5.2.5 Community services not providing an appropriate alternative and there is not sufficient capacity in alternatives.

ISSUE RAISED IN FEEDBACK

Community services not being an appropriate alternative and are overloaded for those patients who in the past would have been admitted meaning that they are now provided with a lower quality of care. Many respondents are positive about community services, but they do not believe they can provide an acceptable alternative to the use of an inpatient bed. The implication from some of the feedback is that the proposal has underestimated how many people cannot have their needs met through services such as the Community Mental Health Hubs, MHCAS and other community based care.

DISCUSSION/EVIDENCE

It is important to have inpatient beds within the pathway of care for people with mental health needs, as there are some patients who will need an admission to inpatient care. As an NHS Trust, CNWL will always find a bed for someone where that is the most clinically appropriate route for care, and this will be as close to home and their local community as possible. However, there are many cases where someone will be better cared for by less restrictive services in their local community, where they can maintain the links with their networks.

Since the temporary closure of the inpatient wards at the Gordon, there have been a number of changes in the community and community-based crisis pathway in CNWL, and particularly in KCW to support the services in this area to move faster to meet the needs of people where there has been a reduction in inpatient care. This has included testing a number of different models and adapting when the new services have not been seen to be meeting people's needs. There is always a decision to make in the NHS about where investment should be directed, and we believe the pathway in place now is the best one to meet the needs of the most people in the most efficient and effective way.

We also know that mental health services everywhere are under pressure. We know that our community teams often feel overloaded. That is very common across the whole country and is a natural consequence of national under- investment in mental health, which we and the ICBs across the country are trying to address.

Community mental health hubs

Prior to the implementation of the Long Term Plan, community mental health teams were split into multiple separate teams requiring referrals between them and held a small number of people on caseloads for a long time – often for life. This made it more difficult for other people to access support from these teams and led to people being passed around between services to get different elements of care. The new Community Mental Health Hubs have been designed to make it easier to get into and to receive interventions based on need. This has meant that we have seen across KCW an increase in new service users accessing community mental health services since before the temporary closure of the wards and an over 60% decrease in waiting times to receive care in these teams.

The transformation grew the Community Mental Health Hubs by 35 additional whole time equivalent staff in KCW and added a number of partnerships with the VCSE to provide additional services that people can access to provide them the most appropriate care. Each staff member with a caseload supports around 20 people at a time meaning that the additional capacity in across KCW is around 700 people. This is much higher than the reduction of 220 in the number of people admitted in 2023/24 compared to 2019/20. In other words, we have provided more than sufficient additional capacity to handle the additional workload.

CNWL also benchmarks high in terms of the activity in our community teams compared to other providers and the Trust is the highest in London in terms of contacts per 100,000 people.

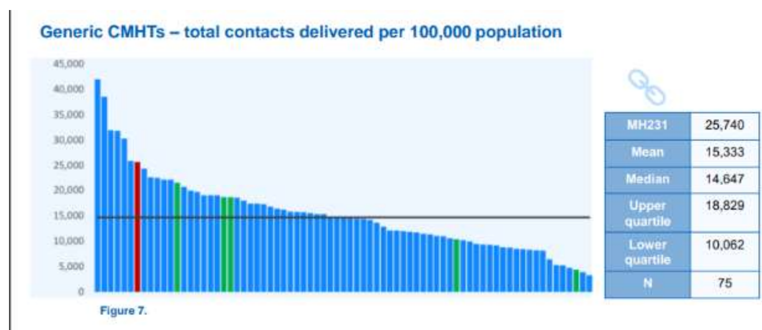


Figure 7.

CNWL are continuing to monitor patient and partner feedback on our community mental health hubs and adapting the model to meet people's needs.

Crisis services

The pathway of care for people in crisis has developed significantly since the temporary closure of the inpatient wards. Developments and changes include:

- The introduction of the Cove based in North Westminster. The Cove is a voluntary sector led service to support people who are in crisis who might otherwise have gone to A&E. The service is open access for everyone over 18 to attend when their mental health needs are escalating to access, social support and peer support. In 2023/24 the Cove in KCW provided care for 687 people.
- The Mental Health Crisis Assessment Service (MHCAS) opened in 2022 as a pilot over the winter period to support pressures in A&E. The service is a therapeutic alternative to A&E for people with mental health needs who do not have serious physical health needs. It also provides a safe and better location for people who would have been admitted as short stay patients for assessment.
- In order to provide more appropriate places for people to receive care when they have been sectioned by the Police, CNWL has expanded the number of rooms in the HBPoS suite at St Charles from 3 to 4. This ensures that people have a safe place to access care in a crisis rather than being taken to A&E.

NW London ICB has carried out an evaluation of the crisis lounge services across CNWL including the MHCAS - see Appendix 4. This demonstrated that the MHCAS service is delivering good care, and positive impact in pressures on acute services in A&E. It does show that the

capacity of the service has reduced due to the increased length of stay following the addition of beds to the service. The expansion set out in the preferred model will be important to improve the flow through this service.

Change in service use/capacity

Across all the transformed or newly opened services in KCW, there is capacity for an additional 1,200 people to be cared for in different community based teams compared to what we had in 2019/20. This is much higher than the reduction in admissions, there were 220 fewer admissions in 2023/24 than 2019/20. We fully accept that some of this increase in capacity is being used for patients with less acute illness; however, part of the reason for enhancing the capacity was to ensure we could fully meet the needs of the higher acuity patients.

It is important to recognise that virtually the only difference between the care that can be delivered within the community and that which can be delivered in a ward, is that the ward is restrictive and is run in a way to ensure patients cannot harm themselves or others. The Community Mental Health Hubs offer the full range of care that someone suffering from an acute mental illness may need.

The change in service access has followed the shift to more community based care, and while it is challenging to demonstrate that all the need is being met, some proxy measures have been considered to demonstrate whether community services have the capacity and capability to support people who would previously have been admitted.

- An increase in referrals to all community teams in both K&C and Westminster, and an increase in unique service users accessing community teams in Westminster. The unique service users accessing community teams in K&C has dropped slightly from the baseline amount
- There has been a reduction in admissions from both boroughs, particularly driven by a reduction in informal admissions where service users are able to be offered less restrictive care in community settings
- As described in section 5.2.1(a), the number of patients admitted under section has remained steady which suggests the people who would previously have been admitted informally are now being effectively cared for in the community and not escalating to the point of needing a formal admission.

Access to support in an emergency

CNWL is held to targets of meeting the needs of people referred with their needs set as urgent or very urgent, which should be seen within 24 or 4 hours respectively. Between August 2022 and July 2024

- 97% of very urgent referrals were seen within 4 hours
- 95% of urgent referrals were seen within 24 hours. It should be noted that since November 2023, performance has been consistently above this 95% average and was 98.8% in July 2024.

CONCLUSION/RESPONSE

We believe our community based services are fully equipped to the meet the needs of patients with acute mental illness, unless they have judged to have a high level of risk of harm to self or others. They can offer the full range of care needed, and within an environment that is far more conducive to effective recovery than a locked inpatient ward. We have substantially added to the capacity, increasing it by far more than would be needed just to handle those patients who would in the past have been within an inpatient unit. When people are in a crisis our community services are demonstrating they can provide an immediate response.

5.2.6 Location of inpatient services and impact on access

ISSUE RAISED IN FEEDBACK

Irrespective of views on the model of care and the number of inpatient beds, some organisations and individuals have fed back that they believe there should be a mental health acute inpatient site in both boroughs. This includes the view that a borough the size of Westminster ought to have its own inpatient unit. This has been a consistent theme during the development of the PCBC as well as in the public consultation. Responses noted the issues for visitors in having to travel further in terms of both time and cost. There has also been feedback that people should not have travel outside their own borough to receive inpatient care.

DISCUSSION/EVIDENCE

We fully support the aim to limit travel times to inpatient units particularly for families and friends who may want to visit several times during an inpatient admission. We know that moving from having one inpatient unit in each of the two boroughs to just one unit inevitably increases travel time and possibly costs for many patients and their visitors.

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 calculated in the IIA 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.
- ***Costs of travel.*** In terms of costs, the IIA says that the increase in travel costs for people travelling in a private car is minimal but the average increase in costs for those who have to take a taxi is £5.45 and the maximum increase is £27.

While our main measure of impact is appropriately based on actual patient travel time rather than administrative boundaries, we have also looked at the issue of the need for patients and their visitors to travel either out of KCW or out of Borough

It should also be noted that not all London boroughs have a mental health inpatient unit within their boundaries. Of the 32 boroughs in London, 9 do not have an inpatient facility in the borough; 5 of those 9 have a larger population than Westminster.

Figure 22 : Map of adult acute mental health inpatient units across London (pins note the borough not the exact location of the unit)

Travel out of KCW.

It has always been the case that (because there can be peaks and troughs in local demand) some patients have had to travel out of KCW to receive their care. Since 2023, we have been able to ensure they are always treated within CNWL hospitals, but sometimes they could need to go to Northwick Park, Hillingdon or Park Royal hospitals. In the year before the temporary closure we had, on average, 6 patients at any one time being treated outside KCW. In the years immediately after that increased significantly and has been at an average level of around 17 patients at any one time. Under our proposals this will reduce over time because

- The opening of an additional 7 beds in Brent will allow us to ensure fewer Brent and outer borough patients are occupying space at the St Charles.

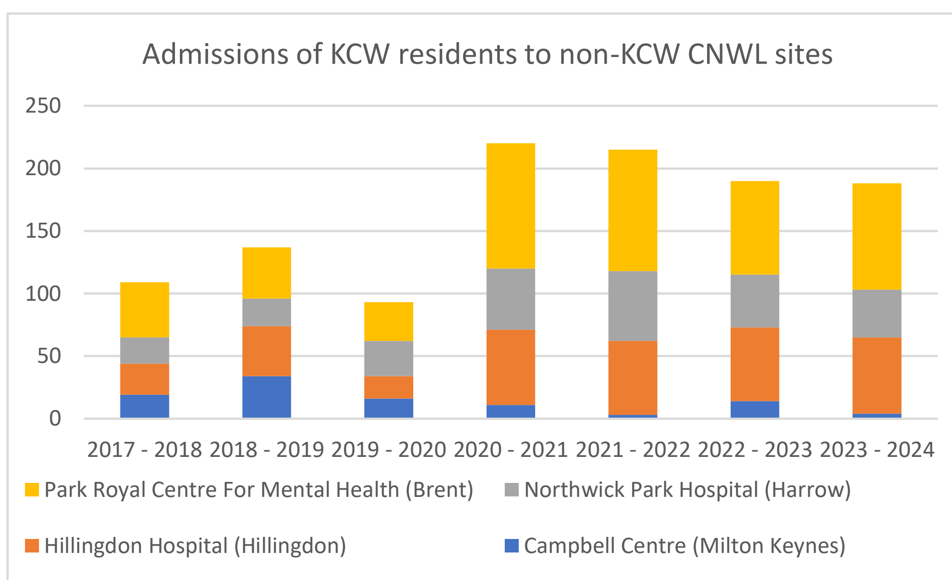
- Our work to reduced admissions and length of stay further (see Section 0) will lower our occupancy levels and increase capacity.

We have calculated that we will be able to move over the next few years to the position where the number of inpatients treated outside KCW will return to the levels it was at before the inpatient closure (more detail in Section 0)

Travel out of Borough

Our IIA has a detailed analysis on out of Borough travel. This analysis is summarised below in terms of admission. The key point to note is that since the sharp rise in 2020/21 the numbers have been decreasing each year, and the expectation is that this will reduce further with the new ward opening in Brent.

Figure 23 : Admissions out of Borough



Two sites in KCW?

We have always recognised that there is a trade-off between travel times/costs and other factors, and our option appraisal did consider a number of options which would have retained inpatient sites in each borough, one at the St Charles and one at the Gordon. In this specific case, the increase in travel time is not considered to be substantial.

Those options could not be recommended as a deliverable way forward because

- ***The current condition of the Gordon*** is not fit for purpose for high quality inpatient accommodation (see Section 5.2.7 for more detail). The ICB could not agree to a proposed way forward which did not deliver good quality facilities for inpatient care. The capital cost to address this was not affordable.

- The NHS has very limited capital available. Individual Trusts such as CNWL are highly constrained in capital terms and much of their capital funding has to be spent on essential building maintenance and information systems. As demonstrated in the PCBC if the Trust was to spend significantly more than £3m on restoring inpatient accommodation at the Gordon it would lead to significant and unacceptable risk to the quality of care on other sites and to the Trusts service development plans.
- The cheapest option that would allow inpatient care to return to the Gordon is £5m, which would allow a single standalone ward at the Gordon to be refurbished with 13 beds meeting most but not all quality standards. Standalone wards are not recommended as it is harder to provide a safe and good quality service as there is no on-site resilience in the event of a crisis. The 13 beds option was considered at the PCBC and performed very badly compared to other options.
- A 34 bed option at the Gordon was also considered for 34 beds to the same quality standard but also allowing two wards which performs much better in terms of providing a safe service. However, that option was clearly unaffordable in revenue terms as it added £3m per annum to revenue costs. This option was clearly demonstrated to be the worst value for money of all options considered at PCBC. The only way to obtain the capital at this level without prejudicing high priority capital development in NW London would be to apply for national capital funds. The process we would be required to follow is driven by HM Treasury "Green Book Guidance" and a comprehensive business case checklist. This guidance demands that the best value for money option should be chosen. It also requires that affordability be demonstrated. Based on the evidence of the PCBC option appraisal is not realistic that this option could be shown to be best value for money or to be affordable.

- ***Lack of alternative buildings in Westminster that could be used without significant capital costs for refurbishment.*** As part of the PCBC, we looked for possible locations in Westminster that could be more attractive than the Gordon as in an inpatient facility. We also asked Local Authority Colleagues if they were aware of possible sites. None could be identified. There were no alternatives raised as part of the public consultation.
- ***Any options involving new build would inevitably cost significantly more than refurbishing facilities at the Gordon.*** The increased capital costs level would be equally difficult to source, and the revenue consequences would mean savings were needed in core services which would directly impact on patient care.

CONCLUSION/RESPONSE

We understand the desire to have a unit in every borough, but as is the case with any form of specialist healthcare, the NHS has to consider whether providing services in every locality is feasible either clinically or financially. Given the limited financial resources available to the NHS and the priority we give to ensuring clinically safe and high quality services in fit for purpose facilities it is simply not feasible to deliver this in KCW.

We recognise this has a negative impact on access but the level of increases in average and maximum travel time is not viewed as substantial in terms of accessing a specialist service of this nature.

5.2.7 The Gordon hospital as an inpatient facility

ISSUE RAISED IN FEEDBACK

Suitability of the Gordon as an inpatient facility. One of the key reasons why the consultation did not recommend an option with the Gordon continuing as an inpatient facility was that physical constraints did not allow good access to high quality inpatient space. Some feedback has suggested that this issue is overstated, and that other factors where the Gordon is actually superior to St Charles are equally or more important. For example, Professor Jill Manthorpe's report for the two local borough councils places significant emphasis on the quality of neighbouring facilities to the Gordon suggesting that there are multiple transport and social options believed not to be available at St Charles and suggesting that the roof garden is an attraction of the hospital.

DISCUSSION/EVIDENCE

Mental health professionals believe the quality of inpatient facilities is of particular importance for inpatients with acute mental illness because of the length of time they have to stay (around 4 weeks), the necessarily restrictive nature of care for patients under section, and the paramount importance of patient and staff safety. We have assessed the ability of the facilities at the Gordon to meet the nationally defined standards for good quality facilities and the Gordon Hospital is a long way away from being able to meet them.

Key areas where there is failure to meet Health Technical Memoranda or Health Building Notes:

- HTM 03 – Heating and ventilation – not met. The building cannot be appropriately ventilated, and the building structure prevents upgrade.
- HTM 04 – Water systems – significant work required to make water systems safe.
- HTM 07 – Environment and sustainability – mostly compliant; some issues where it is easy for service users to throw waste out of windows to places that are not accessible to dispose appropriately.
- HBN 03-01 – Adult acute mental health units – not met. The windows have been identified as a significant ligature risk

Key areas falling short of RCPsych standards:

Tier 1 (essential):

- *17.14: Risk assessment of all ligature points, action plan and mitigations of risks.* Following recent review, windows are identified as significant ligature risk; anti-ligature windows will be challenging and costly to install because of building structure and design.
- *6.1.11: Patients have access to safe outdoor space every day.* There is no outside space except the roof garden. This does provide a basic level of access each day and is popular. However, it is extremely limited; only a few patients can use it at a time, and patients must always be escorted. Because patients can only visit on a set schedule, it cannot be used as a place for calming or de-escalation when required.
- *17.15: Patients are cared for in the least restrictive environment possibly, while ensuring appropriate levels of safety.* There are extremely difficult security issues within the building, which will be technically difficult to overcome. In the past there have been serious incidents where patients have absconded.
- *17.10: The environment complies with current legislation on disabled access*. There are issues of DDA compliance; for example, many of the doors do not have the required opening, and none of the bedrooms meet the required size. There is only one bathroom on each ward suitable for disabled access.

Tier 2: (expected):

- *17.17 Staff and patients can control heating, ventilation and light on the ward / unit.* Neither staff nor patients can control the site heating settings – maintenance staff need to attend.
- *17.5: The ward / unit has at least one bathroom / shower room for every three patients.* There is currently only one for every five patients. The Trust's view is that all patients should have rooms with their own ensuite facilities (as recommended for Tier 3 below).
- *17.21: The ward / unit has at least one quiet room or de-escalation space other than patient bedrooms*. There is no seclusion suite on any of the wards, nor is there a de-escalation space on any of the wards.

Tier 3: (desirable):

- *17.6: Every patient to have an ensuite bathroom*. There are no ensuite facilities in the bedrooms, and the infrastructure will not allow provision without significant cost and a reduction in the number of bedrooms on each floor to about 12 – 13.

It should be noted that most of these issues could be resolved with sufficient capital expenditure but as described in Section 5.2.6, we do not see any prospect of being able to fund the capital required to do so. The main issue which could not be solved, even with an unlimited capital budget, is the provision of safe access to outdoor space every day or additional bathrooms without reducing bed numbers.

It should also be noted that in contrast to the Gordon, the current St Charles Hospital facilities meet all of the above standards except in relation to the desirable standard of every patient having an ensuite bathroom (while a majority of the rooms meet the standard in a small number of cases two rooms share one bathroom).

While we fully accept the point that the Gordon is well placed in terms of travel and social facilities the same is true of St Charles which is easily accessible by tube, overground and a number of buses. It's also a short walk from Portobello Road which gives good access to food options for staff and service users when they are admitted informally or on leave.

CONCLUSION/RESPONSE

Options have been considered around the potential to refurbish the ward to meet more of the required standards for inpatient facilities. We believe it would be inappropriate to reopen the Gordon inpatient wards without substantial investment to address the current problems with the hospital facility described above. Given the need to prioritise scarce NHS capital funds we do not believe we could justify substantial capital expenditure to do this at a time we already have a fit for purpose facility at St Charles which addresses all but one of the standards comprehensively and which we believe provides the capacity we need.

5.2.8 Restoring inpatient beds and retaining enhanced community provision

ISSUE RAISED IN FEEDBACK

The preferred option should include restoring inpatient beds numbers without reductions in community based services.

Several respondents, including our major council stakeholders, have consistently argued that the NHS should both restore significant numbers of inpatient beds and retain all the community provision which has been put in place since the temporary closure.

It should also be noted that the Mayor's independent report on the first 4 of the London Mayor's six tests suggested that it was not obvious that there had to be a trade-off between having either additional beds or additional community services, because the system had shown it had funding for some extra beds in Brent, and had not reduced community services to enable it.

DISCUSSION/EVIDENCE

It is not an option to invest substantially in restoring inpatient beds while also retaining the investments we have made in enhancing community provision. If the NHS had unlimited funding, we could of course make choices of this nature. However, the ICB has a duty to live within its financial means and make best use of the limited capital and revenue resources it has available. Restoring inpatient beds would require significant amounts of both capital and revenue to be allocated.

- ***Capital availability***. As noted in section 5.2.7 above, it would not be possible put inpatient services back in the Gordon without substantial investment to address the numerous quality and safety problems identified; nor are there other options for increasing inpatient beds in KCW which would not require investment of at least this level and probably far more. The ICB Mental Health Strategy shows that across the ICB we have the right number of beds overall. In this context is inconceivable that approval would be given to commit very scare capital resources to delivering additional beds as it would effectively be spent on over-capacity.
- ***Revenue funding.*** Inpatient bed provision is very expensive to staff as it requires 24/7 care. Providing therapeutic and other support needed for people with serious mental illness is much more cost effective when provided within the community.
  - ~ While the ICB is fully committed to increasing funding for mental health services, it still has to make choices within a limited overall budget. Additional monies provided by the government for mental health has been prioritised for community provision. If we chose to reinvest in mental health inpatient services our budgets would not be increased, and we would have no choice but to make savings elsewhere. Such savings would directly impact on patient service provision. The PCBC provides significant detail on the financial impact of different configurations with a large number of inpatient beds, and on the extra investment made in community based provision.
  - ~ In these circumstances, if we substantially add to inpatient provision our only option would be to take back the funds we used to enhance community services so that those beds were not needed. Otherwise, we would have to reduce other mental health services or take money away from overstretched GP practices o busy acute hospitals. More detail can

This does not mean some new funds cannot be found each year. There are sources of funding such as the Mental Health Investment fund, and efficiency savings. However, these sources are too small to allow for the very substantial increases required to increase bed numbers if there are no other funding sources.

It is true that we have been able to provide some additional inpatient beds in Brent, but the circumstances were different:

- It was a much smaller number of beds than the 51 at the Gordon, which would be an addition to an existing site with other inpatient beds. We included an option of 13 beds at the Gordon in the consultation; it would have resulted in an isolate small ward, which would have cost much more to ensure safe staffing.
- The capital funding required (£2.1) lower than would be required for returning beds to the Gordon because an existing facility that could be refurbished/extended was available, and because of the specific nature of the Gordon building.

- As set out in the PCBC nearly a third of the revenue funding was provided using £800k of the savings from temporarily closing the Gordon inpatient wards. It was agreed for this purpose because it would contribute to freeing up space currently occupied by Brent/outer borough residents at the St Charles for KCW patients. It was also anticipated that the result would be to lower expenditure on expensive private providers. The problem of revenue funding was therefore substantially mitigated in a way which would not be possible for additional beds in KCW.
- The net additional revenue (£2.2m) has been requested as part of the mental health investment standard uplift in 2023/24. This is possible as it is a third of the amount that would be required to reopen the 3 wards at the Gordon.

More detail can be found on the limitations of both capital and revenue funding in the North West London Medium Term Financial Strategy 2023 (See Appendix 16).

CONCLUSION/RESPONSE

We understand why some of our stakeholders believe we should retain inpatient services at the level they were at before the temporary closure, and also that they the value the new community services. However, there has been no feedback or evidence suggesting how this could be done within the resources we have available. The reality of our position is that there is a trade-off. If we put our money back into inpatient beds we would have to take away from other services.

Similarly, we understand the desire for the Gordon to be retained as a high quality inpatient hospital, but we have received no feedback or evidence, as to how we could afford the capital funding required without cutting back on other higher priority schemes

5.3 Homelessness

There is considerable feedback on the subject of whether the proposed model can meet the needs of homeless people with acute mental illness.

Key points are that:

- Westminster has the highest rate of rough sleepers in the country and overall, a significantly higher level of homelessness than the country as a whole. Homeless people have a much higher rate of acute mental illness than the general population and so greater consideration needs to be given to their needs in the proposed model.
- Admissions to the service of homeless people have dropped significantly since the Gordon closure. The experience of voluntary organisations and GPs is that it is very difficult to get a homeless person admitted (with the implication being that these are people who cannot have their needs met in the community)

- Community based services are not geared up to support homelessness and so cannot offer an effective alternative to an inpatient bed.
- There is a requirement for more step down beds for the homeless.
- People experiencing homeless may require longer inpatient stays than others either because their issues are exacerbated by homelessness, or because they will not be able to access community provision if they are discharged back onto the streets

This quotation in the Healthwatch report covers many of the issues raised. "The trouble with homelessness is that no community mental health team will get involved. It's difficult to assess risks or organise mental health assessments and then in hospitals, the bed pressures mean that admissions aren't very long, and I think our clients always require slightly longer admissions. There are always more problems associated with homelessness that aren't immediately treated. So, the added bed pressure from the Gordon closing is one of the main things that we've seen affecting the success of mental health care and treatment and subsequent housing of the clients we work with. I think from our point of view, there is a disproportionate effect on homeless clients."

In the development of the decision making business case a Task and Finish group was convened with the stakeholders who had fed back through the consultation to design mitigations for the consultation. This group included representatives from

- Dr Hickey Surgery
- Great Chapel Street
- Church army
- EASL (Enabling Assessment Service)
- Groundswell
- The Passage
- Westminster Homelessness Partnership
- Turning Point
- Westminster City Council
- St Mungo's
- Look Ahead
- CNWL
- NWL ICB

The group met to review the current pathway, potential impacts from the temporary changes and agree improvements for the pathway. Their discussions inform the sections below.

5.3.1 Key information on homeless people's access to and use of services

ISSUE RAISED IN FEEDBACK

The model needs to take more account of the needs of the homeless and more information is needed on how they will be affected by the changes.

"GPs, psychiatrists, social workers, mental health leads and advocates working with the rough sleeping community in Westminster… invariably described how the closure of the Gordon Hospital acute mental health services is linked to increased acuity of mental health needs among the rough sleeping population in the borough."

DISCUSSION/EVIDENCE

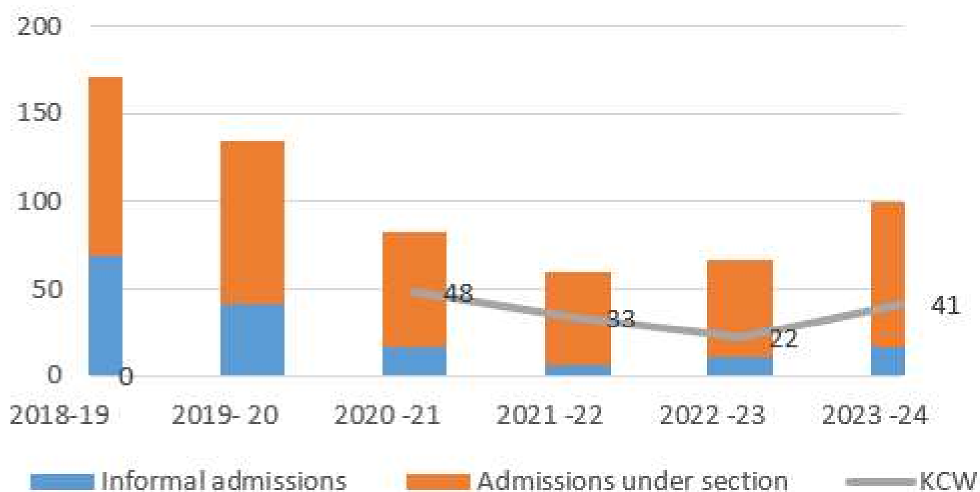
Reviewing the data on people who are homeless or rough sleeping in Westminster and K&C has shown that:

- In Westminster, the number of people assessed as needing duty for homeless status has increased in the last two years having dropped during the pandemic. The same is not true for K&C where the numbers remain lower than they were before the pandemic.
- The number of rough sleepers in both boroughs dropped during the pandemic and have not risen to the level they were before the pandemic.

Admissions

The chart below shows how inpatient admissions within CNWL have changed over time. Unfortunately, our data over this time period does not allow us to break this down by borough until 2020/21 which was after the Gordon wards closed. The grey line in the chart shows the KCW specific admissions from 2020/21.

Figure 24 : Homeless admissions (KCW shown since 2021/2)



- There has been a reduction in admissions for people with no fixed abode which is in line with the reduction in all admissions. This has gone from 134 admissions in 2019/20 (92 under section and 42 informal) to 110 in 2023/24 (84 under section and 16 informal). It can be seen that as with the population as a whole the most significant reduction is in informal admissions. It should be noted that the reduction started during 2019/20 – i.e. before the inpatient wards at the Gordon closed.
- We can make a rough estimate that the KCW total admissions in 2019/20 are likely to have been within 40% and 60% of the total. In the following years that breakdown fluctuated significantly but was always in this range. That would mean that KCW homeless admissions in 2019/20 were between 53 and 80 people. Assuming a similar ratio for the population as a whole the informal admissions would have been around 30% of the total and so would have been between 16 and 25 people

Beds occupied and length of stay.

The total bed usage of patients identified as homeless in CNWL in 2019/20 was 7.8 beds (at 100% occupancy). On the same basis as set out above for admissions this suggests that in 2019/20 KCW patients were probably occupying between 3 and 5 beds at any one time. Of these between 2 and 3 would have been under section and between 1 and 2 informal admissions.

If we consider the most recent year (2023/4) homeless people were occupying a total of 3.8 beds in CNWL with 3.2 of the beds being the average at any one time for beds occupied by people on section, and 0.6 by people who were informal admission. 40% of these admissions were from KCW patients so they probably accounted for around 1 to 2 beds in total.

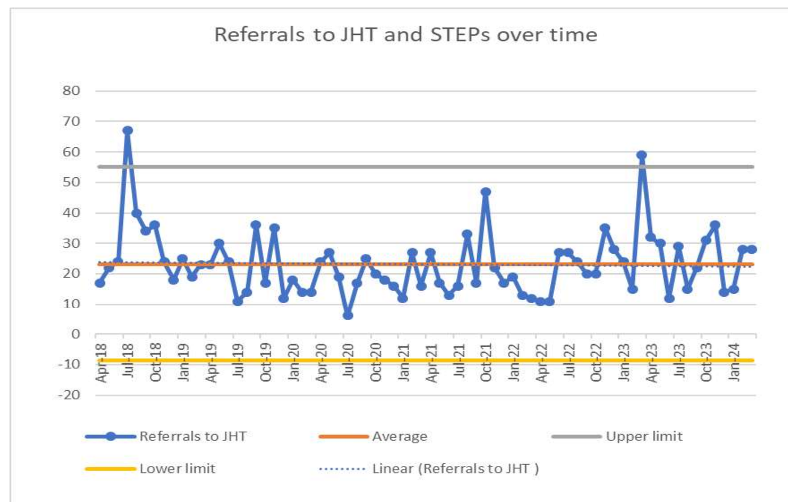
In terms of the overall reduction in bed usage in KCW this suggests that we have moved from 5-7 beds in 2018-19 for KCW homeless patients to 3-5 beds 2019/20 in the year before the closure, to 1-2 now. If demand in 2023/4 was broadly similar to the earlier years that would mean we are now supporting 4-5 more people every day within the community rather than in an inpatient bed.

The reduction in length of stay for this population broadly reflects the reduction in length of stay overall and has gone from 42 days to 30 days. The highest proportion of people are staying between 7 and 30 days.

Service provision in the community

Referrals to the Joint Homelessness Team (JHT) have remained at around the same level through the whole period with some fluctuation, the chart below shows community referrals to both the JHT and STEPs (Statutory Team Enabling Pathways) team over time.

Figure 25 : ***Referral to specialist homeless teams in the community***



We are not aware of any data that shows the acuity of mental health needs has changed for this group.

<u>Locations for care provision in the community</u>

We have been unable to access good information to show where patients registered as homeless who would have been admitted in the past are being accommodated, and whether this is a suitable environment for their care. We recognise the feedback that some homeless people may not be able to benefit from the care offered in the community because of the living situation. We do know that our step down provision is available to them (as to all our patients) as an option if they no longer need restrictive care under section but are not yet ready to be supported in the community. We aim to never discharge people directly to rough sleeping and they may be supported in Step Down where the average length of stay is 35 days, or in bed and breakfast for the time that they are receiving care from Home Treatment Team which will vary. Over 50% of people who are admitted to Step Down beds are admitted there while waiting for accommodation, either mainstream housing or supported housing. We also know that the JHT and the STEP team are working hard to ensure that they have somewhere to live that is appropriate while they are receiving treatment and care needed for recovery from a mental health crisis.

CONCLUSION/RESPONSE

We know that there is a large homeless and rough sleeping population in Westminster, and there has been a change in profile of service use. Therefore, we have worked with stakeholders across the system to consider whether those changes we can identify are causing any adverse impacts and, if so, what we can do to mitigate them. We recognise we need to do more to understand the issue so we can fully mitigate it, and we are proposing a mitigation to address this.

5.3.2 It is too hard for homeless people to be admitted when they need it

ISSUE RAISED IN FEEDBACK

Groups working with the homeless have said that it is very difficult to get homeless people who need hospital admission into an inpatient bed.

"The consequences of the lost beds in the Gordon Hospital … have rendered CNWL inpatient beds almost completely inaccessible to our highly vulnerable homeless population."

"The greatest harm and lack of dignity comes from allowing acutely psychotic people to be homeless, unwell and on the streets of Westminster. Community staff are desperately trying to get the person the help they need but lack of inpatient bed spaces and wait times for Mental Health Act Assessments lead to high levels of distress and knock on economic effects across the public sector (A&E attendances, crime, housing issues, care needs etc)."

"Sometimes the only way an individual's (who is sleeping rough) physical and mental health conditions are treated is through forced detainment either in hospital or prison. Community care is just not an option for people in this situation."

DISCUSSION/EVIDENCE

As set out in section 5.3.1 there has been a reduced number of admissions of people who are homeless or rough sleeping.

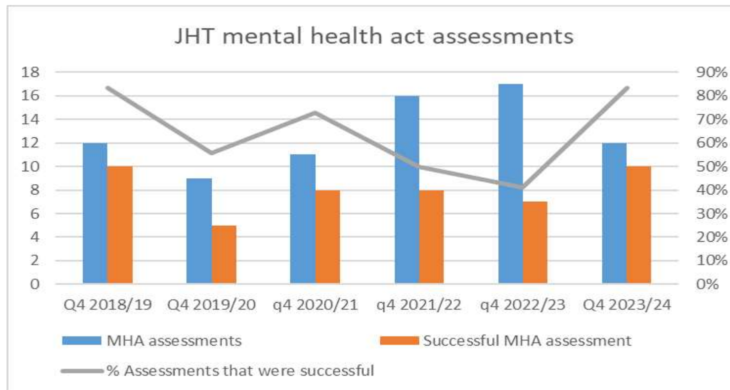
A key point we need to make from the start is that "forced detainment" as described in the feedback quote above would be illegal unless the person was at risk to themselves or others.

Even before the temporary closure the majority of people in inpatient care were admitted under section, and this was true for the homeless population as well. There has been a relatively small decrease in the number of homeless people admitted under section since 2019/20 – the year before the closure (from 92 to 84) over the whole year. Every admission under section is based on careful consideration by the relevant clinical team about the specific risks in relation to the individual concerned and we have no way of using the data to explain if the reduction is simply normal fluctuation in a small number of patients or is because we are now better able to safely risks in the community, or because of shortage of beds. The best proxy measure we can find is the success rate for Joint Homeless Team mental health act assessments. The team reports on the number of these assessments that have been successful, which means they have completed and ended in the appropriate outcome. An unsuccessful assessment might mean that the patient had absconded or had to wait too long (for example because a bed was unavailable).

The chart below shows the proportion of mental health act assessments from JHT that were successful in Q4 of each year from 2018/19 to 2023/24. The number and proportion of successful assessments dropped over 2019/20 and 2022/23, but in the last year was back to the level from before closure of the Gordon wards. So, while there have been some challenges

in the time since the wards have been temporarily closed, it appears that the position has improved.

Figure 26 : JHT MHA Assessments (success % on right hand axis)



This suggests that the service changes have not impacted on our ability to admit homeless people under Section.

We do not have evidence in either direction in relation to informal admissions. In particular, it is very hard to show directly whether the people who would in the past have been admitted informally are able to receive the same or better quality of support within the community as they would have had from the inpatient service.

We believe that people within temporary accommodation can be appropriately supported through the main Community Mental Health Hubs, and that, just as we have argued for the general population, they are better off receiving that care in the community than in a restrictive inpatient ward.

The area where we recognise work is required is with rough sleepers who in the past might have been admitted an informal admission. We do have specialist services for rough sleeper. For example, the JHT was specifically set up to assist in the delivery of mental healthcare to rough sleepers and the STEP team, set up in 2023, also offers support for people who have had at least two failed referrals to other services (indicating that they are not getting the support they need.) However, we do not yet have data to assess as whether the services those teams can provide are sufficient to outweigh the problems caused by rough sleeping for mental health recovery.

CONCLUSION/RESPONSE

By the nature of the issues raised it is always difficult to get good data on how well services for the homeless are working to meet their needs.

We believe we can continue to be confident that where people are at risk to themselves or others, they are able to be admitted as a sectioned patient.

Taking account of stakeholder feedback in this area we recognise there is a need to do further work on the question of whether homeless people who would in the past have been admitted as informal patients are now getting the same or better quality of service and outcomes as they would have in the past. The data in Section � above suggests this could be a maximum of

4 to 5 people at any time. Some of these people would have been discharged to temporary accommodation, but some may have gone back to rough sleeping. We do not believe the solution is likely to be to have more locked inpatient beds, but there may need to be additional support of some kind for a relatively small number of patients. This support could be in provision of appropriate accommodation to support them for a few weeks while recovering from their mental health crisis. Our proposed way forward includes clear actions to ensure that the homeless population receive the care they need (see Section 6.2.3)

5.3.3 Homeless people are being discharged too early from hospital

ISSUE RAISED IN FEEDBACK

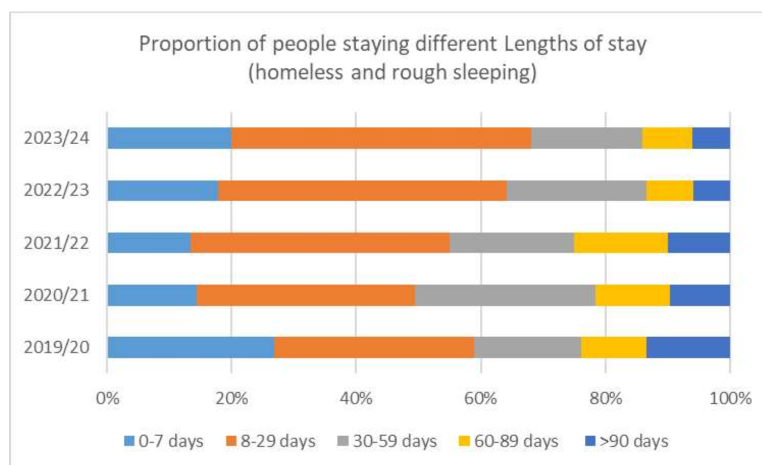
Patients are being discharged too early without appropriate care being available elsewhere

Feedback suggests that there is pressure on staff to discharge patients who are homeless too quickly, and before the inpatient stay has achieved the necessary improvement in health. Given the challenge of meeting needs of recently discharged inpatients who are homeless, more step down provision is needed. The HealthWatch report quotes a response that "We don't have that many homeless mental health supported housing, and the threshold to get into that is extremely high. I think we need more investment in mental health supported housing and rehab placements."

"The problems (of people rough sleeping) are minimised, and they are often then discharged with a one-week stay in a hotel, after which they can get much worse… "

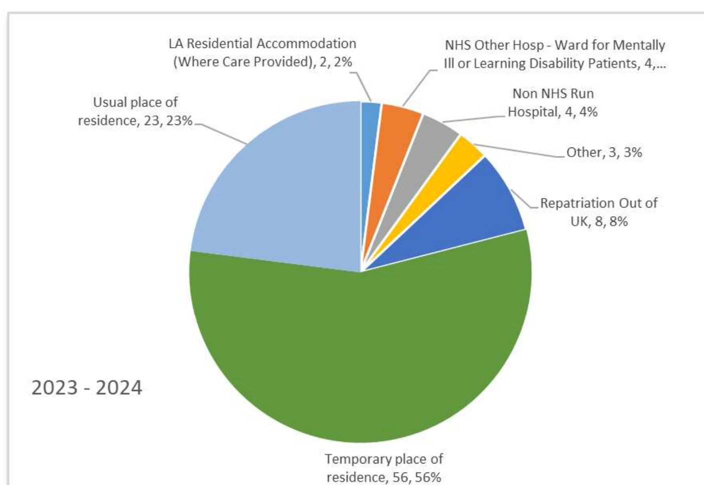
DISCUSSION/EVIDENCE

The average length of stay for those admitted with no fixed abode has reduced from 42 in 2019/20 to 30 days in 2023/24. This is a larger reduction than the general population, but when broken down into the proportion staying in an admission for different lengths, the main reduction has been in those staying longer than 60 days, and a smaller proportion are now admitted for less than 7 days. The majority of people are still staying on the wards between 8 and 29 days which is similar to the rest of the Trust admissions.



People who are homeless and admitted have the same processes followed to support discharge as set out in section 5.2.3. However, due to the requirement for follow up care, the wards at CNWL aim not to discharge people to the streets and will provide a bed in Step Down, a space in a Bed and Breakfast or support to access housing from the Local Authority.

The wards report discharge destination for patients when they are discharged. There are some data quality issues with this metric as "usual place of residence" is used as a proxy in many cases. However, is shows that 59% of discharges for people who are homeless or rough sleeping were to either a temporary place of residence or local authority provided accommodation.



In order to ensure that patients who are admitted receive the care that they need and are appropriately supported at discharge, stakeholders have agreed that

- Training should be offered to improve the understanding of mental health services in the specialist needs of this population
- Involvement of the 'professional family' of these patients should be prioritised when they are admitted ensuring their full care needs are met
- Options should be explored to develop an in-reach team who are specialist in care for this population to support the wards when someone who is homeless or rough sleeping has been admitted.

CONCLUSION/RESPONSE

We believe it is important that people are not forced to stay longer in restrictive inpatient care than is necessary. Equally we are working hard to ensure that when people are discharged, they are going to accommodation suitable for their continuing support.

As with our conclusion in the section above we recognise there is a need for further research on how well services are meeting the needs of the homeless after their discharge, and there may be a need to take action to improve this. We do not believe the solution is to keep patients in locked wards for longer.

5.3.4 Community based services ability to support the homeless

ISSUE RAISED IN FEEDBACK

The ability of community based services to meet the needs of the homeless

Feedback within the consultation suggested that some community services are not willing to get involved with homeless and that homeless people cannot access mainstream services. This included comments that it was difficult for homeless people to gain support through the MHCAS.

DISCUSSION/EVIDENCE

Issues with how community services can best support homeless people were at the heart of the work of the task and finish group described above in the introduction to section 5.3. Issues discussed have included:

- The challenge of accessing services and attending appointments - the need for letters or phone calls to confirm appointments
- Limited support for comorbidities with drug and/or alcohol use that can be common in this population
- Greater likelihood of reaching crisis point before they engage with services
- Additional trauma through experiencing crisis on the streets
- The need for respite from chaotic lives and to have some stability and safety to enable recovery – challenging to provide community support when someone's living situation is psychologically unsafe
- The need for a holistic service providing rest, nourishment and access other health and care support.

The discussions demonstrated that the current pathway for people who are homeless can be complicated and feel like all doors are the wrong door. We do not have evidence that these problems are caused by the lack of inpatient beds. Rather they reflect the need for stronger joint working, and potentially for some focussed changes to community based service provision to address the very complex needs of rough sleepers.

There have been a number of changes to the pathway discussed to support this population, but these are not necessarily directly related to the consultation. Therefore, the implementation of these processes will be considered more through the work of the BiBorough in the development of the Integrated Neighbourhood Team, including CNWL. INTs are being developed across England following the Fuller Stocktake of Primary Care[26].

[26] Microsoft Word - FINAL 003 250522 - Fuller report [46].docx (england.nhs.uk)

Homelessness is a key focus for the development of the Westminster Integrated Neighbourhood Team and providing more joined up care and support for this population will be taken forward as a priority.

There are specialist parts of community mental health services to support this population. In K&C there is a RAMHP (Rough Sleeping and Mental Health Programme) worker to provide outreach to rough sleepers who need mental health support. In Westminster the Joint Homelessness Team and STEP service support rough sleepers with their mental health needs.

The excellent work of both of these teams has been acknowledged but it was felt by the task and finish group there was more than could be done by mainstream services to provide support. A particular area that was agreed to be explored is a pilot of joint care planning across all organisations that someone is working with to provide one care plan covering all of someone's needs and knowledge across organisations of who can support a service user.

It was also agreed to improve the care for this group there would be more mental health input into a borough wide escalation meeting attended by those working with people who are homeless or rough sleeping to discuss complex cases and input into joint care.

CONCLUSION/RESPONSE

The work of the task and finish group has shown that there are significant improvements which can be made in how we provide care within the community to people experiencing homelessness with acute mental illness. The solutions are wide ranging and require joint working which we believe will be best delivered through the new Integrated Neighbourhood Team for who homeless have been identified as a priority. Given the importance of ensuring we are doing the best we can for this vulnerable group the recommendations for implementation of the preferred way forward includes further work to monitor progress in achieving better outcomes for the homeless in the future.

5.3.5 Loss of the expertise and capability of working with the homeless that was a feature of the Gordon hospital

ISSUE RAISED IN FEEDBACK ***Expertise in meeting the needs of homeless people*** There is feedback that staff at the Gordon had a strong expertise in working with homeless people and a sympathy for them which allowed them to provide a responsive and effective service. The feedback suggested that this expertise and approach were not shared by staff at the St Charles.
DISCUSSION/EVIDENCE The Gordon hospital was not a specialist service for people who are homeless or rough sleeping, but due to the high numbers of this population, it was likely that expertise built over time. Staff have been redeployed across the Trust, but may not all be based in the other wards. It is important to work with the other wards to build knowledge and understanding of the needs of this population, as well as building relationships with the organisations who are working with them.
CONCLUSION/RESPONSE We fully recognise that staff at the Gordon had developed a strong expertise in working with homeless people. We believe our key emphasis now needs to be in ensuring expertise through all our community based services in meeting the needs of this vulnerable group.

5.4 Impact on other vulnerable groups and inequalities

Feedback points included:

- The need to do more to consider the impact on inequalities and to address structural racism.
- The need to consider the impact on autistic people and people with a learning disability

5.4.1 Inequalities and structural racism

ISSUE RAISED IN FEEDBACK

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

Both the JHOSC and the Mayor's Office suggested we needed to provide more information on the impact of the proposals on inequalities. (See Sections 7.4.1 and 7.2.2 for the detailed points they raised).

DISCUSSION/EVIDENCE

The IIA document supporting the PCBC includes substantial analysis related to inequalities impacts particularly considering those groups making disproportionate use of the service. We have updated the document further with the benefit of the consultation feedback (The IIA Appendix sets out the assessments of relevant groups to include.)

The analysis included consideration of the impact of the service change on

- Vulnerable geographies (vulnerable geographies are defined as an index of deprivation, ethnicity and poor health outcomes)
- The Black population (and independently black males and females, and specifically young black men)
- As far as the data allows it considers the impact on neuro-diverse and homeless population. We have used the Learning Disabilities and Autism population as the best proxy for the neuro-diverse population, but the data is limited. We have examined the number of admissions for the homeless population in St. Charles and the Gordon, although this is a limited view because by definition the homeless population known to NW London acute mental health services may be admitted to other hospitals due to their transient nature.

We have considered the impact analysis with input from a facilitated workshop of key stakeholders. The workshop included over 70 stakeholders including

- CNWL staff
- Service user and carer reps
- Voluntary sector organisations including
- KCSC
- One Westminster
- Hestia
- The Passage
- Turning Point
- Westminster Council

- RBKC Council
- The Police

Our aim has been to focus on the population directly affected by the proposals. In terms of KCW this means a population of around 800 patients per annum (i.e. the number of people who were admitted as inpatients in the year prior to the temporary changes). This is a small population to work with when considering the impacts on very specific groups and communities, and we recognise that for some kinds of analysis the low level of numbers means that we cannot be assured any year on year changes are statistically significant.

That said, by focussing on less restrictive, more community based provision 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 carried out in Central and North West London by Buckinghamshire New University which showed the negative perceptions of many black users of the inpatient care they had received and the inpatient environment. Minimising unnecessary admissions to those restrictive settings is positive step towards addressing experienced inequalities.

Drawing on the discussions at the workshop and on our assessment of the IIA's finding we have identified a number of key areas requiring mitigating action. They are detailed in Section 6.4.5. The headline areas where we believe mitigation actions are a priority are:

- The additional travel time for patients and their visitors from the area of South Pimlico for service users who need an admission
- The potential impact on carers for people who need an admission, particularly those from South Westminster
- The potential impact of service change for the residents of North Kensington, including the Grenfell bereaved and survivors.
- Mitigations for the Black population
- Mitigations for the homeless

In addition to these specific areas which are the ones most relevant to the service change under consideration both the ICB and the Trust are committed to working to address inequalities and structural racism in service provision. We provide significant detail on the approach and detailed plans for this in section 6.2.5.

CONCLUSION/RESPONSE

The IIA accompanying this DMBC provides a comprehensive analysis of equalities issues. This DMBC describes our approach for working within services and with system partners to address the major inequalities in mental health.

We believe that our work since the PCBC has fully addressed the points raised by both the JOSC and the Mayor's Office.

5.4.2 Impact on people with a learning disability and/or autism/other special needs/groups

ISSUE RAISED IN FEEDBACK

Insufficient assessment of the impact of proposals on these groups

Some feedback including from the Mayor's Office and the JHOSC has suggested we needed to provide more information on provision for specific groups within the inpatient service.

For example, the Mayor's Office Report says, "it is not made clear how the future bed base will be broken down in terms of secure levels, gender-specific accommodation, or environments suitable for those with a learning disability or autism, so there is a risk that future provision may not be appropriate to the specific shape of future demand."

There has also been a general suggestion that we needed more information on the impacts on people with a learning disability and autism.

DISCUSSION/EVIDENCE

A bed base appropriate for the different groups of patients

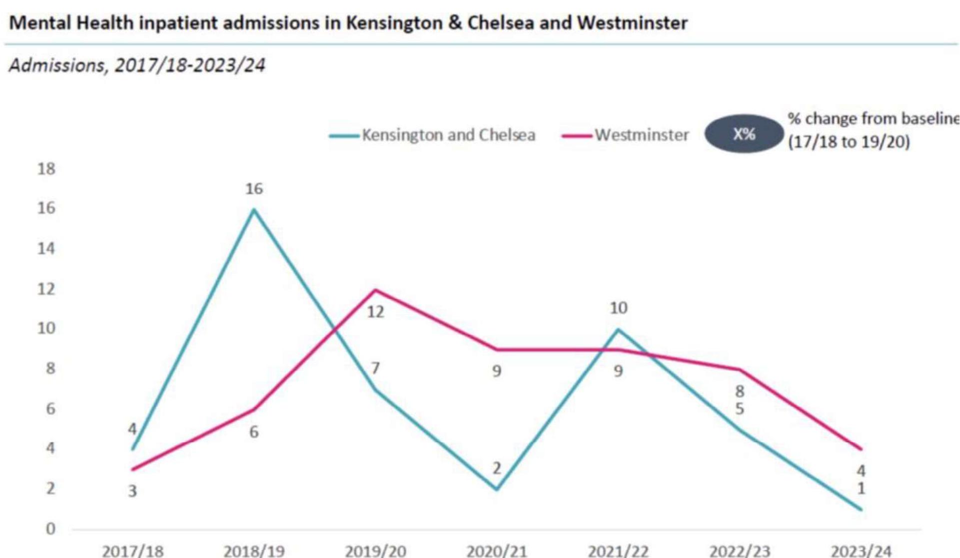
The beds included in the scope of the consultation are only for adult mental health patients of working age and as such do not include wards with higher levels of security, Psychiatric Intensive care units (PICU), wards with higher levels of security, or assessment and treatment units for people with a learning disability. This means that the risk identified by the Mayor's Office that the future provision might not match the needs of patients requiring more secure services or specific services for people with a learning disability does not apply. All specialist provision for people with a learning disability with higher level needs is provided through the separate assessment and treatment units and not through services we are consulting on.

It is also not the case that the service risks being out of balance in terms of the need to support male and female patients. The 4 acute wards at St Charles are all mixed gender (with appropriate single rooms and ensuite bathrooms and areas that are designated for one gender). There are some beds on the wards that are able to be flexed to be male or female depending on the demand.

The impact for people with a learning disability or autism

We recognise that each year we admit a number of people who may have a mild to moderate learning disability and/or autism to our general mental health wards. The number of people we have admitted and who we know have a learning disability or autism in the last few years has fluctuated, but it has done so from a very low base as shown in the figure below. It should be noted that this may be an underestimate as there are data quality issues.

Figure 27 : Admissions of patients knows to have a learning disability or autism



We do not believe it is necessary or appropriate to have different facilities/beds for people who may also have a learning disability or autism. We recognise that inpatient ward environments are often not appropriate for people with sensory needs as they can be chaotic, noisy spaces. In recent years there has been significant work put into making CNWL's acute inpatient wards more suitable for people who have sensory needs, particularly those with a learning disability or autism. We work hard to address this. In 2022, CNWL purchased sensory kits for all the wards across the Trust and sensory training for ward staff to support them to use these with service users. More recently work has begun on the outside spaces at St Charles to adapt them into sensory friendly spaces.

Community based services are more easily able to adapt to meet the needs of each individual who presents to the service, particularly in the new needs-based model of care in the community mental health hubs. All teams in CNWL work to ensure that they are making reasonable adjustments to support people with learning disabilities or autism. In order to improve the way our mainstream mental health services help people with complex needs we have recently introduced a complex care forum led by staff with expertise in working with people who are neurodiverse. The forum can be used to obtain advice on specific cases and to help identify and get support for appropriate adjustments.

It is challenging to assess the separate impact of these proposals on people with a learning disability or autism because there is limited data recorded in this area and therefore there are a very small number of patients we can identify through it. However, we believe the impact is unlikely to be substantially different from that for the general population. We would expect the benefits that apply to the general population of care in a less restrictive environment from flexible community based services would fully apply, in fact this population may be more likely to find a busy and loud inpatient environment challenging.

The impact for people with a disability

While all the wards across CNWL are accessible, the Gordon, being the only site without ensuites, does not provide the privacy appropriate for people with a disability. There is only one toilet on each ward that is accessible and with only 3 for the whole ward, there's no way to ensure that this is available when needed.

While some people who are admitted with a disability may need to travel further for an inpatient admission, the shift in care to be delivered in the community means that more people overall are being treated closer to home by their community teams than needing to be admitted to an inpatient facility at all.

CONCLUSION/RESPONSE

We do not believe there is a risk that the shape of future provision does not match the specific demand from women/men, for people needing different levels of security, or for people with learning disability/autism. Our services our flexible enough that they can meet the needs of all those groups within both inpatient services and community based services. We cannot identify any significant negative impacts for these groups compared to the general population.

5.5 Mental Health Crisis Assessment Service

Several feedback points were made regarding the MHCAS element of the proposal. In particular there was feedback that:

- The service model
  - Should be further developed using a codesign process with stakeholders
  - Was unclear in some areas and more detail was needed.
- The location of the service needed further consideration:
  - Whether there should be an MHCAS at both the St Charles and the Gordon
  - Whether it was appropriate to move the MHCAS away from St Charles.

5.5.1 MHCAS model

ISSUE RAISED IN FEEDBACK

There should be further codesign work on the model

DISCUSSION/EVIDENCE

When the MHCAS was initially developed this was done jointly with partners from across the system, with an aim to address the mental health needs of people who would otherwise have gone to A&E.

In response to the feedback in the consultation an independently facilitated workshop was held with stakeholders including

- CNWL Staff
- Service users and carers
- Local voluntary and community organisations from the Westminster and K&C Partnership groups
  - Hestia
  - KCSC/One Westminster
  - The Passage
  - Unfold
  - Health watch
  - Rethink
- The Police
- NWL ICB

The aim was to address both what sort of service model the MHCAS needed to offer, and to consider the specific issue of MHCAS location Discussion points at the workshop included what was good about the MHCAS, what could be improved and where the MHCAS should be located. Headline feedback from attendees is summarised below.

What is good about the MHCAS?

- The MHCAS provides a safety net for service users who need crisis support and are not at the point of needing admission.
- It provides a service that enables faster access back into the community, with improved support from other services who are able to reach into the MHCAS.
- The model is dynamic and able to adapt to what people need.
- When people are admitted from the MHCAS, the length of stay on inpatient units is shorter because they have been able to start treatment in the MHCAS before admission. Current flexibility in the length of stay in the MHCAS was praised by stakeholders

What could be improved?

- Improved awareness of the MHCAS is needed to ensure people know about the service and what it can offer, it is clear that a lot of stakeholders are unaware of the service. Particularly if there's a walk in option, it is important that people know about the service
- Further work with Police and London Ambulance service to ensure they know about the MHCAS offer and are able to use it
- Strengthen links with the MHCAS and other community services including, SPA, The Lighthouse at St Mary's, the local voluntary sector
- Improve the offer of therapies on the MHCAS for people to access these interventions if they are in the MHCAS for longer periods
- Provide more information about other mental health services in the MHCAS so people can find out more about what else they can access
- Ensure people's story is in their notes so they don't need to tell it more than once

MHCAS location

Views were divergent but the following opinions were expressed:

- Stand-alone unit at the Gordon sounded unsafe - remaining at St Charles is the safer option because of co-location of other services
- St Charles is more central for the wider community
- There does need to be a mental health hub in Westminster
- Having only one MHCAS is not ideal for those who do not live close to it
- Making MHCAS accessible for all residents is important - a transport service to St Charles would help
- Concern that A&Es at St Thomas' and Guy's being used by Westminster residents, rather than going to St Charles for MHCAS – a knock on effect of this could be being sectioned if doctors do not know patients

Following further consideration of this feedback we are proposing changes to the services model as set out in Section 0

ISSUES RAISED IN FEEDBACK ON THE MODEL

Several issues have been raised in feedback. These are discussed below:

1. The MHCAS model needs more information on case mix and who can use the service
2. AMHPs' views were generally that MHCAS was not a useful resource for them because the process of getting a service user into the system there was complicated and time consuming. They said that MHCAS was not a good replacement for previous services

3. Whether the length of stay proposed in the PCBC model was appropriate and whether the operational efficiencies highlighted in the PCBC (56 patients a month out of Emergency Departments) are being achieved
4. There should be more clarity on what happens after discharge
5. Whether the model was suitable for the homeless
6. Providing clarity on length of stay, and on the appropriateness of the model for people who needed to stay longer than 72 hours, and whether this would mean delays to treatment while being transferred to an inpatient hospital
7. There should be evidence on the ability of the model to reduce pressure on Emergency Departments
8. The model should explain more clearly how the model contributes to avoiding crisis.

DISCUSSION/EVIDENCE

1. The MHCAS model needs more information on case mix/admission criteria

The MHCAS service is for anyone who is experiencing a mental health crisis where there is not a co-occurring physical health need. People can self-refer and just walk in. There is no exclusion based on diagnosis.

2. Getting a service user into the system there was complicated and time consuming.

The MHCAS is a relatively new and developing model with feedback from staff, partners and service users informing continuing improvements to the model. We will continue to work to improve our processes.

3. Whether the length of stay proposed in the PCBC model was appropriate and whether the operational efficiencies highlighted in the PCBC (an additional 56 patients a month out of Emergency Departments) are being achieved

The additional patients that would be seen in the 4 beds are not being seen yet, as the additional beds have not been introduced. This section looks at the expectations described of the overall service when it was opened and updated expectations for the expansion based on a pilot of beds in the service within the current capacity of 8 spaces.

The MHCAS was opened with 8 spaces and a planned length of stay of 12-24 hours enabling 56-112 patients to use the service each week. We have concluded that because of the people who were coming through, and to incorporate learning from the Crisis House pilot, it would be better to enable a slightly longer stay for some patients who are brought in to a bed. This will allow MHCAS to fully meet the needs of people who in the past would have required a short stay admission. As a result of the change in length of stay the MHCAS is currently seeing 23-40 patients a week. This is why the additional beds in the MHCAS will be important to ensure we are still able to meet the needs we are seeing in A&E. Currently there are 5 spaces for patients who will flow through in a day and 3 beds for longer stayers, the additional 4 spaces will be split into 3 recliner chairs with a higher throughput of use and 1 bed so we would expect to be

able to see an additional 21-42 patients a week in the shorter stay bays and at least 2 a week in the bed.

4. There should be more clarity on what happens after discharge or transfer

The expected outcome for most people would be that they return to living within the community with appropriate support from the range of community based services discussed in Section 0. Since launching 47% of people have been referred from the MHCAS to another community service, 20% have been admitted to a ward and 31% have completed their treatment.

Since starting the service, we have added support from the British Red Cross to offer social support to those who are high intensity users of the service. This is based on the model of support offered by the British Red Cross in A&E.

5. Whether the model was suitable for people who are homeless.

We have addressed the specific needs of homeless people in Section 5.3. However, there is no reason why the service cannot provide appropriate support to a homeless person in a crisis which will form part of the solution towards them not requiring inpatient care.

6. Potential delays to treatment while being transferred to an inpatient hospital.

A primary purpose of the MHCAS is to provide more appropriate assessment and support for people in a mental health crisis with no physical health needs than can be done within an A&E. It is hoped that in the future the MHCAS will be the first service that someone comes to instead of going to A&E.

When service users present to A&E and have no physical health needs, they can be transferred to the MHCAS to receive care in a calmer environment. In cases where it is clear that someone will need a longer term admission the aim would be to admit them straight from A&E without being transferred to the MHCAS first. However, there are cases where with a bit more treatment and support it is likely that the admission could be avoided, and in these cases the beds in MHCAS could be used. If someone does then get admitted, they will have started their treatment within the MHCAS, which will then be continued later within an inpatient unit. The MHCAS can draw upon all the necessary expertise that could be provided within the inpatient service.

7. There should be evidence for the ability of the model to reduce pressure on Emergency Departments

We provided evidence in the PCBC annex on MHCAS which included the following

- An external evaluation of our own service identified that:
  - Mental Health A&E presentations have not increased as expected and remained below August 2022
  - 12 hour inappropriate waits did not increase as expected and remained similar to pre-winter levels

- ~ Admissions remained stable over winter
- ~ Admission avoidance – Only 19% of patients were admitted to inpatient beds. 50% less than First Responder assessment to admission from Nov 21-22. MHCAS conversion rates continues to improve and is currently around 10%, from 19%.
- ~ Overall feedback from patients - 79 patients described their experiences as 'very good' or 'good'. Only 5 of SUs indicated having a negative experience

- The Camden and Islington MHCAS service had reduced mental health Emergency Department referrals by 60%

8. The model should explain more clearly how the model contributes to avoiding crisis.

The MHCAS provides a safe location for the immediate assessment of the needs a patient experiencing acute mental health symptoms and has the appropriate expertise available on 24/7 basis to provide immediate treatment and support, and to develop an appropriate treatment plan, which ideally would not demand a restrictive admission. It is well illustrated by the following patient story.

Patient Story

In the first 2 weeks of the service an individual arrived in MHCAS after spending 10hrs in A&E. She said when she is in a crisis she tends to go to A&E, although she dreads going. As the waits are long and the environment in A&E adds to her anxiety. She described arriving to the MHCAS as being very welcoming, staff with smiles and very clean. She said she was immediately assessed and could see that the staff assessing her really cared and wanted to help her. She said once she finished her assessment, she was offered food and relaxed in her MHCAS suite. She said the recliner chairs were very comfortable and clean. She said she hadn't slept for 72hrs, but had a good 1-2hrs hours sleep a few hours after arriving in MHCAS.

She said she had multiple 1:1 sessions with various staff and was overwhelmed with the support she was getting 'I'm not use to this'. She said she was referred to the Hillingdon Crisis House, which she felt was the perfect pathway, after being described what it offers. She said if she is ever in a crisis again, she will come to MHCAS instead of A&E as she will be seen straight away, have a full assessment, which is not rushed and she has the freedom to go out for fresh air with the support of staff if needed.

She said 'This service should have been created years ago'

CONCLUSION/RESPONSE

We are continuing to develop and refine the MHCAS model. Our work with stakeholders on the MHCAS has helped us to identify ways to make the service better, and we fully expect it to continue to evolve as we learn more and more from our experience with it, and from feedback from patients and colleagues. We believe we have clearly explained its role and approach and how it adds value.

5.5.2 The right location for the MHCAS

ISSUE RAISED IN FEEDBACK

MHCAS location should be reconsidered with some suggestions that the service should be implemented at both sites, but also suggestions that it was wrong to move the service away from the St Charles. This was both on the ground of access but also because it was argued he MHCAS should be collocated with inpatient services so there was cross cover.

"As a crisis service, moving here (to the Gordon Hospital) there is really nothing else here. You haven't got that infrastructure that other in-patient sites have. If interventions were needed who would do that if MHCAS need support with disturbed patients?"

"There needs to be really good thinking about the fact that MHCAS is not co-located. The systems and processes that wrap around that need to be robust enough to ensure that there are adequate safe transfers, that there is adequate provision to be able to continue to work in partnership

DISCUSSION/EVIDENCE

Further work has been done to consider this feedback:

- To identify whether there was a suitable location on the St Charles site where the NHCAS could be located for the longer term
- To review whether the PCBC had underestimated the quality and safety issues for patients of the service being on the Gordon site isolated from inpatient services
- To look at whether it is possible to have MHCAS services at both locations.

Estates options

The PCBC did not include an option that retained the MHCAS at the St Charles (it is currently temporarily located there in a ward is needed in the longer term for older people's inpatient services and it too small to house the enhanced MHCAS envisaged in our proposals). At the time of the PCBC, it was believed there were no suitable alternative locations at the St Charles. It was also known there would be suitable space at the Gordon, and it was considered to be a benefit that it would retain a crisis service presence with beds within Westminster. However, our review of the estate at the St Charles since the PCBC has shown that there is a suitable location (currently used for a kitchen and some storage) that could be developed with a low capital cost as a good home for the MHCAS.

Quality and safety issues of not collocating with inpatient services, urgent care centre and HBPoS

We have been able to review our initial assumptions about practicalities of delivering MHCAS based on our recent experience of service provision at the St Charles. This has made us re-evaluate whether it is appropriate to separate the MHCAS from the main inpatient service and from the Health Based Place of Safety (HBPoS) because:

- In recent months, the length of stay in the MHCAS has begun to increase with some people staying up to 3 days before discharge, and most patients being in the service for 24 to48 hours. This introduces similar challenges about the Gordon building as if there were to be inpatient admissions as there will be a problem with having no access to outside space.
- The increased length of stay and use of the service for patients who have been sectioned under the Mental Health Act also means there is likely to be an increase in acuity of people in the service and so the support from other services will be important. Since January 2024 there have been 27 reported incidents in the MHCAS, at least 1 per month of these required support from other staff at St Charles to be managed safely.
- Discussions have begun with Central London Community Healthcare Trust regarding the support that MHCAS and the Urgent Care Centre can offer each other to provide physical health and mental health support to people without going to A&E. These developments would be lost if the MHCAS were to move to the Gordon.

Potential to have two MCHCAS locations in KCW

We understand the desire to have locations in both boroughs as it would have obvious access benefits, but it is not viable because there are significant critical mass issues:

- The aim is to provide a 24/7 service. With a single site service all patients from KCW would go to the single site. This makes an efficient use of staff time because of the number of patients going through the service. With two services that staffing would need to be virtually doubled, without actually having any additional patients going through. This would be hugely expensive in revenue terms (approximate annual cost £4.4m). We could not invest this amount of money in the service without finding equivalent savings in services elsewhere.
- Stakeholders have proposed consideration of additional access points to the MHCAS in different parts of the patch which would enable people to present in different locations and receive care from the MHCAS without the prohibitive cost. This has been included as a mitigation.

CONCLUSION/RESPONSE

Given the analysis above, we needed to reconsider whether the best location would actually be at the St Charles rather than the Gordon. We have addressed through the revised option appraisal we have carried out and summarised in Section 6.1. That option appraisal confirms that the St Charles would indeed be a better location than the Gordon, and that has informed our revised proposal.

5.6 Information provided in the consultation

A number of responses have identified areas where further information is required to ensure the rationale for the proposals is correct and that there is a proper understanding of their impacts. The key areas not already covered in one of the sections above are:

- 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

5.6.1 Need for an overarching mental health strategy and inequalities reduction plan

ISSUE RAISED IN FEEDBACK

Concern that the consultation proposals were not set in the context of a clear overall mental health strategy and inequalities reduction plan.

The Mayor's report says, "Proposals critically lack the benefit of an overarching local mental health strategy and inequalities reduction plan that we would expect to inform their development." It says this should include assessment of comparison of access, experience and outcomes compared to a peer group.

DISCUSSION/EVIDENCE

We have described in the Mental Health Strategy for North West London which was adopted recently by the ICB. This provides the necessary context and reassurance that the proposals are in line with the overall vision for mental health and the future direction of travel. Section 5.2.1(b) sets out the details of the relationship between the overarching modelling of need and capacity for NW London with the specifics in the consultation proposal.

The ICB fully recognises the importance of addressing inequalities related to mental health provision. It does not do through this through an overall inequalities strategy setting out detailed targets and action plans as suggested by the Mayor's Office Report but through a group of focussed workstreams in areas identified as priorities for action. These are reviewed yearly and the current year areas of focus for mental health are:

- NHS Talking Therapies recovery (by deprivation)
- Children and young people's mental health access (by deprivation and ethnicity)
- Rates of total Mental Health Act Detentions (by deprivation and ethnicity)
- Rates of restrictive interventions (by deprivation and ethnicity)

- Adult mental health inpatient rates for people with a learning disability and autistic people (by deprivation and ethnicity).

We have described in Section 5.4.1 how these proposals directly impact on inequalities. Section 6.2.5 provides further information on our overall approach and strategy for addressing inequalities through

- The Workforce Race Equality Standard (WRES)
- The Patient and Carer Race Equality Framework.

These are the prime mechanism for setting out detailed targets and plans for the specific groups affected by this service change.

CONCLUSION/RESPONSE

We have shown that the proposals are set in the context of an overall NW London strategy, and that we have a clear process in place to help us to address inequalities in service provision.

5.6.2 Additional financial information

ISSUE RAISED IN FEEDBACK

Further detail on reuse of funding from the Gordon inpatient services and additional investment

The JHOSC have asked that this be provided and this should include information on the choices made within funding levels and how additional government funding has been used. There was also a suggestion that information should be provided showing clearly which boroughs had benefitted from the redistributed funding from the Gordon inpatient services especially for services that were not focussed on KCW. This was mentioned in the Hammersmith and Fulham Save Our NHS (HAFSON) feedback in terms of expenditure on proposed beds at Park Royal. HAFSON also wanted to know the costs associated with relocating the MHCAS from St Charles to the Gordon.

DISCUSSION/EVIDENCE

Since the temporary closure of the inpatient wards at the Gordon, there has been £11m new investment and redirected investment from the Gordon wards invested into KCW. This has been split across different community and community based crisis services and has been invested into services working with people from KCW. Where the funding is in a trust-wide service the amount used from the Gordon savings has been calculated based on the proportion of the provision for residents of Kensington & Chelsea and Westminster (so that it is clear that money from the savings is being used for the benefits of those residents). The PCBC sets out in detail how the funds from the Gordon have been used. This investment and

the new investment to the boroughs has been directed to additional staffing or new services in the following areas:

- A number of contracts with Voluntary sector partners in Westminster to support delivery of the Community mental health hub offer to provide an earlier access to support
- Inner London Health Based Place of Safety (HBPoS) based at St Charles. The HBPoS is a secure space the provides a safe health run location for someone to be assessed when in a crisis and to begin their treatment
- Ward staffing – some of the funding has been directed into improving the therapeutic offer on the wards at St Charles. Additional therapeutic staffing has supported the roll out of Trauma Informed Approaches on the wards at St Charles
- 24/7 Central Flow Hub is a team that manages admissions across the trust to ensure that people are admitted quickly and as close to home as possible
- Step Down beds are a community based bedded provision to support rehabilitation into the community for people who have been in inpatient units and need more support before going back to their usual place of residence
- MHCAS provides a more therapeutic environment to provide crisis assessments and interventions to people who may otherwise have gone to A&E or been admitted
- Additional bed provision, opening a ward in Brent to provide somewhere for admissions of outer borough patients who were being admitted to St Charles beds
- Pilot of Open Dialogue in south Westminster. Over the last year CNWL has been piloting a new clinical way of working that improves the involvement of service users and their network in their care. This has been piloted in all community teams in south Westminster. In previous areas that have embedded Open Dialogue, there has been improved recovery, reduction in admissions and improved staff wellbeing.
- Community Access Service is a team working with people as they are discharged from inpatient units, providing social support to people as they move back into their daily lives
- Community mental health hubs have been expanded and the model of care has been adapted to provide easier access, joined up care aligned with the community mental health framework
- Talking therapies teams have continued to expand with new trainees annually and increased therapy staff as these individuals qualify
- Liaison teams in Chelsea and Westminster Hospital and St Mary's Hospital to offer mental health support in A&E and on acute physical health wards have been expanded

Table 9 : Increase in services since the temporary closure in KCW

SERVICES	Increase in investment			Increase in staffing		
	Westminster	RKBC £'000	KCW £'000	Westminster WTE	RKBC WTE	KCW WTE
Community VCSE contracts	400		400	10		10
Inner London HBPOS	450	450	900	9	9	18
Ward staffing	350	400	750	6	6	12
Delivery of 24/7 central flow hub	100	100	200	2	2	4
Stepdown beds (40)	300	300	600	8	8	16
MHCAS	700	700	1,400	9	9	18
Additional Bed provision *	400	400	800	6	6	12
Open Dialogue	200		200	3		3
Community Access Service (CAS)	75	75	150	2	2	4
Community Mental Health Hubs	1,000	800	1,800	19	16	35
Talking therapies	1,700	1200	2,900	25	21	46
Liasion teams	400	500	900	5	8	13
Total	**6,075**	**4,925**	**11,000**	**104**	**87**	**191**

It is very difficult to answer the question on relative expenditure and reuse of savings by borough. The detail of the reuse of the funds is set out in the table below. As a highly specialist service CNWL do not organise a lot of their service provision based on borough boundaries but on the overall needs of the population. Inpatient provision is not planned on a borough basis. What we can say is that all of the services we reinvested the saving in were chosen because they supported the overall model of working with fewer beds (or without beds specifically at the Gordon) and enhanced community services. So, for example:

- Community VCSE provided more support for people in the community to prevent step up to a level of acuity where they need admission.
- HBPOS enables the police to take people somewhere safe and with provision of healthcare when they are under s136 of the Mental Health Act.
- The ward multi-disciplinary team investment reflected a recognition that the reduction in beds was likely to result in an increase in patient acuity on wards (because those patients most suitable for the community provision would be of lower acuity)
- The Central Flow Hub would make better use of our smaller inpatient capacity by improving flow through beds and preventing unnecessary delays
- The stepdown beds would make it easier to discharge patients who no longer needed the restrictive care of an inpatient unit, but did need further support prior to discharge
- The MHCAS was designed to reduce the number of unnecessary admissions, prevent the reduction in beds from impacting upon the Emergency Department, and to help reduce length of stay for people for whom it was necessary
- The additional beds in Brent were to help ensure that Brent and outer borough patients did not take up capacity in the St Charles

- Community Access service helps to ensure people are discharged in a timely way and supported back into the community by a support worker and social worker

Table 10 : Reinvestment of savings from temporary closure in context of total Trust investment

	Investment			Staffing		
SERVICES	TOTAL NEW INVESTMENT	*GORDON WARD RE-INVESTMENT*	*MHIS INVESTMENT / OTHER*	TOTAL NEW INVESTMENT	*GORDON WARD RE-INVESTMENT*	*MHIS INVESTMENT / OTHER*
	£0	*£0*	*£0*	WTE	*WTE*	*WTE*
Community VCSE contracts for Westminster	400	*400*	*0*	10	*10*	*0*
Inner London HBPOS	900	*900*	*0*	18	*18*	*0*
Ward MDT investment in line with roll out of Trauma Informed Approach	2,050	*750*	*1,300*	28	*12*	*20*
Delivery of 24/7 central flow hub	1,000	*200*	*800*	19	*5*	*13*
Stepdown beds (40)	1,600	*600*	*1,000*	44	*17*	*28*
MHCAS	2,800	*1,400*	*1,400*	36	*18*	*18*
Additional Bed provision	2,500	*800*	*1,700*	37	*13*	*24*
Open Dialogue Pilot	200	*200*	*0*	3	*3*	*0*
Community Access Service (CAS)	620	*150*	*470*	12	*3*	*9*
	12,070	***5,400***	***6,670***	**207**	***99***	***112***

We can confirm that the costs of moving the MHCAS to the Gordon would be approximately £2m, if it were to move to the newly identified location at St Charles this would cost £3.2m in capital.

CONCLUSION/RESPONSE

We believe we provided comprehensive information on the key financial elements of the proposal in the PCBC. We have summarised that information above in response the JOSC questions.

5.6.3 Mental health services in NW London being "underfunded"

ISSUE RAISED IN FEEDBACK

Affordability of the options and funding.

The Mayor's report suggests that a better understanding is needed of NW London's expenditure on mental health services in terms of per person funding.

"On revenue funding, the PCBC states that "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." This is a significant investment but, without a full needs analysis, it is not possible to be sure of the appropriateness of its scale and focus. This is especially so in a context where, according to the Royal College of Psychiatrists 2022 local area report for North West London[27], spending per person on mental health services was 14.3% lower than the average for England".

DISCUSSION/EVIDENCE

It is agreed that benchmarking suggests spending on mental health in North West London is relatively low compared to other health economies. Our Medium Term Financial Strategy (Sept 2023) says that we are underinvesting in mental health by 20%.

The ICB recognises that this needs to be addressed, in line with national policy which is to increase relative funding for mental health. It has to do so in a difficult context, especially as in terms of national funding it receives significantly less per head of population (after weighting for need) than the national average (£1,887 allocation per needs weighted head of population against the national average of £1,946). The ICB is currently in financial balance.

In order to achieve this, it has set out a programme of medium to long term action designed to reduce unnecessary expenditure on acute services, and to use the funding released to enable growth in mental health expenditure.

So far, we have been unable to make significant progress in achieving this goal. The only way to deliver significant extra funds to support mental health in the short to medium term would be to substantially reduce funding for our acute hospitals which would direct negative impacts on patient care, and we do not believe they would be supported by local people.

As we showed within the PCBC we have been significantly increasing our expenditure on mental health, and we expect to continue to so whenever the resources available.

When those resources are available, we expect that our priority will continue to be for investment in community based services rather than adding inpatient care capacity. As we have consistently argued, it is better for patients and more cost effective for the NHS to

[27] North West London (rcpsych.ac.uk)

support patients within the community, unless they genuinely need inpatient care, and we believe we have the right level of capacity for that group.
CONCLUSION/RESPONSE We recognise underfunding of mental health services is an issue we need to address in the medium term. However, we would expect those additional funds to continue to be spend on community based service unless further experience over time made it clear that our inpatient capacity was insufficient to meet the needs of patients for whom it is necessary.

5.6.4 Financial costs for service users and families of extra travel

ISSUE RAISED IN FEEDBACK ***Travel costs*** The Mayor's report suggests that a better understanding is needed of the travel costs related families and carers as well as service users resulting from needing to travel further to the St Charles potentially several times in the course of an impatient admission
DISCUSSION/EVIDENCE We have set out a detailed analysis of additional likely travel costs in the revised IIA (Appendix 2). 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.
CONCLUSION/RESPONSE We have included this as an area for mitigation action

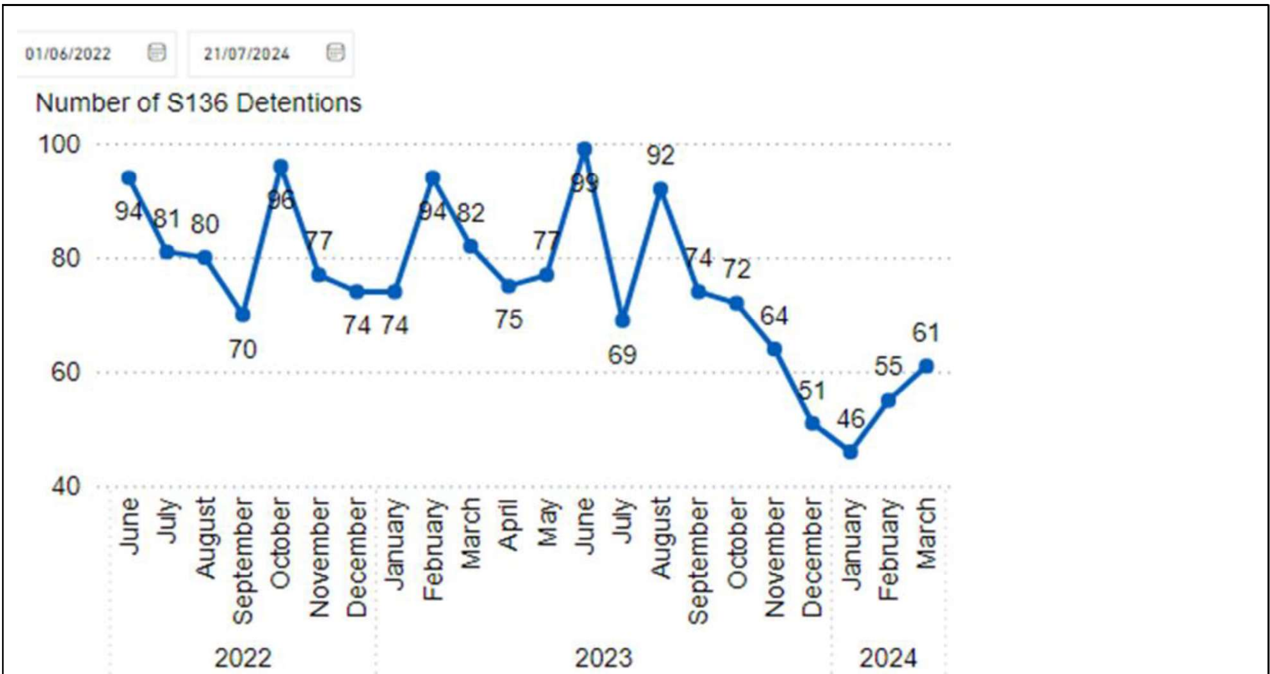
5.6.5 Impacts on Social Care

ISSUE RAISED IN FEEDBACK
Impact on social care Feedback has suggested that more information is needed on this. For example, the Mayor's Report says "There are credible arguments presented that there would not be a material impact on social care services. For assurance, formal assessment of this should be undertaken or explicit confirmation secured from social care services that they share this view." The Mayor report also asks if there are credible, funded, joint NHS/LA plans to meet any additional costs? It says "No such costs are identified in the proposals. It would be helpful to present evidence that no additional social care costs arise from these proposals. We assume that the consultation process is enabling social care leaders to evidence any alternative view."
DISCUSSION/EVIDENCE As the changes have been in place for some time NW London ICB and CNWL have been working with colleagues from both Local Authorities to gather data from social care and AMHPs to understand the impact of the changes on social care. Throughout the work Local Authority colleagues have asserted anecdotally that there's been an impact on social care colleagues including - More assessments from AMHPs needing to reassess patients for bed needs - Increased travel time for social care colleagues to other inpatient units. This led to a request for data in May 2023. Data on the number of AMHP assessments was received in December 2023. The data from the local authorities appears to show a rising number of AMHP assessments, and in particular a rising number of assessments recommending admission under section. This contrasts with data from CNWL showing a relatively flat number of admissions under section. A meeting with local authority colleagues in February 2024 discussed the potential reasons for the discrepancy. **[Placeholder for text to be agreed with Local Authority colleagues on work to reconcile data]** *Other changes in the system* It should also be noted that in the last year across KCW we have been coming out of our section 75 arrangement with the local authorities which has also impacted ways of working with social care colleagues.
CONCLUSION/RESPONSE **[Placeholder for text to be agreed with Local Authority colleagues on work to reconcile data]** An ongoing work programme is being agreed to ensure a shared understanding of access to services in the future.

5.6.6 Impacts on the police and of the policing operational model "Right Care Right Place"

ISSUE RAISED IN FEEDBACK ***Impact on the police and impact of the RCRP policy*** Professor Manthorpe's report[28], commissioned by Westminster Council and RBKC, raised a concern that there was pressure on the police with them being unable to find a space in a Health Based Place of Safety and about the time and travel implications of transporting patients from Westminster to the St Charles. "Travelling to and from St Charles Hospital takes up considerable amounts of Police Officers' time (average 2-3 hours; sometimes necessitating 4-8 officers) with some people in further distressing situations of handcuffs and leg restraints." Feedback has also raised the question of how the changes have impacted upon Section 136 detentions The Mayor's letter accompanying his report said, "I note that the proposals do not include specific consideration of the 'Right Care, Right Person' (RCRP) operational policing model introduced in November 2023. The DMBC would be greatly strengthened by work to identify the potential impact of RCRP on demand, access, experience and outcomes for the future service, including in terms of unequal impacts across different population groups"
DISCUSSION/EVIDENCE It should be noted that the Health Based Place of Safety at the Gordon was relocated to St Charles prior to the closure of the inpatient wards and is not within the scope of this consultation. We understand the issues raised by the locations of HBPoS, but it is not affected by these proposals. In order to understand the impact on police, data published on the Thalamos platform has been reviewed to consider changes in s136 use over time. This data is only available from 2022 so does not go back to before the temporary closure of the wards. The graph below shows the number of s136 detentions where CNWL, Imperial or Chelsea and Westminster were the Trust of the final Place of Safety. The number of s136 detentions decreased over 2023 but has started to rise again.

[28] https://www.westminster.gov.uk/media/document/the-gordon-hospital-options-and-ambitions-23-may-2024



The graph below shows the average police involvement time when someone is detained for the same group which has remained relatively steady over time.

In November 2023 the Metropolitan police introduced Right Care Right Person which aimed to reduce Police attendances to mental health call outs where another organisation is more appropriate to respond. The Trust worked closely with the local officers to support the roll out of this new policy. All Boroughs have an interface partnership meeting with the police to share learning and escalate issues. Based on reporting of incidents related to the right care right person implementation, CNWL has not seen a significant impact on our services and people are being cared for by health professionals rather than the police.

CONCLUSION/RESPONSE

We have seen no significant impact on the Trusts services for patients as a result of the RCRP new model.

The location of the HBPoS is of course relevant for police time and input but is not part of this consultation proposal. We would hope that police resourcing has been helped by the reduction in Section 36 detentions since 2022.

5.6.7 Information robustness

ISSUE RAISED IN FEEDBACK ***Real world experience contradicting data*** Feedback suggested that the real world experience of long waits in Section 136 Suites, MHCAS, Emergency departments, and difficulties in finding a bed suggested that the information on these issues provided in the consultation was flawed
DISCUSSION/EVIDENCE We always recognise that individual's specific experience of issues may differ from the messages we are able to extract from the information we have. In some cases, this is simply inevitable as there will always be individual cases where problems have occurred. However, where we have had substantial feedback on areas where people's personal experience is different from what the PCBC or consultation suggested we have tried to improve our understanding of the data and carry out additional analysis. For example, we have carried out extensive additional work to review the experience of people experiencing homelessness because of the feedback we received.
CONCLUSION/RESPONSE We have welcomed all feedback from people's own experience and have used this DMBC to address it as comprehensively as we can. Our aim has been to base our conclusions on robust information and data.

5.7 The PCBC and consultation process

Key areas raised in feedback to the consultation in relation to the process followed were:

- Engagement in option development
- The scope of options considered, particularly considering plans for additional inpatient beds in Brent
- Reach of consultation
- Engagement activities

5.7.1 Option development

ISSUE RAISED IN FEEDBACK

Option development and choice of preferred option. A number of responses suggested that there was insufficient engagement in the development of the options, bias in the way the options appraisal was carried out, and a lack of transparency

DISCUSSION/EVIDENCE

The PCBC described a process where the project team drew on pre consultation engagement exercises to help identify what people considered important for these services, and then had a series of facilitated workshops with a range of external stakeholders to assist in the development and assessment of the options. These included a wide range of people from:

- Westminster City Council
- Royal Borough of Kensington and Chelsea Council
- London Borough of Brent
- Directors of Social Care from Westminster and RBKC, and across the bi-Borough area
- North West London ICB
- Service leads from Central and North West London NHS Foundation Trust
- Metropolitan Police
- General practice
- Imperial College Healthcare Trust
- Voice Exchange
- Listen to Act
- Service user representation
- Carer representation.

The workshops went through a structured process to consider the case for change, input on the potential longlist and shortlist of options, and advice on the relative merits of those options as is typical for an options development process, the process was designed to “funnel” from a wide range of potential permutations of services and locations into a set of options for consultation.

This was achieved through a series of five workshops, in which a group of stakeholders with consistent core membership considered the characteristics of a high quality service, reviewed the alternative potential clinical models, developed criteria to support shortlisting, produced a longlist and then shortlist of options, and considered the likely impacts of these on equalities groups, communities and cohorts of patients. During each workshop, discussions were recorded and a summary report produced after each event which was published in the CNWL website.

This demonstrates a very high level of engagement in the option development work. A good example of how the engagement affected the option development was that the project team added a specific additional option at the request of RKBC councillor (this was effectively a two

site inpatient option which returned some beds to the Gordon so that the overall bed number reduction would be less. We recognise that there was a perception among some stakeholders of bias. We believe this perception largely related to the belief expressed by clinicians and others that for many patients community services could provide better care than what would be possible in an inpatient ward. We recognise that some local people disagree with this. However, we believe the material used at the workshops and the presentations fairly reflected national policy and best practice guidance, rather than any individual bias. We would not agree that the option appraisal process was anything but transparent. The information used to support it was comprehensive, and when stakeholders asked for additional information (for example: greater clarity on how the funds from the closure of the Gordon had been used) we have been happy to provide it. We recognise that some stakeholder would have wished us to take other options to consultation or to have chosen an option not recommended in the consultation (particular ones which retained inpatient care at the Gordon). However, we could not identify any way that the options which did retain inpatient care there could be afforded and still allow the provision of high quality care. Respondents were given the opportunity to propose additional options in the consultation; no options were raised through the feedback that had not been considered through the process.
CONCLUSION/RESPONSE We believe that the option development and appraisal process for the PCBC was robust in that it allowed us to go to public consultation with a deliverable proposal that was clearly identified as being better than all other realistic options considered or suggested at the time. We do not agree that it was not transparent or was biased. This DMBC recognises that some elements of the proposal could be further improved as a result of our consideration of the feedback in the consultation. This in itself means that the consultation has fulfilled its purpose in allowing challenge and new ideas to improve the original proposals. We do not believe it was biased or not transparent.

5.7.2 Scope of options considered

ISSUE RAISED IN FEEDBACK

Whether the CNWL development of an additional 14 bed ward in Brent should have formed part of the PCBC option appraisal.

The London Mayor's Office Report suggested that "a key element in the delivery of the preferred option is the establishment of 14 additional beds in Brent to create capacity at St Charles. Arguably, the proposal for those additional beds should be integrated within these proposals and the associated consultation"

This comment is linked to the analysis in the PCBC which showed that a benefit of the Brent investment was that it would enable Brent and other out or Borough residents who currently occupied beds at the St Charles to be supported more locally, thus freeing up capacity in St Charles, which in turn would make it less likely that KCW residents would need to be admitted out of KCW.

DISCUSSION/EVIDENCE

It is understandable that people would consider the decision to invest capital on the additional Brent ward should have been linked the decision making on the options in the PCBC. However, they are in fact fundamentally separate, because the original decision made by CNWL to make the investment was not for the purpose of freeing up capacity in St Charles over the longer term.

The CNWL Trust took the decision to invest £2.1m capital to refurbish an existing building on the Park Royal site in Brent in 2022 and the capital works began in Jan 2023 prior to the PCBC option appraisal. The key drivers of the decision were as follows

Medium to long term:

- ***To provide decant capacity for the Trust.*** The Trust has a large number of inpatient wards in different buildings in different states of repair. It is therefore inevitable that at fairly regular intervals specific wards will need to be closed to allow for essential repairs and maintenance or in emergencies. The only way to be able to do this is to have an alternative location which can provide temporary accommodation for the patients who would have been in that ward. It is common practice among Mental Health Trust to have such a facility, which up to that point CNWL did not have.

Short term while the temporary closure remained in place:

- ***So that the ability to open additional beds would prevent patients needing to travel out of area or go to expensive private sector facilities***. At the time of the investment decision the Trust was spending at least £3.5m a year on such patients. This gave an imperative for rapid delivery.

- ***The recognition that the occupancy levels at the King Charles Hospital were high.*** This was partly caused by the number of patients from Brent and the outer boroughs being supported at the St Charles. Some additional beds in Brent would clearly assist in this and could be important for as long as the Gordon beds remained closed (see below)
- ***The Brent site*** was the only location within CNWL where a decant ward could be developed at a relatively low cost (because it was just refurbishment of a good quality building). The Trust would never put a decant ward on a site which did not have currently operational inpatient facilities as it has significant health and safety and clinical quality issues.

Given these drivers the investment made strategic sense for the Trust at the time of decision as it would help improve quality for patients for as long as the temporary closure of the Gordon was in place, while in the long term it could provide a strategic decant facility if it was no longer needed for these immediate purposes because of reopened beds at the Gordon. The Trust was aware that should the ICB decide that inpatients services should return to the Gordon there would still be a period of several years before that could take place. This period would include the time up to decision making on the Public Consultation (up to 2 years) and then, given the size of the investment required to make the Gordon wards fit for purpose, a period of several years for the development and approval of a capital business case and the subsequent building programme, with no certainty that the capital could be obtained. The Trust took the view that given the rapidly realisable benefits of the ward facility and of reducing placements out of area and in private facilities, the investment would still be the right thing to do even if in the longer term additional capacity would be developed at the Gordon

The capital investment decision was therefore independent and taken in advance of the option appraisal process. At the time of the appraisal the capital was effectively sunk cost and therefore irrelevant to option choice.

However, the subsequent option appraisal did appropriately consider the opportunities provided by that capacity in relation to options which delivered fewer overall beds. This particularly affected revenue implications when the detailed possible options were being identified and worked up. Under some of the options retaining the ward as a decant facility had less value than using the space to ensure that Brent patients did not need to travel to the St Charles, therefore increasing the capacity at St Charles (also meaning that fewer KCW residents would need to be admitted elsewhere). These options therefore included the revenue costs of staffing those beds (this was affordable because saving from the original ward closures would be used). Under the options where the inpatient beds at the Gordon were to be reopened, the option appraisal assumed that those beds would not be staffed as there would be no need to free up additional capacity in KCW and the staffing would instead be used at the Gordon. Under those options the only beds opened in the Brent facility would have been those where the staffing costs could be justified on the basis that they were preventing the need to use private facilities elsewhere, and otherwise the physical space would have been retained as potential decant.

The PCBC option appraisal did, however, identify two factors linked to this:

- That under the options where inpatient beds were reopened at the Gordon, CNWL would retain a whole ward decant facility in Brent (part of the original purpose of the investment). This should have been noted as a potential benefit
- That under these options more Brent patients would still need to travel to KCW for care rather than being supported in Brent. The PCBC appraisal noted travel benefits for KCW but did not note the additional Brent patient travel as a disbenefit.

For this reason, the DMBC re-evaluation of the original option appraisal has considered specifically whether these factors could in any way have changed the outcome. (See Section 6.1))

CONCLUSION/RESPONSE

We conclude that, independently of the ICB, the Trust made a reasonable decision to spend a limited amount of capital on developing a facility at Brent in advance of the PCBC option appraisal, and that decision made strategic sense irrespective of which of the consultation options was taken forward. Given this was already under development we believe the option appraisal in the PCBC addressed the issue appropriately, but as it did not fully consider all the factors that might have influenced decision making, we have included those elements in the process we have undertaken as part of this DMBC to confirm if the PCBC option appraisal is still valid.

5.7.3 Consultation Reach

ISSUE RAISED IN FEEDBACK

Several responses suggested that some communities were not sufficiently engaged with in the consultation. They have said there was inadequate engagement with service users, people experiencing homelessness, service users and people from Black and minority ethnic communities.

DISCUSSION/EVIDENCE

The consultation evaluation report clearly shows the extensive number of ways we tried to engage (see summary in Section 3.5). We believe this shows that we made substantial efforts to encourage and promote participation. When people identified areas where they believed we needed to do more we responded quickly with additional events and locations as shown in Section 3.8. While we would have welcomed more people giving their views, we recognise that can only invite people to participate, and make sure we have given them the opportunity to be involved.

- We recognise the challenge of engaging people experiencing homelessness and who have had an acute mental health condition in a health service consultation. We therefore established meetings with the Joint Homelessness Team and Homeless providers.

- We also recognise that the inpatient services for mental health are specialist; in 2019/20 there were less than 900 people from KCW admitted. In that context. In the consultation we engaged directly with 88 services users in face to face and online meetings. 61 service users took the time and trouble to complete and consultation questionnaire. We also do not know how many service users may have attended open public meetings. We believe that for a patient population of this size that is a significant level of engagement.
- We reached out to organisations working with Black and minority ethnic communities, and as well as agreeing to promote the consultation, some supported the consultation by hosting discussion at six meetings attended by 106 people. People from Black and minority ethnic communities also attended other focus groups, user engagement and open public meetings. Of those completing the questionnaire, 17 per cent (29 people) of those who stated their ethnicity were from Black/Black British, Asian/Asian British or Mixed backgrounds.

A key test of the "reach" of a consultation is the level of feedback received and not simply in terms of numbers of people responding, but in the detail of the questions and the comments made (e.g. ideas about what is good or bad about the proposal and could be improved). We were pleased with substantial level of feedback we received as described in Section 3.7. The Consultation Evaluation Report clearly shows a substantial range of views and opinions being expressed on important issues. This was particularly the case with the issue of acute mental services for people experiencing homelessness with extensive comments both on the perceived impact on the homeless of the temporary closure of inpatient beds at the Gordon, and on the nature of the services needed for homeless people. We also received excellent feedback on the issues affecting the whole population of services users summarised in over 25 pages in the Consultation evaluation report and leading to the range of issues we have assessed and responded to in this DMBC.

CONCLUSION/RESPONSE

Our overall conclusion is that:

- 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 staff 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.

5.7.4 Engagement activities/events

ISSUE RAISED IN FEEDBACK

Criticisms focussed on the number of meetings for the public and the number of attendees at events, the level of publicity, the difficulty of participating in Teams events, the need to hear more voices from community and voluntary groups, the need to explore specific elements of the mental health pathway

DISCUSSION/EVIDENCE

Public meetings

We knew from the outset that some individuals/groups would be unlikely to participate to formal meetings which is why we established a significant programme of proactive outreach to community groups.

It is always challenging to know how many meetings should be set up in different geographic areas for the consultation. Overall, we had 8 deliberative meetings open to the public, and 29 drop in sessions. As set out in section 3.8 this was an increase on the original plan (with two extra face to face sessions and 2 extra public online events and 4 extra drop-in sessions. The increase because we heard the feedback that more were needed and that some areas. A total of 84 individual participations were achieved through the meetings and drop ins. We would like to have had more attend these meetings, but we recognise it is up to individuals to decide if they feel the issues matter to them enough for them to wish to attend.

Difficulty of participating in online events

We recognise that many people find online events difficult to participate in. However, we also know that for others online events are the best way to participate because they do not have the time and costs of travel. We used Zoom to make the online sessions as accessible as possible, and ran meetings 'in the room' in addition to enable participation by those less confident or less well-equipped to use digital. We believe that the balance of face to face and online events was reasonable and in line with best practice.

Level of publicity

The Independent Consultation Evaluation report section 4.1.1 provides full details on the extensive publicity carried out to promote engagement with the consultation. Section 5,2 of that report also shows the significant attempts made to outreach through voluntary groups, community groups and other stakeholders. That report also concludes that "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. ……………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."

More voices from community groups and voluntary organisations.

We were very pleased with the number of community groups, voluntary organisations and other organisations who wished to participate and provide feedback. As set out in Section 4.2, we had 13 organisational responses providing detailed commentary and 21 of the questionnaires were received from people who said they were representing organisations. We directly contacted many more and asked them to participate, and we made arrangements to meet with any groups that requested it.

Specific elements of the pathway

We set up 8 meetings on specific elements of the pathway covering areas such as Eight additional meetings were arranged covering key service areas/groups such as Homelessness, Single Point of Access, AMHPs, Primary Care, MHCAS, Acute Trust links.

CONCLUSION/RESPONSE

We believe that the engagement activities and the publicity supporting them were comprehensive and resulted in the ICB achieving extensive and useful feedback. 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, we believe the consultation engagement and publicity was fit for purpose and meets best practice requirements.

5.7.5 Consultation materials

ISSUE RAISED IN FEEDBACK

Some people fed back that they thought the consultation document and the materials used in presentations were complex and difficult to understand.

DISCUSSION/EVIDENCE

We recognise that this consultation was addressing complex issues. These included the balance between inpatient beds and community services, what is needed in a good quality inpatient building

In developing consultation materials, we wanted to make them as simple and clear as possible while also showing that we had properly considered the relevant options and issues and giving them enough information that they could understand them. What we did to ensure they were as accessible as possible was:

- Ensure that publicity, consultation documents and social media were distributed through partners and in community locations (with clear language and inclusive imagery).
- Ensure support was 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

~ Offering to make audio, large and Braille formats available on request. (We understand that no requests for these were received.) ~ Providing an Easy Read version of the consultation document in digital format on the consultation website. (This was downloaded frequently.) Support was also offered to people with learning disabilities or difficulty in communicating. (We understand that no requests for these were received.) Following feedback during the consultation that some people found some of the documents and presentations to be complex or unclear, the ICB produced updated documents on the main proposal including: • Simplified information about the MHCAS • A simplified summary of the consultation proposal. These were made available at meetings and on the ICB website: https://www.nwlondonicb.nhs.uk/download_file/view/6636/1294 https://www.nwlondonicb.nhs.uk/download_file/view/6637/1294
CONCLUSION/RESPONSE We believe that 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

6 Proposal for Decision

Section 5 reviewed all the main consultation feedback and for each area made conclusions on how that feedback should be taken into account.

This section sets out our overall conclusions on what this means for our proposed way forward. Some of these areas have been proposed as mitigations through the work to develop further with partners as part of the implementation of the final proposal.

It covers:

- Our re-evaluation of the PCBC Option Appraisal, specifically including further consideration of the MHCAS location.
- Our revised proposed model for the future – particularly noting changes we are making in response to feedback and new information.
- The revised financial case in support of the way forward
- Our updated Integrated Impact Assessment and ICB Equalities Impact Assessment (EQIA) and our proposed mitigations for impacts.

6.1 Re-evaluation of PCBC option appraisal

The PCBC option appraisal is described in Section 2.9.

Following receipt and consideration of all the consultation feedback and any new information available the Project Team updated the PCBC option appraisal described in Section 2.9 to reflect new information and judgements. The revised assessment is attached to the DMBC as Appendix 6. This was reconsidered by the Project Board on 01 October 2024 and the Project Board confirmed agreement with the revised option appraisal conclusions.

The PCBC option appraisal suggested the Option C was the best way forward. The key features of this Option were:

- ***Service Model –*** Transformed model as now with lower bed base of 67 beds and a higher level of community alternatives, included an enhanced MHCAS service offering short stay inpatient facilities (the enhanced MHCAS provided 4 additional spaces of capacity, and the ability to support patients for overnight stays). Additional capacity in Brent would also free up 7 beds worth of activity at St Charles
- ***Service locations –*** All core inpatient provision at the St Charles, enhanced MHCAS at the Gordon Hospital.

As we received considerable feedback on the location of the MHCAS, we developed a variant of this option. The significant difference in the variant is that the enhanced MHCAS

would be located at the St Charles in a new location currently occupied by stores/kitchen. This would require capital expenditure at St Charles rather than at the Gordon Hospital.

To consider the new option the DMBC renames the PCBC preferred option C as "Option C1" and called the variant option with the MHCAS at the St Charles "Option C2".

The new option C2 is very similar to the PCBC Option B4, the only difference being that Option B4 does not enhance the current MHCAS model but retains it as it is now at the St Charles. Option C2 is able to enhance the model to enable additional capacity and overnights stays but also bases the MHCAS at the St Charles.

We have therefore excluded Option B4 from the new appraisal as it is so similar to option C2 in all aspects except that it does not enhance the MHCAS. There is no realistic possibility that it could be chosen as the preferred option ahead of Option C2.

The table below draws together the conclusions on the performance of the options against the objectives and sets that alongside the assessments of affordability. The description of the PCBC options is set out in Table 4 : in Section 2.9.

Table 11 : Revised option appraisal rankings (preferred option highlighted)

Option	Service Quality	Access to inpatient care	Access to Community Support	Quality of inpatient facilities	Promoting equality	Affordability/VFM
A1	6th	4th	6th	6th	6th	5th
B1	=3rd	=1st	=3rd	=3rd	=3rd	4th
B2	=3rd	=1st	=3rd	=3rd	=3rd	6th
C1	2nd	5th	2nd	2nd	2nd	=1st
C2	1st	5th	1st	1st	1st	=1st
D	5th	3rd	5th	5th	5th	3rd

There is a very clear pattern that options A1, B1, B2, and D perform poorly against nearly all objectives. The single area where they are better than options C1 and C2 is in access to inpatient care.

The decision between Option C1 and C2 is clear. C2 is better for service quality in an area of significant importance (patient safety), access to community support, and inequalities and it is equal in affordability terms,

Based on these assessments, our updated conclusions on the options are 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. It enables the Trust to have better decant capability to support ward upgrades when required.
Cannot be recommended as the way forward

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 as the way forward

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 as the way forward

Option C1: This option is both viable and delivers well on all our objectives. All inpatient care is from a high quality environment. It ranks well against all objectives except the access objective. Its significant shortcoming is that the MHCAS solution does not provide as the same level of safe high quality care as the new option C2. Although it does increase travel time compared to some other options the increase is not substantial. 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 revenue terms, than Option B4. It is within our capital threshold in terms of the essential expenditure required.
A good option but not as good as C2.

Option C2: This option is both viable and delivers well on all our objectives. All inpatient care is from a high quality environment. It ranks well against all objectives except the access objective. It provides the best solution of all options for high quality and safe patient care. Although it does increase travel time compared to some other options the increase is not substantial. The only options performing significantly better on access are A, 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 revenue terms, than Option B4. It is within our capital threshold in terms of the essential expenditure required. It provides the best location in access terms for the MHCAS.
Recommended as the 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 B4 and C1/C2 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. It enables the Trust to have better decant capability to support ward upgrades when required.
Cannot be recommended as the way forward

In conclusion it is proposed that Option C2 is taken forward as the preferred way forward

The appraisal also concludes that while both Options C1 and C2 are good options, Option C2 should be preferred. It offers significant additional benefits above C1 in terms of quality and safety of care in the MHCAS because of the colocations of the services on one site, as opposed to having the MHCAS isolated from inpatient care. It has lower revenue costs (because the isolated service would need extra security staff to address safety issues). There are obviously different access considerations as the two MHCAS locations are quite separate. The overall conclusion on access in terms of the two locations is that the St Charles location is significantly better for access for two reasons:

- Overall, it is better for people from KCW living in areas of higher deprivation.
- The MHCAS is used by people from Brent, Harrow and Hillingdon. Access is significantly better for these areas. These boroughs also have higher deprivation levels.

The revised option appraisal therefore proposes that ICB should confirm option C2 as the way forward.

6.2 The proposed model following the public consultation

6.2.1 Overall service model

As set out in the PCBC, and the NW London ICB Mental Health Strategy, the ICB aims to provide high quality care, in the least restrictive setting as close to home as possible. 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 and limit the number of people have to be in restrictive inpatient care.

- Maintenance of high quality inpatient care in the 67 beds at St Charles for residents of Kensington & Chelsea and Westminster, with the new beds in Brent used to ensure that all outer borough patients are admitted to the outer boroughs (this means more KCW residents will be able to be treated within KCW). This will be supported by further reductions in admissions and length of stay (especially for people who are clinically ready for discharge) which will reduce occupancy levels and enhance the quality of care for patient who need to be admitted.
- Enhanced crisis assessment services through the MHCAS expanded to 12 spaces, with 4 beds for longer term assessment and treatment, in a new and better location at the St Charles site. The model will continue to develop (e.g. to offer the ability to take in patients under Section).
- Further development of the Gordon as an asset for South Westminster by providing different community services from the space. (More details in section 6.2.4).
- Extending our place based integrated working with partners particularly in Westminster. We have worked with VCSE partners to co-design services and have embedded nine formal partnerships with six VCSE organisations in our community model across both Westminster and RBKC. All these schemes help our services reach out into the community in accessible and flexible ways, improving access and especially responding to the individual needs of those who might otherwise be disadvantaged. In the future, we intend to build on these successes; for example:
  - Support from the British Red Cross to help users with social issues that may be causing them to regularly access services.
  - Developing Hope in the Community, an open access community centre on the ground floor of the Gordon which will be a space owned by the VCSE from which to provide different groups and sessions.
  - Continuing the regular partnership forum held in both boroughs to bring together VCSE and other partners, which we will continue to use to develop and co-design services across the sector.

We recognise that in order for us to have sufficient bed numbers over the medium to longer term, while also reducing current high occupancy levels it is essential that we continue to monitor the effectiveness of our community services in reducing the need for inpatient admissions and reducing length of stay. We are confident in the programme of actions we have put in place to deliver the performance on length of stay improvements that will be required, but we are committed to ensuring that there are sufficient bed numbers in the long term and will take remedial action if that is proven not to be the case.

Should additional capacity be required this will be built into the normal business planning processes of the Trust and the ICB. Our expectation is that it is unlikely that any such capacity expansion is needed in actual inpatient bed numbers; our prime approach would be to build up community based capacity first as this is the least restrictive and more

effective option. Only in the event that this was proven to be insufficient would we then consider additional inpatient beds. For critical mass reasons any additional inpatient bed capacity would need to be on an existing inpatient site. For the reasons set out clearly in the PCBC and the DMBC that site would not be the Gordon Hospital as it too difficult to convert into a fit for purpose inpatient facility that delivers a high quality environment for patients.

6.2.2 MHCAS Model and location

We are continuing to develop the MHCAS model as we learn from experience (it remains a relatively new service). That learning has recently been enhanced through the useful input from stakeholders in the workshop described in Section **Error! Reference source not found.**

Some of the changes we have identified since we began the services we are already implementing are:

- ***Enabling the MHCAS to reduce the number of people admitted for short stays to impatient acute care.*** We have piloted having 3 beds to support the move of people to the MHCAS who need slightly longer care than 12 to 24 hours, enabling them to stay overnight. This has meant that we are able to move more people out of A&E and avoid admissions that would have been less than 7 days.
- As a result of the above, there has been a change to the length of stay that people spend with most people staying between 24 and 48 hours. This means that they start to receive care and treatment while in the MHCAS, before being discharged or referred to another service as appropriate.
- We are embedding a British Red Cross worker into our MHCAS to offer support to users with social issues that may be causing them to regularly access services.
- We have been piloting admitting people to the MHCAS who are under Section 2 if there were indication that a very short and intensive admission could deal with the issues that required them to be sectioned.

The overall MHCAS model is summarised below.

Figure 28 : MHCAS model

What is MHCAS?

- MHCAS The CNWL Mental Health Crisis Assessment Service (MHCAS) opened on 28th November 2022 as an alternative to A&E within the St Charles Hospital site providing:
  - Therapeutic space for people in a MH crisis
  - 24/7 medical and nursing led care
  - Direct conveyance by LAS and police to MHCAS
- It was launched in response to pressures in A&E and aims to provides a therapeutic alternative to attending A&E for those experiencing a MH crisis and a better patient experience for those without an urgent physical medical need

Service description

- A therapeutic alternative to attending A&E for those experiencing a MH crisis, and who do not have an urgent physical medical need
- Offers a range of therapeutic interventions in an appropriate space and opportunity to access a more prolonged and informed assessment of needs
- For residents of Kensington and Chelsea, Westminster, Brent, Harrow or Hillingdon. But will take out of area patients from A&Es in those boroughs when appropriate
- LoS should be less than 12 hours and no more than 24 hours
- Each shift is covered by a consultant, 3 qualified nurses and 2 HCAs.
- Social support is being embedded in the MHCAS with VCSE workers.

Referral routes

SPA
Access for patients over 18 and professionals is through CNWL's Single Point of Access (SPA) on 0800 0234 650 and if assessed as appropriate the patient can then attend or be brought to MHCAS. We welcome referrals from LAS, Police, 111, GPs and patients themselves.

Referrals through Acute Hospital Emergency Departments, Liaison Psychiatry Team
If patients have attended an A&E, referrals will be made through the A&E's Liaison Psychiatry Team who will complete an initial assessment first.

Walk-ins
The MHCAS also accepts walk-ins

Who's the service for?

People who have attended an Accident and Emergency (A&E) department within Kensington and Chelsea, Westminster, Brent, Harrow or Hillingdon or are a resident of these boroughs and in another A&E, as long as there are no urgent medical needs.

People who would otherwise have attended an A&E department but who have gone straight to MHCAS for their crisis assessment

6.2.3 Homelessness model

There is a large homeless population in Westminster and the correlation between homelessness and mental health is well known It was fed back through the consultation that the needs of the homeless population had not been sufficiently considered so a workstream has been run post consultation to consider the impact on this population and anything that is needed to ensure this group is receiving the care they need. There have been a number of mitigations discussed and agreed to meet the areas that there may have been an impact from the temporary changes.

Expertise in working with this population

The Task & Finish group discussed the expertise of the staff at the Gordon Hospital for working with this group. The Gordon Hospital was not a specialist service, but as a result of its location and consequent take of homeless people (particularly rough sleepers), staff there developed expertise that it is felt is not as strong in other CNWL inpatient units. In order to further develop the skills and expertise of wider mental health staff the group agreed the following should be explored.

- Develop a specialist team to in reach to all inpatient wards to provide support for people who are homeless or rough sleeping and are admitted to the wards. This team should sit with JHT but enable more focus on support during an admission and support with discharge. The proposed make up of this team is:
  - ~ One social worker.
  - ~ Two peer support workers.
  - ~ One nurse aligned.
- Training for CNWL staff in the needs of this population. This training should particularly focus on inpatient staff but would be useful more widely with all mental health staff.
- Particular focus on someone's professional family to be involved in their care, both in care planning and discharge planning. This should take learning from the Triangle of Care programme implemented across CNWL to support the consistent involvement of carers.

Suitability of community services

It is important to note that this population will have differing situations that result in different needs for community based care.

- There are some people who are homeless in temporary accommodation who will be treated in this temporary accommodation.
- People who are rough sleeping, may need to be supported into appropriate accommodation to receive care.
- Only those who meet the criteria for admission or to be sectioned should be admitted to an inpatient facility.

There are a number of specialist provisions for people with mental health needs who are homeless or rough sleeping

- Westminster Joint Homelessness Team.
- Westminster STEPs team.
- K&C Rough Sleeping Mental health practitioners (RAMHP workers).

While these services are able to provide specialist community support there has been feedback that without somewhere psychologically safe to receive community based care it is challenging for this population to get what they need from community services. The Task and Finish group agreed to focus in the following areas

- Cross organisational care plans for these patients who often have multiple health needs. This should include, GPs, mental health services, drug and alcohol services, social care and any voluntary sector organisations working with the individual

- Increased access to the Dual Diagnosis service to recognise the dual support needs of this population who may not be able to access some services as a result of co-occurring drug or alcohol use.

Ensuring that the needs of the homeless are being appropriately met within the community

The ICB recognises the concerns raised by many people over whether homeless people, who are a particularly vulnerable group, have been negatively impacted upon by the changes. In the response to the detailed feedback in Section 5.3 we have set out how we believe the community model remains the right one for homeless people as well as for the general population. However, we have also recognised that the data we have on the experience and outcome for homeless people with the new service model is not robust. For example, we do not have good data on where people who are receiving community based care are living and whether those places are providing a good enough environment for their treatment to be effective.

It is therefore proposed that as part of the decision making on the proposal the ICB will commission an audit of care to the homeless in KCW who are suffering from an acute mental illness over the period of a year. The details of the audit should be agreed with key stakeholders and the aim will be to identify where there are shortfalls and to make specific, detailed proposals on addressing them. Should the audit determine that any of those shortfalls are specifically because of the reduction in inpatient provision (which would probably mean they are related to where the patients are living) the ICB will prioritise addressing those issues in its funding plans for the future.

6.2.4 Future role of the Gordon Hospital

In considering the proposals for this consultation the ICB and Trust have consistently said to the public that the Gordon should have an important future as the home for health and related services supporting the local community.

Working with system partners we have considered a number of ways to ensure the building is being used to its full potential to offer care and support to those in the south of the borough.

Our core proposal is to turn the building into a community services hub to support the development of the Octopus model[29] of care and Integrated Neighbourhood Team in Westminster. The ideas to support this include

[29] A model that delivers health and care working in a truly collaborative way across health, VCSE and Local Authorities in Westminster. Aiming to work in a way that is more relational and compassionate and improves equity in health care.

- Move the South Westminster Community MH Hub to the Gordon Hospital to offer a full range of community services from the open access Hope in the Community service to our crisis based Home Treatment Team from the same building.
- Offer clinics from other health care providers from the building, including the potential to run GP Clinics, Talking Therapies sessions and other VCSE led services from the space.
- Maintain some of the building as a training space to be used by the system as this is currently something teams are spending significant investment in to rent spaces externally.
- Provide an access point to CNWL's crisis services, particularly the MHCAS. This would involve some staff being available at the Gordon to support triage and transport to the MHCAS for patients in crisis, providing somewhere in the south of Westminster to improve access. Details of the model will be worked up with stakeholders.

We have yet to finalise the detail, and we should note that the proposals are dependent on capital expenditure which will need to be shown to be value for money as described in the section below.

6.2.5 Addressing inequalities

CNWL and the ICB are committed to addressing structural racism and inequalities alongside implementing the proposed model of care. As set out in section 2.2.3 we recognise that the causes of inequalities in mental health are complex and multi factorial; some of them can only be addressed through integrated action from all elements of government and society. Other elements relate more directly to mental health service provision and the staff who work within those services.

CNWL has a substantial programme of work to address those elements related to service provision with two headline approaches.

- The Workforce Race Equality Standard (WRES)[30]
- The Patient and Carer Race Equality Framework (PCREF) [31]

The ICB is also committed to working with its system partners to address the wider societal causes of inequality.

Workforce Race Equality Standard

[30] NHS England » NHS Workforce Race Equality Standard

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

For staff there is a clear action plan developed for the WRES which the Trust has been part of since 2015 and is monitored against annually. The annual reports are published on CNWL's website[32] and the 2022/23 annual report on progress is included as Appendix 13.

The Trust objectives for 2023-2026 are

Objective 1: Use SCARF[33] (safe, compassionate, accountable, reflective, fair) principles as our behaviour framework to enable all people to integrate Equality, Diversity and Inclusion into their daily work as leaders and healthcare professionals.

Objective 2: Continue to monitor and review our Employment and service delivery processes with a focus on reducing biased based decision-making.

Objective 3: As part of SCARF behaviour work build measure, assess and undertake targeted action to enable individual's unique contribution and sense of belonging measured through an inclusion index.

Objective 4: Improve staff and patient voice to shape a better experience, particularly for those from diverse community backgrounds

Objective 5: Build trust cultural competencies to address inequalities.

Objective 6: Establish the Trust as a System Leader on EDI.

Patient and Carer Race Equality Framework

The PCREF was launched nationally for all Mental Health Trusts at the start of 2024/25 following early implementation by 10 Trusts. Through the PCREF development the Trust is monitoring the following areas to improve understanding of ethnicity, use of services, access and outcomes for service users from all ethnic backgrounds

- Ethnicity data reporting.
- Use of the Mental Health Act.
- Use of restrictive interventions.
- Delivery of physical health checks.
- Access to community services.
- Outcomes recorded.

---

[32] Public equalities documents: Central and North West London NHS Foundation Trust (cnwl.nhs.uk)

[33] SCARF is a framework for explaining behaviour. It stands for Status, Certainty, Autonomy, Relatedness and Fairness

. Trust wide work has focused on

- The ongoing integration of the PCREF workstream into CNWL's Community Collaboration programme to embed the framework across the Trust.
- The PCREF Data workstream looking into the statutory and legislative reporting duties of PCREF, identifying gaps in data and ensuring that data relevant to the Framework is accessible to all divisions, services and teams across the Trust via a central, standardised dashboard.
- The PCREF project team continues to engage with other NHS Trusts, including PCREF pilot and early adopter sites, and with minority ethnic service user and carer forums and VCSE organisations representing the needs of culturally and ethnically diverse communities, in an effort to collate and learn from best practice in the field, informed by lived experience and expertise.

Priorities for local areas are being developed through local engagement with experts by experience and local community organisations, building on the EDI report developed with New Buckinghamshire University. Specific projects include

As the Trust is in the process of developing the PCREF strategy we are working up metrics as part of the wider programme.

As set out in section 2.2.3 inequalities are complex and multi-faceted, therefore this is not something that CNWL or the ICB can solve alone. Each Borough is working closely with system partners to deliver improvements in access to and outcomes for service users from different backgrounds. Each borough has developed a clear action plan to enable a more targeted approach to embedding the framework, geared more towards the demographics and needs of local populations and services The ICB is committed to continuing to work with system partners to improve prevention, the cultural competence of services and the variety of service offer.

6.3 The revised financial case

We have revised our financial case from the PCBC to take account of the final proposal, considering both capital and revenue implications.

6.3.1 Capital requirements

The capital requirements for the different options are set out below, with the preferred option highlighted.

Table 12 : Capital costs

Option	Core costs to deliver service option £m	*Additional costs next 3 years £m **	***Total Potential costs £m***
A1	**12.00**		***12.00***
B1	**8.00**	*1.10*	***9.10***
B2	**15.00**		***15.00***
C1	**2.00**	*2.20*	***4.20***
C2	**3.20**	*3.30*	***6.50***
D	**5.00**	*2.20*	***7.20***

* Optional capital expenditure to refurbish remaining vacant space at the Gordon and save lease costs elsewhere

The full £6.5m cost includes two separate elements:

- The work to deliver the key clinical service component (an enhanced MHCAS at the St Charles) costing £3.2m.
- The work to refurbish all the remaining space to make it usable by other services, a maximum of a further £3.3m.

[It should be noted that the costs of option C2 represent an increase of £1.2m above those identified for C1 in the PCBC. The CNWL Financial Director has reviewed capital availability and confirms that £3.2m will be affordable as set out below. The PCBC suggested that the maximum level affordable was £3m but this assessment is a year old, and the Trust is confident it can deliver the additional £200k funding.]

CNWL has identified services (see section 6.2.4) which it plans to move into 2/3 of the available space at the Gordon. The capital cost to enable this on its own would be £2.1m (rather than full £3.3m identified). However, that would enable substantial revenue savings on leases elsewhere amounting to £1.2m per annum so the payback would be very rapid. A decision on the remaining £1.1m investment to refurbish the remaining vacated space will be dependent on whether the Trust, the ICB or other system partners can identify services appropriate to move into the remaining floor, and the level of savings they could achieve on premises elsewhere to make the capital expenditure worthwhile.

The CNWL Trust does not have sufficient capital in the short term to deliver the full amount and so it is proposed that this will be done in two phases matching the two components above. The first tranche of £3.2m can be delivered over two financial years (2024/25 and

2025/26); second tranche of investment of at least £2.1m will be targeted at taking place in the years immediately following as soon as the capital can be prioritised for it. Whether this is increased to the full £3.2m is dependent on identifying value for money usage of the remainder of the space as above.

6.3.2 Revenue implications

The tables below show the revenue impacts first of the core proposal in this DMBC, and then the impacts if the vacated space at the Gordon is fully reutilised with appropriate capital expenditure as set out above. The preferred option is highlighted in green

Table 13 : Revenue impacts of core proposals

Option	Released from current services £m	Additional staffing costs £m	Non pay inc soft and hard FM £m	Cost of capital £m	Facilities savings £m	Total £m
A1	-5.4	6.6	0.3	0.6	0	**2.13**
B1	0	0	0.2	0.4	0	**0.62**
B2	0	2.2	0.3	0.8	0	**3.29**
C	0	0.2	0	0.1	0	**0.31**
C2	0	0	0	0.2	0	**0.17**
D	-2.2	3	0.1	0.3	0	**1.16**

Table 14 : Revenue impacts including additional use of vacated space

Option	Released from current services £m	Additional staffing costs £m	Non pay inc soft and hard FM £m	Cost of capital £m	Facilities savings £m	Total £m
A1	-5.4	6.6	0.3	0.6	0	**2.13**
B1	0	0	0.2	0.5	-0.6	**0.08**
B2	0	2.2	0.3	0.8	0	**3.29**
C1	0	0.2	0	0.2	-1.2	**-0.78**
C2	0	0	0	0.3	-1.8	**-1.46**
D	-2.2	3	0.1	0.4	-1.2	**0.08**

The tables show that the additional costs to the NHS of implementing the core proposals will be £110,000 per annum. However, if all the vacated space is reused this will change to a maximum potential annual saving of £1.52m. If this was achieved it would be directly reinvested in enhanced services, supporting some of the mitigations identified within this DMBC. The minimum likely savings would be around £0.9m. (That minimum is delivered if the only effective use could be found for the remaining vacated space did not deliver any

savings on premises costs elsewhere. Any premises savings elsewhere would increase the savings achieved).

6.4 Revised Integrated Impact Assessment (IIA)/Equalities Impact Assessment (EQIA)

We have carried out a very detailed Integrated Impact Assessment which has been updated for this DMBC and is attached as Appendix 2.

We have also updated the PCBC EQIA in the ICB's normal format. This is attached as Appendix 3. The EQIA is based upon the IIA and draws its conclusions from it.

As this service change is limited to the highly specialist services, we provide for people experiencing acute mental illness our analysis has focused closely on identifying if there are significant inequalities impacts in relation to that group (rather than for all people with mental illness) and on ensuring the development of appropriate mitigations.

6.4.1 Overall findings

The Executive Summary confirms that "The IIA did not identify major disproportionate impacts for Option 3, however there are some populations where mitigations should be put in place".

Headline messages from the IIA in terms of the impact of our proposals are summarised below.

Findings from the Integrated Impact Assessment

- To better care for the populations of Kensington and Chelsea and Westminster (KCW), mental health resources have been diverted to reducing inpatient stays and expanding community services.
- The closure of the Gordon Hospital in 2019 allowed for these changes to be put in place and since the closure of the inpatient wards at the Gordon, KCW has seen an overall decrease in inpatient admissions, length of stay, readmissions, whilst community referrals and unique service users increased.
- Within KCW, some underlying differences in the experience of different groups since 2019/20 were seen including:
    - Greater decreases in the number of inpatient admissions for the Black and White populations in Kensington and Chelsea, whilst the largest decrease was seen for the Mixed population in Westminster – the referrals for all patients are the highest for the Black, Mixed and females suggesting needs are being identified within the community
    - A slight, but not significant, reduction in the number of unique service users in Kensington and Chelsea compared to pre-inpatient ward at the Gordon closure

- ED attendances being consistently higher in Westminster than Kensington and Chelsea perhaps reflecting a greater need for this population

- Admissions by section has continued to increase over time. This suggests that with the temporary model, more people are able to be seen in the community whilst not preventing those who need more structured support from receiving it
- Whilst overall inpatient activity has decreased and community referrals have increased for the catchment population compared to pre-Gordon closure levels, out of borough[34] admissions have risen slightly for the black population and males in KCW but not beyond levels expected for the provision of out of borough beds
- Furthermore, whilst acute mental health Emergency Department attendances have risen for all population, they have also continued to rise nationally due to COVID-19. The number of attendances for the Black and Asian populations continue to remain 20% higher than baseline levels and national average (13% and 20%) although they are trending down towards baseline compared to the national average, which continues to increase.

6.4.2 Affected population groups

The IIA carefully considered specific population groups considered to be the most vulnerable for this service as set out in the extract in the figure below.

Figure 29 : Population groups

Concerns have been raised about potential impacts on these four population groups and have been explored in more detail

Population groups	Rationale
Black & Black African People	• Previous work has found there to be an over-representation of Black and Black African people in inpatient units, particularly younger Black men • Furthermore, this population tends to have poor experience of inpatient care and worse outcomes, and there is a potential for negative impact of fewer beds if needing inpatient care
Carers	• Carers may struggle to visit inpatients if care is far from home due to increases in travel expenses • Older carers may be particularly impacted if they have to travel further to visit inpatients or have an added burden of care if their loved ones are cared for in the community
Homeless People	• Homeless people may have difficulties paying travel expenses, and may be particularly vulnerable to changes in travel distance • Furthermore, the homeless population may not have anyone to care for them when in community settings
Vulnerable geographies	• Vulnerable geographies may be impacted of the proposed service change due to deprivation / geographic proximity to the Gordon

[34] Out of borough refers to admissions outside of the catchment area but within CNWL (e.g. a K&C resident admitted in Brent)

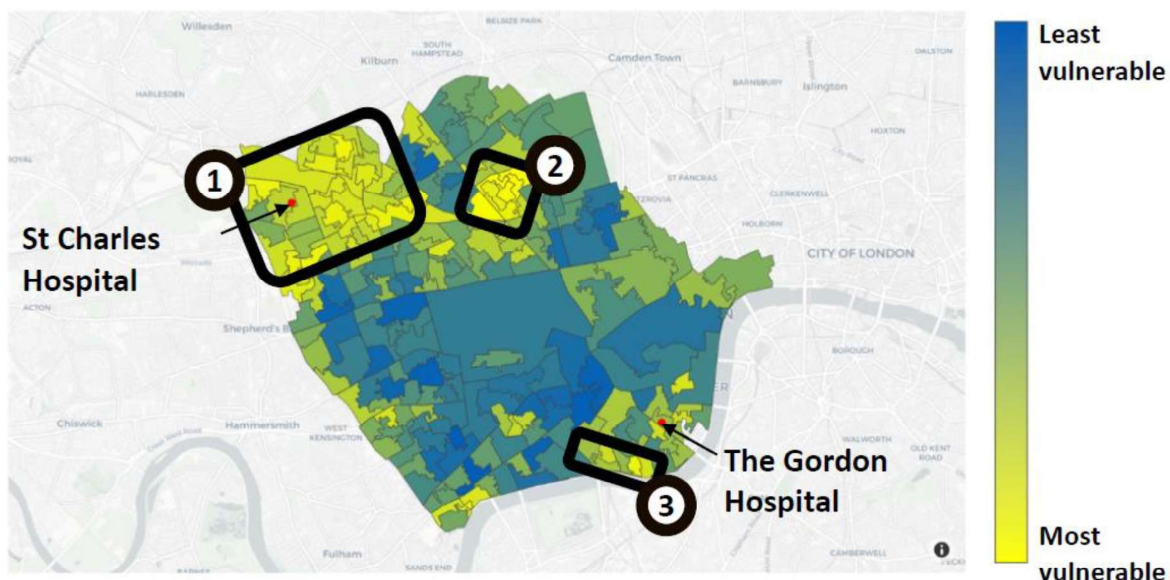
6.4.3 Affected geographies

It identified which geographic areas were of greatest concern

These are shown in the figure below:

- Area 1 is North Kensington in which the St Charles is sited (this area includes the site of the Grenfell tower fire tragedy) and the population affected by it.
- Area 2 is Church Street which is an area in North Westminster with a highly vulnerable population
- Area 3 is Pimlico South which is the area surrounding the Gordon Building

Figure 30 : Vulnerable geographic areas



6.4.4 Service model effects

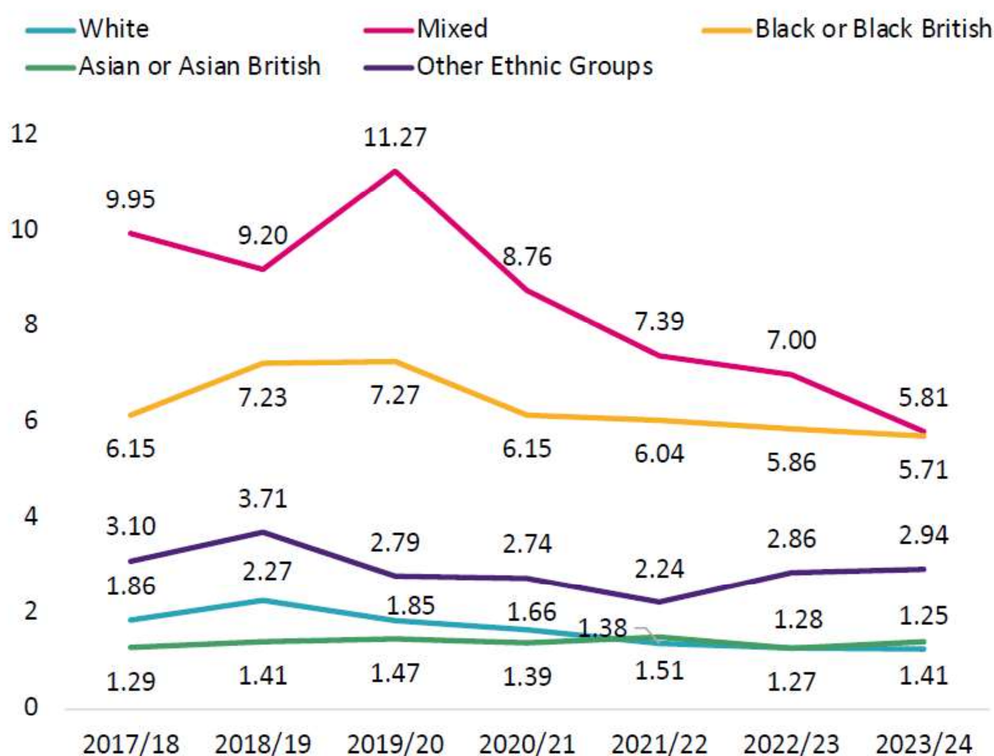
As would be expected the biggest changes the IIA identifies for the KCW population are in relation to the balance of services since the temporary closure took place with significant reductions in inpatient admissions and matching rises in the uses of community provision. This is directly in line with the ambitions of the proposed model, which is to rebalance services in this way, reducing our usage of restrictive inpatient admissions.

Admissions to inpatient care

The IIA reviews admissions in significant detail and its key findings in relation to admissions are:

- Overall admissions for the general population decreased by 27% - despite the fact that the bed closures were in Westminster the decrease was greater in K&C (21% decrease for Westminster and 35% for K&C)
- Admissions reduced for all ethnic groups, but there were some differentials as shown in the chart below.

Figure 31 : Admission rates per 1000 population by ethnicity

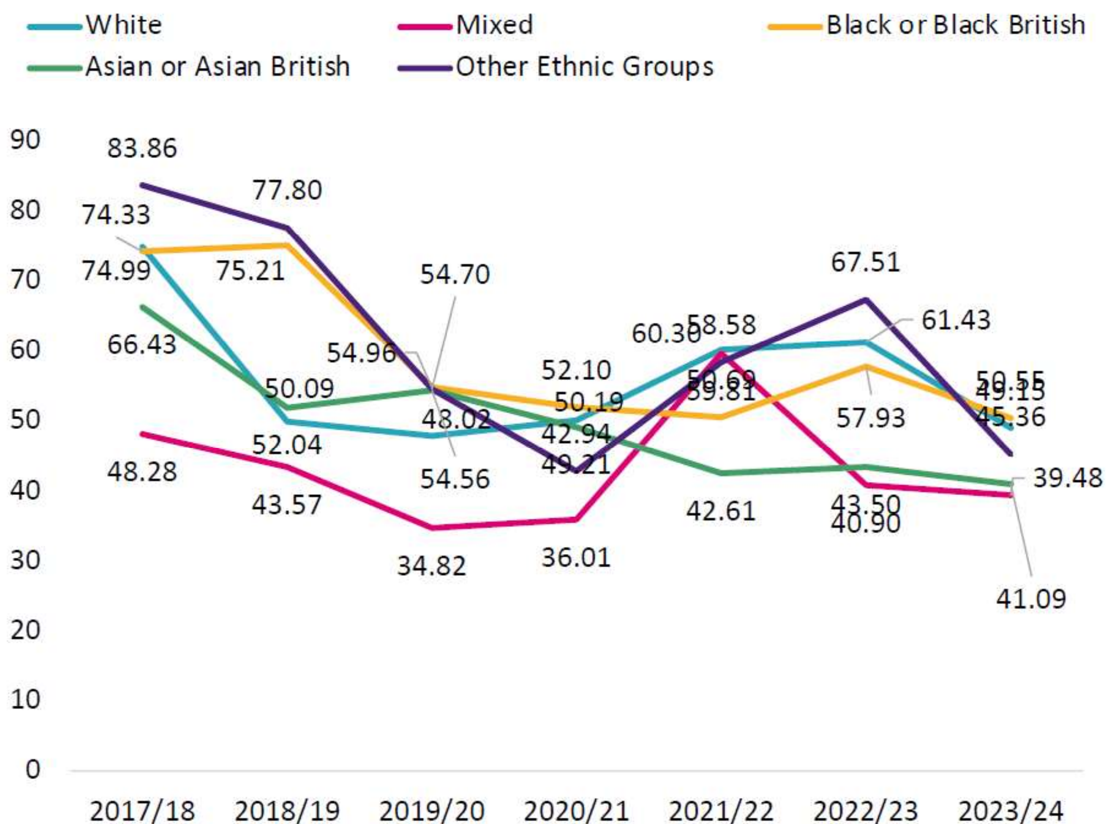


- In considering these changes we have to be aware that the absolute numbers in the groups mean we have to be careful about the significance of changes. The key points we can note are that:
  - ~ The overall drop in number of admissions was 27%
  - ~ Two groups experienced a significantly greater than average drop in admissions (mixed was the greatest at 48% drop, and then white at 32%). In terms of our proposed service model this would be good for these groups (because it means more patients are not having to experience care in a restrictive setting).
  - ~ One group ("Other") experience an actual rise in admissions. However, this group only consisted of 112 patients in 2019/20, and consists of whole range of different individual communities, so it is not possible to know whether this is significant for any individual community.

- The drop for black people was 21% compared to the average of 27%. This could be a negative impact but with this size of population (219 people in 2019/20) it would only take a reduction in admissions of 11 for this group to be at the 27% general population average.

- Length of stay has not changed significantly since 2019/20 (although it was higher in the two years before 2019/20). Relative length of stay for different ethnic groups fluctuates significantly year, without an obvious pattern. This is likely to reflect the relative low numbers of patients overall and normal fluctuations within that.

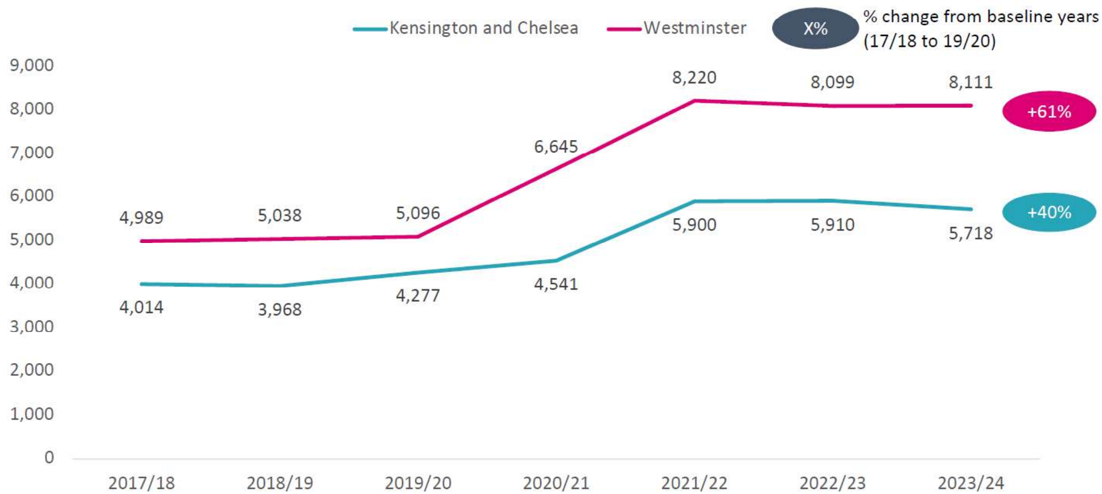
Figure 32 : Length of stay

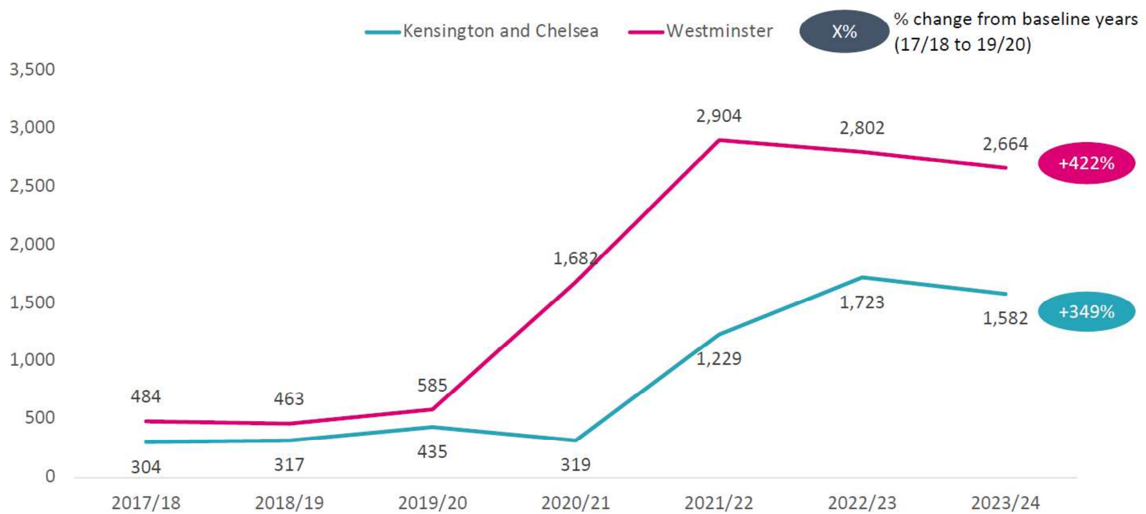


<u>Use of community provision</u>

In line with our preferred service model there has been significant enhancement of community capacity and in terms of access to community services

Figure 33 : Increase in referrals to Community services and to Community Mental Health Hubs





<u>Service user experience</u>

Some key areas identified by the IIA are:

- Waiting times to access community based services have decreased by 60%

- Out of borough admissions (patients having to be admitted outside the borough they live in) have risen, as would be expected because of the closure of a service in one borough. The average for the three years prior to the closure was 133 patients a year going out of borough, while in 2023/4 it was 171, and increase of 38.
- Readmissions per head of population within 30 days have dropped substantially (by approximately 40% for Westminster and 60% for K&C). Readmissions within 180 days have also reduced by 22% and 41% respectively)
- Waiting times to see community mental health services have dropped substantially (approximately 60%).

Notable impacts on different populations

The IIA shows:

- The number of inpatient admissions for people with a learning disability/autism have fluctuated around a very low base (7 people admitted in 2018/19 in KCW was the lowest, and 22 in 2019/20 the highest). Admissions were 5 in 2023/4.
- The number of inpatient admissions for homeless people in NW London has decreased since the closure by 26% comparing 2019/20 to 2023/24. Admissions dropped further from 2021 to 2023 but rose in the following year. Length of stay for homeless people has dropped by 19% which is a significant difference to the general population. No change identified in use of community services by the homeless population
- The analysis of admissions by geography shows there has been little change in the overall pattern of admissions and referrals to mental health services suggesting this has not been significantly affected by the temporary closure.

Travel time and cost impacts

The IIA travel time analysis focuses on service users who are admitted (and their visitors) and this inevitably shows an overall increase in travel times. In reality, the picture is more complicated; it should be recognised that there is a significant improvement in travel times for service users who now do not need to be admitted at all, and obviously for their family and carers (as they do not need to travel to a hospital to see them). We do not have a robust way of accurately estimating this benefit, but it is clearly substantial.

The IIA shows an overall small increase in average travel time per journey (approximately 4 minutes by car at peak travel times and 10 minutes by public transport.) The analysis does not show a disproportionate impact based on deprivation or protected characteristics.

Figure 34 : Average travel time impact

Population	Average travel times (mins)			
	Option 3			
	Peak	Difference to BAU	Public Transport	Difference to BAU
General population	13.27	+4.18	28.76	+9.60
Ethnic minorities	12.44	+3.52	25.96	+7.38
Deprived populations	12.89	+4.08	26.91	+8.43
Disabled populations	12.55	+4.08	26.24	+8.23
Women of child bearing age	13.55	+4.14	28.21	+8.88
18-25 year olds	13.75	+3.98	28.33	+8.89

Maximum travel times inevitably vary but as shown in the figure below the worst increase is 9 minutes by car and 19 minutes public transport.

Figure 35 : Maximum travel time impact*

	Peak driving				Public transport			
	Avg. travel time (mins)	Difference from BAU (mins)	Maximum travel time (mins)	Difference from BAU (mins)	Avg. travel time (mins)	Difference from BAU (mins)	Maximum travel time (mins)	Difference from BAU (mins)
Baseline (BAU):	9.09	-	18.20	-	19.16	-	35.40	-
Option 1	9.09	*Same service model as BAU*	18.20	*Same service model as BAU*	19.16	*Same service model as BAU*	35.40	*Same service model as BAU*
Option 2	9.09	*Same service model as BAU*	18.20	*Same service model as BAU*	19.16	*Same service model as BAU*	35.40	*Same service model as BAU*
Option 3	13.27	+4.18	26.83	+8.63	28.76	+9.60	54.12	+18.72

* The difference from BAU number for maximum travel time is the difference between the maximum travel time now by public transport (i.e. 54.12 minutes) and the maximum travel time as it was in the baseline (i.e. 35.4 minutes)

The IIA explores travel costs. For people travelling by private car the impact per journey is a maximum increase of £2.55 a journey.

The IIA does not cover public transport costs as they will be dependent on

- Whether or not they already use travel cards for other purposes in which case the journeys would have no cost impact
- Whether they would have taken public transport to the Gordon before it closed, in which case the fare would be likely to be identical as it all in Zone 1.

In the case of people without travel cards and would in the past have walked but now would use public transport the cost would be £5.60 for a return journey.

The IIA has calculated cost for visitors needing to use taxis and says those cost would increase by an average of @£5.50 per journey. There is no disproportionate impact identified based on deprivation or protected characteristics.

Travel times have been calculated using the home addresses for the actual patients who were admitted in 2019/20 and 2023/24. This is the best indication for how easy it is for an individual to remain embedded in their local community when admitted to an inpatient facility.

In reality we know that people are often admitted from another NHS site (e.g. A&E), and NHS transport is arranged in these cases.

An assumption has also been made that the travel time from someone's home address is a reasonable proxy for travel time for carers and family to visit them when in hospital.

In the case of family visiting, the travel times above will be likely done multiple times during someone's stay in an inpatient unit. Therefore, the overall increase in travel time and cost will likely be higher for people visiting. The mitigations for supporting people with this increase is set out in section 6.4.5.

Impacts on vulnerable geographies

The IIA looks specifically at the three geographies identified as vulnerable:

- ***North Kensington.*** No impact identified as it is much closer to the St Charles than the Gordon.
- ***Church Street.*** There is a minimal increase in travel times to receive inpatient admission
- ***Pimlico South.*** Is analysed in more detail below because the average travel times to inpatient care for patients from this area increase by 19 minutes by car and 38 minutes by public transport. In 2023/24 there were 15 inpatient admissions for residents of this area; this means the negative travel impact was affecting 15 patients and their visitors.

Pimlico South is identified in the IIA as having the following characteristics

- 61% of households are deprived with 25% being economically inactive
- 49% of the population are of an ethnic minority
- 4% of the population have poor English proficiency
- 17% of the population are disabled, with 7% reporting poor general health
- 40% of the women in the population are of childbearing age

In terms of service usage, the IIA notes that:

- There has been an increase in unique mental health service users for this population from a pre-Gordon closure average of 10 to 12 in 2023/24
- This increase has a corresponding increase in referrals with over 110 more referrals in 2023/24 compared to the pre-Gordon closure average at (386 vs. 267)
- Despite these increases, the volume of inpatient admissions has decreased to 15 admissions in 2023/24 compared to 36 per year pre-Gordon closure

6.4.5 Implementation mitigations to address potential issues and inequalities impacts

Mitigation area	Reason identified as a priority	Mitigations
1. The additional travel time for patients and their visitors from the area of South Pimlico for service users who need an admission	Identified as a vulnerable geography and has most increased travel time for service users who need an admission	Explore provision and access to local step down beds Work with local transport to provide shuttle buses to improve access to services Subsidising travel for patients and visitors Better signposting of local services - Hub of Hope is CNWL's official signposting partner, so improved access to the tool locally so people can get information about the services available to them. Better liaison with social care Add community psychiatric nurses - Continue to build on the development of the community mental health hubs in South Westminster to ensure people have access to qualified mental health professionals local to home in the community.
2. The potential impact on carers. Particularly those from South Westminster for people who need an admission	Carers in the South facing further to travel when someone is admitted and extra travel costs	Develop NW London carers strategy - Building on the Triangle of Care, work with the CNWL Carers Council and other carers from across the area to develop a strategy outlining the importance of carers in mental health support and how to ensure they are involved in service delivery. Consider carers within treatment plans - Continue the roll out of Triangle of Care in mental health services to ensure involvement of carers in care planning Consider subsidising carer travel - CNWL already provides support to carers to visit inpatient units, when they do not have the means. Ensure this is incorporated into policies to make the offer consistent

Mitigation area	Reason identified as a priority	Mitigations
3. The potential impact of service change for the residents of North Kensington, including the Grenfell bereaved and survivors.	The population of North Kensington has many areas of high deprivation which is known to have a high correlation with mental health needs. This area also contains the Grenfell tower and it's important that the offer of services to this population is sufficient.	Get better patient experience data - Project is underway to improve the options for collecting patient experience feedback, both through Experts by Experience gathering feedback following service use and a text option being piloted. Roll these out to the services in North Kensington to understand experience of services from this community Further review needs of Grenfell population - Work is underway to consider with the Grenfell community what the specific service offer for this population will look like for the next 5 years. Look at more local crisis service provision - Regardless of where the MHCAS is located, access points to this service and for people who need support in a crisis should be considered in all localities to give a different offer than A&E
4. Mitigations for the black population	While the data did not show a disproportionate impact on this group, it is known that they are often over represented in terms of numbers of patients admitted under section. There was also an increase in A&E attendances for the black population, primarily driven by black females.	Mechanisms to improve engagement with community services and improve signposting - Hope in the Community on the ground floor of the Gordon looked to have some services specific to supporting this population. Continue to develop this offer to provide access to appropriate community based services Improving local community focus and better involvement of 3rd party organisations to meet holistic needs. - Continue working with the local borough based voluntary and community organisations to understand the needs of this population and ensure they have access to appropriate care. Improve discharge pathway - Do further engagement work with this population to understand what support should be offered on discharge to ensure someone has enough appropriate support on discharge to stay well

Mitigation area	Reason identified as a priority	Mitigations
5. Mitigations for the homeless	Identified as a priority area because of the high levels of prevalence in Westminster, the clear correlation between homelessness and mental health issues, and the feedback in the consultation that the new model is not working as effectively as it needs to for the homeless.	Develop specialist provision for the homeless further as outlined in Section 6.2.3

7 Assurance and advice

7.1 Legal duties

The main legal requirements for the ICB to consider in engaging, consulting and decision making on service change are:

1. The duty of public involvement set out in the NHS Act 2006. This duty has been addressed through
   1.1. The engagement carried out in advance of the public consultation (as described in the PCBC)
   1.2. The extensive efforts to engage with local people, service users, staff and stakeholders within the public consultation described in Section 3 of this DMBC
   1.3. The ICB taking full account detailing and consideration of the feedback within the consultation set out in the Consultation Evaluation Report and Sections 4 and 5 of this DMBC
2. ***The duty to consult with local authorities*** which has been met through our engagement with the Joint HOSC as set out in Section 7.2 below.
3. ***The Public Sector Equality Duty under section 149 of the Equality Act 2010 and the duty to reduce health inequalities*** evidence for which has been provided through the Equalities Impact Assessment and Integrated Impact Assessment together with the analysis and mitigations set out in the latter and in this DMBC.
4. ***NHS commissioner duty to secure continuous improvement in quality and duty to promote integration*** which has been met through the careful consideration in the PCBC of the impacts of the temporary service change related to the closure of inpatient services at the Gordon, and the further analysis in this DMBC of all service quality issues raised.

The Gunning Principles for lawful consultation establish a clear framework for the ICB to consider. The principles are set out below together with evidence on how they are met.

Table 15 : Conformance to the Gunning Principles

Gunning Principle	How met
1. Proposals are still at a formative stage A final decision has not yet been made, or predetermined, by the decision makers	The ICB did not take a view or predetermine any outcome of the consultation prior to the consultation period. This DMBC and the Consultation Evaluation Report provide the ICB with the information it requires to make a final decision
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	Section 0 sets out the information provided within the consultation, the efforts made to ensure it was accessible, and to provide people with the information they needed to consider the proposals, including providing additional clearer information when it was requested. Section 5.6 covers feedback from participants in the consultation on the information provided.
3. There is adequate time for consideration and response There must be sufficient opportunity for consultees to participate in the consultation.	The consultation period extended over 16 weeks (extended during the consultation by 2 weeks over the original plan). The normal consultation period is 3 months. The longer period allowed for the Christmas holiday period and to ensured additional events could be offered to provide wider participation
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.	This will be evidenced both by this DMBC and its appendices including the Consultation Evaluation report, and the consideration and decision making of the ICB Board which will take place in public.

In addition to the formal public consultation, we have met with the local authority JHOSC to seek their views on the consultation report and our response. We have also taken on board feedback based on the Mayor of London's six tests for major service reconfiguration. We have revisited our clinical model, pathways and approach to reflect the recommendations of the London Clinical Senate.

7.2 Joint HOSC

7.2.1 How the Joint HOSC was engaged

The ICB engaged with the NW London Joint HOSC in the pre consultation period to agree the scrutiny arrangements for the consultation based on the services covered by the process. It was agreed that there would be a separate JHOSC panel set up from councillors from Westminster City Council and the Royal Borough of Kensington & Chelsea. The JHOSC held five meetings to scrutinise the pre-consultation business case and process taken through the consultation.

These meetings were attended by members of the consultation project group to input into discussions and answer questions on the process and documentation. The consultation process was adapted based on feedback from the Joint HOSC to ensure that all audiences had been engaged with.

Westminster City Council and Kensington and Chelsea Royal Borough Council commissioned a report from the Professor Emerita of Social Work at King's College London, Gillian Manthorpe, (included in Appendix 8) on the proposals. The councils intended the report to be included in their formal response to the consultation. While submission of the report was delayed by the process of checking for factual accuracy, we have treated it as part of their consultation response. Much of the report comprises opinions expressed by people interviewed by Professor Manthorpe and discussion of those views. We have treated the report as a valuable qualitative response to the consultation, alongside the HealthWatch reports (Appendix 10), the opinions expressed during consultation events, the free text accompanying the questionnaire submissions and the written responses to our proposals.

7.2.2 Initial feedback from the Joint HOSC

Following the completion of the Public Consultation the Joint HOSC issued a report on February 29th.

This report set out six recommendations which the JHOSC wished to be considered prior to decision making. These recommendations are set out below, together with an assessment of the relevant issues and a proposed response.

It should be noted that where specific points raised by the JHOSC have been covered sufficiently in Section 5 the information has not been repeated but is cross referenced.

JHOSC RECOMMENDATION 1 **The Mental Health Crisis Assessment Service model is further developed in advance of any decision being made, in consultation with and using a co-production approach that involves partner organisations (including councils), stakeholders and the local community.** Specific points raised included:

- That the MHCAS model needing developing further
  - There should be clarity on people who needed to stay for longer than 72 hours "the MHCAS proposal lacked clarity on the length of stay for those who need longer than the indicated maximum 72 hours; would patients who are acutely unwell have treatment delayed or stopped in order to be transferred to a long-stay hospital to resume treatment"
  - Information needed on the effect on patients signposted to less restrictive treatment
  - Evidence that it would reduce pressure on Emergency Departments
  - Clarity on how MHCAS contribute to avoiding crisis
- Whether there could be two locations for MHCAS (one at the Gordon and one at St Charles)
- That the model was not sufficient to prevent the need for inpatient beds. "The MHCAS is not an alternative to in-patient care" and more staff would be needed in the community for those who have been discharged

Response

Section 5.5 shows how we have carried out substantial further work with stakeholders to develop the MHCAS model. As a result, we have made the specific proposals for changes to the model set out in section 0.

It would not be realistic to have MHCAS in two locations as suggested. This kind of 24 hour services needs a critical mass of patient activity and staff which would not be possible to sustain in two locations in KCW. It would result in substantial additional costs without meeting the needs of additional patients as we believe a single site can provide the right capacity for the population.

We agree that the MHCAS model does not mean we do not need inpatient beds. However, the evidence we have from here and elsewhere is that it can reduce both the number of residents requiring and their length of stay, and therefore reduces the number of inpatient beds we need. In Sections 0 and **Error! Reference source not found.** we address the question of whether our community services have the right capability and capacity in place to support those patients who would otherwise have been admitted.

We believe we have addressed this recommendation in full.

JHOSC RECOMMENDATION 2

The Financial Case is further developed.

Particular points raised were

- Providing further detail on reuse of funding from the Gordon inpatient services and new investment (including the utilisation of extra funding from central government for mental health), and the choices made on funding
- Whether the extra 100 staff funded would meet the needs of people with different and complex needs

"The JHOSC would like greater clarity on where the savings from the temporary closure of the in-patient beds at the Gordon Hospital had been reinvested. In particular, members wanted to understand where the reinvestment had been in Westminster and Kensington and Chelsea and if some of the funds had been invested in other boroughs. The JHOSC also felt that funds should not be diverted from inpatient beds, even though community services are needed."

Response

We have set out answers to these points in Section 5.6.2 and we believe this addresses the recommendation in full.

JHOSC RECOMMENDATION 3

The proposal does not reflect the need for inpatient beds to mitigate the pressures of admissions across the two local authorities. This should be considered.

The report refers to

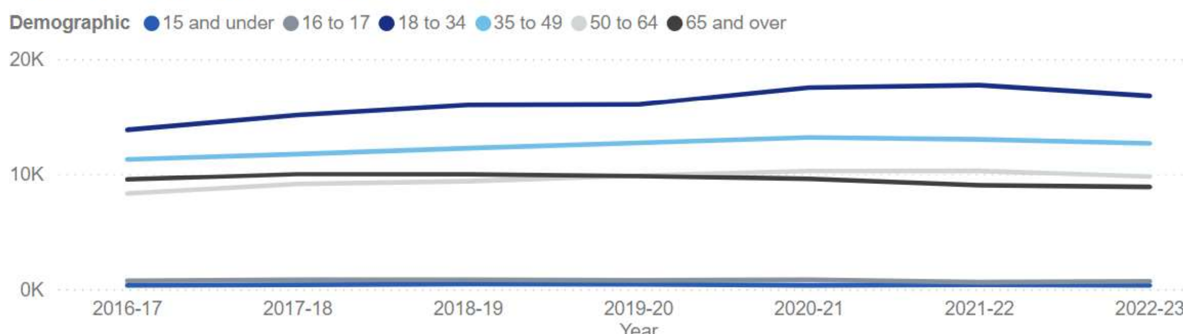
- Escalating demand for inpatient beds as a national trend
- Prolonged waits for mental health beds at St Mary's and how this is being mitigated
- The MHCAS not providing a sufficient alternative to inpatient beds
- Potential negative impact on future increased trauma for the Grenfell community because of the future inquiry and decisions regarding the future of the tower.

Response

We have comprehensively described in Section 5.2 why we believe we have sufficient capacity in terms of inpatient beds.

We do not recognise the statement there is an escalating demand for inpatient beds as a national trend. The data in the chart below shows the national statistics for Mental Health Admissions over the last 7 years, and it can be seen that there is very little variation.

Figure 36 : Detentions Under the Mental Health Act[35]



Irrespective of this we have analysed this very carefully in terms of the needs and demand within KCW.

We have carefully assessed the issue of waits for mental health beds from Emergency Departments and believe that the services we have put in place together with our proposals for enhancing the MHCAS and reducing unnecessarily long lengths of stay for people who are clinically ready for discharge are a better way of addressing the issue than simply providing more inpatient beds.

We have never suggested the MHCAS is a direct alternative to inpatient beds. The MHCAS does reduce the need for beds because it prevents unnecessary admissions and helps to short length of stay. As stated above it also reduces pressure on Emergency Departments. Our belief is that the whole network of community provision we have put in is providing an effective alternative to inpatient beds. There is no treatment that a patient can receive in an inpatient bed that they cannot receive in the community – the difference is simply that inpatient beds are needed when patients pose a risk to themselves or others.

We fully recognise the issue of trauma for the Grenfell community, but we have no evidence at all which suggests that this is leading to an increase in the number of people who need inpatient care rather than care within a community setting.

As requested, we have considered all the points raised by the JHOSC. Our conclusion remains that we do not believe there is an unmet demand for inpatient beds that cannot be better met by enhancing community provision, including the MHCAS, and by tackling the issue of accelerating the discharge of those patients occupying inpatient beds who no longer meet the criteria to reside.

[35] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2022-23-annual-figures

JHOSC RECOMMENDATION 4

There should be more in-depth analysis provided on the impact of proposals across the groups disproportionately admitted into mental health inpatient care as well as in case load referrals since the temporary closure of the in-patient beds at the Gordon Hospital.

- The PCBC does not provide sufficient information on the impact levels on different groups including those from black and ethnic minorities

Response

We have provided with this DMBC a substantive Integrated Impact Assessment which directly addresses the question of impacts on these communities. Its overall assessment is that those impacts are not significant.

JHOSC RECOMMENDATION 5

The proposal should be flexible to take into account the unique location of the local authorities and the challenges around beds and occupancy to specifically address the homeless population and high levels of visitors.

Specific points made:

- An occupancy level target of 85% may be too high "if acute mental health needs increase in the future"
- There are specific mental health needs in KCW relating to acute beds there are not considered that option 3 "may not adequately meet". The point is particularly made in terms of the homeless population.

RESPONSE

We believe that relying on community based services is more flexible in the face of uncertain demand than tying up resources in inpatient beds which may not be needed. An occupancy level of 85% is well below that achieved by the majority of NHS Trusts across the country and we believe it offers substantial flexibility for the future. Should mental health needs rise, we can off course consider the need for additional services including beds when we know that is going to happen. We do not have any reason that the need for acute inpatient beds is going to rise.

We recognise that both Westminster and Kensington and Chelsea experience large numbers of visitors – tourists, shoppers, commuters and those visiting for other reasons. These visitors may experience mental ill health requiring acute mental health care during their visit. However, NHS policy for many years has been to repatriate such patients to their place of

residence[36] for treatment (including inpatient treatment should that be required). They were not – bar an exceptional handful of cases over the years – admitted to St Charles or the Gordon; they have not been admitted to either facility since the temporary closure of the wards at the Gordon; and, unless NHS policy changes, would not be admitted in the future.

We agree there is a need for more work to confirm if the proposal is meeting local needs in relation to homelessness. While we believe that our services do have the capacity to provide the care needed by this vulnerable group, we recognise that data is limited We are therefore proposing that we will carry out a detailed audit over a year of how well our services our meeting the needs of the most acutely ill homeless people and identify if there are any gaps in provision. The ICB has confirmed in this DMBC that addressing these gaps would be a priority for future investments.

JHOSC RECOMMENDATION 6

A new hospital site to be considered for the future, and in the more immediate term alternative sites for more acute mental health beds should be revisited. Specific points made include:

- Travel impact of not having locally based inpatient services for both social staff and services users and their visitors
- The proposal does not prevent out of borough placements "the number of residents in the two local authorities placed out of borough is still around 70 percent which has risen to an average of 14.8 people per month in 2023/24"
- More consideration should be given to continuity of care especially for those treated out of borough
- There should be more consideration of future plans in the proposal including the possibility of a new location for inpatient services

RESPONSE

We have carefully taken account of the additional travel time impacts of not having services in two locations as discussed in Section 5.2.6. This shows that the increase in travel times is not very significant for most people. We do not consider that the number of patients travelling over a specific administrative boundary is as significant as how much further how many people have to travel. We have recognised the potential need to mitigate additional travel costs for patients from South Pimlico.

[36] Those considered homeless count as resident; place of residence here includes the five boroughs of North West London where CNWL providers treatment (W, KC, Harrow, Brent and Hillingdon)

We acknowledge that there is a travel impact, particularly for those based in the south of Westminster that visit inpatients. This includes some social care staff. We have been endeavouring for over a year to work with the local authorities to understand this impact. However, constraints on local authorities' staff have limited their ability to engage.

We have also shown how the out of borough admissions are reducing and are on track to being very similar to what they were before the closure.

CNWL has substantial experience at maintaining continuity of care between its hospitals and community services. The reality has been for many years that many people have not been treated in the hospital closest to their home, and we have had to develop the appropriate expertise to address this.

We have for many years operated mental health services in Westminster and Kensington and Chelsea as a "bi-borough system" – with patients from the north of Westminster being more likely to be admitted to St Charles, and patients from the south of K&C being more likely to be admitted to the Gordon. Indeed, before the move of the acute mental health inpatient wards formerly at St Mary's Hospital to St Charles, there were no acute inpatient beds for working age adults in Kensington and Chelsea.

We have endeavoured to identify other potential locations for inpatient services, and indeed have asked the local authorities to work with us to do so. Neither we nor the local authorities have been able to identify potential suitable sites. Should such a potential site be identified, we would of course consider it. Such a site would, of course, need to offer good value for money. W

7.2.3 Later feedback from Joint HOSC

A letter from the JHOSC was sent on 8 August 2024. This is attached in Appendix 9. It raised several specific points in relation to the DMBC, each of which we have addressed below.

The table below sets out the key points in that letter (as direct quotations) and our response.

Table 16 : JHOSC letter issues and our response

1. Review of efficacy of community alternatives to crisis care.
We have extensively reviewed this within the DMBC Section 5.2.5. We are confident that the additional service provision we have introduced and will further enhance is more than sufficient to meet the needs of those patients who would in the past have been admitted. We also believe strongly that doing so without requiring them to be located within restrictive institutional care is beneficial to those patients
2. Agreeing a co-design process going forward, and more structured approach to joint working to provide MH services.
We have developed North West London's mental health strategy for adult residents with a working group that included officers from each local authority and consider this a model we can build on for future work. The ICB also has officers from local authorities on its Strategic Commissioning Committee and elected members on its Board. The ICB is very happy to work closely with the Local Authorities to develop such mechanisms further.
3. Further refinement and clarity around MHCAS model.
The DMBC in Sections 0 and 0, together with the MHCAS appendix of the PCBC provides extensive information on the proposed MHCAS model
4. Engaging homelessness agencies/ specialist care services in shared review of existing provision, and participation in planning.
We established a substantive one off workshop with stakeholders to consider the specific needs of the homeless population and have demonstrated in the DMBC how we are addressing the concerns raised about the model. We are committed to continuing to engage all partner agencies in working on better solutions for his population group and are recommended forward invite stakeholder partners to join with us to develop an audit of care for homeless people with acute mental health issues which will identify and gaps
5. Further review of the data and collective analysis among ICS partners.
We have reviewed the data with ICS partners – indeed we held a specific workshop in June 2023 to review the data received from our May 2023 Call for Evidence with all partners from across the ICS. Since the close of the consultation, we have held further workshops to review the additional data contained within this DMBC on the 22nd of July with over 70 attendees from CNWL, the ICB, both Local Authorities, local VCSE organisations and service users and carers. There is a particular issue on reviewing data held by local authorities. We received further data on AMHP assessments in December 2023. These appear to show a mismatch between the number of people that AMHPs recommend for admission under section, and the number of people admitted by CNWL under section.

[Placeholder for text to be agreed with Local Authority colleagues on work to reconcile data]

6. Survey questions and interpretation of the results – the Committee raised concern that the results can be chosen to be interpreted a certain way, considering the perceived weighting towards the preferred option. For instance, many are concerned that with options 1 and 2 there would be a loss to community services so may have agreed to Option 3 on this basis, but this does not necessarily mean there is not a significant demand for beds. What does come through from the information the Committee has read is that there is significant pressure on beds, sometimes long waiting times for beds and concern that admissions are too brief so as to increase bed availability and the Committee feels these issues must be addressed in the Decision-Making Business Case.

The ICB is not interpreting the consultation results as meaning everyone endorsing the preferred option agrees that bed number reductions are appropriate. However, we have been completely open with the public in the consultation that there is a choice we have to make about the balance of provision, and whether it is better to have more people in restrictive inpatient beds, or more people supported by enhanced community services. It is likely that those endorsing the option believe that it is better to reduce bed numbers than reduce community based provision. The DMBC addresses in detail whether the proposal contains sufficient inpatient beds. We agree that there is pressure on all services including inpatient beds (as is true of mental health services everywhere in the country). We particularly agree that occupancy rates are too high and the DMBC outlines plans to reduce this without impacting on quality of care. We have specifically addressed the question of admissions being too brief, and we disagree with the assertion. We remain of the view that every day longer a person stays in a restrictive/locked institutional setting when they do not require it for their own or others safety is a day too long.

7. Timing – the Committee noted feedback that staff are 'completely overwhelmed' by numbers of acute mental health patients and suggest that it is too soon to reduce numbers of beds for those in need of inpatient care. The Committee, whilst noting that there was feedback from some staff in favour of the preferred option, questions whether there is enough time for CNWL and ICB to adequately investigate and balance these issues before drafting the Decision-Making Business Case. This view is supported by commentary by organisations such as Healthwatch and the Royal College of Psychiatrists who state that the proposals have not been adequately co-produced and will have significant adverse impact, including on surrounding hospitals, staff safety and morale, quality of care, patients being discharged too early and inappropriate out of area placements.

The timing is very much driven by the need to resolve the future pattern of services. We note that local authority colleagues have urged us to move to a speedy resolution.

We also note that HealthWatch is explicit that:

- Their report, "is a summary of what we have heard after speaking with over 100 people about their experiences and perspectives of mental health services in the biborough" (October 2023 report), and
- There is not a consensus in what they have heard in favour of any one option, and
- Their report is limited by its reliance on qualitative data, and they were unable to supplement their methods using quantitative data.

The DMBC does consider valuable qualitative input, such as the HealthWatch report, along with the quantitative data to support its conclusions.

We recognise that many staff feel very much under pressure, and we also know that this is normal within mental health Trusts.

We have had far more time to learn from the temporary closure of the inpatient beds in 2019/20 than is ever normally the case on a planned service change. We believe it very clear from the data we have on the number of people being sectioned (which has not risen) and the number of out of area admissions (which have been zero for 198 months) that our overall inpatient capacity is sufficient to ensure that every for whom there is a risk to their own safety or to others can be admitted.

We do not believe it correctly represents the letter written by the Royal College of Psychiatry or the Healthwatch reports to say that those organisations believe the preferred way forward will have significant adverse impacts. They do identify some concerns, and we believe they are all fully addressed in this DMBC.

- ***Co-Production*** – *We* are very pleased with the input we have had from stakeholders on the MHCAS service model as described in Section 0. We believe we have also worked as closely as possible with stakeholders in developing and considering the options as set out in Section 1.5 of the PCBC and Section 0 of this document.
- ***Impact on surrounding hospitals.*** Section 5.2.1(e) shows how the concerns raised by the Royal College of Psychiatry were based on out of date data on Out of Area Performance. Section 5.2.4 addresses the concerns related particularly to the impact on quality of care at the St Charles and shows that on key quality and safety indicators we are performing better than before, and that we have added staff to address increased acuity.
- ***Staff safety and morale.*** Section 5.2.4 shows how assaults and physical violence have reduced since the temporary closure. Our staff surveys show that our staff
- ***Quality of care.*** We believe Sections 5.2 to 0 fully address all the concerns raised in terms of quality of care.

- ***Patients being discharged too early.*** Section 5.2.3 shows why we believe this is not the case.
- ***Inappropriate out of area placements.*** There have been no such placements since January 2023. As above this feedback was based on out of date information.

8. Location – the Committee reiterated previous issues around out of area placements and out of borough placements. The lack of provision in South Westminster was of particular concern.

The DMBC specifically addresses feedback on both these areas. There remain no inappropriate OOA placements. We specifically address the question of whether we it is feasible to return to two substantive inpatient units in KCW in DMBC section 5.2.6

9. Engagement – people from black, African and Caribbean backgrounds are overrepresented in the mental health system and did not feature sufficiently in the consultation so more engagement with these groups must be considered before drafting the Decision Making Business Case.

We have set out in sections 3.5 and 5.7.3 our extensive efforts to engage with all affected groups.

Throughout the consultation the priority was to ensure it was easy to participate, with a range of different opportunities and information in accessible formats, and well-promoted with a focus on outreach through community groups and voluntary sector networks.

People from Black African and Caribbean backgrounds were included in this approach – and 11 organisations with specific reach to these communities were contacted by the ICB. As well as being asked to encourage participation across their networks, we offered to facilitate or attend meetings of their members and undertook a flexible range of in person and online sessions to suit the organisations' preferences.

As a result, 3 meetings were conducted attended by 55 people, detailed in the Evaluation Report section 11.3.2.

An additional 30 engagement sessions were held with service users, carers, staff, communities in key localities and NW London residents. Because of the variety of formats used it was not possible to capture monitoring data systematically at these, however across the piece there was a significant degree of cultural diversity among participants at meetings, including people from Black African and Caribbean backgrounds.

The only data available on the profile of participants is drawn from the questionnaire response, and 29 questionnaire respondents (17%) identified as being from Black / Black British; Asian / Asian British; or Mixed backgrounds. Although the sample is small, this suggests participation around half the level of the local population.

We note that the Integrated Impact Assessment found no disproportionate impact of the preferred consultation option on the Black African and Caribbean communities, apart from a small increase in the number of women from these communities attending Emergency Departments, and we would propose to explore this in more depth in future engagement.

The over-representation of people from Black African and Caribbean backgrounds remains a concern: indeed, the preferred consultation option was developed in large part based on qualitative research to suggest that secure environments can be traumatising for these service users and experience and outcomes of inpatient care have been poor.

The Trust has committed to further engagement and since the consultation has established a Black Service User Group to strengthen involvement as part of the CNWL Patient and Carer Race Equality Framework (PCREF).

It is proposed to use the Black Service User Group as the main vehicle to ensure that engagement is targeted on service users with lived experience and is focused on informing, testing and developing service improvements.

10. Best interest – the Committee noted the concerns raised by the Royal College of Psychiatry regarding the proposed options and believe they should be given careful consideration to ensure that any decisions made are in the best interest of patients and healthcare providers alike. Addressing these concerns will not only enhance the credibility of the proposed options but also ensure that the solutions implemented are comprehensive, effective, and aligned with the highest standards of psychiatric care. The Committee noted the London Clinical Senate published a report in October 2023 and feel it would be helpful to the Committee in its scrutiny to understand how ICB/CNWL have responded to the series of recommendations made.

We have given careful consideration to the concerns raised by the representative from the Royal College of Psychiatry (London Division). The letter is attached in Appendix 11, and we have provided a detailed response to it in Section 7.5.

We are confident that we have fully addressed the issues identified in the Royal College of Psychiatry letter (some of which are based on out of date/incorrect information) and shown that the proposals are in the best interest of the local population.

It is important to note that the detailed London Clinical Senate review said ""The case for change to reduce inpatient beds and strengthen community provision is consistent with current best practice guidance that quality of care can be enhanced for people in their communities and outside institutions. The proposed model also provides an opportunity to manage inequalities working closer with communities through place-based partnerships. Centralising the most acute and ill patients on the St Charles site

provides more modern facilities and has the potential of greater workforce flexibilities."
11. Crisis Recovery House – more consideration should be given to this as an option in drafting the Decision-Making Business Case.
The MHCAS model is being developed with learning from the crisis house to support people for slightly longer periods of time. We believe the MHCAS provision is better targeted at meeting the needs of people in crisis than the Crisis Houses were. However, we will continue to monitor the service delivery of the MHCAS, and to review and develop our service offer for people in crisis based on outcomes over time.
12. Accessibility – there are concerns that the consultation was inaccessible to those stakeholders whose first language is not English. Whilst it is acknowledged the survey had a translation function, as indeed did the website, the summary report needs to be made accessible in different languages and there could have been more engagement with different non-English speaking communities across the two local authorities.
Accessibility was a priority throughout the consultation and material was produced in formats such as Easy Read and access was offered to Braille or BSL interpretation. As the ICB does with large-scale public engagement exercises: • Online information had a translation function and provided a link through which print translations or interpreting can be requested • The summary report is made available as a translation (a language panel on the print/PDF version advertised this in English and the main five community languages) • The full consultation document and questionnaire print/PDF version provides a phone contact through which either the translated summary or an interpreting service can be accessed. Of the 45 voluntary organisations initially invited to participate 7 (16%) represented communities which are predominantly non-English speaking and similarly of the 18 thematic local meetings 3 (17%) attended by 73 of a total of 249 participants (29%). This represents a good practice approach to access for non-English speaking communities and compares well with NHS public consultations of similar scale and type.

7.3 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.

7.3.1 Strong public and patient engagement.

The PCBC set out the extensive patient and public engagement that has been carried out prior to the consultation, and which has directly informed the design and development of the range of services in the proposed way forward. It highlighted:

- The Voice Exchange project, commissioned in partnership with Healthwatch: a citizen's advisory panel on the future model of care.
- New Bucks University and CNWL's report on Equality, Diversity and Inclusion, engaging with people of Black African and Caribbean heritage to hear their experiences.
- Wider engagement including a series of open virtual Q&As with public and staff.
- The structured process of workshops with stakeholders/pathway experts to inform the option appraisal in the PCBC.

Section 3 of this DMBC and the Consultation Evaluation report provided full details of the substantial work of the ICB in providing the maximum opportunity for people to engage with the consultation itself. Overall, we had

- 770 attendances (excluding Trust/ICB staff and facilitators) at our consultation events and other meetings where we engaged with people on the proposals
- 200 completed questionnaires on the proposal
- The benefit of the HealthWatch run pre-engagement process which involved 133 people (the process was documented in one of the two major reports from HealthWatch which form part of the feedback considered in this DMBC)
- Substantial written feedback with 13 organisational responses and more than 35,000 words in comments written in questionnaires explaining people's views. In total around 120,000 words of feedback were considered in the Consultation Evaluation Report.

The independent Consultation Evaluation Report included a specific statement that "in our view, this [the information provided in the report on engagement and participation] shows that the ICB has made all reasonable efforts to comply with requirements." It also said, "we heard some themes consistently, and believe that this report is based on a sufficient level of information provided by individuals bringing a sufficiently broad range of perspectives to enable us to draw conclusions about the views of service users, staff and other stakeholders and summarise the issues raised to inform development of the DMBC."

There has been feedback criticising the consultation process, and the process leading up to it. This is explained, assessed and responded to in Sections 0 and 0. On the basis of this assessment, the information within the PCBC on the process before engagement, the detail in Section 3 on the approach used for the consultation, and the engagement level achieved we believe that the overall process meets the requirement.

7.3.2 Consistency with current and prospective need for patient choice

The model of care set out in the proposed option in the consultation represents a substantial extension of choice for service users in terms of the range of treatments offered to service users, providing an alternative to inpatient admission and flexibility to respond to the specific needs of each individual.

In terms of choice of location for inpatient care, the preferred option for consultation maintains the consolidation of inpatient beds on a single site at the St Charles site, rather than re-opening full inpatient beds at the Gordon Hospital (although Option C enhances this with provision of crisis assessment at the Gordon Hospital). This results in an impact on travel time, particularly for people living in South Westminster. While the number of people overall travelling more than 30 minutes is *less* in our proposed options (because of the alternative services on offer), the number of people travelling more than 60 minutes is higher.

There is often a balance to be achieved between the number of places where treatment is offered to patients and the quality of the treatment. This was shown to be the case in this PCBC. The option assessments showed clearly the advantages of the proposed options in terms of range of services offered and physical quality of the inpatient facilities, while also showing that they had worse impact than other options for patient access to facilities near them.

The Consultation Evaluation Report directly considered the issue. One of the questions in the consultation questionnaire asked for responses to the statement that they would prefer to travel further (30-45 minutes) to receive inpatient care in hospital with facilities offering a better patient experience and met national standards. 48% of responses said they agreed with the statement while 31% disagreed.

Overall, we believe that the extension of treatment options offered to people who require acute mental healthcare in a crisis delivered by the proposed way forward ensures an increase in overall patient choice.

7.3.3 Clear, clinical evidence base

The clinical evidence base supporting the model of care proposed in both our options for consultation was set out in detail in the PCBC. In addition, the guidance and advice of the Royal College of Psychiatrists informed its assessment of the acceptability of the quality of physical accommodation implied in each of the options that we have considered.

The Clinical Senate report provided to support the PCBC confirms that the proposal follows best practice guidance and outlined a number of recommendations in relation to strengthening the evidence base. All of these recommendations have been addressed.

The three most senior clinicians in the Trust covering the relevant services (the Trust Chief Medical Office, the Medical Director for the Division, and the Clinical Director for

Westminster have written to the ICS Chief Executive to confirm their support for the proposals. They have reconfirmed their support for the proposed option having taken account of the feedback provided through the consultation process and their letter is attached to this DMBC.

7.3.4 Support for proposals from clinical commissioners

This PCBC, all the options considered, and the option put forward for consultation have been developed by the North West London ICB in collaboration with CNWL NHS Foundation Trust. Support from commissioners was initially demonstrated by approval of the ICB of this PCBC.

[Draft text. The consideration and approval of this DMBC by the ICB Strategic Commissioning Committee on xxxx and ICB Board on xxxx will confirm this support remains after due consideration of the consultation feedback]

7.3.5 Bed reductions – condition(s) met

The requirement in this test is that: *"If significantly reducing bed numbers, demonstrate that sufficient alternative provision will be put in place alongside or ahead of closures; and/or show that new treatments or therapies will reduce admissions."*

The range of alternative services that have been put in place as alternatives to inpatient admission are set out in detail in the PCBC.

There is substantial consideration of the consultation feedback in relation to whether or not the proposal retains enough inpatient beds and on the availability of sufficient alternative provision in Section 5.2. We believe this section evidences that:

- The ICB has a clear strategic plan for the number of inpatient beds required in North West London to meet patient demand, and these proposals are consistent with that plan.
- The reduction in bed numbers proposed relates to beds for people previously admitted as informal (voluntary) admissions. We have provided the right community capacity to ensure that those patients are receiving at least as good (and we believe better) treatment, care and support as they would have in inpatient facilities.
- The sufficiency of the alternative provision is demonstrated by our recent history and performance in terms of out of area admissions, the fact that there has been no increase in the number of people being sectioned, and the fact that readmissions have not risen from the levels they were at in 2019/20.
- Realistic plans are in place across North West London including in KCW to reduce hospital occupancy rates to ensure resilience to any future increases or spikes in demand.

In addition, the Clinical Senate, which has a particular responsibility for considering this condition has supported the preferred way forward as being aligned with best practice.

We believe the condition is met.

7.4 The London Mayor's Tests

The Six Tests are a framework for assessing major health and care transformations in London. They inform the Mayor's position on proposed changes to ensure that they are in Londoners' best interests. The Six Tests cover:

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

The Mayor has provided a letter of feedback dated 26 January 2024 to set out his initial position based on the independent review he commissioned from the Strategy Unit, and to describe additional information he believed necessary to show that the tests had been met. The letter and accompanying report are attached as Appendix 7. The letter focusses on the first four tests.

[A second letter….. Text TBA in relation to the letter received prior to the ICB considering the DMBC]

The subsequent sections set out our assessment of how these proposals meet the 6 tests, and directly address the matters raised by the Mayor's letter and independent report. The requests for more information from the Mayor cover areas which were also subject to consultation feedback and are assessed in Section 5. To avoid duplication of material this section answers each key point from the Mayor's letter in headline but may cross refer to the relevant additional detail in other sections.

7.4.1 Health and healthcare inequalities

The requirement in this test is that: "*The proposed changes have maximised the opportunities available to the health system to reduce health and healthcare inequalities, which have been set out transparently together with an evidenced plan for further action. The plans clearly set out proposed action to prevent ill-health, including targeting action and resources to improve the healthy life expectancies of the most disadvantaged.*"

The PCBC stated that equalities impact assessment carried out by the ICB demonstrated that the option recommended is the one best placed to reduce health and healthcare inequalities. It said that in particular, the development of the MHCAS and the longer term commitment to focus on community based provision would have a positive impact on inequalities which would not be achieved if we returned to an inpatient focused model.

In its consideration of this test the Mayor's letter of 26 January said that the DMBC should:

- Set out analysis of the factors that are causing inequalities within the current service
- Draw on analysis of current inequalities and the reasons behind them to shape the future model of care and to develop specific plans for reducing them, working closely with the groups experiencing these inequalities
- Set ambitious targets for reducing inequalities and describe the metrics that will be used to track progress on this
- Consider how the needs of people with a learning disability, autistic people and people experiencing homelessness will be met by the future service
- Directly and robustly address structural racism with clear plans and targets
- State the expected impact of the changes on travel times and costs for patients, families and carers across a typical course of treatment, and identify any inequalities in these impacts across different population groups
- Consider the 'Right Care, Right Person' (RCRP) operational policing model introduced in November 2023. The letter says "the DMBC would be greatly strengthened by work to identify the potential impact of RCRP on demand, access, experience and outcomes for the future service, including in terms of unequal impacts across different population groups."

Each of these items is addressed below.

Factors causing inequalities

Our analysis in this area covers two separate components:

- ***Inequalities relevant for all mental health services.*** Section 2.2.3 identifies the determinants of inequalities in mental health and notes that numerous intersectional issues come together to drive them. The most significant determinants are societal factors such as poverty and structural racism. Our general approach for addressing inequalities for all mental health services is described in section 6.2.5
- ***The specific impact on inequalities of the proposals we are making in this DMBC.*** We have carried out a very detailed Integrated Impact Assessment which has been updated for this DMBC. It is summarised in Section 6.4 and is attached as Appendix 2. The IIA analysis is specific to the changes being proposed which only affect the relatively small population of local people with SMI which is so acute that they are at risk of needing to be admitted to a restrictive inpatient setting. We have set out mitigations for the key potential impacts in the IIA in section 6.4.5. As set out in Section 6.4 the IIA does not identify many significant inequalities that are likely to be associated with the service changes proposed. The issues we have identified for equalities that are directly related to the service change proposed are set out below along with the actions we are taking to address them:

- ***Increased travel time and costs for visitors and carers to inpatient services for the vulnerable population of South Pimlico.*** This is the inevitable consequence of losing the inpatient services at the location closest to this area. We have therefore considered this as an area requiring mitigation – see proposed approach for this in Section 6.4.5
- ***A significantly greater reduction in admissions from South Pimlico than we would have expected between 2019/20 and 2023/24.*** (15 admissions in 2023/24 compared to 36 per year pre-Gordon closure). This is a more substantial fall than the general population (27% reduction). However, we are sure that the greater than expected fall cannot be explained by the temporary closure of the Gordon wards. Patients are not admitted following attendance at an inpatient hospital such as the Gordon. They will have been assessed as requiring admission somewhere else (such as by a Community Mental Health Team or at a main hospital emergency department), and then transported by the NHS to the inpatient location. The vast majority of admissions are not voluntary, and patient choice is not a factor for sectioned admissions (meaning it could not be accounted for by patients saying that would not attend a hospital because it was further away). Given the very small number of patients involved, data analysis does not provide any explanation of the fall, and it may therefore be simple fluctuation of numbers. We have not set out a mitigating action but will continue to monitor admissions from this area to ensure there is not a continuing issue.
- ***A substantially greater decrease in admission rates per head of population for the Mixed ethnic group and the white ethnic group (although to a lesser extent), alongside a smaller decrease than the average for the Black ethnic group.*** We do not have data that allow us to analyse what might have caused these variances. The highest increase in referrals to community MH services is also from the mixed population. However, we do not believe that the data on its own is evidence of inequalities in the service provision, and it does appear that needs of this group are being picked up in the community mental health teams.

- ***Homelessness.*** The key risk we have identified for the homeless population is that under the preferred option they may be receiving treatment and support for an acute mental health condition while rough sleeping or in inappropriate accommodation. We believe the changes would only be affecting a small number of patients. Before the closure we estimate that on an average day around 5 beds would have been occupied by homeless people. We have mobilised several services to meet the needs of those patients, but we do not yet have data to tell us how well those service is working to meet needs. We are therefore proposing a mitigating action of a focussed audit to identify any gaps, and the ICB is committed to prioritising investment identified by the audit as being needed to meet those gaps.

<u>Shaping the future model of care and plans to reduce inequalities, setting targets and describing metrics, directly address structural racism with clear plans and targets</u>

Our model of care is driven by the belief that a more community focussed service is better for all groups of patients, and so is not directly driven by the overall desire to reduce inequalities, but to increase the quality of care for all.

Our overall plans to address inequalities are described in Section 6.2.5. In line with mental health services across the country we are in the early stages of developing our Patient and Carers Race Equality Framework (PCREF), and this will be where we set targets and metrics in more detail.

As set out in Section 6.4.5 we are proposing to build our mitigations for the inequalities we have identified as being linked to the service change into our implementation of the preferred model. We will, wherever possible, engage with the groups most directly affected the shape the detail of those plans.

Consider how the needs of people with a learning disability, autistic people and people experiencing homelessness will be met by the future service.

We have directly considered these groups within this DMBC in Sections 5.3 (for homelessness) and 0 (for people with a learning disability or autism).

Impacts of the changes on travel times and costs for patients, families and carers across a typical course of treatment, and identify any inequalities in these impacts

The IIA covers this in detail. See Section 6.4.4 for summary. The analysis does not cover the costs of a typical course of treatment because they will vary substantially dependent on the mode of travel chosen and the particular circumstances of the relevant family members/carers (such as whether or not they use public transport with a travel card in which additional journeys add no cost).

Right Care, Right Person' (RCRP) operational policing model

We have, as requested considered the impact of this new model as set out in Section 5.6.6. In summary CNWL has not seen a significant impact on our services and people are being cared for by health professionals rather than the police and so there can be no differential impact on inequalities.

Overall conclusion

Conclusion: We believe that the test is met

7.4.2 Hospital beds

The requirement in this test is that:

"Any plans which involve a proposed bed capacity that is less than that implied by demographic projections should meet at least one of the following conditions:

- Demonstrate that sufficient alternative provision is being put in place alongside or ahead of the proposed changes, and that the additional workforce required will be there to deliver it.
- Show that specific new treatments and therapies will reduce specific categories of admissions."

The PCBC stated that that the consultation proposal did not propose capacity should be less than implied by demographic projections. The population in both boroughs is expected to drop slightly in the years up to 2030, in line with the pattern over the past few years. There would be no reason to increase the bed capacity as a result of demographic projections.

It said that the community based alternative provision in relation and the closure of the wards at the Gordon Hospital was largely in place already and that the review of the impact of changes since the temporary closure demonstrated that admissions had reduced with no detriment to quality of care. It also said that the additional capacity provided by the MHCAS under our preferred option would further add capacity resilience, as would the extra 14 beds which the Trust will be developing in Brent. The workforce is already in place to deliver the model proposed.

In its consideration of this test the Mayor's letter of 26 January said that the DMBC should provide more information and plans related to:

- A refreshed, comprehensive assessment of mental health needs across NW London ICS within its overall mental health strategy, which should be used to develop detailed demand and capacity modelling for the DMBC
- More detailed modelling of need, demand and capacity that demonstrates how the future service will meet population need.

The letter specifically says "to be fully assured that the proposed configuration of community and inpatient services is appropriate to the needs of the population, I would need the DMBC to set out a more detailed modelling of need, demand and capacity that demonstrates how the future service will meet population need. This should include demand from outside the two boroughs in the catchment area and should be broken down by population group and types of mental health conditions, in line with the recommendations set out in my independent review. Setting this analysis out would enable greater assurance that the modelling assumptions of 85% bed capacity and a 32-day average length of stay are realistic when tested against current performance."

The letter is accompanied by helpful and comprehensive report making suggestion on how the PCBC modelling should be strengthened. We have addressed these suggestions in detail as part of our overall response to feedback on the service model and the adequacy of the inpatient bed numbers proposed, the modelling on which it is based, and whether the alternative community provision is meeting the needs of the relevant patients.

We are not repeating the information here, but the table below highlights where in this DMBC we have addressed the key points raised.

Table 17 : Hospital beds test – issues and response

Mayor's Letter/report issue	Our response
Consistency with NW London mental health strategy and needs assessment. The letter points out that "such a strategy should be a fundamental part of the context within which proposals are developed, understood and evaluated. It is crucial that the strategy, like the proposals, is informed by demand and capacity modelling based on a comprehensive assessment of needs across NW London ICS".	We believe the modelling is entirely consistent with the NW London acute mental health strategy and bed modelling, and that it properly addresses the question of whether need is being met • Section 5.2.1(b) covers the NW London wide strategy and capacity planning • Section 5.2.1(a) addresses the question of whether the modelling takes proper account of patient need
More detailed modelling of need demand and capacity. The DMBC should set out a more detailed modelling of need, demand and capacity that demonstrates how the future service will meet population need. This should include demand from outside the two boroughs in the catchment area and should be broken down by population group and types of mental health conditions, in line with the recommendations set out in my independent review. Setting this analysis out would enable greater assurance that the modelling assumptions of 85% bed capacity and a 32-day average length of stay are realistic when tested against current performance. This should extend beyond the current catchment population of Westminster and Kensington and Chelsea, given that the future service will be used by patients beyond these boundaries and that the preferred option relies on establishing additional beds in Brent.	We believe the modelling carried out is robust and provides sufficient assurance that there is enough capacity to meet need. In particular: • Section 5.2.1(b) covers the overall demand in all the boroughs in NW London • Section 5.2.1(c) covers the level of detail at which the modelling has been done. It suggests that modelling by types of mental health conditions would not add value as we do not allocate beds by condition and have no reason to believe that length of stay is primarily driven by it. There is also a national move away from diagnosis as it can increase stigma and often changes regularly throughout someone's care. • Our IIA breaks down previous admissions by many population groups. This shows that numbers in individual groups have fluctuated significantly making forecasts based on those groups much less likely to be useful.

Mayor's Letter/report issue	Our response
	• Section 0 provides detail supporting the realism of our assumptions on admission reduction across NW London, lengths of stay and occupancy. • Section 5.2.1(f) provides more detail on the relationship of these proposals with the separately planned development of inpatient beds in Brent. Section 0 specifically addresses the issue raised by the Mayor's report of whether the Brent beds should have been included as part of the option appraisal. • Section 0 sets out how our community provision is successfully meeting the needs of the population who would in the past have been inpatients

Our overall conclusion is that our bed modelling approach is appropriate and provides sufficient detail to provide assurance that our projections should ensure we are meeting the needs of our local population. We believe that the community services are successfully demonstrating their ability to replace the inpatient beds which were temporarily closed.

7.4.3 Financial investment and savings

The requirement in this test is that "*Sufficient funding is identified (both capital and revenue) and available to deliver all aspects of plans including moving resources from hospital to primary and community care and investing in prevention work.*"

The PCBC analysis suggested that the preferred option is affordable to the system in terms of both capital and revenue resources. It pointed that £5.4m of savings released by the temporary closure had been invested into services largely within the community and all related to ensuring that the revised more community focussed service model could be delivered while retaining the quality of inpatient care. It identified that an additional £5.6m of resources above this had been allocated to community services in KCW since the temporary service change.

In its consideration of this test the Mayor's letter of 26 January said that the DMBC should provide more information and plans related to:

- Demonstrating that sufficient capital and revenue funding has been secured for the future service.

- Demonstrating how funding allocations meet population need, and whether they do so in an equitable manner.

Table 18 : Financial investment and savings

Mayor's Letter issue	Our response
Capital and revenue funding. The letter points out that some of the consultation options were stated to be not affordable and asks for evidence that there was sufficient capital and revenue funding for the future service.	**[Note: draft text as relevant committees have not yet met. Section 6.3 demonstrates the financial and revenue implications of the case which are fully supported by the ICB and the Trust. We are therefore confident the service change can be delivered.]**
Sufficient and equitable funding for mental health services need. The letter asks whether current and planned levels of funding are sufficient and appropriately targeted to population need. It points to evidence that in every year between 2018/19 and 2021/22, per-person spending on mental health services in North West London has been lower than the average for England.	This is addressed in Section 00. The ICB recognises the need to increase the level of investment in mental health services overall and its medium term financial strategy addresses this.

7.4.4 Social care impact

The requirement in this test is that "*proposals take into account a) the full financial impacts on local authority services (including social care) of new models of healthcare, and b) the funding challenges they are already facing.*"

The PCBC concluded is that the transfer of resources between inpatient and community services which we temporarily put in place in 2019, and which we would extend under our preferred option, is the approach most likely to reduce overall pressures on local authority services. It pointed out that under the preferred option, resources are placed in the community to support wider population needs, including social care. In this way we are supporting local authority colleagues in the funding challenges they are facing. It identified relevant services as including stepdown beds (normally funded by the Local Authority but here funded by the NHS, reducing risks of long hospital stays resulting in loss of independence and needing more social care, community rehabilitation teams and investment in VSCEs all of which will help reduce the burden of social care. The PCBC recognised the pressure on social care resource but argued that there was no evidence that the temporary change had in fact increased those pressures.

In its consideration of this test the Mayor's letter of 26 January said that the DMBC should provide more information and plans related to the expected impact of changes on social care services.

Present a clear assessment of the expected impact on social services

Mayor's Letter issue	Our response
Impact on social services. The letter says "My review notes that the proposals put forward credible arguments explaining why the changes will not materially impact social care services but did not show that these arguments were based on a formal assessment or modelling. To be fully assured that these changes will not materially impact social care services, I would need the DMBC to present a clear assessment of expected social care and the extent to which local social care services agree with this assessment."	This is addressed in Section 0. The areas of concern for the Local Authorities are the AMHP assessments which in some cases need to be done more than once and travel time for social workers. The ICB recognises that there is substantial pressure on local social care services, but we have no evidence to suggest that this has been driven by the changes implemented through the temporary closure.

7.4.5 Clinical support

The requirement in this test is that "*proposals demonstrate widespread clinical engagement and support, including from frontline staff.*"

The consultation has had senior clinical oversight throughout with the Chief Medical Officer chairing the Project Board and day to day clinical leadership of the project by the Medical Director for Jameson Division and the Clinical Director for Westminster. The workshops run to agree the options proposed in the PCBC included representation from different clinical groups including psychiatry, psychology, nursing and occupational therapy. This was supported through a workshop held for lead psychiatrists across the two boroughs to further develop the proposals. Clinical staff have been and will be instrumental to the implementation of the proposals.

The PCBC noted that there had been significant engagement with staff in developing the proposals and considering the options and that the proposal had strong clinical support for the proposals from the lead clinicians responsible for the service.

The consultation Evaluation Report notes that 42 NHS staff completed the section of the consultation questionnaire asking, "*To what extent do you agree with the preferred option*". 190 people in total answered that question. As the Evaluation Report notes views in respondents are quite polarised, but it is notable that a significantly higher proportion of NHS staff favour the change than do for the responses as a whole.

Table 19 : NHS Staff views

Agreement with consultation proposal	All	NHS Staff
Total (number)[37]	190	42
Total Agree (%)	48%	60%
Neither / nor (%)	13%	14%
Total Disagree (%)	37%	26%
Net Agree (%)	10%	33%

Figure 2: Support for proposals from Lead Clinicians

"We have been closely involved in leading and shaping the development of the Pre-Consultation Business Case (PCBC) with these stakeholders across our system and communities. Our proposal was presented to the London Clinical Senate, and we have ensured that their feedback has been responded to in the case we now put forward for your consideration. We have discussed the proposals with clinical colleagues across the Trust and in a well-attended workshop with 15 senior clinicians. We have heard from them both support for the new community-based models of services, and suggestions on how we should further develop and improve our services to ensure that we give the best possible care to those who need it.

There is always the conundrum within health care services of how best to allocate our scarce resources. We believe that pursuing models of care which seek to maximise people's autonomy and freedom whilst being inclusive of those important to them and their communities is the best way to develop the care we provide. There will continue to be a need to provide inpatient services for those people with the most acute needs, and we will always endeavour to ensure that these are provided in a timely manner, as close to a person's home as possible.

We commend to you our preferred option within the PCBC, as senior clinical leaders we believe it provides the best possible configuration of service to deliver for the residents of our boroughs, and we are committed to continuing to enhance and improve services further."

As set out in the PCBC our proposals were reviewed by the London Clinical Senate. Their report endorsed the overall model and direction of travel and asked for more information and analysis to be provided on a range of areas. We have fully addressed those requests in the PCBC.

[37] NB. Some people in more than one category

As part of the Consultation, the London Division of the Royal College of Psychiatrists submitted a response which overall did not have a view on the proposals but raised some concerns. These have been fully addressed in detail in Section 7.5.

7.4.6 Patient and public engagement.

The requirement in this test is that "*proposals include meaningful patient and public engagement, including with marginalised groups, in line with Voice Exchange recommendations.*"

This test is effectively the same at the Secretary of State's first test discussed in Section 7.3.1. As set out in that section we believe we have fully met the requirement.

7.5 Royal College of Psychiatrists

We received a letter from the London Branch of the Royal College of Psychiatrists about the change proposals. This is attached as Appendix 11.

The letter sets out some important points but also a number of concerns which are not based on correct information, and so we are responding in detail below.

In particular the letter is headlined as a response to "NHS plans to cut central London mental health provision". It is completely wrong to suggest there are any plans to cut provision compared to what it was in 2019/20. Rather our proposals are based on a substantial increase in overall provision. What we are doing is also changing the balance so rely less on a form of provision which involves restrictive care in inpatient wards, and more on provision near where people live in the community.

Key point raised	Response
The high rate of homeless people sleeping rough in Westminster and concerns about increased acuity of mental health needs	As the letter requests, we have carefully considered the impact on this group and done substantive additional work to explore the issues since the letter was written. This includes exploring this in detail in the IIA, Section 5.3 covers this in detail. It suggests that we have moved from 5-7 beds in 2018-19 being used for KCW homeless patients to 3-5 beds 2019/20 in the year before the closure, to 1-2 now. If demand in 2023/4 was broadly similar to the earlier years that would mean we are now supporting 4-5 more people at any one time within the community rather than in an inpatient bed. Some of those patients are being supported the same way as everyone else (i.e. through Community Mental Health Hubs), and some through more specialist teams. We do not have good enough data from recent years to be certain that those patients

Key point raised	Response
	are getting all the services they need, and so we have committed to carry out a detailed audit of this and prioritise investment to address any shortfall identified. It is very unlikely that any shortfall will best be met by having more restrictive inpatient beds.
Vital to complete a comprehensive needs assessment of the potential adverse impact particularly on people with a of black/African/ Caribbean background, black African, LGBTQ+, and for women	We believe all groups requiring acute mental health services benefit through the move to care provision in a less restrictive environment. However, a comprehensive Integrated Impact Assessment has been carried out which showed no significant disproportionate impact on any group. Despite this, mitigations have been developed with key stakeholders for populations that we know are high users of Acute mental health services, including people from Black African and Caribbean backgrounds. Detail can be found in the IIA in Appendix 2.
"We are concerned that closing the hospital will mean such a large population will no longer have dedicated local acute mental health services in the borough despite a high level of demand"	We do not believe this is an accurate characterisation of the position. Westminster is one of the smaller London boroughs. Its population of 211,000 makes it the 6th smallest of the London Boroughs (excluding the City of London). There are 8 other boroughs in London which do not have an inpatient unit, 6 of them having larger populations than Westminster, one of them being double the size. Our inpatient bed calculations have taken careful account of the specific needs of the local population – see Section 5.2.1. We do not believe that the number of patients being treated out of borough is a significant issue; what matters is actual travel time and cost. We have considered both these issues in Section 5.2.6 and 5.6.4. There are some impacts on a relatively small number of patients and their visitors, but we believe these are outweighed by the overall benefits of a less restrictive care model. However, consideration has been given to the increased travel times for people who do need an admission, and mitigations developed to support these service users and their carers.
Impact on other hospitals, particularly at the St Charles, "This has led to a	The prime concern raised in the letter on this subject is the level of inappropriate Out of Area admissions. This concern was based on old data, and as we have shown there have been no such admissions for 18 months for KCW residents and for over a

Key point raised	Response
number of issues including with capacity, staffing, impact on staff health and morale, quality of care, patients being discharged too early, and an increase in thresholds for people to be admitted”	year across the whole NW London system. Most of the other evidence quoted in the letter in relation to this is not based on data but anecdotal evidence in the HealthWatch report. We have shown in Section 5.2 that the bed numbers we are proposing across KCW and the whole system are appropriate for population need, and that there is no evidence that patients are being discharged to early, or that thresholds have been changed. What has changed is the ability of community services to support patients. We recognise occupancy remains high, but it is no higher than it was before the temporary closures, and we have a clear plan to address it over time.
“the proposed options all include a cut to services whether it be relating to inpatient care or some of the community and crisis services. Demand for mental health services is increasing in this Borough, as well as the surrounding Boroughs, and therefore there needs to be a solution that addresses this demand, whilst ensuring a seamless and high level of mental health care provision in an effective and timely manner	This characterisation of the proposal as a cut in acute mental health services is incorrect. There were 94 staff working in the Gordon inpatient services; we now have additional 207 staff working in community services or adding to the staffing in the remaining inpatient service – a net increase of 113 staff providing care. (See Section 5.6.2). All the funds saved from the Gordon inpatient services have been reinvested in care provision, and substantial additional investments have been made. Rather than in investing in having more restrictive mental health bed capacity than we need we have developed community based provision which meets the needs of those patients better. We entirely agree that mental health services as a whole need to develop more to meet demand. The ICS has committed to prioritising investment in mental health over time. However, we also believe that by far the best way to meet the need is to focus the limited investment we have available on community based service that meet people needs effectively without requiring them to be confined in locked inpatient wards.

8 Governance and implementation

8.1 Governance

The final agreed model will be implemented by the Trust with oversight from NW London ICB's MHLDA programme. Each major area of work will have a steering group that will be overseen by CNWL Trust Executive Board and the NW London MHLDA Programme Executive. While accountability of delivery will be with CNWL and be driven by CNWL's Board, ultimate accountability will be to the ICB Board.

8.2 Implementation approach

A number of the proposed changes in the preferred option have been implemented already, but the additional changes that are required include:

- Move of the MHCAS to a new location on the St Charles site
- Further development of the MHCAS model in line with the new location
- Further development and implementation of the mitigations
- Year long analysis of the service offer and potential impact on the homeless population.

8.2.1 MHCAS model and location move

A Steering Group will be set up to oversee the plans for the MHCAS location to meet the needs of the service model. This will be informed by the following workstreams

- Estates – to design and implement the capital works to fit in the new location
- Clinical – to support the estates design and adapt the service model, policies and procedures as appropriate based on feedback and requirements
- Processes – to ensure that any changes in workforce, budget, IT or systems and picked up and adapted to meet the needs of the service in the new location
- Communications – recognising the feedback received that people are not aware of the service, a comms workstream will be tasked with informing people of the changes and advertising the service for the longer term.

8.2.2 Homelessness

As set out throughout the DMBC we believe that mitigations have been developed help meet the needs of this population. CNWL will continue to work with the Task and Finish group set up as part of this work to develop and implement the ways of working across organisations to deliver a more joined up pathway. There is also engagement with the work of HealthWatch to further understand and propose needs for mental health services for people who are homeless.

While it is felt there is a list of fairly comprehensive mitigations, in order to be sure that there hasn't been an impact work will take place over the next year to fully understand what is happening with the care for this population and if there is a group who are not receiving the same level of care they were in 2019/20.

Working with the stakeholders who work with people who are homeless or rough sleeping, CNWL will audit cases of care for this population to understand the detail of what is happening in these cases and measure how many, if any, would have been appropriate for inpatient care and did not get it, as well as building an understanding of the support these patients are getting in the community and its outcomes.

Following this period of targeted data collection, a proposal will be developed for any additional requirements in this pathway of care, this will be submitted to the ICB to be considered for prioritisation of any future funding.

8.3 Working with partners

In the implementation of the proposals, we will work closely with system partners and service users and carers to continue to design the MHCAS space, pathway, services available at the Gordon and to identify any additional requirements in terms of support for those people who are homeless or rough sleeping.

All implementation will be informed by and delivered with both the Bi-Borough placed based partnership which has representation from all providers in the area, GPs, voluntary sector and experts by experience.

In order to continue to drive and improve co-production, CNWL working with partners and led by St Mary Abbot's Rehabilitation and Training (SMART) are relaunching a Bi-Borough wide bi-annual event which brings together all organisations working with people with mental health needs and service users and carers to network, share information about services and hear feedback to support improvement. This network will be engaged with throughout the implementation of the final model of care and to support the evaluation.

In the case of the MHCAS, it should be noted that this is a CNWL wide service, so further developments will involve partners from other NW London boroughs too.

8.4 Timescale

The MHCAS project plan sets out a delivery expectation of the service being developed in a new location by December 2025 with an evaluation taking place through January to April 2026.

Project	Task	Q3 2024-25	Q4 2024-25	Q1 2025-26	Q2 2025-26	Q3 2025-26	Q4 2025-26	Q1 2026-27
Governance	Final decision of the ICB							
	JHOSC meeting to review the decision							
MHCAS	Design new MHCAS location							
	Estates work to develop the site							
	Work with stakeholders to review model in line with estates and develop operational procedures							
	Relocate staff and service							
	Begin delivery of new model							
	Formal evaluation							
The Gordon	Work with stakeholders in Westminster to further design the use of the Gordon building							
	Estates work to develop the Gordon site							
Homelessness	Continued work with stakeholders to understand the impact of the changes and design improvements for the pathway							
	Proposal submitted to the ICB with detailed understanding of what is needed to offer care for the mental health needs of the homeless population							

8.5 Change management plan

A majority of the changes in the proposed have been made already so significant change management has been undertaken by the Trust to date. To support the further work that needs to happen there will be early identification of key stakeholders and the impact of proposals on them.

Some of the mitigations will require some change management. We will ensure stakeholders are kept informed of or involved in plans as they develop and are implemented. A plan for information sharing and involvement in each project will be developed to ensure information is being shared at appropriate times through the project.

The project to move the MHCAS will have a communications workstream to ensure that people are kept up to date with changes and information on the service and location.

8.6 Success measures

We will measure success of the changes through the following measures:

- Improved patient and staff experience
- Reduction in admissions
- Reduction in readmissions
- Achieving bed occupancy of 85-90%

- Reduction in A&E breaches, particularly those where a bed is the main reason for delay
- Improved scores on DIALOG+
- Reduction in crisis presentations for those on community team caseloads.

8.7 Risks

ID	Risk	Consequence	Mitigation
1	Risk of challenge to the final decision on which option to implement.	Unable to implement proposal if challenge successful. Delay in implementation even if challenge is unsuccessful.	Due process has been followed throughout the consultation process. Fully consider all relevant issues raised in consultation prior to ICB decision making. Involvement of stakeholders in the development of the proposals, and the development of the decision making business case.
2	Clinical risk of changing the MHCAS model that has been running to date	Impact on patients at the point in time when transfer occurs	Ensure significant and ongoing clinical involvement in transition planning and delivery. Include any required training as part of the programme plan
3	Risk of implementation timescales slipping due to construction delays on the move of the MHCAS.	Impact on the timescales for delivering the improvements set out.	Produce realistic and achievable plans for implementation, and manage delivery effectively to reduce the likelihood of slippage Produce realistic and achievable plans for implementation, and manage delivery effectively through a project environment to reduce the likelihood of slippage
4	Risk of cost overrun	Budget is consumed before changes have been implemented. Delivery of improvements is not achieved, or is delayed	Manage the implementation plan effectively to minimise potential budget overruns. Cost estimates to include appropriate contingencies. Work is being planned across multiple financial years to provide more sustainability in the budget

9 Recommendations to the Integrated Care Board

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

The main features of the consultation proposal were:

- ***Service Model –*** Transformed model as now with lower bed base of 67 beds and a higher level of community alternatives, included an enhanced MHCAS service offering short stay inpatient facilities. Additional capacity in Brent would also free up 7 beds worth of activity at St Charles.
- ***Service locations –*** All core inpatient provision at the St Charles, with enhanced MHCAS at the Gordon.

The key question for the ICB to consider now is whether it is clear that the proposal is still the best option in the light of:

- Careful consideration of the consultation feedback received
- Other changes and developments since the PCBC.

This DMBC recommends that

- The ICB should endorse the consultation proposal but with one important amendment which is that the enhanced MHCAS should be located at the St Charles and not the Gordon, as this will provide a higher quality and safer services.
- The ICB should implement the mitigations proposed within Section 6.4.5 which cover mitigations for the population as whole and Section 6.2.3 which specifically focuses on mitigations for 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.

The revised option is described in detail in Section 6.