London Borough of Hammersmith & Fulham

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

Minutes

Tuesday 7 October 2014

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Hannah Barlow, Andrew Brown, Joe Carlebach and Elaine Chumnery

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

Other Councillors: Sue Fennimore and Vivienne Lukey

Witnesses: Daphine Aikens (H&F Foodbank) and Simi Ryatt (H&F CAB)

H&F CCG: Daniel Elkeles (Chief Operating Officer), Dr Tim Spicer (Chair) and Dr Susan McGoldrick (Vice-chair)

Imperial Healthcare Trust: Dr Tracey Batten (Chief Executive), Professor Chris Harrison (Medical Director). Steve McManus (Chief Operating Officer) and Professor Tim Orchard (Director, Clinical Division for Medicine)

Officers: Hitesh Jolapara (Bi-borough Director for Finance), Sue Perrin (Committee Co-ordinator), Sue Spiller (Head of Community Investment) and Rachel Wigley (Tri-borough Director of Finance, Adult Social Care)

13. MINUTES OF THE PREVIOUS MEETING AND ACTIONS

The minutes of the meeting held on 22 July 2014 were approved as an accurate record and signed by the Chair, subject to the following amendment:

2. Declarations of Interest: First paragraph, second sentence should read Councillor **Lukey** declared an interest as Chair of Hammersmith & Fulham MIND.

14. APOLOGIES FOR ABSENCE

There were no apologies for absence.

15. DECLARATION OF INTEREST

Councillor Joe Carlebach declared an interest as a: Trustee of Arthritis Research UK, which is a landholder at Charing Cross hospital site; a non-executive director of the Royal Orthopaedic Hospital Trust; Member of Court, Newcastle University.

16. HAMMERSMITH & FULHAM FOODBANK

The Chair introduced the item by reference to the administration's pledge to support foodbanks in its manifesto and specifically to:

- Support local food banks and take measures to sort out the causes of food poverty
- Make the council sort out its ineffective processes that contribute to food poverty'

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The Chair welcomed the guests who had been invited to provide evidence to the committee, and then asked them to briefly introduce themselves.

Daphine Aikens stated that she had set up and managed Hammersmith & Fulham Foodbank for just over four years. The number of people using the foodbank was increasing each year, and there were many reasons for this.

Simiti Ryatt stated that she had three years' experience as the manager of Hammersmith & Fulham Citizens Advice Bureau (CAB), which issued around 150 foodbank vouchers per year.

Sue Spiller introduced herself as the Head of Community Investment at Hammersmith & Fulham Council, with responsibility for the Council's corporate grant.

Mrs Aikens then outlined the work of the foodbank, which was an independent charity and one of over 400 Trussell Trust foodbanks across the country. There was one full time member of staff (Mrs Aikens) and two part-time members of staff, plus volunteers.

Charities and other organisations referred people in crisis and issued them with a foodbank voucher. There were three distributions a week, two from the Fulham centre and one from the Shepherd's Bush centre. Volunteers welcomed clients and provided a hot drink. Mrs Aikens stressed the welcoming, non-judgemental environment.

Food was provided from stock and a packing list ensured adequate food for a nutritionally balanced diet.

The foodbank could signpost to other agencies including CAB. In Hammersmith & Fulham, a large number of fulfilled vouchers came from Government Job Centre plus, CAB and the local support payments team. Referrals also came from family services and the child protection team.

Data was collected in respect of names, addresses, number of adults and children, ethnicity, age and the nature of the crisis. During the year, food had been provided to 1,724 people and 572 children, a total of some 17,000 meals. Food for ten meals was provided for each request.

The main reasons given were delayed or reduced benefits and low income.

Most food was donated by members of the public via permanent collection points. £300 had recently been spent to maintain the right stock balance.

Ms Spiller stated that most individuals regarded the foodbank as a last resort, and commended the warm and welcoming and non-judgemental environment. The reasons for using the foodbanks were related predominantly to benefit changes and delays, and mainly those received from the DWP. There were specific problems in respect of individuals deemed no longer eligible, as an appeal could take up to six months.

Mrs Aikens then responded to members' queries.

The foodbank had contacted every school in the borough to provide information and hold vouchers. It was suggested that it was worthwhile to repeat this initiative.

The police had refused to hold foodbank vouchers, but had approached the foodbank for help in emergencies. Councillor Carlebach offered to contact the Borough Commander for help.

The foodbank had no direct funding and relied on donations. These could be left at the distribution centres during opening hours, a number of supermarkets, the Halifax Building Society, LBHF libraries and occasionally churches. Tesco gave a 30% top up to donations made at its neighbourhood food collections.

It was suggested that the Council might be able to help with training and support for volunteers and that the data collected could be shared with Council services. Mrs Aikens stated that training for volunteers was provided, guided by the Trussell Trust and this was considered to be effective. Other organisations had been asked to talk to volunteers, for example the Job Centre had given several talks. The data collected was owned by the Trussell Trust, which would need to be consulted in respect of data sharing. Pay day loans had been mentioned by clients, but this was not part of the data collected.

Mrs Aikens was not aware of the reasons why some vouchers were not fulfilled.

A member asked if the foodbank was able to help everyone whom it would like to help. Mrs Aikens responded that the foodbank could help only those who had been issued with a voucher. In addition, some people did not use their vouchers, even though they were in need of food.

Ms Spiller suggested that the Council might be able to help the foodbank in the analysis of data.

In respect of an earlier comment regarding pay day loans, Ms Spiller noted that loans taken against benefits income would not necessarily be pay day loans.

Additional collection points were suggested, possibly at the Town Hall and at schools. It was noted that supermarket collection points had the benefit of being immediate, rather than relying on people remembering to take items to a collection point.

Ms Spiller emphasised the importance of capturing information on why people needed food vouchers. The 'Warm Homes Healthy People' fund provided support for the most vulnerable in their communities during winter, and could include the distribution of food by volunteers.

Ms Ryatt stated that it was important to address the root causes of food poverty, which were benefit delays, low income and unemployment. There was a direct link between income poverty and food poverty. A long term sustainable solution was required, with partnership work co-located, an understanding of how the benefits system worked and services and support structures in place.

Mrs Aikens responded to a query in respect of repeat attenders, that the foodbank provided short term support, and tried to limit to two/three attendances so that people did not become dependent on the foodbank. There was a mechanism for referral to other groups, for example CAB or Age UK.

A member queried the areas of particular need within the borough, and the impact of cultural or linguistics issues. Mrs Aikens responded that she was not aware of any cultural issues and that linguistics was not a major problem. Advice points were situated in Askew Ward, Avonmore & Brook Green, North End, Sands End, Hammersmith Broadway, Shepherds Bush Green and Town. The foodbank would like a base in White City.

The Trussell Trust had piloted schemes in a number of foodbanks to provide nutritional advice on preparing meals.

The Leader confirmed that the Council was committed to supporting the foodbank and to combatting food poverty.

A member queried what the foodbank would like the Council to do. Mrs Aikens responded that she wold like the Council to assist with introductions to more voucher partners; a base in White City; a centrally sited warehouse/storeroom; a housing adviser working with the foodbank; guidance to council offices to use the foodbank; signposting; and parking.

RESOLVED THAT:

The committee endorsed the Council's commitment and recommended that support be directed to the specific aspects identified by Mrs Aikens.

The Leader noted that he agreed with the recommendations and that the Administration would work with the Foodbank to implement them. The PAC could then scrutinise the implementation of the recommendations at a future meeting.

The implications of DWP benefit delays was raised as a matter of concern for residents. Ms Ryatt responded to a query that Universal Credit had been piloted in Hammersmith & Fulham on a limited basis and there was no direct link with food poverty. Employment support allowance was a bigger issue.

The Chair thanked Mrs Aikens, Ms Ryatt and Ms Spiller for their attendance.

17. 2015 MEDIUM TERM FINANCIAL STRATEGY (MFTS) - UPDATE

The committee received a report on the medium Term Financial Strategy forecast. Due to significant and ongoing reductions in funding received by the Council, there would be a budget gap before savings of £24.9 million in 2014/2015, rising to £67.1 million by 2018/2019.

In responses to a query regarding the current cost of servicing the Council's debt, a written response would be sent.

Action: Hitesh Jolapara

Mrs Wigley noted that the Adult Social Care budget was set in the context of a gross expenditure budget for 2014/2015 of £86.9 million. The department had a budgeted to collect income of £22.5 million from health funding contributions from customers and government grants to arrive at a net general fund budget of £64.4 million. Within this amount, £7.2 million was in respect of non-controllable budgets as they were controlled by Corporate Services. The total controllable budget held within the department was £57.1 million.

The report set out the budget split by client group. Savings targets had been allocated to departments in proportion to their net direct expenditure. Adult Social Care had been set a savings target of £6.5 million, rising to £15 million in 2017/2018.

The savings proposals being developed aimed to protect the core services provided to customers. This would be achieved through better alignment of services, enhancing prevention strategies, closer working with health services and more efficient procurement.

A member queried the breakdown of the prevention strategy between health care causes, for example a reduction in stroke related incidents. Mrs Wigley responded that a range of preventative work was being undertaken with the Council's strategic partners, for example work with community independence services to support people to live in their homes longer and transformation work with Public Health colleagues.

A member commented that the gross budget of £35.8 million for residential and nursing placements seemed high and outliers in terms of supervised care. Mrs Wigley responded that a programme was in place to reduce outliers and keep people nearer to home. There was a set contribution from the NHS and people would also make a contribution towards the costs. In addition, Adult Social Care continued to work towards supporting people to remain at home. However, it was likely that those who were admitted to nursing or residential care would need a higher level of support.

A member queried whether the Independent Living Fund would be ring fenced, support for Queensmill School, High Dependency people and commented on agency fees incurred because the Council did not employ directly.

Mrs Wigley responded that the Council was working with other agencies to lobby for ring fencing of the Independent Living Fund. Transition from children to adult services was part of budget preparation work. In respect of agency fees, nothing had been ruled out and Adult Social Care would consider a wide range of initiatives, including a new homecare contract and would not necessarily accept the lowest bid.

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Councillor Lukey stated that the Council would be looking to investing more quality in contracts, even if resources were less. Quality of homecare was important. Contractors would be asked to pay the living wage. There was one contract with zero hours and this was coming to an end. 15 minute visits would be stopped through the qualification criteria.

A member commented that the integration of health and social care would produce considerable savings, yet there would be more dependency on social care to help people remain at home.

Councillor Lukey noted that the Better Care Fund was a major piece of work and the main plank of the community independence service. Savings in non-elective admissions was at the forefront of what health and social care were trying to achieve.

RESOLVED THAT:

The report was noted.

18. HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP/IMPERIAL COLLEGE HEALTHCARE TRUST

The Chair welcomed senior managers and clinicians from Imperial College Healthcare Trust (the trust) and Hammersmith & Fulham Clinical Commissioning Group (CCG).

Mr McManus updated on the closure of Hammersmith Hospital Emergency Unit, which had taken place from 9am on Wednesday 10 September 2014 and the Assurance Framework.

The Urgent Care Centre (UCC) at Hammersmith Hospital had expanded to be open 24 hours a day, seven days a week. The UCC provided direct access to GPs for minor illnesses and injuries, that were urgent but not life threatening. Anyone who self-presented at Hammersmith Hospital and was found to have a serious condition would receive immediate care and be transferred by the London Ambulance Service to the A&E or specialist unit most suitable for their health needs. Patients suspected of having a heart attack would continue to be taken straight to Hammersmith Hospital.

There had been an increase in activity, with some volatile peaks, for which the trust was looking to provide capacity. The waiting time target had been missed in the first two weeks, at 94.35% and 94.68% respectively, but had recovered at 95.2% in the third week.

Whilst it was anticipated that most of the patients who would previously have been treated in Hammersmith Hospital's A&E would now go to St. Mary's Hospital's A&E, capacity at Charing Cross Hospital's A&E had also been expanded. The report set out the changes implemented at both the St. Mary's Hospital site and Charing Cross Hospital site.

Members raised concerns in respect of the treatment of children in addition to adults at the UCC, Hammersmith Hospital, and the lack of paediatric trained clinicians. Dr Spicer responded that there was a standard specification for UCCs across the whole of North West London and the CCG had issued appropriate guidelines and processes in respect of children, which were monitored carefully. 167 children had been seen in the month before the closure of the A&E department and 220 in the month after closure, of which one child had been transferred out of Hammersmith UCC.

The UCC was a primary care facility equipped to see patients in a GP setting, with additional back up in the hospital. It provided much safer care for children, with trained paediatric doctors.

Members were concerned that there was not adequate back up at Hammersmith Hospital and that children would be conveyed by ambulance across North West London. Dr McGoldrick responded that the UCCs at Hammersmith and Charing Cross had been open and treating children for a

number of years There were trained anaesthetists on site and the paediatric pathway was more robust than before the A&E closure. The CCG did not encourage people to take seriously ill children to the UCC.

A member commented that the onus should be on the paediatrician to decide if a child was seriously ill and refer to a centre of excellence at either St. Mary's or Chelsea and Westminster Hospital.

Members asked how waiting times at Charing Cross and Hammersmith Hospitals compared with previous waiting times. Mr McManus responded that waiting times for type 3 attendances had been maintained in excess of the 95% performance standard.

The Chair noted the 'red' rating in respect of the assumptions/modelling to assess performance trajectories (A&E four hour target) on surrounding A&Es and asked for assurance that the trust would continue to meet the 95% target.

Mr McManus responded that the 95% target would be maintained, although it had been missed twice at St.Mary's Hospital. The volatility of attendances had resulted in significant additional patients at some times on some days. The trust was recruiting additional staff to cover these peak periods. Mr McManus stated that it was confident of achieving and sustaining the 95% target.

Mr McManus responded to a query that the data had been interrogated for time of attendance, nature of visit and age profile. The findings gave a difference between the busiest and quietest period of 95 people.

A member queried the half an hour waiting time target of in respect of an ambulance delivery into a department. Mr McManus confirmed that the waiting times were being recorded and that some people had waited longer than half an hour. The trust was working to meet this target and would continue to monitor.

A member queried the trust's ability to cope in an emergency and with for example Ebola cases. Mr Elceles responded that this was included in the assurance framework. NHS England was responsible for emergency resilience. Ebola cases were treated in the specialist unit at the Royal Free Hospital.

Mr Elkeles stated that he had a daily telephone call with trusts and the Ambulance Service to review the previous 24 hours.

A member commented that Ebola was hugely resource intensive and that the Royal Free would not be able to manage all contacts. Mr McManus responded that the trust's emergency incident programme was well tried and tested, with specific protocols in place. The processes, which would isolate cases from the rest of the hospital, had been tested with the infection control team.

Mr Macmanus agreed to provide information in respect of flu vaccination rates for staff.

Action: Imperial College Healthcare Trust.

A member queried the Communications and Engagement Plan and stated that there had been no engagement with the Old Oak Estate community centre.

Action:

Information in respect of community engagement to be resent.

Action: Committee Co-ordinator.

Engagement with Old Oak Estate Community Centre to be actioned.

Action: Shaping a Healthier Future

Mr Elkeles responded that there had been a major public awareness campaign to ensure that local people knew where to access healthcare urgently or in an emergency and there had been a number of focus groups. The number of people attending Hammersmith Hospital UCC had not decreased. They were not going to St. Mary's Hospital. A small number of people had been transferred, indicating that people were making good judgements about where to go.

There were some 650 weekly attendances at the UCC, with 580/600 being treated and discharged and approximately 8% referred. There had been two emergency transfers by ambulance and a total of eight transfers in three weeks from Hammersmith Hospital UCC to an A&E department.

A member suggested that the 95% waiting target was not a proper measure of activity, and that outcomes would be a better measure. It was noted that the trust had the third best mortality rate in the country. Dr Spicer responded that the length of time people waited to be seen and treated could bring about some deterioration in their condition.

A member queried consultant availability for emergencies. Dr Spicer responded that consultants were on site until 10pm. Two consultants were being recruited to provide a service from midnight and consultants would stay late where necessary. Children would be treated by doctors trained in emergency medicine.

A member suggested that there would be further closures/changes throughout North West London, and that careful monitoring was needed. Demand for health services was rising at the same time as capacity was being reduced.

Members queried progress in respect of the Clinical Strategy. Dr Batten responded that, at the July meeting, the Trust's board of directors had approved the clinical strategy. An outline business case (OBC) had been sent to the CCGs. An overall implementation business case would be put together for North West London.

Mr Elkeles added that the finance required was £1.1billion. OBCs had to be approved by the CCGs and providers by mid-November, for submission to NHS England and the NHS Trust Development Authority in January 2015. The final decision would be taken by the Department of Health.

Mr Elkeles confirmed that the OBC would be in the public domain, although some information would be commercially in confidence.

Mr Elkeles responded to a query that, of the £1.1 billion, £0,4 million was in respect of Imperial College Healthcare. Members noted the need to invest in GPs and out of hospital care, as well as all hospitals.

A member queried engagement with Arthritis Research UK, which was a landowner at the Charing Cross Hospital site. Dr Batten responded that there were a number of stakeholders and the trust would be engaging with all stakeholders later in the process.

A member queried the inclusion of an emergency centre at Charing Cross Hospital (as stated in the trust's written report to the committee). Dr Batten responded that this wording was confusing, and that the Keogh review included the use of consistent language across the country. Charring Cross Hospital would have emergency services appropriate to a local hospital. The exact services would be set out in the OBC at the end of 2014/2015. Approval of the full business case (FBC) was scheduled for the end of 2015/2016. The main construction would start at the beginning of 2016/2017 and take four years to the end of 2019/20.

A member commented on the challenges in respect of the infrastructure at Hammersmith Hospital. Most of the estate was over 100 years old and not fit for patient experience and queried whether the additional people moving into the area as a consequence of the Mayoral Development Corporation regeneration of Old Oak Common had been included.

Dr Batten responded that the OBC included a £10 million development at Hammersmith Hospital and that a master plan for the site was being developed with Imperial College. Projected population changes would be factored in to the FBC.

A member referred to patient outcomes and significant issues between GP practices and the acute sector, and the importance of a seamless transition and support in the community. Dr McGoldrick responded that the CCG was working with providers to improve communications both ways, and improvements had been made.

Dr Spicer added that staff training was being provided in GP practices and that additional health checks were being offered to vulnerable people. The Better Care Fund would help support people to live independently in the community.

A member asked Dr Spicer to describe an emergency department in a local hospital. Dr Spicer responded that the description would be clarified by the Keogh Review. When pressed for his personal opinion, Dr Spicer responded that a local hospital would provide rapid access for frail and elderly people. It would undertake assessments and provide care plans to help people remain in the community. It would bridge the gap between primary and secondary care, and there would be an out-patient department.

An UCC was led by primary care, whereas an emergency unit would also have secondary care specialists, who would undertake assessments and management of patients.

The Chair suggested that the emergency centre at Charing Cross Hospital would be a GP led facility. Dr Spicer responded that the emergency centre would be a combination of primary and secondary consultants and all grades of clinical staff designed to break down separation between primary and secondary care. The co-location of clinicians, working together would provide a coherent response to the needs of patients.

The Chair queried whether this meant a video conference with consultants on other sites. Dr Spicer responded that the whole of a local hospital would be led by primary care physicians, but a patient receiving care could be managed by either a primary or secondary physician. Complex needs would be managed as appropriate.

The Chair emphasised the importance of clarity. The strategy differed from that brought to the previous meeting. The trust should communicate precisely what services would be provided on the Charing Cross Hospital site.

The Leader stated that different classifications caused confusion and queried whether the confusion around category 1,2 and 3 patients had put lives at risk.

Professor Harrison responded that the Keogh Review would clarify and provide a specification, with which the trust could work. He was not aware of any lives being lost as a consequence of the different categories. Dr Spicer stated that he was also unaware of any lives lost as a consequence of the different categories. In respect of a specific question regarding the Barnet & Chase Farm A&E closure and Serious Incident Investigation over a child death, he did not have a medical opinion.

Mr Elkeles stated that the categories were an internal NHS classification, not advertised to the public. In respect of Chase Farm, the UCC was not open. If the UCC had been open, there would have been a better outcome. The learning from this incident was that, all UCCs would be open 24/7.

Hammersmith Hospital had taken the decision to open the UCC 24/7 in the interest of patient safety.

Mr Elkeles clarified that Charing Cross Hospital UCC did not fit into patient categories 1,2 and 3. The type of emergency care for the future was changing and would meet specific needs, rather than medical and clinical purposes. It was not possible to reply further, in advance of national policy. There were few blue light ambulances in comparison with non-blue light ambulances, some of which would go to a UCC.

The Leader queried the decision to wait for the Keogh review. The decision had been made by the Secretary of State in 2013, and the business case for implementation should have been written at that stage.

The Leader suggested that the changes should be deferred until after the forthcoming election, when the NHS could ask for an electoral mandate to implement the proposals, which were highly controversial. Lives were being put at risk with different A&E categories. The Leader stated that the proposals had been rejected by the public and he urged the NHS to defer agreement of the business plan until after the election. In May, the Secretary of State had agreed that there would be a fully functioning emergency department at Charing Cross. There needed to be clarity as to what the public could understand by this.

The Leader commented that there had been 16 meetings of the trust board since the Shaping a Healthier Future proposals had been approved but the proposals had been discussed at only nine of these meetings and queried the level of governance. Dr Batten responded that, in addition to the bi-monthly trust board meetings, there were private workshops and strategic service reviews. A written response in respect of the board level meetings at which the proposals had been discussed would be provided.

Action: Imperial College Healthcare Trust

The Leader raised concerns that the trust did not have adequate control of its expenditure. Dr Batten responded that the first few months had been challenging and it had been important to maintain quality of care. In the year to date the trust was showing a small surplus and this was a key priority for all executive directors.

The Chair proposed, and it was agreed by the Committee, that the guillotine be extended to 10.15pm.

The Leader then referred to the closure of ICU beds. Dr Batten responded that the beds had not been shut, but the classification for some of these beds had been changed to HDU. A range of strategies had been put in place to control expenditure and the Medical Director and Nurse Director had initiated a risk rating for any which impacted on patient care. Dr Batten stated that the cost improvements focused on non- direct patient care, on for example, salaries and wages, reduction in bank and agency staff, cross cutting

strategies to use resources more effectively and more effective procurement through joint purchasing with other trusts.

The Leader queried the status of the foundation trust application. Dr Batten responded that the Care Quality Commission report would be available at the end of November/beginning of December. A good outcome would mean that the trust could proceed to the next stage of the process, at which financial stability would be considered. The trust would not be able to proceed with its application if it could prove financial stability. Dr Batten stated that the Director of Finance and the Investment Committee had actions in place to bring the trust back to a stable position.

The Leader queried whether there had been a review of systems and processes. Dr Batten responded that the foundation trust process had a number of assurance steps, including governance, quality systems and financial performance. This information had been verified by independent consultants who would re-assess at a later stage. Dr Batten would check if this information was in the public domain.

Action: Imperial College Healthcare Trust

Mr Slaughter, MP raised concerns in respect of the trust's performance, confusion as to which service people should use, and whether the same level of service would be received at Hammersmith UCC.

Mr McManus responded that performance information had been provided to the committee. The number of patients being seen in Hammersmith UCC and having to be transferred was being monitored. Mr McManus stated that this information would be shared. The 'dashboard' would be included in the quarterly CCG performance report.

Mr McManus stated that there were no plans to close the A&E department at Charing Cross Hospital.

Dr Batten responded to the comment that the proposals were substantially different from the previous proposals, that the clinical strategy was consistent with all public consultation undertaken by Shaping a Healthier Future in 2012/2013.

The Chair concluded the discussion by stating that the exact proposals needed to be communicated and together with the outline business case, be brought back to the committee. The current proposals were dramatically different from the original Shaping A Healthier Future proposals and there should be full public consultation, and the decision on the outline business case should not be made until after the General Election.

The committee voted on the recommendation that there should be full public consultation on the current proposals and that a decision on the outline business case should be deferred until after the General Election:

For: 4

Abstain: 1

RESOLVED THAT:

The committee recommended that there should be full public consultation on the current proposals. and that a decision on the outline business case should be deferred until after the General Election

19. WORK PROGRAMME

RESOLVED THAT;

The work programme be noted.

20. DATES OF FUTURE MEETINGS

17 November 2014

3 December 2014

January 2015 (date to be confirmed)

4 February 2015

13 April 2015

Meeting started: 7.00 pm
Meeting ended: 10.15 pm

Chairman .....

Contact officer: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk