London Borough of Hammersmith & Fulham

Health and Adult Social Care Policy and Accountability Committee

Draft Minutes

Wednesday 16 November 2022

PRESENT

Committee members: Councillors Natalia Perez (Chair), Genevieve Nwaogbe, Amanda Lloyd-Harris and Ann Rosenberg*

Co-opted members: Lucia Boddington, Victoria Brignell - (Action On Disability)* and Jim Grealy - H&F Save Our NHS; and Keith Mallinson

Other Councillors: Ben Coleman

Officers/Guests: Jo Baty, Assistant Director Specialist Support and Independent Living, Social Care, H&F; Mick Fisher, Head of Strategic Communications & Stakeholder Relationships, Imperial College Healthcare NHS Trust, Merril Hammer, HaFSON; Dr Christopher Hilton, Chief Operating Officer (Local and Specialist Services), West London NHS Trust; Andrew Hodgson, President, National Federation for the Blind UK; Linda Jackson, Director Independent Living (Social Care) & Corporate Transformation; Dr Nicola Lang, Director of Public Health, H&F*; Helen Mangan, Deputy Director Of Local & Specialist Services, West London NHS Trust; Bryan Naylor, H&F resident; Prof. Tim Orchard, Chief Executive, Imperial College Healthcare NHS Trust; Lisa Redfern, Strategic Director of Social Care, H&F*; Stephen Scowcroft, Director, The Macular Society

*Attended virtually

1. MINUTES OF THE PREVIOUS MEETING

RESOLVED

That the minutes of the meeting held on 20 July were agreed.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Patricia Quigley and Roy Margolis.

3. DECLARATION OF INTEREST

None.

4. WESTERN EYE HOSPITAL AND OPHTHALMOLOGY SERVICES

Councillor Natalia Perez introduced this item by way of reference to the Council's focus on co-production and the importance of listening to residents voice whose contributions were welcomed and evidenced an inclusive approach.

Prof. Tim Orchard provided a short presentation identifying key highlights from the report. Historically, the Western Eye hospital had been situated on Marylebone Road in its current building since 1930. The building was not ideal for delivering 21st century healthcare and a redevelopment of the facility had been considered for many years. Imperial as an acute hospital trust was included within the "40 hospitals" development programme but it was recognised that this could not form the entirety of a viable and holistic solution for service delivery at Western Eye, going forward.

Western Eye had coped extremely well in delivering general ophthalmic and tertiary services given the condition of the estate. Reflecting on the national register of outcomes for, for example, cataract surgeries, the output of the two eye centres based at Central Middlesex and Western Eye, placed them generally first and second, respectively, with the results at Western Eye being particularly impressive having cleared the backlog of cases that had accumulated during the pandemic. Independent experts had evaluated the site and highlighted concerns about fire safety, precipitating a decision to close it. Some services had been relocated to other floors and Charing Cross hospital. Currently, there were no patients who were waiting longer than two years for treatment, and about a 100 people waiting for a year. In general, the waiting time for a cataracts operation was about two to three weeks but the need to expand outpatient capacity was recognised.

Prof. Orchard confirmed that £9 million in funding had been secured as part of the national Targeted Investment Fund (TIF) as capital spend for a particular project. Site work had commenced and would eventually include an additional operating theatre increasing capacity to three theatres. Pre-assessment areas would be refurbished as would pre and post operative areas to offer improvements in the patient experience by Spring 2023.

Prof. Orchard acknowledged that the current provision of ophthalmology services in NWL was fragmented and that the variation in rates of avoidable blindness in the different NWL Boroughs was concerning. A key focus in transitioning from the pandemic was to ensure that health inequalities affecting groups with protected characteristics were eliminated. It was acknowledged that patient transport in this context was also a concern, and a potential response would be predicated on building a more responsive, sector wide ophthalmology strategy with a tailored hub and spoke model. Including optometrists and high street opticians in a digitised network could offer

enhanced diagnostic capabilities in secondary and tertiary provision. Informing this with the patient voice was an important aspect of ensuring that service would be co-designed and help to achieve consistent standards across the system.

Bryan Naylor, a resident, commented that national and local caseloads were likely to increase the need for ophthalmology services, underpinned by improved future techniques. As the Integrated Care Board (ICB) sought greater integration within primary care, there were opportunities to improve links to tertiary and secondary care. The pressure on A&E stemmed from treating people that did not require emergency treatment. Professor Orchard's integrated approach was welcomed as it advocated for a whole systems approach that also included social care, pharmacists, optometrists and the third sector.

Stephen Scowcroft from The Macular Society outlined the organisations perspective on future developments and treatment that might become available. This added pressure highlighted the need for more advocacy and to raise awareness about the challenges of having ICBs. He welcomed the innovative, local NHS developments at Imperial, and the transformation and recovery work from covid currently being undertaken locally and nationally. While he recognised that there were workforce challenges, there was a need to better utilise the services available through high street opticians and other allied health professionals. He outlined his support of the national Eyes Have it campaign and the formation of a national plan supporting local delivery and national accountability.

Andrew Hodgson, a H&F resident and President of the National Federation of the Blind UK, a campaigning charity that provided support for those experiencing impairment or sight loss, focusing on rehabilitation. The pathway from diagnosis to treatment and how services could be improved were key areas of interest. Recognising the existing pressures and barriers, he also indicated his support for the Eyes Have It campaign and welcomed news of the work currently being undertaken at Imperial.

Co-optee Victoria Brignell referenced her personal experiences as a patient at Western Eye and enquired if its A&E service could be reinstated as 24 hours as there was a need for a night time service. Recounting the Charing Cross A&E experience of a friend whose treatment been compromised due to ineffective signposting to Western Eye reflected a need to address the issue.

Councillor Amanda Lloyd-Harris welcomed the report and enquired why referrals historically were not accepted from the hubs. Co-optee Keith Mallinson observed that there was an impact on A&E as a consequence of the difficulties people had experienced in accessing primary care services. He enquired how the NHS trusts could liaise with primary care to ease the pressures, and how hubs could be better signposted. Addressing an earlier comment regarding presentation at A&E, these could be eased by ensuring clearer signposting of patient pathways. As an ex-teacher, he also observed that he had identified eyesight issues in children but the tools to spot these

issues were limited and it was important to support schools in undertaking early intervention work.

Professor Orchard reiterated that eyecare service provision was fragmented, and although most people understood basic primary care provision they were not always aware of treatment pathways and interconnectivity between providers. There was an opportunity to model a service specification with the Integrated Care System (ICS) to consolidate current provision into one service specification. Referrals from different sectors varied and there were specific pathways for wet macular conditions. There were 270 optometrist practices in the NWL area and Professor Orchard ambitiously envisaged these as the front door for accessing services. There was potentially greater equity in unifying sector provision through establishing diagnostic hubs networked through the same digital platform, which could help tackle high volume low complexity surgeries. Imperial as a trust included the patient "voice" into all improvement and strategic, capacity building development work. Prof. Orchard offered Bryan Naylor an opportunity to be further involved in the development of the North West London sector strategy work to shape future ophthalmology services.

Co-optee Jim Grealy endorsed the point made about early intervention work in primary schools, having had a similar experience as a former teacher. He asked about the integration of the ICS and the ICB, whether each of the trusts operated autonomously, and how widely this approach was replicated across other trusts. He observed that it was important to address the diversity and health inequalities issues strategically. Professor Orchard concurred regarding the value of early intervention work in primary schools. He explained that a sector wide approach was being developed and led by a clinical director at Western Eye and clinical reference group. Innovations such as this could be undertaken autonomously of NHS England, but a co-ordinated sector wide approach was required.

ACTION

Victoria Brignell to share information about signposting services with Professor Tim Orchard.

RESOLVED

That the report and actions were noted.

5. IMPROVING PLANNED ORTHOPAEDIC INPATIENT SURGERY IN NORTH WEST LONDON

Professor Tim Orchard outlined the need for an elective orthopaedic hub that could efficiently handle a large volume of cases with clinically low complexity. A prioritised waiting list in terms of increasing deterioration of a patient's condition was in place. There would be capacity for treating life limiting conditions which could lead to other secondary issues. A public consultation was ongoing, details of which had been shared with the committee and wider NWL communities. It was important to recognise that the consultation would

inform the process, to both understand and work to alleviate the integral concerns and views of the public. Operationally, procedures would be undertaken at Central Middlesex Hospital, with follow-up treatment pathways identified locally. Ensuring transport was a primary factor and an imaginative and sensible approach would be required. Patients would have a choice as to where their procedures would be carried out, and not choosing the elective hub option would not result in a delay to receiving treatment.

Keith Mallinson, co-optee emphasised the importance of face to face consultations in Musculoskeletal (MSK) pathway (virtual fracture clinic for patients with acute bone injuries), with reference to two clients who had not found this approach helpful during recovery. Professor Orchard confirmed that the MSK pathway was not one that Imperial delivered across the eight boroughs but concurred that effective triaging of patients through a video consultation was an issue. It was acknowledged that there was variability in delivering the MSK pathway across NWL. An opportunity to address this would ensure a fully integrated pathway and would be welcomed by providers and also the council. Patient transport was fundamental to ensuring that patients were effectively triaged. It was noted that Linda Jackson was planning a letter to MSK on behalf of the council to seek clarification about this issue and how it could be resolved.

Councillor Genevieve Nwaogbe referenced page 20 of the agenda pack enquired about the use of the phrase “completely separated from Emergency Care” and used throughout the report. The Central Middlesex hub would be used for elective orthopaedic care; however, clarification was sought about an example where a person experienced a non-life threatening accident and how they received their treatment. Councillor Nwaogbe also sought funding information about the Trusts intention to make the most of digital and other advanced technologies, which although welcome, required significant investment. A final comment was with regards to the travel cost and transport issues which could negatively impact some individuals and Councillor Nwaogbe asked how the Trust would overcome these.

Councillor Lloyd-Harris sought clarification about the 4000 cases in NWL that would be treated at the hub facility and what the outcome would be for any additional capacity, once these had been resolved given the potential downtime in terms of capacity, and if these would be offered to other trusts. Councillor Lloyd-Harris also asked if travel modelling realistically reflected accurate travel times which could vary significantly depending on traffic in a given locality. Cross borough public transport links were not ideal, and it took far longer to navigate than realised.

Professor Orchard acknowledged that patient pathways were fragmented and although Imperial was not responsible for the MSK path way there was a question as to how effectively patients were being triaged. He agreed that he could not envisage a cost disadvantage to putting in place the best digital solutions, as this could help generate greater inefficiencies. It was unlikely that the hub would be a major cost programme supported by the Targeted Investment Fund (TIF). Professor Orchard did not have a solution to the transportation issue but felt strongly that any solution offered must not

disadvantage individuals by moving the service. Addressing the issue of any spare capacity being offered to other trusts, Professor Orchard felt that there were several potential solutions to configuring services efficiently. The hub was likely to operate 6 days per week and any additional capacity would be repurposed to other types of high volume elective care.

Addressing the difficulties of MSK virtual consultations, Councillor Ben Coleman agreed with Keith Mallinson and felt that post-pandemic consultations should return to in person contact. He confirmed that the council would be writing to MSK advocating support for this. Transport and travel were a concern for many patients and their families which needed to be resolved. Lisa Redfern queried that if clinical expertise was centralised at Middlesex how would this affect local diagnostic services? Also, transport solutions need to be considered.

Professor Orchard responded that an imaginative solution to transport would be required, for example appointing a private transport provider or similar. He confirmed that orthopaedic services would continue to be delivered at other sites, recognising that while the new hub would efficiently tackle the backlog of cases, there would be vulnerable patients who would struggle. Jim Grealy suggested that the Trust explored the potential of developing a dedicated transport service. This was a solution that the trust had considered but there was a distinction between pre and post operative transport needs. There were efficiencies that could be achieved in developing a sector wide solution, but this was balanced against other competing priorities.

Professor Orchard clarified that pathways to the EOC would need to be properly integrated, which was separate to the issue of how services were commissioned. The EOC would operate to a stringent criterion, identifying which patients could be included and that this would be widened as the service progressed. It was noted that not all patients would be suitable for the EOC and that there would be a need to ensure that the provision was fully supported by trained and experienced staff.

Merril Hammer (Hammersmith and Fulham Save Our NHS) confirmed that a submission about the proposal had been made. Querying financial implications for the service she asked whether it would be financed by PFI (private finance initiative), and in addition, how the Trust intended to address the difficulties that some groups experienced in accessing digital information and services. It was confirmed that the proposal would not be PFI funded. In response to digital inclusion, Professor Orchard explained that an in person offer would be in place to aim to not disadvantage people. Councillor Natalia Perez highlighted the importance of reaching out to underrepresented communities. Professor Orchard confirmed that significant work had ben undertaken with black and Asian minority ethnic groups.

Councillor Perez thanked Professor Orchard and colleagues for the presentation. While the EOC proposals were welcomed, the committee noted that the Trust recognised the need to resolve patient transport and travel issues, ensure access to information and clearly signposted pathways including initial, localised diagnostics and post-operative recovery.

ACTION

For the committee to pass along details of any groups that they were aware that could be contacted and supported.

RESOLVED

That the committee noted the report.

6. WEST LONDON NHS TRUST UPDATE

6.1 Service update following CQC report

Dr Chris Hilton outlined the Trusts current activities in response to the recent Care Quality Commission (CQC) report which had highlighted several areas of concern. The safety domain had moved from "requires improvement" to "inadequate", and that the Trust "required improvement" overall. Positive feedback had been received regarding the Mental Health Integrated Network Team (MINT), details of which were summarised in paragraph 2.6 of the report. He acknowledged the challenges faced by the Trust which had arisen from a difficult and disruptive period during the pandemic. Dr Hilton indicated that the CQC had not highlighted any concerns that the Trust was not unaware of through its own internal governance procedures. The Trust had previously agreed to keep the committee informed of progress in addressing vacancy rates and waiting times. Commenting on the negative impact of vacancy rates, Dr Hilton acknowledged that this had hindered the Trust's delivery of a consistent and high quality service. The CQC report had recorded staff concerns to mitigate risks identified in clinical assessments and the committee had previously also noted the difficulties in achieving waiting time targets resulting in significant delays for patients accessing treatment.

At the time of the CQC report, Dr Hilton reported that the Trust had decided to migrate from using two patient record systems and consolidate this into a single system which had resulted in added complexities. In addition, there had been other issues highlighted including lone working practices, and inadequate clinical premises in Ealing and Hounslow, not H&F. Dr Hilton referred to additional information in a slide deck that had been circulated to members of the committee and officers, but these were not received in time for inclusion in the agenda papers (appendix 1). Key elements of this were the implementation of clinical controls with regards to the Trusts risk register system, better integration of business intelligence data, the successful implementation of links between operating systems, a review of standard operating procedures, the establishment of a clinical action group to undertake follow up work with patients who missed appointments to ensure co-ordinated care and simplification of the Trusts patient record system.

It was confirmed that there were several actions that the Trust was in the process of implementing to address the areas of concern identified in the CQC report, categorised as either suggested or required, and to be in place by March 2023. The Trust intended to work with the Health and Care

Borough Partnership to help address the demand on services. Dr Hilton thanked the council's specialist support and independent living social care team and Sobus for their support.

Councillor Genevieve Nwaogbe referred to paragraph 2.6 of the report and enquired what immediate actions were being undertaken taken by the Trust to improve staff safety in relation to lone working, poor supervision breaks and staff feeling unsupported. Councillor Nwaogbe asked if there were any legal consequences resulting from health and safety breaches. Co-optee Keith Mallinson commented that he welcomed the report, and he outlined the positive feedback received for MINT and the support that Dr Hilton and Jo Baty had provided. Co-optee Jim Grealy asked how likely it was that the Trust would be able to recruit staff given the scale of the vacancy rates and what the impact of this would be on patient safety and the implications for continuity of care. The waiting period of 64 days exceeded the waiting time target, the figure for which was not included in the report. The combined effects of austerity, cost of living and post-pandemic recovery would significantly impact on mental health and wellbeing and this was likely to lead to delays in treatment. Jim Grealy also requested a breakdown of the waiting list figures by ethnicity and income. Co-optee Lucia Boddington expanded on these points and reflected that the current economic climate would be a key factor in waiting time delays impacted by increased demand, for example, face to face family therapy, for which there were long delays that she was aware of locally.

Dr Hilton explained that the current actions around measures to mitigate workforce issues to appoint permanent staff rather than temporary or agency staff. The headline figure excluded additional clinical staff. The Trust also had also identified workforce recruits at source (university graduates specialising in mental health) and many dozens of staff had been recruited in this way. Workforce was a challenging issue influenced by difficult market factors, and some disciplines were harder to fill than others. The Trust recognised that there were barriers to recruitment and were exploring other options such as recruiting from abroad or identifying refugees or asylum seekers with clinical skills. The Trust was engaged in business transformation activities which would address the issue of safeguarding staff highlighted in the CQC report. There were a number of actions focused on improved risk assessments to address inadequacies and to mitigate risks. The mean wait time was 64 days and currently there were no patients awaiting triage at the Claybrook facility.

Lisa Redfern welcomed the report and asked who was leading on the performance improvement plan and the extent to which staff had been involved in developing this. Dr Hilton described the leadership and oversight structure which include multiple levels of governance. A quality committee was chaired by a non-executive director, Professor Stephen Barber, and a monthly MINT specific board had oversight of a more granular action plan, which he chaired himself. There were also individual working groups chaired by Dr Julia Benton, a clinical director. It was anticipated that remedial work would be needed to support the transformation process which would take a number of years, but satisfactory progress was being made to mitigate

against staffing pressures. Dr Hilton shared a personal frustration about the two electronic patient record systems which he was keen to see resolved to reduce risk and to implement a definitive solution. In terms of staff involvement, information was being cascaded through the organisation, with staff working in in subgroups to contribute to the process involving clinical directors, operational managers and clinical leads.

Lisa Redfern expressed concern about the staff supervision rate which was closely linked to monitoring staff performance. Dr Hilton acknowledged the concern and stated that supervision was being undertaken regularly at a team level and during routine performance meetings. There was variation between services, for example, mental health teams had consistent and high rates of supervision and by comparison, community adult health services had poorer rates of supervision. Two factors influenced this: first culture of "doing" supervision, and second, the process of recording this, both of which the Trust was working to improve.

Lisa Redfern outlined additional concerns about the reduction of 13 mental health beds in Ealing and clarification was sought about the correlation between this and the strength of community health services, which needed to be sufficiently robust to cope with local demand. All health and social care providers were routinely inspected but there was always scope for improvement despite the lack of investment in community mental health services. Dr Hilton responded that he shared the concerns and Helen Mangan described the front end diagnostic work being undertaken with RW Health (business intelligence consultancy) on patient flows to understand the interdependencies between community and hospital services. This together with some focused engagement work and a task and finish group had produced a useful MINT (liaison Psychiatry) dashboard highlighting a continuity of care need for those who were seen infrequently and who might be at high risk.

Merril Hammer commented that the additional paper lacked clarity because it contained a lot of jargon and need to be more accessible. Referring to page 37 of the agenda pack and related graphs, an explanation of the decrease in new referrals was sought and additionally, the variations in the number of referrals between the different primary care networks. Dr Hilton apologised for the use of anacronyms recognising that this was unhelpful. He clarified the context of the graphs which offered more assurance about the data which indicated that a post-pandemic increase was now stabilising. With reference to the primary care network referral data, information from the MINT team used weighted population data which anticipated demand to calculate the deployment and distribution of resources rather than reflecting the historical patterns of access. It was recognised that further work was required to address this to address and inherent health inequalities.

Councillor Lloyd-Harris sought further context about the high number of suicide figures and what preventative actions could be taken. Lisa Redfern responded highlighting an initiative by the leader of the council, Councillor Steve Cowan that had led to the establishment of multiagency suicide preventative working group. Commonly, many who did take their own lives

were found to have had a dual diagnosis of mental health and substance misuse issues. Dr Lang explained that there were other factors locally such as higher rates of unemployment which could correlate to higher rates of suicide. Fingertips public health data indicated that the borough had the fifth highest rate of suicide in London. A segment of 58 suicides in the borough was examined, of which two thirds were linked to substance misuse or an underlying mental health condition. The council's work on this would be published shortly and available for further scrutiny. This included recommendations working across the mental health trust with children's services and working with Emergency Services as well. Dr Lang commended instrumental contributions to this work by Helen Mangan, together with the Hammersmith and Fulham Care Partnership and the mental health campaign group, reflecting the value of adopting a multiagency and universal approach. Another significant piece of work was a peer review with the Local Government Association which had undertaken an audit of individuals who self-harmed, presenting at A&E, and contained 23 recommendations.

Councillor Ben Coleman emphasised that the council had recognised the significant concern about the rates of suicide in the borough and commended the initiative. The adoption of a multi-agency approach incorporating insights from a range of expert health partners and organisations reflected the importance of this work. Full data and information about the work would be published on the councils Joint Strategic Needs Assessment website page and a link circulated to the committee. Dr Hilton offered to share information about suicide preventative work supporting bereaved families and activities undertaken by the Trust with third sector organisations.

Councillor Coleman congratulated Dr Hilton on his new appointment as Chief Operating Officer (Local and Specialist Services) and commended the partnership work undertaken. Helen Mangan directed the committee to an embedded document within the additional information which offered details of all the organisations that were involved reflecting the synergies arising with work undertaken with the most complex families.

Linda Jackson welcomed the additional information about the required improvement action plan covering areas where regulations had been breached and provided shortly before the meeting. In the interests of transparency, a request was made for the Trust to share the 16 "should do" recommendations.

ACTIONS:

1. Dr Hilton to provide a figure for the number of staff recruited at source from colleges and universities;
2. WLT to share waiting list on the number of those exceeding a 28 day waiting period;
3. WLT to share data about waiting list numbers broken down by ethnicity and income;
4. WLT to share and discuss the issue of referral data further with the committee;

5. The Director of Public Health to circulate a report from the Local Government Association on self-harm, and a link to the council's suicide multi agency prevention work to be circulated, when available; and
6. Dr Hilton to share information about suicide preventative work supporting bereaved families and activities undertaken by the Trust with third sector organisations.

RESOLVED

The committee agreed a guillotine to extend the meeting by 15 minutes.

6.2 Reduction of Mental Health Beds Capacity, Ealing

Dr Hilton explained that an enhanced engagement period was currently underway regarding a proposal to remove inpatient mental health beds in Ealing, a decision that was also likely to impact the boroughs of H&F and Hounslow. He apologised for any possible perception that there was a lack of engagement. A three borough provision had been in place for many years and so a perception by residents that the beds were "out of borough" was not applicable. The model of care provision had evolved, and Crisis intervention teams were now in place, aligned with a recovery house based in Ealing and available to the residents of all three boroughs as an alternative provision. The Trust had struggled to maintain two wards built in 1831, which did not offer safe infection prevention and control and were not fit to deliver modern health care services, a criticism of the CQC.

The proposal to permanently close the wards was based on clinical risk and the financial savings arising from this would be ring fenced to ensure reinvestment into the crises mental health system. A total of 31 beds had been closed and 18 re-provided at Lakeside Mental Health Unit, West Middlesex Hospital, with an overall reduction of 13 beds. Staffing was also being provided to section 136 suites and other crises related care.

Councillor Perez expressed her concern and disappointment that news of the proposal had not been directly shared with the committee and that this information had been shared by the director of social care, Ealing.

Councillor Nwaogbe expressed her specific interest in how the proposal affected borough residents and the number of residents admitted as mental health inpatients. An additional question was whether the Trust had a secondary plan, should this proposal not be implemented. It was explained that 25 H&F residents had been admitted to either the Ealing facility or Lakeside Mental Health Unit. However, the Ealing facility was not fit for purpose. Since the start of the pandemic, a model of care had been operating without the Ealing beds as these wards had been temporarily closed. The Charing Cross mental health unit had been utilised as another source of provision for the benefit of residents from all three boroughs. Dr Hilton assured the committee that since early 2020, the Trust had continued to retain patients with the system. It was acknowledged that should the results of the enhanced engagement indicate that the wards reopen, this would present a significant and difficult challenge, given the condition of the hospital

estate. Dr Hilton indicated that the Trust would prefer to commit to investing in new, purpose built inpatient mental health facilities in all three boroughs, however, this was unlikely to materialise in the short term.

Councillor Coleman reported that the information provided to H&F had lacked some of the information provided in the Ealing consultation document, together with a letter, and in addition a modified slide deck presented initially to Ealing had also not been provided. This had been unhelpful as Councillor Coleman explained that he had been working to understand the situation based on information given to Ealing, rather than what had been provided to the committee. Addressing the Trust's intention to reinvest ring fenced funding into community mental health services, Councillor Coleman expressed his concern that the CQC had evaluated existing provision as "requires improvement", and "inadequate" in its lack of staffing safeguards. He invited Dr Hilton to indicate how the Trust intended to improve community services to replace the 13 inpatient beds. Dr Hilton responded that within his portfolio of work there were two sets of community services, one was planned care, (the subject of this discussion), and in addition, a range of non-elective, community-based crisis services which included Crisis teams, home treatment, Health based places of safety and the recovery house, Richmond Fellowship. Dr Hilton clarified that the funding that was being reinvested from the 31 beds had already been spent in part to address the estates issue, but the remainder would be ring-fenced. The latter would also be applied to step down provision in supported living accommodation.

Councillor Coleman reiterated the concerns outlined briefly by Councillor Perez about not informing the committee of the proposal. He enquired if the Trust intended to properly consult. Dr Hilton stated that there was no holiday period in January, a period which would meaningful engagement with stakeholders less likely. Dr Hilton welcomed the suggestion and indicated that it would be possible to extend the engagement period.

Lisa Redfern reiterated that had she not been informed of the closure by a colleague the council would not have been aware of the proposal. She expressed concern that the closure of 13 beds was significant and warranted formal notification and consultation. While the substandard nature of the facility was not to be dismissed, her concern was that loss of the beds being redeemed by the provision of additional beds in Hounslow was an incomplete resolution. Commenting on the provision of step down beds, these were not the same as acute, inpatient provision that usually supported seriously ill patients and required a higher level of care and intervention. The travel and transport needs of H&F residents visiting loved ones with long term conditions placed at the Hounslow facility had also not been fully considered which was why a full consultation was needed.

Councillor Perez thanked members of the committee for their patience in discussing this important issue. Dr Hilton also thanked the committee for their feedback to the report and reiterated a commitment to have further conversations about the proposals acknowledging the concerns of the committee. He added that the temporary closure of the beds over the previous two and half years had allowed the Trust to build a portfolio of

evidence based on service performance and that the issue was about making a temporary closure permanent.

RESOLVED

That the report was noted.

7. WORK PROGRAMME

The committee noted that the next meeting would focus on the following items (TBC):

- Public Health Update (as per actions raised at the 20 July 2022 meeting)
- Model of Care Working Group (feedback on data analysis)
- Budget – Medium Term Financial Strategy

8. DATES OF FUTURE MEETINGS

Wednesday, 25 January 2023.

Meeting started: 7pm
Meeting ended: 10.15pm

Chair .....

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