Minutes of the Meeting of the Adult Social Care & Health Select Committee held in Committee Room 1, Kensington Town Hall W8 7NX at 6.30 pm on Thursday, 29 June 2023

PRESENT

Committee Members

Cllr Lucy Knight (Chair)
Cllr Anne Cyron (Vice-Chair)
Cllr Mona Ahmed, Deputy Leader, K+C Labour Group
Cllr Gerard Hargreaves, (Chair, Audit & Transparency Committee, Vice-Chair, Planning Committee & Planning Applications Committee)
Cllr Sam Mackover
Danni O'Connell, Healthwatch Service Manager

Others Present

Simon Hope, Borough Director, West London, NHS North West London
Gareth Jarvis, Medical Director
Ann Sheridan, Community Services Manager
Dr Andrew Steeden, Borough Medical Director, West London
Kevin Driscoll, Programme Manager
Lucy Rumbellow, Immunisations and Flu Lead
Cllr Mary Weale, Chair, Overview and Scrutiny Committee

Council Officers

Emily Beard, Governance Officer
James Diamond, Scrutiny & Policy Officer
Bernie Flaherty, Bi-Borough Executive Director of Adult Social Care & Health
Manisha Patel, Director of Adult Social Care Governance Operations
Anna Raleigh, Director of Public Health
Rachel Soni, Director of Health Partnerships
Anna Cox, Senior Public Health Strategist
Seth Mills, Acting Director of Social Care

1 MEMBERSHIP AND CHAIR/VICE-CHAIR

The membership of the Committee and the Chair and Vice-Chair, as agreed at the Council meeting on 24 May, was noted by the Adult Social Care and Health Select Committee.

2 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Stuart Graham and Portia Thaxter.

3 DECLARATIONS OF INTEREST

Cllr Mona Ahmed declared an interest as an employee of the NHS.

4 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meeting held on 2 May 2023 were confirmed as a correct record and signed by the Chair.

It was agreed that the minutes of the meeting held on 24 May 2023 would be signed by the Chair, subject to an amendment to reflect that Cllr. Sam Mackover was in attendance.

5 CHILDHOOD IMMUNISATIONS

The Chair invited Anna Raleigh, Bi-Borough Director of Public Health, to introduce the report and the following points were raised:

1. Noted that Susan Elden (NHS England), who had written the main report, had sent apologies due to unforeseen circumstances.

2. Explained that NHS England commissioned primary care immunisation services and school-based immunisation. There was also a team to coordinate responses to specific diseases.

3. Public health held an oversight function, whereby they looked across the system, identified challenges and brought people together to respond.

4. There had been some improvement in uptake recently, but the Council was among 25% lowest (13th lowest) in England. There were a significant number of children that remained unvaccinated or that were missing one vaccine.

5. There was significant geographical variation in uptake across the borough, with a lot of children following foreign vaccine schedules.

Kevin Driscoll, Programme Director, was then invited by the Chair to introduce the report and shared the following points with the Committee:

1. There were a number of measles cases confirmed recently across five boroughs in North West London, but there were no confirmed cases in the tri-borough (Kensington and Chelsea, Westminster and Hammersmith and Fulham). There was a plan focused on supporting the uptake of mumps, measles and rubella and polio immunisations.

2. The plan included focus on three areas: school-based delivery, enhancing primary care, and the outreach model. School-based delivery work, provided by Central North West London NHS Foundation Trust, was focused on areas with low uptake of vaccination. The primary care work included making contact (at least three attempts) with parents who had children that were unvaccinated or partially vaccinated.

Following the introductions, the Chair invited the Committee to ask questions and the following points were raised in the discussion:

1. Queried why the Council was the worst performing borough in North West London regarding immunisation uptake, and asked how those involved were removing barriers. Andrew Steeden explained that this had been an issue for some time, and it was difficult due to the transient nature of parts of the population and population mobility. Both Kensington and Chelsea and Westminster had been improving and Kensington and Chelsea had been joining some of Westminster's initiatives, such as raising awareness using family hubs and care coordinators. There were no actions to improve immunisation uptake that Kensington and Chelsea was not doing that other boroughs were. The message around immunisations landed differently in each community.

2. Enquired whether contact with parents and reasoning for declining others was recorded. Andrew Steeden shared that a record was kept of offers and whether they were accepted or not, but not of the reason. Anecdotally they had been told reasons such as: following a different regime from a private doctor, receiving vaccinations when they return home, and not convinced by vaccinations. It was also noted that there was still work to be done to remove the claim made between the mumps, measles, and rubella vaccination and autism by Andrew Wakefield. Primary care made sure appointment availability was provided at weekends and after school.

3. Questioned whether there were data on illness rates which could correlate with low vaccination rates. Andrew Steeden and Kevin Driscoll explained that the measles outbreak illustrated this, as most of the cases were from children that were unvaccinated.

4. Asked whether there was longer term data on uptake. Anna Raleigh shared that the data she referred to in her introduction was the most recent annual data (2021 – 2022). The data included in the report was from quarter 3 (2022 – 2023) and quarter 3 were sometimes influenced by the flu vaccination programme. Kevin Driscoll added that no area in England was meeting the World Health Organisation's target of 95%. London was always behind other areas of the country due to the complexities of its population.

5. Enquired about 'ghost' patients and keeping GP lists up to date. Andrew Steeden explained that they tried to keep lists as accurate as possible, however, it was difficult as London experienced a 30% turnover rate per year for GP lists. There was a national programme to contact patients to check they still lived in the area if there was no activity for two to three years.

6. Queried what was being done to address the lack of trust amongst certain groups in the community. Andrew Steeden shared that they held hyperlocal educational events. Community Health and Wellbeing workers worked with small groups in communities to get to know families well and build trust and then tell them about the importance of vaccines. They were currently based in Chelsea Riverside and Colville wards, and other wards in North Kensington. Anna Raleigh added that after a year of Community Health and Wellbeing workers working in areas in Westminster, they were seeing a

higher uptake of immunisation, screening and generally better engagement with health services.

7. The Healthwatch co-optee raised the difficulty of there being a large number of agencies involved, which posed a challenge when directing individuals, and noted the lack of trust they had seen in communities. Anna Raleigh responded that they needed to link Healthwatch to the Immunisations Board. Andrew Steeden shared that all GPs and health professionals involved in care were encouraged to undertake cultural competency training, and Simon Hope told the Committee about the Vibrant and Healthy Communities Programme.

Action by: *Bi-Borough Director of Public Health*

8. Questioned the discrepancy of uptake between Kensington and Chelsea and Westminster, despite having similar populations. Andrew Steeden replied that their performance crossed over each other throughout the year; however, Kensington and Chelsea may be slightly behind overall. Simon Hope added that learning could be copied quickly and make big differences. The Committee asked for uptake data to be shared on a quarterly basis, including the previous quarter and a three-year average including the sample size.

Action by: *Bi-Borough Director of Public Health*

9. Asked how primary care approached situations with those that did not have any historical record of vaccinations. Andrew Steeden explained that they ensured registration with a GP and recorded any general health history. They would receive vaccinations as quickly as possible if not known.

10. Enquired about the effectiveness of the response to the measles outbreak. Kevin Driscoll shared that the outbreak in Hillington occurred a few weeks ago and the plan was shared last week, which they were pushing to implement and deliver. It was expected that the impact would be seen over the coming weeks. They would update the Committee on progress.

Action by: *Programme Director*

11. The Lead Member for Adult Social Care and Health queried whether there was more that could be done in collaboration with schools, especially as a large proportion of the children in the borough used private GPs. Andrew Steeden shared that new codes for vaccines had been developed which allowed more data to be recorded, especially for those with foreign and private records.

Actions to be completed, with information requested by the Committee to be sent to the Governance Officer for circulation:

1. The Bi-Borough Director of Public Health to link Healthwatch with the Immunisations Board.

2. The Bi-Borough Director of Public Health to share with the Committee immunisation uptake data on a quarterly basis, including the previous quarter and a three-year average including the sample size.

3. The Programme Director (NWL ICS) to update the Committee on progress of the response to the measles outbreak in some boroughs of London.

6 UPDATE ON THE GORDON HOSPITAL

At the Chair's invitation, Ann Sheridan, Managing Director, and Gareth Jarvis, Medical Director, introduced the report raising the following points:

1. Central and North West London NHS Foundation Trust (CNWL) had been working closely with the Integrated Care Board (ICB) who were responsible for the consultation on the Gordon Hospital. CNWL were developing a pre-consultation business case and had been running a series of workshops with key partners including councils, service users, carers, the police, acute hospitals, ambulance services, social care, and the voluntary sector. They had been looking at priorities around the future model of care and have created a short list of viable options.

2. CNWL had been looking at the equality impact of options, as well as data and financial implications. The London Clinical Senate were due to provide feedback within the next three weeks on the clinical implications of the proposals.

3. The ICB was due to seek approval to proceed with the consultation from NHS England in September. Until then, CNWL would continue their engagement with staff, users, and families.

The Committee were invited by the Chair to ask questions and Members:

1. Enquired what evidence was available to suggest that patients were receiving better care than before the temporary closure of the beds, as stated in the report on page 41 of the main report. Ann Sheridan explained that data had shown that despite a large number of patients accessing mental health services, only 10% needed an in-patient admission, and of those which did, spent less time in hospital. There would continue to be a need for in-patient beds for people at times, however, the range of alternatives had worked well. Step-down services had helped people to stay well in the community.

2. Queried the definition used for out of area placements. Gareth Jarvis shared that out of area placements were those outside of the CNWL bed system, which was a definition set by NHS England. Out of area placements were around six to eight per month prior to the temporary closure, they then increased during the pandemic, and in the last six months they had been eliminated.

3. Asked what had been learnt from patients directly, either past or current. Ann Sheridan explained that CNWL had been speaking to a range of patients and their families as part of the engagement, including those who had received care at the Gordon Hospital previously. There had been a mixed response from patients, and it was important that the variety of views were included.

4. Questioned how the themes were taken and turned into a consultation and noted that based on the wording in the report, it looked impossible for the beds to be reopened. Gareth Jarvis shared that Verve was running the pre-consultation process and CNWL was facilitating the workshops. The Gordon Hospital was a Victorian building which had been built over 130 years ago for surgery. There were size limitations of what was expected from a modern, mental health ward. In order to have ensuite bathrooms, there was space for no more than 13 beds. There was also an old plumbing system. It would need a large amount of capital investment to refurbish the current site and potentially to need for an additional site. CNWL had conducted a site search and had been unable to find a viable alternative site. Ann Sheridan confirmed that the consultation would include an option to reopen and refurbish the hospital. The community services that had been introduced since the temporary closure would have to stop as that funding would be required for the refurbishment.

5. Clarified whether the definition of better care used by CNWL was care that was least restrictive and kept people out of hospital that did not need to be in hospital. It did not address those that needed to be in hospital in an inpatient bed. Gareth Jarvis replied that least restriction was important to care. A Committee Member queried how long a stay could be in a mental health crisis assessment centre or a crisis house. Gareth Jarvis informed the Committee that prior to the closure, approximately 96 beds per month were needed for the borough's population, whereas now approximately 65 beds were needed as individuals were being diverted at the point of crisis. The average stay in an in-patient bed was 32 days. There were 67 beds at St Charles Hospital which was enough for the demand from the borough's population. The majority of patients that would have gone to the Gordon Hospital were now going to St Charles Hospital, where the facilities were of a high standard. The Chair said it would be helpful for the members to visit the unit at St Charles.

6. Questioned how CNWL had reduced the number of in-patient admissions per month by a third without changing the criteria or threshold for admission. Gareth Jarvis acknowledged that there was still a need for in-patient provision when appropriate, but it had its limits as it was an extremely restrictive and difficult environment. Ann Sheridan added that they had been working with home treatment teams to support people better so that they did not have to come into hospital. The mental health crisis assessment service had a higher staffing ratio than in-patient wards, with medical staff on site at all times. The Committee noted that anecdotally they had heard of residents waiting days or weeks for a bed and would appreciate an invite to visit the services.

Action by: *Governance Services*

7. Raised concern that placements in boroughs, such as Hillingdon, were not considered close to home for Kensington and Chelsea residents. Gareth Jarvis explained that a proportion of cases had to be treated outside of the borough prior to the temporary closure and there remained a small amount of displacement now. They had to operate across the CNWL system.

8. Enquired whether refurbishment of the Gordon Hospital was impossible due to a lack of funding. Gareth Jarvis explained that it would cost £3 million to £5 million of capital funding to upgrade it to minimum safe standards, which would only produce four bathrooms for 18 patients and would be non-viable beyond five years. It would cost £13 million to get it to longer term standards and would produce a maximum of 13 beds. To reach minimum staffing levels, NHS England no longer considered it economically efficient to run a hospital with less than 16 beds. The running costs would be at least £4.5 million. Ann Sheridan added that the only outside space was a caged roof garden, that operated with a rota system. Some patients could be admitted for up to a year and the access to outside space was extremely limited. The Committee asked that the option be phrased with more positive language in the consultation document.

9. Asked about the next steps. Gareth Jarvis informed the Committee that the decision was likely to be taken towards the end of 2023 or early 2024.

10. The Lead Member noted that the beds would have been closed for almost four years once the consultation was over and thus, the decision had essentially been made. The Lead Member also raised the importance of data and questioned that there was no suitable NHS estate available to open beds temporarily whilst the consultation was ongoing. Gareth Jarvis explained that data was difficult to produce, as there were so many agencies involved and there were no nationally set key performance indicators. CNWL had put an appeal out to partners for data. Gareth explained it was challenging to maintain safety and quality in an isolated ward, as staffing levels could easily drop and physical interventions could not be performed.

11. The Committee requested data on detention rates, length of admissions (pre and post closure), failed discharge rates (pre and post closure).

Action by: *CNWL*

The Committee RESOLVED to recommend that Central and North West London NHS Foundation Trust:

1. Ensures that the Pre-Consultation Business Case includes the option of refurbishment and investment at the Gordon Hospital so that modernised inpatient services can be re-opened which meet high-quality standards of care for patients.

2. Ensures the Pre-Consultation Business Case reviews the implications of rising demand for mental health services in Royal Borough of Kensington and Chelsea, what inpatient services will be needed to help meet the mental health needs of Royal Borough of Kensington and Chelsea residents, particularly in the context of the Grenfell tragedy, and commits to commissioning additional acute mental health inpatient provision for Royal Borough Kensington and Chelsea residents as required.

3. Urgently reviews any pressure on services at St Charles Hospital, and wider mental health services in Royal Borough of Kensington and Chelsea, which have resulted since the temporary closure of the Gordon Hospital wards.

Actions to be completed, with information requested by the Committee to be sent to the Governance Officer for circulation:

1. Officers to organise visits for Committee Members to Central and North West London NHS Foundation Trust services at the St Charles Unit.

2. The Managing Director of Jameson Division (CNWL) and the Medical Director of Jameson Division (CNWL) to provide data on detention rates, length of admissions (pre and post closure), failed discharge rates (pre and post closure).

7 DIRECTORATE SCENE-SETTING

Manisha Patel, Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street, introduced the report, highlighting that the Directorate was confident that they would deliver a balanced budget, despite financial pressures and uncertainty from one-off grants.

The Chair invited Committee Members to ask questions and the following points were raised in the discussion:

1. Questioned how the Adult Social Care reforms could affect the Directorate. Manisha Patel informed the Committee that the majority of the reforms had been delayed until 2025, which included the introduction of a lifetime cap for contributions, the fair cost of care, and changes to upper capital limits. The White Paper had limited detail and the Directorate was unclear about the future funding model. Bernie Flaherty, Bi-Borough Executive Director of Adult Social Care & Health, reassured the Committee that the Directorate was ensuring that it had all the funding it was expecting, making sure the markets were strong, and ensuring quality measures were right. The new inspection assurance regime was due to come in by September/October 2023.

2. Questioned about those receiving care out of borough (326 service users). Manisha Patel clarified that they were still residents of Kensington and Chelsea. If they chose to move out of borough and received care there, they were no longer the responsibility of the Council.

3. The Committee requested that a performance summary of the Directorate to be shared on a quarterly basis.

   Action by: Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street

4. The Committee requested information on how commissioning decisions were made, the providers used, and the quality assurance process.

   Action by: *Bi-Borough Director of Integrated Commissioning*

5. Raised concern about the high levels of life expectancy within the borough but also high levels of discrepancy throughout the borough. Anna Raleigh, Bi-Borough Director of Public Health, explained that the borough's population

was diverse and included very affluent residents living alongside very deprived residents. The life expectancy gap had also been increasing nationally.

6. Asked about the benchmark for the data on one in four adults in the borough reporting feeling anxious. Anna Raleigh explained that due to factors such as the Covid-19 pandemic and the cost-of-living crisis, there had been a significant increase in rates of anxiety and depression nationally. There was variation across the borough with children and young people. The Public Health team monitored data on suicide closely and there had been no increase to local data. The Committee requested comparison data on anxiety levels across London boroughs.

Action by: *Bi-Borough Director of Public Health*

7. The Committee asked for information to be provided on actions taken on the Directorate's 2023/24 priorities.

Action by: Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street

Actions to be completed, with information requested by the Committee to be sent to the Governance Officer for circulation:

1. The Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street to share Directorate performance information with the Committee on a quarterly basis.

2. The Bi-Borough Director of Integrated Commissioning to provide information on how commissioning decisions were made, the providers used, and the quality assurance process.

3. The Bi-Borough Director of Public Health to share data on residents reporting feeling anxious across London boroughs.

4. The Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street to provide information on actions taken on the 2023/24 priorities for the Directorate.

8 WORK PROGRAMME REPORT

The Committee confirmed their scrutiny priorities for the 2023/24 municipal year and agreed to develop a detailed work programme.

The Committee noted the actions and responses to recommendations.

9 ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT

The Lead Member informed the Committee that there would be an event held on Thursday, 6 July 2023 at 6pm on mental health with members of the community.

The meeting ended at 8.35 pm

Chair