London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Draft Minutes

Wednesday 26 January 2022

PRESENT

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

Co-opted members: Lucia Boddington, Victoria Brignell, Jim Grealy, Keith Mallinson and Roy Margolis

Other Councillors: Ben Coleman and Patricia Quigley

Officers/guests: Jo Baty, Assistant director specialist support and independent living; Prakash Daryanani, Head of Finance (Social Care and Public Health); Merril Hammer, H&FSON; Emily Hill, Director of Finance, Dr Nicola Lang, Director of Public Health; Dr Christopher Hilton, Executive Director of Local and Specialist Services, WLT; Linda Jackson, Director of Covid and Lead for Afghani Refugees; Helen Mangan, Deputy Director of Local Services, WLT; Lisa Redfern, Strategic Director of Social Care

1. MINUTES OF THE PREVIOUS MEETING

Councillor Lucy Richardson, Chair, noted that the actions raised at the previous meeting under Agenda Item 6, Mental Health Update had been responded to by the trust and would be followed up and that the minutes of the previous meeting held on 10 November 2021 were noted, with one minor typo.

2. APOLOGIES FOR ABSENCE

Apologies for lateness were noted from Councillor Mercy Umeh.

3. ROLL CALL AND DECLARATION OF INTEREST

None.

4. PUBLIC PARTICIPATION

The Chair noted that public questions had been submitted by Merril Hammer (**H**ammersmith **a**nd **F**ulham **S**ave our **N**ational **H**ealth **S**ervice) in respect of Agenda Item 6, Mental Health Integrated Network Team).

5. COVID-19 UPDATE

5.1 Councillor Richardson welcomed back Dr Nicola Lang and Linda Jackson who provided an update on the council's ongoing Covid-19 response. The rate of infection for borough was currently 875 for every 100,000 and was in a slow decline, similar to the rest of London. At the end of December 2021, the rate was 2600 per 100,000. Most of the borough's schools had reported cases, predominantly higher in primary school, amongst children aged 5-10 years, replicating the peak of cases arising in secondary schools over autumn.

5.2 Co-optee Keith Mallinson commended the work and commitment of Dr Lang and her colleagues, which he felt was undermined by the comparatively poor response of Transport for London (TfL). Councillor Amanda Lloyd-Harris endorsed comments in respect of Dr Lang and also TfL. Enquiring about the rates of infection primary schools, she sought a comparison with overall London figures. Dr Lang confirmed that there were approximately 1800 new cases being reported weekly which was slowly decreasing. The current rate ranked the borough as the 12th highest (mid placed overall). One of the underlying factors attributed to higher local figures was the volume of testing which was predominantly one of the highest in London.

5.3 Residents were well motivated about getting regularly tested and the council continued to work closely with primary, secondary and special needs schools, offering support and guidance on preventative measures. Dr Lang observed that younger children found it harder to maintain social distancing and also attributed the higher rates prevalent amongst primary aged children to being unvaccinated, as they were the last of the population groups to be vaccinated. Dr Lang commended the excellent work of local headteachers who had worked hard to boost morale and encourage greater resilience amongst their pupils during a very difficult period, dealing with wave after wave of Covid-19. In response to a follow up question from Councillor Lloyd-Harris, Dr Lang confirmed that she was not aware of parents holding "Covid-19" parties so that children could become infected.

5.4 Lisa Redfern thanked and commended Dr Lang's clinical foresight in 2020 to appoint an infection control nurse. It was likely that H&F was the only local authority amongst the eight north west London (NWL) boroughs to have taken this approach which strengthened the council's outbreak management control. Expertise applied to support care homes and for those in receipt of direct payment, was also applied to support schools. Health colleagues had acknowledged the huge benefit of this kind of well balanced, and dynamic intervention, which had helped facilitate a controlled reopening of care homes. Cllr Richardson commended the response of council officer teams, led by Dr Lang and Lisa Redfern.

5.5 Co-optee Victoria Brignell sought an update on the hospitalisation numbers, whether this had plateaued or was declining. She also sought an update on vaccination rates. Dr Lang reported that the vaccination rate for H&F, was 63% of registered patients (not by the number of residents). Numbers had

gradually increased, partly attributed to concerns about Omicron, some of whom had come forward for their first vaccination, roughly equating to 20-30 per day. The success of local booster vaccination was attributed to a nimble pop up system supported by ten pharmacies, and two sites at Charing Cross and Hammersmith hospitals. Similar agility had also helped with second doses and reflected a slightly different pattern of take up in other boroughs. Councillor Coleman added that the rate of 63% was calculated based on the Office for National Statistics projected figures used by the government. This gave the current population figure 225, 000. However, a more accurate figure based on Greater London Assembly (GLA) data was 190,000. Based on the GLA figure, this indicated a vaccination rate of 88% for first doses, 84% for second doses, and 52.9% for boosters. A letter had been sent to central government highlighting the disparity and explaining that inaccurate reporting had fundamentally undermined local morale. NWL health colleagues had concurred with the council's perspective but it was not possible to change the formulation for the entire country. This had particularly disadvantaged H&F and other local authorities in a similar position.

5.6 Dr Chris Hilton, an NWL NHS Gold committee member, provided a headline update on hospital rates. There were currently 460 occupied beds representing a rate of 15% of acute to adult hospital beds and which was stabilising. Councillor Richardson thanked Dr Hilton for stepping in the absence of local National Health Service (NHS) colleagues.

5.7 Councillor Richardson led comments from the committee in commending the work of officers who had worked unstintingly to deliver the council's Covid-19 response. It was imperative that this impressive work continued as the UK came out of Covid-19 restrictions and remained agile in responding to future variants. Jim Grealy commented that a Fulham pharmacist had recently told him that he had 23 no shows for Covid-19 appointments and that those doses had been "wasted" indicating spare capacity. It was not possible to understand if this was occuring elsewhere but it did not detract from what was otherwise a remarkable performance by the NHS in delivering scaled up vaccination. Dr Lang observed that this was not a supply but a demand issue. The surge in Omicron rates also meant that an infected person was required to wait for 28-days before vaccinating.

5.8 Victoria Brignell sought information about the vaccination levels amongst NHS staff and an indication as to how many might lose their jobs if they remained unvaccinated by the April deadline. Linda Jackson explained that there was an ongoing dialogue with care and NHS staff about their reasons for not being vaccinated. The implementation of the April deadline would also require legalities that were yet to be announced. Lisa Redfern added that the impact of NHS staff refusing vaccination was a concern, given the implications for maintaining safe staffing levels but business continuity plans were in place to respond to this scenario. There had been similar concerns anticipating an impact on care homes but the outcomes had been minimal. A cautious approach was recommended with regards to the potential number of unvaccinated staff leaving the NHS.

5.9 Dr Hilton confirmed that the protocols in place for the preparation of business continuity plans at WLT would be similarly replicated across partner NHS trusts. It was reported that, as of 25 January 2022, there were 189 individuals within the organisation who were unvaccinated, out of a potential 4000 staff members. To date, five members of staff had left the organisation voluntarily because they had declined vaccination. He confirmed that there were ongoing conversations with staff to encourage them to accept vaccination before the April deadline.

5.10 Councillor Lloyd-Harris commented on the disproportionate percentages of H&F population figures and how this impacted on the local vaccine take up, and the need consistency. Councillor Coleman confirmed that it had not taken 18 months to identify the issue of inaccurate population figures. This was a long standing issue that the borough had asked the government to rectify for many years and had similarly affected other local authorities (Royal Borough of Kensington and Chelsea and Westminster City Council), and across the UK where there were high rates of movement into and out of the area.

ACTIONS:

1. **The numbers of local, NWL NHS staff who might lose their jobs if unvaccinated; and**
2. **That percentage details about vaccination rates for first, second and booster vaccination would be provided following the meeting.**

RESOLVED

That the verbal report and actions were noted.

6. MENTAL HEALTH INTEGRATED NETWORK TEAM (MINT)

6.1 Councillor Richardson welcomed Dr Chris Hilton and Helen Mangan from West London Trust. This was a follow up report to one that was provided at the previous meeting of the committee and provided members with insight into the MINT service provision for H&F residents. Although a brief was agreed, it was explained that unfortunately health colleagues were only able to meet this in part, due to severe Covid-19 related service pressures. It did not cover transitional mental health care for children and young people, to adult services, which was subject to ongoing transformation work and Dr Hilton assured the committee that he would explore this further with members at a future meeting. In addition, some demographic information had only been superficially covered, focusing on the ethnic coding of individuals accessing the MINT service. Dr Hilton commented that MINT represented a new community mental health service reconfiguration. Referencing page 19 of the report, he accepted that the detail of this had lacked clarity for service users. The MINT service offered a different, geographical configuration replacing the previous service pattern. What was primary care mental health, accessible as part of the SPA set of services, included treatment and recovery teams, had been augmented. They now geographically aligned with the north and

south centres of the borough to integrate more closely with the local primary care networks.

6.2 Co-optee Keith Mallinson commented that the report lacked clarity about the SPA issue and did not address the previous concerns identified by the committee. In his experience, individuals who suffered a mental health episode and need to be seen urgently, or a relative who needed urgent support and information, required clear guidance and direction towards the SPA. The reality was that this was not the experience of many service users who felt "pushed" towards Accident and Emergency (A&E). He felt that streamlined, SPA services focusing on service users was required to help navigate mental health pathways.

6.3 Dr Hilton acknowledged that navigating the SPA could be confusing and referenced page 24 of the report, which set out service details. He explained the Trust's SPA provision, which was intended to run 24 hours a day, seven days a week, offering an advice and support line for patients and carers. The SPA did not itself deliver services but helped to identify the appropriate care service, including crises care. This was a freephone service, open to all H&F residents, and in particular, for those individuals requiring immediate assistance. Dr Hilton apologised for the confused messaging and frustration for service users that this had caused. A review was currently underway to avoid individuals from being passed between multiple teams and a SPA would help improve capacity. The SPA, however, was primarily for planned referrals as well as an advice and support line and distinct from MINT, which offered planned care.

6.4 Councillor Richardson observed that the issue of the SPA raised questions about the consistency of care provided and the advice offered by staff. Dr Hilton explained that the SPA was a service that was distinct from MINT, and that it was a call centre function, offering advice and support for patients, managed and based within the call centre, delivered by a team of mental health advisors and clinicians. Dr Hilton clarified that clinicians were specially trained to provide interventions and telephone calls were recorded for training purposes. The SPA received thousands of call each month covering a range of issues, with some individual callers calling in distress. These also included referrals and calls from emergency services. Dr Hilton assured the committee that consistency in customer service was a priority for the Trust and welcomed further feedback on how it could be improved.

6.5 Jim Grealy welcomed the report which he felt contained more information than the previous paper, despite the significant pressures experienced by the Trust. He commented on the issue of ethnic coding highlighted in section of 5 of the report and felt that this offered more clarity. He asked what strategic plans were in place to understand the reasons for this. The borough also had a low rate of dementia diagnosis and a second question was about the report's connection between dementia in older people and mental health which was never fully examined. Further information was sought about the correlation between the mental health of men and dementia. National figures indicated that there was a growth in dementia rates in this cohort, and he asked how hoped to plan the Trust future dementia services. On a further

point, Jim Grealy welcomed the inclusion of staffing numbers as this highlighted concerns about recruitment and how this could impact on the successful delivery of the MINT programme. A final point was about the role of GPs within this new configuration. Given that many people currently had little opportunity to see their GPs, he observed that Imperial College Healthcare NHS Trust were seeing increased numbers through A&E and urgent care centres. There were a range of cases that presented with physical symptoms but these sometimes disguised underlying mental health conditions. The structure of this was important as the integrated care system (ICS) developed.

6.6 Dr Hilton concurred with the concerns about ethnic coding, not dissimilar to H&F or NWL, and work was being undertaken to address, for example, the Ethnicity and Mental Health Improvement Programme (EMHIP, page 29 of the report). The intention was to understand the different reasons populations have for coming into contact with mental health services and that support was culturally competent. It was acknowledged that there was little information about older people in the report as the brief was focused on MINT. In addition, dementia services were delivered by a different part of WLT. It was hoped that WLT could develop similar models for older people within the next year and additional investment had been received to support better integration of the older person's experience. Dr Hilton described the organisation of dementia services in H&F and within the WLT, led by Mr Nevil Cheeseman, consultant and clinical director, with oversight of cognitive impairment and dementia services.

6.7 Dr Hilton acknowledged that there was a concern about the significant level of vacancies in the organisation. An increase in new vacancies had been prompted by additional investment, resulting in greater recruitment challenges which were also reflected across the NHS. The Trust hoped to invest in recruitment and grow services. New initiatives included apprenticeship routes into nursing and identifying new roles such as peer support workers and graduate mental health workers, who were often psychology graduates seeking a career in mental health. Overseas recruitment was another initiative and these formed part of a collective approach to improve recruitment and retain staff. Commenting on the interface between GP and hospitals, Dr Hilton agreed that were concerns about this. Declaring his clinical interest as a consultant liaison psychiatry, Dr Hilton explained that he saw patients in a general hospital setting. There were a number of structures with NWL's acute hospitals such as the NWL Urgent Care Board for Mental Health, which monitored mental health presentations across A&E departments. The Board also monitored the use of alternative pathways, including those provided by MIND.

6.8 Jim Grealy welcomed Dr Hilton's response but pointed out that colleagues who regularly attended meetings of the NWL clinical commissioning group (CCG) meetings reported that reports on mental health were not considered and enquired how this might be addressed within the implementation of the ICS. Dr Hilton agreed that mental health services should be well represented within the ICS and was concerned that reports might not be reaching the Board, which he agreed to follow this up with Carolyn Regan, Chief Executive

Officer, WLT. It was confirmed that information was being provided to the ICS executive team.

6.9 Jo Baty reported that she had been working with Peggy Coles, H&F Dementia Action, to deliver dementia friend sessions across the Adult Social Care department and the wider council. One new social worker, (within the mental health team) was unclear as to dementia pathways, where it sat within their sphere of work and how it connected to MINT. It was clear that further work was required to raise the profile of dementia and this was an opportunity to undertake joint workforce development with WLT.

6.10 Councillor Lloyd-Harris enquired about service pathways and the response times and whether this was consistent with times reported by other trust providers, depending on an individual's episodic experience and treatment pathway and the follow up contact they might receive. Dr Hilton explained that there were two key pieces of information about this and the first was referenced page 24 of the report. There were a number of different pathways, including the 4 to 24 hours crises team and the MINT service, which responded within a routine response time of one day or up to 28 days, standardised and measured against national response time targets. The implementation of response time standards was a recent introduction for mental health services to ensure greater accountability. A third response time indicator was a waiting time of up to three months for a routine appointment which the Trust aimed to reduce to one month. This was a challenging target that reflected work in progress, given the increased ratio of referrals to discharges. This was being monitored and measures had been implemented to ensure timely and adequate triaging and assessment. In response to a follow up query, Dr Hilton explained that the programme was modelled on the level of approximate demand expected, with a forecast that would reduce following the transition period (pandemic related) and which was informed by the Trusts staffing model. An added difficulty was the current number of staff vacancies which compounded the issue.

6.11 Merrill Hammer, HAFSON, thanked Dr Hilton for the report which raised a number of further questions. This was the beginning of genuine dialogue and engagement which she found very helpful. One particular concern was the separation of older people from those that were employed, which was regarded as an unhelpful dichotomy. While it was accepted that the SPA was not part of MINT, this remained an area that lacked clarity, particularly around the awareness of what was available and how this data was collected, analysed and applied in modelling the service. Dr Hilton indicated his agreement to a future report and welcomed opportunities to engage with HAFSON and the committee. There were concerns about the use of a broad, ethnic coding framework and how further refinement of the categories would better inform mental health services so that these could be more responsive.

6.12 Helen Mangan responded to points about the SPA and ethnic coding which she acknowledged was blunt and not good enough. It was possible to provide data on the total number of calls but this lacked contextual details about the calls. A detailed review of telephony services was currently underway with a view to upgrading existing provision. At the same time as a review of the

functionality of the service, the review would also examine the functions of the workforce underpinning the service. It was noted that there was a distinction between different functions and that these need to be separated out more clearly, for example, a dedicated crises line, and another helpline which facilitated therapeutic interventions. Dr Hilton added that the services were being further developed to include an older people's pathway within MINT and the further engagement that had been discussed. While this was not dissimilar to the one used within the council, Dr Hilton agreed that a further refinement of the ethnic coding categories was warranted.

6.13 Co-optee Lucia Boddington sought further clarification around waiting times (up to 90 days in some cases) and whether there was a correlation with staff shortages or increased demand. She enquired when the Trust envisaged that they would to be able to meet the 28 day target and if there was a fast track pathway, querying if there was a process of identifying urgent referrals or those that present through the SPA. She also asked how quickly people would be discharged from MINT, and the length of time it would take to be re-referred. Dr Hilton explained that the target of 28 days had not been possible for some time and was regarded as a 'new' target that they hoped to meet. The target of 90 days was in place but Dr Hilton acknowledged that some wait times exceeded this. Extensive work was required to meet the 28 day target but it was deliverable within the available resources. In respect of the assessment process, Dr Hilton explained that there were at least three steps in the initial assessment: triage and how the patient had been referred, followed by clinical contact with either the referrer or the individual to understand their current presentation and any psychiatric history; and a risk of self-harm assessment and whether their mental health condition was likely to deteriorate. This information would indicate whether a crises or routine intervention was required. There were mechanisms in place to support individuals where the condition deteriorated and tools to help guide triaging and decision making. Discharge times would vary according to patient need but some people remained in the service for a long time. The benefit of MINT meant that it could respond to the needs of both short and long term patients.

6.14 Dr Hilton clarified that the CAMHs (Children and adolescent mental health service) to adult mental health services was a separate, national piece of work around transitions services for young people aged 16-25 years which WLT was involved with and that co-production work with this cohort across NWL had been undertaken.

6.15 Carleen Duffy enquired whether how a discharge process was managed where the patient was homeless and how they might be readmitted if in crises. Dr Hilton confirmed that there were strict protocols that the Trust adhered to, which ensured that individuals who were homeless received the support they were entitled to, based on any details linked to their last known address and where they had presented. The mental health trusts across London were part of a compact with agreement about the support provided to this cohort with targeted investment to support rough sleepers.

6.16 Councillor Coleman welcomed the report and the Trust's positive efforts in providing information. In response to a number of questions, Dr Hilton

welcomed the suggestion to identify a date by which the 28 day target might be achievable aspiration, given Councillor Coleman's concern about a 90 day waiting time, in some cases. On the issue of mapping demand, Dr Hilton responded that provision had been based on demand projection data from multiple sources, but he welcomed a suggestion for further joint work with the ICP and the council's Business Intelligence Unit to collectively analyse data, including the Joint Strategic Needs Assessments (JNSA) policy. The work around transition services was welcomed and it was noted that this had this information had not been requested as part of the brief for the report.

6.17 On a final point, Councillor Coleman questioned the government's formula for calculating the registered population, given that the actual population figure for H&F was 190,000. The differential had significant implications for resourcing for the borough across range of areas. In terms of demand projections, it was expected that this would be impacted by Covid and modelling of the MINT was being developed to include monitoring data from the SPA. The suggestion of a mystery shopping exercise was welcomed and an offer from Healthwatch to support this was also welcomed, together with further engagement with Dementia UK and the input of Peggy Coles and the council. Referencing page 26 of the report in the context of denominators for vaccination, Dr Hilton noted that the figure provided as the registered population by the CCG was 341,178 and that this incorporated the patient numbers for GP at Hand (Babylon). A large portion of this number would affect the figures given as open to WLT mental health services (7461), and of which were adults age of 18 years (6538). Most of the MINT services were for residents rather than GP registered patients.

6.18 Jim Grealy referred to the immense work undertaken to date on the co-production of services for people with disabilities and one of the groups most affected by the pandemic and mental health pressures. He asked how closely WLT was working to co-produced tailored provision with the borough's mental health team and across neighbouring boroughs, and the extent to which this would form part of the framework of the MINT pathway. Dr Hilton responded that there was insufficient engagement with disabled groups and welcomed opportunities to have conversations with the disabled community, facilitated through the ICP mental health campaign, and the council's co-production network of contacts. Jo Baty added that, together with Helen Mangan, they aimed to develop a consistent approach to co-production and engagement, through the mental health campaign and across the ICP and build on the work of the council's Disability Commission, and Dementia Strategy. The importance of having diverse conversations with communities that were often furthest away from decision making was noted.

ACTIONS:

Please see the attached appendix for a list of the actions.

RESOLVED

That report, comments and actions were noted.

7. MEDIUM TERM FINANCIAL STRATEGY 2022/23

7.1 Councillor Richardson reported that there was a minor amendment to the papers to replace appendix 2 of the report. Emily Hill provided a corporate overview to the Medium Term Financial Strategy 2022/23 (MTFS) within the context of government policy. The borough had seen a funding reduction in real terms since 2010, with about 20% less lower funding overall, although social care demand had increased exponentially. The 2021 autumn spending review implemented changes to local government public spending anticipated within the next three to four years. Greater efficiency savings were required, identifying and eliminating waste to protect service provision. The amount that could be saved without impacting on services was rapidly shrinking as efficiencies became increasingly difficult to identify.

7.2 A one off government grant allocation of £6 million was an additional investment to compensate for the increase in national insurance. An added concern was the increase in inflation, most recently at 5% which added further cost pressures, particularly impacted by Covid-19. Over arching corporate concerns included Covid recovery and how this was likely to develop, regardless of covid restrictions, demand or potential variants. In addition to inflationary increases, Brexit remained a concern together with wider economic developments, future local government financial and levelling up reforms which were likely to be detrimental to London.

Lisa Redfern highlighted key Adult Social Care (ASC) achievements and despite another difficult year, frontline services would continue to be delivered, and within a balanced budget. The volume of demand was significant and the department continued to maintain its vision to compassionately support residents. Home care services and the direct payment scheme supported over 2000 residents, including older and disabled people. The Meals and A Chat (previously Meals on Wheels) service model had been refreshed to help address social isolation and loneliness. ASC also worked preventively with residents, with the support of CAN (Community Aid Network) volunteers. Other compassionate, financial decisions included no increase to Careline charges and paying contractors and sub-contractors a London living wage. A decision to close care and residential homes had actively helped to protect vulnerable residents. The council had also been an early adopter of lateral flow testing and had ensured that isolating care staff had received financial support. Workforce development had considered how demand could be better managed working closely with care home providers, helping to prevent delayed discharges. Whole systems working between social and primary care colleagues had shaped and improved reablement practices, working with providers to actively support residents.

7.3 The department consistently sought innovative ways in which residents could be supported and services protected, such as using Amazon to order community equipment to be sent to residents quickly. Better value and efficient service delivery were key hallmarks of innovative provision that included strong leadership and workforce sustainability practices to effectively manage services. The River Court short break service dealing with high

needs cases had achieved a third, “outstanding” Care Quality Commission (CQC) rating, which was a significant achievement, as had the reablement service, which had also been categorised as “outstanding”. To provide context, this had been critical in nurturing a high performance of hospital discharges, despite the high volume of pandemic cases. During the December-January period, up to 400 people across North West London had been discharged per day, including many with high and complex needs. The pressure on beds caused by the pandemic had a corresponding effect with rapid and phenomenal discharge rates. The multi-agency safeguarding hub was functioning very well, triaging safeguarding referrals which allowed them to be effectively dealt with in a timely manner.

7.4 Challenges were highlighted and in line with corporate concerns. A new white parliamentary white paper, People at the Heart of Care: adult social care reform, December 2021 did little to address the social care funding crisis. The fragility of social care funding had been further exposed by Covid-19 and Lisa Redfern advocated for parity of funding for social care. The first year of the pandemic had seen a number of care home provider closures highlighting the fragility of the care market and reflecting a national pattern. Locally, there was less reliance on care homes as many H&F residents preferred to be supported in their own homes. As alluded to by Emily Hill, the department was finding it harder each year to identify savings, against a backdrop of increased demographic and demand pressures, and the growing cost of transition services from children’s to adult services.

7.5 Prakash Daryanani provided technical details underpinning the social care spending plans for 2022/23. Approval of the gross social care budget of £95.6 million was anticipated in February 2022, in line with the council’s budget strategy. This an increased investment on the previous year in response to the challenges and pressures being experienced in social care. Appendix 1a of the report outlined a planned expenditure schedule for the additional £5.5 million. Demographic pressures and learning disabled transitioning cases were a significant cost pressure in terms of market management and inflationary costs, including cost of living increases. A planned £67.58 (71%) million of the budget spend was apportioned to care homes or direct payments. Approximately 85% of the total budget directly supported services, with about 9% on management and frontline social care staff. The department was now supporting significantly more residents than in previous years as residents were being discharged from hospital with greater acuity of need. This coupled with the need to pay the London Living Wage to residential care and nursing home staff and increased market unit costs represented significant financial challenges. There had been a slight increase in direct payments, attributed to the council’s strategic policy to increase the number of residents in receipt of direct payments as this offered greater independence and control.

7.6 Dr Nicola Lang outlined the council’s Public Health Covid-19 response during waves 1 and 2. The council’s agile decision to implement testing in care homes was the first nationally in April 2020, followed by staff testing in May 2020. This innovative and ground-breaking partnership approach was replicated in other areas which fostered closer links between health and

social care. The borough was also the first in London to adopt lateral flow testing. Working in partnership with environmental health colleagues, the approach had also helped to influence a change in prisons policy, persuading the Ministry of Justice to replicate Covid-19 testing in care homes. An innovative H&F decision to appoint an infection control clinician in a senior role ensured that social care was better able to represent the community voice in discussions with health colleagues.

7.7 In terms Public Health finances, Prakash Daryanani explained that the 2022/23 grant was likely to include an inflationary increase (reported in the October 2021 local government spending review) with an additional grant allocation to be used for public health priorities. Efficiency savings of £170k had been identified (Appendix 1b) but much of this would be reinvested in public health to protect resources. Schemes to address food poverty, promotion of healthy eating, and an increase during the summer in substance misuse would receive reinvested resources. The Public Health budget was £22.6 million, allocated across a range of different services protecting children and families delivered by different council departments providing public health outcomes. The entire budget was fully grant funded so did not include council taxpayer funding.

7.8 Councillor Richardson welcomed the report and commended the work of reablement services and River Court for their outstanding CQC recognition. Councillor Richardson also thanked officers for their continued commitment to the residents of H&F, their tenacity, good sense and compassion in responding to the pandemic.

7.9 Councillor Jonathan Caleb-Landy echoed Councillor Richardson's heartfelt words. He sought further details about the cost savings in relation to employees and planned efficiencies in response to austerity. Lisa Redfern responded that social care had borne the brunt of nationally imposed financial cuts over the past decade since austerity was introduced. There was an obligation and responsibility on senior officers to reform and improve care through innovation and modern reforms without curtailing services. They had explored different ways of working, such as working with the CAN volunteers, with a mix of unqualified volunteers working with frontline staff. The use of digital services was being explored to maintain contact time with residents who have complex needs. It was recognised that simple equipment purchases through an online provider like Amazon could meet day to day, basic needs. Better efficiencies could also be obtained around health commissioning and contracting, and finally, an outstanding reablement service ensured that residents were encouraged to maintain their independence rather than cutting services and help to avoid longer term dependency on care. Prakash Daryanani endorsed the response and added that much of the work built on what had already been achieved. However, much could be done in utilising digital skills in response to service demand, through better leadership and management.

7.10 Councillor Caleb-Landy welcomed the responses and commended the desire to maintain ruthless efficiency in spending while maintaining and improving primary services, in a challenging financial environment. He agreed that

social care was an area that required greater funding and enquired if there was a government plan for delivering social care within the next three years. In terms of social care funding Lisa Redfern responded that there was currently no solution. Referencing a recent presentation to John Jackson, a former director of adult social services and accountant, she explained his view that that the financial position for social services was bleak and likely to deteriorate further. There were expectations about white paper, People at the heart of care which had not materialised but currently, at least the residents of H&F were not required to pay for their home care direct payment, or anything else that supported their quality of life or independent living.

7.11 Unfortunately, this was not replicated nationally at this time and Councillor Coleman predicted that in three years' time, any additional allocation will be passed to the NHS. Currently, H&F was supporting residents in their own homes, ensuring that they avoided admission or readmission into hospital, and which was a cost saving to the NHS. Councillor Coleman urged the NHS to reflect on areas of work by social care which was being provided more efficiently and effectively than the NHS, currently.

7.12 Councillor Richardson reflected on the stark picture presented by officers, recognising that the government a faced a compelling obligation to support the most vulnerable in the community through social care. She enquired if all the covid-19 funding allocated to H&F had been received, and if Covid-19 related expenditure had been recouped. Prakash Daryanani explained that there had been a range of government grants and some funding received via the 'hospital' process which required a detailed monthly returns report. However, the initial funding allocations had been received and reimbursed to providers, in line with regulations. A further £7 million in Covid-19 related support would be allocated until the end of the financial year with no expectation that further funds would be made available post-April. Emily Hill added that it had been a particularly difficult time for social care to manage specific grants that were passported through to social care providers. The council had also received Covid-19 grant funds which had covered additional Covid-19 related costs but had not been fully compensated for income losses from the government scheme. It was confirmed that there was no Covid-19 funding planned post April.

7.13 Councillor Richardson commented that granularity around the continued problems relating to the provision of NHS healthcare for people with complex, high needs and how their care was funding was a concern and this was confirmed by Lisa Redfern. It was a monthly struggle to ensure that those eligible for 'free' NHS support to cover all aspects of their care was provided by social care, at a significant cost, which they sought to recoup back from the NHS. This had on occasion warranted strongly worded letters or the threat of legal action and discharge to asses actions were a good example of where the Integrated Care System was seeking to recharge the department and which Lisa Redfern and her colleagues were battling against.

7.14 Councillor Amanda Lloyd-Harris commended the work led by Lisa Redfern and her colleagues in identifying efficiencies across the board and acknowledged the difficulties inherent within this. She commented that there

would need to be efficiencies in other parts of the council, such as gangs unit and enforcement, in order to support social care provision to meet the needs the of an aging population. Councillor Lloyd-Harris also commended the work of officers, and particularly volunteers during the pandemic and asked whether the connections established through this could continue, and if further outreach to new volunteers could be undertaken. Councillor Lloyd-Harris also concurred that money would not go beyond the NHS to fund social care provision. Lisa Redfern stated that they would try to ensure that volunteering opportunities continue to be utilised and expressions to volunteer were followed up, particularly to help with preventative work. Councillor Lloyd-Harris welcomed this, particularly as she was aware of many, including herself, who had offered qualified support which had unfortunately not been utilised.

7.15 Councillor Coleman welcomed Councillor Lloyd-Harris's agreement on NHS funding but clarified that funding for enforcement and the gang's unit was well spent. Funding had been identified as a consequence of ruthless financial efficiency and resolved issues inherited by administration. Councillor Coleman stated that a strategic and farsighted approach to managing social care services within a limited budget had demonstrated that it was possible to do so without the loss of frontline services. The investment in law enforcement teams was necessary to address residents' concerns about anti-social behaviour, to tackle problem gangs, support victims of crime and those drawn into gang culture. In the brief discussion that followed Councillor Coleman advocated support for this approach, in contrast to Councillor Lloyd-Harris's fundamental viewpoint. Councillor Coleman stated that the police gang's unit was a different provision compared to the council's Children's Services unit, and that the police representation on the council's Health and Wellbeing Board indicated a willingness to engage with the council.

7.16 Councillor Coleman commended public health and social care officers for their significant efforts and commitments supporting the residents of the borough, and in particular, Lisa Redfern, Dr Nicola Lang, Linda Jackson, and also, Prakash Daryanani, Jo Baty, Christopher Nicklin, Roy Morgan, Julius Olu, Phyllis McKenzie, Lee Fernando and many other officers who had done extraordinary work.

ACTION:

Director of social Care to further explore how qualified volunteers could be utilised.

RESOLVED

That the report be noted.

8. WORK PROGRAMME

Councillor Richardson reported that the committee's response to the NWL consultation on palliative care would have to be co-ordinated outside of the meeting as this was due on 23 February 2022 (date subject to confirmation by

the CCG). Merrill Hammer reported that a wide range of consultation and engagement activities had been arranged and subsequently cancelled, which may require an adjustment of the consultation timetable.

9. DATES OF FUTURE MEETINGS

Wednesday, 20 July 2022.

Meeting started: 6.30pm
Meeting ended: 9.10pm

Chair .....

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