Notice of Meeting

Adult Social Care & Health Select Committee

Thursday, 12 October 2023 at 6.30 pm

Committee Room 1, Kensington Town Hall W8 7NX

Link to livestream broadcast:
youtube.com/kensingtonandchelsea

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

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Issue Date: Wednesday, 4 October 2023

Chief Executive – Maxine Holdsworth

Membership: Cllr Lucy Knight (Chair), Cllr Anne Cyron (Vice-Chair), Cllr Mona Ahmed, Cllr Stuart Graham, Cllr Gerard Hargreaves, Cllr Sam Mackover and Cllr Portia Thaxter

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Agenda

72 SECONDS' SILENCE

There will be 72 seconds' silence to remember those who lost their lives in the Grenfell tragedy.

Pages

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Any member of the Council who has a disclosable pecuniary interest in a matter to be considered at the meeting is reminded to disclose the interest to the meeting and to leave the Chamber while any discussion or vote on the matter takes place.

Members are also reminded that if they have any other significant interest in a matter to be considered at the meeting, which they feel should be declared in the public

interest, such interests should be declared to the meeting. In such circumstances Members should consider whether their continued participation, in the matter relating to the interest, would be reasonable in the circumstances, particularly if the interest may give rise to a perception of a conflict of interests, or whether they should leave the Chamber while any discussion or vote on the matter takes place.

3. MINUTES OF PREVIOUS MEETING 5 - 14

The minutes of the meeting of Adult Social Care and Health Select Committee held on 29 June 2023 are submitted for confirmation.

4. HOMECARE TRANSFORMATION PROGRAMME UPDATE REPORT 15 - 22

The purpose of this report is to:

1. Update the Select Committee on the progress of the Homecare Transformation Programme.
2. Invite the Select Committee's comments and questions on the progress, model, and challenges described.
3. Update the Select Committee on the timescales for the Homecare procurement.

5. REVIEW OF PALLIATIVE CARE SERVICES IN NORTH WEST LONDON 23 - 44

This paper aims to:

- Provide a comprehensive update on the progress made by the programme team since our last presentation to the Adult Social Care and Health Select Committee on 29 November 2022.
- Seek the Committee's support and gather the Committee's opinions on the proposed new model of care before officially launching the engagement process.

6. SUICIDE PREVENTION AND ADULT MALES AS A HIGH-RISK GROUP - WORKING GROUP 45 - 50

This report sets out the select committee's proposal to establish a working group to carry out an in-depth review in the municipal year 2023/2024.

7. WORK PROGRAMME REPORT 51 - 76

This report is an update on the select committee's development of the work programme for the municipal year 2023/24.

8. ANY OTHER ORAL OR WRITTEN ITEMS WHICH THE CHAIR CONSIDERS URGENT

[Each written report on the public part of the Agenda as detailed above:

(i) was made available for public inspection from the date of the Agenda;

(ii) incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and have been relied up onto a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and

(iii) may, with the consent of the Chair and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]

Note: Exclusion of the Press and Public

There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985.

The next ordinary meeting of the Adult Social Care & Health Select Committee will take place at
6.30 pm on Thursday, 30 November 2023

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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

ROYAL BOROUGH OF KENSINGTON AND CHELSEA

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE – 12 OCTOBER 2023

HOMECARE TRANSFORMATION PROGRAMME UPDATE

The purpose of this report is to:

1. Update the Select Committee on the progress of the Homecare Transformation Programme.
2. Invite the Select Committee's comments and questions on the progress, model, and challenges described.
3. Update the Select Committee on the timescales for the Homecare procurement.

FOR DISCUSSION

1. EXECUTIVE SUMMARY

1.1. There are three contracted Homecare providers in the Royal Borough of Kensington and Chelsea (RBKC), one in the north patch and two in the south patch. They provide support to an average of 400 service users per month for a total of £5.7m in 2022/23. The amount spent is based on activity required as determined through social care assessments and reviews, rather than a fixed figure within the contracts. However, forecasts of activity volumes can be made with a fair degree of accuracy, enabling providers to plan appropriately.

1.2. We also use 19 spot providers outside of the contracted agencies. These are used to meet specialist needs, as well as to provide cover when the patch providers are unable to take on additional work at any one time. These providers support an average of 200 service users per month for a total spend of £2.9m in 2022/23.

1.3. The Homecare Transformation Programme is acting on feedback from extensive engagement with residents, service users, homecare providers, care workers, Adult Social Care (ASC) teams, Health and the Voluntary and Community Sector partners. Since February 2023, the programme has been working to bridge a gap to make the ambitious vision for homecare a reality, optimising the chances of the tender success.

1.4 The tender is set to go live in February 2024.

2. RECOMMENDATION(S)

2.1. The Select Committee is asked to note the report and make any comments regarding homecare services for residents before a formal decision is taken

through a Key Decision Report (KDR) on the final model in the Commissioning and Procurement Strategy.

3. INFORMATION ABOUT THIS REPORT

3.1. Homecare is one of the Committee's priorities, and this report updates Members on the Homecare Transformation Programme. Members' views are also sought on progress and proposals before a Key Decision on the Commissioning and Procurement strategy is made.

4. MAIN REPORT

Context

4.1. The Council's Adult Social Care and Health directorate (ASCH) commissions a range of services for people who use social care. Many people aim to live independently in their own home, and homecare is a service commonly used to achieve that aim.

4.2. Homecare is a service regulated by the Care Quality Commission (CQC). The types of interventions delivered to residents range from helping someone with meal preparation to the delivery of complex, personal care for someone with a chronic or long-term condition such as dementia. This type of support improves residents' quality of life and their health and wellbeing outcomes. The support and tasks are agreed as part of an individual's care plan.

4.3. The Council has a statutory duty under the Care Act 2014 to:

- Ensure appropriate personalised care and support to meet the individual assessed needs of service users.
- Maximise independence, focusing on choice and control.
- Ensure consistency and continuity of care, minimising service disruption for vulnerable adults and younger adults with disabilities.

4.4. The current Homecare contracts have been in place since 2015 and have not been re-tendered. Whilst the service specification captures the Care Act ambitions, people's preferences and choices have continued to develop, so the service's design needs to be updated accordingly. Commissioners, social care staff, partners, residents, and providers have been working to understand better how the current arrangements need to change and how best to prepare for the new tender.

Homecare Market

4.5. There are three block providers in RBKC: MiHomecare, Healthvision and Sage Care. Healthvision has 44% share of the market, followed by 40% for MiHomecare and 16% for Sage Care. They operate across two geographical patches divided into four smaller geographic areas. They deliver a total of 4,600 hours of care each week (66% of total hours).

4.6. There are also 19 spot providers delivering approximately 3,800 hours of support per week (34% of total hours). These providers cover specialist needs and care packages that patch providers are unable to take on.

Spend and Reach

4.7. In 2022/23, the total homecare spend in RBKC was £8.7m (£5.8m in patch and £2.9m in spot) for over 270,000 hours of care that benefited over 600 residents. The cost is activity-based and fluctuates each year.

4.8. The 2023/24 annual uplift was agreed in line with the rising cost of living. The hourly rate for patch is £21.21, and £19.21 for spot and direct payments; reablement is paid at £22.15 per hour. Costs across London boroughs range from £16.60 to £23.47. The differences in hourly rates reflect specialisms and the additional contractual requirements for patch providers.

Performance

4.9. All providers are CQC registered. Two have a 'Good' rating and one (MiHomcare) has a 'Requires Improvement' rating. Market Managers and the Quality Assurance (QA) Officer meet with MiHomecare colleagues once every three weeks to review performance statistics, provide support and most importantly go through client experiences by way of talking through outcomes of safeguarding, any complaints and quality of care issues. This provides the opportunity to help manage any risks and prevent escalation.

4.10. To quality assure the services, the QA Team contacted 20% of service users from MiHomecare in March 2023 to assess the satisfaction with their homecare in relation to punctuality, carer attitude, completion of tasks and communication. This provided an overall fair response. Regular meetings with the provider and reporting has evidenced improvements on these issues.

4.11. As a further follow up, officers contacted the people that had raised concerns earlier in the year again in August and September and they noted an improvement in service.

4.12. Following its inspection in August 2022, CQC returned to MiHomecare in the week commencing 18 September to re-inspect the service. The outcome of the inspection is yet to be announced.

4.13. There are currently no concerns regarding providers' performance. Appendix 1 provides an overview of RBKC's Homecare patch providers' performance.

4.14. Recruitment and retention, 'no replies', and cancellations remain the main challenges across the market for both providers and commissioners.

Service User Feedback

4.15. Through regular contract monitoring and annual service reviews, commissioners receive and analyse feedback regarding the performance of

homecare providers. A summary of the most recent user feedback is set out below.

4.16. From the annual survey, HealthVision scored 93% satisfied or very satisfied in all areas: safe, effective, caring, responsive and well led; caring receiving the highest score. In their survey, 88% of 276 users would recommend the service to a friend or relative.

4.17. From the annual survey, Sage Care scored 95% in user satisfaction, and 88% of the 194 users would recommend the service.

4.18. MiHomecare did not have results from an annual survey but sought feedback as a spot check exercise. They received responses from the survey from 32 users and they shared they would all recommend the service.

Homecare Transformation Programme

4.19. The Homecare Transformation Programme started in 2019. There have been many changes since then: staff turnover, a global pandemic, and significant changes within the provider market.

4.20. Engagement has happened in four phases with a wide range of internal and external stakeholders:

- Phase 1 (2021): Discussing with residents and service users what their 'best lives' look like, developing a vision for the service, and exploring how it can holistically support residents to live their 'best lives'.
- Phase 2 (2021 - 2022): Reviewing the existing service with service users, homecare providers, care workers, Adult Social Care (ASC) teams, Health, and the Voluntary and Community sector.
- Phase 3 (2022 – 2023): Following on from Phase 2, hosting further workshops, one-to-one sessions and events with service users and other stakeholders (such as those previously listed) to explore and co-design new elements of the homecare service, including potential pilots.
- Phase 4 (2023 onwards): Mainstreaming the approach of having service users involved in the procurement process for homecare and other new ASC contracts and providing feedback on their care and support.

Drivers and progress towards the revised Homecare model

4.21. The drivers are in line with the Care Act ambitions: personalised care, independence, choice and control, and consistency and continuity of care. Figure 1 below shows the vision for the Homecare model. Further, the intended outcomes for it are:

- I have considerate support delivered by competent people – my support is co-ordinated and cooperative and I know who to contact to change things.
- I am in control of planning my care and support and can use technology to help.

- I have access to the information I need and to support that helps me remain a member of my community.
- I can decide the kind of support I need and when, where and how to receive it.
- I feel safe, can live the life I want, and am supported to manage any risks.
- I have care and support that is directed by me and responsive to my needs.

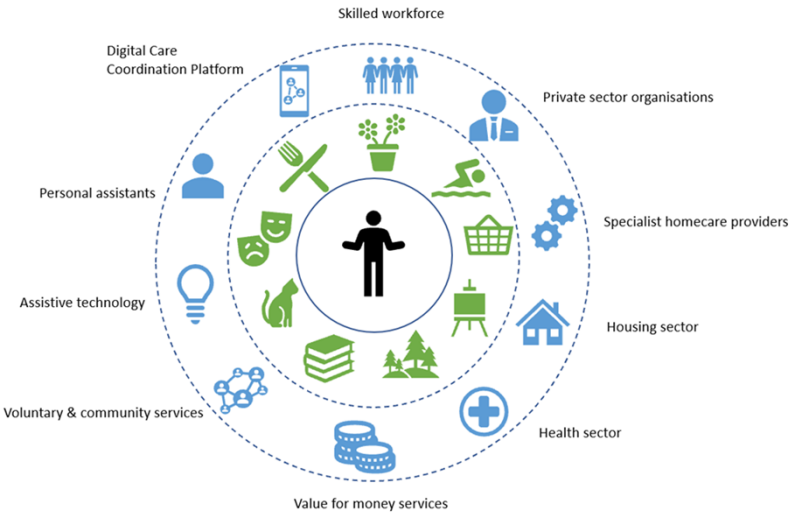


Figure 1 Vision for the homecare model

4.22. Key examples of progress to date towards the new model are set out below.

- Reviewed systems and processes to allow our data recording and flow to be more efficient and accurate. This can increase capacity and responsiveness to meeting needs.
- Decommissioning our Finance Manager and Case Management Business Intelligence systems in July 2023, which was the preferred approach for both Homecare providers and commissioners. A new approach to automating both processes is now being implemented.
- Started piloting an outcomes-focused approach with digital solutions, and exploring how to change our systems to accommodate this move away from 'time and task' through the outcomes pilot.
- Explored and modelled ways to incentivise the market to better recruit, support and retain the workforce and support sustainability, through benchmarking, modelling, and exploring efficiencies.
- Explored flexible yet sustainable digitalisation and personalised approaches through our outcomes and direct payment pilots and digital and data workstreams.

- Carried out an in-depth cost needs analysis of patch, spot, direct payment and reablement activity.
- Concluded benchmarking with other councils' Homecare models.

Outstanding work

4.23. Co-produce a service delivery model options appraisal in line with lessons learned from benchmarking and work to date to support and inform the decision on the final revised model.

4.24. Final stakeholder engagement and market testing of the revised model before the Procurement Strategy is finalised and taken through the sign-off process.

4.25. Evaluate reasons for why ambitions in existing contracts have not been realised and explore iterative contracting as a solution with Procurement and Legal colleagues.

4.26. Continue work with pilots, digital and data solutions and financial modelling. Whilst some of these will go beyond the tender go-live date, there will need to be a process in the iterative contracting approach to ensure lessons are learned and any scaling up from pilots can be achieved.

4.27. The timescales for re-tender activities are set out in the table below.

Key activity	Date
Formal market engagement	September – October 2023
Approval of Procurement Strategy	November – December 2023
Finalise specification and Invitation to Tender	January 2024
Tender period (assuming a 2-stage process)	February – April 2024
Evaluation and Selection of shortlisted providers	April – May 2024
Approval and announcement of award	May – June 2024
Contract signing & Mobilisation phase	June – November 2024
New services in place	November 2024

5. TIMESCALE FOR CONSIDERATION

5.1. Consideration, comments, and feedback, including any extra information needed to support those, needs to be communicated by mid-October 2023.

6. FURTHER INFORMATION

6.1. Appendix 1 been added to provide further insight into current providers' service quality.

Gareth Wall
Director of Integrated Commissioning

Appendix 1

Overview of Homecare Patch providers in RBKC, 2022/23

i. Over the course of the 2022/23 financial year, 326,423 home care visits were completed in RBKC, for a total 270,121 hours of care. This is broken down by each area, as presented in Figure 2.

ii. Notably, there were nearly 10,000 more visits in the Sagecare patch than in the Healthvision South patch, but only 358 more hours in Sagecare. This is likely because Sagecare had the shortest visit length average (45 minutes) while Healthvision South had the longest visit length average (53 minutes), as shown in Figure 3. However, neither of these visit length averages vary significantly from the borough visits length average of 49 minutes (see Figure 4).

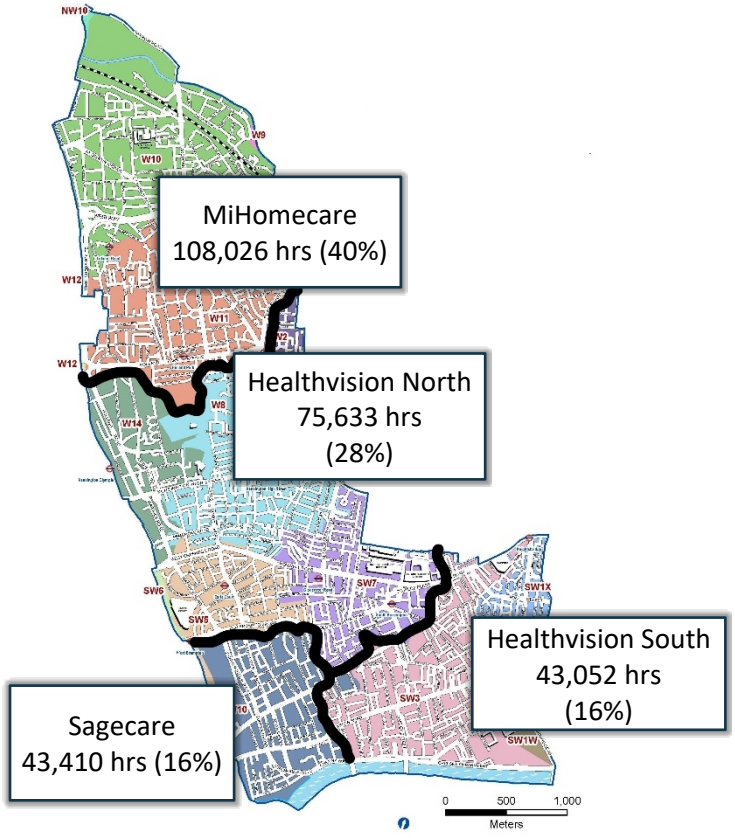


Figure 1. Map of RBKC homecare patches with hours of care delivered in 2022/23 financial year.

iii. MiHomecare had the highest average number of care workers on contract (78) and active at the time of data reporting (62). MiHomecare also had the lowest turnover rate, with 19 staff leaving and 55 new staff recruited (as shown in Figure 3).

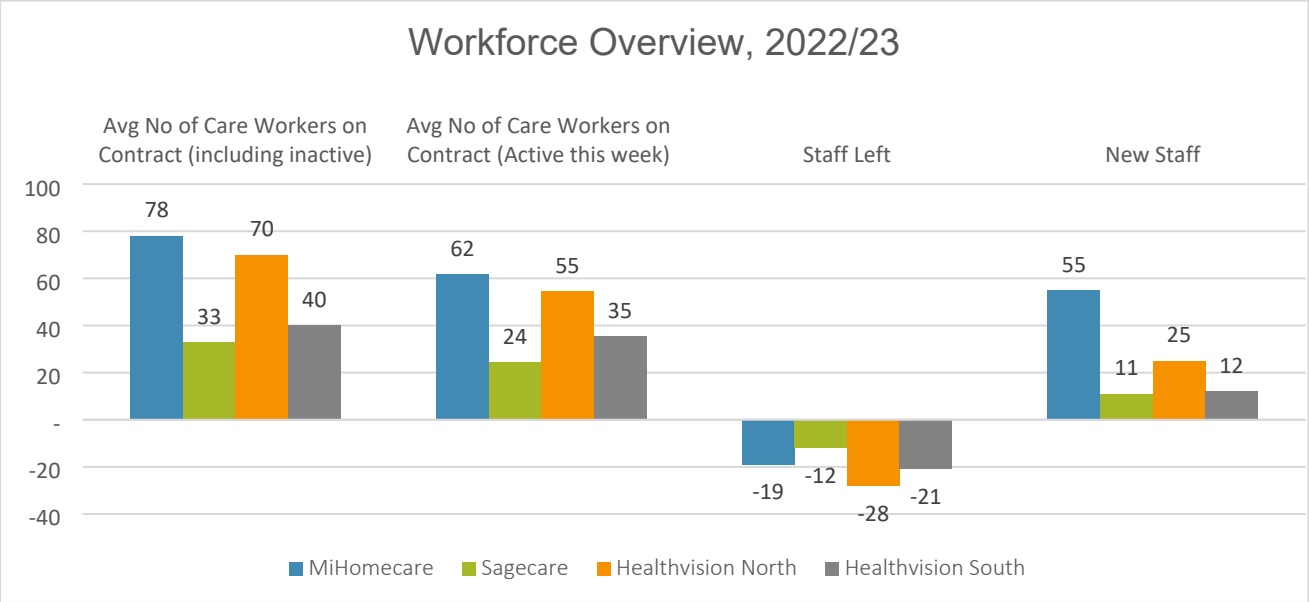


Figure 3. Bar chart comparing workforce related measures for each patch.

North West London Integrated Care System

NHS North West London

Royal Borough of Kensington and Chelsea

Adult Social Care and Health Select Committee

12 October 2023

NW London adult community-based specialist palliative and end-of-life care for adults (18+) review programme:

This paper aims to:

- Provide a comprehensive update on the progress made by the programme team since our last presentation to the Royal Borough of Kensington and Chelsea, Adult Social Care and Health Select Committee on 29 November 2022.
- Seek your support and gather your opinions on the proposed new model of care before officially launching the engagement process.

As key stakeholders, we highly value your ongoing involvement and collaboration in this programme.

www.nwlondon.nhs.uk/cspc

NHS North West London programme team last attended the Royal Borough of Kensington and Chelsea, Adult Social Care and Health Select Committee on 29 November 2022, Since then, the NW London community-based specialist palliative care new model of care working group, has been diligently working to co-produce and agree the proposed new model of care for adults' (18+) community-based specialist palliative care.

The new model of care working group included residents of seven out of eight boroughs (excluding Hounslow). Starting from May 2022, the model of care working group has met 38 times and successfully concluded their discussions on 6 June 2023.

The engagement approach and the work of the model of care working group have been recognised as best practice by the North West London Integrated Care Board (ICB). The feedback from the working group members about their participation, the approach taken, the transparency of the programme team, and the outputs of the working group has been overwhelmingly positive.

For instance, one of the 12 patient representatives on the group, who is also a clinician working in NW London, expressed that being part of the group and engaging in the discussions has significantly enhanced her understanding of palliative and end-of-life care. This knowledge has directly influenced and improved her practice, leading to better outcomes for the patients she has supported with palliative and end of life care needs.

On 22 August 2023 we published our first draft of the proposed new model of care for adults (18+) community-based specialist palliative care on our NW London Integrated Care System (ICS) website. We wrote to partners in North West London sharing this documentation to gather feedback on the proposed new model of care and make sure that we were on the right track or if there was anything else we needed to consider.

As well as launching a simple online survey, we have also held three North West London wide engagement events in September 2023 about the model of care. In partnership with local borough based partnerships, we have subsequent engagement events commencing Monday 2 October 2023 through to Thursday 5 October. This includes a bi-borough specific event being held on Monday 2 October 2023, from 1.30pm to 3pm.

On 14 September 2023, we attended the North West London Joint Health Overview Scrutiny Committee to provide an update about the model of care and answer questions from committee members. On the 18 September 2023, at the request of a number of public members who are part of the new model of care working group, we met with them and a number of additional interested members of the public and Central London Community Healthcare NHS trust (CLCH) (who provide the Pembridge palliative care services at the St Charles Centre for Health and Well-being).

The aim of this session was to have an open dialogue regarding the challenges and any opportunities about Pembridge in-patient unit. The unit has been suspended

since 2018 due to difficulties with recruiting and retaining a palliative care consultant to support safe operation of the inpatient unit. This was a constructive meeting and a further meeting will be held on the 09 October 2023 to progress the dialogue that has started.

During the meeting CLCH highlighted the actions they have taken to support recruitment including:

- September 2018 to date* – attempts to recruit locum Consultant in Specialist Palliative Care to cover Pembridge beds – unsuccessful
- October 2018 – Locum Consultant in Rehabilitation Medicine with experience in SPC as a junior doctor recruited, but following a supervised probation period of 2 weeks, arrangement was discontinued due to safety concerns leading to suspension of admissions to the inpatient unit
- September 2018 - February 2019 – Substantive Consultant for inpatient post advertised and recruitment process – unsuccessful in recruiting to post
- March - May 2021 – Discussions with Imperial Hospitals and St John's Hospice to recruit to cross site SPC Consultant roles – suspended as acute colleagues could not support the proposition
- May 2022 – July 2022 – Internal service development to enhance appeal of role in Pembridge unit, including additional Consultant leadership role within the service. Put in place by increasing current locum PA allocation.
- June 2023 – November 2023 - Consultant Job Description updated and will be progressed to recruitment after internal and Royal College of Palliative care approval.

To date, ongoing efforts to recruit a locum Consultant in Specialist Palliative Care to cover Pembridge inpatient beds have been unsuccessful due to:

- Shortage of Consultants in SPC wanting to work in Hospice settings
- No availability of locums willing to individually or collaboratively work the number of days required to safely run the
- inpatient unit
- No availability of locums willing to commit to longer than a three-month contract
- Uncertainty about the future of the unit

An action for the NHS NW London programme team from the Royal Borough of Kensington and Chelsea, Adult Social Care and Health Select Committee in November 2022 was to provide results of the survey given to families who had been offered alternative services to the Pembridge.

In 2022/2023, 94 patients from Pembridge palliative care services catchment area received specialist inpatient care at alternative hospices that are commissioned by North West London. These include St Luke's Hospice, St John's Hospice and Royal Trinity Hospice. The majority of these patient were supported at St. John's Hospice in-patient unit. In 2021/2022, 102 patients in the same catchment areas were supported at alternative hospices, with St. John's Hospice again supporting the majority of these patients.

Whilst recognising the importance of engaging with these individuals and their family to understand their views and experience of receiving care at these alternate hospices as opposed to the Pembridge in-patient unit, it has proven challenging to engage with these inviduals and to hear their views and to date we have not received any response to the survey that asked our hospice providers to support with disseminating This is for a number of reasons:

- **Complex and Challenging Care**: Patients who require hospice in-patient care have the most complex palliative and end-of-life care needs. This is a challenging and emotionally charged time for both patients and their families/care givers and those important to them. During this period, they have to absorb a lot of information and address numerous questions related to the patient's current needs and treatment. As a result, filling out surveys about their experiences is often not a high priority for them.
- **Emotional and Sensitive Context**: Patients admitted to hospice in-patient units are often very unwell, and some may pass away during their stay. Engaging with patients who are seriously ill and their grieving loved ones during this emotionally charged and sensitive time can be difficult for the staff during the admission as well as engaging with the loved one’s post death.
- **Identification of Patients**: There is also a challenge in identifying and accessing these patients for engagement. The finance team responsible for the NW London program can track these patients separately, but the delivery teams providing care on the ground may not easily recognise them as "Pembridge in-patient unit catchment patients." This lack of recognition makes it challenging to reach out to them for feedback at the time of admission.
-

We will however continue to try to engage with these patients and their families/ caregivers and those important to them throughout this programme of work, and hope to hear more from these individuals at the local borough based partnership engagement events.

North West London’s proposed new community-based specialist palliative care model of care for adults (18+)

Our vision and aims

North West London residents and their families, carers and those important to them have equal access to high quality community-based specialist palliative and end-of-life care and support, that is coordinated, and which from diagnosis through to bereavement reflects their individual needs and preferences.

We want to make sure service provision is sustainable and that we can continue to deliver the same level of high quality care in the future.

The proposed new model of care encompasses several core service lines designed to make sure we can improve equity and accessibility. These are underpinned by a

number of key principles and enabler also agreed upon by the model of care working group, and are in line with best practice, engagement feedback and national guidance. These services include:

1. **Care in your home**
    - Community Specialist Palliative Care (SPC) team providing support at home, including support to care homes
    - Hospice at home service
    - 24/7 specialist palliative care telephone advice
2. **Community Inpatient bed care:**
    - Enhanced end-of-life care beds
    - Specialist hospice inpatient unit beds
3. **Hospice outpatient and well-being services**:
    - Hospice multi-disciplinary team outpatient clinic appointments
    - Dedicated Bereavement and psychological support services
    - Lymphoedema services
    - Other day care and well-being services provided in the main by charitable hospices

In 2021, we recognised there was a need to carry out a review of community-based specialist palliative care services because it was the most fragile part of all the palliative and end-of-life care services (generalist and specialist) in NW London. We identified eight key issues we needed to address and published an Issue Paper that set out these reasons and engaged with local residents and partners to find out what was important to them.

Our aim is to develop a new model of care for adult community-based specialist palliative care that will help us deliver high-quality services for the next five years and provide the foundation for the longer term. Beyond this we will make sure our services have sufficient flexibility to increase service provision against a projected growth in demand, as and when that arises.

A model of care is a framework that explains what care will be provided and how services work together to deliver care that meets the needs of the population and incorporates best practice. Providers will then use the framework to deliver care with the expectation that we improve overall care for people. A model of care will bring together regulatory, organisational, clinical and financial factors to outline the way in which care will be delivered locally.

The role of the model of care working group has been to jointly co-produce a future model of care for community-based specialist palliative care for adults (18+ years) in NW London with advanced or life limiting conditions, collaboratively agreeing “what good looks like’ and setting a common core offer across the various services. The group also collaboratively agreed the design principles.

Some of the services within the new model of care already exist across all boroughs, while others are new additions. This is particularly significant for boroughs where the services currently do not exist or there is significant variation for boroughs. The recommended model of care would deliver the following for all NW London adult residents for the first time:

Service area 1: Care at home

- Adult community specialist palliative care team:
    - 7-day service with working hours of 8 am - 8 pm – this is a change from 9am - 5pm working hours and some services (Harrow) only operating 5 days a week at present.
    - Increased support to care homes – common core level of training and support.
- Hospice at home:
    - Supporting up to 24-hour care at a patient's home (including overnight sitting services) in close collaboration with usual community care teams. This is currently not being provided across all existing services.
    - Expansion of services to additional boroughs currently without this service: Hammersmith & Fulham, Ealing, and Hounslow.
    - 24/7 specialist telephone advice line - a common core service for patients who are already known to community-based specialist palliative care services as well as unknown patients. This is a change from current 24/7 specialist palliative care advice line services, which in the main only support known patients and have variation in the level of advice and support offered.

Service area 2: Community specialist in-patient beds

- An increased number of beds in the community, which includes dedicated enhanced end-of-life care beds available across all of NW London for patients who either do not require a hospice bed but cannot stay at home due to medical and social needs, or who do not wish to stay at home, or who do not want to, or do not meet the need to be in a hospital.
- Maintaining the current number of operational hospice in-patient unit beds to support our patients with the most complex specialist palliative care needs.

Service area 3: Hospice out-patient services, hospice day care services and well-being services (including psychological and bereavement support services for patients and families)

Whilst all our boroughs currently have access to hospice out-patient clinics, hospice day care services and well-being services via their local providers, variation in the level of support provided was identified:

- We aim to make sure hospice out-patient multidisciplinary team (MDT) clinics (including but not limited to medical and nursing clinics, rehabilitation via therapists, and dedicated lymphoedema services) deliver the same core level of service. This refers particularly to the boroughs of Ealing and Hounslow where doctor and nurse led clinics are currently not available via Meadow House Hospice, as well as Harrow where there is currently a gap in provision of lymphoedema services for non-cancer patients. We propose to expand lymphoedema service provision for these non-cancer patients in Harrow.
- We aim to make sure well-being services (including hospice day care support groups, family and carer practical support and education, complimentary

therapies, and dedicated psychological and bereavement support services deliver a core level of service. Particularly for psychological and bereavement support services for patients, their families, carers and those important to them which includes: a more streamlined pathway to access these services; increased personalisation of care for example offering one-to-one and group sessions, face-to-face and virtual support; and increased cultural and spiritual sensitivity to delivery of this care and support. While all boroughs currently have access to some psychological and bereavement services, this varies in level of support.

Key Enablers: The successful implementation of the new model of care relies on several key enablers:

- Effective use of data and digital optimisation in service delivery
- Workforce development and planning
- Organisational development and community-based specialist palliative care staff training
- Strong leadership and governance.

Addressing the eight key issues

The new model of care aims to address the eight key issues outlined in an issues paper published by the programme in 2021 which launched this work. By incorporating these issues into our ongoing engagement and co-production of the new model of care the model, we are committed to creating a more comprehensive and responsive community based specialist palliative and end-of-life care system for the residents of North West London.

We can demonstrate how both the process and resulting product of this work responded to the original eight issues highlighted below:

The eight key issues we need to respond to		Key examples of how the issue has been built into the approach or model of care
1	Respond to future need	• Used data to model 5 and 10-year demand for community-based specialist palliative care services and applied this to current services to understand future service demand. • Examined feedback from national surveys and reports to explore changing public expectations on care at the end-of-life and included this in model of care development.
2	Address service variation	• Developed a new model of care that addresses the current variation in service offerings to residents across our eight boroughs to support improving equitable access to services to make sure everyone can access services more fairly and consistently.
3	Respond to inequalities	• Undertook a travel mapping exercise (travel analysis) to understand impact on communities travelling to

		current in-patient units. We will undertake further travel analysis as part of the next phase of this work to understand impact of proposed options to deliver the new model of care. • Made sure there was representation of different faiths/ethnicities in the NW London model of care working group and made sure our engagement strategy reaches our diverse communities. • The model of care working group have agreed five key enablers to support the successful implementation and delivery of the new model of care. Development of a strategy and plan for supporting organisations to achieve cultural competency so they can effectively provide care in line with the new model of care.
4	Integrated delivery	• Care co-ordination has been recognised as being key element of the new care model, which includes making sure that appropriate information is shared among providers to support seamless delivery of care. Improving co-ordination will be embedded in to the structure as part of the implementation of the new model of care.
5	Responding to feedback and engagement	• Involved patients, carers, clinicians and members of the public in co-producing the model of care, ensuring the voice of local residents is truly reflected in service design • Hosted various NW London and borough based events, culminating in published engagement reports which have fed into the model of care working group discussions and design principles.
6	Align with policy & best practice guidance	• Reviewed best practice and national guidance and integrated these within model of care working group discussions to shape and develop each core service offer • Actively engaged with other organisations, areas and systems who have been implementing new models to inform our local work.
7	Financially sustainable	• Made sure financial sustainability is a key principle and key hurdle criteria within the programme to make sure that actions and development are not only impactful but enduring for the longer term.
8	Recruitment and retention	• Engaged staff and care providers throughout development to ensure the future model of care is clinically sound and reflects good practice, making NW London an attractive place to work. Engagement will be ongoing through the development of the enablers and implementation phase of this work.

What does this mean specifically for the borough of Kensington & Chelsea residents

Summary of service improvements for Kensington & Chelsea residents with the proposed new and improved model of care for community-based specialist palliative care services for adults

The proposed NW London community specialist palliative care model of care for adults (18+) will deliver the following services for Kensington & Chelsea residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Kensington and Chelsea residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- This service already exists, but will be improved with a common core offer which includes support up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community in-patient bed care

- Kensington and Chelsea residents will have access to an increased number of beds in the community, which includes the introduction of dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Kensington and Chelsea residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Kensington and Chelsea residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.
- This existing service will be expanded to support Kensington and Chelsea residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Kensington and Chelsea residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support across NW London services
- Kensington & Chelsea residents will have improved access to bereavement and psychological support services with a common core

offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed care model aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population, including the specific needs of Kensington & Chelsea residents and underserved communities.

The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all Kensington & Chelsea residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

Next steps - formal engagement about new model of care

We are currently engaging with members of the public and other stakeholders, seeking input from the public on the proposed model of care. During this engagement phase, we aim to engage widely and work with our public and stakeholders to:

- Provide an overview of the development process of the model of care
- Outline the contents of the model of care (What is the model of care NOT how and where it will be delivered), and seek feedback from the public on the new model of care.

While the engagement document will not present options for the delivery of the new model of care, it will emphasise the importance of a well-distributed service that ensures equal access to the necessary care.

People can respond to the model of care by completing **our simple survey**., emailing our team at nhsnwl.endoflife@nhs.net or attending local Borough Based Partnership events.

or attend the

Engagement on the model of care will continue throughout the summer and early autumn.

Next steps after this engagement phase –October 2023 onwards:

- We will publish feedback received and potentially a revised model of care which has considered that feedback.
- We will explain the next steps of the process to support having this model of care agreed and implemented for NW London.
- The programme team will develop a long-list of options for delivery of the new model of care with the steering group doing the initial shortlisting.

We will then move to the next stages of making recommendations about options for any formal consultation should this be deemed necessary.

We will continue to work with NW London residents and stakeholders throughout this process and we are immensely grateful for the continued engagement and contributions which are vital to the success of this transformative initiative.

If you have any questions or require further information, please do not hesitate to contact us at nhsnwl.endoflife@nhs.net.

APPENDICES

Ten-year demand projections for in-patient hospice care

To understand whether we have the hospice inpatient beds needed to serve the inpatient needs of our population, we have undertaken an analysis of future demand and compared this with

The methods used for projecting future need

1. Understand how mortality in NWL changes over the next 10 years based on national statistical studies and applying local data.
2. Apply the annual rate of mortality growth to number of people who may require palliative care.
3. Include additional allowance for needing to address unmet need i.e. people who are not currently accessing care but need it.
4. Apply the rate of growth to bed use over 10-year period.
5. Compare future bed use with available capacity to determine when and if the demand for beds exceeds available capacity.

Mortality in our population

- We anticipate increasing number of deaths each year, climbing from 12,300 in 2023 to 14,500 in 2033.
- This is driven largely by an ageing population. This is expected to result in a corresponding increase in number of people needing palliative care. In addition, there are likely to be people who are not receiving palliative care when they should be we refer to this as ‘unmet need’.
- If we assume we steadily work to improve public awareness and meet the palliative care needs of our whole population, we expect the number of people with a palliative care need to grow from 31,000 in 2023 to 37,000 in 2033.

Hospice inpatient demand

- If we assume the demand for inpatient care grows proportionally to overall palliative care need and there are no changes to the length of time each bed is used each time it is used, we can expect the number of bed days needed to grow from approximately 15,000 bed days per year in 2023 to 18,000 in 2033.
-

Conclusions arising out of analysis

- If the number of beds we use does not change over time, we can expect to have space (capacity) for approximately 20,400 bed days each year.
- Comparing expected increase in demand with available capacity, we will have enough beds to meet our needs until 2031.
- Beyond this time, we would need to make adjustments to either demand or capacity.
- According to our data analysis and based on an assessment of unmet need and demographic growth, we do not require more specialist hospice in-patient beds than those currently being commissioned and used.

Travel mapping and analysis

Hospice in-patient bed provision currently works on the basis of catchment areas. In some cases, they overlap with the catchment area of other hospices. To understand how accessible, the units are to our population, we undertook a travel mapping analysis.

We looked at travel times for people accessing their closest hospice in-patient bed care unit (by travel time) and found that:

- Average peak time travel was 40 minutes by public transport and 19 minutes by car (driving).
- Populations in south Hillingdon and Hounslow have among the longest travel times to a hospice in-patient bed care unit because of the absence of alternatives in the area.
- With Pembridge Palliative Care Services in-patient unit suspended, average peak time travel for the whole NW London population is increased (by three minutes for public transport and two minutes for car).
- Looking more closely at the population for whom Pembridge Palliative Care Service is the closest hospice in-patient unit (in terms of travel time), shorter travel times to access the unit were experienced, when open, compared with the overall population travel times. The current suspension increases this group of residents travel time by 12 minutes on public transport and six minutes by car. The travel times for this group to the next nearest hospice is 43 minutes by public transport and 23 minutes by car which is comparable to the experience of the whole population (see table below for more information).
- Broadly, our hospice sites are located in areas within close proximity of deprived communities. People living in these areas are not adversely impacted by longer travel times.

	Average peak time travel when using public transport	**Average peak time travel when driving**
All current in-patient units	40 mins	19 mins
All currently available in-patient units (reflecting suspension of services at Pembridge Palliative Care Services in-patient unit)	43 mins	21 mins
Travel times for those people where Pembridge Palliative Care Services is their closest in-patient unit (when Pembridge Palliative Care Services in-patient unit open)	31 mins	17 mins
Impact of on directly affected populations with Pembridge Palliative Care Services in-patient unit being suspended	43 mins	23 mins

Respond to future need - meeting the palliative care needs of NW London's changing population

When we embarked on the review of community-based specialist palliative care one of the eight issues we needed to respond to was making sure that we developed services that met the future palliative care needs of NW London's changing population.

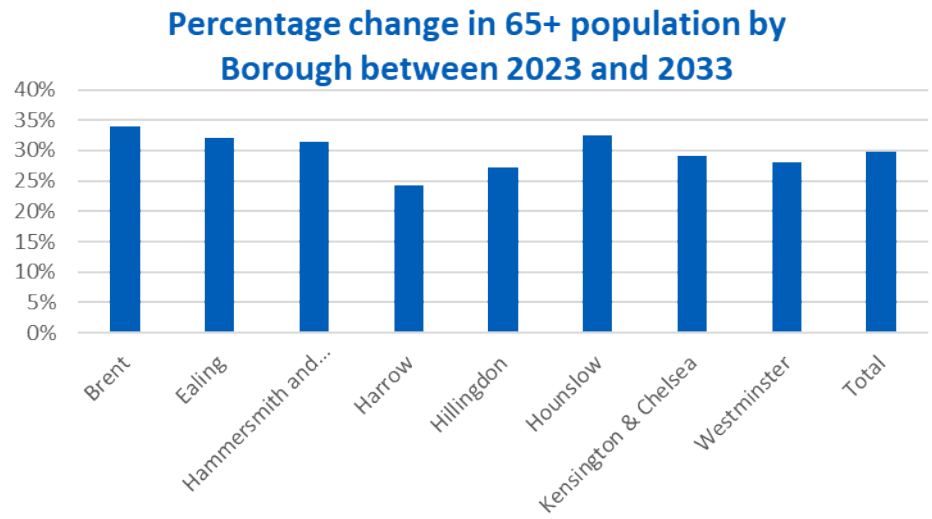
In order to do this, we committed to undertaking further demand modelling and population projections for a ten-year period to support future services modelling.

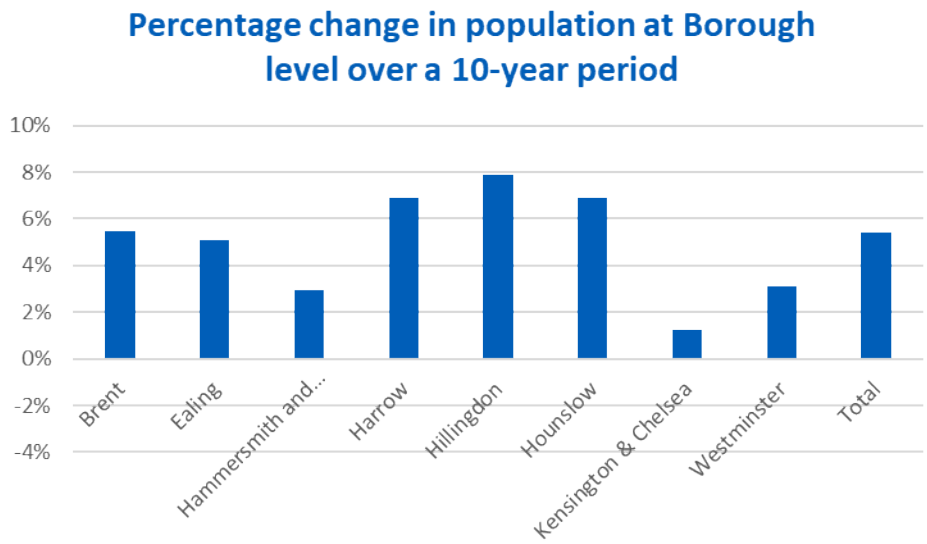
The outcomes of this work show that we can expect growth in hospice/ specialist palliative care service inpatient unit beds use to be in-line with the growth in the overall number of deaths in the NW London population over time. This is the result of an ageing population, population growth and a number of other factors such as increasing morbidity from chronic illness.

When we factor this in, we anticipate that we have sufficient of these specialist inpatient beds across our current hospices to accommodate local need for hospice specialist palliative care beds until 2031.

How is our population likely to change over time?

We are expecting the population of NW London to grow by 5% over the ten-year period between 2023 and 2033, similar to the growth in population expected across London.





During this time, the population size will grow from approximately 2.17 million people to 2.28 million. At this time, we anticipate the greatest growth in Hillingdon, Harrow and Hounslow.

Nationally, 85% of deaths occur in people over the age of 65 years. In NW London, the 65+ population is expected to grow by 30% over the same ten-year timeframe - a much faster rate than overall population. Looking further still, approximately 55% of deaths occur among the 80+ population and this group is expected to grow by 32% in NW London.

How do we expect deaths to change over time?

Due to the impact of Covid-19 pandemic, we are cautious about applying mortality projections based on 2020 and 2021 data. In 2022 we recorded 12,111 deaths across NW London boroughs. Based on this, we expect annual deaths to increase to 14,587 by 2033.

This is impacted by ageing population and population growth and is based on the pattern of change modelled nationally.

How many people need palliative care each year?

Across our eight Boroughs, we are responsible for the health and care needs of approximately **2.1 million** people. Of those, 1.7 million are aged 18-years and over.

As at February 2023, we have approximately **31,000 people** identified as potentially needing some degree of palliative care. We are also aware this may miss people who are unknown to us and estimate around **900 people** may not be included here.

In 2022 approximately 12,000 deaths were recorded for our registered population. Not all of these would be individuals who received specialist palliative care services

What are the causes that contribute to this?

Leading causes of deaths among adults include dementia, ischaemic heart disease, chronic lower respiratory disease, stroke and cancer. You can find out more about leading causes of death through the office of national statistics.

Where do people die?

National data (see below) shows that at present around half of people die in a hospital, whilst just over a quarter die at home. A further 12% of people die in care homes and 5% die in hospices. The proportion of deaths in care homes and hospices has remained broadly similar over time. Whereas the proportion of deaths occurring in hospital has fallen and the proportion of deaths at home has increased over time, indicating potential changes in proactive end-of-life care planning and changing attitudes around remaining in the home environment.

While preferences on place of death haven't been collected locally, the National Survey of Bereaved People (2015) suggested 81% of people wished to die at home (a contrast to the 28% who actually die at home), 8% of people stated a preference for a hospice, 7% for a care home and only 3% for a hospital.

Public engagement has also highlighted that people change their mind or that their circumstances change, affecting their preferred place of death.

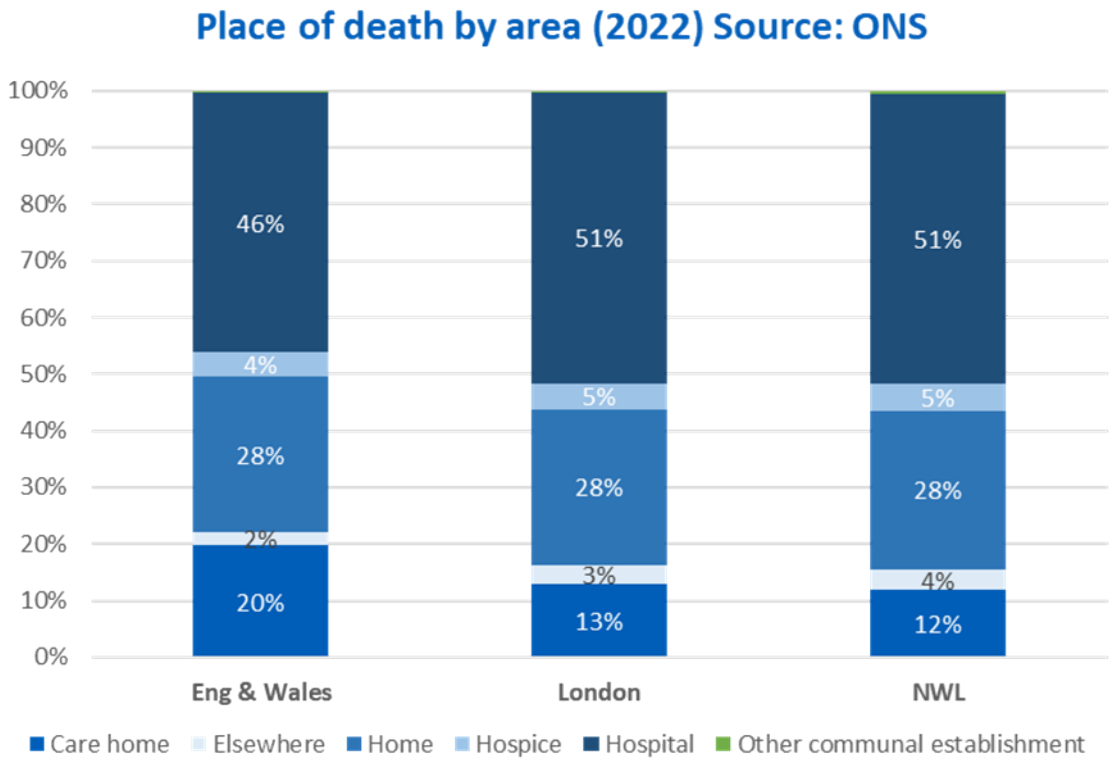


Figure 1: Source ONS 2022 (Death registrations and occurrences by local authority and health board)

The model of care group used the information to look at different ways to model future demand recognising that there is no exact way of predicting this, but with an

expressed desire to factor in unmet need (ie not just roll forward the activity we have now, increased to reflect population growth). This modelling approach shows we currently have sufficient numbers of the most specialist hospice in-patient beds across our current hospices to accommodate all patients who need this type of highly specialist support and care until 2031.

Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026

Work is currently underway to map how the proposed new model of care would help address the six ambitions as laid out in the framework on a borough level.

Summary of service for NW London residents

Summary of service improvements for North West London residents with the proposed new model care for community-based specialist palliative care services for Adults

The proposed NW London Community Specialist Palliative Care model of care for adults (18+) would deliver for all North West London residents for the first time:

Care in your home:

- Community specialist palliative care SPC Team:
  - 7-day working hours (8 am - 8 pm) – a change from 9am - 5pm with some services which worked only 5 days a week.
  - Increased support to care homes – common core level of training and support
- Hospice at Home:
  - Supporting up to 24-hour care at home (including overnight sitting) in close collaboration with usual community care teams. This is currently not being supported across all existing services.
  - Expansion of services to additional boroughs currently without this service: Hammersmith & Fulham, Ealing, and Hounslow.
- 24/7 specialist telephone advice line – a common core offer including support for known and unknown patients.

Community inpatient care:

- Increased number of beds, which includes dedicated enhanced end-of-life care nursing home beds across all of NW London for patients who do not require a hospice bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or meet the need to be in a hospital.
- Existing hospice inpatient unit beds to support our patients with the most complex specialist palliative care need.

Hospice outpatient and well-being services:

- Hospice outpatient MDT clinic and well-being services – a common core offer for the services this encompasses, including lymphoedema, bereavement, and psychological support services:
- Expansion of lymphoedema services for non-cancer patients in Harrow, addressing the current gap in provision
- Dedicated bereavement and psychological support services with common core offer– whilst all our services currently offer bereavement and psychological support this varies in offer and accessibility.

The proposed model of care aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population. The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural

competence training for staff, and actively collaborating with local organisations and partners.

The ultimate goal is to ensure fair access to high-quality community-based specialist palliative and end-of-life care for all North West London residents, while creating a supportive and inclusive environment throughout all aspects of care and services.

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THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

12 OCTOBER 2023

REPORT OF THE SCRUTINY MANAGER

REVIEW OF PALLIATIVE CARE SERVICES IN NORTH WEST LONDON

1 EXECUTIVE SUMMARY

1.1 This report gives an update on the provision of palliative care in the borough and proposals by the NHS for a re-organisation of services in North West London.

2 RECOMMENDATIONS

2.1 Members of the select committee to consider the information provided in the report by the NHS as attached in appendix 1.

3 REVIEW OF PALLIATIVE CARE SERVICES

3.1 The report was requested by members following the last presentation to the Royal Borough of Kensington and Chelsea Adult Social Care and Health Select Committee on 29 November 2022 on the review of palliative care services, including the Pembridge Hospice. In particular, members wanted to be updated about the new model of care which has been developed as part of the review.

3.2 Representatives from the NHS North West London Integrated Care System, who are leading on the review of adult community-based specialist palliative and end-of-life care, have been invited to the select committee to discuss the report.

3.3 Following the Health and Care Act 2022 new statutory guidance on health scrutiny is expected to be published. However, a set of five principles, agreed by the Department of Health and Social Care, Centre for Governance and Scrutiny and Local Government Association has been published to help inform the ways of working between health scrutiny committees and NHS partners, to help ensure the benefits of scrutiny. These five principles for health scrutiny are:

- outcome-focused
- balanced
- inclusive
- collaborative

- evidence-informed. [1]

3.4 The Adult Social Care and Health Select Committee may make reports and recommendations to any relevant NHS bodies or healthcare providers; however, any reports or recommendations are expected to be based on evidence and there should be an explanation of any recommendations made. [2]

3.5 The remit of the Adult Social Care and Health Select Committee, as set out in Part 5, Section 3 of the Council's Constitution, includes health partnerships where adult social care is a significant partner in terms of service delivery or management accountability, and services provided by NHS organisations including NHS Trusts, NHS Foundation Trusts and other relevant health service providers.

FOR DISCUSSION

Jacqui Hird
Scrutiny Manager

Background papers used in the preparation of this report: None other than previously published documents.

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[1] www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

[2] Local Authority Health Scrutiny: Guidance to Support Local Authorities and Their Partners to Deliver Effective Health Scrutiny (Department of Health, 2014) pp.21-22

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

12 OCTOBER 2023

REPORT OF THE SCRUTINY MANAGER

SUICIDE PREVENTION AND ADULT MALES AS A HIGH-RISK GROUP

1 EXECUTIVE SUMMARY

1.1 This report sets out the select committee's proposal to establish a working group to carry out an in-depth review in the municipal year 2023/2024.

2 RECOMMENDATIONS

Select committee is recommended to:

2.1 Review the scoping document for the working group and agree the terms of reference and membership as set out in Appendix 1.

3 SUICIDE PREVENTION STRATEGY AND ADULT MALES

3.1 The Adult Social Care and Health Select Committee has a remit to scrutinise the provision and performance of adult social care services, partnerships associated with the delivery of adult social care, Public Health, and related plans and strategies. The select committee also has a remit to scrutinise NHS organisations, Trusts and health providers and to review healthcare services. [1]

3.2 On 2 May 2023 the select committee discussed a report on the Bi-Borough Suicide Prevention Strategy 2022-2025 and one-year action plan. The report set out that nationally around three quarters of registered suicides are by adult males, particularly in the 45-54 age group, and that reducing the risk of suicide in high-risk groups, including middle-aged men, is a priority. The 2022/2023 action plan is working to mitigate risk factors in males, particularly those in middle age.

3.3 The Royal Borough of Kensington and Chelsea and City of Westminster Bi-Borough Public Health Team leads on the action plan and co-ordinates the Suicide Prevention Partnership Group which includes mental health and care services, primary care representatives, community-based organisations, voluntary agencies, employers, schools, colleges, universities and people with lived experience.

3.4 The Department of Health and Social Care has recently published a national strategy on suicide prevention 2023 to 2028. The new national strategy

[1] Part 5 Section 3 RBKC Constitution

identifies middle-aged men as one of seven priority groups, and states that middle-aged men have the highest rates of suicide of any other group. The strategy cites national evidence which shows that these men experience risk factors such as living in highly deprived areas, experiencing unemployment or financial difficulties such as debt, housing problems, alcohol or drug misuse, contact with the justice system, relationship problems, and social isolation.

3.5 There is a London-wide initiative, led by the London Health Board and the Mayor of London, to help improve mental health among communities in London, which has as one of its six aims making the capital a zero-suicide city.

3.6 There is a significant amount of academic literature and research on male mental health and suicide prevention. In particular, this includes the 2021 study 'Suicide by Middle-Aged Men' by the National Confidential Inquiry into Suicide and Safety in Mental Health led by Professor Louis Appleby. Professor Appleby also led on the report Suicide Safety in North Kensington, commissioned by Central and North West London NHS Foundation Trust, published in 2020, and which was discussed at select committee on 19 April 2021.

4. SCOPE OF THE WORKING GROUP

4.1 In line with the 2019 statutory guidance on overview and scrutiny, the development of the scoping document and terms of reference have considered:

- outcomes for a scrutiny members' working group on this issue
- a clearly focused terms of reference and how the work on this subject can be best carried out
- timeliness
- engagement with the Lead Member and officers. [2]

4.2 The scoping document in Appendix 1 sets out the potential themes for each evidence session. The working group will need a clear idea of what it hopes to get out of each session and how this will contribute to an evidence-based report.

4.3 The final output of the working group will be a report with recommendations. Recommendations should be evidence-based and SMART, i.e. specific, measurable, achievable, relevant and timed. The working group will share the draft report and recommendations with interested parties. It is suggested that six to eight recommendations are sufficient to enable a complete response. [3]

4.4 A project plan, shared with officers and members, will be produced to support the working group, which will report back to select committee with a full report and recommendations on 25 April 2024 for members to agree.

4.5 There will need to be ethical considerations when carrying out this work, particularly in the evidence-gathering stage.

[2] 2019 statutory guidance overview and scrutiny
[3] ibid

FOR DISCUSSION

Jacqui Hird
Scrutiny Manager

Background papers used in the preparation of this report:

'Suicide Prevention Strategy Update' 2 May 2023, Adult Social Care and Health Select Committee

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APPENDIX 1:

Scoping Document: Select Committee Working Group

Process:

1. Proposal

Initial outline of the proposed review is proposed at select committee or as part of the review of the Annual Scrutiny Work Programme agreed by the Overview and Scrutiny Committee.

2. Scoping document

If agreed in principle, a working group or member will work with the Scrutiny and Policy Officer to agree on the scoping document, involving executive directors and heads of service, the chair of the select committee and the chair of the Overview and Scrutiny Committee.

3. Select committee agreement

If the scoping document is agreed a select committee agree the terms of reference, based on the scoping document, and membership including the chair and any co-opted members.

4. Start review

Members of the working group complete the review supported by the Scrutiny and Policy Officer, according to a project plan highlighting the evidence sessions and participants.

5. Complete review

The working group will report back to the select committee within a specific timescale and deliver a full report and recommendations within its original terms of reference.

Review Title: Suicide Prevention and Adult Males as a High-Risk Group
Select Committee: Adult Social Care and Health Select Committee
Outcomes: 1. To engage with the voluntary sector, community organisations and affected residents, the academic community, NHS and Public Health professionals to understand the key issues relevant to suicide and suicide prevention amongst men. 2. To produce recommendations to influence the local authority and partnership's suicide prevention strategy and action plan. 3. To contribute to the development of proposals in the Suicide Prevention Strategy's action plan, particularly to reduce the risk factors for men.

Terms of Reference:

1. To understand in-depth the population profile of adult males who are at a higher risk, and the influence of the wider determinants of health.

2. To assess the risk factors affecting adult men as well as the protective characteristics among men which can inform prevention.

3. To review the issue of men's engagement with wider services, preventative services, barriers to seeking help or support at an early stage, and stigma.

4. To gain insight from the third sector, communities and community organisations in RBKC.

5. To review best practice in support services which may be tailored to men specifically from local and national charities and local third sector organisations.

Evidence Gathering:

The proposal is to start with two evidence sessions. The themes for these sessions to include:

Session 1
Review of local and national reported suicide data, risk factors particularly relevant to men, current priorities and actions.

Session 2:
Review of CNWL workstream on mental health and suicide prevention for men and engagement with representatives from national charities and the third sector in RBKC to understand best practice, preventative approaches and support for adult males and propose amendments and/or additions to current plans.

This will be followed by two other evidence sessions, including engagement involving the national third sector, and national experts as the working group develops.

Membership:

Cllr Lucy Knight, Chair
Cllr Mona Ahmed
Cllr Gerard Hargreaves

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THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

ADULT SOCIAL CARE AND HEALTH SELECT COMMITTEE

12 OCTOBER 2023

REPORT OF THE SCRUTINY MANAGER

SELECT COMMITTEE WORK PROGRAMME

1 EXECUTIVE SUMMARY

1.1 This report is an update on the select committee's development of the work programme for the municipal year 2023/24.

2 RECOMMENDATIONS

Select committee is recommended to:

2.1 Agree the work programme as set out in Appendix 1.

2.2 Note the response to actions and recommendations as set out in Appendix 2 and Appendix 3.

3 SELECT COMMITTEE WORK PROGRAMME

3.1 As set out in Part 5 Section 3 of the Council's Constitution, the Adult Social Care and Health Select Committee has a remit to scrutinise the provision and performance of adult social care services, partnerships associated with the delivery of adult social care services, the provision of the Public Health service, and related plans, strategies and decisions. The select committee also has an external remit to scrutinise NHS organisations, Trusts and health service providers and to review the provision of healthcare services.

3.2 The select committee has reviewed proposals by Central and Northwest London NHS Foundation Trust (CNWL) to vary services provided at the Gordon Hospital in the City of Westminster and St Charles Hospital Mental Health Unit in the Royal Borough of Kensington and Chelsea following the temporary closure of two inpatient wards at the Gordon Hospital. At the 29 June 2023 meeting the select committee agreed three recommendations to which the chief executive of CNWL has formally responded. This response is in Appendix 3.

3.3 The North West London Integrated Care Board (ICB) are now managing the formal public consultation process about the proposals for acute mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea. Following a period of discussion with CNWL and the ICB and other local authorities in the geographical area surrounding the area of the proposal it has been agreed that these two authorities that should constitute a new, specific joint health overview and scrutiny committee for the purposes of scrutinising the proposal. However, this means that assuming Full Council

agrees on 11 October 2023 to constitute the Inner West London Mental Health Services Reconfiguration JHOSC the borough's Adult Social Care and Health Select Committee will no longer review or respond to this proposal in future.

3.4 The select committee is advised to keep its work programme under review. It is proposed to move the report on the development of a new strategic plan for learning disabilities to the meeting on 1 February 2024 from 30 November 2023 to allow for the further development of the plan. It is also proposed to have report on the budget for Adult Social Care and Public Health, including the savings and growth options at the 30 November committee meeting.

3.5 Select committee members are advised that Overview and Scrutiny Committee will be reviewing the Annual Complaints Report 2022/23, including social care complaints and reports of the Social Care Ombudsman, on 15 November 2023. A report specific to complaints in the Adult Social Care department can also be brought to a meeting of the select committee.

3.6 One of the priority areas for select committee in this municipal year is maternity services. Care Quality Commission (CQC) reports for maternity services at Chelsea and Westminster Hospital Foundation Trust and Imperial College Healthcare NHS Trust Maternity services have now been published following inspections as part of the national maternity services inspection programme. The CQC rating for Chelsea and Westminster's maternity services was Good, and the CQC rating for maternity services provided at St Mary's Hospital, which is part of Imperial College Healthcare NHS Trust, was Outstanding.

3.7 As well as developing the work programme setting out the focus for meetings there was a commitment to develop a schedule of visits which will support the priorities of the work programme and will help members to better understand the delivery and operation of key departmental services in the borough. This is set out as part of the meetings of the select committee in Appendix 1. Other proposed visits include meeting officers at the NHS North Kensington Recovery Programme, and to a carers' charity in the borough or City of Westminster.

FOR DISCUSSION

Jacqui Hird
Scrutiny Manager

Background papers used in the preparation of this report: None other than previously published documents.

Contact officer: James Diamond, Scrutiny and Policy Officer

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Appendix 1

Adult Social Care and Health Select Committees 2023-24

Date of Meeting	Item	Outcomes	Source of Item	Lead Member/Officers
29 June 2023	Immunisation Services in RBKC	Scrutinise delivery of immunisation services in the borough	Annual Work Programme	Susan Elden, Consultant in Public Health NHS England Kevin Driscoll, NHS North West London, Integrated Care Board
	Update on the Gordon Hospital Inpatient Provision	Review the proposals for consultation following temporary closure of two wards	Select committee 2 May 2023	Ann Sheridan, Managing Director Jameson Division, Central and North West London NHS Foundation Trust Dr Gareth Jarvis, Medical Director, Central and North West London NHS Foundation Trust
	Directorate Scene Setting Report	Information item on the department's priorities and services	Annual work programme	Bernie Flaherty, Bi-Borough Executive Director Adult Social Care and Health Manisha Patel, Director of Operations, Governance
	Select Committee Work Programme Report	Select Committee to agree priorities for municipal year.	Annual Work Programme	James Diamond, Scrutiny and Policy Officer Jacqui Hird, Scrutiny Manager

Date of Meeting	Item	Outcomes	Source of Item	Lead Member/Officers
12 October 2023	Community-Based Palliative Care Services and Pembridge Hospice	To scrutinise the new model of care for palliative care community services and options for inpatient provision at Pembridge.	Select committee 29 November 2022	Dr Lyndsey Williams, NWL GP Clinical Lead for End of Life and Care Homes Jane Wheeler, Director, Local Care, North-West London NHS
	Home Care Recommissioning and Market Management	Scrutiny of proposals for new model of home care services in RBKC.	Annual Work Programme	Cllr Josh Rendall, Lead Member for Adult Social Care and Health Gareth Wall, Bi-Borough Director of Integrated Commissioning
	Suicide Prevention and Adult Males as a High-Risk Group	To convene a working group by agreeing terms of reference and membership.	Annual Work Programme	James Diamond, Scrutiny and Policy Officer Jacqui Hird, Scrutiny Manager
	Select Committee Work Programme Report	Select Committee to review the work programme.	Annual Work Programme	James Diamond, Scrutiny and Policy Officer Jacqui Hird, Scrutiny Manager

Date of Meeting	Item	Outcomes	Source of Item	Lead Member/ Officers
30 November 2023	Safeguarding Adults' Executive Board Annual Report 2022/23	Accountability for improvements to safeguarding of adults.	Annual Work Programme	Aileen Buckton, Independent Chair Safeguarding Adults' Executive Board Louise Butler, Bi-Borough Director of Adults Safeguarding
	Dementia Services in the Borough	To scrutinise new plan for dementia services in RBKC.	Annual Work Programme	Cllr Josh Rendall, Lead Member for Adult Social Care and Health Visva Sathasivam, Bi-Borough Director of Adult Social Care
	Adult Social Care and Public Health Budget	Scrutiny of budget and resources	OSC	Lisa Taylor, Director of Financial Management
	Select Committee Work Programme Report	Select Committee to review the work programme	Annual Work Programme	James Diamond, Scrutiny and Policy Officer Jacqui Hird, Scrutiny Manager

Date of Meeting	Item	Outcomes	Source of Item	Lead Member/ Officers
1 February 2024	Pharmacy Services in RBKC	Scrutinise enhanced services and local offer of community pharmacies and work with primary care	Annual Work programme	Chair, Local Pharmaceutical Committee Andrew Steeden, Borough Medical Director West London Anna Raleigh, Bi-Borough Director of Public Health
	Carers in RBKC	Support for carers in the borough and development of a new carers' strategy	Annual Work programme	Cllr Josh Rendall, Lead Member for Adult Social Care and Health Visva Sathasivam, Bi-Borough Director of Adult Social Care
	Learning Disabilities	To review new strategy for learning disabilities in the borough.	Annual Work Programme	Cllr Josh Rendall, Lead Member for Adult Social Care and Health Visva Sathasivam, Bi-Borough Director of Adult Social Care
	Select Committee Work Programme Report	Select Committee to review the work programme	Annual Work Programme	James Diamond, Scrutiny and Policy Officer Jacqui Hird, Scrutiny Manager

Date of Meeting	Item	Outcomes	Source of Item	Lead Member/Officers
25 April 2024	Grenfell Item: Mental health and Communities	Review results of services to improve adults' emotional wellbeing and mental health	Annual Work Programme	Cllr Josh Rendall, Lead Member for Adult Social Care and Health Gareth Wall, Bi-Borough Director of Integrated Commissioning
	Select Committee Work Programme Report	Select Committee to review the work programme	Annual Work Programme	James Diamond, Scrutiny and Policy Officer Jacqui Hird, Scrutiny Manager

Adult Social Care and Health Select Committee Visits 2023/2024

Date	Visit	Purpose	Organisation/Officers
June 2023	Alan Morkhill House	To understand care home services for older people particularly dementia support. The select committee will be reviewing the dementia strategy in 2023/2024.	Gareth Wall, Bi-Borough Director of Integrated Commissioning Miranda MacGill, Head of Care Design Bi-Borough Integrated Commissioning
July 2023	RBKC Learning Disability Resource Centre	To better understand day centre services for those with learning disabilities. The select committee will be reviewing the learning disability plan in 2023/2024	Gareth Wall, Bi-Borough Director of Integrated Commissioning Kevin Williamson Head of Provider Services (Adults)
August 2023	St Charles Mental Health Unit	Members to be aware of services provided at the unit ahead of a public consultation. Visit to the site discussed at select committee on 29 June 2023.	Ann Sheridan, Managing Director CNWL Jameson Division Dr Gareth Jarvis, Medical Director CNWL Jameson Division
TBC	Royal Brompton Hospital	Members invited to see the new diagnostic centre and facilities opened at the hospital. Opportunity for members to be updated on any service reconfiguration plans.	Luke Blair, Head of Communications, Royal Brompton Hospital

Adult Social Care and Health Select Committee Action Tracker

Key: red = incomplete, amber = in progress, green = complete
Complete actions will be removed from the tracker subsequent to being reported completed

Reference Number	Select Committee Meeting	Agenda Item	Action/Request for Information	Responsible Lead	Status	Response
A20221020/1	**20 October 2022**	**A5. Developing New Community Diagnostic Centres**	NHS staff to keep the Committee involved with ongoing progress and roll out of the scheme, and report back at a later date, including around the potential for a site in the borough.	NWL CCG	Officers have been contacted for an update.	
A20221020/2	**20 October 2022**	**A6. Lead Member's Priorities and Updates on ASCH and Public Health**	The Lead Member offered to bring the Home Care recommissioning programme back to the Committee at a future date.	Governance	Complete.	Scheduled for the 12 October 2023 meeting.
A20221020/3	**20 October 2022**	**A7. Mental Health Plan Development**	Officers to bring the final version of the plan back to the Committee, upon completion.	David Bello	Report has been postponed.	
A20221020/5	**20 October 2022**	**A9. Work Programme Report**	The Committee requested the circulation of relevant data about dentistry in the borough for future discussions.	Policy and Scrutiny Officer	Ongoing.	Scrutiny Policy Officer has requested the data on dentistry services from the NW London

						Integrated Care Board (ICB) as members will be aware that commissioning of pharmaceutical, general ophthalmic and dental (POD) services will rest with the ICB from 1 July 2023.
A20221129/6	**29 November 2022**	**A4. North-West London Palliative Care Services**	The Committee requested that colleagues share the Model of Care when it was ready.	NWL CCG	Complete.	Scheduled for 12 October 2023 meeting.
A20230227/8	**27 February 2023**	**A4. Winter Pressures**	NHS officers to provide data to the Committee on the effectiveness of the vaccination campaigns.	NWL CCG	Officers have been contacted for an update.	
A20230227/9	**27 February 2023**	**A7. Work Programme Report**	The Committee agreed that an update on Gordon Hospital, home care recommissioning, and the Health and Wellbeing Strategy	Governance	Complete.	Scheduled for the 12 October 2023 meeting.

			should be brought to the meeting on 2 May 2023.			
A20230502/1	**2 May 2023**	**A4. Update on the Gordon Hospital**	Data on all pathways' admission wait times prior and after the closure of Gordon Hospital to be shared with the Committee.	CNWL	Response circulated on 28/06/2023.	Attached as Appendix 1.
A20230502/2	**2 May 2023**	**A4. Update on the Gordon Hospital**	To consider what additional support would be made available when Grenfell tower comes down for the community.	CNWL	Response circulated on 28/06/2023.	Attached as Appendix 2.
A20230502/3	**2 May 2023**	**A5. Health and Wellbeing Strategy**	For the outcomes framework to be shared with the Committee once it has been formulated.	Bi-Borough Director of Health Partnerships	Ongoing.	A framework is being produced and the first draft and action plan will be ready by 23 November 2023.
A20230502/4	**2 May 2023**	**A6. Suicide Prevention Strategy Update**	To provide a background report to the Committee outlining projects where additional investment had been targeted.	Bi-Borough Director of Public Health	Response attached to June tracker.	

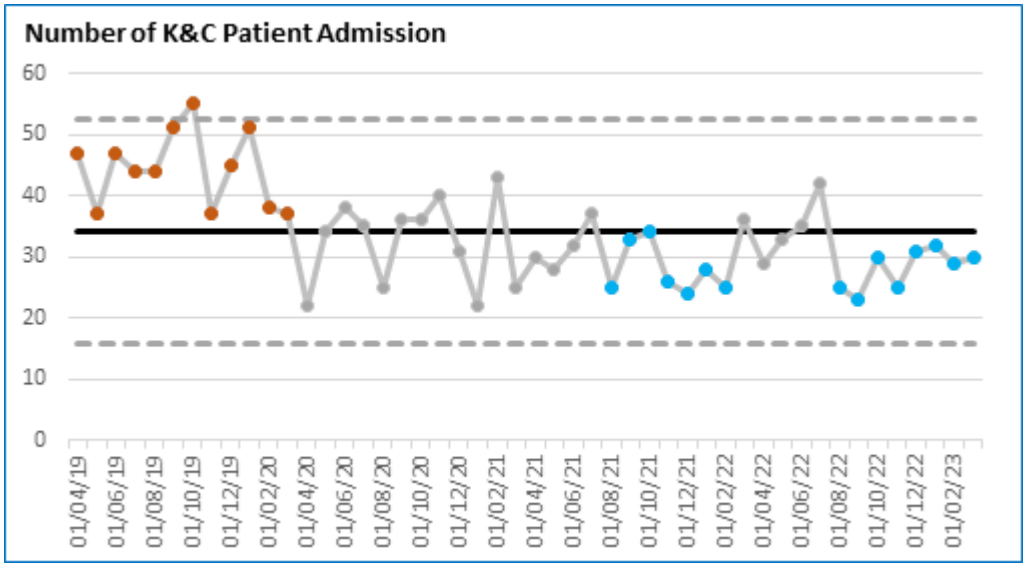
A20230502/5	**2 May 2023**	**A6. Suicide Prevention Strategy Update**	Officers to work with Healthwatch and improve community engagement online.	Bi-Borough Director of Public Health	Ongoing.	Officers will be engaging with Healthwatch as part of the development of its mental health digital platform and training offer. More details will be available at a later date once the engagement and user research is completed.
A20230629/1	**29 June 2023**	**A4. Childhood Immunisations**	The Bi-Borough Director of Public Health to link Healthwatch with the Immunisations Partnership Board.	Bi-Borough Director of Public Health	Complete.	The Healthwatch representative has been invited to the next meeting of the Board.
A20230629/2	**29 June 2023**	**A4. Childhood Immunisations**	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.	Bi-Borough Director of Public Health	In progress.	Will be provided on a quarterly basis, with the first update due at the end of October 2023.

A20230629/3	**29 June 2023**	**A4. Childhood Immunisations**	The Programme Director (NWL ICS) to update the Committee on progress of the response to the measles outbreak in some boroughs of London.	Programme Director (NWL ICS)	Officer has been contacted for a response.	
A20230629/4	**29 June 2023**	**A5. Update on the Gordon Hospital**	Officers to organise visits for Committee Members to Central and North West London NHS Foundation Trust services.	CNWL and Governance Services	The Committee are visiting the St. Charles Centre for Health and Wellbeing Centre in August 2023.	
A20230629/5	**29 June 2023**	**A5. Update on the Gordon Hospital**	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).	CNWL and Governance Services	Response provided on 07/08/2023.	Attached as Appendix 7.
A20230629/6	**29 June 2023**	**A6. Directorate Scene-setting**	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.	Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street	Will be provided on a quarterly basis.	Attached as Appendix 5.

A20230629/7	**29 June 2023**	**A6. Directorate Scene-setting**	The Bi-Borough Director of Integrated Commissioning to provide information on how commissioning decisions were made, the providers used, and the quality assurance process.	Bi-Borough Director of Integrated Commissioning	Response provided on 24/07/2023.	Attached as Appendix 4.
A20230629/8	**29 June 2023**	**A6. Directorate Scene-setting**	The Bi-Borough Director of Public Health to share data on residents reporting feeling anxious across London boroughs.	Bi-Borough Director of Public Health	Response provided on 19/07/2023.	Attached as Appendix 3.
A20230629/9	**29 June 2023**	**A6. Directorate Scene-setting**	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.	Bi-Borough Director of Adult Social Care Governance, Operations and Oxford Street	Response provided on 02/08/2023.	Attached as Appendix 5.

Appendix 1 (to Action Tracker)

Admissions have decreased following the temporary closure of the Gordon. We weren't collecting data on waits for a bed prior to the temporary closure as this data is measured manually through our Central Flow Hub which was set up in 2020, as such we can't compare this information. Everyone who needs a bed gets one, and we have sustained a position with no inappropriate out of area placements out of the Trust for 5 months. We know that waits for beds can be too long and are working with approved mental health professional leads on the processes within the pathway to bring these waits down.



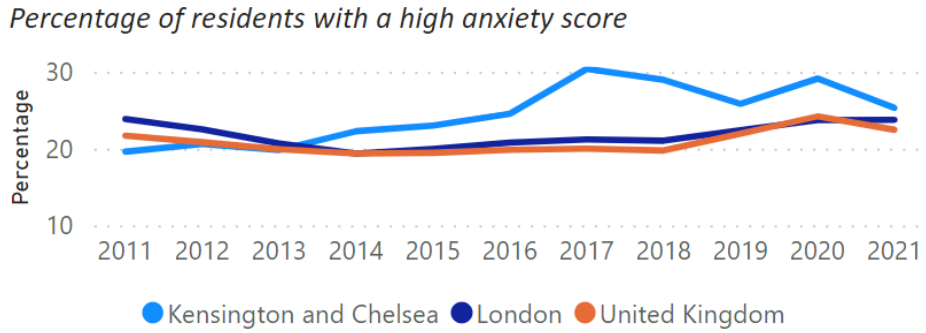
Appendix 2 (to Action Tracker)

In terms of Grenfell, the dedicated service and health and wellbeing service leads are working closely with the Community to understand the support that they feel is needed and we are working with them on a business case to the Integrated Care Board which will include clear plans for the future service. The Bi-Borough place based partnership mental health workstream is planning to have a specific focus on the Grenfell community, to ensure the new Integrated Neighbourhood Teams work for this community.

Appendix 3 (to Action Tracker)

In Kensington and Chelsea, 25% of residents report feeling anxious in 2021. This is equivalent to 1 in 4 adults

This is similar to the London (24%) and England (24%) average. There has been no significant change over the past few years, however more frequent national measurement detected increases in anxiety at the start of lock down periods.



Source: ONS personal wellbeing estimates, Annual Population Survey as included in the Office for Health Improvement & Disparities (OHID) Public Health Outcomes Framework Public Health Outcomes Framework - Data - OHID (phe.org.uk)

Across London, Greenwich has the highest self-reported anxiety score of 32%, while Barking and Dagenham has the lowest of 14.6%.

Self reported wellbeing: people with a high anxiety score 2021/22 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	-	22.6	22.1	23.0
London region	-	-	23.8	22.5	25.0
Greenwich	-	-	31.7	24.1	39.3
Richmond upon Thames	-	-	30.1	23.4	36.8
Kingston upon Thames	-	-	29.9	22.4	37.4
Southwark	-	-	29.5	21.1	37.9
Lambeth	-	-	28.4	21.0	35.8
Westminster	-	-	28.2	19.8	36.5
Camden	-	-	28.0	19.5	36.5
Croydon	-	-	27.4	20.1	34.6
Wandsworth	-	-	27.2	20.3	34.0
Hammersmith and Fulham	-	-	25.7	17.1	34.3
Kensington and Chelsea	-	-	25.3	18.3	32.3
Hillingdon	-	-	25.2	17.2	33.2
Haringey	-	-	25.1	18.2	32.0
Hackney	-	-	24.6	17.0	32.2
Harrow	-	-	24.5	17.6	31.4
Merton	-	-	24.5	18.0	31.0
Enfield	-	-	24.3	17.9	30.7
Hounslow	-	-	24.1	16.8	31.4
Barnet	-	-	23.5	17.7	29.4
Brent	-	-	22.7	14.2	31.2
Sutton	-	-	22.4	16.3	28.5
Bromley	-	-	22.0	16.3	27.7
Redbridge	-	-	21.6	14.6	28.5
Bexley	-	-	20.2	14.6	25.9
Lewisham	-	-	20.2	14.3	26.0
Islington	-	-	20.0	13.5	26.5
Havering	-	-	19.4	14.3	24.5
Newham	-	-	17.9	11.3	24.5
Ealing	-	-	17.9	12.0	23.8
Tower Hamlets	-	-	17.7	10.9	24.5
Waltham Forest	-	-	16.3	10.5	22.1
Barking and Dagenham	-	-	14.6	7.9	21.2
City of London	-	-	*	-	-

Source: Annual Population Survey (APS), Office for National Statistics (ONS) as included in the Office for Health Improvement & Disparities (OHID) Public Health Outcomes Framework [Public health profiles - OHID (phe.org.uk)]

Appendix 4 (to Action Tracker)

1. Commissioners work with a range of providers including the Voluntary Sector, NHS, Housing Providers, Charities, Care Quality Commission (CQC)-regulated providers, and grass root organisations such as Community Interest Companies (CICs) to deliver the range of services required for residents. Services are designed, planned, monitored, and reviewed in partnership with key and relevant stakeholders. This includes working together from the design stage with evidence-based approaches that use data from Joint Strategic Needs Assessments, service reviews, and benchmarking. Commissioners also undertake localised consultations to agree desired outcomes that can be measured and used to support service delivery.

2. Sometimes this entails working with the market to make adjustments or create new provision according to residents' preferences. This is often referred to as "market shaping". In all cases, this ensures that appropriate monitoring and oversight is in place to secure value for money and evidence added social value. Through contract management and market oversight, the Commissioning team also complements the roles of the CQC, local safeguarding and quality assurance teams, who check the quality of care residents receive.

3. Any new contracts, extensions and significant variations to service contracts are agreed through a governance process involving approvals though the Contract Governance Review Board and through a Key or Executive Decision process as appropriate.

4. All contracts include service specifications with key performance indicators that provide reassurance on several areas including equalities data, service outcomes, volumes of activity, and risks. Monitoring frameworks provide clarity on the information that is required from providers at agreed intervals. Analysis and review of the information is supported by monitoring meetings and visits to services. The meetings can be multi-disciplinary and involve other relevant teams across operational services, such as Quality Assurance, Health and Housing.

5. There are also a range of partnership forums that take place with providers, such as the North Kensington Recovery Forum. These enable collaboration and the sharing of good practice and information with key partners such as Kensington and Chelsea Social Council, Health and departments across the Council.

Appendix 5 (to Action Tracker)

1. **Wording in the report**: Working across the Council to strengthen joined-up working between housing, public health, housing and community safety, and trialling Community Health Workers in Golborne ward and the World's End estate.

   Progress update*: Community Health and Wellbeing Workers are proactively approaching residents across the World's End estate, the Kensal Rise estate, Trellick Tower and Edenham Way. They do this from an assigned list on a monthly basis, with a focus on building a trusting relationship that will enable meaningful engagement and support around health and wellbeing and positive outcomes around prevention, early intervention, community engagement and general support. There is positive feedback on how the team have been able to engage and connect with other council services to achieve positive outcomes for residents, such as repairs, pest control and cost of living support.*

2. **Wording in the report**: Following the end of the s75 agreement, re-assigning staff to the respective Council's management while maintaining high service standards will be a priority.

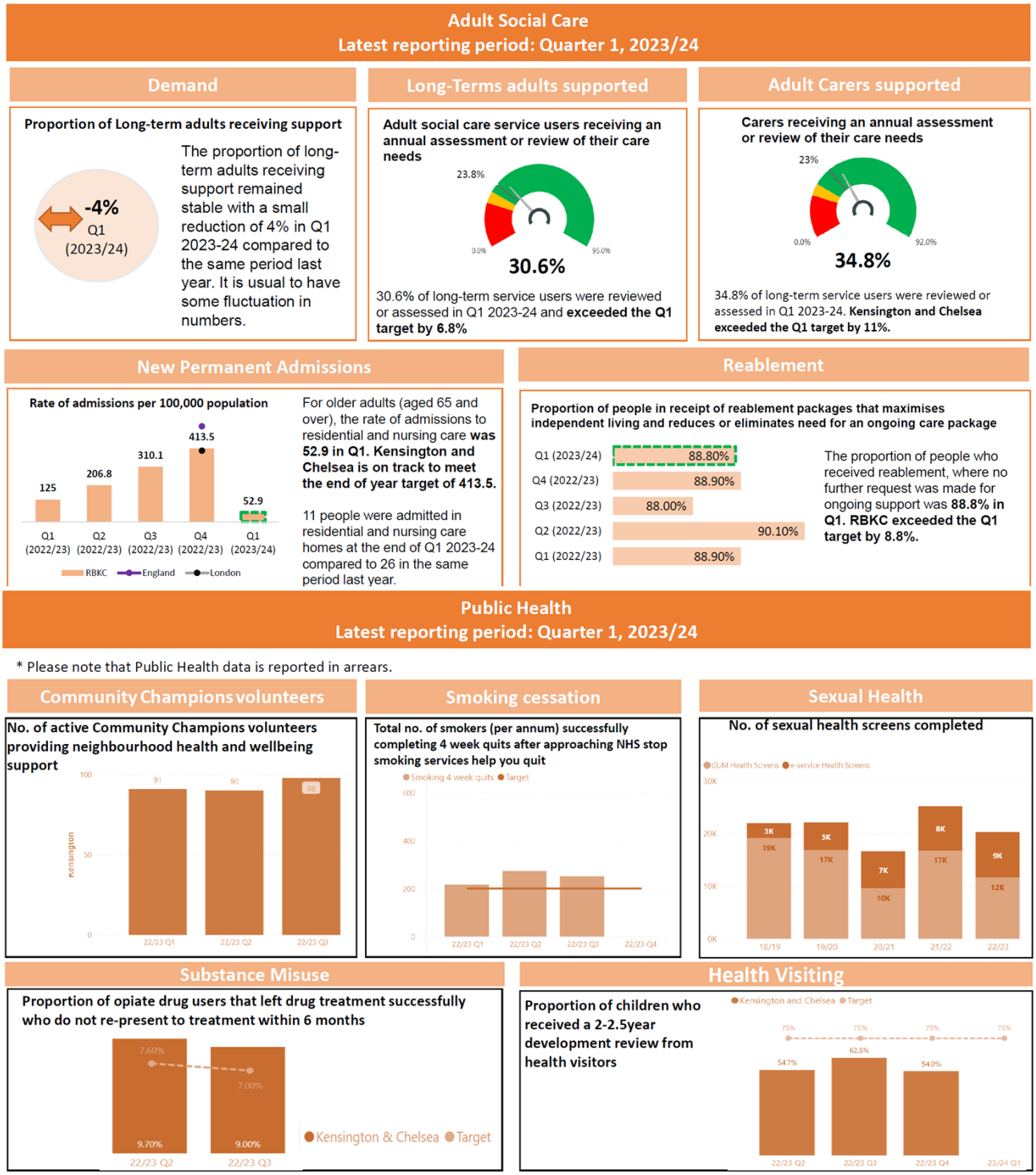
   Progress update*: The s75 consultation has finished, and the new staff structure is planned to go live in September 2023. There is currently a transitional plan in place to ensure a smooth handover and that the transformation's intended outcomes are embedded in the way the service operates.*

3. **Wording in the report**: Ensuring the physical infrastructure is in place to provide appropriate and high-quality care for service users through, for example, building a world-class facility to support adults with learning disabilities at Maxilla in north Kensington.

   Progress update*: The Maxilla site will create more shared community space in North Kensington and will include a new day service location for adult social care and a café run by the community group. The demolition work will commence in Autumn 2023, which will be followed by construction in July 2024.*

Appendix 6 (to Action Tracker)

Adult Social Care Main Performance Indicators – Latest reporting period: Quarter 1, 2023/4



Appendix 7 (to Action Tracker)

The table below shows the changes in the requested metrics for residents of Kensington and Chelsea in the year before and the years since the temporary closure of the Gordon.

Data on the number of detentions is held by Approved Mental Health Professional (AMHP) services in the area which are Local Authority services. We have provided the information about total admission numbers, a proportion of these will be informal admissions. When looking at AMHP data on detention rates, it is important to remember that the Gordon and St Charles would only admit residents of a Central North West London borough who are 18-65 years old.

Total admissions have gone down as we are caring for more people in the community which is in line with the direction of travel in the Long Term Plan to provide more care in the least restrictive setting.

Average length of stay dropped in the year following the Gordon closure. We measure Length of Stay on discharge and have a programme of work focused on reducing the number of people who are staying longer than 60 days which impacts average length of stay.

Rather than failed discharges we have the measure of rates of patients who were readmitted within 28 days, this could be for a number of different reasons. For Kensington and Chelsea residents we have seen a drop in readmission rates in the years since the Gordon wards temporarily closed.

	2019/20 (pre temporary closure)	2020/21	2021/22	2022/23
Total admissions *Monthly average*	44	32	30	30
Length of stay *Average*	37 days	32 days	37 days	36 days
Readmission rates *Monthly average*	9.9% (4.5 people a month)	8.4% (2.75 people a month)	7.6% (2.3 people a month)	8.5% (2.5 people a month)

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Central and
North West London
NHS Foundation Trust

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3 August 2023

Councillor Lucy Knight
Chair, Adult Social Care and Health Select Committee
Royal Borough of Kensington and Chelsea
Kensington Town Hall
Hornton Street
Kensington
London W8 7NX

by e-mail via: james.diamond@rbkc.gov.uk

Dear Councillor Knight,

Thank you for your letter dated 5 July 2023 and for the invitation to speak at the Adult Social Care and Health Select Committee. We welcome the opportunity to work with the Committee on this important matter.

The consultation process is led by North West London Integrated Care Board (NWL ICB) and as such I have copied our response to Rob Hurd, Chief Executive, and Toby Lambert, Executive Director of Strategy and Population Health.

Turning to the recommendations of the Committee in relation to the Pre Consultation Business Case (PCBC) and how we are ensuring these are reflected in our work:

1. Inclusion of an option of refurbishment and investment at the Gordon Hospital so that modernised inpatient services can be reopened which meet high-quality standards of care for patients

We are assessing a number of options involving the reopening of inpatient services at the Gordon. These include fully reopening the three wards with bed numbers the same as in 2019, and options which reopen with fewer beds, but which are closer to delivering good quality modern facilities. None of these options will fully meet a standard of "high quality modernised inpatient services," because the physical constraints of the building and its location mean it is impossible to provide high quality modern inpatient services that comply with the Royal College of Psychiatrist's essential, expected and desirable standards – for example, good, safe unlimited access to outdoor space.

2. Consideration of the implications of rising demand for mental health services in RBKC, the inpatient services needed to help meet the mental health needs of RBKC residents (particularly in the context of the Grenfell tragedy), and commissioning of additional acute mental health inpatient provision as required

We have closely monitored the demand for inpatient care throughout the temporary closure of the wards and have seen a drop in the number of admissions across RBKC and the City of Westminster. We are required to find an inpatient bed for every resident who needs one, with assessments carried out by NHS and Local Authority staff. In RBKC, we were admitting an average of 44 people a month in 2019/20. This number has fallen to 30 people a month in 2022/23. We believe this is as a result of improvements in community services which allow us to meet the needs of more people in the community and prevent the need for an admission. Evidence tells us that treatment and support in the community is clinically more effective in most cases.

We know there will be times when the right care for a resident involves an admission, and it is our duty to provide an inpatient bed for anyone who needs one who is a resident of the boroughs CNWL serves. We currently have no inappropriate out of area placements (inpatient admissions for residents of CNWL boroughs to beds not provided by CNWL).

We have considered future demand for inpatient services as part of our analysis. Projections suggest an increase in demand is unlikely, however we will be monitoring this closely and if we need to commission additional beds to support changing demand in the future we will work with NWL ICB to do so.

<u>Dedicated Service and Grenfell Health and Wellbeing Service</u>

Our Dedicated Service and Grenfell Health and Wellbeing Service have worked with the bereaved and survivors to understand the support that they want and need. We know that overwhelming demand is for improved community services. All the information we have suggests that while the Grenfell tragedy has increased demand for community mental health services, there has been no corresponding increase in demand for inpatient hospital provision. We are continuing to work with the Grenfell community and NWL ICB to define the future of these really important services.

3. Urgent review of any pressure on services at St Charles Hospital, and wider mental health services in RBKC, which have resulted since the temporary closure of the Gordon Hospital wards

We continue to monitor the impact on other, non inpatient services in the City of Westminster and RBKC. We believe the reduction we have experienced in inappropriate out of area placements suggests we have the right overall bed capacity across NWL, once we take into account additional beds which we are putting in place to support patients from outer London boroughs who

historically received care at the Gordon and would currently need to be admitted into St Charles.

We have seen more than twice the amount of people accessing community mental health hubs in RBKC over the last three years and are proud that our community teams are seeing and meeting the needs of many more people in the borough.

We are working closely with your officers to understand any impact on AMHP services and with the Police to do the same and are grateful for their support. We have yet to find any data or evidence which suggests that the best way of addressing pressures on wider mental health services is to significantly increase inpatient provision.

Although we are able to place residents into a bed when they need one we accept that sometimes the process is too long and admissions can be delayed as a result. We believe the services which will have the biggest impact on wider pressures are those such as the Mental Health Crisis Assessment Service (MHCAS) which are directly focussed on supporting people experiencing crisis. Our experience shows that those who are assessed in the MHCAS are less likely to end up needing an acute bed than those assessed in A&E. The options under consideration for the consultation include how we can further augment this provision.

Thank you again to the Committee for your support and input into the process so far. Please do not hesitate to contact me or my team if you would like to discuss any aspects further.

Yours sincerely,

Claire Murdoch
Chief Executive

cc.
Rob Hurd, Chief Executive, North West London ICB
Toby Lambert, Executive Director of Strategy & Population Health, North West London ICB
Ann Sheridan, Managing Director, Jameson Division, CNWL

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