City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster Health & Wellbeing Board

RBKC Health & Wellbeing Board

Date:	28 January 2021
Classification:	**General Release**
Title:	*Equality Impact Assessment Results and CNWL Mental Health Provision for KCW Residents*
Report of:	Robyn Doran, Chief Operating Office of Central and North West London NHS Foundation Trust
Wards Involved:	Gerard, Ebury, Vincent wards
Financial Summary:	N/A
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1. Executive Summary

1.1 The aim of this paper is to report the results of an Equality Impact Assessment (EIA) appraising the impact of the temporary closure of the Gordon inpatient wards to the Health & Wellbeing Board, and to update the Board on the current provision for Westminster and Kensington & Chelsea residents, including patient activity levels and access to inpatient and community-based services.

1.2 In March 2020, the inpatient wards at the Gordon Hospital were temporarily closed as part of CNWL's COVID-19 response primarily due to serious concerns regarding infection control in the building, along with the need for rapid flexibility of our service provision to support mental health care during the pandemic. Due to the level 4 emergency status caused by COVID-19 and its impact, as with many frontline partners, CNWL found it necessary to make this decision rapidly and was not able to fully consult with local partners as per normal practice.

1.3 This EIA (see Appendix A for full version) is focused on the immediate response CNWL had to undertake in response to the pandemic and during a Level 4

emergency status (as outlined under point 2 of this document). CNWL is planning to publicly consult on the future of the Gordon Hospital once the emergency status is lessened, and will complete a further EIA for the long-term closure of the Gordon as part of that consultation work.

1.4 A paper was brought to this Health and Wellbeing Board in July to clearly outline the current position, rationale and proposal for the future. This detail is in Appendix B for reference. At the request of the last Board, as well as further sessions with stakeholders, this paper provides detail on the impact of the ward closures on patients and the extensive transformation and strategic work already underway to assure quality mental health provision to meet the needs of Westminster and Kensington & Chelsea residents, supporting care closer to home in the least restrictive setting as per national direction, and ensuring when admission is required this is through timely access and in therapeutic settings.

2. Key Matters for the Board

The board is asked to note the strategy and approach for ensuring access and quality mental health provision for KCW residents, and to work collaboratively in the long term towards the increase in community-based care and access to appropriate therapeutic inpatient care when indicated.

3. Aim of the Service Change

As mentioned above, in March 2020 the inpatient wards at the Gordon Hospital were temporarily closed as part of CNWL's COVID-19 response primarily due to serious concerns regarding infection control in the building, along with the need for rapid flexibility of our service provision to support mental health care during the pandemic. This need to close one of our inpatient sites was to enable staffing flexibility to cover for sick and isolating staff, to temporarily redeploy staff to meet service pressures, and to offer emergency response alternatives to A&E.

The Gordon Hospital was chosen as the place to close temporarily as part of this response for key reasons linked to quality of care provision. CNWL had serious concerns following assessment of the wards' risk for infection prevention and control (IPC), e.g. lack of en-suite bathrooms, narrow corridors, and limited access to outdoor space. This issue regarding IPC risk was a key quality driver for the decision to close the Gordon inpatient wards given the particular vulnerabilities facing those with mental health disorder, both due to being in a confined space (with heightened risk of infection spread) and also the high physical comorbidities in our patient group meaning they are at particular risk of the consequence of infection[1][2]. These IPC constraints at the Gordon are contrasted with other

[1]Addressing Comorbidity Between Mental Disorders and Major Noncommunicable Diseases, WHO https://www.euro.who.int/__data/assets/pdf_file/0009/342297/Comorbidity-report_E-web.pdf

[2] Disparities in the Risk and Outcomes of COVID-19, Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

sites such as St Charles, where the majority of Westminster patients are now admitted, which has high IPC compliance and en-suite bathrooms for service users.

4. Assessing Positive Impact of Service Change

Evidence shows there are disparities in the risk and outcomes from COVID-19, with some protected characteristics such as gender, age, and ethnicity correlating with higher risk of infection, severe health outcomes, and/or death[3]. As the Gordon Hospital inpatient wards were temporarily closed primarily due to concerns around IPC risk, this action contributed to reducing the risk for both infection and adverse health outcomes for those particularly vulnerable Westminster patients.

For example, Public Health England (PHE) found ethnicity and deprivation to be associated with increased risk, with the risk of dying among those diagnosed with COVID-19 higher in those of Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups, and people living in deprived areas having higher diagnosis and death rates (COVID-19 mortality rates in the most deprived areas were more than double those in the least deprived areas)[3]. Westminster has a larger BAME population when compared with Greater London (particularly high Mixed/other representation), and both boroughs have a higher proportion of residents living in areas classified as most deprived compared with the London average[3]. Given these specific demographics of the KCW population, by reducing infection control risks through the temporary ward closures, CNWL was mitigating health risks and the further exacerbation of these COVID-19 disparities.

The inpatient wards were also temporarily closed to enable staffing flexibility during the pandemic to meet service pressures and support the continuity of core services. This promoted access to services which were able to remain operational during the pandemic due to this increased staffing flexibility for all KCW residents, regardless of protected characteristic.

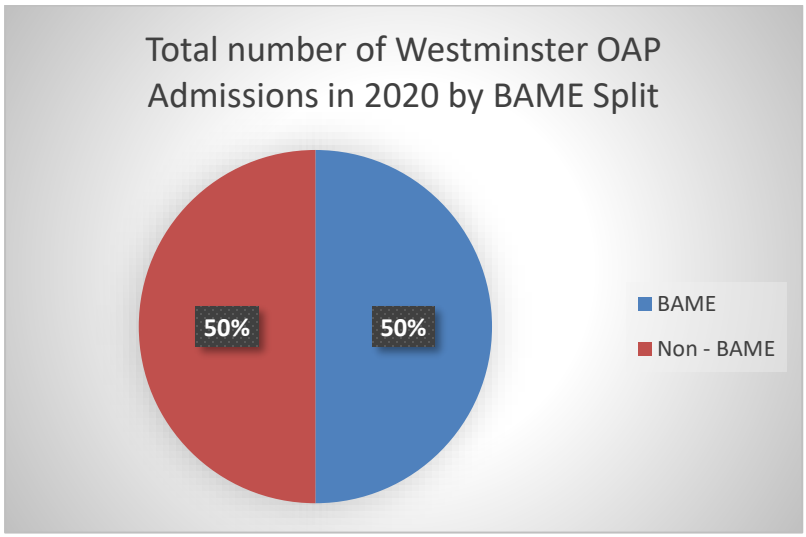
5. Assessing Potential Negative Impact of Service Change

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of protected characteristic. An analysis was conducted for the protected characteristics thought most likely to be systematically impacted by this service change: race/ethnicity and gender. The results of this analysis found there to be no disproportionate negative impact to these groups based on the temporary ward closures.

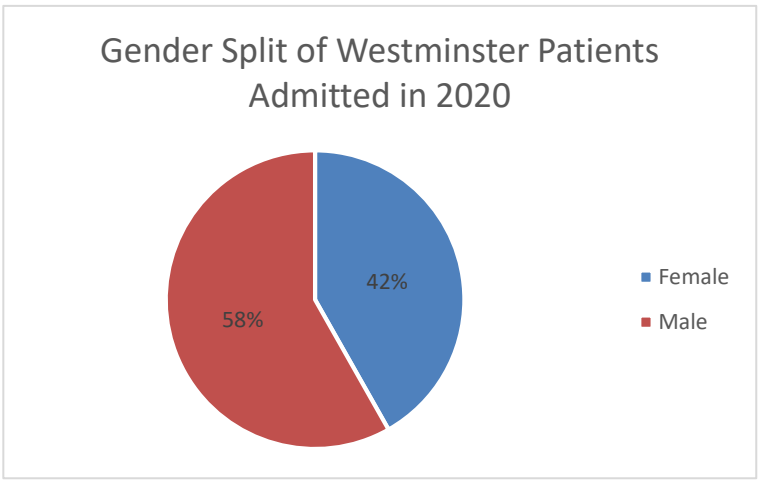
Race/Ethnicity: Analysis found readmissions declined for Westminster patients from Black and Asian backgrounds in 2020, and out of area placements (OAPs)- as defined by NHS

[3] Joint Strategic Needs Assessment: Mental health and wellbeing in Kensington and Chelsea, and Westminster https://www.jsna.info/sites/default/files/Mental%20Health%20and%20Wellbeing%20JSNA%20Full%20Report_0.pdf

England- occurring equally within Westminster BAME and Non-BAME patients (see graph below). This represents an improvement in OAPs over 2019 for Westminster BAME patients, and brings the metric more in line with borough demographics (44% BAME, 56% White)[3].



Gender: The Gordon wards in question were mixed sex wards, meaning there weren't disproportionately more male or female beds removed from the bed base as a result of the temporary ward closures. Data supports this, with no large changes in the percentage breakdown of out of area placement (OAP) admissions based on gender for Westminster patients from 2019 to 2020. Additionally, the percentage of admitted Westminster patients who identify as male has reduced to 58% in 2020, bringing it more aligned with the population breakdown in Westminster by gender of 51% male and 49% female (see below).



6. Patient Impact Since Closure: Activity Levels and Inpatient Access

In the immediate term after the temporary closure of Gordon wards, during the first lockdown period, use of mental health beds reduced, as did attendance at A&E

(therefore bed availability increased). Every patient on community caseloads was contacted and our mental health services remained open and working throughout this period to meet their needs. Over August and September, following the easing of lockdown measures, demand for acute mental health beds became high across London. To meet this heightened demand for beds the Trust accessed some private beds (Extra Contractual Referrals). We know this is not ideal and occasionally we have had to place patients further away than we would have wished, but at the time our concern has been safety and care. However we have redoubled our efforts in response to reduce this use of ECRs as detailed below.

We have been working towards eliminating adult acute ECRs over the past 18+ months as part of the Five Year Forward View for Mental Health (2016) (date) and Long Term Plan (2019). This has been through a significant number of evidence-based initiatives, outlined in this paper, as well as robust clinical and operational leadership.

Detail: Westminster

Since the temporary ward closures, the majority (~70%) of Westminster patients admitted to inpatient wards were placed at St Charles Hospital where they are given priority based on its proximity to Westminster. Over the COVID-19 period all patients on the Westminster CMHT caseload, including those recently discharged, have been contacted and all discharged patients have received 72-hour follow-up as per our CCG CQUIN scheme. Those discharged to HTT have been provided continued support closer to home as an alternative to admission. We routinely monitor readmission to hospital of patients discharged as a quality indicator to ensure patients are being precipitously discharged, whilst recognising the relapsing and remitting nature of mental illness. Of those cohort of patients discharged at the time of the Gordon ward closures, only seven have been readmitted to an inpatient ward as of 3rd December, representing a lower than normal readmission rate.

Westminster has always had access to the beds at St Charles, including a designated ward - now Westminster patients are looked after on all the acute inpatient wards at St Charles, with better flows between the Health Based Place of Safety to PICU beds should these be required. Because of our wider bed base across Harrow, Brent and Hillingdon, we are able to flex our use of beds when there are peaks in demand and our patients, wherever they are, receive CNWL services. Typically, Westminster has had a range of 5 to 10 patients over the last months in the outer borough beds. When it is not possible to place a patient within KCW, we try to use these other beds for those with no links to the borough, such as foreign nationals as travel restrictions ease.

To ensure timely discharge for Westminster patients placed in our CNWL beds in the outer London boroughs and transfer to CNWL beds for patients if they are in ECRs, we have appointed additional discharge support including dedicated consultants and a new patient flow lead. ECRs have daily reviews to bring patients closer to home as soon as possible, there are weekly meetings to look at patients who have a length of stay greater than 30 days to understand what the recovery plan is and how quickly and safely we can get patients back into their communities with support where they need it. Although we are still on a journey, the month-on-month decline in ECRs for KCW from August to

October, representing a 79% reduction in ECRs from the height of post-lockdown demand in August, indicates that community support and the transformational shifts are working, as we have not seen a larger adverse impact with fewer beds.

An example of this community support is Westminster's Home Treatment Team (HTT), whose caseloads seen on average an increase of over a third in the past Quarter, with a steady decrease in admissions, indicating that our new 24/7 model and skills mix is embedding and we are seeing more patients in their homes and the least restrictive environment. Another example is the KCW "Cove", a crisis haven which has received positive feedback from service users and offers crisis alternatives intervening upstream to avoid escalating patient acuity.

Additionally, the average Length of Stay (LoS) of Westminster patients on discharge has decreased since April (see Table 1 below) and, when compared to April-November of 2019, LoS for Westminster patients (excluding leave) following the temporary ward closures has decreased by 7.5 days. This means each care episode is shorter, patients are being discharged home earlier with support from HTT or other services, and fewer beds are required to serve the same number of patients.

Table 1. Length of Stay average for Westminster patients

April	May	June	July	August	September	October
34	52	20	31	51	35	28

Detail: Kensington & Chelsea

As of 3rd December, 200 K&C patients have been admitted to inpatient services since the temporary closure of the Gordon wards, with ~75% being placed at St Charles Hospital. Additionally, Kensington & Chelsea have been consistently operating within, and often below, their allocated bed base since the closure of the Gordon inpatient wards, indicating that the placement of Westminster patients at St Charles have not had a negative impact on K&C residents' ability to access inpatient beds.

When Westminster or K&C patients must be placed outside London, support is provided based on individual need to retain regular contact with their families, carers, and support networks based on NHSE Principles of Continuity. This can include supporting patients and their families in accessing transport or technology to facilitate maintaining care networks and ensuring safe and high-quality care for all our patients (https://www.cnwl.nhs.uk/news/reimbursing-patients-and-carers-cost-travel-when-placed-out-area-residence-inpatient-units).

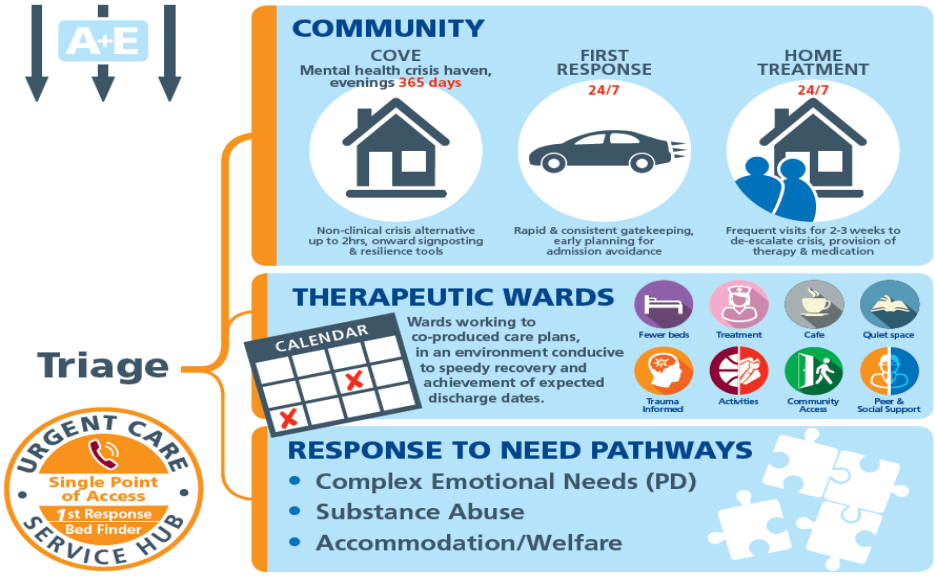
7. Patient Impact: Investing in Transformation

Looking forward and in line with national asks, we recognise that care for our local people should be provided in the least restrictive setting and closer to home, by shifting provision to a more community-based offer. This includes expanding existing, and developing new, provision available within the community to ensure care, support, and interventions are available and accessible locally, supported by ~£5.4m investment across KCW.

CNWL is currently investing in and delivering transformation work in the below areas, with the aim to develop further to provide the best possible care for KCW residents.

- Moving care closer to home wherever clinically possible and appropriate
- Working with local VCSE, facilitating a broader offer to our population
- Working to prevent admissions unless no clinical alternative
- If admission is needed, it will be purposeful and in a therapeutic environment with dedicated identified beds within the NWL system for KCW patients, including building on existing bi-borough co-location of beds at St Charles. Long-term, we want this consolidation to be within modernised facilities that enhance the delivery of high-quality treatment.

Figure 1. Our Care Closer to Home Vision & Model Overview



CNWL is using Long Term Plan and locality investment to take forward the following:

1. Developing and improving our **Home Treatment Team** (HTT) model to:
   - Refocus function to ensure fidelity to a recommended model that offers a genuine alternative to admission, 24/7, 365 days a year.
   - Make HTT responsible for staying within their local bed allocations and enabling HTT to in-reach to wards to facilitate early discharge.

- Support productivity and new ways of working (including significant investment in new technology to enable mobile working and reduced administrative burdens) to increase clinical patient facing time.

Since April, 48% of Westminster inpatients were discharged to Home Treatment Team, with over 96% followed up in 72 hours. The average HTT LOS is 11 days with an average of 8 contacts per care episode- this means patients were seen at least 1-2 times a day by the Westminster HTT following their discharge from hospital. Similarly for K&C, since April, 51% of inpatients were discharged to Home Treatment Team, with over 98% followed up in 72 hours. The average HTT LOS is 8 days in K&C with an average of 6 contacts per care episode, meaning patients were receiving intensive support on average 5-6 times a week by the K&C HTT team when they were discharged from hospital.

2. A new **First Response Service** now offers 24/7 assessment to our residents, wherever they are in the community. This means patients across our boroughs can be cared for in the community, supported by our experienced mental health practitioners when they are in need of urgent mental health support, 24 hours a day, 7 days a week. We have diversified our workforce, encouraging a range of skill mix including peer support workers, alcohol support workers, occupational therapists as well as nursing and social work. In KCW, we have 9 mental health practitioners and expect an additional 6 WTE new mental health practitioners split evenly across both boroughs to take on a first responder role, providing urgent assessment to patients with the aim to signpost them to other services in the community, such as the Coves, as alternative to admissions.

3. "**The Cove**" crisis haven opened on 21 May to provide digital support to patients amid the pandemic. On 3 August, the Cove for Kensington, Chelsea and Westminster began to offer face to face appointments in the evening from 5:30pm to midnight at Paddington Arts Centre. Each Cove is staffed by 1 team manager, 2 recovery workers or peer support workers, and 2 volunteers depending on the shift. Service users are provided with 1:1 support, signposting, practical advice, and coping techniques to service users across the boroughs. The Coves have received a lot of positive feedback from service users, who have appreciated the time and space to staff have taken to listen and support them.

4. New community offers provided by the **third sector (VCSE)**, which for Westminster residents includes specific support to people with coexisting MH and substance use problems, specialised Arabic outreach workers through the Oremi centre, and additional BAME support workers in the community. The specific remit of these workers is to engage with service users from BAME communities particularly vulnerable to exploitation by gangs and drug dealers, radicalisation by extremist groups, and/or with alcohol and substance misuse issues. In K&C, the arts therapies and occupational therapists have partnered with the organisation Key Changes, which provides in-reach services for young people and adults receiving treatment in mental health hospitals through music therapies and activities to support patient recovery and social inclusion.

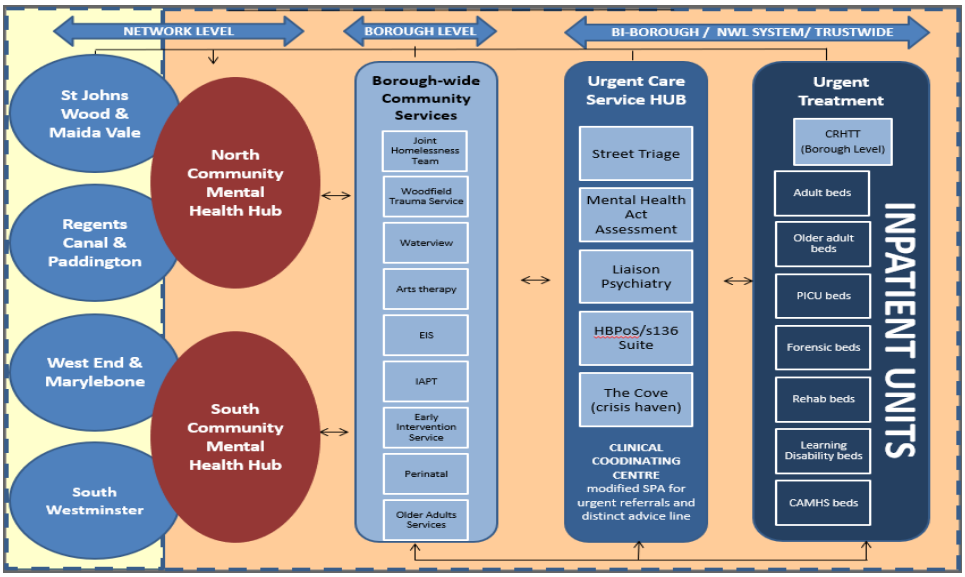
5. CNWL is working with British Red Cross on implementing a new high intensity users (HIU) programme to support service users who are attending services frequently for a variety of reasons, including social or financial, but cannot be supported by traditional services. We are working jointly with the RightCare HIU Lead to develop a CNWL bespoke approach, with the aim of launching an early pilot across Brent, Harrow, and Westminster early 2021. We will be taking learning from the Kensington and Chelsea Liaison Team in Chelsea and Westminster Hospital who in October have partnered with British Red Cross to introduce a High Intensity Users Lead to work alongside their psychiatric liaison service. Service users will be provided with same day signposting or up to 4 weeks support.

6. If a bed is required, a new **Central Flow Hub** launched at the end of March, will find a suitable bed in a timely way and is supporting the elimination of the use of beds out of area through external providers (Out of area placements – OAPs) via improved flow management. Inpatient admissions are now supported by new investment in embedding an evidence-based Trauma Informed Approach for all patients admitted to CNWL beds.

7. Investment in a new "**Community Access Service**" to ensure our patients do not stay longer than clinically required on wards and are supported through re-enablement to live as independently as possible, due to go live in the next few weeks. The team is comprised of an occupational therapist, a social worker and some peer support workers who will facilitate discharge at St Charles Hospital, supporting specifically Kensington, Chelsea and Westminster patients. We have also partnered with Single Homeless Project and Citizens Advice Kensington and Chelsea to provide a part time peer support worker into the CAS team, to provide floating housing support to enable service users to live independently within their own home.

8. **Community Mental Health Hub (CMHH)** – Westminster received transformational funding through NHS England as an early implementer site of a new model of care for the provision of community mental health care. After partnership development work across health, social care, and local community partners for over a year, the Community Mental Health Hubs North and South for Westminster launched 1st September. It has been described by national teams as a "truly transformational model", and is based on these agreed principles:
   - Enhance patient experience: intervention emphasis > assessment
   - Enhance professional/staff/provider experience: conversations & 'tasks'
   - Minimise primary and secondary care divide: no thresholds
   - Minimise bureaucracy & optimise use of community-based resources
   - Maximise 'One Team' feel: camaraderie, communication, relationship building
   - Encourage shared responsibility for patient & encourage shared responsibility for resource
   - Maximise support for MH professionals, GPs & other providers
     Establish an effective framework to measure meaningful outcome measures

Figure 2. Community Mental Health Hub (CMMH) Model for Westminster



The hub offers integrated care to Westminster residents and investment has included recruitment of new staff including an additional two Community Navigators, two family therapists, a Lived Experienced 'Personality Disorder' pathway specialist and a senior 'Personality Disorder' Nurse, a GP based Eating Disorder specialist, four newly developed graduate mental health worker roles, and two new Social Prescribers through a partnership with One Westminster. Westminster is also part of a community pharmacy pilot in the hubs. These new staff provide the offer shown below.

Figure 3. Community Hub Offer in Westminster

8. Summary and Next Steps

The wards at the Gordon currently remain closed and we are proposing to consult formally on its future later this year depending on the status of the National Emergency.

We are working across the system to embed the changes articulated above to support Westminster residents getting access to care in the community wherever possible through a broadened community offer. We recognise that an essential part of providing good quality mental health care is also to facilitate timely access to modern inpatient services when community alternatives are not possible, preferably as close to home as possible. Without in anyway predetermining the outcome of the proposed consultation, we are exploring planning to consider development of a potential alternative inpatient site within Westminster.

The temporary closure of the Gordon Hospital is a significant change which has been forced upon us at considerable pace due to the COVID-19 pandemic and the need to respond rapidly to ensure quality of care for all our patients was maintained within this context. This has inevitably raised challenges and we are keen to listen to and respond to concerns. We are committed to working with our patients and their families, our communities, and our partners to not just monitor and respond to these challenges but also to work collaboratively to plan for the right inpatient service to meet the mental health needs of Westminster residents. Plans to enable this include:

- We have commissioned Healthwatch to set up an advisory Citizen's Panel to help us deliver our inpatient strategy in Westminster, ensuring local engagement, a meaningful consultation, and true co-production. The first meeting will be held in January 2021.
- We would like to have a Roundtable Discussion with Councillors to promote transparency and an open dialogue and we are working with the local authority to facilitate taking this forward.
- We are hosting a series of Stakeholder Engagement Forums to provide space for discussion, open dialogue, and supportive enquiry.
- We have appointed a Community & Partnerships Lead to support partnering with and championing local VCSEs providing services/support to vulnerable and at-risk groups, and partnering with voluntary sector and local authorities to increase alternative forms of provision for those in crisis.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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Email: [robyn.doran@nhs.net**]**

Telephone: [020 3214 5758**]**

APPENDIX A: Equality and Human Rights Impact Assessment – Full Version

Equality and Human Rights Impact Assessment Form

This form is protected. You can only complete the fields that are shaded. They will expand as you type so that you are not limited to how much you write. You can move between the fields using the cursor up and down keys.

1. What is the **name** of the Policy, Service Development, Business Plan, Strategy or Organisational Change being assessed?

Temporary closure of Gordon Hospital inpatient wards.

2. Briefly describe the **aim** of the Policy, Service Development, Business Plan, Strategy or Organisational Change that is being Impact Assessed. What needs or duties is it designed to meet? What are its intended outcomes?

In March 2020, the inpatient wards at the Gordon Hospital were temporarily closed as part of CNWL's COVID-19 response primarily due to serious concerns regarding infection control in the building, along with the need for rapid flexibility of our service provision to support mental health care during the pandemic. This need to close one of our inpatient sites was to enable staffing flexibility to cover for sick and isolating staff, to temporarily redeploy staff to meet service pressures, and to offer emergency response alternatives to A&E. Due to the level 4 emergency status caused by COVID-19 and its impact, as with many frontline partners, CNWL found it necessary to make this decision rapidly and was not able to fully consult with local partners as per normal practice.

The Gordon Hospital was chosen as the place to close temporarily as part of this response for key reasons linked to quality of care provision. CNWL had serious concerns following assessment of the wards' risk for infection prevention and control (IPC), e.g. lack of en-suite bathrooms, narrow corridors, and limited access to outdoor space. This issue regarding IPC risk was a key quality driver for the decision to close the Gordon inpatient wards given the particular vulnerabilities facing those with mental health disorder, both due to being in a confined space (with heightened risk of infection spread) and also the high physical comorbidities in our patient group meaning they are at particular risk of the consequence of infection[4][5]. These IPC constraints at the Gordon are contrasted with other sites such as St Charles, where the majority of Westminster patients are now admitted, which has high IPC compliance and en suite bathrooms for service users.

3. Does this development have an impact on information quality, information security and/or information compliance, including staff or patient privacy? **Yes** or **No**

No

4. If yes, have you completed an information governance impact assessment form or otherwise contacted the Information Governance team? **Yes** or **No**

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[4] Addressing Comorbidity Between Mental Disorders and Major Noncommunicable Diseases, WHO https://www.euro.who.int/__data/assets/pdf_file/0009/342297/Comorbidity-report_E-web.pdf

[5] Disparities in the Risk and Outcomes of COVID-19, Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

For the purposes of this assessment, the relevant protected characteristics are: **Age, disability, gender reassignment, pregnancy and maternity, race/ethnicity, religion or belief, gender/sex, sexual orientation.**

MEETING THE GENERAL DUTIES

5. How does the service / policy / procedure / development **contribute in a positive way to**:

(a) eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

Evidence shows there are disparities in the risk and outcomes from COVID-19, with some protected characteristics such as gender, age, and ethnicity correlating with higher risk of infection, severe health outcomes, and/or death[2]. As the Gordon Hospital inpatient wards were temporarily closed primarily due to concerns around IPC risk, this action contributed to reducing the risk for both infection and adverse health outcomes for those particularly vulnerable Westminster patients.

For example, Public Health England (PHE) found ethnicity and deprivation to be associated with increased risk, with the risk of dying among those diagnosed with COVID-19 higher in those of Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups, and people living in deprived areas having higher diagnosis and death rates (COVID-19 mortality rates in the most deprived areas were more than double those in the least deprived areas)[2]. Westminster has a larger BAME population when compared with Greater London (particularly high Mixed/other representation), and both boroughs have a higher proportion of residents living in areas classified as most deprived compared with the London average[6]. Given these specific demographics of the KCW population, by reducing infection control risks through the temporary ward closures, CNWL was mitigating health risks and the further exacerbation of these COVID-19 disparities.

The inpatient wards were also temporarily closed to enable staffing flexibility during the pandemic to meet service pressures and support the continuity of core services. This promoted access to services which were able to remain operational during the pandemic due to this increased staffing flexibility for all KCW residents, regardless of protected characteristic.

(b) advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share that characteristic.

People are admitted to CNWL's inpatient wards based on clinical need and not demographic or protected characteristics.

As mentioned above, characteristics such as ethnicity and deprivation are associated with disproportionately high COVID-19, risks making it particularly important for health care settings in areas with larger proportions of those populations (such as KCW) to mitigate and eliminate IPC risks wherever possible.

[6] Joint Strategic Needs Assessment: Mental health and wellbeing in Kensington and Chelsea, and Westminster https://www.jsna.info/sites/default/files/Mental%20Health%20and%20Wellbeing%20JSNA%20Full%20Report_0.pdf

(c) fostering good relations between persons who share a relevant protected characteristic and persons who do not share that characteristic.

Race / Ethnicity

COVID mortality rates are higher among BAME communities, and Westminster has a larger BAME population than both the London and national averages[4]. The temporary closure of a site with IPC concerns would arguably have a positive impact on the KCW BAME population by mitigating the IPC and associated COVID-19 risks.

Disability

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit disabled patients by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Gender

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless of gender by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Gender Re-assignment

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless of gender re-assignment by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Sexual Orientation

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless of sexual orientation by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Religion or Belief

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless of religion or belief by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Age

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless of age by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Pregnancy and Maternity

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless pregnancy and/or maternity by reducing their risk of contracting COVID-19 and associated negative health outcomes.

Marriage and Civil Partnership (applies to a. above only)

The mitigation of IPC risks posed by the Gordon inpatient wards would benefit patients regardless of marriage or civil partnership status by reducing their risk of contracting COVID-19 and associated negative health outcomes.

ADVERSE IMPACT

6. Is there any evidence that the subject of this EHRIA could affect people having a protected characteristic disproportionately, thus leading to an adverse impact? The disproportionate effect or adverse impact might be actually happening or have the potential to happen.

Potential Adverse Impact: Lack of access to local inpatient beds for KCW residents.

Supporting Information:
Various reports, including a recent deep dive from the Getting it Right First Time national team (GIRFT) and NHS Benchmarking, show CNWL has a higher than expected bed base and number of admissions for our population at 25.1 per 100,000 weighted population (19/20 benchmarking data)[7]. After the temporary closure of the Gordon wards, CNWL's bed base remains higher than four neighbouring London trusts and the national average, and the number of Westminster beds remains in line with the benchmarked range for its weighted population accounting for specific characteristics of Westminster including number of foreign nationals, homelessness, and race/ethnicity.

Since the temporary ward closures, the majority (~70%) of Westminster patients admitted to inpatient wards were placed at St Charles Hospital where they are given priority based on its proximity to Westminster. From the height of post-lockdown demand in August, the number of extra contractual referrals (ECRs) declined each month, resulting in a 79% reduction in ECRs from the peak in demand by October. These improvements indicate that community support and transformational shifts are working, as we have not seen a larger adverse impact with fewer beds. When Westminster or K&C patients must be placed outside London, support is provided to meeting continuity principles (https://www.cnwl.nhs.uk/news/reimbursing-patients-and-carers-cost-travel-when-placed-out-area-residence-inpatient-units).

Potential Adverse Impact: Knock-on access impact for K&C patients as more Westminster patients are placed at St Charles Hospital.

Supporting Information:
Since the closure of the Gordon inpatient wards, a large majority (nearly 75%) of K&C patients admitted to inpatient services have been placed at St Charles Hospital. Additionally, Kensington & Chelsea have been consistently operating within, and often below, their allocated bed base since the closure of the Gordon inpatient wards, indicating that the placement of Westminster patients at St Charles have not had a negative impact on K&C residents' ability to access inpatient beds.

Potential Adverse Impact: Reduced access and/or insufficient capacity in community services due to increased demand.

Supporting Information: Community services have sufficient capacity.

CNWL's community mental health model and offer is in line with national requirements. Additionally, significant investment of ~£5.4 million across KCW, with continued increase on the basis of the long-term plan, supports new services including additional staff and additional third-sector/VCSE offers to ensure sufficient capacity within all KCW community services.

[7] NHS Benchmarking Network, Mental Health Benchmarking: Registered Population Report

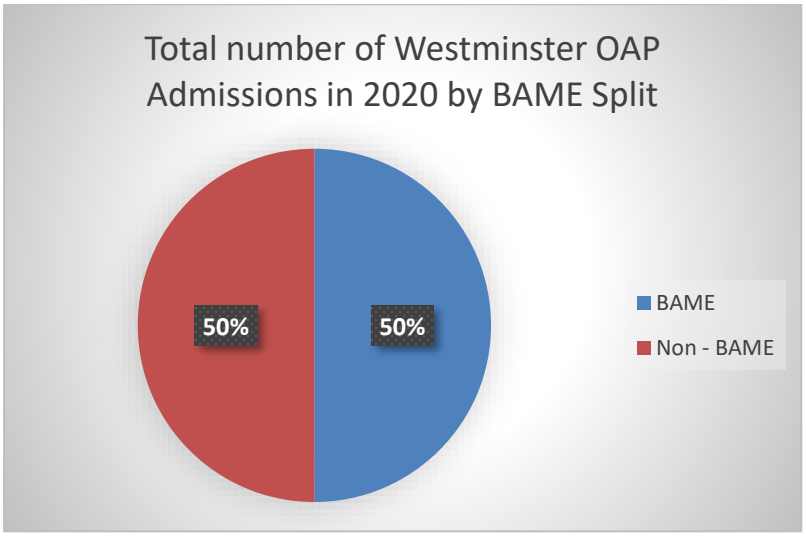
What evidence have you analysed to inform your conclusion? For example, evidence might be from equalities data on patients accessing/not accessing the service, findings from patient or staff surveys, service user complaints, staff grievances, concerns from local or national pressure groups or public concern in the local or national media.

We have analysed and routinely monitor internal patient access and flow data, cross-referencing with protected characteristics and equalities data including data on admissions, readmission, LoS, and OAPs (see above and below). Service user complaints are also logged and reviewed at the borough level as part of standard practice, in addition to weekly whole pathway meetings where data is used to monitor and discuss these issues.

Race / Ethnicity

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of race/ethnicity.

Data supports this, with readmissions declining for Westminster patients from Black and Asian backgrounds in 2020, and out of area placements (OAPs)- as defined by NHS England- occurring equally within Westminster BAME and Non-BAME patients (see graph below). This represents an improvement in OAPs over 2019 for Westminster BAME patients, and brings the metric more in line with borough demographics for ethnicity (44% BAME, 56% White)[3].



Disability

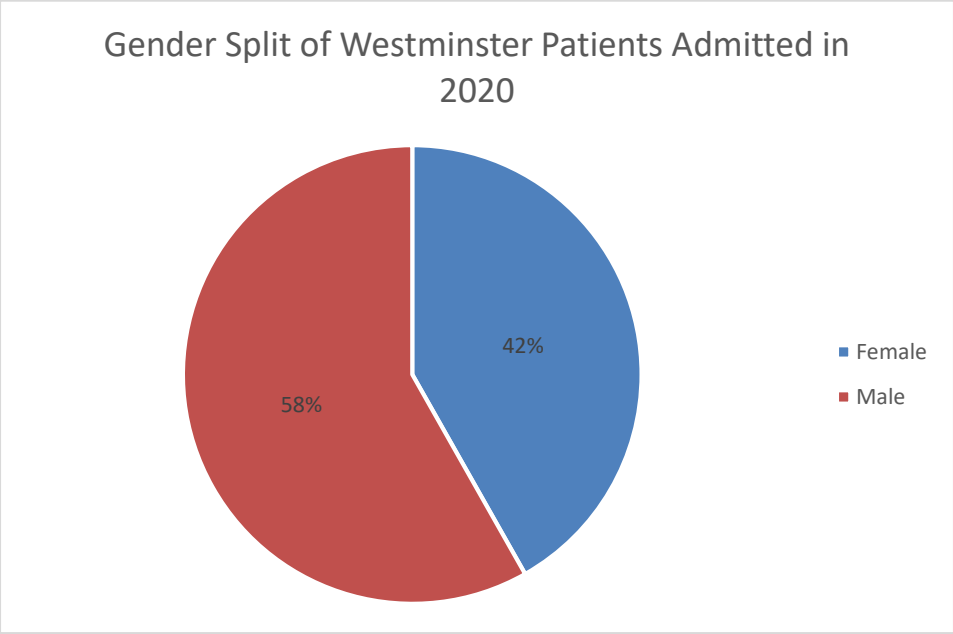
Review & assess any impact on staff with disability – i.e. will a disproportionate number of disabled staff be affected – discuss what will be done to mitigate this fact

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of disability. We look to make appropriate reasonable adjustments for anyone accessing our wards with a disability (e.g. designated rooms for wheelchair users and designated wards for patients with a learning disability).

Gender

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Additionally, the Gordon wards in question were mixed sex wards, meaning there weren't disproportionately more male or female beds removed from the bed base. Therefore, the temporary closure of the wards should impact all populations equally, regardless of gender.

Data supports this, with no large changes in the percentage breakdown of out of area placement (OAP) admissions based on gender for Westminster patients from 2019 to 2020. Additionally, the percentage of admitted Westminster patients who identify as male has reduced to 58% in 2020, bringing it more aligned with the population breakdown in Westminster by gender of 51% male and 49% female (see below).



Gender Re-assignment

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of gender re-assignment.

Sexual Orientation

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of sexual orientation.

Religion or Belief

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of religion or belief. Additionally, there is access to faith and spiritual support where needed for all service users across our inpatient sites.

Age

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Additionally, as the Gordon wards in question were Adult Inpatient wards, and not Older Adult or CAMHS, the size of the bed base for those age populations remains

unchanged. Therefore, the temporary closure of the wards should impact all populations equally, regardless of age.

Pregnancy and Maternity

Patients are admitted to CNWL inpatient wards based on need, and not any demographic or protected characteristic. Therefore, the temporary closure of the wards should impact all populations equally, regardless of pregnancy and maternity.

HUMAN RIGHTS

7a.How does the subject of this EHRIA contribute to encouraging respect for human rights?

See above regarding responding to IPC risks, promoting rights to both health and life, as well as the continuity principles.

7b.Is there any evidence that the subject of this EHRIA is at risk of unlawfully restricting an individual's human rights?

No.

CONSULTATION

8. Have you consulted representatives from groups having protected characteristics (staff, service users, carers, other stakeholders or expert groups) as part of your assessment? Please give details of who have you consulted, the method used, the results of the consultation, how the results have been used and where they have been published.

This EIA is focused on the immediate response CNWL had to undertake in response to the pandemic and during a Level 4 emergency status (as outlined under point 2 of this document). CNWL is planning to publicly consult on the future of the Gordon Hospital once the emergency status is lessened, and will complete further EIA for the long-term closure of the Gordon as part of that consultation work.

The temporary closure of the Gordon Hospital is a significant change which has been forced upon us at considerable pace due to the COVID-19 pandemic and the need to respond rapidly to ensure quality of care for all our patients was maintained within this context. This has inevitably raised challenges and we are keen to listen to and respond to concerns. We are committed to working with our patients and their families, our communities, and our partners to not just monitor and respond to these challenges but also to work collaboratively to plan for the right inpatient service to meet the mental health needs of Westminster residents. Plans to enable this include:

- We have commissioned Healthwatch to set up an advisory Citizen's Panel to help us deliver our inpatient strategy in Westminster, ensuring local engagement, a meaningful consultation, and true co-production. The first meeting will be held in January 2021.

- We would like to have a Roundtable Discussion with Councillors to promote transparency and an open dialogue and we are working with the local authority to facilitate taking this forward.
- We are hosting a series of Stakeholder Engagement Forums to provide space for discussion, open dialogue, and supportive enquiry.
- We have appointed a Community & Partnerships Lead to support partnering with and championing local VCSEs providing services/support to vulnerable and at-risk groups, and partnering with voluntary sector and local authorities to increase alternative forms of provision for those in crisis.

RESPONDING TO ADVERSE IMPACTS / BREACHES IN HUMAN RIGHTS

9. Can any identified adverse impacts relating to Equality or breaches in Human Rights be justified? If they cannot be justified, how do you intend to deal with it?

None identified.

MONITORING

10. Provide information on how you intend to monitor for actual adverse impact in the future

Patient access and flow data is routinely collected and analysed across all boroughs within CNWL to ensure we are continuing to meet the needs of all our patients. This data will continue to be monitored to ensure appropriate provision for KCW, and to ensure there are no unintended adverse impacts on specific populations. Patient complaints are also routinely collected and monitored at the borough level- this practice will continue for KCW.

Equality and Human Rights Impact Assessment Action Plan

The following actions will be undertaken as a result of the Equality and Human Rights Impact Assessment to address identified adverse impact:

Adverse impact identified	Action to be taken	Timescale	Responsible manager
KCW residents' inability to get access to inpatient beds close to home?	To ensure timely discharge for Westminster patients placed in our CNWL beds in the outer London boroughs and transfer to CNWL beds for patients if they are in ECRs, we have appointed additional discharge support including dedicated consultants and a new patient flow lead.	Current	Ela Pathak-Sen, Borough Director and Graham Behr, Borough Clinical Director
KCW community teams lacking sufficient capacity due to increased demand	Additional investment in community offer to increase new service	Ongoing	Graham Behr, Borough Clinical Director with

	offers and capacity of existing services (~£2m in Westminster)		support from transformational teams

To be signed by the manager undertaking the full assessment

Name: Ela Pathak-Sen, Westminster Borough Director

To be countersigned by the Senior Manager, i.e. Service Head, Line Manager, Director, as

Name: Ade Odunlade

Designation: Managing Director, Jameson Division

To be countersigned by the Senior Manager, i.e. Service Head, Line Manager, Director, as

Name: Robyn Doran

Designation: Chief Operating Officer, CNWL

APPENDIX B: Background Detail (outlined at previous board)

Initial Gordon Hospital closure:
In March of 2020, the inpatient wards at the Gordon Hospital were rapidly closed as a key part of CNWL's COVID-19 response. Due to the level 4 emergency status caused by COVID-19 and its impact, as with many frontline partners, CNWL found it necessary to make this decision rapidly and was not able to fully consult with local partners as per normal practice. This need to close one of our inpatient sites was to enable staffing flexibility to cover for sick and isolating staff, to temporarily redeploy staff to meet service pressures, and to offer emergency response alternatives to A&E.

The Gordon Hospital was chosen as the place to close temporarily as part of this response for two key reasons, both linked to quality of care provision. Firstly, we had serious concerns following assessment of its risk for infection prevention and control (IPC), e.g. lack of en-suite bathrooms. This issue regarding IPC risk was a key quality driver for the decision to close the Gordon inpatient wards given the particular vulnerabilities facing those with mental health disorder, both due to being in a confined space (with heightened risk of infection spread) and also the high physical comorbidities in our patient group meaning they are at particular risk of the consequence of infection. Furthermore, The Gordon Hospital is a standalone site (i.e. not co-located with an acute hospital or other services), which raises associated risks of not being able to access rapid physical health support for inpatients, which is particularly important given the risk of COVID-19.

Proposal for the future of the Gordon:
Provided national guidelines surrounding emergency state allow, we aim to consult on the future of the Gordon Hospital next calendar year exploring the option to not reopen the site. We propose keeping the wards closed from this point and throughout the process to enable staffing flexibility for possible future COVID-19 spike(s), in light of the identified IPC risk, and to support the move towards a long-term shift in care to the community to support providing care closer to people's homes.

The key drivers for this approach include:

1. *National and Regional Policy*: Supporting the delivery of the NHS Long Term Plan & Five Year Forward View for Mental Health which centres on local community provision of services to support people at home as well as aligning with standards for providing care in a therapeutic and fit-for-purpose environment for all patients.
2. *Local Vision and Clinical Objectives:* Aligning our estates strategy/portfolio with existing transformation work and priorities to provide care in the least restrictive environments and move care closer to home in the community.
3. *Quality of the Estate:* Ensuring the best provision for our local patients in a therapeutic environment that is fit-for-purpose. The Gordon inpatient wards do not comply with standards around fit-for-purpose physical environments for care, and have posed long-standing challenges including safety issues for patients and the public. The COVID-19 pandemic has heightened the need to urgently address these and explore much more modern approaches to providing inpatient care when needed.

Quality of the Estate

The inpatient wards at the Gordon do not comply with the Royal College of Psychiatrists standards relating to “a physical environment that is fit for purpose”. National guidance for mental health acute inpatient environments[iii] includes outlining the need for:

- En-suite bedrooms
- Direct access to an outdoor garden space
- A welcoming and therapeutic environment with decoration, furnishings and fittings chosen to provide a pleasant atmosphere, minimise institutional features and encourage activity and social interaction
- Spaces (particularly unsupervised spaces e.g. bedrooms and toilets) are designed, constructed and furnished to create a homely atmosphere and limit the opportunities for harm and self-harm
- Ensuring that inpatient environments promote the sexual safety of people using the service

CNWL has worked with our estates colleagues to try and address estate pointers at the Gordon, however the following remain:

- No outside space and not possible to create
- No en-suites to the bedrooms and the infrastructure won’t allow for installation
- Extremely difficult security issues with the building, which will be technically difficult to overcome

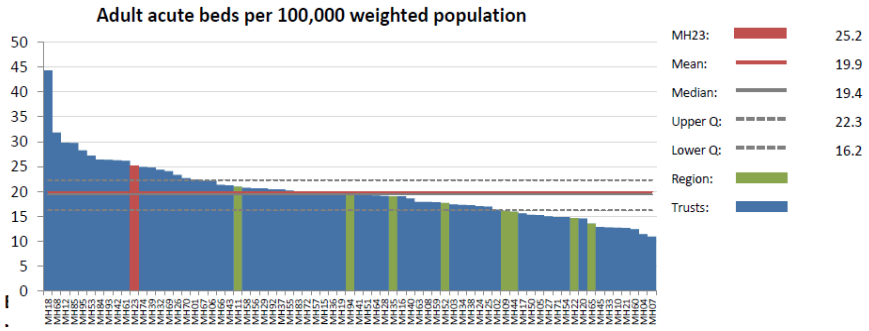
Building is within a conservation area, so fully modernising the facility would not be appropriate in its location– in addition the plant and infrastructure needs a capital investment of approximately £25m, just to bring up adequate H&S standards

Maintaining Within This Bed Base

Right balance of acute to community

We know from various reports, including a recent deep dive from the Getting it Right First Time national team (GIRFT) and NHS Benchmarking, that CNWL has a higher than expected bed base and number of admissions for our population. The graph from 18/19 benchmarking data (NB. 19/20 data not yet available) shows CNWL (MH23) at 25.2 beds per 100,000 weighted population, above the national and regional average. Accounting for the closure of Gordon wards, CNWL remains higher than five neighbouring London trusts and above national average for beds per weighted population and the number of available beds for Westminster remains above the average per weighted population.

Figure 4. Acute beds per 100,000 weighted population



Westminster had a total of 68 allocated beds prior to the closure of the Gordon wards, and are now operating with an allocated bed base of 52 meaning a total reduction of 16 inpatient beds as a result of the ward closures. This new bed base brings Westminster in line with other London trusts and the national average. CNWL is confident this is the appropriate bed base side for Westminster as it was calculated based on national benchmarking, taking into account the unique characteristics of the Westminster population including accommodation and employment status, length of contact with mental health services, ethnicity, and prevalence of foreign nationals.

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[i] *MHA Review report/recommendations*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/763547/Modernising_the_Mental_Health_Act___increasing_choice__reducing_compulsion___summary_version.pdf

[ii] *DHSC Health Building Note 03-01: Adult acute mental health units*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147864/HBN_03-01_Final.pdf