Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Monday 27 January 2020

PRESENT

Committee members: Councillors Lucy Richardson (Chair), Jonathan Caleb-Landy, Bora Kwon, Mercy Umeh and Amanda Lloyd-Harris

Co-opted members: Victoria Brignell - Action on Disability (Action On Disability), Jim Grealy - H&F Save Our NHS (Save Our Hospitals), Roy Margolis, Keith Mallinson (Healthwatch) and Jen Nightingale

Other Councillors: Ben Coleman and Patricia Quigley

Officers: Vanessa Andreae, Vice-Chair, H&F CCG; Jo Baty, Assistant Director, Mental Health LD Provider; James Benson, Chief Operating Officer, CLCH; Olivia Clymer, Chief Executive, Healthwatch; Janet Cree, Managing Director, H&F CCG; Prakash Daryanani, Head of Finance (Social Care); Hitesh Jolapara, Strategic Director of Finance and Governance; Eva Psychrani, Engagement Lead, Healthwatch; and Lisa Redfern, Strategic Director of Social Care.

31. MINUTES OF THE PREVIOUS MEETING

RESOLVED

The minutes of the meeting held on 11 September 2019 were approved as a correct record and signed by the Chair.

32. APOLOGIES FOR ABSENCE

There were no apologies for absence.

33. DECLARATION OF INTEREST

The Committee agreed to the appointment of Roy Margolis as a co-optee.

34. APPOINTMENT OF CO-OPTEE

RESOLVED

The Committee agreed to the appointment of Roy Margolis as a co-optee.

35. REVIEW OF LOCAL PALLIATIVE CARE SERVICES - UPDATE

Councillor Richardson provided a recap setting out the Committee's consideration of the issue. This was the third time that members had considered the in-patient unit at Pembridge House in the context of local palliative care provision which was currently suspended due to the lack of a lead palliative care consultant.

Janet Cree referred members to the CCG paper which provided update on specialist palliative care review and accompanied. A letter dated 17 January 2020 was sent collectively from all the CCGs commissioners and providers (included in the pack). The letter set out public engagement undertaken so far, and a summary of the work planned for the future model of care. Feedback had identified that there was an inequity of access to services across the four boroughs with 48% of residents accessing specialist in-patient palliative care services. The Committee was informed that the CCG would be planning a programme of engagement and discussion once potential solutions had been published to develop a future model of care. The information would be collated and analysed to indicate whether a full consultation was required. The local overview and scrutiny committees would have an opportunity to provide feedback. The Committee was informed that the CCG was aware of what the in-patient unit at Pembridge meant to residents, but it had not been advisable to recruit during a period of transition, as set out in the letter. It was confirmed that the day patient service would remain open.

James Benson assured the Committee that providers understood importance of the in-patient unit to residents but reinforced the CCG's view that it was not advisable to recruit during a period of transition and reiterated Janet Cree's earlier reference to the 17th January letter.

Co-optee Victoria Brignell asked if health colleagues acknowledged that there was a need for in-patient services at Pembridge. Janet Cree responded that this would be identified as part of the review of in-patient services and that critical to this was to achieve the right balance of services. Responding to a follow up point that the unit had been shut because the provider had been unable to recruit to the post, Janet Cree clarified that the recruitment process

could not continue while the service was in transition. A potential candidate would have to take on a position in a service that was undergoing transition.

Councillor Lloyd-Harris queried the 48% statistic and asked why it was as low as it was. The figure implied that people were not aware of the provision. Janet Cree acknowledged that the anomaly was part of the issue that needed to be addressed. The current service was inaccessible or unavailable and one of the outcomes that was hoped for was to ensure that uptake of the service was increased. Councillor Lloyd-Harris commented that residents needed to be informed because it appeared that the service was intentionally being run down with many obstacles that prevented progress toward a suitable resolution. Janet Cree countered that the main priority was to achieve the right service specification. It was explained that the CCG had tried to consider sharing a lead consultant but that even if a suitable person had been found the unit could not have been re-opened. James Benson added that the providers were unanimous that this was not feasible. The acute trusts had indicated that they did not have the resources available to support a 13-bed unit. They had explored alternative options for a lead consultant and in conjunction with the acute trusts a prospective appointee had been trialled, but this had been unsuccessful. It had been unsafe to continue and therefore he had agreed with the CCG to suspend recruitment. Co-optee Jen Nightingale suggested that there would still be a need for a lead clinician regardless of what the future service specification looked like. James Benson responded that there existed potential leadership within the community specialist palliative care service. The question was whether there was a need for separate leads for both this and the in-patient service, with a new model of care.

Councillor Richardson probed this point further and queried why there had been such sustained difficulties over an extended period. Janet Cree felt that it was not possible to explain the difficulties in recruitment, but the review had led to a shared position agreed by commissioners and providers which would be sustained until it was possible to recruit to the correct resource.

Co-optee Jim Grealy sought clarification that the CCG did not want to recruit during the review process but was aware that there were two phases during this process. He reported that he had recently attended an event at RBKC and had read the Penny Hansford independent review (also included in the papers). It appeared that in-patient beds of any kind had been ruled out as if the decision had already been made and he suggested that there must be a way in which the provider and the acute trusts could work together.

Jen Nightingale enquired what arrangements were in place to ensure that there was an out of hours service in place. James Benson explained that there was an on-call system in place cover for which was shared between nurse leadership team, provider and acute leads.

Co-optee Keith Mallinson queried the recruitment issue and asked what the difficulties in recruitment existed in London and within the home counties (Hertfordshire) given that they did not appear to have similar problems. James Benson replied that colleagues in acute trusts did have the same

issues. He was aware the St John's Hospice had struggled but had managed to maintain their position. Many palliative care workers were employed part-time which was a positive given the operational requirements, but this was more than just a local issue and there were wider national concerns in parallel.

Councillor Quigley recounted her personal experience of Pembridge where her mother had been looked after in 2012. The care and support that her family had received had been much valued. She asked the CCG to explain what might have changed to such an extent since this time that had led to the current recruitment problem. James Benson welcomed Councillor Quigley's positive comments and stated that the CLCH had always been proud of the service offered by the palliative care team. This was a difficult situation however a decision was needed, and he could not offer any further insight as why it was so difficult at this time. In response to Cllr Quigley's further query as to whether this was because of the lack of qualified clinicians or if CLCH was refusing to recruit James Benson clarified that a key factor had been the sequence of events and the timing of when the vacancy had arisen. He reiterated the current position was to not recruit while the review was underway.

Councillor Bora Kwon questioned why there had not been a contingency plan in place and that it appeared precarious to run the unit without taking account of workforce changes. The issue had been discussed first in December 2018 by the Committee and Councillor Kwon was unclear what efforts had been undertaken during this period and queried if there was an issue with the post that had prevented movement. Councillor Kwon suggested that lessons should be learned from this experience.

Councillor Freeman informed the Committee that RBKC had written to Central and West London CCGs to say that they while they recognised the challenges every effort should be made to keep Pembridge open. There was an expectation that the CCGs would work together to address the challenges around recruitment. Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust had confirmed that they were unable to stretch resources to provide the level of cover required however he hoped that a further meeting was planned with Chelsea and Westminster and which might be helpful. Referring to the RBKC event it was clear that the overwhelming response of residents was that the Pembridge was a service that was enormously valued, and it was important that it remained open. Pembridge was also one of the very few palliative care providers funded by the NHS in contrast to those which were funded by charities.

Councillor Jonathan Caleb-Landy referred to an earlier point regarding the recruitment in the home counties. This was one example and he queried why this was being viewed as a national crisis. He asked to what extent the CCG and CLCH had been working with others to resolve this. Councillor Caleb-Landy also sought further details about any contingency plans formulated given the lack of a replacement and enquired what allowances had been put in place to allow people to travel to hospices in other areas such as St Johns or Trinity. He pointed out that each time this issue had been discussed the

Committee had received incredibly powerful, personal testimonies about Pembridge. James Benson explained that two palliative care consultants were not needed to run a unit like Pembridge. Historically, when the in-patient unit had been closed, the contingency plan had been to share the lead clinician with St Johns. There were junior doctors and community consultants that could step in and he acknowledged the lack of foresight in not having a contingency plan in place. Initially they had felt that it might be possible to recruit, had offered accommodation and explored a wide variety of options. They had also approached hospices that were closing but this was also unsuccessful. It was confirmed that given that they were not recruiting they had not therefore taken steps to speak with other providers. They had tried to work with multiple providers to recruit which the acute trusts had been aware of.

Councillor Richardson pointed out that it would have been helpful to have shared this information so that the Committee could understand the challenges. Janet Cree responded that Dr Joanne Medhurst had articulated this point at the previous meeting of the Committee. Councillor Lloyd-Harris added that it would have been helpful to have had this clarified to facilitate shared working but that it did not appear that this was intended.

Councillor Coleman thanked Councillor Freeman for the event organised at RBKC and for all his efforts. He referred to an earlier point that a potential solution might be identified by the beginning of February and asked if this would include in-patient services. Merril Hammer (H&F Save our NHS) commented that there was a need to find more radical and innovative solutions to address the shortage of clinicians without letting services disappear. Querying the statistic of 48% referred to earlier in the discussion, it was reported that a clinician from Imperial at the RBKC event had stated that not everyone who was dying needed specialist palliative care support. However, the CCG had inferred that this was an issue attributable to the lack of patient outreach work. These were two distinct arguments to explain the low take up of services: was this due to the lack residents requiring specialist care or because they were not aware of the service being available. It was pointed out that the Penny Hansford review had set up the foundation for potential conflict between care in the community and establishing an in-patient unit. This was not the case and those who had attended engagement events had made it clear that both were required. In a final point, the Penny Hansford report did not take into consideration local democracy or social factors. Pembridge was in one of the most deprived areas of the borough populated by large numbers of, single person households, vulnerable and elderly residents. A further question was why an NHS funded facility such as Pembridge had been targeted.

Janet Cree responded that their aim was to ensure that patients who received palliative care were ensured a smooth end of life. Much of end of life care took place within the community or in a nursing home and they did not all have access to specialist palliative care. The CCG wanted to ensure that the service was more widely provided. They sought to achieve a balanced provision that met the needs of in-patient care and community-based care services and to get this balance right. It was never intended to preclude in-

patient beds from the review. Patients receiving palliative care in the community also had access to the in-patient service. There was good palliative care provision within the community but there was not always access to the specialist provision that would enhance that experience for family and friends. This is what the CCG hoped to address, and nothing had been predetermined within the review.

Councillor Coleman sought clarification about what the review entailed and if this meant that the CCG would work through the views already received, or would they undertake a consultation. Councillor Coleman also asked if the potential solution paper currently being drafted would form the basis of further consultation. Janet Cree responded that there was an on-going engagement process and referred to the 'What Next' section of the 17 September letter which was read out. Councillor Coleman probed further and suggested that the Committee might be able to consider some real ideas at its next meeting. He asked when the document would be available and if it would touch on the future of the in-patient's unit. Janet Cree replied that she had not indicated that it would "touch" on in-patients but would address in-patient access to specialist palliative care. The expectation was that the service would be offered as part of the whole range of provision for the local population. It was confirmed that the Committee would be included in the engagement process and that members would be able to scrutinise concrete proposals and solutions. Following further discussion, it was clarified that this document might be available at the beginning of February or at the latest, within two to three weeks.

James Benson picked up the earlier point that had been made regarding the statistic of 48% take up and acknowledged that this was low however, not everyone required specialist palliative care and further work was required to understand figure. Janet Cree added that this point could be made more clearly during the next stage of the review process and that this would be rectified in future briefings.

A member of the public reported that they had participated in the engagement workshops and a member of the Tri-borough Residents End of Life Care Group. Pembridge Hospice was distinguished by the fact that it was wholly NHS funded and that creating a broad service that would meet the need of an increasing local population would have to be achieved within a limited budget.

Lisa Redfern observed that it was hard to understood what different skills were required by a lead palliative care consultant, supervising both community care teams and hospice staff. Whilst it was acknowledged that there were concerns about recruitment it was accepted that this was a difficult process to manage. The need for a lead consultant was queried. Janet Cree confirmed that a lead consultant was the only option and that a junior specialist clinician would not be appropriate. In reviewing the Hospice UK Workforce report Lisa Redfern was of the view that there did not appear to be recruitment difficulties. In a final point, concern was expressed regarding capacity within the existing configuration given the potential closure of Garside and the part closure of Pembridge which indicated that this would be an issue across the four boroughs in terms of nursing capacity.

Julia Gregory, a journalist from West London News, asked about and an aspiration to have 75% of patients receiving access to specialist palliative care services, a point that had been made at the RBKC event.

James Benson responded to the points raised in reverse order. Regarding the point made at the RBKC event, it was clarified that this point had been made by Professor Ursch that probably, 75% of residents should be able to access the service and that in his view, it was unlikely to be 100%. It was explained that there was a fundamental difference between nurses in the community and the in-patient unit which required specific leadership. An additional complexity was that if the unit was opened with a shortage of clinicians. This would require cover to be provided by either St Johns or St Elizabeth's which they would not be happy to do. Having inconsistent cover would not work operationally and would present significant challenges in running the unit. An in-patient unit like Pembridge would expect to see more complex cases and would need an experienced lead.

Addressing the point raised by Lisa Redfern on capacity, Janet Cree commented that Garside care home currently had suspended admissions due to quality issues but had recourse to alternative provisions elsewhere with the system. In the interests of transparency James Benson commented that additional support was being provided to assist residents while they remained at Garside.

A member of the public queried the suspension of the service at Pembridge, given that the CQC had in 2018 rated it as "good", outlined events to date and reported that they had been informed that the unit could no longer accept patients who had previously been sent to Pembridge to undertake control of their pain management. Pembridge had been providing a service across the wider community. James Benson acknowledged that Pembridge and the quality of leadership had been regarded as "good" and repeated his previously articulated response about the need for a full-time lead specialist palliative care consultant in order to deliver good quality care. Janet Cree added that they were closely monitoring patient take up of the current services available from other providers.

ACTION: The CCG and provider to provide further updates and for the PAC to continue to monitor developments closely. Further engagement work was planned by the CCG and CCG was to report back potential solutions within two to four weeks.

ACTION: For the issue to be considered at a further meeting of the PAC, planned for February 2020.

RESOLVED

That the Committee note the report and that issue continues to be closely monitored.

36. PARSONS GREEN WALK IN CLINIC - UPDATE

Janet Cree clarified that the CCG had not taken a decision to close Parsons Green WiC but had requested an extension from NHS England to keep the WiC open so that the existing service would remain. Further information was contained in a letter on the CCG's website. At the present time there were no plans to change the WiC.

Councillor Richardson enquired what had led to the confusion, a reprieve had been sought, then refused and then reprieved supposedly again following a Parliamentary announcement from Matt Hancock, Secretary of State for Health. Janet Cree responded that NHS guidance had set out that a change was required in December 2019 which was reported to the Committee. The CCG had dialogue with NSH England during this time.

Jim Grealy pointed out that the initial directive to close had come from NHS England but that the CCG statement indicated that Parsons Green would not continue. He asked if it was necessary now to rename Parsons Green since it cannot be called a "WiC" and that it would have to put in place a bookable appointment system. There was a difference between a WiC, and urgent need and it would be helpful to understand this. Janet Cree responded that several GP surgeries offered WiC appointments and wound care and was of a similar model. The CCG planned to utilise workforce and capacity within the existing system which was not being used optimally and replace this with a mixed model of care. This could have GP and nurse appointment systems running simultaneously.

A member of the public sought further clarity about when the WiC intended closure around the end of March and whether any extensions were likely. Janet Cree confirmed that was the case, but changes would not need to have happened by the end of March. The CCG planned to undertake required engagement with stakeholders and although WiC provision may no longer be offered at Parsons Green, the unit may look different in future. It was confirmed that 53% of patient activity was from residents of H&F. The wider patient footprint comprised of residents from other boroughs. Councillor Coleman observed that opposition to the closure of WiC across the country indicated widespread concern. Reflecting on the parliamentary comments about Parsons Green remaining open, it was noted that the Secretary of State had confirmed that there would be no need for the WiC to change to appointment only. Councillor Coleman acknowledged that this placed the CCG in an insidious position and potentially opened the floodgates to judicial review if the CCG decided to follow the Secretary of States' policy.

Councillor Caleb-Landy asked if it was possible to establish what the financial impact would be on the budget to reconfigure the WiC. Janet Cree responded this could be checked and would depend on the specification which might comprise of both WiC and appointments. In a response to a question from Victoria Brignell Janet Cree noted that Parsons Greens was regarded as a centre of excellence for ear syringing and that the service would continue after 31 March 2020

ACTION: CCG to identify the financial impact on reconfiguring the WiC.

ACTION: For the PAC to feed into the engagement work planned by the CCG. Further information about the CCGs plans for the WiC post 31st March 2020 to be shared given that it no longer meets the required NHSE standard for urgent treatment centres.

RESOLVED

The CCG and provider to provide further updates and for the Committee to continue to monitor developments closely.

37. CQC RATINGS / CCG OVERVIEW

The Committee received a joint presentation from Janet Cree and Vanessa Andreae. This had been prompted by a "requires improvement" CQC rating given to a local GP practice. It was noted that the practice has an action plan and that the role of the CCG was to provide support and guidance as the responsibility for improvement lay with the practice itself.

Councillor Mercy Umeh asked what the impact on residents had been. It was confirmed that most residents would be unaffected.

Jim Grealy welcomed the update and reassurance offered and the fact that 19 practices had performed well with 8 achieving a "good" rating. However, 50% of those that were not deemed good were in deprived parts of the borough. He expressed concern about the equalities impact on residents and urged the CCG to review this as a priority. It was noted that practices were private businesses and that if a practice was rated as inadequate, he asked what monitoring procedures were in place, and, what was the monitoring process was to review matters before this stage. Vanessa Andreae acknowledged that there was an impact on patients but observed that patients were also very loyal to their practices. CQC inspection regimes had evolved over the years and had become more policy and procedure based, monitored by the GP Federation. If a practice had not reviewed its policies then it was likely to be challenged. Janet Cree added that the newly established Primary Care Networks (PCNs) were perceived as part of the solution and that changes implemented across a PCN enhanced provision. Vanessa Andreae highlighted as an example of the this the low take up of immunisations which could result in a "requires improvement" rating. This had been an issue in H&F and there had been an immunisation working group but that this had been disbanded. In another example, a local GP practice had received a national award on their work to improve the number of women undergoing cervical screening. It was noted that there was a need for more proactive collaborative work and the Committee indicated that it would welcome innovative opportunities for the Council to assist the CCG in for example, advertising health information and guidance for residents regarding flu prevention on the Council website.

ACTION: Council to assist the CCG in for example, advertising health information and guidance for residents regarding flu prevention on the Council website

Referencing an earlier point about inequalities it was noted that the PCN was part of the solution around supporting both the network and offering peer support, particularly where there was workforce retention.

It was confirmed that there was regular monitoring of individual practices. A practice would receive a two week notice in advance of a CQC visit and the GP Federation was allocated resilience funding to support prior to a practice inspection.

RESOLVED

That the Committee considered and noted the report.

38. PRIMARY CARE NETWORKS, INTERIM CCG CLUSTERS AND INTEGRATED CARE SYSTEM STRUCTURES

Mark Easton provided a brief update on numerous changes to the CCG operating model. Engagement had commenced about the move towards a single CCG. The CCGs had begun to explore what would happen within the transitional year and to develop an understanding of what happened at both CCG and borough levels. This had led to some engagement work prior to December 2019 and there were proposals in train to cluster management teams. It was clarified that this was not about having four clusters that would exist as autonomous structures. The intention was to have 8 CCGs with 8 managing directors and to maintain some shared functions with 20% of staff working between boroughs and 80% working locally.

Councillor Coleman commented that the move towards clusters presupposed a merger which was yet to be agreed and that the criteria and conditions for the merger had not been made known. Councillor Coleman requested that the NWL Collaborative CCGs provided information about what conditions would have to be met for a merger to proceed. He also requested that the Committee be provided with the details of the work plans identified in paragraph 1.3 of the report. He continued that he had been surprised by a letter consulting CCG staff about prospective cluster arrangements without having discussed these arrangements with the Council. It had been reported that H&F would be clustered with Ealing and Hounslow, but this was not the case. H&F CCG was to be potentially clustered with Central and West London CCGs, an unwanted arrangement that reflected a historic local government arrangement between the three boroughs and which no longer existed. Councillor Coleman also sought clarification about the financial and administrative needs of GP at Hand and how this would be met by the NWL Collaborative.

In response Mark Easton referred to agreement reached between the 8 CCGs to merge in principle. In a caveat to this, there remained several issues that members of the governing bodies requested further information about.

Broadly speaking these were encapsulated by five bullet points contained at page 13 of the Agenda. A more detailed paper had been submitted to the Joint Committee (of the NWL Collaborative) and covered the areas which the governing bodies said that they wanted to be satisfied about before they recommended that their members should vote in favour of a merger. Currently, the Collaborative was developing the answers to the questions posed by the governing bodies. It was confirmed that this would be shared with the Committee when it was finalised. The document was essentially a derivative of the document produced in December 2019 and was currently in development. It was anticipated that this would be ready over the course of the next week. It was hoped that a further consultation document would be published for staff but that the priority would be to work out arrangements for the interim year before worked commenced on the longer-term changes. In response to a question about when this might be made available it was explained that this currently being worked on and that it would be shared when it was fit for public consumption and at the earliest opportunity. This would be a question of weeks as it would need to be ready before it was presented to the governing bodies in June 2020.

Responding to Councillor Coleman's earlier point regarding consultation about cluster arrangements Mark Easton contended that the Council had been consulted by describing and making known the potential options available. The chief executive officers of each Council had been informed by letter. Councillor Coleman expressed his fundamental disagreement that this qualified as 'consultation' and that this had not been discussed with the Council. Mark Easton asserted that his view was different. The clusters would share 20% of the costs arising from the shared functions referred to earlier. The groupings would not form the basis of integrated care and were subject to on-going discussions. This was an emergent point in development, and he explained that the CCGs were aware that WCC regarded the potential cluster arrangement as being 'bi-borough'. It was confirmed that the administrative cost of GP at Hand would be broadly shared. It was acknowledged that this was a huge financial burden for H&F CCG, but that this was expected to reduce. Prompted by a request for further details about the shared functions and what these were Mark Easton felt it was not appropriate to share the details in advance of sharing this with CCG staff.

ACTION: To receive a briefing about the conditions required to be met in order to for the CCGs to move forward with plans to merge.

ACTION: For the NWL Collaborative to share work plans once finalised.

RESOLVED

That the Committee considered and noted the report.

39. HEALTHWATCH UPDATE

Councillor Richardson welcomed from Healthwatch Olivia Clymer and Eva Psychrani who presented their recently published report "Healthcare in the Digital Era an Exploration of young people's health needs and aspirations in

Hammersmith & Fulham". The report explored the impact of digitisation on young people nationally a link to which was included in the pack together with a consultation link inviting comments from the public and stakeholders. Key findings in the report which had engaged with young people in H&F included the use of technology was not necessarily linked to health, concerns about finding the right information online and that young people were more comfortable with accessing the NHS online using log in credentials. There was also an emphasis that maintaining a digital approach did not infer that traditional face to face access should be 'lost'. The report had received a positive response and would ensure that NWL CCGs engagement plans around digital was communicated clear to residents to help alleviate patient difficulties in accessing services. Reference was made to the previous point about with 48% of people using specialist palliative care services implying an issue around signposting which might be replicated in technology. This was an opportunity to develop an approach early on.

Councillor Richardson identified that the Council's approach to addressing mental health focused on prevention. Jo Baty confirmed that this was an issue that was being covered at Health and Wellbeing Board. Prevention was a big area of work and endorsed the findings of the report.

Co-optee Roy Margolis welcomed the report and its interesting recommendations and asked if more detail was available about the recommendations and specifically if any work had been undertaken on the cost of implementing them. Olivia Clymer responded that the role of Healthwatch was to identify issues, provide challenge and affect change so that the patient voice was heard and acknowledged. There were further details in the main report and could be included in an appendix to the report. Keith Mallinson, as Chair of the Healthwatch Central West London Committee reported that he had recently attended a CAB forum presentation and was shocked at how many people were being signposted to services which were no longer accessible.

Jim Grealy asked how many young people consulted a GP in person and if there was a sense of whether having a digital approach was preferred in place of attending an appointment at a GP surgery. Eva Psychrani explained that there was a sense that follow up and prevention work could be digitised but that everyone needed the confidence and reassurance that arose from a face to face appointment.

It was noted that this was a valuable report in given the number of people who were being turned away from CAMHs (Children and Adolescent Mental Health Services). Councillor Lloyd-Harris observed that it was helpful to have a definition of mental health which normalised the issue. The perception for example that drugs, and alcohol issues were 'normal' and therefore not perceived to be a problem by the current generation but may have been by a previous generation. Eva Psychrani responded that in some ways mental health concerns had been normalised and reported that the focus group had been aware of the effects of smoking and alcohol. It was clarified that the recommendation for a mental health app was not linked to having a mental health digital intervention. Mental health needs had been identified through

first exploring the issue in conversation with young people and then linked to digital intervention.

RESOLVED

At 9.50pm the Committee agreed that the meeting be extended to 10.15pm.

Jo Baty confirmed that the Council would welcome the opportunity to work with Healthwatch in reviewing mental health services and acknowledged that transitioning from Children's Services to adult services could be a tricky time. Young people were not always aware that they might have a mental health issue which might have been missed earlier. It was recognised that information and guidance could always be improved.

A member of the public enquired about what support was in place for H&F residents who lived on the Edward Woods estate and had been affected by the Grenfell Tower fire. Councillor Coleman responded that the Council had reassured residents who were concerned about losing their homes and had committed £20 million to implementing fire safety measures which included the installation of fire safety doors regardless of whether residents were tenants or private owners. Lisa Redfern reported that a great deal of work had been undertaken to support residents since Grenfell in practical terms with a variety of Council services being offered.

ACTION: For the Strategic Director to identify what support had been put in place for H&F residents on the Edward Woods estate following the Grenfell Tower fire.

Councillor Coleman observed that the report interesting and that the Council had been working with the Youth Council to develop an app on information about available activities within the borough. This dovetailed with the work on social isolation and loneliness which also addressed mental health. Councillor Coleman also observed that there was a clear contrast highlighted between young people accessing services and young professionals accessing GP at Hand.

RESOLVED

That the Committee welcomed and noted the report.

40. 2020/2021 MEDIUM TERM FINANCIAL STRATEGY (MTFS) - ADULT SOCIAL CARE AND PUBLIC HEALTH

Lisa Redfern led a presentation that informed the Committee of planned departmental financial spending for the forthcoming year and the intention to deliver again a balanced budget. Key achievements included free home care, subsidised meals on wheels, the commencement of a podiatry service and ensuring that all contractors paid staff the minimum living wage. Two in-house services had been rated as outstanding and improvements to other services had received positive feedback from residents. A safeguarding peer review by the Association of Directors of Social Services had achieved an outstanding

result. Delayed transfer of care figures had now placed the borough as the third lowest in London and a quality assurance framework had just been launched. These were all achieved under challenging circumstances with increased demand, greater acuity of need, and complexity of care within an ever-reducing budget.

Councillor Lloyd-Harris enquired about the current level of the Council's reserves. Hitesh Jolapara responded that the reserve figure needed to be considered in the context of ten years of austerity. H&F was average in London in terms of the level of reserves which was currently retained at £90 million. The Corporate budget would contribute a further £7.2 million to reserves which included income received through business rates. The Council's intention was to continue to be ruthlessly financially efficient.

41. WORK PROGRAMME

RESOLVED

That the Committee notes the report.

42. DATES OF FUTURE MEETINGS

Tuesday, 24 March 2020.

Meeting started: 7pm
Meeting ended: 10.15pm

Chair .....

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