London Clinical Senate

London Clinical Senate Review

Adult acute Mental Health Services in the City of Westminster and the Royal Borough of Kensington and Chelsea

London Clinical Senate Council Report

26th October 2023

Contents

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2. Foreword

On behalf of the London Clinical Senate, I am pleased to share the final report of the London Clinical Senate review of *Adult acute mental health services in the City of Westminster and the Royal Borough of Kensington & Chelsea.*

I would like to thank North West London colleagues for their ambition to secure these improvements for patients and the thoughtful work that has informed the proposals.

My thanks also to members of the Senate Council and subject matter experts who contributed their time and expertise to undertake this important review. Their breadth and wealth of experience has been instrumental in developing this report, in which we have endeavoured to provide a constructive and rounded perspective.

Providers of mental health services in London are having to respond to many challenges particularly aligning demand and capacity; reducing inequalities in provision and outcomes; and retaining and supporting workforce. We support North West London colleagues in their ambition to improve the care and outcomes for their local population in this context.

This following report provides an account of the discussion and views of the panel including several recommendations, which we hope will enable the North West London programme team to strengthen and improve the proposals.

At the time of the review a draft equalities impact assessment was available with a full independent review being undertaken. Therefore, whilst the report references inequalities, it was difficult for us to make any specific recommendations in this area. We anticipate that the full report will make some recommendations and that any mitigations and responses to this will further enhance the subsequent business cases.

Finally, I would like to thank our Senate team for their work and diligence in bringing the review panel together and developing this report.

Dr Mike Gill

Chair London Clinical Senate

3. Executive summary and key recommendations

3.1 The London Clinical Senate welcomed the work of North West London (NWL) Integrated Care Board (ICB) in developing the Pre-Consultation Business Case (PCBC) regarding *Adult acute mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea.*

3.2 The panel supported the plans for increased community provision as an alternative to inpatient beds, noting the plans are also consistent with current best practice opinion and guidance.

3.3 However, they also observed that some of the evidence base for the patient cohorts for whom this service model might work, and the workforce required, is evolving. The importance of prevention, early intervention, and access to local services more widely is fundamental to this model. The panel made several recommendations, which are summarised as:

- Additional information on how the plans will facilitate the further development of other community-based services to improve population mental health.
- Additional assurance regarding capacity and demand in the context of pressures across London, highlighted by individuals presenting to Emergency Departments in crisis.
- Reviewing the proposals for the bedded Mental Health Crisis Assessment Service. The panel recommend further work on the detail of the service model, the pathways underpinning the model, the sustainability of workforce and the overall value of this model for patients and the community.
- Greater assurance around workforce and workforce modelling.

The full list of recommendations is detailed below:

R1. Provide further detail on the data sources, assumptions, and time periods (pre and post covid) modelling methodology for occupied bed day (OBD) requirements which are detailed as 23,300 needed and 25,900 available. We recommend that this includes, how many people are:

- Requiring placements from outside the boroughs of Kensington, Chelsea, and Westminster, either within or outside of NWL.
- Receiving inpatient care in Kensington, Chelsea, and Westminster from outside of these boroughs, split by borough within and outside of NWL.

R2. Provide further detail on the anticipated system impact of the changes to service configuration waits in acute hospital emergency departments, time to admission etc. comparing pre covid and post covid (recognising that during will not be a complete picture). We understand that some of this data is already in the PBCB and some of this analysis is built into business as usual.

R3. With reference to data, demonstrate how the proposed plans will cope with surge in demand and mitigate the current risk of people in mental health crisis waiting in the community and emergency departments.

R4. Continue to undertake further engagement with stakeholders to inform the plans. This should include ambulance service including NHS 111.

R5. The changes have invested in 20 community placements. Consider whether some flexibility in the numbers would help mitigate for periods of high pressure on assessment services.

R6. Respond and plan mitigations to the full equalities impact assessment. Building on the place-based partnership look to co-design with local communities those mitigations and services.

R7. Highlight place-based partnerships, particularly their involvement in developing the proposals and the ways the plans will support further integration to improve local services.

R8. Implicit within the model is the local infrastructure in the community. Plans would benefit from specific engagement with charitable and voluntary organisations to influence how the model is developed and delivered.

R9. Further engage people with lived experience of services in the area, and their families, especially those from some minorities, in supporting the development of service models that would allow for more community treatment and reduce admissions.

R10. Undertake further engagement with:

a. Primary care, to build in their knowledge of local population and flows.

b. Social care, building in their knowledge of local population and flows.

c. Student health provision and universities

R11. Highlight further how education and support to other providers can facilitate improved outcomes throughout the pathway. The work described to sustain and enhance knowledge and skills in primary care and acute hospitals is supported. Both areas will be crucial to enable the proposed changes by helping mitigate risks associated with any surge and excess demand.

R12. Include detail on the further emerging evidence regarding the Mental Health Crisis Assessment Service e.g., the work at South London and Maudsley, St Pancras and South West London and St Georges.

R13. Articulate the evidence for Mental Health Crisis Assessment beds, and their contribution to the occupied bed day provision- articulating the bed type, clinical cover required, standard operational procedures and the intended outcomes.

R14. Provide details on the patient pathway (including any transport arrangements) for common mental health emergencies and crisis before and after the proposed Mental Health Crisis Assessment service. This should note the operating model and proposed operating policy: hours of operation; patient selection criteria; staffing numbers and skill mix in and out of routine hours; emergency support if required as well as access criteria e.g., agreed pathways for direct access from community, GP, and ambulance to avoid Emergency Department.

R15. Provide further detail on how ongoing evaluation will be undertaken and how plans can be adjusted if required from such real time evaluation and feedback and thus mitigate potential risks.

R16. Community services and the extended support required are often supported by the third sector (charitable and voluntary) which is under considerable pressure. Consider how the system can support these providers to mitigate the risk of that provision being discontinued (e.g., Red Cross support for refugee populations). This may be possibly through place-based partnerships.

R17. There is mention of new workforce roles. The review team supports the plans to innovate with new roles which might mitigate other workforce recruitment risks. Further detail on these plans including retention and wellbeing of existing staff, addressing training and recruitment shortfalls and/or contingency planning would be helpful.

R18. Workforce transformation requires planning and organisational development and takes years and not months. Any work undertaken or in progress during the temporary changes should be enhanced to improve the likelihood that workforce developments will be long term, sustainable and link to the NHS Long Term Workforce plan.

4. Background

4.1 Central North West London NHS Foundation Trust (CNWL) provides a range of services across a person's life including Adult Mental Health Services for the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea.

4.2 In 2019 CNWL began a transformation programme for Adult Mental Health services. This was to consider how a community-based model might be implemented in line with national policy. National reviews and evidence recommend that inpatient care should be focussed on people whose needs cannot be met in a less restrictive setting, which aligns to patient preference to be cared for within their communities and provides better outcomes.

4.3 The transformation programme was informed by GIRFT (Getting it Right First Time) evidence that the balance of inpatient provision for CNWL was 25.2 beds per 100,000 weighted population, which is above the national average of 19.9 and the highest of all the Trusts in the London region[1].

4.4 In March 2020, inpatient wards at the Gordon Hospital in south Westminster were temporarily closed. This was undertaken rapidly due to concerns the building was unable meet the requirements around COVID-19 safety. The small corridors and lack of ensuite bathrooms were not able to meet infection prevention and control requirements which were increased during the pandemic. At this time, the inpatient provision for the City of Westminster and the Royal Borough of Kensington and Chelsea was consolidated at the St Charles Hospital, North Kensington.

4.5 Until the temporary closure, the Gordon Hospital accommodated 51 beds, spread over 3 wards. The age, design, layout, and condition of the building did not meet the recommended standards by the Royal College of Psychiatrists. St Charles currently provides four wards with a total of 67 beds for the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea[2]. These two hospitals provided around 95% of the inpatient care for the residents of Westminster and the Royal Borough of Kensington and Chelsea[3]. The largest number of occupied bed days and admissions from outside these two boroughs come from the London Borough of Brent, about 4% of Brent's activity going south to the hospitals in Westminster and Kensington and Chelsea[4].

4.6 North West London Integrated Care Board are seeking to consult on the future of the acute mental health services at this site, looking at the configuration of inpatient and

[1] Pre-Consultation Business Case v2.4 Draft, Service Direction in 2019/20 Paragraph 1, Page 8.
[2] Pre-Consultation Business Case v2.4 Draft, Provision in Westminster and Royal Borough Kensington and Chelsea, Page 7
[3] Pre-Consultation Business Case v2.4 Draft, The Service Context 3.1 Acute Mental Health Services in 2019/20 Inpatient Activity in 2019/20, Page 44.
[4] Pre-Consultation Business Case v2.4, The Service Context 3.1 Acute Mental Health Services in 2019/20 Inpatient Activity in 2019/20, Page 45.

community provision across the City of Westminster and the Royal Borough of Kensington and Chelsea.

4.7 The proposals are in line with the national direction of travel for mental health services as set by the NHS Long Term Plan in working towards more community-based care, underpinned by the Community Mental Health Framework[5], whilst recognising there will continue to be service users for whom safe, effective, and temporary inpatient care is the most appropriate treatment. In 2022, NHS England also introduced a new programme of work to look at the quality of care in inpatient settings.

4.8 Since the temporary closure, CNWL has been working closely with service user and carer groups to understand from their perspective what good looks like for mental health care and are therefore taking this opportunity to review the way services are delivered.

[5] Pre-Consultation Business Case v2.4, 2.2.2 National Policy, Page 27

5. Approach to the review

5.1 The review was undertaken by the London Clinical Senate via Microsoft Teams on 20th June 2023, chaired by Dr Mike Gill, Chair of the London Clinical Senate.

5.2 The Terms of Reference for the review were agreed by representatives from both the London Clinical Senate and North West London (Appendix G).

5.3 The London Clinical Senate were asked to review:

A) The clinical case for change.

To include the evidence regarding patient care outcomes and quality of services since the temporary closure of the inpatient beds, which may include reviewing historic and contemporaneous data.

B) The different clinical care model options and their implications for delivering inpatient mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea.

To include:

i) Addressing need and demand in the City of Westminster and the Royal Borough of Kensington and Chelsea in a timely fashion.

ii) The balance of inpatient and community care and impact of those options in terms of quality of care and service user experience, and impacts on wider system services (e.g., police and social care) recognising feedback from wider stakeholders.

iii) The location of inpatient services.

iv) Addressing inequalities in access, outcomes, and experience within the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea.

v) Workforce.

5.4 To ensure a complete and independent panel, representatives for the panel were invited from the London Clinical Senate Council and additional subject matter expertise was secured to complement and extend the panel membership.

5.5 All members were asked to sign a confidentiality agreement and to register their interests. Members considered conflicted did not contribute to the review. Whilst most review panel members were able to attend on the day, some were unable due to unforeseen circumstances. Provision was made for these review panel members to contribute electronically (Appendix D).

5.6 Upon receipt of the draft Pre-Consultation Business Case as well as other supporting documentation from North West London (Appendix C), draft Key Lines of Enquiry (KLOE) (Appendix A) were produced by the Senate team. These were developed with reference to the *London Clinical Senate Principles* and the 5 NHS key tests for changes, as outlined in the Terms of Reference.

5.7 The KLOEs were discussed in a panel pre meet on 13th June, with subject matter experts commenting and enriching the KLOEs to facilitate a rounded exploration. They were then shared with North West London colleagues and informed the content of their presentation on the day of the panel.

5.8 The review was held on 20th June. The format was a presentation from representatives of North West London followed by questions from the review panel, and finally an opportunity for the review panel to deliberate and draw together its conclusions (Appendix B).

5.9 To support North West London's desired timeline for consultation an initial and informal discussion of the draft recommendations was provided on 25th July with an initial draft working document provided on 10th August 2023.

6. Findings of the Senate Review Panel

A) The clinical case for change.

To include the evidence regarding patient care outcomes and quality of services since the temporary closure of the inpatient beds, which may include reviewing historic and contemporaneous data.

6.1. The case for change in North West London is to provide a community based, adult mental health service and to reduce inpatient beds. This is consistent with best practice guidance, as outlined in the NHS Long Term Plan (2019) and the NHS Mental Health Implementation Plan 2019/20- 2023/24 (2019) that quality of care can be enhanced for people in their communities and outside institutions.

6.2. Specifically, 51 beds across 3 wards at the Gordon Hospital in south Westminster were temporarily closed during covid. The case for change proposes that these remain closed and that adult mental health services are provided through a combination of increased community provision and beds at the St. Charles Centre for Health and Wellbeing which has 67 beds across 4 wards[6] to serve the community of Westminster in addition to the Royal Boroughs of Kensington and Chelsea, as they were initially configured.

6.3. The premise of the case for change is that:

- The transformation programme which began in 2019 suggested that a community-based model would reduce the number of occupied bed days required, makes more effective use of resources, and improve outcomes. The programme considered GIRFT calculations, which revealed that CNWL had 25.2 beds per 100,000 weighted population, above the national average of 19.9[7].

- The Gordon Hospital estate is not currently fit for purpose to provide the number of beds required. Infection control concerns highlighted by the COVID pandemic in 2020 resulted in a temporary closure of the beds at the site.

- The refurbishment of the Gordon estate could address some infection control and estates issues e.g., ensuite rooms. However, not all Royal College of Psychiatry requirements would be met e.g., access to outside space. The programme team

[6] Pre-Consultation Business Case v2.4, The Service Context, 3.1 Acute Mental Health Services in 2019/20 page 44
[7] Pre-Consultation Business Casev2.4, Service Direction in 2019/20 Paragraph 1, Page 8.

believe these resources would be better directed at enhancing community provision.

- The programme team maintain that inpatient beds will continue to be needed for psychosis, substance misuse and forensic patient cohorts. They believe that there is sufficient capacity to provide these at the St Charles hospital.

- The programme team are exploring the provision of some Mental Health Crisis assessment service beds on the Gordon Estate.

6.4. The panel endorsed the ambition for improvement, and the plans to increase community provision as an alternative to inpatient beds, noting this is supported by national best practice. They observed that the model also provides an opportunity to manage inequalities by working more closely with communities through place-based partnerships and that centralising the most acute and ill patients on the St Charles site provides more modern facilities and the potential for greater workforce flexibility.

6.5. The panel explored the data that was available since the temporary closure, which does indicate a positive move to community-based provision. For example, an average comparison from March 2020 to March 2023 reveals:

- A monthly increase of referrals to community mental health hubs from 203 to 704.
- An annual increase in community mental health hub contacts from 39,731 to 69,855
- A monthly reduction of inpatient admissions from 79 to 57[8]

However, the panel considered that there was a need for further information on some areas of the case for change to provide assurance regarding the service quality and responsiveness to the population.

6.6. The panel discussed that a clear evidence base to support the case for change is limited. Whilst it is the accepted direction of travel, granular detail about service models and outcomes are not available. Given this, they encourage greater clarity regarding modelling assumptions and data, (recognising that modelling is complex and requires consensus/ value judgements about who requires a bed at a certain time). It will be important to review the populations/ diagnoses for which the model works effectively and where there may be disadvantages to address.

The panel also reflected on system pressures across London, which are highlighted by individuals presenting to Emergency Departments in crisis.

[8] Pre- Consultation Business Case v2.4, 3.2.3 How learning has shaped our services, table page 53.

6.7. The panel explored flows through A&E, and were advised that:

- The Emergency Departments across the ICB see 200 patients with mental health needs per week (across all 5 CNWL boroughs).
- About 60-70% of people assessed have corresponding physical healthcare need so there needs to be partnership working.
- There is a 1 hr standard for psychiatric liaison services assessment, which is mostly achieved.
- 20-30% of assessments result in a bed request.
- Where a more comprehensive assessment is required the first response or home treatment team are requested to assess to enable the least restrictive measures possible.
- Since the introduction of the community model, NWL Adult Mental Health services have noticed no change in A&E waits outside the national picture where 12-hour waits have grown. Waits for people with mental health needs following the same pattern. A process to investigate each 12-hour wait is in place and being analysed across the 4 Emergency Departments with all stakeholders.

The inclusion of this information and associated data in the consultation business case would be helpful, as well as further articulation to:

- Describe the process/ flow for a patient in A&E currently and going forwards.
- Describe how the new model helps with the flows.
- Outline plans to ensure that when patients are being admitted to acute hospital for physical health care, those that require mental health input do not miss the opportunity for a mental health treatment plan, which may be a hidden need.

6.8. The panel also explored the impact of changes anticipated nationally, where the police will reduce their input to emergency mental health (999) calls and the possible impact of this to the model. Some assurance was provided by NWL who shared that local conversations indicated the police will continue to attend calls where there is risk to life and limb. NWL also noted that data indicates a slight fall in usage of section 136 of Mental Health Act alongside expanding health-based place of safety at St Charles and Hillingdon.

6.9. The panel also considered that pressures on capacity on the St Charles site may present a significant risk. Describing plans how capacity can be flexed should there be demand for extra inpatients would be prudent as the modelling is quite tight: 23,300 bed days needed and 25,900 bed days available.

6.10. It will also be important to continue to liaise with stakeholders such as London Ambulance Service and neighbouring boroughs to understand the impact of the model,

any unforeseen consequences and to reflect and adjust plans accordingly. This will assist in managing demand and assuring contingency if elements of the community model are unsuccessful.

R1. Provide further detail on the data sources, assumptions, and time periods (pre and post covid) modelling methodology for occupied bed day (OBD) requirements which are detailed as 23,300 needed and 25,900 available. We recommend that this includes, how many people are:

- **Requiring placements from outside the boroughs of Kensington, Chelsea, and Westminster, either within or outside of NWL.**

- **Receiving inpatient care in Kensington, Chelsea, and Westminster from outside of these boroughs, split by borough within and outside of NWL.**

R2. Provide further detail on the anticipated system impact of the changes to service configuration: waits in acute hospital emergency departments, time to admission etc. comparing pre covid and post covid (recognising that during will not be a complete picture). We understand that some of this data is already in the PBCB and some of this analysis is built into business as usual.

R3. With reference to data, demonstrate how the proposed plans will cope with surge in demand and mitigate the current risk of people in mental health crisis waiting in the community and emergency departments.

R4. Continue to undertake further engagement with stakeholders to inform the plans. This should include ambulance service including NHS 111.

R5. The changes have invested in 20 community placements. Consider whether some flexibility in the numbers would help mitigate for periods of high pressure on assessment services.

B) Implications of the clinical care model options

The different clinical care model options and their implications for delivering inpatient mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea.

i) Addressing need and demand

Addressing need and demand in the City of Westminster and the Royal Borough of Kensington and Chelsea in a timely fashion.

6.11. The panel explored the need and demand within the City of Westminster and the Royal Borough of Kensington and Chelsea.

The Pre-Consultation Business Case describes that the populations in both boroughs are expected to drop slightly in the years up to 2030, in line with a recently observed patterns. It projects a slight decrease projected in the adult population of 18- 65-year-olds and slight increase in the 56–69-year-old population, with a relatively even gender balance. The conclusion reached is that any increased need will arise from changes in prevalence and not demographics[9]. The panel made four key reflections in relation to meeting need, with the latter two being explored in fuller detail below:

- Covid has impacted on mental wellbeing- how might a community-based model might support this?
- Greater visibility of engagement for the high population of 18–25-year-olds and the student population would be helpful. NWL advised of specific work undertaken to meet the needs of 16–25-year-olds where specific leads for younger adults in each borough, and community navigators had been introduced.
- There is need to ensure services address the known health inequalities within the borough, which in Westminster are particularly stark.
- The impact of need outside the boroughs of the City of Westminster and the Royal Borough of Kensington and Chelsea can result in inflows and capacity pressures.

Integration at place and health inequalities

6.12. Westminster has significant health inequalities with extremes of wealth and poverty. Additional information in the PCBC and supporting documentation to demonstrate how the needs of communities are being met will be important. The appendices received by panel

[9] Pre-Consultation Business Case v2.4, 2.2.4 Population forecasts, p23

included a draft equalities impact assessment. It is important that the inequalities impact assessment and associated actions are further developed and integrated to fully consider the implications on different demographic populations and that these inform the PCBC and/ or mitigating actions as required.

6.13. The proposals are grounded in two place-based systems, notably the Westminster place- based partnership. The plans go beyond a community model to integration which has the potential to provide increased opportunity for meeting the need within the local populations.

This approach emerged during the presentation and discussion with the panel and was commended by the panel. Further emphasis on this vision within the PCBC will be important to demonstrate the full connectivity, opportunities and potential to address some of the health inequalities highlighted above.

6.14. The senate panel also recommends continued engagement and co production to ensure that the plans are informed by communities and the practical experience of service users. It was noted that ongoing engagement and feedback is also required to ensure that the new pathways established are used and optimised, with opportunities for service improvement maximised. This will include ensuring that the knowledge of the attitudes to mental health conditions across different cultures and communities, impacts on need and help seeking behaviours are integrated into service models. For example, learning from the “Time to Change” national campaign (2007-2021) which focussed on building knowledge and awareness in communities and considering the use of language to describe mental wellbeing.

Additional recommendations around health inequalities are addressed in section 2d below.

Potential inflow and capacity pressures arising from need outside the boroughs of the City of Westminster and the Royal Borough of Kensington and Chelsea

6.15. Whilst the needs of the population can be predicted and responded to with some degree of assurance, there is potential demand from other boroughs. This formally sits outside of the scope of this review; however, it does have the potential to impact the daily operational experience and demand on services.

Outer boroughs within the ICB area have a growing population including a substantial housing development in Hammersmith and Fulham. There is also demand from Brent which, looking at patterns from the previous two years cannot quite be contained within borough. There is also occasional demand from Hillingdon.

Considering this, the senate panel looked for assurance that a clear schedule of plans was in place to ensure the longer-term sustainability of the wider system. It is important that planned bed capacity across the whole Integrated Care System is sufficient to meet

demand and, as referenced in the section 1, to ensure inbuilt flex for capacity should pressures increase.

R.6 Respond and plan mitigations to the full equalities impact assessment. Building on the place-based partnership look to co-design with local communities those mitigations and services.

R7. Highlight place-based partnerships, particularly their involvement in developing the proposals and the ways the plans will support further integration to improve local services.

R8. Implicit within the model is the local infrastructure in the community. Plans would benefit from specific engagement with charitable and voluntary organisations to influence how the model is developed and delivered.

R9. Further engage people with lived experience of services in the area, and their families, especially those from some minorities, in supporting the development of service models that would allow for more community treatment and reduce admissions.

ii) The balance of inpatient and community care

The balance of inpatient and community care and impact of those options in terms of quality of care and service user experience, and impacts on wider system services (e.g., police and social care) recognising feedback from wider stakeholders.

6.16. The review panel welcomed the thoughtful work that had contributed to the Pre-Consultation Business Case. There is consideration of the case for change and the balance between inpatient and community services in section 1 of the findings of this report.

As noted, the panel supports the principle to continue to enhance community provision as an alternative to in hospital beds. They recognise that community treatments based closer to the patient's home have the potential to be flexible, responsive, and meet needs more effectively. This is particularly important for groups who may experience inequalities of illness, access, and outcomes.

6.17. There is also some evidence of the effectiveness of the model. For example, since the implementation:

- More community assessments have been undertaken.
- There has been a reduction in out of area placements.

- The average length of stay has been relatively consistent in the last 3 years; suggesting people experiencing more serious conditions are on average staying shorter lengths of time as many people who would have been admitted for short stays in 19/20 are now being treated in the community[10].

6.18. The ambition to improve quality of care through the service model is also clear, for example:

- Focus on prevention, early intervention, and access to local services.
- New pathways e.g., for complex emotional needs are being introduced, including enabling hubs with provision of psychological therapy, occupational therapy, and individualised medical care to focus on support for those with greatest illness.
- Increased provision of talking therapies for people with mood disorders by investment in community teams and less use of informal inpatient beds.
- A variety of discharge models available from inpatient care including step down and Home Treatment Teams.
- Range of service offers in the community and the work alongside the 3rd sector, including consideration to those individuals with additional challenges such as homelessness and no recourse to public funds.
- Model of trauma informed care.

6.19. However, the impact on quality of care and service user experience is harder to capture and determine, given that data is more readily available on activity rather than outcomes. The panel suggest that to enable a fuller analysis of the quality of care, and measurement of outcomes, further consideration is given to:

- Ensuring that there is clarity on the patient cohort being served. Is the service meeting the needs of people who would otherwise have been seen in inpatient beds? To what extent are community activity levels rising from serving hitherto unmet need (which is also important)?
- Providing greater clarity on proposed patient flows and outcomes, based on personal health benefits. This can be built into patient pathways and should go beyond admission avoidance.
- Ensuring that the contact and follow up for the community patient cohort is reliably taking place.

[10] Pre-Consultation Business Case v2.4, Section 5.4.2 Assessment of Options against objectives, page 81

- Providing additional information on how the plans will facilitate the further development of community-based services e.g., more detailed pathways for service offers available for the different cohorts.
- Paying attention to and providing detail of the responsiveness of community services for patients who not happy to travel e.g., the operational model for rapid response service- staff need to be come out to patient homes (operational model).

Impacts on wider services and feedback from wider stakeholders.

6.20. The panel explored the input of wider stakeholders to the development of the Pre-Consultation Business Case, recognising the connectivity to the wider system and the important whole system pathway perspectives that could be offered to strengthen proposals. The discussion and recommendations are articulated below:

Primary Care

6.21. The panel learned that GPs were included as part of the place-based partnership discussions, with the programme team attending GP meetings, presenting clinical care pathways, and taking questions. They were advised that there had been positive feedback from GPs. Developments which support this connectivity and allowed good links and resilience between primary and secondary care allowing relationships to be built:

- Octopus model, enabling independent aspects of the services to be connected through a common core, training place from July and August.
- Community teams have been aligned to GP networks to build strong relationships.
- Link workers and band 7 prescribers spend 50% time in GP and community teams.

The panel recommends highlighting this work in the consultation business case as well as further exploration of the opportunities for primary care to support patients upstream, to improve service quality and mitigate some risks associated with any surge and excess demand.

Acute Trusts

6.22. The panel noted and endorsed the aim to improve all mental health care by supporting education and training in all environments including Acute Trusts. They acknowledged need to improve services for patients with acute mental health crisis waiting in Emergency departments when inpatient intervention is required will need monitoring.

Social Care

6.23. Whilst the programme team have engaged with the overview and scrutiny committees in the Local Authorities, there is little reference to the wider social care teams. Where there is existing integrated working, (particularly in the place-based partnerships) it would be helpful to bring this out in the business case. There are also likely to be wider opportunities for engagement and feedback.

London Ambulance Service

6.24. The senate panel strongly recommend formal discussion with London Ambulance Service to inform the Pre-Consultation Business Case. The NWL team described effective working relationships on the ground and intention to gain feedback as part of the consultation. The senate panel consider that London Ambulance service have a crucial role in the patient pathways, valuable data sets on patient flows and first response experience of patient needs that could constructively inform and strengthen the PCBC.

R10. Undertake further engagement with

a. Primary care, to build in their knowledge of local population and flows.

b. Social care, building in their knowledge of local population and flows.

c. Student health provision and universities

R11. Highlight further how education and support to other providers can facilitate improved outcomes throughout the pathway. The work described to sustain and enhance knowledge and skills in primary care and acute hospitals is supported. Both areas will be crucial to enable the proposed changes by helping mitigate risks associated with any surge and excess demand.

iii) Inpatient services and Mental Health Crisis Assessment beds

The location of inpatient services (with reference to Mental Health Crisis Assessment beds)

6.25. The review panel recognised that the Gordon hospital estate is unfit for purpose and action is required.

They were persuaded by the argument that fewer beds will be required with the introduction of an extended community model.

6.26. Regarding the location of the beds, whilst the St Charles estate has the potential to provide better quality facilities, the additional travel times for a proportion of residents needs to be considered. The equalities impact of longer journeys and mitigating actions is important to highlight.

6.27. The panel did not explore the modelling in terms of the finances required to make the Gordon estate fit for purpose, but recognised the intractable nature of some of the issues described that are not dependent on finance e.g., access to outside space. They did however note that a lower level of capital could make an attractive and useable community space at the Gordon hospital.

Mental Health Crisis Assessment Service

6.28. The NWL programme team described plans for a Mental Health Crisis Assessment Service (MHCAS) the Gordon hospital site. They noted that the model was iterating, with early positive analysis and experience.

Currently the MHCAS exists on the St Charles site, operating to a slightly different model to that proposed for the Gordon hospital site. Emergent data was shared:

- 12% of assessments translate into admission.
- Subsequent inpatient stays are reduced as the treatment plan is already in place.
- Patient feedback of MHCAS is positive.

6.29. The MHCAS on the Gordon site was described as an alternative to Emergency department, where the public could attend directly, and section 2 of the mental health act could be applied for assessment and treatment of mental disorder.

The panel reflected that the MHCAS is a new model with the potential to enhance local and timely assessment of people with acute mental needs in Westminster. They supported the acute assessment service model but required more clarity on service delivery and had concerns about how this might be developed into a small adjacent bedded option. Crisis, by its very nature is unpredictable, and it is uncertain where this will lead. Consequently, there may be risks to separating these beds from general adult inpatient beds and close monitoring of outcomes will be essential.

The panel recommend that as the programme team further iterate the model, they consider:

- Specifying the ambition, improvement, and tracking outcomes.
- Clarifying the evidence for an extended assessment unit or inpatient unit.
- Identifying the patient cohort served and the anticipated impact on the wider system.

- Clarifying the workforce and governance
- Addressing the potential risk of hidden demand i.e., if a patient is not in A&E will the time to admission be monitored?
- Maximising on learning from elsewhere. For example, similar services have been established at St Georges and Camden and Islington with important emergent findings. Practical experience from the panel who worked at St Georges was that these beds are quickly filled and the requirement for careful inclusion criteria meaning that this can be quite restrictive and possible to get wrong.
- Addressing the implications of the geographical move from the other beds. What is the corresponding pressure on transport services? Could this result in discontinuity of care? The number of stops to the inpatient destination has the potential to affect the outcome. The estates changes that will be required to make this a satisfactory environment.

6.30. Given the implications of the geographical move from other beds and the potential impact on continuity of care for patients who required longer term admission the panel suggested exploring other bed contingencies that could be used e.g., MHAC beds at St Charles rather than Gordon.

In doing so, they recognise NWL wish to ensure that they are listening and collaborating with feedback from service users and the community for the need for something in the south.

R12. Include detail on the further emerging evidence regarding the Mental Health Crisis Assessment Service e.g., the work at South London and Maudsley, St Pancras and South West London and St Georges.

R13. Articulate the evidence for Mental Health Crisis Assessment beds, and their contribution to the occupied bed day provision- articulating the bed type, clinical cover required, standard operational procedures and the intended outcomes.

R14. Provide details on the patient pathway (including any transport arrangements) for common mental health emergencies and crisis before and after the proposed Mental Health Crisis Assessment Service. This should note the operating model and proposed operating policy: hours of operation; patient selection criteria; staffing numbers and skill mix (in and out of routine hours; emergency support if required as well as access criteria e.g., agreed pathways for direct access from community, GP, and ambulance to avoid Emergency Department.

R15. Provide further detail on how ongoing evaluation will be undertaken and how plans can be adjusted if required from such real time evaluation and feedback and thus mitigate potential risks.

iv) Addressing inequalities

Addressing inequalities in access, outcomes, and experience within the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea.

6.31. The Pre-Consultation Business Case is designed to improve the quality of services for all, by ensuring that inpatient bed capacity is provided for people who need it, and a more culturally responsive community model is available for those whose needs are better met in this environment.

There are opportunities for place-based partnerships which have the potential to address inequalities in access, outcomes, and experience. It is important that proposals are developed to ensure that the needs of the most vulnerable are met and work continues to maximise the opportunities presented and that outcomes are tracked.

6.32. The move of location from the Gordon site to the St Charles site has an impact of travel time for certain populations as well as associated impacts of public transport costs or congestion charging, Ultra-low emission zone (ULEZ) and parking. This will need to be explored and mitigations proposed for the most vulnerable and deprived populations.

6.33. It is vital the proposals respond to a full integrated equalities impact assessment and areas for mitigation noted. When monitoring the impact of the changes, it will be vital to track outcomes at population level for all communities including those most vulnerable not only to confirm improvements but to also highlight any unanticipated and unintended consequences.

v) Workforce

6.34. Workforce transformation to enable this change can be extensive. Any work undertaken or in progress during the temporary changes should be enhanced to improve the likelihood that workforce developments will be long term, sustainable and link with the NHS Long Term Workforce Plan.

6.35. The programme team outlined plans to recruit, train and develop staff from the local population where possible, which is consistent with the ICB and trust roles as anchor institutions and key local employers.

6.36. The panel were advised that the directly employed staff within the community model will be supplemented by the wide breadth of skills and support in the voluntary sector. They learned of a range of engagement and forums bringing together the voluntary sector across the boroughs and that positive relationships are being developed, irrespective of formal contractual arrangements.

6.37. Exploration of new roles included support workers, people with lived experience, graduate mental health workers and community navigators. The panel were advised that these have been informed not only by national concepts but also learning from engagement with the Grenfell community. The programme team were commended on the intention to support and enable more culturally aware services through different and bespoke models and recommend that this is further emphasised in the PCBC. Opportunities also exist with maximising the use of the community pharmacy workforce, particularly as all pharmacists will qualify as independent prescribers from 2026 onwards.

6.38. The panel noted NWL experience was that the larger community model may be helpful in attracting a skilled workforce. However, it should still be noted that staffing of the service, as is a common theme nationally, is a key risk and needs to be acknowledged with contingency plans.

6.39. The panel reflected that good progress had been made regarding workforce plans, which should be enhanced and continued going forwards, with consideration to:

- Ongoing workforce and development planning
- Roles and support to voluntary and community sector
- Mitigating plans for model if recruitment and retention is challenging.

R16. Community services and the extended support required are often supported by the third sector (charitable and voluntary) which is under considerable pressure. Consider how the system can support these providers to mitigate the risk of that provision being discontinued (e.g. Red Cross support for refugee populations). This may be possibly through Place based partnerships.

R17. There is mention of new workforce roles. The review team supports the plans to innovate with new roles which might mitigate other workforce recruitment risks. Further detail on these plans including retention and wellbeing of existing staff, addressing training and recruitment shortfalls and/or contingency planning would be helpful.

R18. Workforce transformation requires planning and organisational development and takes years and not months. Any work undertaken or in progress during the temporary changes should be enhanced to improve the likelihood that workforce developments will be long term, sustainable and link to the NHS Long Term Workforce plan.

Appendix A- Key Lines of Enquiry (KLOE)

Key Lines of Enquiry

Version 0.3

London Clinical Senate review of Adult Mental Health provision in the City of Westminster and The Royal Borough of Kensington & Chelsea

The sponsor has asked the Clinical Senate to explore:

1) **The clinical case for change.**

To include the evidence regarding patient care outcomes and quality of services since the temporary closure of the inpatient beds, which may include reviewing historic and contemporaneous data.

2) **The different clinical care model options and their implications for delivering inpatient mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea.**

a. Addressing need and demand in the City of Westminster and the Royal Borough of Kensington and Chelsea in a timely fashion
b. The balance of inpatient and community care and impact of those options in terms of quality of care and service user experience, and impacts on wider system services (e.g., police and social care) recognising feedback from wider stakeholders
c. The location of inpatient services
d. Addressing inequalities in access, outcomes, and experience within the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea
e. Workforce

1) The Clinical Case for Change

Key Line of Enquiry	Notes
a) To include the evidence regarding patient care outcomes and quality of services since the temporary closure of the inpatient beds, which may include reviewing historic and contemporaneous data.	
Context- how do the proposals align to the aims of integration of health and social care led by ICBs?	
Greater clarity on the goals/aims of the secondary mental health care - keeping people out of hospital, improving outcomes, more local provision etc would be helpful	
Nationally there is ongoing challenge and a gap around evidence of what works e.g., a theory of change around a community model that translates to less need for beds. What national, international, or other evidence (including local) has been used to inform the development of the model?	
Section 3.3. details the measurements that have been made assessing the impact of changes during Covid. These primarily look at service utilisation. What data is available on the clinical outcomes and how will you be measuring this going forwards?	
There is a heterogeneity of patient diagnosis. What is the proposal and associated theory of change for each patient group? Please clarify referencing: - Pathways - Model of intervention	
Pathways- please describe how the service sits within broader primary care to tertiary care pathways. How are GPs linked and integrated to the community services? How will the changes improve links between physical and mental health care?	
The PCBC notes current pressures on bed availability due to usage by outer London borough's- esp. Brent. CNWL is proposing to increase bed capacity at Park Royal Hospital to meet this need. What are the timescales and to	

what degree is this contingent on alternative provision- and what plans have been made?	
What are the specific needs/ requirements relating to Grenfell and how are these being met?	
What is the process for out of areas placements. Has this changed at all e.g., any “gatekeeping” that could have impacted data?	

2) The different clinical care model options and their implications for delivering inpatient mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea.

Key Line of Enquiry	**Notes**
a) Addressing need and demand in the City of Westminster and the Royal Borough of Kensington and Chelsea in a timely fashion	
Demographic data shows a stable AMH and growing Older adult population. What consideration has been given to potential increased need for MHOA service?	
What work has been done to understand the needs of 18-25 year olds so that you can be sure of meeting the needs of young adults in their new model of care? Demographic data also shows a high student population. How have/ can needs of students be considered?	
Data is currently showing that the waits from decision to admit have increased. What are the plans to gain feedback from partner agencies e.g., police and social care on impact of changes? As the Metropolitan Police Commissioner has advised that "The Metropolitan Police will no longer attend 999 calls linked to mental health	

incidents from September" how will these proposals help to mitigate the risks to patients?	
Do the trends in mental health act detention in the area have any relevance to numbers of beds needed? One could argue that effort over the last 10 years to build locality services intended to reduce acute needs through earlier intervention and prevention might now be advanced enough to reduce bed needs, but if there is rising demand is that sustainable? What are the trends in local demand and how do you plan to respond to those trends going forward?	
The high readmission rate at the Gordon Hospital has been related to the standard of the estate. Have other characteristics for this issue been explored e.g., differences in type of care?	
b) The balance of inpatient and community care and impact of those options in terms of quality of care and service user experience, and impacts on wider system services (e.g., police and social care) recognising feedback from wider stakeholders	
Beds- please clarify the reprovision/ investment in community services. What is considered the scope of community services e.g., acute hub? Described pathways may help.	
What is the contingency plan for beds and community provision? How will risks of pressure of inpatient bed capacity be manged over time? Are there flexible beds at any of the sites? PCBC Qualitative Feedback (5.4.3) suggest that there is limited flexibility in the model “wards with bays cannot take the more acute cases”. How might peaks in demand be managed?	

Can you provide a patient journey/ pathway showing the difference between the with previous and proposed model (s) with consideration to the number of access points for emergency care and the ambition associated with this?	
The proposed MH Crisis admission alongside community services is new. What is the model/ pathway for the Mental Health Crisis admission centre? What benefits do you anticipate being realised from the Mental Health Crisis admission centre and how is this evidence based? What evidence and information on the outcomes has been used and will be monitored going forward? What are the issues associated with separating MHCAS from St Charles- and how can these be mitigated? *Qualitative Feedback (5.4.3)*	
Is there potential to support liaison psychiatry and reduce waiting times from decision to admit through the Mental Health Crisis admission centre?	
You note that there are plans to liaise further with the wider system. Can you provide more detail?	
Discusses whether the evidence for the service improvement in community services is sufficient to cover the potential loss of beds. Do you have numbers of mental health patients admitted and/ or waiting in acute general secondary care beds because there isn't capacity in the current MH provision? What referral/ community waiting data has informed the model(s) proposed?	

c) The location of inpatient services	
The number of people needing inpatient beds has reduced. But there appears a disproportionate detrimental effect on the most vulnerable/ deprived who require the inpatient service. What does the EIA suggest and how can this be mitigated?	
Patient journey times- can you walk us through some examples of before and after pathways?	
d) Addressing inequalities in access, outcomes, and experience within the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea	
How will the EIA consider the evidence about particular characteristics and disparities in outcomes?	
Will the trusts be including other QI initiatives in configuring the services to better meet the needs of the local population and those with protected characteristics? How does this proposed change fit into the wider picture?	
e) Workforce	
What is the sustainability plan for community services? Qualitative Feedback 5.4.3 suggests that the model relies too heavily on volunteers to deliver community-based services. What are the risks and how might these be mitigated?	
Please can you provide further detail on the impact on staffing/ workforce. Is there a workforce plan?	

3) Speciality/ Service Specific Areas for Consideration

Patient and Public Engagement	
What are your plans/ how will you develop plans for engaging and working with communities? The strategy is currently relatively high level.	
Environmental Sustainability	

Wellbeing/ outdoor green space/ environmental sustainability. How has this been considered?	
Digital	
What is the intra-operability of digital systems and records between sites and services?	
What is the potential of digital interventions as a supporting part of the options?	

Appendix B – Panel Day Agenda

London Clinical Senate

London Clinical Senate Council Review:
Adult Mental Health provision in Westminster and the Royal Borough of Kensington & Chelsea

AGENDA

Microsoft Teams meeting
Click here to join the meeting
+44 113 486 0108,,907895392# United Kingdom, Leeds
Phone Conference ID: 907 895 392#

Date: Thursday 20th June 2023 | **Time:** 16:30 -19:00

	Time	Description	Papers	Lead
1.	16:30-16:40	**Convene on Teams and pre-meet** *(Clinical Senate Panel Only)*		Mike Gill, Chair of London Clinical Senate
2.	16:40-16:45	**Welcome and introductions** Key task/advice requested Conflicts of interest declaration and confidentiality agreement Notes	Terms of Reference Key Lines of Enquiry	Mike Gill, Chair of London Clinical Senate
		Presenting team join the meeting		
3.	16:45-17:05	**Presentation addressing the Key Lines of Enquiry:** Summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, clinical model and engagement	Presentation to be given on the day	Toby Lambert Executive Director of Strategy and Population Health, NWL ICS Gareth Jarvis Medical Director, Jameson Division, CNWL

4.	17:05-18:05	**Panel Questions and Answers in relation to Presentation** between the clinical senate Panel and the Presenting team relating to key lines of enquiry and the presentation.	All documentation including PCBC and appendices	Mike Gill, Chair of London Clinical Senate
5.	18:05-19:00	**Panel discussion and deliberation:** Key findings, evidence base and emerging themes for recommendations	All documentation- including PCBC and appendices	Mike Gill, Chair of London Clinical Senate

Appendix C- Documentation provided by North West London ICB

Papers provided to Panel

- Review Terms of Reference
- Review Key Lines of Enquiry

Document Pack

- PCBC Version 2.4 DRAFT for Clinical Senate
- Annex 1 Consultation CE Strategy v3
- Annex 2 Consultation Project Board TOR v3
- Annex 3 Brent Population Information
- Annex 4 Workshops 1 and 1a Report
- Annex 5 Workshop 2 Report
- Annex 6 Workshop 3 Report
- Annex 7 Voice Exchange final report
- Annex 8 EDI Final Report 26.07.21 v1
- Annex 9 EIA
- Annex 10 Clinical Senate Presentation 20th June 2023_vf

Appendix D– London Clinical Senate Review Panel membership and declarations of interest

Name	Roles	Interests Declared
Richard Ballerand	London Clinical Senate Patient and Public Voice member	I have no conflicts of interest but, for the record, note that I have been a public governor of Chelsea and Westminster Hospital NHS Foundation Trust since 2017 (Desk based contribution)
Lucy Brett	London Clinical Senate, Chair Patient and Public Voice member	None
Adrian Capp	Head of Therapies, Queen Square Division, University College London Hospitals	None
Mary Jane Docherty	Consultant Liaison Psychiatrist, King's College Hospital, Deputy Medical Director, South London and Maudsley NHS Foundation Trust, Clinical and Strategic Director, Royal College of Psychiatrists - College Centre for Quality Improvement	I have no relevant interests or activities to declare
Kath Evans	Director of Children's Nursing/Chair of the Children's Board, Barts Health. Nursing & Academic Fellow, School of Health Sciences, City University, Babies, Children & Young People's Clinical Lead, North East London Integrated Care System. Participation Clinical Champion for NHS England, London Babies, Children and Young People Transformation Programme	None
Mike Gill	Chair London Clinical Senate	None
Mike Greenberg	Medical Director, Barnet Hospital	Nothing noted

Charlotte Harrison	Clinical Director, Acute & Urgent Care	None
Jas Khambh	Chief Pharmacist and Clinical Director, Medicines Optimisation and Pharmacy Procurement, NHS London Procurement Partnership	None
Marianne Leach	Consultant Paediatrician, St Georges University Hospital	Nothing Noted
Judy Leibowitz	Clinical Psychologist Camden and Islington NHS Foundation Trust	Employed as a Consultant Clinical Psychologist in Camden and Islington NHS Foundation Trust – as Head of Psychology in Camden Borough Division and Head of Trust Talking Therapies Services Honorary Contract with NHSE for 0.5 sessions per week as Clinical Lead with the London Mental Health Clinical Network
Richard Leigh	Consultant Podiatrist, Royal Free London NHS Foundation Trust Co-Chair NHS England (London) Foot Care Network & Foot Care Workstream	None
Eleanor Levy	London Clinical Senate, Patient & Public Voice member	Paid roles: Public advisor to Applied Research Collaboration, Kent Surrey, Sussex Advisory work for Surry University for a few hours per month. Lived experience to NHSE regarding quality improvement for services delivered to patients detained under the Mental Health Act. Voluntary roles: Discretionary input to Changing Futures programme and charity coalition Making Every Adult Matter (vouchers received).

		Work with Independent Mental Health Network.
Carly Lynch	Consultant Nurse for Mental Health, London Ambulance Service	None
Geeta Menon	Vice Chair, London Clinical Senate, Postgraduate Dean, South London, NHS England	Nothing Noted
David Parkins	Chair - London Eye Health Network NHS England – London.	None
Heather Richardson	Education, Research and End of Life Policy Lead, St Christopher's Hospice	None
Alex Rickett	Nurse Consultant /Non-Medical Prescriber (V300). Thanet Liaison Psychiatry Service, Thanet Mental Health Unit, Margate	None
Manjit Roseghini	Director of Midwifery for assurance, Co-chair for LMNS South West London, Integrated Care System	None
Sanjiv Sharma	Medical Director, Consultant Paediatric Intensive Care, Great Ormond Street Hospital for Children NHS Foundation Trust	None
Fenella Wrigley	Chief Medical Officer, London Ambulance Service	I am the Chief Medical Officer for London Ambulance Service but do not foresee any conflict.
Gladys Xavier	Director of Public Health & Commissioning, London Borough of Redbridge	None

Notes

All panel members completed Confidentiality and Register of Interests forms.
Where information was given, this has been included above.
Where members left their forms blank this has been transcribed as “nothing noted”.

Appendix E - Presentation Panel

Sujaa Arokiadass	Clinical Director Westminster, Consultant Psychiatrist
Graeme Caul	Chief Operating Officer, CNWL
Lucy Cook	Borough Director Westminster, Occupational Therapist
Ross Graves	Chief Strategy and Digital Officer, CNWL
Gareth Jarvis	Medical Director, Jameson Division, CNWL
Toby Lambert	Executive Director of Strategy and Population Health, NWL ICS
Sally Milne	Associate Director of Strategy, System Transformation and Partnerships
Philip Perkins	Patient and Public Voice
Ann Sheridan	Managing Director, Jameson Division, CNWL

Appendix F -Glossary

CNWL	Central and North West London Foundation NHS Foundation Trust
EIA	Equalities Impact Assessment
GIRFT	Getting it Right First Time
ICB	Integrated Care Board
ICS	Integrated Care System
MH	Mental Health
MHCAS	Mental Health Crisis Assessment Service
Senate review panel/ panel	The senate review panel. See appendix D for details of members.
PCBC	Pre-Consultation Business Case
VCSE	Voluntary, Community or Social Enterprise
WTE	Whole Time Equivalent

Appendix G - Terms of Reference

London Clinical Senate

Terms of Reference

Adult London Mental Health Provision - Inpatient and Community Services supporting people with acute mental health needs.

Date: 16th May 2023

Email: england.londonclinicalsenate@nhs.net

Web: www. Londonsenate.nhs.uk

INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

Title	Adult London Mental Health Provision - Inpatient and Community Services supporting people with acute mental health needs
Sponsoring Organisation:	North West London ICB
Clinical Senate:	London Clinical Senate
NHS England regional or team:	NHS England- London
Terms of reference agreed on behalf of the London Clinical Senate by:	Dr Mike Gill, Chair, London Clinical Senate Council
Terms of reference agreed on behalf of North West London ICB	Toby Lambert – Executive Director of Strategy and Population Health, NWL ICS
Date	14th June 2023

Contents

1 Background

Central North West London NHS Foundation Trust (CNWL) provides a range of services across a person's life including Adult Mental Health Services for the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea.

In March 2020, inpatient wards at the Gordon Hospital in south Westminster were temporarily closed.

This was undertaken rapidly due to concerns around the ability of the building to meet the requirements around COVID safety. The small corridors and lack of ensuite bathrooms meant the building was not suitably able to meet infection prevention and control requirements which were increased during the pandemic. At this time, the inpatient provision for the City of Westminster and the Royal Borough of Kensington and Chelsea was consolidated at the St Charles Hospital, North Kensington

CNWL has historically benchmarked very high for acute inpatient beds; the wards at the Gordon Hospital do not meet Royal College of Psychiatrists (RCPsych) standards. North West London Integrated Care Board are seeking to consult on the future of the acute mental health services at this site, looking at configuration of inpatient and community provision across the City of Westminster and the Royal Borough of Kensington and Chelsea.

The proposals are in line with the national direction of travel for mental health services as set by the NHS Long Term Plan towards more community based care, underpinned by the Community Mental Health Framework, whilst recognising there will continue to be service users for whom safe, effective and temporary inpatient care is the most appropriate treatment. In 2022, NHS England also introduced a new programme of work to look at the quality of care in inpatient settings.

Since the temporary closure, CNWL has been working closely with service user and carer groups to understand from their perspective what good looks like for mental health care and are therefore taking this opportunity to review the way services are delivered.

2 Aims of the review and advice requested

The London Clinical Senate are asked to review:

1)The clinical case for change.

To include the evidence regarding patient care outcomes and quality of services since the temporary closure of the inpatient beds, which may include reviewing historic and contemporaneous data.

2) The different clinical care model options and their implications for delivering inpatient mental health services in the City of Westminster and the Royal Borough of Kensington and Chelsea.

To include:

a) Addressing need and demand in the City of Westminster and the Royal Borough of Kensington and Chelsea in a timely fashion
b) The balance of inpatient and community care and impact of those options in terms of quality of care and service user experience, and impacts on wider system services (e.g. police and social care) recognising feedback from wider stakeholders
c) The location of inpatient services
d) Addressing inequalities in access, outcomes and experience within the populations of the City of Westminster and the Royal Borough of Kensington and Chelsea
e) Workforce

3 Scope of the review

"Planning, assuring and delivering service change for patients" (NHS England, updated March 2018) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners

In 2017 the NHS Chief Executive introduced a 5th new patient care test for hospital bed closures, specifying that alternative provision is in place before any beds are closed.

The clinical senate's advice will be focused on the third test of clinical evidence and the fifth 'beds' test as relevant. It is also cognisant of London Mayor's tests and encourages commissioners to consider their response to these in developing their Consultation Business Case

The London Mayor's Six tests, introduced in 2017, were designed to ensure that the changes are in the best interests of Londoners. These are conditions that must be met before the mayor will support any major health and care transformation or service reconfiguration in London.

The six areas, which are considered post consultation are:

- Health and healthcare inequalities
- Hospital Beds
- Financial investment and savings
- Social care impact
- Clinical support
- Patient and public engagement

These were refreshed in late 2022, with key changes being:

- Strengthening the health inequalities test and additional supplementary question that highlights the role of the NHS
- Recognising new opportunities afforded through the use of digital healthcare within the Hospital Beds test.

4 Principles for improving quality and outcomes

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council seeks evidence of, and promotes, these principles in the issues it considers and the advice that it provides.

They are:

- Promoting **integrated working across health and across health and social care** and ensure a seamless patient journey
- Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services)
- Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not, and being responsive to the diversity within London's population)
- Demonstrating **parity of esteem between mental and physical health** for people of all ages
- Supporting **self-care** and **health and wellbeing** Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation)
- Ensuring **value** (achieving the best patient and population outcomes from available resources)
- Demonstrate how **environmental sustainability and moves to carbon neutral** are included in plans and developments. This includes reference to the National ambition to reach carbon Net zero by 2040 and the London Health Board ambition to ensure that every Londoner breathes safe air.

4 Review Panel

The clinical senate will complete a review via Microsoft Teams on Tuesday 20th June

Chair

The panel will be chaired by: *The Chair of the London Clinical Senate Council, Dr Mike Gill.*

Membership

Membership of the review panel will be multi-professional. Its members will have expertise in the services and pathways being considered. Subject to agreement with the Chair, membership will include expertise independent of North West London that are unrelated to the changes proposed. Advice on membership will be sought from the London Clinical Senate Council with relevant expertise, and professional bodies as necessary.

The review panel will seek advice from other independent experts on specific issues if indicated. The review panel will not include anyone who has been involved in the development of the proposals being considered or associated with the bodies.

Conflict of Interests

All review panel members will be required to formally declare any interests (which will be noted in the review report) and sign a confidentiality agreement.

5 Method and Approach

In determining the review approach and formulating advice the Clinical Senate Council and Review Panel will draw on the following, which includes guidance on testing an evidence base:

- Clinical Senate Review Process: Guidance Notes, NHS England, August 2014
- NHS England's Service Change Toolkit
- Planning, assuring and delivering service change for patients, NHS England, March 2018

The review is expected to involve the following steps:

Step 1: **Establish the review panel**

Step 2: **Brief the review panel** and circulate key documentation

Step 3: Hold a **review panel meeting** to:

a. agree the overall methodology applied to formulate the advice
b. identify issues that need to be explored, clarified or validated to assist in formulating the advice
c. agree any further information/documentation required to inform the review

Step 4: Hold an expert review panel via Microsoft TEAMS on 20th June 2023 to undertake the following:

a. Meet and discuss the proposals/solutions with stakeholders (commissioners and providers) involved in their development to explore key lines of enquiry
b. Provide an opportunity for stakeholders impacted by the proposals to share views with the review panel
c. Debate findings within the review panel and finalise conclusions
d. Identify any outstanding issues and agree the process for following up (and further review panel discussion as agreed necessary)

Step 5: **Prepare a report** setting out overall findings, conclusions, advice and any recommendations. This will be circulated to the review panel and if required, a meeting agreed to discuss matters of accuracy and agree amendments.

The sponsoring organisations will be provided with a copy of the draft report for a factual accuracy check.

Step 6: Once agreed by the review panel**, share the report with the Clinical Senate Council** who will:

- Ensure the terms of reference have been met
- Comment on any specific issues where identified by the review panel
- Agree that the report can be issued

Subject to the schedule of Council meetings the Senate Council Chair may undertake this on the Council's behalf.

Step 7: Issue the report.

6 Documentation required by the Clinical Review Panel

In formulating advice, the review panel will review documentation that has both informed and been developed by commissioners.

Where possible relevant sections/pages of documents should be highlighted where the whole document does not apply to the proposals or context of a Clinical Senate review.

The documentation that it is anticipated will inform this review is listed below. Further requirements may be confirmed following establishment of the review panel.

- The draft Pre-Consultation Business Case (PCBC)
- The Case for Change (rationale for the proposed change and evidence base)
- Proposed clinical models (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, patient transport, performance against key quality indicators benchmarking data/patient experience data – available information should be provided initially, and any further specific requests will be discussed
- Relevant Care Quality Commission (CQC) inspection and Getting it Right First Time (GIRFT) reports
- Schedule of evidence and best practice that have informed the proposals
- Equality impact assessment
- Alignment to ICB plans
- Relevant Trust Clinical Strategies
- Process used to develop the proposals including staff, service user and public involvement.
- Summary of outcomes of patient and public engagement
- Summary of outcomes of stakeholder engagement, including neighbouring trusts and services
- Programme risk log
- Assessment regarding sustainable healthcare considerations and carbon footprint

The review panel will formulate the advice requested based on consideration and triangulation of the documentation provided, discussion with key stakeholders and panel members' knowledge and experience. The advice will be provided as a written report.

7 Timeline

The figure below details the milestones in the review process.

- By 27th March 2023 clinical senate to convene panel with 8 weeks' notice.
- By midday 30th May 2023 NWL ICB submit draft PCBC and associated appendices to clinical senate for review.
- T13th June clinical senate panel only pre meet
- 20th June 2023 panel review. To be undertaken over Microsoft TEAMS.
- 11th July recommendations issued to NWL
- 7th August draft report issued to NWL for matters of accuracy check
- Wb 4th September final report issued.

8 Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting the appropriately experienced review panel members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

9 Reporting arrangements

The review panel will report to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report.

The Clinical Senate Council will submit the report to the sponsoring organisation and this advice will be considered as part of the NHS England assurance process for service change proposals.

10 Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracies prior to completion. Comments/corrections must be received within 5 working days.

Communication and media handling

North West London ICB will be responsible for publication and dissemination of the report. The expectation is that it will be made publicly available as soon as possible following completion. The London Clinical Senate will post the report on their website at a time agreed with the sponsoring organisation.

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of review panel members.

Disclosure under the Freedom of Information Act 2000

The London Clinical Senate is hosted by NHS England and operates under its policies, procedures, and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

11 Resources for the review

The London Clinical Senate will recruit review panel members and cover members' reasonable expenses. It will also provide management support to the review panel, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level. The sponsoring organisation will also organise accommodation for meetings and the review panel day.

If during the course of the review the review panel identifies any additional requirements to formulate the advice requested, the review Chair or Clinical Senate Senior Project Manager will, if necessary, discuss these with the sponsoring organisation and may seek resources for this.

12 Accountability and Governance

The review panel is part of the London Clinical Senate's accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate risk to patients it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that depending on the nature of the issues identified the Clinical Senate Council may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

13 Functions, responsibilities and roles

The sponsoring organisation will:

- Provide the review panel with the proposed PCBC, and associated resources.
- Respond within the agreed timescale to the draft report on matters of factual inaccuracy.
- Undertake not to attempt to unduly influence any members of the review panel during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

The **London Clinical Senate Council and the sponsoring organisation** will:

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

The **London Clinical Senate Council** will**:**

- Appoint a review panel which may be formed of members of the Senate, external experts, and/or others with relevant expertise.
- Endorse the terms of reference, timetable and methodology for the review.
- Consider the review recommendations and report (and may wish to make further recommendations).
- Provide suitable support to the review panel.
- Submit the final report to the sponsoring organisation.

The **review panel** will:

- Undertake its review in line with the methodology agreed in the terms of reference.
- Submit the draft report to the London Clinical Senate Council for comment, consider any such comments made and incorporate relevant amendments into the report. Review panel members will subsequently submit a final draft of the report to the London Clinical Senate Council.
- Keep accurate notes of meetings.

The **review panel members** will undertake to:

- Commit fully to the review and attend/join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology).
- Contribute fully to the process and review report.
- Ensure that the report accurately represents the consensus of opinion of the review panel.
- Comply with the confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
- Declare to the review panel Chair any conflict of interest prior to the start of the review and/or any that materialise during the review.

14 Contact details of key personnel coordinating the review process

For the London Clinical Senate:

Emily Webster

Senior Programme Manager

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For North West London

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