Minutes of the Meeting of the North West London Joint Health Overview & Scrutiny Committee held in the Committee Room 3, Kensington Town Hall, Hornton Street W8 7NX at 10.00 am on Tuesday, 12 September 2023

PRESENT

Committee Members

Cllr Ketan Sheth (Chair)
Cllr Natalia Perez (Vice-Chair)
Cllr Nick Denys
Cllr Chetna Halai
Cllr Lucy Knight
Cllr Angela Piddock
Cllr Marina Sharma
Cllr Claire Vollum
Cllr Ben Wesson

Others Present

Rob Hurd, Chief Executive Officer
Gareth Jarvis, Medical Director
Rory Hegarty, Director of Communications and Engagement
Toby Lambert, Director of Strategy and Population Health
Carolyn Regan, Chief Executive Officer
Michelle Scaife, Programme Delivery Manager - Last Phase of Life
Jane Wheeler, Director, Local Care
Katie Horrell, Assistant Director - Mental Health Transformation
David Harman, Communications Manager

Council Officers

Emily Beard, Governance Officer (RBKC)
David Bello, Head of Mental Health Services & Substance Use Team (RBKC)
James Diamond, Scrutiny & Policy Officer (RBKC)
Jacqui Hird, Scrutiny Manager and Statutory Scrutiny Officer (RBKC)

1 APOLOGIES FOR ABSENCE AND CLARIFICATION OF ALTERNATE MEMBERS

No apologies for absence were received.

2 DECLARATIONS OF INTEREST

The Chair, Councillor Ketan Sheth (Brent Council), declared a non-pecuniary interest that he was the Lead Governor at Central and North West London NHS Foundation Trust (CNWL).

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 18 July 2023 were confirmed as a correct record and signed by the Chair.

4 MATTERS ARISING

There were none.

5 PROPOSALS FOR CONSULTATION ON THE NORTH WEST LONDON WIDER REVIEW OF PALLIATIVE CARE

The Chair invited Jane Wheeler, Acting Deputy Director (Mental Health), NHS North West London, to introduce the report and the following points were made:

1. The proposed model of care had been co-produced.

2. Currently, not all boroughs in North West London provided the same offer of palliative care for residents within their own homes. The support for support residents received from out-patient services was also inconsistent.

3. There was currently some unmet need for people that needed to be in bedded provision which is therapeutic and provides access to a specialist team.

4. Engagement was ongoing and would progress to engagement over the options of delivery and commissioning, prior to formal consultation on the new model of care.

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

1. Questioned whether the new model of care would ensure that there would be sufficient capacity for inpatient beds in the future. Jane Wheeler shared that they had completed detailed modelling on future demand, and it showed that there were approximately 3,000 residents that needed specialist services, not bedded care. Unmet need had also been modelled and projections showed that capacity would be sufficient for seven years.

2. Asked for an update on the Pembridge Hospice and whether it was considered to be part of the inpatient capacity in the future. Jane explained that consideration of Pembridge would happen at the next stage, where options for delivery would be considered. Most of the changes were about services not in bedded units. Consultation on options for delivery, including Pembridge, would happen through the winter months.

3. Sought assurance that palliative care specialists would be recruited and retained to enable successful delivery of the model. In response, Jane shared that providers had been working closely together on workforce and had been

sharing approaches. Plans for workforce would be phased and there was a multi-year plan to bring in the proposals on workforce and organisational development. The modelling and plans took into account current activity across the boroughs and unmet need.

4. Queried how engagement would involve diverse communities. Jane shared that the engagement had included working across North West London, individual boroughs, and specific demographic groups. Outcomes of the initial work with specific groups had been published on their website, including a table of different conversations and groups. They had gone back to groups to see if the proposed model addressed issues raised initially. The key message had been about the importance of personalised care. Jane felt that the 24/7 advice line responded to that and the issue of not knowing who to call.

5. Questioned the criteria for determining the appropriate length of stay at each stage and how stepping up and down would be facilitated. Jane explained that the majority of patients would need little bits of all of the service. In the new model, the care coordination function would be enhanced, with a single person for a patient to go to and would help with stepping up and down. Michelle Scaife added that hospice inpatient beds were not for long term stays, the intention was to use them to stabilise a patient and then return them to their previous place of care. In Hillingdon, enhanced end of life care beds were currently running with a three-month stay. The idea was to meet needs every step of the way, with needs varying throughout the journey.

6. Enquired whether the review would be presented to the Hounslow Borough Based Partnership and noted that there had been review of Meadow House Hospice, which states that it was struggling to meet capacity. Jane said that they had linked in with each boroughs for opportunities to speak and they would go back to check they were booked in at Hounslow, however, they had engaged with Hounslow at the Hounslow Borough Based Partnership. They were aware of the pressures at Meadow House and noted that the south of Hillingdon and Hounslow had the worst access to inpatient units, whilst experiencing high levels of population growth. This would be taken into account when looking at placement of provision.

7. Sought assurance that resources were going towards advance care planning. Jane shared that the universal care plan was able to integrate with the ambulance service systems and they needed to promote uptake of that. There was now a dashboard to track the delivery of this. Michelle Scaife added that they were looking to support specialist palliative care teams, primary care and district nurses with advance care planning.

8. Queried whether the expectation would be for patients to travel further and where would the provision be provided, and asked how the new model of care would help those with complex needs. Jane explained that responding to residents' needs with the right support as an entire system means that those with the most specialist support have better access to the capacity and skills they need. Jane clarified that at the options stage it would be decided where provision would be located which would be focused on responding to needs with the right support. Options would be discussed with partners and

residents, there would be trade-offs as services currently span very large geographical areas.

9. Noted that the community engagement report detailed concerns about communities accessing services in a timely and appropriate way that reflected cultural and faith needs, and asked what was being done to address this. Jane acknowledged that not enough was being done on this yet, however, as options were developed the work would happen to ensure that services would be culturally competent and sensitive. Michelle Scaife added that all providers were committed to being more inclusive and some were already doing this work. The current provision did not include all religious leaders, however, there was a commitment to personalised care to meet a patients' religious needs.

10. Asked about the offer and support for unpaid carers. In response, Jane shared that support for carers was increasing, with the 24/7 advice line, as well as wellbeing and practical support. Michelle noted that there was respite support that allowed carers to leave the home for up to four-hour blocks and there were alternative options for those who could not be cared for at home. There was also advice for funeral planning and will-making. A Committee Member questioned how such block visits would be staffed. Jane clarified that there was an NHS funded caring workforce, but they were aware of pressures. Taking on additional specialisms allows for career development and would help to retain the workforce.

11. Asked about the steps taken to standardise provision for consistent quality of care across services and boroughs, and queried whether there was best practice in the NHS. Jane explained that there was best practice but there was not an off the shelf answer, which is why they had to co-design to such detail. Wellbeing services were co-founded with the charitable funding, as were some hospices. Work was being undertaken to identify such services and standardise the offer.

The Committee RESOLVED to recommend that North West London Integrated Care System:

1. Design principles around partnership working to enable patients and families to hold partners to account, following the implementation of the new model.

2. Bring a report on advanced care planning for palliative and end of life care to come to a future JHOSC meeting.

Actions to be completed, with information requested by the Committee to be sent to the JHOSC Support Officer:

1. To provide information on where the gaps in resource with palliative and end of life care are, how they will be addressed and how this will be monitored.

6 NORTH WEST LONDON MENTAL HEALTH STRATEGY

At the Chair's invitation, Carolyn Regan, Chief Executive, West London NHS Trust, introduced the report raising the following points:

1. Data analysis was being completed to assess need, prevalence and demand and would be available by the end of September 2023. There was a Working Group which included representation from all boroughs and there had been some engagement events.

2. The approach was building on Joint Strategic Needs Assessments and setting out key principles.

3. The first phase was only looking at adult services, and children and young people would be brought in at phase two.

4. The ambition was for the first draft to be shared with stakeholders in October 2023.

The Chair then invited questions from the Committee. Committee Members:

1. Queried why a phased approach was being taken. Carolyn clarified that it has been decided to approach it in bitesize pieces and from speaking to service users, it was clear that there were key differences between adults and young people. The next phase would focus on the transition period for 16- to 25-year-olds.

2. Expressed concern that the Strategy duplicated the work of their borough's Health and Wellbeing Strategy and suggested that the Strategy should include a greater focus on ensuring sufficient community provision for mental health patients. Carolyn shared that there were differential ways of managing the beds across North West London, with one of the limiting factors in some places was supported housing.

3. Sought to understand what work was being undertaken on neighbourhood population health and questioned if the team was working with primary care networks to address where need was greatest. In response, Carolyn explained that the work was currently taking place to map community mental health teams against primary care networks and third sector partners. Gareth Jarvis added that there was variation of provision, and they were trying to find best practice examples. Gareth encouraged all boroughs to provide the data that had been requested for the analysis.

4. Asked whether the Mental Health Crisis Assessment Service (MHCAS) would continue and if additional MHCAS would be established elsewhere in North West London. Gareth Jarvis responded that it had been successful, despite originally starting as a temporary winter measure. However, there was limited funding and lots of moving parts to consider as part of the consultation. The Member emphasised the importance of communication of the MHCAS. Carolyn explained that there were alternative options to accident and emergency in all boroughs but only 50% of advance calls asked where alternative provision was located, and the NHS would like to increase this. They were exploring setting up an MHCAS in the West of North West London. Rob Hurd acknowledged that communication had been a recurring issue and it was something that they needed to continue to work on.

5. Shared that Hillington Council were completing a review of children's mental health services and enquired whether the two phases could run in conjunction, as a lot of the work needed to be done together. Katie Horrell explained that they would run in parallel. The work on children and young people had begun and it tied in with the refreshment of the transformation plan and the work of Imperial College Health Partners. They were happy to link in with any local work on this area.

6. Asked about whether they were working alongside Councils' public health team for their engagement work. Carolyn confirmed that they had been working with Council's public health teams, engagement teams and borough teams. The Committee requested further details on the engagements plans when available.

7. Noted that there was recognition in the report that priorities were not currently being met and that there were gaps in the offer and asked what those gaps were. Katie explained that this had come through during engagement and had included things such as ability to access services, support when waiting, offering services in non-traditional environments and support when experiencing loneliness and isolation. Workforce was also a big theme. Rob Hurd added that Imperial College Health Partner's Mission Three was about understanding of factors and root cause for demand.

8. Enquired whether enough preventative work was taking place, particularly in schools. Carolyn shared that there were mental health teams linked to most schools in North West London and they were conducting a stocktake of what this work involved.

9. Questioned if provision was consistent across partners. In response, Carolyn explained that they had greater infrastructure with MIND than other third sector partners. In West London, MIND ran three of the alternative safe spaces. Gareth Jarvis added that there was specific funding for each borough dedicated for the voluntary sector. Rob Hurd explained that there was £30 million of additional investment into mental health generally and this needed to be redistributed to need and outcome levels across the boroughs to produce equity of funding.

10. Asked whether school curriculums were being utilised to break down the taboo of mental health. Carolyn shared that part of their engagement work was speaking to communities they had previously had less engagement with to understand how to reach out better to these groups. There was also data to understand who mental health services were struggling to reach.

11. Queried whether there were any early indications in conversations about themes related to wider determinants and a desire for a more holistic approach. Carolyn confirmed that factors such as the cost of living and housing were coming up in a large majority of conversations. Requests for more holistic support, for example, not just prescribing medicines, was also a big theme. Gareth Jarvis acknowledged that more work needed to be done around social determinants and intersectionality. There was currently borough analysis and ward analysis being undertaken in this area.

The Committee RESOLVED to recommend that North West London Integrated Care System:

1. Provide a report to a future JHOSC meeting on the engagement with Directors of Adult Social Care at each borough around coordinated activity on mental health within the region.

2. Provide a report around mental health provision for children and young people to come to a future JHOSC meeting.

Actions to be completed, with information requested by the Committee to be sent to the JHOSC Support Officer:

1. To receive the details of the alternative provision to accident and emergency located across the boroughs.

2. To receive further details around on the engagement plans when available.

3. To receive more information around plans or existing activity to support people and communities in deprived areas or intersectional needs.

7 CONSULTATION PROPOSALS ON THE FUTURE OF THE GORDON HOSPITAL

Toby Lambert, Director of Strategy and Population Health, North West London Integrated Care Board (ICB), introduced the report and explained that it was solely about the future of acute mental health services for adult residents of the Royal Borough of Kensington and Chelsea and Westminster City Council and where to allocate mental health investment.

There were four options which had come out of the workshops, which included:

1. To return to the status quo in 2019 (prior to the closure).

2. To continue with the current provision, with inpatient services only available at the St Charles Centre for Health & Wellbeing.

3. To move the Mental Health Crisis Assessment Service to the Gordon Hospital and keep everything else the same as current arrangements.

4. To reopen some beds at the Gordon Hospital, at a smaller scale than previously.

It was yet to be decided which options would be included in the formal consultation but the ICB and Central North West London NHS Foundation Trust's (CNWL) were committed to a discussion about all options.

On invitation from the Chair, Committee Members:

1. Noted that it was concerning that the report incorrectly stated that Kensal Town was an area of high deprivation in the Royal Borough of Kensington and Chelsea, as Kensal Town was located in Brent. Toby Lambert apologised

for the error and shared that they had conducted considerable work on understanding where the patients who used Gordon Hospital had come from and where they were currently going to.

2. Enquired as to what the feedback had been from service users of the Gordon and families who had supported patients. Gareth Jarvis confirmed that service users and carers of those who had used the Gordon in the past had been part of all workshops. There had been a range of views, some of which had not been aligned with CNWL's views, whilst others did align. They all expressed that they felt heard through the process. The core demographic was previous service users of the Gordon Hospital. The Committee requested to see the feedback and the numbers of those individuals who attended the workshops. Toby confirmed that they could provide commentary and output of workshops (which was also available online), the specific engagement events with service users and carers, 2019 reports from service users of the Gordon Hospital, and the full consultation plan.

3. Enquired whether there was historical demographic data of Gordon Hospital service users. Toby confirmed that they could provide data broken down by age, ward, and ethnicity. They also had data on those who were attending St Charles Centre for Health and Wellbeing who would have previously attended the Gordon Hospital and the associated travel time.

4. Asked whether the voices of other residents in North West London had been heard. Toby explained that 85 to 90% of the service users were residents of the Royal Borough of Kensington and Chelsea or Westminster City Council. The next largest group was Brent Council whose residents accounted for almost all of the remainder of service users.

5. Questioned how the consultation would be accessible for those less competent with technology. Toby Lambert shared that they had data on the particular wards with high levels of usage, which can be broken down by ethnicity and age. Groups have been identified and there was an extensive schedule of engagement to reach such groups and a planned programme with messages and outreach.

6. Queried whether they had taken into account any of the London Mayor's six conditions. Toby explained that they had done some preliminary work on this. The Mayor of London had confirmed that he would be applying the six tests on the process. The first four tests would run in conjunction with the first part of the consultation and the last two tests, would follow afterwards. Rory Hegarty added that there were also NHS England tests and scrutiny in forums such as the JHOSC.

7. Enquired whether there had been any learnings from mental health beds in Ealing. Carolyn responded that learnings had included the importance of engagement at a very early stage and making information clear. Rory Hegarty invited feedback on areas that they may be missing or areas of particular focus.

The Chair then asked a question on behalf of a member of the public who:

1. Sought assurance that there would be information available on the resource and funding issues and how the options would provide better outcomes. Toby responded that there was information available in the report about the pre-consultation workshops, however, acknowledged that it may not be easily digestible for someone who did not attend. The Committee emphasised the need for jargon-free, understandable information. Rob Hurd added that this was not about saving money, as mental health investment had increased over recent years.

The Committee then discussed the proposal of a separate Joint Health Scrutiny Committee being established by the Royal Borough of Kensington and Chelsea and Westminster City Council for the purpose of continuing the scrutiny of the Gordon Hospital proposals. The discussion included the following points:

1. It would provide more focus and benefit the residents of the boroughs who are most effected by the proposals.

2. Legally, only one Joint Health Overview and Scrutiny Committee could provide the formal feedback to the consultation and thus, there would need to be clarity on this.

3. It would be difficult for other boroughs to contribute to the scrutiny as the impact was minimal to their residents, however, would be happy to support the two boroughs to scrutinise.

4. Would value the opportunity to input to the scrutiny, in the spirit of collaboration.

5. There was value in all eight local authorities contributing even where the impact is more limited, especially to understand best practice models.

The Committee supported the Royal Borough of Kensington and Westminster City Council's intention to form a Joint Health Overview and Scrutiny Committee comprising the two boroughs to carry out the formal scrutiny. It was decided that the Chair would decide in due course if an update was required in December 2023 at the next Joint Health Overview and Scrutiny Committee meeting.

Actions to be completed, with information requested by the Committee to be sent to the JHOSC Support Officer:

1. To provide the following:
    - The commentary and output of the pre-consultation workshops.
    - Completed and upcoming events with service users and carers.
    - Service users' experience of Gordon Hospital.
    - A more detailed consultation plan.
    - Historical reports of Gordon Hospital service users over the last 5 years.
    - Historical demographic data of Gordon Hospital service users.

8 LONDON JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE RECOMMENDATIONS TRACKER

A Committee Member suggested adding two items to the Work Programme:

1. Oversight of the review of the Better Care Fund.

2. The national programme for Integrated Care Systems to reduce overhead costs and the associated impact on local NHS commissioning.

9 ANY OTHER URGENT BUSINESS

There was none.

The meeting ended at 12.02 pm

Chair