Minutes of the Meeting of the Inner West London Mental Health Services Reconfiguration Joint Health Overview and Scrutiny Committee held in the Westminster City Hall, Rooms 18.01-03, 64 Victoria Street London SW1E 6QP at 6.30 pm on Monday, 22 July 2024

PRESENT

Committee Members

Cllr Concia Albert (Chair) (Westminster City Council)
Cllr Lucy Knight (Vice Chair) (Royal Borough of Kensington and Chelsea)
Cllr Gillian Arrindell (Westminster City Council)
Cllr Dr Mona Ahmed (Royal Borough of Kensington and Chelsea)
Cllr Lorraine Dean (Westminster City Council)
Cllr Anne Cyron (Royal Borough of Kensington and Chelsea)

Others present

Clive Caseley (Verve Consultancy)
Cleo Chalk (Service Manager at Healthwatch Brent)
Toby Lambert, North West London Integrated Care Board
Sally Milne, Associate Director of Strategy, System Transformation & Partnerships, Central and North West London NHS Foundation Trust
Professor Jill Manthorpe, Kings College London

Council Officers present

David Bello, B-Borough Director of Health Partnerships
Jacqui Hird, RBKC Scrutiny Manager and Statutory Scrutiny Officer
Clare O'Keefe, WCC Lead Policy and Scrutiny Advisor
Robert Sheppard, RBKC Head of Governance & Mayoralty

1 APOLOGIES FOR ABSENCE

Apologies were received from Councillor Anne Cyron (the Royal Borough of Kensington and Chelsea). No other apologies for absence were received.

2 DECLARATIONS OF INTEREST

Cllr. Mona Ahmed indicated that she was an NHS employee, a psychiatrist working at St.George's Hospital in SW London. No other declarations of interest were made.

3 MINUTES OF PREVIOUS MEETINGS

a) Minutes of the Meeting of 20 February 2024

The minutes of the meeting held on 20 February 2024 were confirmed as a correct record for the Chair's signature.

b) Minutes of the Meeting of 26 February 2024

The minutes of the meeting held on 26 February 2024 were confirmed as a correct record for the Chair's signature.

4 ACTION TRACKER

The Chair provided a recap on the establishment of the Joint Committee between Kensington and Chelsea and Westminster Councils and summarised the Joint Committee's work over the five meetings to date.

The Action Tracker report was received and noted.

5 REPORT OF THE INNER WEST LONDON MENTAL HEALTH SERVICES JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

The report was received and noted.

6 COMMUNITY PERSPECTIVES ON THE IMPACT OF THE CLOSURE OF ACUTE MENTAL HEALTH SERVICES AT THE GORDON HOSPITAL

Cleo Chalk (Service Manager at Healthwatch Brent) introduced the report and explained that Healthwatch had been invited to do this work to gather information on patient experiences and their views on the proposed changes. This engagement activity was carried out during July-September 2023 but continued during the consultation period.

In terms of key findings, there was no clear consensus on the 'best way forward' and as such Healthwatch was not lending its support to any one option. However, one message that did come through quite clearly was that whilst good community provision was valuable it could not make up for a lack of in-patient acute beds. Other concerns centred on issues around continuity of care, especially for homeless people, and the limitations of the Gordon Hospital as a therapeutic space.

Cleo also flagged some disappointment at not having received as much direct feedback from service users as had been hoped – an issue reflected in the consultation as a whole. It was important to note too that the Verve report did in many ways echo Healthwatch's findings, namely that while there was a slight preference for Option 3 (the preferred option), questions remained around this and various issues needed to be further explored, ideally through co-production/co-design.

Questions and issues raised by Members included the following:

- The need to engage more, in terms of vulnerable groups, with the learning disabled
- The need to give further though to the best ways of getting service users more involved in co-production/co-design of services.
- The qualitatively valuable feedback from frontline staff both in the community or on the acute wards. In response Cleo noted that staff were

overwhelmingly concerned about handling service pressures and needed reassurance on the ability to maintain service quality in the face of an upsurge in patient numbers: there were concerns too that proper triage was crucial to prevent more patients coming via community services when that might not in reality, be the best treatment for them.

- In response to a question about key themes not already mentioned, Cleo flagged two, perhaps conflicting, themes – one from those who know the Gordon Hospital, who didn't feel it was an appropriate place for in-patient care; and, on the other hand, a feeling that Westminster does need acute in-patient capacity in-borough.

The Chair thanked Cleo Chalk for the report and for her presentation.

7 THE GORDON HOSPITAL - OPTIONS AND AMBITIONS

Professor Jill Manthorpe, CBE spoke to her report, which was commissioned by the two councils in order to hear from their staff and from a wide range of partner organisations. She noted widely held perceptions that the Gordon Hospital had been 'closing' for some time, e.g. while the Care Quality Commission has the Hospital registered as having 51 beds, at the time of the pandemic there were only 23 in-patients there. As such there was a clear hope expressed that councils and their partners could be involved in service development (such as the community-based pilots that had been starting); and there were particular concerns expressed about the homeless, their often fragmented way of life, and the challenges this posed. Mention was also made of the needs of service users with protected characteristics.

Some of those consulted, such as those in the councils' Supported Housing Teams, who are key providers for people in distress, clearly felt that they were somehow 'on the sidelines' when it came to discussions on support, prevention etc. Staff also flagged the issue of south Westminster having its own special spectrum of problems and, perhaps being somewhat overlooked in service terms: and whilst St.Charles might not be far away 'as the crow flies', it did feel out-of-area to many. Others mentioned the need not to overlook the 'Grenfell context'. Whilst many referenced an ideal situation where no acute beds were needed at all, there was a strong feeling that for now some in-patient provision was still needed in south Westminster.

In all this there were also some very positive comments, from staff in a range of organisations including the Police, about the Gordon Hospital – in particular where it is located and the quality of care it provides.

Questions and issues raised by Members included the following:

- Whether there were service changes which might make the Gordon Hospital an 'anchor institution in south Westminster, even if it were not to remain principally an in-patient facility? In response Prof. Manthorpe indicated that was possible, if that's what service providers, staff, partner organisations and users wanted.
- What are they key themes from this engagement that CNWLMHT should be considering in moving forward to take these decisions? In response Prof. Manthorpe flagged the need above all to resolve issues around the Mental

Health Crisis Assessment Service remaining a local resource (not relocated to St.Charles) as a visible manifestation of commitment.

- Given that the highest volume of acute admissions have been from BAME communities, what were the themes that came out engaging with those groups, especially in relation to those with severe and enduring mental health issues who might need support for long periods? In response, Cleo Chalk confirmed that these themes, and the complexities that often underpinned these cases, did emerge from the consultation and very much needed to be borne in mind when developing proposals. The Committee noted in this context that the Royal College of Psychiatrists had particularly identified those from a black African and Caribbean background.
- In response to a question, Prof. Manthorpe confirmed that Supported Housing providers very much wanted to play their part – given they are in practice the 'third workforce' in tackling these mental health issues.
- Continued inter-agency engagement with the Police was important, especially as they have their own pressures and, as already publicised, don't want to have to respond to welfare calls as a result of service 'gaps' elsewhere.
- In response to a question, CNWLMHT representatives confirmed that the 51 bed capacity remained, but the number of people admitted had been reduced down between Jan-March 2020 in response to Covid infection control guidance released by the Government at the start of the pandemic: this was something that was happening, at that time, nationally.
- In response to a question about the Crisis Recovery House pilot, Prof. Manthorpe suggested it would be helpful to see some sort of evaluation report, shared with partners, to establish whether this might be part of future service provision.
- In response to a question about the 'out of area' and 'out of Borough' distinction, Prof. Manthorpe suggested concerns about services 'out of borough' seemed to be more of an issue for south Westminster residents as Royal Borough residents were already familiar with St.Charles Hospital.
- Residents had commented about overly brief admissions, early or premature discharges, and the need to display more acute unwellness (with an impact on safety on wards) - all as a result of bed pressures (touched upon on pages 72-73). Prof. Manthorpe commented that it was important to listen to such comments whilst noting that there were different types of bedspaces, including crisis assessment places and long-stay beds. The challenge is establishing what's appropriate for this area.

8 CONSULTATION EVALUATION REPORT

The Chair welcome to the table Toby Lambert (ICB), Clive Caseley (Verve) and Sally Milne and Gareth Jarvis (CNWLMHT) then invited Clive to provide an introduction to his report.

Clive noted that there were 34 conclusions in the report, and picked out the following 'headlines':

- from the questionnaire there was a small majority, an 11% majority, in favour of the preferred option.
- behind this there is an enormously polarised set of views, with 'strongly disagree' the largest single category. So, this report tries to drill down into what underpins responses.

- the data suggests that service users and carers have a slightly more positive view of the preferred option, although service users are least certain or polarised in their views.
- NHS staff are the most positive group. There were a high proportion of responses from staff across a range of organisations, many clearly made from a professional perspective.
- views from frontline staff and service users, whilst really insightful, had proven most difficult to gather.
- there was total consensus that inpatient care is essential for some people some of the time but there was a much more divergent set of views on the best model for everybody, and especially around the community model and its efficacy for all.

In conclusion Clive stressed there was lots of depth in the responses, and it was now important, moving forward, that the voices of respondents is seen to be taken into account in taking and implementing the decision.

The Chair thanked Clive Caseley for his helpful summary, then asked CNWLMHT and ICB colleagues whether they wanted to add anything.

Toby Lambert explained that he didn't propose to respond formally to the consultation today, but did flag on page 297 of the agenda pack the further workstreams that would be taken forward. He mentioned in particular (i) the need to hear the voice of the rough sleepers in Westminster; (ii) an assessment of the efficacy of community services and for which groups are these a more appropriate response than in-patient care (which all feeds into the decision on the quantum of inpatient beds required); (iii) commentary on the MHCAS model and the appropriate location – St. Charles or south Westminster?; and (iv) more work on the impact on different communities and how these might be mitigated.

Questions and issues raised by Members included the following:

- How do we know that staff are responding from a professional rather than personal view? In response Clive confirmed that this wasn't clear in respect of those who 'self-declared' as staff, however there were a lot of comments from professional groups, indeed more of the in-depth feedback came from these groups rather than individual staff. This revealed a marginal majority in favour of the proposal, but this was not a referendum.
- In response to a question, Toby Lambert confirmed that the questionnaire and consultation details were available in languages other than English, but Clive confirmed that no responses in other languages had been received. There was then further discussion on the extent to which the consultation was available to, and reached out to, groups who might not speak English.
- How do you make the correct decision here when there are quite opposing views? In response, Clive explained that the report was an attempt to bring out key themes and considerations for the decision-makers – but there were no recommendations. Toby explained that Verve had presented the areas of most and/or strongest feedback which now needs to be considered and used to underpin clinically and service-user based judgements and form a proposal.
- One theme that had emerged was concern about overly speedy discharges, seen as the result of limited bedspaces, yet there is evidence of continuing demand for in-patient capacity (with 16 new bedspaces now available in Brent

for example). In response Toby repeated that the efficacy of community services and their suitability for client groups will inform decision on the number of in-patient bedspaces required. Brent has seen a sharp increase in demand in Brent and funding had been found from another pot of money. Importantly there will be no reduction in funding in-borough for residents of Westminster and Kensington and Chelsea. Savings from the reduction in beds at the Gordon Hospital has already been recycled into community services. Dr. Gareth Jarvis commented that one of the purposes of community services was that if and when people are treated earlier in their pathway they are less likely later to require inpatient care. The Committee noted this but queried whether the reduction in in-patient capacity was, perhaps, premature given current demand.

- What is coming through in the qualitative feedback is that significant demand for, and pressure upon, the limited bedspaces remains. In particular where admissions are too brief there may well be a rise in 'revolving door' admissions. As such it's probably not especially reassuring that the majority seems to support option 3 - people are simply being put in a position of choosing either/or – and just because Gordon Hospital isn't 'fit for purpose' doesn't mean those beds aren't needed. In response, Clive agreed, emphasising that there was still a decision to be made, but did note too that there was a significant number of people who felt the in-patient model was traumatising and ineffective. But there does seem to be consensus that inpatient capacity is needed for some people some of the time. The ICB Board will need to look at the rationale behind the various views expressed, balance these, and take a decision.
- The Committee noted that the two GP practices which had responded were both strongly against. Clive explained that both these were very specialist GP practices working with the homeless community, albeit that a leaflet was sent to all GP practices in both boroughs.
- In response to perceptions that the consultation was weighted towards one of the options, Clive ran through the four 'Gunning principles' and confirmed that the consultation followed best practice and had fully adhered to these principles.
- Clive clarified what had been done to engage with patients and patient groups. Letters were sent to current and past service users and both drop-ins and outreach were used. About 80 or so service users were involved all-in-all.
- The Committee expressed concern at feedback from staff indicating they feel 'overwhelmed'. In response Gareth suggested this was no different from across much of the NHS, where there was a real sense of 'burnout', and it was crucial for service leadership to respond as far as possible to levels of acuity on the wards.
- In terms of the need for acute beds, Toby confirmed that there was a finite budget and a difficult decision to be made make about the balance in the service (both now and looking ahead too). But the ICB has consulted with an open mind and its mind remains open. The ICB has four major questions to explore – probably five now including the point about pressure on acute beds - which will lead the ICB to decide one way or the other.
- The Committee referenced the report from the Royal College of Psychiatrists and the points made about the needs of those with black African and Caribbean background. Tony confirmed that this would be part of one of the workstreams already identified.

The Chair thanked all present and sought confirmation that the ICB's draft decision would be available for consideration at the for the 16 September meeting, the papers for which would need to be published on Friday 6 September. Toby confirmed that this was the current plan, and he would discuss with officers the timetable for the Committee's consideration of the final ICB decision.

In terms of other issues for consideration, the Committee flagged that it would be good to hear more about the Crisis Recovery House and any developments in relation to the new Government's agenda in relation to mental health.

The meeting ended at 8.50 pm

Chair