- Help residents to live independently

Covid-19 Impact

Covid-19 has resulted in a number of services either pausing or changing delivery approach since mid-March. This will have significant effect on performance and data submission. It is anticipated that services can where possible continue to deliver services remotely, via telephone and virtual support groups. A number of programmes have been paused as a result of Covid-19 and will remain under review, until appropriate to recommence.

Key Achievements at Q4

*This is the latest data available but may not reflect full-year performance

55%
(target: 50%) smokers using Stop Smoking services who quite

51%
(target: 50%) entering Improving Access to Psychological Therapy treatment who recover

124
(target: 134) new permanent admissions to residential and nursing care

Key Challenges at Q4

*This is the latest data available but may not reflect full-year performance. Where outline is red, impact is due to Covid-19.

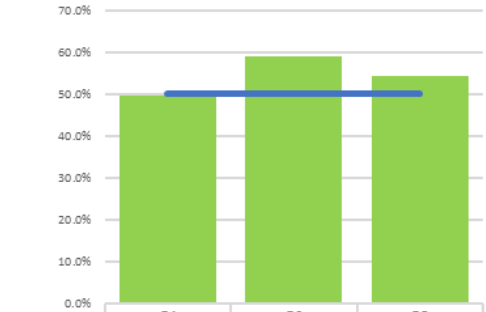
15%
(target: 20%) drug users who complete treatment and do not re-present in 6 months

84%
(target: 95%) discharged from hospital into enablement services

7
(target: 5) beds per day occupied by patients deemed to be a delayed transfer due to Social Care

Health and independence Ensuring our residents can lead healthy and independent lives

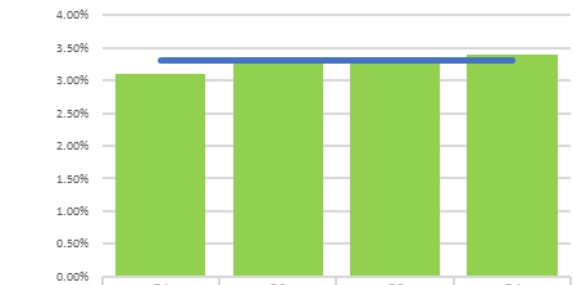
Percentage of smokers using Stop Smoking Services who quit (measured after quit date)



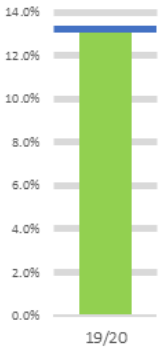
	Q1	Q2	Q3
Performance	49.6%	59.0%	55%
Target	50.0%	50.0%	50.0%

19/20 Performance	**54.5%**
19/20 Target	**50%**
Direction of Travel	▲
Comments	Q4 data will be released on 8 Jun '20 and thus the YTD figure and position will be determined in due course once the data and narrative has been received. We expect the indicator of percentage of successful quits will remain on target, despite changes in activity towards the end of March due to Covid'19

Percentage of eligible population (40 – 74) who receive an NHS Health Check

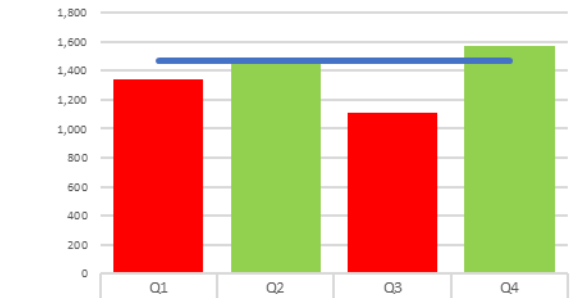


	Q1	Q2	Q3	Q4
Performance	3.10%	3.3%	3.3%	3.4%
Target	3.3%	3.3%	3.3%	3.3%

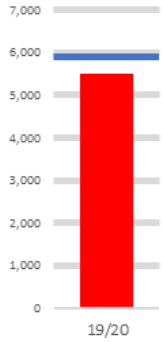


19/20 Performance	**13.1%**
19/20 Target	**13.2%**
Direction of Travel	▲
Comments	The NHS Health Checks target for Q4 was met at 3.4%. The year to date figure is 13.1% compared to an expected target of 13.2%. Towards the end of March the NHS Health checks programme was paused due to Covid-19 to reduce patient contact and visits to the GP. The programme will remain under review and will start up again at an appropriate time in line with national guidance. ***Significant Covid-19 impact requires interim suspension of this indicator***

Number of people entering treatment with the IAPT service (Improving Access to Psychological Therapies)

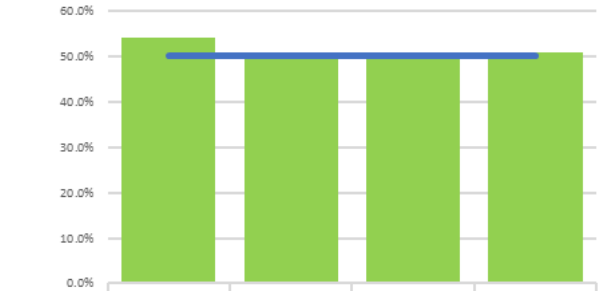


	Q1	Q2	Q3	Q4
Performance	1,344	1,492	1,111	1,570
Target	1,473	1,473	1,473	1,473



19/20 Performance	**5517**
19/20 Target	**5892**
Direction of Travel	▼
Comments	Improvement on last year but below target this year

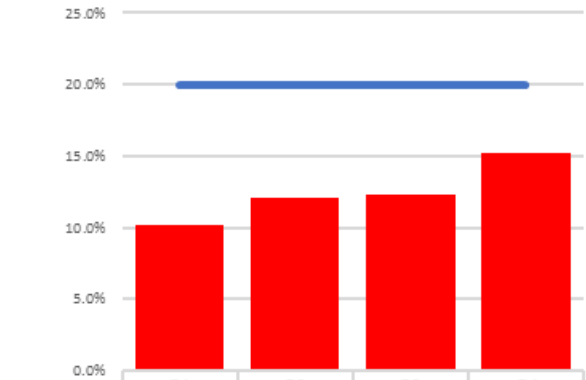
Percentage of those entering IAPT treatment who recover



	Q1	Q2	Q3	Q4
Performance	54.0%	50.8%	51.0%	51.0%
Target	50.0%	50.0%	50.0%	50.0%

19/20 Performance	**51%**
19/20 Target	**50%**
Direction of Travel	▲

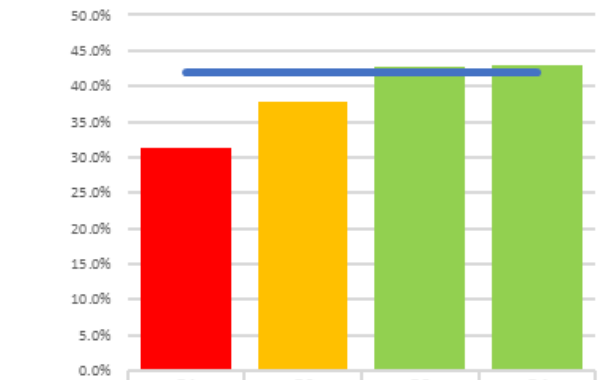
Percentage of drug users in drug treatment who successfully complete treatment and do not re-present within 6 months



	Q1	Q2	Q3	Q4
Performance	10.2%	12.1%	12.3%	15.2%
Target	20.0%	20.0%	20.0%	20.0%

19/20 Performance	**15.2%**
19/20 Target	**20%**
Direction of Travel	▼
Comments	Although the target of 20% for successful drug treatment was not met, there has been a 5% increase over the year. Whilst social distancing measures are still in place, it is anticipated that substance misuse providers will continue to offer services remotely e.g. telephone support, virtual groups via Zoom, and the use of digital apps. Measures that have been put in place since COVID 19 like longer prescription frequency, will remain in place until capacity within community pharmacies is more stable. Services are reporting increases in demand for treatment, particularly for opiate and alcohol users.

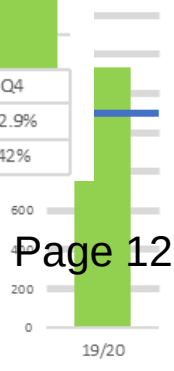
Percentage of alcohol users who successfully complete the treatment plan



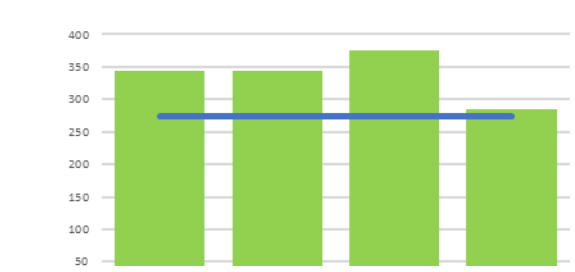
	Q1	Q2	Q3	Q4
Performance	31.4%	37.7%	42.7%	42.9%
Target	42.0%	42%	42%	42%

19/20 Performance	**42.9%**
19/20 Target	**42%**
Direction of Travel	▲
Comments	The alcohol target was met and there was a 10% improvement from Q1.Services are reporting increases in demand for treatment, particularly for opiate and alcohol users. It is anticipated providers will continue with a phone and virtual offer.

Number of Long Acting Reversible Contraception (LARC)

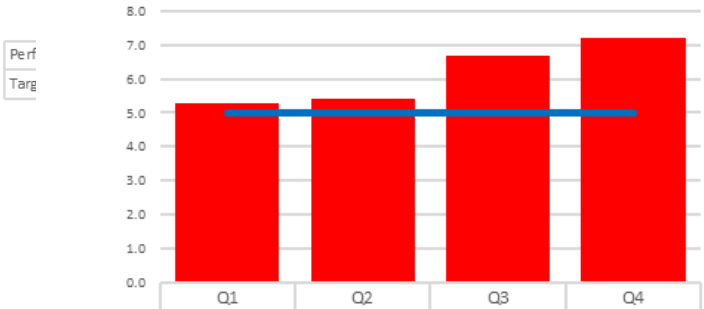


prescriptions in local integrated sexual health services



19/20 Performance	1335
19/20 Target	1100
Direction of Travel	
Comments	The number of Long Acting Reversible Contraception (LARC) prescriptions made in local integrated sexual health services has exceeded the annual target by 235. However, this activity was significantly effected in March due to Covid-19, with only 52 LARCs in this month, approx.. 50% of previous activity.

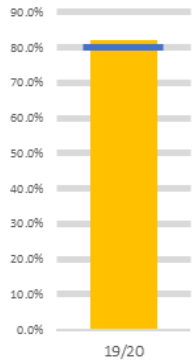
Average number of beds per day occupied by patients deems to be a delayed transfer due to Social Care (in both Acute and MH hospitals)



	Q1	Q2	Q3	Q4
Performance	5.3	5.4	6.7	7.2
Target	5.0	5.0	5.0	5.0

19/20 Performance	7.2
19/20 Target	5
Direction of Travel	
Comments	This is the average number of delayed beds per calendar days due to Social Care in both Acute and MH divided by number of calendar days in reporting period. Data is published on a two-month delay and publication is on hold in light of

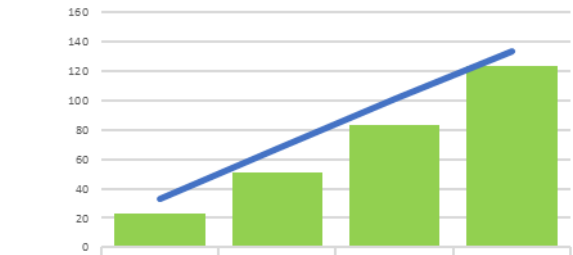
The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact



19/20 Performance	82%
19/20 Target	80%
Direction of Travel	
Comments	for Feb 20 Although data collection for the 2019/20 Adult Social Care User Survey ended pre Covid-19, data entry of returned surveys were not completed prior to the lockdown period. Only 36% of survey responses have been entered and the official submission deadline has been delayed. This is a provisional figure based on survey responses entered thus far

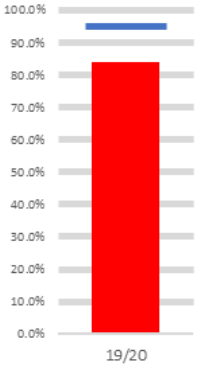
Number of new permanent admissions to residential and nursing care (65+ year olds) in both MH and non-MH settings

19/20 Performance	124
19/20 Target	134
Direction of Travel	
Comments	Figure may change due to delay in logging admissions on LAS. Also reported as part of ASCOF 2A (2) indicator (new actual admissions in both MH and non-MH settings)



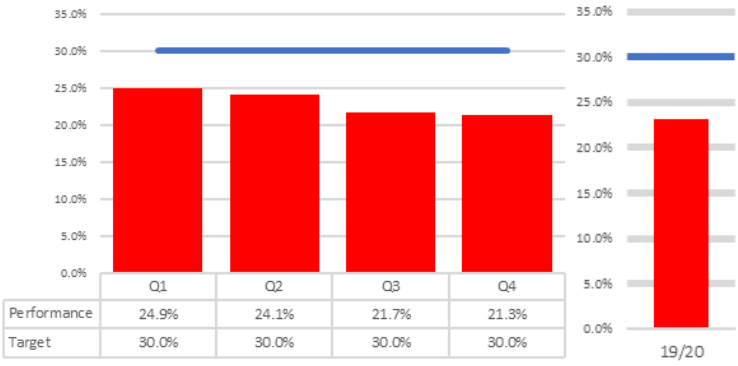
	Q1	Q2	Q3	Q4
Performance	23	51	83	124
Target	33	67	101	134

Percentage discharged from hospital into enablement services who are at home or in a community setting within three months



19/20 Performance	**84%**
19/20 Target	**95%**
Direction of Travel	
Comments	Last year (2019/20) figure was calculated using the assumption that anyone who was neither deceased nor in nursing or residential care was assumed to still be at home 91 days after reablement. We have refined the reporting methodology this year to better reflect SALT requirements. This figure does not include individuals we were unable to reach in the denominator

Percentage of service users receiving care in the community through use of direct payments



	Q1	Q2	Q3	Q4
Performance	24.9%	24.1%	21.7%	21.3%
Target	30.0%	30.0%	30.0%	30.0%

19/20 Performance	**23.2%**
19/20 Target	**30%**
Direction of Travel	
Comments	Although below the target of 30%, end of year performance is in line with performance end of year in 2019/20 (24%).

HEALTH AND CARE SCRUTINY COMMITTEE – WORK PROGRAMME 2020/21

Agenda Despatch Date – 8 July 2020

16 JULY 2020

1. Health and Wellbeing Board update – Situation report
2. Work Programme 2020/21
3. Scrutiny Review – Draft Report – Adult Paid Carers- Consideration of extending scrutiny to cover issues relating to COVID 19 – Deaths of residents in care homes, sheltered accommodation, PPE, deaths of staff, Payments for carers/domiciliary staff, Impact on BAME staff in all sectors
4. Performance update – Quarter 4
5. COVID 19 update
6. Moorfields Quality Account

Agenda Despatch Date – 2 September 2020

10 SEPTEMBER 2020

1. NHS Whittington Trust – Performance update
2. Camden and Islington Mental Health Trust – Performance update
3. Scrutiny Review – Adult Paid Carers – witness evidence
4. Health and Wellbeing update – situation report
5. Work Programme 2020/21
6. COVID 19 update
7. Scrutiny Review GP Surgeries – 12 month report back

Agenda Despatch – 07 October 2020

15 OCTOBER 2020

1. Health and Wellbeing update
2. Work Programme 2020/21
3. Scrutiny Review – witness evidence
4. Healthwatch Annual Report/Work Programme
5. COVID 19 update
6. Camden and Islington Mental Health Trust – Quality Account
7. Introduction of Test and Trace – update
8. Merger of CCG's /Hospital backlog due to COVID 19 - update

Agenda Despatch – 18 November 2020

26 NOVEMBER 2020

1. Scrutiny Review – witness evidence
2. Health and Wellbeing Update
3. Work Programme 2020/21
4. Alcohol and Drug Abuse update
5. Annual Safeguarding report
6. London Ambulance Service – Performance update
7. Performance indicators – Quarter 1
8. COVID 19 update

Agenda Despatch – 13 January 2020

21 JANUARY 2021

1.Scrutiny Review - witness evidence
2 Health and Wellbeing update
3. Work Programme 2020/21
4. Local Account
5. Executive Member Health and Social Care - Annual Report
6. Performance update – Quarter 2
7. COVID 19 update

Agenda Despatch – 24 February 2020

4 MARCH 2021

1. Scrutiny Review – witness evidence
2. Health and Wellbeing update
3. Work Programme 2020/21
4. Annual Health Public Report
5. UCLH Performance update
6. COVID 19 update

Agenda Despatch – 21 April 2021

29 APRIL 2021

1. Health and Wellbeing update
2. Work Programme 2020/21
3. Scrutiny Review – Draft recommendations
4. Moorfields NHS Trust – Performance update
5. Performance update – Quarter 3

JUNE 2021
Quarter 4 Performance update/Council Targets 2021/22