London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Tuesday 20 January 2015

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Elaine Chumnery (Vice-chair), Andrew Brown and Joe Carlebach

Co-opted members: Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

Other Councillors: Vivienne Lukey (Cabinet Member for Health & Adult Social Care), Sue Fennimore (Cabinet Member for Social Inclusion), Sharon Holder (Lead Member for Health & Adult Social Care) & Max Schmid (Cabinet Member for Finance)

Imperial College Healthcare NHS Trust: Steve McManus (Deputy Chief Executive) and Dr William Oldfield (Deputy Medical Officer)

H&F CCG: Dr Tim Spicer, Chair

NHSE: Lynda Gibbon, Interim Immunisation Manager for London

Officers: Prakash Daryanani (Head of Finance, ASC), Stuart Lines (Deputy Director of Public Health), Hitesh Jolapara (Bi-borough Director for Finance), Sue Perrin (Committee Co-ordinator) and Rachel Wigley (Deputy Executive Director & Director of Finance & Resources, ASC)

40. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 3 December 2014 were approved as an accurate record and signed by the Chair.

41. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Hannah Barlow and Sharon Holder, Debbie Domb and Liz Bruce.

42. DECLARATION OF INTEREST

Councillor Carlebach declared an interest as an ambassador of MENCAP.

43. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: ACCIDENT & EMERGENCY WAITING TIMES

Mr Steve McManus and Dr William Oldfield gave a presentation of Accident & Emergency (A&E) performance at Imperial College Healthcare NHS Trust (ICHT).

Whilst there had been no increase in the total number of attendances at ICHT, there had been an increase in St. Mary's Hospital (SMH) T1 (a consultant-led 24-hour service with full resuscitation facilities). This had been in line with the planned increase following the closure of the Hammersmith Hospital (HH) emergency unit closure.

The Charing Cross Hospital (CXH) T1 attendances had been broadly static, although there had been some variations. The figures did not reflect the patterns of attendances. There were surges in activity, particularly at SMH, where there could be a difference of 100 in attendances from one day to another. In addition, T1 activity included a greater level of category A/London Ambulance Service activity. This had become the normal level of activity.

The presentation set out: the key initiatives in place in respect of winter resilience planning; and the additional actions being taken in respect of the A&E improvement plan; and referred to the NHS review of A&E services in NW London.

In conclusion, Mr McManus stated that ICHT was not where it wanted to be, but was focusing on improvements and deploying resources to bring about these improvements.

Mr Naylor outlined his recent experience at CXH, when he had attended A&E on a Monday afternoon. The area had been full and staff overworked. Mr Naylor had been admitted to an Assessment Ward where he had overheard staff discussing how to move patients to other areas of the hospital. Mr Naylor queried what ICHT was doing to implement its promises.

Mr McManus responded that it was recognised that teams were working very hard to deliver appropriate care, and they were being supported through additional capacity in terms of beds and staff, at both SMH and CXH. It was likely that Mr Naylor had attended CXH during the outbreak of infection, when 22 beds had been closed. This infection had been contained and the beds re-opened.

Mr Naylor commented that it did not make sense to close A&E departments and close beds. Mr McManus stated that ICHT was not looking to close the CXH Emergency Department, but was waiting for national guidance on Emergency Departments. In the foreseeable future, there would be no changes or services withdrawal. Dr Oldfield added that it was not just an issue of capacity, but also staff who were able to make decisions. The six emergency consultants in place from mid-December were joint appointments between SMH and CXH.

Councillor Carlebach queried the number of patients who had received the flu vaccination. Dr Oldfield responded that patients who were thought to have flu related illnesses were asked about the vaccination, but this data was not captured.

Councillor Carlebach queried whether there was any evidence of patients with fairly serious illnesses contacting their GPs and being told to go to A&E. Dr Oldfield responded that there was no evidence. However, patients who needed primary care would be treated in the Urgent Care Centre (UCC).

Councillor Brown queried whether ICHT was learning from those trusts which were performing above target. Mr McManus responded that within NW London and London as a whole, there were a number of organisations of similar complexity with which ICHT was actively working, including Chelsea and Westminster NHS Foundation Trust. The Emergency Care Intensive Support Team provided support at a national level for trusts to learn from best practice around the country and to implement sustainable improvements.

Councillor Brown queried the percentage of patients presenting inappropriately at A&E and UCCs and what could be done both locally and from the wider NHS perspective. Dr Oldfield responded that all patients presenting at A&E and UCCs needed help. However, there was a need to signpost people to available services and to educate people to access healthcare at the right point and at the right time.

Councillor Brown suggested that the measures should have been put in place sooner and that the delays with the Northwick Park Hospital refurbishment had had significant impact. Mr McManus agreed that it would have been beneficial, but it also needed the right people to take decisions. There were interdependencies across the sector and pressures at one hospital were likely to challenge other organisations. Dr Oldfield added that there was a realisation that decisions made by senior staff resulted in shorter inpatient stays and better outcomes. ICHT was moving towards extending consultant led services, but there were insufficient consultants and also insufficient occupational therapists.

Councillor Chumnery queried: how attendances compared with previous years; whether there was a trend in respect of increase in attendances at certain times; and for how long the additional actions had been in place.

Mr McManus responded that there had been an increase in attendances of 0.7% over the previous 2/3 years. A further increase to 0.8% was forecast to the end of March. In addition, there had been some changes in terms volatility and acuteness. It was believed that there had been larger increases in activity across the country. ICHT had taken a pro-active approach in respect of known seasonal trends. The presentation set out the key initiatives in respect of winter planning, including additional beds.

Dr Oldfield added that there had been a change in the hours senior doctors worked and an increase in ward rounds. Patients on the medical acute unit were seen on a daily basis. In addition there had been improved diagnostic facilities, changes in treatment and huge changes in work practices. A combined discharge team including social workers, housing and health supported people back into the community. ICHT liaised on a daily basis with the lead commissioner to discharge people into more appropriate settings.

Mr McVeigh queried if there were any aspects of the relationship with the Council which could be improved. Mr McManus identified two aspects: a single discharge team instead of three separate teams; and pro-active discharge of patients into a safe location for on-going assessment.

Councillor Lukey stated that the Council appreciated the hard work of NHS staff and of Adult Social Care on a seven day basis, and particularly around hospital discharge. There was the basis of good joint work

Councillor Lukey stated that the Council had previously been told that it was not possible to recruit additional clinicians and therefore the number of A&E departments had to be reduced. Councillor Lukey noted the impact on bed usage and queried where local patients who went to CXH A&E were transferred.

Dr Oldfield responded that to ensure the consistency of senior decision makers, there would be consultants on site from 8am to 10pm and then consultants on call from home. The Trauma Centre at SMH would have consultants on site throughout the night. Mr McManus added that ICHT was actively increasing the length of time in the day during which consultants were available on site. An additional six emergency consultants had been in place from mid-December. It was intended to further increase the hours to midnight from April 2015, and expand cover across a seven day week.

Dr Oldfield stated that patients were regularly transferred because of clinical needs, for example to the Cardiac Centre at Hammersmith Hospital and to CXH for specialist neurology. Councillor Lukey queried whether patients were moved to other hospitals because of bed shortages. Dr Oldfield responded that, whilst it might be necessary to move patients because of bed capacity, they would not be moved out of the ICHT group.

Councillor Fennimore stated that the Council had been told that there would be no impact on capacity from the closure of Hammersmith Hospital A&E, and queried whether closure at that time had been a mistake.

Mr McManus responded that the year to date (18 January 2015) performance figures for four hours waiting time showed 94.1% against the target of 95% and 94% nationally. It was believed that the measures put in place had been sufficient. The target had just been missed because of seasonal fluctuations. ICHT had increased medical beds and moved senior decision making staff from HH to CXH and SMH.

ICHT would still have wanted to close HH A&E, as it was not safe. It had not been run by emergency consultants and could not provide safe emergency care. In respect of the timing of the closure, there was no right time to close facilities. The unit had been struggling to recruit senior and junior medical staff. It was not designated as an A&E unit and therefore working at the unit was not a substantive career appointment for junior doctors. The unit had been staffed by acute medical consultants. There had been no out of hours consultant cover and junior doctors were employed from agencies. The level of activity transferred from HH was in line with that planned. The increased activity was a national situation, not just North West London.

Councillor Cowan queried whether ICHT had been surprised and disappointed at the CQC rating of SMH A&E. Mr McManus responded in the affirmative. An action plan would be taken to the Trust Board the following week, and ICHT would be attending the February PAC.

Councillor Cowan queried ICHT's preparation for the inspection, and specifically briefings of doctors and other staff engaged in medical activity. Mr McManus confirmed that ICHT had organised mock inspection visits. Each of the clinical services had undertaken a self assessment of the five domains of quality. The mock visits had been peer reviewed, looking at the different domains and there had been extensive briefings on what would be involved. Staff had been encouraged to speak openly and honestly and to engage with the CQC.

Councillor Cowan queried what ICHT had learnt from the CQC report. Mr McManus responded that ICHT had learnt some positive things about its care and services, but there had been issues in respect of cleanliness at SMH A&E These had been acted upon immediately and the required improvements put in place. There had been a re-inspection in November and the report had been re-issued with the re-inspection findings.

Councillor Cowan suggested that there were wider issues in respect to the quality of the plan around CXH, when fundamental problems had not been spotted. Mr McManus responded that managers were leading a complex system and there were significant forward plans. There had been recent changes to the leadership and ICHT was now in a stable position. There had been a significant endorsement of the plans, particularly in respect of the way forward.

Councillor Cowan referred to the financial alarm in September and suggested that a consultant should be engaged and the issues raised put right rapidly. Mr McManus responded that the financial pressures were significant across

the country and that ICHT was actively working to keep finance on track, together with quality.

Councillor Cowan queried whether the CQC report had led ICHT to question any aspect of its resource planning. Mr McManus responded that as part of the CQC Action Plan, ICHT had reviewed how it had got those issues wrong and planned to learn from the report.

Councillor Cowan queried whether ICHT had withdrawn its bid to become a foundation trust. Mr McManus responded that ICHT could not proceed with its foundation trust bid until it was rated by the CQC as 'good' or better. The challenges across the country in the emergency pathway were reflected in NW London.

Mr Andrew Slaughter, MP, queried whether it had been sensible to close HH at that time and the impact on CXH. Mr McManus responded that CXH was relatively static. The movement of HH patients to CXH was not anticipated. There had been a significant increase due to the winter period. The T1 patient category could not be correlated with HH. There had been a step change in activity figures from HH to SMH.

Mr Slaughter queried the drop in A&E performance T1 to 65/70% and whether the postcodes of CXH attendees had been analysed to find out if the additional workload was commensurate with the closures. Mr McManus responded that post HH closure, the volatility of attendances had been up to 100 on different days, commensurate with winter pressures. There had been an increase in category A, covering particularly acute cases. This was regarded as the new norm, with which ICHT would have to cope and manage capacity.

Dr Oldfield commended the hard working staff at ICHT and noted ICHT's achievement as the fourth best performing trust in respect of mortality. Councillor Cowan responded that the Council also commended the staff, but had concerns about the quality of management and the significant failures.

RECOMMENDED THAT:

1. That an update on A&E Waiting Times be provided for the meeting on 4 February.

2. That urgent steps be taken to improve waiting times.

3. That Chelsea and Westminster NHS Foundation Trust be invited to a future meeting to report on A&E Waiting Times.

4. That a report on how ICHT worked with Social Care to improve the discharge process be brought to a future meeting.

44. UNDER FIVES FLU VACCINATION PROGRAMME IN HAMMERSMITH & FULHAM

The Chair asked Mr Stuart Lines, Ms Lynda Gibbon and Dr Tim Spicer to explain the responsibilities of Public Heath, NHS England (NHSE) and GPs in respect of the Under Fives Flu Vaccination Programme.

Mr Lines stated that Public Health had local responsibility for ensuring that the system was working properly and that as many children as possible received the vaccination. NHSE commissioned services with primary care.

Ms Gibbon stated that NHSE commissioned GP providers to offer free flu immunisation to all eligible children. NHSE funded and monitored services and worked with CCGs to identify any sub-optimal performance.

Dr Spicer emphasised that the services were commissioned with individual providers. The role of the CCG was to improve the quality of primary care and to support practices in difficulties. In addition, it was responsible for some operational issues and working with 31 practices to gain consensus.

Ms Gibbon added that Public Health England was responsible for the national procurement of the vaccine. The vaccine was supplied free of charge to NHS commissioned providers. NHSE monitored the uptake as GP providers were contracted to provide activity data on a weekly basis via the public health surveillance system. Public Health England was responsible for publicity and had produced a range of resources for parents.

Ms Gibbon responded to a number of queries raised by Councillor Vaughan. The current uptake figures for Hammersmith & Fulham were:

Cohort	Cohort of healthy children	Cohort with long term medical conditions
2 years	24.8%	36.4%
3 years	21.6%	33.8%
4 years	18.1%	42%

Ms Gibbon explained that the cohort of children with long term medical conditions sat within the cohort of all children/adults at clinical risk. Contractually, there were no uptake targets. The World Health Organisation target of 75% had been adopted as best practice. The contract for children with long term medical conditions which ran from 1 September to 31 March, would be reviewed mid-point and extended beyond March if necessary.

Similarly, there was no specific target for uptake amongst healthy children. The aim was to exceed the previous year's uptake.

Ms Gibbon stated that an example of sub optimal performance would be a practice not reporting activity data. The national IT issues in September, which had now been resolved, had impacted on initial data reporting.

Individual contracts had been put in place with independent GPs and community pharmacies across London. In addition, NHSE had developed a service level agreement for GP Practices to enable them to offer flu vaccinations to unregistered individuals who might present opportunistically or out of hours and to provide weekend sessions.

Councillor Carlebach stated that the figures quoted by Ms Gibbon were different from those given to him by the CCG. There were a number of key players but a lack of co-ordination. He had seen no plan or letter going out to children in the borough. There had been no letter given to children at his son's nursery. There was no ownership of the programme. Hammersmith & Fulham was the worst performing borough across London in respect of vaccinations for pregnant women and people over 65.

Dr Spicer responded that he would ensure that Councillor Carlebach was provided with the correct figures.

Action: Dr Tim Spicer

Dr Spicer considered that for children with long term medical conditions, the vaccination should be part of their overall GP care. For well children, this was a new vaccination and it could take a number of years to get across the message to all parents and to change behaviour. Mr Lines added that the budget did not sit with Public Health, but the Council had supplemented the publicity through the distribution of leaflets and posters to all 31 GP practices, primary schools, nurseries and libraries and also publicised it on the Council website and twitter feed.

Councillor Brown stated that at the previous meeting it had been agreed that a plan would be put together by the Council and the providers, and be shared with the committee. This had not happened.

Councillor Cowan queried whether Hammersmith & Fulham had the worst vaccination rate in London. Ms Gibbon replied that it was not the worst, but comparable. Councillor Cowan queried whether, if the NHS could not manage the vaccination programme, it could manage the wider responsibilities given to GPs and through Care in the Community. Ms Gibbon stated that the contracts ran to the end of March. The NHS was still actively delivering the programme and expected to move closer to the target.

Dr Spicer stated that the CCG did not commission the programme or manage GPs, and therefore the flu vaccination programme did not reflect its abilities to manage the wider reforms.

Councillor Carlebach stated that he was seriously worried that vulnerable children in the borough were being left exposed.

Councillor Cowan considered that the programme should be reviewed, to identify where not effective and to recommend improvements.

Mr Naylor noted that two years previously, GP practices had opened specifically to provide the flu vaccination and had employed additional staff. Dr Spicer was unable to comment on individual practices.

Councillor Carlebach stated that he had no confidence in the programme. He had not seen evidence of a plan or letters being sent and queried whether there had been contact with organisations such as Action on Disability and Mencap. Vulnerable people were at risk.

Councillor Lukey stated that at the last PAC, it had been agreed that there would be an action plan, and since that time there had been various meetings, including a meeting with Clare Parker, Chief Officer of H&F CCG. Councillor Lukey had personally checked on the availability of seven day opening and walk in centres. Dr Susan McGoldrick, CCG Deputy Chair had explained the process followed by GPs in respect of vulnerable children, and explained that parents not only got a telephone call but also a text message from their practices. A lot of work had been done in respect of raising consciousness. However, there was still a lot of scepticism about the value of the vaccination, from both parents and older people. It had been a major failure that NHS publicity did not explain that the vaccination was a nasal spray.

There was a particular problem with the number of people not registered with GPs, and a corresponding surge in parents taking young children to A&Es between 4pm and 7pm.

Councillor Lukey considered that the Council had made progress and worked conscientiously and tried to hold other organisations to account. It was a complex problem and the Council would keep working for the remainder of the flu season. There were still opportunities to get things done, but from 1 April there needed to be a joint campaign to improve figures for the following year.

Councillor Brown considered that the Council should have negotiated with GPs to put staff into children's centres and nurseries. There should have been a programme in place for people cared for by Adult Social Care cares and e-mail information provided to other groups. There had been a missed opportunity to do more.

Councillor Cowan responded that the Council was reviewing how children's centres could be used for the provision of health care and to promote all aspects of public health.

Councillor Cowan considered that there seemed to be no strategic control over the actions of individual GP practices. Issues such as the flu vaccine should be dealt with in the light of best practice. The Council itself was in robust negotiations with all parties, and would continue to promote the vaccination and work with the NHS to put the borough in the top quartile.

Councillor Vaughan concluded the discussion and summarised the key conclusions and recommendations;

1. There had been an offer by the different parties to work constructively to promote the vaccine for the following year.

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2. The CCG considered that it had communicated with GP practices and that the flu vaccine had been publicised, but the committee's impression was mixed on this point.

3. There appeared to be a fragmentation of responsibilities, with NHSE commissioning the providers and a mixed picture of communication by GPs.

4. There were a number of issues around the take up of the vaccine, including communication that it was a nasal spray, rather than an injection.

RESOLVED THAT:

1. The PAC recommended that the Council and partners should continue to work together to promote the vaccine during the current year.

2. The partners should work together to learn the lessons and drive forward the programme.

3. There should be better communication nationally to promote the vaccine as a priority for under five year olds and that it is a nasal spray.

4. The clear benefits for all age groups should be promoted.

The Chair proposed and it was agreed by the committee that:

1, Item 8 be deferred to a future meeting: and

2. the guillotine be extended to the end of the discussion in respect of items 6 and 7.

45. 2015 MEDIUM TERM FINANCIAL STRATEGY

Mr Hitesh Jolapara highlighted the key points on the corporate overview of the revenue budget and Medium Term Finance Strategy (MTFS), namely the MTFS position, the budget assumptions, the Government grant, fees and charges (main expceptions to the standard increase), budget risks/balances/earmarked reserves, 2016/17 and beyond, the Autumn statement and expenditure and resources forecast 2014/15 to 2021/22.

The proposed savings overall was £23.8million for 2015/16 and £40.9million for 2016/17 (cumultative savings). The Council Tax would be reduced by 1% in 2015/16. There were further reductions to be made and by 2019/20 there would have been a reduction in total of around 57%.

Mrs Rachel Wigley highlighted the key points in respect of Adult Social Care, namely the service vision, the major changes for 2015/2016, the budget headlines, LBHF/ASC Efficiencies, Fees and Charges, the Gross Spend Plan 2015/2016, Risks and Plans for the Future. The presentation set out the Better Customer Experience by Increasing Efficiency and Partnership Working totaling £6.5 million.

It was proposed to abolish charging for home care services; reduce the cost of meals on wheels to £3; and freeze charges for Careline.

The report set out the Public Health budgets and issues. Savings of £366k general fund were proposesd to make Public Health a fully grant funded service.

Councillor Carlebach queried the savings in respect of the reconfiguration of services with the Learning Disabilities client group. Mrs Wigley responded that there were three measures: a review of customers placed in out of borough supported accommodation; maximising in house day care provision; and a review of residential care home facilities.

Councillor Lukey stated that the proposals were in line with feedback that: out of borough placements were unpopular because of high transport costs; there should be a range of housing options; and the proposal to close the in-house learning disabilities service was rejected.

Mr McVeigh noted that some specialist care was provided out of borough and this might be difficult to replicate.

Councillor Lukey stated that whilst this was a finance driven strategy, there were other important isssues and specifically safeguarding, and finance would not determine where people were placed.

In respect of the Independent Living Fund (ILF), all social care support would be provided by the Council and ILF funding would be transferred to the Council via a grant. Confirmation of funding levels was awaited. However, the Council had agreed that current ILF users would continue to receive ILF funding until 30 June 2016, if they were still eligible. Mr McVeigh stated that officers should be breifed to give this assurance. Councillor Lukey responded that she had written to 55 individuals, and she had thought that this was eveyone in receipt of the ILF. There had also been a number of meetings.

Councillor Brown stated that the overall budget was disappointing, and specifially the Adult Social Care savings of £6.5 million, especially when money was being received from the NHS throught the Better Care Fund. Councillor Brown queried whether the dependency on better integration of care with the NHS was seen as a risk. Mrs Wigley responded that investment from the Better Care Fund, approved by Cabinet, would help fund the requirements of the Care Act. In addion, by working together with the NHS, it was hoped to make between £1.6 million and £2.5 miilion savings which was included in the total figure of £6.5 million.

Councillor Brown queried the criteria for paying for home care services and the percentage of people currently paying the charges. Mrs Wigley responded that 25% of people were currently paying the charges. Mr Daryanani added that, in line with current legislation, ability to pay was assessed on the basis of income. Capital and disability related income were disregarded. Charges for home care services were £12 an hour.

Councillor Brown suggested that the wealthier people would benefit from this policy. Councillor Lukey responded that people on benefits would not have paid for the service, whereas people in the middle would have had to pay the full charge, which might have been a deterrent to using the service.

Councillor Cowan staed that should people not use the service because of cost they could be placing themselves at risk. The abolition of charges would result in a loss of income of £441,000. This could be funded through savings made in the PR budget and senior management posts.

Councillor Brown stated that whilst he was not oppossed to this policy, it would mean that there would have to be deeper cuts elsewhere.

Councillor Cowan stated that the Administration had gone though the budget to look at where better and more intelligent support could be given, such as meals-on-wheels and pre-funding the ILF. It was intended to completely review all services and move to a zero based budget approach.

Councillor Scmid stated that a large part of the £6.5 million cuts was acutally investment from the NHS. There had been over £2 million investment. The Council was looking robustly at the detail of the agreements which it was making. The same type of approach had been taken with suppliers and developers ot get the best possible deal across all budgets.

Councillor Brown referred to the proposed Public Health savings of £346k from the general fund. Mrs Wigley confirmed that Public Health could be funded through the ring fenced budget.

Councillor Brown stated that the funding of third sector grants from the Public Health budget was a major concern for the Public Health community, and asked for a rough estimate of the amounts invlolved. Councillor Schmid responded that there had been a £3 million under spend and to use this under spend, the Council had worked with voluntary bodies to deliver good public health outcomes.

Mr Jolapara stated that only items with a direct link to public health had been charged to this budget. In addition, the account would be audited at the year end.

Councillor Carlebach queried why home charges had been abolished for those who could afford to pay, and suggested that it would be better, for example, to invest in heating for the elderly. Councillor Cowan responded that the abolition of home care charges was part of a cohort of plans which the Administration would be rolling out going forward. Councillor Lukey stated that

these people had been assessed as in need of home care and the money saved on these services and on meals on wheels could be spent on heating.

Mr Naylor queried how many people were currently affected and whether it was expected that demand would rise and the likely cost. Mr Daryanani responded that there were 1,266 service users of whom 313 were contributing to the cost. On a previous occasion, only ten people came back into the system.

Councillor Lukey stated that people might not need the same level of service, but a more appropriate service. The Council was working with the NHS on the reconfiguration of services.

Mr Naylor stated that he would like to see a link between these services and loneliness and isolation. He would like to see more work and more budget allocated, particularly for older people. Councillor Lukey responded that the Council was working on more community based initiatives and referred to the discussion in respect of meals on wheels at the previous meeting. The Council would look at new models of service delivery as isolation could be a major issue in the borough as older people no longer had their networks.

Councillor Fennimore updated that she would be meeting with the Casserole Club on the following Monday and hoped to get Hammersmith & Fulham into a project with them. She was pro-actively following up opportunities to work with third sector organisaitons and make much stronger relationships.

Mr Lines stated that the Council was using the Public Health ring fenced budget in an innovative way to invest in community projects with a range of organisations. A report setting out the projects was tabled.

Councillor Brown queried the eligibility criteria for home care, which was currently upper moderate. Councillor Lukey responded that whilst the Care Act abolished local discretion and set its own care standards, there were no local plans to remove anyone from the service.

Mr Jolapara responded to Councillor Brown that the Council was satisfied that it had adequate reserves.

46. ABOLITION OF CHARGING FOR HOME CARE SERVICES

This item had been discussed with the previous item.

Councillor Lukey paid tribute to Debbie Domb and HAFCAC, who had lobbied for the abolition of charging for home care services.

RESOLVED THAT:

The PAC recommended to the Cabinet:

1. To abolish charging for home care services provided to customers in the borough on 31 March 2015.

2. For services delivered up to 31 March 2015, for which charges will still apply, to pursue these charges for a period of three months, ending 30 June 2015.

3. To write-off total estimated home care debt of £133,000 as at 1 July 2015, and delegate authority to write-off the debts to the Executive Director of Finance and Corporate Governance and Deputy Executive Director and Director of Finance and Resources, Adult Social Care and Health.

4. To request additional provision for bad debts of £91,000 from the Corporate Finance from the bad debt provision account.

47. OVERVIEW OF THE PUBLIC HEALTH SERVICE FOR THE THREE BOROUGHS

This item was deferred.

48. WORK PROGRAMME

This item was deferred.

49. DATES OF FUTURE MEETINGS

4 February 2015
9 March 2015
13 April 2015

Meeting started: 7.00 pm
Meeting ended: 10.40 pm

Chairman .....

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