NHS
North West London

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

Decision Making Business Case

Working Draft - Version 1.7

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Executive Summary

Introduction

The North West London Integrated Care Board (ICB) approved a Pre-Consultation Business Case (PCBC) in October 2023. Following this, a public consultation was undertaken on proposals for changes for acute mental health services for adult residents of Kensington, Chelsea and Westminster (KCW). The consultation was therefore primarily focussed on the two boroughs of the City of Westminster and the Royal Borough of Kensington and Chelsea.

These proposals covered:

- ***The overall service model for acute mental health care for adults of a working age***, particularly the balance of care between inpatient services and community provision.
- ***The location of some of those services,*** specifically where inpatient mental health beds and the Mental Health Crisis Assessment service (MHCAS) should be based.

Those proposals were set in the context of a temporary closure of inpatient services at the Gordon Hospital in 2020 because of the Covid-19 pandemic. The closure was accompanied by a significant enhancement of community services to make it possible for more patients to have their needs met without admission.

The consultation took place over 16 weeks and concluded on 16th February 2024.

The purpose of this Decision Making Business Case (DMBC) is to support the ICB in making a decision on the way forward for services after taking account of the consultation feedback and other feedback and information since the PCBC.

The services within scope are those within KCW supporting adults of a working age with an acute mental health problem that might require admission to an inpatient mental health bed. It does not include forensic and intensive care services or specialist services for people with a learning disability/autism, or services for children and older adults. All these services are provided by the Central and North West London NHS Foundation Trust (CNWL).

The DMBC has been developed by a Project Board with senior management and clinical representatives from both the ICB and CNWL.

The PCBC was itself informed by extensive public engagement which supported the development of the proposals and the identification and consideration of options.

Strategic Context, the PCBC and the Consultation Proposal

The local population

KCW has a diverse population with close to 420,000 residents. The most important areas of need identified in relation to the proposals are in the following areas:

- ***The high levels of homelessness***, particularly in Westminster which has the highest number of rough sleepers in the country. There is a significant link between homelessness and mental health issues. Mental health illness is often cited as a cause of homelessness; equally, experiencing homelessness may have an impact on mental health.
- ***Prevalence of serious mental illness (SMI).*** SMI is relatively high in KCW compared to the rest of the country (23% above the London average, and 43% above the national average).
    - The total number of people over the age of 18 who have been diagnosed with a SMI is above the North West London average in Kensington and Chelsea at 4,176 people. The prevalence of SMI in Kensington and Chelsea is among the highest in North West London, with a rate of 98 people per 1,000 of the population.
    - In comparison, the Westminster population includes 3,763 people with SMI. Prevalence of SMI in Westminster is the lowest in North West London, with a rate of 58.2 per 1,000 of the population.
- ***Mental Health inequalities.*** As in the rest of the country there are significant inequalities in terms of the likelihood of experiencing mental illness and access to services. Of most relevance to the services in the scope of this consultation is the over-representation of black and mixed race people in inpatient care and subject to Mental Health Act Section, and poor access rates to community based services for black people.

Wider context for mental health services

The PCBC described how emerging best practice models for acute healthcare nationally and internationally are focussed on ensuring that people are only supported within restrictive inpatient care if their needs cannot be safely met within the community. It drew the conclusions that:

- For some patients there will always be a need for hospital admission, as hospital will be the only place where we can provide safe and effective treatment and care.
- Where we have a choice, we should prioritise effective community-based alternatives to inpatient care over institutionalised hospital care that takes people away from their homes and communities. We know that unnecessary hospital admission can lead to greater loss of independence, a longer road to recovery and a worse patient experience.

- We should not accept a situation in which anyone with a need for inpatient provision has to experience their care in an environment which is simply not fit for purpose or is in any way "an obstacle to the delivery of therapeutic care".

These conclusions are fully aligned with the three "big shifts" outlined as essential for the development of the government's 10 year NHS Plan, as one of those shifts is the move from hospital to community based care.

These principles reflect the law as set out in the Mental Health Capacity Act (2005) which sets out that we should follow the "Less Restrictive Option". (Not all our patients lack mental capacity but we believe that the principles are equally relevant for all acutely ill mental health patients). The Code of Practice on the Act says "Before somebody makes a decision or acts on behalf of a person who lacks capacity to make that decision or consent to the act, they must always question if they can do something else that would interfere less with the person's basic rights and freedoms. This is called finding the 'less restrictive alternative'. It includes considering whether there is a need to act or make a decision at all. and says that "regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action".

The North West London Context

Since the PCBC was written the ICB has developed and published its overarching mental health strategy. The strategy confirms agreement with the conclusions above, and sets three key ambitions:

- Raised awareness and promoting of wellbeing.
- Increased equity and equality of access.
- Care in the right place.

It is also set out an overall need, demand and capacity analysis. This concluded that based on current plans including the proposals in this DMBC the system in 2029 will have well balanced capacity with sufficient beds overall to meet the needs of the local population and maintain occupancy at good practice levels. This conclusion is based on our plans to continue to reduce length of stay by reducing the number of patients within inpatient beds who are clinically ready for discharge.

Service provision and change in 2020

Prior to the temporary closure inpatient services for adult residents of KCW were provided at:

- The Gordon Hospital, which is located in the south of Westminster which accommodated 51 beds in three wards.

- St Charles Centre for Health and Wellbeing which is in the north of Kensington. It provides four wards with a total of 67 beds.

At that time there were a much higher number of inpatient beds per head of population in KCW than the national average, and the highest in London. On the other hand, expenditure on community based provision was lower than in other areas.

Following the temporary closure, a whole range of community based services were developed including step down beds, a Mental Health Crisis Assessment Service (MHCAS), enhanced services from voluntary, community and social enterprise (VCSE) partnerships and the Coves as a non-medicalised crisis alternative. There was also investment to improve quality of care and patient flow in inpatient services.

Impact of the service changes made in 2020

The key impact of the changes has been a shift in the balance of care. There are now fewer patients being supported in restrictive inpatient provision and more within the community. There has been no reduction in the number of patients admitted under section[1], but a substantial drop in the number of informal (voluntary) admissions. Key impacts are that:

- Inappropriate out of area admissions (OOA)[2] have dropped to zero.
- Readmissions have remained at similar levels to what they were before the closure.
- Length of stay has not changed overall.
- The community model means fewer people now need to make journeys to inpatients facilities
- Overall, more people in KCW with acute mental health needs now receive a service.

Case for change supporting the public consultation proposal

The key points from the PCBC case for change were that:

- Before the temporary closure too many people were cared for in a restrictive inpatient setting, and we did not have the right services to support people within the community. The new lower bed base was at the right level to meet the needs of people really requiring inpatient care.
- Waiting time for admission under the new model were not yet what they should be.

[1] Meaning patients who are detained for reasons set out within the sections of the Mental Health Act of 1983.

[2] There is a national target to have no Out of Area Admissions. In the local context this means no admissions outside the are supported by the CNWL Trust. It does not equate to “out of Borough”.

- The quality of the inpatient wards at the Gordon was not good enough for modern healthcare and failed to meet too many quality standards relating to safety and patient experience.
- Where appropriate therapy could be provided in either an inpatient or a community setting, restrictive inpatient care represents a poorer experience than community care.
- Access and travel time to care is better within community provision than in inpatient services. However, some of those who do need inpatient care (and their visitors) would face longer journeys if there was only one inpatient site in KCW.
- Maintaining the Gordon Hospital as a key component in delivering excellent mental health services should be an important part of the way forward**.**
- Since 2020 there has been a substantial increase in investment in mental health services in KCW with £11m revenue investment supporting 193 staff (about half funded from resources released from the closed wards). There is no "spare" money for mental health so if we reinvest in inpatient services we will have to reduce community based services. In addition, there is not sufficient capital available locally to allow the quality of the Gordon building to be improved to a level that would make it fit for purpose to deliver good inpatient care.

Options for the future configuration of services and the PCBC proposal

The PCBC considered a whole range of options (with support from multiple stakeholder workshops). Those options included reinvesting in inpatient services at the Gordon. The option assessment identified that, while some of these options would be welcomed by some stakeholders, they were not deliverable. The assessment concluded that three options should be described in the Public Consultation. It also recommended that only one of those options should be set out as the preferred way forward.

The recommended option was ***Option C (referred to as Option 3 in the consultation).*** This option would not reopen the wards at the Gordon but would maintain and add to the full range of community services that had been put in place since the closure. In particular, the MHCAS service would be enhanced to provide more capacity and enable short stay patients to be treated there.

The options described but not recommended were

- ***Option A1 (referred to as Option 1 in the consultation).*** This was the closest option to the status quo in 2019 and involved refurbishing 3 inpatient wards at the Gordon and staffing those as before. Staffing and resources would be removed from the new community services to enable this.
- ***Option D (referred to as Option 2 in the consultation).*** This would involve restoring a single ward at the Gordon. This would be enabled by reducing some but not all of the new community based provision.

The public consultation process

The consultation was led by the ICB with the support of staff from CNWL. The consultation period was between 24 October 2023 and 16 February 2024. The consultation had independent external support from Verve Communications Ltd which also produced the Consultation evaluation report. The consultation was designed to ensure that:

- Good practice guidance was followed, and all legal requirements met.
- Full information was provided to the public to enable them to understand the proposals and to allow them to engage. Accessibility of information was a key focus.
- Feedback could be provided through many different channels as easily as possible.
- Participation was promoted effectively, with substantial numbers of stakeholder organisations and voluntary groups being proactively approached and invited to participate, as well as promotion through all normal channels.
- There was a particular effort to involve priority groups – those identified by the Equalities Impact Assessment of being most likely to be affected by the proposals.
- We worked hard to engage service users, carers and staff.

There was substantial engagement, particularly considering the specialist nature of the services involved. 200 questionnaires were completed, 60 feedback documents were evaluated including organisational submissions, correspondence and meeting notes (from 37 independently facilitated events). There were 88 inputs from service users, and 36 from carers, 135 inputs from clinicians, professionals and CNWL staff, and 249 inputs from communities facing inequalities or having protected characteristics.

During the consultation we received feedback on what we could do better, and we responded directly to produce clearer information, arrange additional meetings, provide events on particular estates, meet with people representing the homeless, and provide more time to respond (by adding 2 weeks to the consultation period).

Consultation questionnaire feedback

We received 200 questionnaire responses. Not every response answered every question. The table below show the overall support for the proposed consultation option. Views were very polarised but of those who completed the questionnaire slightly more were in favour (90) than against (71). (As many people attended meetings and gave views but did not necessarily complete questionnaires, the questionnaire responses may not be wholly representative of the views of all people who were involved.)

Analysis based on number of responses		All	Service Users	Carers	NHS Staff	Other
In favour	Stongly Agree	47	11	8	13	16
	Agree	43	14	4	12	14
	Total Agree	**90**	**25**	**12**	**25**	**30**
Against	Stongly Disagree	55	12	5	9	29
	Disagree	16	5	1	2	8
	Total Disagree	**71**	**17**	**6**	**11**	**37**
Other	Neither	24	12	3	6	3
	Total Other	**24**	**12**	**3**	**6**	**3**
Total responses to question*		**185**	**54**	**21**	**42**	**70**
Net numbers in favour		**19**	**8**	**6**	**14**	**-7**

Assessment of consultation qualitative feedback and response

We received a great deal of qualitative feedback following which we established 5 priority areas for us to explore in detail. The priority areas were as follows:

- ***Overall service model and balance of care between inpatient and community based services – two linked areas***

  1. Whether we were planning sufficient inpatient beds numbers to meet the needs of our population.

  2. The ability of community based services to meet the needs of patients who would in the past have been admitted.

- ***Ability of the model to meet the needs of more vulnerable groups and address inequalities*** (this work area included the development of a completely revised and enhanced Integrated Impact Assessment (IIA).

  3. Meeting the needs of people who are homeless, particularly rough sleepers.

  4. Addressing inequalities and structural racism

5. Meeting the needs of vulnerable groups/groups with protected characteristics potentially impacted on by the change and groups with disproportionately high use of acute mental health services

- ***Mental Health Crisis Assessment service***

6. Work on the detail of the service model, and the best location for the service

In addition to these priority work programmes this DMBC also addresses issues raised by respondents in two other areas. These are:

- ***Information*** **-** Whether we had provided sufficient information on key issues
- ***Process*** **-** Whether we had considered the right options with the right engagement, and whether the consultation process was appropriate and sufficient.

We have summarised the main issues raised in each of these areas and our response below.

Overall service model

1. Sufficient inpatient beds numbers to meet the needs of our population?

The biggest feedback challenge to the overall service model was that it does not include enough inpatient beds to meet the needs of the local population and deliver a high quality of care.

Concern raised	Response
That we had not planned enough beds to meet the needs of the population taking account of its unique local needs such as the level of Serious Mental Illness (SMI)	Our analysis shows that compared to other areas we have a relatively high number of admissions for people under section (reflecting the level of SMI). However, we have a very low level of voluntary admissions, and this is the biggest change that followed the reduction in beds in 2019/20. The evidence suggests that the people who were having voluntary admissions are continuing to receive the care they need. The purpose of voluntary admissions is to provide support for people and reduce the risk of people needing to be sectioned. However, we have not seen an increase in patients who need to be sectioned, so this suggests that the community services are managing the risk at least as effectively as the inpatient services used to. This, together with the lack of out of area placements, suggest we have rightsized capacity.

Concern raised	Response
That the KCW modelling of inpatient beds needed to be understood within the context of an overall NW London wide strategy and needs/capacity assessment	In July 2024 the ICB approved a mental health strategy which includes a need and capacity analysis. This concludes that over a 5 year time horizon NW London has the right number of beds. It sets out an approach to improving occupancy levels (largely through reducing the number of patients in beds who are clinically ready for discharge) and addressing waits in emergency departments (through good use of crisis alternatives). It is consistent with the proposals in this consultation.
Whether the modelling needs to be more granular based on specific mental health diagnosis, and whether we had provided sufficient detail on assumptions on length of stay and admissions.	Our clinicians tell us that patient need has to be determined individually and is not driven by the specific mental health diagnosis. The modelling is at the appropriate level of detail to show we have the right capacity to meet the needs of local people. This DMBC sets out and justifies the assumptions in our modelling on both admissions and length of stay.
Whether we had sufficient capacity to deal with peaks in demand and prevent Out of Area Placements.	Recent data shows that our system is flexible enough to manage peaks in demand while preventing the need for out of area placements. Our work on length and stay and admissions reduction will improve occupancy levels and add further resilience, As noted above inappropriate Out of Area Placements have not taken place for over a year.
Whether the changes had resulted in increased delays in Emergency Departments and in community settings for patient needing an inpatient admission.	We recognise that waits in Emergency Departments have been an issue, and for some of those waits the reasons have related to ability to quickly access an inpatient bed. The latest data suggests that this now affects around 6 people a week within KCW (this could equate to one additional inpatient bed being needed in the system). The proposals to enhance the MHCAS capacity, add additional beds in Brent and free up beds through reductions in length of stay will provide more than enough capacity to fully address the issue of long waits in Emergency Department. We have also reviewed patient waits for admission within community settings (from Health Based Place of Safety, MHCAS and from the community, not in another MH bedded facility). These are also higher than they should be, and we have a clear programme in place to address them. We have also shown that very few additional beds could possibly be needed to fully address them (far less than we plan to add to the system anyway).

Concern raised	Response
Whether the quality of care for inpatients had suffered as a result of increased patient acuity, and patients were being discharged too early because of pressures on beds.	We recognise that patient acuity has risen and, given our aim of reducing the number of less acutely ill people within inpatient settings by treating them in the community, closer to home, this is what would be expected. We have increased staffing levels on wards to take account of this. Length of stay has not reduced overall, although we have successfully worked to reduce it for patients under section and we can reduce it further by reducing the numbers of patients in beds who are clinically ready for discharge. Those reductions are not because we are discharging patients too early but because of a focussed set of actions to minimise delays and improve flow without impacting on the quality of patient care. A key indicator of service quality is the number of adverse events (e.g., absence without leave, assaults and serious incidents reported). These have all fallen or remained level since 2019/20.

2. Ability of community services to meet the needs of people who would have been inpatients in the past

The concern about having enough inpatient beds was linked to the belief that community services based provision was not able to meet the needs of people who would in the past have been inpatients.

Concern raised	Response
Whether community services could provide an appropriate alternative treatment for those patients who had been admitted as informal patients	We are confident community services can provide as good and often better services than was possible in inpatient wards. Immediate assessment can be provided quickly and thoroughly through MHCAS. The full range of treatments patients may need is available through Community Mental Health Hub teams. The only difference is that patients are not in a restrictive environment designed to prevent risk of harm to self or others. We have invested substantially in community capacity – for example with 16 more staff supporting step down beds, 18 staff supporting MHCAS, 35 additional staff in Community Mental Health Hubs, and 46 extra staff in talking therapies. Overall, we have put in much more capacity than would have been needed just to take on those patients who would in the past have been admitted.

Other service model issues raised

Concern raised	Response
Whether it was wrong not to have two inpatient facilities in KCW, with one in each borough.	We recognise that having only one inpatient unit increases travel times and potentially costs, especially for visitors but also for staff from other services such as social workers. The implications of having one inpatient unit not two are: • ***Public transport.*** An average journey time increase of just under 9 minutes. When there were two sites the maximum journey time to an inpatient unit would have been 35.4 minutes and is 54.12 minutes, an increase of 19 minutes. • ***Private car.*** An increase in average travel time of 4 minutes. The maximum journey time used to be 18.2 minutes and is now 26.8 minutes. It is true that the number of people being admitted out of their borough of residence has increased since the closure (about 60 people a year), but the key measure is travel time, not the crossing of an administrative boundary. While we would prefer not to add to travel times at all the reality is that we do not have the financial resources to create two good quality inpatient units in KCW. We cannot simply reopen the Gordon as it requires substantial expenditure to meet basic quality standards. This expenditure would prejudice other investments which are more critical to the delivery of good quality healthcare. There are no other appropriate locations, and the cost of new build would be prohibitive. 9 of London's 32 boroughs do not have an inpatient site within the borough boundaries for working age adults acute (including Westminster).
Whether the Gordon can be a good inpatient facility.	We recognise that the Gordon is well located with good access to community facilities (as is St Charles) but the nature of the building and its age mean that it is not fit for purpose for the delivery of the best quality modern healthcare. There are 13 key standards for health buildings and good quality mental health facilities which it fails to meet. These include lack of ensuite facilities and lack of safe,

Concern raised	Response
	good access to outdoor space. It would take substantial capital expenditure to remedy these, and the issue of outdoor space cannot be remedied.
Why we cannot both increase inpatient beds and retain our enhanced community provision	Both our local councils have argued this is what we should do. Unfortunately, the NHS does not have unlimited funding. There has been some growth funding each year, but we have to carefully prioritise how it is spent. We expect future increases to be small and not nearly enough to fund adding inpatient beds and the enhanced community services. If we used the money to increase inpatient beds, we would prejudice other services which are much more likely to have a positive impact on patient outcomes.

Ability of the model to meet the needs of more vulnerable groups and address inequalities and structural racism

3. Meeting the needs of people experiencing homelessness with acute mental health issues

We received significant feedback from the consultation that our preferred option did not sufficiently address the needs of people experiencing homelessness, and that this was particularly important because of the high levels of homelessness in Westminster. As a result, we engaged with key stakeholders and voluntary organisations working to support the homeless to consider concerns and develop appropriate mitigations.

Our headline response is that the model we have chosen is better for the whole population, including homeless people. However, we now intend to do a detailed audit over a period of several months to identify if there are specific gaps in the care we provide for the small group of homeless people who would in the past have been admitted but are now supported in the community, particularly those who are rough sleepers. We are committed to prioritising investment to address any gaps we may identify.

Concern	Response
Need to understand the needs of the homeless in relation to the new service model.	We recognise homeless people with acute mental health issues are a very vulnerable population, and there is a particularly high prevalence in Westminster. There was a significant amount of feedback through the consultation on the needs of this population, which has shaped our consultation proposals (see sections 5.3 and 6.2.3) so it is clear people were able to comment on the impact of the proposals on this population. Following this feedback, we have provided additional information in this DMBC on the homelessness issue, and on the use of acute mental health services by homeless people. Data is not very accurate for this group, but our analysis suggests that in 2023/4 at any one time we were probably supporting around 4-5 more homeless people with acute mental illness in a community setting rather than in an inpatient bed.
That it is too hard for homeless people to be admitted, and they are discharged too quickly.	Our assessment is that there is no change in the ability to admit homeless people who have been sectioned, but that as with the rest of the population we are admitting fewer patients as informal admissions. People within temporary accommodation can be appropriately supported within the community; that being the case it would be wrong to place them in restrictive care. We recognise this is more of an issue for rough sleepers. We have also looked at the question of whether we are discharging people too early. Our data does not reliably tell us whether people are being discharged to accommodation which can support their treatment and recovery. We are therefore committed to a more detailed audit over the next year to review whether homeless people are able to access the treatment they need in the community, and if the review identifies that there are gaps to address them as a priority.
That community based services do not provide as good support for the homeless as the inpatient service would have done.	We have worked with stakeholders who support the homeless population to identify where there are weaknesses in the services we provide. We recognise there are unique challenges in providing good quality services to this population. While we remain of the view that it is better for everyone who is not at risk of harming themselves or others to be supported within the community rather than in restrictive inpatient care, we recognise we need to audit the care we are providing this group and address any gaps identified.

4. Addressing inequalities

A key feedback theme was that we needed to do more to consider the impact of inequalities and provide stronger plans to address them. Some feedback suggested we had not sufficiently considered the impact on people with learning disabilities or autism.

Concern	Response
Both the Joint HOSC and the Mayor's Office questioned if we had sufficiently considered inequalities and structural racism.	Our overall approach for addressing inequalities is through a substantive programme of work addressing the full range of mental health services, and not simply those covered within this proposal. It is fully consistent with the NHS strategy for addressing Mental Health inequalities. By focussing on less restrictive, more community based provision these proposals ensure that everybody at risk of inpatient admission has the opportunity to benefit from a better service. As many vulnerable groups are over-represented within the cohort of people with acute mental health needs the proposals will positively impact on inequalities. The proposal is informed research work[3] carried out in Central and North West London by Buckinghamshire New University which showed the negative perceptions of many black users of the care they had received as an inpatient and of the inpatient environment. Minimising unnecessary admissions to those restrictive settings is positive step towards addressing experienced inequalities. This DMBC includes an updated and very detailed Integrated Impact Assessment (IIA) which provides a substantial assessment of the specific impacts of the service configuration proposed. It looks at the impact on vulnerable geographies, different ethnic groups, and other protected groups. We have also updated the Equalities Impact Assessment. These provide appropriate information to support the ICB in decision making. The IIA does not identify significant inequalities impacts but does suggest key areas requiring mitigating action, including travel times and costs from South Pimlico, the impact on carers, support to address impacts on black people, and the homeless. This DMBC

[3] Disproportionate Representation of People of Black African and Caribbean Heritage in Crisis Pathways & under Mental Health Act[1/2]Final ReportJuly 2021

Concern	Response
	included mitigations in these areas which were discussed at a well-attended stakeholder workshop.
Whether we had sufficiently considered the impact on people with a learning disability/autism and taken account of them in the overall bed numbers	Our IIA provides information on the potential impact for these groups. We have also shown in the DMBC that admissions for people known to be in these groups has fluctuated significantly since 2018/19 but around a low number (19 in 2021/2, 5 in 2023/4). There is no need for people within these groups to have a different kind of bed or overall support than the general population. We have, however, improved the wards at St Charles to make them a better environment for people with sensory needs. There is no reason to believe that the same benefits all patients receive from being supported within the community rather than a restrictive bed do not apply to for these groups.

Mental Health Crisis Assessment Service

There were several positive comments on the new service. However, we also had feedback that we need to do further develop the model through a codesign process, that more detail was needed on how the model would work, and that we needed to consider whether it was appropriate to move the MHCAS to the Gordon site.

5. MHCAS service model and location

Concern	Response
The need for co-design work on the MHCAS model, and more detail on how it would work	The MHCAS model for the current pilot service was itself developed with significant input from stakeholders and we are continuing this approach. We had good attendance at a recent stakeholder workshop which we used to gain further invaluable information on where we could improve the service, and on the best location for the service. We are continuing to learn from our actual experience with the pilot and have already made changes and improvements, including ensuring everyone stays for the right amount of time to keep flow through the service, but enable some longer stays where appropriate. We provide more detail in the DMBC on the model.
What is the best location for the MHCAS in future.	An important concern expressed in the consultation was whether it was appropriate or safe to have the MHCAS in a

Concern	Response
	location where it was isolated from mental health inpatient services. Some respondents suggested that an isolated unit was higher risk, as in the event of serious incidents there was no backup on site. Taking account of our learning so far, we have carefully reviewed this specific issue, and this review has suggested that it would be better for the MHCAS to be collocated with an inpatient unit. In the light of this we have re-examined the space potentially available for an enhanced MHCAS at the St Charles site (at the time of the PCBC we did not believe we had a location on St Charles site that could physically house the enhanced MHCAS service). The further review has identified a suitable location on the St Charles which can be refurbished to enable this. As part of this DMBC's review of the PCBC option appraisal we have therefore considered an additional variant option of the preferred way forward which would have the MHCAS location at St Charles. The option appraisal review suggests that St Charles location is preferred (more detail below).

Level of information provided within the consultation

Some responses said we needed to include further information to allow an appropriate decision to be made. Key areas respondents said were not fully covered above were:

- The lack of an overarching mental health strategy and inequalities reduction plan for North West London to provide context for the proposals.
- Further details on the costs and financial case.
- More analysis of the impact on social care and other organisations.
- Information robustness and quality.

Concern	Response
That the proposals should be set in the context of a clear inequalities reduction plan for the ICS and plans to address structural racism	We recognise the importance of reducing inequalities across the ICS and the ICS has a clear approach for doing this through a number of focussed workstreams described in more detail in Section 0. CNWL works to address structural racism through

Concern	Response
	• The Workforce Race Equality Standard (WRES)[4] • The Patient and Carer Race Equality Framework (PCREF) [5]
Additional information needed on costs	This DMBC and the PCBC provide the information requested by the JHOSC.
More information on potential additional costs for service users and their visitors in relation to additional travel	Our IIA has a specific section focussed on this. Our conclusion is that for most people the additional costs will not be substantial, but we have identified that for residents of South Pimlico (which is a vulnerable area) we may need to provide visitors with help in managing additional travel costs.
Impacts on social care being underestimated particularly in relation to AMHPs workload, and travel times for social workers.	The work we have done to assess social care impacts has not provided evidence that the changes made in 2019/20 have increased the burden on social care colleagues. Social care colleagues have told us anecdotally that there has been an impact on the travel time for social workers, but the data they have supplied does not demonstrate this. We have worked hard to engage Local Authority Partners in identifying relevant data and jointly assessing of the impact **[Placeholder for text to be agreed with Local Authority colleagues on work to reconcile data]**
Impact on the police and the impact of the Right Care Right Place Policy	We do not believe the changes have had an impact on the police service. The main link between our services and the police is with the location and operation of Health Based Places of Safety. The location and number of these units is not in the scope of this consultation. In terms of the RCRP policy the Trust has reviewed services since the policy was admitted and not identified any significant impacts on service provision.
Information robustness, and particularly the contrast between individual respondents' experience and the data in the PCBC/Consultation.	We always recognise that individuals' specific experience of issues may differ from the messages we are able to extract from the information we have. We have welcomed all feedback from people's own experience and have used this DMBC to address it as comprehensively as we can. When addressing concerns people have raised about the impacts of

[4] NHS England » NHS Workforce Race Equality Standard

[5] NHS England » Patient and carer race equality framework

Concern	Response
	the changes our aim has been to triangulate information and analysis from three areas; • Whether there is a clear rationale which explains why the changes are likely to have caused the impacts described. • The most robust data we have available on the topic. Where we are uncertain about the data we have said so (for example in some of the data on homelessness care). • The feedback from individuals and groups with expertise/experience on the ground, particularly where this contrasts with the data. We then have to draw conclusions based on all three elements.

The PCBC and consultation process

Some stakeholders, particularly Local Councillors, have raised questions about the appropriateness of the processes followed prior to the Consultation and to some elements of the Consultation Process itself. These are discussed below.

Concern	Response
Insufficient engagement in the development of the options, bias in the way the options appraisal was carried out, and a lack of transparency	The PCBC demonstrated the significant engagement we undertook in the process to develop and assess the options and shows how that process materially influenced our assessments. This has continued with this DMBC and some of the feedback we received in consultation has influenced a change in the proposals for the preferred way forward. What has been described as bias by some respondents is the clinical advice provided in terms of the balance of inpatient and community provision; that advice is consistent with national best practice, and with the experience of those clinicians on the ground. We do not accept there is any lack of transparency.
The London Mayor's office suggested that we should have included the decision on an additional ward in Brent within the PCBC option appraisal.	We do not agree with this because the decision was made (and implementation commenced) by CNWL independently from the ICB before the PCBC options and implementation commenced. The decision would still have made sense, whichever option was ultimately chosen within the PCBC; with a limited investment the Trust could secure flexible long term capacity in an uncertain future, which would have a particular benefit as a decant facility. Even if the PCBC had identified a preferred way forward involving refurbishing the Gordon as an inpatient unit the extra capacity would have been useful for the period of several years that it would have taken to deliver the refurbishment.
Some responses have said that some communities were not sufficiently engaged within the consultation (referring mostly to service users, people experiencing homelessness, and people from black and minority ethnic communities).	The consultation made significant efforts to engage with service users and all priority communities. Where it was challenging to get direct input, particularly with people experiencing homelessness, we ensured that we got input directly from services inside and outside the NHS working with those groups. The level of participation from service users in general was good. The depth and quality of information received in responses received from the consultation on issues affecting service users as a whole, and service users experiencing homelessness in particular shows the effectiveness of the consultation.

Concern	Response
	It is always better to receive more input, particularly from groups with protected characteristics, but everybody has had a good opportunity to contribute their views if they wished to.
Concerns about the number of events and the level of publicity.	The engagement activities and the publicity supporting them were comprehensive and resulted in the ICB achieving extensive and useful feedback. At the start of the consultation, we recognised that, while public meetings were an essential part of the process, many of the people and groups we would want to engage would be unlikely to attend formal meetings. We knew feedback was likely to be limited from some groups, and so from the outset we worked on proactive outreach working with community and patient groups. Recognising the scope and scale of the consultation, the willingness of individual and organisations to engage, the time demands on busy clinicians supporting consultation events, and the costs involved the Consultation engagement and publicity was fit for purpose and met best practice requirements.
Complexity of consultation materials.	The consultation documents and materials were comprehensive and provided the necessary information to understand the proposals and comment on them. The range and depth of feedback received during the consultation is good evidence that we had provided information which allowed people to understand the issues and engage with them

The Proposal for decision

Revised option appraisal

As part of the DMBC process we have revised the original PCBC option appraisal so that we can ensure it takes account of points made in consultation feedback and new information. The purpose was to confirm if Option C1, the basis of the consultation proposal, was still demonstrably the best way forward.

We considered all of the options which were subject to detailed analysis in the PCBC and added a new variant option which was the same as the core consultation proposal with the exception of the location of the MHCAS. Under the new variant option (Option C2) the enhanced MHCAS would be located in a new refurbished facility at the St Charles, rather than being moved to the Gordon.

The DMBC option appraisal confirmed that the two Option C's performed significantly better against the objectives than any of the other options. It also suggested that the clinical, safety and access advantages of having the MHCAS at St Charles rather than the Gordon were significant. It will require additional capital expenditure than the move to the Gordon Hospital (£3.2m rather than £2m), but the service at the Gordon would cost £200k more per annum than at St Charles because of the need to have additional staff to manage safety and security risks. The overall conclusion is that Option C2 should now be the preferred way forward.

The proposed service model and location

The final proposed model includes

- Maintaining and continuing to enhance the community based services that have been put in place since the temporary closure of the inpatient wards to provide as much care in the community as possible. This should limit the number of people who have to be in restrictive inpatient care.
- Maintenance of high quality inpatient care in the 67 beds within KCW.
- Enhanced crisis assessment services through the MHCAS being expanded to 12 spaces, with 4 beds for longer term assessment and treatment.

In terms of location, it is proposed that:

- The 67 inpatient beds and the MHCAS will both be located at the St Charles site.
- There will be further development of the Gordon hospital as an asset for South Westminster by providing different community services from the space. (More details in section 6.2.4).

The MCHAS model will continue to develop as we learn from experience

Based on our work with the task and finish group on homelessness we will look to improve service delivery for this group through

- A specialist team for in-reach into wards for people who are homeless or rough sleeping.
- More training for CNWL staff in the needs of this groups.
- Better multi-disciplinary care planning across organisations.
- Making better services for the homeless a key priority for the new Integrated Neighbourhood Team.

We will also implement a one year audit of the quality of care provision for the homeless in community settings to identify and address any remaining gaps, and any areas which should be a priority for investment – particularly if they appear to be linked to these service changes.

Our proposal for the Gordon hospital is that it should be a community services hub for the system, supporting a range of other services, including the potential for some rentable training space.

The proposed way forward is supported by a comprehensive approach to address inequalities through the development of the Patient and Carers Race Equality Framework programme in the Trust.

The revised financial case

The capital requirement to deliver the option is £3.2m over the next two years to refurbish space at the St Charles for the MHCAS. We also anticipate a need to spend up to £3.3m in recreating the Gordon as a community facility. The timing of this second element will depend on capital availability in the years immediately after that.

There is anticipated to be a small additional revenue cost to fund the enhanced MCHAS of £0.11m per annum. However, the reuse of the space at the Gordon should allow savings in the future on other lease costs which could deliver a net saving of £0.9 to £1.5m per annum which can be used to support other service developments.

Updated Integrated Impact Assessment and Equalities Impact Assessment

A very detailed IIA has been developed to support this DMBC. It carefully considers the impact of the changes, particularly upon vulnerable groups. The overall conclusion we have drawn from the IIA is that there are some relatively minor impacts on inequalities which we should mitigate. We have identified key mitigation actions above. The EQIA produced for the PCBC has been updated based on the revised IIA. The ICB and CNWL are committed to the reduction of inequalities, and the proposals go alongside our core programme to deliver this across all our services.

Assurance and advice

Legal duties

The DMBC summarises the legal requirements for the ICB to consider in engaging, consulting and decision making on service change. On the basis of the legal advice we have received we believe we have met those requirements.

Joint Health Oversight and Scrutiny Committee (JHOSC)

We have had two formal inputs from the JHOSC which were a letter in February and a further letter in July. Those letters set out detailed points for us to address. We have addressed them all within this DMBC We look forward to further discussions with the JHOSC.

Secretary of State's tests.

The performance of the proposed option in the consultation against the key national NHS tests was evaluated in the PCBC. That evaluation has been reviewed and updated in the light of new information and feedback from the consultation. Our updated evaluation confirms that we c we have met these tests in full.

London Mayor's tests.

The London Mayor has 6 tests by which he evaluates consultations on service change. We had an initial letter and report in January focussing on 4 of those tests in which he set out helpful feedback on a range of issues he expected to be addressed within the DMBC.

This DMBC gives a detailed response to each requirement. It shows that we have met the tests as described in relation to the specific service changes we are proposing. We recognise there will always be more to do in terms wider inequalities within mental health and will continue to work with partners to make progress in reducing them.

Governance and Implementation

If the proposal is agreed CNWL will lead on the implementation of the proposals with oversight from the ICB.

The implementation is not a substantial one as much of the model is already in place. The main changes to be delivered will be:

- The relocation of the MHCAS on the St Charles site.
- The further development of the MHCAS Model.
- Further work to reduce length of stay and admissions in line with our aims to reduce occupancy rates. This will need to take place at both Trust and ICB level.
- Further development and implementation of the mitigations identified, including the audit of care within the community for homeless people.
- The continued development of our wider plans to reduce inequalities.

We expect the Trust to work closely with all the ICS partners and other stakeholders in the implementation process.

Our aim would be that the enhanced MHCAS service will be in full operation in its new location by December 2025.

We have established a range of key metrics we will use to measure success and risks we will need to manage.

Recommendation

The PCBC approved by the ICB in October 2023 suggested that the consultation proposal (Option C1 in this DMBC) represented the best way forward for acute mental services for adults of a working age in KCW.

The key question for the ICB to consider now is whether that proposal is still the best option in the light of careful consideration of the consultation feedback received and other changes and developments since the PCBC.

While the ICB has had a lot of feedback and many people remain concerned about the proposals, this DMBC has carefully assessed those concerns and suggests that the overall service model remains robust. Unlike most other significant service change consultations, we have the benefit of 4 years of evidence on the ground of the new model's impacts. The clear weight of evidence in the DMBC is that those impacts are positive. Returning to the model we had in 2019 would be a retrograde step negatively impacting on patient experience and outcomes.

This DMBC recommends that

- The ICB should endorse a variant of the consultation proposal (Option C2 in this DMBC) Under Option C2 the enhanced MHCAS would be located at the St Charles and not the Gordon Hospital, as this will provide higher quality and safer services.
- The ICB should ensure the mitigations proposed are implemented. These include those within Section 6.4.5 which cover mitigations for the population as whole and those in Section 6.2.3 which specifically focus on people experiencing homelessness who have acute mental illness.
- The ICB and CNWL should continue to develop and implement their plans to reduce inequalities in mental health, working with system partners.

1 Introduction

1.1 Purpose and background

The North West London Integrated Care Board (ICB) met on 17 October 2023 and approved a Pre Consultation Business Case (PCBC) containing proposals for the future of Acute Mental Health Services in Westminster, Kensington and Chelsea (together, KCW).

These proposals related to:

- ***The overall service model for acute mental health care for adults of a working age***, particularly the balance of care between inpatient services and community provision.
- ***The location of some of those services,*** specifically where inpatient mental health beds and the Mental Health Crisis Assessment service (MHCAS) should be based.

The proposals were set in the context of the temporary closure of inpatient provision at the Gordon Hospital in 2020 (as a result of the Covid-19 Pandemic), and the related development of a range of community based services designed to reduce the need for acute inpatient provision.

The preferred way forward set out in the PCBC was to:

1. Develop and enhance the new community-based services put in place from 2020 onwards.
2. Further develop support for people in a crisis by expanding the Mental Health Crisis Assessment Service, moving it to the Gordon Hospital from St Charles Hospital, increasing its capacity, and including within it the ability to offer short admissions while people are in a crisis.
3. Continue to provide good quality inpatient facilities at St Charles for the residents of the Royal Borough of Kensington and Chelsea and the City of Westminster. This meant that the temporarily closed inpatient services at the Gordon Hospital would not be reopened. Continue to provide good quality inpatient facilities at St Charles for the residents of the Royal Borough of Kensington and Chelsea and the City of Westminster (collectively referred to in this document as KCW). This meant that the temporarily closed inpatient services at the Gordon Hospital would not be reopened.

The proposals were approved for submission to public consultation so that the ICB could fully consider the views of the public, service users, stakeholder organisations and staff before a final decision was made.

The consultation took place between 24 October 2023 and 16 February 2024.

The purpose of this DMBC is to support the ICB in making a decision on the way forward for services after taking account of the consultation feedback and other feedback and information since the PCBC.

NHS England's guidance "Planning, Assuring and Delivering Service change" (2018) says that "The DMBC should ensure that the final proposal is sustainable in service, economic and financial terms and can be delivered within the planned for capital spend, and show how views captured by consultation were taken into account."

In order to do this the DMBC is arranged as follows:

- Section 2 summarises the PCBC case for change, assessment of options and recommendation on the way forward to be taken to consultation.
- Section Three describes how the consultation was carried out.
- Section Four summarises the consultation feedback.
- Section Five is our assessment of the key feedback messages and how they should be taken account of in deciding on the proposed way forward.
- Section Six sets out the detail of the proposed way forward, what this means for the service model, finances and how this affects the Integrated Impact Assessment.
- Section Seven describes our compliance with legal requirements, key NHS tests and the London Mayor's Tests and our response to feedback from the Joint Health Oversight and Scrutiny Committee (JHOSC).
- Section Eight describes the proposed governance and implementation approach.
- Section Nine makes specific recommendations to the ICB for approval.

1.2 Scope

The services within scope are for adult residents of KCW with an acute mental health problem that might require admission to an inpatient mental health bed. These include:

- People of adult working age who are suffering an acute phase of a serious mental illness, suspected to have an acute mental illness, or a relapse of long-term mental illnesses and as a result are vulnerable, with potential risks of harm to self or others.
- Those who have been detained under the Mental Health Act (including Community Treatment Order (CTO) recalls).

The services also support people who have a dual diagnosis of learning disability, substance misuse etc; however, the primary reason for inclusion will be that they have an acute phase of a serious mental illness.

The business case therefore covers inpatient bed provision, and also the range of services designed to provide less restrictive alternatives to inpatient admission, or to allow an earlier discharge from inpatient care. The following services are not included in the scope of the consultation proposals or this DMBC:

- Less acute general mental health services, for example Talking Therapies.
- Services for children and young people.
- Services for older adults.
- Forensic and intensive care services.
- Specialist services for people with a learning disability/autism.
- Services for visitors to KCW with acute mental health needs (although it does include those without a place of residence).
- The Health Based Place of Safety that was located at the Gordon. This was relocated in 2018/19 before the temporary change in 2020/21.

The services within scope primarily support the population living in the City of Westminster and the Royal Borough of Kensington and Chelsea (RBKC). However, a number of residents from other local boroughs were supported at the Gordon Hospital (until it was temporarily closed), and some continue to come to St Charles Centre for Health and Wellbeing when there are no more local beds available for them. Similarly, some residents of Westminster and RBKC have been treated at Park Royal Centre for Mental Health in Brent and other facilities in the CNWL footprint.

1.3 Governance of DMBC

The DMBC has been developed for the ICB by a project team with membership from both the ICB and the Central and North West London NHS Foundation Trust which provides mental health care for this population (CNWL or "the Trust").

The team has worked under the supervision of a Project Board which also supervised the production of the PCBC. The project team has drawn extensively on support from clinicians and managers from within the relevant services, and on appropriate technical support from Trust and ICB finance, communications and engagement, quality and governance and strategy teams. It includes:

- CNWL Chief Medical Officer (The Senior Responsible Officer)
- Senior clinical and operational leaders from CNWL, including
  - ~ Medical Director and Managing Director from the relevant clinical division
  - ~ Trust Executive Director for Strategy and
  - ~ Chief Operating Officer
  - ~ Borough clinical and operational leadership
- Key ICB senior leaders
  - ~ ICB Executive Director for Strategy

  - Mental Health Leads
  - Borough Leads
- Trust and ICB communications leads
- Service user and carer representatives

It is also attended by Project Team members.

See Appendix 12 for details of Project Board membership.

Where the document uses the terms "we" and "our" this refers to the ICB unless it is within a quotation from another organisation.

[This DMBC has been reviewed and scrutinised at the following meetings.

- **The Project Board on 27 August 2024**
- **CNWL's Finance and Performance and Quality Committees on 19 November 2024**
- **The Inner NW London JHOSC on 12 December 2024**
- **NWL ICB Strategic Commissioning Committee on 20 December 2024]**

1.4 Public engagement and involvement prior to consultation

The PCBC section 1.5 described an extensive process of engagement that took place prior to public consultation, covering mental health services in general and the development of its options and proposals for acute mental health services in particular. It is summarised here.

- The PCBC was developed by a Project Board including senior staff and clinicians from the NW London ICB and the Central and North West London NHS Foundation Trust (CNWL), and service user and carer representatives.
- Its proposals were informed by extensive engagement with stakeholders over a period of several years, learning from the experience of our service users, carers, staff and others. A general programme of engagement over this period has sought views and insights on a wide range of issues affecting mental health service provision.
- Two large-scale engagement projects were particularly significant in development of the PCBC and options appraisal:
  - The Voice Exchange report (Healthwatch) which focused on the experience of service users of the Trust's care
- The Equalities Diversity and Inclusion report into the lived experiences of users from Black African and Caribbean backgrounds which demonstrated that inpatient care could be especially traumatising for this group

- The ICB and the Trust met and worked hard to engage with local councillors on the issues they raised during the preparation of the PCBC, recognising that some local councillors had (and have) strong views that there should be significant inpatient provision within South Westminster, either at the Gordon Hospital or in another more suitable location.

- In addition, in developing the options and proposals in this PCBC the ICB hosted a series of workshop events to ensure that a broad range of insights and perspectives informed the formal process of developing and assessing the options. Attendees included representatives from Local Authorities, the police, the voluntary sector, clinical staff and service users and carers. These had a significant impact on the process. For example, we identified two additional options in response to stakeholder concerns, one of which was identified as the consultation's preferred way forward. In May 2023 we also invited all stakeholders to provide us with any information they might have that could inform our consideration of the proposals for change.

2 Strategic Context, the PCBC and the Consultation Proposal

2.1 Introduction

This section largely summarises (but does not repeat in full) the key information from the equivalent section in the PCBC. Where there is significant new information available since the PCBC this is described. This section should therefore be read in the context of the original PCBC. The DMBC includes additional information on health inequalities.

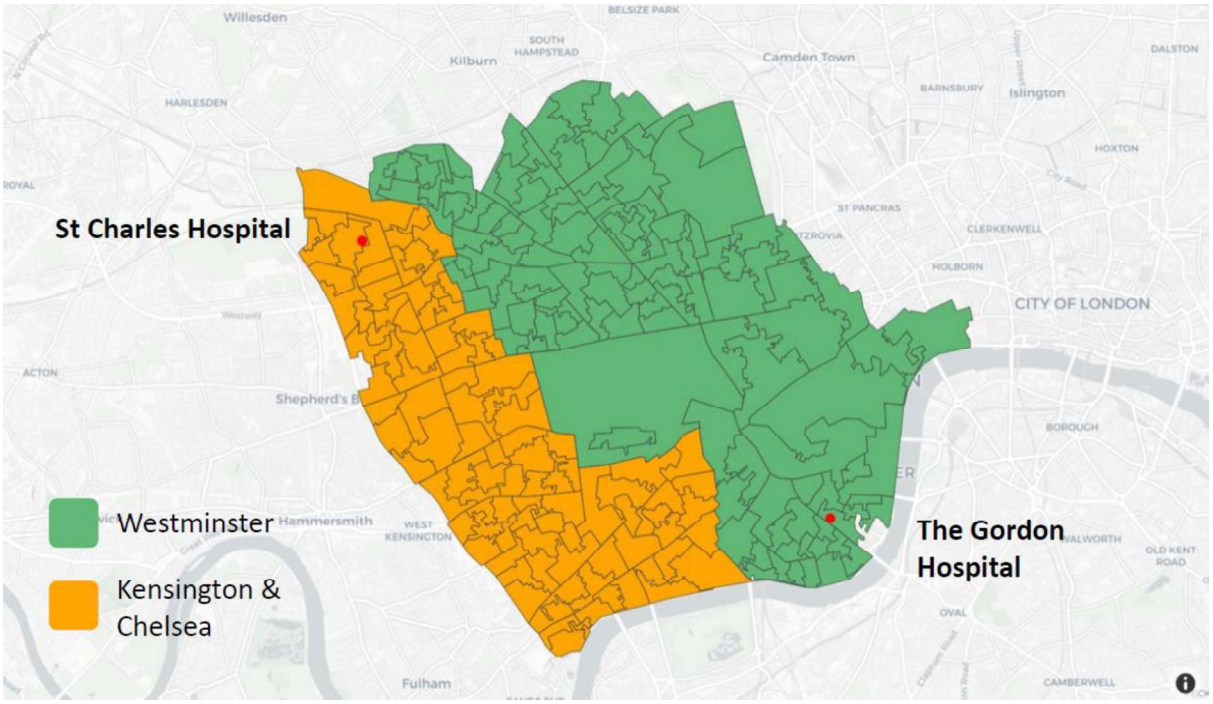
2.2 The local population

2.2.1 General

KCW has a diverse population with close to 420,000 residents. The boroughs have areas of both high and low relative deprivation. Healthy life expectancy varies significantly between individual wards. The PCBC identified that the prevalence of depression, diabetes, hypertension, obesity, and severe mental illness in the GP registered population is, overall, higher amongst people who identify themselves as being from a Black, Asian, Minority or Mixed ethnic background compared to residents of a White ethnic background. The RBKC includes the community affected by the Grenfell fire.

The figure below shows the KCW boundaries

Figure 1 : Boundaries and locations of inpatient services in the options

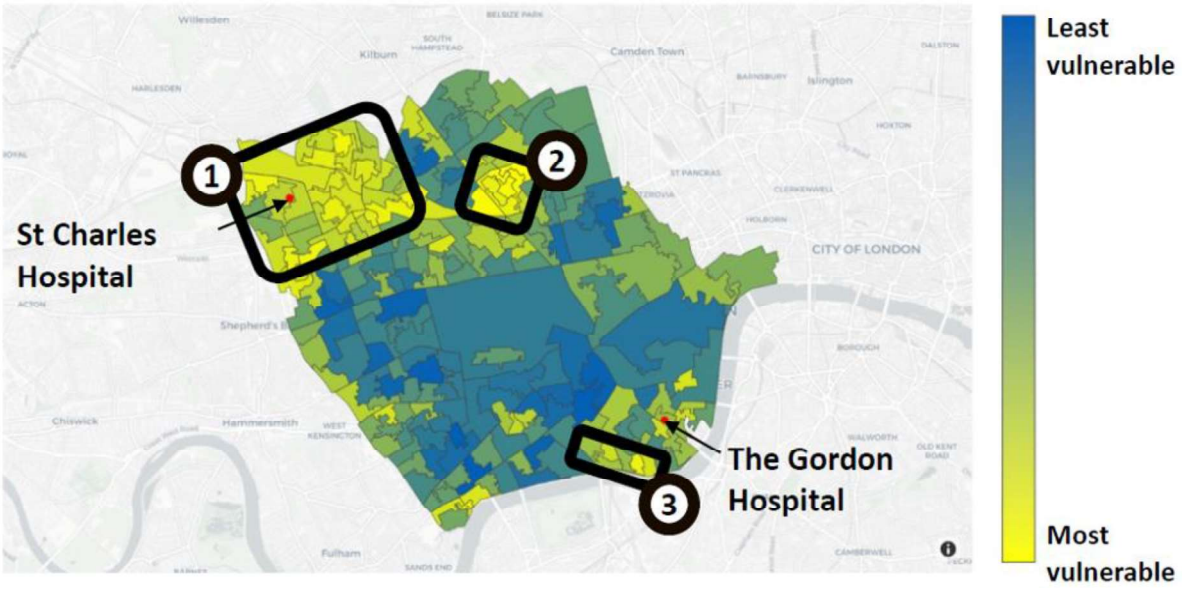


Prevalence of serious mental illness (SMI) is relatively high in KCW compared to the rest of the country (23% above the London average, and 43% above the national average).

- The total number of people over the age of 18 who have been diagnosed with a SMI is above the North West London average in Kensington and Chelsea at 4,176 people. The prevalence of SMI in Kensington and Chelsea is among the highest in North West London, with a rate of 98 people per 1,000 of the population.
- In comparison, the Westminster population includes 3,763 people with SMI. Prevalence of SMI in Westminster is the lowest in North West London, with a rate of 58.2 per 1,000 of the population.

The figure below indicates key areas with potentially vulnerable populations by the rank of the percentage of ethnic minorities, deprivation and poor health outcomes.

Figure 2 : Vulnerable populations in KCW



According to the 2021 Census both Boroughs have people recorded whose residence was outside the UK one year before indicating potential migrant status. In K&C is this 4% of the population, and in Westminster it's 4.9% of the population. The intersection of trauma, displacement, cultural adjustment, and systemic barriers can place a disproportionately larger burden on the mental health of refugees, migrants, and ethnic minorities underscoring the urgent need for accessible, culturally sensitive care that addresses refugees and migrant challenges.

2.2.2 Homelessness

Homelessness has been raised as key theme by respondents to the consultation and following subsection provides some more detail on Homelessness in KCW.

Homelessness is a significant issue within KCW, and particularly within Westminster as illustrated in the table below.

Table 1 : Homeless households[6] rates (data for October to December 2023)

Geographic area	Number of households assessed as homeless	Number of households assessed as homeless per (000s)
England	44,760	1.87
London	9680	2.73
Kensington and Chelsea	143	1.88
Westminster	550	4.35

Westminster has the highest number of rough sleepers in the country and the number of people who are assessed as homeless in the borough is much higher than in Kensington & Chelsea. The homeless and rough sleeping population in both boroughs reduced over the years during the COVID pandemic but have increased again in the last two years. Homelessness in Westminster has increased to a higher level than in 2018/19, but the number of rough sleepers remains below pre-pandemic levels.

[6] Figures obtained from Government Official Statistics https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness#statutory-homelessness-live-tables

Figure 1[1]: Data on Homeless households – Kensington & Chelsea and Westminster

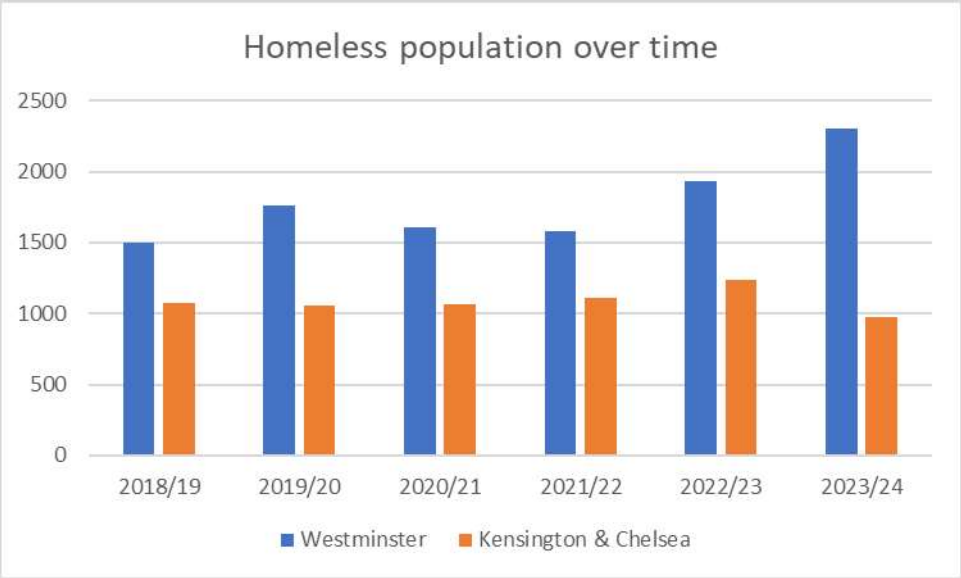
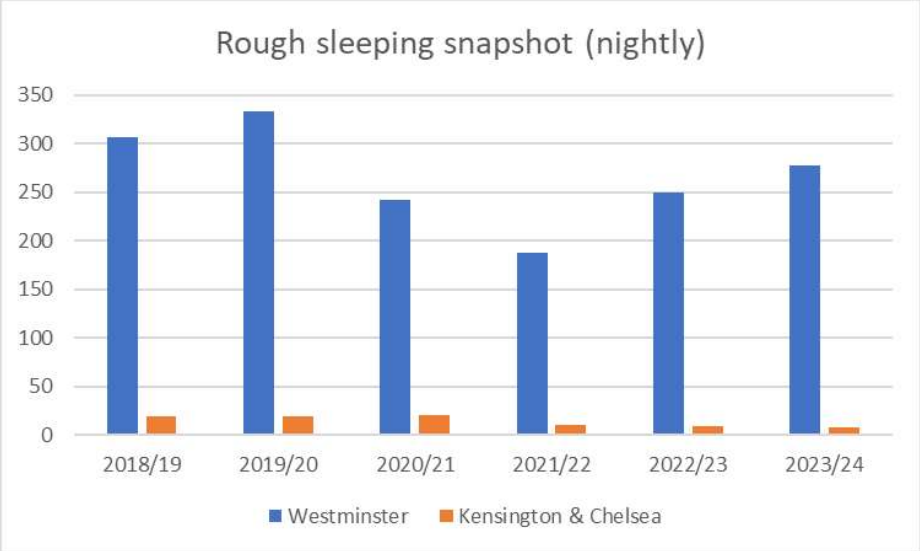


Figure 2: Nightly snapshot of Rough sleepers each year[7]



People who are homeless or rough sleeping often have multiple health needs with co-morbidities of physical health, mental health and drug and alcohol needs. There is a significant link between homelessness and mental health issues. Mental health illness is

7 https://app.powerbi.com/view?r=eyJrIjoiZjIzY2FiMGItODY4Mi00N2M1LWFlMzMtODY3Y2YyYjBjOTZlIiwidCI6ImJmMzQ2ODEwLTljN2QtNDNkZS1hODcyLTI0YTJlZjM5OTVhOCJ9. Data provided by the Department for Levelling Up, Housing and Communities, "Rough Sleeping Snapshot in England; Autumn 2023"

often cited as a cause of homelessness; equally, experiencing homelessness may have an impact on mental health.

The Mental Health Foundation quote World Health Organisation Data saying that:

- In 2014, 80% of homeless people in England reported that they had mental health issues, with 45% having been diagnosed with a mental health condition.
- Studies have reported a higher prevalence of mental health problems in the homeless population compared to the general population, including major depression, schizophrenia and bipolar disorder. Statistics suggest the prevalence of mental health conditions in this population to be at least 25–30% of the street homeless and those in direct access hostels

They also point to the Department of Health annual report of 2013 which said, "The most prevalent health problems among homeless individuals are substance misuse (62.5%), mental health problems (53.7%) or a combination of the two (42.6%)."

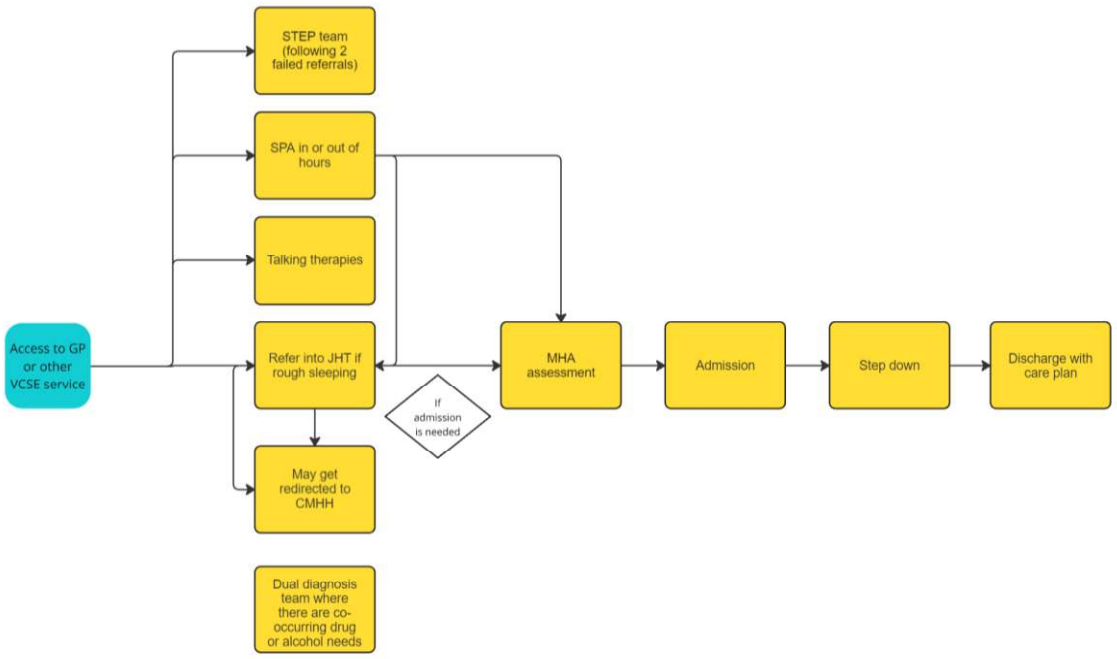
Joined up working with multiple organisations is important to provide appropriate care for people experiencing homelessness.

The term "homelessness" applies both to rough sleepers, and to people who may be in temporary accommodation such as a refuge, or hostel or "sofa surfing". Their needs in terms of healthcare provision are not the same: Broadly speaking

- People who are homeless but in temporary accommodation access all the same services as the general population – so in the community the prime support for people in a mental health care crisis would be through the Community Mental Health Hubs and the Mental Health Crisis Assessment Centre.
- Rough sleepers have access two specialist community services
    - ~ Joint Homelessness Team (JHT) - a multi-disciplinary community mental health service that works with people who sleep rough in Westminster and who have a mental illness. Service users referred to the team will usually have had a history of admissions to hospital, possibly detained under the Mental Health Act, and may have arrived from other countries or elsewhere in the UK. Service users have often encountered problems with medication treatments.
    - ~ Statutory Team Enabling Pathways (STEP) service which sits with the JHT and works with people who do not meet the threshold for JHT. The team is a multi-disciplinary team delivering trauma informed mental health support for people who make regular unplanned contact with the NHS and criminal justice system who may previously have fallen through the gaps between services. People receiving care from STEPs will likely have a combination of many complex health needs including trauma, brain injury, substance use, neuro diverse conditions and learning difficulties.

Both these services support people who are rough sleeping with their mental health needs and support people who need admission and on discharge. The full specialist pathway for people with mental health needs who are homeless or rough sleeping is below.

Figure 3 : Pathway for people experiencing homelessness/rough sleepers



2.2.3 Inequalities in mental health

National background

There are substantial inequalities in mental health. These inequalities exist locally, nationally and internationally. The Commission for Equality in Mental Health produced three briefings and a final report "Mental Health for All" in 2020[8]. They summarised those inequalities in the UK in 2020 in relation to:

- ***Likelihood of experiencing mental health issues.*** For example, they noted that
  - ~ Men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk and are more likely to be diagnosed with schizophrenia.

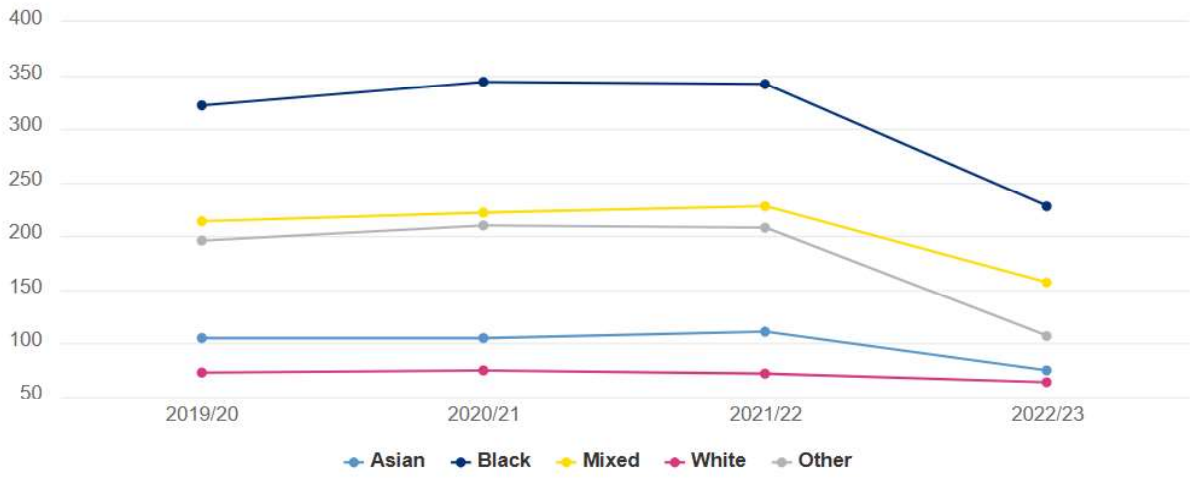
[8] https://www.centreformentalhealth.org.uk/commission-equality-mental-health/#:~:text=The%20commission%20sought%20evidence%20about,might%20be%20reduced%20or%20eradicated.

- People who identify as LGBT+ have higher rates of common mental health problems.
- Children from the poorest households are four times as likely to have serious mental health difficulties by the age of 11 than those from the wealthiest 20%. Children with a learning disability are three times more likely than average to have mental health problems.

- ***Access to services.*** They said that groups facing particularly high levels of poor mental health also have the greatest difficulty in accessing services. For example:
  - Black adults are the least likely ethnic group to report being in receipt of medication for mental health, counselling or therapy.
  - Black people are less likely to have the involvement of GPs before a first episode of psychosis than white people and are far more likely to experience police involvement in their first contact with mental health services.
  - Only a quarter of children and young people who experience both a learning disability and a mental health problem have had any contact with mental health services

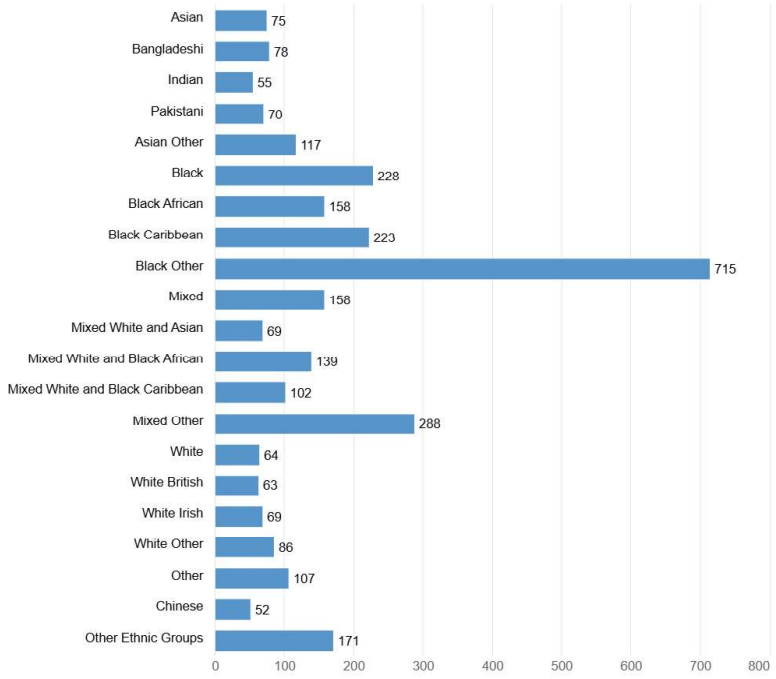
However, the inequality of greatest direct relevance to a service change in relation to inpatient services supporting people who have been sectioned under the mental health act is the wide disparity between different groups in terms of likelihood of being sectioned. Government statistics on mental health act detentions[9] are shown in the figures below

Figure 4 : Detentions under the Mental Health Act per 100,000 people by 5 aggregated ethnic groups (standardised rates)



[9] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/

Figure 5 : Detentions under the Mental Health Act per 100,000 people by individual ethnic group (standardised rates) – April 2022 to March 2023



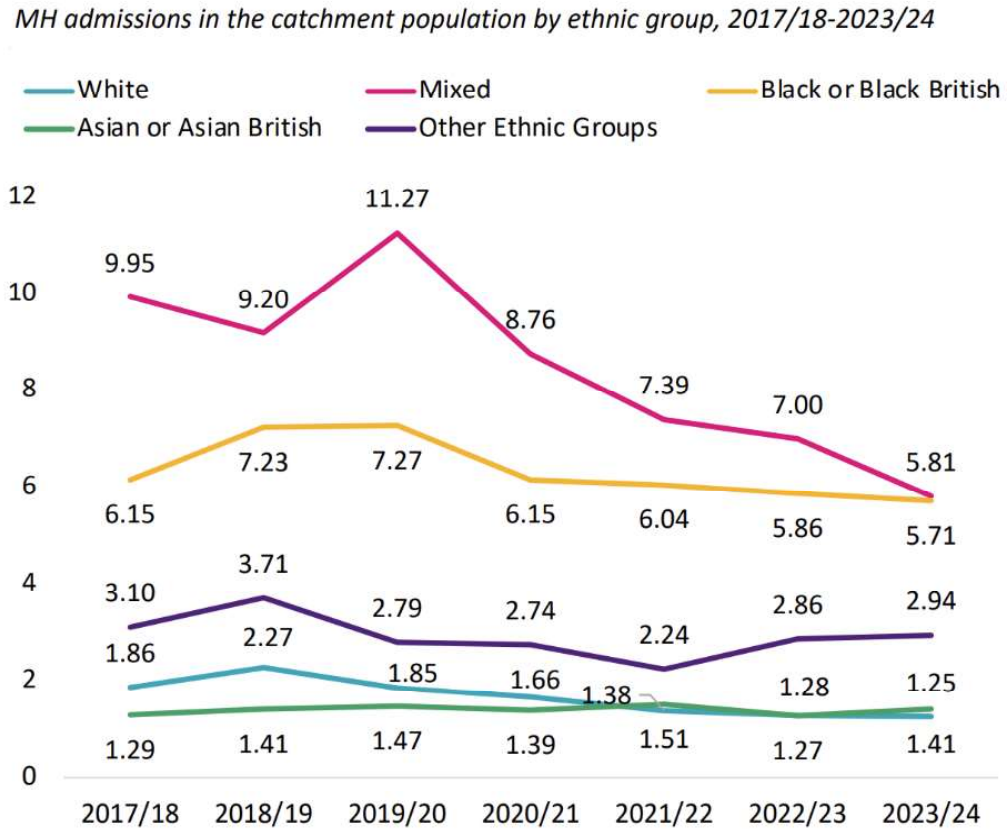
As would be expected, mental health inequalities within KCW are similar to those identified at a national level. Two key areas of inequalities relevant to the services we are consulting on are:

- ***Admissions per head of population by ethnic group***. Mixed and black ethnic groups have substantially higher admissions per 1000 people than all other groups (see figure overleaf). Over the 2017/18 to 2023/24 period the black ethnic group has accounted for 17-21% of admissions each year, and mixed race 23% to 17%.[10]

- ***Use of community mental health services.*** Given their relatively high use of inpatient services, it would be expected that mixed and black ethnic groups would also be high users of community mental health services. However, over the same years as above the black ethnic group only accounted for between 10-12% of referrals to community mental health hubs compared to the 17-21% figure for inpatient services. (The mixed race group accounted for 17-21% which is very similar to the figures for inpatient admissions). The disparity suggests that, while black people are much more likely to face restrictive inpatient treatment than other groups, they are also experiencing barriers in accessing community mental health services.

[10] See Appendix 2 IIA for more detail.

Figure 6 : Mental health admissions per 1000 population in KCW by ethnic group (IIA Appendix 2)



The causes of mental health inequalities such as those identified above are multi-factorial and complex. The Commission for Equality in Mental Health tells us that[11] "While evidence about the determinants of mental health is still emerging and often contested, it is clear that the environment we live in, from conception onwards, has a major influence on both mental and physical health". In their briefing on the issue, they identify income inequality as a major risk factor but say it is linked to many others such as poverty, homelessness, exclusion and discrimination or oppression. They also point out that "The determinants of mental health interact with these inequalities in ways that put some people at a far higher risk of poor mental health than others. Coming from a particular social group may not in itself put you at higher risk of mental ill health; but the experiences and injustices that too often come with it mean that you face a higher likelihood than others."

In relation to underuse of community mental health services, they say "There is also longstanding evidence that in African and Caribbean communities, mistrust of mental health

[11] Briefing 1: Determinants of Mental Health 2020

services comes from a fear (backed up by statistics) of being at greater risk of being sectioned and subject to coercive treatments – mirroring wider experiences of oppression from the state in this community".

In a later briefing document[12] they suggest that "Unequal access to mental health support has a significant bearing on inequalities in later experiences and outcomes. The point at which a person begins to receive help for their mental health and the quality of the contact they have at that time have a major bearing on their outcomes longer term. In some cases, a bad start to a person's relationship with health and care services – battling unsuccessfully to get help followed by a coercive response when they become very unwell – has a prolonged impact on their experience of care, leading to compulsory hospital admissions and long periods in institutional settings far from home…… There is significant evidence of ethnic disparities in access to early help. GPs, for example, are much less likely to be involved in the care of Black people leading up to a first episode of psychosis than they are with white patients by contrast, Black people are far more likely to experience police involvement in their first contact with mental health services (Bignall et al., 2019). Experiencing help via the police can feel frightening and punitive – at its worst it can damage a person's relationship with the institutions which are ultimately meant to protect their mental health"

They suggest that referral systems in the NHS may unintentionally exclude groups of people. Even if there is no intentional bias an absence of evidence of "individual level, conscious and prejudicial attitudes of clinicians" does not mean that systemic racism can be ruled out, as: "…racism is not obvious nor easily detected in everyday life…[but] behaviours and communications may be seemingly innocuous, yet can signal prejudicial attitudes, a lack of trust, fear or avoidance."

The key suggestions highlighted by the Commission as potentially valuable in addressing inequalities all relate to wider societal issues such as

- Community-led peer support and social change movements.
- Prioritising early years interventions, including parenting programmes.
- A whole school approach to mental health with a focus on equality.
- Action to increase the price and reduce the availability of alcohol.
- Addressing income inequality, work insecurity and working conditions.
- Improving housing quality and security and preventing homelessness.

In 2020 NHS England published its strategy for addressing inequalities in Mental Health ("Advancing mental health equalities strategy").

[12] Briefing 3: Inequalities of experience and outcomes

This document provides the framework for our approach to addressing mental health inequalities in North West London and has three broad areas of action:

- ***Actions to support local health systems to deliver improvements.*** These included actions to identify and develop best practice models to roll out nationally. Most importantly it confirmed that a Patient and Carers Race Equality Framework (PCREF) should be developed and used to support mental health services to address race based inequalities. As set out in section 6.2.5 CNWL is now using the development of a PCREF as a key pillar of its approach for addressing inequalities.
- ***Actions to improve the quality, flow and use of data on mental health inequalities.*** The strategy said that "More accurate, comprehensive and transparent data at a national level will allow more systematic analysis and learning and can be used to increase accountability and incentivise schemes and initiatives which support better patient outcomes." PCREF is data driven and as part of this work, the Trust has created a dashboard of inequalities data which is being reviewed at all levels of the organisation to improve data quality and understanding of what's happening for different population groups.
- ***Actions to support the development of a representative workforce at all levels, equipped with the skills and knowledge to advance mental health equalities.*** In line with the strategy the Trust is working on a programme to deliver the "Workforce Race Equality Standard"

2.3 The wider context for acute mental health services

The PCBC described how emerging best practice models for acute healthcare are focussed on ensuring that people are only supported within restrictive inpatient care if their needs cannot be safely met within the community.

As long ago as 2005 the Mental Health Capacity Act (2005) set out five statutory key principles which sets out that we should follow. The Code of Practice on the Act says "Before somebody makes a decision or acts on behalf of a person who lacks capacity to make that decision or consent to the act, they must always question if they can do something else that would interfere less with the person's basic rights and freedoms. This is called finding the 'less restrictive alternative'. It includes considering whether there is a need to act or make a decision at all.

More recently the Independent Commission on Acute Adult Psychiatric Care which produced a major report "OLD PROBLEMS, NEW SOLUTIONS: Improving acute psychiatric care for adults in England"[13]. The report said that the purpose of inpatient care is *"to provide treatment when a person's illness cannot be managed in the community, and where*

[13] Crisp, N., Smith, G. and Nicholson, K. (Eds.) Old Problems, New Solutions – Improving Acute Psychiatric Care for Adults in England (The Commission on Acute Adult Psychiatric Care, 2016)

the situation is so severe that specialist care is required in a safe and therapeutic space"; and that *"Admissions should be purposeful, integrated with other services, as open and transparent as possible and as local and as short as possible."* The commission's work suggested that across England a high proportion of people currently admitted as inpatients could be better supported within the right community settings. It suggested that patient care and recovery is best served by the preference for most people to be treated within the community because:

- If people are admitted for longer than is clinically necessary, then there is a risk that they become institutionalised and find it hard to resume normal life. They may lose jobs, benefits and places to live.
- Recovery and rehabilitation need to take place as near as possible to where they will live. Training people in activities of daily living in hospitals does not equip them to use these skills in the community and may serve no purpose other than to keep them longer in hospital.
- The experience of inpatient care can be very poor for both patients and carers.

There is a general consensus among most recent national reviews and reports that inpatient care should be focused on people whose needs cannot be met in a less restrictive setting. It is recognised that this results in better outcomes for patients, as well as being in line with the preference of most people to be cared for within their communities. National policy reflects this, and the aim is to achieve a shift from inpatient focussed care towards community-based services – both to provide an alternative to admission, and to enable swifter and better supported discharge from inpatient care.

There is also recognition of the need to improve the facilities within which inpatient care is delivered. The Royal College of Psychiatrists (RCPsych) has developed core standards for inpatient care, including for the ward environment.

The key principles drawn from the national context are that:

- For some patients there will always be a need for hospital admission, as hospital will be the only place where we can provide safe and effective treatment and care.
- However, where we have a choice, we should prioritise effective community-based alternatives to inpatient care over institutionalised hospital care that takes people away from their homes and communities.
- We should not accept a situation in which anyone with a need for inpatient provision has to experience their care in an environment which is simply not fit for purpose or is in any way "an obstacle to the delivery of therapeutic care". This has direct relevance for this DMBC as the Gordon Hospital is currently not fit for purpose as a high-quality inpatient hospital – for example it cannot offer good access to safe outdoor space and will require substantial and costly investment to enable the provision of ensuite bathrooms.

2.4 The North West London Context

Since the PCBC was written the North West London ICB has developed and published its overarching mental health strategy. This was approved by the Integrated Care Board's Public Board on 16 July 2024.

The strategy is attached to this DMBC as Appendix 1. It provides key context for this DMBC.

In summary the strategy

- Identifies that NW London has significant unmet need in addressing common mental health disorders and that residents with severe mental illness are more likely to die prematurely.
- Demonstrates that services have evolved significantly in recent years with over £100m of additional investment in services since 2018/19 (including £10.8m in adult crisis care) and £1.7m to improve the therapeutic environment of inpatient settings. These services include with 24/7 community teams, a range of crisis alternatives to A&E and inpatient care available across the North West London as well as expanding liaison psychiatry teams to every A&E department.
- Says that the approach is continued focus on prevention, continuing the shift to more community based care and investing in alternatives to admission.
- Recognises that in too many services patients are waiting too long to receive the support they need.
- Confirms that compared with many other areas our relative investment in mental health services in North West London is low. The ICB aims to correct this inherited position over time but recognises that it will take many years to address (as set out in the ICB Medium Term Financial Strategy).
- Confirms that in line with recommendations from the Royal College of Psychiatrists, best practice and national policy, care has been expanded for people with severe mental health and acute needs in the least restrictive setting appropriate, using admission only when there is no better alternative.
- Sets three key ambitions:
  - Raised awareness and promoting of wellbeing.
  - Increased equity and equality of access.
  - Care in the right place – for inpatient services it says this means high quality inpatient facilities that provide timely care, by an expert team in a therapeutic and compassionate environment.

The strategy includes services for adults with higher acuity mental health needs and covers a number of areas relevant to this DMBC. In particular it says:

•We continue to implement the principle that acute inpatient care should only be used when there is no better alternative. There will be improved support to reduce risk of re-admission.
•When hospital based care is required, it will be delivered in a timely way, by an expert team, within a therapeutic and compassionate environment.
•We will provide inpatient facilities that meet modern standards of acute mental health care, supporting patient dignity and privacy, with ease of access where required.

The strategy makes an assessment of the overall inpatient capacity required across the ICB and how this will change over 5 years. It concludes that that the system in 2029 will have well balanced capacity with slightly more beds overall than what will be required to meet the needs of the local population while working to an overall bed occupancy of 90%. Achieving this desirable occupancy level requires us to work to reduce length of stay, with a particular focus on people within inpatient beds despite being clinically ready for discharge. More detail is provided on how this conclusion is reached in Section 0.

2.5 Service provision in KCW

CNWL provides a wide spectrum of services covering the full adult mental health pathway, from talking therapies through to psychiatric intensive care. The scope of this consultation focuses particularly on services for patients at risk of needing adult acute inpatient care, and so covers both the inpatient wards and all those services developed to avoid or shorten admissions through community and crisis alternatives – including crisis assessment and step-down beds.

There are two inpatient sites within the two boroughs:

- The Gordon Hospital is located in south Westminster. Until the temporary closure of acute wards in April 2020, it accommodated 51 beds in three wards. The age, design, layout and condition of the building have been the source of issues and concerns for many years. Despite past investment, there are some problems that are inherent in the building that would be impossible to solve, and some which are very difficult and costly to address.
- St Charles Centre for Health and Wellbeing is in north Kensington. It provides four wards with a total of 67 beds. It meets the standards recommended by the Royal College of Psychiatrists. It is also the home of the current MHCAS service, which was established as a pilot, but which is proposed to become a permanent and enhanced service. The PCBC said that St Charles did not have the physical space available to continue to support the enhanced MHCAS. However, a review of estates possibilities as part of our response to feedback in the consultation has shown that this is not the case, and it would be possible to have an enhanced MHCAS at the St Charles. This is discussed in detail in Section 0.

Acute mental health services in 2019/20

National and local benchmarks tell us that in 2019/20, the balance of services between inpatient and community-based care across CNWL was skewed in favour of inpatient provision. The number of beds and admissions was substantially higher than would be expected for the population covered. At that time, CNWL was providing 25.2 beds per

100,000 weighted population, well above the national average of 19.9, and the highest of all the Trusts in the London region. This emphasis on inpatient rather than community provision was reflected in the balance of investment (we were spending more on inpatient provision and less on community services than other areas).

Transforming the service 2020 to 2023

In March 2020, the Covid pandemic struck, and all parts of the system had to adjust. Part of CNWL's covid response was to temporarily close the three inpatient wards at the Gordon Hospital and consolidate all inpatient provision for Westminster and RBKC at the St Charles site. This was necessary for several reasons, including serious concerns relating to infection control and the need to create a flexible workforce to ensure adequate staffing during the pandemic.

Gordon Hospital ward staff, and the revenue funding associated with running the Gordon Hospital wards, were redeployed on a temporary basis to support a range of community-based alternatives to inpatient care so that all those people who would have been admitted could still have high quality care that met their needs.

These services continued to be developed and enhanced, working with our partners, learning from experience and from feedback from staff and service users. As a result, the range of provision for acute mental health for the people of Westminster and RBKC has transformed over the three years since the inpatient wards at the Gordon Hospital were closed in March 2020. The main changed elements of the care are summarised below.

Table 2 : Summary of key service changes from time of temporary closure

Element	March 2020	Now	Description	Launched
Inpatient beds	118	67	Temporary closure of 51 beds at the Gordon	
Step Down beds	0	9	Beds to facilitate supported discharge from inpatient care for patients who are ready to move to a less restrictive community setting	December 2020
Mental Health Crisis Assessment Service (MHCAS)	0	8	Launched as a pilot during the winter of 2022-23 the MHCAS is designed to provide a more therapeutic location for service users to receive care when in a crisis than A&E.	November 2022
24/7 Central Bed Flow team	Not quantifiable		Established centralised bed management team to enable effective coordination across CNWL of beds, capacity, flow, and	April 2020

Element	March 2020	Now	Description	Launched
			consequent reduction in Out of Area Placements (OAPs).	
Community Access Service (CAS)	Not quantifiable		A team in each inpatient unit made up of social workers and peer support workers to support service users in the lead up to discharge.	June 2020
Voluntary, Community and Social Enterprise partnerships	Not quantifiable		Investment in community initiatives to support recovery, staying well and advancing equalities for populations with severe mental illnesses who may be with community mental health hubs and/or being discharged from hospital.	Various 2020/21
Mental Health Emergency Centre (The Lighthouse)	0	4	The MHEC (Lighthouse) is based at the acute site at St Mary's and is a service where people can go away from A&E to receive care and support in a MH Crisis, currently undergoing evaluation	May 2023

The balance of investment and activity across CNWL has also shifted, to become much more aligned to national norms. The benchmarking data available nationally used in the PCBC showed that in 2022, CNWL had 17.8 beds per 100,000 weighted population. This was above the national average (which for 2022 was 17.3) but is much closer to the norm both nationally and within London. We now have the latest benchmarking data from the NHS Benchmarking network. This says that for 2023 CNWL had 23 beds per 100,000 population with the national average also being 23. (CNWL bed numbers did not increase between 2022 and 2023, so it is believed the methodology for the calculation must have been different, but the message that we are now about average is the same).

2.6 Impact of the service changes made in 2020

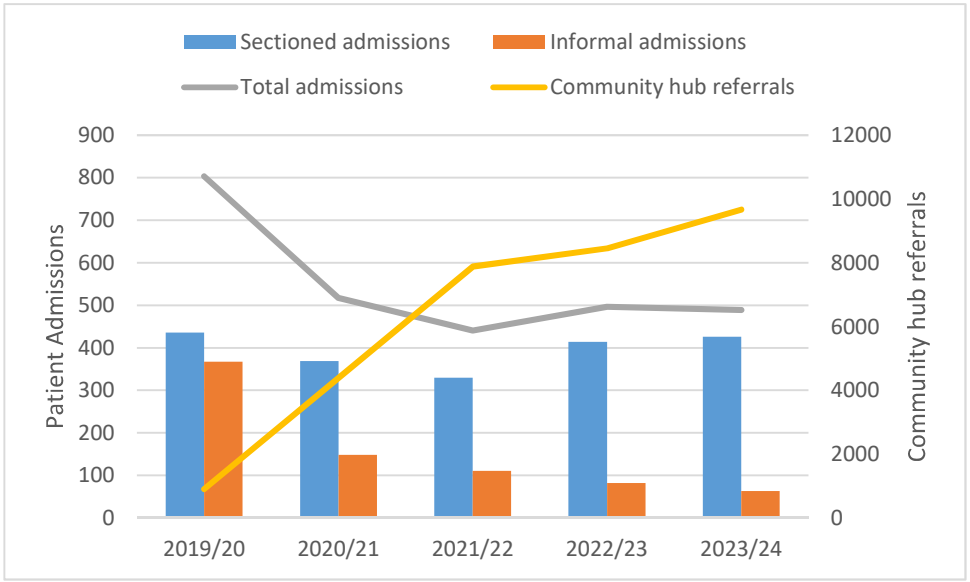
The PCBC set out in detail a review of the impact of the changes made in services. Its summary conclusions were set out as below. We have identified where consultation responses or new information has suggested that further analysis is required. Where such analysis is needed it is included in detail in Section 5, which is where the DMBC sets out how we need to take account of specific consultation feedback.

Has the new model of care achieved a shift to less restrictive settings?	
PCBC Analysis	PCBC conclusion
Admissions and occupied bed days have reduced. Use of community alternatives has increased CNWL, and the two boroughs in scope, are now closer in line with national benchmarks on the balance of provision. Key quality and safety measures of assaults, incidents and absences without leave (AWOLs) have reduced.	Our conclusion from these analyses was that **a true shift in balance from inpatient provision to care in community settings has taken place**, that the people of Westminster and RBKC are now receiving more support than before the temporary closure of beds, in more appropriate, less restrictive settings and aligned to national norms and evidenced best practice. This has been accompanied by a fall in the numbers of absences without leave, assaults and serious incidents reported.

DMBC feedback review and new information

Since the PCBC we have updated our analysis on admissions and relevant community activity from KCW. The chart below shows how admissions have changed between 2019/20 and the most recent full year 2023/4 (using the left axis), and how community based mental health hub activity has increased (using the right hand axis)

Figure 7 : The balance of inpatient and community provision in KCW



The data shows how the number of people requiring admission under section has remained at very similar levels every year. The substantial change has been in the number of informal admissions which have reduced from 367 in 2019/20 to 63 in the most recent year. The sharpest fall occurred in the year when the Gordon inpatient service was temporarily closed, but there has continued to be a gradual decrease. As would be expected community based mental health provision has increased substantially.

A number of responses to the consultation have suggested that the change described means that people who actually need inpatient care are unable to receive it. Respondents mostly have recognised that there has been a shift to less restrictive settings, but they argue that is has been taken too far with the result that some people are not receiving the care they need. This assessment is therefore reviewed in Section 5.2

The table below is an extract of the latest national benchmarking in relation to the services under consideration. It should be noted that these figures are for the CNWL Trust as a whole and not just KCW, but they provide useful context.

Table 3 : Benchmark data (CNWL is MH231)[14]

Metric	Low – High	MH231	Mean	Median
Beds per 100,000 resident population at 31st March 2023		23	23	22
Bed occupancy rates (excluding leave)		97%	93%	94%
Admissions per 100,000 resident population		249	207	215
Admissions - patients not previously known to services (as a % of all patients admitted)		10%	12%	8%
Admissions - patients of no fixed abode (as a % of all patients admitted)		3%	3%	2%
Average length of stay (excluding leave)		33	38	39
Admissions under the Mental Health Act as a proportion of all admissions		85%	50%	52%
Admissions under the Mental Health Act per 100,000 resident population		211	93	83
Average length of stay for Mental Health Act detentions		35	42	43
Delayed transfers of care as a proportion of occupied bed days		3%	7%	6%
Readmission rate within 30 days		7%	9%	8%

[14] Adults and Older People's Mental Health Services 2022/23 NHS Benchmarking Network

The key points to draw out are:

- Occupancy rates are overall high, and this emphasises the desire set out in the ICB mental health strategy to reduce them.
- Length of stay is relatively low, and this goes alongside a relatively low readmission rate.
- The starkest difference with other providers is in the proportion of admissions which are under the Mental Health Act, rather than being informal admissions. Here CNWL is much higher than the average. This reflects the KCW specific information shown above demonstrating the relative change in proportions between Mental Health Act admissions and informal admissions.

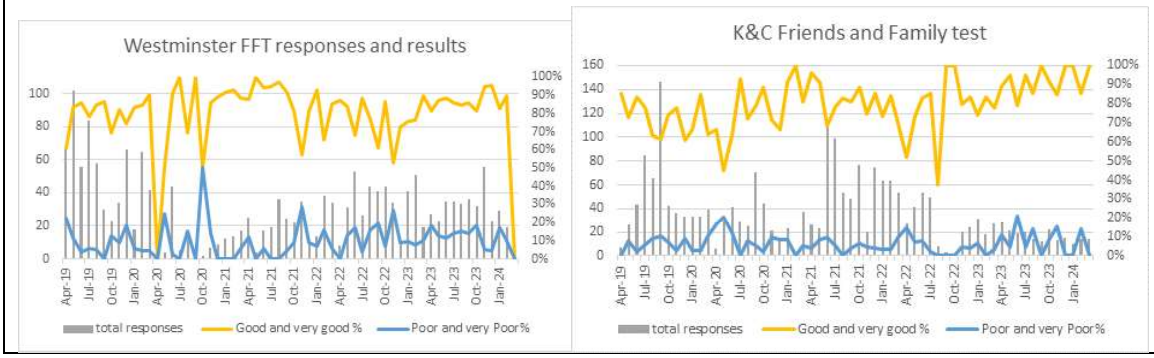
Question: Do we still have enough beds to meet the needs of our residents?	
Analysis	PCBC conclusion
Out of Area Placements (OAPs) have reduced to zero for both boroughs. Placements within CNWL but outside of Westminster and RBKC are higher than before; but this is due in part to beds at St Charles being used by people from the outer boroughs because of inadequate capacity there. CNWL are increasing capacity in Brent, and this will result in sufficient beds being freed up at St Charles to meet the needs of local people. Waiting times for a bed (including rising A&E waits) are higher that we wish, and in the last two years have risen. We have not been able to demonstrate whether the shift of services from inpatient beds to community alternatives has resulted in a rise in wait times for admission, or whether the rise is due to other factors (and may have been even greater had the community services not been in place).	Our conclusion from these analyses was that we do have enough beds to meet the needs of people in KCW. However, to ensure this continues we needed to have additional capacity within the outer boroughs to maximise availability of beds at St Charles for KCW residents. Six additional beds have been opened recently in Brent, and we plan to add a further 8 in a new ward at Park Royal Centre for Mental Health. There is clear pressure on the system resulting in rising wait times for beds and adding to the pressure on A&E departments. This appears to be driven by rising demand rather than bed reductions, and we believe the solution is to provide more effective crisis and community interventions rather than simply more beds. The PCBC proposal was to increase the capacity of the existing Mental Health Crisis Assessment Service, move it to vacated space at the Gordon Hospital, and expand its remit to offer short-term admission for crisis care. It said that by increasing the number of spaces at the MHCAS we would be able to move approximately an additional 56 people a

Question: Do we still have enough beds to meet the needs of our residents?	
Population projections are static, suggesting no related requirement to increase beds.	month out of A&E, which will significantly reduce waits in Emergency Departments.
DMBC feedback review and new information	
A significant theme in the consultation feedback is that both organisational and individual respondents believe that we do not have sufficient beds. The main concerns are: • That the new community services do not sufficiently reduce the need for inpatient beds but are needed in addition to the inpatient beds they replaced • That there has been a negative impact on the quality of care at the St Charles hospital as a result, with increased patient acuity on wards resulting in stress to staff and less good quality of care for patients • That the reduction in beds has not allowed for the specific needs of the homeless, as community focussed care is ineffective if people do not have somewhere to live. This DMBC therefore reviews these issues in more detail (See Sections 5.2 and 5.3). Another key theme from the feedback is that the fact that out of area placements have reduced to zero does not demonstrate that there are enough beds, as it can still mean that patients are travelling out of their local borough. This issue is therefore addressed in more detail in Section 5.2.6	

Question: Are discharges from inpatient beds being managed well?	
Analysis	PCBC conclusion
Readmission rates have fallen in both boroughs.	Our conclusion was that people are not being discharged prematurely – in fact discharges are being supported better and more sustainably than they were in 2019/20 when the Gordon beds were open.
DMBC feedback review and new information	
A number of consultation respondents have suggested that in fact there is too much pressure to discharge patients before they are ready, and before their treatment has been completed effectively. As with the point above, the specific group of the homeless were identified as being particularly affected by this. This DMBC therefore reviews the issue in more detail (See Section 5.2.3).	

Question: What has been the impact on travel times?	
Analysis	PCBC conclusion
• Average travel times for those who require admission have increased, because there is now only one inpatient site rather than two. • The impact is greater for those in Westminster. • However, the number of people who need admission is much less because alternative services are available. • Overall, there has been a reduction in the number of people travelling more than 30 minutes. • For a small number of people, travel times have risen.	Our conclusion is that the burden of travel has reduced overall, because more people are being cared for within their own communities rather than being admitted to an inpatient bed. However, it is important to recognise that for a small number of people travel times have risen, and we need to do what we can to mitigate the effect on these individuals.
DMBC feedback review and new information	
Information in the consultation responses and our further travel time analysis within our Integrated Impact Assessment (IIA) do not contradict the PCBC conclusions, but this DMBC considers potential mitigations for the additional travel time and costs for some patients and their visitors. (See Section 6.4.5).	

Question: Has there been any adverse impact on our partner organisations?	
Analysis	Our conclusion
We have worked with our partners to identify the impact on them. It has proven difficult to extract conclusive data but taking our combined information sources together our tentative conclusions are as follows. • It appears that partners' overall work in mental health has increased, but we have not seen data that this is true for the specific subset of working age adults who are residents in the Royal Borough of Kensington and Chelsea or the City of Westminster – the subset that our acute adult wards are specifically for. • There appears to be a downward trend in Section 136 orders (where Police are the first attenders). • The proportion of informal admissions has decreased, suggesting that community services are offering effective alternatives. • Out of area placements (our best indicator of under-capacity) are at zero.	Our conclusion is that, while partners' overall MH activity may have increased, in general the new model of care has not increased pressures on partner agencies. This is not to argue that they do not face increasing pressures; rather it is that the evidence we currently have suggests that such pressures are not driven by the reduction in inpatient beds. We believe that the new community-based services are reducing pressure on our partners, and that our focus needs to be on ensuring people's needs are met in the community to prevent step-up into crisis. Our focus on enhancing the crisis assessment capacity in the system is designed to do that. However, we continue to welcome input and additional data to help us understand the situation as well as we can and are continuing to work with our partners to do so.
DMBC feedback review and new information	
A number of consultation responses have suggested that there may have been a negative impact on partner organisations, including social services and the local acute hospitals. However, no data has been provided which shows that pressures faced in those services is driven by the specific changes made to inpatient beds. This is clearly important for system partners and this DMBC therefore reviews the issue in more detail (See Section 5.2.1(b) for further consideration of the impact on Emergency Departments and Sections 0 and 5.6.6 for impacts on social services and police.)	

Question: What has been the impact on measured feedback from service users?	
Analysis	PCBC conclusion
• The "Friends and Family Test" is used throughout the NHS as a measure of patient experience. • The results in Westminster and RBKC continue to show a high proportion of people responding that the service they received was "good" or "very good".	Our conclusion is that the change in service model has not had a measurable impact on the responses gathered through the Friends and Family Test. We have also ensured that the services have been designed in direct response to feedback received over the years from service users.
DMBC feedback review and new information.	
We have updated our data to include the most recent period and in the most recent year we have continued to receive feedback showing a high proportion of people responding believe services are good, as shown in the figure below ***Figure 8 : Friends and Families Test*** 	

2.7 Summary of PCBC Case for change

The PCBC said that there is a clear case for change to enhance the pattern of service we now have and offer extended options for people experiencing a mental health crisis. The case is built on factors that relate to the quality of services, the quality of facilities, the experience of patients, the access to services, and to finance and resources. It can be summarised in twelve key messages.

In the past our service model did not support recovery in the most effective setting. Too many people were cared for in a restrictive inpatient setting, and we did not have the right services to support people within the community. As a result, many people who could have been supported within the community had to be admitted to hospital. This sort of unnecessary hospital admission can lead to greater loss of independence, a longer road to

recovery and a worse patient experience. Insufficient community-based services also result in unmet demand for care. This is why we believe we should keep the balance of service provision we have had since 2020, with resources in inpatient beds reduced to support an increase of resource within the community. The result has been that far more people have been able to have access to acute mental healthcare than was possible before the change. About 500 more people a month are being referred to community-based services than was happening in 2019 and about 13 people more a month are accessing step down beds. However, there are ways we should improve the service model further – particularly in relation to crisis services.

The 67 inpatient beds we have at St Charles provide us with enough inpatient capacity to meet the needs of those people who really need inpatient care. Since the closure of inpatient beds at the Gordon Hospital we have been able to care for significantly more residents within the community in a better way, reducing the numbers that need to be admitted and also seeing a reduction in assaults, serious incidents, and "absences without leave". Since February 2023, we have not had to send any patients inappropriately out of area – this suggests that we now have the right number of inpatient beds, and the reinvestment of resources in community-based services has been effective. There have been pressures on local bed availability at St Charles, primarily due to beds being taken up by residents of the outer Boroughs (such as the London Borough of Brent). The Gordon Hospital did previously serve some Brent residents who are now receiving care in St Charles Hospital. The right solution for this issue is to provide capacity in Brent for these people, and CNWL will be opening 14 additional beds at Park Royal Centre for Mental Health, where there is space to do so. This will free up 7 beds of capacity at St Charles for local people.

There will always be people for whom inpatient care is the most appropriate service. Although we believe we have about the right number of inpatient beds for those patients, waiting times for admission remain too long. We recognise we need to focus on reducing the length of time it takes to admit people when they do need admission and providing the right capacity for swift support and if necessary immediate admission when people are experiencing a crisis. We believe the most important thing we can do is enhance the capacity of the Mental Health Crisis Assessment Service and make it possible for people under its care to be temporarily admitted for one or two days while we identify the best way to support their treatment.

<u>Quality of facilities</u>

The quality of the inpatient wards at the Gordon was not good enough for modern healthcare. When someone needs inpatient care, they should receive it in high quality, safe, modern facilities which support recovery, privacy and dignity. Patients staying in hospital for a long time should be safe, have their own rooms preferably with ensuite bathrooms, and should have good access to outdoor space. That was not the case at the Gordon Hospital at the time it was temporarily closed. It would take major investment in the Gordon to improve this, and the constraints of the building and its site means that however much was spent on renovation some issues could never be addressed there (such as good access to

outdoor space). Patients receiving their care at St Charles do not experience these problems.

Patient experience

Where appropriate therapy can be provided in either an inpatient or a community setting, inpatient care represents a poorer experience than community care. Investing in community-based care to prevent the need for inpatient admissions should lead to substantially better experience and outcomes for many people with acute mental health issues.

Access

Access and travel times are important because of the impact on service users and their families and carers. The best way to reduce the impact is for the patients not to need to go to an inpatient unit at all. The new model of care with fewer beds and more community services is delivering that.

For some patients (and their visitors) who do need to be admitted to inpatient care there is a negative impact on travel times of moving from having two inpatient units in KCW to one. The travel time differences for inpatient beds are important for visits from family, friends and carers, as typical lengths of stay will be a month or more. We know the importance of these visits in supporting recovery. The size of any travel time difference is dependent on exactly where the visitors and carers live, and we are using "time from the patient's home" as an indicator of the likely travel time for the patient's family and friends.

Overall, the number of people being admitted to beds more than 30 minutes from their home has fallen, despite the consolidation of beds into a single unit. There has been a rise in the number of people who are in a bed more than 45 minutes from home, although this is a relatively small number of people; and this needs to be recognised and mitigated wherever possible.

Maintaining the Gordon Hospital as a key component in delivering excellent mental health services should be an important part of that way forward. We understand how valuable local facilities supporting acute care are to their communities and have heard a consistent message from local people and their representatives about how facilities like the Gordon Hospital are valued.

Finance and resources

We know that, for many years and across the UK, the NHS has not invested sufficient resource in health and care to meet the mental health needs of our population. We have been substantially increasing investment in services supporting KCW residents since the closure of the Gordon. New investment totals £11m supporting 193 WTE staff. All of the £5.4m funding released as a result of the temporary closure has been reinvested in these services and we have added £5.6m on top of this.

While we are increasing resources spent on mental health services, our funds are limited. We have prioritised plans for future investment of any additional funds the Government provide – and those plans focus on continued enhancement of community-based services***.***

If we choose to significantly increase the resources, we have within inpatient care we will have no choice but to reduce the amount we spend on community-based care, and to transfer staff from community services back into the hospitals. Even our choice of where to redeploy resources from will be limited, because some of those additional funds are "earmarked" – they can only be spent on specific types of service that the NHS Long Term Plan has prioritised.

There is no likelihood of sufficient NHS capital being available to allow us to invest enough money in the Gordon hospital wards so they could be more appropriate for modern healthcare. The capital that we have available locally is nearly all dedicated to essential maintenance of buildings and services. The additional capital available from the Government is nearly all already committed to programmes such as the New Hospitals Programme. In any business case for significant investment, we have to prove that our project meets national priorities or is required because patients are currently receiving unacceptable care and is affordable. We see no prospect of being able to fund additional substantial investment in inpatient facilities in KCW as none of these would apply.

2.8 PCBC description of service model for the future

This section summarises the service model vision set out in the PCBC. Proposed changes to this service model following assessment of feedback are set out in section **Error! Reference source not found.**

The PCBC described a service model for the future which consists of:

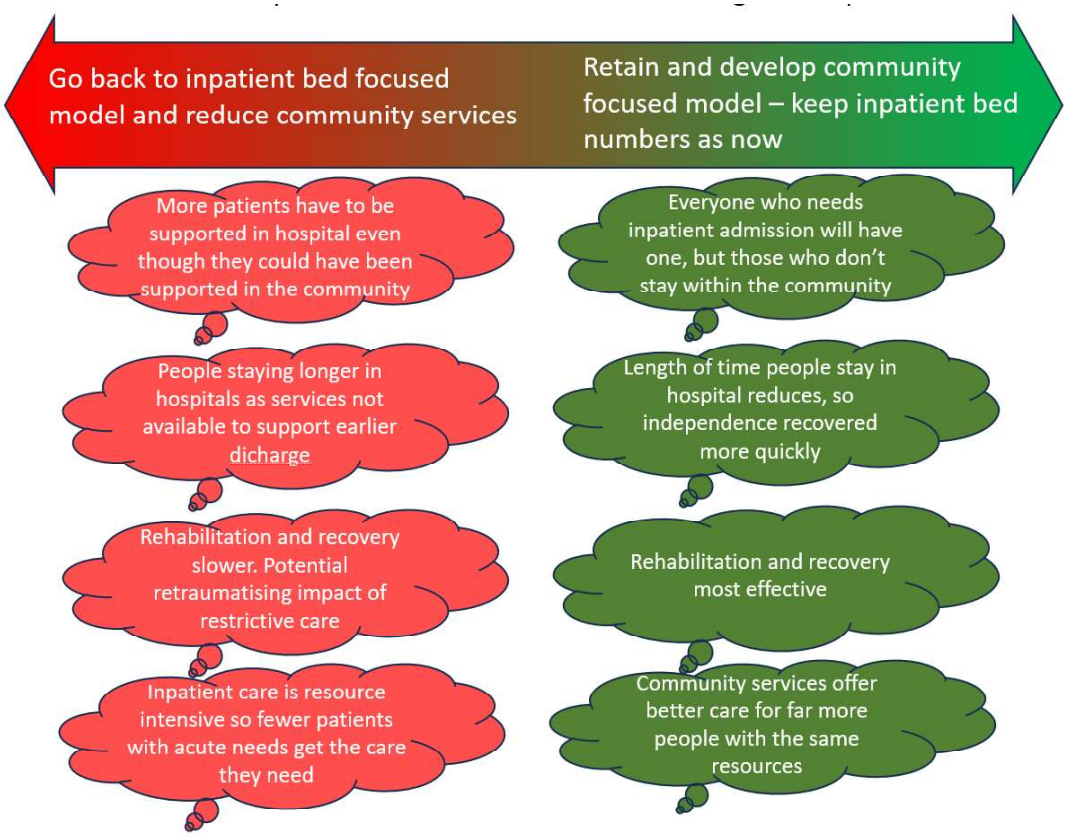
- Flourishing community-based provision preventing the need for inpatient admission and reducing length of stay, alongside sufficient inpatient beds to ensure that everyone who needs an admission gets one
- Enhanced services for people in crisis.
- Inpatient provision for those who need it in the best possible environment – one conducive to rapid recovery

<u>Flourishing community-based provision alongside the right number of inpatient beds</u>

The PCBC recognised that many people would like us to reopen the wards at the Gordon. However, it argued that if we do so, we will need to redeploy the extra staff and resources we put in to the community services back into inpatient care. We would go back to a position where we have more inpatient beds than we need, and less community service provision than we need, meaning people wait longer for treatment or potentially not receive it. Patients who could have been treated in the community by the new services will have to

be admitted to a restrictive inpatient environment, which is not the best place for their care. The reasons the PCBC gave as to why we should continue the approach of prioritising the community-based services rather than adding inpatient beds are summarised in the figure below.

Figure 1: Summary of why we are proposing a service model based on enhancing community provision



The PCBC said that:

- Options which are based on going back to the old level of bed numbers and reducing community-based provision take us in the wrong direction. They will provide a lower quality of care and will mean that local people do not have the right access to community-based care near their homes.
- Engagement with our service users and patients has given clear messages that a community-focused pattern of service is the aim. This is particularly true for Black service users, who are over-represented as detained patients and who told us[15] that they felt retraumatised by inpatient admission.

[15] Disproportionate Representation of people of Black African and Caribbean Heritage in Crisis Pathways and under Mental Health Act Final Report – Buckinghamshire New University and CNWL (2021)

- National evidence, and the recommendations of the national Mental Health Act Review (2018), support this feedback.
- The evidence from the last three years shows that after the immediate implementation period the transition to a community focussed model has been achieved successfully while still maintaining access to acute inpatient care when needed, with OAPs reduced to zero, and no "revolving door" of readmissions. In light of all this, our clear conclusion at present is that the right balance of inpatient and community-based service for the future is one based broadly on what is now in place – one with many fewer beds than in March 2020, but a much enhanced and developed pattern of community-based alternatives to admission.

Enhanced services for people in a crisis

The PCBC recognised the need to continue to work on:

- How we can reduce the length of time it takes from initial assessment to the point of inpatient admission, or admission to the appropriate community-based service.
- Ensuring that where possible our services provide support which limits the pressures on partner services. It said that the most important way we can deliver this is to significantly enhance our Mental Health Crisis Assessment Service. This service has proved highly effective in preventing the need for admission, reducing overall length of stay and in providing a positive patient experience. Extending this service should have a very positive impact.

As a result, the PCBC proposed that the MHCAS be established on a permanent basis, and that it be extended to support 12 people at any one time. This would include four additional short-term assessment beds to enable people to receive intensive support for up to three days. The PCBC proposed that the enhanced MHCAS should be created at the Gordon Hospital (which although not physically suitable for inpatient care, would be a good facility for short term assessment beds). This idea would have provided an enhanced service to the people of south Westminster, being developed as mental health Clinical Decision Unit and working as part of a mental health urgent care hub offer. However, a key reason for the proposal to locate the service at the Gordon was the belief that it was not possible to locate the enhanced MHCAS at the St Charles as there was no suitable space. As discussed in Section 0 this assumption was not correct and this DMBC reviews this location choice in Section 5.5.2.

The PCBC stated that the addition of the ability to offer overnight stays within MHCAS will allow the service to increase the number of patients who are suitable to be supported by the service.

2.9 Options considered in PCBC and preferred option

This section provides a high level summary of the Option Appraisal process described in detail in the PCBC. The option appraisal process was supported through three workshops with key stakeholders to inform the process and to ensure the option choice was influenced by the views of those stakeholders.

The option appraisal in the PCBC involved the development of a long list and short list of options which were assessed against an agreed set of objectives. The objectives were:

- ***Service Quality*** - A pattern of services in place that results in the best possible outcomes and experience for our service users
- ***Access to inpatient care***. To ensure that access to inpatient services is available whenever needed, within reach of family and friends.
- ***Access to community support***. To deliver community-based services that are accessible to our patients and service users where they live
- ***Quality of inpatient facilities.*** To deliver our inpatient services from facilities that are therapeutic and safe
- ***Promoting equality.*** To reduce inequalities in outcomes, access and experience.

The options were considered in two dimensions:

- ***The Service Model choice:*** What balance of inpatient beds and alternative provision do we intend to provide? These ranged from a heavily inpatient focussed model which restored bed numbers to what they had been before the temporary closure of the Gordon inpatient beds but also reduced the community provision that had been put in place to enable that closure, to the more community focussed model now in place with fewer beds and greater community based provision.
- ***The facilities/location choice***: Where should the inpatient beds/MHCAS be provided, and at what quality of environment?

Those options which were not deliverable because of the physical constraints of the relevant buildings were not shortlisted for detailed appraisal. The revised shortlist was as below. It should be noted that some options were included in the shortlist even though it was considered they would be unaffordable in terms of the capital required. This was because it was considered important to look in detail at some options which retained significant bed numbers at the Gordon because that was the position when the temporary closure was put in place and several stakeholders (such as local councils) were strongly in favour at maintaining beds at the Gordon.

Table 4 : PCBC Options subjected to detail appraisal

Model A. 2019 model - Highest bed base (118 beds), reduced community and crisis alternatives.	
Option A1	***Two site inpatient service (at St Charles and the Gordon) with facilities at the Gordon meeting "safe" standards only.*** 67 beds at St Charles Centre and 51 beds at the Gordon Hospital. Community and alternative services cut versus current levels, with these being stood down entirely or reduced, including: the HBPoS at St Charles, the 9 Step Down beds, the 8-space MHCAS, the Community Access Service, and the nine VCSE partnership investments. There would be less additional capacity created in Brent than in the "B" and "C" options, so some people from the outer boroughs would continue to use inner borough beds. There would also be a reduction in the multi-disciplinary support to other wards, which has been enhanced
Model B. Transformed model as now – lower bed base of 67 beds, and a higher level of community alternatives.	
Option B1	***Two site inpatient service (at St Charles and the Gordon), beds split across both sites, with facilities at the Gordon meeting "safe" standards only.*** Reduce the number of beds at St Charles by (approx.) 34 and open the same number at the Gordon. Result is 33 beds at the St Charles and 34 beds at the Gordon. Maintain community alternatives, including all those reduced / stood down under Option A1. Additional capacity in Brent will free up seven beds at St Charles.
Option B2	***Two site inpatient service (at St Charles and the Gordon), beds split across two sites with both facilities meeting most key national standards for quality*** Reduce the number of beds at St by (approx.) 34 and open the same number at the Gordon. Result is 33 beds at the St Charles and 34 beds at the Gordon. Maintain community alternatives, including all those reduced / stood down under Option A1. Additional capacity in Brent will free up seven beds at St Charles.
Option B4	***Single site service with all 67 beds at the St Charles*** Maintain community alternatives, including all those reduced / stood down under Option A1 Additional capacity in Brent will free up seven beds at St Charles.

Model C. Transformed model as above – lower bed base of 67 beds and a higher level of community alternatives – plus enhanced crisis assessment service with crisis inpatient unit.	
Option C	***Single site inpatient service (with 67 beds at the St Charles) but with enhanced MHCAS with short stay overnight capacity at the* Gordon.** Option as for B4, except that it includes the transfer of the MHCAS from St Charles to the Gordon Hospital and expanding it from being able to support eight people to having capacity for 12 people at any one time. This would include four additional short-term assessment beds which will enable people to be admitted and receive intensive support for a longer period.
Model D. A partially transformed model. Mid-range bed base of 80 beds, with some reductions in community and crisis alternatives but less than under Model A	
Option D	***Two site inpatient service (67 beds at St Charles and 13 at the Gordon), beds split across two sites with both facilities meeting most key national standards for quality*** The 13 beds would deliver a single additional ward at the Gordon. There would be a need to stand down some community services to be able to redeploy staff and resources back to the inpatient wards. For the purposes of examining this option, we are assuming that the service that would be stood down to open the ward would be the MHCAS (because this service is most closely matched in terms of patient need); and there would be less additional capacity created in Brent than in the "B" and "C" options, so some people from the outer boroughs would continue to use inner borough beds.

The conclusions reached by the PCBC in terms of those options were as follows.

Option A1: This option represents the closest representation of the "baseline" position as it was in 2020, before the temporary closure of the Gordon wards. The assessments above show that it does not perform well compared to other options, except on access. In particular it does not provide the quality of environment that our inpatients deserve and experience at other sites such as St Charles and has a major detrimental impact on community based provision. It has a high capital requirement which we have no way of funding so is not within our capital threshold. It adds significantly to revenue costs and would require us to make cuts in other services.
Cannot be recommended for inclusion in the consultation as a good option but should be described in the consultation document as it represents the former status quo.

Option B1: This provides a slightly better environment than option A1 and does not have the same detrimental impact on community provision. The patient environment

is not viewed as acceptable. Despite this it has a substantial capital cost which we have no way of funding. It has access benefits, but these cannot outweigh the problems with the environment and the level of capital cost which is not within our capital threshold.
Cannot be recommended for inclusion in the consultation as a good option as not deliverable financially and performs poorly against most objectives.

Option B2: This provides a much better environment than option A1 or B1 and does not have detrimental impacts on community provision. It has benefits for travel times, but the patient environment, while improved, is still not ideal. The most significant problems with this option are the sheer level of cost. It has the biggest increase to revenue costs and has the highest capital costs of all and is not within capital threshold.
Cannot be recommended for inclusion in the consultation as a good option as not deliverable financially, as well as performing poorly against some objectives.

Option B4: This option is both viable and delivers well on all our objectives. All inpatient care is from a high quality environment. It performs well (although not the best) against all objectives except access. It has no immediate capital cost and may deliver some small revenue savings. This option is better than all options which retain a long-term inpatient facility at the Gordon, but the lack of an enhanced MHCAS means it does not perform as well as Option C.

Is not recommended for inclusion in the consultation document as the analysis shows option C (which is very similar except for the inclusion the enhanced MHCAS) performs significantly better clinically in a way which outweighs the more marginal advantage B4 has in financial terms).

Option C: This option is both viable and delivers well on all our objectives. All inpatient care is from a high quality environment. It performs best, or equal best, against all objectives except the access objective. The only options performing significantly better on access are B1 and B2 which are not feasible in capital terms. It provides additional local access to acute mental healthcare, including admissions, in Westminster. It is slightly more costly, in both capital and revenue terms, than Option B4. It is within our capital threshold in terms of the essential expenditure required.
Recommended for inclusion in the consultation as the proposed way forward.

Option D: This option represents a partial step back towards the service model that was in place in 2019, although it retains some of the new community provision. It provides a much better environment than options A1 or B1 and has some benefits for travel times. It has a detrimental impact on community provision, although not as much as A1. The loss of the current MHCAS is particularly significant. It has a poor rating on the quality assessments, including safety

concerns. The only objective it performs well on is access. it is ranked towards the bottom in most other assessments. In affordability terms it is close to Options B and C although not as good as them. The initial capital cost of £5m is above the capital affordability threshold, which means the option is unlikely to be deliverable in the foreseeable future.
Cannot be recommended as a good option as not deliverable financially because it is over the capital threshold and performs poorly against objectives. However, the option was included at the request of external stakeholders and so it is important to explain the reasons why it cannot be recommended within the consultation document.

Additional note on option labelling in the PCBC and Consultation

The Public Consultation identified option C as the preferred option and also described two of the other options. It would have made the consultation document too long and complex to describe and assess all of the options considered in the PCBC appraisal. The two other options included were:

- Option A1 as it represented the former status quo
- Option D because in the option appraisal process stakeholders asked that we consider an option which would maintain inpatient beds at the Gordon without having the same negative impact on community provision and unacceptably high capital costs as Option A.

For simplicity in the consultation document the three options described were numbered from 1-3 and they correlated to the PCBC option appraisal as follows:

- Consultation Option 1 was the same as Option A1 in the PCBC
- Consultation Option 2 was the same as Option D in the PCBC
- Consultation Option 3 was the same as Option C in the PCBC (the option proposed to be taken forward)

3 The public consultation

3.1 Introduction

The consultation was led by NHS North West London, which is the ICB responsible for commissioning NHS care for people living in the eight North West London boroughs. It had the support of staff from CNWL.

The consultation period was between 24 October 2023 and 16 February 2024, following an agreement to extend the original planned consultation deadline by two weeks to ensure additional time for participation.

Expert support for the consultation was provided by Verve Communications Limited, a company which specialises in supporting consultation exercises and patient, public and stakeholder engagement by NHS organisations. Verve was also commissioned to provide an independent review and analysis of the comments received, and to prepare an independent report evaluating the consultation exercise and summarising the key findings.

Verve's report "Consultation Evaluation Report" is attached to this DMBC as Appendix 5.

This section summarises the elements of the Verve report which describe the overall consultation process and how it was carried out, covering

- The consultation approach and best practice guidance.
- The information provided.
- The publicity for the consultation.
- How the engagement was designed to reach priority groups and communities.
- The details of how the engagement was carried out.
- How the engagement/consultation plans developed in the light of early feedback.

3.2 Approach and principles for the consultation

The ICB's consultation plan was designed to comply with all the necessary legal duties and statutory requirements including:

- ***The NHS Act (amended)[16] – 'Duty to Involve' as amended by the Health and Care Act 2022.*** The related statutory guidance sets out 10 principles for working with people and communities. Appendix 11.6 of the Consultation Evaluation Report demonstrates in detail how the consultation complied with those principles.

- ***The Gunning Principles*** established by the courts as guiding fair consultation exercise. These are set out below. The first three items are relevant to the consultation itself, and have been fully complied with, and it is the purpose of this DMBC to enable the ICB to comply with the fourth item.

  1. **Proposals are still at a formative stage.** A final decision has not yet been made, or predetermined, by the decision makers.

  2. **There is sufficient information to give 'intelligent consideration'.** The information provided must relate to the consultation and must be available, accessible, and easily interpretable for consultees to provide an informed response.

  3. **There is adequate time for consideration and response.** There must be sufficient opportunity for consultees to participate in the consultation.

  4. **'conscientious consideration' must be given to consultation responses before a decision.** Decision-makers should be able to provide evidence that they took consultation responses into account.

- ***The Equality Act 2010[17].*** There are two principal duties
  - ~ To meet the Public Sector Equality Duty (PSED)[18].
  - ~ To take account of the likely implications for changes to services or the location or access arrangements for groups or individuals protected under the Act.

  Alongside the PCBC the ICB produced an Equalities Impact Assessment (EQIA) and an Integrated Impact Assessment (IIA). These identified the group that could potentially face disproportionate impact, and they were therefore treated as priorities for engagement (See Section **Error! Reference source not found.** for more detail). The EQIA and the IIA have been updated for the DMBC are attacked as Appendices 2 and 3.

[16] https://www.england.nhs.uk/get-involved/resources/docs/ Working in Partnership with People and Communities - Statutory Guidance (NHS England, July 2022 Version 1. Publication reference: B1762)

[17] https://www.legislation.gov.uk/ukpga/2010/15/contents

[18] https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty

- ***The Government's Consultation Principles[19].*** In 2018 the Government produced 11 principles in relation to consultation. These principles were also born in mind the design of the engagement and consultation process.

In their independent Consultation Evaluation Report Verve Communications Limited confirm they believe that the consultation was carried out in line with legislation, statutory guidance (NHS England) and good practice. Their view is set out below.

"In summary, our view on the consultation engagement is:

- The ICB, supported by the Trust, made significant efforts to ensure that everyone with an interest had the opportunity to give their views.
- This included reaching out through community and voluntary sector networks to hear the voices of service users and people most likely to be impacted, offering flexible and accessible approaches and actively seeking to engage groups facing exclusion and inequality, including those sharing protected characteristics.
- Additional activity was undertaken in response to comments heard from local organisations, the JHOSC and others about how the engagement could be strengthened.
- Overall, there was a high degree of involvement by, and feedback from, people representing a range of perspectives: service users and carers; staff; voluntary and community organisations; and local residents. In total 770 individual views were received in response to the consultation and 13 responses were received from organisations. (In October, Healthwatch published the results of its own engagement with 133 service users, staff and stakeholders prior to the consultation, and these were also included within the evaluation analysis.)
- Throughout the process, a focus was maintained on seeking feedback relevant to the consultation proposals and to fully consider views which would enable the ICB to make a well-informed decision.
- It is always possible to engage more. However, given the level of involvement and the richness of responses received, we believe this process meets the engagement requirements for public consultation."

[19] https://www.gov.uk/government/publications/consultation-principles-guidance (Cabinet Office, 2018)

3.3 Consultation information

The key information made available online to the public from the start of the consultation was:

- The consultation document* and associated questionnaire *.
- The summary leaflet* and an Easy Read version.
- The full PCBC and its appendices.
- Events schedule and sign-up links.
- Information on how to respond.
- Email and telephone numbers for further contact.

Those marked with "*" were also distributed in hard copy formats in appropriate community locations

Following feedback suggesting a need for some less complex material the ICB added:

- Simplified information about the MHCAS.
- A simplified summary of the consultation proposal.

Support was made available to those who needed it to access information or compete the questionnaire. This included:

- Translated versions or access to interpreters was offered for people for whom English is not a first language or who need a BSL signer.
- The consultation materials stated that audio, large and Braille formats would be made available on request. (We understand that no requests for these were received.)
- Easy-Read version of the consultation document was available in digital format on the consultation website. (This was downloaded frequently, as detailed later in this report.)
- Support was also offered to people with learning disabilities or difficulty in communicating. (We understand that no requests for these were received.)

3.4 Feedback channels

People were invited to feedback through a range of channels including:

- The questionnaire.
- Emails.
- Letters.

- The engagement events carried out.
- Speakers were offered to charities and community groups who could attend existing or bespoke meetings to fit the groups' needs and take feedback.

3.5 Promoting participation

The ICB made significant efforts to encourage participation using a variety of channels including social media, new media, shared promotion with Local Authority partners, promotional materials on CNWL sites, contacting former service users, door drops in some key areas. Full details of the promotion are provided in Section 4.1 of the Consultation Evaluation Report.

Throughout the consultation there was a particular focus on engaging with priority groups and communities that had been identified through the Equalities Impact Assessment, which was informed by stakeholders attending an equalities workshop and the Integrated Impact Assessment. The key groups scoped for targeted outreach through this process were set out in the PCBC and are shown below for reference. We recognised that people within our priority groups might be unlikely to attend formal public meetings, which is why we also focussed on providing "drop-in" options and working through existing community groups. The Consultation Evaluation Report provides further detail on outreach to and engagement with those groups

Table 5 : Priority groups to reach

Younger adults	Gender reassignment	Families of service users
Older adults	Pregnancy and maternity	Substance misusers (including Wet hostel)
Sex/gender related	Black and Black African people	ESL and immigrant communities
People with mental health issues	Religion or belief	Those sectioned by the police
People with physical disabilities	Carers	Residents of Westminster and K&C
People with neurodiversity	Deprived communities, including people who are unemployed	Staff
People with comorbidities	Homeless people	

3.6 Proactive engagement in the consultation

The key ways the ICB engaged directly with people during the consultation were:

- ***Outreach to communities with (and through) third sector organisations.*** At the start of the consultation the ICB approached over 45 groups identified as being best able to promote engagement with key affected groups. It offered to provide information publicising the consultation and promoting engagement, to attend online or in person meetings which could be facilitated group meetings or existing meetings already in place, and to provide briefings.
- ***Engagement with CNWL service users and carers.*** Engagement included 5 onsite meetings/drops in with service users (some attended by staff members), 3 facilitated focus group sessions, 5 meetings arranged through groups with reach to mental health service users, 3 focus group meetings with carers. In total, 88 service users and 36 carers participated in these meetings.
- ***Staff engagement, led by CNWL.*** This included bi-weekly staff drop-ins, an online meeting for GPs, 2 online staff meetings for frontline staff from the Gordon and community services for people with serious mental health needs, 2 sessions for MHCAS staff, 2 sessions for Acute Trust staff, a meeting for Single Point of Access staff, 2 meetings for services working with people who are homeless including the Joint Homelessness Team, and 1 for AMHPS from the local authority. Overall, 135 staff participated.
- ***Facilitated focus groups and thematic local meetings (independently facilitated) which reflect priorities heard from partners at the Equalities Workshop and summarised in the EIA and staff in key services***. 18 meetings were convened, organised or attended by the ICB with groups related the areas of disability, homelessness, maternity, race, sex and local communities. In total, 249 people participated.
- ***Open meetings***. This included 8 clinically led, independently facilitated public meetings and 7 drop in sessions. 65 people attended open meetings and 29 came to drop ins.
- ***Healthwatch meetings/events.*** Healthwatch was formally invited to make responses to the consultation and hosted an online engagement session. To inform the consultation further, Healthwatch Kensington and Chelsea and Healthwatch Westminster conducted a series of meetings and events between June and August 2023 through which 133 service users, staff and stakeholders gave their views. This was published in October as the Community Perspectives report and includes many comments providing rich insights into the views of these groups. Healthwatch also provided a report with their own perspective.

3.7 Summary of participation achieved

The Consultation Evaluation report was able to draw on an enormous amount of data received by the ICB. In addition to the questionnaire, Verve reviewed more than 60 documents including organisational submissions, correspondence and meeting notes, including 37 independently facilitated events and groups. There were more than 35,000

words of free text comments submitted through the questionnaire alone, and in total around 120,000 words of feedback were considered. The overall participation level by individuals is summarised in the table below (separately identifying the participation enabled by HealthWatch described in Section 3.6).

Table 6 : Participation by individuals informing this DMBC

Activities	Number of participants
Service users and carers through face-to-face sessions either in person or online to supplement public meetings	88 service users 36 carers
Staff through face-to face sessions either in person or online	10 CNWL staff (general) 125 clinicians and professionals
Communities facing health inequalities, local people sharing protected characteristics and others likely to be impacted by proposed changes	249 individuals (NB. 29 professionals also included in staff summary)
Meetings and drop-ins (open to the public, with structured 'deliberative' agenda) – in person and online	55 at deliberative meetings 29 at drop-ins
Questionnaire responses	200
Other individual responses (various formats)	7
Total individual engagements during consultation	**770**
Participants contributing through HealthWatch events/meetings	133
Total individual engagements informing this DMBC[20]	**903**

3.8 How engagement plans changed in the light of feedback

As part of its commitment to ensure the most effective possible engagement in the consultation process the ICB encouraged feedback on its engagement plan, and ongoing feedback through the consultation process so that it could take action to enhance the process if needed.

[20] Some people will have contributed more than once

A number of concerns were articulated from within public meetings, by local authority communications staff and by the JHOSC. The ICB responded to this constructive feedback by adjusting the approach during the remaining period of the consultation as follows:

- ***Concern that public meetings were held in the wrong locations, at unsuitable times and/or poorly promoted.*** The ICB recognised from the outset that public meetings, while necessary, were unlikely to be well attended by those we wished to hear from. Nevertheless, two additional face to face, and two additional online public meetings were arranged.
- ***Concerns that more engagement on specific elements of the pathway or with specific groups was needed.*** Eight additional meetings were arranged covering key service areas/groups such as Homelessness, Single Point of Access, AMHPs, Primary Care, MHCAS, Acute Trust staff.
- ***Consultation documents too complex.*** Simplified information was provided about the MHCAS and the preferred option.
- ***Use of council communication channels.*** Weekly meetings were held to co-ordinate work between the organisations.
- ***Need to hear more voices from community level organisations and voluntary sector networking bodies.*** Four additional meetings were arranged, and one existing meeting attended with a range of community/voluntary groups.
- ***The importance of engagement on some specific estates.*** 4 additional drop in sessions were arranged to cover those estates, and additional promotion of the consultation took places in some localities.
- ***The need to consider the specific issues related to homeless people with acute mental illness.*** A meeting was arranged with local VCSE organisations working with this population and members of the Joint Homelessness Team and another with homeless housing providers.
- ***The consultation did not give enough time for people to properly engage and feedback on their views.*** The consultation was planned for 14 weeks, two weeks longer than the required 12, to account for the Christmas period. It was then extended to run in total for 16 weeks for the public and a further 2 weeks were allowed for the JHOSC scrutiny process. The extension was requested by the JHOSC following the identification of some stakeholders who had not yet been able to engage in the consultation, so it was extended to enable them to be consulted with properly. The 2 weeks enabled them to be engaged with enough time to fully consider and respond to the proposals. In this time there were also additional public meetings held in different areas of the two boroughs.

4 Consultation Feedback

4.1 Questionnaire responses

4.1.1 Breakdown of respondents

A total of 200 questionnaires was completed. In summary

- 61 of the responders identified themselves as service users. 12 of these had received care at the Gordon hospital and 26 at the St Charles.
- 22 of the responders identified themselves as carers.
- 42 of the responders identified themselves as NHS staff.
- 21 respondents said they were completing the response on behalf of an organisation.
- 91 respondents said they lived in Westminster and 61 in Kensington and Chelsea.

The consultation report also includes a detailed breakdown in terms of age, gender identity, disability, ethnicity, religion/faith, sexual orientation.

4.1.2 Level of agreement with the consultation proposals

The main question where feedback can be quantified from the consultation questionnaire is the extent of agreement with the preferred option. The key messages are:

- Overall, more people agreed with the consultation proposal (48%) than opposed it (37%) (the remainder neither agree nor disagree).
- The responses are very polarised with over half of the responses being either strongly agreeing or disagreeing.

The tables below summarise the responses to the consultation questionnaire question of "To what extent do you agree with our preferred option?".

Table 7 : Analysis of views on proposal

Analysis based on number of responses		All	Service Users	Carers	NHS Staff	Other
In favour	Stongly Agree	47	11	8	13	16
	Agree	43	14	4	12	14
	Total Agree	**90**	**25**	**12**	**25**	**30**
Against	Stongly Disagree	55	12	5	9	29
	Disagree	16	5	1	2	8
	Total Disagree	**71**	**17**	**6**	**11**	**37**
Other	Neither	24	12	3	6	3
	Total Other	**24**	**12**	**3**	**6**	**3**
Total responses to question*		**185**	**54**	**21**	**42**	**70**
Net numbers in favour		**19**	**8**	**6**	**14**	**-7**

* Two responses ticked more than one category

Analysis based on % of responses		All	Service Users	Carers	NHS Staff	Other
In favour	Stongly Agree	25.4%	20.4%	38.1%	31.0%	22.9%
	Agree	23.2%	25.9%	19.0%	28.6%	20.0%
	Total Agree	**48.6%**	**46.3%**	**57.1%**	**59.5%**	**42.9%**
Against	Stongly Disagree	29.7%	22.2%	23.8%	21.4%	41.4%
	Disagree	8.6%	9.3%	4.8%	4.8%	11.4%
	Total Disagree	**38.4%**	**31.5%**	**28.6%**	**26.2%**	**52.9%**
Other	Neither	13.0%	22.2%	14.3%	14.3%	4.3%
	Total Other	**13.0%**	**22.2%**	**14.3%**	**14.3%**	**4.3%**
Total responses to question*		**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Net % in favour		**10.3%**	**14.8%**	**28.6%**	**33.3%**	**-10.0%**

* Note: any apparent discrepancies are due to rounding. People who did not answer the question excluded.

4.1.3 Most common reasons given for supporting the proposal

Overall, respondents who agreed with the preferred option were more likely to comment on:

- ***The suitability of facilities.*** St Charles Hospital is seen as providing superior facilities and a high quality environment for patients, in contrast to the Gordon Hospital, which is described as inadequate and distressing, and lacking facilities like ensuite bathrooms and good outdoor space.
- ***Community support and local access.*** The importance of accessibility to community-based services for patients and carers was emphasised, joined-up with local support networks.
    - ~ Support was expressed for the model of community-based care, and some called for increased funding for holistic care to support recovery and recognise the wider determinants of health.

- Community-based care is perceived as less traumatic and more effective in supporting patients compared to inpatient units and is seen as safer, providing a better experience and more cost-effective.
- Within this, crisis care is seen as key to preventing readmissions and supporting patients transitioning from inpatient care to living independently at home.

The comments made by service users who agreed or disagreed with the preferred option were in line with those of other respondents.

Carers who agreed with the preferred option were more likely to emphasise the importance of community services like MHCAS and the need for better transitions between inpatient and community care. This group expressed concerns about the suitability and quality of inpatient facilities, particularly the Gordon Hospital.

NHS Staff who agreed with the preferred option were more likely to comment on the need for increased investment in community mental health services to address wider determinants of health and provide flexible, holistic care. They were also more likely to express concerns about the Gordon Hospital, its suitability for inpatient mental health care for both patients and staff.

4.1.4 Most common reasons given for opposing the proposal

Overall, respondents who disagreed with the preferred option were more likely to comment on:

- ***The need for more inpatient beds,*** expressing concerns about inpatient capacity, the inadequacy of community services and advocating for the reopening of wards at the Gordon Hospital.
  - They were more likely to express concerns about the negative impact of bed shortages on patient care, including waiting times, short admissions, early discharge with poor outcomes, and disproportionate impacts on patient groups, such as women, and people experiencing homelessness.
  - Some highlighted the importance of local access to mental health services and expressed concerns about the loss of local provision.
- ***Concerns about the location of inpatient services.*** Some opposed relocating mental health services, citing service disruption, longer journeys, safety concerns, and the need for familiar surroundings during crises.
  - They were also likely to stress the importance of proximity of inpatient beds to home and existing support networks.
- ***Criticism of options development and consultation process.*** Respondents who strongly disagreed with the preferred option were more likely to criticise the consultation process and the proposed options, raising concerns about bias, inflexibility, and lack of transparency.

- Some respondents also question the adequacy and viability of the proposed options, calling for more detailed consideration of alternative options and models.

The comments made by service users who disagreed with the preferred option were in line with those of other respondents.

Carers who disagreed with the preferred option were more likely to emphasise the need for crisis services, highlighting the importance of immediate access to care during emergencies, and emphasising the importance of early intervention with community-based support, non-medical interventions and seamless transitions between mental health services.

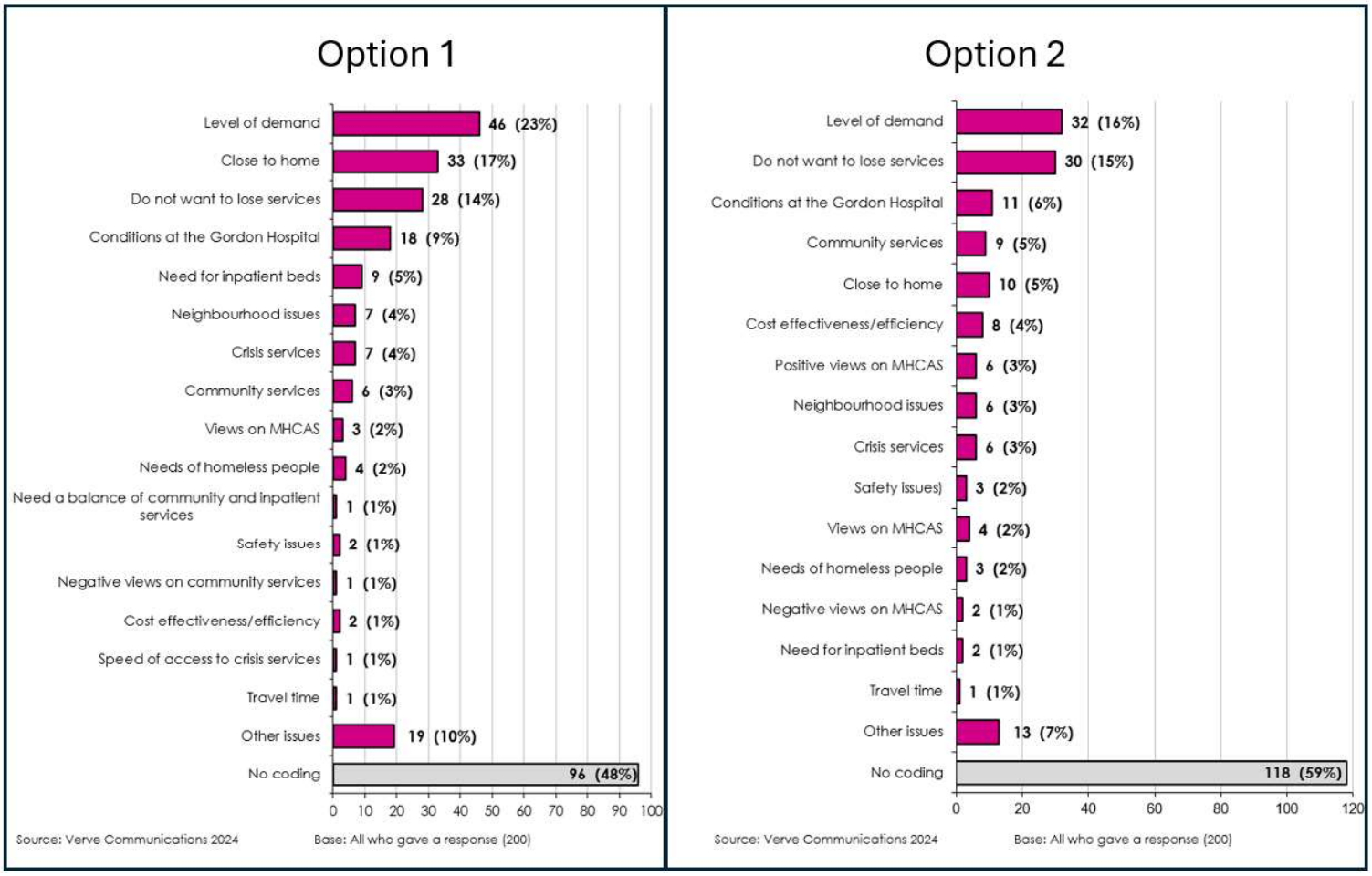
NHS staff who disagreed with the preferred option were more likely to

- Comment on the need for more psychiatric inpatient beds, citing long waiting times, early discharges, and concerns about patient safety.
- Be critical of community mental health services, especially in replacing inpatient care, be concerned about deskilling staff, and about creating additional barriers to care for certain patient groups, and increased acuity on wards all leading to worse outcomes.

4.1.5 Strengths and weaknesses of the other options

The questionnaire asked people to describe strengths and weaknesses of the Options 1 in the consultation document (described as Option A1 in the PCBC) and of Option 2 (Option D in the PCBC). Option 1 the option which would most closely resemble returning to the position prior to the temporary closure of the Gordon hospital inpatients beds when there were more inpatient beds but less provision of community based alternatives. Option 2 is the consultation proposal which has 13 inpatients at the Gordon and keeps some of the enhanced community provision but not all (e.g. not the MHCAS).

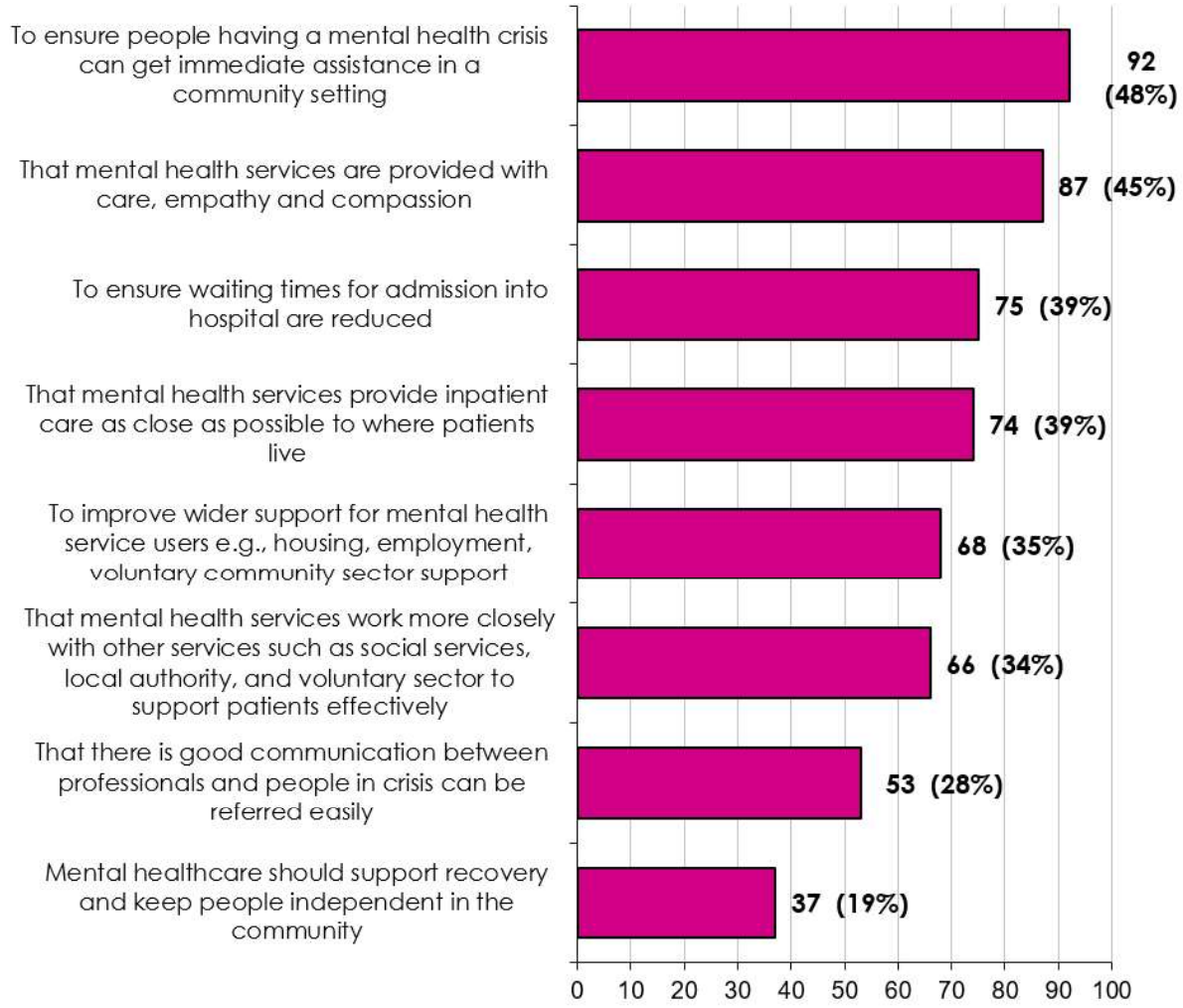
Figure 9 : Strengths and weaknesses of other options identified in the questionnaires



4.1.6 Views on priorities for acute mental health services

The questionnaire asked for comments on priorities for services for people with serious mental health problems. The figure below summarises the most responses

Figure 10 : The most important priorities



Source: Verve Communications 2024 Base: All who gave a response (192)

People were also asked to indicate their level of agreement with some statements designed to draw out views on the location of care and whether community based services should be the first priority. The answers were as shown in the figure below.

Figure 11 : Preferences on service model issues

Source: Verve Communications 2024 Base: All who gave a response (given after each statement)

4.2 Organisational responses

Substantive responses were received from 13 organisations. The Consultation Evaluation report includes those as appendices, and also summarises the main point made. The table below provides a very short summary of responses. It should be noted that all the points made in organisation responses are taken account of in the Consultation Evaluation Reports qualitative analysis which is summarised in section 4.3

Key points regarding the proposal	Views on the consultation options
Service user or representative groups	
Healthwatch, identified concerns raised by wide range of people that community based provision is not sufficient to make up for the loss of beds. They identified problems with long waits, disjointed care, pressure on services at St Charles, impact on vulnerable groups, issues with the Gordon hospital, and issues on the pre-consultation process	Healthwatch has not heard a unified consensus on the suitability of the options, and is not lending support to any option
Voice Exchange suggested that the proposed service lacks support for people who fall in the gap between the crisis service and people with more serious mental health needs	Not stated
BPV-Brent Patient Voice say that the proposal does not show the increasing demands on mental health services, specifically in Brent.	We can't see any logic for selecting 3 options only, nor for the specific 3 options presented.

Key points regarding the proposal	Views on the consultation options
Local authorities	
Westminster City Council raise concerns about patients needing to travel to other boroughs and argues that residents should have both acute and community services available in borough with no reductions in either. It says the Gordon hospital needs to be re-opened	The closest proposal to the Council's view is Option 1 The Council supports both reopening the Gordon Hospital inpatient beds and maintaining services in the community.
Royal Borough of Kensington and Chelsea Council raises the same concerns as the Westminster City Council above. It also says there should be an option which re-opens the Gordon and keeps the MHCAS at St Charles and retains all community services.	Option 1 is the best option for Kensington and Chelsea residents. The Council supports both reopening the Gordon Hospital inpatient beds and maintaining services in the community.
"The Gordon Hospital – options and ambitions" A report by Prof Jill Manthorpe written as part of the response from the two Councils above. This wide ranging report collates feedback and anecdotal evidence as well as reviewing some data and questions whether the proposal makes good use of the potential of the Gordon Hospital as a community asset in Westminster. It stresses the respect in which services at the Gordon were held. It also questions whether sufficient beds are provided by the proposal and whether it can address inequalities and the needs of the homeless, particularly in Westminster. It questions whether the proposals meet the Secretary or State's tests for public consultations, and those of the London Mayor. It does not draw definitive conclusions, but the tenor of the report is that further consideration should be given to restoring the Gordon Hospital as a significant provider of acute inpatient mental health care.	Does not state a definitive view Its summary concludes that "Changing the function of the Gordon Hospital to one of providing short-term 'crisis' places for people in great distress arising from their mental health problems with the possibility of some four 'overnight beds' may not make the most of the huge potential of the hospital to provide care close to home that is legally authorised, therapeutically orientated and providing the optimal route to recovery."
Clinical bodies	
Royal College of Psychiatrists raise concerns about the impact on vulnerable groups and on surrounding hospitals particularly St Charles.	The Royal College of Psychiatrists London Branch does not have a view on the specific proposals set out
Specialist third sector providers	
Westminster Homeless Partnership. Concern that model does not adequately address needs of homeless (access, too early discharge loss of skills from Gordon Hospital, risk of absconding from community services.	None stated.
The Connection. Concern over rough sleepers, including community care often not practical solution for them, discharges do not work well for this group, MHCAS has access issues, not enough spaces in Westminster.	Disagree strongly with Option 3 (preferred option)

Key points regarding the proposal	Views on the consultation options
Kensington and Chelsea Mind Peer Support Community services are very important. They can help patients before their mental health reaches a critical stage and provide immediate assistance in a crisis in community setting	Agree with Option 3 (preferred option.
General practices	
Great Chapel Street Medical Centre, Westminster The preferred option does not take into account the many complex and vulnerable homeless people in the borough. Gordon met their needs well, and community services not suitable for this group. Long waits for MHA assessments, not enough inpatient beds, NHCAS not effective for this group.	Disagree strongly with Option 3 (preferred option). Option 2 could work.
The Doctor Hickey Surgery The most urgent problem is the acute lack of bed spaces within the system, most especially those accessible to people experiencing homelessness. Has been recent large increase in homeless numbers with SMI.	Disagree strongly with Option 3 (preferred option).
Campaign or advocacy groups	
Ealing Save Our NHS. Concerned over reduction of acute mental health beds is opposed to the planned closure of the Gordon Hospital.	Opposed to the permanent closure of Gordon Hospital wards
Hammersmith and Fulham Save Our NHS. Gordon hospital had good quality of care. Equalities and structural racism not explored. Should not close beds while there is no overall strategy for mental health in NW London.	We feel the Gordon beds should be reopened

4.3 Qualitative feedback

The Consultation Evaluation report explains in detail how the feedback was evaluated to ensure all key messages were heard.

'Qualitative' responses refer to the free text comments which were received during the consultation. These come from a variety of sources:

- Questionnaire free text questions.
- Focus groups – from facilitator notes.
- Deliberative events – notes from group discussions and Q&A session.
- Drop-in events – collected through pro forma.
- Miscellaneous comments – received by post or email.
- Organisational responses.

Qualitative data was analysed by recurring themes, similarities and differences within and between groups and types of participants. Verve used an analytical framework derived from the main topic areas of the consultation and the themes arising.

The key qualitative feedback areas outlined in the Consultation Evaluation report can be summarised as follows:

- ***Is the overall service model proposed the right way forward?*** This takes account of feedback that:
  - The model does not include enough inpatient beds. As a result, it is difficult to access beds in a crisis, and patients are being discharged too early and the quality of care in the remaining wards has suffered because they are too busy.
  - Community services are valuable but cannot always meet the needs of patients who would have been in an inpatient bed in the past.
  - There should be inpatient locations in both K&C and Westminster.
  - The Gordon Hospital could provide a good quality inpatient environment.
  - The best way forward would be an option which restores bed numbers to 2019 levels and retains all investment in community services. The PCBC options which increased inpatient beds also reduced community based provision. Respondents have argued that this trade-off between the two service areas is wrong, and both areas should be invested in.
- ***Whether the proposed service model can meet the needs of homeless people with acute mental health issues.*** Irrespective of whether the overall service model described is the correct one for local residents, there has been significant feedback in the consultation that the specific needs of the homeless population cannot be met effectively with the proposed service model. The issues are similar to those identified above, but as homelessness is a very substantial area of feedback the DMBC looks in detail at the specific issues raised in terms of the homeless including:
  - The proposals not taking sufficient account the needs of homeless people with serious mental illness who are a vulnerable group, especially considering the very high numbers of homeless people in the area.
  - Homeless people cannot access inpatient care when they need it and are discharged too early.
  - Community services are not geared up to meet the needs of patients living on the streets, and there are not sufficient places in services like stepdown.
  - The Gordon Hospital service model and ethos were well geared to meet the needs of the homeless and this expertise and approach has been lost.
- ***The impact on inequalities and groups which are disproportionately high users of acute mental health services.*** Feedback concerns were that:
  - Insufficient assessment of the impact of proposals on people in groups disproportionately admitted to inpatient care, existing inequalities and structural racism, and detailed plans for addressing inequalities.

- The proposals did not sufficient consider the impact on people with a learning disability and/or autism.

- ***The appropriateness of the Mental Health Crisis Assessment Service*** element of the proposals has received significant feedback.
  - Lack of clarity on the model.
  - The need to co-produce the future service model for the service.
  - The right location for the MHCAS – particularly suggestions that there should be one in each borough, and suggestions that the service should not move away from the St Charles.

- ***The quality of the information provided within the consultation.*** Respondents suggested several areas where they felt additional information was needed to support a robust decision including
  - Information relating to disadvantaged groups.
  - Capacity/demand modelling.
  - Financial information.
  - Impacts on related services such as police and social care.

  It was also suggested that in some areas the information provided was at odds with real life experience on the ground.

- ***The robustness of the consultation process.*** Several issues have been raised in feedback on this including concerns over
  - How the options were developed, and
  - The accessibility, reach and effectiveness of consultation engagement.

The next section of this DMBC takes each of the areas described above and, in each case, explains the concerns in more detail, analyses the relevant issue, provides relevant information, and then comes to a conclusion on how the specific feedback should be taken into account in the decision making.

In addition to the specific areas above the Consultation Evaluation Report also summarised the views provided in feedback on strengths and weaknesses of the options in the consultation document. As would be expected the strengths and weaknesses described correlate with the feedback described above.

- ***Option 1 would restore all the inpatient beds at the Gordon but reduce some community based provision such as the MHCAS***
  - Those supporting this option largely believe that more inpatient beds are necessary, and community based provision cannot meet the needs of sufficient patients to reduce the numbers of inpatient beds.

- Those against the option largely believed that community services were the priority.

- ***Option 2 would provide a 13 bed ward at the Gordon and not include the enhanced MHCAS.*** This option had little support. The Consultation Evaluation Report says, "Rather than a strong compromise, it tended to be seen as bringing the worst features of both." Those believing in more inpatient beds considered the increase was too little, and those favouring a community focus opposed the loss of the MHCAS.

- ***Option 3 – the consultation proposed option would retain the enhanced community based provision, enhance the MHCAS and not re-open inpatient beds at the Gordon.*** Those opposing the option focus on more inpatient beds being needed, and the need for an inpatient service in both boroughs. Those in favour believe the enhanced community services offer the best model of care

As noted above a number of respondents want a different model to the consultation options which would have both all the beds at the Gordon hospital being restored and retain and develop the enhanced community provision.

5 Analysis and assessment of feedback

5.1 Introduction

The purpose of this section is to consider the key issues raised by both consultation respondent organisations and to assess their impact on the decision the ICB needs to make in terms of whether the consultation proposals should go ahead or should be amended. It is structured to respond to each of the main themes outlined in Section 4.3.

Taking account of the Consultation Evaluation Report we established 5 priority areas for us to explore in detail. The priority areas were as follows:

- ***Overall service model and balance of care between inpatient and community based services –*** two linked areas, both covered in Section 5.2.

    1. Whether we were planning sufficient inpatient beds numbers to meet the needs of our population.

    2. The ability of community based services to meet the needs of patients who would in the past have been admitted.

- ***Ability of the model to meet the needs of more vulnerable groups and groups with disproportionately high use of acute mental health services.***

    3. Meeting the needs of people who are homeless, particularly rough sleepers – covered in section 5.3.

    4. Other vulnerable groups/groups with protected characteristics potentially impacted on by the change – covered in Section 5.4.

- ***Mental Health Crisis Assessment service*** covered in Section 0.

    5. Work on the detail of the service model, and the best location for the service.

In addition to these priority work programmes this DMBC also addresses issues raised by respondents in two other areas. These are:

- ***Information*** **-** Whether we had provided sufficient information on key issues – see section 0.
- ***Process*** **-** Whether we had considered the right options with the right engagement, and whether the consultation process was appropriate and sufficient – see Section 0.

5.2 Overall Service Model

The biggest feedback challenge to the overall service model is the suggestions that it does not include enough inpatient beds to meet the needs of the local population and deliver high quality care. This was often linked to the belief that community services based provision was not able to meet the needs of people who would in the past have been inpatients. The key issues and concerns raised for inpatient care were:

- That the bed modelling undertaken to support the proposal needed further justification and might underestimate future capacity requirements. Several related points were made. They include:
  - Whether the proposal sufficiently recognises the unique needs of our local population, particularly given the relatively high level of serious mental illness in KCW.
  - That the bed modelling for KCW needed to be understood in the context of need demand and capacity across the whole of North West London.
  - That modelling should be more granular based on the needs of specific groups with different mental health diagnoses.
  - That assumptions on future performance in terms of length of stay, occupancy and admissions should be justified.
  - That the proposal should be clearer about how peaks and troughs in demand will be managed and how this relates to performance on Out of Area Admissions both for KCW and the wider ICB.
  - That there needs to be greater clarity on the relationship with demand from Brent and other Boroughs
- That the reduction in inpatient beds since 2019 has meant raised admission thresholds and knock on impacts on other services like hospital emergency departments and neighbouring mental health hospitals
- That patients were being discharged too early because of shortage of beds.
- That there was now a poor quality of care at the St Charles as a result of occupancy levels being too high, combined with higher acuity patients
- That community services are not providing an adequate alternative for patients who would in the past have been inpatients.
- That there is insufficient capacity within community services
- That locating all inpatient services in KCW at St Charles was not acceptable in terms of access implications, particularly for the Westminster population.
- That the Gordon hospital could be a high quality inpatient facility

- That there should not need to be a trade-off – in particular that there should be options which included both more inpatient beds and retaining the enhanced community provision.

Each of these points is addressed in a sub-section below.

It should be noted that several respondents have said that these issues apply particularly for people experiencing homelessness. Because this is significant area of feedback about an affected vulnerable group Section 5.2.6 is focussed specifically on whether the model is meeting the needs of homeless people.

5.2.1 Does the bed modelling supporting the proposal demonstrate that enough inpatient beds are being provided within KCW (and the ICB as a whole)?

As set out above this overall challenge has several different elements, each of which is covered separately below.

5.2.1(a) Does the bed modelling take account of the unique needs of the local population?

ISSUE RAISED IN FEEDBACK

Not enough beds planned for the needs of the population. The PCBC suggested that there were sufficient beds within KCW to meet the needs of the local population. It suggested that comparisons with other areas showed that in terms of numbers of acute mental health beds per 100,000 population the proposal still meant that there would be a greater number of beds than is average for a population of this size across the country as a whole, and at about average for London. Feedback received has suggested that this did not take account of the distinct health needs of the local population.

For example: the London Mayor's Office report says "The PCBC states that, in 2019/20, CNWL had 25.2 beds per 100,000 weighted population, above the national average of 19.9, and that it had the highest ratio of all the Trusts in the London region. There is a clear but unevidenced suggestion that fewer beds is better, and the ratios quoted are not linked to specific assessments of local needs." It also suggests that there is a risk the proposals could be "resource driven" rather than "needs driven" (reflecting funding availability rather than need).

One other key area raised in some feedback was whether the proposal took account of the fact that the area includes the population affected by the trauma of the Grenfell Tower tragedy.

DISCUSSION/EVIDENCE

Updated information since PCBC

The most recent information we have on population need and benchmarking relevant to this issue is summarised below.

- The analysis of the level of serious mental illness (SMI) in KCW described in Section **Error! Reference source not found.**, shows that the recorded prevalence of SMI is 23% higher than in the rest of London and 44% higher than the national average. Most people with SMI are supported within the community, but this could be expected to result in a greater number of acute inpatient beds being needed and/or a greater level of resources to be required for this group in a community setting.
- We have new and updated figures on how the numbers of acute beds we have per 100,000 population compared to other parts of London and the country.
  - ~ This shows that in KCW we now have 23 beds per 100,000 population. This is just above the median rate of around 22 beds per 100,000 people.
  - ~ Our occupancy rates are relatively high (at 97% compared to the median across the country of 94%).
  - ~ Our admissions per 100,000 are higher than the average at 249 per 100,000 compared to the median of 215.
  - ~ Our average length of stay is 33 compared to the national median of 39
- The areas where we differ most from other parts of the country are that
  - ~ in KCW a much higher proportion of inpatient admissions are under the mental health act - 85% compared to a median of 52%. (See Section 2.6). We have more than double the number of admissions under section per 100,000 population than the median mental health Trust (211 compared to 83).
  - ~ Benchmarking show that CNWL Community Mental Health Teams are delivering a much higher number of community contacts compared to our population than the vast majority of other Trusts in England, as shown in the chart below.

Figure 12 : Changing nature of inpatient admission and community services

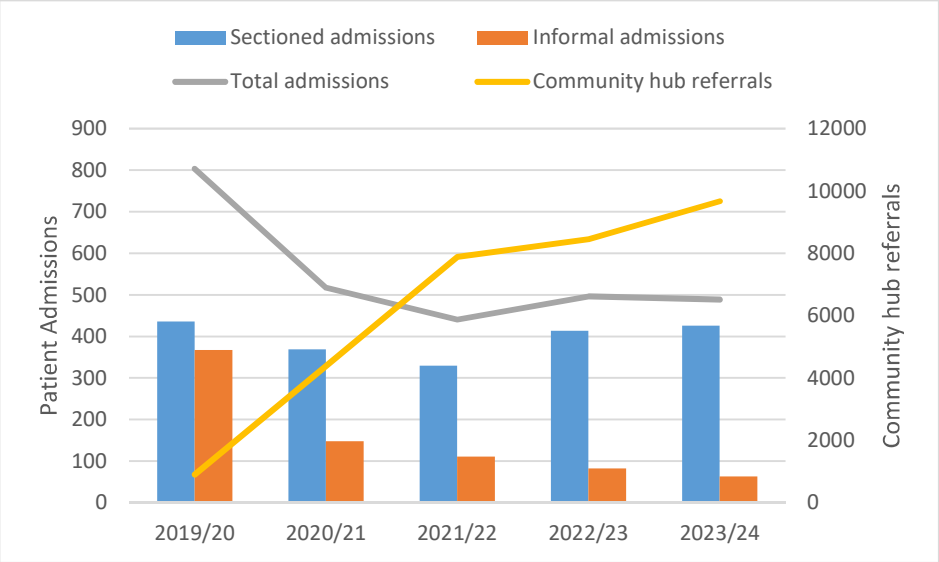
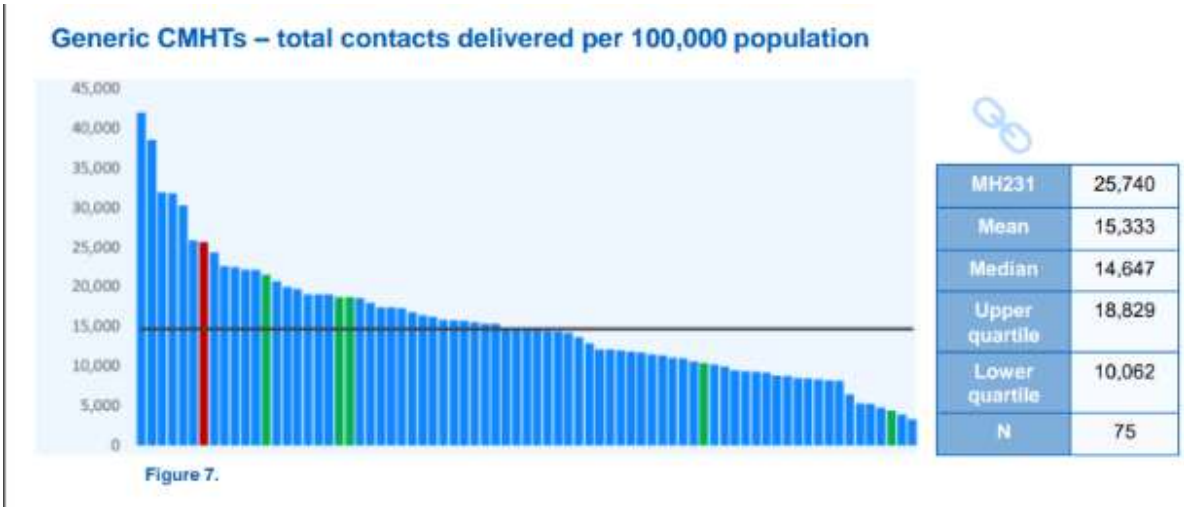


Figure 13 : Benchmarking of community mental health services



In considering the most up to date information on admissions and inappropriate Out of Area Placements key points are that:

- While the number of admissions has dropped over time, this is all from a reduction in informal (voluntary) admissions. The number of Mental Health Act admissions have remained broadly constant.
- Inappropriate Out of Area Placements (OAPs) dropped to zero in 2023 and have remained at zero since then. We recognise that there was a period after the closure when OAPs were taking place, but we took action to address this by tackling issues like patient flow, and since that time inappropriate OAPs have not been required.
- Readmission rates fluctuate significantly month on month, but and were slightly lower in the year 2023/4 than they were in the year 2019/20. There was an increase readmission rate in

2023/24 from 2022/23 which has been driven by substance misuse leading to readmission and some disengagement with community services. CNWL has launched a project with service users to understand reasons for disengagement from services and implement appropriate changes to ensure services are offering what people need to stay engaged.

Discussion

We recognise that there is a high incidence of serious mental illness in KCW and that this could be expected to result in increased demand for mental health provision.

Our inpatient beds' most important function is to meet the needs of the Mental Health Act patients who are detained under Section (because they are considered to be a risk in terms of harming themselves or others). The fact that we have a high number of admissions per 100,000 for Mental Health Act Patients is very likely to be linked to the high level of SMI in the area covered by CNWL. We know that we are continuing to be able to provide the necessary capacity for all sectioned patients because we do not have inappropriate Out of Area Admissions.

The key change since the temporary closure of the Gordon inpatient beds is that we have substantially reduced the number of people being "informally" admitted. These are people who are admitted on a voluntary basis. The prime reason for such admission is to lower the risk of a later need for someone to be admitted under Section. As the data above shows we admit far fewer people per 100,000 of population on an informal basis than most other mental health services.

We view this as a positive development. The key purpose of informal admissions is to provide support which will reduce the risk of a later admission under section. The new community services approach we have introduced now means that we can achieve this reduction in risk by providing people with the help they need in a community setting rather than a restrictive inpatient unit. The addition of beds to the MHCAS service supports this by providing more intensive community based support for this group.

The fact that admissions under section have not increased since 2019/20 despite the significant reduction in informal admissions suggests that the community services are as effective at preventing a later need for a Mental Health Act admission as inpatient care. For this reason, we do not believe that the high mental health support needs of our local population require us to have more beds; rather it requires us to have the right sort of community provision to prevent the need for those beds. This is covered in more detail in Section 00. We have shown above how CNWL community mental health teams are delivering a much higher number of community contacts than most other organisations. That reflects both our aim of delivering maximum support for people within the community rather than investing our resources in inpatient beds, and how we are addressing higher than average levels of serious mental illness. In other words, we are able to meet the needs of our patients with fewer inpatient beds than other mental health Trusts because of our successful focus on community provision.

CNWL are currently in the process of rolling out DIALOG+ across community teams to get a better understanding of outcomes of people's care in community teams. However, it is not yet able to provide good outcomes data and would not assist in assessment of how those outcomes may have changed since before the temporary changes.

In the absence of such data the best proxy to identify whether community services are providing effective care is to look at how many patients who are on the community services caseload are admitted while they are actively being supported, or within 6 months of being discharged from those services. This is because an admission suggests that the community services have not been able to successfully manage their care.

- In 2019/20 of 10,586 people who accessed a community service 40% (4234) were admitted during their time on the community caseload, or within 6 months of discharge.
- In 2023/24 of 17,398 people who accessed a community service only 23% (4001) were admitted during their time on the caseload or within 6 months of discharge.

The conclusion is clear – the number of people being supported by our community services who have an outcome meaning they require restrictive inpatient care has reduced even though those services are supporting more people overall. We would therefore challenge the statement in the Mayor's Office report that we have assumed without evidence that "fewer beds is better". We do, however, believe that if we can meet people's needs effectively in a community setting this provides a much better quality of service than providing support within a restrictive inpatient environment. It is therefore better to use scarce resources within the community, than to have an unnecessarily high number of inpatient beds. As highlighted in the Mayor's Office report, this belief is "in line with the national direction of travel reinforced within the NHS Long Term Plan" and the London Clinical Senate "has noted that the plans are consistent with current best practice opinion and guidance". Our bed modelling is predicated on that core approach, and we have four years of experience on the ground which suggests that our community model is working, and the consequence is

- We now have a stable position with no inappropriate Out of Area Placements (there was an immediate increase in OAPs after the inpatient ward closure, but this was probably inevitable as it took time to develop the best possible community alternatives)
- There has been no increase in the number of admissions required under the Mental Health Act – which shows that our community provision is working just as well to prevent the risk of such admissions as our previous model of informal admissions.

We recognise that we have financial resource constraints. However, we would challenge the suggestion that this means the proposals are driven by the need to save money. We have in fact invested more money in mental health services in North West London since the inpatient ward closure. Of course, there can always be improvements in care and in our ability to meet population need. However, we believe the evidence shows that we are meeting local needs better now than we were when the Gordon inpatient beds were open.

The Grenfell Tower tragedy inevitably had an important effect on the mental health of the local people affected. However, we have no evidence that there is any greater need for inpatient admission to a mental health hospital as a result to the extent that it would affect the number of beds we require.

CONCLUSION/RESPONSE

In summary:

- We fully recognise that the high level of SMI within KCW results in additional need. Our high level of inpatient admissions under the mental health act reflects this.
- We have sufficient capacity to meet the need of those patients admitted under section.
- We do not admit nearly as many people as informal admissions as we used to, or as many as most other English Mental Health Trusts do. However, we believe this is the right model because we have shown that our community services are just as good at preventing the need for admission under the Mental Health Act as informal inpatient admissions were. This belief is fully supported by national best practice guidance.
- We have four years' experience of working with an improving new model which evidences that the new model is effectively meeting the overall need of the local population using the key measures of Out of Area Admissions, and numbers of people admitted under the Mental Health Act.

5.2.1(b) Understanding the beds numbers proposed for KCW in the context of the whole of North West London

ISSUES RAISED IN FEEDBACK

That the modelling needed to be seen within the context of an overall need, demand and capacity model for the North West London area, not just KCW. The Mayor's Report specifically says that

- It should fit within "a wider analysis of mental health needs across North West London."
- "There remains a reliance on capacity in other boroughs to manage peaks in demand and, …, it is still not clear whether the capacity proposed would be adequate."

DISCUSSION/EVIDENCE

As set out in Section 2.4 the ICB approved an overarching mental health strategy on 16th July 2024 for the whole of NW London. This is available as Appendix 1 to this DMBC.

The strategy fully supports the overall model in this DMBC of enhancing community based provision to minimise the need for inpatient admission to a restrictive setting. For example; it confirms that, "We continue to implement the principle that acute inpatient care should only be used when there is no better alternative. There will be improved support to reduce risk of re-admission." It has a high level assessment of needs within the borough. Within this it is identified that in some areas needs were not being fully met (see below).

At the time the strategy was produced there were 343 acute mental health beds for working age adults available in NW London (not including the temporarily closed beds at the Gordon). The strategy modelling considered a range of factors to take account of patient need including demographic change, the need to reduce pressure on emergency departments from mental health patients, the requirement to eliminate inappropriate out of area admissions, the potential to reduce admission for patients who could receive their care in a community setting, and the potential to reduce length of stay to good practice levels. Taking account of all these

factors and of a plan to increase overall beds to 351 the strategy concludes that the bed capacity is the right size for the needs of the local population and will be able to meet those needs within an overall occupancy level of 90%. More detail on the assumptions behind this conclusion is included in Section 0. The key point to note is that the demand modelling in the strategy is consistent with that carried out for the KCW population within this DMBC.

CONCLUSION/RESPONSE

The recently published NW London mental health strategy addresses the gap identified by the feedback. We believe it provides the necessary context to show that the proposals in this DMBC are:

- Fully aligned with the overall mental health strategy.
- Consistent with the overall bed modelling carried out by the ICB for NW London

The strategy will also deliver lower occupancy levels across NW London which will increase resilience in the system to manage peaks in demand.

5.2.1(c) Level of detail within the modelling

ISSUES RAISED IN FEEDBACK

Whether more detailed modelling of need and capacity is required

The bed modelling carried out by both CNWL and the ICB has been broadly based on modelling for the whole inpatient population. It has taken the existing provision as a baseline and modelled in growth based on anticipated demographic change. Specific factors have then been looked at as indicators of unmet demand such as inappropriate Out of Area Admissions, overlong waits for admission from Emergency Department.

Feedback, particularly from the Mayor's Office has been that the modelling should be more granular, focussing on the needs and capacity for specific types of diagnosis. The Mayor's Report particularly questioned how demand modelling can be robust if based on care needs rather than diagnosis. It suggested that "Without this detail, it is hard to be clear that a certain configuration of community services, aspects of which are novel, will adequately replace previously established inpatient services." It also said that it would like to see "expert views on potential changes to the current baselines of clinical need and presentation.

DISCUSSION/EVIDENCE

We have looked carefully at the data sources available to us, and we do not believe either the ICB or the Trust has access to the sort of detailed data which would allow projection of need and demand based on mental health diagnosis. While we recognise that such nuanced analysis often adds value, we do not believe that it would assist us in this particular case, either in forecasting the requirement for inpatient beds or in assessing whether the community services planned will be sufficient

Inpatient bed forecasting

The key reasons for modelling based on detailed diagnosis rather than for the whole population when considering the need for an inpatient bed would be that both of the following applied:

- Specific diagnoses affecting a significant number of people were likely to make a substantial difference in the risk of admission and/or the length of stay, or to the type of inpatient bed required.
- There is evidence that the current proportion of people with those diagnoses was likely to change significantly.

We do not believe that this applies to either of the two main groups of patients admitted (those detailed under section, and those under informal admission).

The vast majority admissions in KCW are patients detained under the Mental Health Act. The key factor in the decision to admit a patient under section is not diagnosis but a person specific clinical assessment of risk of harm to themselves or others. In 2023/24 there were 426 sectioned patients and 63 informal admissions. This means that 93% of our bed usage is for sectioned patients. It is hard to see how modelling inpatient beds by diagnosis for this group of patients would change our overall conclusions on how much capacity is needed. Admissions of sectioned patients are very close now to the number in 2019/20. Admission of sectioned patients in KCW have been fluctuating around an average 400 per annum since 2019 (436 in 2019/20 and 426 in 2023/24). We have identified no specific reasons beyond overall demographic change (for which we have accounted) which would lead this to change significantly.

We have considered whether there is merit in detailed modelling by diagnosis for informal admissions but given the relatively small number of beds currently used within KCW for informal admissions (4 beds at 100% occupancy) it is too small a number to make diagnosis specific modelling for the future relevant. Even if this were not the case, we have not identified any factors based on diagnosis alone which would allow us to determine with any certainty that a patient with that diagnosis was more likely to benefit from an informal admission than community based services.

<u>Community services capacity requirements</u>

For the reasons set out in earlier in Section 5.2.1(a) we believe that the evidence already shows that the community provision we have in place is doing as good a job at reducing the risk of inpatient admission as the previous higher level of informal admissions was doing. The question is whether that will continue. We deal this in more detail in Section 0 below. In summary we believe the overall commitment of the NW London mental health strategy to continue to enhance community based alternatives, and the opportunities we have identified to create additional community capacity will together ensure that we are able to continue this into the future.

The Medical Director overseeing this service has said “We have not seen a significant change in clinical presentation other than people are presenting more often with social needs. The

adaptation to our community mental health teams to work in a joined up Hub model and the pilot of Open Dialogue as a clinical model, along with appropriate input from social care would be more appropriate to meet these needs than an admission to an inpatient facility. Our services and the care someone receives is based on need rather than diagnosis so services would not be forecast based on diagnosis"
CONCLUSION/RESPONSE We have reviewed our modelling of future requirements for capacity, taking clinical presentation into consideration and believe that our approach in both inpatients and community provision is appropriate and provides sufficient confidence that we can match need and demand with the overall level of inpatient and community services. Our lead clinician has provided an expert view that the model we are proposing is aligned with presenting need.

5.2.1(d) Assumption on length of stay and occupancy levels and admissions

ISSUES RAISED IN FEEDBACK

That more confidence could be placed in the capacity provided by the proposals if assumptions on admissions, length of stay and occupancy levels were more explicit with explanation of why those assumptions are achievable.

For example, the Mayor's Report says, "Achieving 85% bed occupancy is seen by proposers as providing resilience to peaks in demand but it is not clear how that occupancy level will be achieved and sustained."

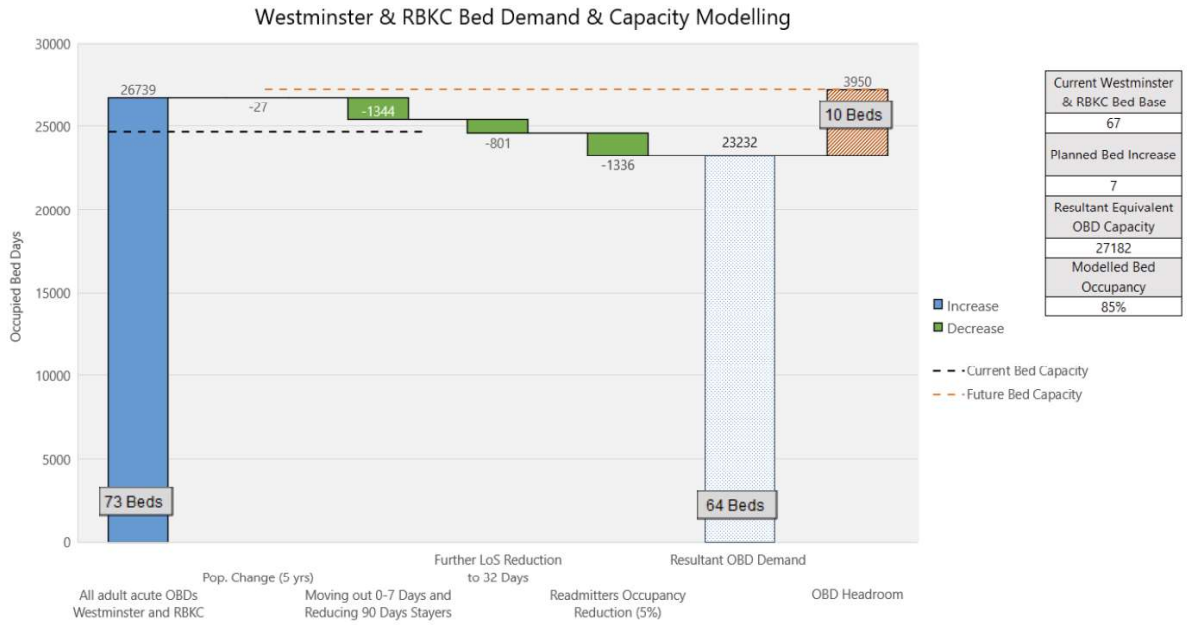
DISCUSSION/EVIDENCE

We have addressed this below firstly from the KCW perspective, and then from that of NW London as a whole.

KCW specific modelling

For the PCBC we specifically modelled the bed capacity requirements over five years for the KCW population as shown in the figure below.

Figure 14 : KCW bed requirements

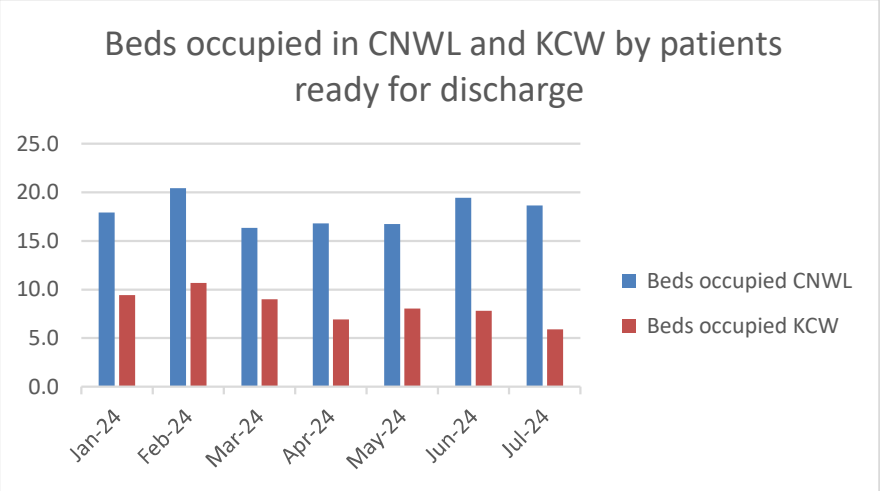


The key points to note in our assumptions are:

- The modelling showed a 73 bed capacity requirement at 100% occupancy for the KCW population best on actual bed days consumed.
- Demographic change implies an insignificant drop in bed days required
- Positive action the Trust is taking that will reduce admissions and length of stay in line with good practice is as follows:

- Substantially reducing very short admissions (7 days or less). Our model for the enhanced MHCAS is directly designed to ensure that people who only require a few days admission for immediate assessment and treatment planning will not need to be admitted.
- Targeted work (with our community services and our partners) to reduce the number of people within our inpatient beds who have been signed off by the clinical team as ready for discharge, but who for various reasons are not being discharged at that point. The initial work is focussing on those patients staying more than 60 days, but we will then be widening the work so that we are consistently meeting the national target of 32 days average length of stay. The size of the opportunity both for KCW and for the CNWL Trust as a whole is significant as shown in the figure below. For example, for KCW patients an average of over 8 beds are occupied by patients who are clinically ready for discharge. Our long term aim would be for this to be zero, but realistically we are targeting bringing this down to 2 beds. This on its own will deliver the LOS reduction shown above.
- Further work to improve services so that risk can be managed safely within the community, increasing the potential to discharge patients earlier.

Figure 15 : Beds occupied in 2024 by patients clinically ready for discharge



- We are also working with our community services to target further reductions in readmissions which will reduce the pressure on beds.

Combining the assumptions above on these factors means that the KCW overall demand for inpatient beds should be reduced by between 9 and 10 beds so that our total requirement will be 64 beds at 100% occupancy which equates to 71 beds at 90% occupancy (our NW London overall target), or 75 beds at the Trust ambition of 85% occupancy.

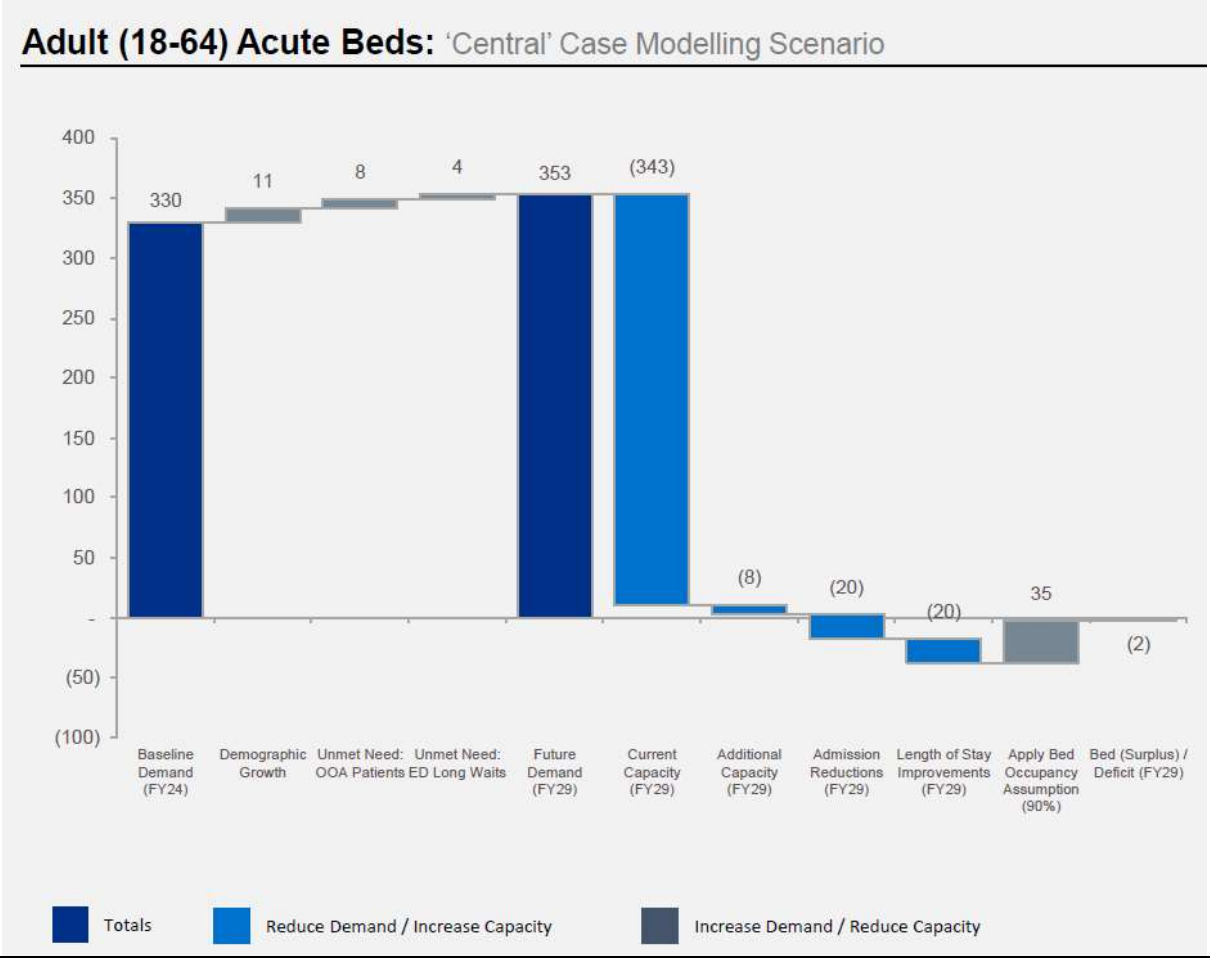
We have 67 inpatient beds at St Charles. However, we are reusing some of the savings from the Gordon inpatient bed closure to develop an additional 7 beds at Brent, specifically targeted on ensuring the KCW population has sufficient capacity, effectively taking us up 74 beds of capacity to cater for this population (although 7 of the beds are not located in KCW). We know that this means a number of patients each month will need to be supported outside KCW if we are to achieve our desired occupancy levels (7 patients on average to achieve 85% and 4 to achieve 90%).

Since the temporary closure we have been using beds in other boroughs to provide sufficient capacity for the KCW population. This was occurring before the temporary closure (for example in 2019/20 on average we had 6 patients from KCW not being admitted within KCW). This increased to between 15 and 18 during the years following the temporary closure. The plans above will ensure that within a few years the level of patients having to be supported outside KCW is back to what it was in 2019/20 before the closure.

North West London modelling

The figure below from the NW London mental health strategy shows the key rationale for the ICB's assumption that we will have sufficient capacity across NW London in the future.

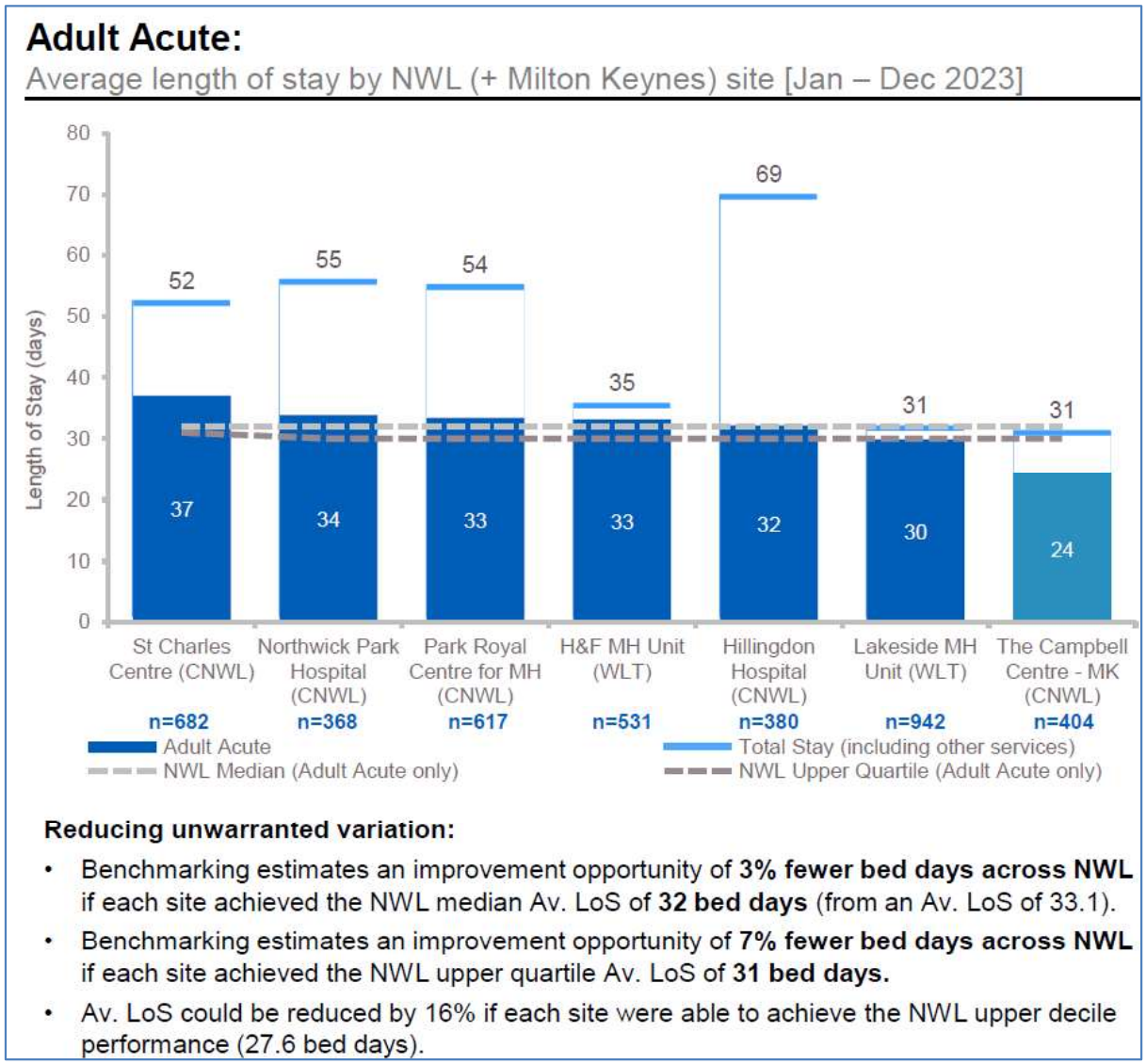
Figure 16 : Acute beds – modelled requirements for North West London)



The strategy says that:

- There will be a need for 23 additional beds above what was in place in 2023/4 in the future in order to meet needs and
  - ~ Ensure no inappropriate out of area patients (8 beds).
  - ~ Reduce the risk of longer waits in Emergency Departments (4 beds).
  - ~ Address demographic demand driven growth (11 Beds).
- Service changes including addressing patient flows and enhancing community-based provision to reduce the need for admissions and length of stay (similar to those described in this DMBC for KCW) will reduce the overall need for beds by 40 based on achievable and realistic reductions in admissions (6%) and length of stay (6%).
  - ~ *Admission reduction.* Data analysis shows that three of the boroughs In NW London (Hillingdon, Harrow and Hounslow) have lower incidence of SMI than other boroughs in NWL (such as KCW) but their admissions per 100,000 population are higher than other boroughs (weighted for mental health as used in national benchmarking) and if they were simply able to achieve the mean achieved by other boroughs that would reduce admissions across NW London by 6%. If all boroughs were able to achieve upper quartile performance, it would reduce total admissions by 11%. It is not expected this will be achieved by significant reductions within KCW as these boroughs are already below average.
  - ~ *Length of stay.* The length of stay opportunity has been quantified across NW London through the ICB benchmarking which suggests a 6% reduction can be achieved by providers as set out in the extract from the strategy in the slide below. As with the Trust, a key focus will be on reducing the number of patients still in beds despite being clinically safe for discharge (see figure 11).

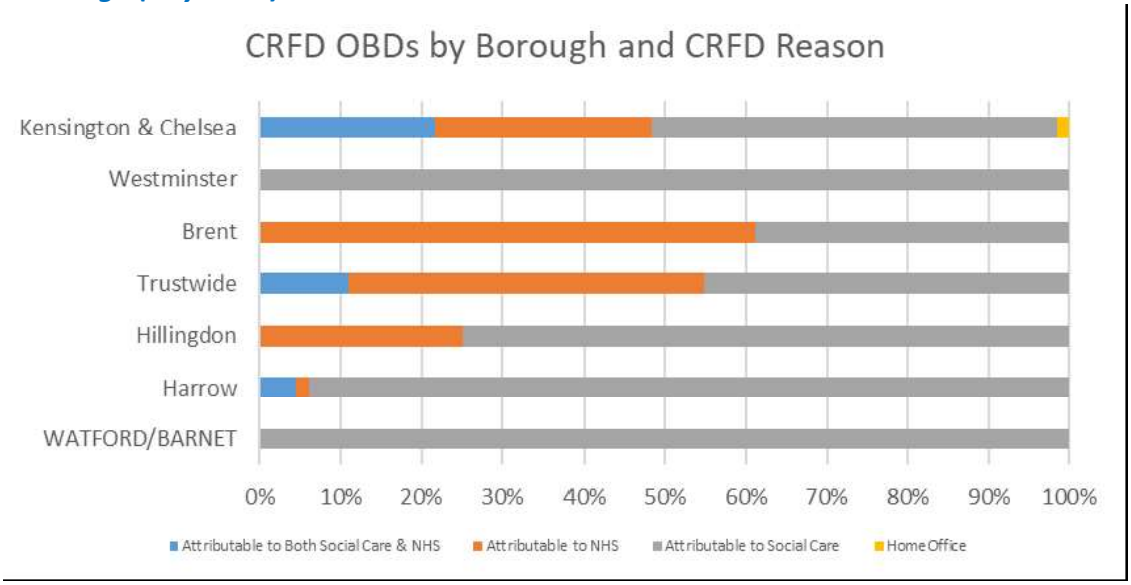
Figure 17 : NWL LOS opportunity



Reducing unwarranted variation:

- Benchmarking estimates an improvement opportunity of **3% fewer bed days across NWL** if each site achieved the NWL median Av. LoS of **32 bed days** (from an Av. LoS of 33.1).
- Benchmarking estimates an improvement opportunity of **7% fewer bed days across NWL** if each site achieved the NWL upper quartile Av. LoS of **31 bed days.**
- Av. LoS could be reduced by 16% if each site were able to achieve the NWL upper decile performance (27.6 bed days).

Figure 18 : Reasons for people remaining on the wards when they are clinically ready for discharge (July 2024)



- Additional work with the system will support the continued reduction of people who are clinically ready for discharge. Figure 14 shows across the boroughs the reasons for people to remain on the ward when they do not have a clinical reason to be there. Further work with the Local Authority and the Community Access Service to ensure people's potential needs on discharge are addressed will continue to reduce length of stay and occupancy on the wards. While this is important for the reduction of occupancy, it is not an impact of the temporary closure of the wards, if the wards were still open, there would still be a need for people who are CRFD to be moved to a more appropriate location.
- 8 additional beds were added to the total system capacity available in 2023/4 related to a planned development of a 16 bed inpatient ward in Brent (8 beds replace a ward that was set up temporarily to manage demand).

The overall impact of the changes described above will mean that NW London will have the right capacity and will allow an improvement in occupancy levels to 90% (which effectively means that on average 10% of our beds will not be occupied). This will be carried out through a programme focussing on improving discharges and discharge planning across all the CNWL boroughs, actions to deliver include

- Agreeing clear updated expectations of all teams around admission to ensure purposeful admissions with a support package from community teams on discharge which is accessible and culturally sensitive and helps prevent readmissions
- Recording of estimated date of discharge (EDD) to improve focus on discharge from the point of admission. It has been demonstrated that wards where EDD is recorded discharge 2-3 more people a week
- Each borough to hold a weekly MADE meeting to discuss patients who are becoming clinically ready for discharge to unblock any needs in the community to ensure discharge is easy when they are clinically optimised.

More detailed on our programme to improve occupancy levels through reducing length of stay is attached within Appendix 15.
CONCLUSION/RESPONSE It is important that occupancy is reduced to ensure staff and service users have a better and safer experience. Based on the feedback received we have reviewed the opportunities to further improve the position. In this section, we have shown above that the ICB and CNWL have developed realistic and achievable assumptions on performance on admission, length of stay and the potential to achieve desired occupancy levels. We will be working with our community services and our system partners to ensure they can be delivered.

5.2.1(e) Resilience against peaks and troughs in demand and or Out of Area admissions performance

ISSUES RAISED IN FEEDBACK

That the modelling should make specific allowance for peaks and troughs and provide more detail on how this relates the Out of Area admissions across NW London, and greater justification that current performance can be maintained.

The London Mayor's Report says "The DMBC and/or the strategy in development should include a clearer setting out of ICS performance in terms of out of area placements, how these and other proposals may affect the future need for such placements, and how the proposed bed capacity would be resilient to normal variations in demand over an extended timeframe". Both the Mayor's Report and the response from the Royal College of Psychiatrists question the OOA figures. The Mayor's report quotes the Royal College of Psychiatrists local area report for North West London as saying "in the three months to June 2022, there were 2,180 inappropriate out of area placement days across North West London compared to 1,375 in the corresponding period to June 2021. This is a 58.5% increase compared to a 12.1% decrease when looking at the same two periods in England overall."

DISCUSSION/EVIDENCE

Out of Area Placements

There have been no inappropriate Out of Area Placements for the CNWL since March 2023 when there was 1 in a Psychiatric Intensive Care Unit bed. There have been no such placements for acute beds or for KCW since January 2023. We are confident that this performance can be sustained because of the number of initiatives we have in place which will help us to reduce admissions and length of stay (see section 0 above, together with the additional beds the ICS strategy is adding to the system. As set out in Section 5.2.1(b) the ICS overall bed strategy allows for additional beds in terms of resilience against the need for Out of Area placements.

Managing peaks and troughs in demand

Bed demand is not static and therefore there needs to be a way of managing demand through peaks. While it is not fully possible to predict peaks in demand, we know that it follows annual patterns that it is possible to plan for.

- Demand across the whole NHS peaks through winter, but we see this specifically in demand for mental health beds through January to March, with the peak in February and through June to September with a peak in August. Monitoring annual peaks in demand allows us to plan for them and put in place temporary solutions to provide capacity. For example, previous schemes have included additional step down capacity to move people out of beds without the reliance on placements or packages of care being arranged prior to discharge. Every year the system plans for these peaks in demand and implements schemes to manage them.

- In cases where peaks in demand cannot be predicted there are plans to ensure that there is sufficient available capacity across the system to be able to admit people. The Trust has been managing within its bed base for over a year, demonstrated by not needing to have any inappropriate out of area admissions.

The key to sustaining this good position in the future will be in achieving the planned performance in terms of length of stay reduction and admissions as described in Section 0

CONCLUSION/RESPONSE

In summary:

- The ICS as a whole and KCW in particular have had no inappropriate Out of Area Placements for 18 months. Further resilience will be provided on this, and on addressing peaks in demand through
  - ~ Additional capacity allocated within the ICS mental health strategy capacity modelling.
  - ~ Our plans for delivering reduced admissions and length of stay across the ICS.
- We also have the capability of providing temporary solutions to peaks in capacity.

Overall, we are confident that the ICS wide and KCW specific modelling provides sufficient resilience to ensure we can continue our current performance level on inappropriate OAPs which has been sustained for over a year.

5.2.1(f) Clarity on relationship with Brent demand

ISSUES RAISED IN FEEDBACK

The London Mayor's Report suggests it is difficult "to assess the adequacy of the proposed supply to meet likely demand where demand from outside the two boroughs is not entirely transparent. It is indicated that 7 beds' worth of Brent activity could be freed up at St Charles and that 14 additional beds are proposed to be located in Brent, but it is not possible on current information to triangulate this with what is proposed in the other two boroughs. In 2019/20, a total of 59 Brent residents attended either the Gordon or St Charles, accounting for an average use of just over one inpatient bed at the Gordon and three at St Charles. It is indicated that 7 beds' worth of Brent activity could be freed up at St Charles and that 14 additional beds are proposed to be located in Brent, but it is not possible on current information to triangulate this with what is proposed in the other two boroughs.

DISCUSSION/EVIDENCE

The creation of an additional ward in Brent partly reflected experience from several years that showed a clear under capacity for both Brent patients and outer borough patients (Harrow and Hillingdon). It should not be assumed that the development in Brent is only relevant for Brent patients. The Brent location is much closer for all three outer boroughs than St Charles. In 2019/20 the total from the three boroughs attending one of the Gordon or the St Charles was 109 patients occupying around 7 to -8 beds (compared to the figure of 59

quoted in the Mayor's Report). This has continued since the temporary closure and is a key reason for the pressure on capacity at the St Charles as it has continued to be the case that around 8 beds are occupied by patients from outside KCW.

Table 8 : Bed days and admission of outer borough patients in KCW

Occupied bed days		2019/20	2020/21	2021/22	2022/23	2023/24
The Gordon	Brent	374				
	Harrow	281				
	Hillingdon	122				
	Total	**777**				
St Charles	Brent	1179	1201	1321	967	1705
	Harrow	745	222	347	325	583
	Hillingdon	147	370	666	549	788
	Total	**2071**	**1793**	**2334**	**1841**	**3076**

Number of people		2019/20	2020/21	2021/22	2022/23	2023/24
The Gordon	Brent	20				
	Harrow	11				
	Hillingdon	11				
	Total	**42**				
St Charles	Brent	39	53	53	44	58
	Harrow	14	9	11	12	18
	Hillingdon	14	19	19	19	27
	Total	**67**	**81**	**83**	**75**	**103**

All of these beds are included within the ICB wide capacity planning as discussed in section 5.2.1(b)

CONCLUSION/RESPONSE

Following the feedback, we have reviewed the position on the relationship with the consultation regarding Brent and the outer boroughs and consider this to be correct. Patients from the outer boroughs are using beds in St Charles and by enabling these patients to be admitted in the outer boroughs, the beds at St Charles can be dedicated to KCW patients.

5.2.2 Shortage of inpatient beds impacting on access to the right care

ISSUE RAISED IN FEEDBACK

Difficulty accessing the right care. Raised admission thresholds and difficulty in gaining admissions for patients who need it resulting in delays to access to care and patients who should be admitted not being admitted including from emergency departments, MHCAS and Section 136 suites. Concerns have been raised that too many people are waiting in Emergency Departments because of a lack of inpatient bed provision.

"It is not made clear from current operational performance data whether the expected efficiencies are being achieved and, therefore, whether the balance of community and inpatient services proposed will be adequate. For example, proposals do not give a clear understanding of the waiting times for admission associated with current occupancy levels or the impact of waits on service users, carers, other services, or the wider community." *London Mayor's Office report*.

DISCUSSION/EVIDENCE

Admission thresholds

It is not accurate to say that admission thresholds have been changed since the Gordon inpatient service was temporarily closed. Clinicians continue to make the judgement based on individual patients how their care needs can be met safely and effectively. What is different is that we have enhanced community provision and capability. The result is that judgements on where someone can be safely supported now reflect that greater capacity and capability to offer safe care in the community. This means that fewer people need to be admitted, but we do not believe there has been any change in terms of the core criteria used.

Evidence of number of inpatient beds resulting in delays within Emergency Departments within CNWL

Following the temporary closure of the Gordon we have put in place additional crisis services designed to minimise any impacts on Emergency Departments. This has been a mix of requirements through the Long Term Plan and additional services identified to meet the needs of the population. These include:

- The Coves run by Hestia[21] – The Coves provide unlimited, open access to support and guidance for people in, or at risk of, a mental health crisis.
- The Mental Health Crisis Assessment Service (MHCAS) offers an alternative to A&E to support people with emergency mental health needs. The MHCAS has taken learning from a crisis house model and has some beds for people who need a slightly longer assessment or short term admission to de-escalate their crisis and start treatment.

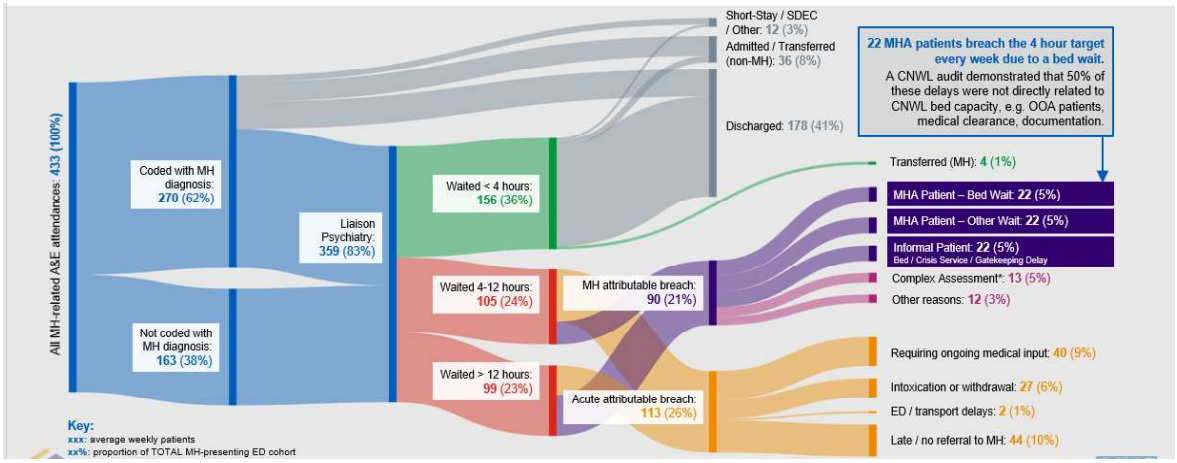
[21] The Coves: Central and North West London NHS Foundation Trust (cnwl.nhs.uk)

- Social support from the British Red Cross for service users who are high users of emergency support, particularly A&E. The British Red Cross provide intensive support to manage the reasons that someone is regularly presenting for crisis support.

However, we recognise that despite these services colleagues in acute hospital Emergency Departments are still experiencing pressure with patients in a mental health crisis waiting too long in Emergency Departments.

CNWL has been carrying out a detailed analysis of delays within Emergency Departments that relate to mental health services in general, and the need for an inpatient bed or MHCAS support in particular. The most recent CNWL position is set out below. This shows that, in June 2024, 11 people a week waited more than 4 hours where the wait for an acute mental health bed was the main cause of the delay. Of these, around 6 are in KCW A&Es.

Figure 19 : Reasons for delays within Emergency Departments in CNWL between June and July 2024



Of the 6 patients a week waiting for more than 4 hours in Emergency Departments situated in KCW because of difficulties accessing an acute mental health beds less than 30% of these are waiting more than 12 hours. Even if we assumed all 6 patients were there for a full day this would suggest that having an average of 1 additional bed free in the acute mental health inpatient service would solve the problem, insofar as it relates to acute mental health capacity. The plans we are putting in place with this proposal will deliver substantially more capacity than this

- Eight extra beds to open this year in Brent (specifically aimed at freeing up capacity in the St Charles by taking Brent and Outer Borough patients away from St Charles)
- The enhanced MHCAS service with capacity for an additional 4 people and to offer overnight stays.
- Further reductions in length of stay by reducing the number of patients in inpatient beds who are clinically ready for discharge (see Section 5.2.1(a)).

It should also be noted that the NW London mental health strategy specifically suggests that there will be an increase of 4 beds of capacity in the inpatient base directly targeted on reducing waits within emergency departments across the whole of NW London.

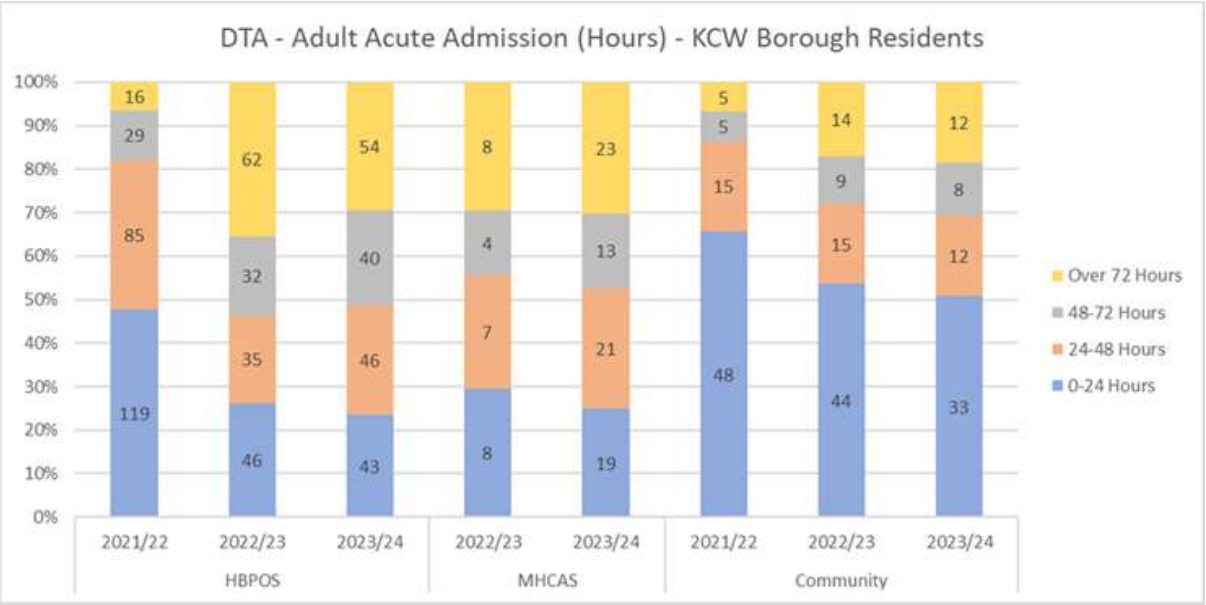
Evidence of delays in accessing inpatient beds from people within community services

The three main sources of admissions to mental health inpatient beds apart from hospital emergency departments are:

- Patients who have been taken to a Health Based Place of Safety (HBPoS). These are the spaces NHS mental health service providers provide and manage for police officers to take people who have been detained under Section 136 or Section 135 of the Mental Health Act; people are taken to HBPoS for assessment by mental health care professionals. Following that assessment, the person may need an inpatient admission.
- Patients who have come the MHCAS. The purpose of the MHCAS is to provide assessment and immediate treatment, and then direct patients to the best pathway of care. In some cases, this may be an inpatient admission.
- Patients being supported by other community services where health professionals have determined that it is necessary for those patients to be admitted.

We do not have data on waiting times within these services back to 2019/20 and so we cannot determine how far they may have changed since then. We do however have data for patients from each of these three areas from more recent years as shown in the figure below. MHCAS launched in 2022, so the data is only for 2 years.

Figure 20 : Waiting times in community based settings following decision to admit



HBPoS waits are not currently at an acceptable level (they should not exceed 24 hours). HBPoS waits account for over 2/3rd of all people waiting longer than 24 hours in the last 3 years. CNWL has an action plan in place to address this issue which includes:

- Clear escalation process for patients who have been in the HBPoS for 24 hours
- Weekly audits of any patients who waited longer than 24 hours to learn from these situations and put in place actions to ensure they aren't repeated
- Improvements in bed flow as set out in the rest of the paper will also improve flow of patients out of the HBPoS

MHCAS waits are not considered to be a significant problem. The whole point of an MHCAS service is that assessment and treatment can commence immediately, with the aim of being able to avoid inpatient admission. Inevitably, for some people it will be determined that a longer inpatient admission is needed. While it would be ideal if those patients could all be transferred immediately to the inpatient unit the patient can continue to have appropriate treatment and support during any waiting period.

Community waits. These affect relatively small numbers of people – less than 40 people waited more than 24 hours in each of the last two years. However, our approach towards reducing this is:

- To improve access from community services to the MHCAS to support people who may need a short stay admission
- To improve bed flow as set out in the rest of the paper to ensure that when people need a bed there is one identified in a timely way.

Relationship with inpatient bed numbers

While we do not have data based evidence for the causes of these waits, we fully recognise that our current high levels of occupancy in our wards are bound to be a factor. We have set out in Section 5.2.1(d) and how we plan to ensure occupancy levels are reduced substantially, and this should resolve the issue.

It is important to note that as with waits in ED there is no reason to believe a substantial increase in bed numbers is needed to resolve this issue. In 2023/4 there were 332 admissions from community settings (I.e. HBPoS, MHCAS and other). We have calculated how long those patients stayed in those settings after the decision to admit had been made; over the whole year the equivalent occupied bed days spent in one of those settings totals just under 800 days. Given that it is inevitable there will always be some delay this suggests that if bed availability was the sole factor causing the long waits for all patients just over two fully available inpatient beds would be sufficient to resolve the issue completely. Given the additional beds we are adding to the system and the length of stay improvements our plans will deliver it is clear that the issue can be fully addressed without further significant bed number increases.

CONCLUSION/RESPONSE

Emergency department waits

We recognise the current challenges in the system and continue to work closely with other partners to understand waits in ED and put in place actions to address them, we are confident that the overall approach we are taking with the preferred option will increasingly address the necessary reduction in mental health patients waiting longer than 4 hours in emergency departments. We have amended the plans based on feedback and evidence gathered through improved data reporting on the A&E pathway. This increases our confidence that the proposal set out here would mitigate the small number of patients waiting in A&E for a bed. The plans we have put in place will provide substantially more additional capacity than would be required solely to eliminate patients waiting in Emergency Departments in KCW for too long because of a shortage of inpatient beds. It would be completely disproportionate to add substantial number of beds back into the system in order to address the issue of Emergency Department waits

We will also continue to work closely with our acute colleagues to ensure that the drivers for waits other than beds are being addressed through other areas of improvement.

Community waits

We recognise that the current community waits in HBPoS are not acceptable. However, we have a clear action plan to address these, and as with the ED waits above, we are confident that we are adding more than enough overall capacity to the system with our plans for additional beds and continued length of stay reductions to mitigate this issue effectively.

5.2.3 Patients being discharged too early

ISSUE RAISED IN FEEDBACK

Patients being discharged too early to relieve pressures on bed occupancy.

Feedback from some sources have suggested that staff are under pressure to discharge patients too early, and that some patients are being discharged are not yet ready to be supported in the community or find that the community services they need are not available on discharge.

DISCUSSION/EVIDENCE

Evidence linked to discharging patients too early

We have looked for any evidence to suggest we are discharging patients too early because of the reduction in beds.

The key indicator on this is whether patients later need re-admission within 30 days, as this could suggest that the initial stay had been too short to allow the necessary recovery. National

benchmarking covering the period 2022/3 suggests that our readmissions rates are relatively low at 7% for CNWL compared to a national average of 9%.

For KCW patients readmissions rates have fluctuated since 2019/20. The highest they have been is just above 9% and the lowest is just under 6%. For the most recent year those rates were 8.4% compared to the figure of 8.8% in 2019/20 (the year before the temporary closure of inpatient beds).

Has length of stay reduced?

The first point to make is that the relevant national policy guidance is that we should be aiming for an average length of 32 days[22], which is the target we have set ourselves. In other words, we should not assume that a reduction provides a poorer quality of service. Rather a reduction should mean patients are needing to spend less time in a restrictive environment and away from their daily living.

Overall average length of stay has not become shorter since 2019/20 for KCW patients. The average in 2019/20 was 34.5 days and it is now 35.6. However, we now have a much smaller proportion of informal admissions, and it would be expected that informal admissions would be shorter than admissions under the mental health act. The average length of stay for Sectioned patients has reduced from 43 days in 2019/20 38.8 days in 2023/24.

Clearly, we still have further to go in terms of delivering length of stay reductions in line with the national plan. Section 0 describes our plan to achieve this by focussing on patients clinically ready for discharge while still providing excellent quality care.

All admissions have a plan at the start to ensure the admission is meaningful and offers the individual the care they need. All discharges are planned for with the community mental health team and agreed by the ward consultant. The community mental health hub or home treatment team will then follow up with the person who has been discharged within 72 hours of discharge. Currently across CNWL 83.7% of people are followed up within 3 days, and 87.7% when discharged from St Charles. Both easily meet the national target of 80%. Amendments to the inpatient pathway to ensure people stay on the ward for the right amount of time include the following

- An improved therapeutic offer of care on the wards, by increasing the staffing, particularly to improve the multi-disciplinary offer by increasing therapies support for people who have been admitted. Based on the new Multi-Disciplinary Team model of staffing there would be an additional 23 staff on the inpatient wards to meet the new model of care.
- The role out of Trauma Informed Approaches[23] on the ward to embed recovery focused care that takes into account an individual's previous trauma and its impact on their current mental health needs.

[22] NHS Mental Health Implementation Plan 2019/20 – 2023/24 (england.nhs.uk)

[23] Trauma-Informed Approach and Trauma-Specific Interventions - MentalHealth.org

- The Community Access Service, which is made up of social workers and support workers to work to address potential barriers to discharge from the point of admission. These may include access to packages of care, addressing someone's housing needs so they are able to be discharged when they are clinically ready. The CAS teams also provide support to service users post discharge to ensure there is continuity of support into their community based care.
- Introduction of Step Down beds. Step down is community based bedded rehab provision which enables service users to remain in supported care beyond the point that they are clinically ready for discharge on the wards, but in a location that is open and enables reintegration in the community with intensive social and health care being offered.
- Significant increase in investment and change in the model of care in community mental health teams.
- In order to continue to improve the offer of care in the community, CNWL is currently piloting the use of Open Dialogue in community based teams in South Westminster[24]. Open Dialogue is a clinical approach which involves a service users' network and improves listening to what someone wants from their care. In other areas of the world where it has been rolled out there has been a significant reduction in the use of medication and admission to inpatient units.

CONCLUSION/RESPONSE

Having reviewed the We believe there is no evidence from the data suggesting we are discharging patients too early. Readmissions have remained at previous levels. There have been some length of stay reductions for patients under section, but this a positive development, and is explained by the service model improvements we have made since 2019/20.

5.2.4 Inpatients wards too busy to provide good quality of care

ISSUE RAISED IN FEEDBACK

Poor quality of care in the St Charles inpatient wards because of high occupancy levels and higher acuity of patients than in the past. A quote from Healthwatch report is "The thing in terms of threshold is that the acuity of people on the wards is so much higher than it was. The wards are becoming less safe. People are shouting, screaming, responding in this way because there's so few beds, these very, very distressed people are all crunched together in this environment."

DISCUSSION/EVIDENCE

It is important to recognise that inpatient wards can be challenging environments for both staff and service users and mental health Trusts need to work to make sure that these are as safe as

[24] Peer Informed Open Dialogue: Central and North West London NHS Foundation Trust (cnwl.nhs.uk)

they can be. This is also why the ambition is for admission to be a last resort as we know the environment can be retraumatising for patients.

The first point to make is that we always expected acuity on our wards would increase as a result of treating more people in the community. Inevitably, those people who can be cared for within the community rather than on wards are the lower acuity patients. This is why we used some of the savings (£500k) from the Gordon closure to significantly increase staffing levels and skill mix and wards, as we recognised that this was necessary.

Recognising that acuity on the wards fluctuates, CNWL has been collecting information against the Mental Health Optimal Staffing Tool (MHOST) since 2020[25]. This collection was developed by the Shelford group in partnership with Health Education England and sets out ideal staffing compliment based compares acuity on the wards to the staffing numbers to highlight where there are gaps in staffing to meet the needs of the service users on the wards. This enables the Trust to adjust safer staffing numbers for the actual acuity on the wards. The most recent full results show the wards on St Charles had 38% more WTE than required for the acuity on the wards at the time of the survey.

The evidence from the PCBC showed that any increased acuity has not resulted in poor performance on our key quality and safety metrics.

- The overall incidence of assaults and physical violence in mental health services in KCW settings reduced significantly between the year before the closure and 2022/3 and remained at a similar level through 2023/24.
- The number of reported serious incidents has stayed at a very low level (one or two patients a month in each borough in most months).
- Absences without leave have reduced overall.

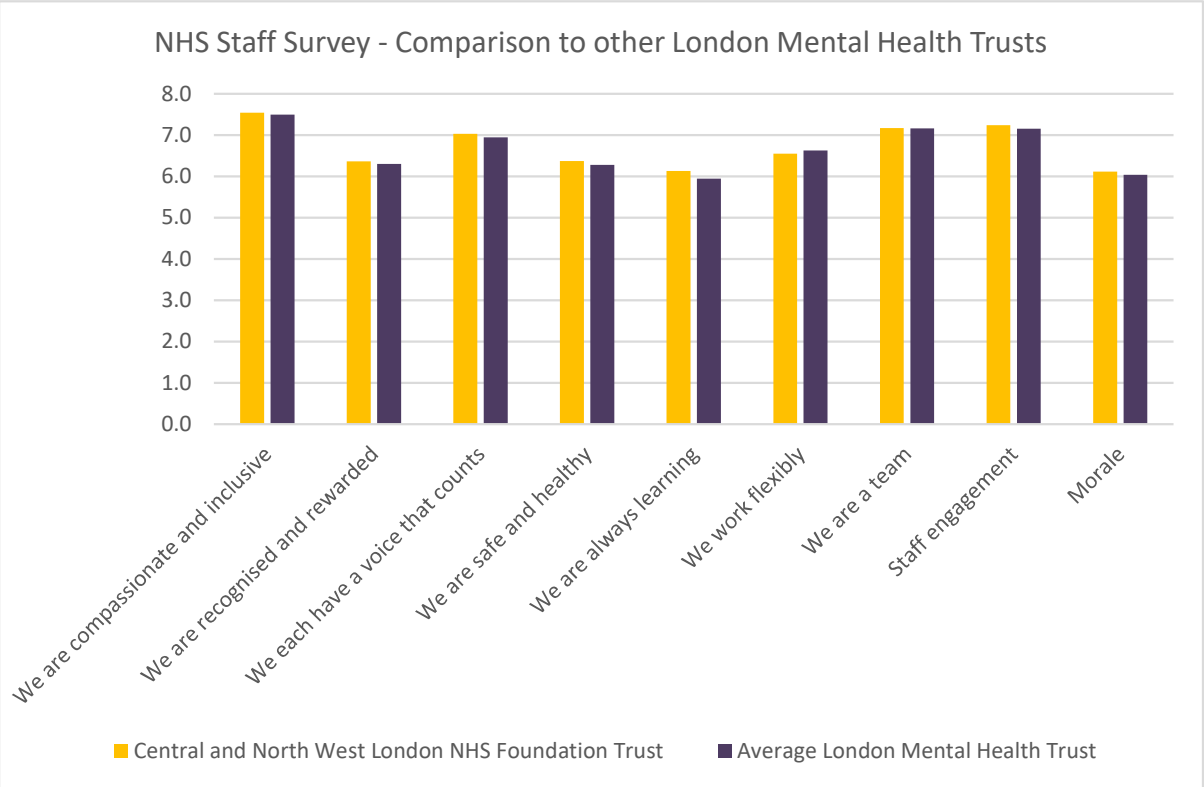
Bed occupancy on the wards at St Charles is high but has not increased since the temporary closure of the wards. The Trust has an ambition to reduce occupancy on the wards further, and the modelling carried out as part of the PCBC demonstrated potential to reduce the occupancy to 85%. This is set out in more detail in section 5.2.2.

CNWL staff all input annually to the NHS staff survey, the results below show that for all the sections CNWL scores between 60-80% on all the domains. Each year the Trust reviews the results and puts in place an action plan to improve wherever there is room for improvement.

We have compared our results to other mental health Trusts within London as shown in the figure below. This confirms that on key measures of staff satisfaction we are mostly doing slightly better than the average London Trust. This suggests that although the service model we have introduced has not overall led to reduced staff morale (as other London Trusts have not yet implemented the same model with such a substantial reduction in informal admissions).

[25] NHS safer staffing tool now available to mental health trusts - Shelford Group

Figure 21 : Relative performance in staff survey 2023



CONCLUSION/RESPONSE

We know that mental health services nationally are under pressure, and it is inevitable that this has puts staff under pressure too. We have no reason to believe that is any different in CNWL than in other Trusts.

We believe that the wards are staffed appropriately to meet the needs of patients. We have no reason to believe the new model has resulted worsening the overall work environment for our staff.