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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, **29 April 2021 at 7.00 pm.**

Link to meeting: https://weareislington.zoom.us/j/93862434272

Enquiries to : Peter Moore
Tel : 020 7527 3252
E-mail : democracy@islington.gov.uk
Despatched : 21 April 2021

Membership

Councillors:
Councillor Osh Gantly (Chair)
Councillor Jilani Chowdhury (Vice-Chair)
Councillor Tricia Clarke
Councillor Roulin Khondoker
Councillor Martin Klute
Councillor Phil Graham
Councillor Clare Jeapes
Councillor Rakhia Ismail

Co-opted Member:

Substitute Members

Substitutes:
Councillor Anjna Khurana
Councillor John Woolf
Councillor Sara Hyde

Substitutes:

Quorum: is 4 Councillors

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

B. Items for Decision/Discussion **Page**

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 Date Not Specified

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

www.democracy.islington.gov.uk

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London Borough of Islington

Health and Care Scrutiny Committee - Thursday, 15 April 2021

Minutes of the meeting of the Virtual meeting of the Health and Care Scrutiny Committee held at on Thursday, 15 April 2021 at 7.00 pm.

Present:	**Councillors:**	Gantly, Clarke, Jeapes, Khurana, Khondoker
Also Present:	**Councillors**	Lukes and Turan

Councillor Osh Gantly in the Chair

234 INTRODUCTIONS (ITEM NO. 1)

The Chair introduced Members and officers to the meeting

235 APOLOGIES FOR ABSENCE (ITEM NO. 2)

Councillor Klute and Councillor Khondoker for lateness

236 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

Councillor Khurana stated that she was substituting for Councillor Klute

237 DECLARATIONS OF INTEREST (ITEM NO. 4)

None

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

RESOLVED:

That the minutes of the meeting of the Committee held on 4 March 2021 be confirmed and the Chair be authorised to sign them

239 CHAIR'S REPORT (ITEM NO. 6)

None

240 PUBLIC QUESTIONS (ITEM NO. 7)

The Chair outlined the procedure for Public questions

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

Councillor Nurullah Turan, Executive Member Health and Social Care was present for this item and during discussion the following main points were made –

- Noted COVID progress and that the Annual Adult Safeguarding report had been considered
- Work taking place with educational institutions in relation to increase in neglect, domestic violence, substance misuse, gangs/criminal exploitation and local priorities were being adjusted in response to COVID

- Noted that Healthwatch had suspended services at the start of the pandemic however it was intended to recommence these in May
- NCL looking at the indirect effects of COVID on issues such as air quality, mental health, social isolation etc.
- In response to a question it was stated that waiting lists for NHS treatment were a concern, as were the number of new variants of COVID

The Chair thanked Councillor Turan for his presentation

242 **COVID 19 UPDATE (ITEM NO. 9)**

Councillor Sue Lukes, Executive Member Community Safety and Pandemic response was present and accompanied by Jonathan O'Sullivan, Acting Director of Public Health. A presentation was made, and outlined to the Committee, copy interleaved

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

- Reduction in case rates are slowing down and has levelled out over the last few weeks, however in the last week there had been a further reduction and there had been 40 positive cases the lowest since September. In the over 60 age group there were only 2/3 infections per week at present
- Number of infections decreased in 5-10 year olds but have increased slightly for 11-24 year olds
- Testing – rates of symptomatic testing are slightly decreasing and positivity rates have also decreased and is now 1.1%
- PCR testing rates are highest amongst the most deprived areas of Islington and in the school population and the positive rate is extremely low
- Second wave of mortality due to COVID 19 is showing signs of slowing down and the latest week of deaths from all causes shows overall numbers are similar to the average of 2015-2019 deaths. Noted that there had been no deaths from COVID the previous week
- Noted 50000 residents had now had their first vaccination and in the over 70 age group this was 83%
- There are still differences in vaccination take up in certain BAME communities and a number of pop up centres had been utilised and this would continue
- Noted that a shopping centre campaign had been launched with shopkeepers to assist people in keeping safe, and shops are being encouraged to sign up to COVID safe premises
- In response to a question it was stated employers were also being encouraged to let staff get tested and vaccinated in work time
- A Member stated that she had heard that some Council staff were being told to get vaccinated or tested before or after work and Councillor Lukes stated that this should not be the case and that she would investigate this

- Vaccinations – noted that there has been a difficulty with supply and these had been erratic at times. Noted that if there are difficulties with getting an appointment for a vaccination We are Islington can assist and communication in different languages was taking place
- Concern was expressed that some restaurants did not appear to be operating social distancing and it was stated that if there were instances of this they should be notified so that action can be taken
- In response to a question as to disabled people not being assisted properly at vaccination centres on some occasions it was stated that volunteers are trained however Councillor Lukes stated that she would look into this and ensure appropriate measures were investigated to assist disabled residents, such as GP appointments, signage etc.
- In response to a question it was stated that a number of options for pop up vaccination centres were being looked at, such as vaccine buses and Members would be kept updated on this
- Discussion took place as to the report that 23% of the deaths from COVID within 28 days had been registered as COVID, deaths when in fact these deaths had not been from COVID but from other causes. It was stated that over 100000 people had died from COVID, in addition to the implications of long COVID on people

The Chair thanked Councillor Lukes and Jonathan O'Sullivan for attending

243 SCRUTINY REVIEW - ADULT PAID CARERS FINAL REPORT (ITEM NO. 10)

The Chair stated that amendments were being made to the report and therefore this would not be considered that evening

RESOLVED:

That consideration of the report be deferred to the next meeting of the Committee

244 WORK PROGRAMME 2020/21 (ITEM NO. 11)

RESOLVED:
That the report be noted

MEETING CLOSED AT 8.05 p.m.

Chair

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Update to Health & Social Care Scrutiny

Covid-19 - Adult Social Care response

Stephen Taylor / Jon Tomlinson

April 2021

ASC Covid Risk analysis

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Our approach

- ASC's response to previous lockdowns was to establish a live risk assessment for key areas of delivery to identified client group and this is reported to each meeting of Silver command. The aim of this was to:
  - Provide a collective account of what we are doing across ASC to respond to the needs of vulnerable people, in relation to Covid 19.
  - Identify particular pieces of work to address inequalities and disproportionality.
  - Develop robust awareness of what is happening across ASC and wider system where there are numerous dependencies.
- Our current focus has been on recovery planning as we move towards the likelihood of restrictions being lifted. What we found from the current analysis was that:
  - Much of the short & long term concerns are consistent across majority of the groups of people who need ASC services- however, particular priorities are around the social and wellbeing impacts for older people, people with dementia, Safeguarding, domestic violence, people with mental health needs, people with a learning disability and our staff.
  - Covid has highlighted and heightened long standing issues of inequality not only for Black and Asian communities but also for those with wider protected characteristics
  - ASC services are not organised around the person experience but around how service are structured
  - Language and the narrative around Covid and our roles as "paternalistic protectors of the vulnerable" needs to be challenged particularly as we move towards a more strength based approach
  - Risks and mitigations have minimal financial impact however potential increased demand and long term pressure due to needing to respond to higher acuity of need

ASC Covid Risk analysis

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Our actions

- Better understanding of our communities becomes even more essential
    - Performance and PH to look at how we can modernize our approach to data and community insight
    - move away from sole focus on KPIs and transactional data- need to value qualitative and transformational data.
    - Testing assumptions and modelling future demand.
    - Future demand management considerations in everything we do
    - Better understanding of demographics in more granular detail
- Making things more accessible – info advice, access to services need to get it right for people who have traditionally been marginalized. (As part of the Transformation programme)
    - Stream lining pathways, access to support becomes even more essential going forward.
    - Delivering things in more flexible ways
    - Making better use of system wide resources
    - Connecting more services to provide whole system change where there is social value and makes strategic sense to do so Directing support and staff resources where it is most needed
    - Modelling services around the person rather than around the organization
    - Focus on cultural competency when shaping services in everything we do
- Long term focus on wellbeing – for workers and people who use services
- Culture of challenge- in terms of the language, decision making and narrative
- Understanding the impact and social value of our communication campaigns particularly for our diverse communities
- Cultural competency and challenging inequalities in everything thing that we do
- Learning from our workforce by building better two way channels of communication
- Increased availability of income maximization and employment support

Overview

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- **Work has been underway since mid-December 2020 with local partners to prepare for and roll out COVID vaccinations to local residents and care staff. To date:**
    - **All care home residents (OP/MH/LD) have been offered their first COVID vaccine.**
    - **All residents living in extra care have been offered their first COVID vaccine.**
    - **All supported living residents have been offered their first COVID vaccine.**
    - **All residents in commissioned supported housing have been offered their first COVID vaccine.**
- **Work is underway to provide second doses to residents in accommodation-based settings.**
- **Commissioners are continuing to promote vaccination to local frontline health and care staff. Last week access to the national booking system was withdrawn without notice from staff age under 50. To address this local arrangements have been put in place to enable walk-in access at various vaccination sites within North Central London. Officers will continue to work with local NHS partners to review and develop this.**
- **The Learning Disabilities (LD) Team have been working with local health partners to vaccinate residents with LD in the community e.g. arranging specific clinics, hosting a webinar, work on desensitisation for needle-phobic residents.**
- **Officers, in partnership with local services are promoting access to vaccines for unpaid carers.**

Officers will continue to work at pace with local and NCL partners to promote vaccination uptake amongst eligible groups.

Care Homes and Domiciliary Care Overview.

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Older people's care homes

- There are eight older people's care homes in Islington – over the course of the pandemic **there have been COVID situations of varying scales in all homes**.
- There was an increase in care home resident cases in late December 2020/January 2021 **– this is likely linked to significantly increased rates of community transmission.**
- **The nature of cases reported has changed over time with a decrease in symptomatic residents presenting and an increase in asymptomatic residents identified through whole setting testing.**
- **Staffing levels in Older People's care homes have remained generally stable** throughout the course of the pandemic.
- There has been **extensive proactive work across Adult Social Care and Public Health to support care homes** – including with provision of bespoke clinical and infection prevention and control support and advice.

Mental Health and Learning Disabilities Care Homes

- There are **three learning disabilities care homes and five mental health care homes registered with the Care Quality Commission in Islington.**
- Over recent months there have been **small numbers of resident and staff cases identified via routine testing in these settings.** In all instances services have been supported by the local Public Health and Adult Social Care teams to ensure all appropriate steps are taken to reduce COVID risks.
- **There have been no COVID-related deaths in mental health or learning disabilities care homes in Islington.**
- **Staffing levels remain stable.**

Domiciliary care

- **Domiciliary care agencies report that they have cared for relatively low numbers of residents who have been confirmed COVID positive or who have been COVID symptomatic. Domiciliary care agencies have reported no COVID-related deaths of residents they care for to commissioners.**
- **After some initial workforce challenges in the sector staffing levels have stabilised and there is capacity within the market.**

Please see slides overleaf for information on COVID-related trends in older people's care homes.

OP home sector level trends – resident cases reported over time

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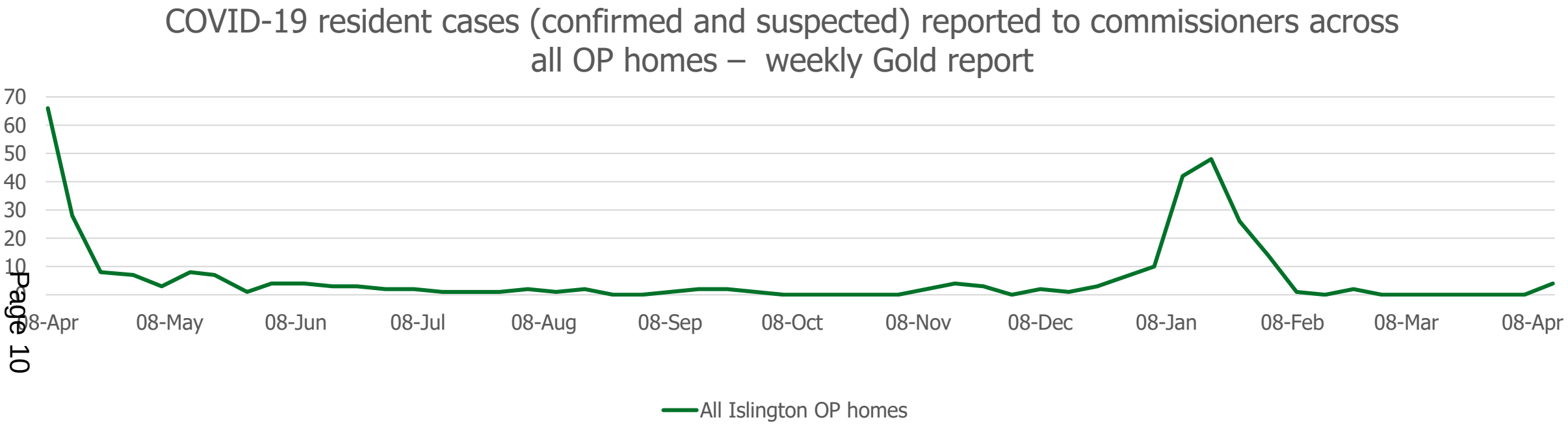

- All OP care homes have reported on the number of confirmed and suspected cases on a weekly basis to ASC commissioners since 8th April 2020. Prior to this, reporting was ad hoc, if there were cases suspected or confirmed. The above presents the total number of cases reported at weekly check ins, using 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 was an increase in care home resident cases in late December 2020/January 2021 – this is likely linked to significantly increased rates of community transmission. Following a decrease over mid-February to early April, four new asymptomatic cases were identified this week – commissioners are monitoring this closely.

OP home sector level trends – cumulative COVID-related resident deaths

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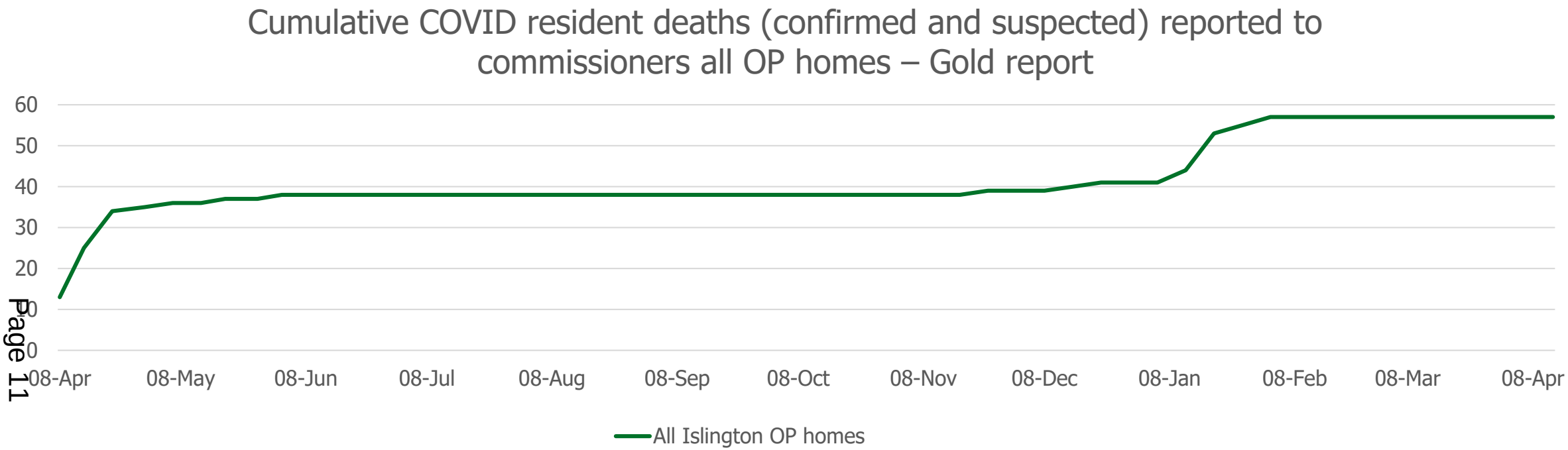
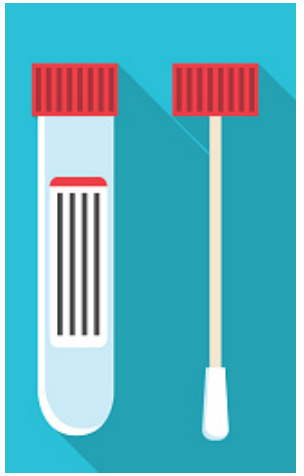


- All OP care homes have reported on the number of COVID-related resident deaths on a weekly basis to ASC commissioners since 8th April 2020. In the first report, commissioners asked providers to report on deaths that had occurred since 25 March 2020. The above presents the cumulative total COVID-19 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 period of relative stability from April to November there was sadly an increase in the number of COVID-related resident deaths throughout December 2020 and January 2021, primarily linked to two large outbreaks. There have been no new deaths since the start of February.

Domiciliary care COVID testing update

NHS Test and Trace continues to make weekly COVID-19 testing available to all homecare workers in England. Homecare agencies are responsible for ordering and distributing test kits to all homecare workers for them to conduct at home on a weekly basis. Homecare worker testing should only be conducted on Thursdays, Fridays, Saturdays, and Sundays (if the homecare worker is able to access a priority post box with Sunday collections).



Feedback from providers:

- All providers are completing regular weekly staff testing but measures/process/success varies across providers. Many reported that providing accurate figures for weekly home testing is quite challenging as testing is not mandatory for care workers. This makes it difficult for some providers to enforce weekly testing and relies on staff sharing results back with the employer promptly.
- Providers have reported accessing local testing centres over home test kits as they found results faster and more reliable, and workers prefer it.
- Providers are making a concerted effort to encourage and facilitate staff testing weekly and have been training staff to use test kits correctly, calling/reminding carers regularly, informing staff of full wage payments if they have to self-isolate and how to access local test centres.
- The ASC Infection Control provider briefing continues to promote the benefits of regular staff testing for providers.

COVID-19 update

Date: 19th of April 2021

Jonathan O'Sullivan, Acting Director of Public Health - Islington

Camden and Islington Public Health

Key messages

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Cases

- The reduction in case rates in Islington has been steady over the last fortnight, with around 40 confirmed cases per week. This follows three months of declines. Rates are similar to September 2020 levels.
- For the latest week, the rates are slightly lower than London (18.6 per 100, 000 In Islington compared to 23.3 per 100,000 in London). The number of infections have decreased or remained stable apart from those aged 19-29 where there has been a slight increase. Number of cases by ethnic groups are now small so rates are subject to fluctuations.
- There are no local signs that the first stage of the roadmap's easing of lockdown restrictions has resulted in increased cases. This data is too early to pick up any trends following the second stage of easing, beginning 12 April.
- London level estimates indicate an R value of 0.8-1.1, which indicates a steady or possibly slightly increasing trend in new infections in the capital, but infection rates remain low.

Testing

- Rates of symptomatic (PCR) testing decreased slightly this week compared to the previous week, and the positivity rate has slightly decreased between the latest week and the previous week. Islington's most recent positivity rate from PCR testing is 0.9%, slightly lower than the London rate of 1.1%. PCR testing rates are highest amongst the most deprived areas of Islington and in the 11-18 year old population.
- Non-symptomatic LFD tests in community settings have rose significantly during March, due to LFD testing in schools. Positivity rates remain low, at 0.1% in the most recent week. Overall, community testing rates have reduced over the last 2-3 weeks, and were just under 7,400 in the most recent week compared to a peak of 19,000 in mid-March. The difference is that more tests are now available to be done at home, which are not recorded in these figures. Community LFD testing remains higher in people from Black communities than other ethnic groups.

Key messages cont..

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Covid-19 deaths

The second wave of mortality due to COVID19, hopefully, appears now to have largely concluded, and there have been no new deaths reported in the last three weeks.

Islington's cumulative mortality rate due to COVID19 remains at 148.1 deaths per 100,000 which is lower than the averages for England (231.2 per 100,000) and London (212.1 deaths per 100,000)

Covid Vaccinations

The pace of first vaccinations has slowed in the last two weeks in existing cohorts compared with previous weeks, reflecting the London and national picture also. It remains the case, as in previous reports, that those groups and cohorts with lower current vaccination uptake continue to narrow the gap with those with higher, albeit also at a slower pace.

Eligibility for vaccination has now extended to the cohort of people aged 45 and over.

Second vaccinations are rolling out to people in the first priority vaccination groups.

As of 14 April, at least 57,000 local people had had their first vaccination, and almost 3,000 their second.

Islington epidemic curve: September to March

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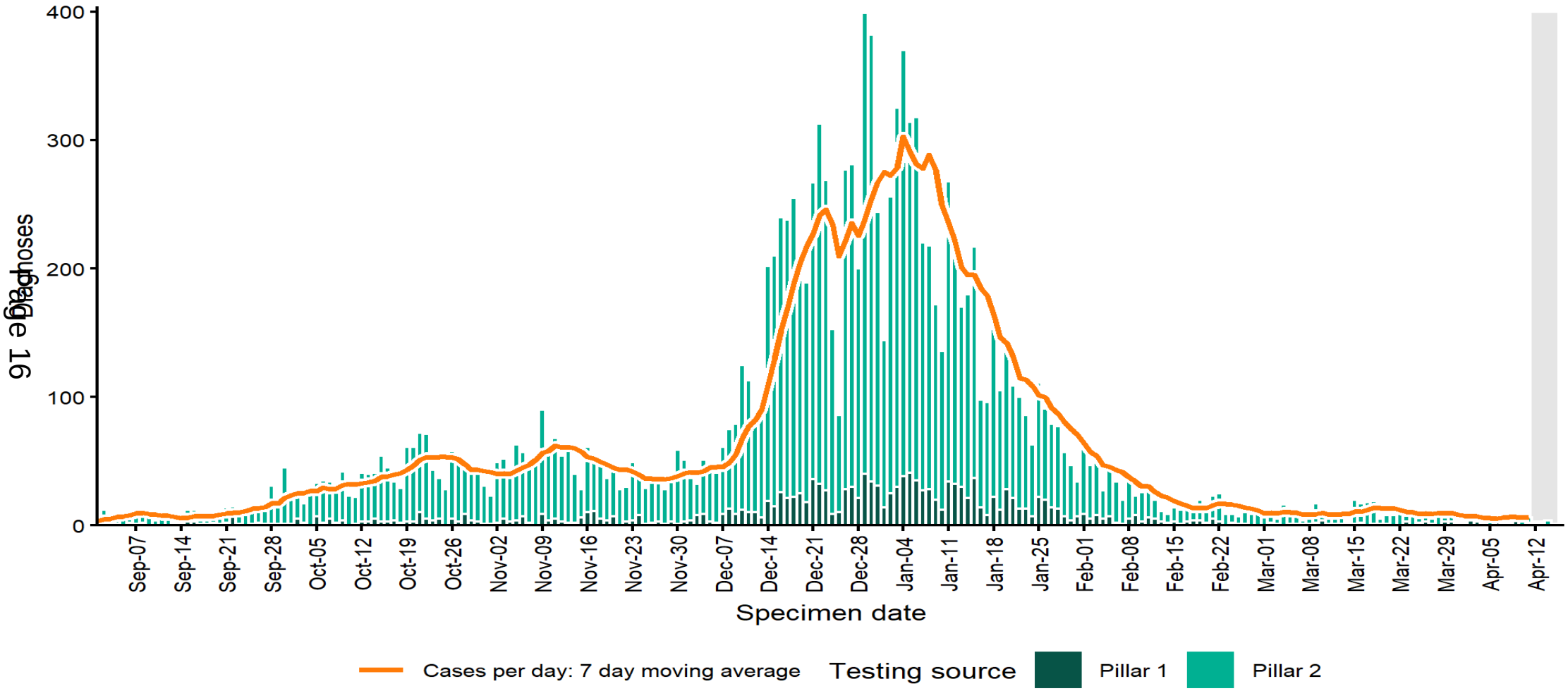

COVID19 in Islington – New cases

This week 5th April to 11th of April

Last week 29th of March to 4th of April

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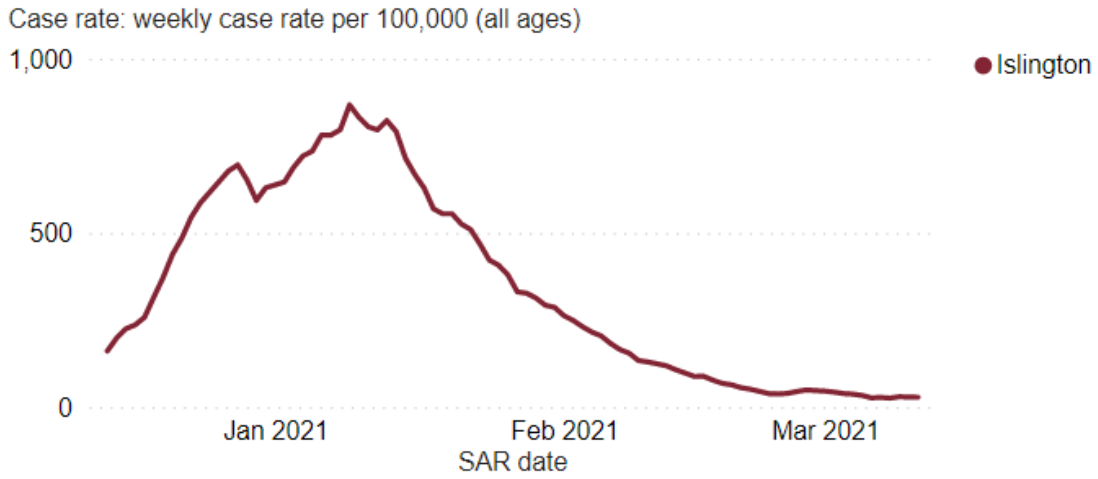

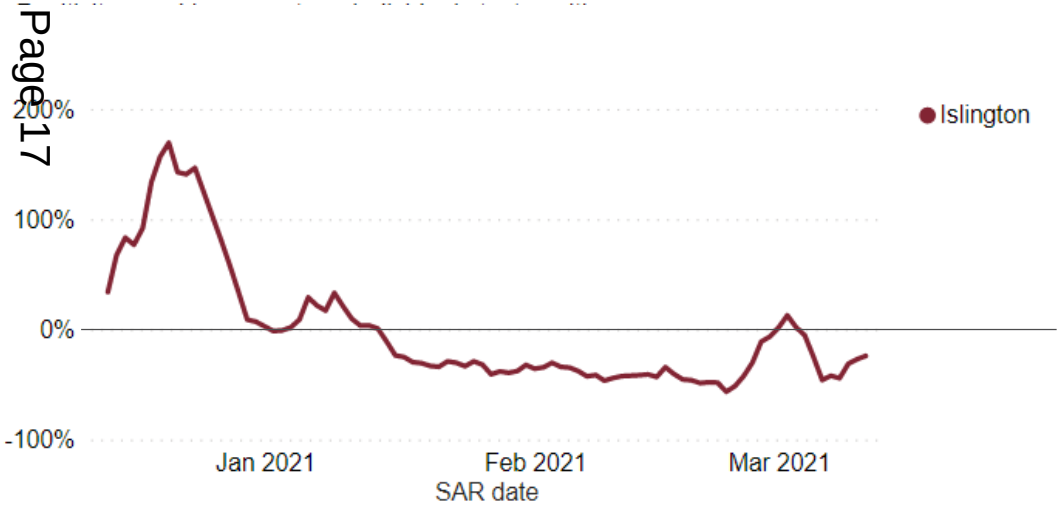

New cases in the latest week

45 ▲

Last week 40

Rate of weekly cases (per 100,000)

18.6 ▲ **All ages** **Last week 16.5**

6.7 ▼ **60+** **Last week 16.7**

Wards with highest infection rates this week ***Top 3:***

St Peters (42 per 100,000

Mildmay (34.5)

Hillrise (31.8)

Rising: **0**/16 wards significantly increased compared to last week

Rate of cases by age (7 day rolling average per 100,000) 4th of April

0-4	5-10	11-16	17-18
8 ↔	7 ↔	16 ↓	0 ↓

19-24	25-29	60-79	80+
30 ↑	22 ↑	8 ↓	0 ↔

Direction of travel compared to 29th of March

Case rate ethnicity (slide 5):

- As the number of cases are now small COVID rates by most ethnic groups are now less than 5 so rates will fluctuate widely

Positive tests (%)

Positive tests in the latest week

0.9% ▼

Last week 1.o%

1.1 %

London

COVID19 testing - residents

This week 5th April to 11th of April

Last week 29th of March to 4th of April

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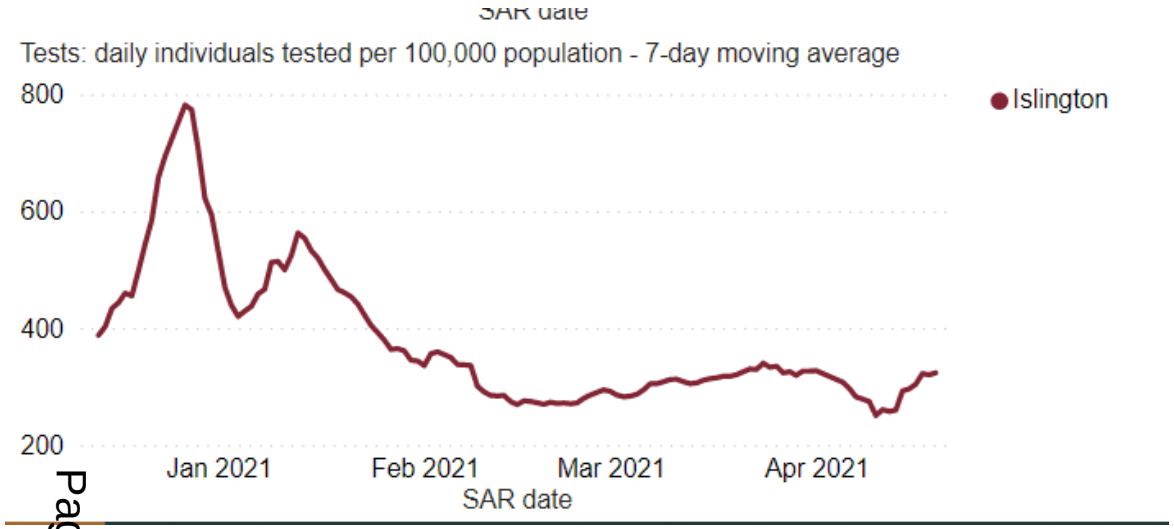
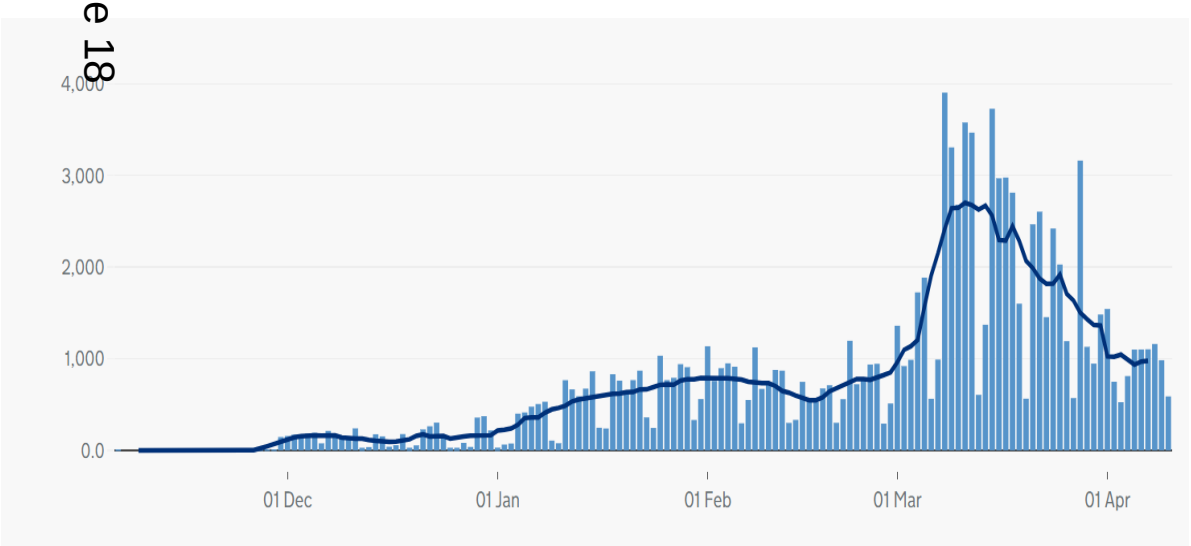




PCR Tests

Tests this week

5,570

Last week 5,992

Rate of tests per day (per 100,000), 7 day rolling average

304.1

Last week 274.5

Testing rate by age this week
Highest among 11-18 year olds

Deprivation and Ethnicity
Highest rates of testing in the most deprived decile. Rates similar across all ethnicities.

Lateral Flow Device Tests

Tests this week

7,399

Last week 7,227

Rate of tests per day (per 100,000)

426

Last week 416

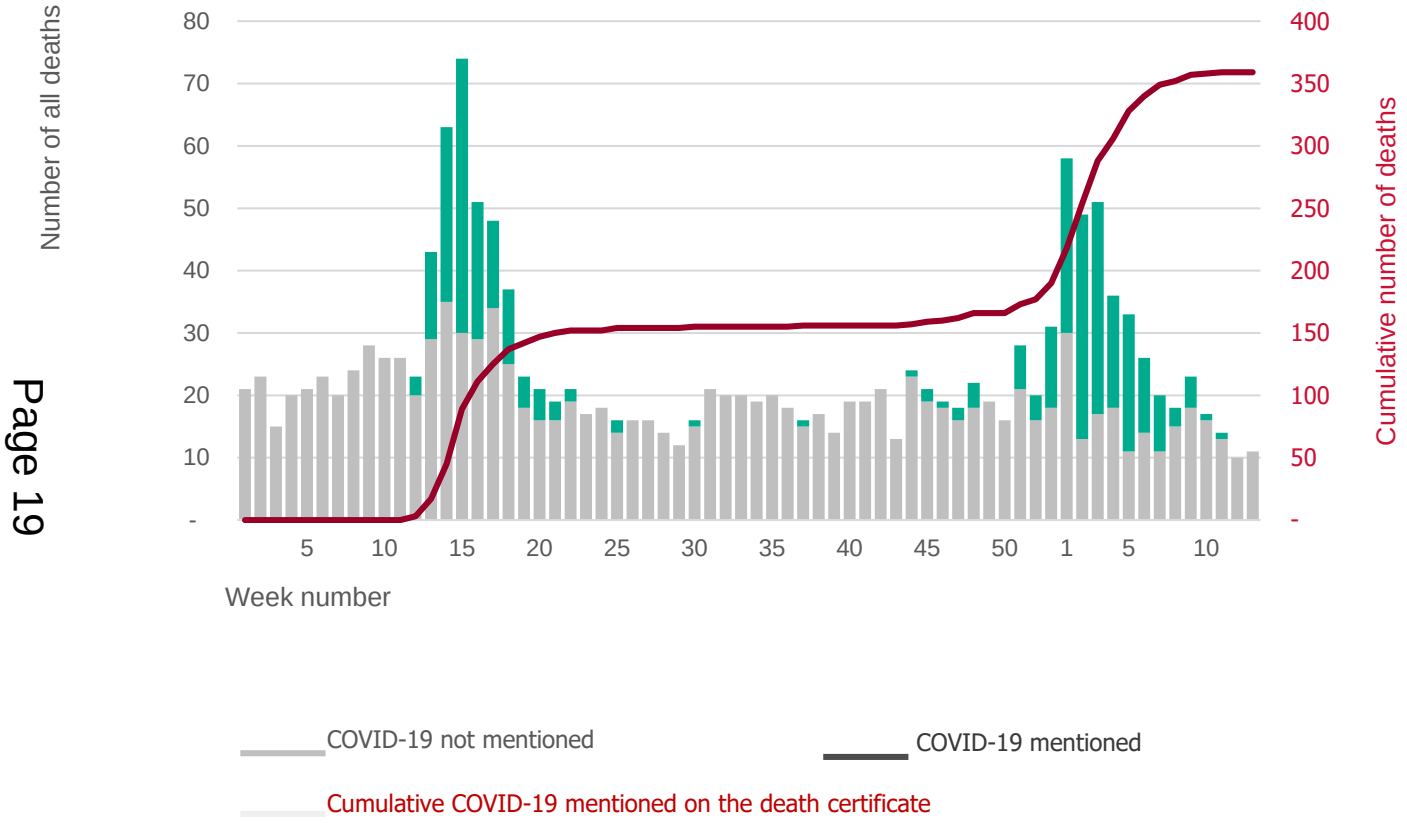
Positivity rate

0.1% (9 positives)

Last week 0.2% (15 positives)

Highest LFD testing rate in Black population, followed by other and lowest in Asian and White.
Significant rise in LFD testing rates amongst 12-18 year olds

Deaths from COVID: deaths that occurred up to 2nd of April but were registered up to 10th of April



- Total of 359 deaths with COVID19 mentioned on death certificate
- Latest week of data shows 0 Covid related deaths.
- 8 fewer deaths overall (all causes) seen this week compared to the 2015-19 average for the week

OFFICAL PUBLISHED STATS

The number of people who have been vaccinated for COVID-19, split by LTLA of residence and age group. All figures are presented by date of vaccination as recorded on the National Immunisation Management Service (NIMS) database.

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	Number received first dose	Estimated Eligible population	% of total population	Rank amongst London boroughs*	Highest uptake in London	Lowest uptake in London
80 and older	4,392	5357	81.99%	22/32	Bexley (94.0%)	Hackney (77.0%)
75-79	3,371	4,029	83.67%	19/32	Bromley (93.7%)	Westminster (75.8%)
70-74	5,020	6,042	83.09%	17/32	Bexley (92.9%)	Westminster (70.8%)
65-69	5,740	7,258	79.09%	17/32	Bexley (90.6%)	Westminster (67%)
60-64	7,623	10,028	76.02%	18/32	Bexley (88.17%)	K&C (62.90%)

Source: COVID19 Vaccinations – NHSE, 11th of April published on the 15th of April
Rank where 1 is borough with highest uptake

FURTHER INFORMATION

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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 information for schools data pack

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.

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ISLINGTON

Chief Executive Department
Town Hall, London N1 2UD

Report of:

Meeting of: **Health and Care Scrutiny Committee**	**Date:** **29 April 2021**	**Ward(s):**

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Quarter 3 Performance Report

1. Synopsis

1.1 The council has in place a suite of corporate performance indicators to help monitor progress in delivering the outcomes set out in the council's Corporate Plan. Progress on key performance measures are reported through the council's Scrutiny Committees on a quarterly basis to ensure accountability to residents and to enable challenge where necessary.

1.2 This report sets out Quarter 3 2020/21 progress against targets for those performance indicators that fall within the Adult Social Care outcome area, for which the Health and Care Scrutiny Committee has responsibility.

1.3 It is suggested that Scrutiny undertake a deep dive of one objective under the related corporate outcome over a 12-month period. This will enable more effective monitoring and challenge as required.

2. Recommendations

2.1 To note performance against targets in Quarter 3 2020/21 for measures relating to Health and Independence

2.2 To suggest one objective under related corporate outcome for a deep dive review, to take place over a 12-month period.

3. Background

3.1 A suite of corporate performance indicators has been agreed for 2018-22, which help track progress in delivering the seven priorities set out in the Council's Corporate Plan - *Building a Fairer Islington.* Targets are set on an annual basis and performance is monitored internally, through Departmental Management Teams, Corporate Management Board and Joint Board, and externally through the Scrutiny Committees.

3.2 The Health and Care Committee is responsible for monitoring and challenging performance for the following key outcome area: Adult Social Care.

3.3 Scrutiny Committees can suggest a deep dive against one objective under the related corporate outcome. This will enable a comprehensive oversight of suggested objective, using triangulation of data such as complaints, risk reports, resident surveys and financial data and, where able to, hearing from partners, staff and residents, getting out into the community and visiting services, to better understand the challenge and provide more solid recommendations.

4. Quarter 3 performance update – Adult Social Care

4.1 Key performance indicators relating to Adult Social Care.

PI No.	Indicator	2019/20 Actual	**2020/21 Target**	**Q3 2020/21**	On target?	Q3 last year	Better than Q3 last year?
HI8	4.2 Average number of social care beds delayed per day	7.2	**5.0**	**NA**	**NA**	NA	**NA**
HI9	4.3 Percentage of ASC service users receiving long term support who have received at least one review	43%	**55%**	**44%**	**No**	49%	**No**
HI10a	4.4 Average number of full care act assessments completed per month (18-64)	41	**39**	**41**	**No**	38	**No**
HI10b	4.5 Average number of full care act assessments completed per month (65+)	71	**68**	**107**	**No**	69	**No**
HI11	4.6 Percentage of ASC enquiries where a risk is identified and the risk is removed or reduced	96%	**99%**	**96%**	**No**	97%	**No**
HI12	4.7 New admissions to nursing or residential care homes (all ages)	159	**142**	**115**	**No**	125	**Yes**
HI13	4.8 Percentage of service users receiving services in the community through Direct Payments	23%	**30.0%**	**27%**	**No**	22%	**Yes**
HI14	4.9 The percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact.	75%	**80%**	**NA**	**NA**	NA	**NA**

4.2 *Average number of social care beds delayed per day (Delayed Transfers of Care)*

This indicator cannot be updated at this point because NHS Digital have paused the collection and publication of official Delayed Transfers of Care statistics due to COVID-19 and the need to release capacity across the NHS to support the response. There is not yet an indication of when publication of these statistics will resume.

4.3 *Percentage of ASC service users receiving long term support who have received at least one review*

This is a new indicator for 2020/21. As of Q3 2020/21, 44% of service users who have been receiving services since the beginning of the year have had a review in the last 12 months. This is below the target for 2020/21 of 55%, but higher than the end of year 2019/20 position (43%).

1. Why is this not on target?

   Challenges in Quarter 1 and 2 of 2020/21 have continued to present challenges in Quarter 3, including COVID-19. In this case, challenges to the Community Placement and Review Team, North and South Integrated Community Social Work Teams and Occupational Therapy teams affecting reviews have been staffing levels, working with service users, and reviewing residents in care homes. Recruitment is ongoing to address gaps in staffing. It is also important to note that **we have overall done more reviews in 2020/21** than at this point in 2019/20, **despite the increased pressure on the service**. Because of the **necessary prioritisation of COVID reviews**, we have done these reviews on a different group of service users than the service users captured by this indicator.

2. What action are you taking to get it back on track?

   Although COVID-19 presents ongoing challenges, there have been steps taken to improve the waiting list. The Community Placement and Review Team are in a much better place, with a robust allocation system that is reducing their list. We have established two COVID-19 specific review trays that hold cases for the North and South Integrated Community Social Work Teams, and three social workers have started in phases from June onwards and they are working through reviews. COVID-19 packages have changed in duration and are only for six weeks and when a case is allocated to a social worker, they will take the review.

3. When do you expect it to be back on track?

   We hope to see improvement in our figures for Q4 2020/21 and ultimately when the pandemic stabilises.

Average number of full care act assessments completed per month (18-64)

4.4 This is a new indicator for 2020/21 that monitors the level of demand flowing through the adult social care service. At the end of the year in 2019/20, the average number of full care act assessments completed per month among adult social care service users aged 18-64 was 41. We have set a target to reduce this figure by 5% this year, so a target of 39 assessments per month. As at the end of Q3 2020/21, this indicator is slightly above target, with an

average of 41 full care act assessments completed per month among adult social care service users aged 18-64.

We have also introduced an indicator to provide additional context for this figure, the percent of full care act assessments resulting in a new service. We have not set a target for this indicator, as it is just to provide additional context and for monitoring. As at the end of Q3 2020/21, 72% of full care act assessments in this age group had resulted in a new service, higher than the end of year figure for 2019/20 of 71%.

4.5 *Average number of full care act assessments completed per month (65+)*

This is a new indicator for 2020/21 that monitors the level of demand flowing through the adult social care service. At the end of the year in 2019/20, the average number of full care act assessments completed per month among adult social care service users aged 65+ was 71. We have set a target to reduce this figure by 5% this year, so a target of 68 assessments per month. As at the end of Q3 2020/21, this indicator is off target, with an average of 107 full care act assessments completed per month among adult social care service users aged 65+.

We have also introduced an indicator to provide additional context for this figure, the percent of full care act assessments resulting in a new service. We have not set a target for this indicator, as it is just to provide additional context and for monitoring. As at the end of Q3 2020/21, 78% of full care act assessments in this age group had resulted in a new service, higher than the end of year figure for 2019/20 of 75%.

1. Why is this not on target?

   In 2020/21, the number of full Care Act assessments for both age groups and the percentage of these resulting in a new service **increased as a direct result of the COVID-19 pandemic. This was due to increases in demands for support, welfare calls and safeguarding alerts that came through the Adult Social Care front door** (Access & Urgent Response service) as well as **increased activity to support hospitals** during COVID and requests for support in locality social work teams from existing caseloads. In addition, the **reablement service has been paused** during this period, and staff refocussed to support the huge volume of hospital discharges. This has also likely to have contributed to this issue as people who would have had reablement care plan/service are now receiving care act assessments and support through external care agencies.

2. What action are you taking to get it back on track?

   Additional social work staffing resources were provided to the Urgent Response Service and the We are Islington teams in order the address this increased demand. Adult Social Care and Customer Services are also currently reviewing processes and systems at the first point of contact to improve the customer experience as well as looking to resolve issues swiftly and therefore reduce the demand on Care Act assessments in the future.

3. When do you expect it to be back on track?

   Reductions in demand for support from adult social care will not realistically reduce until the current COVID-19 pandemic is resolved. The prioritisation of this group for vaccination will contribute to this and we would expect to see additional improvements in this area once the reablement offer is back in place.

Percentage of ASC enquiries where a risk is identified and the risk is removed or reduced

4.6 This is a new indicator for 2020/21 and it helps the service monitor safeguarding. The percentage of ASC enquiries where a risk is identified and the risk is removed or reduced in Q3 of 2020/21 (96%) was similar to the year end 2019/20 figure (96%) and the figure for Q3 is slightly less than the 2020/21 target (99%).

The safeguarding adult's duties are enshrined in the Care Act 2014. The Care Act formerly introduced the requirement for local authorities to safeguard people using a personalised approach. This approach is Making Safeguarding Personal (MSP). MSP places the service user at the centre of safeguarding conversations, decisions and actions. A key element of this approach involves working with the person who has experienced harm/abuse to identify any risks and desired outcomes required to keep them safe.

A key indicator to measure the success of any safeguarding adults intervention is the removal or reduction of risks being experienced or faced by the person who has experienced harm/abuse. There will be a small number of cases where we are for a variety of reasons unable to reduce or remove a risk in a safeguarding concern. We maintain an oversight of professional decision making via case file audits, regular practitioner workshops and the mandatory inclusion of Safeguarding cases in supervision sessions. If we were to discover significant numbers of safeguarding cases where risks has not been reduced or removed we would carry out further assurance exercises to understand the trend, any reasons for it and develop mitigations if required.

1. Why is this not on target?

We are unable to completely remove or reduce a risk to a person experiencing harm or abuse if the person themselves chooses to remain in an abusive relationship or they decline the support identified by the practitioner that is considered appropriate to remove or reduce the harm from occurring/reoccurring. We use a person centred approach to safeguarding which can occasionally result in a lower success rate than we would like.

In some safeguarding cases, **practitioners were unable to carry out face-to-face visits due to COVID restrictions and a reluctance from adults at risk to allow**

practitioners to visit them in person. Remote communication methods place additional difficulties upon building rapport and trust between practitioners and adults at risk. This can make it harder for people to engage fully in the safeguarding process and agree to propose safeguarding protection plans.

We have seen an **increase in the number of safeguarding cases** overall. Around 2,000 more concerns logged* in 2020/21 compared to 2019/20, with increases specifically in domestic abuse and self-neglect cases during the COVID pandemic. The lower level of cases where the risk has been removed or reduced may be due to the **decrease in available community-based services** where people would ordinarily receive support. A number of **voluntary organisations and other services accessible by the public have remained closed since the first lockdown.**

**It is important to note that not all safeguarding concerns progress to safeguarding enquiries.*

2. What action are you going to take to get it back on track?

We continue to support staff to ensure that they have access to training, support and supervision on all safeguarding cases. Management oversight of safeguarding cases provides an increased level of senior input and steer. This provides an invaluable quality check to ensure that all areas of the safeguarding enquiry have been addressed.

We are ensuring that staff follow a risk-based approach for face-to-face visits and it is hoped that with the increase in vaccination levels within our local community that people will be happier to accept face-to-face visits from practitioners.

We are working collaboratively with colleagues across the council who are able to provide additional support for DV cases and are participating in the Daily Safeguarding Meetings, which are providing rapid safety measures and positive outcomes for victims of domestic abuse.

We are supporting community-based organisations and voluntary groups to recognise and respond appropriately to safeguarding concerns.

3. When do you expect it to be back on track?

We have seen a significant increase in the numbers of safeguarding concerns being raised during the COVID pandemic and our current position remains with a higher than average level of concerns being reported. It is likely that the ability of practitioners to engage people fully with protection plans to remove risks may continue to be affected by the challenges of remote communications and reduced options for community-based support.

We expect to see an increase in the numbers of safeguarding enquiries where the risk has been removed or reduced in correlation with the increase of face-to-face visits and the re-opening of community-based services. They provide a key safety measure for many people who do not use statutory services but do require assistance with safeguarding.

New admissions to nursing or residential care homes (all ages)

4.7 This indicator has been amended in 2020/21 to reflect new admissions to nursing or residential care homes from all ages, whereas in previous year's only new admissions of service users aged 65+ were reported.

The Council provides residential and nursing care for those who are no longer able to live independently in their own homes. The aim is to keep the number of permanent placements as low as possible, supporting more people to remain in the community. To meet transformation targets, a target of 142 total placements in 2020/21 has been set (a reduction from 152 in 2019/20). At the end of Quarter 3 2020/21, we have had 115 new admissions, with an end of year projection of 153, above the 2020/21 target.

1. Why is this not on target?

Due to COVID-19 and the restrictions the pandemic placed on care homes, admissions to nursing and residential homes were very limited in Quarters 1 and 2 of 2020/21. This situation has improved now with the availability of COVID-19 testing prior to admission to care homes and the **increase in Quarter 3 may reflect suppressed demand during the first half of the year**. In addition, decreased admissions to care homes in 2020/21 has also been influenced by pathway 3 discharges from hospital being led by health, a process established to maintain flow during the pandemic. These patients are assessed through the NCL Continuing Health Care team, and this contributed to late loading of these cases on our system. **Despite these challenges and the increased pressure on our services due to COVID-19, our current projection for end of year total is currently in line with the end of year position in 2019/20.**

2. What action are you taking to get it back on track?

Admissions to Care Homes from hospital and in the community are scrutinised and approved by Heads of Service and Service Leads in Adult Social Care. A strengths based approach to support planning is taken and attempts are made to support people to remain in their own homes wherever possible with support from home care, telecare, and community equipment and informal/community support.

3. When do you expect it to be back on track?

When the pandemic has stabilised and the number of hospital admissions and discharges reduces to a more normal level.

Percentage of service users receiving services in the community through Direct Payments

4.8 Although below the target of 30%, in Q3 2020/21 27% of all Islington community care and support is provided through Direct Payments, compared to 22% at this point last year. The total number of service users receiving services in the community through direct payments has decreased slightly, to 590 compared to 619 at this point last year

Personalisation is a key work stream of the Adult Social Care Transformation Plan. This work stream aims to improve processes and systems resulting in individuals in need of care and support having greater choice and control over their lives as well as increasing the number of people accessing direct payments. The key areas of work are; improving the training offer for direct payment users and personal assistants, updating the Personal Assistant Finder online tool, developing training for staff in adult social care around personalisation, reviewing the allocation of direct payments to ensure they are adequate to meet need and equitable, developing new policies and procedures and finalising a new commissioning framework for managed direct payment accounts.

A Direct Payments' Forum is in operation so that people using Direct Payments and their carers can discuss issues arising with Direct Payments processes and their experiences with council staff, and make suggestions for improvements. People using Direct Payments and their carers are also involved in a co-production working group to take forward actions from the forum and plan future events. These include setting up a peer support group for people using Direct Payments, and improving the training and support offer to people using Direct Payments and their Personal Assistants, and making it easier for people to find Personal Assistants. These are currently all taking place on line rather than in person to reduce the risk of infection.

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

4.9 Social isolation refers to a lack of contact with family or friends, community involvement or access to services. Results from the 2019/20 Social Care User Survey showed a decreased percentage of working age adults known to Adult Social Care feeling that they have adequate or better social contact (75%, compared to 78% in 2019/20). *This indicator is updated annually so was not updated for this report.*

During COVID 19 a significant amount of people were contacting the Council via We Are Islington for support with a range of essential services such as food packages, financial support and medicine delivery. It soon became apparent that a large number of people were also feeling socially isolated, some of these people were known to Adult Social Care (ASC) but others were not. As part of this identification of need three key things took place to support people feeling isolated at home:

1. Initially Adult Social Care and We Are Islington staff undertook welfare checks to all vulnerable people (known to ASC) and those on the governments shielding list – to ensure that essential services were in place and that people could access support including for social isolation.

2. Following the feedback from the welfare calls and calls to We Are Islington colleagues from Public health undertook a mapping of local befriending and other community connecting services in Islington and found 85 local services offering this support
    - This developed into a briefing, which was shared with a wide range of front-line staff and commissioners across the council, NHS and VCS organisations to raise the profile of the available support.

- Islington Council website was updated to help people seeking such support.
- A resident leaflet has been developed, sign-posting residents to support and is being widely distributed.
- Elected members and a range of VCS and statutory organisations, including Mutual Aid Groups and befriending services now come together regularly as the Social Connectedness Network. The Network has themed sessions to support organisations to understand the offer available and ensure residents get the appropriate support they need to keep connected.
- Adult social care and public health worked with We Are Islington and Islington contact centre colleagues to develop an open questions 'script' to support strength based conversations and check on people's feels of isolation and loneliness

3. It became clear that professionals from ASC, WAI and the Mental Health Trust found it difficult to navigate the huge number of options available to residents from the VCS. Therefore
    - ASC established a single point of access with a local VCS provider Manor Gardens where referrals could be go. Manor Gardens operated a triage service which established which organisations and interests were best suited to meet the individual's needs and help put them in touch
    - Work is underway to develop this access point in localities and with strong links to VCS so that people can find or be routed to VCS for support to connect with a wide range of befriending and community activities that are available – many of these are now operating remotely on the phone or on-line, others still do face to face support where safe to do so.
    - Work is underway to improve the navigation and search functions on Islington Council's website so residents and professionals will find it easier to use and find the support they need. There will always be a role for face-to-face contact but improving digital access too will support a greater number of residents.

5. Implications

Financial implications:

5.1 The cost of providing resources to monitor performance is met within each service's core budget.

Legal Implications:

5.2 There are no legal duties upon local authorities to set targets or monitor performance. However, these enable us to strive for continuous improvement.

Environmental Implications and contribution to achieving a net zero carbon Islington by 2030:

5.3 There are no environmental impact arising from monitoring performance.

Resident Impact Assessment:

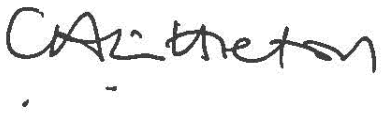
5.4 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010).

5.5 The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

6. Conclusion

6.1 The Council's Corporate Plan sets out a clear set of priorities, underpinned by a set of firm commitments and actions that we will take over the next four years to work towards our vison of a Fairer Islington. The corporate performance indicators are one of a number of tools that enable us to ensure that we are making progress in delivering key priorities whilst maintaining good quality services.

Signed by:



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ISLINGTON

Chief Executive Department

Town Hall, London N1 2UD

Report of:

Meeting of:	**Date:**	**Ward(s):**
Health and Social Care Scrutiny Committee	**March 2021**	**All**

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: Quarter 3 Performance Report: 2020-2021

1. Synopsis

1.1 The council has in place a suite of corporate performance indicators to help monitor progress in delivering the outcomes set out in the council's Corporate Plan. Progress on key performance measures are reported through the council's Scrutiny Committees on a quarterly basis to ensure accountability to residents and to enable challenge where necessary.

1.2 This report sets out Quarter 3, 2020-2021 progress against targets for those performance indicators that fall within the Health and Social Care outcome area, for which the Health and Social Care Scrutiny Committee has responsibility.

1.3 It is suggested that Scrutiny undertake a deep dive of one objective under the related corporate outcome over a 12-month period. This will enable more effective monitoring and challenge as required.

2. Recommendations

2.1 To note performance against targets in Quarter 3 2020/21 for measures relating to Health and Independence

2.2 To suggest one objective under related corporate outcome for a deep dive review, to take place over a 12-month period.

3. Background

3.1 A suite of corporate performance indicators has been agreed for 2018-22, which help track progress in delivering the seven priorities set out in the Council's Corporate Plan - *Building a Fairer Islington.* Targets are set on an annual basis and performance is monitored internally, through Departmental Management Teams, Corporate Management Board and Joint Board, and externally through the Scrutiny Committees.

3.2 The Health and Social Care Scrutiny Committee is responsible for monitoring and challenging performance for the following key outcome area: Public Health

3.3 Scrutiny committees can suggest a deep dive against one objective under the related corporate outcome. This will enable a comprehensive oversight of suggested objective, using triangulation of data such as complaints, risk reports, resident surveys and financial data and, where able to, hearing from partners, staff and residents, getting out into the community and visiting services, to better understand the challenge and provide more solid recommendations.

4. Quarter 3 performance update – Public Health

PI No.	Indicator	2018/19 Actual	2019/20 Actual	**2020/21 Target**	**Q3 2020/21**	On target?	Q3 last year	Better than Q3 last year?
HI1	Population vaccination coverage DTaP/IPV/Hib3 at age 5-6 months	New Corporate Target	New Corporate Target	No target set.	Q3 data to be confirmed due to data quality assurances issues.	N/A - New Indicator for recovery	N/A	N/A
HI2	Population vaccination coverage MMR2 (Age 5)	New Corporate Target	New Corporate Target	No target set.	Q3 data to be confirmed due to data quality assurances issues.	N/A - New Indicator for recovery	N/A	N/A
HI3	Number of child health clinics run per week (out of a pre-COVID19 quota of 12/week).	New Corporate Target	New Corporate Target	No target set.	11 Clinics	Yes	N/A	N/A
HI4	Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services.	N/A	1335	1100	261	No	375	No
HI5	Percentage of smokers using stop smoking services who stop smoking (measured four weeks after quit date).	N/A	57%	50%	53.2%	Yes	54.5%	No But above quarterly target.
HI6	Percentage of drug users in drug treatment who successfully complete treatment and do not re-present within six months.	N/A	15.2%	20%	12.8%	No	12.3%	Yes
HI7	Percentage of alcohol users who successfully complete the treatment plan.	N/A	42.9%	42.0%	29.6%	No	42.7%	No

5. Key Performance Indicators Relating to Public Health

New corporate indicator;

5.1 Population vaccination coverage DTaP/IPV/Hib3 at age 5-6 months. As this is a recovery target, no annual target is set.

5.1.1 There has been no change in the provision of childhood vaccinations. They have continued to be provided by primary care throughout the pandemic. However, the take-up may have impacted by either concerns about over-burdening health systems or fears about the safety of accessing healthcare during the COVID 19 pandemic.

5.1.2 The HealtheIntent childhood immunisation dashboard is a relatively new platform for use within primary care. This provides daily updates on vaccination status, coding errors and overdue vaccinations. It is the intention that this data will drive an improvement in the call-recall processes within primary care in order to increase the childhood immunisation rates.

5.1.3 Unfortunately, data is not available for Q3 due to quality assurance issues with the new North Central London (NCL) HealtheIntent dashboard. However, national Q3 data is likely to be available within the next month. Public Health hope to have the current issues with HealtheIntent resolved before the next reporting period.

Thus far national data is only available for Q2 of 2020-21 and showed a take-up of 86.9% at age 1 compared to 88.4% in Q2 2019-20.

5.1.4 The key successes have been that frequent messaging has gone out via health visiting services and in school communications; reminding parents of the importance of keeping all childhood vaccinations up to date and of the safety of the environment in which vaccines are delivered.

5.1.5 The key priorities for the final quarter of 2020/21 remain to ensure that as many children as possible receive vaccinations at the scheduled time; moreover that those who have missed or delayed vaccinations due to COVID 19 are proactively followed up to provide catch-up vaccinations. This (and the following quarter) is perhaps when Public Health might expect the biggest impact on vaccination take-up resulting as an indirect consequence of the impacts of Covid-19.

New Corporate Indicator;

5.2 Population vaccination coverage MMR2 (Age 5). As this is a recovery target, no annual target is set.

5.2.1 There are similar concerns that the MMR vaccination rates will have been affected by the COVID 19 lockdown. Local and national rates of vaccination at age 3 were already well below the national target of 95% recommended by the World Health Organisation to achieve and maintain the elimination of measles.

5.2.2 For 2019-20, the percentage of children fully vaccinated (i.e. 2 doses) against measles, mumps and rubella (MMR) at age 5 was at 70% in Islington, compared to 77% in London and 87% in England.

5.2.3 Thus far, national data is only available for Q2 of 2020-21. This showed a take-up of 69.9% for MMR2 at age 5, compared with 69.1% in Q2 2019-20. The data on the population uptake of 2 doses of the MMR Vaccine in Q3 are yet to be verified due to current quality assurance issues with the new NCL HealtheIntent dashboard/system.

5.2.4 Public Health continues to work with partnerships across the system to improve the uptake of childhood immunisations, for example;

- By working with the GP Federation and Quality Improvement team for GP practices to improve the use of data to drive the childhood immunisations programme. With the wider Islington immunisations group, Public Health will advocate for robust call-recall within GP practices.

- The aim of the setting up a dashboard to start monitoring the uptake of immunisations by different equalities groups in HealtheIntent, as has been done for flu, will be used to ensure that there is appropriate communications and engagement to specific communities, working with the NHS, other partners and community leaders to look at how to improve uptake.

- As part of the wider programme on immunisations, work among Islington school children in January was carried out looking at the benefits of immunisations, which aims to ensure that families are aware of the importance of immunisation. We are also working with parent and COVID 19 champions to promote the uptake of immunisations.

New Corporate Indicator;

5.3 Number of child health clinics run per week (out of a pre-COVID19 quota of 13/week).

5.3.1 The Health Visiting Service is a universal service delivering the Healthy Child Programme to all families in the borough with children aged 0-5. This includes 4 mandated developmental reviews of young children between birth and age 2. Home-visiting to carry out these reviews is an essential feature of the service in terms of safeguarding and early identification of problems.

5.3.2 The Child Health Clinics (13 weekly across the borough pre–covid) provide easy drop-in access to the service and the clinics have always been well used by parents, particularly to check weight (growth) and to discuss any concerns such as feeding, sleeping or emotional health.

5.3.3 This service reduced face-face visits significantly during the first lockdown, including the short term closure of all drop-in clinics. Both home visits and clinic access have gradually been re-introduced and the clinics are appointment-only to ensure COVID 19 security.

5.3.4 Despite the new lockdown, Health Visiting has continued to offer home visits to all parents for either their new birth visit or for their 6-8 week check. For those who do not want to have a home visit, a face-face clinic appointment is an alternative. This ensures that the majority of families are receiving a face-face visit within 8 weeks of birth. Together, these ensure that a physical growth check is carried out on the baby before 2 months and that any other concerns can be picked up early.

If staff resources are limited due to the impacts of Covid-19, home visits/face-face appointments will be triaged (this has only been necessary in limited localities and for limited periods) and a video alternative is offered.

The demand for appointments at a child health clinic (normally drop-in, but now appointment only) has been high, and the service has increased the number of clinics to 11 per week during Q3, offering 67 appointments. Access is through a triaged single duty phone line, allowing same-day access to a health visitor. A face-face appointment is always made available for urgent situations.

5.3.5This service has also responded to increased demand and conducted a "mystery shopping" exercise to identify where waiting lists for clinics were longer. This has resulted in the introduction of increased capacity, a single duty line number for access to the service (across the 3 localities), and assurance that any mother and baby can be seen promptly on time, although an immediate appointment may not be available in their most local clinic.

Physical space for clinics has been a limitation with most children's centres closed and some health centre spaces prioritised for COVID 19 vaccinations, but workarounds have been found. Repeat waiting list checks to ensure urgent face-face appointments are available where necessary.

5.4 Number of Long Acting Reversible Contraception (LARC) prescriptions in local integrated sexual health services. The annual target of 1100, which is the same target as last year.

5.4.1 Long Acting Reversible Contraception (LARC) is safe and highly effective in preventing unintended pregnancies. Unlike other forms of birth control, it is a non-user dependent method of contraception. Increasing the uptake and on-going use of LARC thereby supports a reduction in unintended pregnancies, particularly teenage pregnancies.

5.4.2 The local integrated sexual health service is a mandated open access services providing advice, prevention and promotion, testing and treatment services for all issues related to sexually transmitted infections and sexual and reproductive health care. This service also provides other services to North Central London Boroughs such as outreach, training and specialist services. It is the largest provider of LARC in London.

5.4.3 COVID 19 has severely impacted on activity into these services through lockdowns; the stay at home instructions; staff redeployment to COVID care; staff sickness and shielding; and PPE requirements. Additionally, the ability to use some of the estates safely whilst maintaining social distancing guidance has also constricted the service. The first wave of the pandemic in March 2020 saw a significant level of staff redeployment to provide care and support to acute hospitals in responding to COVID hospitalisations. This reduced in the proceeding months and staff redeployment was less pronounced during the third lockdown. Critical services were prioritised and there was a move to telephone or digital consultations for most service users with triage available prior to clinic visits for people with face-to-face needs, significant clinical risk or vulnerability factors, symptomatic infection or other urgent needs.

5.4.4 The key performance indicators for LARC activity were significantly affected initially as this activity was stopped or delayed for a period of time during Q1. During this period, some LARC users were able to extend the use of their contraceptive and for others alternative methods were available and could be used, in line with new clinical guidelines issued in response to the pandemic. In Q2, the service saw a significant rise in activity as staff returned to the services adapted to working safely within Covid-secure requirements which enabled additional clinics to be prioritised for this activity.

This reduced again in Q3 with the second lockdown in November 2020 and the tiered restrictions throughout December, with figures lower than this time last year (261 during this quarter in 2020/21 compared with 375 in Q3 2019/20).

5.4.5 As well as the sexual health service, a number of GP practices provide a LARC service. This activity has been deprioritised nationally for similar reasons including staffing pressures and the challenges of delivering services within Covid-secure measures, and more recently to help ensure capacity for the vaccine rollout. Commissioners have arranged alternative provision to support increased capacity with alternative providers.

5.4.6 The alternative providers identified include commissioned abortion services who have staff with the required skills to fit LARC and where contraception has always been part of their service offer. The clinics and their staff are extremely sensitive to the services they provide and offer a very women-friendly environment. Further, as a result of current social distancing requirements and changes in legislation to allow for the provision of 'pills by post' (abortion pills delivered to and taken at home) during Covid, there is considerably less in-clinic activity taking place. LARC clinics in abortion services will be managed through telephone triage and arranged at separate times to abortion activity. It is anticipated that this will provide additional capacity to help manage 'catch up' activity as the impacts and lockdown restrictions of the second wave ease.

5.4.7 The key priorities for the next quarter include plans to recover service activities that have been affected by the most recent wave of COVID 19 and to continue with plans to improve LARC capacity across providers when it is safe to do so.

5.5 Percentage of smokers using stop smoking services who stop smoking (measured at four weeks after quit date). The annual target of 50%.

5.5.1The Stop Smoking Service 'Breathe' offers behavioural support and provides stop smoking aids to people who live, work or study in Camden & Islington. The 3-tiered service model ensures that smokers receive the support that is appropriate for their needs and suited to their lifestyle and circumstances.

5.5.2 During COVID 19, 'Breathe' continues to offer telephone support and postal nicotine replacement therapy, which has been well used and successful. The community service continues to work closely with Whittington Hospital clinical teams, which has proven very effective for patient outcomes. The availability of stop smoking support is steadily increasing in GP and pharmacy settings but is yet to reach pre-Covid levels.

5.5.3The overall success rates of the service remain above the target of 50%, (53.2% in Q3), despite pandemic restrictions. The community service has treated more smokers than Q2 with a high success rate. A coordinated approach with Whittington Hospital continues to result in improved quit outcomes for patients.

5.5.4 The community service has treated more smokers than last year and success rates remain above target. However, stop smoking activity in pharmacy and GP settings remains below 2019-20 levels which affect the overall number of smokers who quit this year. The overall quit rate is on target above 50% for Q3 (53.2% this year compared with 54.5% in the same quarter last year).

5.5.5 Islington residents received a high quality stop smoking service in Q3, with flexible options for support. Further proactive identification and referral of smokers by health professionals across all settings would ensure that vulnerable residents are prioritised during the pandemic.

5.5.6 In Q4 'Breathe' will support the NCL smoking in maternity programme by recruiting a specialist advisor to provide enhanced support to pregnant women, as the number of referrals is expected to increase. 'Breathe' will also pilot the provision of a type of disposable e-cigarette to smokers in supported accommodation, to assess how it may be able to contribute to increases in quit attempts in this target group.

5.6 Percentage of drug users in drug treatment who successfully complete treatment and do not re-present within 6 months. The annual target is 20%.

5.6.1'Better Lives' is an integrated drug and alcohol treatment service in Islington. The service is commissioned to provide comprehensive support to local residents aged 18 plus who need support in addressing their alcohol and/or drug use. This includes:

- Harm minimisation advice
- 1:1 structured support
- Substitute prescribing
- Group sessions
- Peer support
- On-site mutual aid (pre-covid)
- Education, training and employment
- Family support service
- Psychiatric and psychological assessment and support

5.6.2 During the first lockdown period, the initial focus of support was on ensuring that residents could access the critical elements of their care. Assessments were carried out both by phone and in person, with the necessary PPE safety measures in place. Since then it has been possible to offer other types of remote support including online groups and online key-working. By the end of September, a number of on-line groups were available to service users including mindfulness, support for sobriety and relapse prevention. The service has been working hard to re-instate as much face-to-face provision as possible, although these activities have to be carefully managed so that social distancing can be maintained in buildings. Consideration will be given to the newest lockdown measures before further face-to-face support is offered.

5.6.3 Performance for Q3 at 12.8% is lower than the quarterly target of 20%. The previous quarter's performance figure was 16.7%. However, the service has seen an increase in the number of people entering drug treatment which has partly been driven by substance misuse support offered to rough sleepers placed in emergency accommodation. This has increased the cohort of people in drug treatment, who as a group bring higher levels of complex needs and issues. In addition, the treatment service has actively been retaining people in treatment (instead of discharging them) in order that service users are best supported during the pandemic. This will have affected the percentage of people who have left treatment successfully, since more service users who have otherwise successfully 'completed' treatment have been staying under the care of the treatment service. The capacity of the service to meet the increase in service users has been kept under regular review, and there has been sufficient resource to meet the increase and manage new ways of Covid-secure working.

5.6.4 The key priorities for the service going forward are:

- Ensuring that all critical face to face interventions are reinstated safely and as soon as possible. These include drug screening and blood borne virus screening

- Provider-led work streams on lessons learnt through service changes during the pandemic to identify effective ways of working and delivering services which could be continued going forward and to develop new ways of working post COVID 19.

5.7 Percentage of alcohol users who successfully complete the treatment plan. The annual target is 42%.

5.7.1 Commissioners are working with service providers to manage current demand and to ensure support and advice are widely available for any Islington resident who may be concerned with their own or others' alcohol use. For example, by promoting a new alcohol awareness app "Lower My Drinking" which is available for all Islington residents. 'Better Lives' have also launched their first podcast on the subject of alcohol dependency and the effect on the individual and others: https://soundcloud.com/thatalcoholanddrugpodcast/alcohol

5.7.2 Performance for Q3 saw a slight increase in the percentage of alcohol users successfully completing treatment at 29.6%, compared with performance of 28.6% in the previous quarter. However, the effect of the pandemic has been significant throughout 2020/21 and the target of 42% has not been met during any quarter. The service has reported an increase in demand for alcohol interventions, with a number of previous service users reporting not being able to manage recovery during the lockdown and they have subsequently begun drinking again.

5.7.3 As was reported last quarter, services have seen an increase in the number of people entering alcohol treatment. At the same time, fewer people are being discharged from treatment services in order that they are supported during the pandemic. Therefore, both of these factors have resulted in an increase in the number of people being supported by the service and also affected the percentage of people leaving alcohol treatment successfully. Commissioners continue to work with service providers to manage current demand and to ensure support and advice are widely available for any Islington resident who may be concerned with their own or others' alcohol use.

6. Implications

6.1 Financial implications:

There are no financial implications arising as a direct result of this report.

Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Council.

6.2 Legal Implications:

There are no legal implications arising from this report.

6.3 Environmental Implications and contribution to achieving a net zero carbon Islington by 2030:

There is no environmental impact arising from monitoring performance.

6.4 Resident Impact Assessment:

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good

relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010).

The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

7. Conclusion

The Council's Corporate Plan sets out a clear set of priorities, underpinned by a set of firm commitments and actions that we will take over the next four years to work towards our vision of a Fairer Islington. The corporate performance indicators are one of a number of tools that enable us to ensure that we are making progress in delivering key priorities whilst maintaining good quality services.

Signed by: Jonathan O' Sullivan

Director of Public Health
Corporate Director and Exec Member Date: 31st March 2021

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ISLINGTON

REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

ADULT PAID CARERS

London Borough of Islington
April 2021

CHAIR'S FOREWORD

COUNCILLOR OSH GANTLY
Chair of Health and Care Committee

Adult Paid Carers - Scrutiny Review

Evidence

The review took place between June 2019 and April 2021 and was extended due to the COVID 19 pandemic

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 Robbie Rainbird, L.B.Islington, Sweet Tree Specialist Care – Nikki Bones, Denis Repard, Centre 404 – Jo Mackie, Wellbeing Teams – Helen Sanderson. Andrew Berry – UNISON,Christine Lehmann, Stephen Taylor, Katie Logan, Robbie Rainbird - L.B.Islington,

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 was extended to take in the COVID 19 pandemic

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 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 is 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

The Committee also heard evidence that some domiciliary care users, especially those BAME clients with cultural differences, such as female carer being provided for a Muslim women, did not always receive the appropriate care needs that they requested, although the Committee noted that providers did endeavour to do this where possible

(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 ensure that where there are

requests from clients that carers needed to be provided to respect cultural differences, measures be put in place to ensure clients wishes are respected

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 provision of provision of London Transport concessionary fare passes to the carers for those people with disabilities

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 is 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

The Committee heard evidence that some carers did not feel that the time allocated for travelling between clients was being adequately recompensed by providers, and that travel time often took longer than time allocated by providers, and that this was unfair

(m) The Committee recommend that the Council reaffirms its commitment to ensure that carers are adequately recompensed for travel time between

clients, and that quality control measures are put in place with providers, in order to ensure that this takes place

The Committee were concerned at the effect the COVID 19 pandemic may have on the domiciliary care, and whether the service would be sufficient capacity among providers to continue to be able to operate on an effective basis and provide a service to residents who require care at home

(n) The Committee recommend that the Council congratulate the Home Care providers, partners, We are Islington, the voluntary sector, community organisations and Adult Social Care for ensuring that residents who needed it were able to continue to receive care at home during the pandemic. This is due to the excellent collaborative work, and in particular the dedication of domiciliary care staff. The Council ensured providers had access to adequate Council PPE stocks, at points where their normal supply routes failed, enabling carers to provide care safely

The Committee noted that small local organisations were potentially at a disadvantage when tendering for contracts, compared to large organisations with experience of bidding for contracts

(o) The Committee recommend that more work should take place in order to ensure that local organisations are able to bid more effectively for future contracts, as this will provide increased social value, local employment and keep money in the local economy. There needs to be adequate training and support provided to enable local organisations to establish and grow to enable them to bid for contracts, and more emphasis in the Council's Procurement strategy should be placed on social value

The Committee heard evidence that some domiciliary care users, especially those BAME clients with cultural differences, (such as a female carer provided for Muslim women) did not always receive the appropriate care needs that they requested, although the Committee noted that providers did endeavour to do this wherever possible

(p) The Committee recommend that providers should ensure that where there are requests from clients that carers needed to be provided to respect cultural differences, measures be put in place to ensure clients wishes are respected

The Committee considered the charging policy that the Council has put in place for domiciliary care for residents that are in receipt of pension credit and Disability benefits. The Committee considered that such benefits are awarded to residents, as they do not have sufficient money to cope within their existing income, and therefore these should not be counted in assessing their income for charging for domiciliary care

(q) The Committee recommend that consideration be given to the implications of removing charges for those residents in receipt of domiciliary care that are in receipt of pension credit, the Disability Living Allowance care component,

Personal Independence Payment Disability Living component, or Attendance Allowance. The removal of charges would apply to residents with capital in excess of £23250

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 some time ago, but 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. 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 should 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. The Committee also heard evidence that whilst some providers endeavoured to ensure the provision of culturally appropriate carers if requested by clients, this was not always possible. The Committee were of the view that clients wishes should be respected if such a request was made and we have made a recommendation in this regard

58. 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

59. 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

60. 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 the improvement of the experience of the workforce, pay rates, and the 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)

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

62. 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.

63. 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

64. 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

65. 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

66. 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

67. 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

68. 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

69. 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

70. 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

71. 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

72. 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

73. 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.

74. 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

75. 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

76. 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

77. 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

78. 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

79. 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 provision of London Transport concessionary fare passes for carers of those people with disabilities. The Committee are of the view, that given the shortage of home carers, commissioners and providers should also investigate other possible recruitment/retention measures that could be put in place to help alleviate such shortages

80. 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

81. 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

82. 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

83. 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))

84. 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

85. 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

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

87. 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

88. 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

89. 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

90. 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

91. 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

92. 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

93. 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

94. 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

95. 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

96. 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

97. 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

98. 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)

99. 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

100. 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

101. 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

102. 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

103. 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

104. 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

105. 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

106. 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

107. 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

108. 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

109. 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.

110. 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

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

112. 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

113. 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

114. 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

115. 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

116. 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

117. 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

118. 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

119. 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

120. 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

121. 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

122. 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

123. 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

124. 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

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

126. 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

127. 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

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

129. 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

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

131. 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

132. 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

133. 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

Andrew Berry – UNISON

134. The Committee also received evidence from UNISON, in relation to the review, and as a result invited UNISON to future meetings of the Committee to provide an input into the Committee's considerations

Charging Policy

135. The Committee decided that the review should be extended, in order to assess the implications of the pandemic on the situation with Adult Paid Carers, and how they had coped with issues such as payment when self-isolating, PPE, problems faced by carers etc. and charging policy of the Council to residents for domiciliary care

136. The Committee heard evidence from Robbie Rainbird. Head of Processing Services in relation to the charging policy for domiciliary care for residents

137. Members noted that whilst residents were not charged more than it is reasonably practicable to pay, they were concerned that resident's income, which determined these charges included pension credits, disability support allowance, employment support allowance, and incapacity benefit. It was noted that everyone has a certain level of income protected so that they can meet their basic living expenses, and each service user will receive an individual assessment of their expenditure. In terms of financial capital assessment you will have to pay the full cost of your care if you have capital of over £23250, and if savings exceed £14250 a tariff income is charged for every £250, or part £250 a resident has

138. The Committee requested a comparison of charging policy with other Councils, and it was stated that of 77 Council's surveyed they all carried out a financial assessment to determine if an individual can contribute towards the cost of care in the home

139. All 77 Councils have a capital limit of £23250 above which service users pay the full cost of care. In terms of the minimum income guarantee for 18-24 year old service users, 37 of the Council's provide an allowance of £72.40, which is in line with Islington's policy. Other rates vary from £72, with one Council providing £189

140. In relation to the minimum income guarantee for 18-24 year old service users with a disabliliy premium, 43 of the Council's provide an allowance of £112.75, which is in line with Islington's policy

141. The minimum income guarantee of 18-24 year olds who receive disability premium and enhanced disability premium 55 of the 77 Councils provide an allowance of £132.45, in line with Islington's policy. Other rates vary from £91.40, with one Council providing £189

142. In terms of the minimum income guarantee for those users aged 25 to pension credit age, 47 of the 77 Councils provide an allowance of £91.40 in line with Islington, and other rates vary from £92.94 to £194

143. In terms of the minimum income guarantee amount for service users 25 years of age with a disability premium, 50 of the 77 Councils provide an allowance of £131.73, and others vary from £131.69 to £194

144. The minimum income guarantee of service users between the age of 25 to pension age with disability premium or enhanced disability premium is £151.45 in Islington and 57 Councils are in line with Islington. Others vary from £131.75 to £217.19

145. The minimum income guarantee for service users over pension credit age in Islington is £189 in line with 57 of 77 of the other Councils surveyed. Others vary from £194 to £221.40

146. In relation to provision of an additional allowance for service users with dependent children it was noted that 66 of 77 Councils provide an allowance in line with Islington and 57 of the 77 Councils provide an allowance of £83.65, which is in line with Islington's policy

147. With regard to an additional allowance for those service users entitled to carers premium it was noted that 64 of the Councils surveyed provided an additional allowance which is in line with Islington and 27 of the 64 provide an allowance in line with Islington of £43.65 with other allowances varying from £34.60 to £46.88

148. Disability related expenditure within the financial assessment is calculated and 59 of the 77 Councils complete an assessment in line with Islington's policy. In relation to a maximum and minimum charge for care and support at home and in the community, 55 of the 77 Councils have a minimum charge, with most using £1, which is in line with Islington, and 65 of the 77 do not have a maximum charge similar to Islington

149. In terms of the level of chargeable income used to calculate the contribution towards the cost of care, and 75 of the 77 Councils charge 100% of chargeable income, which is line with Islington's policy. Islington's household expenditure items counted within the financial assessment, and Islington is in line with other local authorities with allowances provided for Rent/Council Tax/Mortgage payments/Buildings Insurance/Service Charges and Ground rent

150. Members were of the view that these benefits referred to above in relation to disability benefits etc. were paid to residents to assist them with their care and should not be taken into account when assessing charges for receipt of domiciliary care

COVID 19 – Extension to Review

151. Members were informed that from 27 March – 26 November 2020 there had been 765.74k of PPE distributed at an estimated cost of £272.08k

152. Members noted that whilst there were initial difficulties with PPE excellent work had taken place between commissioners, partners and providers and that the service had had adequate provision of PPE throughout the pandemic and there were adequate supplies to cope with further waves if they occurred

153. Members also had discussions with carers during the pandemic on the issues of travel time, and the lack of provision by providers to carers. The adequate payment of travel time was exacerbated in the pandemic period, where travel by public transport was difficult. Members were of the view that adequate travel time should be paid to carers, and we have made a recommendation in this regard

154. Members noted that providers have reported relatively low numbers of residents to date who have confirmed COVID positive or asymptomatic. Domiciliary care agencies have reported no established COVID related deaths of residents that they care for to commissioners to date

155. Members welcomed the excellent work that had taken place between providers, care staff and commissioners in maintaining the service during the pandemic

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.

Types of evidence

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.

APPENDIX B

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

Substitutes:

Satnam Gill OBE
Anjna Khuruna
Mouna Hamitouche MBE

Co-opted Member:

Vacancy- Healthwatch

COMMITTEE MEMBERSHIP 2020/21

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Jilani Chowdhury – Vice Chair
Tricia Clarke
Roulin Khondoker
Martin Klute
Phil Graham
Clare Jeapes
Rakhia Ismail

Co-opted Member:
Vacancy – Healthwatch

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

Officer Support:
Peter Moore – Democratic Services
Lead officer/s- Jess McGregor, Nikki Ralph, Stephen Taylor, Jon Tomlinson- Housing and Adult Social Care

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